HENNEPIN HEALTHCARE GOVERNANCE TRANSITION

Edelson Feedback to Administration's 17 Recommendations

W/ HHS Feedback from their Letter & Comparative Research I pulled

Prepared for September 15, 2026 County Board Briefing

Briefing recommendation organized around Administration's 17 items

1. Board compensation: MODIFY / Continue Legal review / Legislative Change

- Administration proposes no compensation other than expenses in part because Minn. Stat. §383B.905, subd. 4 provides civil-liability protection to uncompensated HHS directors.
- There is an equity issue with this as an unpaid-only model favors retirees, independently wealthy candidates or people whose employers will subsidize their service. It can exclude working clinicians, nurses, community members and patient representatives - the very perspectives the Board wants.
- Minnesota's Direct Care and Treatment Executive Board is a particularly relevant public health care comparison. The Minnesota Compensation Council set voting-member compensation at $500 per day effective July 1, 2025 - it noted the prior $55/day amount was insufficient and that $500 remained at the very low end of compensation for similarly sized health-care organizations.
- Minnesota county-hospital law §376.06 expressly allows a county board to authorize compensation and expense reimbursement for a county hospital board. This does not itself control HHS, but shows that compensation for public hospital governance is not new to Minnesota law.

Other public-hospital examples:

- Washington public hospital district commissioners receive $161/day as of 2024, subject to a $15,456 annual cap
- Nevada county / hospital-district trustees receive meeting or monthly compensation depending on county size
- Grossmont Healthcare District in California pays $141.47 per qualifying meeting under its 2026 policy
- AHA's 2025 governance survey found 35% of health-system boards compensated members in 2024, up from 25% in 2018.
- **Suggested direction:** Legal design options for a modest per-meeting/per-day public-service stipend, annual cap, waiver option and expense reimbursement, while specifically analyzing whether and how §383B.905 liability protection would change. Do not select an amount until that analysis is complete.

HHS concern: No specific compensation objection was raised in the September 11 response.

2. No current HHS employees / CEO and clinical representation: MODIFY

- Agree that the CEO can appropriately be ex officio and non-voting because the Board hires, evaluates, compensates and may remove the CEO. This is not an unusual structure: AHA's 2018 survey found 54% of responding hospital/health-system CEOs were not voting board members; among freestanding hospitals, 79% reported the CEO was not a voting member.
- But separating the CEO from the vote should not become a blanket rule eliminating every voting clinician or person with current hospital-level clinical knowledge.
- UNM Hospital is a useful public-hospital model: its CEO is an ex-officio non-voting trustee, while its non-voting ex-officio group also includes the hospital Chief of Staff, School of Medicine dean and executive physician-in-chief building formal clinical voices into governance.
- Cook County Health provides another model for clinical integration: its Quality and Patient Safety Committee is chaired by a physician board member and includes clinical board members; medical staff presidents, medical directors, nursing leadership and quality leadership participate ex officio without vote.
- Parkland Health's current 11-member public Board of Managers includes physician and nursing expertise; its public biographies include physician trustees and a registered nurse with direct Parkland emergency-department and quality/safety experience.
- AHA governance guidance is directly relevant: boards are responsible for clinical quality, patient safety, medical-staff quality, credentialing and privileges. AHA has also described a strong clinical voice on the board as essential and reported that three-quarters of surveyed boards had at least one physician.
- *Suggested direction*: CEO remains non-voting, guarantee meaningful voting clinical expertise through the board matrix and/or a defined clinical seat. At minimum, require the Quality & Safety Committee to include substantial voting clinical expertise and formal medical-staff participation.

HHS concern: HHS specifically says excluding all current HHS employees as voting members reduces direct clinical perspective and warns that the proposed board composition does not explicitly ensure quality and patient-safety governance expertise.

3. Minnesota residency: MODIFY

- Strong preference for Minnesota residents is reasonable, but do not unnecessarily eliminate exceptional safety-net candidates.
- Suggested direction: require Minnesota residency OR strong, demonstrable Minnesota ties/history for example prior Minnesota residency, substantial Minnesota health-care/public-service experience, long-term professional ties, or another meaningful connection to Minnesota while retaining a strong preference for current Minnesota residents.

4. Board matrix and statutory qualifications: STRENGTHEN

- The 2026 law is stronger than a generic 'good board member' standard. Chapter 127 amended §383B.903 to require an 11–15 member board that includes people with the professional training and expertise needed to govern a health system and safety-net hospital.

