System–Subsidiary Board Relations in an Era of Reform:

Best Practices in Managing the Evolution to and Maintaining "Systemness"

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Executive Summary

Based on a literature review, interviews, results from a recent Governance Institute survey, and presentations and discussion at The Governance Institute's System Invitational in April 2011, this white paper builds on The Governance Institute's 2005 *Pursuing Systemness* publication[1] by helping organizations with the transition from a holding company to an operating company model of governance. This white paper provides an update on the "systemness" environment in healthcare since 2005 and focuses on how to move effectively along this continuum without creating resentment and undermining effectiveness at the local or system level.

Environmental Pressures for Greater "Systemness"

Regardless of whether some or all of the elements of healthcare reform remain in place after the legal challenges to the legislation have been resolved, health systems still face a variety of external pressures that require "nimble" responses. Many of these pressures were clearly delineated at the aforementioned April 2011 meeting, where speakers highlighted the following pressures and strategic imperatives for health systems:

- **Relentless pressure on cost structure**: Due to pressures on the federal and state governments, health system leaders should expect continued downward pressure on Medicare and Medicaid reimbursement (at the same time that enrollment in both programs is growing significantly under reform legislation). 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 (an especially big problem for specialists). Success will require making difficult, system-wide decisions related to integrating physicians into the organization and evaluating and acting on their performance over time.
- **Significant investments in information technology**: Hospitals and health systems have 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 seek 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.

Positioning on the Systemness Continuum

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

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

1 B. Bader, E. Kazemek, and R. Witalis, *Pursuing Systemness: The Evolution of Large Health Systems* (white paper), The Governance Institute, 2005.

- **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.

Strategies and Tactics to Manage the Transition along the Continuum

The best systems plan the transition carefully, with the groundwork being laid even before the system forms and continuing over time. This section reviews 12 strategies and tactics specifically designed to facilitate the transition from a holding company to an operating company model.

Strategies before and during System Formation

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

- **Emphasize the benefits of systemness and make expectations clear upfront**: The most successful, nimble systems came together with a clear expectation that this transition would occur. Consequently, discussions about systemness should take place as a precursor to forming the system (or bringing another entity into the system). Institutional leaders who are contemplating forming or joining a system need to buy into the benefits of being a part of the larger organization, and understand and accept what that step will mean from a governance perspective.
- **Consider a "trial period" before finalizing the deal**: Even with open, honest pre-merger dialogue among leaders who believe in the value of systems and more centralized governance authority, some resistance is likely to remain at the entity level even after the system forms. For this reason, some newly formed systems have explicitly created a "trial period" during which the individual entities get to know and learn to trust each other. During this period, any entity can relatively easily exit the organization.
- **Establish clear, written lines of authority**: Early on, system and local leaders need to work together to clarify the specific authority and responsibility that will reside at the system and subsidiary level. The goal is to give system leaders the authority they need to run the organization as an integrated system while simultaneously leaving meaningful and valuable responsibilities at the local level that are of value to the system as a whole. To aid in this process, systems should create written documents that clearly describe the roles and responsibilities of the various levels of governance, using as clear and accurate language as possible. These roles should also be communicated during new director orientations and reinforced through board education and evaluation processes.

Ongoing Strategies

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

- **Regularly bring local and system boards together**: Most pioneering health systems bring the members of their various boards together regularly to build and maintain personal relationships and to review and clarify the respective responsibilities of the boards.[2] These gatherings can be an effective means of building systemness and ensuring smooth system–subsidiary board relations. Often CEOs, other administrative leaders, and physician leaders at the system and subsidiary level attend these sessions as well.
- **Have system leaders attend subsidiary board meetings (and vice versa)**: One common strategy is to have system-level administrative and board leaders regularly attend subsidiary board meetings, thus providing a visible reminder of the local entity's role within the larger system. Many systems also invite local leaders to attend system board meetings.
- **Let local boards decide their own outcome:** Several pioneering systems have adopted the explicit strategy of not forcing local boards out of existence, but rather letting them come to the conclusion over time to do so, *if appropriate*. As long as relative responsibilities and authorities have been clearly and appropriately spelled out, there is likely no benefit for a system-level board to decide unilaterally to terminate a local board, as such a decision could create significant animosity and anxiety at the local level.
- **Consider forcing an "in-or-out" vote at the appropriate time**: While systems need to give local board members and leaders adequate time to recognize and appreciate the benefits of systemness, at some point there may be a need to force an "in-or-out" vote. Despite a system's best efforts, a local board may not be willing to make the concessions necessary to allow the system-level board to do its job effectively. If a board is not willing to do that, it may be best at some point to make them hold an "in-or-out" vote, effectively forcing them to "play ball" or leave the system.
- **Look for and cultivate "system thinking" in new directors and administrators**: Many systems inherit and/or initially embrace the idea of having "representative" boards at the system level, with designated slots for representatives of particular entities, including hospitals and physician groups. Such an approach, however, runs counter to operating like a system, causing forward-thinking organizations to abandon the representational approach. Instead, these organizations look for explicit competencies and skills when replacing directors, including but not limited to the ability to think at a systems level. Effective systems also put in place orientation and training programs that reinforce system thinking, with the goal of ensuring alignment between boards' responsibilities and the knowledge and skills of directors.

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

- **Standardize board structure and processes**: One of the most effective strategies for promoting systemness and ensuring smooth system–subsidiary board relationships is to standardize as much as possible across all levels of governance, including board size and term length; board bylaws; director nomination and induction processes; director training; meeting agendas and the structure of meeting minutes; committee structures (including charters and operating processes); compliance and risk management policies and processes; reporting on quality/safety, financial, and strategic planning issues; board self-evaluation processes; and the role of the board in evaluating local CEOs.[3, 4]
- **Develop and regularly use multiple communication vehicles**: Maintaining good system–subsidiary board relations and keeping local board members engaged and enthusiastic requires constant attention. In addition to the regular, formal retreats outlined earlier, the best systems use a variety of communication vehicles to keep directors from throughout the organization informed, with communications focusing on system-wide issues and emphasizing both the benefits of systemness and the important role that local entities play in achieving those benefits.
- **Evaluate system–subsidiary relations as part of the annual assessment**: Virtually all systems have a regular process in place to evaluate the performance of its various boards and individual directors. These assessments should include an evaluation of the relationships between boards, including how well respective roles and responsibilities have been clarified, how "connected" the local board feels to the overall system, and the effectiveness of communication across boards.
- **Constantly reevaluate and confirm structure**: As with most quality improvement processes, maintaining and improving system–subsidiary board relations requires constant reevaluation. To that end, system leaders should periodically review and question the structure of governance to ensure that it remains clearly defined, continues to support the organization's mission, and avoids unnecessary redundancies and complexities.[5]

3 E. Lister, 2010.

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

5 E. Lister, 2010.

Introduction

The leaders of health systems need to react quickly to the many pressures facing their organizations, including those created not only by federal healthcare reform legislation, but also by market-driven and other pressures to rein in costs and improve quality of care and population health status. While these pressures may not be new, their intensity has markedly accelerated in recent years, due in large part to the tremendous budget pressures facing federal, state, and local governments and the need for corporations to further streamline cost structures in the face of a tepid economic recovery. With payrolls already cut to the bone, health benefit costs represent a logical place for cost-cutting today and for the foreseeable future.

