GOOD GOVERNANCE CASE STUDY

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Restructuring Governance for the New Healthcare Environment:

The Evolution of System Governance and Development of Best Practices

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Restructuring Governance for the New Healthcare Environment:

The Evolution of System Governance and Development of Best Practices

America's health systems are currently in the midst of transforming themselves from "holding companies" of individual hospitals largely functioning independently of each other to more integrated models of care. The ultimate aim for most systems is to realize the benefits of working together in a streamlined and cohesive manner, reducing or eliminating duplication of services, streamlining layers of operations, and standardizing care processes and procedures to improve quality and lower costs. This process, when fully realized, will ultimately put health systems in a stronger position to achieve the Triple Aim[1] and deliver value-based care.

Some current objectives of health systems in transforming to an integrated model of care include:

- Delivery of team care through interdisciplinary clinical collaborations
- Standardization of clinical service line strategies
- Minimization of ineffective clinical process variation
- Expansion of financial risk strategies with payers while building competencies for success in this regard
- Creation of capital asset efficiency and aggressive cost reduction
- Economically productive geographic expansion
- Optimization of patient/customer access
- Electronic "wiring" of the system, including direct connections to patients
- Realignment of internal operating incentives through new compensation models
- Attention to the development of informatics capacities
- Development of longer-term approaches to workforce planning
- Creation of a more positive, supportive, and engaged work environment
- Creation of capabilities and capacity to innovate in order to address business disruption and remain competitive in the marketplace

Any one of these objectives is a complex endeavor, and that complexity increases exponentially when trying to pull them all off simultaneously. But many health systems fail to accomplish their goals not because they are so operationally complex, but because they do not have the right pieces in place at the governance level.

The many mergers and consolidations that have taken place over the last 15 years generally have not created the level of integration systems need to achieve these critical goals. Rather, in many cases we have seen it create the opposite—large, unwieldy

1 The Triple Aim is a framework developed by the Institute for Healthcare Improvement to optimize health system performance through the simultaneous pursuit of three dimensions: improving the patient experience, improving the health of populations, and reducing the per capita cost of care. Learn more at www.ihi.org/tripleaim.

organizations in various stages of flux and growth, many involving merger deals that include keeping the management and boards of the systems being merged in place for a period of time, in order to ease the change of ownership transition. This means more boards and more layers of complexity, substantially slowing down the decision-making process and delaying systems acting like a single organism. To combat this, systems are now in various stages along an evolutionary journey—depending on how long ago, how they became systems, and how they have grown over time—to rebuild and integrate the individual moving parts so that they can all move in the same direction.

In order to do this, the first and most important step is restructuring governance to enhance "systemness," a concept The Governance Institute developed in a 2005 white paper describing a new corporate governance model to facilitate an organization's ability to "look and act more like a single, integrated organization rather than a collection of independently functioning pieces." The concept and definition include:

- A shifting of decision-making responsibility and authority away from the subsidiary operating units to the corporate level
- Centralization and/or standardization of key management systems and processes[2]

In 2005, the holding company—operating company spectrum looked like this:

Holding Company

- Goal-setting, oversight, and decision making are decentralized
- Local boards retain significant fiduciary authority and responsibility
- Parent has limited reserved powers or rarely exercises them
- Parent board composition often based on representational governance
- Local executives have considerable power
- Little standardization of or centralization of key business functions; few or no platforms to share best practices
- Very lean corporate staff
- Common to have large and multiple boards composed of stakeholders
- Governance processes can be cumbersome because of desire to involve man stakeholders and achieve consensus
- High priority placed on fulfilling mission and meeting local/market needs

Shared Governance

- Goal-setting, oversight, and decision making are shared with local fiduciary boards
- Premium placed on local input into system-wide decision making
- Parent applies influence in key strategic areas and uses reserved powers sparingly
- Standardization, centralization, and sharing of best practices implemented where they add value
- Alignment promoted by enterprise-wide strategic planning, capital planning, system-wide policies, and accountability for performance targets
- Moderate-sized corporate staff
- Parent board composition not based on representational formula
- Local executives are evaluated by parent CEO with local board input
- Governance structures and processes are streamlined
- Mission and meeting local/market needs is balanced with financial requirements

Operating Company

- Goal-setting, oversight, and decision making are centralized at corporate level
- Authority shift from subsidiary to parent level
- Reduction or elimination of local boards, or conversion to advisory status
- Business functions centralized, intense standardization, mandatory use of best practices
- Strategic planning and capital planning are driven from the top
- Large corporate staff to manage key functions
- Local executives are evaluated by parent
- Flatter governance and management structures
- Corporate financial and quality performance takes priority over subsidiary considerations
- Lean board size and committee structure

Corporate Control, Capability, Coordination, and Centralization

Less ⟷ **More**

2 Barry S. Bader, Edward A. Kazemek, Roger W. Witalis, and Carlin Lockee, *Pursuing Systemness: The Evolution of Large Health Systems* (white paper), The Governance Institute, 2005.

Over the past year, we asked for current reactions to this spectrum from the marketplace and found the following:

Holding Company	Shared Governance	Operating Company
• 10 years ago, this model was more prevalent than it is now. • Some corporate support was provided, with no directing done at the corporate level.	• Most systems are beginning a journey to a more streamlined structure, however there are very real tensions that hold them back, primarily around challenges with getting local buy-in to give up control due to a fear of future closure/ consolidation of services. • Of the various models that are evolving, leaders are asking: Is there a best practice? Is one model structure ideal for all? What are the market/cultural factors that justify a more complex structure?	• This feels to many leaders like more of a big business, for-profit approach. • Very few systems have created a true operating model. • There is some uptick in outside board member talent on boards, and more focus on new competencies. • This will potentially result in an increase in board member compensation.

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 must do so at a pace and in a manner that is right for the individual system. 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 may move further and/or faster along the continuum, transitioning to a single system board and few if any subsidiary boards.
- **Need for local directors to remain engaged**: Health systems, particularly those operating in diverse geographies, can benefit from having talented individuals at the local level who provide guidance and leadership. Systems that centralize most or all authority at the system board level may find that, over time, the ability to attract and retain talented board members at the local level declines markedly.

- **State law**: Some states require the existence of local boards that retain certain fiduciary responsibilities, such as medical staff credentialing. Consequently, large systems operating in these states need to strike a balance between legislative requirements and the desire for a governance structure that supports systemness.
- **Diversity and complexity of entities within the system**: Some systems are made up of very different types of organizations. For example, an academic medical center that serves as a regional referral center and provides tertiary/quaternary care operates very differently than a small community hospital or a network of community clinics in a suburban or rural area. Effectively overseeing this complexity may prove too difficult for a single system board.

Furthermore, these demands on today's healthcare systems, the complexity of the issues they face, the rapid pace of industry change, and the increasing scale of many systems mean that service on a healthcare system board today is less like service on a not-for-profit charity's board and more like service on a corporate board. Board members must be creative, intelligent, and nimble, and bring experiences and perspectives to the board that will advance the healthcare system's organizational priorities and strategic areas of focus.

As systems consider restructuring governance, key issues will include:

- Aligning the governance structure with the operational structure and key organizational initiatives and strategic focuses.
- Ensuring representation of needed skills and competencies on the board.
- Determining the appropriate size of the board.
- Determining the best structure, including the relationship between parent and subsidiary boards (if appropriate) and committee structure.
- Striking the right balance between meeting frequency and board agenda demands.

As a result of these concerns, Governance Institute members have been asking difficult questions of themselves and have reached out to us in search of best practices. We set out to determine if there was one governance model that could apply to most systems. This paper provides observations from what we learned from four different large health systems that have gone through various stages of governance restructure. We review governance structure charts from several other health systems that have shared them with us. We include data from our 2015, 2017, and 2019 biennial surveys of hospitals and healthcare systems that show how systems across the U.S. have shifted over time in allocation of decision-making authority and responsibilities to their subsidiary boards. Finally, we put our findings together to present best practices for systems to lay out a rigorous process to determine and implement an improved, streamlined governance structure.

The Numbers: How U.S. Systems Are Allocating Authority to their Subsidiaries

In 2015, most systems (52%) had a system board as well as separate local/subsidiary boards with fiduciary responsibilities. In 2017 and 2019, the systems responding to our surveys were more evenly split with regards to governance structure. As of 2019:

- 34% have one system board with fiduciary oversight for the entire system
- 34% have a system board and subsidiary fiduciary boards
- 27% have a system board and subsidiary advisory boards (boards that do not make fiduciary decisions but rather make recommendations to the system board)

Most systems approve a document or policy specifying allocation of responsibility and authority between system and local boards, and this has been increasing since 2015 (82% of systems currently do this). However, a smaller percentage of systems consider this responsibility and authority to be widely understood and accepted by all boards; about a third of systems say this is an area that needs improvement.

While a majority of subsidiary boards report sharing most of their responsibilities with the system board in 2019, there has been some movement historically of certain practices moving towards the system level, and others moving towards the subsidiary/local level.

The areas of responsibility that we see moving towards the system level (away from subsidiaries) since 2015 include:

- Setting the subsidiary's strategic goals
- Setting the subsidiary's quality and safety goals
- Approving the subsidiary's medical staff credentialing appointments
- Determining the subsidiary's capital and operating budgets
- Electing/appointing the subsidiary's board members
- Appointing/removing the subsidiary's chief executive
- Determining/approving the subsidiary executive's compensation

Areas of responsibility in which local boards indicate a strong degree of responsibility (whether they are fiduciary or advisory boards) include:

- Setting our organization's customer service goals
- Identifying our organization's community health needs through the community health needs assessment (CHNA)
- Setting our organization's community health goals
- Setting our organization's population health improvement goals, with approval from the system
- Addressing social determinants of health for our organization's community

This indicates to us that systems are working slowly towards increasing and retaining responsibilities at the system level that affect the system as a whole, especially affecting the system's ability to achieve strategic priorities and the system's ability to control quality of care, cost, and clinical variation. Systems are allowing local boards to retain responsibility for those items that have the most connection to their individual communities. However, we caution that for those items listed above remaining at the local level, systems must put in place mechanisms to ensure that subsidiaries are performing up to the system's standards and expectations.

Primary System Governance Structure Models (Simplified)

The data, our case examples, and the various other governance structure charts we have looked at (see the appendix) reveal four basic models of governance that most systems fall under (with grey areas in between):

- **Multi-layer:** One system board with fiduciary oversight of system-level matters, and local boards at each hospital that retain most or all fiduciary responsibilities concerning their individual hospital and patient population. Often these local boards have their own strategic plans that ideally align with the system's strategy but are implemented separately.
- **Regional:** One system board with very few committees, primarily focusing on strategy, along with fiduciary boards overseeing the operational performance of hospitals within their respective regions. The majority of the committees are at the regional board level and report to the regional board, which reports to the system board. Normally the regional boards do not have separate strategic plans from that of the system.
- **Hybrid Regional:** The above, with the addition of local boards that may have limited fiduciary or only advisory capacity, usually with very few to no committees at the local level.
- **Single Layer:** One system board with fiduciary oversight of the entire system. In this model, management at local hospitals and other care settings have more responsibility to carry out CHNAs, retain community ties, and make recommendations to the system regarding community and population health improvement.

All of these models usually include other boards for accountable care organizations (ACOs), foundations, physician groups, etc. that serve different purposes and may or may not report to the system or regional board. If your system has boards that fall into these categories, it is important to review their structure and reporting requirements to determine if any changes need to be made. For example, we have encountered many systems that have a separate ACO board that provides periodic reports to the system board, or sometimes annually or not at all. We believe in these cases this lack of connection results in care delivery transformations being siloed within the ACO and makes it more difficult for the system to translate those changes system-wide.

