Health System Governance: Board Organization

Part 2 of our series on health system governance by Rex Killian, former Senior Vice President of Governance and Sponsor Relations and general counsel at Ascension Health.[1]

How a board is organized can have a tremendous impact on how effectively it can perform. Before discussing the board's culture, work, processes, and monitoring, at the outset, health systems need to make sure the right board organization is in place and the right people are on the board. Board organization pertains to board size, composition, structure, competencies, committees, and staffing. If these are not established correctly, it will be difficult for the board to be efficient and effective.

The following is a fairly simple framework for board organization that helps ensure the board is organized in a manner that facilitates its work and that the right people are on the board.

Organizational Framework

Step 1. The Board's Purpose: Clearly state the board's purpose and function. This can vary significantly depending on the type of organization (system parent, local parent, hospital, foundation, and so forth) and the governance model (parent holding, shared governance, or operating model). Professor Richard Chait has stated in *Governance as Leadership: Reframing the Work of Nonprofit Boards*[2] that the fundamental issue facing healthcare boards is one of purpose. Since form follows function, we need to start with the function or purpose of the board before we can address its form.

Step 2. Board Roles and Responsibilities: Delineate and be very clear on the short list (five or six) of the board's key roles and responsibilities. This is truly foundational and will drive many of the organizational steps. What is the responsibility of the board with respect to policy, strategy, quality, fundraising, board education and development, finance, operations, etc.? With respect to each responsibility, is it one of oversight, development, input, guidance, or monitoring? The board's responsibilities should be distinguished from an individual board member's fiduciary duties.

Step 3. Work of the Board: The work of the board should naturally flow from the board's roles and responsibilities. For example, if one of the board's responsibilities is to provide oversight for system-wide efforts to evaluate and improve the quality of care provided in its institutions, that should drive a set of work and benchmarks for the board so it can fulfill that responsibility.

Step 4. Board Member Competencies: The defined work of the board will dictate what individual and collective competencies are needed to conduct the board's work. Thus, in addition to certain core competencies that all board members should satisfy, the board, as a collective body, should be well rounded and evidence the special competencies needed to do the work. Once these are clearly set forth, the board's governance committee can periodically evaluate the composition of the board against these necessary competencies and make informed decisions on board member appointments and reappointments.

Step 5. Board Recruitment: The above steps lead the board to an effective board recruitment and board succession planning effort in which recruitment is targeted to the competencies needed. This framework is supportive of the best practice that boards should be competency based and not representational.

Board Size

Much has been written about the ideal board size for an organization. A health system board with multiple sites or hospitals needs to be large enough to include persons with the collective competencies needed to complete the responsibilities of the board but not so large as to tie up the board in gridlock. Based on my experience, I would recommend a board size of 10 to 15 members, larger than most public company boards and smaller than foundation boards. This size is large enough to foster good dialogue, capture the competencies needed for a diverse health system, and populate committees. If the board is an operating board, I would suggest a smaller number; and if one of the key responsibilities is fundraising, the board could be larger.

> It is clear that the size of the board is dictated largely by the responsibilities of the board.

When I see boards in healthcare with 20–30 members, generally one of the key or even primary responsibilities is fundraising. In those instances, it is preferable to split off this activity into a foundation or advisory board and keep the fiduciary board to no more than 10 to 15 members.

Composition

Like board size, the composition of the board is dictated by the type of organization and the responsibilities of the board. The composition of a hospital board could be very different from that of a multi-hospital system board. In any case, however, I strongly recommend that all boards be *competency based* rather than representational. Given the increased scrutiny from both the public and private sectors on the role and effectiveness of governance, systems need to raise the governance bar.

Structure and Staffing

The last piece of the organizational puzzle is to ensure that the board is structured and staffed appropriately to complete the work of the board. Many of the board's responsibilities can be delegated to board committees for the processing of the work and making recommendations to the board. In my experience, core committees for health systems include executive, finance, audit, mission, quality, and executive compensation committees.

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1 An overview of approaches to health system governance was set forth in the August 2007 article, "Health System Governance: An Overview of Practical Approaches to Effective Governance." *BoardRoom Press*, August 2007. The remaining articles in this series will cover board culture, the work of the board, board processes, and monitoring performance.

2 Chait, R. P., Ryan, W. P. and Taylor, B. E. (2005). *Governance as Leadership—Reframing the Work of Nonprofit Boards.* Hoboken, New Jersey: John Wiley & Sons, 2004.

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Although not yet as common with not-for-profit health systems, I strongly urge health systems to borrow a page from the public sector and form a governance committee. This committee would assume many of the responsibilities now assigned to the board as a whole and, in my opinion, would devote a much needed focus on such key governance issues as annual board goals, board recruitment, succession planning, board education and development, and best practices. In addition, by delegating these functions to the governance committee, more time is available at board meetings to concentrate on strategy and the generative mode of governance. With this special focus on structure and staffing, it is much more likely that best practices will be identified and implemented and thus lead to a higher performing board.

Finally, systems need to commit the resources to properly staff the governance function. A chief governance officer or similar position, with administrative staff, is necessary support for the board. As noted in the Report of the Blue Ribbon Panel on Health Care Governance, "… health systems with multiple boards can benefit from having executive-level and other dedicated staff devoted to the governance function, rather than assigning responsibilities to staff that also has other duties within the organization."[3]

Based on my experience as Senior Vice President of Governance and Sponsor Relations at Ascension Health, I would strongly support this recommendation of the Panel. As the former general counsel and one who, in that capacity, attended board meetings and participated in the preparation of the board meeting agenda and materials, I can vouch for the fact that upon transition to the new role, my focus on governance matters became much broader, more comprehensive, and of more value to the board.

Once the board is organized and the right people are on the board, we can next address the board culture, the work of the board, and how the board processes its work. These areas will be the subjects of subsequent articles.

The Governance Institute thanks Rex P. Killian, J.D., president of Killian & Associates, LLC and Governance Institute faculty for contributing this article.

3 *Building an Exceptional Board: Effective Practices for Healthcare Governance*—Report of the Blue Ribbon Panel on Healthcare Governance, 2007, Health Research and Educational Trust. See also Prybil, L. D. "Characteristics of Effective Boards," *Trustee*, Vol. 59, No. 3, March 2006.