System Focus
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Restoring Governance Alignment within a Health System

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There are two great forces in the universe: momentum and inertia. Momentum causes difficulty in changing the direction and speed of an object once in motion. Inertia causes difficulty in starting motion of an object that is at rest.

Ironically, in opposition these two forces can keep health system boards from being as fully aligned as they could and should be. How? Since most systems were formed via mergers, acquisitions, or other consolidations of existing hospitals—each of which had a board with its own understanding of its own role and function—misalignment often reflects the existing momentum of local boards plus inertia at the parent level to assume responsibilities in critical areas such as quality, strategy, credentialing standards, and occasionally even finance. Numerous articles have been published on addressing the root causes of parent–subsidiary dysfunction[1] and on the future of hospital subsidiary boards.[2] This article focuses on common examples of governance misalignment that have created barriers to high system performance. We also include a recent case study that highlights what one regional health system did to realign its governance model and how it learned to overcome misdirected momentum and inertia.

Barriers to High Systemwide Performance: Lack of Governance Alignment

Exhibit 1 on the following page, presents common symptoms of governance misalignment that create barriers to providing consistent performance and value in all sites of care and markets served. These illustrative examples have been compiled from a decade of real-life experience working with multi-state, regional, and local health systems. They are provided to stimulate your own thinking about typical problems and what can be done to restore governance alignment to address them.

Intentional Governance Realignment at Central Maine Healthcare

Central Maine Healthcare (CMHC) was established in the early 1980s as the parent corporation of 250-bed Central Maine Medical Center, located in Lewiston, Maine. In 1999, two smaller rural hospitals merged with CMHC. Today, CMHC is an integrated healthcare delivery system, serving a region of 400,000 people through its one flagship medical center; two rural, critical access hospitals; and an extensive variety of primary and specialty care practices located in 15 communities.

Through 2015, the system operated more like a network than a fully integrated delivery system. Each CMHC hospital maintained a fiduciary board, primarily populated by individuals with long histories on the local board. Within the powers reserved to the parent, the hospital boards generally continued to function as they historically had done. Oversight of individual entity financial and quality performance was their primary focus. There was limited awareness of, and little interest in, sharing best practices. Instead of a common focus on high performance across all locations, the "our market is different" belief inhibited collaboration and sharing of best practices.

With a system-level leadership change in 2016, the CMHC board embarked on a journey to strategically and financially reposition the system—through "quick win" margin improvements, business reconfiguration/growth strategies, and clinical redesign. Interviews with local and system board leaders immediately revealed that, to accomplish these objectives, board members felt they needed more clarity about "who does what" at each board level as well as greater alignment between and among myriad boards.

The Process

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1 Michael Peregrine, "Addressing the Root Causes of Parent–Subsidiary Dysfunction," E-Briefings, The Governance Institute, September 2017.

2 Marian Jennings, "To Be or Not to Be: The Future of Subsidiary Hospital Boards," System Focus, The Governance Institute, May 2018.

