

When Systems Change: Breaking Free from Traditional Governance Models - the New Optimal?

by Luanne R. Stout

*“I cannot say whether things will get better if we change; what I can say is they must change if they are to get better.”—
Georg C. Lichtenberg*

Health systems and hospitals are becoming increasingly complex, expanding beyond the traditional hospital/parent company model to include new structures and strategic partnerships to support a wide range of care for patients in their communities. Yet, many health care organizations continue to utilize the same approach to governance that they have been using for decades—for hospitals and non-hospitals alike.

The traditional community-based hospital board has been part of our culture in health care governance for so long that it has become a fixture, a constant, and something we don't often think about changing in our quest for transformational governance. The mere suggestion that a governing board in a health care organization, particularly those that are non-profit or public, might not be a community board is bound to raise a gasp or at least an eyebrow. Hospitals and health systems must maintain ties to the communities they serve. But is a community board for every business venture in a health care system the best model in today's environment?

Evolution of Community-based Boards

Non-profit boards typically serve on behalf of constituents who have a significant stake in the organization's performance and success. While these stakeholders are often broadly defined as the community served by the non-profit, most health care organizations have expanded the definition to include physicians, employees, and even suppliers and vendors.

Over the years, “the community” came to be loosely defined as the market area

served by a hospital. Board members—often business and community leaders—were selected to represent the community and to be both a voice for community needs and an advocate for the hospital.

As governance continues to evolve, today's non-profit hospitals and health systems are striving to compose their boards to better reflect the diverse populations they serve and seeking individuals with competencies boards need to carry out their work. The American Hospital Association's Center for Healthcare Governance (the Center) has identified core competencies for trustees of health systems and hospitals and created interview guides and other tools to help boards apply competencies in their work.

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Challenges of Community Boards Today

If organizations were truly trying to select community board members that: (1) reflect the community's age, gender, ethnic, racial, industry, political, economic and thought diversity; (2) represent the highest level of business and community leadership; and (3) embody carefully selected competencies that best support the board's work, would they have the same boards they have today?

A survey of 355 health care governing boards of all types (Peisert, 2015) indicates the average health care board has 13-16 members. Larger hospital boards (2,000+ beds) have an average of 5.1 percent females and 3.2 percent ethnic minorities, while smaller boards have even fewer (2.8-4.6 percent females and 0.6-2.4 percent ethnic minorities).

Board member ages range from 45 to 75, with an average age of 58.4. More than 62 percent of these boards have one or more board members who represent a religious sponsor; philanthropic foundation; medical group, physician organization or medical staff; or are a member of management. By and large, these data indicate many health care boards do not yet reflect the increasingly diverse communities they serve.

When it comes to competencies, the question is whether boards are focusing member recruitment on the competencies needed to govern the next evolution of health care or are continuing to look for the same blend of competencies they have always had – financial, business, legal, physician, construction, real estate, fundraising, etc. While many traditional competencies are still needed, boards also should be seeking individuals with transformational competencies such as expertise in patient-centered care, quality and safety, outcomes management,

population health management, risk contracting, value-based payments, accountable care organizations (ACOs), strategic partner development and consumerism. Competencies that reflect personal capabilities, such as the ability to deal with complexity, being skilled at navigating uncertainty or acting collaboratively, are also behaviors boards are seeking to govern more effectively in a transforming health care environment.

Recruiting for competencies, especially those that reflect skills or behaviors, can be a challenge. Some competencies are difficult to begin recruiting for because they reflect emerging areas of expertise, such as population health or value-based payment, and prospects may not be plentiful or readily evident based on professional background or prior community involvement.

Even when candidates appear to possess needed competencies, verifying them often requires specific interview methods or questions to determine whether candidates have actually demonstrated the competencies being sought. Even when candidates possess the right attributes, there is no guarantee they will apply them to board work or be dedicated to the organization and bring the still-valued community connection to their board service.

Even if a governing board has found the optimal trustee recruiting and selection method and established the perfect balance of competencies, there is no guarantee that the future pool of candidates will provide the same level of competencies and engagement. The Center's monograph *Effective Governance in Systems* (Stout, Stock, and Totten, 2015) addresses evolving recruiting challenges for boards. For example, individuals in the Millennial, Generation X and Generation Y age groups have viewpoints about community service that do not necessarily involve being on a community board. Many corporations also are no longer as actively encouraging their executives to serve on community boards, as they once did. And, assembling a great board with the right competencies is only the beginning. Once selected, best-in-class orientation and educational programs to adequately prepare new board members to make decisions in the new health care environment are critical.

For stand-alone or public hospitals, doing their best in the face of these and other challenges may be the only option; and there are those who have succeeded. For health care systems, the challenges are amplified when multiple hospitals and other entities exist, each of which has a governing board. For organizations that are adding other types of business units, such as health insurance companies, ACOs, physician organizations, free-standing emergency rooms, behavioral health centers and outpatient centers, the challenge to maintain effective community-based boards for some or all of these entities can become quite daunting, particularly since these boards may require different competencies and educational focus. Therefore, it is not surprising that some leading organizations are beginning to consider and utilize different governance paradigms.

