Hennepin County

Hennepin Healthcare System Governance Review

Report provided to the Hennepin County Board of Commissioners

June 30, 2026

Table of contents

Executive summary

On December 11, 2025, the Hennepin County Board of Commissioners approved Resolution 25-0513 directing the County Administrator to conduct a comprehensive review of Hennepin Healthcare System (HHS) governance and to provide a final report by June 30, 2026.

This report fulfills that directive and summarizes the county's evaluation of the existing governance model, benchmarking against comparable systems and insights gathered from more than 50 current and former stakeholders across HHS and the county.

The purpose of this executive summary is to clearly outline the tasks before the county board, the decisions that must be made in both the short- and long-term, and the staff recommendations for next steps.

Tasks before the county board

Short-term decisions (now through January 15, 2027)

The county board must determine its short-term governance direction within the existing statutory structure, including:

- The county's desired financial relationship with HHS in the near term.
- The degree of mission alignment and influence the county intends to exercise over HHS operations now.
- The level of oversight and reserved powers the county board requires based on that financial relationship and that degree of mission alignment.

These short-term decisions must be made before January 15, 2027, when the county is required to reconstitute the HHS board and transition governance to the newly-appointed board.

Long-term decisions (2026-2027 and beyond)

The county board must also begin considering broader questions about the county's future role and relationship with HHS, including:

- Whether the current subsidiary governance model remains a viable and effective model.
- What level of oversight, responsibility, and financial support the county intends to maintain over time.
- Whether alternative structures — greater separation, greater integration, more state involvement, or other public governance models — may better position HHS for long-term stability.

These long-term decisions will shape the county's participation in the state advisory task force that was created by the 2026 Minnesota Legislature to examine the future of HHS ownership, governance, and financing. The state advisory task force will include representatives from Hennepin County and HHS.

Summary of staff recommendations

Short-term (Q3 2026-Q1 2027)

Staff recommend that the county board prioritize decisions needed by January 15, 2027, within the current statutory framework, including:

- Providing direction on updates to governance documents (bylaws, operating and funding agreement, lease, shared services agreement).
- Setting expectations for HHS board size, qualifications, and compensation, within existing statutory limits.
- Advancing the HHS board recruitment process, in collaboration with an outside consultant.
- Approving updated governance documents and completing board candidate vetting.
- Appointing the reconstituted HHS board by January 15, 2027, and transitioning governance to that board with a plan for onboarding, engagement, and alignment.

Long-term (2026-2027)

Staff also recommend that the county board begin work in 2026-2027 on developing its long-term vision for the county role and relationship with HHS:

- Engaging with the state advisory task force to shape long-term ownership, governance and funding options.
- Adopting a 2027 legislative platform aligned with the county's long-term vision for HHS.
- Receiving ongoing briefings as state-level recommendations evolve.

How to use this report

Following this executive summary, this report is organized into four sections:

- **Preliminary framework:** Distinguishes the short-term priority decisions about how to navigate the roles and relationship of the county and HHS under current statutory structure, from the long-term decisions about the county board's vision for the future roles and relationship of the county with HHS.
- **Key governance features:** For each feature, details the current state (statutes or bylaws, etc.), provides information on comparable systems (if available), and includes themes and summary feedback from stakeholder interviews.
- **Other learnings:** Shares feedback and ideas from stakeholders on areas of needed transformation, opportunities to improve transparency and alignment, and ways to improve engagement.
- **Recommendations:** Provides a detailed, quarter-by-quarter implementation timeline for the county board's next steps.

Background

The Hennepin County Board of Commissioners directed that the comprehensive review of Hennepin Healthcare System (HHS) governance may identify:

- Aspects of past governance that have been successful;
- Aspects of past governance that have not been successful;
- Areas of needed transformation;
- Opportunities for improving transparency and alignment with the county; and
- Ways to improve engagement with community, workforce, patients/clients, leadership, and elected officials.

As outlined in the March 2026 progress report, the governance review included three activities:

1. Evaluate the current state of HHS governance (statutes, bylaws, agreements)
2. Evaluate governance at comparable hospital systems (public, safety-net, teaching)
3. Collect input and insights from key current and past stakeholders (via interviews)

County staff provided several interim updates to the county board regarding these activities:

- **April 18, 2026:** Item #1 above, staff's evaluation of current governance features.
- **April 23, 2026:** Item #2 above, staff's evaluation of governance at comparable systems. The county board also had a public briefing on April 23 with updates related to the governance review and legislative activities related to HHS.
- **May 29, 2026:** Item #2 above, staff's evaluation of additional information on comparable systems, plus update on legislative changes related to HHS governance.

This final report includes summaries of the feedback provided during dozens of stakeholder interviews (Item #3 above), and organizes all of the information collected during this governance review according to the topics identified in Resolution 25-0513: Key Governance Features (i.e., aspects of past governance that have been successful or not successful) and Other Learnings (i.e., areas of needed transformation, opportunities to improve transparency and alignment with the county, ways to improve engagement with various stakeholders).

Interviews

As part of this governance review, staff interviewed more than 50 individuals, hearing a range of perspectives from current and past staff and board members from both the county and HHS. Some interviewees were involved in the original creation of HHS as a subsidiary (~2006-2014), some were involved in the governance model during a middle era of transition (~2015-2019), and some were involved more recently (2020-present).

The feedback from these interviews has been synthesized into themes and is not attributed to specific individuals. The feedback often included conflicting points of view, and the full range is offered here to provide the county board with the diversity of perspectives, *not to specifically endorse or reject any particular viewpoint*. Many themes and ideas were relevant to more than one issue and so may be repeated in different sections of this report.

We express our gratitude to everyone who participated in an interview for their time, their thoughtful contributions, and their candor. A list of interviewees is included as an attachment to this report.

Report overview

This final report is primarily organized around the language in the county board's resolution. Below is a brief report overview; also see the previous table of contents.

Preliminary framework: The opening section of this report lays out a preliminary framework for key issues and decisions facing the county board. It highlights short-term priority decisions required to guide the work of the county and HHS in the near term. It distinguishes the issues that will require a long-term view about the future roles and relationship of the county with HHS (if any), including choices that would require state partnership or legislative change.

Key governance features: The main section of this report centers on key governance features in the current model (i.e., HHS as a subsidiary of the county, with county reserved powers and county funding support). These sections provide information on aspects of past HHS governance that have been successful, or not successful, based on the feedback received during stakeholder interviews. For each key governance feature, we have included details on the current state (statute or bylaws, etc.), as well as information on comparable systems (if available). We also have included themes and summaries of feedback we received during stakeholder interviews.

This report includes information on the following key governance features:

- HHS board qualifications
- HHS board size
- HHS board compensation
- HHS board nominations and appointments
- Commissioners on HHS board
- CEO selection and role
- Exemptions from public entity laws
- General reserved powers
- Legal counsel and lobbying
- Lease agreement
- Health services and plan
- Uncompensated care formula
- Financial backstop
- County board briefings

Other learnings: The secondary section of this report includes summary feedback from the interviews on the other topics outlined in the county board resolution:

- Areas of needed transformation: During the interviews, several themes for transformation emerged, including roles and responsibilities, HHS board education and onboarding, future briefings, and accountability.

- Opportunities for improving transparency and alignment with the county: During the interviews, stakeholders offered a range of ideas for improving transparency and alignment.
- Ways to improve engagement with community, workforce, patients/clients, leadership, and elected officials: During the interviews, stakeholders offered a range of ideas for improving engagement.

Recommendations: The final section of this report includes a staff recommendation for county board activities, organized in a high-level timeline. In general, the staff recommendation focuses on short-term priority items:

- Q3 2026
    - County board provides preliminary direction on updates to county-HHS governance documents, including bylaws, operating and funding agreement, etc.
    - County board provides preliminary direction on HHS board size, qualifications, and compensation.
    - HHS board recruitment begins.
- Q4 2026
    - County board takes action to approve updates to county-HHS governance documents.
    - County board completes vetting of HHS board candidates, with support from staff and outside consultant.
    - County board provides direction on strategy and plan for engagement and alignment with HHS.
- Q1 2027
    - County board appoints reconstituted HHS board by January 15.
    - County board transitions governance to HHS board by January 15.
    - County board implements its plan for engagement and alignment, with support from staff.

More detail is provided in the Recommendations section. The timeline also includes suggested county board activities for developing a long-term vision for the county's future role with HHS.

Attachments: As references, we have included several attachments at the end of this report:

- Hennepin County Board Resolution 25-0513
- Governance Review Interviewees
- Other Systems Tables

Preliminary framework

This section provides a preliminary framework for key issues and decisions facing the county board. It highlights the short-term decisions required to guide the work of the county and HHS in the near-term, under the existing statutory structure and the deadline to transition governance back to the reconstituted HHS board by January 2027. It distinguishes the issues that will require the county board to consider a longer-term view of the county's role and relationship with HHS (if any), since those choices may require state partnership or legislative change.

Why this framework matters

The county board must make both immediate decisions within the current statutory model and begin shaping a long-term vision for the county's future relationship with HHS. Interview feedback made clear that there is no single consensus on the ideal governance model; instead, there are tradeoffs, risks, and opportunities that require board deliberation and judgment.

At the same time, the county board's authority is not absolute. Much of the current governance structure is defined in statute. Some features can be changed through county board actions and county-HHS agreements (bylaws, lease, etc.); others cannot be changed without new state law. This reality requires a dual-track approach: one track focused on decisions needed now and another focused on strategic questions for the future.

Decisions, direction, and vision

Short-term decisions (within current statutory model)

Before the HHS board is reconstituted in January 2027, the county board must determine the short-term governance direction for the organization.

These decisions fall into three general categories: financial relationship (short-term), mission relationship (short-term), and oversight and reserved powers (short-term).

Financial relationship (short-term)

The county board must determine:

- What level of financial support the county will provide in the near term, including the county's financial exposure and risk tolerance.
- How the financial relationship should influence oversight and reserved powers.

Mission relationship (short-term)

The county board also must clarify:

- The degree of county influence over HHS's mission, priorities, and strategic direction.
- How the mission relationship and alignment should influence oversight and reserved powers.

Oversight and reserved powers (short-term)

Once the county board has made decisions on the financial relationship as well as mission relationship and alignment, the county board must determine:

- Which decisions the county board will retain vs. what will be delegated to the HHS board.
- Which oversight and reserved powers are needed in the short-term.
- Whether the county's reserved powers strike the right balance — comparing oversight and reserved powers against the county's role, risk, or responsibility for HHS's mission and financial sustainability.

These choices will shape immediate expectations for the next HHS board and any changes or updates to accompanying governance documents (bylaws, funding agreement, lease, etc.).

Even within the existing statutory structure, the county board has a crucial opportunity to refresh and reconsider the county-HHS relationship — on mission, funding, and the roles, responsibilities, and limits for each board.

Short-term direction drives operational updates

Once the county board provides direction on financial, mission, and oversight expectations, staff can translate that direction into updates to core governance documents, including:

- **Bylaws** (e.g., how the HHS board conducts itself; any constraints imposed by the county related to HHS board qualifications or nominations; HHS committee structures or membership and responsibilities; delegations to the HHS CEO, etc.).
- **Operating and funding agreement** (any county funding support, any reporting expectations).
- **Lease agreement** (asset preservation, maintenance, capital considerations).
- **Shared services agreement** (services provided, required, and funded).

These documents operationalize the county board's short-term governance decisions and form the foundation upon which the new HHS board will begin its work.

Long-term vision (potentially beyond current statutory limits)

While short-term decisions must be made within existing statutes, the county board also must begin considering broader questions about the county's long-term roles and relationship with HHS. Interview themes reveal widely varied perspectives but center on a few foundational questions.

What is HHS's core identity, or what should it be?

- Is HHS primarily a safety-net hospital? If yes, is public ownership or public funding necessary to maintain that mission?
- Is HHS primarily a teaching hospital? If yes, is public ownership or public funding necessary to maintain that mission?
- Is HHS primarily a private nonprofit that needs to compete in the market? If yes, is public ownership or public funding appropriate?

Is the current model still viable and effective?

- Should HHS continue as a public corporation that is a subsidiary of the county?
- If the model is retained, what refinements are needed for it to function more effectively?

Some interviewees believe the subsidiary model can still work with shared understanding of roles, responsibilities, and any expectations around engagement and alignment. Others believe the two-tier board structure is too complex or has more downside than benefit.

Should the model evolve into something different?

Stakeholder ideas spanned a wide spectrum of other governance models, including:

- Full county ownership and operation as a public hospital, like the early 2000s
- A revised county-subsidiary model with updated roles and boundaries
- Greater state involvement or co-governance
- A more integrated relationship with a university or another government entity/entities
- A more independent public entity (e.g., hospital district or authority)
- A more private sector-like governance model, such as a nonprofit board, with county board oversight or reserved powers either reduced or eliminated
- Mergers, joint ventures, or partnership structures
- Rebranding or renaming to reflect regional service
- Transferring clinics to Federally Qualified Health Center (FQHC) model
- Increasing autonomy (including banking, lobbying, and legal functions)

In any model, what should the county's long-term financial role be?

- Should the county continue providing financial support?
- If so: How much, for what purposes, and through what mechanisms?
- If not: What alternative funding sources would be necessary, and how would that change HHS's autonomy or the county's oversight and reserved powers?

Long-term financial decisions are a key driver for long-term governance structure or relationship.

In any model, what roles, responsibility, or reserved powers should the county maintain (if any)?

- How much oversight is appropriate relative to financial risk? Relative to HHS's identity, mission, public funding, etc.?
- Should oversight decrease if county support decreases or increase if support remains high?

Some stakeholders suggested that reducing county risk could justify reducing the county's role and reserved powers. Others argued that ongoing public safety-net responsibilities require robust oversight. Others emphasized reserved powers as key accountability for any level of public funding support, since the HHS board is not accountable to residents, taxpayers, and voters.

These questions represent philosophical choices about identity, mission, and accountability, not immediate decisions.

Long-term vision connects to state-level work

A strategic long-term vision is essential as the county participates in the upcoming state advisory task force. The state advisory task force will examine the future of HHS ownership, governance, and financing. Having a shared county board vision of the county's desired role, preferred governance model, and financial relationship (if any) will position the county to influence that work constructively.

County board decisions needed

Short-term (now-January 2027)

- The county's near-term roles and relationship with HHS
- The county's expectations related to HHS mission and financial support
- Which decisions belong to the county board vs. the HHS board
- Which oversight and reserved powers are needed given near-term roles and relationship
- Updates to foundational governance documents
- A framework that sets up the newly-reconstituted HHS board for success through shared understanding, alignment, and engagement

Long-term (2026-2027 and beyond)

- HHS's core identity and purpose
- Whether the current subsidiary model remains appropriate
- Whether a different governance model better supports mission and sustainability
- The county's long-term financial and oversight role
- How the county wants to position itself in state-level conversations about HHS's future

Key governance features

HHS board qualifications

Current state

- **Minnesota Statutes 383B.903:** This statute was recently amended to revise the required qualifications for HHS board members. In particular, the statute now requires that at least 75% of the board's members (other than commissioners) must have expertise in hospital administration, finance, business management, law, or health equity, or have other experience relevant to the administration of a health system and safety-net hospital, with a preference for members with experience working in an urban setting with diverse cultural communities; up to 25% of the board's members (other than commissioners) may represent urban, cultural, and ethnic perspectives of the population served, and the patient or consumer perspective.
- **Tenth Amended Bylaws Section 4.3:** Directors shall possess a high degree of experience and knowledge in relevant fields and possess a high degree of interest in the Corporation and support for its mission. Directors shall be appointed based in part on the objective of ensuring that the Corporation includes diverse and beneficial perspectives and experience including, but not limited to, those of medical or other health professionals, urban, cultural and ethnic perspectives of the population served by the Corporation, business management, law, finance, health sector employees, public health, serving the uninsured, health professional training, and the patient or consumer perspective.

Other systems

Qualifications vary widely between other systems analyzed for this report. Requirements range from broad, general qualifications (e.g., Jackson Memorial in **Miami-Dade, FL**: "outstanding reputation of integrity, responsibility, and commitment to serving the community") to more comprehensive qualifications (e.g., **Alameda, CA**, which includes both general qualifications with corresponding desirable skills, and specific qualifications with a 13-point list of desirable skills).

See more in Attachments: Other Systems Tables, under "Qualifications"

Key questions

I. What is the role of the HHS board?

II. What are the responsibilities of the HHS board?

III. What experience would be most helpful for the HHS board to execute their role and responsibilities?

   a. Past employment experience?

      i. At what level? (e.g., executive, leadership)

   b. Past board experience?

IV. What skills would be most helpful for the HHS board to execute their role and responsibilities?

V. What is the appropriate balance/mix of desired experience, skills, and diversity on the HHS board?

   a. Should this mix be wholly represented as voting membership? Are there other ways to include these perspectives (e.g., staff to the board, committee members, non-voting members, etc.)?

VI. How will desired experience, skills, and diversity be determined?

   a. How will the preferred mix of board qualifications be documented and implemented (e.g., through an ongoing and updated board matrix)?

VII. Should current HHS employees be on the board?

Summary feedback from interviews

High-level themes

- Interviewees frequently mentioned the HHS board needs to be a highly professional board and should be trusted with HHS operations.
- Commissioners are not necessarily subject matter experts; the HHS board should have hospital-specific expertise and some members with experience in running the day-to-day operations of a hospital.
- Also, need a board that is able to leverage their expertise to hold leadership accountable.
- One interviewee said if roles and responsibilities are not addressed, then competencies will not matter.
- The HHS board was not asking the hard questions or solving the hard problems; those just got asked of the county instead.

Mission/public/safety-net/government

- Understanding/connecting to/passion for HHS's identity is key.
  - Identity: public, safety-net, teaching, trauma, governmental entity.
  - Board members should embrace the HHS identity and not chase other identities.
  - HHS is in a competitive environment, but the hospital is in a unique position within that environment, which should be recognized and embraced.
- Public sector (government) experience is important.
  - At the executive/administrative (decision-making) level (e.g., mayors, city managers).
  - State/federal agency experience and connections could also be helpful, especially considering new state funding in the picture.
  - Need to understand how decisions will be scrutinized by community/public.
  - Must have some political savvy and experience with public scrutiny.

    - Could include social services/behavioral health understanding given relationship to the county.
    - Not someone in a current public/elected position.
    - Government experience is key — in some ways, HHS works more like a government than a private hospital.
- Public vs. private hospital experience:
    - Be careful of too much private sector mindset — the HHS board needs to understand the public nature of the hospital and the relationship with the county, as well as its employee unions.

General qualifications (job experience)

- Many mentioned that:
    - executive level experience is preferable.
    - healthcare-specific experience, regardless of specialty, is important. Even with excellent appointments, it can be burdensome for other board members to educate non-healthcare appointees on health-sector specifics.
    - the size of the organization should be considered; mostly came up in the context of budgets (e.g., an executive who oversaw a $5 million budget would not have financial experience as relevant as an executive who had a $1 billion budget).
    - the board should be heavy hitters, very high bar, super qualified.
- Some mentions that:
    - qualifications depend on what the governance structure and the roles therein end up looking like; could require re-evaluation.
    - the county board needs to clearly delineate what they want to see in candidates; past lack of clarity has led to complications.
    - the qualification list should not be overly prescriptive, particularly considering how quickly the health landscape is changing.
    - a diverse makeup across all expertise will be important.
- One interviewee noted the importance of balance in board makeup between fully independent voices and those associated with HHS (electeds, leadership, employees), cautioning against too many HHS-associated voices for objectivity.
- One interviewee noted that hospitals are some of the most tightly regulated entities in the country and understanding that landscape should be pre-requisite.
- A few interviewees said, in the case of comparable public safety-net hospital expertise, it may make more sense to recruit elsewhere; candidates do not necessarily have to be from here.

Specific job sectors mentioned

- Health Administration
- Hospital Governance
- Operations
- Compliance
- Quality and Safety
- Finance
    - Finance background paired with government experience/familiarity is preferable.
    - Presence is key for the CFO to have sounding board and check.
- Tech and Innovation
    - Consider AI impact and influence.
- Care Delivery
- Legal
- Risk
- Academia (e.g., national expertise)
- Community organizations (health-specific)
    - Nonprofit experience cannot replace health experience because 501c3s have such different regulatory schemes, but helpful to have health nonprofit experience relating to social determinants of health (SDOH).
- Business
- Management
- Philanthropy/Investment
- Facilities (e.g., campus planning work)
- Social Services
- Equity (non-clinical, SDOH experience mentioned)
- Program development
- Policy
    - Responses were focused on insurance and federal health policy due to HHS's payor mix, revenue, and the rapidly changing health policy landscape.
- Health-adjacent sectors like marketing, supply chain.

Community/Community Advisory Boards (CABs)

- Frequent mentions of how critical community voices/values are to have on the board, as well as community ties.
- Frequent mentions that it is important to have community representation but also maintain a professional board; community representatives also should have professional health experience.

- Consider whether their presence on the board is bringing solely a community perspective, or a community perspective paired with relevant healthcare expertise. If not from healthcare sector, could be on Community Advisory Board (CAB) instead.
- Some interviewees see CABs as a good model for community/patient input on the next iteration of the board.
- Commissioners provide the community point of view on the board.
- Community voices should not be overrepresented if it impacts overall competency.
- Concern that inexperienced community members could become too friendly with HHS leadership, presenting a risk to overall board competence.
- Past iterations of the HHS board, and other county entities, have utilized CABs as a successful model.
- Mentions that patient representatives should have a voice (e.g., those who are called on for press conferences), maybe neighborhood association representatives.
- Alternative: Some think the HHS board should be majority-community, but with constrained authority. Federally Qualified Health Centers (FQHCs) like NorthPoint are mandated to have 51% community/patient presence on their boards.

Miscellaneous qualities (non-job experience)

- Political savvy/experience (connections/network/skillset)
- Backbone to make hard decisions
- Community ties should be prerequisite
- Entrepreneurship
- Curious, eager to learn and address big picture issues
- Astute
- Must be able to ask hard questions and hold HHS leaders accountable
- Good listener
- Not quick to judgment, thoughtful
- (Chair especially) Good mediator, facilitator, negotiation skills; aware/conscientious about potential power dynamics at play in group
- Respect
- Long-term strategic thinking
    - This next iteration of the board especially will need to be able to pivot from survival to strategy; not just responsive to acute crises but also future planning
- Influence
- Preparedness
- Understand role of HHS Executive Leadership Team
- Must have credibility with the county board
- Must be visible and engaged

- Strong understanding of the role (public/private, two boards)
- Enthusiasm about the work being done at HHS
- Must understand/appreciate role of unions and not be opposed to labor perspective (philosophical alignment)
- Prior relationship with county board helpful
- Especially gifted with presenting information clearly to a general audience
- Ego can handle there being another decision-making body at play; bring expertise but are not threatened by disagreements, can have open dialogue
- Understand board governance specifically and know board best practices, regulations, and standards
- Payor side experience
- Objectivity
- Need to be a national-draw board, high prestige — will help with development and advancement work, could also help make the board more desirable
- Private sector (health and non-health sector) experience — to be able to challenge HHS administration and providers
- Geographic distribution

Recruitment

Matrix

HHS has used a qualifications matrix to consider new potential nominees and evaluate what was needed on the board. This practice has varied considerably over time.

- The earlier HHS board utilized a qualifications matrix to consider new potential nominees. It was evaluated at annual retreats, then the HHS board handled board recruitment using that matrix as the framework.
- Seems like it was not used in all eras, and/or changed significantly through the years.
- A good matrix is key; it ensures that expertise bases were covered (e.g., a finance person leaves, they would be replaced by a finance person).
- It has the potential for over-reliance; if an applicant's qualities were not included on the matrix, they would not be considered, even if they could provide needed expertise.
- Use of the matrix got complicated when the county board started pressuring for measures not represented on the matrix.
- NorthPoint board has a matrix that guides who it recruits; works very well.
- Requires defining responsibility for creating and managing the qualifications matrix and identifying effective ways to tap into available networks.

Other process considerations

- In the past, board members did trial runs, which was a good way to determine whether the applicant understood the role of the board and how they might act in certain situations.
- During interviews, various example scenarios were given to applicants.
- Applicants should be screened for board process metrics and their dedication to them (e.g., agendas, votes, procedures).
- Must understand that they are not an independent board structurally; accepting this should be a pre-requisite.
- Must screen for conflicts of interest, avoid competitors.

Employee representation

Labor (front-line, patient-facing staff)

Varied responses: there should be HHS labor representation on the board, should be labor representation but not be current HHS employees, should not be any HHS labor representation on the board. Interest in building labor into CAB structure or committees.

Should be there

- HHS labor employees serving on HHS board
    - If physicians are represented, labor should be, too.
    - If there is HHS labor representation, it needs to be someone who centers the role, not the individual (because the individual can change).
    - If someone is too close to an issue, it is not as helpful.
- Non-HHS labor representative serving on the board
    - Does not work well to have current labor, should be from elsewhere.
    - Should be someone in healthcare field, but not HHS employee.
    - Can be tricky position, each union has different perspectives; difficult to parse what feedback is structural, actionable issues vs. personal.

Should not be there

- Not appropriate for any current employee to serve on the board; could be former employee.
- Puts them in a tough spot; prefer to engage labor through advisory board or committees.
- Helpful feedback but more focused on operations, which is not what the HHS board should be focused on.
- The purpose of HHS is not as an employer, but to provide service to the community. The board needs to keep the public mission in mind, to stay focused on the constituent group of the community it serves.

- Difficult for the HHS board to play its oversight role on HHS administration or providers when they are on the board.

Physicians

- No employees should serve on the board.
- If medical doctors (MDs) are there, they should be appointed by the physicians organization and limited to MDs who have admin/financial responsibility (e.g., department heads).
- Credentialed providers can provide a deeper understanding of the care model; non-HHS employee clinician/physician expertise would be helpful.
- MDs have been overrepresented and have had outsized influence on the board.
- Outsized power and influence make it important to keep them at the table; historically, has been counterproductive to push them away.

Prior board experience

- Prior board service is a plus, but not necessarily requirement.
- Prior board service should be a prerequisite.
- If no prior board service, should at least be someone in a management position who interacted frequently with a board.
- Necessary to understand the dynamics.
- Committees are an opportunity to provide experience to non-members.

HHS board size

Current state

- **Minnesota Statutes 383B.903:** The HHS board will consist of 11 to 15 directors, two of whom are current county commissioners.
- **Tenth Amended Bylaws Section 4.3:** The Board of Directors shall consist of between eleven (11) and fifteen (15) Directors. The Board of Directors shall include two (2) County Commissioners currently serving on the County Board, the Chief Executive Officer of the Corporation and the President of the HHS Medical Staff.

Other systems

The other systems analyzed for this report have governing body sizes between 5 and 15 voting members, with the majority being between 11 and 13.

- **Santa Clara, CA:** Santa Clara's 5-member county board is the governing body of the health system.
- **Miami-Dade, FL:** In statute, Miami-Dade's governing body can be 5-7 members but is regularly 7.
- **Westchester, NY:** Westchester Medical Center's governing body is made up of 19 members, though only 15 are voting members. The non-voting members include the CEO ex officio, and one appointment reserved for each: the county executive, majority leader of the county board, and minority leader of the county board.
- *See more in Attachments: Other Systems Tables, under "Size"*

Key questions

I. What is the purpose of the board?

II. How many voting members are required to serve that purpose?

III. Are there parts of the purpose that could be served without voting membership?

   a. Non-voting member seats?

   b. Committee seats?

   c. Advisory boards?

Summary feedback from interviews

Appropriate size

15 is too large

- Most interviewees who thought 15 is too large coalesced around 9-13 members, most commonly 11, stating that membership over 11 gets unwieldy.

- Especially during times of high turnover, it can be cumbersome to get new appointees up to speed with 15 seats.
- There is less engagement from board members at 15 people. It dilutes responsibility and qualifications.
- The board needs to be small enough for meaningful relationship building with staff.
- Boards too large create a two-tier structure within the board and increase tension among members.

