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Enhancing Governance at Academic Medical Centers: If You've Seen One, You've (Probably) Seen One

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The popular phrase, "If you've seen one, you've seen them all" has often been modified when used to describe governance within academic medical centers (AMCs). Most governance experts today would *instead* say, "If you've seen one, you've seen *one*."

This opinion was recently substantiated by research conducted on behalf of an AMC that was interested in learning about best practice governance structures utilized by its peers. One of the results of that study was a surprising lack of consistency regarding the use of governance structures within AMCs across the United States.

Key Board Takeaways

Boards within AMCs should, at a minimum, ask themselves the following questions to determine whether it is time to enhance their governance efficiency and effectiveness:

1. Are our boards talking about the future performance of the entire AMC or are we primarily focused on the current challenges of individual entities?
2. Do board members view themselves as advocates for their constituents or for the best interests of the mission of the entire organization?
3. Would our various board members describe the roles and duties of their boards and others in the system in a basically consistent manner?
4. The focus on population health and value-based payments and patients' increased expectations of integrated care will continue to blur the lines of care historically provided by physician groups and hospitals as well as pre- and post-acute care providers. Is our governance structure and board composition well positioned for this environment?

Varying Legal, Corporate, and Governance Structures

There was a wide range of approaches to the corporate, legal, and governance structures for AMCs' three key entities—i.e., university/medical school, health system/hospital(s), and faculty practice. Some examples of the various corporate structures utilized by AMCs include, but are not limited to, the following:

- Three totally separate, parallel corporations with separate boards for each of the three key entities (connected by legal contracts/agreements)
- Two corporations and boards that are separate and parallel where the third is a subsidiary corporation (with its own board)
- One parent corporation (and board) with all the other entities as subsidiary corporations, each with its own board
- All three entities within one corporation with one board

Faculty Practice Corporate Structure Variation

One area that is most in flux is the corporate and governance structure for the faculty practice (i.e., the employed physicians group that serves as faculty to the medical school and provides clinical care). In many cases, the faculty practice is a separate corporation with its own board, but in more recent scenarios, the faculty practice corporation (and board) have been integrated into one of the other corporations. For example, one midwestern health system created an "all in" clinical enterprise approach where the previously separate faculty practice corporation (and board) has been consolidated into the health system/hospital corporation and its board. The university and its medical school stayed in a separate, parallel corporation. The main reason for this change was to increase the

delivery system's ability to function as an integrated organization.

An even more forward-thinking approach is used by Rush University Medical Center (RUMC) in Illinois. From its inception, Rush has used an integrated approach to its multiple missions of healthcare delivery, research, and education. There is one parent corporation and board that oversees the hospitals, university/medical school, and faculty. (*Note:* RUMC has subsequently become a subsidiary of the Rush System corporation and its board, but the RUMC board retains a committee called the Rush University Board of Governors.)

Board Composition Differences

Another area in which the governance of AMCs varies widely is the size and composition of their boards. AMC boards are often relatively large and highly "representational"; in other words, certain board seats are reserved for specific types of people. One health system board surveyed had 22 seats, 18 of which were "earmarked" (e.g., one for the CEO of the health system, one for the dean of the medical school, two for university board members, four for individuals from specific parts of the state, one for the governor or his/her appointee, etc.). The remaining four seats could be filled by the board itself.

The original intent of this approach was to ensure enough linkages and information flow among the key parties. And, candidly, the university had wanted to retain control of the health system and its assets. However, this representational approach to board composition created many problems. For starters, it resulted in a board that was too large for effective group dynamics. With so many people in the room, some board members did not speak up whereas others dominated the discussions.

In addition, some of the individuals occupying the various seats were there because of their role; they had not been selected to provide specific expertise. Some of these board members felt that they were on the board primarily to advocate for the entity they were "representing." They did not all understand their legal obligation to be stewards of the mission of the *whole* system.

Another challenge is that there were not enough seats left on the board to add all the skills, competencies, and perspectives needed to oversee the complex organization.

A related AMC practice is to have overlapping board memberships. For instance, the chair of the university board might also sit on the health system board to ensure sufficient representation and information flow. However, this situation can create inherent dualities of interest that are difficult to manage.

By contrast, another AMC recently revisited the size and composition of its board to ensure that it had no more than 15 members, and that all of them were selected based on an updated skills and competencies matrix. This approach is more consistent with advanced governance practices.

Increased Oversight of Research

Some AMC boards are concerned that they are not providing enough oversight of the research part of their mission. This is often the case when most of the directors are community members and clinicians. To provide more focus on this area, an emerging best practice is to create a research committee of the parent board and to add national as well as local researchers to that committee. This practice can elevate the board's ability to provide needed oversight of this important component of an AMC.

Ownership Realities

One reason for the different legal structures and varying board composition approaches is the variety of ownership models for AMCs. Some AMCs are public/governmental organizations, whereas others are private, 501(c)(3) not-for-profit corporations. Governmental entities must often remain in existence according to their "organizing documents" whereas most likely, 501(c)(3) corporations have more flexibility regarding their corporate structures. Therefore, many 501(c)(3) AMCs have been able to become more efficient by combining corporations and boards. This option may not be easily available to public boards, which might have to secure approval for the elimination of corporations from the state government.

AMC boards that are serious about ensuring their governance supports their organizations' multiple missions should dedicate time to discussing what, if any, changes they could make to their governance structures and practices to ensure they provide the best support possible.

Governance Best Practices

There are many advanced governance practices that can be used regardless of an AMC's ownership, governance structure, or board composition. High-performing AMC boards explore the following governance practices to improve their own effectiveness and efficiency and to increase communication and integration among their entities. These best practices include:

- Streamlined corporate, legal, and governance structures (where possible)
- Streamlined and integrated committee structures, with common charters
- Right-sized boards and committees (where possible)
- Competency-based board and committee composition (to the extent possible)
- Written board member and officer position descriptions
- Clear governance authority matrix
- Common governance orientation and continuing education
- Consistent, updated governance policies and procedures (e.g., conflict-of-interest and independence policies)

Conclusion

AMC boards that are serious about ensuring their governance supports their organizations' multiple missions should dedicate time to discussing what, if any, changes they could make to their governance structures and practices to ensure they provide the best support possible. The "Key Board Takeaways" sidebar includes some questions that could be part of that conversation.

Hopefully, the next time an academic medical center study is conducted, there will be more consistency across the country regarding the utilization of governance best practices.

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