Health system success in such an environment will not be possible without a governance structure that allows for quick decisions and action, even if such decisions prove controversial in certain parts of the organization (e.g., consolidating clinical service lines across subsidiary hospitals). In 2005, The Governance Institute released a white paper entitled *Pursuing Systemness: The Evolution of Large Health Systems*. The paper described a gradual evolution taking place within the governance structures of large health systems, with general movement away from the traditional "holding company" model characterized by largely autonomous local boards, with relatively little control, capabilities, and coordination at the system or "corporate" level. The first step in the evolution typically involves a shared governance model where the system and local boards divide authority and responsibility. Some systems stick with this model, while others continue along the continuum toward the "operating company" model characterized by much more power and authority at the system or corporate level (see **Table 1**).

In April 2011, The Governance Institute hosted a health system invitational in Scottsdale, Arizona, during which the leaders of pioneering health systems from around the country discussed a

Table 1: Three Models of Health System Governance and Management

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

Corporate Control, Capability, Coordination, and Centralization

Less ⟷ **More**

variety of critical issues facing their organizations in today's turbulent environment, including appropriate governance structures and challenges related to system–subsidiary board relations. General consensus seemed to exist on the need to move away from the traditional "confederacy" approach, in which local subsidiary boards wield much of the power and authority, to a more unified approach with greater control at the system level. While different organizations are executing this transition to varying degrees (e.g., some may stop with shared governance) and/or at varying speeds, the direction of the movement seems clear.

A recent Governance Institute survey (conducted during June–July 2011) suggests that this evolution is well underway, as evidenced by the following actions taken by a sizable proportion of the 46 respondents:

- **Consolidating subsidiary boards**: Among respondents with subsidiary boards, 54 percent have consolidated two or more of these boards into one and/or merged the system and hospital boards. Another 14 percent are considering this strategy.
- **Reducing subsidiary board power**: Among respondents with subsidiary boards, just over a third (34 percent) have changed their responsibilities from fiduciary to advisory in nature, with another 12 percent considering this strategy. Similarly, 45 percent of respondents with subsidiary boards have changed their responsibilities to primarily include oversight and monitoring of system-wide goals set by the system board. Another 7 percent are considering this strategy.
- **Centralizing oversight of key business functions**: Over 85 percent of respondents have assigned oversight of key business functions (such as finance, audit, and strategy) for the organization to a system-level board committee.
- **Setting system-wide policies**: Over three-quarters of respondents have set or are considering developing system-wide policies regarding quality standards and measurement, evaluation, and continuous improvement of governance structure and practice.
- **Eliminating membership overlap**: Roughly one in four respondents with subsidiary boards have eliminated overlapping membership between system and subsidiary boards.

The net result is that for most organizations, the system board is either responsible for or shares responsibility for many key issues that in a lot of cases used to be in the domain of subsidiary boards. For example, the survey found that for over 90 percent of respondents with subsidiary boards, the system board is either responsible or shares responsibility for the following:

- Setting subsidiary strategic, financial, quality/safety, and customer service goals
- Selecting and evaluating the subsidiary chief executive officer

The survey showed that many subsidiary boards maintain substantial responsibility relating to the approval of medical staff appointments and physician employment contracts, with nearly half (47 percent) of subsidiary boards being primarily responsible for these areas.

Done well, the transition to centralized governance will prove popular with and be supported by all major stakeholders in the organization (including those at the local level), thus positioning the organization to make and successfully execute the difficult decisions needed to succeed today and into the future. Done poorly (or not at all), the transition may breed animosity and gridlock, rendering the organization incapable of making needed decisions or taking needed actions.

Local boards do need to retain authority over certain areas, as discussed in more detail in various sections of this white paper. Additionally, local boards will not be effective or engaged if they do not feel they have enough responsibility/authority to make a difference. The key is finding the right balance and having clear, designated responsibilities for local boards that are separate from the system board.

It is important to note that The Governance Institute does not advocate for the complete removal of local/subsidiary fiduciary boards, or shifting local boards to a purely advisory nature in all cases. Organizations working through a system–subsidiary restructure must keep in mind the specific needs of the local communities, as well as state and federal laws (especially new provisions in the healthcare reform bill pertaining to community health needs and the ability to manage/improve population health status), and ensure that all fiduciary duties are being fulfilled at all levels of the system. In some cases, having no local boards (or only advisory boards) is appropriate; in other cases, this kind of structure is not appropriate. Examples to this effect are provided throughout the white paper.

These data make clear that the transition away from the holding company model is well underway. Successfully executing the transition, however, can be quite difficult, and in some ways the job is never done. Many systems' governance structures came together without careful planning, with the end result being a structure that has a "life of its own" and that has grown to "unmanageable proportions."[6] The problem tends to be worse for systems that have formed or grown by acquiring or merging with other established entities rather than growing organically (many systems do both). For example, the roots of Eastern Maine Healthcare Systems (EMHS) began many years ago with the establishment of a flagship hospital and referral center in Bangor, Maine. Through the 1980s, the organization grew organically, spinning off its own for-profit division, creating a separate foundation, opening a 100-bed psychiatric facility, and formalizing relationships with visiting nurses associations. During this organic growth period, keeping

6 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.

governance centralized proved to be fairly easy, as the "child" organizations adopted consistent bylaws and the organization continued to serve a very local market (in and around Bangor). With the pressures to become a larger system, however, EMHS began bringing in other hospitals from very different markets, each with its own history and culture. Integrating these "adult children" (i.e., already established organizations) into system-wide governance takes much longer and requires greater flexibility. Not surprisingly, many of the local boards remained quite steadfast about the need to maintain their autonomy. Convincing them to yield authority to the system takes substantial time and effort.

Many systems throughout the country have come together in a manner similar to EMHS, with some being very reliant on integrating "adult children" into their existing governance structures. And while moving away from decentralized governance structures remains critical to long-term organizational performance (and potentially even survival), doing so can create conflict and disillusionment among those losing autonomy and power.

This white paper, which builds on *Pursuing Systemness*, attempts to help organizations with this transition, with a focus on how to move effectively along the continuum without creating resentment and undermining effectiveness at the local or system level. The information and analysis is based on a review of the literature, interviews with system executives and board members conducted in May–June 2011, The Governance Institute survey on evolving system governance described on the previous page, and presentations and discussion that took place during the April 2011 health system invitational. Footnotes have been provided for content derived from the published literature. Other facts and figures presented in the paper come from the interviews, survey, or system invitational. To that end, it is organized as follows:

- **A review of environmental pressures for greater systemness**: This section briefly reviews the many pressures pushing organizations toward greater systemness. It includes examples of the kinds of difficult decisions that system-level boards and CEOs likely need to make in response to these pressures.
- **Factors that determine the appropriate place on the continuum (and how quickly to get there)**: This section describes various factors that influence where on the continuum the system ultimately should go, and the pace at which the transformation should proceed.
- **Strategies to make the transition work**: This section describes specific, practical strategies and tactics that organizations have used to make the transition work well.

Environmental Pressures for Systemness

Regardless of whether some or all of the elements of healthcare reform remain in place after the legal challenges to the legislation have been resolved, health systems still face a variety of external pressures that require "nimble" responses. Many of these pressures were clearly delineated at the aforementioned system invitational, where speakers highlighted the following pressures and strategic imperatives for health systems.