- The statute further requires at least 75% of non-county-commissioner members to have expertise in hospital administration, finance, business management, law or health equity, or other experience relevant to administration of a health system and safety-net hospital, with a preference for urban/diverse-community experience. Up to 25% may represent patient/consumer perspective which would be 3 members if we went with 15 board members.
- Administration's matrix treats health-care experience as merely preferred. That is legally permissible on the face of the enumerated categories, but it is too weak as a governance design - especially when Administration simultaneously proposes prohibiting every current HHS clinician/employee from voting.
- *Suggested direction*: require that a majority of non-commissioner directors have substantial health-care expertise, with a meaningful subset having direct hospital-level clinical, quality/safety, hospital-administration or safety-net experience. Financial expertise should include hospital finance, payer mix, Medicaid/Medicare, reimbursement and capital—not simply generic finance.
- *Recommended collective matrix:* clinical medicine; nursing; quality/patient safety; safety-net hospital administration; hospital finance/reimbursement; Medicaid/Medicare; academic medicine; behavioral health; workforce/labor; facilities/capital; public health; compliance; health equity; patient/consumer experience.
- Comparators:
    - Cook County Health's ordinance expressly lists finance, legal/regulatory, healthcare management, clinical medicine, community public health, public-health policy, insurance/managed care, labor and patient experience.
    - Parkland visibly incorporates physician and nursing experience.
    - El Camino Hospital uses a formal competency matrix and gap analysis to drive reappointments.
    - AHA recommends selection based on the right mixture of skills, experience, personal qualities and community diversity.

HHS concern: HHS expressly identifies quality and patient-safety governance expertise as missing and says the framework does not visibly articulate the Board's ultimate accountability for quality, safety, culture and continuous improvement.

5. Vetting and hiring process: MODIFY

- The structural challenge is that HHS normally has a Governance Committee that helps recruit and nominate successors, but the new board does not yet exist. For this one-time transition, the interview groups will effectively act as the hiring/nominating committee.
- With the administration proposal, a first round of 4 County staff + 3 HHS staff, followed by a final four-person panel of the HHS Chair, HHS Vice Chair, County Administrator and HHS CEO. That concentrates selection power in current institutional leadership and includes no independent hospital-governance expert.
- Suggested transition model: structure the interview process around 2 County representatives plus 2 HHS representatives and 3 independent hospital experts. Independent experts should include safety-net hospital governance, clinical quality/patient safety and hospital

finance/reimbursement expertise. At least one commissioner should participate in the final interview. ***Or in general add more balance with hospital representatives.***

- Future vacancies after the new Board is seated will require a process to restore a meaningful Governance Committee role, require a competency-gap analysis and external recruitment support, and prevent County Administration or HHS management from becoming permanent gatekeepers.

HHS concern: HHS says the proposal lacks sufficient detail on future board succession and renewal and could undermine independence, expertise and balanced governance over time.

6. Three-year Operating & Funding Agreement: SUPPORT

- Support the 2027–2029 term. Use the period to align with the State advisory task force and two legislative sessions.

7. $38M general subsidy for 2027 only: MODIFY for predictability

- Do not promise ongoing County subsidy, but require a five-year HHS financial forecast with multiple State-funding scenarios and an explicit 2028–2029 contingency framework.

HHS concern: A one-year funding horizon increases risk to cash forecasting, capital planning, workforce stability and accreditation-driven obligations.

8. One-time emergency loan up to $35M: SUPPORT WITH SAFEGUARDS - CFO's can establish liquidity triggers

- Support ending the unlimited County backstop, but establish objective liquidity triggers and an expedited emergency process so County action can occur fast enough to protect payroll, patients and essential services.

HHS concern: A single-use capped loan may not provide sufficient speed or scale during an acute liquidity event.

9. Data and reporting: REPLACE OPEN-ENDED REQUESTS WITH A DEFINED DASHBOARD

- Administration proposes prompt access to broad financial, staffing, operational and outside consultant/regulatory information. A defined dashboard gives the County strong oversight while reducing duplicative ad hoc requests and avoiding a shadow hospital-management structure.

Proposed dashboard cadence: Monthly high-level dashboard to HHS Board/commissioner-directors; quarterly formal County Board briefing; immediate exception reporting when a defined red/yellow trigger is crossed.

An example could look like this:

Domain	Core measures	Trigger examples	Why County needs it
Liquidity & solvency	Days cash on hand; unrestricted cash; 13-week cash forecast; operating margin; debt/covenants; AP aging	Cash below agreed threshold; covenant risk; material forecast deterioration	Taxpayer exposure; emergency-loan readiness
Budget performance	Actual vs budget; material variance by service line; forecast; significant budget amendments	Variance above agreed threshold	Reserved budget powers; fiscal risk
Payer/revenue	Medicaid/Medicare/commercial/self-pay mix; supplemental payments; denials; reimbursement changes	Material payer shift; loss/delay of major payment stream	Safety-net revenue risk
Uncompensated care	Charity care; bad debt; uninsured volume; County-funded obligations	Material increase vs forecast	County indigent-care exposure
Workforce	Vacancy/turnover; agency labor; overtime; critical clinical staffing; labor risks	Critical staffing shortage; material labor-cost variance	Continuity of essential services
Quality & safety	Serious safety events; mortality/HAI/readmission indicators; patient experience; accreditation status	Sentinel/regulatory event; accreditation jeopardy	Patient protection; governing-body duty
Capital & facilities	Deferred maintenance; life-safety projects; capital	Life-safety deficiency; major unplanned capital need	County owns facilities through long-term lease

