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System Governance Structure:
A Resource for System Boards

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Table of Contents

1 Introduction

1 Board Structure Solutions for Systems

3 Coping with Layers of Governance

5 Board Committee Structures for Health System Boards

9 How Population Heath and Value-Based Purchasing affect Health System Governance Structure

11 Background: Biennial Survey Results on System Governance Structure
12 System Governance Structure and Allocation of Responsibility

13 Conclusion

14 References

15 Appendix 1: Governance Authorities Matrix

Introduction

This toolbook provides a guideline for system boards to follow when evaluating their governance structure and discusses how responsibilities should be distributed between the system board and subsidiary boards. Data from our 2015 biennial survey is also presented to provide an example of how system governance structure is organized in hospitals and healthcare systems across the country.

Board Structure Solutions for Systems

The myriad of health system structures 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?

Intentional Governance Assessment: System 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
Our board(s) is/are the right size for our organizational needs.						
Our local/subsidiary boards have clearly defined roles and responsibilities that do not overlap with the role and work of the system board.						
The committee structure of the system board is effective for the needs of our system and system board.						
The committee structure of the local/subsidiary boards is appropriate, effective, and not duplicative to the work of the committees on the system board.						
Our local/subsidiary boards have an effective reporting process in place to the system/parent board.						
The system board is effective in holding local boards accountable to their responsibilities.						
Directors on all boards understand their role and how it might be different from a director that sits on another board.						
Board meetings are as effective/productive as they can be.						

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

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. Health 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.

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. (See **Appendix 1** for a sample Governance Authorities Matrix.)

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

Board Committee Structures for Health System Boards

System boards that are "parent" boards for large organizations will have "all" of the committees because they hold all the fiduciary duties and core governance responsibilities. We consider the "best practice" structure for this kind of board as having the following committees:

- Finance (which includes investment)
- Audit and compliance
- Executive compensation (which includes oversight of all highly-paid employees including employed physicians)
- Quality (which includes clinical quality, patient safety, and service/satisfaction/experience)
- Strategic planning (some boards prefer to do strategic planning at the full board level; see page nine of Elements of Governance®, *Board Committees,* Second Edition, for a discussion of whether to create this committee or use the full board)
- Community benefit (which includes mission fulfillment and advocacy)
- Governance (which includes nominating)
- Executive (this committee requires special care regarding the level of authority it is given to make decisions between board meetings; see the section entitled, "Committee Authority Options" on page 10 of Elements of Governance®, *Board Committees,* Second Edition)
- Investment
- Research and education (if that is part of the mission)

A system with the above committees at the system level could have local boards with limited fiduciary responsibilities or primarily advisory responsibilities with the following committees:

- Executive
- Quality/credentialing
- Community benefit
- Governance and nominating
- Audit and compliance (focus on internal audit and required local compliance functions)

On the flip side, if subsidiary boards have more broad fiduciary responsibilities, there would be more committees at the local level and fewer at the system level (this is not generally recommended if a system is trying to move away from the "holding company" model and achieve a higher degree of "systemness"). Some systems have opted for a middle tier, regional board that would have fiduciary responsibilities for the system. In this case, the regional board would have the bulk of board committees, subsidiary/local boards would be primarily advisory and focus on quality and community benefit (with or without committees), and the system board would have very few or no committees and focus primarily on strategy. (We don't recommend adding layers of governance, as the idea is to streamline the governance structure as much as possible, but this option may be appropriate for larger systems that cross multiple regions or states.)

The important takeaway here is to look at your committee structure across the system, and determine if it could be streamlined down to fewer committees, to enhance efficiency and enable better accountability and reporting up to the system board.

