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About This Publication

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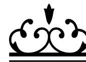

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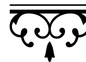

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Introduction

National health reform, the global economic turn down, and many other environmental forces are leading to hospital consolidation and growing systems. Multi-hospital systems are forming and growing in order to pursue three goals:

1. Improve their acute-care performance (increased quality, safety, satisfaction, and efficiency).
2. Develop scale to access capital at competitive rates.
3. Begin the journey to managing the care of a defined population (wellness, prevention, and chronic disease management).

New and already established health systems are working diligently to respond to the realities of the Affordable Care Act (ACA) and successfully transition to an effective governance model. The ACA is asking health systems to use fewer resources, take care of more people, and continue to provide increasingly complex care in their core business (i.e., acute care), while simultaneously reinventing their business model.

Along with legislation, health systems are currently facing a variety of external pressures that require swift responses. Some of the pressures and strategic imperatives for health systems include relentless pressure on cost structure, at-risk revenues dependent on cost and quality performance, increased demand for physician integration, significant investments in information technology, increased public scrutiny, and pressure to build system-wide brand awareness

With so much going on in the healthcare environment, the transition to effective system governance will not be easy. Health systems, including newly formed, those in the process of forming, and those already in existence, will have to leave part of themselves behind, including some outdated notions about governance and leadership. This *Elements of Governance*® looks at the need to set goals and operating objectives, move toward an operating company model, and create an efficient system board structure. It also provides best practices used by high-performing health systems across the country.

Setting System Goals and Operating Objectives

Setting a course to survive and hopefully thrive with this backdrop, most health systems have established a set of goals, such as:

1. Improve acute-care performance.
2. Develop scale to access capital at preferable rates.
3. Begin the journey to managing the care of a defined population.

Most systems also have a set of operating objectives similar to the three below:

1. Foster collaboration in order to reduce fragmentation of care.
2. Standardize care in order to improve outcomes.
3. Centralize control in order to achieve the benefits of systemness.

If health systems are going to achieve these ambitious goals and objectives, then they have to put in place structures to support them. A critical component of that system structure is governance in general and more specifically identifying the required competencies or skill sets of the parent board, determining the size of the parent board, and then figuring out the relationship of the parent to its subsidiaries (i.e., how they are going to share authority). Newly formed systems need to determine how parent board members are going to be selected. (Are they elected by a self-perpetuating board? Are they appointed on a reputational basis by subsidiary organizations? Or do they arrive *ex officio* by virtue of a leadership position?)

Unfortunately, for new systems, once the affiliation agreement has been signed and the task of constructing the parent board has begun, it's not unusual for political considerations to overwhelm the planned intent. As independent hospitals consolidate into multi-hospital systems, governance becomes more challenging because the policy setting, oversight, and decision-making lines of authority between the parent and subsidiaries become blurred. Too often these governing bodies are assembled without sufficient attention to the original purpose of the consolidation, resulting in the creation of a system that has compromised its own effectiveness and, in some cases, rendered itself virtually ungovernable and unmanageable.

There are various reasons for this, but there is one central theme: in order to complete the transaction, the parties compromise on both strategic intent and leadership (board, management, medical staff) structure; a compromise presumably made with good intent but leads to troublesome, and in some cases disastrous, consequences. Often, the very notion of "systemness," the rationale for creation of the system in the first place, was steeped in the pursuit of increased collaboration in order to reduce fragmentation of care, standardization in order to improve patient care outcomes, and centralization in order to achieve the benefits of scale (e.g., capital access).

These are worthy goals that can only be attained by a system with the fortitude to empower its parent board with the authority to pursue them. The challenge is to strike the right balance, recognizing that centralization of decision making is ultimately required to achieve standardization and systemness, while also establishing a transitional process that is sensitive to those constituencies that are being asked to relinquish local control and autonomy.

Moving toward an Operating Company Model

The most fundamental question the system board has to answer is where it falls on the continuum of structural options. To imbue the parent board with the proper level of authority to do its job, leaders must begin by asking two simple, rhetorical questions:

1. What are the end goals?
2. What structure best supports pursuit of those goals?

Assuming the system has two overarching goals (improving quality/patient experience and developing scale), the question becomes which structure best supports these two goals. As complex as system governance is, the job description can be framed in one matrix (see **Exhibit 1**). "Systemness" requires one body to set policies for the entire organization. Thus, in reality there are just two possible governance structures in this scenario:

1. Creation of a holding company with (mostly) decentralized governance authority residing in the subsidiaries.
2. Creation of an operating company with (mostly) centralized governance authority residing in the parent.