Domain	Core measures	Trigger examples	Why County needs it
	plan; facility-condition risk		
Compliance/regulatory	Material investigations, sanctions, corrective action plans, privacy/compliance events	Material regulator action or loss of certification risk	Legal/fiscal/reputation al exposure
Strategic/operational risk	Major service-line changes; access/capacity; material contracts; cyber/business continuity	Closure/reduction of essential service; major operational disruption	Resident access and County mission

- Extraordinary requests should be tied to a County reserved power, material financial exposure, identified risk or a defined dashboard exception, and remain subject to patient privacy, peer-review, privilege and other legal protections.

HHS concern: HHS says expanded reporting plus County approval layers could burden teams and slow time-sensitive patient and workforce decisions.

10. Withholding subsidy for breach: SUPPORT WITH DUE PROCESS

- Require notice, opportunity to cure, proportionality and consideration of patient-care consequences before withholding funds, except where immediate action is legally necessary.

11. Lease: SUPPORT, but require long-term capital plan

- Retain the lease, but require a long-term capital/deferred-maintenance assessment identifying life-safety, accreditation, facility-condition and major replacement obligations for County-owned assets.

HHS concern: HHS notes it remains responsible for County-owned facilities through 2056 and says reduced recurring County support combined with increased oversight heightens infrastructure and asset-preservation risk.

12. Integrate lease and funding agreement: SUPPORT

- Support integration, with clear notice/cure provisions and dashboard reporting for material facilities risk.

13. HHS Board structure / County Administrator access to every meeting: MODIFY SUBSTANTIALLY

- Administration proposes that the County Administrator or designee be entitled to attend any HHS Board or committee meeting, including every closed portion. This is broader than ordinary financial reporting and deserves a specific justification.
- **What County financial or reserved-power risk requires blanket presence in every closed hospital-governance discussion?** Day-to-day governance access should be clearly demonstrated.
- Patient-care concern - closed hospital sessions may involve peer review, credentialing, practitioner matters, patient safety, privileged legal advice, personnel matters or a dispute in which County and HHS interests diverge. Blanket access can create privilege, confidentiality and governance concerns without necessarily improving patient care.
- AHA governance commentary advises that executive sessions should generally exclude non-board members other than legal counsel and emphasizes thoughtful decisions about who should participate. This is not a legal rule for HHS, but it is a useful governance benchmark.
- Comparable public-hospital research did not identify a clear peer model granting a county administrator an unconditional right to attend every closed session of a separately governed public hospital board.
- A useful contrast is Gila Regional Medical Center in Grant County, New Mexico - when an independent board was restored, the county manager, hospital CEO and chief of staff were ex-officio non-voting members, not voting directors.
- Harris County Administration participates in the appointment process for Harris Health trustees, but the materials reviewed do not establish a blanket right to attend all closed hospital-board sessions.
- **Suggested middleground:** County Administrator/designee receives notice of Board/committee meetings and may attend when the matter reasonably relates to County reserved powers, County assets, County funding/liability, required reporting or another defined County interest. No automatic attendance where independent HHS counsel determines participation would impair privilege, peer-review protection, patient confidentiality, an HHS-County dispute, CEO evaluation, or another legally protected independent-board function.
- Require a short written protocol identifying categories where County attendance is expected, categories where it is excluded, and a process for resolving disputes.

HHS concern: HHS specifically warns that administrator-team access to closed sessions could expose credentialing, peer review, quality and practitioner information and risk peer-review privilege, legal confidentiality and accreditation compliance.

14. Commissioner appointees / two-commissioner hold-over: NARROW

- Commissioner-directors should otherwise have the same voting and fiduciary responsibilities as other directors.
- Limit the one-time layover to circumstances where both commissioner-directors reasonably determine an action creates a material, direct and previously unauthorized County financial obligation or liability. Do not use it for ordinary clinical or hospital governance.

HHS concern: HHS says the broader mechanism creates authority not shared by other directors and could delay urgent Medical Executive Committee matters such as credentialing, privileging and peer review.

