Governing the 21st Century Health System

Creating the Right Structures, Policies, and Processes to Meet Current and Future Challenges and Opportunities

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AS NUMEROUS STUDIES HAVE SHOWN, BOARD PERFORMANCE matters a great deal. The importance of board performance will increase as standalone hospitals and other independent agencies continue to merge and/or partner with each other to create more integrated systems of care, and as existing, loosely structured systems seek to become more tightly integrated. These entities are responding to growing environmental pressures for "systemness"—that is, organizations that act and operate as an integrated, coherent whole rather than as a collection of autonomous entities.

Board performance, in turn, depends in large part on having the right policies, practices, and structures in place. To assist long-established and newly formed health systems in responding to these pressures and in achieving the best possible governance at both the system and subsidiary level, this white paper builds on previous work by reviewing leading practices and various considerations related to board structures, policies, and processes, both at the system and subsidiary levels. 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, characterized by mostly centralized authority residing in the parent organization.

Creating the Right Board Structures

Leading practices and considerations related to board structures include ensuring that the board has the following characteristics:

- **The right size**: Tensions often exist between the desire for a small board that can more easily make decisions and the need to have enough directors to ensure a wide range of perspectives and adequate competencies and skills. The goal is to find the right balance to achieve optimal performance. 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,[1] and some recommend even fewer to achieve optimal efficiency and effectiveness.
- **The right people, with the right competencies**: 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. When choosing directors, boards need to consider three sets of attributes. The first set consists of "universal" attributes—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.[2,3] In recent years, pioneering systems have been looking to recruit directors with various skills and expertise needed to succeed in the future, including finance, nursing, insurance and actuarial risk, information technology, manufacturing, social media, strategic orientation, and ability to manage complexity. Various tools are available to assist boards in making sure that individual directors and the board as a whole perform well in recruiting new directors with competencies deemed important.
- **The right relationship between the system board chair and CEO**: In the best-run systems, the system board chair and CEO have a close working relationship focused on the work of the board (efficiency, effectiveness, and the ability to act rapidly with required decision making).
- **The right safeguards to protect 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. Leading practices with respect to structural safeguards include employing targeted, limited use of *ex-officio* positions (both voting and non-voting), representational

1 Don Seymour, "Transitioning to Effective System Governance," *Boardroom Press*, The Governance Institute, February 2013.

2 Seymour, 2013.

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

appointments, supermajority voting requirements to protect subsidiary interests, and system-level reserve powers to protect the interests of the organization as a whole.

Setting Up the Right Board Committees and Advisory Councils

High-performing health systems delegate required work to a handful of committees; they also form *ad hoc* committees for specific, focused undertakings, with specified sunset dates.[4] Best and leading practices with respect to system-level board committees include:

- **Documentation and regular review of each committee's reason for existence**: High-performing systems use board-level committees judiciously and do not create them in the absence of a clear reason for their existence. They start by developing a uniform structure for the committee charter and asking each committee to create a charter using that format and submit it to the board for review each year.[5] At pioneering health systems, the following system-level board committees receive serious consideration: executive, executive compensation, governance, community benefit (an increasingly important committee that many systems have not yet formed), and a physician advisory council (as a potential alternative to designating certain system board seats for physicians).
- **Strategic use of non-directors**: Particularly with smaller boards, non-directors often serve on board-level committees (except for the compensation committee). These individuals bring specific expertise and provide needed manpower to the system board, allowing it to complete its requisite tasks. For example, few system boards include multiple certified public accountants (CPAs), yet the audit or finance committee may need several CPAs and/or other finance experts to do its work effectively. Similarly, system boards may have relatively few people with fundraising and advocacy experience; however, a committee formed to oversee fundraising or a separate foundation board through a system-affiliated foundation may need individuals with this type of experience.
- **Using committees as a training ground for new directors**: Qualitative interviews show that high-performing organizations use system-level committees as training grounds for new directors; they also tend to have extensive and formal education and orientation programs for these new directors.[6]

Determining the Right Roles and Responsibilities for Local Boards

While the days of systems operating as a loose confederation of independent entities has largely passed, not every system moves to the complete opposite end of the continuum (an operating company with virtually all control centralized). Those that do, moreover, do not necessarily get there right away, but rather migrate toward the model over time as dictated by the environment. In addition, even those systems employing a true operating company model still keep some local governance structures in place (e.g., boards, advisory councils), as the leaders of these systems recognize that the organization as a whole benefits from having talented individuals at the local level who provide guidance and leadership in certain areas. The following leading practices relate to determining whether to have local boards and, if so, what roles and responsibilities they should have:

- **Careful evaluation to determine need for subsidiary boards**: System leaders need to consider a variety of factors when determining whether to have subsidiary boards and which ones to have, including the size of the geographic market covered (and the distinctiveness of healthcare markets within the area served), state laws, and the diversity and complexity of entities within the organization.[7]
- **Proactive steps to keep subsidiary directors engaged**: The desire to retain some form of local governance can sometimes create a dilemma for system leaders. Over time, these leaders may find that the ability to attract and retain talented board or advisory council members at the local level declines, as individuals who historically had more power and influence now find that their role has become more limited and advisory in nature. Consequently, these local leaders may become disengaged and/or simply stop serving. To avoid (or at least minimize) this problem, pioneering systems use various strategies, including clearly delineating responsibilities at each level of governance (often spelled out in an "authority matrix"), using formal mechanisms to regularly elicit input and guidance from subsidiary boards, limiting use of a "command-and-control" approach at

4 Daniel K. Zismer and Frank B. Cerra, *High-Functioning, Integrated Health Systems: Governing a "Learning Organization"* (white paper), The Governance Institute, Summer 2012.

5 Seymour, 2013.

6 N.M. Kane, J.R. Clark, and H.L Rivenson, "The Internal Processes and Behavioral Dynamics of Hospital Boards: An Exploration of the Differences between High- and Low-Performing Hospitals," *Health Care Management Review*, Vol. 34, No. 1 (2009); pp. 80–91.

7 Larry Stepnick, *System–Subsidiary Board Relations in an Era of Reform: Best Practices in Managing the Evolution to and Maintaining "Systemness"* (white paper), The Governance Institute, Fall 2011.

the system level, and proactively using various mechanisms to promote collaboration and trust. These mechanisms include regular attendance by system-level directors at subsidiary board meetings (and vice versa), regular orientation and training sessions for directors at all levels, development of standardized board structures and processes across levels, creation of a secure board portal to serve as a one-stop shop for relevant materials for boards and committees at all levels, regular use of various other communication vehicles, and incorporation of an evaluation of system–subsidiary relations and overall governance structure into annual board assessments.

Key Takeaways and Discussion Questions for Board Members and Executives

The leaders of high-performing health systems pay close attention to the structures, policies, and processes that are put in place at all levels of governance, give careful thought to the need for and operation of subsidiary boards, and make substantial efforts to keep those serving on subsidiary boards engaged in the system as a whole.

The following is a list of questions intended to be a starting point for the board's discussion of the issues and recommendations presented in this white paper:

1. Does our system function more like a holding company (with limited central authority) or an operating company (maximized central authority), 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?
2. Is our system board the right size to facilitate engaged discussion and effective decision making? Does it need to be smaller or larger?
3. Do we have the right people and competencies (universal attributes as well as community attributes and skills/expertise) on our board?
4. What is the relationship between the system board chair and CEO? Could it be described as a close working relationship focused on the work of the board? How important is this relationship in helping to facilitate the board's ability to act rapidly and make good decisions?
5. What safeguards do we have in place to protect subsidiary- and system-level interests?
6. Do we have an effective structure in regards to our board committees and advisory councils? Does each committee have a strong purpose and clear charter?
7. Are we making the best use of community members (non-directors) on our committees to help expand the level and variety of expertise we can utilize, as well as using our committees as a training ground for new directors?
8. Do we need subsidiary boards? What purpose(s) should they serve? (The purpose could be different for each subsidiary board depending on the distinctiveness of the healthcare market, size, state laws, etc.) Assuming we have and/or continue to keep subsidiary boards, should they continue to have a full array of committees? Is it practical for management to support these committees?
9. What are some ways we can keep the subsidiary directors passionate and engaged?
10. 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?

