Aligning Management and Governance Structures for System Success

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The American Hospital Association (AHA) reports that 68 percent of hospitals in the United States are now part of a health system.[1] Some hospitals have joined or created systems because of financial challenges (e.g., reduced reimbursement, increased workforce expenses, and expensive information technology); however, most systems were developed because their leaders believed that model would allow for better care at a lower cost.[2] In fact, data from AHA indicates that through hospital acquisitions, systems *have* been successful in reducing costs, lowering expenditures, improving quality, and increasing access to services.[3]

However, too often, the promised benefits of "systemness" and "integration" are not all realized. There are many potential reasons that some systems fail to achieve their desired outcomes. This article focuses on one problem that has not received enough attention: insufficient alignment among the organizational structures.

Within a health system, there are typically four levels of organizational structure/design:

1. Legal, corporate entities (e.g., corporations)
2. Governance structure (e.g., boards and their committees)
3. Management structure (e.g., boxes on the staffing chart)
4. Clinical structure (e.g., medical staff structures)

This article addresses common misalignment between the governance and management structures.

Case Study: Structural Misalignment

A case study will help explain a typical situation in which the governance and management structures were not aligned, causing suboptimization of integration efforts.

The CEO of a Midwestern health system had begun to implement the board-approved vision of increased systemness by changing the management structure to a more centralized model. As with most health system journeys, she started with the non-patient-facing functions, such as human resources, finance, and information technology. The CEO named system-level executives and decided that each individual hospital's senior management in these functions would report to the system Chief Financial Officer, Chief Human Resources Officer, and Chief Information Officer. In addition, the administrative head of each hospital was renamed the President (not CEO) and those individuals now reported to the system CEO.

Although these management structure changes were in line with the vision to become more of an integrated, centralized system, problems arose because the governance structure was still decentralized. Each of the seven hospitals had a board that retained significant authority for key governance tasks, such as approving the annual budget, capital plan, strategic plan, external audit, and their executives' compensation. In addition, the hospitals' bylaws still stated that their boards oversaw the hospital CEO's hiring and evaluation, and if necessary, replacement.

Tension built at both the system and local levels. For instance, the system CFO was frustrated because she was trying to build the annual budget for the whole enterprise but was not receiving the needed data from a local hospital finance director. The hospital board's finance committee chair was frustrated because he thought that their board had the authority to create and approve their own budget. The local finance director felt caught in the middle because he was waiting for approval of their proposed budget from the hospital board's finance committee before providing that information to the system CFO.

The same scenario was playing out in multiple functional areas. One hospital board's executive compensation committee was working with a different compensation consultant than the system board's compensation committee, making it difficult to align compensation approaches across the system. Another hospital board's strategic planning committee had developed their own situational assessment and vision that was not consistent with the system's view of the external and internal environments or its 10-year strategic plan.

To complicate matters, some local hospital presidents and some medical staffs liked having their own board. Physicians could appeal to the board members they knew when they wanted approval of expensive medical equipment that the system had declared redundant. Some hospital presidents wanted to retain more local decision-making authority and used their boards to delay or fight implementation of system initiatives.

››› KEY BOARD TAKEAWAYS

- Too often, health systems are suboptimized because their governance and management structures are not aligned with each other and/or the system's strategy.
- To identify potential misalignment, board members and managers need to be engaged in education and discussion about how best to support achievement of the system's vision and strategy.
- Board and executive leadership should both make changes to their structures and practices to ensure all are rowing in the same direction.

Diagnosing the Problems

In response to these tensions, the system CEO and board leadership authorized an external assessment to diagnose the problems and recommend solutions. As a result of that study, they realized that the decentralized governance structure had become a barrier to the management team's ability to implement the strategic vision of a more integrated system.

Granted, the hospitals' bylaws stated that the system was the sole corporate member and had some reserved powers over the hospital boards. But the hospital boards were still functioning as if they were standalone instead of part of a system. For instance, hospital board committees existed for governance responsibilities that had been delegated to the system board (e.g., executive compensation).

Craig Deao, who co-led Studer Group's journey to become a recipient of the Malcolm Baldridge National Quality Award, shared his perspective on this and similar situations.[4] "Systems are created, bylaws are drafted, all designed to enable the organization to operate as a system; but the governance structure

1 AHA, "2024 Fast Facts on U.S. Hospitals," 2024.
2 See Pamela R. Knecht, "Remind Me: Why Do We Need Systemness?," System Focus, The Governance Institute, June 2018.
3 Sean May, Monica Noether, and Ben Stearns, "Hospital Merger Benefits: Econometric Analysis Revisited," AHA, August 2021.
4 Craig Deao is Managing Director at Huron Consulting Group.

still reinforces optimizing each piece of the system rather than the system as a whole. This goes directly against modern system theory espoused by experts such as Russell Ackoff who said, 'The performance of a system doesn't depend on how the parts perform taken separately, it depends on how they perform together—how they interact, not on how they act, taken separately. Therefore, when you improve the performance of a part of a system taken separately, you can destroy the system.'"

The local hospitals and boards described above were focused on their individual success, and by functioning this way, they were suboptimizing the system's performance.

The Fix

The first step in fixing these problems (and ultimately achieving the benefits of systemness) was to ensure that the strategy was understood and shared by all. The system CEO, executives, and board leaders hosted an all-boards retreat that included education on and discussion about the future healthcare environment, the advantages of systemness, the system's strategy, and trends in health system governance. Each table discussion was led by a facilitator who encouraged participants to ask questions about the strategy and to identify possible implications of the strategy for the boards and their committees.

Subsequently, a governance task force worked with an external consultant to clarify the strategy, develop a case for change, create design principles, and explore governance structure options. The task force ultimately recommended governance changes that created more alignment with the strategy and the management structure. For instance, hospital boards became focused on oversight of quality, safety, patient satisfaction, and community health needs identification. The parent board and its committees now handle strategic planning, operating and capital budgeting, audit, and executive compensation, among other duties. Since the hospital boards were no longer handling those tasks, they eliminated the associated committees. Well-meaning hospital board committee chairs and managers were no longer doing work that was redundant with the system board and executives, so tensions disappeared.

In turn, the system CEO worked with her hospital presidents and other executives to clarify the management structure and processes to be more aligned with the governance structure. In addition, they engaged the hospital boards and management teams in coordinated initiatives to learn about local needs while advancing integration across the system.

With new clarity of purpose, roles, and authority, those serving in governance and management positions were better able to work together towards a common vision. And, when surveyed, board members and managers throughout the system felt that their contributions were more valued and valuable. As a result, the organization had moved much closer to optimizing the systemness needed to improve their communities' health.

*TGI thanks Pamela R. Knecht, President and CEO, **ACCORD** LIMITED, for contributing this article. She can be reached at pknecht@accordlimited.com.*