15 is the appropriate size

- Smaller than 15 would not allow for adequate diversity of opinion.
- Big enough to have a well-rounded group and small enough to get to know peers.
- Big enough to have discrete subcommittees and some separation between them.
- It is on the larger side, but would be difficult to get much smaller, and any larger would result in decreased engagement.

15 is too small

- Alternative view: The board should be at least 21 members with at least 3-4 community advisory boards (CABs). The full board would need an executive committee at this size.
- A bigger number would allow more breadth of experience.

General considerations

- Balance is everything.
- A certain size is required to allow for geographic representation, diversity of views, and political angles.
- The purpose of the HHS board needs to be decided before the size. If the purpose is for high-level, broad strategy then a smaller, tighter group is preferable. If the purpose is to be a representative body with all expertise bases covered, then bigger would be better.
- Flexibility (i.e., 11-15) is good. If someone leaves the board suddenly, flexibility means the appointment doesn't have to be rushed and potentially end up with a less qualified appointee joining.
- The CEO should not have a vote; they are the HHS board's one and only employee; others disagreed and thought CEO should be a voting member.

Committee considerations

- The committee structure — and who gets to be on which committees — should be taken into account with the size.
- Committee structure is another way to build in broader representation without growing the voting member body.
- The structure and cadence of committees should take into account the burden on HHS management.

HHS board compensation

Current state

- **Minnesota Statutes 383B.905:** No statutory requirement for or against compensation, but serving without compensation provides some protection against civil liability.
- **Tenth Amended Bylaws Section 4.5:** HHS board members are not compensated for their service. Expenses for reasonable costs may be advanced or reimbursed.

Other systems

None of the other systems analyzed for this report have compensated boards, except for **Alameda, CA,** whose bylaws allow for an optional small stipend.

See more in Attachments: Other Systems Tables, under "Compensation"

Key question

I. Should HHS board members be compensated?

Summary feedback from interviews

No compensation

Responses opposed to compensating the HHS board fell into three major categories: HHS's mission and status as a public institution, the amount of compensation being prohibitive/impractical, and experience (either interviewee's past personal board experience or their past personal experience of the HHS board).

Mission

- It's the mission of the institution that drives people to want to be on the HHS board; compensation is neither a draw nor a deterrent.
- The HHS board needs people who are passionate about healthcare who are doing it as a public service.
- As public institution, board membership shouldn't be a vehicle to make money.
- HHS is a different type of hospital than neighboring systems; there is no need to match them or the private sector in this way.

Amount

- If the board were compensated, the compensation would have to be enough to pay as if it were a part-time job, which is not practical financially.
- At a time of financial distress, especially when the conversation around that financial distress is public, paying the HHS board would be tone deaf. If HHS cannot pay its own bills, it should not pay the board.

- If HHS had a professional board with highly paid executives as members, the relatively small paycheck earned from being on the board would not make a difference to them.
- Salaries of HHS and county employees being public has been a fraught topic; paying the board could be another headache.

Experience

- Not being compensated is not a barrier at all.
- Of interviewees with other board experience, many noted that they have never served on paid boards.
- Expenses should be covered but anything more is not a motivator for membership.
- HHS has had amazing board members over the years, and none of them were paid.

Compensation

Responses in favor of compensating the board fell into two major categories: market competitiveness and incentive.

Market competitiveness

- The HHS board needs to be paid because other Minnesota metro health systems compensate their board members; the amount should match neighboring systems.
- Paying the board will encourage nominees with higher credentials on a competency/skills basis. These competencies/skills are needed for a board to be able to navigate challenging situations.
- The pay will make people take it more seriously.

Incentive

- The HHS board needs national experts for visibility and members who want to be part of creating and implementing a big vision; compensation would help with both.
- There is value in someone providing their time and expertise. Compensation could be a draw to facilitate finding passionate people. They should be compensated to a level that is not insulting to a professional.

Other considerations

- Compensation should be reserved for community representatives serving on the board, not for high-level executives.
- Paying expenses and small stipends is OK, but it should not be a lot.

HHS board nominations and appointments

Current state

- **Minnesota Statutes 383B.903:** The county board appoints HHS board members by slate; the slate is nominated by a committee of the HHS board.
- **Tenth Amended Bylaws Section 7.6:** The slate shall be nominated by the Governance Committee of the HHS Board.

Other systems

None of the other systems analyzed for this report have self-perpetuating boards, and none of them nominate candidates by slate.

Each other system analyzed for this report has a different process for nominating board candidates. The following list includes the continuum of methods:

1. Community-based nominating committees
2. Individual appointments/delegates per elected
3. Executive nominations
4. Ex officio seats
5. A hybrid approach of options 1-4 above

See more in Attachments: Other Systems Tables, under "Nominations/Appointments Process"

Key questions

I. How much involvement should the county board have in the nominations process?
II. What should the process be?
    a. Self-perpetuating?
    b. Slate?
III. Should the level of involvement change based on changes in governance? How?

Summary feedback from interviews

Self-perpetuating board

Pros of self-perpetuating

- Typical of other nonprofit boards.
- Helpful to give HHS more control of the process to insulate the HHS board from county board politics, though this also carries risk.
- Provides protection for the county board should they be unfamiliar with a nominee.
- A few expressed HHS board is there to help the CEO, so HHS should be able to cultivate its own slate — not be captive to the county board's agenda.

Cons of self-perpetuating

Trust/visibility/accountability

- It weakens the HHS board's connection to the county board.
- Very difficult for the county board to know what is going on; impairs the county's ability to maintain accountability.
- Some mentioned that the subsidiary structure works best when the county board trusts appointees and can let them do their work; self-perpetuation results in less trust and visibility.
- A self-perpetuating board that is spending public dollars needs some accountability to the public — available path is through the county board or could be through the legislature in future iterations.

Power imbalance

- On a self-perpetuating board, existing members choose from their own small networks, and the overall balance of board expertise/representation can get lost.
- When HHS senior staff have undue influence on recruitment and then nomination, accountability for the HHS board is diluted (because it lands on executives).
- Creates an imbalance in board makeup by concentrating power in the HHS board/CEO, making it difficult for the HHS board to play its oversight role on HHS admin and providers.
- A self-nominating board may not have an effective cross-check to include a variety of viewpoints; if the CEO or executive leadership team have an outsized influence in recruiting and vetting candidates, that can impact the board's ability to be independent and hold leadership accountable.
- Nominations are exceptionally important decisions, but sometimes the first time the HHS board became aware of new nomination slates was at the vote.
- Some concerns that the nomination process seemed political and was vulnerable to political pressure.

Time spent

- HHS board spent a huge amount of time on the process for recruiting and vetting board candidates; that left a lot less time for substantive work and issues.
- Probably unfair to ask an uncompensated/volunteer board to spend time on this, plus they may recruit only from their own network.
- Seemed like a rushed process. The timing overlapped with the annual budget approval timeline, so there was not much time for careful, thoughtful nominee consideration.

Changes over time

- Seemed like nominees were decreasingly considered for which gaps they would be filling, how they would fit into the whole, and what role they would play.
- Some mentioned that the first board was so effective because they were chosen by the county board, and the self-perpetuating board is what allowed the efficacy to deteriorate.
- Sometimes boards can start great and then can drift when people are selected after first round (for followership rather than leadership).

Slate

Pros of slate

- Insulates the county board in a way.
- Can be important if the HHS board is trying to balance a few seats.
- Avoids making the nominations a popularity contest (e.g., who received most votes to be appointed, who was unanimously appointed vs. split vote).
- Creates a mutual sense of HHS and the county being in it together.

Cons of slate

- Really impaired public accountability, because those representing the public — the county board — had very little say.
- Constrained the county board's ability to course correct because they had no meaningful authority to remove/not appoint individual members; the only available option was removal of the entire board.
- Shifts too much power to the HHS board/CEO — they can put a disfavored candidate on a slate with a favored candidate to get them through; makes county board rejection too hard a pill to swallow.
- An attempt to shield from politics, but in effect, made the county board a rubber stamp.
- No point in commissioners being involved at all if it is a slate. The county board should approve each one, or be involved in nominations, or be totally out of it.

Individual nominations

- Made it easier to lose track of important qualification metrics for nominees.
- Power balance: If the HHS board is responsible for recruiting, they need to hold more responsibility; otherwise, they need to make sure the county board has meaningful ability to remove individual HHS board members for cause.
- Individual nominations could result in less reliance on county board reserved powers because would have more trust and clarity in what their role is.

Other/preferable options

There were frequent mentions that the level and method of county involvement depends on the governance structure, particularly related to financial responsibility (e.g., if the county is no longer the financial guarantor, the county board can have less involvement; or if the state is involved in the backstop, it could have more influence).

More county involvement

- County board should get back to nominating the board itself, like the first board iteration.
- Several interviewees emphasized the need for HHS and its board to be accountable to elected officials for public funding.

Shared process

- County comes up with starting list, then HHS board chooses from those (as a way to at least ensure experience/expertise gaps in county interest are covered).
- Should be more of a joint process between the county board and HHS board.
- No reason the county and HHS cannot be jointly involved.
- Commissioners should participate in candidate interviews and development of the slate.
    - This also could be a venue for commissioners to help explain how the dual-board system works and help establish norms for the candidates if/when appointed.
- At least one commissioner should be involved in the whole nomination process; they can keep the rest of the county board updated throughout.
- Important for the county to maintain some control over the process but need to prevent it from becoming a political process.

More arm's-length approach

- Could have a nominating committee.
- Could have an external process to vet, interview, propose nominees.
- Could have an outside resource that keeps both the county and HHS in the loop but at arm's-length through the process.
    - An outside resource also could help with recruiting a higher-qualified pool.
    - Should be provided multiple options for approval per vacancy.
- Should be more ex officio positions (e.g., HHS CFO, COO) determined in the bylaws.
- Could have some seats appointed by other stakeholders, like the state (similar to the Ballpark Authority) to keep some broad political support.
- Could be set up more like the Metropolitan Mosquito Control Commission with pre-determined number of seats based on population served.

Other considerations

- Mentions that the county board did not exercise the power they had (i.e., rejecting a slate) and was not explicit enough in their expectations for what nominees they wanted to see.
- County board was provided the slate in isolation, but more context needs to be provided so they can understand the full picture of the HHS board complement.
- County board never had sightlines into the process, became less transparent over time.
- Process is rigid, which has some efficiencies; however, board recruitment is a nonstop responsibility that should be continuously worked on.
- The county's Capital Budget Task Force (CBTF) recruitment is a better model.

Changes over time

- Executive & Governance Committee used to be one committee that typically included a commissioner. It was split into two separate committees, which narrowed the size of the nominating committee further.
- Initial board members were committed; that commitment became harder to recruit for.
- Some view the original board as stacked with friendly faces, so it all went smoothly with the county board but was not in the best interest of HHS.
- Sometimes the nomination/vetting process starts to slip or fail with the passage of time and decreasing clarity — how were people recruited, what was the criteria, how were they assessed.
- Seemed increasingly like a rushed process, particularly towards the end. It is not clear how much the candidate pool was combed through and carefully considered, especially as to how they would be a part of the whole/fill gaps.

Commissioners on HHS board

Current state

- **Minnesota Statutes 383B.903 and 383B.904:** Two Directors on the HHS board must be current county commissioners, appointed or removed by majority vote of the County Board. Based on a recent legislative change, county commissioners are not eligible to serve as officers on the HHS board.
- **Tenth Amended Bylaws Section 4.3, 4.4, 7.3:** The county board appoints two commissioners to the HHS board, each for a one-year term. One of the commissioner-appointees will be offered a spot on the HHS board's Executive Committee (unless they are already a committee member due to serving as an HHS committee chair).

Other systems

Cook County, IL, and **Santa Clara, CA,** include commissioners on their health system governing boards (summarized below). None of the other systems analyzed for this report have a requirement to include elected officials on the health system board. In some cases, an elected official could be appointed through a nominating committee process (e.g., **Miami-Dade, FL**: state legislative delegation gets to appoint one seat on the Jackson Memorial board and that seat is currently filled by a state senator).

- **Cook County, IL:** Board includes an ex officio seat for the chair of the county board's health and hospitals committee. No other county employees may serve on the board, with the exception of the County President's direct appointment who may be a county employee.
- **Santa Clara, CA:** Governing board is the elected county board.
- *See more in Attachments: Other Systems Tables, under "Commissioners on the Board"*

Key questions

I. Should the County Board have seats on the HHS board?
   a. Define the purpose of the role
   b. Set expectations for accountability

II. If yes, how many seats and who serves?
   a. Decide if it should be 2 seats or fewer or more
   b. Decide if the seats should be filled by commissioners or county staff

Summary feedback from interviews

Role

Providing oversight

- The county owns the subsidiary, owns the real estate, and holds significant financial risk in the current relationship, so commissioners are on the HHS board to provide oversight. Some interviewees thought the role could be dialed back if the county's responsibilities were also dialed back.
- Commissioner participation should allow an early warning system back to the county about HHS's financial performance, quality and safety issues, etc., as well as a reality check on the HHS board about the scope and limits of its authority.
- Some thought the oversight role could be performed well if commissioners only weighed in on matters that directly relate to the county's reserved powers (mission, financial performance, real estate, legislative initiatives, etc.) or focused their HHS board and committee participation on reserved powers (finance committee, governance/nomination committee, etc.).
- Some thought commissioners' participation could play a key role in holding HHS leadership accountable or in holding HHS board members accountable.

Ensuring alignment

- The county and HHS must have operational and philosophical alignment, and commissioner participation can help to ensure that alignment.
- Commissioners provide the county perspective and a community perspective to the HHS board. This can help the HHS board understand the context for their decisions (including political and financial realities or constraints), as well as the impacts of HHS decisions on other county services and programs.

Serving as communication liaison

- Some interviewees thought commissioners could or should serve as a two-way liaison — bringing updates to both boards, advocating the county perspective to the HHS board, and advocating the HHS perspective to the county board. Other interviewees thought this was expecting too much and that HHS board members and leaders should share these responsibilities.
- Some interviewees thought commissioners could provide insight that would prevent the HHS board from making decisions that would not have county board support. Other interviewees thought that type of influence would inappropriately constrain the HHS board's decisions.

Being an ordinary member

- Some interviewees thought commissioners should be no different than any other HHS board member, meaning having fiduciary duties only to HHS (irrespective of the interests and concerns of the county/parent organization or the electorate) and being accountable in the same way as other HHS board members.
- Other interviewees recognized that commissioners are on the HHS board to play a different role and considered that a reality of the current governance structure.

Setting expectations

- The county board should determine the role of commissioners and the expectations for engagement, performance, and conduct.
- Appointed commissioners are not accountable in the same way as other HHS board members; only the county board can play this role.
- The county board could consider a rotation or term limit to ensure a majority of commissioners have some understanding of and involvement with HHS.
- Alternatively, the county board could select the commissioners who are best equipped to either perform the role (based on existing knowledge, skills and experience) or to tackle the necessary training and onboarding to get up to speed.

Number

Two is the right number

- Two seats on an 11-to-15-member board is not an outsized influence for the scope of the county's role with HHS.
- Commissioner participation kept the county in mind for the HHS board, plus a majority of patients are Hennepin County residents.
- Having only one seat would be too much of a burden on a single commissioner.
- Having two commissioners allowed some range of perspective and information for a fuller picture of county concerns.

Two is not enough

- The county board should be able to appoint alternates who can participate if the main appointees are not available.
- Having a third commissioner would support the county's oversight role (e.g., on the finance committee).
- Having some minority voting rights, at least for the two commissioners, would protect the county's oversight role (e.g., the right to table a vote to ensure time for discussion and review of controversial issues, similar to the county board's rules and procedures).

Two is too many; should be zero

- Commissioner participation has the unintended consequence of absolving the HHS board of its responsibilities. Their presence implies county consent and awareness. HHS board members can be overly deferential to commissioners or refrain from debate and discussion. Commissioners are either blamed for having outsized influence with their votes, or they are blamed for not having enough influence to keep HHS on track and accountable.
- The commissioners' presence brings too much political influence to the HHS board. The commissioners must navigate a dual role, acting in the best interests of the county or acting in the best interests of HHS, and this creates tension, conflict, and a demoralizing view that there are two classes of board members. It would be better to have the county board appoint the HHS board and then stay an arm's length away (e.g., similar to the Ballpark Authority).
- The commissioners cannot dedicate enough time to be engaged with the HHS board given their other responsibilities. Their time should be spent on the county board's oversight role. Two-commissioner participation is not an effective way to provide oversight. Other checks and balances would be more effective (e.g., related to appointment of HHS board members, public reporting, etc.).
- Some interviewees thought there should not be any commissioners on the HHS board; some thought a non-voting role could be more appropriate to provide perspective and input but not the illusion of influence or control; some thought county staff could be a better fit.
- Some interviewees thought commissioner seats would not be necessary if the county's financial responsibility for HHS were reduced, capped, or eliminated. Others thought the commissioner seats would still be needed for other reserved powers.

Staff instead of elected officials

Appointing county staff

- Having senior county staff could be a way to bring the county role and perspective to the HHS board, such as internal subject matter experts.
- This could reduce some of the perceived challenges related to commissioners' reserved powers and ownership role, as well as potential political influence.
- Staff may be able to dedicate more time to HHS board activities, compared to commissioners.
- This likely would not reduce some of the perceived challenges that county leaders on the HHS board have conflicted loyalties.

CEO selection and role

Current state

- **Minnesota Statutes 383B.907:** The HHS board has the authority to hire and discharge an administrator.
- **Tenth Amended Bylaws Sections 4.1, 4.3, 5.3, 7.3:** The HHS board hires and discharges the CEO and determines the CEO's compensation. The HHS board's Executive committee makes a recommendation on the CEO's compensation. The CEO serves as an ex officio voting member of the HHS board, and also serves as an ex officio nonvoting member of the Executive Committee.

Other systems

In the majority of other systems analyzed for this report, the health system governing body hires and discharges the CEO. Exceptions include:

- **Cook County, IL:** System board hires/discharges CEO, but bylaws note that the decision is subject to the advice and consent of the county board.
- **Miami-Dade, FL**: Board of Trustees hires/discharges CEO. In cases of financial distress, the county board may replace the Board of Trustees with a Recovery Board, who then assumes powers to hire/discharge CEO.
- **Santa Clara, CA:** The County Board appoints and monitors the performance of the County Executive, who appoints and monitors the performance of the Deputy County Executive of the health system. This Deputy County Executive appoints and monitors the performance of the medical center's CEO.
- **King County, WA**: Board of Trustees approves/disapproves of CEO appointment put forward by UW Medicine.
- *Many other systems include provisions relating to performance evaluation of the CEO. See more in Attachments: Other Systems Tables "Evaluation Measures (CEO & Other)"*

Key questions

I. What is the role of the CEO?
   a. In HHS?
   b. In the HHS board? (Voting member?)

II. How should the CEO be chosen?
   a. By whom?
   b. What qualifications/qualities are desirable?
   c. What should the process be?

III. To whom does the CEO report?
   a. Clearly delineate reporting structure

IV. What accountability measures should be in place?
    a. How are they measured?
    b. HHS board to CEO
    c. County board to CEO
    d. CEO to anyone?

Summary feedback from interviews

Accountability

- In the creation of the subsidiary, the mechanism to hold the CEO accountable was the HHS board. This dynamic was successful early on.
- Interviewees stated that in later iterations, the HHS board did not hold HHS leadership — including the CEO — accountable.
- Some attributed the HHS board not holding the CEO accountable to the CEO's oversized influence in the hospital board recruitment process.
- Some stated that a key reason to have a more professional board is that they will be more capable of holding a CEO accountable.
- The lines around the HHS board's power to hire and fire the CEO were blurred. Some interviewees stated that the decision got politicized with influence from the county board.
    - One interviewee stated that some later board members thought hiring/firing was a county reserved power.
- Some interviewees stated that they would like some level of audit built-in between County Administration and the CEO to track taxpayer funds.
    - At least one mentioned considering an external firm to do an annual audit.

Autonomy

- The CEO should be able to make decisions and be the chief administrator of HHS without political considerations.
- A few said everyone needs to line up behind making the CEO successful. The CEO should be a board member, make other board members more like colleagues, and be an extension of the board for management.
- Some interviewees stated that blurred lines around roles and responsibilities can constrain the CEO in their role of running operations (e.g., both boards interfering with the HHS Executive Leadership Team).
- The CEO should know who is meeting with whom; there should be no side meetings cutting the CEO out.

Recruitment/qualifications

- Challenge to recruit a CEO when they must report to two boards who are not aligned.

- Recruiting a CEO is a nonstarter until the governance is sorted out. That needs to be up and running before a search can happen.
- Historical vetting of CEO candidates has not been thorough enough; need to do more.
- Consider hiring outside firm to do CEO recruitment.
- Earlier iterations of the HHS board's CEO recruitment included:
    - Committee with someone from patient advocacy, a commissioner, someone from management, and some board members.
    - Sounding board sessions for applicants to see what skills would be most important from a staff perspective.
    - Thorough consideration of what kind of leader would resonate the most with the culture of HHS.
- Setting the culture of HHS is the CEO's responsibility; that should be prioritized.
- CEO must understand statewide role and its importance; if they are here for the mission, they must be able to take the heat.
- Should be someone who is deeply committed to the mission, will follow the county, and has nonprofit healthcare experience specifically.
- One interviewee estimated around 40 interviews of candidates at one point.
- One noted that when a thorough, thoughtful process was managed, even if some stakeholders were not happy with the ultimate outcome, it was still beneficial to have them be a part of the process and feel that their input was considered.

Reporting to whom

- The CEO should report to the HHS board, not the county board.
- Compare to NorthPoint, where the CEO reports to the community board (even though a county employee). These reporting lines must be clear; however, the CEO can liaise between boards about what the other wants and contributes.
- The CEO may consult with the County Administrator; it is not a reporting relationship.
- Will not be successful for the CEO to report to two boards, especially if they are not aligned.

Challenges

- Between the county board and CEO on strategic decisions.
    - Some of this may be due to the difference between a CEO and an administrator, and how that can impact the role of a board, including a perception that an elected body is ceding power to a CEO.
    - The CEO does not report directly to the county board but that line can be blurred when the CEO is presenting.
- CEO salary became a difficult dynamic when the financial performance of HHS fell, because the CEO is being paid a market rate.

- There was outsized power with the CEO because the HHS board is largely made up of people with other full-time jobs who don't meet that frequently.
- CEO turnover is very challenging and caused a lot of instability at HHS for the workforce at all levels, plus a governance challenge.
- Regarding board recruitment, the CEO had outsized influence and some perceived the CEO as running the recruitment/nomination process to be more aligned with them.
- As the one employee on the HHS board, the CEO should not be a voting member.

Key relationships

- The connection between the CEO and County Administrator varied depending on who was selected as CEO.
- When the CEO and County Administrator had a close, functional relationship, the dynamic was much more successful, and it seemed like the other accountability methods were not as necessary.
- In past iterations, there were more regular (monthly or bi-monthly) 1:1s between commissioners, the CEO, and sometimes the CFO/treasurer.
- CEO should be meeting with county board leaders regularly.
    - Building and maintaining these relationships should be with the CEO rather than with the HHS board. It would be an impractical ask of HHS board members because of the number of relationships; it is a lot to ask of them.
- The CEO used to do monthly rounds, which helped with relationships.

Ideas

- The CEO and County Administrator need to have a standing meeting every two weeks to build and maintain the relationship and situational awareness on either side.
- Consider the role of the CEO at briefings:
    - If they do not report to the county board, should they be the one presenting?
    - What are the expectations for other HHS board members in those settings?
- The CEO (and board chair) could have external, confidential mentors.
- Succession planning: There should be an informal back-up person to the CEO (e.g., someone on the HHS board) who would be the default person to step in should an acute crisis arise, just for stability.

Exemptions from public entity laws

Current state

- **Minnesota Statutes Section 383B.217, 383B.917, and 383B.921:** HHS has limited but meaningful exemptions from the Minnesota Government Data Practices Act, the Open Meeting Law, and public procurement laws. In relevant part, these exemptions allow the HHS board to meet regularly in closed session and to protect a significant amount of information against public disclosure.
- **Tenth Amended Bylaws Section 7.2:** Meetings of HHS board committees may be closed to the public at the discretion of the HHS board. Meetings of an HHS board committee of the whole may only be closed when discussing competitive data or considering strategic, business, planning, or operation issues where disclosure could cause competitive disadvantage to HHS, at the discretion of the committee.
- **Tenth Amended Bylaws Section 10.2:** HHS Board shall keep records of its board and committee proceedings.
- **Tenth Amended Bylaws Section 10.4:** HHS is subject to the Minnesota Government Data Practices Act to the extent provided by law.

Other systems

- **Cook County, IL:** Public notice of meetings, agendas, and minutes. Process to receive written and verbal testimony at meetings. Generally subject to open meeting law and open records act.
- **Miami-Dade, FL:** Public notice of meetings, agendas, and minutes. Meetings are live-streamed and recorded. Generally subject to open records act.
- **Alameda, CA:** Public notice of meetings, agendas, and minutes. Public comment at meetings. Meetings are recorded. Similar exemption from open meeting law and open records act.
- **Santa Clara, CA:** Public notice of meetings, agendas, and minutes. Process to provide written or verbal comments. Meetings are live-streamed. Generally required to meet in public session.
- **Dallas, TX:** Public notice of meetings, agendas, and minutes. Public comment at meetings. The annual budget proposal is the only meeting that is specifically public.
- **Denver, CO:** Public notice of agendas and minutes. Procedure for public comment. Specific requirements to make certain records public, including board resolutions, minutes, annual reports and financial statements, contracts and financial agreements, employee salaries, personnel reports, guidelines, manuals or handbooks (not individual personnel files), plus an account of all money received and disbursed. Similar exemption from open records act to protect certain competitive data. Additional state-law requirement to disclose some financial, operational and executive compensation data to a state agency.

- **Westchester, NY:** Public notice of meetings, agendas, and minutes. Meetings are live-streamed and recorded. Generally subject to open meeting law requirements.
- *See more in Attachments: Other Systems Tables, under "Governing Body Meeting Transparency"*

Key questions

I. Are the exemptions still necessary?

II. What process or standards are needed to balance the exemptions against transparency and public accountability?

Summary feedback from interviews

Exemptions

Necessary and strike the right balance

- The exemptions are necessary because HHS is operating in a competitive market.
- The exemptions allow candid and confidential discussions about strategy and protection for sensitive patient and personnel information.
- The exemptions help to recruit and retain staff; it will be harder to recruit board members if they are expected to operate in public.

Necessary but need reform

- The balance between open and closed sessions needs to be rebalanced; a more formal process or standard may be needed to avoid overuse of the exemptions. There should be basic transparency around meeting date, time, location, and agenda, with options to observe virtually. It seems like use of the exemptions changed over time, and in earlier eras, more meetings were open to the public.
- More sunshine is needed on finances and public dollars. Some interviewees thought this would have to change given the additional state funding. If HHS operates too much in closed session, it results in loss of transparency and public trust.
- Some interviewees thought HHS should be able to protect discussions about strategy, rate negotiations, etc., but other interviewees thought the exemptions are not as necessary anymore to protect competitive data and should be more narrowly applied, since HHS is so unlike other hospitals and not fully in competition.
- Even if some meetings are in closed session, there should be regular public meetings (e.g., overview on budget and programming) or more information shared with the workforce and other stakeholders or more public reporting of aggregate data (what data, how often shared, and with whom).

Overly broad, need more transparency

- HHS is a public entity and supported by public funds, so the default should be transparency for public accountability, especially around finances.
- More information should be shared with the public or at least to other stakeholders (workforce, state agency or legislature); meetings should be accessible to other stakeholders even if not open to the public.
- Once the budget is approved, HHS must disclose any decisions that change the plan (e.g., if a budgeted amount for capital equipment was spent on something else).