Could Emerging Governance Models Be the New Optimal?

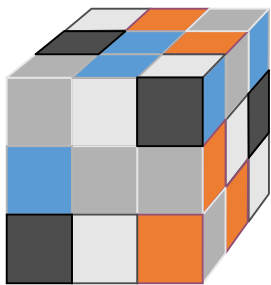
It seems unlikely that health care organizations will completely abandon community boards anytime soon. However, they are becoming increasingly creative about maximizing their trustee pool and streamlining their governance structures. *Effective Governance in Systems* discussed the emergence of several new governance models and the key features of each. Organizations are increasingly adopting these models, or features of one or more of them without embracing any one of them in their entirety.

Mirror Boards (the same individuals serve as board members of multiple corporations). There are several ways to approach this model. If separate corporations are required for legal or other reasons, a single board with the same individuals may be elected to serve each of the corporations. Another method is for the bylaws of each corporation to reserve virtually all authority to a single operating or parent board. Either way, the board would meet on a single occasion for all of the corporations.

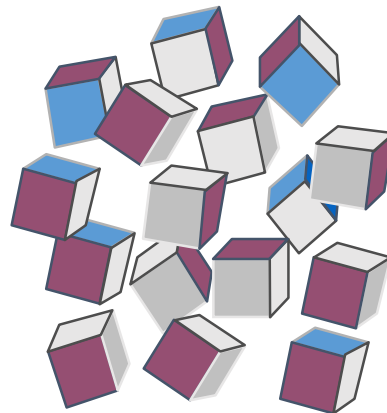
This model is beneficial in that it limits recruiting and selection for trustees to one board. The model also provides an opportunity to oversee all business lines of a particular type in a consistent manner based on a common strategic plan and goals. The model works best when the corporations are of the same type (e.g., all hospitals, all physician organizations, or all insurance companies, etc.) because the needed board competencies, experience and education would be similar.

Non-community boards. Health care delivery units are generally highly visible to the community, and community members may feel invested in their success. Because of their high profile and vital importance to communities, hospitals have long attracted people interested in serving on their boards. Service on the boards of other types of business organizations now part of today's health care systems may not have the same ap-

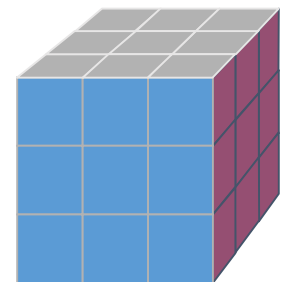
Evolving Governance Models



**Multiple
Community
Boards**



**Re-Evaluating
Traditional
Models**



**Shared/Fewer
Community
Boards**

peal. People may find serving on the board of an insurance company, an ACO, most strategic partnerships, or virtually any entity with an internally focused function less attractive than service on the hospital board. Some health systems are finding it more feasible to populate these boards with non-community individuals with subject matter expertise, either from internal management or externally contracted experts.

Parent company has the only community-based board with centralized decision-making authority. A number of health care systems have adopted a model in which the parent company board is community-based with centralized authority, and individual community boards are advisory. Advisory-only community boards at the local level create a number of potential issues: lower trustee satisfaction, difficulty recruiting top-tier community leaders, and not having the resources required to educate and support them. A viable alternative may be to have only the parent company board be community-based and having all subsidiary boards composed of non-community members (management or contracted experts) or utilizing the parent or single operating board as the board for all subsidiaries (e.g., individual hospitals). The parent or operating board may be comprised of community leaders from across the service area, thereby widening the trustee pool.

Professional/expert-based boards.

Debate is occurring about whether a board of community leaders, even with orientation and education, is qualified to navigate the complexities of the health care environment and make effective decisions. For several years, some hospitals and health systems have been adding outside experts to their boards. These boards are either a hybrid of internal subject matter experts combined with externally hired experts or are populated entirely with outside experts with the competencies most needed to support the leadership team in executing on key organizational strategies.

Board committees limited to the system board level.

Eliminating redundancies and governance layers is often in part accomplished by having one set of board committees for oversight of governance, executive compensation, finance, strategy, audit and compliance, and quality and safety. This single set of committees is populated by community members from across the service area or by experts with needed competencies and allows committee work to be focused in a standard way system-wide. Having these types of committees for each subsidiary board is becoming increasingly rare.

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

Increasingly, chief executives of entities across a health care system

report to the system CEO rather than the individual subsidiary boards. The parent board, or its compensation committee, makes executive compensation decisions organization-wide in a systematic and consistent manner.

Conclusion

There is no question that health care organizations must be connected to the communities they serve. Increasingly, they are evaluating whether community boards for each business unit or even each community are the best means to provide that connection. New avenues for community connectivity, needs assessment, and providing the voice of the customer are being implemented to bring more significant value across a broader spectrum of communities served.

Streamlining governance to the fewest layers possible has always been a fundamental governance principle. While that used to mean consolidating corporations and still does for many, innovative alternatives that maximize resources and board talent may be the new optimal.