2
April 2006
Trustee
Workbook

The Challenges of System Governance

Today, slightly more than 50 percent of the nation's hospitals identify themselves as being part of a health care system. Systems come in all shapes and sizes. Some are large and comprise many hospitals across a wide region, including, among others, nursing homes, physician groups and insurance companies. Others comprise several hospitals, as well as other entities, in close geographic proximity. And still others consist of a single hospital paired with only one other type of health care organization.

Whatever their size and scope, governing a system is different from governing a freestanding hospital because systems must often accomplish several different purposes through several different organizations, all operating within the context of a rapidly changing health care and regulatory environment.

In the 1990s, when system formation and integration were on the rise, those studying these emerging organizations defined and characterized systems in ways that provide insight into the issues and challenges of managing and governing them. Stephen Shortell, Robin Gillies and others formally defined an organized delivery system as *a network of organizations that provides, or arranges to provide, a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served.* The article, "Creating Organized Delivery Systems: The Barriers and Facilitators," appeared in 1993 in *Hospitals & Health Services Administration*.

In *The Future of Health Care Governance* (1996), we described an integrated delivery system as having the following characteristics:

- Integrates care delivery and financing
- Integrates physicians with the organization
- Provides an accessible continuum of care
- Assumes accountability for the health status of specific populations in defined geographic areas
- Provides high-quality, cost-effective care resulting from the integration of services and clinicians
- Has a unified cost and quality information system
- Integrates physicians at all levels of leadership structures and planning activities
- Is led by a new form of integrated, systems-oriented governance.

While some of the characteristics of systems have changed over the past ten years, their governance has focused on gaining a better understanding of what this "new form of integrated, systems-oriented governance" ought to be and how to ensure that it adds value. For systems to truly achieve their potential to provide better health care and services than any of their component organizations could provide alone, system governing boards must also rise to this same challenge.

System boards must lead their organizations toward mutually achieving system goals and, at the same time, lead by example to ensure that governance delivers more than just the sum of its parts. In other words, boards that govern together can achieve more than any one of them could achieve on its own.

HOW IS SYSTEM GOVERNANCE DIFFERENT?

THERE IS SOME TRUTH to the phrase "governance is governance." Various characteristics of good governance and fiduciary duty apply equally to boards of very different organizations (for example, the characteristics of effective governance could largely be the same for a hospital board as for a bank board). However, health system governance has several unique characteristics that set it apart from any other type of governance, including hospital governance. For example:

1. The vast majority of health systems have multiple boards engaging in hierarchical governance. That is, a system or parent board oversees and coordinates the functions and activities of subordinate

CENTER FOR HEALTHCARE GOVERNANCE™

BY JAMES E. ORLIKOFF AND MARY K. TOTTEN

or subsidiary boards, which perform discrete governance functions for their individual entities and report back to the system board. As a result, subsidiary boards within systems require different focus, information, composition and committee structures than do the boards of free-standing organizations.

2. Having a system with multiple boards requires that governance authority, accountability and responsibility be subdivided. Typically, this means that a system board will focus on the big picture for the system as a whole, as opposed to any one organization within the system, while a subordinate or subsidiary board will focus on governing a particular entity or function within the system.

3. Because systems are often composed of different businesses, their boards have the responsibility of integrating their work. The system board must ensure that subsidiary organizations pursue a common system strategy and must oversee the portfolio of different businesses within the system in order to meet overall system goals and objectives. This is, perhaps, one of the most challenging aspects of system governance.

4. In addition to being responsible for the effectiveness of their own governance, system boards are also responsible for the governance improvement and accountability of all subsidiary boards in the system.

5. All system boards must be "system thinkers," keeping the best interests of the system as a whole at the forefront of all their deliberations and decisions. To help them do so, a core challenge of a system board is to frame a compelling definition of the system as a coherent whole formed by and operated as a collection of interdependent parts. If this is communicated effectively throughout the system, subsidiary boards will have a unifying definition of the system, as well as their place within it.

Questions for Discussion

1. Do you have a unifying definition of the health care system or organization that is shared by all the boards and board members within it?

2. Is there a clear distinction among the various boards in your health care system or organization regarding trustee roles, board member responsibilities, authority and accountability?

PRINCIPLES OF SYSTEM GOVERNANCE STRUCTURE

IF ONE OF THE defining characteristics of systems is multiple boards and committees, then it is important to understand the structure of governance within systems. Although too broad a topic to fully cover here, it's important to consider because many systems have found that, without careful planning, their governance structure can take on a life of its own and grow to unmanageable proportions. In fact, when many system leaders are asked why they have the number of boards and committees they do, a common response is "I don't know; it just happened."

Systems with efficient governance structures employ principles, such as those listed below, to guide how their structures develop:

1. Governance structure is based on conscious choices, not on circumstance or history (e.g.,"we've always done it that way"). Effective systems control their governance structures.

2. Fewer boards are better. The principle of "governance minimalism"—having the fewest number of governance structures needed to govern effectively—supports effective system governance. Why have more boards or committees than necessary?