Background and Introduction

AS NUMEROUS STUDIES HAVE SHOWN, BOARD PERFORMANCE matters a great deal. A 2010 *Health Affairs* study found a positive correlation between quality and board engagement.[8] A set of interviews with leaders of 10 high-performing health systems identified the most important factors in achieving strong operating performance; having a committed, engaged board of directors was one of six factors that emerged.[9] Board performance, in turn, depends in large part on having the right policies, practices, and structures in place. A recent Governance Institute white paper summarized various research findings related to specific board practices associated with higher quality and better performance, and highlighted the results of recent research, conducted by The Governance Institute and National Research Corporation, which identified 14 practices related to better performance on CMS process-of-care measures.[10]

The importance of board performance will increase as standalone hospitals and other independent agencies continue to merge and/or partner with each other to create more integrated systems of care, and as existing, loosely structured systems seek to become more tightly integrated. These entities are responding to growing environmental pressures for "systemness"—that is, organizations that act and operate as an integrated, coherent whole rather than as a collection of autonomous entities. A recent Governance Institute white paper laid out the pressures to act more like a true system, which are briefly summarized below:[11]

- **Relentless pressure on cost structure**: Due to pressures on federal and state governments, health system leaders should expect continued downward pressure on Medicare and Medicaid reimbursement (at the same time that enrollment in Medicaid and through health exchanges grows significantly). Systems governed as loose confederations will find it much more difficult to take the steps necessary to aggressively manage costs.
- **At-risk revenues dependent on cost and quality performance**: Systems should expect to get paid no more than 80 percent of their current fees based on volume, with the remaining 20 percent being dependent on performance. Success will depend in no small part on actions taken by the board of directors.
- **Increased demand for physician integration**: To succeed, health systems will need to integrate more closely with physicians, many of whom face their own issues, including compensation that does not keep pace with inflation. Success will require making difficult, system-wide decisions related to integrating physicians into the organization and evaluating and acting on their performance over time.
- **Need for significant investment in information technology**: Hospitals and health systems need to make significant investments in information technology (IT). Clearly, decision making and oversight related to the purchase and implementation of any major IT system will need to occur at the system level.
- **Increased public scrutiny**: Hospitals and health systems face intense scrutiny related to their not-for-profit status; centralized oversight will again be critical to making sure that the system can withstand such scrutiny.
- **Pressures to consolidate**: As reimbursement levels fall and access to capital becomes increasingly limited to the best performers, smaller hospitals may close or request to become part of larger systems. Bringing these facilities into the organization will require careful planning.
- **Pressure to build system-wide brand awareness**: A health system's "brand" can be its most valuable asset, as it can create loyalty among consumers. To maximize effectiveness, branding needs to become more consistent across all sites of care within the system. The system CEO and board of directors play a critical role in this process by articulating very clearly the benefits of a single brand to key stakeholders and by setting the expectation that branding will migrate to a system-wide approach over time.

Illustrative Example: The Importance of Board Performance

After suffering a period of financial losses caused by poor internal decision making and external market forces, system leaders at University of Pennsylvania Health System revamped the organization's governance structures, disbanding existing entity-specific governing boards within the medical school and health system and replacing them with a single board to oversee the entire entity (known as Penn Medicine). In addition, a single administrative leader took charge of the organization's three missions—education, research, and clinical care. This realignment, combined with additional, related changes to leadership responsibilities and process controls, led to improved performance with respect to finances and other aspects of the enterprise, including integration and coordination of programs.[12] (It should be noted that this is a unique approach that worked for this organization but might not work for others.)

8 D.S. Brown, "The Governance Imperative for Nonprofit Hospitals," *Trustee*, January 2010.

9 L. Prybil and S. Levey, "The Right Stuff: Key Leadership Factors for Attaining a High Level of Operating Performance," *Trustee*, July/August 2010; pp. 20–22.

10 Larry Stepnick, *Making a Difference in the Boardroom: Preliminary Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2012.

11 Stepnick, 2011.

12 S.E. Phillips and A.H. Rubenstein, "The Changing Relationship Between Academic Health Centers and Their Universities: A Look at the University of Pennsylvania," *Academic Medicine*, Vol. 83, No. 9 (September 2008); pp. 861–866.

To assist long-established and newly formed health systems in responding to these pressures and achieving the best possible governance at both the system and subsidiary levels, this white paper builds on previous work by reviewing leading practices and various considerations related to board structures, policies, and processes, both at the system and subsidiary levels. 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, characterized by mostly centralized authority residing in the parent organization. This model stands in contrast to the traditional approach used by many health systems, which is for the parent to act as a holding company with mostly decentralized governance authority residing in the subsidiaries (see **Exhibit 1**). As has been discussed in previous Governance Institute publications, the holding company model is unlikely to work in the long term, as decentralization does not allow for an adequate response to the pressures outlined above, 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. By contrast, the operating company allows for the creation of "systemness" by:

- Setting system-wide policies to which all entities must adhere
- Delegating appropriate responsibility to a variety of individuals, committees, subsidiaries, and other entities (such as the medical staff)
- 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

To understand the rationale behind the need for this approach, consider the scenario when a system maintains different standards and policies with respect to patient care across subsidiary organizations. If a patient were to suffer an avoidable injury at one subsidiary location, system leaders could easily be subpoenaed to explain why the standard of care is different (i.e., better) at other subsidiary locations. The only way to avoid this problem is by having a single governing body tasked with setting policy, delegating responsibility, and ensuring accountability.

Exhibit 1: Three Models of Health System Governance and Management

Holding 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

Shared Governance

- 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

Operating Company

- 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

Less ⟷ **More**

> "Too often, these [newly formed system] 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."
>
> —*Don Seymour, "Transitioning to Effective System Governance,"* BoardRoom Press, *February 2013.*

Adopting and effectively governing an operating company model can be quite challenging. To succeed, system boards need to have the right structures, policies, and processes in place. For example, boards need to be the right size and have the right people serving on them. They need to set up and populate system-level board committees to perform critical tasks (using non-directors when the board itself lacks the resources or expertise to do this work). Even with most authority residing at the parent level, the best system boards do not simply dictate their will on those at the subsidiary level. Rather, they exercise their authority judiciously, and tirelessly seek to collaborate and achieve consensus, relying on command-and-control tactics only when necessary.[13] They also ensure that the directors on local boards still have important, meaningful tasks to perform, thus keeping them engaged in critical activities that rightly reside at the local level, including medical staff issues, entrepreneurial ventures, community benefit/outreach, and local fundraising and advocacy efforts. As part of this effort, system boards respect the need to put in place certain provisions designed to protect the interests of individual entities, including requiring a "supermajority" of votes to make decisions on some issues of particular concern to local entities. At the same time, the best system boards also claim certain "reserve" powers at the system level.

The following sections of this white paper describe in detail leading practices for systems to develop their system and subsidiary board structures, policies, and processes, in order to enhance the organization's ability to meet current and future challenges and opportunities.

13 Seymour, 2013.

Creating the Right Board Structures

THIS SECTION REVIEWS LEADING PRACTICES AND CONSIDERations related to board structures, including the "right" board size and composition, along with use of system-level committees.

The Right 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; further discussion of this practice appears later in this white paper).

In The Governance Institute's 2013 biennial survey of hospitals and healthcare systems, respondents had an average (mean) of 13.5 voting members, up slightly from 13.3 in 2011. (System respondents had an average of 16.7 voting members.)[14] Board size seems to be holding fairly steady over time—between 2005 and 2011, the average board size for all types of healthcare organizations ranged between 12 and 14, making these boards moderately larger than the average board in a public company (which has eight to nine members). 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.[15] 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,[16] and some recommend even fewer to achieve optimal efficiency and effectiveness.

Tensions often exist between the desire for a small board that can more easily make decisions and the need to have enough directors to ensure a wide range of perspectives and adequate competencies and skills. The goal is to find the right balance to achieve optimal performance; a recent study of 14 of the nation's 15 largest health systems concluded that the most effective boards are comprised of "highly dedicated persons who collectively have the competencies, diversity, and independence that produce constructive, well-informed deliberations."[17] 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 often larger groups have a harder time getting things done than smaller groups. 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. For example, Dignity Health's bylaws limit the size of its system board to no more than 13 individuals. The system recruits non-directors to populate many of its system-level committees and subcommittees (except for the human resources/compensation committee and executive committee, which deal with sensitive issues that need to remain with the board).[18] (More information on the use of non-directors to population system-level committees appears later in this white paper.) Another approach may be to create a handful of regional subsidiary boards that report to the parent board. For example, the Seton Healthcare Family, a large, regional system located in Austin, TX, created three subsidiary boards that have fiduciary responsibilities—one each for the system's hospital

14 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.

15 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.

16 Seymour, 2013.

17 Prybil, Levey, and Killian, et al., 2012.

18 Interview with Elizabeth Shih, executive vice president and chief administrative officer of Dignity Health, conducted August 5, 2013.

division (made up of 11 hospitals), insurance division (which offers a multiple health plans and other insurance products), and clinical enterprise division, which employs many physicians and includes Seton's outpatient facilities and clinics. (As Seton is part of Ascension Health, certain governance functions reside at the national level.)[19]

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.