Pros and Cons

Maintaining a Single Parent Board

Pros	Cons
• The most streamlined structure	• Must oversee multiple hospitals/care settings
• Centralized accountability for the entire system	• Board meeting agendas can get very long; board might spend too much time reviewing organizational performance.
• Easiest way to achieve standards across system	• Need to delegate more work to committees to free up board time for strategy and future vision
	• Loss of community connection

Maintaining Local Boards

Pros	Cons
• Maintain community connection	• A less streamlined structure may result in an excess of committees, meetings, and preparation work
• Increases pool of potential director candidates, more access to skills and expertise	• System board must work harder to ensure local boards are following system-established standards and accountability
• Allows parent board to focus more on strategy and delegate some areas of oversight to the local level	

For many health systems, the desired structure is somewhere in the middle. The grey areas include various nuances as to how to allocate decision-making authority, and how to restructure and reduce board committees at every level, which is sometimes more appealing than removing local boards all together. Health systems must first determine their answer to the essential question of whether local boards should remain and why. If local boards are determined to be necessary, system leaders must next ask themselves what is the "happy medium" that will help them to realize the most positives of both having local boards *and* centralizing authority.

What We Learned: Different Systems Adjust Their Governance According to Their Own Circumstances

We looked in-depth at four systems that each have been shaped in different ways, over different spans of time, and covering different sizes and types of geographies and demographics. Below is a summary of the restructuring experiences of these four organizations. The complete case examples, including drivers of the restructuring, along with the processes embarked upon, challenges, and lessons learned, are presented at the end of this paper. At a high level, we were able to confirm our hypothesis that there is no single model that could be presented as a best practice for system governance. Each system needs to come to its own model in its own way and at the right pace. Each of these systems embarked on more than one phase of restructuring, some learning through experience what works and what doesn't, and others knowing from the outset that the next phase would serve as a stepping stone to an ideal structure to be reached down the road. Each of these restructuring efforts involved also looking at the operations structure to ensure alignment between the two. Most importantly, the process of restructuring is difficult—it takes time and cannot be rushed. Board members will be greatly affected and need to have the opportunity to participate and provide feedback throughout the process. Trust must be maintained, organizational and board culture must be taken into account, and system leaders must ensure that all involved understand why and how the restructure will help achieve benefits for the system and ultimately the patients in their communities.

> "There is not yet a single model that could be presented as a best practice for system governance structure. Until or if such a model emerges, each system needs to come to its own model in its own way and at the right pace."

Two-Phase Simplified Structure Maintaining Community Boards

St. Luke's Health System in Boise, ID, embarked on a two-phase restructure, the first phase of which was driven mainly by the realization of how much time board members and management were wasting preparing for too many meetings. In the first phase, a regional structure was created with two regional fiduciary boards overseeing the operations of each region, removing most of the fiduciary responsibility away from the community boards. This freed up the system board to focus on strategic issues, and the community boards focused on quality improvement and improving community health via recommendations to the system from CHNAs. This phase reduced the number of committees at each level of governance and also included an operations restructure so that administrators would oversee each region, with reporting up to the system level in a similar manner to the boards' reporting hierarchy. The results of this phase were reduced duplication of services, enhanced and focused efforts of the community boards, and improved clinical and operational consistency.

In the second phase (which was not planned from the start but came about after working through issues and problems with the first phase), system leaders realized that the two regions—while reducing many siloes that previously existed in the system—created two siloes that still resulted in lack of standardization across the two regions. The system was expanding its population health initiatives through increasing risk-based payer contracts, which required more of a complete integration. The final structure became a single system board with eight committees and community boards now reporting directly to the system board. The two regional boards were removed; to account for this and to maintain focus on strategy at the system board level, two new system board committees were created to do much of the work of the former regional boards.

Two-Phase Simplified Structure Removing Community Boards

Sutter Health, a large regional system serving Northern California, had 40 affiliate boards and a system board in 2006. Leaders knew they would need to be able to "behave more like a system," and thus embarked on the first phase of restructure. The comprehensive process ran from 2007–2008 and resulted in a regional governance structure that both reinforced the reserve powers of the system, and also clarified the distinct responsibilities of the system board and the regional boards. Almost all of the 40 affiliate boards were dissolved, and what was left were five regional boards and a few remaining subsidiary boards, all reporting up to the system board.

Then, in 2015, much like St. Luke's, they realized the need to further streamline. They moved to two operating unit boards charged with operations oversight of two regions, reporting to the system board. The two operating unit boards oversee what the five regional boards had previously overseen, and also have fiduciary responsibility. There also remain a few business line subsidiary boards with fiduciary responsibility, such as home health. This round of restructuring was less process-involved, but did require meetings and conversations at each level of governance to gather input.

Multi-Phase Representational Governance Structure Moving to Strategic Pillar Boards as a Stepping Stone

Jefferson Health in Philadelphia went against the grain to add a layer of governance to serve as a stepping stone in its integration process. Since 2015, the system has experienced a period of rapid growth, while giving new joining systems equal representation on the board as a part of the merger negotiation process. The idea from the beginning was to gradually reduce the number of board members over time, to evolve from a representational system board to a true, integrated board with members focusing on the needs of the system as a whole. As each new system joined Jefferson, they retained their local hospital boards, which became "division boards."

In mid-2018, Jefferson announced a three-year reduction of the parent board size, beginning with removing seven board members. Then over the course of the next two years, the plan was to remove another 15 (eight in the first year and another seven by June 2020), making it a board of 25 again. Most recently, the system added a layer of governance in between the system board and division boards by reconstituting some of the system board committees into four "pillar boards," each one

with the sole responsibility of overseeing the successful implementation of their respective strategic pillar. This structure allows board members to have enterprise-wide roles, for non-parent board members and also for people coming off the parent board, most of whom are placed on the pillar boards.

Jefferson leaders consider this a next step in a longer evolution towards a smaller system board of ultimately 12 people, with committees that narrowly focus on no more than four strategic areas to really understand the impact of the various business lines on the enterprise. The four pillar boards would become one board and serve the function of holding management accountable for the enterprise aspect of the pillars. There are not yet plans to remove the division boards, but they are considering some type of regional governance model at some point. As there is not a separate foundation board, Jefferson is also looking to the trustees to be philanthropists for the enterprise. This creates a need to balance board member roles to make sure that they continue to feel engaged and valued, so there is discussion of board member compensation in the future.

Co-Governance Hand in Hand with Co-Leadership

Hackensack Meridian Health in New Jersey also created a representational structure due to what its leaders considered a "merger of equals" that took place in 2016. In order to complete the merger agreements, both sides felt the need to have not only representational but equal governance. The new system board (the "Health Network Board") had 50-50 representation from each side, along with two board chairs and two co-CEOs. They also created a "Hospital Corporation Board" to oversee all hospital operations in the system and report to the parent board. This board is considered a subsidiary of the parent board, and there are other subsidiary boards that oversee other non-hospital aspects of the enterprise, known as "Diversified Health." This includes the ambulatory care network, post-acute care, residential care, and home healthcare. Each of the subsidiary boards have their own committees that report to them. The subsidiary boards are largely "advisory" rather than fiduciary. Major decisions or initiatives over a certain financial threshold go to the parent board for approval.

This representation governance structure was set to be in place for 6.5 years, with the two board chairs and two co-CEOs reducing down to one each 2.5 years from the start of the merger. The purpose of this dual leadership was to ensure smooth cultural transition and integration, building trust with leadership and management that the needs of each legacy organization would be balanced with the needs of the new system. Over time, board members will be termed off both the Health Network Board and the Hospital Corporation Board to gradually reshape both boards so they are no longer representational. System leaders emphasized that co-leadership like this is unusual and normally would not work for others; the scenario in this case example is unique (see the full case example in the last section of this paper for more details).

As of January 2019, both the co-CEO period and co-board chair period ended. The board reduction process is ongoing; by the end of 2019, 12 members left. Part of this process is to ensure that board members who leave the board remain engaged via committee participation or serving on one of the subsidiary boards or committees. Down the road, leaders envision a structure that includes committees of a consolidated "continuum of care board" that would deal with the various aspects of the businesses that are within the larger entity.

Main Benefits of an Integrated Structure

Better efficiency and nimbleness, not just of governance but of operations and overall organizational ability to make decisions more swiftly and therefore more quickly transform, improve performance, and achieve goals

- Enabling faster transformation towards value-based care delivery and better population health management through the ability to mandate standardized, system-wide metrics and reporting, thus focusing efforts and reducing variation
- Allowing the system board to focus more effectively on strategy and innovation
- Aligning strategy for the whole system
- Reducing time spent on governance by the management team, to free them up for other essential activities
- Enhancing system-wide leadership communication
- Better ability to ensure the necessary skills and competencies are incorporated at the right levels of leadership and governance
- Clarifying roles of mid-level and local boards so that they add value to the system, do not serve as barriers to achievement of system goals, and maintain ties to the community

Questions and Considerations for System Boards as they Embark on Restructuring

Our experience along with case examples bring up the following questions and issues for boards to consider for a successful governance restructure.

Aligning Governance and Operational Structure: Key Organizational Initiatives and Strategic Focuses

- Has the organization clearly defined its strategic focuses (e.g., improving consumer experience, preparing to take on risk, innovations in care delivery, horizontal or vertical expansion, etc.)?
- Have there been significant changes in executive leadership that reflect changed priorities in operations or a new strategic direction? Examples might be the addition of a chief experience officer, chief innovation officer, chief population health officer, etc.
- Is governance restructuring being contemplated as the result of a merger of two organizations? If so, have clear priorities and strategic direction been defined for the new/merged organization?

Once the executive and board leadership have a clear, common understanding of operational structure and strategic direction, they can focus on developing a system board with skills and competencies that align with this common understanding.

Ensuring Representation of Needed Skills and Competencies on the Board

- Does the current composition of the board adequately reflect the organization's operational structure and strategic direction? For example, if patient experience is a priority, does the board have member(s) with retail or other consumer business experience? If taking on risk is a strategic priority, is actuarial or health plan expertise represented on the board?
- Does the system primarily serve a single community or is it a multi-community or multi-state system? The larger the size of the system's geographic coverage, the less significant are board seats dedicated to community or constituent representation. Can any of these seats be converted to represent needed competencies or skill sets?
- Are there any "legacy" seats on the board resulting from earlier mergers or acquisitions with other facilities? Could these seats be better occupied with new members that bring needed skills to the organization?
- If a new organization is being created through a merger of two (or more) organizations, is the focus of the composition of the board for the new organization on the needs and priorities of the new organization (not on representation of the merging organizations' past interests)?
- At what level is the organization competing for board talent? Depending on state law, it may be worthwhile to offer compensation to board members. Compensation should account for duties board members will be asked to assume, as well as travel and time commitments (examples of systems using compensation structures include Allina Health in Minneapolis—fairly low compensation for a board drawn mainly from local business and community leadership—and Kaiser Permanente, whose board compensation structure is more like that of a major corporation and whose members come from a wide geography).
- Other characteristics to look for in potential board members include diversity of representation and perspective, and a strong sense of intellectual curiosity/willingness to learn.
- A strong board education and development program should also be implemented to keep board members informed on changes affecting the industry and their impact (actual or potential) on the healthcare system.

Determining the Appropriate Size of the System Board

- As a basic parameter, our research suggests less than 10 as a potentially "too small" board and more than 18 as a potentially "too large" board.
  - » The risks of a "too small" board are that needed skills and competencies may not be represented on the board. A small board may also be challenged in time commitments if, for example, members are asked to serve on three or more committees.
  - » The risks of a "too large" board are that the organization will need to devote more people and time to managing the board, and also that activity will tend to migrate to the executive committee, risking dysfunction/disengagement among other board members.

The benefits of adding members with specific, needed competencies must be weighed against the optimal size of the board. Again, executive and board leadership must honestly assess whether there are redundancies or "wasted seats" on the board that could be traded for stronger competencies.

Determining the Best Committee Structure

- Basic guidelines are "not too many" and "flexibility":
  - » **Not too many.** Recommended committee functions at the system level include finance, executive/strategic planning, executive compensation, audit, quality, and compliance. Subsidiary boards can have even fewer committees, depending upon their size and responsibilities.
  - » **Flexibility.** Consider the formation of other committees or work groups on an ad hoc basis. Getting into the habit of creating and sunsetting ad hoc committees or work groups also builds a culture of change management and a willingness for short-term experimentation ("fast failure" and "rapid expansion" mindset) on the board.