3. If constituency or stakeholder representation is necessary or desirable in governance, it is better to have that representation on the larger subsidiary board (typically, 13 to 19 members), rather than on the smaller system board (typically, 11 to 15 members).

4. Centralize authority, decentralize decision-making. This means that ultimate authority should rest with the system board, but specific decisions should be made by appropriate subordinate boards. For example, the authority for setting systemwide quality policy and strategic direction would rest with the system board, while specific decision-making responsibility for medical staff credentialing would rest with individual hospital boards. Here, the system board has the authority to oversee quality and establish quality and patient safety parameters and goals for the entire system. In turn, the subordinate hospital board has the authority to make decisions regarding quality in its hospital that are consistent with the parameters established by the system board.

5. The philosophy and design for management, clinical, and governance structure should be similar within a system. Many systems have centralized management (i.e., all senior executives within the system report to the system CEO), but have decentralized clinical and governance structures. Such inconsistent leadership structures create significant functional friction and consume inordinate amounts of senior executive and board time. Further, different leadership structures make the system board's job much more difficult as it struggles to create and oversee the execution of a unified system strategy that may be carried out through many channels subject to different leadership styles and interpretations.

6. System board composition should be based on needed competencies and system strategy, not on constituency representation, or the history of any organization within the system.

7. Physician membership on appropriate subordinate boards may be representational (e.g., the medical staff chief serving on a hospital board), but not on the system board. While physician membership on a system board is desirable, it should not be representational.

Questions for Discussion

1. How many boards are in your system or are associated with your organization if you do not define yourself as a system?

2. Does your system or organization have principles for efficient governance structure?

3. How many total governance entities (boards plus board committees) are in your system or organization? How many governance meetings are held every month? Every year?

4. Why is the governance of your system structured the way that it is?

NEW THINKING IN SYSTEM GOVERNANCE

BECAUSE THE VAST majority of health systems formed their governance structure

and function "on the fly," many have implemented changes in the way their system governance works over time. Some of these changes have been made in response to market and strategic shifts, others to pressures for increasing governance effectiveness, while still others evolved in tandem with the businesses and sophistication of systems themselves.

Because many systems were formed as "confederations" of merged organizations, it was common in the 1990s for system governance to reflect the desire of member organizations for autonomy and control. As a result, such systems established a holding company parent board that shared authority with and gave significant autonomy to local or subsidiary boards. In the past, many systems specifically avoided the terms "subsidiary" or "subordinate" boards to describe boards in the system separate from the parent or system board. Rather, these boards were called "affiliate" or "partner" boards to emphasize both the autonomy and control vested in them and the concomitant lack of authority and control held by the parent board.

Recently, however, the momentum has shifted. Systems are now moving away from holding company models and embracing operating company models for their system boards. Not only is this change reflected in the use of the terms "system and subsidiary boards" instead of "parent and affiliate boards," but also in the way systems are approaching how their governance actually functions. Specifically, many systems have moved away from investing autonomy in their subsidiary boards and have invested that authority and ultimate accountability in the system board.

Most systems now assign to the "parent" board:

- Systemwide strategic planning
- Ultimate authority and oversight for system finance and auditing
- System CEO evaluation, compensation and oversight
- Authority over the composition of all the subsidiary boards in the system.

Changes in how systems currently handle quality oversight provide further evidence of this shift. In the past, it was very common for system boards to assign responsibility for quality to local subsidiary boards, while retaining financial authority at the system board level. The theory was that quality was a local issue and therefore local boards were the best governance entity to deal with it. Assigning local boards responsibility for quality oversight also provided them with a meaningful role and function. Recently, however, quality and patient safety have gained national attention and are being seen as a system responsibility just as important as finance or strategy, and therefore, the appropriate province of the system board.

More systems are rethinking how to distribute governance responsibility for quality between the system and subsidiary boards, with the responsibility for establishment and oversight of system quality and patient safety goals more frequently being retained by the system board.

Top Five Criteria Ranked Most Critical for CEO Evaluation

SYSTEM HOSPITAL BOARDS	NONSYSTEM HOSPITAL BOARDS
1. Financial performance	1. Financial performance
2. Physician relationships and integration	2. Physician relationships and integration
3. Vision or other leadership qualities	3. Quality of care and outcome management
4. Strategic plan fulfillment	4. Strategic plan fulfillment
5. Employee relations qualities	5. Vision or other leadership qualities

Source: Health Research & Educational Trust governance survey, 2005

INSIGHTS FROM A NATIONAL GOVERNANCE SURVEY

RESULTS OF A 2005 governance survey, conducted by the Health Research & Educational Trust enables a broad comparison of governance structure and functions in hospitals that are members of systems to those that are not. Some 1,586 chief executive officers (CEOs) and 903 board chairs responded to the survey, with data representing nonfederal general hospitals. Data from the study, the largest of its kind conducted in recent years, show closer similarities in board structure than in the ways boards function between these two different categories of hospitals.