The Right People, with the Right Competencies

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. For example, at the end of 2011, Sierra Vista Regional Health Center in Arizona conducted an informal review of existing board member strength and weaknesses to identify four competency areas currently missing from its current crop of directors—people who have impact and influence, the ability to think innovatively, organizational awareness, and a strategic orientation. The governance committee of the board then used existing tools, including the work of the 2009 Blue Ribbon Panel Report on core competencies,[20] to develop interview questions to be used when evaluating potential directors. The approach generated very positive feedback from those conducting the interviews, and helped the system fill the identified gaps.[21]

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).[22, 23]

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.[24] 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**: Board agendas are becoming increasingly complex and challenging as hospitals consolidate to form regional and national systems, which in turn increases the need for board members with backgrounds and competencies attuned to these issues, including the ability to monitor a broad portfolio of businesses; navigate complex partnerships with clinicians and other providers; develop new programs to create and manage a continuum of care; make wise decisions with respect to investments in new, expensive IT systems; and take on the risk for population health, either on one's own or in partnership with an insurer. These duties represent a fundamental change from traditional obligations.[25]
- **Manufacturing expertise**: Many system and hospital leaders are looking outside the healthcare industry for insights into how to redesign care delivery to reduce unwarranted variations in cost and quality. For example, Virginia Mason Medical Center in Washington State has embraced use of Lean manufacturing techniques, originally developed in Japan by Toyota Motor Corporation. Following Virginia Mason's example, Baystate Medical Center in Springfield, MA, recently recruited a director who has in-depth manufacturing experience and intimate knowledge of Lean practices. As head of the board's quality committee, she has helped the organization apply Lean tools and related techniques in the healthcare setting, something that few other individuals could have done effectively.
- **An outside clinical perspective:** Several pioneering systems routinely look to bring high-caliber clinician leaders from outside the geographic area onto the board. With no stake in the local community or its politics, these individuals can offer objective guidance and a fresh perspective on clinical and other issues. For example, an academic health system on the east coast has regularly consulted with a physician leader at the Harvard

19 Interview with Charles Barnett, board chair and former CEO of Seton Healthcare Family, part of Ascension Health, conducted in August 2013.

20 Center for Healthcare Governance and Health Research and Educational Trust, *Competency-Based Governance: A Foundation for Board and Organizational Effectiveness*, 2009 Blue Ribbon Panel Report, Center for Healthcare Governance, 2009.

21 Mary K. Totten, "Assessing the 'Fit': Using Competencies to Select New Board Members," *Trustee*, July/August 2012; pp. 17–20.

22 Seymour, 2013.

23 Murphy and Totten, 2012.

24 Michael W. Peregrine and Daniel Nygren, "Consolidation and Competency-Based Governance," *Trustee* (Online Exclusives), 2013 (available at www.trusteemag.com/trusteemag/html/WebExclusives1212.html).

25 Peregrine and Nygren, 2013.

Medical School who flies in for quarterly board meetings. These individuals can be particularly effective in serving as the head of the board-level quality committee, as their outside, unbiased perspective allows them to be more effective in identifying and addressing clinical issues (e.g., unwarranted variation), including issues with individual physicians. Too often local clinical leaders lack the perspective to see the problem, and/or are reluctant to "blow the whistle" on their peers. These outside experts are often willing to join the boards of high-profile systems, believing that the experience gives them an opportunity to learn valuable lessons and insights that they can apply at home as well.

- **Greater diversity, local perspective on community benefit issues**: Overall, the nation's largest health systems tend to have a more diverse racial and gender board makeup than do Fortune 500 companies; a growing body of evidence, moreover, suggest that organizations with more diversity on their board outperform the competition.[26] The Governance Institute's 2013 biennial survey found that the average responding health system has 1.7 individuals who are racial/ethnic minorities as voting members of the board.[27] With the passage of the Affordable Care Act and the prospects for many more people to secure health insurance, hospitals and health systems that hope to retain their nonprofit status must pay increasing attention to the community benefits provided by the organization, including efforts to serve low-income minority groups. In fact, a recent report recommended considering enriching boards by striving for greater racial and gender diversity.[28] Some systems are already following this recommendation. For example, Presbyterian Healthcare Services in Albuquerque, NM, serves many patients of Hispanic descent, and for this reason sought to recruit directors from the Hispanic community.[29] Because new and innovative ways to serve those with unmet health needs will be required, boards could likely benefit from recruiting individuals with unique perspectives in this area, such as a principal at an inner-city public school or the head of a local non-profit organization that serves the underserved (e.g., food pantry, homeless shelter, public health clinic).[30] These individuals are ideally suited to head up a system-level community benefit committee, the need for which is discussed later in this white paper.
- **Technology (particularly IT) and social media expertise**: In an era where use of the Internet and other social and mobile media has become so widespread, boards need to play an active role in ensuring that the organization leverages technology to improve not only quality and safety outcomes,[31] but also customer service, patient satisfaction, and brand image. To successfully play this role, system boards increasingly need to recruit one or perhaps a few directors with a strong background in IT, social media, and/or related applications. For example, in the last few years, Dignity Health has added two directors with expertise in the technology arena.[32] As boards look for individuals with these new competencies, they might naturally seek to bring on younger members. However, at the hospital level, the average age of directors has moved up in the last few years.[33]
- **Insurance, actuarial, and/or risk management expertise**: As health systems increasingly get involved in population health management, they will need to have individuals with insurance experience (including actuarial and/or risk management expertise) within the organization. As part of this effort, system leaders might consider recruiting someone with such experience to the board. For example, Indiana University (IU) Health added two individuals to its system board with expertise in these areas, including the chief risk officer from a major pharmaceutical company and the COO at a national insurance company.[34] That said, such action might not be necessary if the system can secure such expertise on a consulting basis and/or through a merger or partnership with an insurance company. On its own, moreover, adding an actuary to the board may not be enough for an organization truly committed to taking on the risks related to population health management.
- **Nursing expertise**: A recent report recommended enriching boards by considering appointment of highly respected and experienced nursing leaders as voting members of the board and/or to board committees to complement physician members and strengthen clinical input during deliberations.[35] The Governance Institute's 2013 biennial survey found that some health systems appear to be taking this advice, with the average number of nurses on the boards of system respondents increasing from 0.42 in 2011 to 0.57 in 2013. In addition, 13 percent of

26 Prybil, Levey, and Killian, et al., 2012.
27 Peisert, 2013.
28 L. Prybil, S. Levey, and R. Peterson, et al., *Governance in High-Performing Community Health Systems*, Grant Thornton, LLP, 2009.
29 M. Wicker, "Competency-Based Governance," *Trustee*, November 2010.
30 Brown, 2010.
31 K.J. McDonagh, "The Board's Role in Technology Advancement," *Trustee*, September 2009.
32 Interview with Elizabeth Shih, executive vice president and chief administrative officer of Dignity Health, conducted August 5, 2013.
33 Totten, 2012.
34 Interview with Daniel F. Evans, Jr., president and CEO, Indiana University Health, conducted on July 29, 2013.
35 Prybil, Levey, and Peterson, et al., 2009.

hospitals and health systems that responded to the survey have a nurse CEO, in contrast with 5 percent that have a physician in this position.[36]

- **Public policy and/or government expertise**: A number of CEOs and board members interviewed at the nation's 14 largest systems identified the need to add one or more directors with extensive experience in public policy and/or working with local, state, and federal government agencies.[37] Dignity Health, for example, is looking to add someone with such expertise to its system-level board.[38]

The overall goal should be to create a diverse board that collectively has the skills, knowledge, experience, and competencies to guide the organization effectively. For example, the Seton Healthcare Family board is made up of 20 individuals, each of whom brings something unique and valuable to the organization. Directors include several individuals with experience running large, global businesses (including a regional head of 3M and the CEO of the largest manufacturer of chemicals for flat-panel displays in the world), along with the heads of several smaller local firms. Other directors have experience and expertise in investment banking, customer relations, and running a national political campaign. The system's current board chair (also its former CEO) firmly believes that the organization's success is due in no small part to the quality and diversity of the board, which is made up of individuals who understand the difference between governance and management and who know how to navigate in an environment marked with significant uncertainty.[39]

Should Organizations Include Physicians on System-Level Boards?

Healthcare systems undoubtedly need clinical expertise at the upper echelon of the organization. In fact, 20 out of 71 CEOs and board members interviewed at the nation's 14 largest systems identified the need for more clinical expertise at the leadership level.[40] What is less clear-cut, however, is whether that clinical expertise should reside at the system board level. Many hospitals and health systems do have physicians as voting members of the board; The Governance Institute's 2013 biennial survey found that responding health systems and hospitals have an average of 2.5 voting physician board members (including employed doctors and independent physicians who are members of the medical staff, as well as outside physicians who are not on the medical staff).[41]

When serving as directors, physicians have the same fiduciary obligations as any other board member, with their duty being to fulfill the organization's mission and serve the community. The Internal Revenue Service (IRS), however, does not recognize medical staff physician directors as independent due to inherent conflicts of interest. For this and other reasons, some large systems have consciously avoided dedicating board seats to physicians. Rather than having such expertise at the system board level, these organizations create separate structures made up entirely or mostly of physicians to provide valuable guidance and input to the CEO/senior management team and the system-level board.[42] For example, a major Midwest system with 16 hospitals (including an academic medical center) has only one elected physician on its parent board. Another large system with multiple hospital campuses and over 2,500 affiliated physicians has no physicians on its 14-member parent board. Instead, the system set up a physician leadership council that meets monthly with the system CEO, and physicians are represented on every committee of the parent board. In some cases, clinical experts are brought in on an *ad hoc* basis to advise the board on specific issues.

