

Aligning Governance and Business Models to Achieve the Best Fit

by Pamela R. Knecht

According to the American Hospital Association's annual survey, more than 62 percent of community hospitals across the country are now part of "systems." Many of those systems comprise multiple hospitals, but others are single hospital care systems. In either case, the traditional acute-care hospital is becoming just one of the entities within a larger system that probably includes primary and specialty care clinics, ambulatory care sites, behavioral health care and post-acute care. In addition, the systems may be employing physicians, developing robust philanthropic organizations, developing entrepreneurial businesses, conducting research and offering medical education.

Most of these systems are also building the capacity to provide integrated, accountable care for an entire population across the continuum of care. Therefore, they may also include accountable care organizations, clinical integration models and even health plans/insurance products. As a result, they are often complex organizations with multiple business lines, various ownership models and many layers of governance. Understanding how governance is structured and functions in various business models now being adopted by health care systems can help boards best align their governance with the business model it is designed to support.

An Example of Health System Governance and Alignment Challenges

The boards and senior management teams of these increasingly complicated organizations often struggle to provide both effective and efficient oversight. One large health system with 12 hospitals; more than 90 clinics; about 30 long-term care facilities; hundreds of employed physicians and many other entities, recently determined that its senior management team was spending approximately 11,500 hours each year in preparation for and participation in 383 board and committee meetings.

When the system board members heard these numbers, they became concerned that their own governance structure and practices were hindering their valuable senior executives from doing their jobs in a highly competitive environment.

And, these data did not include the significant number of hours that the nearly 300 board and committee members were volunteering on behalf of the organization every year. Although these dedicated community members and physicians were devoting significant amounts of time and effort to the organization, some were understandably confused about their role and authority in the multi-tiered governance structure. For example, as a result of many mergers and acquisitions, there were 54 boards including 12 separate hospital boards each with a slightly different interpretation of their responsibilities and authority. Even more important, many of the community board members felt insufficiently informed and engaged by the parent board. Therefore, they did not always feel they were making a valuable contribution to the system.

The challenge that put the parent board "over the top" was when they realized they had recently approved a strategic plan that included transitioning to an operating company philosophy, but their governance structure was more aligned with a holding company business model. The system board wanted the governance structure to support transitioning from a decentralized holding company business model which allowed substantial autonomy at the local level to a more centralized operating company business model in which decisions are made at the corporate level and implemented at the local level. They felt this was the best way to accomplish the system's vision of achieving better health for their communities. This system (and many others) explored the following options for a governance model that would be better

aligned with their operating company business model.

"Pure" Operating Company Governance Model

A "pure" operating company governance model supports a fully integrated operating company model with intense centralization of business and clinical processes. The key components of this governance model include (but are not limited to):

