Effective Governance in Systems

Monograph Series

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The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information visit www.americangovernance.com.

The American Hospital Association's

CENTER FOR HEALTHCARE GOVERNANCE™

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Overview

The ongoing realignment of the health care field has resulted in many community hospitals now being part of larger health care systems. These systems range from national organizations with hundreds of care delivery entities and other not-for-profit and for-profit subsidiaries to small, local, single-hospital systems that may also include ambulatory care facilities and other organizations focused on delivering services to populations of patients across the care continuum. Regardless of their size and scope, all systems are evolving in response to the increasing complexity arising from a field in transformation; and often their structure, function and governance reflect this complexity as well.

The good news is that, because systems have been forming for more than 20 years, some general observations can be made both about how they are developing and how they are being governed (*Great Boards*, Summer 2014). More than two decades of system development also has yielded practical experience about essential governance practices and stumbling blocks to avoid in creating an effective web of governance among multi-organizational systems with many, layered boards. This experience also has produced approaches and tools systems can use to further improve their governance.

This publication discusses observations and trends about system development and identifies models of governance that are emerging as new organizations form and determine what it really means to become a system. It also reviews issues and obstacles that can arise as models of governance change and suggests steps boards can take to address them on the path toward more effective system governance.

The Evolution of Systems and Their Governance

Multiple trends are contributing to system formation. Among them are:

- declining reimbursement;
- increasing out-of-pocket costs to consumers resulting in weaker demand, especially for inpatient health care services; and
- the overall movement toward fee-for-value versus fee-for-service payment.

These trends have fueled the realignment of hospitals, physician practices, ambulatory care facilities, home care, long-term care, fitness and wellness centers and other medical care and equipment organizations into larger care systems. (*Jarousse*, September 8, 2014).

According to Nolan, Dixon and Myers (October 7, 2013), system development occurs in three stages. Asset Aggregation, Functional Integration and System Optimization. Governance at these stages tends to reflect the needs of evolving systems.

In the first stage of Asset Aggregation, health care organizations focus on bringing their hospitals and other assets together under a single parent organization. Governance of these nascent systems is typically decentralized, with boards in place at both system and subsidiary levels. System boards are composed of board members and other "representatives" from subsidiary organizations, often a necessary step to accomplish system formation. Subsidiary boards may retain substantial autonomy and decision-making, because an integrated or centralized form of governance is not yet needed to achieve system goals.

At this stage systems may be hampered by top-heavy governance structures, with multiple boards and committees uncertain about their relative roles, responsibilities and

authorities. Creating a common governance culture can be challenging when board members view their role to be more about governing on behalf of the organization they came from rather than the newly formed system (*Great Boards*, Summer 2014).

In the second stage of Functional Integration, systems focus on achieving efficiencies through centralizing or standardizing functions organization-wide. Governance also tends to move toward a more centralized focus, with more power and authority vested at the parent or system board, which exercises oversight over consolidated functions. System board governance responsibilities often include strategic planning and oversight for finance and system-wide contracting. As these organizations streamline and right-size their structures and activities, governance may also follow suit. Local boards in this stage of system formation may reduce their size or tighten their committee structures as power moves up to the system board and relative roles and authorities among boards become clearer.

Governance effectiveness at this stage hinges on clarity of responsibilities and authority, not only among boards, but also among system leadership. In their report *Governance in Large Nonprofit Health Systems* (2012), Prybil and colleagues note that:

> *"In all complex, multi-level organizations, clarity in the allocation of responsibility and decision-making authority is imperative. A lack of clarity, misunderstanding, and/or uncertainty will create operational problems and adversely affect organizational performance. In the world of health systems, especially those whose hospitals and other delivery organizations are geographically dispersed, a clear definition of the respective roles, responsibilities, and authority between system-level and local leadership is a fundamental indicator of effective governance."*

In this stage of system development, subsidiary hospital boards frequently have more limited fiduciary responsibilities, such as oversight for local organization quality, credentialing, community health needs assessment and community relations. In larger systems, local governing boards may be replaced by boards or councils that primarily provide input to the system board; or local governing board responsibilities are aggregated and assigned to regional boards that oversee performance across broader geographic areas. The goal is to ensure that governance is efficient and adds value at every level.