Exhibit 1: Examples of Governance Misalignment Symptoms and Solutions

The Problem	The Diagnosis	The Solution
• In hiring a new hospital president, the local board is distressed to learn that, while the board will have input, they will not determine who is hired nor will they set performance expectations for the new president. • The local board feels selection of a president is one of the most critical decisions a fiduciary board makes. At the last board meeting, members made their disapproval clear to the system representative on the board.	• The system has moved to an "operating company" management model, in which the local president is selected by the system COO with input from the local board; and the VPs of finance, quality, HR, and compliance have dual reporting relationships to the local president and their functional system SVP. • However, the governance model remains essentially a parent holding company model with fiduciary subsidiary hospital boards.	• Better align the management model and the governance model. They need to be synchronized. • Consider restructuring governance to either a mirror board structure or a model with local advisory boards rather than fiduciary boards. • Conduct a "refresher" for this and other hospital boards related to the roles, responsibilities, and authorities of local boards, the system board, and system management.
• The health system has established systemwide goals for its value positioning (quality, access, consumer experience, cost-effectiveness, and safety) but year after year fails to achieve its targets. • The system wants to launch a major branding campaign with a "brand promise" but realizes that it cannot do this unless there is a consistent value proposition across the entire enterprise.	• While the system sets overall value-related objectives, each hospital maintains its own board quality committee, and each has its charter and local priorities for focus. • There is resistance to sharing best practices ("not invented here" syndrome). • System management provides data on variability of quality, safety, service, access, and cost-effectiveness, but the local board/quality committee believes that "our patients are different … and the system's targets are not relevant or are unreasonably high."	• Recruit system board member(s) with reliability science and/or performance improvement expertise. • Establish a strong system-level board quality and value committee, including chairs of local quality and value committees. Make explicit in the charter its roles in recommending systemwide objectives, sharing best practices, and reducing unexplained variability. • Intentionally use the system-level committee charter as the basis for a common charter for all local quality and value committees; synchronize their education and annual committee work plans.
• A hospital board refuses to approve and recommend an annual budget that conforms to system guidelines/financial targets. Instead, it approves its "own" budget with a projected operating loss and expects to build this lower expectation into the CEO's performance expectations. • Accepting this approach would result in lower-than-acceptable system performance.	• The system establishes financial guidelines/targets for each local hospital and expects management to present this budget for "recommendation" per the governance authorities matrix. • The local board rejects this "top-down" budgeting approach.	• The system board should clarify the role(s) of local hospital boards in the budget approval process and ensure that the local board spends its time more constructively on financial oversight aligned to system objectives. • *If* a local finance committee is maintained, its annual objectives should be directly tied to the system's annual objectives.
• Local board members still refer to themselves as "we" and the system board as "they"—as in, "We know what we should be doing but they wouldn't let us." • It is difficult, if not impossible, for the system to be high performing if subsidiary boards do not feel they are part of a unified governance model, all contributing to system success.	• Local board is continuing its momentum from days of its independence.	• Intentionally increase communications to and from the system board and the local boards, using management as the core communications linkage. Examples include: create a system newsletter that is shared at each local board meeting; start each local board meeting with a system executive update; conclude each meeting with "what, if anything, do we want communicated to the system board from today's meeting?"
• Each local hospital board has formal representation on the system board. The individual sees his/her primary role is to advocate for the local hospital/to "protect" the local hospital from system initiatives/decisions (e.g., consolidation of a service). • Valuing consensus, the system board does not take actions that cause discomfort for one or more board members so controversial decisions are deferred.	• Often an artifact of the merger/affiliation agreement, where the local community wanted assurance that its voice would be heard. • Typically, boards value consensus—and believe it requires everyone to agree—over their own voting requirements where normally a majority vote suffices.	• Move to a competency-based system board, while encouraging a mix of individuals who reflect the diversity of the communities served. • Encourage highly qualified local board members to serve on system-level committees.
• A physician was refused credentials at one system hospital but accepted on the medical staff of another. A system board member asks "Why the inconsistency? Do we really want different standards at different hospitals?"	• Credentialing is done separately by each hospital board, based upon recommendations from the local medical staff.	• To enhance one standard of care, the system should establish a common set of credentialing standards to be used by all hospitals/entities performing credentialing. (Privileging may vary by hospital.)

Note: The examples provided above are unrelated to the Central Maine Healthcare case study. They have been compiled by M. Jennings Consulting from our experience with other healthcare systems across the U.S.

Before any redesign work started, CMHC convened board members from every entity for a half-day retreat, which included education on emerging system governance best practices and a facilitated discussion. Leaders articulated:

- Their strategic aspirations for CMHC (one such aspiration was "to strengthen our culture to preserve and enhance employee morale")
- What they felt were the pressures for CMHC to change governance
- What principles should be used to evaluate alternative approaches (for example, one design principle that emerged was to "foster a 'one CMHC' culture focused on delivering high-quality, safe, and cost-effective care everywhere in our system")

An *ad hoc* work group, including the board chairs from each hospital, the system board chair and vice chair, the system CEO, and the hospital presidents, met seven times over an eight- month period to develop recommendations to realign governance processes, structures, and expectations. They also participated in three retreats involving all board members: the orientation session; a key touch-base when recommendations began to emerge; and a launch for the new model. Importantly, members of this group also served as ambassadors to their local hospital boards and provided invaluable input and feedback to the work group.