A Tale of Two Systems: St. Luke's Health System (Boise, ID), and Scripps Health (San Diego, CA)

St. Luke's Health System spans a large area across the southern half of Idaho. It saw a need to restructure its governance and operations. Below are the key decisions surrounding the restructure, the process for implementation, and results to date:

The Governance Challenge:

- Too many boards and committees, with little to no cross-system communication or collaboration, and inefficient use of board member and staff time preparing for too many meetings
- No ability to realize the benefits of scale, standardize, and devote the best use of system resources

Actions Taken:

- Educating and engaging community board members in a lengthy, bottom-up process to understand the vision and future direction, why the current governance structure would not support it, and soliciting input and ownership into creating the best system structure for St. Luke's desired future position
- Implementation of a regional governance and operating structure, with the system board focusing on strategy and standardization, two regional fiduciary boards overseeing hospital operations in their respective regions, and community advisory boards responsible for community health needs assessments and making recommendations for community health initiatives

Results to Date:

- Enhanced use of resources across the system
- Increased communication and alignment among the community hospitals with system goals
- More clarity on board roles relative to the system as a whole, and agendas and meetings allowing for better decision making
- Better aligned medical staffs, enabling better standardization of care processes and collaborating on quality initiatives
- Community boards maintaining local ties and better positioning the system for population and community health management

On the flip side, Scripps Health, a 5-hospital system that covers San Diego County, removed the hospital boards and restructured, using one single parent board that oversees all care settings across the system. Below are the key decisions surrounding the restructure, the process for implementation, and results to date:

The Governance Challenge:

- Strained relationship between health system executives and the medical staff
- Lack of transparency between the former CEO and the board which resulted in a vote of no confidence in the hospital administration by the medical staff
- Hospitals acting independently and in competition with each other; no benefits of being in a system
- Operating loss of over $20 million, 55 days cash on hand; insufficient to meet bond covenant requirements

Actions Taken:

- Removing governance and management from individual hospitals and creating a unified system-level governance and management structure, with one system board
- Constructing a horizontal management structure focused on service lines across the system, to break down silos, increase efficiency, and reduce variation
- Establishing a physician co-management leadership model to move the system forward into the next era of clinical care delivery transformation and innovation
- Creating the Physician Leadership Cabinet to engage and align physicians from an independent medical staff
- Developing the Scripps Leadership Academy to change the organization's culture starting with middle managers

Results to Date:

- Today, Scripps Health is increasingly functioning as a genuinely integrated system and has cut millions of dollars of waste out of the system.
- It is moving into the population health arena via its ACO, ScrippsCare, which includes the physician leaders of seven Scripps-affiliated medical groups and community representatives.
- CEO Chris Van Gorder wrote in an introduction to the Scripps 2012 annual report, *Partners in Caring,* "Working as partners, our physicians and administrators are designing our clinical care lines to improve care and reduce costs. They are identifying and eliminating unnecessary variations and defining the most effective methods of diagnosing, treating, and preventing illness among the half-million patients we care for each year."

Sources:

1. *Designing Governance for the Future: The New St. Luke's Health System.* San Diego, CA: The Governance Institute, February 2016. Click here to read the full case study.
2. *Building a Culture of Accountability from Within: The Transformation of Scripps Health.* San Diego, CA: The Governance Institute, June 2014. Click here to read the full case study.

How Population Heath and Value-Based Purchasing affect Health System Governance Structure

Health systems have begun changing board structures/practices around PHM or VBP, but there is still room to grow in this area:

	System Changes since 2013:	
	Population Health Management (PHM)	Value-Based Purchasing (VBP)
We have changed our board structure to prepare for PHM.	64%	58%
We have added board members with expertise related to this area.	12% *(PHM expertise)*	12% *(QI expertise)*
We have added board members with predictive modeling/risk management expertise related to this area.	8%	4%
We have added physicians to the board to help us with goals related to this area.	16%	14%

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

The above board competencies are critical for system boards as they deal with strategic issues related to population health and value-based purchasing. Other important "new" competencies to look for at the system level include outside-industry experience related to consumerism/industry disruptors, innovation, and technical expertise related to mobile health technology and cybersecurity.