In her article, "Aligning Governance and Business Models to Achieve the Best Fit" (*Great Boards*, Winter 2014), Pam Knecht describes what governance might look like at this stage, outlining the characteristics of what she calls the Modified Operating Company approach to governance. Knecht suggests that this approach to governing tends to emerge as systems shift their business model from a more decentralized holding company to a more centralized operating company. The box on page 6 provides additional details about governance in the Modified Operating Company business model.

Challenges for boards at this stage include making tough decisions to streamline or eliminate some services or functions as the system begins to focus on strategic growth. As governance becomes the focus for some of these decisions as well, boards need to get comfortable abandoning past practices or roles no longer suited to their evolving enterprise. For example, some board members may no longer participate in governance or be asked to assume different roles that do not involve the breadth of decision-making or fiduciary responsibilities they assumed in the past. Board members also may need to deepen oversight in areas such as compliance, organization-wide risk and board development. They also will need to dedicate themselves to continuous learning to keep up with issues and trends,

Characteristics of Modified Operating Company Governance

- A parent board exists with external community members; it may or may not include members from outside the service area.

- Subsidiary corporations are consolidated, and if possible, eliminated. There is increased use of management boards for the subsidiary corporations that must remain according to state or federal law or for reimbursement reasons.

- Mirror boards (in which the same individuals serve as the board members for multiple corporations) are utilized.

- Subsidiary corporation boards have external community members only if it is necessary (e.g., Accountable Care Organizations' boards must include beneficiaries) or if it is helpful to the parent board for a particular business line to have a separate community board (e.g., for-profit ventures; employed physician group; health plan; care delivery board).

- Subsidiary boards have few or no committees.

- Individuals from throughout the service area serve on the parent board's committees and on subsidiary boards. Each remaining board's and committee's roles and authority are very clear and focused. Each has the correct skills, competencies and perspectives to perform the work described in its charters.

Source: "Aligning Governance and Business Models to Achieve the Best Fit." *AHA's Great Boards*, Winter 2014.

such as consumerism and population health, that are driving changes in care delivery and payment.

As systems further evolve to operate more effectively in a value-based environment, they work to achieve System Optimization—the third stage of system development. Activities in this stage focus on quality improvement, cost reduction and eliminating variation in care delivery through adopting best practices and providing the right services at the right times in the right locations. Here, success requires a centralized approach to governance—what Knecht describes in its most streamlined form as a Pure Operating Company Governance Model (see box on page 7 for more details). Here, the end game is to move to one board. Subsidiary corporations and boards are kept to a minimum. One or more advisory groups or councils may replace local hospital boards to provide broader, local input into system governance.

While the pure operating company model of governance may best position the board(s) to help a system optimize its performance and is sometimes cited by governance experts as the model systems are or should be moving toward, this model exists in relatively few systems today. Prybil and his colleagues found that, of the 14 large health systems they studied, only two came closest to this governance model, with some boards still in place at subsidiary levels due to statutory and other requirements. Far more common today is a system governance model where multiple boards at different levels, such as system, regional or local entity boards, are

Governance in a Pure Operating Company Model

- Only one board exists with external community members—the corporate/parent board.

- The absolute minimum number of subsidiary corporations is retained—only those that are necessary according to federal or state law or for reimbursement or compliance reasons.

- Any subsidiary corporations that remain have management boards, not boards with external community members.

- Local hospital boards are eliminated or become advisory councils.

- Executives throughout the system report to the system CEO (not to subsidiary boards).

- The parent board's size is leaner and the majority of its members are external community individuals, many of whom are from outside the service area because of their expertise.

- Goal setting, oversight and decision-making are centralized at the corporate level board.

- Strategic planning, financial planning and capital planning are driven from the top.

- Quality, patient safety and patient satisfaction goals and processes are set by the parent.

- Committees of the system board oversee executive compensation, audit, compliance, risk management and governance.

- The parent board delegates substantial work and authority to its committees.

- As many processes and decisions as possible are handled within management and medical staff structures within pre-defined parameters (e.g., some financial and quality approvals).

Source: "Aligning Governance and Business Models to Achieve the Best Fit." *AHA's Great Boards*, Winter 2014.