System and nonsystem hospital boards have similarities in board size and composition. Survey results indicate the average number of board members is 13 in both types of hospitals. System and nonsystem hospital boards also have an average of one member from outside the primary service area. Nonsystem hospitals have an average of two physician board members; system hospitals have an average of three.

However, system and nonsystem governance begins to diverge significantly in the way it functions. While only 5 percent of nonsystem boards and 5.2 percent of system boards have the CEO as board chair or president, almost twice as many system hospitals (48.1 percent) have their CEOs as full voting members of the board, compared with nonsystem hospitals (26.4 percent). More system hospital boards (73.7 percent) have formal board self-evaluation processes than nonsystem hospital boards (60.8 percent). Interestingly, while more system than nonsystem hospital boards (63.3 percent and 53.3 percent, respectively) have formal board education programs, more nonsystem hospitals have a specific budget for board education and an annual board education requirement. Some 37.6 percent of nonsystem hospitals had a specific budget for board education compared with 31.9 percent of system hospitals. An annual board education requirement was in place for 12.9 percent of nonsystem hospitals, compared with 11.6 percent of system hospitals.

Differences among system and nonsystem hospital boards in both the criteria considered most critical for CEO evaluation and in the data most commonly reported to or reviewed by the board are more a matter of priority than of type (see shaded boxes).

When asked in what areas the board might change or improve over the next three years, system boards ranked medical

staff alignment, organization and education and measurement as most important. Top priorities for nonsystem boards are medical staff alignment, organization and leadership effectiveness.

MORE INSIGHTS FROM SYSTEM BOARDS

SYSTEM MEMBERS of The Center for Healthcare Governance report a variety of governance issues and challenges. Some, such as the impact of federal and state legislation and regulation, are similar to those that challenge boards of individual or freestanding hospitals. Others are either unique to the more complex, multiorganization, multiboard structure of systems, or need to be examined and interpreted through a system-focused lens.

Recognizing that the bar on performance and accountability has been raised for for-profit and nonprofit boards alike, many Center system members report auditing their own practices and voluntarily complying with applicable provisions of the Sarbanes-Oxley legislation. Strengthening internal audit functions, following prudent financial policies, practices and oversight and certifying the accuracy of financial statements are just a few examples of how these systems are working to ensure their organization's performance meets Sarbanes-Oxley standards.

Achieving "systemness" across multiple entities and boards is a recurring challenge reported by the Center's system members. Issues include:

• Monitoring both collective and individual entity's operating performance and accountability

• Coordinating system and local boards and management to achieve system performance targets

• Creating strategy alignment throughout the system, especially in clinical integration, and developing systemwide standards of care, as well as metrics for measuring and monitoring performance and verifying compliance

• Setting expectations and accountability measures for subsidiary boards

• Ensuring coordination among system-level and local management

• Clarifying system and subsidiary board roles and responsibilities.

Finding the right number and type of trustees to serve on boards throughout a system is a growing challenge. Boards in systems struggle to match individual characteristics and competencies with the specific skills and expertise needed to govern different types of entities within a system. Systems are finding that the skills needed to govern a hospital are different from those needed to govern a foundation or insurance subsidiary. In a multi-entity organization in which many "businesses" surround the core business of care delivery, determining ideal board membership—e.g., where physician members can be most effective and what the appropriate membership diversity should be—are just a few of the challenges. System boards that initially comprised subsidiary board representatives are finding that the expertise needed at the system level may not be available.

According to the Center's system members, education topped the list of areas most in need of improvement for system boards. Issues include:

• The need for effective board orientation and continuing education and board development programs with a multiyear focus

• Mechanisms for staying abreast of health care industry information and trends as well as understanding governance best practices

• Ensuring that physician trustees understand their governance roles and responsibilities

• Putting in place appropriate infrastructure to support governance across multiple entities.

What do system boards feel they most need to improve their governance? Many suggest traditional approaches to improving board performance—but with a twist. Center system members said their boards are looking for:

• Publications and conferences that update board members on health care issues and trends

• Research that identifies governance best practices

• Finally, they want these resources tailored to the realities and challenges of multiorganizational governance. **T**

Data Most Commonly Reported to or Reviewed by the Board

SYSTEM HOSPITAL BOARDS	NONSYSTEM HOSPITAL BOARDS
1. Financial statements	1. Budget performance
2. Budget performance	2. Operating statistics
3. Operating statistics	3. Financial statements
4. Capital planning	4. Quality indicators
5. Quality indicators	5. Patient satisfaction surveys

Source: Health Research & Educational Trust governance survey, 2005

Reprint requests for 100 or more copies should be addressed to:
Margaret Jablonski (312) 893-6890
e-mail: mjablonski@healthforum.com

CONCLUSION The complexities of health care systems require thoughtful and creative approaches to governance. The evolution of board structure and function provides insight into approaches that support effective system governance and those that do not. Health care system and subsidiary organization boards now have a track record of more than a decade of working within this structure that provides many opportunities from which all boards in health care systems may learn and improve.