Other systems take the opposite approach, explicitly setting aside a certain number or proportion of positions for physicians, and/or designating certain clinical leadership positions, such as the chief medical officer, as an *ex-officio* board representative. (A further discussion of *ex-officio* positions appears later in this white paper.) For example, Community Health Network in Indianapolis sets aside 25 percent of board seats for physicians. Few of the system's competitors place physicians on their system boards. It is important to note, however, that Community Health Network and other organizations that take this approach also put in place processes and systems to make sure that physician directors develop and maintain a system-wide perspective.[43]

36 Peisert, 2013.
37 Prybil, Levey, and Killian, et al., 2012.
38 Interview with Elizabeth Shih, executive vice president and chief administrative officer of Dignity Health, conducted August 5, 2013.
39 Interview with Charles Barnett, board chair and former CEO of Seton Healthcare Family, part of Ascension Health, conducted in August 2013.
40 Prybil, Levey, and Killian, et al., 2012.
41 Peisert, 2013.
42 Don Seymour and John M. Murphy, M.D., "Transitioning to Effective System Governance," (Webinar), The Governance Institute, February 28, 2013.
43 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

Case Study: Importance of Having the Right Size and Right Group of Directors

The experience of Presbyterian Healthcare Services, a non-profit organization with an integrated delivery system and health plan located in Albuquerque, NM, illustrates the importance of having a board with the right size and composition. Over the years, the size of the system board grew steadily, vacillating between 24 and 27 members, with the potential to grow even larger. Due primarily to its large size, the board faced challenges in acting as a strategic resource for the organization, instead playing the role of observer. The sheer number of directors made it difficult to keep delicate subjects confidential, and a lack of term limits meant that new members and fresh perspectives could not be brought on to the board without increasing its size. In essence, the board had not changed to meet the changing strategic needs of the system, and the CEO described the board as a "liability" rather than an asset.

Recognizing its own inability to function effectively, the board created a task force to recommend how to restructure itself. Led by this task force, the board decided to require all current directors to resign, reviewed each (now former) director's level of commitment, and identified potential new directors. Anyone who wanted to join the restructured board had to submit a resume and be interviewed. The end result was a completely revamped board made up of 11 individuals, only six of whom came from the old board.[44] In restructuring its board, Presbyterian Health Services distinguished between two sets of competencies—those required for all candidates (e.g., knowledge of areas of governance and the healthcare industry, communication skills, integrity, dedication, commitment to continuous learning) and specific competencies needed in some directors that are important to executing the system's strategy and effective governing, such as finance. For example, the task force considered two individuals with a banking background, but ultimately chose only one so as to fill the specific competency needed without making the board too finance-oriented.[45]

44 Wicker, 2010.
45 Wicker, 2010.

Various tools are available to assist boards in recruiting new directors with competencies deemed important and in assessing and ensuring that individual directors continue to perform at a high level.[46] Some systems, including Presbyterian Health Services, have developed their own tools to help in recruiting individuals with desired competencies; at Presbyterian, this process included two phases—creating and using an original set of tools that ultimately proved too complex and cumbersome, followed by a second effort to simplify them considerably.[47] As part of the effort to create tools, a growing number of systems develop written "job" descriptions for the board as a whole, board officers, and board committees, listing core duties and responsibilities. System leaders review these descriptions annually, adjusting them as needed. This approach creates clarity and ensures proper boundaries to enable effective group dynamics.[48]

Finally, because it can be difficult to identify and retain high-quality directors, some systems have begun experimenting with lengthening the amount of time that directors can remain on the board, beyond the traditional period, which is often nine years (three consecutive three-year terms). This approach may make sense in certain circumstances, as long as the board maintains a rigorous performance assessment process for the board as a whole and for individual directors.[49] With respect to performance assessment, some systems have ended the practice of having three-year terms, instead moving to one-year terms in which each director is evaluated and "re-upped" every year. For example, Community Health Network recently ended the practice of term limits while simultaneously moving to an annual assessment and reappointment of all directors, with the process done as part of the annual assessment of the board as a whole.[50]

The Right Relationship between the CEO and System Board Chair

In the best-run systems, the system board chair and CEO have a close working relationship focused on the work of the board (efficiency, effectiveness, and the ability to act rapidly with required decision making).[51] In fact, a qualitative study found that in hospitals that perform well financially, the board chair and CEO consistently describe a high degree of professional interaction with each other, with meetings taking place at least once a month to discuss strategic issues and the board agenda and to give the CEO a "sounding board" and trusted place for informal discussions.[52] Interviews with 10 high-performing systems identified having strong, values-based CEO leadership and a strong overall management team as one of a handful of factors that account for the

46 The Governance Institute has a set of recommended leadership criteria as well as a number of other resources on board recruitment and individual director assessment; see www.governanceinstitute.com.
47 Wicker, 2010.
48 Seymour, 2013.
49 Murphy and Totten, 2012.
50 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.
51 Zismer and Cerra, 2012.
52 Prybil and Levey, 2010.

strong performance.[53] In addition to creating a job description and annual goals and conducting annual performance reviews, the best system boards nurture the relationship with the CEO through development of a board–CEO "compact" that lays out what the CEO can expect of the board (e.g., integrity) and what the board expects of the CEO (e.g., transparency, timely notification about important issues). Some system boards create the same type of compact with the board chair.[54] Seton Healthcare Family has gone a step further by making the board chair a full-time, employed position within the organization, with the system board chair and CEO having offices near each other.[55]

The Right Safeguards to Protect 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. This section lays out some of the leading practices with respect to these structural safeguards, including use of *ex-officio* positions (both voting and non-voting), representational appointments, and supermajority voting requirements to protect subsidiary interests, along with system-level reserve powers to protect the interests of the organization as a whole.

Generally Limited Use of *Ex-Officio* Members

In an ideal world, all system-level directors would be elected based on their skill and expertise, thus resulting in a self-perpetuating process that brings the "best and brightest" to the board on an ongoing basis. Because no system operates in an ideal world, however, in reality 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 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 (although some maintain that the CEO is employed by the board and therefore should not be a member). They sometimes include 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:

- **Poor fit with board**: Someone other than the board is appointing a member of the board and hence this individual may not fit its culture or aspire to its values.
- **Parochial interests coming first**: The individual may regard him/herself as representing the appointing entity first and the fiduciary duties of the system board second. Consequently, there may be a tendency to vote and/or otherwise act in the best interest of the appointing subsidiary organization (or constituencies within that organization) and not always have system-level interests in mind.
- **Tying up too many positions**: In a system with multiple, independent medical staffs and multiple employed groups, the number of seats required to represent all legitimate constituencies can quickly become quite unwieldy. For example, boards may not be particularly well-served by tying up three valuable board seats (out of 12 or 15 total positions) with medical staff leaders from various subsidiary organizations who, by definition, will only serve on the board for a short period of time (while they hold the position). In addition, singling out certain positions (such as employed leaders of the medical staff) as automatic members of the system board invites other groups, such as nurses or independent physicians in the community, to demand similar treatment, which could lead to a dysfunctional board dominated by those with parochial interests.
- **Increased burden on other directors**: Many *ex-officio* directors are unable to serve in certain positions and hence increase the burden on other directors. For example, an employed physician or nurse generally cannot serve on the compensation committee that determines CEO compensation, since they are not considered independent by the IRS and have inherent conflicts (i.e., they would have authority over the compensation of their boss, the CEO).

To avoid these issues, experts generally recommend having as few *ex-officio* board members as possible. In fact, pioneering systems strictly limit the number of *ex-officio* seats. For example, many leading systems, including Scripps Health and Community Health Network, have only one *ex-officio* director: the system CEO.[56] Rather than relying on *ex-officio* positions, these organizations create other mechanisms and structures to gather input from and otherwise collaborate with key constituencies, such as a physician leadership cabinet that meets with the system board and CEO regularly and that fosters collaboration among physicians.

53 Prybil and Levey, 2010.
54 Seymour, 2013.
55 Interview with Charles Barnett, board chair and former CEO of Seton Healthcare Family, part of Ascension Health, conducted in August 2013.
56 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

Should the Dean of the Affiliated School of Medicine Be on the System Board?