Throughout the process, CMHC adhered to a set of guidelines, which helped leadership successfully align governance across the organization (see sidebar, "Keys to Success: Restoring Governance Alignment").

Current State

Although CMHC launched its new governance model just six months ago, the streamlined and realigned governance model already has shown tangible benefits:

- System-level committees have new life: They have spearheaded and accelerated progress on all three 2016 objectives: "quick win" margin improvements, business reconfiguration/growth strategies, and clinical redesign. For example, CMHC accelerated its move to "one standard of care," demonstrated reductions in variations in care processes and outcomes, and implemented a common approach to credentialing.
- The committees are using annual work plans, coordinating their efforts, and structuring their agendas to allow for generative, future-oriented discussions along with oversight. Importantly, the quality, finance, and compliance committees, by charter, must include individuals from all of the hospitals' service areas.
- Greater focus on community health and wellness: With local community health boards now in place, CMHC's governance focuses more intentionally on improving community health.
- Systemwide strategic thinking: Strategic decisions—whether entering new markets or adding/expanding/closing a service—now are made in the context of "how this impacts the overall system," rather than focusing solely or primarily on the impact on an individual hospital/entity.
- Proactive governance development: CMHC's executive committee, which has assumed governance

Keys to Success: Restoring Governance Alignment

- The chair of the system board must want to drive realignment efforts.
- At the outset, establish "why"' governance needs to change before you start talking about "how" (e.g., models, reserved powers, process changes, bylaws changes, etc.).
- Take the time needed to engage all constituents from the very beginning. Involve representatives from across the system in kicking off the process, identifying guiding principles, and articulating different options to be considered to enhance alignment.
- Create an *ad hoc* group of board leaders representing all constituents with a clear charge; "plan the work and work the plan."
- Be transparent about the work. Provide frequent updates through written and verbal progress reports—and solicit feedback and input every step of the way.
- Do not rush the process, but do not let it drag on endlessly.
- Beware of "allowing the party least willing to change to dictate the pace of change."
- Develop clear and complementary system/subsidiary governance roles and responsibilities in place of unproductive, repetitive decision-making—and codify these in an updated governance authorities matrix.
- Create an annual system board calendar and ensure that subsidiary boards' work is synchronized to the overall calendar.
- Discourage local/hospital boards from maintaining committees that duplicate efforts of system/parent board committees.
- Encourage local/hospital boards to bring in new members who will perform today's governance roles without the natural tendency to default to "what we always have done."
- Expect that members of local/hospital boards may feel a sense of loss when they move away from traditional roles they played, with dedication and passion, for years.
- Communicate, communicate, communicate. Then communicate some more.

committee responsibilities, is actively involved in board and officer succession planning, has a renewed focus on governance education and development, and has utilized competency-based recruiting approaches in identifying its newest board members.

- More effective system leadership team: The CMHC executive team has benefited from having a more empowered system board and system-level committees with which to work, especially when making critical, time-sensitive decisions.

Despite the successes, the transition has not always been easy, especially for former hospital board members struggling with feelings of loss as they assume new roles focused on enhancing community health. Many spent years or decades focused on providing oversight of the hospital's financial and quality performance: roles now filled by the system board and system executives. Their desire to see their local hospitals remain strong is undiminished—but while their "minds" are fine with letting go of traditional roles and assuming new ones, their "hearts" still feel a strong tug from their traditional hospital-centric roles. This is to be expected, and system leaders are focused on ensuring that local governance is meaningful work by providing education, coordinating efforts among local boards, moving local meetings to ambulatory and other non-hospital sites, and changing agendas.

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While CMHC continues its governance realignment journey, the system board clearly has overcome its historical inertia, has a focused new direction, and is gaining speed (accelerating momentum). Local boards are redirecting their momentum toward a broader definition of community health and wellness. Combined, the momentum will help the system meet head-on the challenges of the fast-changing market and provide the agility needed to capitalize on opportunities.

The Governance Institute thanks Marian C. Jennings, President, M. Jennings Consulting Inc., and Governance Institute Advisor, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com.