Exhibit 1: System Board Job Description Framework

Core Focus	Activities		
	Policy Formulation	Delegation & Oversight	Decision Making
Fiduciary Duties[1]			
Quality & Safety			
Financial Oversight			
Management Oversight			
Strategy			
Advocacy & Philanthropy			
Board Affairs			

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[1]Obedience, Loyalty, & Care

The holding company model is a traditional approach used by many health systems. The parent company in this model is the convener, organizing opportunities for subsidiary organizations to discuss potential synergies and opportunities for collaboration, but it has little real authority to ensure this happens. A holding company board, by its very definition, lacks the authority to create and sustain "systemness." The subsidiary organizations usually retain a great deal of local authority, which can create variation across the system and reduce the parent board's role. If a system's goal is standardization and coordination, this model can make it difficult to be successful.

The operating company is at the other end of the continuum. In contrast, an operating company places greater authority in the parent, enabling it to create "systemness" by (outlined in Exhibit 1):

- Setting system-wide policies to which all entities are required to adhere
- Delegating appropriate responsibility to a variety of individuals, committees, subsidiaries, and others (e.g., medical staffs)
- Designating certain decisions as being the purview of only the system board, such as acquiring or merging with an additional hospital or implementing a system-wide electronic health record

Here central authority resides with the parent company, but that doesn't mean there aren't meaningful roles for others. While the parent holds fiduciary responsibility and sets system-wide policies, it delegates 99 percent of all responsibilities to its committees, subsidiary organizations, executives, and medical staffs. Ultimately, an operating company model gives the parent command-and-control authority, at least on paper. The structuring of an operating company has to be done with careful consideration of political sensitivity.

There are also many different examples of a shared governance model in the middle of this continuum. Virtually any authority can be divided between the parent and its subsidiary organization(s) in various ways. For example, the parent company may reserve the right to appoint subsidiary board members even though it actively solicits nominations from the subsidiary. Most high-performing systems fall on the operating company continuum, even though on a day-to-day basis they actually function on a highly

collaborative iterative basis actively soliciting bottoms-up input in decision making that ultimately resides with the parent. In other words, they are structured as an operating company, but from an outsider's perspective they appear to be more of a shared governance model. There is a role for this hybrid model, particularly in evolving systems. It is not unusual for there to be a two- or three-year period where there is more sharing of power and more representational appointment of board members as a system initially comes together. (See **Exhibit 2** for more information on each model of health system governance.)

Implicit in this discussion is the assumption that newly formed and existing systems need to move toward, if not fully adopt, an operating company model for governance. The holding company model is unlikely to work in the long term, as decentralization does not allow for an adequate response to current pressures, nor does it support the pursuit of system goals. In addition, common practices adopted by those using the holding company model—including the creation of representational boards at the system level where each entity holds a certain number of director seats—sustains parochialism.

Exhibit 2: Models of Health System Governance and Management

Holding Company	Shared Governance	Operating Company
• Goal-setting, oversight, and decision making are decentralized • Local boards retain significant fiduciary authority and responsibility • Parent has limited reserved powers or rarely exercises them • Parent board composition often based on representational governance • Local executives have considerable power • Little standardization of or centralization of key business functions; few or no platforms to share best practices • Very lean corporate staff • Common to have large and multiple boards composed of stakeholders • Governance processes can be cumbersome because of desire to involve many stakeholders and achieve consensus • High priority placed on fulfilling mission and meeting local/market needs	• Goal-setting, oversight, and decision making are shared with local fiduciary boards • Premium placed on local input into system-wide decision making • Parent applies influence in key strategic areas and uses reserved powers sparingly • Standardization, centralization, and sharing of best practices implemented where they add value • Alignment promoted by enterprise-wide strategic planning, capital planning, system-wide policies, and accountability for performance targets • Moderate-sized corporate staff • Parent board composition not based on representational formula • Local executives are evaluated by parent CEO with local board input • Governance structures and processes are streamlined • Mission and meeting local/market needs is balanced with financial requirements	• Goal-setting, oversight, and decision making are centralized at corporate level • Authority shift from subsidiary to parent level • Reduction or elimination of local boards, or conversion to advisory status • Business functions centralized, intense standardization, mandatory use of best practices • Strategic planning and capital planning are driven from the top • Large corporate staff to manage key functions • Local executives are evaluated by parent • Flatter governance and management structures • Corporate financial and quality performance takes priority over subsidiary considerations • Lean board size and committee structure

Corporate Control, Capability, Coordination, and Centralization

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Health System Structure: Factors to Consider

While the days of systems operating as a loose confederation of independent entities has largely passed, not every system needs to move to a full operating company. Those that do, moreover, need not necessarily get there right away, but rather should do so over time as dictated by the environment. System leaders need to consider a variety of factors when determining where to reside on the continuum and how quickly to move toward this goal:

- **Geographical spread and market distinctiveness:** Some systems are geographically spread out and hence operate in different natural markets that each have their own local dynamics and characteristics. The most obvious examples are large, national systems that operate in multiple (sometimes 10 or more) states. These organizations often need to maintain local boards that retain some autonomy, thus giving them the flexibility to react and adapt to local market conditions. Even less geographically spread out systems will often operate in somewhat distinct markets, creating the need for retention of local boards with some degree of autonomy and control. Less geographically spread out systems that serve only one market often move further and/or faster along the continuum, transitioning relatively quickly to a single system board and few if any subsidiary boards. Not all local systems, however, find it necessary or even useful to eliminate local boards.
- **Need for local directors to remain engaged:** Health systems, particularly those operating in diverse geographies, can benefit from having talented individuals at the local level who provide guidance and leadership. Systems that centralize most or all authority at the system board level may find that, over time, the ability to attract and retain talented board members at the local level declines markedly.
- **State law:** Some states require the existence of local boards that retain certain fiduciary responsibilities, such as medical staff credentialing. Consequently, large systems operating in these states need to strike a balance between legislative requirements and the desire for a governance structure that supports systemness.
- **Diversity and complexity of entities within the system:** Some systems are made up of very different types of organizations. For example, an academic medical center that serves as a regional referral center and provides tertiary/quaternary care operates very differently than a small community hospital or a network of community clinics in a suburban or rural area. Effectively overseeing this complexity may prove too difficult for a single system board.

To understand the rationale behind the need for an operating company model approach, here are two examples of system policy setting that support this premise. Consider that many newly formed systems have differing standards (policies) of patient care among their subsidiary organizations. Now imagine the following scenario:

- A patient suffers an avoidable injury in the ambulatory surgery center of Subsidiary A.
- System leaders are subpoenaed to explain why the standard of care is different (i.e., better) in Subsidiaries B, C, and D.

If this situation is to be avoided, there has to be a single governing body tasked with setting policy, delegating responsibility, and ensuring accountability.

Now assume the newly formed system recognizes the necessity of constructing a uniform approach to creating an interoperable electronic health record that is user-friendly to patients, physicians, and others. Prudent leaders will all affirm the need to move in this direction, but someone must have the authority to require transition to an interoperable platform by a certain date and to allocate resources to support implementation. Absent a strong parent board and CEO this is unlikely to occur.

There are some things that can be done within the structure of an operating company model to "protect the interest of subsidiaries." So, by way of example, there can be stipulations in the affiliation agreement about powers that will be reserved to a given subsidiary for a specific period of time. For example, no major clinical service can be closed down without a vote of the subsidiary board for a period of five years. Reserve powers can also protect interests of subsidiaries in the longer term and supermajority votes can be used at the parent level to provide levels of security. For example, you might not let a new member into the system without a supermajority vote of 75 percent. (More information on safeguards to protect system and subsidiary interests appears in the following section.)

Holding company model unlikely to work in the long term:

- Decentralization doesn't support pursuit of system goals
- Representational authority sustains parochialism

Operating company model is better suited to support system goals:

- Stipulations can be used to protect interests
- Reserve powers can protect interests
- Supermajority votes can provide measure of security

Caveat: an effective operating company will appear, from the outside, to be a hybrid:

- Nurturing a culture of collaboration and cooperation
- Limiting the use of command-and-control authority

Typical Subsidiary Hospital Board Role in Operating Model

In an operating company, core responsibilities reside with the parent, which includes fiduciary responsibilities for the entire system, operating oversight responsibility for the entire system, self-perpetuating election of the majority of the parent board, and appointment of the system CEO. Typically the operating company also has the power to appoint in some form or fashion subsidiary board members and chief executives, and in addition it will have authority for budgeting and strategic planning. Authority typically delegated to a hospital subsidiary includes:

- Medical staff credentialing, privileging, and peer review
- Community relationships
- Advocacy
- Hospital-specific endowment and philanthropy

Subsidiary hospitals also typically contribute from the bottom up, providing input on:

- Hospital board composition
- Appointment of hospital CEO
- Identification of strategic priorities
- Identification of budgeting priorities
- Participate on system committees

Strategies and Tactics to Manage the Transition

Transitioning to an operating company model takes careful planning. Below are 12 strategies and tactics specifically designed to facilitate the transition.

Strategies before and during System Formation

The most effective systems began talking about the need for systemness even before they came into being. Specific strategies and tactics for this stage include the following:

- **Emphasize the benefits of systemness and make expectations clear upfront**: The most successful, nimble systems came together with a clear expectation that this transition would occur. Consequently, discussions about systemness should take place as a precursor to forming the system (or bringing another entity into the system). Institutional leaders who are contemplating forming or joining a system need to buy into the benefits of being a part of the larger organization, and understand and accept what that step will mean from a governance perspective.
- **Consider a "trial period" before finalizing the deal**: Even with open, honest pre-merger dialogue among leaders who believe in the value of systems and more centralized governance authority, some resistance is likely to remain at the entity level even after the system forms. For this reason, some newly formed systems have explicitly created a "trial period" during which the individual entities get to know and learn to trust each other. During this period, any entity can relatively easily exit the organization.
- **Establish clear, written lines of authority**: Early on, system and local leaders need to work together to clarify the specific authority and responsibility that will reside at the system and subsidiary level. The goal is to give system leaders the authority they need to run the organization as an integrated system while simultaneously leaving meaningful and valuable responsibilities at the local level that are of value to the system as a whole. (See **Exhibit 3** for a continuum of local hospital board roles, ranging from an advisory board with no formal authority to an operating board with

significant fiduciary responsibilities related to oversight and decision making.) To aid in this process, systems should create written documents that clearly describe the roles and responsibilities of the various levels of governance, using as clear and accurate language as possible. These roles should also be communicated during new director orientations and reinforced through board education and evaluation processes.

