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Board Organization and Structure

AN INTENTIONAL GOVERNANCE GUIDE: TRENDS, TIPS, AND TOOLS

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Introduction and Background

Five years ago, the Governance Institute published its signature publication, *Intentional Governance: Advancing Boards beyond the Conventional.*

The premise and concept of Intentional Governance are straightforward: if we want better, high performing, accountable governing boards—we need to take the deliberate "intentional" action to achieve this goal. Success rarely happens by chance. This is true for most things in life: athletes, students, business corporations—even marriages. It usually requires time, willingness, focus and effort.

The same goes with governance. If we want to build and achieve a talented, highly effective board, it takes work and intent. First, we must want it: aspire to have a high-performing, better governing board. Then, we must act: take the deliberate, willful, "intentional" action steps to get there. We define Intentional Governance as: deliberate and intentional processes addressing board structure, dynamics, and culture that enable the board to realize its highest potential. The examination is about who is on the board and why; it is about how directors interact with each other and how they interact with management; it is about how the board uses its time, how it establishes its priorities/agenda, and how it measures its effectiveness. It is about governing with intention.

Intentional Governance: Seven Essential Elements

Intentional Governance is the byproduct of a simple, but important question: what makes an effective board? During our research we identified seven essential elements of governance, each an essential part of the organization and operation of a "good board." These seven elements include:

1. Board Recruitment
2. Board Structure
3. Board Culture
4. Education and Development
5. Evaluation and Performance
6. Continuous Governance Improvement
7. Leadership Succession Planning

Intentional Governance Spectrum

This Intentional Governance Guide addresses the second element, board organization and structure. Each guide in this series is designed to provide takeaway tools and assist readers in developing customized Intentional Governance plans related to each of these seven essential elements.

Board Organization and Structure

Business organization and structure is often considered the "quiet" pillar of corporate governance. This is because it is foundational, often less likely to change under ordinary circumstances. The exception to this rule is when the underlying business or industry is experiencing change, and most especially significant change. It is no secret that this is the case in healthcare. As a result, this often "quiet" pillar of good governance has risen to the fore and now presents some of the most significant healthcare governance challenges.

Each of the seven pillars of Intentional Governance should be reviewed and assessed periodically in order to ensure ongoing high performance at the board level. However, market forces are now driving a broad-based need for organizations to take a critical look at board organization and structure. Board organization and structure needs to compliment organizational structure, while giving appropriate weight and credence to governance functions such as succession planning, board education, and so forth. Simply put, rapid change is outstripping many governing boards' ability to find the time to focus on organization and structure. Hence, all too often, senior management and governing boards hold on to traditional structures and practices. This presents a serious dilemma, as "traditional" structures can strain and steal one of the most important assets for boards and management: time.

The transformation occurring in the healthcare industry over the past five years is outpacing acute-care organizations' ability to construct and/or modify their board structures to accommodate new care delivery models and systems. Since the enactment of the Affordable Care Act (ACA) in 2010, more and more hospitals and health systems have entered into some sort of affiliation, whether through acquisition, membership substitution, joint venture, or clinical affiliation.[1] The pace of consolidation over this period has been unprecedented and surpassed that seen in the 1990s.[2]

The first wave of merger activity in the 1990s necessarily resulted in a great deal of board organization and structure work. The hospital combinations during this time often resulted in constituency boards, retaining a certain number of board members from each organization to make up the new "system" board. This structure naturally results in division and an inability to make decisions benefiting the system as a whole. As these new health systems tried to make "systemness" a reality, there was even more work to be done in order to undo the rigorous trappings that no longer served the right function for these new organizations.

Now, this more recent wave of consolidation is creating a similar problem. This is exacerbated by the fact that many organizations never properly or completely addressed organization and structure in the first place, thereby compounding the problem.

1 Barry Sagraves and Ken Marlow, "The Rise of the Hospital Joint Venture," *E-Briefings,* The Governance Institute, September 2014.

2 Ken Marlow and Rex Burgdorfer, "Continuing a Non-Profit Hospital's Charitable Mission through Mergers and Acquisitions," *BoardRoom Press,* The Governance Institute, April 2015.