Striking the Right Balance between Meeting Frequency and Agenda Demands

- The key consideration is that meetings must be of sufficient frequency and length for the board to thoughtfully address all items on their agenda.
- Limiting the number of meetings (e.g., quarterly or bimonthly) may encourage management and the board to be sharper and more focused in the time they spend together.
- The agenda must leave sufficient time for the board to address major strategic challenges and opportunities facing the health system. This should be weighted more heavily than reports from management. Similarly, the board's focus and discussions should be more strategic than operational (e.g., exploring long-term implications of a performance trend rather than specific actions to alter performance).

Concluding Remarks

Our research confirms that each system needs to come to its own model in its own way and at the right time. The process of restructuring is difficult—it takes time and cannot be rushed. Board members will be greatly affected and need to have the opportunity to participate and provide feedback throughout the process. Trust must be maintained, organizational culture must be taken into account, and system leaders must ensure that all involved understand why and how the restructure will help achieve benefits for the system. Below are some high-level observations of what we learned from our research, which helped to shape our list of best practices for the restructuring process.

High-Level Observations:

Achieving optimal governance structure in a large, complex health system will likely be done in stages or phases, as most systems become more integrated gradually over time, and there is a need to determine what works and what doesn't from a governance standpoint during this evolution.

In general, we find that the regional and multi-layer approaches can be effective for systems that aren't ready to remove a significant number of board members for political purposes, as long as each level of governance has a clearly defined purpose, the boards do not duplicate work of other boards, and they are all working towards a unified strategic plan. Under these types of structures, committees should be minimized as much as possible to enable simplification while still allowing for the local boards to exist.

Along similar lines, we tend to see that models removing local boards work well for systems that are more compact from a geographical standpoint, or serve homogenous patient populations. In the example of Sutter, the hospital CEOs were tasked with maintaining ties to their communities and developing understanding of community health needs to report to the system. In addition, the system board was populated with people who had strong ties to each of the communities served by the system. Thus, it is important to consider ways in which community understanding can be achieved via mechanisms other than a local board (this should not be the *only* reason a local board is retained).

Systems will need to make some difficult decisions regarding removing boards and/or board members, and must be prepared to deal with any resulting backlash. Having a "place" for removed board members to serve in a different capacity for a time can help maintain relationships and connections with valued directors who must step down.

There is no single structure or set of structures that could be considered best practices for most systems, as the nature of their origin, communities served, geographic spread, and number and variety of care settings is different for every system. Rather, we have developed best practices around the *process* of getting to an optimal governance structure to best facilitate integrated care delivery.

"Many systems that have changed the role of their local boards still struggle with those boards understanding their new role and changing behaviors accordingly. We cannot emphasize enough throughout the restructuring process that if a board's role changes, the work to clarify roles and responsibilities can be difficult and needs to be done thoughtfully, early, and often. These boards need explicit instructions regarding meeting agenda structure, committee structure, system expectations, and what it means to make recommendations to the system board vs. making decisions at the local level. This is not accomplished through a single meeting or authorities matrix document—it must be supported and reiterated on an ongoing basis."

Best Practices for the Implementation Process of a Governance Restructure:

- Work towards simplifying the governance structure as much as possible. Expect that it will be a multi-phase process, especially if the system is still in flux regarding growth and consolidation.
- Work towards moving a majority of the fiduciary responsibility to a higher level of governance, whether regional or system, rather than local. This allows for more control over key variables within the system that could cause barriers to systemness, as well as maximizing the ability of the system to ensure that local boards comply with system strategy, goals, and policies/procedures. This may involve converting local fiduciary boards to a mostly advisory role.
- Conduct an analysis of the current structure, including how it is working well and how it is creating barriers to systemness, and develop a set of criteria or guiding principles for what the new structure would need to accomplish. As a part of this analysis, determine the necessity of local boards—how they help the system and how they might hinder accomplishment of system goals, and how necessary they are to remain connected to the communities the system serves. Ask if there are other, non-governance mechanisms to accomplish community relations goals.
- Consider the committees at every governance level and include those in the analysis of potential new structures. If some boards are eliminated, new committees may need to be formed under other boards. Additionally, if local board responsibilities are altered, they might not need to retain the current number of committees as potentially more of that committee work could be done by the full board.

- Work with all boards within the system from the beginning of the process to demonstrate the need for change, ensure multi-directional communication, and build buy-in from board members. Also consider other stakeholders (senior management, medical staff, etc.) who would be affected by a governance restructure, and whether early communication to build buy-in from those stakeholders would be necessary or helpful to facilitate implementation.
- When determining what the new structure will be, consider the system's management/operations structure to determine how the new governance structure will affect it, and whether there need to be complementary changes to the operational structure.
- As the new structure is put in place, create a comprehensive authorities matrix or similar policy or document that clearly articulates the role and responsibilities of each board within the system.
- Hold orientation/education programs for all board members whose roles have changed to educate and communicate how and why the roles are different. Emphasize that new roles remain as important as prior roles. As a part of these programs, work with all board and committee chairs to help them understand how and why meeting agendas and activities will change. Develop agenda and reporting templates to standardize the work of every board within the system.
- Continue to reinforce the authorities matrix over time. Don't assume that if it has been communicated once, that all boards understand it and are abiding by it.
- If board members will be lost or removed in some way due to the restructure, work to find ways for those that made meaningful contributions to continue to be a part of the organization, whether via a director emeritus advisory council, positions on board committees as needed, the foundation board, or other appropriate venue.

Ongoing Strategies

Setting appropriate upfront expectations and clearly defining the various roles and responsibilities go 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**: This helps to build and maintain personal relationships and to review and clarify the respective responsibilities of the boards.[3] 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 levels attend these sessions as well.
- **Have system leaders attend subsidiary board meetings (and vice versa)**: This provides a visible and ongoing reminder of the local entity's role within the larger system.

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

- **Look for and cultivate "system thinking" in new directors and administrators**: Work towards terming off representational directors and look for explicit competencies and skills when replacing them, including the ability to think at a systems level. Orientation and training programs should reinforce system thinking, with the goal of ensuring alignment between boards' responsibilities and the knowledge and skills of directors.
- **Standardize board structure and processes**: Standardize as much as possible across all levels of governance, including 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.[4]
- **Develop multiple communication vehicles**: Maintaining good system–subsidiary board relations and keeping local board members engaged and enthusiastic requires constant attention. In addition to regular, formal retreats, use a variety of communication vehicles to keep directors 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. This also helps to ensure that local directors know their voice is being heard.
- **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**: 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]

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 Lister, 2010.

Case Studies:
System Governance Evolution in Action

St. Luke's Health System: Enhancing Systemness by Streamlining Structure

David C. Pate, M.D., J.D., President & CEO
Christine Neuhoff, Vice President and Chief Legal Officer
Kendra Fiscelli, Director of Governance

Background: Organization Profile

The roots of St. Luke's Health System in Boise, ID go back to December 1, 1902, when the first hospital opened in a converted Boise home. The hospital was founded by Bishop James B. Funsten, who was acting on an immediate need to provide care to retired Episcopal Church workers, but St. Luke's quickly started accepting other patients, thereby becoming a vital source of care for all members of the community.

St. Luke's became a health system as the result of a 2006 merger. Prior to this pivotal merger, Wood River Medical Center had already joined St. Luke's Regional Medical Center. Between 2006 and 2013, several additional smaller hospitals joined the system.

St. Luke's has enjoyed the benefit of long-tenured executive leadership, demonstrated by only three chief executives over the past roughly 50 years. Today, more than a century since its founding, St. Luke's Health System is Idaho's largest, locally controlled healthcare system, with 10 hospitals, more than 200 clinics, and nearly 14,500 employees across southwest and central Idaho, including roughly 850 employed physicians.

Phase One: Regional Governance Restructure to Break Down Silos

When St. Luke's became a system in 2006, it had a system board as well as local boards, known as "entity boards" at Treasure Valley, Magic Valley, and Wood River Medical Centers. There were also several other boards of managed facilities that eventually became part of the system. Each entity board had its own set of four to five committees. This governance structure did not allow St. Luke's to operate like a true system, but rather more of a holding company or "confederation of independent organizations," as described by Dr. Pate.

"We were wasting an enormous amount of time—board member and management time," explained Barbara Wilson, former board member and former chair of the system-level governance committee, during an interview for a previous case

study in 2016. "That was getting in the way of meeting our mission and aligning our system for the future. Management was making the same presentation three or four times. We had agendas that were not focused. We were not tapping into external community resources. We were still very much in the mindset of a hospital, not a health system, which is vastly different."

The goal was to transform a patchwork quilt into a streamlined system while continuing to add hospitals and physician practices. Early questions St. Luke's leaders asked were founded on the need for better care coordination and being more patient-centered:

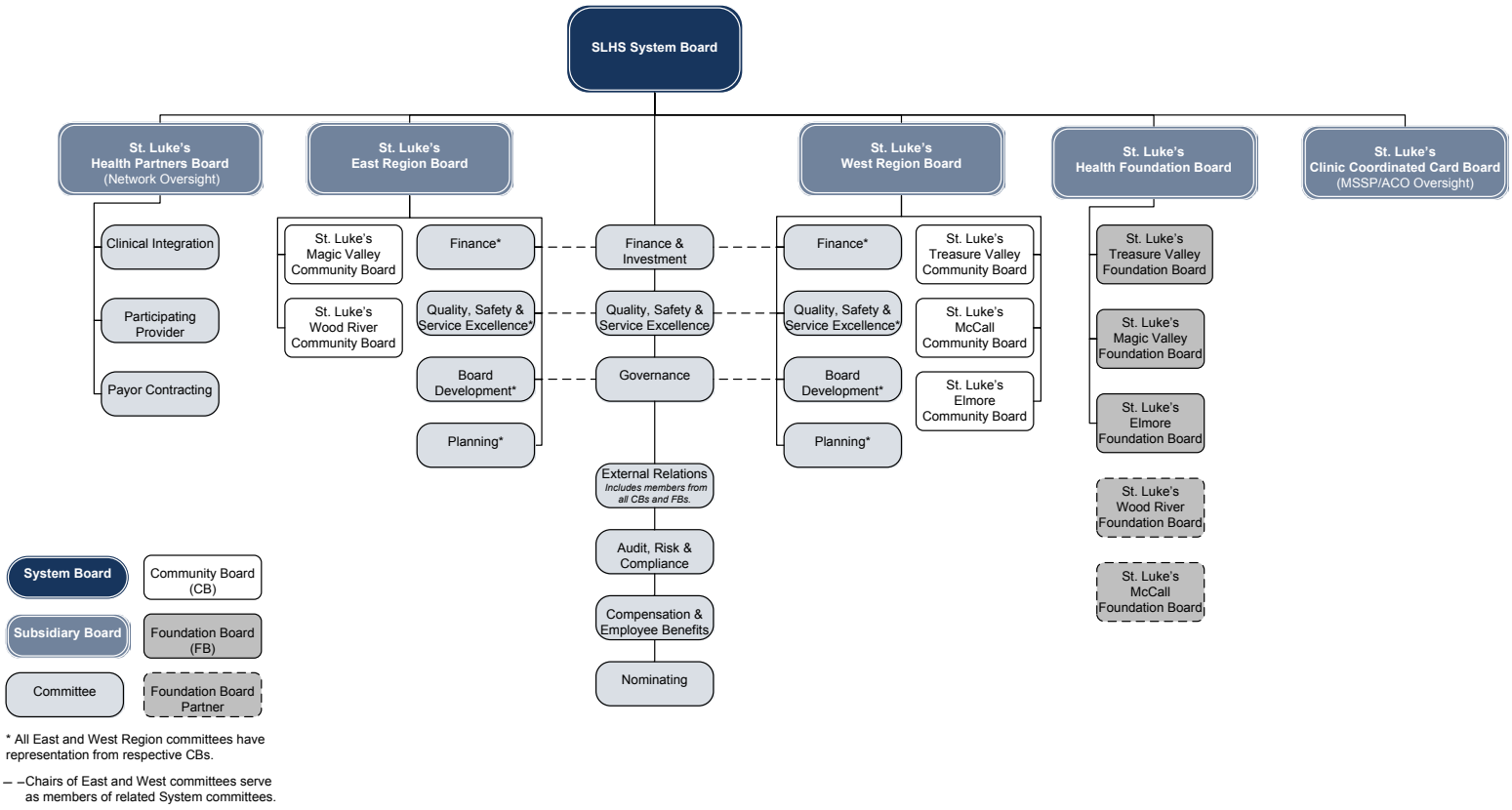
- How should the medical staffs be organized?
- How should we organize our leadership structure?
- What are the governance implications?
- In what ways do we need to engage community leaders?
- How can we better position the system to meet community needs and our mission for the future?