1. Relentless Pressure on Cost Structure

Due to pressures on the federal and state governments, health system leaders should expect continued downward pressure on Medicare and Medicaid reimbursement (at the same time that enrollment in both programs grows significantly under reform legislation). With a sluggish economy and rapidly rising health benefit costs, private employers and their insurers will no longer accept cost-shifting, suggesting pressure on private payer reimbursement as well. Speakers emphasized the need for hospitals and health systems to bring costs down consistently over time (with some advocating for 5 percent reductions year after year), with the goal of being able to achieve a positive margin at Medicare reimbursement levels while still offering high-quality services. Meeting this goal will require meaningful consolidation of clinical services (e.g., closing subscale programs in one facility), much more so than most hospitals/health systems have done to date. Success will also require a relentless focus on standardizing care management based on evidence-based protocols, with ongoing performance monitoring and reporting, along with mentoring of poor-performing doctors (and dismissals of such physicians if they fail to improve over time). Systems governed as loose confederations (closer to the "holding company" model end of the continuum) will find it much more difficult to take the steps necessary to aggressively manage costs.

The recent Governance Institute survey makes it clear that health system leaders share this view. This survey found that roughly two-thirds of respondents had set an aggressive overall goal to reduce costs so as to operate profitably at Medicare reimbursement rates, with another 22 percent contemplating such action. Among those that have taken or are contemplating this strategy, three-quarters consider having centralized governance (rather than a loose confederation) "extremely" important to their ultimate success (as indicated by a ranking of four or five on a five-point scale, with one being "not at all important" and five being "extremely important").

2. At-Risk Revenues Dependent on Cost and Quality Performance

Health systems will increasingly be held accountable for the quality and cost of care delivered to a population, with quality being judged based on adherence to evidence-based protocols and patient satisfaction, mortality, infection, and readmission rates. The failure to perform well in these areas could affect the ability of the organization to survive, as 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. To get full reimbursement, hospitals and health systems will have to produce positive outcomes (e.g., few readmissions and hospital-acquired infections) and high levels of patient satisfaction at a consistently low cost. If history is any guide, meeting this hurdle could prove quite difficult. For example, the vast majority of participants in the Medicare group practice demonstration project received no bonus payments. Success will depend in no small part on actions taken by the board of directors; a recent *Health Affairs* study found board characteristics and activities to be major distinguishing features separating high- and low-performing hospitals on a variety of quality metrics.[7] The recent Governance Institute survey yielded similar findings, with the vast majority of respondents viewing centralized governance as critical to execution of three strategies related to this market dynamic:

- **Setting aggressive subsidiary targets**: Nearly 80 percent of respondents have set aggressive cost and quality targets for subsidiaries, and 79 percent of the leaders of these organizations view centralized governance at the corporate level as critical to successful execution of this task (as indicated by a score of four or five on the previously described five-point scale).
- **Revamping incentives**: Over half (56 percent) of respondents are working with payers and physicians to adjust payment incentives and to standardize care so as to maintain financial viability in preparation for bundled and value-based payments; another 22 percent are contemplating such a strategy. Roughly 82 percent of the leaders of organizations following or considering this strategy view centralized governance at the corporate level as critical to successful execution.
- **Becoming an accountable care organization (ACO):** Roughly a third of respondents are actively working toward applying for and becoming an ACO, with a similar percentage contemplating this strategy. Of these, nearly 83 percent view centralized governance as central to success.

3. 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. Significant physician shortages will continue and may even get worse, particularly for primary care providers. As is already occurring, many physicians will seek employment within hospitals and health systems. To avoid massive financial losses due to practice acquisition and employment (as occurred in the 1990s), hospitals and health systems will have to develop and execute a well-conceived

7 J. Ashish and A. Epstein, "Hospital Governance and the Quality of Care," *Health Affairs,* Vol. 29, No. 1 (January 2010), pp.182–187.

strategy for integrating with physicians, including having good management and measurement systems so as to minimize standalone losses. Some speakers suggested establishing a goal to lose "only" $35,000 per acquired physician, well below the $150,000 to $200,000 losses that occurred in years past. Part of this strategy might involve letting low-performing doctors go after a period of time. As with the other challenges, success will require making difficult, system-wide decisions related to integrating physicians into the organization and evaluating and acting on their performance over time.

As with the other market forces facing health systems, physician integration works best with a more centralized governance structure. The survey results confirm this view, with leaders viewing the success of various physician integration strategies as highly dependent on having a more centralized governance structure:

- **Clinical integration**: The survey found that 86 percent of respondents are working on various models of integrating physicians and clinical services across the system so as to standardize care and produce better outcomes and lower costs. Another 6 percent are contemplating such a strategy. Over three-quarters of the leaders of these organizations view centralized governance at the corporate level to be critical to their success in this area.
- **Standardized patient care management**: Similarly, 44 percent of respondents have standardized most or all elements of patient care management across their organizations through use of standardized algorithms, protocols, and information technology (IT), with a similar percentage considering doing the same. Of these, 82 percent view having centralized governance as central to their success.

4. Significant Investments in Information Technology

Hospitals and health systems have to make significant investments in IT, both to facilitate quality improvement and cost reduction throughout the system, and to allow aligned physicians to meet the federal government's meaningful use criteria. For a large organization with many physicians, an investment of at least $500,000 to $1 million will likely be required. Clearly, decision making and oversight related to the purchase and implementation of any major IT system will need to occur at the system level, suggesting the need for centralized governance. The Governance Institute survey found that three-quarters of respondents have already centralized most or all business and clinical information system functions, with another 17 percent considering this strategy. Once again, more than three-quarters of the leaders of these organizations view centralized governance at the corporate level as critical to successful execution of this strategy.

5. Increased Public Scrutiny

Hospitals and health systems face intense scrutiny related to their not-for-profit status, including a review of whether they provide adequate levels of community benefit to justify their tax-exempt status. Payments to medical directors and other physicians will also be scrutinized as part of fraud detection efforts. Centralized oversight will again be critical to making sure that the system can withstand such scrutiny.

6. Pressures to Consolidate

As reimbursement levels fall and access to capital becomes increasingly limited to the best performers, smaller hospitals may close or seek to become part of larger systems. Bringing these facilities into the organization will require careful planning. The leaders of those entities joining the organization must understand what it means to operate as a system, including the fiduciary power and authority that will rest at the system level. The recent Governance Institute survey demonstrates this point. Roughly a quarter of respondents have recently changed their makeup or ownership by joining another system, closing underperforming hospitals or services, or acquiring another hospital or system, with another 11 percent contemplating such strategies. Of these, 71 percent view centralized governance at the corporate level as being very important to successful execution of this strategy.

7. 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 (including physicians and employees, who become "ambassadors" for the brand) and by setting the expectation that branding will migrate to a system-wide approach over time (rather than individual sites maintaining their brand identities). System CEOs and boards often need to help local boards assimilate into the system brand. For example, one system acquired a smaller affiliate with the intention of renaming the facility with the system's name. However, the local board resisted this move, creating tension within the organization and confusion among consumers, and ultimately diluting the value of the transaction.

The importance of centralized governance to branding can also be seen in the survey results, which found that over 85 percent of respondents are working toward creation of a single brand identity in the marketplace, with the system name dominant in most or all marketing and advertising. Another 6 percent are contemplating such a move. Among those either doing or considering this strategy, 78 percent view centralized governance at the corporate level as critical to their success.