Ongoing Strategies

Setting appropriate upfront expectations and clearly defining the various roles and responsibilities goes a long way in positioning an organization to operate as a true system with good relations between system and subsidiary boards. Maintaining this momentum over time, however, requires the adoption of additional strategies designed to ensure that appropriate communication takes place on a regular basis:

- **Regularly bring local and system boards together**: Most pioneering health systems bring the members of their various boards together regularly to build and maintain personal relationships and to review and clarify the respective responsibilities of the boards.[1] These gatherings can be an effective means of building systemness and ensuring smooth system–subsidiary board relations. Often CEOs, other administrative leaders, and physician leaders at the system and subsidiary level attend these sessions as well.
- **Have system leaders attend subsidiary board meetings (and vice versa)**: One common strategy is to have system-level administrative and board leaders regularly attend subsidiary board meetings, thus providing a visible reminder of the local entity's role within the larger system. Many systems also invite local leaders to attend system board meetings.
- **Let local boards decide their own outcome:** Several pioneering systems have adopted the explicit strategy of not forcing local boards out of existence, but rather letting them come to the conclusion over time to do so, *if appropriate.* As long as relative responsibilities and authorities have been clearly and appropriately spelled out, there is likely no benefit for a system-level board to decide unilaterally to terminate a local board, as such a decision could create significant animosity and anxiety at the local level.
- **Consider forcing an "in-or-out" vote at the appropriate time**: While systems need to give local board members and leaders adequate time to recognize and appreciate the benefits of

Exhibit 3: Continuum of Local Hospital Board Roles

Authority of Local Hospital Board

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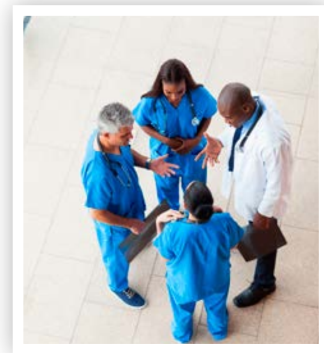
Responsibilities	Type I: Purely Advisory Board	Type II: Quality-Focused Board	Type III: Shared-Authority Board	Type IV: Operating Board
Finance	None	Advisory	Makes recommendations and monitors performance	Approves decisions subject to reserved powers
Strategy	None	Advisory	Makes recommendations and monitors performance	Approves decisions subject to reserved powers
Quality and patient safety	None	Fiduciary responsibility	Fiduciary responsibility	Fiduciary responsibility
Medical staff credentialing and relationships	None	Fiduciary responsibility	Fiduciary responsibility	Fiduciary responsibility
CEO selection, evaluation, and compensation	None	Has input	Has input and a major voice	Has final authority subject to system guidelines and approval
Audit oversight	None	None	Informed	Chooses and oversees auditor subject to system approval
Philanthropy	Advises and participates in efforts	Advises and participates in efforts	Provides leadership for fundraising efforts	Has final authority subject to system reserved powers

Source: B. Bader and E. Kazemek, *Great Boards,* Vol. VII, No. 3, Fall 2007.

1 E. Lister, "Creating Clarity in System Governance," *Trustee,* November 2010.

systemness, at some point there may be a need to force an "in-or-out" vote. Despite a system's best efforts, a local board may not be willing to make the concessions necessary to allow the system-level board to do its job effectively. If a board is not willing to do that, it may be best at some point to make them hold an "in-or-out" vote, effectively forcing them to "play ball" or leave the system.

- **Look for and cultivate "system thinking" in new directors and administrators**: Many systems inherit and/or initially embrace the idea of having "representative" boards at the system level, with designated slots for representatives of particular entities, including hospitals and physician groups. Such an approach, however, runs counter to operating like a system, causing forward-thinking organizations to abandon the representational approach. Instead, these organizations look for explicit competencies and skills when replacing directors, including but not limited to the ability to think at a system level. Effective systems also put in place orientation and training programs that reinforce system thinking, with the goal of ensuring alignment between boards' responsibilities and the knowledge and skills of directors.
- **Standardize board structure and processes**: One of the most effective strategies for promoting systemness and ensuring smooth system–subsidiary board relationships is to standardize as much as possible across all levels of governance, including board size and term length; board bylaws; director nomination and induction processes; director training; meeting agendas and the structure of meeting minutes; committee structures (including charters and operating processes); compliance and risk management policies and processes; reporting on quality/safety, financial, and strategic planning issues; board self-evaluation processes; and the role of the board in evaluating local CEOs.[2,3]
- **Develop and regularly use multiple communication vehicles**: Maintaining good system–subsidiary board relations and keeping local board members engaged and enthusiastic requires constant attention. In addition to the regular, formal retreats outlined earlier, the best systems use a variety of communication vehicles to keep directors from throughout the organization informed, with communications focusing on system-wide issues and emphasizing both the benefits of systemness and the important role that local entities play in achieving those benefits.
- **Evaluate system–subsidiary relations as part of the annual assessment**: Virtually all systems have a regular process in place to evaluate the performance of its various boards and individual directors. These assessments should include an evaluation of the relationships between boards, including how well respective roles and responsibilities have been clarified, how "connected" the local board feels to the overall system, and the effectiveness of communication across boards.