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working toward clarifying and optimally functioning within their relative roles and responsibilities.

To maximize the value they contribute at this stage of system evolution, boards must become facile at mixing advisory and decision-making roles to eliminate confusion and duplication of effort. System boards may meet less frequently for longer periods of time, with committee meetings held before board meetings, similar to public company boards. Information appropriate for governing (high-level; summarized, with the capability to drill down as needed; depicting patterns and trends) and decision-support resources will be needed to ensure boards can adeptly

carry out their responsibilities. Performance evaluation at every level of governance (full board, board member, committee chairs, board officers and board meetings) becomes critical to ensure continuous improvement and accountability to stakeholders. Board membership is competency-based as every board seeks members with the specific knowledge, skills and personal capabilities needed to govern specific organizations within the larger system.

Governance expert Barry Bader sees systems moving toward one of three governance models or borrowing key elements of each to form a unique hybrid model. These models, which reflect many of the governance

Three Models of System-level Governance

Professional Governance Model

- Emerging among health systems that envision themselves as "health companies" that embrace the culture of a high-performing, customer-focused enterprise.

- Incorporates many of the attributes of the more streamlined or centralized governance models described above.

- Governance at the parent level is viewed as a professional commitment with higher standards than those embraced by the typical volunteer board.
  - Directors are removed for non-performance.
  - Directors are chosen based on competencies and not whether they live in the communities the system serves.
  - The board is high-level, strategic and performance-focused.
  - Board members may be compensated.
  - All board members are independent with no conflicts of interest.

Clinical Enterprise Governance Model

- Found among multi-specialty medical groups that own hospitals and other facilities.

- Often features "dual boards"—a parent or foundation board that functions like the Professional Board described above and a clinical enterprise board of senior executives and senior clinicians accountable to the parent that directs the organization's clinical operations.

Enhanced Community-based Governance Model

- Likely to be used by care systems that define themselves by their close connections to the communities they serve.

- Enhanced community boards govern entire or parts of care systems and incorporate elements of the Professional Board and Clinical Enterprise Board models.

- Most board members will be chosen based on competencies, will live in communities the system serves and will not be compensated.

- These boards will include aligned physicians chosen using objective criteria and not to represent the medical staff.

- These boards will adopt best governance practices, place a high priority on strategic thinking and quality performance and value strategic relationships with parent boards, as appropriate, and community partners.

Source: "Advent of "Care Systems" Means Governance Must also Transform." *AHA's Great Boards*. Spring 2013.

characteristics described above, are summarized in the box on this page.

The streamlined and centralized governance models emerging in more mature stages of system development focus on adding value by helping systems optimize their performance. However, they also share some common problems that must be addressed for governance to reach its full potential to support system-wide success. Some of these challenges go beyond the system or its governance and are rooted in larger societal trends, as discussed in the following sections.

Challenges with a Centralized Model

According to a recent study published in the *Journal of Personality and Social Psychology* (Twenge, et. al., 2012), civic orientation and desire to give back to the community has been steadily declining since 1966. Many in the Traditionalist and Baby Boomer generations were instilled with a sense of duty to give back to their community, and local businesses often encouraged board service as an important part of leadership growth. This was beneficial to hospital board recruiting for years, enabling selection of trustees from the brightest leaders in the most successful businesses, who also benefited from the prestige of attaining a coveted board seat in an organization of stature in the community.

According to a report released earlier this year by Richard Fry of the Pew Research Center (2015), Millennials now represent a larger share of the population than any other generation, including the Baby Boomers. According to Twenge, et. al. (2012), Millennials have different priorities; and community service, such as being on a board, means less or something different than more traditional notions of civic duty. As a result, for many health care organizations, board recruiting is becoming increasingly challenging. This trend will likely worsen in the future as availability of Traditionalists and Baby Boomers declines.

When individuals, regardless of generation, decide to serve on a board, they often do so to advance their career and community stature and/or to give back to their community in a meaningful way. Individuals who value community service are crucial to building and maintaining effective, competency-based boards. Serving on a board takes time away from work, family and leisure activities. Even generations prior to the Millennials have been reluctant to sacrifice their time unless they believe that what they are doing really matters. Millennials are even less likely to do so (Twenge, et. al., 2012).