General reserved powers

Current state

- **Minnesota Statutes Section 383B.901 to 383B.928:** Hennepin Healthcare System, Inc., is a public corporation and operates as a subsidiary of Hennepin County. Hennepin County is the sole governing member of the corporation, as represented by the County Board. The Hennepin County Board has several reserved powers, including a few outlined in this section: authority to approve the annual budget of HHS, authority to approve any incurrence of debt through the county, limited authority to remove individual HHS board members, plus authority to remove the entire HHS corporate board or to dissolve or reorganize the corporation subject to new conditions added by the 2026 Minnesota Legislature.
- **Tenth Amended Bylaws, Section 3.4:** The most recent version of HHS's bylaws also address the County Board's reserved powers. In addition to the statutory reserved powers, the bylaws give the County Board additional authority to approve any debt incurrence (other than de minimis debt), any name change, and any legislative initiative or position of HHS.

Other systems

Budget approval

- Other systems have varying methods of approving budgets.
- Many require direct county board approval (such as **Cook County, IL; Miami-Dade, FL; Santa Clara, CA; Dallas, TX**); some include restrictions on spending until the budget is approved by the county board.
- Notable exceptions to direct county board approval include:
    - **Alameda, CA:** District's Board of Trustees approves budget.
    - **Westchester, NY:** Corporation Board of Trustees approves budget (state public benefit corporation).
    - **King County, WA:** Budget approval is split between the county board and Harborview's Board of Trustees – county board approves bigger picture items (long range and capital projects) and Harborview's Board of Trustees approves others.
    - **Cuyahoga, OH:** County board approves budget annually, though if budget is not approved by the start of the fiscal year, it is deemed approved.
- *See more in Attachments: Other Systems Tables, under "Reserved Powers – Budget"*

Budget process

- Other systems do not always specify budget processes in their statutes or bylaws. Some notable budget processes and specifications include:

    - **Cook County, IL**: Annual appropriations, strategic, and financial planning process.
    - **Alameda, CA:** Enumerated list of the District's Board of Trustees responsibilities related to the budget.
    - **King County, WA:** Distinction between budget items approved by the county board in contrast to those approved by the Board of Trustees.
- *See more in Attachments: Other Systems Tables, under "Reserved Powers – Budget"*

Debt approval

- Debt approval is not always specified in the statutes and bylaws of other systems, though it is generally a reserved power of the county.
- There are also cases where it is not explicitly outlined in statutes or bylaws, but exists in practice (e.g., revenue shortfalls can be the sole responsibility of a health district, but should the district be dissolved, debt would be transferred back to the county).
- Some notable provisions:
    - **Miami-Dade, FL:** Written notice from the Public Health Trust to the county commission is required for any debt circumstance. Should a debt circumstance occur, the ordinance lays out next step processes such as audits, a management watch, and the establishment of a Financial Recovery Board to replace the Public Health Trust. This statute has by far the most comprehensive provisions oversight related to financial sustainability.
    - **Alameda, CA:** Revenue shortfalls are the sole responsibility of Alameda Health System (health district).
    - **King County, WA:** The University of Washington needs to seek approval from Harborview's Board of Trustees for any spending outside of the approved budget.
    - **Cuyahoga, OH:** Spending taxpayer dollars and extra-budget spending is not allowed. Any time the amount received from those sources differs from the approved budget amount, the county board may require the hospital board of trustees to revise the county hospital budget accordingly.
- *See more about Miami-Dade's ordinance on financial sustainability in Attachments: Other Systems Tables, under "Reserved Powers – Debt, Financial Sustainability"*

Removal of board

- Typically not specified for other systems, though the option exists in practice through county reserved powers for removal of individuals; (**Alameda, CA,** removed its entire system board in 2020).
- Additionally, since some of the other boards are established via county ordinance such as **Cook County, IL; Miami-Dade, FL;** and **Denver, CO,** the county board could take action to revise their respective ordinances.

Removal of members

- All other systems have provisions that allow for removal of health system governing body members for cause, except for **Alameda, CA,** which states removal can be with or without cause but requires a supermajority of the county board to approve.
- **Alameda, CA**, and **King County, WA**, have provisions stating that the health system governing body can request that a member be removed, with a supermajority vote of the county board or a unanimous vote subject to the approval of the county executive, respectively.
- *See more in Attachments: Other Systems Tables, under "Terms of Office & Removal"*

Audit

- All other systems include some form of audit, most typically an annual external audit. Notable provisions include:
    - **Cook County, IL:** County board has extensive means for internal auditing of the System Board and the health system.
    - **Miami-Dade, FL:** Ordinance states the Trust shall create an Office of Internal Auditor, Public Accountability and Information with powers and purposes outline.
    - **King County, WA:** Shared Services Agreement between the University of Washington and the county states that the county board can at any time conduct an internal review or audit of any books and records related to the performance of the Agreement.
    - *See more in Attachments: Other Systems Tables, under "Reserved Powers – Audit"*

Key questions

I. What is the county's role with respect to HHS, and which reserved powers are necessary to perform that role?

II. What needs to change (if anything) to make the county board's exercise of reserved powers meaningful and not perfunctory?

Summary feedback from interviews

Reserved powers

General

- Some interviewees thought that elected officials must have the ultimate authority for a publicly owned, safety-net hospital, especially with public ownership of the facilities and public funding support. Several thought the reserved powers were reasonably well-designed to target those concerns (mission, budget, debt, board).
- Some interviewees thought the county board has too much reserved power given the amount of county financial contribution to HHS's annual budget.

- Some interviewees thought the reserved powers could be more limited if the county's liability and risk were similarly reduced. Some noted that this might have to happen over time, step by step.
- Some interviewees mentioned that the county board's votes and reserved powers must be used for meaningful points of oversight, with sufficient time and process for dialogue and changes — not a rushed, rubber-stamp action.
- Some interviewees thought the reserved powers had worked well over the years and only caused tension due to HHS's financial crisis and/or due to a blurring of roles. Other interviewees thought the reserved powers had removed some responsibility and accountability from HHS board members and staff.

Specific powers

County board approval of HHS budget

- Many interviewees considered county board approval of the HHS budget to be a key safeguard, essential to public trust, and the main method of accountability for taxpayer funds.
- Several interviewees thought budget approval is necessary given how much financial risk and liability the county holds related to HHS.
- Some interviewees thought that any financial decision at HHS that was not part of the approved budget should be presented to the county board for approval. Others suggested an annual financial audit of HHS by the county, with county staff support, to ensure oversight.
- Other interviewees thought the county board should not have any role in approving the budget. Some said it is not an effective form of oversight given the complexity of the budget, the time available to review and discuss, etc., noting that an aspirational balanced budget was often presented, approved, and then not accomplished. Others thought the HHS board should hold ultimate responsibility for the budget, including holding HHS leaders accountable to meet the budget, because the county's authority to conduct a financial audit provided sufficient oversight.
- Some interviewees thought the county board could have a narrower role in approving the HHS budget; for example, approving only the portions supported by county funding, or being involved for approval only when HHS is running a negative balance.
- Some interviewees expressed concern about how this reserved power can undermine the governance structure and its roles — that it can invite the county board to use its budget approval to wade into the operational decisions of the HHS board and HHS leadership (e.g., closure of a service line or clinic, changes to employee compensation and benefits).

County board process for approving HHS budget

- Many interviewees offered feedback about the process for seeking county board approval of the HHS budget.
- Several interviewees suggested having a commissioner engaged in the HHS finance committee to be involved in and aware of each iterative discussion/decision in the budget. Some interviewees thought the commissioner(s) on the HHS board would be responsible for updating other county board members.
- Other interviewees noted that the county board should be updated and informed on HHS budget challenges and decisions during the quarterly briefings. Others mentioned that in past eras, HHS board members and leaders would brief commissioners individually on the proposed budget to allow time for questions and information on key decisions.
- Several interviewees mentioned the timing and sequencing challenges of matching the HHS budget process up to the county board's deadlines for setting a maximum and final levy. Some interviewees thought HHS should have its own budget hearing before the county board, similar to other countywide elected officials (sheriff and county attorney), to better align.

County board approval of debt

- Under Minnesota Statutes 383B.907 and 383B.915, the HHS board has authority to spend funds and to borrow money and issue bonds in support of HHS's purpose and mission. Under the HHS bylaws, however, this authority was limited: the county board had authority to approve any debt incurrence other than de minimis debt (defined as a certain percentage of budgeted revenues). Under Minnesota Statutes 383B.908, the county board also has authority to approve any change in the HHS bylaws related to the ability of HHS to incur debt through the county.
- This reserved power connects to what role the county board has (or should have) in HHS's capital planning, since most capital projects involve the issuance and repayment of debt. Although HHS has authority to issue bonds, the county has typically used its strong credit rating to issue bonds for HHS capital projects, and HHS repays the county, with the benefit of a low/favorable interest rate.
- Some interviewees thought approval of debt incurrence was a key reserved power, since HHS debt creates an obligation on public tax dollars and impacts the county's credit rating, and since the HHS board is not elected and not accountable to the taxpayer, accountability must be through an elected body.
- Some interviewees thought the need for this reserved power would depend on whether the county serves as HHS's financial backstop and whether the county has to issue bonds (versus the state as issuer).
- Some interviewees thought this reserved power prevented the HHS board from even developing recommendations for capital projects, especially since HHS does not have a banking relationship separate from the county.

County board removal of individual HHS board members

- Under Minnesota Statutes Section 383B.903, the HHS board can remove one of its members without cause on a two-thirds majority vote; the county board can only remove an individual HHS board member in limited circumstances (violation of the director's ethical and legal duties as specified in statute or repeated failure to act in the best interests of the corporation).
- Some interviewees mentioned this limited power of removal was included to address any conflicts of interest that arose for HHS board members.
- Several interviewees thought the county should have some more authority to remove individual HHS board members as a measure of accountability (the flip side of the power to appoint), so the county board would be able to address issues on the HHS board without having to remove the entire board.

County board removal of entire HHS board or dissolution or reorganization of HHS

- Under Minnesota Statutes 383B.908, the county board retained authority to dissolve or reorganize HHS, or to remove the entire corporate board and resume management, on a two-thirds majority vote.
- This reserved power was commonly described as an emergency measure or failsafe to ensure the county board could step back in if necessary.
- The county board exercised this power for the first time in August 2025, and interviewees offered various reasons for this, e.g.: the county was facing too much risk from HHS's financial condition; HHS would have closed if the county had not stepped in; the boards were no longer aligned; the county board lost confidence in the HHS board; the county board could not get the information it needed; the county board did not have sufficient authority to remove individual HHS board members, etc.
- In 2026, the legislature limited this power, allowing the county board to exercise this power only when HHS experiences sustained conditions of financial distress, and requiring the county and HHS to first engage in mediation with assistance from the Minnesota Attorney General.

Legal counsel and lobbying

Current state

- **Minnesota Statutes 383B.922:** The Hennepin County attorney serves as legal counsel to the HHS corporation, and HHS reimburses the County for the costs of those legal services (credited to the budget of the Hennepin County Attorney's Office). HHS and the Hennepin County attorney can enter an arrangement to hire outside counsel for HHS.
- **Tenth Amended HHS Bylaws, Section 3.4(xvi):** Under the HHS bylaws, the County Board has had authority to approve all legislative initiatives and positions of HHS and coordination of all lobbying efforts.
- These features are outlined in the same section because they often came up together in interviews.

Other systems

- Other systems analyzed for this report have varying arrangements for legal counsel. **Cook County, IL; Miami-Dade, FL; and Santa Clara, CA,** have county counsel, whereas the others may have their own Office of Legal Counsel; or, in the case of Harborview in **King County, WA**, legal services are provided through the University of Washington Division of the State Attorney General's Office.
- Lobbying is not typically addressed in the statute or bylaws of other systems. However, the **Cook County, IL,** ordinance includes the following provision:
    - CCHHS shall cooperate with the Cook County Board of Commissioners and the Office of the Cook County Board President and the President's various Bureau Chiefs on operational matters, uncompensated care policies, determining appropriate benchmarking and reporting (including, but not limited to, revenue and finance enhancements, operational and quality improvements and expenditure authority), strategic plans and **the legislative policy agenda for CCHHS to ensure efficiency across County operations.**

Key questions

I. What is the county's role with respect to HHS, and how does the current structure for legal counsel and lobbying impact the county's role? Is it a benefit, a disadvantage, or neutral?

II. What needs to change (if anything) to make the structure for legal counsel and lobbying effective and functional?

Summary feedback from interviews

Legal counsel

County attorney should serve as counsel

- Several interviewees mentioned the benefits of having the Hennepin County Attorney's Office (HCAO) serve as legal counsel to HHS, including knowledge and expertise about the public nature of the institution and its overlapping legal issues with the county (e.g., the history of HHS being created as a subsidiary, public employment labor relations and collective bargaining agreements, the Open Meeting Law and the Minnesota Government Data Practices Act, the municipal tort liability cap, etc.).
- Some interviewees mentioned that having the HCAO serve as legal counsel has been cost-effective, since HHS pays for HCAO legal services at a below-market rate, and since HHS did not have to employ its own in-house counsel. These interviewees thought that HHS's ability to retain outside counsel as needed was sufficient to address any specific legal needs.
- Several interviewees described the HCAO role as another form of county oversight, given the ability of the HCAO to serve as a liaison and help the two entities stay aligned, and also given the special responsibilities of a public attorney to flag issues of concern.

County attorney should not serve as counsel

- Several interviewees expressed the view that the HCAO should not serve as HHS's legal counsel. Some offered a general rationale that this can, at least occasionally, create a conflict of interest for the attorney. Other interviewees recognized that, as with lobbying, there is no genuine conflict because the county is the final decision-maker and ultimate client authority.
- Some interviewees expressed a general concern that, even when all parties understand the arrangement, the dynamic can contribute to tension and dysfunction in the relationship between the county-parent and HHS-subsidiary and undermine the trust between the attorney and their client representatives.
- Others thought the conflicts would be minimal, since the entities' interests should mostly align, but still thought HHS and its counsel should have more independence from the county than what the current arrangement allows, noting that the county's interests might preclude HHS from pursuing a legal option (similar to the county's authority over lobbying creating a barrier for HHS's legislative priorities).
- A few interviewees expressed concern that the HCAO structure does not support the retention and development of the specialized legal expertise needed to support a hospital, though several were complimentary of the attorneys who have provided services to HHS over the years.

Lobbying

County board should control

- Many interviewees expressed the reality that the county and HHS are viewed as one and the same by lawmakers, with significant advantages when the two entities can speak with one voice (e.g., 2026 state funding support) and significant disadvantages when the county and HHS are working at odds or competing for attention and funds.
- Several interviewees mentioned that interests should be mostly aligned, given the populations served by both the county and HHS and the intertwined financial interests.
- Several interviewees also mentioned that the county must manage a broader range of issues and priorities than HHS, which makes final approval of the platform essential to avoid having an HHS position undermine a county priority or create unintended consequences for the county.
- Several interviewees mentioned the need for open communication and coordination to ensure the county board is well informed about HHS's priorities, and HHS stakeholders are aware of the county board's final decision and authority on the platform, so the parties can navigate the session together without becoming adversarial or in opposition. Some interviewees mentioned this is similar to how the county navigates its priorities with the Association of Minnesota Counties, or how the county balances priorities among its different healthcare components (Hennepin Health, NorthPoint, etc.).
- Some interviewees mentioned that the county and HHS have fairly different internal processes for developing their annual platforms, which can make it more challenging to become aligned in the end. Some interviewees mentioned the need for a written protocol, plus greater accountability around any misalignment.
- HHS used to reimburse the county for Intergovernmental Relations (IGR) support through a shared services agreement but hired its own staff lobbyist approximately 10-to-15 years ago. Several interviewees thought that HHS should be able to hire its own lobbyist with the expertise it considered most relevant, while others thought that alignment would be improved if HHS lobbying were performed by a county employee (similar to the legal counsel role).

County board should not control

- Several interviewees thought the county should not have a role in approving HHS's legislative initiatives and platform, with a range of reasons. Some said that there is not a total alignment of needs, interests, and priorities, so the requirement for county approval has the effect of quashing an HHS priority. Some said it was another piece of connective tissue that prevents HHS and its board from being responsible and accountable. Some said this reserved power causes too much conflict and dysfunction in the relationship. Some said the county and its elected officials may not be the best messenger for HHS priorities given their involvement in other county priorities and political issues.

- Others thought this reserved power could be eliminated if the county is no longer the financial backstop or narrowed to focus on any HHS legislative positions that could impact the county's finances.
- Others suggested changing HHS's name to provide more distance between the two entities, both to reflect its statewide role and to reduce the risk that the county and the county board are perceived as responsible for the actions of HHS.

Lease agreement

Current state

- **Minnesota Statutes 383B.913:** The county is authorized to enter into a lease with HHS for the real estate used for operations of HCMC. The lease must address several topics, including continued primary use of the property for health and human services, indigent care, capital improvements, joint ventures and partnerships, assignments and subleases, and changes to hospital capacity.
- **Ground Lease and Sublease (initial term 1/1/07-12/31/26; renewed in 2026 for an extended term of 30 more years):** The county owns the real estate that is used by HHS for its hospital and other locations, and leases the real estate to HHS for a base rent of $1 per year, with HHS generally responsible for maintaining the facilities in good condition and repair.
- **Second Operating and Funding Agreement (SOFA), Article 4 (expires 12/31/26):** The SOFA contemplates that HHS will cover the costs of county-incurred debt for the Ambulatory and Outpatient Specialty Center, and that any County capital contribution or financing will be based on an approved HHS Master Facility Plan as adopted and amended and as included in the County's Capital Improvement Plan, to include an agreement on which entity will repay any financing.

Other systems

For other systems analyzed for this report, counties generally own the property. In some cases with health districts, the district gets significant powers over the property upon creation of the district; the property may be transferred back to the county should the district be dissolved. Property ownership is typically not specified in detail except for **King County, WA**. King County's shared hospital services agreement between the county, via Harborview's board, and the University of Washington includes an exhibit listing each building, the owner, the use, the square footage, and the square footage used by the county.

See more in Attachments: Other Systems Tables, under "Lease Provisions"

Key questions

I. Will the county continue to own the real estate used by HHS?
   a. Evaluate the pros and cons of this arrangement for each entity

II. If the county owns the real estate and leases it to HHS, which entity is responsible for various items under the lease?
   a. Consider maintenance and repair, asset preservation, and capital projects
   b. Consider how state funding support will be used, and where to direct the county's available funding support

Summary feedback from interviews

Ownership

County must own the real estate

- Having the county own the real estate ensures that the public entity retains ownership and control of public assets, including if HHS no longer needs a property or closes.
- Infrastructure and capital costs are a huge item in the HHS budget, and the county must have oversight in its current role.
- The low-cost lease is another form of financial support for HHS, along with the county paying for asset preservation.

County does not need to own the real estate

- The county would not need to own the real estate if it had less responsibility for HHS's mission and financial status.
- The buildings are more of a liability than an asset for the county; let the state own the buildings or let HHS buy them.
- The lease is more of a liability than an asset for HHS because HHS is expected to pay for upkeep or bonds but never gets the asset on its balance sheet.

Capital planning and funding

County role in capital planning

- Several interviewees thought the county must be involved as a decision-maker in capital planning so long as it owns the real estate or is expected to issue bonds or pay any share of a capital project. Other interviewees thought HHS needed to have more say in determining its capital strategy.
- Some thought capital planning should begin immediately given the current condition of the facilities; others thought that capital planning could not be prioritized until HHS's long-term financial viability is stabilized (e.g., a fix to state and federal reimbursement formulas or a stable supplemental revenue stream of state or local funding).

County role in capital funding

- Several interviewees noted that in the past, there was hope that HHS would generate enough revenue (e.g., by improving its payor mix) to pay for its own capital equipment and improvements. Others thought the payor mix would not diversify without investment in the facilities.
- Some interviewees thought that HHS would never be able to pay for capital improvements and that the county would have to pay for any capital project. Others expected that the county would pay for asset preservation.
- Some thought the funding source for capital projects was still to be determined.

Health services and plan

Current state

- **Minnesota Statutes 383B.901:** The purpose of HHS as a corporation is to engage in the organization and delivery of health care and related services to the general public, including the indigent as defined by state and federal law and as determined by the Hennepin County Board, and to conduct related programs of education and research.
- **Minnesota Statutes 383B.908:** The county board retains authority to require HHS to provide other health care or health care related services that the county board determines are in the best interest of the county, so long as the county board provides funds to pay for the services. Payment for the services shall be as agreed between HHS and the county board.
- **Minnesota Statutes 383B.918:** HHS shall prepare a health services plan and submit it to the County Board for review and approval. The plan draws from a population health needs assessment and delineates HHS's role in the community, including education, research, and services to improve the health status of the community including indigent populations. The plan shall contain a description of how HHS shall continue to coordinate with the County to provide health-related services to Hennepin County residents, including the indigent as defined by state and federal law and as determined by the Hennepin County Board.
- **Tenth Amended HHS Bylaws, Section 3.4(ix):** Once every three (3) years, a health services plan will be prepared by HHS in coordination with the Community Health Needs Assessment and implementation plan required under the regulations relating to Section 501I of the Internal Revenue Code (as required for hospitals to maintain nonprofit status with the IRS). In addition to the statutorily-required topics, the health services plan shall describe the principal health services to be provided by HHS, significant changes in the pattern of community health needs and significant plans for change in deployment of resources or sites to meet those needs, in coordination with the efforts of other responsible parties, including the Hennepin County Public Health Authority. The health services plan shall discuss the primary thrust of workforce plans for HHS, including major training initiatives. The health services plan shall discuss the operation and the effect of the indigent care formula established between the County and HHS pursuant to Minnesota Statute Section 383B.928 on the services provided or anticipated to be provided by HHS and on the fiscal health of the HHS.
- **Second Operating and Funding Agreement, Section 1.05 (expires 12/31/26):** HHS shall offer services at the Hospital consistent with the Health services Plan. HHS's obligation is conditioned upon and subject to payments by County under an uncompensated care formula and other funding arrangements mutually agreed upon by the County and HHS for uncompensated care and other services.
- **Hennepin County Board Resolution 25-0507 (Dec. 11, 2025):** The County Board approved HHS's 2025 Community Health Needs Assessment (CHNA) and 2026-28 CHNA

Implementation Plan and the Health Services Plan. The 2025 CHNA Steering Committee included Hennepin County staff representatives.

- **Hennepin County Community Health Assessment 2024-28:** Hennepin County Public Health completes its own Community Health Assessment (CHA) every five years to monitor the health of children and adults in the county. The most recent CHA included HHS staff and others as part of an external steering committee.

Other systems

Other systems have various provisions related to providing health services.

- Many mention providing services to indigent populations in their mission or establishment language, such as **Cook County, IL,** whose ordinance states: "CCHHS shall provide integrated health services with dignity and respect, regardless of a patient's ability to pay."
- **Santa Clara, CA,** and **Alameda, CA:** California state law mandates that counties act as "provider of last resort" for all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein.
- **Miami-Dade, FL:** County ordinance includes language that the Trust shall comply with the health care policies and directives established by the Board of County Commissioners, and avoid unfunded mandates therein. If any such policy or directive will result in a financial impact to the Trust, then the Commission shall provide County funding to the Trust for implementation of and compliance with the policy or directive for the period of time necessary for implementation or compliance.
- **King County, WA:** the Shared Services Agreement between the University and County (via Board of Trustees) outlines reimbursement provisions for the County to provide funding to the University for providing services in cases where federal/state funding has been made available, or not.

Key questions

I. What is the county's role with respect to HHS, and how does the HHS Health Services Plan requirement support that role?
    a. Consider mission, strategy, and funding

II. How will the county be involved in development of the HHS Health Services Plan in the future? What are the expectations for HHS?

III. How does the approved HHS Health Services Plan inform the county's strategy on alignment with HHS or on county funding or financial support for HHS?

Summary feedback from interviews

Healthcare services

Authority to require services

- Some interviewees described this reserved power — where the county can require HHS to provide certain healthcare services if the county pays — as a necessary control to protect against mergers or sales that could undermine HHS's mission.
- This represents one view of the safety-net mission: that the county board should be the final decision-maker before HHS decides to end a service that is critical but not profitable, especially when other systems stop offering those services.
- Other interviewees noted that the county has this authority to ensure services are available, but there is insufficient support from the county board, or from other stakeholders, to cover the full cost (e.g., the county board might object to certain cuts to service or clinic sites, but without providing the funds to maintain).
- Some interviewees thought this should not be a reserved power and that a negotiated services contract is a better model for the county board to request and pay for the services they would like to see, including accountability measures and metrics for how HHS uses the funding, and a mutually beneficial arrangement.

Health services plan

Development and approval

- Some interviewees shared that development of the HHS Health Services Plan had been a thoughtful, meaningful engagement process in the past, including input from the county board. Some interviewees described HHS as the county's instrument for delivering healthcare to residents.
- Some interviewees thought development and approval of the plan had become more perfunctory in recent years and said the Health Services Plan should promote county and HHS alignment on mission, mandated services, and budget.
- Some interviewees thought the HHS Health Services Plan could be organized around the social determinants of health (SDOH), developed in conjunction with health leaders at the county, with input from county and HHS finance staff to gauge the affordability of services, with a focus on the overlap between healthcare and county services.
- Some interviewees thought HHS was engaged in too much work that was duplicative of the county, relating to human services and equity, and that HHS should focus on core healthcare services. Other interviewees suggested that HHS should use a broad interpretation of health.

Uncompensated care formula

Current state

- **Minnesota Statutes 383B.928:** HHS shall provide health care and related services "for the indigent of the county" as required by the lease and consistent with any agreement made with the county for payment.
- **Ground Lease and Sublease, Article 3 (initial term 1/1/07-12/31/26; renewed in 2026 for an extended term of 30 more years):** HHS agrees to use and occupy the Leased Premises, among other things, in accordance with any agreement between the County and HHS regarding indigent care.
- **Second Operating and Funding Agreement, Article 2 (expires 12/31/26):** The county and HHS have an agreement for county funding (as payor of last resort) for services provided by HHS to Hennepin County residents who cannot pay, based upon a formula that is annually reviewed and documented in HHS's budget proposal to the county.

Other systems

It is uncommon for other systems to have language related to a formula for uncompensated care costs. However, other systems do have other dedicated revenue streams, summarized below.

- **Cook County, IL:** No dedicated tax revenue, but county financial contributions in county budget to cover health services.
- **Miami-Dade, FL:** 0.5% sales tax, representing 10.4% of $4 billion revenue, plus direct county funding of 8%.
- **Alameda, CA:** A parcel property tax, plus 75% of a 0.5% sales tax goes to health system, with the balance to county board to fund other indigent care programs throughout the county.
- **Santa Clara, CA:** 0.625% sales tax for 5 years, starting 4/1/26, to fund health care services (anticipated $330 million/year).
- **Dallas, TX:** 0.212% property tax rate per $100 valuation, covered approximately 61% of total uncompensated care cost ($1.4 billion).
- **Denver, CO:** 0.34% sales tax revenue for health system, representing 4% of total funding that stabilized high-demand service lines.
- **Westchester, NY:** No dedicated state or local tax revenue, but significant state investment in recent years, including $1 billion in capital and $300 million in operating funds from state's FY26 budget that went towards six NY safety net systems, including Westchester.
- **King County, WA**: Property tax for public hospitals, voter approved bond program, and some dedicated state funding.
- **Cuyahoga, OH**: Voter-approved levy for county health and human services fund.
- *See more in Attachments: Other Systems Tables, under "Dedicated Revenue Sources"*

Key questions

I. How does uncompensated care fit into the overall picture of county financial support to HHS?
   a. Consider how state funding support will be used
   b. Consider where to direct the county's available funding support (e.g., uncompensated care, capital projects, asset preservation and maintenance, etc.)