For example, the "parent holding company model" is and may be a perfectly good model for many organizations. However, many organizations that adopted this model did not fully recognize some of the issues that attend to the powers, rights, and obligations of their subsidiaries and/or affiliates. Now that we have once again entered into an era of rapid consolidation, some systems are confronted with further complications and challenges: how can the health system continue to grow and expand (perhaps adding new hospital and physician "partners") when the underlying role of the subsidiary and affiliates remains unclear, or worse yet, unworkable. For many hospitals and health systems, time is running out; the luxury to wait and see no longer exists.

Standalone hospitals face board structure issues as well, though they differ to some extent. Many independent hospitals are acquiring physician groups and clinics that have boards of their own, in addition to their own strategic alliances (e.g., affiliations with other community organizations to increase access and improve population health). Many of these hospitals are focusing on revenue generation just to remain viable. Now many of these organizations have the daunting task of determining what their role should be within the community relative to other healthcare organizations in the same market, and how they will work with other organizations across the care continuum.

For many organizations, governance in general, and board organization and structure in specific, are not the highest priority. However, at some point, these organizations come to the inexorable reality that they cannot, or will not fully achieve their goals and objectives with a cumbersome, outdated governance system. Conversely, the right structure (including the structure of board meetings and agendas, committee structure and how those committees work with the board, and strategic partnership governance) will offer the governing board the best opportunity to make a meaningful impact on strategy and performance, thus enhancing the immediate issue and challenge of remaining viable in turbulent, changing times.

Resizing of the Acute-Care Enterprise

Many hospitals and health systems recognize that with the advent of population health, a significant portion of the acute care business is already shifting from inpatient to outpatient and home care. This "shift" in care is creating many challenges: both near term (navigating change in a manner that keeps the enterprise viable) and long term, such as measuring, monitoring, and ensuring quality and safety and avoiding risk.

Further, as healthcare providers assume more population health risk, they are confronted with additional challenges, including caring and being responsible for "healthy patients," many of whom have had no contact with the delivery system; so the board's challenge becomes how to manage those patients outside of the acute care setting, in the newly emerging population health model. For example, when a patient leaves one hospital or health system and goes to another, will the organization responsible for the "covered lives" be able to track that patient's care? Additional governance issues arise when one considers some of the additional, affiliated population health organizations such as ACOs and their governing boards, physician network boards, and questions

regarding how those boards interact with the hospital or health system. Hospitals and health systems will, at some point, need to take the time to clarify roles, responsibilities, and decision-making accountability. All of these issues impact this "second pillar" of Intentional Governance: board organization and structure.

Operating Structure Affects Board Structure

One compelling issue is that the governance structure must align with organizational operations. Simply put, governance and operations structure needs to be aligned with the organization's near-term goals; yet it must be flexible and dynamic enough to adapt to the challenge of change: finding new sources of revenue and strategic partnerships in this emerging, post-modern patient-centered era of care.

The changing healthcare delivery is already impacting operations, resulting in new operational leadership positions in the C-suite, including:

- Chief quality officer
- Chief innovation officer
- Chief experience officer
- Population health officer
- Chief governance officer

These emerging operational positions also impact governance, including new and additional information and reports to the governing board. Conversely, this new and different business of healthcare impacts "board competencies." Does the governing board know the issues and information that it needs to effectively govern? If so, does the board also know the level of detail and appropriate metrics it needs to see, or is the board simply getting more and more (and less and less meaningful) information? Hospitals and health systems need to move quickly. Hence, it is imperative that the board gets the right information that it needs, and that the board organization and structure helps, and does not hinder, change.

Organizational structure dictates board structure; the two should make sense together and support each other. By demonstrating where patients are seeking care, what types of care settings are being used, and what patients' needs are, boards can then see where the cost of care is going and what the service needs are. Today, boards need to "demystify" the acute-care centric model by placing more emphasis on health and wellness and get beyond the bricks and mortar of the hospital. This then allows a greater ability to modify the governance structure to move organizational strategy and performance in the right direction (and, ideally, at a faster pace).