While the practice goes against the notion of minimizing *ex-officio* positions, many systems with an affiliated medical school make the dean an *ex-officio* member of the system board. This practice comes out of respect for the integrated relationship between clinical practice, education, and research within these organizations. Yet the decision to include the dean on the board is not always easy. For example, at one system, leaders vigorously debated the merits of including the medical school dean as an *ex-officio* member of the system board, with some feeling that inclusion gave the medical school too much influence and sent the wrong signal to the rest of the organization. Ultimately, the decision was made to include the dean to avoid alienating leaders of the medical school, which has historically played a central role within the organization. Over time, however, this issue may be reexamined as the system shifts its focus away from acute care to managing population health, and as system leaders and the organization as a whole evolve to embrace a more rapid pace of change.

At other systems, however, including the medical school dean as an *ex-officio* member of the board comes as a relatively easy decision that yields major benefits for the organization. For example, at IU Health, having the dean as an *ex-officio* board member has helped the organization execute a strategy that differentiates the system in the marketplace. By emphasizing a shared vision across all system-level directors and the organization's 18 hospitals the dean has led the effort of bringing academic medicine and clinical trials to local communities and hospitals, something that none of the system's competitors has been able to do.[57]

Limited 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. Often organizations use a variation of the "Noah's Ark" approach to creating the first system board—rather than having two representatives from each subsidiary organization, the system board may be made up of seven or eight directors from the flagship medical center and three to four representatives from each of the community hospitals. In addition, some systems set aside a certain number of board seats (perhaps 25 percent) for employed and/or independent physicians, feeling that doing so promotes good relationships with the

physician community and provides a vehicle for getting valuable clinical input and guidance.

This representational approach may be necessary for the selection of initial board members after the system forms, as in many cases human nature demands that it be used when formerly independent entities come together for the first time. Over time, however, the representational requirements likely need to be relaxed and ultimately eliminated. At Community Health Network, for example, one subsidiary hospital (the first of three from outside the local market area to become part of the system) has, for the past 20 years, had one seat on the system board reserved for a representative of the hospital. Very recently, leaders of this subsidiary hospital raised the issue of modifying this representational seat, as they recognized that the system as a whole could likely function better if the seat were not designated for a single entity. It remains unclear what will happen to this seat—it might rotate among the three subsidiary hospitals from outside the area, it could be eliminated altogether, or some other action could be taken.[58]

Another approach to phasing out representational appointments comes from Fletcher Allen Health Care and Western Connecticut Health Network. In both cases, the initial system board was formed based on representational requirements. However, after the first term for each board member (with term limits having been set up in a staggered fashion), the representational requirement is dropped and subsequent selection of directors will be made by a nominating committee that tries to find the best individual, regardless of his or her organizational affiliation. Consequently, in relatively short order, the system board will transition into a self-perpetuating body. In general, the goal should be to make this transition within roughly three years, five at the most. In many cases, the original appointees may well be reappointed by the nominating committee, as often directors very quickly make the mental transition from working on behalf of the subsidiary organization to working for the good of the system as a whole. Nonetheless, it is important to have a structural mechanism in place to end any representational requirements.

57 Interview with Daniel F. Evans, Jr., president and CEO, Indiana University Health, conducted on July 29, 2013.

58 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

The Perils of Not Ending a Representational Approach

In the 1990s, two community hospitals merged to create a health system. In executing the merger, the leaders of the two hospitals decided to take a pure representational approach to populating the system board—they simply merged the two existing hospital boards to create the system-level board. This decision proved quite shortsighted, as for the next six to eight years virtually nothing got done; the system board failed to enact any meaningful reforms required to manage risk and population health. All major initiatives ended up being shot down by the board, as directors continued to vote along "party" lines, unwilling to enact any measure that harmed one of the hospitals, even if the organization as a whole might benefit. Unable to recognize its own role in the organization's demise, the system board fired multiple CEOs who tried to transform the system.

Another example of the dangers of representational appointments comes from the Hawaii Health Systems Corporation, a public system that came together with a representational board that includes the CEOs of 13 hospitals and long-term care facilities. Since its formation, the organization has consistently been unable to move forward with critical initiatives needed to function as an integrated system, including sharing basic data and information through IT systems. The system may not survive in its current state, and a majority of the organizations within the system are in favor of transferring to a private model. However, it is not clear from the system's bylaws if an individual hospital can exit, and they anticipate legislation will be introduced in January 2014 that would allow one or more parts of the system to privatize.

Targeted and Limited Use of Supermajority Requirements

Rather than or in addition to using representational appointments, some health system boards require that a "supermajority" exist to pass certain motions. Typically calling for the approval of 75 percent or more of system directors to enact a motion, 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 as closing a hospital or a large service line. For example, at Community Health Network, closing a subsidiary hospital requires a supermajority vote of the system board.[59] Similarly, Fletcher Allen Health Care requires an 80 percent majority system board vote to make certain decisions; this stipulation ensures that, in order to pass, motions that will have a disproportionate impact on one of the system's hospitals cannot be passed with the support of only directors who originally came from other entities.

As with representational appointments, however, supermajority requirements should be put in place sparingly and limited to major decisions such as closing a hospital or major service line. Consideration should be given to "retiring" supermajority clauses after a period of time. For example, hospital or service line closings can be made subject to supermajority clauses for the first five years after the system forms, after which such decisions would revert to requiring a simple majority.

As-Needed Use of Reserve Powers at System Level

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 spelling out and judiciously using such reserve powers is critical to the functioning of a high-performing system.

59 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

Setting Up the Right Board Committees and Advisory Councils

HIGH-PERFORMING HEALTH SYSTEMS DELEGATE REQUIRED work to a handful of committees (e.g., executive, finance, audit, compensation, community benefit); they also form *ad hoc* committees for specific, focused undertakings, with specified sunset dates.[60] Best and leading practices with respect to system-level board committees are described in this section.

Documentation and Regular Review of Committee Purpose

High-performing systems use board-level committees judiciously and do not create them in the absence of a clear reason for their existence. In fact, in recent years hospitals and health systems seem to be reducing the number of board committees, with the average having fallen from 7.6 committees in 2011 to roughly 5 in 2013.[61] They start by developing a uniform structure for the committee charter, and ask each committee to create a charter using that format and submit it to the board for review each year.[62] At pioneering health systems, the following system-level board committees receive serious consideration:

- **Executive committee**: In 2013, 75 percent of health systems that responded to The Governance Institute's biennial survey reported having this committee.[63] The executive committee generally consists of a subset of system-level directors (in some cases just board officers); it meets infrequently, since contemporary communication vehicles reduce the need for many traditional committee functions.
- **Governance/nominating committee**: Ninety-two (92) percent of health systems that responded to the 2013 survey have this committee, up from 80 percent two years earlier.[64] It typically becomes involved in a variety of activities, including recruiting and nominating board and committee members, assessing board performance, overseeing orientation and mentoring of new directors, and updating bylaws and policies. Committee members should be appointed, with no *ex-officio* positions.
- **Finance committee**: Eighty-six (86) percent of health systems responding to the 2013 survey have a finance committee.[65] The importance of this committee will clearly increase as organizations take on more risk and have to deal with increasingly complex payment systems, including those where payment is based on value and quality rather than volume.
- **Quality and/or safety committee**: Eighty-five (85) percent of health system respondents to the 2013 survey have a board-level quality and/or safety committee. This figure represents a jump of 11 percentage points from two years earlier, likely reflecting the growing movement to tie payments to performance on quality metrics.[66]
- **Compensation committee**: Health systems have become large (billion-dollar plus), complex entities employing a number of highly paid executives and physicians with complicated compensation structures. As a result, compensation oversight has increasingly been delegated to a dedicated committee with the time and requisite expertise for the task. In the 2013 survey, 85 percent of health systems have a compensation committee.[67] Typically the board chair serves as chair of this committee and leads the CEO performance evaluation process. Non-directors typically do not serve on this committee, given the sensitive nature of compensation information and discussions.
- **Community benefit committee**: Given growing concerns about the extent to which non-profit healthcare organizations are providing community benefits and meeting community needs (and hence are deserving of continued tax-exempt status), there may be a need to create committees and/or other structures focused on understanding and meeting community needs (and documenting the system's activities in this area).[68] The importance of understanding community needs was highlighted in a recent report from The Walker Company; it laid out 10 "never events" for health system and hospital boards, one of which was the "failure to understand real community perceptions and needs." To avoid this problem, the report advocates conducting a regular community needs assessment as the basis for developing strategic plans and related programs and services.[69] A community benefit committee would be the natural entity to perform this task. This committee can define what the organization means

60 Zismer and Cerra, 2012.
61 Peisert, 2013.
62 Seymour, 2013.
63 Peisert, 2013.
64 Peisert, 2013.
65 Peisert, 2013.
66 Peisert, 2013.
67 Peisert, 2013.
68 Prybil, Levey, and Killian, et al., 2012.
69 The Walker Company, *Governance "Never Events": Ten Leadership Failures That Should Never Occur in Hospital Boardrooms,* 2010.