II. Will the county continue to provide funding for uncompensated care to county residents?
   a. Determine the vehicle for this funding (e.g., updated funding agreement with formula, grant or services agreement, etc.)
   b. Determine whether to use the formula, an updated formula, or another model to determine amount
   c. Determine what metrics and reporting will be required for the funding

Summary feedback from interviews

Uncompensated care formula

Source of funding

- County funding of uncompensated care was a way to provide some ongoing financial support to HHS and its board for a key issue but must balance against other county priorities.
- The state used to provide more bridge funding solutions that would boost the federal reimbursement, but that has diminished with time. There were past efforts to request funding support from other counties with no success.
- This is a critical service for the community, so there should be a role for other counties or the state to share the costs or for other systems to share the burden.
- Some interviewees thought the new state funding should help to cover this expense (to reduce or eliminate the county contribution), while others thought the state funding should focus on supporting HHS's other unique services, with this as a more appropriate form of county support.

Purpose of funding

- Interviewees offered a range of rationales for county funding for uncompensated care: to support patients who are not eligible for public programs, to support patients who cannot afford their high-deductible plan, to bridge the gap in the federal reimbursement rate, and/or to subsidize medical education.
- Several interviewees suggested that the model could shift to a grant or services agreement, where the county pays HHS to provide mission-aligned services as a public good (i.e., services that cannot make money or break even).

- Consider whether uncompensated care is the right way for the county to provide funding support.

Amount of funding

- The formula was initially a replacement for the property tax allocation that the hospital received as a county department, with annual adjustment to allow for external factors (e.g., impact of Affordable Care Act, changes in reimbursement, etc.).
- The amount has always been a tension point, where the county provided support but subject to available funding, and HHS expected the county to pay the full amount of uncompensated care for Hennepin County residents. This led to some uncertainty from year to year, especially given the lag in determining the amount of uncompensated care in a fiscal year.
- Some of HHS's comparable peers receive greater amounts of local public funds, which has been a source of tension. The county also provides other forms of support and funding.
- Some interviewees noted that the amount of additional government funding during the pandemic and with directed payments masked some of the underlying financial reality. Some interviewees noted that the prior beliefs that HHS could become self-sustaining or improve its payer mix did not come to fruition and may not have been realistic.
- Consider evaluating the amount of uncompensated care funding over time, on its own, as a percentage of HHS's revenue or services and as a part of overall county support.
- Consider whether there is any scope or limit on which services are covered as part of uncompensated care.
- Consider what vehicle is used to determine the amount (annual negotiation, formula, reimbursement billing, etc.) and what process would be needed for HHS to request additional amounts and/or cap services.

Accountability for funding

- Some interviewees thought the existing process for HHS to annually justify and negotiate the amount of funding, and for the county to negotiate based on available funding, provided some constraint and oversight, with the formula designed to include incentives so HHS would work to collect from available payors and get eligible patients enrolled in public programs. A fixed flat amount could negatively impact these features.
- Other interviewees thought any public funding for uncompensated care should include additional controls, metrics and reporting (such as monthly or quarterly reports, or an annual audit) to ensure public accountability that the county is the payor of last resort and the funding is used for its designated purpose, with consequences for non-performance.

Financial backstop

Also known as liquidity or maintenance of working capital/cash

Current state

- **Second Operating and Funding Agreement, Article 3 (expires 12/31/26):** The County agrees to provide one or more capital infusions, if necessary, to ensure that HHS has a minimum cash and investments balance. Any capital infusion is treated as a cash advance and repayable with interest.

Other systems

See more in this report above, under General reserved powers > Other systems > Debt approval, and also in Attachments: Other Systems Tables, under "Dedicated Revenue Sources"

Key questions

I. How does the financial backstop fit into the overall picture of county financial support to HHS?
   a. Consider how state funding support will be used
   b. Consider the pros and cons of the backstop for each entity (balancing risk/responsibility against oversight/authority)

II. Will the county continue to serve as the financial backstop?
   a. Consider how to reform the backstop, including amounts, mechanism, and process
   b. Consider what metrics and reporting will be required for this feature

Summary feedback from interviews

Financial backstop

Crucial support

- HHS provides critical services that are not profitable, and it plays a safety-net role that other hospitals do not. The financial backstop is a necessary reassurance for its continued viability. The HHS board should not be expected to solve HHS issues without this support; operational efficiencies are important but will never solve the gap.
- Without this support, HHS would have to consider short-term cuts to address financial challenges, with negative impacts due to service closures and reductions in workforce that would undermine stability for patients and long-term strategy for the system.
- Consider how the state could invest and pay attention; the state could (or should) take on at least part of this responsibility since the system is a statewide asset.

Counterproductive

- The financial backstop creates too much risk for the county, which means the county board must stay involved in HHS governance. This has added to the challenges in the county-HHS relationship. If the backstop were eliminated, the entities could shift to explore aligned work and shared priorities.
- The financial backstop undermines the HHS board's accountability for the system's performance. It can undermine the sense of urgency to achieve financial solvency and negatively impact decision-making.
- The financial backstop (and intertwined financial relationship) has prevented HHS from developing its own balance sheet of assets and achieving more self-sufficiency. There are advantages to relying on county assets and credit to issue debt, but it creates challenges as well.

Important but needs reform

- Some interviewees thought the county should not have to provide more than its share of financial support for a statewide asset. The state and other counties should share this responsibility. The new state funding should partially mitigate this risk.
- Some interviewees thought the backstop should be capped or eliminated. The county should only pay for uncompensated care, not capital projects or working capital/cash. Alternatively, providing funds to cover payroll and daily operations seems like backstop, and capital investment seems different, like a county investment in safety-net care.
- Some interviewees thought the backstop should be capped at a maximum amount. Some interviewees expressed that there may be a point at which the county cannot afford to support HHS, no matter how critical and important its services are.
- Some interviewees thought the procedure should be updated; it does not match the current practice. It needs more internal controls, metrics, and reporting on the need for funds and how the funds will be used, and more oversight by the county board. Sometimes the county has provided other funding support without invoking this provision in the funding agreement.
- Consider an annual external audit to ensure the county has information on how county-appropriated funds are used, and the overall financial health of the system.

County board briefings

Current state

- **Minnesota Statutes 383B.217:** The county board may meet in closed session to protect competitive data relating to HHS. HHS shall inform the county board when there are matters that are appropriate for discussion and action in closed session.
- **Tenth Amended HHS Bylaws Section 3.5:** The HHS board chair or CEO must brief the County Board at least quarterly.

Other systems

Other systems have varying approaches to briefing report content and frequency. Notable examples include:

- **Cook County, IL:** CEO through System Board provides quarterly operations and financial reports to the Cook President and county board, plus CEO monthly meetings with Cook President regarding operations including collaboration on operational initiatives.
- **Miami-Dade, FL:** CEO makes quarterly written reports to Board of Trustees, which are disseminated to county leaders upon request.
- **King County, WA:** University of Washington-designated representative and Harborview board president meet with county council and county executive at least annually, with minimum reporting requirements outlined.
- *See more in Attachments: Other Systems Tables, under "County Board Briefings"*

Key questions

I. What is the purpose of HHS briefing the county board?

II. What information would be most helpful to receive at these board briefings to fulfill that purpose?
    a. At what level?
    b. In what format or style (e.g., summaries)?
    c. Using what metrics?
    d. On what timeline?
    e. From whom (e.g., who attends, presents)?
    f. In what setting (e.g., where, what's public)?

III. What actions will be taken based on briefings (e.g., votes on report-outs, etc.)?

Summary feedback from interviews

Original/past iterations

Purpose

- For the HHS board to provide an update on HHS, primarily financial. Main forum for the budget, quarterly meetings were the venue to pass that information on.
- To give the county board enough information to understand the current state and goals moving forward, and to provide the groundwork for a larger budget conversation, presumably in Q4.
- To make sure that there were no surprises for the commissioners when it came time for the Q4 budget briefing.
- One interviewee framed it as the way to get the boards on the same page regarding the financials before the conversation would come up at the next public briefing; covering all big-ticket items that would make it into the public conversation one way or another.

Content

- Primarily financial, also included personnel and real estate, plus the once-annual legislative priority update.
- Seldom, if ever, were there presentations on innovation/programming; that would have been brought to the HHS board, not the county board.
- Used to be much more robust with financial information. Worked very well when there was a county board member dialed into HHS budget and filled in the rest of the county board regularly, so briefing time could be discussion about what they already knew.

Agenda/timing

- First and main agenda item was usually a financial update from CFO.
- Q3 briefing would be preliminary budget presentation, so Q4 budget briefing would not include any surprises — seemed like a black box more recently.
- Agenda development changed over time; it depended on who was in the leadership role and the topic.
- There was an annual planning meeting. It included a review of what happened in prior years, plus attendees would go through and stage various issues for moving forward. It was attended by the attorney, common board staff, CEO, chair, sometimes vice chair.

Preparation

- In the past, HHS board members would talk to county board members weeks in advance of a briefing about plans and would educate on topics.
    - Commissioners found these conversations very helpful, usually conversations around finances.

    - Each side would come with a list of questions prepared for the others.
- In the past, it was helpful to have commissioners set a high bar for HHS's big decisions — helpful oversight; you had to prepare a good argument for the decision.

Personnel

- For a while, the whole HHS Executive Leadership Team attended; more recently only if they had an agenda item.
- In the past, HHS board chair and vice chair (maybe other members) would attend briefings regularly; largely in observational role, not in speaking role but still at the table. Helped with alignment to have them hear the info.
- Prior HHS boards were more engaged; in recent era, the CEO played a bigger role in the briefings.

Recent iterations/issues

Many interviewees stated what they feel briefings should be like, which has parallels to the original/past iterations. Some highlights of the current understanding of what interviewees would like to see in briefings:

- Should be limited to high-level information: vision/strategy, debates over strategic plan, major financial decisions like building a new center, expensive medical equipment.
- These are opportunities for HHS to inform the county board on issues so that commissioners don't hear it first from constituents or the workforce.
- Should not be the time for storytelling — this is a business meeting and should be focused on finance.
- HHS should present on policy context to explain why they are making a major decision.
- Primarily, as the main forum for budget conversations and to share info with the county.
- County needs to be made aware of/have prior knowledge of certain things: major decisions, major budget expenditures, major programming, accreditation changes. County must be informed of changes and the plan for moving forward with those changes.
- Also, an opportunity for commissioners to provide community perspective to HHS board.

Detail

- HHS quarterly is not as effective, too far in the weeds; huge packets are inviting county board to reach into operations, not the right level of governance.
- In recent era, it has been a lot of "fluff" that was not representative or even relevant to the fuller picture.
- Briefing packets were hundreds of pages long and not digestible for the county board; then there would be a 90-minute presentation and no time for discussion afterwards.
- It is a cyclical dynamic:
    - County board is too far into weeds of HHS business.

    - HHS brings the weeds to the county in briefing packets.
    - County board continuously asks for more data, which is not their role.
    - County is not explicit enough in what information they need to have.
    - HHS pushes back by withholding data, bringing further conflict to the relationship.
- The county board is entitled to all data, but it is not the county's role to be in the minutia.

Presentation structure

- Briefings have allowed for some updates to the county board but have not provided a good space for county board discussion/decision on HHS challenges and HHS requests for financial support.
- Too one-directional; just presentation from one side and no time for collaboration or engagement.

Content

- Sometimes a conflict between County Administration and HHS Executive Leadership Team over what to present — are they deciding?
- There has never been a prescriptive list of what was presented on. Financials should always be there and first.
- More recently, often no budget briefing information included at all, which made oversight very difficult.
- Community Health Needs Assessment has become a rubber-stamp exercise; should be tied into the briefings — relates to mission/reserved power.

Preparation/timing

- Full of conflict because full of surprises; not enough regular communication and updates.
- Information is not provided to county board in a packet with enough time to prepare for the briefing.
- For example, challenges arose when HHS was asking for help from the county but there was not enough time to have a working session together on the topic before a vote needed to happen.

Other learnings

On needed transformation

County Board Resolution 25-0513: Authorized the governance review to include areas of needed transformation. The interview feedback centered on four main areas for needed transformation: (1) Roles and responsibilities, (2) HHS board education and onboarding, (3) Future briefings, and (4) Accountability. Each area is further detailed below.

Roles and responsibilities

Key questions

I. What is the role of the county board related to HHS?
   a. Define role
   b. Define responsibilities

II. What is the role of the HHS board related to the county?
   a. Define role
   b. Define responsibilities

III. Decision-making
   a. Determine which decisions lie with which bodies/persons
   b. Delineate areas that require collaboration
      i. Which decisions require prior notice?
      ii. Which decisions require input?
      iii. Which decisions require approval?
   c. Delineate areas where each body has autonomy in decision-making
      i. Which decisions are final?
      ii. Which decisions can be relitigated?
   d. What are the boundaries/guardrails around autonomous decision-making?
      i. Should there be a threshold for when decisions become collaborative?
   e. Determine processes for all

IV. What are the roles, responsibilities, and decisions of other specific individuals and entities?
   a. CEO
   b. County Administrator
   c. Board Chair
   d. Lawyers
   e. Intergovernmental Relations

Summary feedback from interviews

General issues

Centrality

- We could solve the majority of challenges in our system by understanding roles and responsibilities. Using that understanding as a foundation, relationships can be built to navigate the rest.
- This will build more "connective tissue" throughout the system, reducing over-reliance on individual players (e.g., CEO, commissioners on the HHS board).
- Understanding roles and responsibilities is more important than any particular set of board qualifications/expertise. The HHS board must understand the county's powers/rights.
- HHS and county interviewees described how understanding of roles and responsibilities deteriorated/changed over time on both sides.
- Many interviewees thought the lack of clarity around roles and responsibilities was the driver of discord and the ultimate dissolution of the board dynamic.
- One interviewee noted that a key purpose of the subsidiary with a separate board was to create a buffer between the county board and operations/management of HHS, which has gotten blurred.
- There are inherent political risks to HHS and the county being so intertwined. Defining roles and responsibilities is foundational to having good relationships between HHS and the county, which is necessary to ensure smooth navigation of difficult situations.
- HHS is a highly visible institution. This is especially heightened right now, and there are recent examples of this with recent local tragedies.
- Interviewees expressed a desire for autonomy within set boundaries.
- The overall health of the organization, and loyalty to that mission, needs to be the top priority for everyone involved. Once everyone is operating from that same stature, then implementation can be a focus.

Lanes

- HHS and county interviewees noted the lines around who got to make which decisions got very murky over time. Many stated that a top priority should be to lay out which decisions sit with which bodies.
- Need to have clarity and draw lines between what is a county board decision and what is an HHS board decision.
- Interviewees mentioned cultures that developed around lack of decision-making clarity (e.g., less accountability, not meeting budgets, turning to the county).
- There should be defined levels of involvement in decision-making (e.g., being informed prior, being informed afterwards, requiring input or discussion beforehand, ultimate

decision-making authority). HHS created a visual of which decisions belong to each board and the CEO.

- Reduce opportunities for decisions to be second-guessed.

Board education

- Many interviewees stated that roles and responsibilities should be centered or emphasized in board education, both for onboarding and annual education.
- One interviewee stated that in the past, the HHS board's role and responsibility were clearly stated as: hire, fire and evaluate the CEO; help the Executive Leadership Team develop strategy for the organization; evaluate risk to the organization.

Personnel

- Interviewees mentioned that clarity and education around roles and responsibilities should not be limited to the two boards.
- HHS executives, staff and providers also need training/education on the county role/relationship, governance structure and HHS's status as a public/government entity. HHS is not a healthcare entity; it is a public healthcare entity. Maintaining this institutional knowledge is key.

Other considerations

- Consider NorthPoint's processes as a template: NorthPoint co-application agreement outlines county role for shared understanding; NorthPoint bylaws spell out which decisions belong to board versus CEO; and NorthPoint board goes through training/onboarding to understand roles/responsibilities.

County board focus areas

In general

- Many interviewees emphasized that the county focus should be limited to the big picture. Day-to-day should be run by the expert management team at HHS, not the county board.
- One interviewee framed HHS as an instrument for the county to deliver healthcare to residents — what is the right level of autonomy to achieve this?
- Others said HHS is only one piece of the county strategy; the county board cannot advance all county priorities through HHS.
- A few would rather see HHS have an administrator model so that the CEO has less decision-making power; the county board would set the policy direction.
- A major power of the county should be in appointments (i.e., who is on the governing board). This allows the county to stay out of day-to-day operations and be more comfortable trusting HHS board members to be aligned with county interests.
- Some interviewees mentioned this appointment power should extend to the CEO selection as well as the governing board.

- Many interviewees noted that county board focus areas will depend on the governance structure (i.e., if the county is still the financial backstop, then they need to be the ultimate authority; if the county is no longer the financial backstop, then they should focus on aligned work and policy discussions on health and human services overlaps).
- Interviewees had various perspectives on what the county board's role should or should not be, coalescing around the general categories of oversight around the taxpayer interest, workforce, and policy/strategy.

Oversight/taxpayer interest

- The county board has a fiduciary obligation to the taxpayer and must keep oversight. Examples offered by interviewees include:
    - Focus on the bottom line of revenues/expenses — financial performance and capital efforts
    - Control financial oversight, including contracts, personnel, CBAs
    - Have degree of oversight for asset preservation and decisions with major financial impacts, within limits
    - Have sightlines to the budget determined by HHS board with the HHS Executive Leadership Team
    - Be involved in any financial decision outside of the approved budget
    - Make financial decision on cuts — big purchases, big program changes
- Consider structure more like the countywide elected officials (county attorney and sheriff), where HHS would have leeway to make policy decisions, unless they have a financial impact (then they must be approved by the county board).

Workforce

- The county board cannot be involved in personnel decisions; they cannot substitute their judgment for the HHS board/HHS Executive Leadership Team.
- It is too easy for the county board to get bogged down in individual complaints (patient/workforce), which limits their time for big picture policy questions.
- Concerns about conflict of interest with electorate when involved in these decisions.
- The county board should not get into the details of Reductions in Force or pay/benefits — creates cyclical problem (i.e., cuts are proposed by the HHS board, county rejects decision but also does not fund the difference).
- Can be hard to pin down the exact cost of a program (intertwined with other overhead).
- County board should care about the bottom line on revenues/expenses for workforce.

Policy/strategy

- County board should be involved in policy conversations around vision, and areas where there could be alignment with county services/ventures (e.g., Health Services Plan).

- Should focus on teeing up and exploring big strategic issues; their role is not to decide everything; should pick their battles.
- Should be involved in decisions on major changes that intersect with county priorities and strategy (e.g., ending a major program).
- There is an inherent conflict/tension where political concerns could overwhelm the strategy.
- County board should have sightlines into strategy but, ultimately, strategy should be determined by HHS board with the HHS Executive Leadership Team.

HHS focus areas

In general

- Should make sure equity issues are kept in focus; it is critically important and should not be on the back burner.
- HHS should keep the public policy lens.
- Balanced budget should always be a top focus, along with strategy/vision.
- The HHS board needs to focus on asking the right questions around big picture issues (e.g., how to improve the quality of care, how to manage the cost of care, what is the corrective action plan for any problem).
- In the past, some HHS board members had a tendency to micromanage.
- A few expressed the HHS board could be a purely advisory body without control or could be overseen by a small subcommittee of the county board.
- A few expressed concern that the HHS board is not well positioned to be in the driver's seat of decisions considering they are uncompensated and many have full-time day jobs. In addition, they do not have access to information at the same level as the county (e.g., closed legal and labor briefings, etc.) to be informed enough to hold leaders accountable.
- One interviewee noted that an original intent for creating the subsidiary was a perception that the county board was neglecting HHS and wasn't involved enough.

Strategy/vision

- HHS board responsibility includes helping the HHS Executive Leadership Team determine strategy and holding the leadership team accountable to it.
- Also described by interviewees: Determine strategy, growth, or divestiture; determine mid- to long-term performance goals for operations, quality/safety, and finance; discuss potential ventures with external partners.
- Should be empowered for long-term strategic planning; more freedom to do this exploration would be welcome — they should have more than public boards, which tend to be restricted to short-term.
- Could focus on the brand and strategy, either related to or separate from the county's.

- Strategy is key to the rest of the HHS board's work. There are many great ideas, but they need to be filtered through a coherent strategy.
- One interviewee noted the specific strategy needs in the current climate (e.g., there will need to be strategy around market impacts of recent mergers).
- Some noted that the strategic focus of the HHS board has been impaired in recent years due to the financial distress — focused on surviving so no time to strategize.
- Strategy needs to shift focus from survival to the next phase.

CEO/Executive Leadership Team

- The HHS board should have control over hiring, firing, and evaluating the CEO.
    - Alternative view: The HHS board should not make hiring/firing decisions for CEO/CFO without input from county board.
- The HHS board should have input on other executive leaders besides CEO, too.
- The HHS board should focus on accountability/corrective actions for CEO and the Executive Leadership Team.
- One interviewee noted that HHS board members may have contact with senior staff, but directives should be solely in CEO's authority.
- One interviewee noted that there also should be a focus on succession planning for the CEO. Lack of a plan and written protocol/shared understanding led to outsized challenges with high turnover in recent years.
    - Should be addressed in bylaws. Successor must have sufficient experience/exposure with the county because the relationship is so central.
    - Both the county and community need to be able to count on HHS to have sufficient stability to weather any transition.

Finances

- The HHS board should have control of financial decisions (except those reserved for the county, depending on financial backstop relationship in governance) and should do budget oversight.

Operations/services

- The point of having the HHS board is to run the day-to-day; there should not be county involvement.
- The HHS board should make decisions about adding/ending services.

Board governance

- Some interviewees shared thoughts regarding roles and responsibilities as they relate to the HHS board as a governing body.
- The HHS board must build internal infrastructure to support, document and standardize their work (e.g., for evaluating the CEO, holding Executive Leadership Team accountable

to strategy, and general board functioning such as keeping meeting cadences prepared and on track).

  - One interviewee noted that support staff to help with general board functioning could be extremely helpful and noted that the county does an excellent job investing in these key roles.

- HHS board members can get too focused on minutia, which has limited strategy/vision conversations. There needs to be a healthy balance in their role of not being too hands off and not being in the weeds.
  - One interviewee noted that the Executive Committee was not always functional in fully vetting and discussing ideas.
- The board chair is responsible for ensuring their full membership is engaged. They need to make sure conversations stay at the governance level of strategy, and they need to make sure members work as a team/group. HHS leadership and staff cannot be directed by one or a few board members.
- The committees' membership must support discussion and fully vet decisions. Avoid creating a hierarchy among board members; keep all engaged.

Workforce

- The HHS board needs to play an active role regarding safety of staff — not just receiving reports but having options to address/take corrective actions.
- HHS compensation is an HHS board issue, not a county issue.
- Reductions in Force (RIFs):
  - Some interviewees thought the HHS board should decide any RIF or workforce impact.
    - Some interviewees noted the county should be notified or updated.

Programming: Services/innovation/experience

- The HHS board should be responsible for weighing which services can be maintained and which must end.
- Some interviewees thought that reducing benefits would be a management call, but reducing services is an HHS board call.
  - Some noted the county board may want notice or to be more involved.
- The HHS board should focus on patient experience and program innovation; those should not have county board involvement.
  - Alternative view: HHS focuses too much on extras/innovation and needs to prioritize core mission functions first.
  - It also was noted that some of these innovations/programs should be with the county or with an external nonprofit partner.

Levels of involvement

Some interviewees noted specific examples of what level of decision-making each governing body should be involved in, and some flagged concern about how much power could be delegated to HHS leadership (and what reporting is provided on decisions made pursuant to delegation).

Approvals or notice

- County board should get advance notice of any RIF.
- As long as HHS and the county are financially intertwined, the county needs to be aware when the HHS board is trying to make big decisions or spend a lot of money.
    - Prior notice on program changes, capital expenditures, accreditation problems.
- The county should have oversight of any spending outside of the approved budget.
- One interviewee noted an example of the tiers of involvement for the county board:
    - Should be informed about changes in programs
    - Should be given input on leadership (e.g., CEO/CFO), and
    - Should be the decision-maker on major capital projects (e.g. campus plan).
- One interviewee brought up the possibility of the county board committee structure having authority in decision oversight (e.g., could big-budget items go to the chair of the county's health committee for sign-off).

Restrictions

- There should be a limit on involvement for oversight, so the county board doesn't get into operations territory.
    - Even if operational decisions impact finances, that doesn't mean the county has free rein to intervene or influence those decisions; some interviewees mentioned that commissioners' influence or disagreement could be perceived as effectively vetoing an HHS decision.
- Should be restrictions on opportunities to second-guess decisions made by the HHS board/Executive Leadership Team.
    - Creates a cyclical dynamic where decisions are made by the HHS board, the county board relitigates decisions, Executive Leadership Team can't execute on HHS decisions, the HHS board feels they don't have decision power, etc.
- How do you empower the HHS board to make certain decisions and remind the county board not to overrule what they have agreed to let the HHS board decide?
- The county should not be involved with any spending that was approved in the budget but can intervene when HHS is spending outside the budget.

Metrics

- Some interviewees mentioned specific metrics that they would like to see related to roles and responsibilities.
    - Accountability — personnel
        - The CEO needs to be empowered to have autonomy within the boundaries defined. They need to stay within those boundaries, and metrics should be established to evaluate that performance.
        - Should be targets and measures for the CEO as well as the Executive Leadership Team.
    - Accountability — finances
        - There should be a dollar threshold set to determine when county oversight kicks in for asset preservation, decisions with financial impacts.
        - County should have full oversight when HHS spending is outside approved budget; otherwise not involved.
    - Care delivery
        - Should have a plan that includes measurable goals.
        - Note: In the past, the Press Ganey score was used regularly and shared with the county board at briefings.
    - Strategy
        - Should have targets and measures built in.
        - Should create regular reports based on those measures to share with the county board.
        - Mid- to long-term performance goals for operations, quality/safety, care delivery, and finances.
    - Workforce
        - Thresholds should be set for when the county becomes involved in decisions (e.g., if RIF is for fewer than 100 people, solely HHS authority; if more, county gets involved).
    - Reports
        - There should be regular reports (quarterly, monthly) on important metrics such as expanding/contracting services, outside partnerships, and innovations.
        - They should include summary information as well as measurements against state benchmarks or peer sets.
        - One interviewee noted this would improve briefings as well; the county board could already be informed of the changes in these metrics and there would not be a need to dive deeply into them during briefing time.

HHS board education and onboarding

Key questions

I. What forms of education and onboarding would be helpful to ensure the HHS board understands its role and the role of the county board?
   a. Which past forms should be incorporated?
   b. What should be considered as a new or updated form of education and onboarding?

II. What will be the overall plan or strategy for onboarding the reconstituted HHS board? What will the county board's role be in that plan or strategy?
   a. Whose responsibility will it be to develop, update, and conduct HHS board education moving forward? (e.g., county board, HHS Board, or a joint effort)

III. What needs to be documented as part of board education and onboarding?
   a. Examples could include a recent history on county-HHS relationship, an overview of any changes implemented in 2026, or putting specific requirements in the HHS bylaws or elsewhere

Summary feedback from interviews

Norms

- Some interviewees mentioned challenges in board education and onboarding being too norms-based.
  - The process wasn't formally established, so it changed and deteriorated over time with board chair turnover. The process can and will change depending on who is leading the board at any given time.
  - It may be easier to set expectations on the front end, before the opportunity has passed (e.g., decorum norms are difficult to re-establish once they have deteriorated).
  - One interviewee mentioned that establishing these norms more formally could result in more board stability overall, because nominees would need to be able to work within the formal framework; it wouldn't be so personality dependent.
  - Others noted lack of onboarding has resulted in the HHS board not providing the accountability needed and not having a holistic view of the board (too personal).

Institutional knowledge

- Lack of board education on history led to duplication of work because board members were unsure whether something already existed or had been tried previously. This became especially problematic during times of high turnover.
- Interviewees expressed some concern around the lack of documentation from the HHS board to the point of liability.