Emerging System Governance Best Practices

1. Governance must support system transformation into an integrated model of care (see **Exhibit 1**).
2. Health system governance is generally moving to a more streamlined, more centralized, and more aligned governance model.
   - Large, multi-state systems operating with a maximum of two governance levels; NOT with a system, regional, and local board structure (three levels).
   - We expect that five years from now many, if not most, health systems will have further streamlined their structures.

Governance must **support system transformation** into an integrated model of care

1. Team care through **interdisciplinary clinical collaborations**
2. **Standardization** of clinical service line strategies
3. **Minimization** of ineffective **clinical process variation**
4. Financial **risk strategies** with payers
5. Capital **asset efficiency**
6. Economically productive **geographic expansion**
7. Optimization of **patient/customer access**
8. **Electronic "wiring"** of the system, including **direct connections to patients**
9. **Realignment of internal operating incentives** through new compensation models
10. Attention to the development of **informatics capacities**
11. Developing longer-term approaches to **workforce planning**
12. Creating a **productive work environment**

Source: Marian Jennings and Gail Costa, Evolving Roles and Responsibilities of Boards in Health Systems *(Webinar), The Governance Institute, March 2016. For more information, view The Governance Institute's Summer 2012 white paper,* High-Functioning, Integrated Health Systems: Governing a "Learning Organization."

Background: Biennial Survey Results on System Governance Structure

Data from our 2015 biennial survey of hospitals and healthcare systems shows that over half of systems (52 percent; up from 44 percent in 2013) have a system board as well as separate local/subsidiary boards with fiduciary responsibilities. Sixty-nine percent (69 percent) of system boards approve a document or policy specifying allocation of responsibility and authority between system and local boards (about the same as 2013), and 86 percent of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders.

Table 2. System Board Composition

Systems	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2015	**2013**	**2015**	**2013**	**2015**	**2013**	**2015**	**2013**	**2015**	**2013**
Average # of Voting Board Members	17.6	16.7	0.9	1.3	2.0	2.5	12.8	12.6	2.0	0.3
Median # of Voting Board Members	16	17	1	1	1	2	12	13	0	1

*Includes employed physicians.
**Includes physicians who are not on the organization's medical staff/not employed and nurses who are not employed by the organization.
***Includes nurses who are employed by the organization.

Note: Average board size increased, reflected in a slight increase in independent and other board members.

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

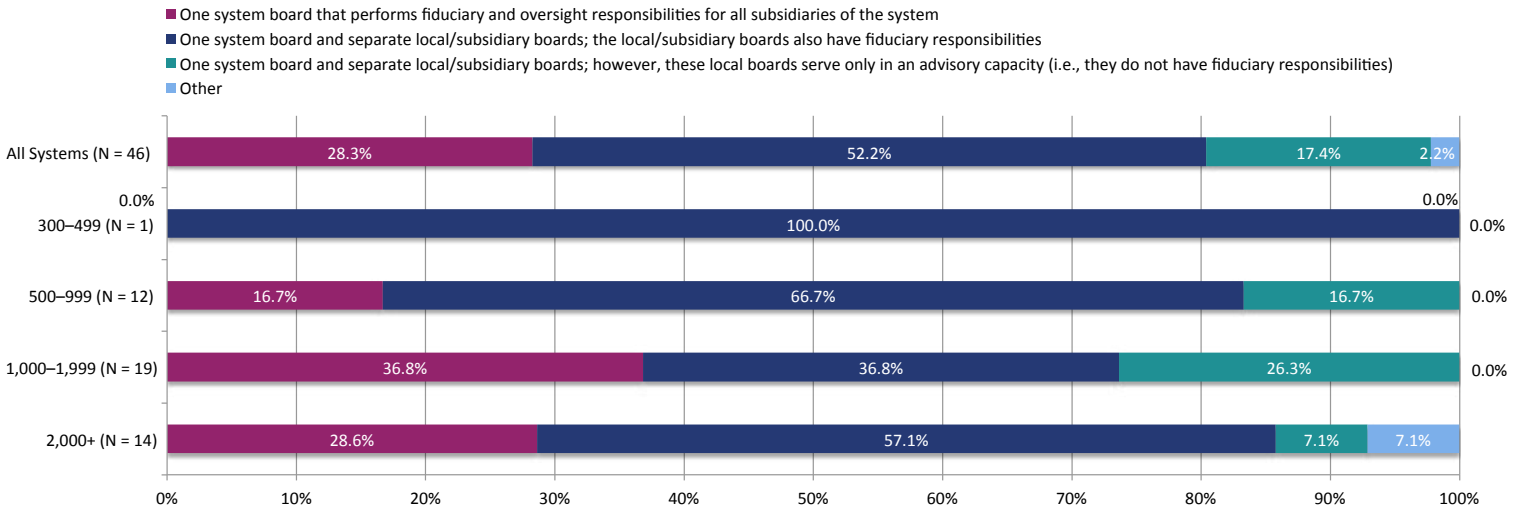
System Governance Structure and Allocation of Responsibility