15. Board accountability / Code of Conduct: SUPPORT AND EXPAND

- Adopt a Governance Code of Conduct and Ethics that applies consistently to citizen directors, commissioner-directors, HHS executives acting in governance roles and County officials/staff participating in HHS governance.
- Complaint process should include: one confidential intake route; neutral threshold screening; referral of HR/compliance/patient-safety matters to the proper process; independent investigation for conflicted/high-level matters; notice and opportunity to respond; confidentiality/non-retaliation; written findings under a consistent standard; separation of fact-finding from sanctions; graduated remedies; limited reconsideration; annual aggregate reporting.
- Anti-weaponization safeguard: policy disagreement, dissenting votes, good-faith criticism, requests for information, whistleblowing, independent fiduciary judgment and legitimate County/HHS oversight are not themselves ethics violations.
- Removal for cause should use objective statutory/ethical standards, notice and an opportunity to respond.

16. Board transparency: SUPPORT WITH PROTECTED-DATA GUARDRAILS

- Support timely posting of meetings, agendas, packets, minutes and board membership.
- Expressly protect patient data, peer review, personnel data, privileged legal advice, competitive data and other legally nonpublic information. Transparency should not be implemented in a way that jeopardizes accreditation, peer-review protection or patient privacy.

17. Financial accountability: SUPPORT, but preserve governance/management line

- The 2026 law requires the County Board to approve HHS's annual budget as presented by the HHS Board and permits County modification in sustained conditions of financial distress while preserving essential health services.
- Define 'significant budget amendment' by objective dollar/percentage/materiality thresholds. Routine operating variances and service-line management should remain with HHS management under HHS Board oversight.
- Limit CEO delegations only where the risk justifies Board action; require regular reporting of delegated decisions rather than routing routine operations back through the County.

HHS concern: HHS warns that expanded County approval for significant amendments plus tighter delegation limits could slow workforce, service-line, quality, capital and operational decisions.

Additional points to raise at the briefing

- Require a formal County–HHS authority matrix: management runs the hospital; HHS Board governs; County exercises powers reserved by statute, agreement, ownership or material County financial exposure. (See proposed Matrix Below)
- Require hospital-board orientation and annual continuing education for every voting and ex-officio director, including commissioners: hospital finance/payer mix, Medicaid/Medicare, safety-net reimbursement, quality/patient safety, credentialing, compliance/privacy, fiduciary duties, governance vs. management, Open Meeting Law/Data Practices and conflicts.
- Require explicit Board accountability for quality, patient safety, culture and continuous improvement - not merely receipt of quality reports.
- Require a five-year financial projection under multiple State and federal reimbursement scenarios.
- Require a long-term capital/deferred-maintenance plan for County-owned HHS facilities.
- Establish objective emergency-liquidity triggers and an expedited process before a crisis occurs.
- Create a permanent board-succession process after the one-time 2026 transition, led by the HHS Governance Committee with competency-gap analysis and external recruitment support.
- Continue legal analysis of a modest stipend/per diem as an equity and recruitment tool, including the effect on §383B.905 liability protection.
- Preserve access to independent HHS counsel when County and HHS legal interests materially diverge.
- Continue the long-term structural discussion about a State-supported public health authority or similar statewide safety-net model.

Selected comparative research and authorities

Minnesota Laws 2026, ch. 127, art. 3, §§7–8: HHS board size/professional expertise and 75% qualification standard. https://www.revisor.mn.gov/laws/2026/0/Session+Law/Chapter/127/

Minnesota Compensation Council, 2025 Report: DCT Executive Board compensation: $500/day effective July 1, 2025; prior $55/day viewed as insufficient. https://www.leg.mn.gov/docs/2025/mandated/250736.pdf

Minn. Stat. §376.06: Minnesota county hospital boards may be compensated if authorized by the county board. https://www.revisor.mn.gov/statutes/cite/376.06

American Hospital Association, 2025 National Governance Survey summary: 35% of health-system boards compensate; quality and patient safety are among the most-used board KPIs. https://www.aha.org/aha-center-health-innovation-market-scan/2026-02-24-aha-national-governance-report-8-key-insights

AHA 2019 Governance Survey: 54% overall reported CEO not a voting board member; 79% of freestanding hospitals reported CEO not voting. https://trustees.aha.org/system/files/media/file/2019/06/aha-2019-governance-survey-report_v8-final.pdf

AHA Trustee Services - Board Member Position Description: Board responsibilities include CEO oversight, financial viability, clinical quality, patient safety and medical-staff quality/credentialing. https://trustees.aha.org/position-description-health-system-or-hospital-board-member

AHA Trustee Services - Executive Sessions Without CEOs: Governance commentary recommends careful limits on non-board participation in executive sessions. https://trustees.aha.org/best-practices-executive-sessions-without-ceos

UNM Hospital Board of Trustees: CEO is ex-officio non-voting; Chief of Staff, School of Medicine dean and executive physician-in-chief also have formal ex-officio roles. https://unmhealth.org/about/leadership/governing-boards/