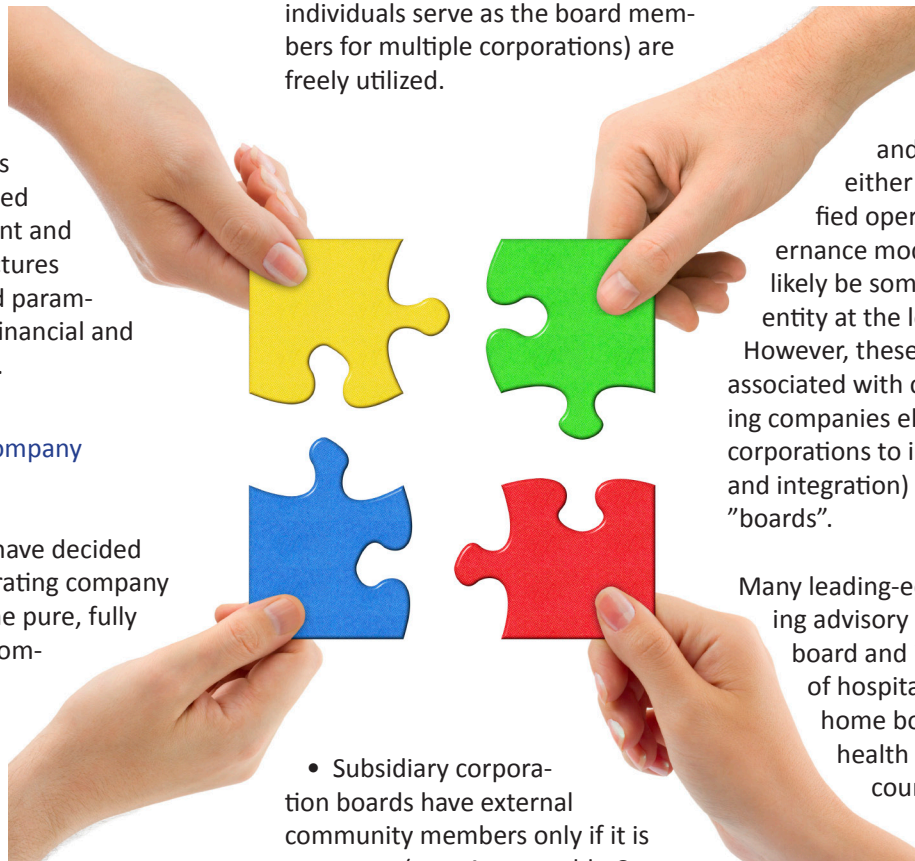
Structure

- Only one board 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 (see the next sections for alternative approaches).
- 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.

Function

- 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.
- Executive compensation, audit, compliance, risk management and governance are all overseen by committees of the system board.
- 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).



Modified Operating Company Governance Approach

Some health systems have decided to use a modified operating company approach instead of the pure, fully integrated operating company model described above. In this model, the system focuses on standardizing, not necessarily centralizing, its business and clinical processes. This approach is most often used if the system is relatively new (for example, recently created through mergers and still in the asset aggregation or functional integration phase*), if it is spread across a large geographic area (such as multiple states) or if the parent board and other key stakeholders place a high value on local/regional involvement.

The modified operating model governance functioning is similar to the pure operating model described above, but the structure would differ in the following ways:

Structure

- There is a parent board with external community members; it may or may not include some 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 freely 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 focused, very clear and each has the correct skills, competencies and perspectives to perform the work described in its charters.

Local/Regional Governing Entities in Operating Company Governance Models

When creating an operating company governance model, one of the main questions is how best to achieve the advantages of centralization, standardization and integration without losing the important knowledge and support of community members and physician leaders. In either the pure or the modified operating company governance model, there would most likely be some type of governance entity at the local or regional level. However, these entities would not be associated with corporations, (operating companies eliminate separate legal corporations to increase "systemness" and integration) so they would not be "boards".

Many leading-edge systems are creating advisory bodies to the parent board and its committees in lieu of hospital boards, nursing home boards and behavioral health boards. These advisory councils are organized by market (as defined by payers) to provide advice on the full continuum of care within that market (not just the hospital). These Market Councils are most often responsible for community health needs identification, community relations, advocacy and public policy assistance and fundraising/philanthropy. Their responsibilities may or may not include credentialing; privileging; and monitoring of quality, safety and satisfaction goals set by the parent board and its committees (state law varies). Successful Market Councils include individuals who are experts in community health and the development of population health management as well as those with connections to potential donors. They most likely include clinicians as well as community leaders.

Shared Authority Governance Approach

There are some health systems that have decided that their business model will not be an operating company model or a decentralized holding company model. Their philosophic approach is to share governance authority with those in their local service areas. In these cases, the parent board may choose to retain legal corporations and their boards at the local or regional level and to delegate some authority to those boards. However, the roles, responsibilities and authority of those boards will be narrowed.

The most typical set of responsibilities for hospital boards in a shared authority governance model include:

- Approval of credentialing, privileging and re-appointments for clinicians.
- Monitoring of quality, patient safety and patient satisfaction/experience goals set by the parent board/committee.
- Identification of community health needs and development and monitoring of plans to address those needs.
- Providing recommendations to the parent board and its committees on potential services and facilities, on

their executive's performance and on individuals to serve on boards and committees.

The composition of these boards is consistent with their role and authority, as opposed to recruiting experts in finance, investment, audit or compliance (which are handled by the parent board).

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Form Follows Function

The health system described at the beginning of this article selected the modified operating company governance model because the merger that had created the system had only occurred a few years earlier. The parent board thought that the governance structure should reflect the system's phase of system evolution; therefore, they created a governance structure that included some highly-focused subsidiary corporations and boards along with active Market Councils.

However, that approach may not be appropriate for other systems. Each health

system's parent board and senior management team must first agree on its mission, overarching strategy and core values. Then, they should decide which philosophy of systemness and which business model they think will best enable them to accomplish the vision within their desired culture. Once those decisions are made, it will be simpler for the parent board to determine which of

a variety of governance structures will be best suited to their unique organization and vision.

As Louis Sullivan famously said, “Form ever follows function.” In other words, the form (structure) should follow the function (strategy).

It is the parent board's responsibility to ensure alignment of its governance structure with its overarching strategic direction and mission.

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