- **Constantly reevaluate and confirm structure**: As with most quality improvement processes, maintaining and improving system–subsidiary board relations requires constant reevaluation. To that end, system leaders should periodically review and question the structure of governance to ensure that it remains clearly defined, continues to support the organization's mission, and avoids unnecessary redundancies and complexities.[4]

Having the right structure is imperative to a health system's success. Health systems need to carefully plan where they want to be on the continuum of structural options and ensure that they clearly define system and subsidiary roles and foster a culture of collaboration. (Pioneering systems often use a formal document to clearly delineate what responsibilities exist at each level of governance. See **Appendix 1** for an example of a formal authority matrix.)

2 E. Lister, 2010.

3 B. Bader, E. Kazemek, P. Knecht, E. Lister, D. Seymour, and R. Witalis, "The System–Subsidiary Relationship in Hospital Governance," *BoardRoom Press*, The Governance Institute, October 2008.

4 E. Lister, 2010.

Creating a Successful System Board Structure

Board Size

Boards must be the appropriate size to facilitate efficient and effective meetings and decision-making processes. Effective boards have enough members to ensure that diverse perspectives will be articulated and considered and to populate needed committees (although non-directors can populate these committees as well). In The Governance Institute's 2013 biennial survey of hospitals and healthcare systems, respondents had an average of 13.5 voting members. (System respondents had an average of 16.7 voting members.[5]) Larger systems, not surprisingly, tend to have larger boards; in 2011, the median board size for the 14 largest systems in the nation was 15.[6] As a general recommendation, experts in this area often recommend that large systems aim to have no more than 15 directors at the system level, and some recommend even fewer to achieve optimal efficiency and effectiveness.

Doing the Math: The Case for Smaller Boards

The case for relatively small boards at the system level makes intuitive sense, as illustrated by the "math" related to board-level discussions of key issues. Assuming that the typical two-hour board meeting allows for 90 minutes of real discussion (since most meetings require at least 30 minutes for standard reports), each director on a 15-member board gets, on average, six minutes to offer his or her perspective. Consequently, even with 15 members, most boards find it difficult to have serious, productive conversations on critical strategic issues. Ironically, therefore, when boards remain or become too large, they often end up ceding these serious discussions (and hence power) to smaller groups of individuals, including the CEO, board officers, and/or members of the executive committee.

Typically the debate about board size sounds something like this: a small board is more nimble therefore better suited to decision making in a complex evolving industry. Those in favor of a larger board argue for diversity in representation and more thought leadership. Clearly there are valid points on both sides. The goal is to find the right balance to achieve optimal performance. In some cases, it may be difficult to get the board size down to 15, particularly right after a merger or partnership of two or more entities. For example, as part of a recent merger proposal between two large entities, the parties agreed to create a system board of roughly 20 individuals, well below the 27 and 24 individuals, respectively, that populated each of the two boards prior to the merger, but still larger than most experts would recommend. However, the need for some degree of representational appointments and the inclusion of several *ex-officio* members made it impossible to agree on a smaller board, at least initially. Systems that have been in place longer may be able to move to smaller boards over time.

Some system leaders argue for larger boards in order to get the requisite board work accomplished. Since most directors have only limited time to devote to board responsibilities, the theory is that a larger board is necessary to ensure adequate manpower to get the work done. This approach may be shortsighted, as larger groups often have a harder time getting things done than smaller groups. With good intent, people arguing for larger boards actually wind up creating a board that is potentially ceding far more power to fewer people. As boards get larger and larger they have to depend more and more on their executive committee, CEO, and other officers. So rather than creating more voices, they are actually limiting the input to the governance function. For many systems, a better approach may be to create system-level committees charged with key tasks (e.g., finance, audit, compensation), and then populate those committees with a mix of directors and, as appropriate, non-directors. Another approach may be to create a handful of regional subsidiary boards with specific responsibilities that report to the parent board.

Board Size Guidelines:

- Small enough to facilitate efficient and effective meetings and decision making.
- Large enough to bring diverse perspectives.
- Effective system boards, through their governance committees, devote great time and attention to selecting the right mix of members and vetting them through three groups of criteria: universal attributes (e.g., team player), community attributes (e.g., socioeconomic status), and functional attributes (e.g., attorney).