Dr. David Pate became CEO in 2009; he was aware of the problems with the governance structure from the beginning. Pate asked a small team of leaders (including the Chief Legal Officer and Director of Governance) and the system board governance committee to evaluate governance models and communicate the need for a change, with the goal of determining which structure would best suit St. Luke's and, then, implement the new structure. With significant hands-on support from the governance committee, the process took just under two years from 2012 to 2014.

The resulting structure, put in place in 2014, was essentially a regional governance structure to support and mirror the regional operational structure of the system, which was built based on an understanding of where patients go for their care within the system. (St. Luke's is considered to be a "regional" health system in that it spans a relatively large portion of the state, with a mix of urban, suburban, and rural care settings.)

The system board would be freed up to focus primarily on strategy. Two regional boards were created to oversee operations of each major region of the system (east and west). The entity boards remained (known as "community boards") and reported to the regional boards. They became primarily advisory rather than fiduciary, focusing on community health needs assessment and quality oversight, and maintaining local ties to the community and bringing the community voice to the system. (See **Exhibit 1**.)

Exhibit 1. St. Luke's Governance Structure in 2014



Some of the rationale behind this structure included:

- A regional governance and operational structure would streamline decision making, enable standardization, simplify lines of authority, increase accountability, ensure the best use of limited board time, and support achievement of the Triple Aim.
- Recognizing that the trend in healthcare governance is towards centralized fiduciary responsibility, a singular governance structure was neither desired nor beneficial given the unique elements of St. Luke's at that time. Further, this approach was not politically or operationally feasible given the system's history, characteristics, and the system board's desire to avoid increasing its own operational oversight. This structure allowed the system board to focus mostly on strategy, giving it the ability to be nimble; the feeling was that moving to a single board structure would significantly impact this important trait.

The regional structure advanced St. Luke's alignment in the interest of delivering on population health. Specifically, under the regional structure, St. Luke's:

- Reduced duplication
- Enhanced and focused efforts of the community boards
- Improved clinical and operational consistency

The new structure allowed St. Luke's to retain (and enhance) the community connections across the large geographic region. The shared system resources were quickly recognized as valuable and relationships became more meaningful.

Perhaps one of the most challenging aspects of the transition to the regional structure was the move from local fiduciary boards to the functions and responsibilities of the new community boards. To help ease this transition, a (now former) regional CEO created a project plan to help the adjustment of regional and community board members, covering board policies, procedures, and practices. Agendas were reworked to clarify the new roles and responsibilities.

Phase Two: From Two Silos to One

The regional governance phase "was a good progression for us," said Dr. Pate in an interview at the end of 2018. "We went from a number of siloes to just having those two regions. And the two regions made sense for us from a population health standpoint of where people typically go throughout the continuum of care for their care. It was a very good stepping stone for us."

Since 2014, St. Luke's has had a significant focus on improving quality and safety to become a quality leader, and the system has been named one of the IBM Watson Health/Truven Health 15 top health systems in the U.S. for the last six years. Much of this improvement has been achieved through standardizing best practices across the system. Specifically, the regional structure brought the system a long way towards clinical consistency, but there remained much opportunity to close the gap even further—to make sure that each site had the appropriate access to system resources and the ability to continuously improve and deliver the best care possible. "We gained an appreciation for the importance of that standardization across the system," said Dr. Pate. "That led us to think about changing our structure from two regions to a single, whole-system approach to drive even more significant quality changes."

Adding to this, in January 2017, St. Luke's engaged in an expanded population health initiative to speed the journey to value through risk-based payer contracts (at which time 34 percent of the system's revenue was in risk-based contracts). This created an even stronger need to adjust the two-region operating model and mindset. "When we informed the system board of this, the system board felt that we ought to [again] change the governance structure to match the operating structure," said Dr. Pate.

The Process

"When the health system board tasked us with restructuring governance again, we worked with the health system board and each regional board to come up with a set of guiding principles—the important principles that should be incorporated into our governance structure and into the decision making," said Christine Neuhoff, Vice President and Chief Legal Officer. "Ultimately, the regional board and the health system board approved the same set of guiding principles, and then we used those guiding principles to evaluate the current structure and some hypothetical structures against those principles."

The guiding principles for St. Luke's 2017 governance restructure stated:

As an Idaho-based community owned and operated health system, the Governance Committee of the St. Luke's Health System board will rely on the following guiding principles as it redesigns St. Luke's governance structure. The principles are meant to honor St. Luke's culture and be consistent with our vision to be the communities' trusted partner in delivering exceptional, patient-centered care.

A new governance structure should:

1. Ensure the needs of our patients, across the continuum of care, transcend other considerations.
2. Support high reliability to deliver the highest quality care to our patients.
3. Align with our operational structure for effective and legally appropriate oversight.
4. Ensure efficient use of resources to deliver value at the lowest total cost of care.
5. Be nimble to support rapid decision making.
6. Eliminate unnecessary layers of complexity or unintended silos.
7. Include meaningful input from our boards, board members, local communities, and key stakeholders.
8. Facilitate effective information flow and communication.
9. Foster collaboration, inclusivity, and participation from all communities we serve.
10. Identify clear board and committee roles, responsibilities, and decision-making authority.
11. Ensure adequate opportunity for meaningful dialogue, deliberation, and oversight.
12. Ensure placement of existing board members within the new structure, consistent with their interests and experience.

Over the next 12–14 months, system leaders had many conversations with all board members, through in-person visits at each site during board meetings, to discuss and engage everyone in evaluating options for a new structure and determining how the changes would be implemented. They also made sure to have conversations with the medical staffs and physician leadership, foundation board members, and other stakeholders. They encountered some pushback from board members in both regions who were concerned about whether there would be too much loss of control (a reaction that was quite similar to the concerns during the first restructure). However, board members who didn't have those concerns emphasized the success of the regional structure, which was a significant help to turn the rest around. Ultimately, the consensus was to merge the work of the two regional boards at the system board level, resulting in a single board for all facilities and care delivery services.

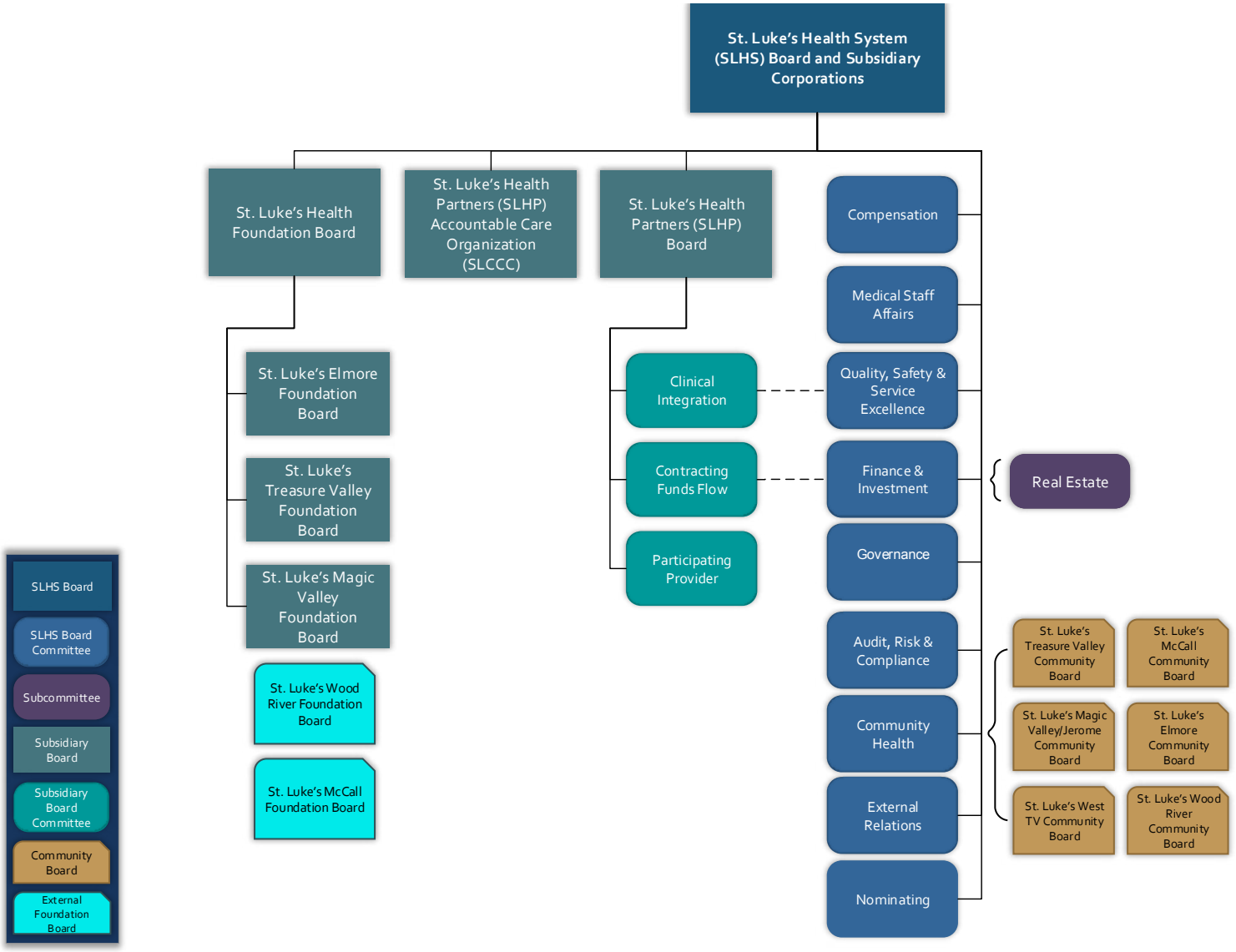
The Result

In phase two, which went into effect on October 1, 2018, a single system structure with eight committees was implemented and community boards now connect directly to the system board structure. "When we moved to the regional board structure in 2014 and implemented the new community board responsibilities at each of the facilities, that [aspect of the governance structure] has been successful," said Neuhoff. "The community boards have now fully internalized their purpose, and so as we were going through our thought process for phase two, we had just finished developing a system-wide community health strategy in concert with the community boards, and it was decided that the community boards should remain."

Removing the regional boards has brought many additional responsibilities to the health system board; the work of the regional boards, which was substantial, is now also the work of the health system board. To account for this, the health system board committees have been restructured and two new committees were created to enable adequate perspective and participation from all of the communities represented by St. Luke's. It is also meant to provide a forum for deliberation on important issues arising across the system. "We have vested those committees with some pretty substantial authority, under the oversight of the health system board," Neuhoff explained.

To enhance bi-directional communication and integration, many community board members sit on the system-level committees. "We've actually decreased the percentage of system board members on the committees and increased a number of these regional and community board members," Dr. Pate explained. "All of the committees have new charters, and now this is where a lot of the work of the system board gets done." This way, the full board can provide effective oversight and retain its focus on strategy during board meetings. "The amount of time devoted to strategy at our board meetings has remained the same. At the end of the meeting, we now add several hours to do a focused site review for one of our various legal entities," said Dr. Pate.

Exhibit 2. New Governance Structure Chart



Benefits of the New Structure

For St. Luke's this "phase two" governance represents the next important step in streamlining all aspects of the system for better efficiency and nimbleness. Removing this tier of governance has freed up even more management time than the first restructure. "We are constantly talking about how complicated healthcare is, so my personal mission is to simplify to the greatest extent possible in those areas where we can," said Kendra Fiscelli, Director of Governance. "This governance structure is a huge opportunity to do that. It frees up time for the board to focus on the future and our strategic initiatives, and it frees up staff time so that we can be directing our energy to providing the best possible care to our patients. And every avenue that

we have to simplify the behind the scenes—the backbone—of the organization, all the better."