We asked system boards about the governance structure of the system overall, whether the system board approves a document or policy specifying allocation of responsibility and authority between system and local boards, and whether that association of responsibility and authority is widely understood and accepted by both local and system-level leaders.

Governance Structure

- Most systems (52 percent, up from 44 percent in 2013) have a system board as well as separate local/subsidiary boards with fiduciary responsibilities.
- Twenty-eight percent (28 percent) of system respondents have one board at the system level that performs fiduciary and oversight responsibilities for all hospitals in the system (a decline from 35 percent in 2013).
- Seventeen percent (17 percent) have one system board and separate local/subsidiary advisory boards without fiduciary responsibilities (about the same as 2013).

Exhibit 2. System Governance Structure by Organization Size *(# of Beds)*



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

Conclusion

Each health system will need to consider several factors before and while determining or redesigning their governance structure. Size, location, needs of the patient population, and culture of the system itself all come into play. Advantages and disadvantages of having multiple boards will also need to be considered when determining the governance structure that will work best. 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.

For more information, click here to view the System Boards resources page on our Web site.

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Appendix 1: Governance Authorities Matrix

Decision		System board	Subsidiary board	System CEO
Governance	System board member election/removal	A		
	Subsidiary board member election/removal	A	R	
	System board officer appointment	A		
	Subsidiary board officer appointment	R	A	
	Add new subsidiaries to system that alter system governance	A		
Executive Oversight	Establish system CEO annual objectives	A		I
	Conduct system CEO performance review and set compensation	A		I
	Establish subsidiary CEO annual objectives	A	I	R
	Conduct subsidiary CEO performance review and set compensation	A	I	R
	Select subsidiary CEO	A	I	R
Strategic Planning	System strategic plan	A	I	R
	New program development at subsidiary	I	I	R
	Close major clinical service at subsidiary	A	A	R
	Strategic plans of other entities (e.g., medical group)	A	I	R
Operational Planning	Integrate key administrative functions (e.g., finance, HR)	I	I	A
	Standardize medical staff credentialing process	I	I	A
	Standardize HR policies and benefits	I	I	A
	Integrate medical education programs	I	I	A
	Establish annual performance objectives and review performance of subsidiary executives	I	I	A
	Medical staff appointments at subsidiary		A	R
Quality Oversight	Establish annual system quality objectives/plan	A		R
	Establish annual subsidiary quality objectives/plan	A	I/R	R
Financial Planning	System operating budget	A		R
	Subsidiary operating budget	A	R	R
	System capital budget (annual/long-term)	A		R
	Subsidiary capital budget	A	R	R
	Approve contracts	A (over $X)	R	A (under $X)
	Debt financing	A		R
	Annual development plan	A	R	R

Authority Matrix Key

A	Approves
R	Recommends
I	Provides Input
Blank	No Role