Board Structure: Intentional Governance Solutions

Board Size

Boards that are too small (less than 10 people) often lack the requisite skills and time required to carry out governance responsibilities. It is very difficult for small boards to populate committees properly. In contrast, boards that are too big (over 18 people) require a great deal of "people" and time management, as board discussions are more easily driven off track, take more time, and can create unnecessary difficulties when consensus is needed to make important strategic decisions. Often, large boards end up executing the majority of board business through the executive committee, which creates cultural dysfunction among members who are not included in this business. The average board has about 13 members, according to The Governance Institute's 2015 biennial survey of hospitals and healthcare systems. System boards tend to be a little larger (about 17 members).[3]

Intentional Governance Assessment: Board Structure
Please indicate your level of agreement with each item.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/ not applicable
The board is the right size for our organizational needs.						
The board's committee structure is effective for the needs of the organization/board.						
The board (including board officers) has clearly defined roles and responsibilities, and holds itself accountable to those.						
Directors understand and demonstrate the difference between management and governance.						
Board meetings are as effective/productive as they can be.						

Board Role, Responsibilities, & Accountabilities

The board cannot function effectively without a clear understanding of its role, responsibilities, and accountabilities. An important first step is to review the board member job descriptions and determine if they need to be updated to reflect the organization's structure and strategic vision.[4] For systems with multiple boards, the first step is determining which role each board should play within the system, what each board should

3 K. Peisert, *21st-Century Care Delivery: Governing in the New Healthcare Industry,* 2015 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

4 Refer to The Governance Institute's sample board job descriptions at www.governanceinstitute.com/templates.

be responsible for, how the boards will report up to the system parent, and how the parent board will hold these boards accountable, and then develop clear job descriptions for each board. For systems that have only one parent board, its job description should include how the board deals with accountabilities for operating performance and strategic oversight for the system as a whole.

Board Structure Solutions for Systems

The myriad of hospital and health systems vary, and range from national "mega-systems" to regional and multi-state systems, down to single-state and local systems that cover smaller geographic areas. The ostensible goal or benefits of creating a system include taking advantage of size and strength for market share and capital investment, attaining uniformity and standardization in care processes, and eliminating redundancy and waste. As systems evolve and grow, each will find its own path to achieve its strategic vision. No single governance structure is appropriate for every system. Several considerations need to be addressed, especially when there are multiple layers of governance. These include:

- **Size of the system:** larger systems might require a nuanced, multi-board and/or regional structure with boards taking on different roles and hierarchies; smaller systems can be successful with one parent board.
- **Location/geographic spread:** systems that are spread out across large regions or state lines might find it difficult to govern in an operating company/single-parent board structure.
- **Level of diversity in the patient populations:** do patients have largely different or similar needs in the various communities in the system's coverage areas? Those with very different needs will need more direct ties to the community.
- **Culture across the system:** Does the organization have many different cultures or a unified culture?

Coping with Layers of Governance

Having multiple boards across the system has advantages and disadvantages. The main disadvantages include:

- Many board and committee meetings, and many board members to track, resulting in a complex labyrinth structure that could strangle innovation and slow down what needs to be fast-moving change
- The time it takes to prepare for such meetings and enact standards and protocols across boards and hospitals
- Boards wanting to retain their own control and focusing on their own community and hospital, making decisions that might be good for the immediate stakeholders but at odds with system goals

Typically, in order to achieve the full benefits of "systemness," the corporate parent board needs to have the appropriate level of control and authority over its affiliates so that it can manage issues in the changing healthcare delivery system including: competition, system brand, major system-wide strategic initiatives, asset investment, and

eliminating waste and duplicity. The governing board's structure needs to allow the system to have flexibility and time to devote to strategic issues, moving forward the strategy and vision for the organization as a whole.

Today, many of the larger systems are raising questions about their subsidiary (local) boards: whether to retain, limit or even eliminate them. That said, retaining local governing boards can offer the system a strategic advantage provided that the system creates the right structure and role for those boards. For instance, each local board offers a "built in constituency" for the system. These local boards, if properly organized and structured, could provide the system with a strategic competitive advantage, especially as systems work to engage their local communities in health and wellness. Note that large, emerging competitors like CVS and Walgreens do not have built in constituencies that care about and want to promote their businesses. Local boards need to be treated with care and repurposed so they can be a strategic asset. If local boards are only responsible for quality and safety, or asked to take on an advisory role, they believe that they have lost their "power." This is a universal dynamic that exists in hospitals today. To counteract this, there need be a cultural mindset within the organization to use this built-in talent for population health and community-based efforts to achieve the Triple Aim.