Neuhoff added, "With the rate of change in healthcare, and in our case, a significant need to focus on the way we are delivering care to improve the health of the population for whom we are at risk, keeping an eye on our governance structure to ensure that we are efficiently and effectively overseeing that work is critically important."

"I talk to a lot of my colleagues around the country about how differently different boards are using their time," said Dr. Pate. "What I hear from a lot of my colleagues is how long they spend listening to committee reports. We have really minimized that and encouraged people to read the committee minutes if they want more information. If you gave each of our nine committees 10 minutes, that's an hour and a half of just committee reports."

The system board spends 10 to 20 minutes during meetings on committee reports, primarily to take action on committee recommendations that require decisions. That frees time for strategy. "If you think about where healthcare is today and the amount of change, the number of threats, I think if boards aren't spending a lot of time on strategy, they're going to be greatly disadvantaged," said Dr. Pate. "That's one of the most important responsibilities of the system board."

Sutter Health: From Scattered to Streamlined

Linda Khachadourian, Chief Enterprise Transformation Officer

Background: Organizational Profile

Sutter Health is a large regional health system with over 20 hospital locations across Northern California, as well as behavioral health, rehabilitation, ambulatory care, home health, hospice, medical groups, independent practice associations (IPAs), and over 12,000 physicians and 53,000 employees. In 2018 the system had almost 2 million outpatient visits, 844,000 ER visits, over 30,000 births, and 188,000 discharges.

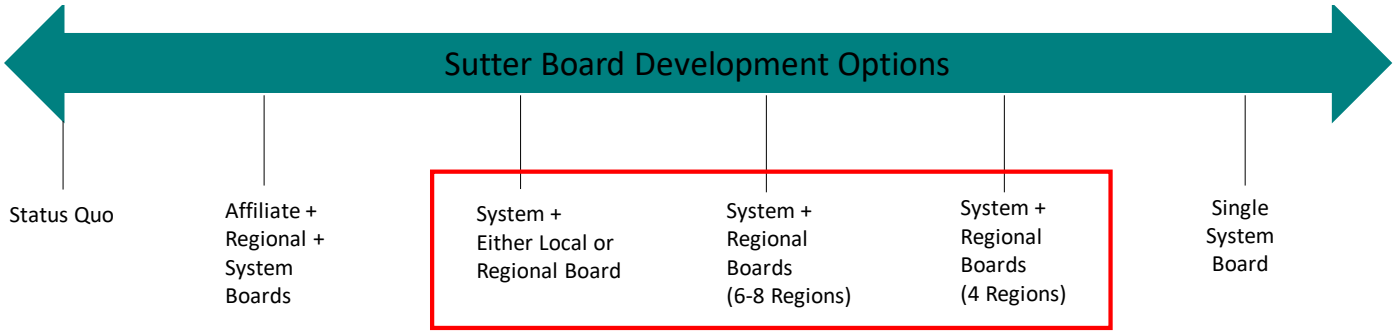
Governance Then

In 2006, Sutter Health had 40 affiliate boards and a system board. At that point in time, system leaders began to realize based on market dynamics that they would need to "behave more like a system." The primary market drivers at this time that led system leaders to this conclusion included:

- Payer consolidations
- An increasingly competitive marketplace
- Reduced reimbursements
- Increasing consumer expectations

So, system leaders engaged with all boards on a governance restructuring process that began with considering options of where fiduciary responsibility should sit. "We asked ourselves, what is the best structure to help support our strategy?" said Linda Khachadourian, Chief Enterprise Transformation Officer. "Local market dynamics really drove the strategy, and then form follows function, so we felt we couldn't deliver on our strategy if we couldn't work better together as a system." Working better together included more streamlined decision making and the ability to make resource allocation decisions across broader geographies. Sutter board members at every level understood this need and their role in creating a system that could build these capabilities, which would begin at the top with an integrated, streamlined governance structure.

The restructuring was a comprehensive, multi-year process throughout 2007–2008. Support staff and management spent endless hours researching structure options via a steering committee of affiliate and system board members. They looked at the market environment, socialized in between board meetings, sent out updates to the affiliates, and gathered their input. Based on this input, staff and management came up with a set of criteria that were applied against a variety of structure options. They then undertook a broad evaluation of what would make most sense for Sutter's communities and the system's future journey. Once the restructure was approved, it took 18-24 months of implementation.



The result was a regional governance structure that both reinforced the reserve powers of the system and also clarified the distinct responsibilities of the system board and the regional boards. "We lost a handful of board

members through that process because they did not feel aligned with the new direction," said Khachadourian. The board members who resigned did so on their own accord because it was very much a governance-led process, rather than mandated by management.

Sutter Health Board: Governance Evaluation Criteria

Community Benefit	• Community value • Quality • Market focus
Financial Sustainability	• Stewardship of Assets
Stakeholder Responsiveness	• People • Physician Relations
Stakeholder Integration	• System-ness
System Performance	• Accountability • Decision-making effectiveness • Decision-making efficiency
Philanthropy	• Philanthropy

> "It took a lot of courage. We could have said this was too complicated. But we had some very strong board leaders who believed in this and supported moving forward. They engaged personally in dialogue with other board members so their voices could really be heard."
>
> —*Linda Khachadourian*

In order to create the new structure, approximately 40 affiliate boards were dissolved, resulting in only five regional and a few subsidiary boards, reporting up to the Sutter Health system board. The boards had to essentially vote themselves out of existence in order to create the new regional structure. "The new regional structure helped significantly for many years. As we continued to evolve and became more integrated, the subject of governance was identified again," Khachadourian explained.

Governance Now

In 2015, Sutter commenced a second restructure, moving to two operating unit boards charged with operations oversight, reporting to the system board. The two operating unit boards oversee what the five regional boards had previously overseen, and also have fiduciary responsibility. There also remain a few business line subsidiary boards with fiduciary responsibility, such as home health. This round of restructuring was less process-involved, but did require meetings and conversations at each level of governance to gather input.

Aligning Strategy, Goals, Communication, and Education

There is currently one strategic plan for the system, and each geographic region has aligned goals each year, including both system initiatives and market-specific projects. Capital decisions have to go up through the system based on certain approval thresholds. "While we are continuing to evolve, we are operating much more as a system, while learning what is working and what is not."

The system and subsidiary boards are focused on two-way communication and input. Sutter hosts an annual symposium for all the boards to come together, and a quarterly board update e-newsletter that goes out to all boards and alumni board members to keep them engaged. Senior management provides system updates in person at subsidiary board meetings. The Governance Forum, a group of all board chairs, meets one or two times per year to help the two-way dialogue. The system is also working to better align the education calendar for board members with the strategic topics the system is working on. The system board meets quarterly and in the interim months, education packets are sent out to board members with an update on management activities and other pertinent news/information.

Benefits of an Integrated Governance Structure

The largest benefits Sutter has realized through its two restructures are the ability to make important, strategic decisions more swiftly, and in a more integrated way on behalf of the system's geography. Rather than making a choice to benefit a particular hospital or physician organization, decisions are made for the direct benefit of the system's communities. According to Khachadourian, they are treating their governance itself "like an integrated delivery system. If we have limited capital, board members are responsible for resource and capital deployment and therefore we make smarter choices."

Another important benefit is the creation of leadership efficiencies that were not possible with the prior structure. For example, a single hospital might not be able to have deep expertise in compliance, finance, or other key leadership skills. At the system governance level, the board has this higher level of skill and experience, which results in higher-level decisions and the ability to essentially "deploy" this leadership capability across the system so every care site can directly benefit from these skills and expertise. Further, despite the lack of local boards, Khachadourian believes this structure allows Sutter to make better choices for its communities based on customer needs and travel patterns, because of the ability of the integrated governance to look across the system, take advantage of system-wide data, and avoid making decisions that benefit one but harm another.

If Sutter had retained its local boards and not made efforts to integrate its governance, Khachadourian believes the system would be facing a higher cost structure with slower decision making and an inability to make good resource allocation decisions. "I don't think we would be as responsive as an organization; we would be much more siloed," said Khachadourian. "Our quality scores and financial metrics are better. Because of our decision-making speed, we show positive trends across all performance indicators."

Maintaining Community Ties

Sutter retains foundation boards in all of its communities. Community benefit efforts are coordinated at the system level but based on CHNAs in each individual community. Affiliate CEOs are accountable for community relations and medical staff relations. Their role has become more important in their communities as they engage more directly with stakeholders. There were fears that that local connection would be lost but those fears have not been realized. "We didn't want representative boards. We have been very conscious to make sure we have a competency-based board, and one area of competency is to have people who are connected to our various communities," said Khachadourian. Operating unit boards have members who are very connected in the system's local geography, and that is an effort that will continue into the future.

Jefferson Health: Governance in Transition

Stephen P. Crane, Trustee and Former Board Chair
Cristina G. Cavalieri, J.D., B.S.N., Executive Vice President and Legal Counsel
John Ekarius, Executive Vice President and Chief of Staff

"Hub and Hub" Growth: Shared Governance on the Parent Board

Since 2015, Jefferson Health in Philadelphia has experienced several years of growth, with six organizations in its region joining together as "One Jefferson." With the first partner, Abington Health System, Jefferson reached out with a "hub and hub" concept of system structure, considering the two systems as equals in the partnership. This concept led to a shared/representative governance structure in which Jefferson offered Abington equal representation on the system board (today known as the Thomas Jefferson University Board of Trustees). This was unique to most health system mergers at the time and became an essential part of the incentive package Jefferson offered to its subsequent partners (Aria Health in 2016; Kennedy Health System and Philadelphia University in 2017; Magee Rehabilitation Hospital in early 2018; Jefferson's most recent partner Einstein Healthcare Network will join upon merger approval by federal and state regulators).

The shared governance model guaranteed parent board seats for each new system joining Jefferson ("governance as currency," as several Jefferson leaders put it), with a longer-term plan to phase out representational governance and renew board member terms based on performance in a true "community board" model. (Beyond this shared governance parent board, each new partner, which were named "divisions," retained its own board at the local level, known as "division boards.")

The goal was to eventually build a parent board that could focus on what was best for the communities, rather than for the legacy health systems, through an intentional process to integrate board members into the system culture and embrace the system's strategic goals. Over time, those board members would not serve or dominate with their legacy interest but rather focus on the interests of the whole enterprise. As CEO Dr. Stephen Klasko noted, the initial mergers were accomplished using board seats as currency, ensuring that decisions about the future of each institution would involve local board members. At first, this meant a large board, commensurate with the initial "holding company" model for Jefferson. But as Jefferson has shifted to an integrated operational platform, the board also must shift to a smaller governing body reflecting the needs of a more focused enterprise. In this model, members of the older boards become experts and serve in new ways, while the governing board focuses on One Jefferson.

The Board Grows, Shrinks, and Grows Again

Naturally, this shared governance process resulted in a very large board as Jefferson brought on more partners. Jefferson volunteered to reduce its board to 11 members when Abington joined (so they would have equal seats—11 also for Abington, for a total of 25 including Dr. Klasko and two independent outside directors). New partners meant new board members, with the parent board growing to 47 people by January 2018 (prior to the anticipated Einstein merger).

In mid-2018, Jefferson announced a three-year reduction of the parent board size, beginning with removing seven board members. Then over the course of the next two years, the plan was to remove another 15 (eight in the first year and another seven by June 2020), making it a board of 25 again. This was to provide capacity for Einstein to add five new board members, so by June 2020 when the "reduction" plan is complete, the board will have about 30 (with potentially one or two additional independent outside board members).

Board members are selected for removal through input from the board chair (Stephen Crane at the time) and the governance committee. "It's been fairly easy so far," said Crane. "When you have [such a high] number of board members,[6] in a big complex organization, we need to have the [time] commitment of trustees, both at the committee and board levels. It becomes apparent who is able to make that commitment via one-on-one discussions."

Once it has been determined who should step aside, it is done without any fanfare, because most of the board members who leave the parent board now have a place to go—the parent board committees have recently been repurposed into strategic pillar boards, the next transitional governance phase.