Finding the Right Board Members

The system board has a fiduciary responsibility to the communities it serves. Regardless of how they come onto the board, every member shares this responsibility. Effective system boards begin with this in mind rather than attempting to represent every political constituency. They start by asking this question: What is the right set of skills to have on this board in order for us to perform our fiduciary duty? Then they set out to find qualified people who bring the right set of skills.

5 Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition* (2013 Biennial Survey of Hospitals and Healthcare Systems), The Governance Institute, November 2013.

6 L. Prybil, S. Levey, and R. Killian, et al., *Governance in Large Nonprofit Health Systems: Current Profile and Emerging Patterns,* Commonwealth Center for Governance Studies, Inc., 2012.

When choosing directors, boards need to consider three sets of attributes. The first set consists of "universal" attributes—i.e., those that all directors must have, such as being a team player and being passionate about and dedicated to serving the organization and the community. By definition, the second and third set of attributes cannot be present in each board member. Rather, they are collective "community" attributes desired for the board as a whole. These include understanding specific racial, ethnic, or socioeconomic groups, and functional attributes, such as possessing certain needed skills or expertise (e.g., finance, actuarial risk, IT, social media, strategic orientation, and ability to manage complexity).[7]

The increasingly complex issues facing regional and national health systems are translating into more complex agendas at both the system and individual hospital levels, which in turn changes the types of background and competencies needed on these respective boards. The qualifications and expertise historically found on individual hospital boards may not translate well to effective service on the boards of regional and national systems. With that in mind, system boards have turned their attention to finding directors with unconventional backgrounds, including (but not limited to) the following:

- Familiarity with complex business issues in diverse organizations
- Manufacturing expertise
- An outside clinical perspective
- Nursing expertise
- Technology (particularly IT) and social media expertise
- Greater diversity, local perspective on community benefit issues
- Insurance, actuarial, and/or risk management expertise
- Public policy and/or government expertise

Physician representation on the system board can also be helpful, but it presents unique considerations. Physicians, understandably, who come on by virtue of their position often regard themselves as medical staff advocates rather than community fiduciaries; however, physicians have the same fiduciary obligations as other board members. Also, the IRS does not recognize physicians as independent due to inherent conflicts of interest. Because of these and other reasons, it is not unusual for health systems to limit the number of physicians on the board and find other ways to incorporate the critical clinical perspective into the governance structure, such as placing physicians on key committees and/or creating a physician advisory council to make recommendations to the board.

The overall goal should be to create a diverse board that collectively has the skills, knowledge, experience, and competencies to guide the organization effectively. System board members can come onto the board in four ways:

1. Board members are elected through a self-perpetuating process with consideration of skill mix and a desire to find the best and brightest (the most common method).
2. A representational board is created, composed of members who are determined by their constituent organizations.
3. *Ex-officio* board members are appointed with or without a vote.
4. Board members are appointed by a public entity.

Effective boards devote great time and attention to making sure they have the right mix of members, in some cases conducting formal reviews to ensure that the board composition is right for the organization moving forward. (See **Appendix 2** for a sample board member competencies tool.)

Safeguards: Protecting Subsidiary- and System-Level Interests

By their very nature, healthcare systems often come together as a collection of previously independent entities and facilities, each with its own staff and management structures, and in many cases its own board of directors. Consequently, there will almost always be a need for a set of structural safeguards designed to protect valued and sacred interests at the subsidiary level, particularly in the early days after system formation when trust may not be fully established across organizations. At the same time, these safeguards cannot become so onerous as to prevent the organization from functioning as a system, and consequently certain structural safeguards may also be needed at the system level. Some structural safeguards to exercise are:

- **Supermajority votes:** Some health system boards require that a "supermajority" exist to pass certain motions. Typically a supermajority vote would be one requiring two-thirds to three-quarters of all board members. A system can determine what it means by supermajority and determine instances where it wants to require a supermajority to approve a particular action (for example, requiring that 75 percent of all system board members must approve the addition of a new system hospital). Supermajority requirements are intended to protect individual entities that may have little or no representation on the system board from decisions that have major implications. Such requirements should be put in place sparingly and limited to major decisions, and consideration should be given to "retiring" supermajority clauses after a period of time.
- **Reserve powers:** To succeed in running the organization, the parent board needs to maintain authority over certain types of decisions, often spelled out as part of "reserve powers" clauses set up when the system forms. Reserve powers typically pertain to approving a new member, operating and capital budgets, strategic planning, issuing debt, modifying bylaws and articles of incorporation, hiring and firing the system CEO, and approving appointments of subsidiary-level board members, officers, and in some cases, CEOs. Clearly articulating and judiciously using such reserve powers is critical to the functioning of a high-performing system. Reserve powers can also be held by a specific member. For example, a subsidiary hospital often has the authority for a defined period of time to determine whether or not a major clinical service can be closed or consolidated.
- **Limiting use of *ex-officio* members:** Some director spots end up being reserved for those in certain positions, known as *ex-officio* positions. These positions are created in recognition of and