Beyond generational differences, people typically do not believe serving on advisory boards, councils or other groups is as worthwhile as serving in a fiduciary capacity as a board member. It likely will be increasingly difficult to recruit reliable, successful leaders to purely advisory boards that have no meaningful or important function other than raising funds or providing a connection to the community.

This may create a conundrum for hospitals or health care systems that desire a more centralized model of governance, but choose to retain some boards that are primarily advisory to maintain a connection to the community. Even gradual loss of experienced community leaders at any board level ultimately results in: 1) boards populated by less seasoned leaders; 2) management-based boards at the local level, which inherently lack wide-ranging, diverse competencies; or 3) elimination of local boards.

Eliminating community boards or governance by management-based boards has implications for a system with multiple hospitals and/or business units. Internal boards may lack competency balance and the diversity of perspectives often needed to govern efficiently and effectively. If local boards are eliminated in favor of regional or system governance, there is generally a loss of community connection and support and the ability to understand cultural variations in different communities served by the system. And, regardless of governance structure, regional or system boards may find it difficult to properly oversee performance and maintain accountability for each hospital and business unit.

Maintaining a fiduciary governing board for each hospital and business unit also comes with challenges. Some health systems retain separate corporations for each business unit, thereby requiring each to have a governing board. However, most states do not also

- Entity boards are referred to as "advisory" and it is made clear that they have no decision-making authority. This leads to board members not believing their time is well spent.

- Entity boards retain some limited authority and oversight responsibilities; however, no board job descriptions or authority matrices exist to clearly delineate the authority of the entity boards in relation to regional and/or system boards. Role confusion leads to frustration, dissatisfaction and lack of engagement, resulting in poor member attendance and retention, as well as ineffective and inefficient governance.

- Sound governance principles and practices are only applied to the system board (e.g., orientation, education, self-assessments, standardized policies and practices, etc.) and not to the entity boards. This creates the perception that the entity boards are unimportant and renders them less effective. This error often goes hand-in-hand with a lack of communication or interconnectedness among the system and entity boards.

- Entity boards function with some degree of authority that is not standardized or aligned under a centralized umbrella. In other words, each board is an island, free to carry out its work in any manner it deems appropriate. This leads to a lack of alignment, no opportunity for standardized best practices and governance principles, and redundancies. This may also lead to inefficient duplication of authorities and structures with the system board (e.g., having the same committees at both levels).

require these boards to have significant decision-making power. As noted above, some health care systems already are centralizing the majority of authority at the system board. A governance model that has a strong parent board and a number of boards with limited decision-making authority can be efficient and effective if the critical mistakes listed in the box above are avoided.

In a transformational health care environment, a model in which entity boards operate as islands, each setting its own course and direction without standardization, is likely to produce fractured, dysfunctional governance. Conversely, a pure operating model of governance with no entity boards and all decisions made at the regional and/or system level while efficient, may leave tattered community and medical staff relationships in its wake.

An Effective Enhanced Community Model

Like any field in transition, governance transformation can benefit from a pause to re-evaluate the fundamentals necessary for optimal efficiency and effectiveness (see box describing Hartford HealthCare governance on page 11).

According to governance expert James E. Orlikoff, effective governance is based on the explicit principles listed in the box on page 11.

With these principles in mind, certain fundamentals should be deployed in determining the best structure for a particular health system:

- *Minimalism.* A health system should determine which entities would benefit

from having a community board. Not all do. In general, non-profit hospitals are largely viewed as community assets. Therefore, having a community-based board may make sense. Conversely, a long-term acute care hospital or outpatient surgery center located on the campus of a hospital may be separate legal entities, but are largely viewed by the community as being part of the hospital. Having separate community-based boards for these types of facilities may create unnecessary governance layers.

Having the same committees for multiple boards is inefficient and creates unnecessary and potentially problematic redundancies. In some large systems, such as Texas Health Resources, system board members chair centralized committees, with membership based on competencies contributed by board members across the system. This not only eliminates redundant committees, but also widens the competency pool and allows for greater interaction and involvement between system and entity board members. Further, entity board members that serve on system board committees are able to go

back to their local boards as emissaries of the system vision and strategies.