6 At the end of 2018, Jefferson Health had approximately 235 board members across the system.

The Next Phase: Tiered Governance with Pillar and Division Boards

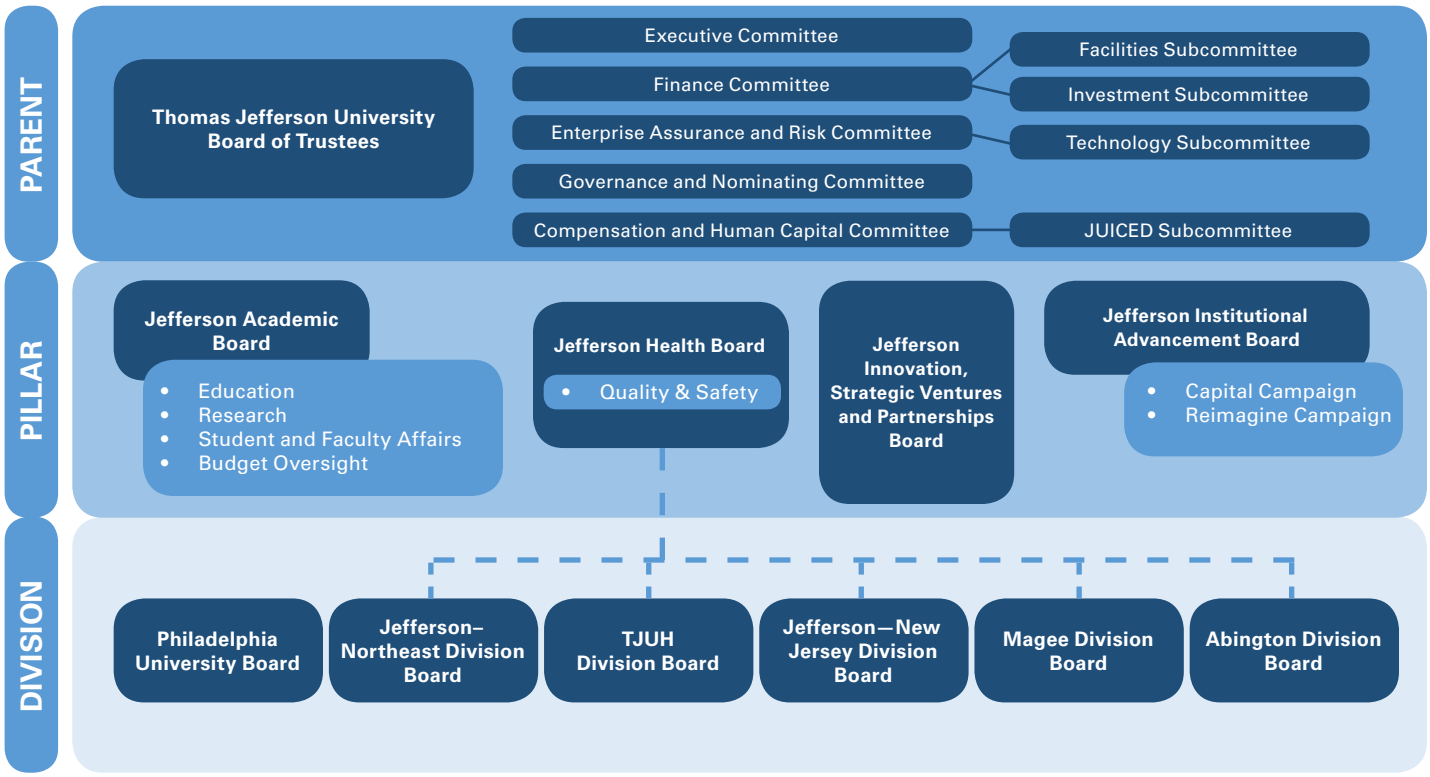
Jefferson's next iteration of governance structure, which began in the second half of 2018, involved adding another layer of governance in between the parent board and division boards by reconstituting some of the parent board committees into "pillar boards," each one with the sole responsibility of overseeing the successful implementation of its respective strategic pillar:

- Jefferson Academic Board
- Jefferson Health Board
- Jefferson Innovation, Strategic Ventures, and Partnerships Board
- Jefferson Institutional Advancement Board

This structure allows board members to have enterprise-wide roles, for non-parent board members and also for people coming off the parent board, most of whom are placed on the pillar boards.

New Governance Structure

(Note: Philadelphia University no longer exists)



With the addition of the pillar boards, the parent board now serves as the strategic body that ultimately oversees mergers and acquisitions and "high-performing strategic activities," according to Executive Vice President and Legal Counsel Cristina Cavalieri.

The system-level enterprise strategic plan has segments for each of the pillars. The pillar boards monitor management's performance against the strategic plan as it applies to their pillar. The consolidation of performance moves up to the parent level. "We are trying to look at the necessary functions, both strategy and operations, assign them to the appropriate group of individuals, and then populate those pillar boards with the right people," said Cavalieri.

Pillar boards will focus on essentially meeting their respective budgets, meeting their respective portions of the strategic plan, and things that are locally grounded: compliance, malpractice, etc. At the parent level, the audit and compliance committee was reworked into an enterprise risk committee, which considers the impacts of disruption and how those affect the strategic plan, and the risks associated with both the internal and external environments. The enterprise risk committee also works to understand how management proposes to manage those risks and hold management accountable.

From a compliance perspective, the issues that would normally be brought to a parent health system board are now brought to the Jefferson Health board, the so-called "clinical pillar," which oversees quality and safety. The remaining governance issues, for the most part, are reported to the enterprise risk committee.

The Jefferson Academic Board was created as a board committee when Philadelphia University came on. It has no independent authority but acts as the parent board's committee to oversee the entire academic operation (including Thomas Jefferson University).

The division boards will remain in place given that the system does not intend to consolidate provider numbers and licenses. Each system that is part of Jefferson Health has its unique attributes, issues, and communities. Part of the strategic plan involves a rationalization and integration of the division board activities.

Each pillar board chair is also a member of the parent board. Members that are now at the parent board may move to the pillar boards if they have the desire and the needed expertise. Some division board members are also on the pillar boards to enable an information/communication interrelationship between all governing bodies.

Why Add a Layer?

Jefferson leaders admit that adding a layer of governance during an overall effort to streamline and minimize complexity is counterintuitive. However, they look at it as a stepping stone in the overall governance evolution. "This is not the way it's going to be five years from now, but this is a way to help decrease the parent board size," said Cavalieri.

Jefferson's governance structure, and therefore its challenges, are unique because it has a consolidated and integrated environment between academics and clinical—it is not strictly a health system. Because of this, "We need to think a little bit differently," said Cavalieri.

Next steps for implementing this new structure involved getting the board members to accept their new roles, remove duplication of information, and reassess/update pillar board meeting agendas to reflect the updated responsibilities of each board.

"The beauty of this is that we haven't increased the number of meetings," added Crane. "We've changed what the boards do, and where we're asking trustees to focus [and how they delegate responsibilities]. These four new pillar boards aren't incremental. They replace four board committees that had more limited roles and didn't do everything we're asking them to do now. We think it's a more efficient and effective way."

Another benefit of this structure is that every member of the management team doesn't need to attend every meeting. Dr. Klasko is the only management board member, and thus attends every meeting. The remaining members of the senior management team attend meetings as appropriate, which has greatly freed up their time to better attend to their own responsibilities. For instance, the system CFO attends meetings as appropriate and he gets in front of each board periodically, but he has a clinical CFO who runs the clinical pillar and another one who runs the academic pillar. (At least one pillar CFO is in attendance at all meetings.) Because of this, board members now know that they shouldn't expect to see all of the management team members at every meeting.

Division Board Hierarchy and Structure

The division boards technically serve as committees of the Jefferson Health pillar board, which oversees the quality and safety of the system. The information that comes to the division boards is reported up to the Jefferson Health board. The intent is to have a cascading communication flow, top down and bottom up.

Reduction of variation in governance and performance will result from development of consistent charters. Each of the division boards would have compliance, clinical risk, and professional liability, all under the same committee. They are also working to standardize the division board agendas and minutes.

Implementation Challenges

Instituting the pillar board structure resulted in very little pushback at the parent board level. "We surprised ourselves with the success of integrating our various community board members [during our initial growth phase]," said Crane. "Now when we bring in a new health system, we know how to get them up to speed, get them educated and involved, make them feel part of the [system], and get them out of the 'what's good for my division' and into a 'what's good for the enterprise' mentality."

Division board members are adjusting to their new roles in certain cases. "They just have to remember that what they used to decide is now more of an advisory capacity," Crane continued.

(In)Equal Partners: Integrating Governance and Operations

When the Jefferson journey of growth began back in 2015, Jefferson and Abington were 50-50 partners. As each new entity has come on board, those mergers were occurring simultaneously while Jefferson was moving from a holding company model to a strategic controller model. When Einstein joins in early 2020, a majority of the governance structures, processes, and policies will have already been in place,

as opposed to when Abington and Jefferson came together and Abington leaders could take part in the governance design. "I remember one case where one of the division boards wanted to maintain its local facilities committee, and the parent board accommodated that because it [seemed reasonable to do so at the time]," explained Chief of Staff John Ekarius. "It's worked very well at the parent level, but we still have some work to do with the [division] boards."

Jefferson is still in a growth period, but also working on integration with those members of the system that are ready for it. They have a robust integration plan that includes rationalization of services (e.g., moving care services to the optimum/most efficient settings and locations; reducing/eliminating duplication). The integration and rationalization process is ongoing and aims to provide each of the division entities an appropriate enterprise identity within the system, with the understanding that each one will need to be different.

The evolution of the board structure for Jefferson Health is intended to support its long-term strategic goal, Ekarius said, to shift from being a "holding company" for each of the merged entities, to a new integrated operational platform with seamless medical standards and customer experiences, supported by integrated services like IT and HR, and integrated management through service lines. This strategic vision is intended ensure Jefferson remains essential for its communities and the tri-state region amidst ongoing changes in the healthcare industry. In optimizing care settings, the parent board is considering each location/community need (geographic prioritization, service line prioritization, and service distribution) and thus its ideal suitability for:

- Acute care
- Academic
- Regional referral center
- Specialty facilities
- Community health

The hub-and-hub model has shifted to the concept of "think globally, act locally," according to Cavalieri. "We need to look globally at the enterprise and what we need to accomplish, and then determine how to best implement that at the division level."

Longer-Term Governance Evolution

"I would like the parent board to end up functioning more like a public company," said Cavalieri. "That will become easier to do as we settle in, so to speak—when the acquisition growth strategy gets translated into a strategic partnership growth strategy, with more unique relationships."

In the future, Cavalieri continued, "we would ultimately want to get the parent board down to 12, and have the parent and its committees narrowly focus on no more than four areas so that they really understand the impact of the various business lines on the enterprise. The pillar boards would become one board and in essence would serve the function of holding management accountable for the enterprise aspect of the pillars."

There are no future plans to remove division boards, but system leaders are considering some type of regional governance model at some point. "If you're getting volunteers, whether it's on the clinical side, on the philanthropy side, as two examples,

it's community-based," Crane explained. "People are interested in their local community, both from a philanthropy perspective and from a community hospital service perspective. It may not be along the historical division lines, but it certainly might be geographical. That makes more sense in the future, but it's certainly not something we're going to move to yet. Ten years from now when nobody remembers where XYZ hospital came from, we won't need to have 14 different boards. We might only need one for the north and one for the city and one for New Jersey."

Jefferson's leaders are also looking to the trustees to be philanthropists for the enterprise. This creates a need to balance board member roles to make sure that they continue to feel engaged and valued, so there is discussion of board member compensation. (There is no separate foundation board because philanthropy is handled by the Jefferson Institutional Advancement pillar board. The foundation/fundraising component is not a separate corporate entity.)

Lessons Learned

Cavalieri, Crane, and Ekarius each emphasized the importance of and need for every board to communicate well with one another, and ensuring that board members build relationships with each other. "That gets harder as we add new systems," said Cavalieri. "It ends up being about trust, because it is not representative governance. When you step into that room, you have to think about the system, not your legacy organization. You ask questions about that, and you understand the impact, but you're not making decisions solely with that legacy institution in mind."