7 Sean Patrick Murphy and Mary K. Totten, "Transformation and the Governance Agenda: Keeping Your Board on Track," *Trustee,* November/December 2012; pp. 15–18.

out of respect for an especially important relationship between the system and another individual, group, or organization. Among others, *ex-officio* appointments typically include the system CEO, the system chief medical officer and chief nursing officer, the dean of an affiliated medical school and/or other university executives, the chairs of subsidiary boards, the CEO of one or more subsidiary organizations, and elected presidents of the medical staffs. Those appointed serve as either voting or non-voting members of the board. However, when the number of *ex-officio* positions becomes substantial, multiple issues and challenges can arise. To avoid these issues, experts generally recommend having as few *ex-officio* board members as possible.

- **Limiting use of representational appointments:** As with the use of *ex-officio* positions, pioneering health systems tend, over time, to limit use of "representational appointments" to the system board—that is, reserving a certain number of positions for a representative of a particular organization. As with limiting *ex-officio* positions, the goal in executing such a strategy is to avoid having system-level directors who feel their role on the board is to promote the interests of a particular subsidiary organization rather than the system as a whole. Representational appointments are often used early in a system's evolution, and in many cases may be seen as necessary when the system first comes together. Over time, however, the representational requirements likely need to be relaxed and ultimately eliminated.
- **Community advisory "boards":** Some systems have community advisory boards to ensure the needs of the community are understood at the system level. These boards do not have much authority but provide valuable guidance and also help to ensure that decisions made at the system level are in fact supported and adhered to locally. System leaders make it a habit to regularly meet with them and get their input and guidance on important decisions.
- **Parent board committee members who are not on the board:** Increasingly, committees of the parent board (except for the compensation committee and typically the executive and governance committees) have members who are not on the parent board. These individuals bring specific expertise and provide needed manpower to the system board, allowing it to complete its requisite tasks. This is a great way of gaining expertise and keeping a large number of people involved from constituent communities, as well as creating a talent pool from which to draw potential new board members.

Other Characteristics of High-Performing Systems

Moving to the right governance model, developing an effective board structure, and protecting the interests of both the system and its subsidiaries are all key to transitioning to effective system governance. The most successful systems share many other characteristics as well, such as:

- **Job descriptions:** Every board, committee, and officer has a written description of its duties and responsibilities that is reviewed and adjusted as necessary on an annual basis. This creates clarity around roles and responsibilities and places proper boundaries to enable functional group dynamics.
- **Subsidiary hospital responsibilities:** While ultimate authority resides with the parent company board, subsidiary hospitals (and other subsidiaries as well) are recognized as important contributors to the overall end goals. Effective operating companies frequently rely on their subsidiaries for oversight of quality and patient safety, enhancement of community relations, philanthropic leadership, and management of local endowments.
- **Subsidiary hospital input:** Effective parents also understand the need for collaboration and consensus. They seek input from subsidiary boards even in areas where ultimate authority resides with the parent (e.g., strategy, budgeting, selection of the subsidiary CEO).
- **System committees:** Effective systems are disciplined in their approach to development of committee charters. Beginning with the axiom that committees perform work on behalf of the board (i.e., not the work the committee decides it wants to do); they utilize a structured, uniform approach to articulation of committee charters. Each committee, working within this structure, drafts a charter and submits it to the board for review and critique. This process is repeated annually.
- **Self-assessment:** The very best system boards relentlessly push themselves to be excellent. They want benchmarks and scorecards; they are disciplined in monitoring their own performance. They insist on conducting periodic self-assessments of overall board performance and individual member assessments at the time of reappointment. They routinely assess the effectiveness of each board meeting (a five-minute exercise) and they evaluate board and committee chairs before reappointing them. These may be high standards for volunteers, but these system leaders know their communities are worthy of such standards.
- **Board/CEO compact:** Beyond job descriptions, annual goals, and performance reviews, the most effective system boards nurture the relationship with their CEO. They do this through a simple exercise designed to answer two questions: 1) What can you (CEO) expect of us (e.g., integrity)? 2) What do we (the board) expect of you (e.g., transparency, timely notification)?
- **Board/chair compact:** Just as committees work on behalf of the board, so does the chair; she/he only has the authority the board grants her/him. It follows that in addition to a written job description, the board and the chair need to discuss the relationship compact. The drill is the same as it is for the CEO.

Conclusion

Healthcare organizations are facing a difficult time and they need to ensure that they are putting the right practices and processes in place to enhance the organization's ability to meet current and future challenges and opportunities. Health systems can start by setting system goals and operating objectives and putting in place structures that will allow them to successfully achieve these targets.

It's becoming necessary to streamline processes and procedures through all levels of the organization, so systems should consider moving toward an operating company model to create "systemness." They may also want to revisit their board composition and identify the required competencies or skill sets of the parent board, determine the size of the parent board, and figure out the relationship of the parent to its subsidiaries. Often, structural safeguards are put in place, at least in the early years of system formation, to protect valued interests at the subsidiary level, as well as the system level. Transitioning to effective system governance will not be easy, but using these and other best practices health systems can make sure they are set up for success.

