



Luanne R. Stout

## Breaking Free From Traditional Models

*Some systems are embracing new governance paradigms.*

*“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,  
German physicist and satirist

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 healthcare organizations continue to use the same approach to governance that they have been using for decades—for hospitals and nonhospitals alike.

The traditional community-based hospital board has been part of our culture in healthcare governance for so long that it has become a fixture, something we don't often think about changing in our quest for transformational governance. The mere suggestion that a governing board in a healthcare organization, particularly nonprofit 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-based board the best model for every business venture in today's healthcare environment?

Whereas the “Governance Insights” column in the January/February 2017 issue of *Healthcare Executive* focused on streamlining and aligning healthcare system governance to facilitate management's ability to efficiently and effectively implement a healthcare system's strategy and align efforts organizationwide around transformation, this column focuses on how some leading healthcare organizations use different governance paradigms to maximize resources and board talent while remaining connected to the communities they serve.

### Evolution of Community-Based Boards

Members of nonprofit 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 nonprofit, most healthcare 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 nonprofit hospitals and health systems strive to compose their boards to better reflect the diverse populations they serve and seek individuals with competencies boards need to carry out their work. The American Hospital Association 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.

### 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?

Responses to The Governance Institute's 2015 survey of 355 health-care governing boards indicate the average healthcare board has 13–16 members. Larger hospital boards (2,000-plus beds) comprise 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 manage or represent a religious sponsor; a philanthropic foundation; or the medical group, physician organization or medical

staff. Overall, these data indicate many healthcare boards do not yet reflect the increasingly diverse communities they serve.

Are boards focusing member recruitment on the competencies needed to govern the next evolution of the healthcare workforce, or are they continuing to look for the same blend of competencies they have always had—financial, business, legal, physician, construction, real estate, fundraising and so on? Many traditional competencies are still needed, but boards also should seek 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, strategic partner development and consumerism.

Competencies that reflect personal capabilities, such as dealing with complexity, being skilled at navigating uncertainty or acting collaboratively, also are behaviors boards seek for governing more effectively in a transformational healthcare environment.

Recruiting for competencies, especially those that reflect skills or behaviors, can be a challenge because they mirror emerging areas of expertise, such as population health or value-based payment, and

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prospects may not be plentiful or readily evident based on professional background or prior community involvement.

*Healthcare organizations are becoming increasingly creative about maximizing their trustee pool and streamlining their governance structures.*

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. Furthermore, candidates might possess the right attributes, but 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.

Additionally, even if a governing board finds the optimal trustee recruitment and selection method and establishes the perfect balance of competencies, there is no guarantee the future pool of candidates will provide the same level of competencies and engagement. AHA's monograph *Effective Governance in Systems* addresses evolving recruiting challenges for boards. For example, individuals in the Generation X, millennial and Generation Z age groups hold viewpoints about community service that do not necessarily

involve being on a community board. Many corporations also no longer actively encourage their executives to serve on community boards.

Assembling a great board with the right competencies is only the beginning. Once selected, new board members must be adequately prepared to make decisions in the new healthcare environment through best-in-class orientation and educational programs.

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 that have succeeded. For healthcare systems, the challenges are amplified with multiple hospitals and other entities, each of which has a governing board. For organizations that include other types of business units, such as health insurance companies, ACOs, physician organizations, freestanding 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 daunting, particularly because these boards may require different competencies and educational focus.

Therefore, it is not surprising that some leading organizations are beginning to consider and use different governance paradigms.

**Could Emerging Governance Models Be the New Optimal?**

It seems unlikely that healthcare organizations will completely abandon community boards. They are,

however, becoming increasingly creative about maximizing their trustee pool and streamlining their governance structures.

*Effective Governance in Systems* discusses 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.

**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 corporation. Another method is for the bylaws of each corporation to reserve authority to a single operating or parent board. Either way, the board meets 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 for the organization 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, all insurance companies) because the needed board competencies, experience and education are similar.

**Noncommunity boards.** Healthcare 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 with an interest in serving on their boards. However, serving on the boards of other types of business organizations that are part of today's health-care systems, such as insurance companies, ACOs or any entity with an internally focused function, may not have the same appeal.

Some health systems are finding it more feasible to populate these boards with noncommunity individuals who have subject-matter expertise, either from internal management or externally contracted experts.

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***Parent company has the only community-based board with centralized decision-making authority.*** A number of healthcare 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 all subsidiary boards be composed of noncommunity members (management or contracted experts). Another option may be to use the parent or single operating board as the board for all subsidiaries (e.g., individual hospitals). The parent or operating board may comprise community leaders from across the service area, thereby widening the trustee pool.

***Professional/expert-based boards.***

There has been some debate about whether a board composed of community leaders, even with orientation and education, is qualified to navigate the complexities of today's healthcare 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 they are populated entirely with outside experts who possess the competencies most needed to help the leadership team execute key organizational strategies.

***Board committees limited to the system board level.*** Eliminating redundancies and governance layers is often accomplished in part by having one set of board committees oversee 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 systemwide. Having these types of committees for each subsidiary board is becoming rare.

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

Increasingly, chief executives of entities throughout a healthcare 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.

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

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**Editor's note:** This article was adapted with permission from "When Systems Change: Breaking Free from Traditional Governance Models—the New Optimal?" published in the American Hospital Association's summer 2016 *Great Boards* newsletter.