Healthcare is still and will remain local; large systems across a wide geographic spread lose efficacy when trying to exert a high level of strategic control from a distant corporate office. Hospitals and systems need to experiment and innovate, to build new systems of care. Accordingly, the governance structures must leave room for local sites to innovate based on their own patient needs and market forces. While layered governance structures have room for improvement and need to be streamlined for maximum efficiency, with the right leadership and clear delineation of roles and accountabilities, local boards can be converted and retained as significant assets, and perhaps even play a more valuable role than they did before.

Questions for discussion:

How does our governance structure relate to strategic plan? Does it support our operating structure appropriately?

_____

_____

_____

How does our current governance structure enable or inhibit achievement of our strategic goals?

_____

_____

_____

Are we too big and too slow?

_____

_____

_____

How many businesses are we running/building?

_____

_____

_____

How can an optimal governance structure allow for nimbleness/making changes more quickly?

_____

_____

_____

Where are the barriers to strategy and innovation and how can we adjust the structure to remove those barriers?

_____

_____

_____

Table 1. Single Parent Board or Parent/Subsidiary Structure? Pros and Cons

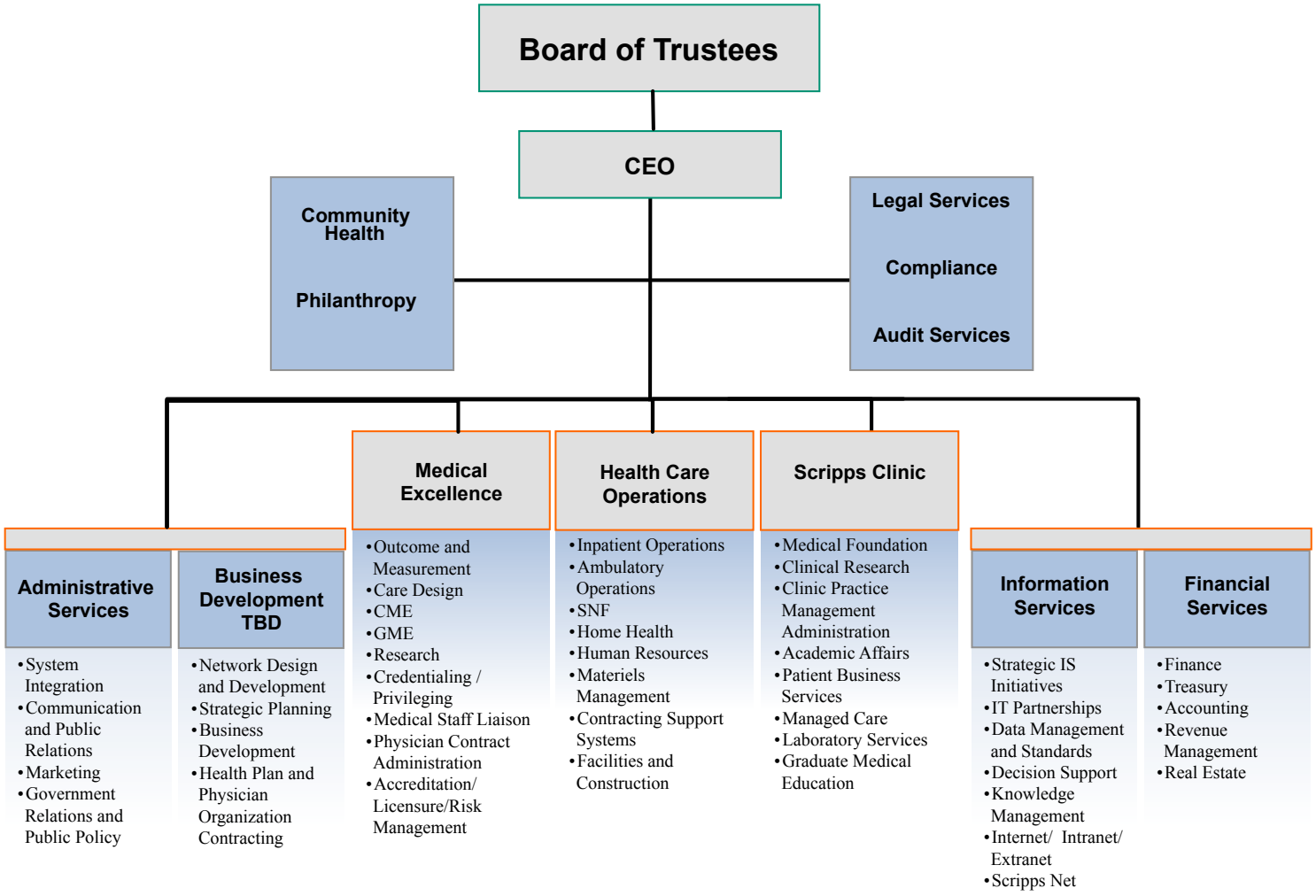
Single Parent Board		Maintaining Local Boards	
Pros	Cons	Pros	Cons
The most streamlined structure	Must oversee multiple hospitals/care settings	Maintain community connection	A less streamlined structure requiring more meetings, more committees (?) and more time to prepare for meetings
Holds accountability for entire system	Board meeting agendas can get very long, can be difficult for the board to focus on future vision if it has to spend a lot of time reviewing organizational performance	Increases pool of potential director candidates, more access to skills and expertise	System board must work harder to ensure local boards are following system-established standards and accountability
Easiest way to achieve standards across system	Need to delegate more work to committees to free up board time for strategy	Allows parent board to focus more on strategy if local boards are tasked with appropriate oversight that works at local level	
	Loss of community connection		