by "community" and perform a regular health assessment within the targeted communities. Part of this process involves redefining what it means to benefit the community, moving away from counting the provision of "charity care" (primarily acute services) and instead focusing on how the organization creates "healthy communities" in partnership with schools, religious organizations, senior citizens and the organizations that serve them, and other community-based entities.[70] To date, however, most hospitals and health systems have not been proactive in setting up this type of committee. In fact, the 2013 survey found that only 21 percent of responding health systems had done so; while a relatively low number, this figure represents a substantial increase from 2007 (15 percent).[71] The largest systems seem to be somewhat more receptive to the idea, with six of the nation's 14 largest systems having a standing committee with responsibility for system-wide community benefit policies, programs, and services.[72]

Along with these board-level committees, some pioneering systems have created a physician advisory council (or a similar entity with a different name) as a complement to or replacement for having physicians on the board**.** As alluded to earlier, system boards that reserve one or more seats for physicians not only face all the aforementioned challenges related to *ex-officio* and representational appointments, but also must be concerned about adhering to IRS guidelines about what it means to be an independent director with fiduciary responsibilities and no conflicts of interest. To get around these issues while still ensuring that the system board receives adequate input and guidance from clinicians, a growing number of systems have created advisory bodies made up of clinical leaders from throughout the organization. For example, Scripps Health set up a clinical council made up of approximately 15 doctors who meet with the CEO on a monthly basis. While this group has no formal authority, it commands tremendous respect and wields significant influence within the organization. The group focuses on how to improve current processes and systems and better support physicians in delivering high-quality, cost-effective care. The CEO keeps the group abreast of key issues facing the organization, and the group keeps Scripps' senior management and board aware of new clinical developments and technologies that may be of importance to the organization. The council is widely accepted by clinicians as an effective vehicle through which to give input.[73]

Strategic Use of Non-Directors

Particularly with smaller boards, non-directors often serve on board-level committees (except for the compensation committee and typically the executive and governance committees). These individuals bring specific expertise and provide needed manpower to the system board, allowing it to complete its requisite tasks. For example, few system boards include multiple certified public accountants (CPAs), yet the audit or finance committee may need several CPAs and/or other finance experts to do its work effectively. Similarly, system boards may have relatively few people with fundraising and advocacy experience; however, a committee formed to oversee fundraising through a system-affiliated foundation may need individuals with this type of experience. Any non-director who becomes part of a system-level board committee must agree to the same conflict-of-interest and confidentiality policies as directors do. In most cases, appointments to these committees are term-limited so as to avoid the risk of someone being a "lifetime" committee member. In addition, any system-level committee should be chaired by a current board member and likely have at least one other director who serves as co-chair or assistant chair. In most cases, non-directors will be appointed to board-level committees in a manner similar to how directors join the system board—that is, a governance nominating committee will take charge of identifying and nominating qualified individuals for consideration by the full board.

The Value of Using Outsiders on Board Committees

Several years ago, Hendrick Health System created a medical staff development committee made up of four current directors, four physicians, and four members of the local community, including business leaders able to provide valuable, unbiased input on what their employees needed in terms of physician specialties and services. By including these outsiders on the committee, the board received valuable feedback on the number and mix of physicians needed in the local community, and this guidance ended up being quite different than would have been given had the committee been made up of only directors and physicians.[74]

Committees as a Training Ground for New Directors

Qualitative interviews with the leaders of hospitals designated as high- and low-performing with respect to finances found that the best performers tend to use committees as training grounds for new directors; they also tend to have extensive and formal education and orientation programs for these new directors.[75] The use of committees as a training ground for new directors often bears fruit; at Community Health Network, for example, two of the last five new system-level directors began as non-director appointments to system-level board committees.[76]

70 Brown, 2010.
71 Peisert, 2013.
72 Prybil, Levey, and Killian, et al., 2012.
73 Chris D. Van Gorder, FACHE, "Scripps' Reorganization Experience: Key Takeaways for Boards and Directors" (conference presentation), The Governance Institute's System Invitational, March 3–5, 2013 in Laguna Niguel, CA.
74 T. Lancaster, "Making Board Meetings Strategic," *Trustee*, March 2010.
75 Kane, Clark, and Rivenson, 2009.
76 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

Determining the Right Roles and Responsibilities for Local Boards

WHILE THE DAYS OF SYSTEMS OPERATING AS A LOOSE CONfederation of independent entities have largely passed, not every system moves to the complete opposite end of the continuum (an operating company with virtually all control centralized). Those that do, moreover, do not necessarily get there right away, but rather migrate toward the model over time as dictated by the environment. In addition, even those systems employing a true operating company model still keep some local governance structures in place (e.g., boards, advisory councils), as the leaders of these systems recognize that the organization as a whole benefits from having talented individuals at the local level who provide guidance and leadership in certain areas. This section discusses leading practices related to determining whether to have local boards and, if so, what roles and responsibilities they should have.

Step One: Determining Whether to Have Subsidiary Boards

As outlined in a recent Governance Institute white paper, system leaders need to consider a variety of factors when determining whether to have subsidiary boards and which ones to have:[77]

- **Geographical spread and market distinctiveness**: Some systems are geographically spread out and hence operate in different natural markets with 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 systems that are not as spread out geographically will often operate in somewhat distinct markets, creating the need for retention of local boards with some degree of autonomy and control. For example, Community Health Network has six hospitals, three of which operate outside the local market area; consequently, the system maintains local boards for these three hospitals.[78] Fletcher Allen, a relatively small system, also utilizes this approach to ensure representation of members in New York and Vermont, some of which operate in markets with vastly different characteristics.
- **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. For example, as noted earlier, the Seton Healthcare Family has 11 hospitals (including academic medical centers, suburban hospitals, and rural facilities), numerous health plan products, and many outpatient surgery centers and clinics (some of which are set up as joint ventures with physicians and other partners). While organizational leaders originally wanted to have a single board for the entire system, the complex nature of the organization led to the decision to create three subsidiary boards that report to the system board—one each overseeing the hospital, insurance, and clinical enterprise divisions.[79] In other cases, subsidiary organizations may be in entirely different lines of business and hence need a local board with directors who have expertise in this business. For example, many systems have foundations that operate as subsidiaries, focusing almost exclusively on fundraising activities. These foundations typically need a separate board made up of local community leaders with the appropriate connections and skills to be successful at fundraising. Similarly, some systems have for-profit subsidiaries that operate in a variety of businesses that are quite different than not-for-profit inpatient and outpatient care. To be effective, these subsidiaries likely need a separate board with entrepreneurial expertise. Community Health Net-

77 Stepnick, 2011.

78 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

79 Interview with Charles Barnett, board chair and former CEO of Seton Healthcare Family, part of Ascension Health, conducted in August 2013.

work, for example, maintains a separate board both for its foundation and its for-profit subsidiary.[80]

Step Two: Keeping Subsidiary Directors Engaged

The desire to retain some form of local governance can sometimes create a dilemma for system leaders. Over time, these leaders may find that the ability to attract and retain talented board or advisory council members at the local level declines, as individuals who historically had more power and influence now find that their role has become more limited and advisory in nature. Consequently, these local leaders may become disengaged and/or simply stop serving. To avoid (or at least minimize) this problem, pioneering systems use various strategies, as outlined below.

Strategy #1: Clearly Delineate Responsibilities

Pioneering systems clearly delineate what responsibilities exist at each level of governance, often using a formal document to do so. The 2013 Governance Institute biennial survey found that just under 70 percent of responding health systems have their board approve a document or policy specifying allocation of responsibility and authority between the system and local boards; the practice is especially common among larger systems.[81] Pioneering systems often create a formal "authority matrix" to delineate the relative roles and responsibilities, an example of which appears in **Exhibit 2.**

In most cases where an operating model is used, the typical subsidiary board takes charge of medical staff credentialing, privileging, and peer review; in fact, 94 percent of subsidiary hospitals responding to The Governance Institute's 2013 survey indicated their board had this responsibility.[82] They also tend to take primary responsibility for community relationships, advocacy efforts, and subsidiary-specific fundraising. The subsidiary board may also review local finances (including operating and capital budgets), although the system chief financial officer typically does this as well and ultimate authority generally resides at the system level. In many cases, the subsidiary CEO and/or subsidiary board maintain authority to approve operating and/or capital expenditures below a certain threshold. One way to establish this ceiling is to fix it at the certificate of need (CON) threshold, assuming the state has CON regulations. In other words, many systems give local subsidiaries a pool of discretionary funds to spend as they see fit to meet local needs. Subsidiary boards often share responsibility for other decisions with the system board, which often has the final say on these matters. The 2013 Governance Institute survey highlighted the following examples of areas where there is often shared responsibility: [83]

- Choosing directors for the subsidiary hospital
- Nominating members to the system board
- Hiring, evaluating, and firing the CEO of the subsidiary hospital
- Determining and/or approving executive compensation at the subsidiary hospital
- Setting customer service and community benefit goals for the subsidiary hospital
- Calculating and/or measuring the level of community benefit provided by the subsidiary hospital
- Establishing the subsidiary hospital's corporate compliance program and board education and orientation programs
- Identifying strategic and budget priorities for the subsidiary hospital

Members of subsidiary boards may also participate on system-level committees. This step serves as an additional safeguard for subsidiary hospitals, providing a vehicle for their voice and input to be heard. In most cases, responsibility for budgeting, personnel policies, financial oversight, and quality oversight will reside at the system level, including setting policies and standards related to quality across the system. (As noted earlier, systems cannot afford to allow quality standards to vary across subsidiaries.) For their part, local boards or structures will maintain responsibility for ensuring adherence to these quality policies and standards.