The push to system-wide branding, however, should not mean the complete elimination of local brands. In fact, for the many situations where a local brand has significant awareness and meaning in a community, system-wide branding efforts often retain the old brand name while adding additional verbiage intended to make the public aware of the local entity's affiliation with the larger system.

Positioning on the Systemness Continuum

While the days of systems operating as a loose confederation of independent entities has largely passed, not every system needs to move to the opposite end of the continuum (an operating company with virtually all control centralized). Those that do, moreover, need not necessarily get there right away, but rather should do so over time as dictated by the environment. The key, however, is to create the expectation that the organization will operate as a unified system, thus allowing the governance structure and associated decision-making authority to evolve as necessary over time.

Whatever system leaders decide with respect to where on the continuum to lie, certain principles should guide the resulting governance structure. The Center for Healthcare Governance and Health Research and Educational Trust laid out the following principles in their 2007 Blue Ribbon Panel Report:[8]

- 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.

With these principles in mind, system leaders need to consider a variety of factors when determining where to reside on the continuum, as outlined below.

Factor 1. Geographical Spread and Market Distinctiveness

Some systems are geographically spread out and hence operate in different natural markets that each have their own local dynamics and characteristics. The most obvious examples are large, national systems that operate in multiple (sometimes 10 or more) states. These organizations often need to maintain local boards that retain some autonomy, thus giving them the flexibility to react and adapt to local market conditions. For example, Providence Health & Services operates in five states—Washington, Alaska, California, Montana, and Oregon. With such a diversity of markets, the system maintains subsidiary boards that have substantial responsibility for oversight (e.g., for medical staff credentialing) at the local level.[9] At Ascension, which operates in 20 states, the system board sets overall policy for the system, including expectations related to performance, and performs oversight with respect to strategy, management, and local governance. Local boards maintain fiduciary responsibility for medical staff privileging and credentialing, and also approve the mission statement for the local ministry and collaborate with the system board on the hiring of local/regional CEOs.

Even less geographically spread out systems will often operate in somewhat distinct markets, creating the need for retention of local boards with some degree of autonomy and control. For example, Sutter Health, a non-profit system with roughly 25 hospitals and many affiliated physician organizations, has executed a transition from having many local boards (one for each hospital and affiliated medical foundation) to having five operating corporations at the regional level, each with its own governing board that retains responsibility for Sutter-affiliated hospitals in the region. Each region also has a separate regional medical foundation that contracts with physician groups, with a board for the foundations as well. In essence, Sutter has moved from having dozens of boards at the local level to having parallel hospital and foundation boards at the regional level, with each region being a distinct geographic market. The process took time and communication (something discussed in detail in the next section), with local board members ultimately voting themselves out of existence to create more streamlined decision-making structures.[10] The Sutter example is representative of a larger trend to streamline governance layers by

Some systems are geographically spread out and hence operate in different natural markets that each have their own local dynamics and characteristics. These organizations often need to maintain local boards that retain some autonomy, thus giving them the flexibility to react and adapt to local market conditions. Even less geographically spread out systems will often operate in somewhat distinct markets, creating the need for retention of local boards with some degree of autonomy and control.

8 Health Research and Educational Trust/Center for Healthcare Governance, 2007.

9 S. Mycek, "Division of Labor," *Trustee,* April 2008.

10 E. Lister, 2010.

moving towards boards that govern multiple facilities in a natural geographic market.[11]

Less geographically spread out systems that serve only one market often move further and/or faster along the continuum, transitioning relatively quickly to a single system board and few if any subsidiary boards. For example: [12]

- Community Health Partners, a two-hospital system in Lorain, Ohio, began with separate boards for each of the hospitals (which were only four miles apart), with some overlap in members. Later system leaders decided to switch to a single board at the system level, with responsibility for the hospital, medical office building, and for-profit subsidiary.
- Bronson Healthcare Group in Kalamazoo consolidated from 20 boards with 130 members to a single, 22-member system board (later reduced to 15–20 members). Bronson relies heavily on working committees.
- Crozer Keystone Health System in Philadelphia replaced individual facility boards with a two-tiered governance structure consisting of a parent board that oversees the whole system and a separate health services board that oversees the system's five hospitals and other delivery enterprises. Policy committees made up of administrative and clinical leaders from the larger facilities provide a forum for attention to local issues and an avenue to make recommendations to the parent and health services board.
- Northeast Health in Troy, New York, a two-hospital system with a geriatric services organization, streamlined its governance structure, initially having three boards (one for the system, one for the two hospitals, and one for the elder services organization). Over time, it became clear that this approach did not foster system-thinking, leading the parent board to approve a transition to a single board, members of which were nominated by a committee composed of the chairs of the three former subsidiary boards.

Not all local systems, however, find it necessary or even useful to eliminate local boards. Sometimes they keep the local boards but consolidate committee-level activities at the system level. For example, WellSpan Health, which serves two counties in Pennsylvania, formed with the coming together of two acute care hospitals, a home health/rehabilitation company, and a medical group, each of which had its own hierarchy of boards and board committees. After coming together, system leaders decided to maintain the subsidiary boards but eliminate most committees at the subsidiary level, replacing them with system-level committees. They now have system-level finance, executive, strategic planning, and quality committees. These committees, which include representatives from the parent and subsidiary boards, have been tremendously effective in ensuring a system-wide focus for governance. System leaders also narrowed the scope for the subsidiary boards, focusing their meeting agendas on performance and performance improvement in the areas of quality and finance. To support this approach, WellSpan put in place organization-wide clinical performance standards across service lines.

Another example comes from Eastern Maine Healthcare Systems. While operating in a single state, the system serves a very broad geographic area (the northern two-thirds of Maine, covering 50,000 square miles) through seven hospitals, long-term care facilities, home care, a research institute, and a for-profit division with various entities. Collectively, the organization spans the full continuum of care. Over time, the system has been moving along the continuum from a holding company to a truly integrated governance model, with the system now being roughly halfway to the end point. It remains unclear, however, whether and when the organization will complete the transition and if so, how soon. At present, the system has 11 subsidiary boards plus the parent board. Each of the seven hospitals has a board, with subsidiary boards also overseeing long-term care, home care, the for-profit division, and the foundation. The system board has final authority over budgets, bylaws, new director/director appointments, and hiring and firing of local CEOs. The system also does budgeting and strategic planning at the corporate level, with the subsidiaries using system-level plans as a basis for local budgeting and strategic planning processes.

Systems that centralize most or all authority at the system board level may find that, over time, the ability to attract and retain talented board members at the local level declines markedly. Accomplished individuals do not want to serve on a board that has no real authority or purpose.

Factor 2. Need for Local Directors to Remain Engaged

Health systems, particularly those operating in diverse geographies, can benefit from having talented individuals at the local level who provide guidance and leadership. As a result, they may want to maintain subsidiary-level boards.

Systems that centralize most or all authority at the system board level may find that, over time, the ability to attract and retain talented board members at the local level declines markedly. Accomplished individuals do not want to serve on a board that has no real authority or purpose. And while there are strategies for keeping these individuals engaged and involved (see next section), sometimes it might make sense to alter the "balance of power" as well, maintaining (or yielding) some degree of authority at the local level. For example, Atlantic Health System in New Jersey enhanced the responsibilities of its local boards. These boards originally served only in an advisory capacity, identifying and monitoring local needs and serving as liaisons between the

11 B. Bader, "When Hospital Boards Merge: 5 Lessons Learned," *Great Boards,* Vol. IV, No. 1, Winter 2004. Available at www.greatboards.org.