When local boards are given clear roles and responsibilities that are not duplicative of the system board, they can add value to the organization. Their role can be fiduciary or advisory, or they can have advisory roles for some items and a fiduciary role for other issues.

Sample oversight roles for local boards:

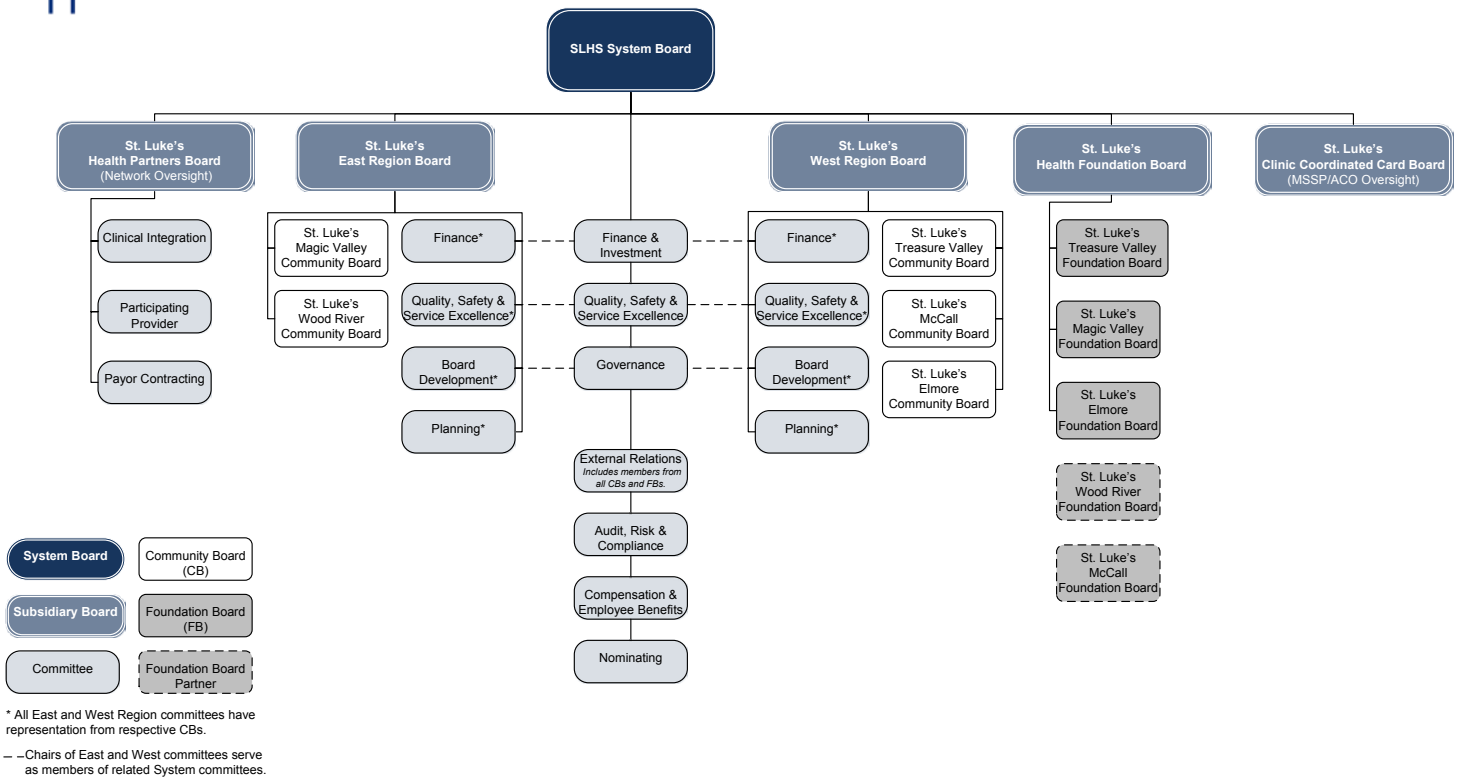
- Community benefit and conducting the community health needs assessment
- Population health initiatives (including the ability to assess which population(s) in the local community are at most risk and prioritizing initiatives accordingly)
- Quality oversight and credentialing (which can be standardized using the same metrics/criteria and reporting as mandated from the system level, while keeping the responsibility at the local level and appropriate levels of reporting up to the system board)
- Board education and development
- Fundraising and philanthropy