- *Consistency.* If it is determined that one or more system subsidiaries should be governed by a community board, that board should be treated as an important governance entity. Such boards should be structured in a standard manner utilizing widely accepted governance principles related to size; competency-based member selection (with attention to competency mix and diversity); roles; responsibilities and expectations; and common approaches to orientation, education and meetings.

- *Authority.* Job descriptions for system and entity boards should be established that clarify relative roles, responsibilities and expectations. An authority matrix that defines the relative authority among the system board, regional boards, entity boards and management also should be developed. These governance tools should be periodically reviewed and discussed with every board.

Intentionality. In multi-board organizations, all entity boards play an advisory role in some fashion, even those with specific decision-making authority (e.g., quality, credentialing). For example, Texas Health Resources has 33 wholly controlled entities. Not all are hospitals, but each has a board, although some related entities share a common board. Hospital boards have direct decision-making authority for medical staff credentialing and some quality functions; most decision-making authority is centralized to the system board. However, unless system board meetings were scheduled monthly for two full days, the system board could not possibly monitor performance (financial, quality, patient experience, etc.) in any great depth for each of those entities. Further, it would be difficult for system board members to ask questions of each entity management team and hold them directly accountable for performance.

At Texas Health Resources, entity boards are charged with overseeing the performance and quality of care provided by their organizations. The system board relies heavily on this oversight role, which allows it to focus on the broader strategic and prospective discussions critical to effective governance at the parent company level. Orientation, education and communication for entity boards emphasize their critical oversight roles and clearly explain their authority. Hence, entity board members recognize the importance of their work and their service to the community.

Communication to and about entity boards is critical to the success of an Enhanced Community Model of governance. Consider what may be gained—and lost—by referring to entity boards as "advisory." Though they may primarily provide valuable input and act in an advisory capacity to both the system board and senior leadership, entity boards also are often charged with critical oversight functions. The word "advisory," which may imply lesser value and importance, should be eliminated from the vocabulary of board members and management. If an organization believes there is value in creating and maintaining a community board, regardless of its level of authority and decision making, that board should be treated and referred to with the dignity and respect it deserves. If there is no value, then it should be eliminated as an unnecessary layer of the governance structure, and the organization should move closer to the Pure Operating Model of governance described above.

Although some organizations are re-evaluating a community-based model of governance, others are flourishing and making that model work effectively and efficiently. Key characteristics are present in the models utilized by these successful organizations.

Making It Work: Building System Governance Effectiveness

Creating positive relationships among system and entity boards and maintaining entity board member satisfaction are issues that frequently arise in conversations about governance effectiveness in systems. Longitudinal data from both system and hospital board self-assessment surveys administered through the American Hospital Association's Center for Healthcare Governance GAP (Governance Assessment Program) also suggest these issues deserve further focus.

Closer examination of the governance structure and practices of organizations struggling with a community governance model often reveals that resources, time and focus are dedicated almost entirely to the system board, with little support given to entity boards. It is not unusual to find that these organizations commonly refer to their entity boards as "advisory," and provide them with little or no orientation, education, self-assessments, structure or other components of a sound governance program. GAP data also indicate lower levels of agreement among respondents about whether hospital boards in systems have job descriptions, regularly conduct board self-assessments, and use assessment results to engage the board or to analyze the board's strengths, weaknesses and development opportunities.

It is also common for community boards viewed as purely advisory to have roles primarily defined by connection to the community and ability to advance philanthropy for the organization. Consequently, selection of board members may be based on philanthropic reach in the community, rather than on a diverse mix of competencies, since competencies may be viewed as less important for an advisory board. This approach to board focus and composition is unlikely to achieve optimal results for the health system or for the individuals serving on these boards.

With the possible exception of fundraising foundation boards, our experience suggests that boards whose members are selected for their philanthropic reach often are not as effective as they could be when tasked with providing operational oversight and input to the system board on strategic, financial and other issues. Board time typically is not spent on fundraising or other topics these individuals find most interesting, meetings are largely filled with retrospective updates that few find energizing, and little attempt is made to engage board members in meaningful discussion. These boards invariably find that member engagement and attendance wane over time, followed by resignations and difficulty recruiting new members.