- Understanding and institutional knowledge declined over time. For example, in more recent iterations of the board, some members did not know how or why HHS became a county subsidiary.
- One interviewee stated loss of institutional knowledge around HHS identity as a major driver of issues over time.

Roles and responsibilities

- By far, the most frequent mention of helpful board education topics, from both HHS and county interviewees, was around roles and responsibilities. Interviewees noted this should be a major/foundational part of the education, along with the distinction between management and governance.

Annual recurrence

- Both HHS and county interviewees mentioned that education should be annual and not limited to orientation/onboarding.
- One interviewee suggested that board members should sign off on this annual education.
- Some mentioned that it would be helpful to have the attorneys present annually to walk through the legal side (e.g., disclosures, rules, regulations).
- Interviewees who have held leadership positions on other boards emphasized how critical it is to prioritize annual education.
- This education should be a full training, not just a retreat.
- Some interviewees mentioned that continuous education of board members is especially important right now due to the rapidly-evolving health landscape.

Materials

- Some interviewees mentioned specific materials that would help set up the HHS board for success. Those included:
    - A large reference guide in plain language laying out roles and responsibilities — with example scenarios to demonstrate them — plus procedural information (e.g., about the budget process).
    - Documentation of past board actions and discussions, as well as physical copies of documents to be referenced by current and future board members.
    - Institutional knowledge documents including historical information with context around past changes (e.g., what led to original subsidiary creation), timelines of relationship dynamics (e.g., Hennepin Faculty Associates), plus more recent events like the dissolution of the HHS board. Some interviewees mentioned how important this information is to maintain stability, particularly during times of high turnover.
    - Document outlining similarities and differences between HHS and the county, including organizational norms, that can be carried over between staff/leadership transitions.

- Once determined, documents laying out strategy (e.g., annual, 3-5 year, etc.), including targets and measurements to which the HHS board will be held accountable.

Methods

- Some interviewees mentioned specific methods that would help set up the HHS board for success. Those included:
  - Shadowing: Could board members shadow for a year before officially beginning their work? Could there be a 3-month onboarding process where recruits join the board as non-voting members to train? In the past, trial runs provided valuable learning for all.
  - Tours: New appointees should go on an HHS tour led by key players. Tours of clinical spaces were done more regularly in earlier iterations of the board and were helpful; they got people closer and more familiar with the organization, plus they made board members feel appreciated and recognized.
  - Mentorship: HHS board members should have assigned mentors. In the past, new members were paired with longer-serving members as mentors. This set-up helped with norms and accountability. For example, the mentor could have a conversation with the mentee if they were going off-track.
  - Training: Should emphasize understanding the public nature of HHS and its constraints. Also build into training: history/context including pain points; board rules, norms, and expectations (e.g., on disagreements, dissenting views, respect for varied expertise); approaches to governance and discipline; meeting commitments and calendar details. Consider hiring external professional trainers. Consider involving the county for team building, information sharing, and role/responsibility delineation (e.g., in a presentation).

Other considerations

- Some interviewees mentioned other considerations, both positive and negative:
  - Personnel: More formal onboarding should not be limited to the board. HHS should consider ways to educate others (e.g., staff, policymakers, providers, labor relations etc.) on their role in a governmental entity — specifically, the county relationship and governance structure.
  - Retreat: Time should be spent thinking about gaps members have, what that means for the next round of recruitment, and getting to know one another better. The more people know and trust one another, the more comfortable they are sharing their opinions. The retreat is a good place to facilitate strengthening those relationships.
  - Annual meeting: Consider an annual meeting of both the HHS and county boards all together. A major governance topic could be covered during each meeting as an agenda item to build continuity in education.

- Cadence: Board and committee cadence could be more frequent so that board education would be more rigorous and kept fresher.
- Recognition: The county should prioritize making board members feel more appreciated and recognized for their service to the county and the public, including when they leave the board. Appointees should be introduced to the county board, similar to when a new county leader starts, to emphasize the start of the ongoing relationship and recognition of their role.

Other past learnings

- Onboarding/orientation for the HHS board were not very successful, not well attended, not engaged. Retreat sessions were better attended but were overpopulated by members who had prior board experience and less by those who needed more training.
- Interviewees noted some software tools being used for board management were unsuccessful and difficult to navigate. There were other resources added to try to help. These tools should be reconsidered.
- HHS board members shadowing HHS leadership, doing tours with management, and touring specific spaces (e.g., simlab) helped board members feel more connected to the organization, as well as recognized and appreciated for their service.
- Interviewees reported it made a big difference to have casual lunches before board meetings. Members could show up for lunch before the start of a meeting, get to know one another better, speak with commissioners and management, etc.
- One interviewee noted that dinners were a less effective venue for this team building.

Future briefings

Key questions

I. What is the purpose of HHS briefing the county board?

II. What information would be most helpful to receive at these board briefings to fulfill that purpose?
    a. At what level?
    b. In what format or style (e.g., summaries)?
    c. Using what metrics?
    d. On what timeline?
    e. From whom (e.g., who attends, presents)?
    f. In what setting (e.g., where, what is public)?

III. What actions will be taken based on briefings (e.g., votes on report-outs, etc.)?

Summary feedback from interviews

Purpose of briefings

- For the HHS board to provide information to the county board that will help commissioners understand the financial picture of HHS.
- To share information to facilitate the county's role in protection of the public's investment in the health system (amount of public funds, where they go, facilities, etc.).

Level of detail

- Many interviewees said information provided from the HHS board should be:
    - What is most useful to the county board in their role as the ultimate governing authority/body accountable to the taxpayer/protector of public investment; and
    - Presented at the appropriate level for commissioners in that capacity.
- Other considerations:
    - Presenting information in too much detail invites micromanagement, which blurs lines around roles and responsibilities and next steps for any proposals.
    - One interviewee mentioned an example of their ideal level of detail: 2-3 slides on pre-set metrics, plus monthly reporting at a high level focused on finances.

Prescriptive agenda, topics

- Interviewees expressed a desire for briefings to be more formally structured.
- Examples include:
    - Set agenda items
    - Set standing reports, based on pre-determined metrics to measure specific outcomes, with accompanying votes
    - Creating a distinction between agenda items (requiring votes) and updates (not requiring votes) and considering which should be included in a briefing setting
    - Annual summary reports (e.g., the previous year's litigation)
    - Processes that kick in when figures reach a pre-determined threshold
    - Set follow-up mechanisms for questions or asks that come up during a briefing; should be process-oriented with accountability measures built in
    - HHS updates should be centered on the well-established health domains of the county including clinical outcomes, financial performance, disparity elimination, and employment
    - There should be an annual process for domain-based items, with quarterly and annual updates built into cadence
    - Conversations should center around balancing mission against available resources

    - One interviewee mentioned that there should be a joint meeting for both county and HHS leaders annually where they agree on four major shared priorities, and the quarterly briefings can be built around that
- Reasonings include:
    - Minimizing back and forth "discussion loop" that results from the current set-up
    - Limiting feedback/directions from individual commissioners, which adds confusion and complexity
    - Report-outs could be submitted to the state for monitoring and broader oversight after county ratification

Content

- Some interviewees had specific topics that they thought should be included in briefings:
    - Financial (including strains, headwinds, opportunities)
    - Employees/employee relations
    - Threats and risks
    - Collaborations/partnerships
- Topics should be narrowed further to areas where there is overlap between HHS and the county.
- One interviewee noted that HHS is such a major community asset, but current briefings do not provide community context/information around what role HHS really playing in the health landscape — mental health, comorbidities, diabetes, etc.

Meetings vs. briefings

- Interviewees also expressed that they would like the briefings to be set up more as meetings than briefings.
- Examples include:
    - Currently, only set up for information sharing, and in cases where there is a need beyond that, it does not work.
    - Needs to be set up for the county board to engage in, rather than just receive, information. There needs to be discussion time built in.
    - The county board should get information further in advance so that they can fully understand it before a briefing happens, and then more briefing time can be used for discussion.
    - In a case where the HHS board is planning a new innovation, this should be the venue to have a robust discussion around that — the context, the need, the impacts, the gaps that would be filled by the innovation, etc.
- Reasonings include:
    - Supporting the county board in their oversight role through more discussion

- Providing a venue for the county board to give input around potential synergy/partnership opportunities that would mitigate duplication between HHS and county

Agenda development

- HHS and the county must align on the cadence and agenda of briefings.
- One interviewee stated that HHS should drive the agenda. It can be subject to county board feedback but could not be directed or managed by County Administration.

Presenters

- There were varying perspectives on who should be presenting at briefings.
- Examples include:
  - Makes sense to have the CEO be the one presenting, both operationally and financially.
  - The CEO should set the table, but the board chair should be actively engaged and do some presentations.
  - Having one person be the presenter makes sense; the structure is not set up for success to have more than one person to answer to.
  - It would be nice if HHS board members played more of a role, but acknowledgment that it isn't their day job and would be difficult to have enough time to prepare and engage.
  - One interviewee described a more prescriptive presentation strategy: financial updates could come from the Executive Leadership Team, and policy updates could come from HHS board leaders.
  - One noted that the CEO presenting is most practical, though it makes sense to have other board members there in an observational role, as possible.
    - They noted that since other board members work full time, there is an inherent knowledge/capacity gap, and they likely would end up deferring to the CEO in those situations for that reason.

Timing/frequency/cadence

- Some interviewees expressed that quarterly briefings are not frequent enough to keep the full county board informed and should be made more frequent.
- Consider whether the committee structure could be used to help with this (e.g., once an item goes to the HHS finance committee or full board for a vote, it could be reported to the county board for situational awareness).
- Consider whether the cadence must be adjusted to allow the county board to reflect on information being presented at briefings for effective oversight.

Transparency

- Some interviewees would like the briefings to be a public process and take place in the boardroom. For example, could they be public meetings structured like the county's child well-being briefings.

Briefing accountability

- Interviewees had differing perspectives on how accountability should be incorporated into the briefings. Examples include:
    - When it comes to board directives, the CEO needs to give honest feedback of what HHS has the capacity to complete and how much it would cost in hard numbers rather than answering based on mission alignment alone.
    - One interviewee mentioned that it would be helpful for the county to have the ability to compel HHS to produce information that has been requested.
    - If information presented in briefings is not clear, the only recourse the county has is to ask the HHS board chair, which is not always successful.

Hennepin Health model

- Some interviewees mentioned that Hennepin Health briefings could be considered as a useful model moving forward. Their comments included:
    - These briefings go well; helpful information is presented in a digestible way.
    - Participants walk away from the briefings with a clear understanding of the financial picture.
    - The briefings have discussion time built in.
    - The materials, particularly the summaries, are great. Useful summary examples include: high level programming, where expanding/contracting, where partnering, where innovating.
    - Performance metrics are built in, including comparison measures showing performance relative to other systems, as well as against statewide benchmarks.

Accountability

Key questions

I. What is the county board's role in creating accountability in the governance model?
    a. What is the HHS board's role?
    b. What is the role of HHS leadership?
II. What current or past accountability measures have been effective?
III. What should be considered as a new or updated accountability measure?
IV. How will the expectations on accountability be shared or documented or implemented?
    a. E.g., adopting board rules and procedures, adopting a code of conduct and reporting procedure, etc.

Summary feedback from interviews

General issues

- Accountability was raised by interviewees as an opportunity for a change and a reset. Interviewees frequently mentioned the need for accountability measures, including written expectations for roles, responsibilities, behavior, confidentiality of information, etc., as well as agreed-upon methods for raising and addressing concerns — for example, a code of conduct, board rules of decorum, board meeting procedures, etc.
- Several interviewees mentioned that each board must be responsible for holding its own members accountable — for their performance, for understanding their role, for respecting the role of others — either through private conversation to address concerns, through a more formal code of conduct or similar measure, or through existing appointment and removal procedures.
- Some thought meeting in public session could encourage respectful interactions; others thought any concerns related to conduct or behavior would be more effectively handled in private conversation rather than a public airing.

Existing accountability measures

- The county board has an existing power to hold HHS accountable through a financial audit. Some interviewees thought this should be done annually for more sightlines of HHS's financial condition and controls.
- The county board also has an existing power to hold HHS accountable through the budget approval process. Some interviewees noted that this served as a constraint, though it sometimes seemed ineffective.
- The county board has an existing power to hold HHS and its board members accountable through the process to approve nominations by slate. Some interviewees noted that this is a constrained power, since the county board would have to accept or reject the slate as a whole. Still, it is a method to hold the HHS board and its members accountable for their performance.
- Several interviewees noted that the county board's options for holding HHS accountable were limited and somewhat inflexible, and they offered ideas (outlined below) that could make the powers more effective and meaningful.
- The HHS board has existing powers to hold its own members accountable (except county commissioners), including the power to remove an individual board member for any reason including performance, behavior, etc. Some interviewees described self-policing as the healthiest model for accountability.
- The HHS board has existing powers to hold HHS leadership accountable, including the authority to set and measure performance goals, to oversee HHS's internal controls, to impose constraints on the CEO's decision-making authority, to discharge the CEO, etc. Some interviewees expressed that the HHS board must be active in its role to provide meaningful scrutiny and oversight of HHS leadership.

Ideas for improving accountability

- The county board could have more authority to remove individual HHS board members for cause. Some interviewees thought this would make commissioner involvement on the HHS board less necessary.
- The county board could have more authority to audit HHS's internal controls and ensure responsible use of public funds.
- The HHS board could adopt a code of conduct, rules of decorum, and meeting rules and procedures. Some interviewees mentioned the opportunity for more rigor around HHS board procedures and activity (e.g., agendas, proposed action items, etc.), as an accountability measure for a publicly-owned entity with public funding.
- The HHS board could implement performance metrics to be included in each board packet to ensure regular reporting by HHS leadership and regular oversight by the HHS board. Some interviewees mentioned that the HHS board used to use the Press Ganey score as a metric for evaluation. Other interviewees expressed concern and frustration that the HHS board packets were not always designed to support or allow the HHS board to engage in meaningful oversight (e.g., long packets provided at the last minute, material that was not on-topic for the board's role).
- Additional members of the HHS Executive Leadership Team (e.g., CFO, CMO) could be directly accountable to the HHS board or could have special responsibilities to flag issues of concern to the HHS board. Several interviewees expressed caution about past perceptions that HHS leaders were accountable directly to the county board.
- The county board or HHS board could impose additional financial reporting requirements on HHS — to the public, to the HHS board, or to the county board — for example, regular reporting on any deviation between the adopted budget and actual expenditures, so the HHS board could consider accountability for HHS leadership or the county board could consider accountability for the HHS board.
- Any agreement for the county to provide funding to HHS could include performance measures. For example, the county could impose constraints on use of Accountable Care Organization (ACO) funds or uncompensated care funds and require reporting on use of funds and results; the agreement could outline any consequence or accountability for the county if it does not provide agreed-upon support.
- A cap on the county's financial backstop for HHS could impose natural consequences and place more responsibility on HHS board members.
- Additional state oversight could be an accountability measure, especially with the new state funding.
- HHS leadership have primary responsibility for handling workforce complaints and for holding providers accountable, but the HHS board could have more oversight of these issues through a regular reporting requirement (e.g., a quarterly summary, a regular listening session, a workforce advisory board, etc.) so that it can hold HHS leadership accountable on these issues.

On transparency and alignment

County Board Resolution 25-0513: Authorized the governance review to include opportunities for improving transparency and alignment with the county. The interview feedback provided a range of ideas and suggestions for improving (1) Transparency and (2) Alignment. Each area is further detailed below.

Transparency

Key questions

I. What is HHS's core identity and purpose?
   a. Consider different perspectives: HHS's identity on its own, as part of the county, or within the state's healthcare ecosystem

II. What is the relationship between the county and HHS in the near-term and long-term?

III. How does HHS's identity and role as a healthcare system, or its relationship to the county, impact expectations for transparency?
   a. What information should be shared, with whom, and how?
   b. How will those expectations for transparency be shared or documented or implemented?

Summary feedback from interviews

General issues

- Several interviewees mentioned concern and frustration that HHS would not share information openly with county commissioners and county senior staff or would not allow county officials to attend HHS board and committee meetings.
- Some interviewees stated that more transparency and data-sharing with the county board and the public will be necessary to rebuild trust; some noted that other public hospitals share more information publicly than HHS.
- Some interviewees suggested that senior county leaders could act as an extension of the county board's oversight by maintaining sightlines into HHS's budget and finances, as well as its services. This could be achieved by including senior county leaders in HHS board and committee meetings (as observers), or by having regular meetings among senior staff, but would require open sharing of information.

Transparency on HHS budget and public expenditures

- Some interviewees thought the HHS budget process should be open to the public, like other parts of the county. At a high level, this would not be a competitive disadvantage and would improve public accountability and trust.
- Several interviewees expressed that at a minimum, HHS should have to be as transparent about its use of state and county funding as any other public entity (like county

departments), for example, by documenting and reporting its use of funds (from the county's ACO, for uncompensated care, for asset preservation, for capital equipment, etc.). HHS is serving the same patient population as Hennepin Health, NorthPoint, and Public Health and should have the same level of public accountability.

- Some interviewees mentioned that HHS should be transparent about any deviation from their adopted budget (e.g., if funds were planned but not spent for a particular purpose), and that HHS board discussions, actions, and decisions should be documented and accessible.
- Ideas for improved transparency: a dashboard of key metrics at HHS with regular reporting on the metrics or return-on-investment for public funds (available either to the public, or at least to the county board and staff); regular reporting to county, state, and other stakeholders on uncompensated care and on use of funds for uncompensated care, including information on interactions among hospitals (i.e., patients transferred to HCMC by other hospitals for uncompensated care).

Alignment

Key questions

I. What is HHS's core identity and purpose?
    a. Consider different perspectives: HHS's identity on its own, as part of the county, or within the state's healthcare ecosystem

II. What is the relationship between the county and HHS in the near-term and long-term?

III. How does HHS's identity and role as a healthcare system, or its relationship to the county, impact expectations for alignment?
    a. Where is alignment required or preferred or unnecessary?
    b. How will those expectations for alignment be shared or documented or implemented?

Summary feedback from interviews

Alignment within HHS

- Some interviewees mentioned opportunities to improve alignment within HHS by clarifying decision-making process and authority.
- Some mentioned that the lack of clarity on decision-making process and authority was causing confusion and impacting employee relations.
- Others thought there is too much department-level decision-making, which is limiting the view of enterprise impacts, including connections to the county.
- Some interviewees mentioned that changes over time at HHS (board members, leadership, and staff) have resulted in some loss of institutional knowledge (including about the relationship with the county) and a loss of county connections.

Alignment on identity, mission/vision and strategy

- Alignment on HHS identity, vision and strategy was mentioned as a repeated concern by interviewees.
- Several interviewees mentioned the lack of shared understanding about HHS's overall identity. Some interviewees emphasized HHS's public nature, while others emphasized that HHS needs to operate and compete like a private nonprofit. Some emphasized the relationship and connection with the county, while others emphasized the separation of the entities. Some said that the lack of alignment on these issues had contributed to conflict between the boards.
- Some interviewees expressed the view that HHS's prior strategy — to compete for more private payers, to attract HHS and county employees as patients, to attract downtown workers as patients — contributed to a shift away from a public safety-net focus and contributed to a lack of alignment with the county. Some thought this strategy made it harder for some of the patient population to get access to providers and appointments.
- Other interviewees thought the county and HHS have always been well aligned on mission, but conflicts arose when the mission cost more than the available resources, and there was no discussion or decision on how to move forward within those constraints.
- Some interviewees considered HHS strategy to be within the purview of the HHS board; others thought the county board would be the ultimate decision maker on vision and strategy. Many interviewees expressed the need for alignment on vision and strategy for HHS, so long as the county is the parent or financially responsible or a funder.
- As an example, interviewees mentioned the need for a review of HHS programs grounded in its mission and financial realities, to inform its strategy for programs/services and capital planning. Many interviewees expressed a concern that HHS cannot be all things to all people and must focus on its core mission and strengths to be both sustainable and fiscally responsible. Some said that the county board needs to clearly define its priorities for HHS, so that HHS can align to those values or expectations.
- Several interviewees said the overall HHS identity, vision and strategy must be understood and supported by the county board (especially as owner and funder) so that it can be implemented. Several expressed the need to build support within the workforce, community, and other stakeholders as well. Several expressed that uncertainty about the strategy and about the final decision maker on strategy had contributed to instability within HHS and confusion over what actions could be implemented by the HHS board and/or management.

Alignment on culture

- Several interviewees gave feedback on the need to build a healthy culture around both collaboration and disagreement — at the board level and among leadership and staff — to engage in problem-solving together.
- Several interviewees gave feedback for the boards to prioritize working together as a governing body — making room in the decision-making process for discussion and

dissenting views, but then reaching a majority decision and implementing it in unison — reducing interpersonal conflict and public airing of disagreements that may undermine confidence and trust.

Alignment on ACO and integrated care delivery

- Many interviewees identified the county's Accountable Care Organization (ACO) as an opportunity for improved alignment with HHS and integrated care delivery, since all partners in the ACO are supported by county board funding from the same residents/taxpayers and are serving overlapping patient populations.
- Interviewees suggested developing a strategic plan for the ACO (clinical, financial, community, policy) with greater coordination and integration with HHS's Community Health Needs Assessment. Some interviewees noted that the ACO is another opportunity for sightlines and oversight, where HHS could report on its impacts to health outcomes, to getting patients enrolled, to reducing uncompensated care costs, and to avoiding duplicating work across county and HHS providers, etc.
- Interviewees suggested connecting the county's financial support for HHS to a return on investment for the county's ACO strategy, including specific projects related to service delivery, improved outcomes and reduced costs/readmits, population health work, coordination on EPIC projects, etc.
- Interviewees mentioned some recent improvements to the ACO model as well as the ongoing opportunity to build relationships across staff involved in the ACO, create shared understanding of ACO priorities and expectations for performance, and improve accountability and alignment on use of ACO funds.
- Several interviewees mentioned an opportunity to continue exploring the Federally Qualified Health Center (FQHC) model for a health network within the boundaries of Hennepin County, similar to the Denver Health model, and building on existing community trust in NorthPoint.

Alignment on salaries

- Salaries were often mentioned as a challenging topic for alignment.
- Several interviewees expressed the view that HHS must pay market rate salaries (aligned with private nonprofit hospitals) to recruit professional leadership and staff.
- Some interviewees mentioned that salaries may be an area where the county and HHS must accept some amount of misalignment, and that this was one reason for the original decision to create a subsidiary (e.g., hospital nurses may have a different compensation rate than clinical nurses).
- Several interviewees expressed the view that HHS leadership roles are public service, not private-sector, and that the executive salaries at HHS are out of line with the public nature and financial challenges of the institution.
- Some interviewees mentioned that salaries may be an area where more alignment is needed to rebuild trust and reduce points of conflict and tension.

- Under Minnesota Statutes 383B.907, the HHS board has authority to approve levels of compensation and benefits recommended by the HHS administrator. Some interviewees suggested imposing constraints on salaries, while others cautioned against viewing salaries in isolation (without also considering benefits).

Alignment on employee and labor relations

- Employee and labor relations were often mentioned as a challenging topic for alignment.
- Some interviewees viewed this as an area where alignment is necessary, both operationally and philosophically, including valuing the role of labor unions and building a collaborative relationship with the workforce and unions, with regular engagement and discussion.
- Several interviewees described HHS leadership as less engaged with or more adversarial toward unions in recent years and acknowledged that the HHS workforce and unions may have brought their concerns to county commissioners out of frustration with the relationship.
- Other interviewees expressed that when the county board or HHS board hears of workforce or labor concerns, those reports and complaints should be routed to HHS management for review and action. Some interviewees mentioned concerns that having one or more commissioners or board members engage individually with staff and unions often undermines the labor-management-board structure.
- Several interviewees recognized the challenge for county commissioners in navigating union concerns while recognizing the respective roles of management versus board(s), given the political impacts of the relationship for an elected official.

Alignment versus duplication

- Interviewees frequently mentioned challenges around duplication between the county and HHS — duplicative operational functions and duplicative services.
- Some interviewees suggested embedding some county staff in certain HHS operations to help bring the county perspective and culture for greater alignment.
- Some interviewees thought that some county-HHS operations should be combined or integrated for both alignment and efficiency. Examples included payroll, budget and finance, human resources and labor relations, and purchasing.
- Other interviewees thought county and HHS operations should not be combined because the approaches are too different or because that would limit the county's ability to consider other governance models (e.g., certain autonomy for HHS, an arm's-length relationship between the county and HHS, a state role, etc.).
- Some interviewees mentioned a need for HHS to streamline internally to reduce duplication (e.g., centralized scheduling versus department-level scheduling). Others mentioned a need for HHS to evaluate where its services overlap with county services (e.g., human services areas). Some interviewees mentioned the need to identify a forum where these issues could be raised and evaluated.

- Other interviewees mentioned that better coordination of HHS's Community Health Needs Assessment and the county's Community Health Assessment and/or ACO strategy would improve alignment and reduce duplicative efforts.

Ways to foster alignment

- Interviewees offered a range of ideas on how to improve alignment between HHS and the county. These included:
    - Build relationships and foster trust between the county board and HHS board. The two entities used to be more aligned but started to drift away from one another over time and as people changed roles.
    - Bring newly-appointed HHS board members and leaders to the commissioners' offices for introduction.
    - Create as many connection points as possible at the staff level: finance, legal counsel, lobbying, operations, clinical staff, etc. Some noted that CFOs and legal counsel had been crucial to maintaining alignment on certain issues.
    - Prepare a historical report on recent actions, decisions, and changes to inform stakeholders (e.g., past several years of HHS board actions, recent history on county board actions to resume interim management, etc.).
    - Prepare an overview of the county-HHS relationship and connection points (including program and service overlaps, agreements, etc.) to educate new board members, leaders, and staff as well as to preserve institutional knowledge and history.
    - Provide HHS board and leaders with more information and understanding of county priorities, domains, and financial pressures.
    - Have HHS board prepare a report for the county board that aligns with the disparity elimination domains.

On engagement

County Board Resolution 25-0513: Authorized the governance review to include ways to improve engagement with community, workforce, patients/clients, leadership and elected officials.
The interview feedback provided a range of ideas and suggestions for improving (1) Engagement with a range of stakeholders, which is further detailed below.

Engagement

Key questions

I. What is the goal and purpose of HHS engagement with each stakeholder group?
    a. This should be informed by the county board's decisions about what the roles and relationship will be in the near-term between the entities (e.g., which decisions are delegated to the HHS board; in what sequence/using what process; what is the county's role on mission, financial support, and oversight, etc.)
    b. Stakeholder groups: county board and county senior staff; HHS board and HHS executive leadership; HHS workforce and union leadership; HHS community and patients

II. What forms of past engagement would help achieve that goal and purpose?

III. What should be considered as a new or updated form of engagement?

IV. How will the expectations on engagement be shared or documented or implemented?

Summary feedback from interviews

General issues

- Better engagement will be possible once roles are clarified and understood. In the past, there was sometimes confusion or disagreement at HHS over who served as main contact with the county and county board (e.g., board chair or CEO).
- Need to build a holistic model with a regular cadence and framework for meetings and engagement, including in-person, so it is not always in crisis and not as dependent on individual relationships. The passage of time, the impact of the pandemic, and staff departures weakened ties between the organizations.
- Need internal pathways and relationships to address concerns and disagreements. When those disagreements happen in public, it can damage trust with one another and with other stakeholders.

HHS with county commissioners

- The level and frequency of interaction between HHS board members or staff and county commissioners or county board has varied widely over the years.
- In the past, it was common for the HHS chair and HHS leaders (CEO, CFO, CMO, etc.) to brief commissioners individually and in-person — in addition to any county board

briefings or meetings — on the proposed budget, legislative priorities, major decisions or challenges, etc. These meetings allowed two-way communication on questions or concerns and resolution of issues while avoiding any surprises.