Sample Single Parent Board Structure
(Scripps Health)



Scripps Health created a horizontal operating structure to address system-wide standardization, charging system COOs with corporate medical, clinical operations, support services, and administrative services system-wide (rather than hospital-specific as before). A physician advisory council also meets regularly with the CEO and board chair and makes recommendations to the board. These two key aspects of the operational structure help contribute to the success of having a single, parent board.

Sample Multiple Board (Regional) System Structure
(St. Luke's Health System)



* All East and West Region committees have representation from respective CBs.

– –Chairs of East and West committees serve as members of related System committees.

Board Structure Solutions for Standalone Hospital Boards

Standalone hospital boards need to have a structure that will enable them to be mindful of the changing healthcare marketplace, the ability to adapt, and to make the best decisions from a strategic and vision standpoint. One potential benefit of the standalone is that its governance structure tends to be less complex, which can provide the ability to be nimble and create change more quickly. This can help with determining effective community partnerships. Questions to ask include:

- Are our monthly board meetings sufficient to expose directors to the voluminous amount of change occurring in the industry?
- Do directors have a strong knowledge of what is going on in their own market, and the industry overall?
- How can we be quicker to change?
- How does our governance structure relate to/work with our physician group and other partner/affiliate boards? Is there a clear delineation of roles and responsibilities? What needs to be improved in this regard?

Board Committee Structure

The optimal board structure is one where the board operates through committees, task forces, or advisory councils. This is not an area where one model fits all, however. Boards may choose to operate nimbly through *ad hoc* committees or through quasi-individual smaller groups. Flexibility is the key word.

The most prevalent committees are: finance, quality/safety, executive, governance/nominating, executive compensation, strategic planning, and audit/compliance.[5] We also recommend creating a community benefit committee for standalone hospital boards and those systems without local boards. These committees are the ones that can do the deep dive work that the board needs to do and is ultimately responsible for, but cannot do on its own during regular board meetings. It is important to ensure that there are not too many board committees, and that the committees that do exist stay in the governance realm and are not operational in nature (such as human resources and facilities/maintenance committees, which should take place at the management level and report relevant information up to the board).