Contrast this with organizations that recruit community leaders to serve on entity boards based on the competencies needed to provide financial, quality, clinical and operational oversight and informed input to a system or parent board. With emphasis placed on their oversight roles and community leadership and with the right board structure and support, members of these boards are likely to find their service to be rewarding and valuable to the community.

Organizations that have largely centralized governance authority, but also maintain high-functioning subsidiary boards, often rely on a consistent board structure and infrastructure through which these boards are informed, hold meetings, and carry out their business. GAP data, however, show that an appropriate degree of standardization may not exist in numerous areas among hospital boards in systems.

These results may indicate a missed opportunity for many organizations. Creating a common governance plan that calls for all hospital boards to have standardized governing documents (articles of incorporation, hospital bylaws, medical staff bylaws; policies and charters; meeting agendas and minutes, etc.) and governance practices (educational opportunities and

resources; regular performance evaluation; access to a board portal, etc.) promotes alignment, and makes the care and feeding of numerous boards more manageable. Having a chief governance officer or, at minimum, a centralized board manager or director devoted full-time to governance can support development and implementation of a system-wide governance plan.

In addition to functioning in a common manner, entity boards also need to interact with each other and the system board. Texas Health Resources holds an annual leadership conference for all system and entity board members, physician leaders and senior executives. This conference combines health care industry education and organization-focused strategic direction. Most importantly, the conference includes significant opportunities for structured interaction among all boards and relationship-building with physician leaders and senior executives. Other organizations also have developed opportunities for bringing system and entity boards together, such as "buddy" or mentor programs or taking boards to an external conference and scheduling time there for a board retreat.

Another effective mechanism for creating strong relationships among system and entity boards involves information sharing at each board meeting. For example, meeting materials for the system board might include a brief report from each entity board describing key activities, issues and performance. Each entity board meeting could include an oral or written presentation from the system that shares highlights of system board discussions and decisions. Entity board members serving on system board committees can share with their entity boards perspectives on what they learned and discussed at system committee meetings. Activities like these can help maintain an ongoing connection between system and entity boards.

Finally, the trend toward making board meetings more engaging by spending more time on prospective and strategic discussion and less time on retrospective reporting offers another opportunity for connection among system and entity boards. Transformational boards are allocating more time to well-planned, forward-looking, facilitated conversations about strategic issues, with discussion questions provided in advance. These discussions should occur early on the agenda, prior to performance updates, and be allotted ample time (e.g., 30-45 minutes). System and entity boards can discuss the same topics and share their perspectives to help create common focus among all boards organization-wide. Through these discussions, entity boards, in particular, can gain knowledge about the health care field and better understand where the system board is focusing, which enhances their ability to effectively oversee entity performance and tie entity strategies to those of the broader system.

Using a Pure Operating Model of Governance

Increased emphasis on population health and on providing care across the lifespan continuum has expanded the breadth and type of business units that comprise health systems. For many, this has resulted in organizational layers that far exceed the simple structure predominant a few short years ago. It is not unusual for health systems to now include employed physician organizations, wellness clinics, urgent care centers and/or freestanding emergency rooms, integrated health campuses, chronic condition treatment centers (e.g., diabetes, congestive heart failure), specialty hospitals, rehabilitation and other post-acute care centers, fundraising foundations, insurance companies and others. And, although the community is aware of and values some of these non-hospital business units, community members may not have the same desire to serve on their boards as they would to serve on a hospital board.

Consequently, even organizations that utilize a more enhanced community model of governance for their hospitals may find that model less than ideal for other business units. Many organizations are utilizing either the same boards for multiple entities and/or purely expert or internal management-based boards as well. Therefore, more than one model of governance can co-exist within the same health system. Large systems in particular may employ an Enhanced Community Model for governing hospitals and something closer to a Pure Operating Model for governing other business units.

Once the breadth and scope of an organization grows, inevitably attention focuses on whether separate community hospital boards are needed. More business units with boards become increasingly complicated and challenging for these organizations to manage. They also realize that the "community" has evolved to a point where having a few area leaders on a hospital board may not provide the optimal connection to the community it once did.