Cook County Health Board / Ordinance: Board qualification categories include clinical medicine and healthcare management; Quality & Patient Safety Committee integrates extensive clinical participation. https://cookcountyhealth.org/about/board-of-directors/

Parkland Health Board of Managers: County-appointed public safety-net board with visible physician/nursing expertise and explicit quality/safety role. https://www.parklandhealth.org/board-of-managers

Washington Public Hospital District governance: $161/day compensation threshold as of 2024, annual cap $15,456. https://www.awphd.org/wp-content/uploads/2024-AWPHD-Legal-Manual.pdf

Nevada Rev. Stat. §450.130: County/hospital-district trustee compensation structure. https://www.leg.state.nv.us/nrs/NRS-450.html

Grossmont Healthcare District Policy BOD-11 (2026): $141.47 per qualifying meeting for district board members/designees appointed to hospital board. https://www.grossmonthealthcare.org/wp-content/uploads/2026/01/BOD-11-Meeting-Compensation-Guidelines-Individual-Policy-01.22.26.pdf

A. Direct Care and Treatment is a meaningful Minnesota comparison

Direct Care and Treatment (DCT) is a useful comparison not only on compensation, but on Minnesota's existing role as an owner/operator of institutional health care. DCT is a statewide public health-care system governed by an Executive Board. It operates hospitals and specialized treatment programs, including the St. Peter campus and its Forensic Mental Health Program (formerly the Minnesota Security Hospital), as well as Anoka-Metro Regional Treatment Center, Community Behavioral Health Hospitals and other residential, forensic and behavioral-health services. This is important context for the longer-term HHS discussion: Minnesota already directly operates hospital-level and institutional care through DCT.

St. Peter is a major part of DCT. The former Minnesota Security Hospital is now the Forensic Mental Health Program on the St. Peter campus. DCT also operates the Forensic Nursing Home there, forensic/competency services, and Minnesota Sex Offender Program facilities and Community Preparation Services in St. Peter.

DCT also operates the Anoka-Metro Regional Treatment Center; six Community Behavioral Health Hospitals; the Child and Adolescent Behavioral Health Hospital in Willmar; CARE substance-use

treatment; Minnesota Specialty Health System programs; community-based services; special-care dentistry; and other statewide programs.

The Minnesota Compensation Council prescribed $500 per day for voting DCT Executive Board members effective July 1, 2025. It expressly found the former $55/day amount insufficient and said $500 was still at the very low end of per-diem compensation for similarly sized health-care organizations.

B. Clinical voice is a governance requirement, not an operational preference

The American Hospital Association states that governing boards have a critical oversight role in quality and patient safety. AHA Trustee Services also describes medical-staff credentialing as a crucial board responsibility tied directly to patient quality and safety. Credentialing and privileging require meaningful interaction between physician and lay trustees.

- AHA's 2026 governance survey summary reports that clinical quality (91%) and patient safety (89%) are among the most commonly used board performance indicators.
- AHA's quality-and-safety guidance emphasizes that governing bodies are responsible for oversight of the hospital's quality assessment and performance-improvement program and should be educated about quality and patient safety.
- AHA's credentialing guidance calls credentialing one of the board's most important patient-quality and safety responsibilities and specifically discusses thoughtful deliberation between physician and lay trustees.
- Therefore: it is reasonable for the CEO to be non-voting because the Board evaluates the CEO. It is not reasonable to use CEO independence as the rationale for creating a voting board that could theoretically contain no one with meaningful clinical experience.
- Recommended minimum safeguard: require meaningful voting clinical expertise on the Board and require the Quality & Safety Committee to include substantial clinical expertise. The Medical Staff President and other clinical leaders can also participate ex officio where appropriate, subject to conflict and recusal rules.

C. Public/safety-net hospital examples to cite

- Cook County Health (Illinois): Its governance framework expressly recognizes expertise including clinical medicine, healthcare management, finance, public health, insurance/managed care, labor and patient experience. Its Quality & Patient Safety Committee incorporates clinical participation.
- Parkland Health (Dallas County, Texas): A county public safety-net system whose Board of Managers visibly includes physician and nursing experience, reinforcing that independent public governance and clinical expertise are compatible.
- UNM Hospital (New Mexico): The CEO is ex officio and non-voting, while the governance structure also formally includes the Chief of Staff, School of Medicine dean and executive physician-in-chief as ex-officio clinical voices.

- Direct Care and Treatment (Minnesota): A state public health-care system governed by an Executive Board, including the St. Peter forensic campus and other hospitals/programs; voting members receive $500/day.

D. County Administrator access - research finding and recommended position

I researched comparable public and safety-net hospital governance models to identify another example where a county administrator has an unconditional right to attend every board and committee meeting, including every closed session. I did not identify a comparable example among the public/safety-net systems I reviewed but of course there is no way I am able to review all of them – it would be helpful to know if we are modeling this access after another hospital?