12 B. Bader, 2004.

community and system board. However, system leaders found it difficult to attract and retain talent at the local board level (and they needed such local talent to help in overseeing the very diverse communities served by the system). As a result, they decided to shift more responsibility for quality oversight and capital budget expenditures to the local level. While local boards remain advisory in nature, their ability to assess needs and make recommendations has been enhanced, and local board members feel they have a greater purpose.[13]

Factor 3. 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. For example, Scott & White Healthcare—a system with nine owned, jointly owned, and managed hospitals—historically had many separate local boards, making it difficult for the system board to engage in discussions and make the decisions needed to succeed in the future. Texas law prohibited Scott & White from eliminating these local boards. Consequently, the system CEO and board chose an alternative approach, deciding to more tightly align and coordinate the subsidiary boards by creating standardized committee structures, agendas, compliance plans, and self-evaluation processes. Scott & White also created a separate foundation board charged with fundraising, but system leaders took great care to map out the foundation board's charter and accountability.[14]

In addition, multi-state systems such as Providence and Ascension must maintain local boards in order to comply with state mandates that certain functions, such as medical staff credentialing oversight, occur at the local level.

Factor 4. Diversity and Complexity of Entities within the System

Some systems include 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. Yet these organizations may well co-exist within a single system. Effectively overseeing this complexity may prove too difficult for a single system board. In some cases, therefore, system leaders may decide to "buck the trend" by adding a subsidiary board. For example, leaders of Mountain States Health Alliance in Tennessee decided to add a subsidiary board when it became clear that the system board could not effectively oversee both the large regional system and the Johnson City Medical Center, a large teaching facility. Creating the subsidiary board freed up the system board to focus on organization-wide issues (e.g., finance and strategy) while ensuring that the medical center had appropriate oversight of local quality, medical staff, and operational issues.[15]

13 S. Mycek, 2008.

14 E. Lister, 2010.

15 B. Bader, 2004.

Strategies and Tactics to Manage the Transition along the Continuum

For many system leaders, deciding where to reside on the continuum from a holding company to operating company likely represents the "easy" aspect of creating an effective governance structure. As noted, there is general consensus on the need to move along the continuum toward an operating company model. The appropriate "resting place" will vary by organization (based on some of the factors laid out in the previous section) and may even evolve over time as market circumstances dictate. In fact, many systems remain in an evolutionary migration toward the operating company approach.

What likely matters more are the specific strategies and tactics that systems use to facilitate and manage the transition over time. These practical steps will determine how successful the organization is in creating a "system culture" with governance structures that can better facilitate the necessary but difficult decisions outlined in the first section of this white paper. The best systems plan the transition carefully, with the groundwork being laid even before the system forms. This section describes a variety of practical steps that pioneering health systems have taken to allow for a smooth transition, and to position the organization to continue to evolve as needed over time. The steps can be taken during different time periods within the evolution, beginning with before the system even forms.

Strategies before and during System Formation

As noted above, the most effective systems began talking about the need for systemness even before they came into being. As a result, the leaders of entities that become part of the organization are not surprised when governance structures within the system tend to concentrate power at the system level. Specific strategies and tactics for this stage are discussed below.

1. Emphasize Benefits of Systemness and Make Expectations Clear Upfront

A local entity and its board should never be surprised to discover that becoming part of a system means that control will shift from the local entity to the system. The most successful, nimble systems came together with a clear expectation that this transition would occur. Consequently, discussions about systemness should take place as a precursor to forming the system (or bringing another entity into the system). Institutional leaders who are contemplating forming or joining a system need to buy into the benefits of being a part of the larger organization, and understand and accept what that step will mean from a governance perspective. Coming in with this expectation serves to reduce any friction or resistance that may occur after joining the system.

The process of creating systems thinking and managing expectations begins with creation of a compelling system vision, ideally before the organization even becomes a system. To the extent possible, moreover, this vision should lay out the "end game" with respect to organizational governance structure. As one CEO said, there should be "no apologies" about the need to act like a system and shift control, and there is no sense in "tiptoeing" around the issue in an effort to woo organizations into the system. The banking industry has used this approach for many years as banks have consolidated. While local bank board members are always treated with dignity and respect, the acquiring bank also always makes clear that the local bank boards will be phased out over time, and that the acquiring bank's brand will ultimately be used.

A number of systems have successfully used this approach and experienced relatively little pushback as they created strong system-level boards that wield substantial power. Examples include:

- **Community Health Partners** (Lorain, Ohio): This organization formed in 1994 as the result of the merger of two hospitals four miles apart, senior leaders laid out a vision of one organization with one board, medical staff, and management team, thus paving the way for reallocation of clinical services at a later date.[16]
- **Texas Health Resources (THR):** THR formed in 1997, first with the formation of a new organization from two major health systems in North Texas (Presbyterian and Harris Methodist), and then with the addition of a single hospital (Arlington Memorial) a month later. The driving force behind the consolidation was the need to operate as a system, and hence all pre-transaction discussions emphasized the need to govern and manage the new entity as a single system. The leaders of the individual entities that made up THR came into the organization fully aware of the impact that creating the system would have on local governance, including the creation of a strong system-level board with ultimate authority for key decisions (including placement and removal of board members from throughout the organization). Consequently, system leaders later faced relatively little pushback at the local level as THR established a system-wide board, along with system-level committees (e.g., governance, finance, audit/compliance, people/culture, quality/performance improvement, strategic planning) that maintain significant fiduciary authority.
- **St. Charles Health System:** This sole community provider in Central Oregon formed with the merger of two hospitals (one in Redmond and one in Bend). From the beginning, those involved made it clear that the ultimate goal was to have a single system board with total fiduciary responsibilities. Hence relatively little pushback occurred when system leaders decided to take that step two years after the merger. St. Charles also leases a small facility in an outlying area; leaders of this small hospital felt they could not survive without being part of a larger entity. Nevertheless, they still feared being "gobbled up" by the system and worried about the impact on local services. To ease the transition, the system CEO and board chair spent a lot of time communicating with the local

16 B. Bader, 2004.

board, and St. Charles agreed to maintain the local board in an advisory capacity, but also made it clear that the board would have no fiduciary responsibilities.

- **WellSpan Health** (York, Pennsylvania): As noted earlier, this system formed with the coming together of two acute care hospitals, a home health/rehabilitation company, and a medical group, each with a governance structure that lost significant authority after the merger. Managing this transition successfully required ongoing communication, beginning with pre-merger discussions where expectations and philosophies were made clear.

2. Consider a "Trial Period" before Finalizing the Deal

Even with open, honest pre-merger dialogue among leaders who believe in the value of systems and more centralized governance authority, some resistance is likely to remain at the entity level even after the system forms. Local leaders may remain rightly concerned that joining a larger system could have negative implications for the local entity and the communities it serves. Consequently, these leaders may resist giving up local authority and control right away. For this reason, some newly formed systems have explicitly created a "trial period" during which the individual entities get to know and learn to trust each other. During this period, any entity can relatively easily exit the organization. For example, St. Charles originally formed as a "two-member" corporation with both a system board and member (subsidiary) boards. During the first two years, either member could pull out of the organization. In reality, however, this period served as a way to alleviate any initial hesitancy or resistance that may have remained. After experiencing the benefits of systemness and seeing the power of the combined entity, the leaders of both entities readily agreed to reincorporate as a single-member corporation under a single system board after the trial period.