- At other times, there was an expectation that the HHS CEO would meet with individual commissioners or handle any updates; sometimes, there was an expectation that the commissioners appointed to the HHS board would handle any communication or updates.
- Consider whether to hold more joint meetings with both boards and what the purpose of those meetings would be: relationship-building, learning more about each board's priorities, refreshing on the governance structure and roles, improving the culture toward collaboration, developing a shared vision or strategy, etc.
- Consider whether and how the county is included in building the annual plan for HHS board and committee meetings.
- Consider who should attend county board briefings related to HHS (HHS board officers or members, HHS CEO or other leaders) and what their role is (facilitate, present, observe, etc.).
- Consider regular meetings between the board chairs, or the finance committee chairs, or other key connections; or a way to routinely provide updates to the county board after each HHS board meeting.
- Consider having a county board committee that focuses on the hospital to allow more information-sharing by HHS staff in a public forum or having work sessions between briefings to allow more opportunities for information-sharing.
- Consider having a joint committee that includes some commissioners and some HHS board members (similar to bench-board meetings).
- Consider informal opportunities for commissioners to engage with HHS board members, like shared tours or ride-alongs, recognition of outgoing board members, etc.

HHS with county senior staff

- Many interviewees mentioned that the county CFO and HHS CFO have maintained regular communication, including weekly meetings and county CFO attendance at HHS finance committee meetings. Some thought this helped with two-way information sharing; others thought this was a form of oversight (i.e., that the county CFO could flag any concerns to the County Administrator or county board).
- In addition, HHS leadership have attended meetings with county senior staff related to the county's Accountable Care Organization (ACO). Some interviewees mentioned recent improvements to the framework for those meetings, and others mentioned that there is still room for improvement on collaboration (e.g., EPIC projects) and on data-sharing around funding use and results.
- Consider whether a similarly structured framework should be expanded to other county and HHS senior staff including the stated purpose. Some ideas would be including key county staff as attendees at HHS board and committee meetings, scheduling regular 1:1 meetings between the County Administrator and HHS CEO, scheduling a regular joint

county-HHS staff committee (administration, finance, human resources, labor relations, overlapping operational areas, etc.) to share updates and resolve issues.

HHS with its board members

- Within the HHS board structure, several interviewees mentioned that there are opportunities to improve engagement through the committee structure and membership.
- HHS board members could be engaged by including brief opportunities to socialize (e.g., lunch prior to meeting start, shadowing management for a day, hosting meetings at clinic sites).

HHS with its workforce

- HHS needs a regular structure of staff engagement so that leaders can provide updates to keep the workforce informed and staff can raise concerns so issues can be addressed early. This would be two-way communication to reduce conflict and find shared priorities. The engagement plan has to be resourced and refreshed regularly as an ongoing priority.
- Ideas include all-staff meetings, all-manager/supervisor meetings, a workforce advisory board, and listening sessions with staff on key issues (e.g., CEO search, financial concerns, etc.).
- Another idea was to include managers (not just executive leaders) on HHS board committees or in committee meetings to improve staff awareness of issues and for staff to know they have representation in the discussion.
- Interviewees shared that in the past, engagement has included a designated HHS board member (sometimes a commissioner) joining HHS leadership to meet with a staff group (such as physicians or union leaders) to resolve issues.
- A recent engagement example was weekly or biweekly meetings between HHS leadership (board members, executive leaders, human resources, intergovernmental relations, etc.) and union leaders on this year's lobbying efforts to obtain funding, with a suggestion that these meetings continue on a monthly or quarterly basis as a supplement to the ordinary monthly management-labor meetings. Legislative priorities is an area where HHS leadership and labor can find common ground and collaboration.
- The monthly management-labor meeting was mentioned as an example of engagement that has some value, but it is not one-size-fits-all, given different unions' differing concerns and size/impact. Some engagement may need to focus on relevant subsets of the workforce. Some interviewees mentioned a need to rebuild labor relations toward greater collaboration, less adversarial relationships, and more transparency (during collective bargaining or meet-and-confer sessions).
- Ideas for greater transparency about HHS board activities include timely posting of meeting dates, locations, and agendas on the public website; giving staff a virtual option to observe HHS board meetings; posting board member names and contact information on the public website; ensuring some public portion of HHS board meetings with

meaningful content; and considering an open forum or another pathway to share concerns directly with HHS board.

- InfoOnCall was mentioned as a resource that HHS uses to communicate with staff, which can be helpful but not as the only method.

HHS with its community and patients

- HHS has built a good working relationship with its neighborhood.
- HHS could build a support network by engaging with the city and other downtown stakeholders.
- In some eras, the HHS board included key community perspectives, and that can and should be a two-way benefit.
- If not represented on the HHS board, then need one or more community advisory boards (CABs) to bring that perspective, with a meaningful pathway for CABs to share input and feedback with the HHS board directly (e.g., annual report, regular updates, CAB chair(s) serving on an HHS board committee, etc.).
- HHS should review how other systems engage successfully with patients and build a strategy (e.g., NorthPoint staff host quarterly patient listening sessions, NorthPoint board reviews patient complaints on a quarterly basis).

Recommendations

Short-term priority

Transition governance to the reconstituted HHS board by January 15, 2027: Recent legislation requires the county board to reconstitute the HHS board by January 15, 2027, and to transition governance to that reconstituted HHS board on the same date. All short-term work must occur within the existing statutory framework (the parent-subsidiary model), but the county board has meaningful authority and flexibility within that framework.

Timeline

Q3 2026 (July-September)

Governance preparation

- Brief commissioners (individually or in small groups) on existing governance documents: bylaws, operating and funding agreement, lease, and shared services agreement.
- Provide the county board with an overview of potential updates to those documents.
- County board offers preliminary direction on the scope of updates and expectations for county-HHS alignment and engagement in 2027.

HHS board recruitment launch

- County board provides preliminary direction on HHS board size, qualifications, and compensation.
- County board provides initial expectations for HHS board member onboarding and education.
- County staff and an external consultant finalize recruitment strategy, application materials, and outreach.
- County staff begin reviewing applications and updating commissioners as the pool develops.

Q4 2026 (October-December)

Finalize governance updates

- Continue commissioner briefings on revisions to governance documents.
- County board approves:
    - Updated bylaws
    - Operating and funding agreement
    - Lease
    - Shared services agreement
- County board approves the HHS budget.
- County board provides direction on the county's 2027 plan for engagement and alignment with HHS.

Advance HHS board recruitment

- County staff conduct initial interviews with applicants.
- Commissioners conduct final candidate interviews.
- County staff provide summary assessments and support county board decision-making.

Q1 2027 (January-March)

Transition to the reconstituted HHS board

- County board appoints the reconstituted HHS board by January 15 (including any commissioner-appointees).
- Governance is formally transitioned to the reconstituted HHS board on January 15.
- New HHS board completes onboarding and education.
- County board initiates its 2027 engagement and alignment plan (e.g., quarterly briefings, joint board-to-board meetings, etc.).

Long-term priority

Develop the county's vision for its future role with HHS: With new state stabilization funding and a state advisory task force reviewing HHS's future governance and financing, the county board has an opportunity to define its long-term vision and share it with state and system partners.

Timeline

Q3 2026 (July-September)

- County representative and HHS CEO begin participating in the state advisory task force.

Q4 2026 (October-December)

- Commissioners receive briefings on task force discussions and emerging themes.
- County board adopts its 2027 legislative platform.

Q1 2027 (January-March)

- Commissioners review the state advisory task force's preliminary recommendations.
- County engages with the 2027 legislature on governance and funding considerations.

Q2 2027 (April-June)

- Ongoing county engagement with the 2027 legislature as state advisory task force recommendations advance.

Attachments

- Hennepin County Board Resolution 25-0513
- Governance Review Interviewees
- Other Systems Tables

HENNEPIN COUNTY
MINNESOTA

300 South Sixth Street
Minneapolis, MN
55487-0240

RESOLUTION

Board of Hennepin County Commissioners
RESOLUTION: 25-0513

At a meeting of the Board of Hennepin County Commissioners, a motion was made by Commissioner Fernando, and seconded by Commissioner Goettel, that the Resolution be adopted. The motion passed.

Resolution:
BE IT RESOLVED, that the Hennepin County Board of Commissioners directs the county administrator, or their designee, to perform a comprehensive review of Hennepin Healthcare Systems, Inc. governance; and

BE IT FURTHER RESOLVED, that the comprehensive review includes but is not limited to identifying those aspects of past governance that have been successful, those aspects that have not been successful, areas of needed transformation, opportunities for improving transparency and alignment with the County, and ways to improve engagement with community, workforce, patients/clients, leadership and elected officials; and

BE IT FURTHER RESOLVED, that the county administrator be authorized to utilize internal and external resources to assist with this work, subject to normal County Board contract approval requirements; and

BE IT FURTHER RESOLVED, that a progress report be provided to the Hennepin County Board of Commissioners by March 15, 2026 and a final report containing background and recommendations be provided to the Hennepin County Board of Commissioners by June 30, 2026.

Recommendation from County Administrator: Recommend Approval

RESOLUTION ADOPTED ON 12/11/2025

The question was on the adoption of the resolution with the votes as follows:

Aye: 7 Commissioner Fernando, Commissioner Greene, Commissioner Conley, Commissioner Lunde, Commissioner Edelson, Commissioner Anderson, and Commissioner Goettel

Maria Rose M. Rose

Maria Rose

Governance Review Interviewees

Hennepin County Commissioners

- Dr. Irene Fernando, Chair
- Debbie Goettel, Vice-Chair
- Jeffrey Lunde, District 1
- Marion Greene, District 3
- Angela Conley, District 4
- Heather Edelson, District 6
- Kevin Anderson, District 7

Former Hennepin County Commissioners

- Jan Callison
- Jeff Johnson
- Randy Johnson
- Peter McLaughlin

Former HHS Board Members

- Mark Bernhardson
- Kyle Makarios
- Sharon Sayles Belton
- Steve Thompson
- Diana Vance-Bryan
- Craig Warren

Hennepin County Administration and Executives

- Jodi Wentland, Hennepin County Administrator
- Kareem Murphy, Deputy County Administrator
- Dan Rogan, Deputy County Administrator
- Joe Mathews, Hennepin County Chief Financial Officer
- Mike Herzing, Hennepin Health Chief Executive Officer
- Kimberly Spates, NorthPoint Health and Wellness Center Chief Executive Officer
- Liz Young, Hennepin County Intergovernmental Relations Director

Former Hennepin County Administration and Executives

- David Hough, Former Hennepin County Administrator
- Rex Holzemer, Former Assistant County Administrator

- Dave Lawless, Former Hennepin County Chief Financial Officer
- Anne Kanyusik Yoakum, Former Hennepin Health Chief Executive Officer
- Stella Whitney-West, Former NorthPoint Health and Wellness Center Chief Executive Officer

Current and Former Hennepin County Attorneys

- Ben Schweigert, Hennepin County Attorney's Office Civil Division Director
- Henry Parkhurst, Senior Assistant Hennepin County Attorney
- Katie Lynch, Senior Assistant Hennepin County Attorney
- Andy Mitchell, Former Senior Assistant Hennepin County Attorney
- Marty Munic, Former Senior Assistant Hennepin County Attorney

HHS Administration and Executives

- Dr. John Cumming, HHS Chief Executive Officer
- Abdi Abdirahman, HHS Chief Financial Officer
- Wendy Stulac-Motzel, HHS Chief Operations Officer
- Dr. Nathan Scott, HHS VP of Hospital Acute Care Services
- Dr. Tom Wyatt, HHS Chair of Emergency Medicine and Former HHS Board Member

Former HHS Administration and Executives

- Dave Albright, Former HHS Vice President of Finance
- Dr. Mick Belzer, Former HHS Chief Medical Officer
- Derrick Hollings, Former HHS Chief Financial Officer
- Dr. Eric Ling, Former HHS Chief Medical Officer

HHS Union Leaders/Representatives

- Santiago Morgan, Hennepin Healthcare Interpreter Unit Chair, MN Newspaper and Communications Guild TNG-CWA 37002
- Minnesota Nurses Association (MNA)
    - Janell Johnson Thiele, HHS MNA Tri-Chair
    - Jeremy Olson-Ehlert, HHS MNA Tri-Chair
    - Mariah Tunkara, HHS MNA Tri-Chair
- John Ewaldt, HHS MNA Labor Relations Specialist
- Claire Van den Berghe, Deputy Director of CIR-SIEU Great Lakes Region
- Derrick Givens, IBEW Business Agent for HHS Technicians
- Dan McConnell, Minneapolis Building and Construction Trades Council – Business Manager
- Shane Hallow, HHS HCAPE President

Other Systems Tables

Contents

NOTE: The information below for Denver Health and Parkland Memorial in Dallas reflects what is in statute only as their health system bylaws are not readily available online. The information below for all other systems reflects what is in both statute and bylaws.

Governing Body/Structure

County System	Provisions for Comparable Health Systems
Cook County, IL | *Population ~5.6M* (Cook County Health & Hospital System)	Governed by Cook County Health Board of Directors
Miami-Dade, FL | *Population ~2.8M* (Jackson Health System)	Governed by Public Health Trust of Miami-Dade County
Alameda, CA | *Population ~1.6M* (Alameda Health System)	Hospital Authority governed by Board of Trustees, plus Joint Powers Agreement with City of Alameda Health District
Santa Clara, CA | *Population ~1.9M* (Santa Clara Valley Healthcare)	Health System governed by elected County Board of Supervisors
Dallas, TX | *Population ~2.6M* (Dallas County Hospital District d/b/a Parkland Health)	Hospital District governed by Dallas County Hospital District Board of Managers (Parkland Health Board of Managers)
Denver, CO | *Population ~780K* (Denver Health System)	Health and Hospital Authority governed by Board of Directors
Westchester, NY | *Population ~1.0M* (Westchester Medical Center Health)	New York state public benefit corporation governed by Board of Directors
King County, WA | *Population ~2.3M* (Harborview Medical Center)	Harborview Medical Center is owned by King County, governed by county-appointed Board of Trustees, managed under contract by the University of Washington through Hospital Services Agreement
Cuyahoga, OH | *Population ~1.2M* (MetroHealth System)	Health System governed by Board of Trustees

**Denver, CO is a consolidated city-county municipality. References below to the City, Mayor, City Council refer to the County.*

Qualifications

County	Provisions for Comparable Health Systems
Cook County, IL	The appointed Directors shall include persons with the requisite expertise and experience in areas pertinent to the governance and operation of a large and complex healthcare system. Such areas shall include, but not be limited to, finance, legal and regulatory affairs, healthcare management, employee relations, public administration, clinical medicine, community public health, public health policy, healthcare insurance management, managed care administration, labor affairs, patient experience, civil or minority rights advocacy and community representation. Criteria to be considered in nominating or appointing individuals to serve as Directors shall include: (1) Background and skills needed on the Board; (2) Resident of Cook County, Illinois; (3) Available and willing to attend a minimum of nine monthly Board meetings per year, and actively participate on at least one Board committee; and (4) Willingness to acquire the knowledge and skills required to oversee a complex healthcare organization.
Miami-Dade, FL	Each member of the Board of Trustees shall be a United States citizen and a permanent resident and duly qualified elector of Miami-Dade County, unless the Board of County Commissioners waives the residency requirement by a two-thirds vote of its membership, and shall be of an outstanding reputation of integrity, responsibility, and commitment to serving the community. Before entering upon the duties of office, each appointee to voting membership on the Board of Trustees shall give bond in the amount of one hundred thousand dollars ($100,000.00) to the Clerk of the Commission for the faithful performance of the duties of office and shall take the prescribed oath of office. The membership of the Board of Trustees should be representative of the community at large and should reflect the racial, gender, ethnic and disabled make-up of the community.
Alameda, CA	A. General Qualifications The Board of Trustees should, to the extent feasible, reflect both the expertise necessary to maximize the quality and scope of care of AHS in a fiscally responsible manner and the diverse interests that the AHS serves. Desirable skills include, but are not limited to, business management, public health, health care administration, personnel management and labor relations, medical services, managed care, consensus building, finance, fund raising, and cultural sensitivity.

	B. Specific Qualifications Qualifications that are desirable in Trustees include the following: 1. A familiarity with the health care delivery systems; 2. A working knowledge of the existing health care funding sources; 3. An understanding of the multitude of issues relating to participating in managed care programs; 4. Experience with employee organizations; 5. A strong business management, legal, finance and/or program management background; 6. Experience with managing hospital services; 7. Experience with, or understanding of, the delivery of health care services by non-profit entities; 8. An interest in or experience with the health care needs of the AHS's patient populations; 9. Experience in advocating for safety net institutions including, but not limited to, the pursuit of public funding for the delivery of health care services; 10. Reside in Alameda County (except that this need not be considered desirable when selecting the Medical Staff representative); 11. A familiarity with public sector collective bargaining, including interest-based bargaining; 12. A willingness to work collaboratively and maintain positive relationships with AHS partners, including the County of Alameda; and 13. A willingness to hold the Administration, including the Chief Executive Officer and other members of the Executive Leadership Team, accountable for AHS's financial and operational performance. C. Disqualified Persons 1. Persons who are providers of medical care, or are employed by a provider of medical care, who are or, in the view of the Board of Supervisors, may be in competition with AHS. 2. With the exception of the representative of the Medical Staff and the Chief Executive Officer, persons employed by or who are contractors/vendors of AHS or who are employed by a contractor/vendor of AHS. Except where prohibited by law, any disqualification may be waived by majority vote of the Board of Supervisors.
Santa Clara, CA	[County Board is Health System Board]
Dallas, TX	To be eligible to serve as a director, a person must be a resident of the county or hospital district that appoints them. An employee of the district may not serve as a director.

Denver, CO	None specified in statute.
Westchester, NY	Each voting director should possess a high degree of experience and knowledge in relevant fields and a high degree of interest in the corporation. The appointment of any voting director to the corporation shall be based in part on 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.
King County, WA	Statute specifies: In making appointments to the board, an effort should be made to assure that diverse geographic, social, cultural, ethnic, racial and economic backgrounds and perspectives are considered. Candidates should possess: demonstrated leadership ability, and recognized experience in management or administration, planning, finance, health service delivery, consumer representation or institutional operation; and the ability to work cooperatively with others of diverse backgrounds and philosophies. Additionally, all candidates must be willing to commit to the amount of time necessary to perform trustee duties, serve on board committees and serve as an advocate for the medical center. Qualifications not named in bylaws.
Cuyahoga, OH	Statute: (1) Members shall be electors and representative of the area served by the hospital, except that not more than two members may be electors of the area served by the hospital that is outside the county in which the hospital is located. (2) A physician may serve as a member, including a physician who is authorized to admit and treat patients at the hospital, except as follows: (a) Not more than two physicians may serve as members at the same time; (b) No physician who is employed by the hospital may serve as a member. Bylaws: Pursuant to Ohio Revised Code Section 339.02, no more than two Trustees shall be electors of the area served by the organization that is outside Cuyahoga County. Each Trustee shall be qualified to vote on any issue that may properly come before any meeting of the Board and to hold any office of the Board to which such Trustee may be elected or appointed, subject to the conflict of interest policy of the Board and the provisions of the Ohio Revised Code.

Size

County	Provisions for Comparable Health Systems
Cook County, IL	12-member Board of Directors
Miami-Dade, FL	5- to 7-member Public Health Trust, incl. at least one physician if required by law or regulation
Alameda, CA	9-member Board of Trustees
Santa Clara, CA	5 members (elected Board of Supervisors)
Dallas, TX	11-member Hospital District Board
Denver, CO	11-member Hospital District Board
Westchester, NY	19-member Board of Directors: 15 voting directors, plus 4 non-voting directors
King County, WA	13-member Board of Trustees
Cuyahoga, OH	10-member Board of Trustees

Compensation

County System	Provisions for Comparable Health Systems
Cook County, IL	Except for the President's direct appointment, the appointed Directors are not employees of the County and shall receive no compensation for their service, but may be reimbursed for actual and necessary expenses while serving on the System Board.
Miami-Dade, FL	Trustees shall serve without compensation but shall be entitled to reimbursement for necessary expenses, including the expense of performance bonds, incurred in the discharge of their duties.
Alameda, CA	The Trustees by a resolution adopted by a majority vote of the members of the board, may authorize the payment of not to exceed two hundred dollars ($200) per regular or special board or committee meeting, not to exceed four meetings a month as compensation to each member of the Board of Trustees. The Trustees are not otherwise precluded from receiving compensation in connection with individual pursuits. Any reasonable modification of the compensation plan, within the limits set forth above, may be made upon a resolution adopted by a majority of the members of the Board of Trustees, at a regularly scheduled meeting of the Board. Trustees shall be reimbursed for actual and reasonable expenses incurred in the performance of official business of AHS assigned by the Board of Trustees. Actual and reasonable expenses in the form of airfare/hotel accommodations shall be reimbursed as established by policy of the Board of Trustees.
Santa Clara, CA	[County Board is Health System Board]
Dallas, TX	A board member serves without compensation.
Denver, CO	Members of the board shall receive no compensation for such services but may be reimbursed for necessary expenses while serving on the board.
Westchester, NY	No voting or nonvoting director of the Corporation shall receive any compensation for any services performed by him or her as a director, but shall be reimbursed for all their actual and necessary expenses incurred in connection with the carrying out of his or her duties
King County, WA	A board member shall not receive any compensation or emolument whatever for services as a board member and shall be governed by the county code of ethics and state law regarding conflict of interest. Board members may be reimbursed for travel expenses.
Cuyahoga, OH	Board of Trustees is composed of voluntary members.

Nominations/Appointments Process

County	Provisions for Comparable Health Systems
Cook County, IL	12-member Board of Directors. 1 appointment by Board President (who may be employee of the county), & 1 Ex Officio Director who is the Chair of the Health & Hospitals Committee of the County Board. Upon vacancy of any other Director position, 13-person Nominating Committee* provides 3 nominees per vacancy to the Board President. Nominating Committee is appointed by Board President. Board President then submits their nominee selections to County Board for approval (by individual); no limit on how many nominees County Board can reject. *Nominating Committee is made up of representatives from: (a) Chicago Civic Federation; (b) Civic Committee of Chicago Commercial Club; (c) Chicago Urban League; (d) Healthcare Financial Management Association; (e) [Reserved]; (f) Illinois Public Health Association; (g) Illinois Health and Hospital Association; (h) Health and Medicine Policy Research Group; (i) Chicago Department of Health; (j) Cook County Physicians Association; (k) Chicago Labor Federation; (l) Chicago Medical Society; (m) Association of Community Safety Net Hospitals; (n) Midwest Latino Health Research Center.
Miami-Dade, FL	Different nomination process for different appointees. • For minimum 5 voting trustees: Candidates are submitted individually by Nominating Council*, County Board has appointment power by simple majority vote. *Nominating Council (9-members): (a) 5 voting members of Public Health Trust; (b) President of local AFL-CIO; (c) County Board Chair; (d) County Mayor; (e) Chair of County Delegation in State Legislature. • For other 2 trustees (optional): County Commission may ratify appointment for County Mayor to appoint 1 member, and Legislative Delegation to appoint 1 member.
Alameda, CA	9-member governing body: 8 approved by majority vote of Board of Supervisors, with each Supervisor making at least one appointment. Board of Trustees may present recommendations to Board of Supervisors. At least 1 of the 8 is appointed by Board of Supervisors without input from Board of Trustees or medical staff. 1 of 9 is representative of medical staff, also approved by Board of Supervisors.
Santa Clara, CA	N/A (County Board is Hospital Governing Board)

Dallas, TX	11-member Hospital District Board: • 1 appointed by County Board overall • 2 appointments *per* County Commissioner (x4) • 2 appointments by County Judge (County Executive)
Denver, CO	11-member Hospital District Board: Mayor appoints the members of the board whose appointments are conditioned upon confirmation by the Denver city council.
Westchester, NY	19-member Board of Directors (15 voting directors, 4 non-voting directors): - 15 voting directors, ALL subject to approval by the County Executive • 8 appointed by NY Governor • 7 appointed by Westchester County Board - 4 non-voting directors • CEO of the corporation • 1 appointed by County Executive • 1 appointed by Majority Leader of County Board • 1 appointed by Minority Leader of County Board
King County, WA	13-member Board of Trustees. • 9 appointed by King County Council, with each Councilmember providing one nomination to represent their district (appointed by County Executive who can choose not to select nomination, & request Councilmember to re-nominate) • 4 at-large positions nominated by the Council (each Councilmember nominates, County Executive selects appointments)
Cuyahoga, OH	Appointed by County Executive, subject to confirmation by County Council

Commissioners on the Board

County	Provisions for Comparable Health Systems
Cook County, IL	1 Ex-officio voting member: County Commissioner Chair of Health & Hospitals Committee
Miami-Dade, FL	None specified, though there is currently a state senator serving on Public Health Trust who was nominated by county delegation of the state legislature
Alameda, CA	None specified
Santa Clara, CA	County board is health system governing board
Dallas, TX	None specified in statute
Denver, CO	None specified in statute
Westchester, NY	None specified
King County, WA	Explicitly ineligible - A person shall not be eligible for appointment as a member of the board who holds or has held, during the two years immediately before appointment, any salaried office or position in any office, department or branch of county government.
Cuyahoga, OH	None specified

Committee Structure

County	Provisions for Comparable Health Systems
Cook County, IL	Standing Committees: Audit & Compliance, Finance, Human Resources, Quality & Patient Safety, Managed Care. Committees can create subcommittees, either standing subcommittees or special subcommittees.
Miami-Dade, FL	Subcommittees of the Whole: Audit & Compliance, and Pension Plan. Chapter 25A* Committees: Compensation & Evaluation, Trust/Medical School Annual Operating Agreement Negotiating Committee, Trust/Miami-Dade County Annual Operating Agreement. (*Chapter 25A is the county ordinance establishing/governing the Trust)
Alameda, CA	Executive Committee; Finance Committee; Joint Strategic Planning Committee; Medical Credentialing & Policy Committee; and Audit & Compliance Committee. The Joint Strategic Planning Committee shall be comprised of two (2) members of the Board of Trustees and two (2) members of the Board of Supervisors.
Santa Clara, CA	Governing body is County Board. The Health and Hospital Committee is a committee established by the Governing Body to serve as a formal means of medico-administrative liaison among the Governing Body, the SCVMC administration and the Medical Staff. The voting members of the Health and Hospital Committee consist of two members of the Governing Body. Non-voting members of the Health and Hospital Committee include the following or their designee: County Executive, County's Chief Operating Officer, President of the Medical Staff, Deputy County Executive SCVHHS, Chief Executive Officer SCVMC, President-elect Medical Staff, Chief Financial Officer SCVHHS, Chief Medical Officer, Chief Nursing Officer/Director of Patient Care Services, Public Health Administrator, Director of Mental Health Department, Director of Alcohol and Drug Services, the Public Health Officer, and County Counsel.
Westchester, NY	Executive Committee, a Finance Committee, a People, Culture and Compensation Committee, an Audit and Corporate Compliance Committee and a Committee on Quality. Special Committees are: a Governance Committee and an Access, Patient Experience and Community Engagement Committee. Additionally, the Information Technology Committee is a Committee of the Corporation.
King County, WA	Executive Committee; Finance Committee; Joint Conference Committee; Strategic Planning Committee; Governance Committee; and the Employee Relations Committee. Composition, delegates (if applicable), purpose, and responsibilities laid out for each. Executive Committee Composition: The Executive Committee of the Board shall consist of the president of the Board, who shall serve as chairperson of the Committee, the first vice president of the Board, and the immediate past president of the Board. The three at-large members shall be appointed by the president, with the approval of the Board
Cuyahoga, OH	Executive Committee; Governance Committee; Facilities and Planning Committee; Finance Committee; Audit and Compliance Committee; Quality, Safety and Experience Committee; Health Equity & Diversity Committee; Human Resources and Compensation Committee; and such other standing committees as the Board may authorize.