One pitfall in particular that boards must be mindful to avoid is to carry committees beyond the temporal needs that led to their creation. Too often, committees are set up to address a specific need, and end up staying as formed, with somewhat amorphous agendas, because members like to chair committees, and committee members treasure the close relationships and routine tasks to which they have become accustomed. Instead, these kinds of committees must come and go as they acquire or lose relevancy. Setting up committees for the sake of having committees, organizing an advising board to serve termed-out board members, or creating executive committees because it makes the organization and the directors look larger and more prestigious, are not decisions driven by the exigencies of the organization, but by the self-interest of the board members, and actually hinder the progress of the board.

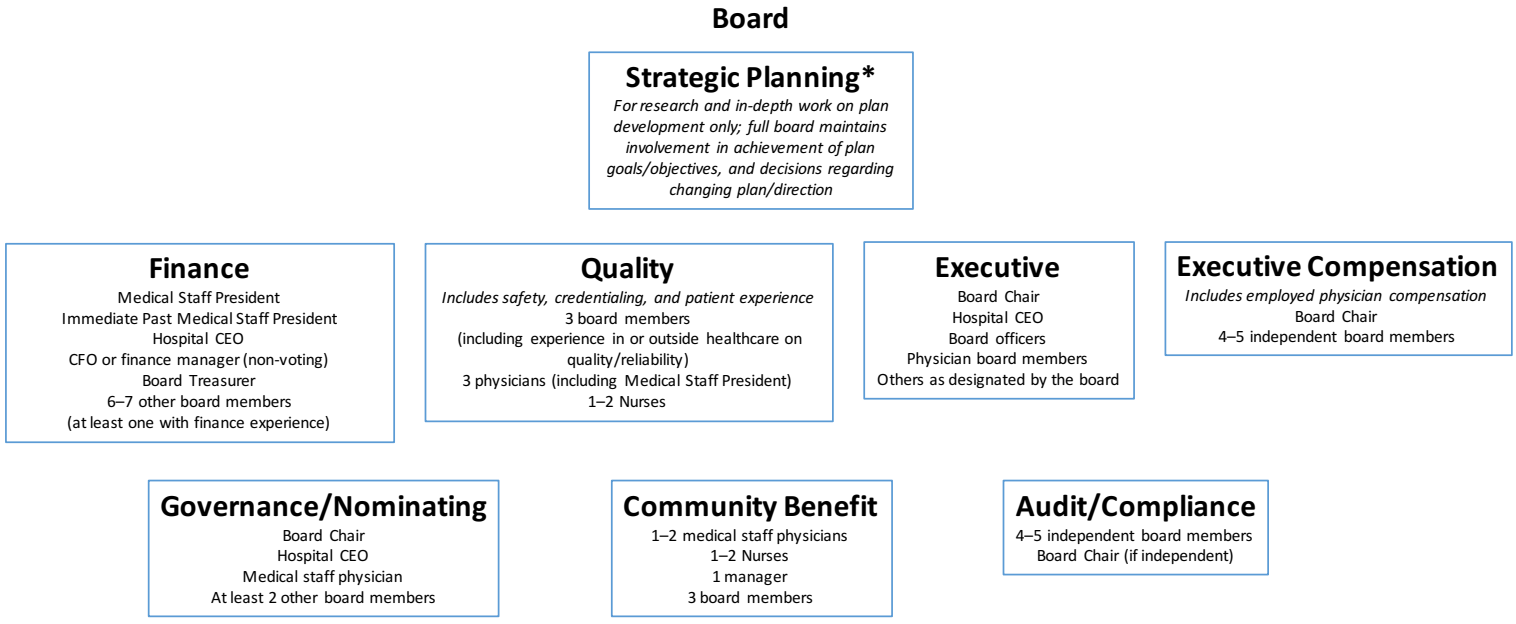
5 K. Peisert, *21st Century-Care Delivery: Governing in the New Healthcare Industry,* 2015 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