3. Establish Very Clear, Written Lines of Authority

Early on, system and local leaders need to work together to clarify the specific authority and responsibility that will reside at the system and subsidiary level. The goal is to give system leaders the authority they need to run the organization as an integrated system while simultaneously leaving meaningful and valuable responsibilities at the local level that are of value to the system as a whole. Barry S. Bader, president of Bader & Associates, and Edward Kazemek, chairman and CEO of **ACCORD** LIMITED, have identified a continuum of local hospital board roles, ranging from an advisory board with no formal authority to an operating board with significant fiduciary responsibilities related to oversight and decision making. (See **Table 2**.) Most subsidiary boards will be somewhere in the middle, with fiduciary responsibility for quality/safety and medical staff credentialing, along with an advisory role with respect to strategic planning, budgeting, and other decisions (with authority for these areas resting with the system board). [17]

> As one CEO said, there should be "no apologies" about the need to act like a system and shift control, and there is no sense in "tiptoeing" around the issue in an effort to woo organizations into the system.

Table 2. Continuum of Local Hospital Board Roles

Authority of Local Hospital Board

Less ⟵ ⟶ **More**

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

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

17 B. Bader and E. Kazemek, "Subsidiary Boards: Window Dressing or Opportunity?" *Great Boards,* Vol. VII, No. 3, Fall 2007.

To aid in this process, systems should create written documents that clearly describe the roles and responsibilities of the various levels of governance, using as clear and accurate language as possible. These roles should also be communicated during new director orientations and reinforced through board education and evaluation processes.[18] Often this process will involve clarifying responsibilities within a specific area, such as quality improvement. For example, the system board will likely take responsibility for overseeing organization-wide quality improvement efforts. If so, then the document must specify the role of local boards in overseeing clinical quality within their institution in a manner consistent with system-level policy, including their role with respect to medical staff credentialing, approving investments in quality-enhancing technology, and monitoring quality/safety performance versus established benchmarks.[19] Failure to clarify these roles can create significant confusion, and potentially create legal issues if litigation were ever to occur. Language will be critical in these instances—for example, use of the term "board" can create an assumption of authority where none actually exists (if the local "board" only has advisory duties).[20]

System boards should create formal written charters for all boards/advisory bodies that clearly spell out what they are and are not responsible for overseeing, including any formal fiduciary duties.

To assist with this process, pioneering systems often create formal written charters for all boards/advisory bodies that clearly spell out what they are and are not responsible for overseeing, including any formal fiduciary duties.[21] Ascension used this approach, developing an "authority matrix" in 2002–2003 (several years after its creation through the merger of two systems) that clearly defines which authorities reside at each level of governance. THR has also successfully used this approach since 1997. Immediately after the system's formation, a multidisciplinary group of experts developed an authority matrix that clearly describes in detail the decision-making responsibilities of the various boards and committees within the system. The document provides clear guidance not only on governance-related issues, but also on operational issues such as contracting. System and subsidiary leaders refer to it on a regular basis to clarify issues related to where authority lies within the organization. The document is regularly reviewed and revised, although relatively few changes have been made with respect to governance structure and authority since 2002. The matrix has proven invaluable to the organization. For example, since 2008, it has been instrumental in allowing THR to integrate a large physician organization that has grown to over 600 employed doctors, including helping to ensure the smooth integration of 250 physicians at one time at the end of 2010. Going forward, the document will continue to benefit THR as it transitions to span the full continuum of care by integrating outpatient centers, rehabilitation facilities, long-term care facilities, home care agencies, and other organizations.

The recent Governance Institute survey suggests that many systems have attempted to clarify the responsibilities of system and subsidiary boards. In fact, roughly three-quarters of respondents with subsidiary boards indicated that they have given these boards clear responsibilities that differ from those of the system board. Another 13 percent are considering doing the same.

Ongoing Strategies to Promote Systemness and Maintain Strong System–Subsidiary Board Relations

Setting appropriate upfront expectations and clearly defining the various roles and responsibilities goes a long way in positioning an organization to operate as a true system with good relations between system and subsidiary boards. Maintaining this momentum over time, however, requires the adoption of additional strategies designed to ensure that appropriate communication takes place on a regular basis. This section reviews nine specific strategies being used by pioneering systems to maintain strong system-subsidiary board relations over time.

1. Regularly Bring Local and System Boards Together

Most pioneering health systems bring the members of their various boards together regularly to build and maintain personal relationships and to review and clarify the respective responsibilities of the boards.[22] These gatherings can be an effective means of building systemness and ensuring smooth system–subsidiary board relations. Often CEOs, other administrative leaders, and physician leaders at the system and subsidiary level attend these sessions as well. The need for such regular gatherings becomes particularly important in the early stages of system development. In many instances, members of the various boards may not have spent much time with one another (and in some cases may not have even met) before formation of the system. Hence these gatherings serve as a way for the various levels of governance and senior leadership to get to know and trust one another, and to discuss issues and challenges related to operating and acting more like a system. Examples of how various systems periodically bring their boards together include:

- **EMHS**: Eastern Maine Healthcare Systems developed a "council of chairs" made up of board chairs, vice chairs, and chief executives from each of the organizations within the system. This council meets four times a year to discuss governance strategy throughout the system. The CEO and system board chair also host an annual summit for directors from throughout the system where the CEO gives a "state of the system" address and the chair leads a day-long program featuring both EMHS and national presenters. At the operational level, EMHS has set up a parallel structure, using "affinity" groups to aid with system-wide planning. For example, CFOs from all subsidiary organizations come together as the finance affinity group to drive the budgeting process.
- **THR**: At THR, 340 directors from across the system come together every September to focus on strategic, quality, and national issues; this three-day forum gives local board members an opportunity to provide input to system leaders, including clinical leaders and

18 B. Bader and E. Kazemek, 2007.
19 R. Killian, "Health System Governance: The Work of the Board," *Boardroom Press,* The Governance Institute, February 2008.
20 E. Lister, 2010.
21 E. Lister, 2010.
22 E. Lister, 2010.

senior executives. In March, the system-level board gets together with senior executives, entity presidents, and the local entity board chairs for one-and-a-half days to focus on strategy, with the goal of creating local ownership for system-level issues and priorities.

- **WellSpan**: WellSpan hosts an annual several-day retreat that brings together board members from every level, along with physician leaders and management. At the local level, CEOs hold confidential meetings with the local board's officers each month, giving them an opportunity to talk about sensitive issues not appropriate for a full board meeting.
- **Ascension**: Every two years, Ascension holds a convocation in which 800 individuals—including system board members, system leaders, local board members, and corporate members—spend several days together reviewing the organization's progress and celebrating successes. During this gathering, local board members, system board members, and the system CEO come together to discuss specific issues. Ascension also hosts regional governance meetings twice a year in each of five different cities, with local board members in the region coming together to discuss strategic and other important issues. At least one system board member attends each regional meeting. These meetings proved to be very effective in the system's early years by providing an open forum to discuss controversial issues and decisions, and by allowing members of various boards to get to know one another. Finally, once a year local board chairs and local CEOs meet with the system CEO and board chair to discuss governance and other issues.