This process has its benefits too. "With each of our transactions, we brought in new members from the other boards so that we're in a unique position to get a real group of talented, dedicated trustees," said Crane. "Each of the divisions have sent us the most dedicated and experienced trustees [for the parent board]. We have very few holes to worry about. We have skill sets across all disciplines, from governance to clinical to philanthropy to finance."

With this new governance structure, the parent board and leadership can better direct new partners towards the type of person they should select for the parent board. Necessary attributes include experience sitting on a large board and a broad perspective. "We have a very complex $6 billion academic medical center. We want to make sure that the trustees are used to engaging on a *governance*—not an operations—level," said Crane. "We try to make sure that people understand how a board member is supposed to act. And then we look at the talent and skills: legal, accounting, finance/investment, healthcare [clinical and business model], academic, and philanthropy." The Jefferson parent board has been focusing on diversity as well, and aims to continue increasing diversity as it moves forward.

Hackensack Meridian Health: Merger of Equals Informs Governance Structure

Robert C. Garrett, CEO
Tom Flynn, FACHE, Senior Vice President & Chief Compliance Officer

Background: Organization Profile

Hackensack Meridian Health is New Jersey's largest and most comprehensive health network, including 17 hospitals and more than 500 patient care locations. Services range across the continuum in an integrated delivery network of ambulatory care centers, fitness and wellness centers, home health services, rehabilitation centers, behavioral health, and skilled nursing centers spanning from Bergen to Atlantic counties.

Current Governance Structure

Hackensack Meridian Health System is governed by a "Health Network Board" that essentially serves as the system/parent board and retains all reserve powers (currently 24 members). It has several committees that report directly to it, such as quality, finance, human resources, strategic planning, and governance. Under the parent board there are subsidiary boards; the primary or most important subsidiary board is the Hospital Corporation Board, which has 32 members on it currently (both the Health Network Board and the Hospital Corporation Board will be intentionally reduced in size over the next few years). The Hospital Corporation Board oversees all hospital operations in the system and reports to the parent board. The remaining subsidiary boards oversee other non-hospital aspects of the enterprise, known as "Diversified Health." This includes the ambulatory care network, post-acute care, residential care, and home healthcare. Each of the subsidiary boards have their own committees that report to them.

Certain responsibilities are delegated to the subsidiary boards, although they are largely "advisory" rather than "fiduciary." For example, the Hospital Corporation Board does have some fiduciary authority, but the budgets and ultimate financial authority are approved at the parent board level. Some quality decisions are made at the subsidiary board level. Some decisions around strategic initiatives are made by the subsidiary boards. Major decisions or initiatives over a certain financial threshold go to the parent board for approval.

Merger and its Impacts on Governance Structure

Hackensack Health System and Meridian Health merged about three years ago. At the time of the merger, the leaders installed a structure of a representational governance to be in place for a period of 6.5 years. For the first 2.5 years there were two board co-chairs—one from the legacy Hackensack organization, the other from the

legacy Meridian organization—and the membership of the Health Network Board was 50-50 equal representation. Over time, board members will be termed off (for both the Health Network Board and the Hospital Corporation Board) to gradually reshape both boards so they are no longer representational. "We're contemplating potentially expediting that process because six and a half years is a long time," explained CEO Robert Garrett. "We're into it almost three years now. I think both legacy sides of the [parent] board feel that we've really achieved [the level of] integration [we need], and that we should now be looking at board competencies and getting the best possible board member who is the best fit and who can contribute the most to achieve our objectives. We are now moving in that direction."

When the Hospital Corporation Board was formed, it was written into the bylaws that the board would have to be reduced in size because the initial board encompassed representation from all hospitals across the network. A process was put in place at the outset that reduces the board's size every two years to eventually level off at a range of 14 to 16 members.

By the end of 2019, 12 members have left. Part of this process is to ensure that board members who leave the board remain engaged via committee participation or serving on one of the subsidiary boards or committees.

The board members knew that the board would shrink over time and that the first adjustment would take place at the end of 2019. They also knew that the process to determine who would stay and who would leave would be worked out through the governance and board development committee. "We have reminded them that this is coming up at the end of the year, and that we are setting up a formal process based on competencies, need, and diversity," said Garrett. "We take several factors into consideration and the board development committee ultimately makes recommendations for the Health Network Board about which board members should stay at that level and which should leave." Those who leave the Hospital Corporation Board are placed somewhere in the governance network, whether it is serving on a committee or somewhere within a comprehensive structure of advisory boards and foundation boards within the system.

Why This Structure?

The nature of the "merger of equals" between Hackensack and Meridian, as is often the case with mergers, was essentially what shaped the initial post-merger governance structure. "We had to create a few nuances and a unique structure of not only representational governance but equal governance," said Garrett. Co-leadership for a period of time was also needed in order for the merger to go through and for both sides to feel that they were adequately represented at the governance level. As a result, the governance structure was set up in this 50-50 manner with two board chairs and equal representation, in addition to the senior leadership structure, with co-CEOs for the same period of 2.5 years (Robert Garrett of Hackensack and John Lloyd of Meridian). "That is unusual, but it is one way to address a merger of two organizations of equal size," Garrett explained.

Running a complex healthcare system is difficult enough with one CEO, let alone two. "We defied all odds with this co-CEO structure," said Garrett. "There were a lot of doubting Thomases out there as to whether it was going to work. Surely the healthcare textbooks would tell you it wouldn't work, and other industries might say

it wouldn't work, but it did work very well in our case." Garrett cites three primary reasons that it worked in this very unusual situation (which is unlikely to be replicated in other mergers but still serves as a powerful lesson for those building a governance and management structure post-merger).

First, a succession plan spelled out in the original agreement between Hackensack and Meridian stipulated that John Lloyd would retire at the end of the 2.5-year period (essentially a transition period), and then Garrett would take over as the sole CEO. (Lloyd had already planned to retire in a similar timeframe regardless of the merger, so it was, in that sense, "easy" to determine who would become the sole CEO at the end of the transition.) That was in the definitive agreement between the two organizations, and it was well-communicated not only to the board, but to the entire organization from the beginning.

Second, in this case, the two co-CEOs had different strengths—complementary but different. Garrett came from a traditional hospital operations background, and Hackensack's focus was on hospital operations, clinical quality, and academics and research. According to Garrett, one of the things John Lloyd is most proud of in his career was establishing a continuum of care at Meridian. He recognized early on that all healthcare isn't delivered within the four walls of the hospital, so he focused on building ambulatory and post-acute care networks. Meridian needed the clinical chassis that Hackensack offered, the academic infrastructure, and the research endeavors. Hackensack needed the continuum of care service lines.

As a result, both sides benefited and it was a very complementary merger. To make this arrangement even stronger, the two executives agreed early on about who was going to be responsible for which areas of the enterprise.

Third, and perhaps most unique of all, Garrett and Lloyd had known each other for 30 years. They respected each other and followed each other's careers closely. They each held onto a solid level of trust coming into the co-CEO model. "We don't recommend this for most other organizations," cautioned Garrett. "You must enter into it very carefully and make sure those success factors are there."

Integrating Governance and Management

In January 2019, both the co-CEO period and co-board chair period ended. Similar to the co-CEO transition period, the two co-chairs also enjoyed "good chemistry." Both sides were very thoughtful regarding who they nominated to be co-chair. "They're both very collaborative individuals," said Garrett. "They did not know each other like John and I did, but they got to know each other through the merger discussions. There was a lot of mutual respect and they've been very thoughtful in terms of how they run meetings, alternating during the meetings as to who takes the chairmanship role for different parts of the agenda. They speak offline to align on a variety of issues, and there hasn't been much conflict. We did a lot of integration planning with the board before the merger actually took place."

This integration planning took place about seven or eight months prior to the merger, and it gave board members the opportunity to not only get to know one another, but also to develop a set of aligned strategic priorities for the new Hackensack Meridian Health. "When we closed the deal, we were able to hit the ground running with these aligned strategic objectives," said Garrett. They held a board retreat before the merger with the new board to align the strategic priorities. From

the first board meeting post-merger, Garrett indicated that it was very difficult to discern who was a Hackensack legacy person or a Meridian legacy person, even in terms of where they sat in the room. "It was very natural from the beginning. The two co-chairs set that tone from the beginning and the board integrated effectively and quickly as a result," said Garrett.

In order to ensure a smooth transition, potential bumps along the journey were anticipated. Pre-merger, both sides agreed on 85 to 90 percent of how things were going to be structured. A lunch meeting was held offsite with the two future co-chairs, two future co-CEOs, and legal counsel to work out the remaining 10 to 15 percent. It took about two or three hours, and even a few of the more contentious items were resolved in that single meeting. Those decisions were taken back to the respective boards and everything was ratified.

The clinching of the merger between Hackensack and Meridian was really a cultural match-up. An outside consulting group conducted a cultural alignment strategy and interviewed people at the board level all the way down to frontline team members. Leaders of both sides knew from that exercise that there existed a high degree of cultural alignment throughout each level of the organization. That provided validation that the culture was strong, and served as a significant springboard to enable the integrated culture to dominate virtually immediately.

Next Steps and Priorities for an Evolving Governance Structure

As described earlier, both the parent board and the Hospital Corporation Board are currently in process to move away from representational governance and to become "right sized." The system has a host of other subsidiary boards that oversee various businesses outside of the hospital that make up the continuum of care. There are many of them and Garrett and the board see some opportunity for consolidation. For example, there are currently multiple boards overseeing ambulatory and post-acute care; they are considering whittling that down to one ambulatory board and one post-acute board.

Garrett envisions a structure that includes committees of a consolidated "continuum of care board" that would deal with the various aspects of the businesses that are within the larger entity. The separate board structures are a bit cumbersome, difficult to manage, and can lead to confusion amongst the board members as to what entity is responsible for which business line.

However, the system is still growing, with Carrier Clinic the newest member as of early 2019. "I think what serves us well is that we have established an integration model, both for governance and for operations, that can be repeated," explained Tom Flynn, Senior Vice President and Chief Compliance Officer. "We have established a process and repeated it, as far as how we're integrating the entity and management operations."

Flynn strongly believes that success requires the management structure to align with the governance structure. "As our governance structure evolves, I absolutely believe that's going to be the case. We have divided our operational structure into three regions. We're now working on creating three regional advisory boards that will represent each of those regions and the activities that go on within those regions. And then they will report up to either the Hospital Corporation Board or the Health