- The County unquestionably needs financial, asset and reserved-power oversight. That does not automatically establish a need for blanket attendance in peer review, credentialing, practitioner matters, CEO evaluation, privileged legal discussions or disputes between HHS and the County.
- HHS specifically warns that blanket access could expose credentialing, peer-review, quality and practitioner information and compromise privilege, confidentiality or accreditation protections.
- **Recommended middle ground:** notice to County Administration and attendance where a meeting relates to County reserved powers, County-owned assets, County funding/liability or required reporting; defined exceptions where independent HHS counsel determines attendance would impair privilege, peer-review protection, patient confidentiality, CEO evaluation, an HHS–County dispute or another protected independent-board function.
- Ask Administration to identify the specific patient-care, financial or taxpayer-protection benefit that requires blanket closed-session access rather than targeted access tied to County responsibilities.

E. Proposed County–HHS oversight dashboard

The dashboard should replace open-ended, duplicative information demands with predictable oversight. Each measure should have a baseline, target, yellow trigger, red trigger, trend arrow, responsible executive and short corrective-action narrative. It should distinguish information needed by the HHS Board to govern from information the County needs to exercise reserved powers and protect taxpayers.

Domain	Measures	Monthly	Quarterly County	Immediate trigger	County purpose
Liquidity	Days cash; unrestricted cash; 13-week cash forecast; AP aging; debt/covenants	✓	✓	Cash/covenant threshold	Emergency-loan/taxpayer exposure

Domain	Measures	Monthly	Quarterly County	Immediate trigger	County purpose
Operating results	Operating margin; actual vs budget; forecast; service-line material variance	✓	✓	Material $/% variance	Budget/reserved powers
Payer/ revenue	Payer mix; Medicaid/Medicare; directed/supplemental payments; denials	✓	✓	Material revenue loss/delay	Safety-net sustainability
Uncompensated care	Charity care; bad debt; uninsured volume	✓	✓	Material trend above forecast	County/public mission exposure
Workforce	Vacancy; turnover; agency; overtime; critical clinical staffing	✓	✓	Critical staffing risk	Continuity/access
Quality & safety	Serious safety events; infections; mortality; readmissions; patient experience; QAPI	Board	✓ aggregate	Sentinel/regulatory event	Patient protection

Domain	Measures	Monthly	Quarterly County	Immediate trigger	County purpose
Credentialing/accreditation	Accreditation status; material deficiencies; corrective actions	Board	✓ protected summary	Accreditation/certification jeopardy	Essential service risk
Capital/facilities	Deferred maintenance; life-safety; capital plan; facility condition	✓	✓	Life-safety/major unplanned need	County-owned assets
Compliance/ regulatory	Material investigations; sanctions; CAPs; privacy/compliance	Board	✓ protected summary	Material regulator action	Legal/fiscal exposure
Strategy/access	Major service changes; capacity; essential-service access	Board	✓	Closure/reduction of essential service	Resident/public mission

- Dashboard guardrail: peer-review material, patient-identifying information and privileged legal advice should not be pushed into a County dashboard. The County should receive the level of information necessary to understand material risk without defeating protected clinical processes.
- Quarterly briefing presenters: HHS Board Chair + CEO + CFO, with Chief Medical/Quality leadership participating for quality/safety matters as needed.
- Annual deep dives: five-year financial forecast; capital/deferred-maintenance plan; quality/safety governance review; workforce strategy; State/federal reimbursement outlook.

F Governance Code of Ethics and Conduct

Adopt a Code that should apply to all voting and ex-officio HHS directors and, when participating in HHS governance, commissioner-directors, HHS executives, County officials and County staff. The purpose is to protect patient care, fiduciary decision-making and respectful governance.

Proposal language:

- **Patient care and safety first.** Put patient safety, quality, access to essential care and HHS's safety-net mission at the center of governance while maintaining long-term financial sustainability.
- **Fiduciary responsibility.** Act in good faith, with appropriate care and loyalty to HHS and its public mission, rather than as a delegate of a political, employment, business or outside organizational interest.
- **Governance, not individual management.** Individual directors and commissioners do not direct employees, intervene in individual personnel matters or manage daily hospital operations outside authority delegated by the Board.
- **Respectful conduct.** No bullying, intimidation, retaliation, personal attacks or conduct that materially undermines the Board, workforce or ability to raise patient-safety concerns.
- **Confidentiality.** Protect patient information, personnel data, peer review, credentialing information, privileged legal advice, competitive data and closed-session material.
- **Conflicts and recusal.** Annual disclosures; prompt disclosure of new conflicts; recusal when required; documentation of material recusals.
- **Political independence.** No use of HHS governance to reward/punish political allies or opponents, influence campaigns or pressure management outside legitimate governance oversight.
- **Non-retaliation / speaking up.** Protect good-faith reporting of patient-safety, compliance, financial, ethics and governance concerns.
- **Responsible communications.** Members may state personal views but may not represent them as official HHS positions unless authorized; protect nonpublic deliberative information.
- **Education.** Annual acknowledgement of the Code plus recurring governance, ethics, quality/safety, finance and confidentiality training.