Board Committee Structure for Subsidiary Boards

Most subsidiary boards have too many committees. First, they must look to the role that the system board wants them to play as laid out in a governance authorities matrix; then they should eliminate as many committees as possible and use the board as a whole to undertake the work. A committee should be used only if needed for legal/regulatory reasons (e.g., compliance or audit). In a more evolved governance structure, local boards do not need to maintain a finance committee or strategy committee. Executive compensation oversight can be done by the executive committee. Recommended committees for subsidiary boards include:

- Executive committee
- Governance committee
- Quality/credentialing committee
- Community benefit committee (responsible for community needs assessment/ addressing community need; this is a key role and allows for active involvement of non-board community members)
- Audit and compliance (focus on "internal audit" and required local compliance functions, linked to regulatory/accreditation/legal requirements)

Sample Single-Hospital Board and Committee Structure



*Some boards do strategic planning as a committee of the whole rather than having a separate committee, both to emphasize its importance and also to ensure all board members fully understand and agree with the strategic direction.

Board Committee Assessment Worksheet

How do we determine which committees we need to have? *(Ask the question, if we had no committees, what kinds of work would we need to do at the full board level, and how long would this work take each month? Then determine appropriate buckets of the work and which committees would be most appropriate to carry out this work. The amount of work required of each committee will dictate how often and how long the committee should meet.)*

Do our committees report up to the board appropriately, or is our board redoing the committee's work?

Do we have strong committee charters and committee chair job descriptions?

Are our committee operating processes and practices effective, and are they followed in each committee?

Managing or Governing?

An aligned governance and operational structure helps enable the board to govern, not manage. Too many boards and board members are engaged in overseeing the details of the programs they put in place (managing) rather than keeping their gaze focused on the big picture and looking at the collective direction that their efforts contribute to (governing). Ineffective boards carry a myopic vision from the committee sub-meetings to the boardrooms, checking all the right boxes but still missing the fact that the train may be off the tracks.

A key challenge is lack of information alignment. Board members might feel the need to ask details about operations that may take staff a great deal of time to gather. Processes should be put in place so staff knows what the board will need to know ahead of time, and board members should be educated by the board chair and CEO about the difference between governance-level metrics and those that management need to track and why. Then, board members will be less likely to ask management to spend time gathering information that is not at the appropriate governance level.

Key points to consider:

- The very nature of governance "roles" helps boards take strategic approaches to issues rather than focus on operational matters.
- Boards stray into operations and away from policy for two main reasons: 1) they pursue what is most familiar to them, and 2) they lose faith in the CEO.
- Ideally, the board and the CEO have a symbiotic relationship, each being accountable to the other and pursuing the same goals. Optimal organizational performance is a joint endeavor.

Making our Time Count: Effective Meetings

Having the right structure is a foundational component to having effective meetings, but it is not a guarantee that boards will have effective meetings. Getting the structure right is the same as putting your house in order to make certain it is habitable and livable, and enables the type of lifestyle you need. Once this essential component is in place, it frees up the board's ability to work on the rest in a more effective, swift, nimble (and satisfying) way. Conducting a post-meeting evaluation is a recommended practice and a good starting point to determining how meetings can be made more effective. (For more information on having effective board meetings, see *Elements of Governance®:* Effective Board Meetings, Second Edition, at www.governanceinstitute.com/EOG.)

Conclusion

Healthcare is changing dramatically. Meanwhile, our governing board organization and structure is often ignored, or postponed because of other, significant priorities. Hence, our governing boards are placed lower on the agenda, and the "last to change," to catch-up to market changes. Organizations that intentionally place their best talent at the front-end (governing boards) are less likely to be surprised and better able to partner with the CEO and management to help navigate challenges and changes to our healthcare delivery system, and realize and actualize opportunities. Having the right governance structure is the beginning, essential foundational component to effective, Intentional Governance.

Questions to consider:

- How will healthcare industry changes affect our hospital or health system—in the near-term, and potentially the long term?
- Is our healthcare world growing faster and larger than we thought? Are we ready to embrace uncertainty?
- Who is looking toward the future, to protect and advocate for one of the communities most important community assets—its hospital and health system?
- CEOs and boards come and go—but it was and is the visionary that has left the legacy that most of us take for granted: our hospitals, physicians, nurses, and healthcare providers. Who is looking out for the next generation?