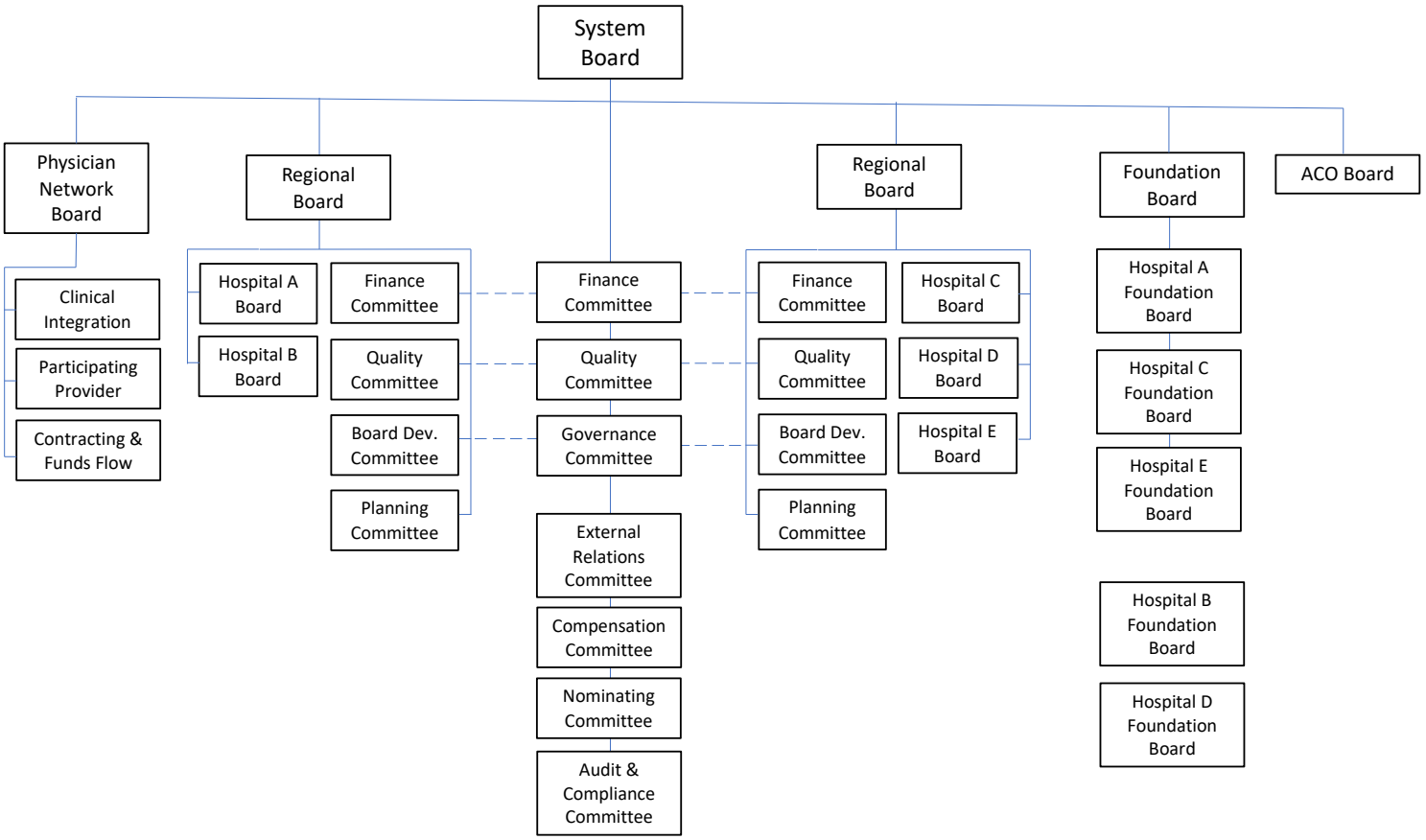
Network Board. So that's a good example of how governance will change to reflect the operational structure."

Finally, the system is working diligently on transforming the care delivery model, and to date has created several care transformation services centered on the most common chronic diseases. The governance structure will have to be modified to reflect how the system is looking at delivery of care and care transformation moving forward. To that end, they have created a Care Transformation Committee of the Health Network Board to oversee these activities.

Appendix 1.
Examples of Health Systems Moving Toward Operating Company Models

Health System A
Pacific Northwest
Net Patient Revenue: $2 billion

System Structure Jan. 1, 2017

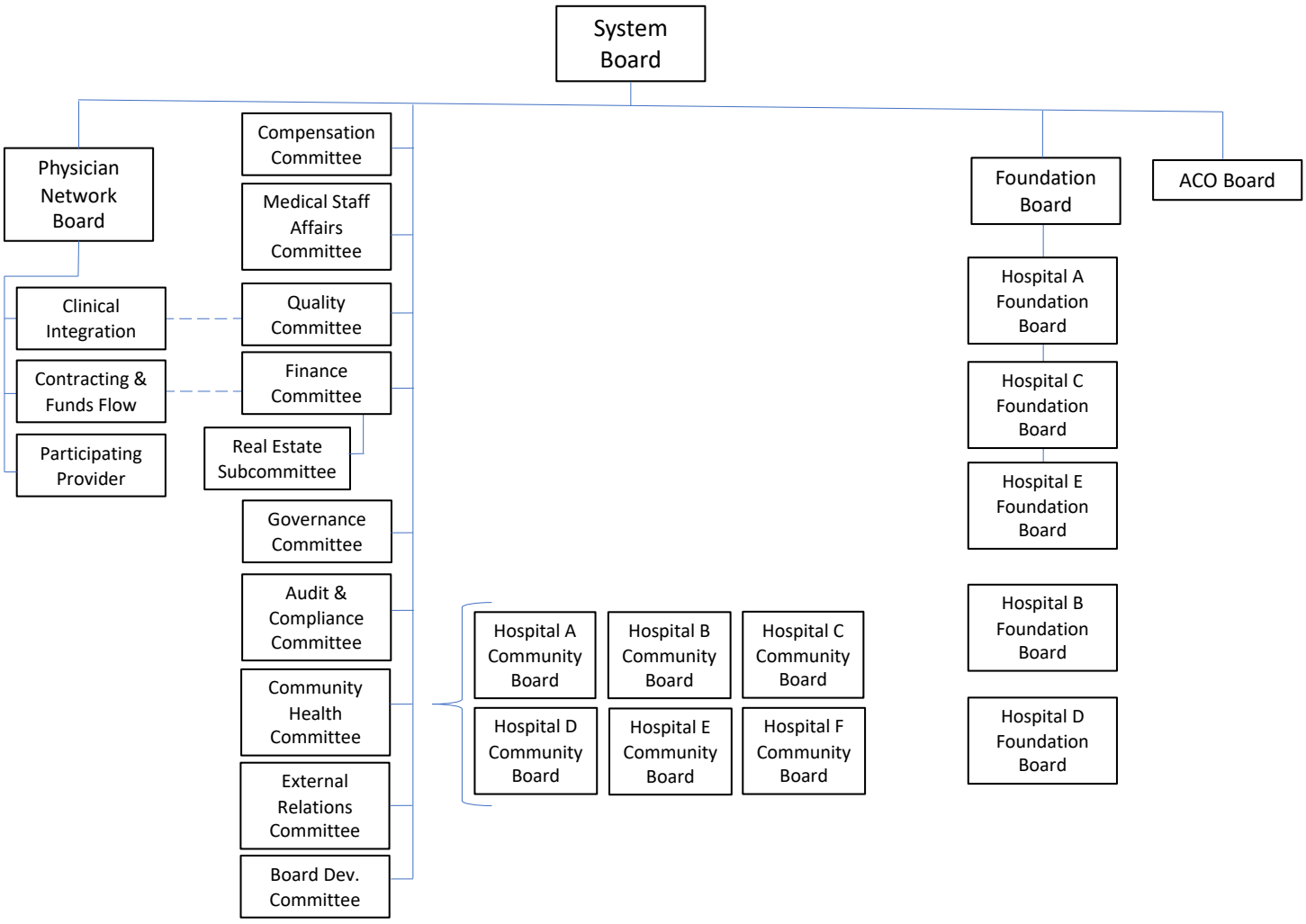


Health System A

Pacific Northwest

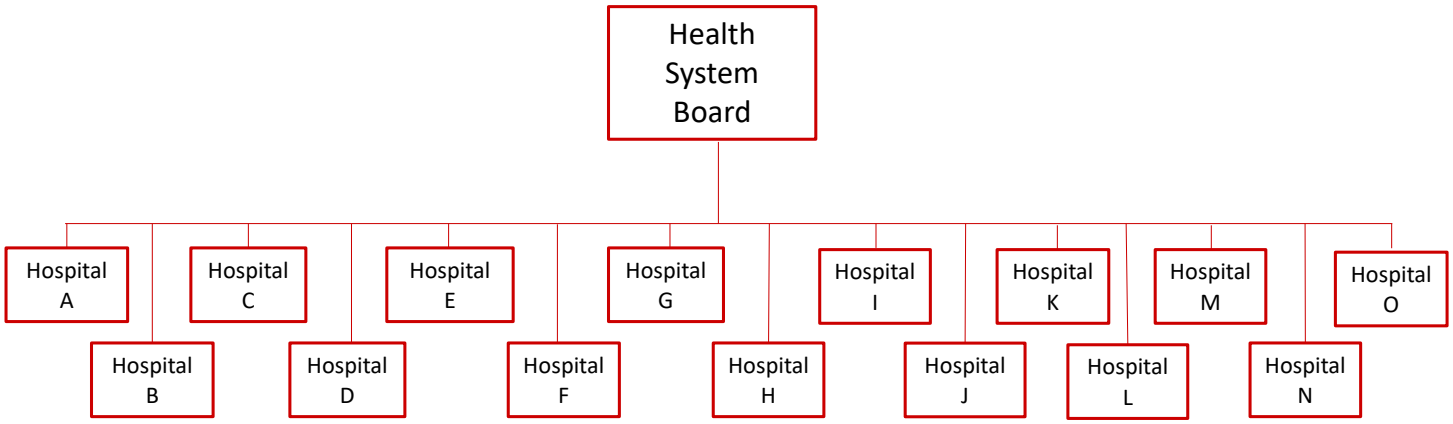
Net Patient Revenue: $2 billion

System Structure Oct. 1, 2018



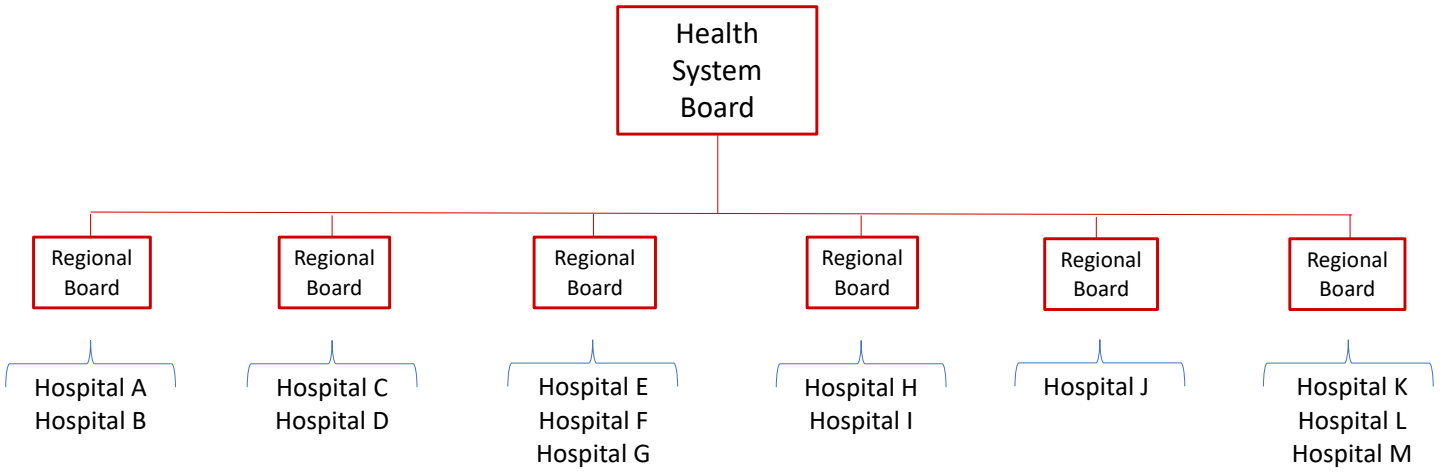
Health System B
Midwest
Net Patient Revenue: $4.5 billion

System Structure Jan. 1, 2013



Health System B
Midwest
Net Patient Revenue: $4.5 billion

System Structure Jan. 1, 2018



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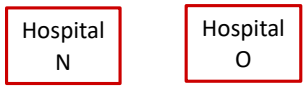

Appendix 2.
Sample Authority Matrices

Health System B Authority Matrix

Key:

A: Approves I: Provides input and recommendations

Decision	System Board	Regional Board
Strategic Planning		
System Strategic Plan	A	I
Community strategy development in region (aligned with system strategy)	A	I
Monitors performance and accountability	I	I
Financial Operations & Management		
System operating budget	A	
Region operating budget	A	I
System capital budget (annual/long-term)	A	
Region capital budget	A	
Debt financing	A	
Integrate key administrative functions (Finance, IT, HR)	A	
Quarterly performance reviews	A	I
Quality/Medical Staff Oversight		
Establish scorecard metrics and annual system quality objectives/plan	A	
Accountability for region scorecard; establish region quality objectives/plan	I	A
Region medical staff appointments		A
Medical staff bylaws	I	A
Executive Oversight		
Select region president	A	I
Establish region president's annual objectives	A	I
Conduct region president's performance review and set compensation	A	I
Values & Ethics		
System community benefit plan and report	A	
Annual mission and values plan	A	
Region community benefit plan and reports		A

Another Sample Health System Authority Matrix

Key:

A: Approves R: Recommends I: Informs

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