The following questions are a starting point for boards to begin the discussion around the ideas and recommendations in this publication:

1. What are our goals and operating objectives going to be, and what structures will we put in place to support them?
2. Does our health system currently function more like a holding company or an operating company, or somewhere in between? How does this way of functioning benefit the system? Will it continue to serve the system in the future? If we determine that we need to move more towards an operating company model, what are some steps to begin this process?
3. Do we have an authority matrix that clearly delineates the roles and responsibilities of the system board versus the subsidiary boards? If not, should we consider developing such a matrix? If it already exists, does it need revisiting?
4. Is our system board the right size to facilitate engaged discussion and effective decision making? Does it need to be smaller or larger?
5. Do we have the right people and competencies (universal attributes as well as community attributes and skills/expertise) on our board? If not, what changes need to be made and what competencies are we lacking?
6. What safeguards do we have in place to protect subsidiary- and system-level interests?
7. What best practices have we not yet adopted that would help improve our governance systems (e.g., assessing board performance, developing committee charters, seeking input from subsidiary boards even in areas where ultimate authority resides with the parent, etc.)?

Appendix 1: Sample Authority Matrix

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

Source: Norwalk Hospital/Western Connecticut Health Network, John M. Murphy, M.D., CEO.

Authority Matrix Key

A = Approves
AS = Approves subject to supermajority requirements
R = Provides recommendation
I = Provides input
Blank = No role

Appendix 2: Sample Board Member Competencies Tool

Core Competencies Key:
0 = N/A or No Experience
1 = Basic Level of Understanding
2 = Experienced Practitioner
3 = Qualified to Teach or Lead in This Area

		Board Member 1	Board Member 2	Board Member 3	Board Member 4	Board Member 5
Board Member Competencies	**Name:**	**Mr. X**	**Mr. Y**	**Mr. Z**	**Mrs. A**	**Mrs. B**
PERSONAL QUALITIES						
Accountable: performs assigned tasks on time and thoroughly						
Achievement oriented: results oriented						
Analytical thinker: separates the important from trivial						
Change leader: accepts that change is constant						
Collaborative: feels collaboration is essential for success						
Community oriented: always keeps stakeholders in mind						
Impactful and influential: decisive in the right moments						
Information seeker: willingness to raise constructive questions						
Innovative thinker: dares to be great and innovative						
Manages complexity: appreciates complexity of tasks						
Professional: possesses openness and honesty						
Relationship builder: will work to build consensus						
Strategic thinker: sees big picture and long-term						
Develops talent: values continuing education						
Team leader: perceives self as servant leader						
Tolerating risk: tolerance to operate in the unknown						
PROFESSIONAL EXPERTISE						
Healthcare delivery and performance						
Business finance						
Human resources						
Law						
Government relations						
Military						
Education						
Small business						
Large business						
Community advocacy						
Investment						
Mergers and acquisitions						
Acuity with insurance payers						
Actuarial analysis/awareness						
Clinical experience						

Board Member Competencies	Name:	Board Member 1 Mr. X	Board Member 2 Mr. Y	Board Member 3 Mr. Z	Board Member 4 Mrs. A	Board Member 5 Mrs. B
ORGANIZATIONAL LEADERSHIP EXPERTISE						
Has led a group through a change initiative						
Has led a collaborative team						
Has participated on a collaborative team or committee						
Has experience in not-for-profit governance						
Has been accountable for the overall performance of an organization or company						
Has experience managing conflict or has mediation skills						
Has led a strategic planning process or program						
Has participated in a strategic planning process or program						
Has experience with Lean continuous performance improvement tools and management system						
Has financial analysis or financial management experience						
Has experience recruiting or developing talent						
Has managed or led groups of clinicians						
Has direct experience delivering clinical care						
Has managed or overseen management of facilities or other real estate						
Has developed or managed communication plans and programs						
Has developed or overseen branding or image-building programs						
Has led or participated in organized philanthropy						
Has been accountable for delivering customer service						
BOARD MEMBER DEMOGRAPHICS						
Gender						
Race						
Age						
Occupation						
Previous board experience						

References

Seymour, Don, "Advisors' Corner: Transitioning to Effective System Governance," *BoardRoom Press*, The Governance Institute, February 2013.

Seymour, Don, and Murphy, John, *Transitioning to Effective System Governance*, Webinar, The Governance Institute, February 2013.

Seymour, Don, and Stepnick, Larry, *Governing the 21st Century Health System: Creating the Right Structures, Policies, and Processes to Meet Current and Future Challenges and Opportunities*, The Governance Institute, White Paper, Fall 2013.

Stepnick, Larry, *System–Subsidiary Board Relations in an Era of Reform: Best Practices in Managing the Evolution to and Maintaining "Systemness,"* The Governance institute, White Paper, Fall 2011.