H. Specific ethics/complaint reporting and resolution process

1. **One clearly identified reporting channel**. Create a confidential online form/email/telephone route administered outside the chain of command of the person complained about. Allow complaints from directors, employees, County officials, patients/community members and others with direct knowledge. Permit anonymous reports, while explaining investigatory limitations.
2. **Receipt and conflict check.** A designated Governance Ethics Officer/independent intake function logs the complaint, preserves records and determines whether the normal reviewer has a conflict. Complaints involving the CEO, a commissioner, County Administrator, HHS Board Chair, senior executive or County–HHS dispute automatically receive independent screening.
3. **Threshold screening.** Within a defined period, determine whether alleged facts - if true, could violate the Governance Code. HR, compliance, patient-safety, credentialing, peer-review or legal matters should be routed to the legally appropriate process rather than automatically converted into an ethics case.
4. **Independent investigation when warranted.** Use independent outside counsel or a qualified outside investigator when the allegation involves high-level leadership, a commissioner,

County official, HHS Board member, CEO/senior executive or a material County–HHS conflict. Establish a prequalified investigator pool before a complaint occurs.

5. **Notice and fair opportunity to respond.** Give the subject sufficient notice of the allegations and a meaningful opportunity to provide documents, witnesses and a response, subject to patient privacy, whistleblower, peer-review and legal protections.
6. **Confidentiality and non-retaliation**. Protect information to the extent allowed by law. Retaliation for a good-faith report or participation in an investigation is itself a serious violation. An unsubstantiated complaint is not a false complaint absent evidence of knowing fabrication or malice.
7. **Written findings.** Use a consistent evidentiary standard and written categories such as substantiated, unsubstantiated, inconclusive or outside the Code's scope.
8. **Correction Action**. The investigator determines facts and whether the Code was violated. The Board or other legally authorized body determines corrective action.
9. **Graduated remedies.** Education/coaching; warning; corrective action; recusal; committee reassignment; censure; referral to another authority; or removal where legally authorized. Serious retaliation, intentional disclosure of protected information, patient-safety misconduct, major conflicts or substantial fiduciary breaches warrant stronger action.
10. **Limited reconsideration.** Allow reconsideration for material factual error, significant new evidence, substantial procedural failure or a remedy inconsistent with the Code/law.
11. **Annual aggregate reporting.** Provide HHS and County Boards an annual de-identified report of complaint types, disposition, time to resolution and systemic recommendations.
12. **Anti-weaponization safeguard.** A policy disagreement, dissenting vote, request for information, good-faith criticism, whistleblowing, exercise of independent fiduciary judgment or legitimate County/HHS oversight is not, standing alone, an ethics violation.

I. Adopt a Governance Authority Matrix

Adopt a Governance Matrix in the bylaws so it is explicit and clear to board members.

Proposed Matrix could look like:

Function	Hennepin County Board	HHS Board of Directors	CEO / HHS Management	Medical Staff / Clinical Governance
Mission & public purpose	Retains statutory/public-owner powers and protects County interests.	Governs HHS; protects mission, safety-net role and long-term sustainability.	Executes Board-approved strategy and mission.	Advises on clinical implications and patient-care mission.
Board appointments / succession	Appoints and removes directors as authorized by statute; exercises	Governance Committee should assess competency	Supports recruitment administratively; no independent	May advise on needed clinical competencies.

Function	Hennepin County Board	HHS Board of Directors	CEO / HHS Management	Medical Staff / Clinical Governance
	reserved appointment powers.	gaps, succession and future nominations.	appointment authority.	
CEO oversight	No routine supervisory role over HHS CEO except where a specific reserved County power applies.	Hires, evaluates, compensates and may remove CEO; sets CEO performance expectations.	CEO accountable to HHS Board; manages executive team.	No CEO supervisory role.
Strategy	Acts on matters expressly reserved to County or materially affecting County obligations/assets .	Approves HHS strategic direction, major priorities and material strategic changes.	Develops recommendations and implements strategy.	Advises on clinical quality, access and care-delivery implications.
Annual budget	Exercises statutory approval/reserved authority over annual HHS budget.	Reviews and approves HHS budget before County action; monitors performance.	Prepares budget; manages operations within approved parameters.	Provides input on clinical resources, staffing and patient-care needs.
County funding / financial exposure	Approves County subsidy, loans, guarantees and material new County obligations.	Monitors HHS financial condition and recommends action.	Manages liquidity, revenue cycle, costs and financial operations.	No routine role.
Hospital operations	No routine operational management role.	Oversees organizational performance; does not manage daily operations.	Runs hospital and health-system operations.	Leads clinical practice and medical-staff functions within