Evaluation Measures (CEO & Other)

County	Provisions for Comparable Health Systems
Cook County, IL	Cook County Ordinance, under System Board Powers includes: To develop measures to evaluate the CEO's performance and to report to the President and the County Board through the Health and Hospitals Committee at six-month intervals regarding the CEO's performance;
Miami-Dade, FL	Miami-Dade County Ordinance for Public Health Trust states: The Board of Trustees shall annually evaluate the performance of the Trust Chief Executive Officer and refer such evaluation to the special Trust Compensation and Evaluation Committee for the compensation recommendation it deems appropriate, based on the Board's performance evaluation of the Trust Chief Executive Officer.
Alameda, CA	Bylaws state: The Board of Trustees shall conduct a formal evaluation of the Chief Executive Officer's operational and financial performance every six months. The Chief Executive Officer shall not be present during the discussions of his/her performance except that the Chief Executive Officer shall be given the opportunity to address the Board of Trustees as part of the evaluation process. Board of Trustees Powers and Duties include: The Board of Trustees shall conduct an annual self-evaluation of its performance of the duties specified in Article 2, Section 7, of these bylaws. The scope and results of such annual report shall be reduced to writing and provided to the Board of Supervisors on a not less than annual basis and shall include a section detailing the key accomplishments of the Chief Executive Officer for the review period.
Santa Clara, CA	(County Board is Governing Body). Bylaws state duties and responsibilities include: To appoint and monitor the performance of the County Executive, who, as the chief administrative officer of Santa Clara County, shall appoint and monitor the performance of the Deputy County Executive of SCVHHS.
Westchester, NY	Bylaws state Governance Committee responsibilities include: advise and coordinate Corporation Board activities in the areas of governance of the Corporation, including evaluation of board performance and education. People, Culture, and Compensation Committee responsibilities include: review the performance of the President and Chief Executive Officer ("CEO") and Chief Financial Operating Officer ("CFO"); review and evaluate the annual objectives of the President and CEO and the CFO and report to the Board thereon, and subsequently lead the Board's annual review of the President and CEO's and CFO's performance in light of approved objectives; review the CEO's assessment of the performance of employees at the level of Executive Vice President and above; review the President and CEO's decisions with respect to the salaries, bonus determinations and other compensation for all eligible staff (with the exception of the CFO) at the level of Executive Vice President and above and make an appropriate report to

	the Board; review, through the President and CEO, the management succession plan and professional/personal development plans for each senior vice president and above;
King County, WA	Bylaws state Governing Board Powers and Duties include: Conducts the Board's process for the annual Chief Executive Officer Performance evaluation in conjunction with the President, UW Medicine Hospitals & Clinics. Executive Committee responsibilities include: Coordinates input into the Chief Executive Officer evaluation process by the President, UW Medicine Hospitals & Clinics, consistent with the board-approved process, and in a manner that promotes trust and candid communication between the Board and CEO, ensures that the CEO understands the Board's expectations, and provides constructive feedback to the CEO on her/his performance consistent with the hospital services agreement.
Cuyahoga, OH	Bylaws state: Regular and special meetings: The Board shall hold a special meeting not less than once biennially to review the organization's mission and to evaluate the Board's role and performance related to achieving that mission unless the Board has otherwise accomplished such review and evaluation through regular meetings and/or Board retreats. CEO: The Board shall review the performance of the President and Chief Executive Officer, which shall include the institutional objectives and goals established by the Board, from time to time as the Board deems appropriate. Executive Committee: The Committee shall be responsible for coordinating evaluation of the President and Chief Executive Officer's performance, which evaluation shall be completed by the full Board. Audit and Compliance Committee: The Audit and Compliance Committee shall be responsible for: (i) oversight of the quality and integrity of the organization's financial statements, (ii) oversight of the audit and review of the organization's financial statements by the independent auditors, (iii) oversight of the organization's compliance with legal and regulatory requirements and the independence and *performance of its independent auditors,* (iv) recommending to the Board of Trustees the appointment of the independent auditors, and (v) performing all other functions prescribed by the Board of Trustees and permitted by applicable law.

Governing Body Meeting Transparency

County	Provisions for Comparable Health Systems
Cook County, IL	Board website: The annual meeting calendar & location is published with agendas & minutes. They receive written testimony from the public for meetings, and have a process to pre-register for in-person or virtual public testimony. Statute specifies: The System Board may hold public hearings as it deems appropriate to the performance of any of its responsibilities. Such public hearings may be held provided that the following requirements are satisfied: 1. a notice containing the time, place and subject matter of the hearing and solicitation of pertinent public testimony shall be placed on the CCHHS' website and provided to the County for posting on its website. 2. any other applicable meeting notification requirements found elsewhere in these Rules or law. The System Board shall comply in all respects with the Illinois Open Meetings Act as now or hereafter amended, and found at 5 ILCS 120/1, et seq.(f)The System Board shall be an Agency to which the Local Records Act, as now or hereafter amended, and found at 50 ILCS 205/1, et seq. applies.
Miami-Dade, FL	Board website: The annual meeting calendar & location is published with agendas & minutes. Meetings are livestreamed. Statute specifies: The Trust shall hold and televise regular meetings of the Board of Trustees at the main campus of Jackson Memorial Hospital or in Commission chambers. Except as provided by law, all meetings of the Board shall be public and audio recorded and written minutes of the proceedings thereof shall be maintained by the clerk of the Board. All actions taken at the meetings of the Board shall be promptly and properly recorded. Upon request, copies of minutes or resolutions of the Board shall be provided to the County Mayor, Commissioners or the Clerk of the Board of County Commissioners. Bylaws further specify compliance with Sunshine Law regulations.
Alameda, CA	Board website: The annual meeting calendar & location is published with agendas & minutes. All Board meetings allow for public comment on items that are either on the agenda or are under the purview of the Board; email to board notifying participation requested, with specific committee instructions for participated listed on their respective agendas. Audio recordings of meetings since 2006 provided on website. Statute specifies: Records relating to trade secrets, payment rates or the determination thereof, and contract negotiations not subject to CA public records law, as well as the transmission of those records to the board of supervisors. Notwithstanding any other law, the governing board may order that a meeting held solely for the purpose of discussion or taking action on hospital authority trade secrets shall be held in closed session. The requirements of making a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description devoid of the information constituting the trade secret. The governing board may delete the portion

	or portions containing trade secrets from any documents that were approved in the closed session that are provided to persons who have made the timely or standing request. Open sessions of the hospital authority constitute official proceedings authorized by law within the meaning of Section 47 of the Civil Code. The privileges set forth in that section with respect to official proceedings apply to open sessions of the hospital authority.
Santa Clara, CA	Board website: Meeting calendar, agendas, & minutes provided online. Option to provide written public comments as well as request process to speak in-person or virtually at meetings. Meetings livestreamed. Statute specifies: The Health and Hospital Committee meets at least once a month with the exception of the month of July. Minutes are recorded and sent to each member of the Governing Body and the members of the Health and Hospital Committee. The meetings of the Health and Hospital Committee are considered public meetings, and as such, any member of the public, including SCVMC staff and physicians, may address the Committee on any matter of public interest.
Dallas, TX	Board website: Meeting calendar, agendas, & minutes provided online. Members of the public may speak at Parkland Board meetings; there are rules provided for pre-registration of speakers for public comment on both agenda items & non-agenda items. Statute specifies: the annual budget proposal meeting is the only meeting specified to be a public hearing.
Denver, CO	Board website: Agendas & minutes provided online, as well as procedures for public comment at meetings. Procedures include adherence to subject matter restrictions, rules to notify board staff by phone prior to meetings, time restrictions (max. 15 minutes of public comment per meeting, no more than 3 minutes each). Statute specifies: All resolutions shall be recorded and authenticated by the signature of the secretary of the board of directors. The resolutions and other proceedings of the board of directors, minutes of the board meetings, annual reports and financial statements, certificates, contracts and financial agreements, employee salaries, and bonds given by officers, employees, and any other agents of the authority, and any personnel reports, guidelines, manuals, or handbooks, other than individual personnel files, are a public record as defined in section 24-72-202 (6) and subject to part 2 of article 72 of title 24. The account of all money received by and disbursed on behalf of the authority is also a public record. Notwithstanding any provision of this section to the contrary, EMR contents & PHI is not a public record, including writings and other records concerning the modification, initiation, or cessation of patient care and authority health-care programs or initiatives shall not be deemed to be a public record if premature disclosure of information contained in such writings or other records would give an unfair competitive or bargaining advantage to any person or entity. Note on state level transparency provision: in July 2024, CO enacted the Hospital Transparency & Reporting Act which requires all CO hospitals to publicly disclose extensive financial, operational, and executive compensation data to the CO

	Dept. of Health Care Policy & Financing (HCPF), HCPF then creates & releases an annual comprehensive report to the public.
Westchester, NY	Board website: Meeting calendar, agendas, & minutes provided online, including archived minutes going back to 2017. Public meetings are livestreamed & archived past meeting livestreams also provided. In Statute: Under New York Open Meeting Law, monthly Board of Directors and Board Committee meetings are open to the public (unless otherwise noted). Meeting locations, agendas, materials, & updates to the schedule are posted prior to each meeting, and minutes are published following the meetings. The meetings are livestreamed on their website.
King County, WA	Board website: 2026 meeting calendar, agendas for upcoming meeting for full board and every committee, and Zoom sign-in info for the next meeting are provided, along with directions to submit public comment via email or letter. Statute: All meetings of the board shall comply and be consistent with the provisions of the state "Open Public Meetings Act (RCW 42.30). Committee meeting shall be open to the public whenever feasible. The board shall establish guidelines for this practice within its by-laws. By-laws and other rules and regulations by the board shall be consistent with the "Public Disclosure Act (RCW 42.17). (Ord. 6818 § 11, 1984). Bylaws: All meetings of the Board shall be called and conducted in compliance with the Open Public Meetings Act Chapter RCW 42.30 as amended where applicable. Meetings of Committees shall be open to the public except when the Chair of the Committee determines that the Open Public Meetings Act allows for the meeting to be closed as provided by RCW 42.30.110 and RCW 42.30.140, as amended.
Cuyahoga, OH	Board website: 2026 meeting schedule and location provided, plus minutes for all past meetings starting January 2024 provided. Meetings are livestreamed via YouTube and available afterwards. Public comment periods available for every regular board meeting, request to board chair prior to meeting start is required, comments limited to 3 minutes. Statute: All meetings of any public body are declared to be public meetings open to the public at all times. A member of a public body shall be present in person at a meeting open to the public to be considered present or to vote at the meeting and for purposes of determining whether a quorum is present at the meeting. The minutes of a regular or special meeting of any public body shall be promptly prepared, filed, and maintained and shall be open to public inspection. The minutes need only reflect the general subject matter of discussions in executive sessions authorized under division (G) or (J) of this section. Exception is provided for county hospitals to hold executive sessions related to trade secrets after majority roll call vote.

	Bylaws: The Board shall hold regular meetings at its principal office, or other convenient location as designated by the Chairperson of the Board, no less frequently than four times per year. A Schedule of Board and committee meetings for the coming year shall be adopted by the Board at its last regular meeting of the preceding year, and such schedule shall be made available to the general public upon request, in accordance with the Ohio Revised Code. A policy of the Board relative to the open meetings law, consistent with the requirements of the Ohio Revised Code, shall be adopted by the Board.

County Board Briefings

County	Provisions for Comparable Health Systems
Cook County, IL	The CEO shall provide, through the System Board, quarterly reports to the President and County Board concerning the status of operations and finances of the CCHHS and issue other reports as may be required by the County Board or the President. The CEO shall report to the System Board and shall also meet monthly with the Cook County Board President and his/her designees regarding CCHHS operations and shall collaborate with the Office of the President and his/her Bureau Chiefs on various operational initiatives that impact County policy and appropriations, including, but not limited to, human resource and labor issues, financial matters, operational issues, informational technology issues, address capital needs, determine benchmarking, set uncompensated care policies and determine the CCHHS legislative.
Miami-Dade, FL	Office of Internal Auditor, Public Accountability and Information - The Office of Internal Audit shall report directly to the Chairperson of the Audit and Compliance Subcommittee or other committee or subcommittee of jurisdiction of the Trust. This Office through the Chief Executive Officer shall make quarterly written reports to the Board of Trustees at its regular meetings. Upon request, the written reports shall also be disseminated to the County Mayor, Board of County Commissioners, the Commission Auditor, and Miami-Dade Office of Inspector General. 25A-4(m)
Alameda, CA	The Board of Trustees is accountable to the Board of Supervisors as provided in CA statute Section 101850 and shall report to, and make accountings to, the Board of Supervisors as set forth in written agreements executed by and between the Board of Trustees and the County of Alameda.
Santa Clara, CA	CEO responsibilities include providing report to Health and Hospitals Committee and Governing Board (county board), and Deputy County Executive SCVHHS, on the overall activities of SCVMC as well as federal, State, and local developments which affect SCVMC. Health and Hospitals Committee duties include: receiving regular reports on financial and operational matters, and providing regular oversight of the functioning of activities relating to the delivery of quality patient care services, performance improvement, risk management and financial management. Also, providing regular reports to the governing body on matters within its oversight functions, on financial and oversight matters, and matters of policy and planning.

King County, WA	At least annually, the UW Medicine CHSO/VPMA (or successor in function) and the Board President will be invited to meet with the County Council and County Executive to report on the status and performance of the Medical Center at a meeting of an appropriate committee of the County Council. Reporting requirements laid out in county code include: A. At a minimum, the board shall provide the executive and the council with an annual report including the following items: o A financial report and statement for the medical center's preceding fiscal year; o A summary of the proceedings of the board including the attendance record of the trustees during the preceding fiscal year; o A summary of the medical center annual proposed operating budget including anticipated plans and highlights for the coming year; o A report on medical center programs and services including the quality of patient care; o A report on the extent and type of care provided to priority patients, and proposed changes for improvement; o An annual fixed assets inventory report for medical center property and equipment; and o A report on all Harborview agreements to occupy space. B. The report required by subsection A. of this section shall be transmitted by September 30 of each calendar year in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff to the budget and fiscal management committee or its successor and the committee of the whole or its successor. C. The county governing authority may prescribe the format and content of reports required and set dates for submission to the county, as appropriate, consistent with the requirements of state law and regulations. (Ord. 19706 § 4, 2023: Ord. 18635 § 9, 2017: Ord. 6818 § 10, 1984). Additionally, UW Medicine shall collect and maintain accurate information on the nature, scope, and content of its operations including financial statements and shall provide such information as reasonably requested by the county.

Terms of Office & Removal

County	Provisions for Comparable Health Systems
Cook County, IL	Staggered 4-year terms. No limit specified. Removal: Any appointed Director may be removed for incompetence, malfeasance, neglect of duty, or any cause which renders the Director unfit for the position. After notification & appearance process, Director can be removed by majority vote of the County Board.
Miami-Dade, FL	For the Public Health Trust members appointed by the nominating committee: 3-year terms, staggered. No more than 2 consecutive terms, no more than 3 total. County Mayor & Leg. Delegation appointments: 2-year terms, no more than 3 consecutive. Removal: Any PHT member may be removed by majority vote of County Board.
Alameda, CA	3-year terms. May serve more than 1 term if re-appointed by County Board, no more than 3 consecutive terms. Removal: A Trustee may be removed by the Board of Supervisors during his or her term with or without cause, on its own initiative or following consideration for removal submitted by the Board of Trustees, but only upon the affirmative vote for removal of at least four (4) members of the Board of Supervisors. Provisions for automatic removal for non-attendance.
Santa Clara, CA	(County Board of Supervisors – elected to 4-year terms, no more than 3 terms).
Dallas, TX	Staggered 3-year terms. Members must resign after 2 consecutive terms, but may be reappointed by Commissioners Court if still qualified to serve. Removal not specified in statute.
Denver, CO	Staggered 5-year terms. Any member is eligible for reappointment, but voting members are not eligible to serve more than two consecutive full terms. Removal: any member may be removed for cause, with required notice and opportunity to be heard.
Westchester, NY	Staggered 5-year terms, term limits for members not specified in statute or bylaws. However, officer positions (chair, vice chair(s), secretary, treasurer) are 2-year positions with no more than 3 consecutive terms. Removal provisions: Statute: Members may be removed from office by the board for cause, with notification and hearing opportunity requirements. inefficiency, neglect of duty or misconduct in office, after the board has given such member a copy of the

	charges against him or her or opportunity to be heard in person or by counsel in his or her defense, upon not less than ten days notice. Bylaws: A voting or non-voting director, officer or employee of the Corporation who knowingly and intentionally violates any of the provisions of the New York State Code of Ethics may be fined, suspended or removed from office or employment.
King County, WA	Staggered 4-year terms, no more than 3 consecutive terms. Removal – bylaws: The Board may recommend to the County that a member of the Board be removed in accordance with law and regulation. Such recommendation may be taken at any meeting of two-thirds vote of the entire Board, provided that the affected member shall have been given at least ten (10) days written notice of such intended action and has been advised of the basis for such action. The affected member shall have the right to be heard and to explain to the Board why he or she should not be recommended for removal. Recommendations for removal by the Board shall be made directly to the County and shall not be effective until approved after notice and opportunity for hearing as required by RCW 36.62.150.
Cuyahoga, OH	Staggered 6-year terms. Term limits not specified in statute or bylaws. Removal– statute: Any member of a board of county hospital trustees may be removed from office by the appointing authority for neglect of duty, misconduct, or malfeasance in office. The member shall be informed in writing of the charges and afforded an opportunity for a hearing before the appointing authority. The appointing authority shall not remove a member from office for political reasons.

Payor Mix

HHS	County	Payor Mix for Comparable Health Systems
[2025] • 40% Medicaid • 29% Medicare • 18% Commercial • 9% Self-Pay • 4% Other	Cook County, IL	[2025] • 51% Medicaid • 22% Uncompensated (uninsured) • 18% Medicare • 9% Commercial
	Miami-Dade, FL	[2025] • 36% Medicare • 20% Medicaid • 29% Commercial • 13% Self-pay & other
	Alameda, CA	[FY24-25] • 60% Medicaid • 28% Medicare • 6% Commercial • 6% Self-Pay & Other
	Santa Clara, CA	[FY23-24] • 58% Medicaid • 26% Medicare • 13% Other Third Parties • 1% County Indigent • 2% Other Indigent
	Dallas, TX	[2025] • 43% Charity/Self-Pay • 21% Medicaid • 17% Medicare • 15% Commercial • 3% Other

	Denver, CO	[2025] • 47% Medicaid • 20% Medicare • 16% Commercial • 10% Self-Pay (incl. charity care & bad debt) • 6% Self-Funded/Elevate (CO marketplace plan) • 1% Other (correctional care)
	Westchester, NY	[2024] • 28% Medicare • 23% Medicaid • 49% Commercial insurance, health maintenance orgs, & other
	King County, WA	[2022] • 33% Medicaid • 32% Medicare • 25% Commercial • 4% Self-Pay • 6% Other, inc. worker's comp
	Cuyahoga, OH	[2025] • 37% Medicare • 30% Commercial • 26% Medicaid • 7% Self-Pay
Note: Payor categories include Managed Care options (e.g. Medicare percentages include both Medicare Fee-For-Service plan and Medicare Advantage plan revenues)		

Dedicated Revenue Sources

County	Provisions for Comparable Health Systems
Cook County, IL	Cook County Health System is supported by the County, but there is **no dedicated local tax revenue stream**. County financial contributions flow through the county budget to cover health services, public health, pension, and some debt service. County MCO plan (CountyCare) accounts for significant income – county budget projects $3.5 billion in revenue for FY26.
Miami-Dade, FL	**0.5% Sales Tax** (approved by voters 1991) In 2025, revenue from the sales tax made up 10.4% of Jackson Memorial's roughly 4 billion dollar total revenue. Around 43% came from patient services revenue & direct County funding was 8%. Note: In 2013, Miami-Dade voters approved a $830M property tax increase that was spread over 10 years, ending 2024.
Alameda, CA	In 2024, 10.2% of Alameda Health System's overall ~$1.5B revenue came from dedicated taxes (Measure A & Parcel Tax): **Measure A**: **0.5% sales tax** (75% of revenue goes directly to Alameda Health System, balance goes to County Board to fund various other indigent care programs throughout County). • 2024 revenue from Measure A: $144,070,000 **Parcel Tax**: County levies parcel tax ($298 per parcel) on behalf of the *City* of Alameda Health Care District.* • 2024 revenue from parcel tax: $4,788,000 *The City of Alameda Health District operates to allow for the collection of parcel taxes and certain rental income from which the City of Alameda District pays their operating expenses. Excess earnings are remitted to Alameda Health System (AHS) in order to support the operations of the Alameda Hospital by AHS.
Santa Clara, CA	**0.625% Sales Tax** (enacted on 4/1/26) November 2025: In response to an anticipated $1B cut to Santa Clara County's Medicaid revenue following federal changes, voters supported a ballot measure to increase County sales tax by 0.625% for 5 years to fund health care services. This is projected to bring in $330M revenue per year.

Dallas, TX	Dallas County Hospital District d/b/a Parkland Health **has taxing authority*** (as do all Hospital Districts in Texas), with rates determined annually. In 2025, the **property tax rate was .212 per $100 valuation**. This generated ~$863M in revenue in 2025, roughly 23% of total revenue. This property tax revenue covered ~61% of total uncompensated care cost (~$1.4B). Remaining total revenue included 45% from patient services, 19% from government programs, and 13% other. *Process: Some circumstances require voter approval, but generally the Hospital District Board of Managers determines ideal rate based on annual Appraisal District data, which then requires final approval from County Board.
Denver, CO	Denver Health & Hospital Authority has taxing authority. **0.34% sales tax** (enacted on 1/1/25) November 2024: Denver voters approved ballot measure 2Q, a 0.34% sales tax to go towards Denver Health. In 2025, this tax revenue totaled ~$65 million. Denver Health states that 2Q revenue represented ~4% of total funding for 2025, but played a disproportionate role in stabilizing high-demand service lines.
Westchester, NY	No dedicated revenue stream from any level of government. However, there has been high investment levels from NY state in recent years. **$2.6 Billion Health Care Safety Net Transformation Program** – NY FY25 Enacted Budget Initiative for 6 safety net hospitals (including WMC) to incentivize partnerships with other healthcare organizations. It provides "strategic capital and operating support, in addition to required regulatory flexibility, to improve the resilience and sustainability of safety-net hospitals and expand access to high quality care." In the case of WMC, initial funding went towards integrating a nearby charity health system under the WMCHealth umbrella, unify their EMR system, expand their residency program, and improve health access. The NY FY26 Enacted Budget included an additional $1 Billion investment in capital & $300 Million in operating funds to the Health Care Safety Net Transformation Program.

King County, WA	**Public Hospitals Property Tax** 2025 annual tax rate: 10 cents per $1,000 of assessed value (half of the allowable rate). Raised $87 million. 2026 annual tax rate: 15 cents per $1,000 of assessed value (3/4 of allowable rate). Projected to raise $275 million over the biennium. **Harborview Bond Program** In 2020, voters authorized $1.74 billion in general obligation bonds to fund health, safety, and seismic improvements at Harborview. As of July 2025, less than 4.75% of overall funds had been expended. 2026-2027 Proposed Budget includes $327 million from the bond program for capital projects. **State Initiatives** WA Trauma Care Fund (est. 1997) Annual budget roughly $17 million. Funded partially by vehicle fees and traffic ticket surcharges, the remainder through Medicaid match funds. Pass-through funds subsidize costs based on a hospital's proportionate share of undercompensated trauma care, hospital participation in state trauma system, and hospital rehabilitation participation. Pass-throughs also for medical program directors and prehospital participation. State Health Care Authority supports through supplemental hospital trauma care Medicaid distributions and increased physician trauma care Medicaid distributions. **Shared Hospital Services Agreement Note:** The Agreement (parties are King County, Harborview Board of Trustees, and UW) states that the Harborview Board allocates $5 million annually to a fund to support Mission Population Programs currently being provided by the County. It establishes a committee comprised of representatives from the Parties to coordinate on reducing costs incurred by the county. The $5 million allocation is adjusted down based on savings or revenues identified by the committee.
Cuyahoga, OH	**County Health and Human Services Fund** Voter-approved levy (renewed 2024): $131 per $100,000 of assessed value for 8 years. 2026 levy brought in ~281 million, $35 million of which is earmarked for MetroHealth.

Lease Provisions

County	Provisions for Comparable Health Systems
Cook County, IL	System Board has limited authority to purchase, lease, or transfer real property, within its mission; but County Board must approve any such transaction with a value over $150k
Miami-Dade, FL	The Trust can lease property, but cannot purchase, sell or mortgage real property without the County Commission's approval
Alameda, CA	County Board of Supervisors controls any county real property (including any sale or lease); the District has its own authority to own real property but cannot sell or lease the property without consent from Alameda Health System.
Santa Clara, CA	[County Board is system governing board, County owns property]
Dallas, TX	The hospital district's board can purchase, sell, lease, or mortgage property.
Denver, CO	The health authority was authorized to acquire or lease real property from the City of Denver through an agreement between the authority and the city, and that agreement had to include protections against liability for the city.
Westchester, NY	County owned the real property and leased it on a long-term basis to the health care corporation.
King County, WA	County owned the real property and made it available to the medical center for operations.
Cuyahoga, OH	The hospital board of trustees can purchase or lease real property, and can finance capital improvements through hospital revenues or by issuing revenue bonds.

Reserved Powers – Audit

County	Provisions for Comparable Health Systems
Cook County, IL	Cook County Ordinance Sec. 38-88. Managerial and financial oversight. The County Board may conduct financial and managerial audits of the System Board and the CCHHS. 1. The County Board may examine the business records and audit the accounts of the System Board or CCHHS or require that the System Board examine such business records and audit such accounts at such time and in such manner as the County Board may prescribe. The System Board shall appoint a certified public accountant annually, approved by the County Board, to audit the CCHHS' financial statements. 2. The County Board may initiate and direct financial and managerial assessments and similar analyses of the operations of the System Board and CCHHS, as may be necessary in the judgment of the County Board, to assure sound and efficient financial management of the System Board and the CCHHS. 3. The County Board shall initiate and direct a management audit of the CCHHS as deemed advisable and approved by the County Board. The audit shall review the personnel, organization, contracts, leases, and physical properties of the CCHHS to determine whether the System Board is managing and utilizing its resources in an economical and efficient manner. The audit shall determine the causes of any inefficiencies or uneconomical practices, including inadequacies in internal and administrative procedures, organizational structure, types of positions, uses of resources, utilization of real property, allocation of personnel, allocation of salary, purchasing policies and equipment. 4. The County Board may direct the System Board to reorganize the financial accounts and management and budgetary systems of the System Board or CCHHS in a manner that the County Board deems appropriate to achieve greater financial responsibility and to reduce financial inefficiency. Any such reorganization shall be in keeping with best practices adopted by the Professional Financial Accounting Standards Board. 5. The County Board may consult directly with CCHHS management or the System Board to recommend management related changes based upon the recommendations of any management audit initiated by the County Board. If the System Board or CCHHS does not accept the recommended changes, then a public hearing of the County Board shall be held at which the Chairperson of the System Board and the CEO of the CCHHS must explain why the changes were not accepted.