For some health systems, the bringing together of various board members over a period of time becomes the primary vehicle for hastening the transition from a "federation" model to more centralized governance. For example, in 2005, Conemaugh Health System in Pennsylvania completed its last acquisition of a hospital, making it a four-hospital system. At the time, Conemaugh's governance structure followed a classic holding company model, with each subsidiary (the four hospitals plus several other organizations) having a board and each board having veto power from a finance and strategy perspective. As the CEO noted, "six to one represented a tie vote, as any individual organization could hold the entire system back." To address this situation, Conemaugh brought in an outside consultant to help transition the organization to more centralized governance. This process required a series of retreats, with discussions focused on the benefits of being a system and what it means from a governance and operational perspective to act like a system. At the first meeting (attended by 120 different board members), a resounding majority expressed concerns that the organization acted more like a federation than a system. At subsequent retreats, board members got to know each other (many had not met before, even though the system had existed for a number of years), with members breaking into groups to discuss where the organization was today and where it should go in the future. To facilitate the process, an *ad hoc* governance committee reviewed bylaws and got buy-in from key stakeholders. As part of this process, the consultant also established principles for system-wide governance as a vehicle to promote organizational strength, synergy, and growth. The entire process took nearly two years, with the CEO and system board members spending a tremendous amount of time and effort communicating the benefits of systemness.

The need for communication and regular retreats did not end after the transition to centralized authority had been executed. In fact, the three local hospital boards continued to come together on a quarterly basis to get a sense of what it meant to work together on system-wide issues. As confidence grew, attendance at these sessions dropped off. To this day, however, Conemaugh continues to use regular retreats as a vehicle for promoting systemness. While control over strategic planning and budgeting now clearly resides with the system board, Conemaugh's strategic planning process relies on a series of retreats over a three-month period (January to March) to gather input from strategic management teams at the local level. The system's senior leadership team also holds a monthly off-site retreat where board members and local management teams discuss how system-wide planning issues affect local entities, with adjustments made to these plans as needed.

> "Holding a few more meetings and taking a little more time won't matter in the long run. You need to give local leaders the latitude they need, and let them see how the system works over time. Don't take away this crutch on the journey to systemness."
>
> *—Scott A. Becker, FACHE, CEO, Conemaugh Health System*

2. Have System Leaders Attend Subsidiary Board Meetings (and Vice Versa)

One common strategy used by pioneering systems is to have system-level administrative and board leaders regularly attend subsidiary board meetings, thus providing a visible reminder of the local entity's role within the larger system. Many systems also invite local leaders to attend system board meetings. For example:

- **THR**: The senior executive vice president for system alignment and performance and at least one representative from the system governance team attend all board meetings of each entity. In addition, the system board chair and CEO attend at least one board meeting of each subsidiary organization during the year.
- **EMHS**: While local organizations approve their own strategic plans, the system CEO attends all local board meetings and has voting rights on most of the subsidiary boards, allowing her to influence the process if the local board's strategic plan seems to be deviating from system-wide goals.
- **St. Charles**: The system CEO attends every local board meeting. In addition, the CEO and medical staff president of each hospital prepare a regular report for the system board and attend all system board meetings.
- **WellSpan**: To keep physicians engaged, the system board invites the chairperson of the medical group board to attend its meetings, and invites private practice and employed physicians to be members of the board-level committees. The goal is to assure physicians that their point of view will be represented at the table.

- **Ascension**: As noted, system board members always attend regional meetings that bring together the local boards within a geographic region. In addition, system leaders and board members regularly attend as many local board meetings and retreats as they can.

3. Let Local Boards Decide Their Own Outcome

Several pioneering systems have adopted the explicit strategy of not actively removing local boards, but rather letting them come to the conclusion, over time, to remove themselves *if appropriate*. As long as relative responsibilities and authorities have been clearly and appropriately spelled out, there is likely no benefit for a system-level board to decide unilaterally to terminate a local board, as such a decision could create significant animosity and anxiety at the local level.

For example, at the completion of the lengthy process described earlier, the boards of three of the four hospitals and the physician board took a formal vote where they relinquished complete economic and strategic control to the system, essentially voting themselves out of existence. (As of July 1, 2011, Conemaugh now has only a system-level board and a single hospital board overseeing the three facilities.) They did this because they now clearly understood the benefits of being part of a centralized system, and recognized that they no longer needed to operate as a board with fiduciary responsibilities. Letting them come to this realization over time made for a very smooth transition.

Several systems continue to rely on this strategy, believing that, over time, local boards will begin to recognize the need for some consolidation. THR's leaders expect that this may play out as the organization seeks to become an integrated system that spans the full continuum of care. Leaders hope to move away from entity-centric local boards and instead evolve into regional boards that oversee an integrated provider system serving natural geographic markets.

4. Consider Forcing an "In-or-Out" Vote at the Appropriate Time

While systems need to give local board members and leaders adequate time to recognize and appreciate the benefits of systemness, at some point there may be a need to force an "in-or-out" vote. As noted earlier, St. Charles set up an explicit two-year trial period after which the two hospitals had to decide whether to remain with the system and reincorporate as a single entity. The two-year period made the decision uneventful, as both hospitals readily agreed to do so.

Sometimes, however, despite the best efforts, a local board may not be willing to make the concessions necessary to allow the system-level board to do its job effectively. If a board is not willing to do that, it may be best at some point to make them hold an "in-or-out" vote. For example, as noted earlier, three of the four hospitals that made up Conemaugh Health System readily agreed to give complete economic and strategic control to the system board. However, the board of the fourth hospital did not, voting to leave the system and remain an independent entity. System leaders decided to force the vote once they realized that no amount of additional time or effort would change the minds of local board members. They knew the outcome before the vote occurred, but felt the system would be better off letting the hospital go than facing continued local resistance to the difficult system-level decisions that needed to be made to ensure the organization's future. The decision appears to be the right one, as Conemaugh recently turned in its most prosperous year ever, while the hospital that left the system seems to be struggling.

5. Look for and Cultivate "System Thinking" in New Directors and Administrators

Many systems inherit and/or initially embrace the idea of having "representative" boards at the system level, with designated slots for representatives of particular entities, including hospitals and physician groups. Such an approach, however, runs counter to operating like a system, causing forward-thinking organizations to relatively quickly abandon the representational approach. Instead, these organizations look for explicit competencies and skills when replacing directors, including but not limited to the ability to think at a systems level. For example, EMHS changed its model in choosing system board members. Subsidiaries no longer have a designated number of seats on the system board, which is increasingly made up of individuals with no current affiliate board appointment. System board seats are now filled based on needed competencies and skill sets, consistent with the strategic plan. Because the system covers such a wide geographic area, the system board tends to have natural geographic diversity that prevents excessive focus on the market around the system's headquarters. However, no explicit formula exists to ensure a certain number of seats from each geographic area. Similarly, at St. Charles, system board members are chosen based not on the entity they represent, but rather on their talent.

The same approach is often used to replace administrators at the local level. For example, the EMHS system board has explicitly targeted individuals with system-level experience and perspectives when searching to fill local CEO openings that have come about due to natural turnover.

In addition to looking for the right people, effective systems also put in place orientation and training programs that reinforce system thinking, with the goal of ensuring alignment between boards' responsibilities and the knowledge and skills of directors. For example, all new St. Charles board members tour each of the system's facilities, which helps them understand these entities and how decisions made at the system level might affect them. At Ascension, every new system-level and local director spends two half days at the system's headquarters in St. Louis, where they meet the senior leadership team and get indoctrinated into Ascension Health, with the goal of providing a clear understanding of how they and their local facilities fit into the system.