In decades past, the community surrounding a given hospital was homogenous in many areas. Today, the growth of systems has expanded the number and types of communities they serve as well. Community needs assessments also have indicated, for example, that there is not just one Hispanic American population or one Asian American population. Health care decision making will vary within a population, based on its members' levels of acculturation, economic status, generation and other factors. Today health care organizations are beginning to stratify their patients based on generation, age, family size and configuration, economic status, ethnicity, incidence of chronic disease, and other variables. With consumerism on the rise, these differences not only affect care delivery, but also have implications for governance.

Increasingly diverse communities may not perceive the typical community board

comprised of largely white, middle-aged males with some degree of ethnic and age diversity as community leaders who understand their needs. Even the most diverse boards may be challenged to encompass the breadth of perspectives needed to effectively connect to the communities they serve, while also adhering to sound governance principles such as competency-based selection and ideal board size.

The evolution of new paradigms such as population health, consumerism, bundled payments, managing care across the continuum and new market players also are influencing the board competencies needed to thrive in this environment. These emerging governance competencies are sometimes difficult to recruit into health care organizations themselves and may not reside among available community leaders. The need for new expertise, internal and/or external, paid or not, is emerging at an alarming pace.

These factors are leading some organizations, particularly larger health care organizations that have adopted best-practice governance, to consider alternative ways to connect to the community and eliminate community boards in favor of regional boards, a single operating board, or a system board that assumes the responsibilities once discharged by community-based hospital boards.

The changing community, evolving consumer interaction with health care, and the need for a greater degree of expertise are leading to fewer boards increasingly populated by carefully selected experts with specific skills and experience not necessarily available through traditional community leader models. This approach is much closer to the Pure Operating Model of governance. Although only a few organizations deploy the purest form of this model today, a slow transition in that direction is occurring among many health care systems in America.

Conclusion

There is no one governance model that works for all organizations. Health care organizations, with expert guidance, can benefit from examining their goals and needs to determine which governance model will position them well today and in the future (see box on page 17 titled Dos and Don'ts of Effective System Governance). Organizations that select a Pure Operating Model will eliminate unnecessary governance layers and clearly define how board work can be done optimally within that structure. Organizations that opt for enhanced community-based governance also must dedicate the necessary time, resources and expertise to balance responsibilities and authorities among boards and to nurture, support and enhance all boards in the system.

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Dos and Don'ts of Effective System Governance

Do:

- Drive standard governance processes and tools across all boards. This not only conveys that all boards are equally valued and important, but also creates alignment and efficiencies.

- Deploy staff resources, time and focus to support all boards. The infrastructure devoted to governance support is an investment in board effectiveness and member retention.

- Make entity board work engaging and satisfying by establishing clear responsibilities and expectations and thoroughly planning board meetings with carefully crafted agendas, targeted materials and dedicated discussion time.

- Be clear on relative roles, responsibilities and authorities. Develop well-defined job descriptions for both system and entity boards outlining roles, responsibilities and expectations. Create an authority matrix that delineates relative authority among the system and entity boards and management.

- Require all boards to engage in governance best practices, including competency-based recruitment and selection, a thorough orientation program, continuous education and regular performance assessment.

- Create positive relationships among system and entity boards. Build in opportunities for interaction through mechanisms such as entity board member participation on system committees and at educational retreats.

- Create touch points. Communication and interaction between and among system and entity boards should be ongoing, two-way and focused around the needs of the system as a whole.

- Repeatedly convey the value an entity board brings to a system. Entity boards provide critical functions of oversight and feedback to the system board; their work is different—not less. Communicating with entity boards about their value reinforces their importance and facilitates engagement and retention.

Don't:

- Use the term "advisory board" without careful consideration of its often negative connotation. Most entity boards retain some limited authority and oversight responsibilities for quality, credentialing and community need.

- Avoid making tough decisions to streamline governance. As systems mature, some past governance practices or roles may no longer suit the system.

- Assume that alignment will evolve on its own. Careful strategy and execution are required to put diverse organizational structures, practices and cultures together.

- Allow entity boards to operate as "islands," setting their own course without system-wide standardization of authorities, practices and structures.

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