Function	Hennepin County Board	HHS Board of Directors	CEO / HHS Management	Medical Staff / Clinical Governance
				delegated authority.
Human resources / labor	No routine role in HHS HR administration or bargaining; may act on a defined County reserved matter.	Oversees workforce strategy, culture, labor risk, compensation philosophy and material financial/patient-care implications.	Runs HR; selects negotiating team; conducts labor relations and bargaining; administers compensation/benefits within approved parameters.	Provides clinical workforce input where appropriate.
Quality & patient safety	Receives high-level assurance where relevant to County public purpose/risk; does not manage clinical quality.	Ultimate governing-body oversight of quality, patient safety and performance improvement.	Implements quality/safety systems and corrective action.	Central clinical role; develops, evaluates and recommends clinical standards/actions.
Credentialing & privileging	No routine role.	Exercises final governing-body responsibility consistent with law/accreditation and medical-staff recommendations.	Provides administrative support and implements Board action.	Evaluates practitioners and makes credentialing/privileging recommendations through medical-staff processes.
Clinical decisions	No role in individual clinical decisions.	Sets governance-level quality/safety expectations; does not practice medicine.	Supports clinical operations and resources.	Clinical professionals make clinical decisions; medical staff governs professional practice under bylaws.

Function	Hennepin County Board	HHS Board of Directors	CEO / HHS Management	Medical Staff / Clinical Governance
Capital / County-owned assets	Exercises reserved authority over County-owned property and new County financial obligations.	Approves HHS capital strategy and monitors asset condition/major needs.	Develops and implements capital plan; maintains facilities under governing agreements.	Advises on clinical functionality and patient-care implications.
Compliance / enterprise risk	Receives information necessary to understand material County exposure/reserved-power issues.	Oversees enterprise risk, compliance, audit and major legal/regulatory risks.	Operates compliance, legal, privacy, security and risk-management programs.	Participates in clinical compliance, peer review and patient-safety processes.
Information & reporting	Receives defined information needed for County reserved powers, assets, funding/liability and material risk.	Broad access to information necessary to fulfill fiduciary and governing duties, subject to law and protected processes.	Provides timely Board reporting and defined County dashboard/exception reporting.	Peer review, credentialing, patient information and protected clinical processes remain protected as required by law.
Individual directors	County officials exercise County authority only through lawful County processes.	Directors govern collectively. Individual directors may seek information but do not independently direct staff or exercise Board authority.	Management takes direction from the HHS Board/CEO chain of authority, not individual directors.	Clinical authority follows medical-staff bylaws and delegated clinical structures.
Commissioner-directors / dual role	Commissioner retains separate County responsibilities	When acting as an HHS director, commissioner participates as a	CEO should not treat an individual commissioner-director request	No change to clinical authority because a

Function	Hennepin County Board	HHS Board of Directors	CEO / HHS Management	Medical Staff / Clinical Governance
	and should identify when acting in County capacity.	member of the collective HHS governing body and owes applicable fiduciary duties.	as operational direction unless authorized by the HHS Board or County under a reserved power.	director is also a commissioner.

Recommended governance guardrails

- No individual-director authority. Individual directors, including commissioner-directors, exercise authority through action of the HHS Board unless specifically authorized. Information rights do not create individual management authority.
- CEO/management boundary. The HHS Board establishes strategy, policy, financial parameters, quality and patient-safety expectations, and CEO accountability. The CEO is responsible for administration and operations, including personnel management and labor relations.
- Protected clinical processes remain protected. Peer review, credentialing, patient information, privileged legal advice and other protected matters should be handled under applicable law

Comparable public hospital governance models

1. **Cook County Health (Illinois):** A separately governed county health system. The Cook County Board retains defined public-owner powers while a distinct Health & Hospitals System Board governs the system. Its governance framework is a useful example of separating public oversight from hospital operations, including protections against political interference in personnel and contracting. Cook County Board of Commissioners
2. **Parkland Health / Dallas County Hospital District (Texas):** Dallas County Commissioners Court appoints the public hospital Board of Managers and retains defined statutory/budget authority. The Parkland Board establishes governing policy and oversees the hospital system, while management operates it.
3. **Harris Health System (Texas):** Harris County Commissioners Court appoints trustees. Harris Health's board framework emphasizes trustees' fiduciary responsibility to the health system as a whole and distinguishes collective Board governance from operational authority delegated to the President/CEO.