6. Standardize Board Structure and Processes

One of the most effective strategies for promoting systemness and ensuring smooth system–subsidiary board relationships is to standardize as much as possible across all levels of governance, including board size and term length; board bylaws; director nomination

and induction processes; director training; meeting agendas and the structure of meeting minutes; committee structures (including charters and operating processes); compliance and risk management policies and processes; reporting on quality/safety, financial, and strategic planning issues; board self-evaluation processes; and the role of the board in evaluating local CEOs.[23, 24]

The Governance Institute survey suggests that some organizations have standardized key processes, as outlined below:

- **Committee structures**: Half of respondents with subsidiary board committees have standardized their structures, with another 15 percent contemplating this action.
- **Bylaws**: Nearly six in 10 respondents (58 percent) have standardized hospital and medical staff bylaws across the system, with another 19 percent considering such action.
- **Board agendas and minutes**: Just over 60 percent of respondents with subsidiary boards have standardized their meeting agendas and processes for writing board minutes, with an additional 7 percent considering such action.

For example, at THR, every board within the organization is the same size (11 members); has the same bylaws and articles of incorporation; uses the same agenda, annual self-assessment process, and planning processes; and undergoes the same robust orientation program that focuses on system-level issues. Similarly, at Ascension, all boards have the same set of model bylaws and must have between nine and 15 members. At EMHS, boards evaluate senior executives from across the organization using a standardized performance management process and tools. EMHS has also begun to use the same reporting formats across all boards, including the same balanced scorecard, financial reports, and strategic formats. Local entity performance and strategic plans are shown side-by-side with those of the entire system. Another example comes from Community Health Partners, which presents all budgets in rolled-up formats; frames individual facility strategies within the context of the larger, system-wide strategy; and sets goals and performance targets at the individual facility level in accordance with those system-wide goals.[25]

7. Develop and Regularly Use Multiple Communication Vehicles

Maintaining good system–subsidiary board relations and keeping local board members engaged and enthusiastic requires constant attention. In addition to the regular, formal retreats outlined earlier, the best systems use a variety of communication vehicles to keep directors from throughout the organization informed, with communications focusing on system-wide issues and emphasizing both the benefits of systemness and the important role that local entities play in achieving those benefits. Communications often emphasize benefits that local board members may not fully appreciate, including potential economies of scale, branding advantages, enhanced access to capital, better negotiating leverage with payers, etc. They also remind subsidiaries why they may need to relinquish authority to achieve such benefits, including the need to eliminate clinical and operational redundancies and competition across facilities. At the same time, these communications also need to emphasize the importance of those responsibilities that remain at the local level, such as oversight of quality and patient safety and meeting local community needs.[26] Several examples of the ongoing communication strategies used by pioneering systems include:

- **EMHS**: EMHS created a system-wide board portal, which provides a vehicle for electronic communications that go out to all board members at every level on issues of interest to the entire system.
- **THR**: THR developed a Web portal for directors, along with a monthly electronic and quarterly paper-based newsletter that goes out to all directors. These communications focus on system-level strategies and other relevant information for the system as a whole. THR also uses email and fax messages to communicate time-sensitive information that requires transmission within 24 to 48 hours to directors.
- **Ascension**: Ascension sends out synopses of every system board meeting to all local ministries to be shared with the local board. Ascension also uses The Governance Institute's board portal to facilitate communication across its various boards.

> The respective responsibilities of system and local boards should not be fixed. Instead, they can and should change based on changes in the environment.

8. Make Evaluating System–Subsidiary Relations Part of the Annual Assessment Process

Virtually all systems have a regular process in place to evaluate the performance of its various boards and individual directors. Often this process relies on self-assessments, with directors using any of a number of tools to assess their own performance and that of the overall board on which they serve. Historically, these assessments have not focused much on 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. During the aforementioned health system invitational in April 2011, a small group of system CEOs and directors came together to discuss The Governance Institute's board self-assessment tool. Based on that conversation, The Governance Institute developed and tested questions that were ultimately used to create a new, system-specific assessment tool as a way to make subsidiary–board relations a formal part of the annual self-assessment process. This information will assist system leaders in identifying and addressing problems in a timely manner.

23 E. Lister, 2010.
24 B. Bader et al., October 2008.
25 B. Bader, 2004.
26 B. Bader and E. Kazemek, 2007.

9. Never Rest: Constantly Reevaluate and Confirm Structure

As with most quality improvement processes, maintaining and improving system–subsidiary board relations requires constant reevaluation. To that end, system leaders should periodically review and question the structure of governance to ensure that it remains clearly defined, continues to support the organization's mission, and avoids unnecessary redundancies and complexities.[27] They should also regularly confirm that every board understands its responsibilities and duties.[28] However, the respective responsibilities of system and local boards should not be fixed. Instead, they can and should change based on changes in the environment.[29] As the previous case examples make clear, systems seldom reach their desired "end game" with respect to governance structure right away—in fact, the appropriate end game may not even be clear. The leaders of every organization interviewed for this paper periodically review their governance structure and assess the need for change. While few see a need to radically alter things, they do expect to "fine-tune" their governance structures on a periodic basis as changes in the healthcare landscape dictate.

> "You can't remain stagnant with your governance; you can't do the same thing year after year. Rather, governance needs to be flexible, pliable, and forward-thinking."
>
> *—Douglas D. Hawthorne, FACHE, CEO, Texas Health Resources*

27 E. Lister, 2010.
28 E. Lister, 2010.
29 R. Killian, 2008.

Conclusion

Health system leaders need to react quickly to the many pressures facing their organizations, including federal healthcare reform legislation and market-driven pressures to rein in costs and improve quality of care and population health status. Such external pressures are not new to healthcare leaders, but their intensity has accelerated in recent years, and created an acute need to streamline processes and procedures through all levels of the organization. Health system success in such an environment will not be possible without a governance structure that allows for quick decisions and action.

The transition from a holding company to an operating company model of governance will be an important step for many systems to gain, maintain, or enhance their ability to respond to such external pressures. Health systems must take care to move effectively along the systemness continuum without creating resentment or undermining effectiveness, especially at the local level.

Not every system needs to move to the opposite end of the continuum (an operating company with virtually all control centralized). Additionally, those that do should do so over time as dictated by the environment. System leaders need to consider a variety of factors when determining where to reside on the continuum and how quickly to move towards this goal, including geographical spread and market distinctiveness, the need for local directors to remain engaged, state law, and the diversity and complexity of entities within the system.

Ideally, the transition is planned early, with the groundwork being laid even before the system forms and continuing over time. Organizations in this position can employ specific strategies and tactics at this stage, including emphasizing the benefits of systemness and making expectations clear upfront, considering a "trial period" before finalizing the deal, and establishing clear, written lines of authority.

Maintaining this momentum as the system is transitioning over time requires additional strategies designed to ensure that appropriate communication takes place on a regular basis, including regular meetings of the local and system boards together, cross-attendance at board meetings, cultivating "system" thinking in new directors and administrators, and developing multiple communication vehicles. Finally, the most important strategies include evaluating system–subsidiary board relations on a regular basis, and continuously reevaluating and confirming that the system and subsidiary governance structure is appropriate and effective (and changes as the organization's needs change over time).

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