In addition, local entities often take responsibility for implementing system-wide strategies at the local level. For example, local boards can play an important role in helping systems transition from the historic model of providing acute, episodic care to managing population health, something many systems are implementing in response to the transition from volume- to value-based payments by payers. Those at the local level often have existing relationships with other entities in the community (e.g., the local public health department, non-profit agencies, long-term care facilities, unaffiliated providers) that can be valuable partners on specific initiatives to improve the health status of the population, such as immunization drives, cancer screenings, and post-hospital care management for at-risk patients. The 2013 Governance Institute survey highlights the importance of the transition to value-based payments and population health management to hospitals and health systems. Over half of responding organizations added goals to their strategic and financial plans that specifically relate to these areas; among health systems, over 70 percent have taken this step. In addition, more than a third of health systems have added physicians to their management teams to help fine-tune traditional, volume-based service line tactics and to prepare for value-based payments and population health management.[84]

Strategy #2: Elicit Input and Guidance, Limit Command-and-Control Approach

Recognizing that subsidiary hospitals and other subsidiaries remain critical to meeting organizational goals, high-performing systems explicitly collaborate with subsidiary boards and seek to achieve consensus by garnering input from them, even on issues where ultimate authority resides with the parent.[85] In other words, even though the "buck stops" with a

80 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.
81 Peisert, 2013.
82 Peisert, 2013.
83 Peisert, 2013.
84 Peisert, 2013.
85 Seymour, 2013.

Exhibit 2: 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

system-level board that on paper has command-and-control authority over almost everything, use of that authority seldom becomes explicit. A system board or CEO may have hire-and-fire authority over the subsidiary hospital CEOs, but in pioneering systems, that authority would seldom be exercised without the support of the local hospital board or advisory council. Rather, the system board and its subsidiary counterparts find a way to work collegially and cooperatively with each other, including putting in place regular mechanisms to get input from local stakeholders. For example, Henry Ford Health System maintains a network of local advisory boards made up of roughly 300 community leaders. While these boards have no real authority, system leaders make it a habit to regularly meet with them and get their input and guidance on important decisions. While this approach requires a significant commitment, system leaders believe it is time well spent, as these local advisory boards provide valuable guidance and also help to ensure that decisions made at the system level are in fact supported and adhered to locally. In addition, members of these local advisory boards tend to remain very engaged in and supportive of the system, including taking an active role in raising funds and promoting the organization through local media.

Strategy #3: Ensure Regular Communications

Pioneering health systems put in place formal and informal mechanisms to facilitate communication between the system and subsidiary boards:

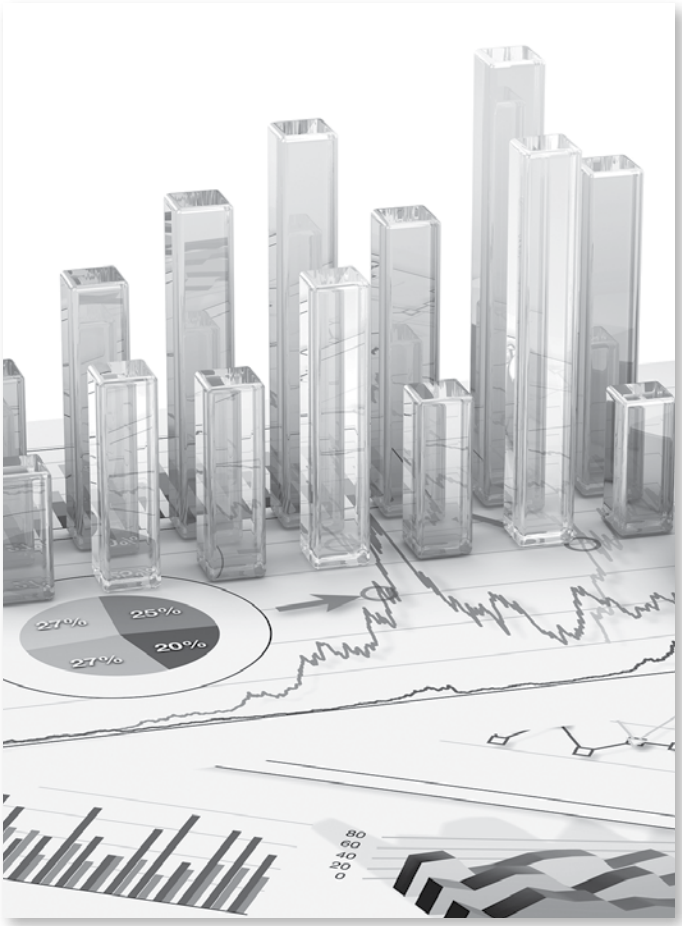
- **Regular meetings that bring local, system boards together**: Most pioneering health systems bring the members of their various boards together regularly to build and maintain personal relationships and to review and clarify the respective responsibilities of the boards.[86] For example, Dignity Health holds an annual session in which the board chairs from all local hospital community and foundation boards join with senior leaders from throughout the system and the system board chair for education, networking, and dialogue.[87] These types of formal retreats and other sessions can be an effective way to build a systems perspective, highlight the value being produced at both the system and local level, and otherwise ensure smooth system–subsidiary board relations. Often CEOs, other administrative leaders, and physician leaders at the system and subsidiary levels attend these sessions as well.
- **System leader attendance at 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. For example, at Community Health Network, the system CEO or one of his direct reports attends every subsidiary board meeting, often in conjunction with a system-level director or executive. The CEO or his designate provides both a verbal and written report on key system-level issues during the meeting.[88] Similarly, many systems also invite local leaders to attend system board meetings or otherwise provide an update on local activities; at Community Health Network, each subsidiary entity provides a written update to the system board in advance of every system board meeting.[89]
- **Orientation and training to reinforce system thinking:** Pioneering systems put in place orientation and periodic training programs for subsidiary board members that reinforce system

86 Eric D. Lister, M.D., "Creating Clarity in System Governance," *Trustee*, November 2010.

87 Interview with Elizabeth Shih, executive vice president and chief administrative officer of Dignity Health, conducted August 5, 2013.

88 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.

89 Interview with Bryan Mills, CEO of Community Health Network, conducted on July 3, 2013.



thinking, with the goal of ensuring alignment between board responsibilities and the knowledge and skills of directors.

- **Standardization of board structures 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; bylaws; director nomination and induction processes; director training; meeting agendas; 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.[90, 91]
- **Secure board portal**: Many health systems have developed secure portals that serve as a one-stop shop for all relevant materials for boards and committees at both the system and subsidiary level. Directors and others have differential access to these materials—i.e., not all users have access to all materials, with access determined by their position and enforced through various levels of security within the online system.
- **Other communication vehicles**: Maintaining good system–subsidiary board relations and keeping local board members engaged and enthusiastic requires constant attention. In addition to the board portal and the meetings and 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.
- **Regular evaluation of system–subsidiary relations as part of annual assessment**: Pioneering systems have a regular process in place to evaluate the performance of its various boards and individual directors. These assessments 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.
- **Regular evaluation of overall governance 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 overall structure of governance within the system (including the use of subsidiary boards) to ensure that it remains clearly defined, continues to support the organization's mission, and avoids unnecessary redundancies and complexities.[92]

90 Lister, 2010.

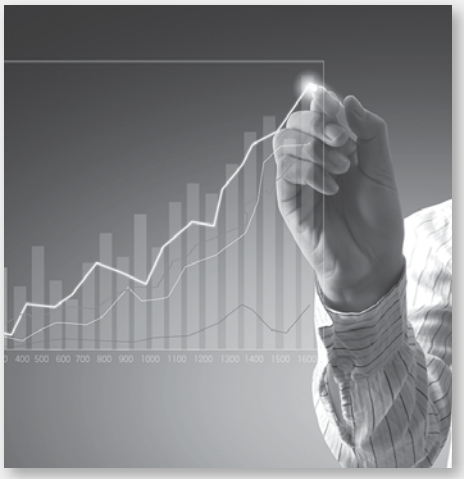
91 Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Eric D. Lister, M.D., Don Seymour, and Roger W. Witalis, FACHE, "The System–Subsidiary Relationship in Hospital Governance," *BoardRoom Press*, The Governance Institute, October 2008.