	The System Board and the CCHHS shall be subject to audit in the manner now or hereafter provided by statute or ordinance for the audit of County funds and accounts. A copy of the audit report shall be submitted to the President, the Chairperson of the Finance Committee of the County Board, the Chairperson of the Health and Hospitals Committee, and the Director of the County Office of the Auditor. Bylaws: Audit and Compliance Committee Duties: oversee CCHHS's internal audit and corporate compliance functions, as well as oversee the independent audit of CCHHS statutory financial statements. This Committee shall receive and review reports prepared by the internal audit and corporate compliance departments. This Committee shall oversee the selection of independent auditors for the CCHHS in accordance with the Ordinance, review accounting policies and financial reporting and disclosure practices of the CCHHS, and review the effectiveness of the CCHHS financial and operating controls. Additionally, the Committee will assist the System Board in fulfilling its oversight responsibilities of the CCHHS corporate compliance effort. This Committee shall assess its responsibilities as business conditions require, and determine a plan to implement those responsibilities.
Miami-Dade, FL	Miami-Dade Ordinance states the Trust shall create an Office of Internal Auditor, Public Accountability and Information -- The purpose of the Office of Internal Audit shall be to (i) provide internal auditing functions, (ii) act as the central depository for public information relating to public record requests, (iii) review and account for any and all relationships between the Public Health Trust and private entities, and (iv) interface and coordinate with and serve as the Trust's liaison to the Miami-Dade County Office of Inspector General. The Office of Internal Audit shall report directly to the Chairperson of the Audit and Compliance Subcommittee or other committee or subcommittee of jurisdiction of the Trust. This Office through the Chief Executive Officer shall make quarterly written reports to the Board of Trustees at its regular meetings. Upon request, the written reports shall also be disseminated to the County Mayor, Board of County Commissioners, the Commission Auditor, and Miami-Dade Office of Inspector General. The Chief Executive Officer of the Trust shall develop written policies and procedures for the organization and operation of the Office of Internal Audit and submit the same to the Board of Trustees for approval. Upon the Trust's creation of the Office of Internal Audit, the Trust shall do all things necessary or required to effectuate and merge all existing internal auditing functions into this Office and to provide sufficient funding and staffing. The Internal Auditor of Miami-Dade County shall at all times have the right to audit all records of the Trust, and the external auditor of the County, at the direction of the Board of County Commissioners, shall be empowered to audit all records of the Trust. + see Reserved Powers Table for Recovery Board Provision

Alameda, CA	Bylaws: An audit of AHS's financial operations shall be conducted by a firm of independent certified public accounts at least annually, and the audited financial statement of AHS shall be reviewed by the Chief Executive Officer and the Board of Trustees at least annually. Such financial statements shall be available to the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") at the time of AHS's accreditation survey and shall be forwarded to the County of Alameda within 30 days.
Santa Clara, CA	County board is governing body. Audit not named specifically in statute or bylaws, but bylaws state a Health and Hospitals Committee duty is to receive regular reports on financial matters.
Westchester, NY	Bylaws: Audit and Corporate Compliance Committee. The Audit and Corporate Compliance Committee shall be comprised of three or more Directors who are not employees of the Corporation or members of the Medical Staff, and who do not have any relationship, which in the opinion of the Chairman of the Board of Directors, would interfere with the exercise of independent judgment in carrying out the responsibilities of a member of the Committee, and who are able to read and understand fundamental financial statements. The Chairman of the Committee should have accounting or related financial management expertise, if possible. The Committee shall have direct responsibility for the appointment, compensation and oversight of the work of the independent auditors employed by the Corporation for the purpose of preparing or issuing an audit report or related work, and such independent auditors shall report directly to the Committee which, in turn, will report and make recommendations to the Board of Directors. The Committee shall have such other duties and powers as are established in an Audit and Corporate Compliance Committee Charter approved by the Board of Directors, and shall have the resources and authority appropriate to discharge its duties, including the authority to retain and receive advice and assistance from outside legal, accounting or other advisers. The Committee shall meet no less than on a quarterly basis.
King County, WA	Shared Hospital Services Agreement: Audit Reports. In the event that any Federal or State auditor conducts an audit of the University and such audit has a material effect on the operation of Medical Center, the University shall make available the relevant portions of any final audit report prepared by such auditor to the County within fifteen (15) business days of receipt by the University. Audits. Additionally, upon reasonable prior notice of not less than ten (10) business days, the County may audit any books and records related to the performance of this Agreement, regardless of location. The County may conduct such audit through a third party. All audits shall be conducted during normal business hours. Any audits of books and records by the County shall be conducted in a manner that is least disruptive to the operations of the Medical Center and the University.

	Bylaws state a purpose of the Finance Committee is to review Medical Center internal and external audit reports.
Cuyahoga, OH	OH statute: The board of county hospital trustees shall provide for the conduct of an annual financial audit of the county hospital. Not later than thirty days after it receives the final report of an annual financial audit, the board shall file a copy of the report with the board of county commissioners. Bylaws: The Audit and Compliance Committee shall be responsible for: (i) oversight of the quality and integrity of the organization's financial statements, (ii) oversight of the audit and review of the organization's financial statements by the independent auditors, (iii) oversight of the organization's compliance with legal and regulatory requirements and the independence and performance of its independent auditors, (iv) recommending to the Board of Trustees the appointment of the independent auditors, and (v) performing all other functions prescribed by the Board of Trustees and permitted by applicable law.

Reserved Powers – Budget

	County	Notable Provisions for Comparable Health Systems
Budget Approval	King County, WA	Budget approval is split between the county board and Harborview's Board of Trustees – the county board approves the *long-range* capital improvements plan, annual capital improvement budget and project plans submitted by the Board of Trustees. The Board of Trustees approves, implements, and monitors the annual capital and operating budgets, as well as controls all designated, restricted, and general operating funds. King County Code specifies: County Budget Authority: • Review and approve the medical center's long range CIP plan, the annual capital improvement budget and project plans. Board of Trustees powers, duties, responsibilities: • Manage the financial affairs of the medical center in a prudent and responsible manner. • Review and approve the long range CIP plan and project plans, including service impacts, prior to submission to the county governing authority. • Approve, implement and monitor the medical center annual capital budgets in accordance with applicable law, subject to the review and approval requirements of the governing authority specified in state law and elsewhere in this chapter. • Approve, implement and monitor the medical center annual operating budget in accordance with applicable law • Review and approve all remodeling and construction projects.
Budget Process	Cook County, IL	Cook County Ordinance Sec. 38-83. Preliminary CCHHS budget and annual appropriation ordinance. (a) The System Board shall not make expenditures unless such expenditures are consistent with the County's Annual Appropriation Bill ("Annual Appropriation Ordinance") as provided in 55 ILCS 5/6-24001 et seq. (b) The System Board may, if necessary, recommend and submit to the President and the County Board, for approval by the County Board, a request for intra-fund transfers within the Public Health Fund to accommodate any proposed revisions by the System Board to the line items set forth for the Bureau of Health Services in the existing Fiscal Year 2008 Annual Appropriation Ordinance.

		(c) The System Board shall recommend and submit a balanced Preliminary Budget for the CCHHS to the President and the County Board, for approval by the County Board, not later than 45 days prior to the first date for submission of budget requests set by the County's Budget Director. (d) Each Preliminary Budget shall be recommended and submitted in accordance with the following procedures: 1. Each Preliminary Budget submitted by the System Board shall be based upon revenue estimates contained in the approved Strategic and Financial Plan applicable to that budget year. 2. Each Preliminary Budget shall contain such information and detail as may be prescribed by the County's Budget Director. Any applicable fund deficit for the Fiscal Year ending in 2008 and for any Fiscal Year thereafter shall be included as an expense item in the succeeding Fiscal Year's Budget. 3. Each Preliminary Budget submitted by the System Board shall be balanced with expenditures matching the revenue estimates for the fiscal year. Such revenue estimates may include requested appropriations from the County Board which will be subject to County Board approval. (e) The County Board shall approve each Preliminary Budget if, in its judgment, the Budget is complete, is reasonably capable of being achieved, and will be consistent with the Strategic and Financial Plan in effect for that Fiscal Year. The Board shall approve or reject each Preliminary Budget within 45 days of submission to the County Board or such Preliminary Budget is deemed approved. Such Preliminary Budget shall be included in the President's Executive Budget Recommendation. (f) The CCHHS's Annual Appropriation shall be monitored as follows: 1. The County Board may establish and enforce such monitoring and control measures as the County Board deems necessary to assure that the revenues, commitments, obligations, expenditures, and cash disbursements of the System Board continue to conform on an ongoing basis with the Annual Appropriation Ordinance. If, in the discretion of the County Board, and notwithstanding the approved Annual Appropriation Ordinance, the County Board imposes an expenditure limitation on the System Board, the System Board shall not have the authority, directly or by delegation, to enter into any commitment, contract, or other obligation that would result in the expenditure limitation being exceeded. Any such commitment, contract or other obligation entered into by the System Board in derogation of this section shall be voidable by the County Board. An expenditure limitation established

		by the County Board shall remain in effect for that Fiscal Year or unless revoked earlier by the County Board. Sec. 38-82. Strategic and financial plans. (a) As soon as practicable following the establishment of the System Board, the President shall provide to the System Board copies of the audited financial statements and of the books and records of account of the Bureau of Health Services for the preceding five Fiscal Years of the County. (b) The System Board shall recommend and submit to the President and the County Board Strategic and Financial Plans as required by this section. (c) Each Strategic and Financial Plan for each Fiscal Year, or part thereof to which it relates, shall contain: 1. A description of revenues and expenditures, provision for debt service, cash resources and uses, and capital improvements, each in such manner and detail as the County's Budget Director shall prescribe; 2. A description of the strategy by which the anticipated revenues and expenses for the Fiscal Years covered by the Strategic and Financial Plan will be brought into balance; 3. Such other matters that the County Board or the President, in its discretion, requires; provided, however, that the System Board shall be provided with a description of such matters in sufficient time for incorporation into the Strategic and Financial Plan. (d) Strategic and Financial Plans shall not have force or effect without the approval of the County Board and shall be recommended, approved and monitored in accordance with the following: 1. The System Board shall recommend and submit to the President and the County Board, on or before 180 days subsequent to the date of the appointment of the initial Directors or as soon as practicable thereafter, an initial Strategic and Financial Plan with respect to the remaining portion of the Fiscal Year ending in 2008 and for Fiscal Years 2009 and 2010. The Board shall approve, reject or amend this initial Strategic and Financial Plan within 45 days of its receipt from the System Board. 2. The System Board shall develop a Strategic and Financial Plan covering a period of three Fiscal Years and a representative of the County Board President and the Cook County Chief Financial Officer or his/her designee shall assist the System Board in developing the Strategic and Financial Plan. 3. The System Board shall include in each Strategic and Financial Plan estimates of revenues during the period for which the Strategic and Financial Plan applies. In the event the System Board fails, for any

		reason, to include estimates of revenues and expenditures as required, the County Board may prepare such estimates. In such event, the Strategic and Financial Plan submitted by the System Board shall be based upon the revenue estimates approved by the County Board. 4. The County Board shall approve each Strategic and Financial Plan if, in its judgment, the Strategic and Financial Plan is complete, is reasonably capable of being achieved, and meets the requirements set forth in this section. After the System Board submits a Strategic and Financial Plan to the President and the County Board, the County Board shall approve or reject such Strategic and Financial Plan within 45 days or such Strategic and Financial Plan is deemed approved. 5. The System Board shall report to the President and the County Board, at such times and in such manner as the County Board may direct, concerning the System Board's compliance with the Strategic and Financial Plan. The President and the County Board may review the System Board's operations, obtain budgetary data and financial statements, require the System Board to produce reports, and have access to any other information in the possession of the System Board that the President and the County Board deem relevant. The County Board may issue recommendations or directives within its powers to the System Board to assure compliance with the Strategic and Financial Plan. The System Board shall produce such budgetary data, financial statements, reports and other information and comply with such directives. 6. For each Strategic and Financial Plan applicable to a Fiscal Year subsequent to the current Fiscal Year, the System Board shall regularly reexamine the revenue and expenditure estimates on which it was based and revise them as necessary. The System Board shall promptly notify the President and the County Board of any material change in the revenue or expenditure estimates in that Strategic and Financial Plan. The System Board may submit to the President and the County Board, or the County Board may require the System Board to submit, modified Strategic and Financial Plans based upon revised revenue or expenditure estimates or for any other good reason. The County Board shall approve or reject each modified Strategic and Financial Plan pursuant to paragraph (d)(4) of this section.
	Alameda, CA	Budget-related Board of Trustees powers and duties. Bylaws specify: • Determine that the fiscal year shall be from July 1 through June 30. • Adopt a balanced budget by June 30 for the following fiscal year.

		• Strive to maintain a balanced budget, making adjustments to offset unanticipated expenditures or unrealized revenues as needed. • Surplus revenues shall be retained by AHS to be expended in a manner consistent with its mission. Revenue shortfalls shall be the sole responsibility of AHS. • Adopt an operating and capital expenditure budget. This budget shall delineate the scope of services to be offered, costs of programs and justification for capital expenditures. • Adopt a policy concerning how adjustments to the operating or capital expenditure budgets may be made. This policy may reflect participation of appropriate members of the administration and Medical Staff. • Analyze periodic financial reports in addition to the budget.

Reserved Powers – Debt, Financial Sustainability

County	Notable Provisions for Comparable Health Systems
Miami-Dade, FL	Miami-Dade County Ordinance Sec. 25A-9. - Financial Sustainability**.** *(a)Conditions*. The Commission finds that it is in the best interest of the public it serves to take action to preserve the Trust and to ensure its financial sustainability by requiring the Trust to notify the Commission, the Mayor and the Commission Auditor when any one of the following conditions occurs: 1. Trust failure to, within the same fiscal year in which due, timely make any applicable debt payments as a result of a lack of funds. 2. Trust failure to pay uncontested claims from creditors within ninety (90) days after the claim is presented, as a result of a lack of funds. 3. Trust failure to transfer at the appropriate time, due to a lack of funds: i. Taxes withheld on the income of employees; or ii. Employer and employee contributions for either federal social security or any pension, retirement, or benefit plan of an employee. 4. Trust failure to pay for one pay period, due to a lack of funds: i. Wages and salaries owed to employees; or ii. Retirement benefits owed to former employees. 5. An unreserved or total fund balance or retained earnings deficit, or unrestricted or total net assets deficit, as reported on the balance sheet or statement of net assets on the general purpose or fund financial statements, for which sufficient resources of the Trust, as reported on the balance sheet or statement of net assets on the general purpose or fund financial statements, are not available to cover the deficit. Resources available to cover reported deficits include net assets that are not otherwise restricted by federal, state, or local laws, bond covenants, contractual agreements, or other legal constraints. Fixed or capital assets, the disposal of which would impair the ability of the Trust to carry out its functions, are not considered resources available to cover reported deficits. 6. An advance of any County funds to the Trust, due to a lack of Trust funds to address operational needs, to support operational needs and expenses. 7. The Mayor reports that PHT management and/or the Board of Trustees are not making acceptable progress in developing and implementing a corrective action plan to address managerial and financial deficiencies in accordance with the letter agreement (dated March 23, 2010) entered into pursuant to Resolution No. R-323-10.

	(b)Notice. When one or more of the conditions specified in Subsection (a) have occurred, or likely will occur within one hundred twenty (120) days, the Trust shall submit written notice to the Mayor, Chairperson and members of the Commission, and the Commission Auditor. Upon receipt of such notice, the Chairperson of the Commission shall place the item on the agenda for consideration at the next regularly scheduled Commission meeting, or a special meeting may be called in accordance with Commission rules, in order to address the item. *(c)Assistive measures.* Upon notification by the Trust or another party that one or more of the conditions in Subsection (a) have occurred or likely will occur, the Commission shall determine whether the Trust needs assistance to resolve or prevent the condition. If assistance is needed, the Commission may implement assistive measures which may include any one, or any combination of, the following: 1. *Management watch.* The Commission may direct the Mayor or the Mayor's designee to place the Trust on management watch on such terms and conditions as the Mayor, or the Mayor's designee, deems appropriate, including the authority to assign support personnel and staffing to the Trust as needed. The Commission intends that the more stringent review and oversight of the Trust by the Mayor or the Mayor's designee would improve the functioning of the Trust and promote necessary planning, assessment and monitoring of the Trust's financial health, and ensure essential management to advance the Trust's financial sustainability. The Commission may direct the Mayor or the Mayor's designee to periodically report to the Commission on the Trust's compliance with the terms and condition of said management watch and the Trust's progress toward resolving the conditions specified in Subsection (a). The Trust shall remain under management watch for such period of time as determined by resolution of the Commission. 2. *Recovery plan.* The Commission may require and approve a plan, to be prepared by the Trust in consultation with the Mayor, or his or her designee, and the Board of County Commissioners prescribing actions that will cause the Trust to no longer be subject to this section. However, if the Commission establishes a Financial Recovery Board and requires preparation of a recovery plan, the Trust may prepare the recovery plan in consultation with the Financial Recovery Board as well as the Mayor, his or her designee, or the Commission. The plan shall be submitted to the Commission within sixty (60) days of the Commission's action requiring the plan, or such longer period of time as determined by the Commission. The Trust shall submit copies of the plan to the members of the Commission concurrently with submission to the Mayor. The plan must include, but need not be limited to: i. Provision for payment in full of obligations outlined in Subsection (a), designated as priority items, that are currently due or will come due. ii. Establishment of priority budgeting or zero-based budgeting in order to eliminate items that are not affordable. iii. The prohibition of a level of operations which can be sustained only with nonrecurring revenues.

	3. *Audit.* [See Audit Table] 4. *Technical Assistance.* The Commission may provide technical assistance to the Trust. 5. *Financial Recovery Board.* The Commission may establish a Financial Recovery Board ("Recovery Board"). The County Commission's determination to establish a Recovery Board shall be by adoption of a resolution setting forth the time period such Board shall be in existence and the types of Board action which may be vetoed by the Commission and the timetables and procedures for exercise of such veto authority. Actions of the Recovery Board subject to Commission veto shall be filed by the Recovery Board with the Clerk of the County Commission, who shall place same on the next regularly scheduled County Commission agenda for County Commission consideration without the requirement for committee review. Such actions of the Recovery Board shall become effective upon the adjournment of the next regularly scheduled County Commission meeting unless vetoed by an affirmative vote of two-thirds (⅔) of those Commissioners then in office. A County Commission veto of any action taken by the Recovery Board shall be final and determinative. Notwithstanding any provision of the Code to the contrary, the Recovery Board shall be authorized and empowered to serve as the governing body of the Trust effective upon appointment of at least four (4) members and subject to Commission veto authority all as provided herein. The Mayor and the County Attorney shall provide support to the Recovery Board. Additionally, the Recovery Board shall comply with any Commission directive to the Recovery Board, as set forth from time to time by resolution of the Commission. A resolution adopting a directive that undoes or modifies action of the Recovery Board or any of its committees shall require an affirmative vote of two-thirds (⅔) of those Commissioners then in office. During the tenure of the Recovery Board, the governance powers of the currently sitting Trust Board of Trustees shall cease and the currently sitting Board of Trustees shall be dissolved and shall no longer serve as the governing body of the Trust. The terms of all currently sitting voting members of the Board of Trustees and ex officio members shall automatically expire upon appointment of four (4) members of the Recovery Board. During the tenure of the Recovery Board, the provision of Sections 25A-3(d) (Appointment and removal of Trustees), and 25A-3(e) (Tenure of Trustees), herein shall not apply. The Application of Sections 25A-3(d) and 25A-3(e), herein shall commence on the conclusion of the tenure of the Recovery Board. The Nominating Council set forth in Section 25A-3(d), herein shall convene in accordance with such section, except that the membership shall include five (5) members of the Financial Recovery Board in lieu of the voting Trustees of the Board of Trustees, not less than ninety (90) days prior to the conclusion of the tenure of the Recovery Board for the purpose of assigning members of the expiring Recovery Board to

	staggered initial terms as voting members of the reestablished Board of Trustees and submitting said assignments to the Commission for ratification. i. *Powers and duties.* The Recovery Board shall hold regular meetings and record such meetings in accordance with the requirement for the Board of Trustees as described in Section 25A-3(f) (Organization, powers and duties of the Board of Trustees), herein. Except as specifically provided in Section 25A-9(c) (Assistive measures), herein, during its tenure, the Recovery Board shall have all of the powers, duties and responsibilities customarily vested in the Board of Trustees of the Trust and as provided for in Chapter 25A of the Code, except that those powers and duties shall be limited by the Commission's veto authority as provided herein. The Recovery Board shall exercise supervisory control over the operation, maintenance, and governance of all designated facilities and of all functions and activities taking place in connection with the operation of designated facilities and shall be authorized to exercise such powers as provided for in Section 25A-4 (Powers and duties of the Trust), herein, except as modified hereinafter: A. Appointment and evaluation of the Chief Executive Officer. The Recovery Board shall be empowered to evaluate, appoint, suspend and remove a Chief Executive Officer of the Trust. The Recovery Board shall evaluate the Chief Executive Officer's performance periodically, at its discretion, but no less than annually. Any employment contract for a Chief Executive Officer appointed by the Recovery Board shall require prior County Commission approval before becoming effective. B. Health care delivery policies. The Recovery Board shall develop policies, procedures and practices to promote successful operation of the Trust and its designated facilities and to ensure financial sustainability of the Trust. The Recovery Board shall recommend health care policies to be approved by the Commission relevant to the short and long term financial sustainability of the Trust and the designated facilities. C. Intergovernmental cooperation. The proposed annual operating agreement between the Trust and Miami-Dade County, as described in Section 25A-4(i) (Intergovernmental cooperation), herein shall be approved by the Recovery Board and then submitted to the Board of County Commissioners for approval in September of the applicable year. During the tenure of the Recovery Board, the Trust/County Committee as described in Section 25A-4(i), herein, shall cease to meet, review, approve, and make recommendations regarding the Annual Operating Agreement. D. Contracts. For purposes of compliance with the formal bid requirements of Section 5.03(D) of the Charter of Miami-Dade County, Florida, the term "Board" as used in Section 5.03(D) shall be construed to be "Recovery Board."

	E. Personnel. Any personnel actions or policies taken or issued by the Recovery Board shall not be inconsistent with any applicable collective bargaining agreements, as amended. The Recovery Board shall recommend to the Commission policies for labor management and the negotiations of labor agreements with organizations representing Trust employees. Additionally, the Recovery Board shall recommend to the Commission proposed labor agreements negotiated with labor organizations representing Trust employees. Notwithstanding any other provision of Chapter 25A, the Commission may approve or take other action regarding the proposed agreement by a majority vote, except that the Commission may only disapprove or amend the proposed agreement by a two-thirds (⅔) vote of those Commissioners then in office. F. Issuance of bonds and ability to borrow money. The Recovery Board shall be empowered to enact resolutions requesting that the County Commission effectuate the issuance of bonds or authorizing the Trust to borrow money. G. UM Annual Operating Agreement Committee and FIU Annual Operating Agreement Committee. During the tenure of the Recovery Board, there shall be a UM Annual Operating Agreement Committee ("UM Committee") and a FIU Annual Operating Agreement Committee ("FIU Committee"). The Trust Chief Executive Officer shall negotiate the annual operating agreement with the University of Miami and shall submit his/her recommendations to the UM Committee. The Trust Chief Executive Officer shall also negotiate the annual operating agreement with Florida International University and shall submit his/her recommendations to the FIU Committee. The UM Committee and the FIU Committee shall make recommendation regarding the respective annual operating agreements to the Recovery Board. The UM Committee and the FIU Committee shall semi-annually review fiscal reconciliation reports of funds provided to UM and FIU respectively for services provided under the annual operating agreements, and shall report thereon to the Recovery Board. The UM Committee and the FIU Committee shall oversee the methods and manners by which the Trust holds the universities accountable for performing in accordance with the terms of the agreements and shall report thereon to the Recovery Board. The UM Committee and FIU Committee shall each consist of three (3) Recovery Board members as appointed by the Recovery Board Chairperson. H. Reporting. Upon appointment, the Recovery Board shall report to the Commission monthly at a Board of County Commissioners scheduled meeting, or as otherwise determined by the Commission. I. Additional powers. Upon appointment, the Recovery Board shall have the power to: approve or disapprove all budgets and budget amendments; establish an estimating conference process for determining and monitoring revenues, expenditures, cash flow and deficits; establish a fiscal sufficiency advisory board; make

	recommendations to the County Commission of any actions it may take to resolve the Trust financial condition; and perform other duties assigned by the County Commission. J. Recovery board structure ii. Recovery Board structure. A. Composition and Qualifications. The Recovery Board shall be composed of seven (7) voting members, none of whom shall be an employee of the Trust. Each member of the Recovery Board shall be a United States citizen and a permanent resident and duly qualified elector of Miami-Dade County, unless the Commission waives the residency requirement in its discretion. Each member of the Recovery Board shall be of an outstanding reputation of integrity, responsibility and commitment to serving the community. Each member of the Recovery Board shall have experience in hospital operations, management, finance, business or other experience relevant to the Recovery Board's duties and responsibilities. No member of the Recovery Board shall have any conflict of interest, as defined in the Conflict of Interest Ordinance, with the Trust or its designated facilities. Members of the currently sitting Board of Trustees, or former Board of Trustees members, who meet the qualifications provided herein, may be nominated to serve on the Recovery Board. A member of the Recovery Board may be removed for cause by a majority vote of the Board of County Commissioners. B. Organization. The Recovery Board, by majority vote following nomination, shall elect its Chairperson and Vice-Chairperson. The Recovery Board may adopt, modify, and amend the existing bylaws and rules and regulation of the Public Health Trust for the Recovery Board's governance and for the operation, governance, and maintenance of designated facilities. Such bylaws and amendments shall not be inconsistent with the ordinances of the County. The Recovery Board shall form subcommittees to assist in its work. The subcommittee membership shall not be limited to members of the Recovery Board. C. Appointment. The Commission shall appoint four (4) members of the Recovery Board from a list of persons nominated by each Commission member. The Commission shall vote on all nominees. The four (4) nominees with the greatest number of votes shall be appointed as Recovery Board members. The Commission may ratify appointment of the remaining voting members as follows: One (1) member of the Recovery Board shall be designated by the Mayor in writing, and a copy thereof shall be filed with the Clerk of the Commission; one (1) member of the Recovery Board shall be designated by the Chairperson of the Miami-Dade Legislative Delegation in writing, and a copy thereof shall be filed with the Clerk of the Commission; one (1)

	member of the Recovery Board shall be designated by the President of the South Florida AFL-CIO in writing, and a copy thereof shall be filed with the Clerk of the Commission. Upon receipt of any written designation to fill an initial or subsequent vacancy by the Mayor, the Chairperson of the Miami-Dade Legislative Delegation, or the President of the South Florida AFL-CIO, the Clerk of the Commission shall serve copies on each member of the Commission. Any Commissioner may request that the designations be presented at the next regularly scheduled Commission meeting for review. Such request shall not be subject to committee review or to the four-day rule. Absent any disapproval at the next regularly scheduled Commission meeting, the designees shall be deemed ratified, and shall be deemed appointed to the Recovery Board. Upon any vacancy occurring on the Recovery Board, the Recovery Board shall notify the Chairperson of the Commission and shall request that the vacancy be filled as provided herein. D. Term. The Recovery Board shall serve for no longer than twenty-four (24) months, or such shorter or longer period of time as determined by resolution of the Commission. The Recovery Board may recommend shortening or lengthening its tenure by submitting to the Commission a duly enacted resolution of the Recovery Board. The Commission shall consider any such resolution, however, the Commission shall be under no obligation to take affirmative action upon the recommendation. The Commission may consider, among other factors, whether the conditions specified in Subsection (a) have resolved, or are likely to resolve promptly, when determining whether to shorten or lengthen the Recovery Board's term. Upon conclusion of the term of the Recovery Board, the Board of Trustees shall be reestablished. The initial appointments to the reestablished Board of Trustees shall include all members of the expiring Recovery Board. Each voting Trustee shall serve the terms they are appointed to in accordance with Section 25A-3(d) (Appointment and removal of Trustees). Following the reestablishment of the Board of Trustees, all subsequent vacancies shall be addressed in accordance with the nominating process set forth in Sections 25A-3(d) (Appointment and removal of Trustees) and 25A-9(c)(6) (Financial sustainability), herein. E. Bond. Before entering upon the duties of office, each appointee to the Recovery Board shall give bond in the amount of one hundred thousand dollars ($100,000.00) to the Clerk of the Commission for the faithful performance of the duties of office and shall take the prescribed oath of office. This bond also is required of currently sitting Trustees. Recovery Board members shall serve without compensation but shall be entitled to reimbursement for necessary expenses, including the expense of performance bonds, incurred in the discharge of their duties.