92 Lister, 2010.

Special Issues for Systems Forming Accountable Care Organizations

In collaboration with public and private payers and employers, some health systems have developed (or are considering developing) "accountable care organizations" (ACOs) and/or "clinical integration networks" (CINs) that take on partial or full risk for managing the health of that payer or employer's population. In most cases these ACOs and CINs will each have their own board of directors that functions much like other subsidiary-level boards within the system. For example, Dignity Health has developed multiple ACOs and CINs that function in this manner, and the system board retains authority to approve the appointment of directors to these boards.[93]

However, health systems that have applied to become part of formal Centers for Medicare & Medicaid Services (CMS) ACO programs (such as the Medicare Shared Savings Program and the Pioneer ACO Program) must meet two specific standards when setting up the ACO board. First, at least 75 percent of directors must be representatives of provider organizations participating in the ACO, with each participating provider being afforded appropriate proportionate representation on the governing board. Second, the ACO board must include at least one Medicare beneficiary, with the goal of ensuring that the beneficiary community has a voice in operations and management. CMS also stated that the ACO governing board must be distinct from the boards of participating ACO providers, unless the ACO is already a self-contained, financially integrated entity whose governing board meets the ACO criteria.[94]



These governance requirements could potentially create significant challenges for systems interested in participating in CMS-sponsored ACO programs. Issues may arise with respect to the composition and function of the ACO board vis-à-vis the system board. In addition, the representational requirements created by CMS may serve to undermine the ability of the ACO board to govern effectively, as the ability to take on and manage the risk inherent to the Medicare ACO program may be compromised if the ACO board ends up being dominated by representational appointments and hence cannot make the difficult decisions needed to manage population health and related risk effectively.

In a recent Webinar presentation, the law firm Ropes & Gray laid out two options for structuring ACOs under CMS programs: a "clinically integrated provider network" and a "collaborative multi-provider network arrangement." Under the clinically integrated approach, a single legal entity provides medical services, with single points of accountability for quality and payment. Under this model, the ACO uses a shared governance approach, with significant overlap between the sponsoring health system and the ACO with respect to the composition of the governing board, management, and participating members.[95] For example, Eastern Maine Health Systems used this approach with its ACO, known as Beacon Health, LLC. The ACO board largely mirrors that of the health system board, with the addition of one Medicare beneficiary/community advocate to the ACO board. In contrast, under the collaborative network approach, a contractual relationship exists between the entities owning the ACO and the participating members, with sufficient levels of coordination between the participants to address antitrust concerns. In most cases under this approach, the ownership entity and the ACO have fairly distinct governing bodies.[96] Under either approach, moreover, ACO functions may be performed by a separate legal entity or a "virtual" ACO.[97]

Governance Institute interviews with systems forming or contemplating the formation of ACOs suggest that success or failure will likely depend not on the structure or governance framework chosen, but rather on the degree to which the organization has the components outlined in **Exhibit 3**. In particular, successful ACOs will need strong capabilities with respect to capturing and analyzing data. The best ACOs will have IT systems that allow for effective population health management through proactive identification of, outreach to, and coordination of care for at-risk populations. These same systems must also provide real-time data and decision support for those on the front lines of care, thus ensuring that patients receive appropriate, timely services.

93 Interview with Elizabeth Shih, executive vice president and chief administrative officer of Dignity Health, conducted August 5, 2013.

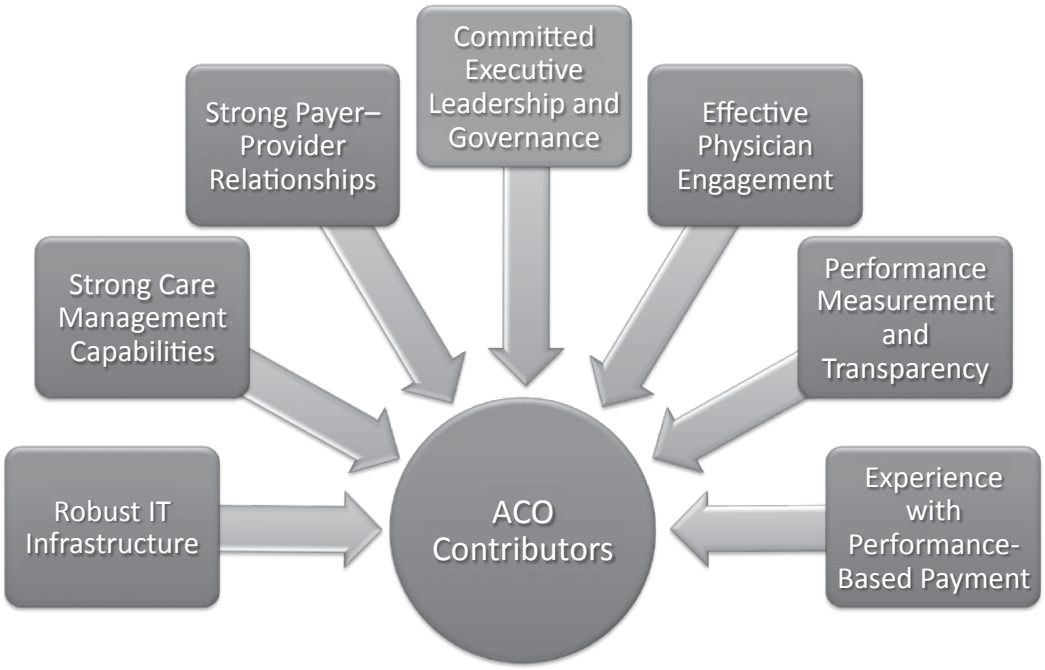
94 Andrew J. Demetriou and J.A. Patterson, Jr., "ACO—Legal Structure, Governance and Leadership," *ABA Health eSource*, April 2011. Available at http://bit.ly/Hujg3u.

95 Ropes & Gray Health Care Group, "ACO Governance: Decision-Making and Accountability for ACO Functions" (Webinar), December 15, 2010.

96 Ropes & Gray, 2010.

97 Ropes & Gray, 2010.

Exhibit 3: Components of a Successful ACO Formation



Conclusions and Lessons Learned

AS THIS WHITE PAPER MAKES CLEAR, THE LEADERS OF high-performing health systems pay close attention to the structures, policies, and processes that are put in place at all levels of governance, give careful thought to the need for and operation of subsidiary boards, and make substantial efforts to keep those serving on subsidiary boards engaged in the system as a whole. This white paper is intended to help these leaders with these tasks. In addition to evaluating the merits and relevance of the specific practices laid out in this white paper, system leaders should consider developing a set of guiding principles for setting up system-level and subsidiary governance structures, policies, and processes. One such set of principles comes from the Health Research and Educational Trust, which laid out the following principles in its 2007 Blue Ribbon Panel report:[98]

- Base the governance structure on conscious choices, not circumstance or history.
- Strive for as few boards and committees across the system as practical.
- If constituency or stakeholder representation is desirable or necessary, focus such representation on subsidiary board(s) rather than the system board.
- Choose system board members (including physician representatives) based on needed competencies and their ability to provide systems-level thinking and perspective.
- To the extent possible, centralize authority and decentralize decision making. For example, have the system board set system-wide policies with respect to quality and strategic direction, then let subsidiary boards make specific decisions consistent with those policies. The system board can play an oversight role to ensure adherence to parameters established in the system-wide policies.
- Use the same philosophy and design for governance structure as is done for administrative and clinical management. For example, systems with centralized governance should also employ a centralized approach in these other areas.

In addition to considering these principles, The Governance Institute urges system leaders to adhere to the following "rules of the road" with respect to governance structures, policies, and processes:

- Determine the competencies, skills, and experience needed for the board and then identify and recruit the best individuals with those competencies.
- Have the right-sized board—small enough to ensure effective deliberations and decision making, yet large enough to ensure that the requisite skills and diversity of opinion exist to make good decisions and get the work done. As noted, the most effective system boards often rely heavily on system-level committees populated with non-directors to get the work done. These committees also serve as a way for subsidiary organizations to have input into board-level decisions and as a training ground for future system-level directors.
- Avoid the "Noah's Ark" approach where many board seats are reserved for representatives of certain subsidiary organizations.
- Employ term limits and use as few *ex-officio* positions as possible, thus creating a self-perpetuating board where the vast majority of individuals are elected.
- Assess individual director and overall board performance regularly and make changes and adjustments as needed.
- Proactively plan for succession.

98 Health Research and Educational Trust, *Building an Exceptional Board: Effective Practices for Health Care Governance*, Report of the Blue Ribbon Panel on Health Care Governance, Health Research and Educational Trust, Center for Healthcare Governance, 2007.

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