



PURSUING SYSTEMNESS:

The Evolution of Large Health Systems



A GOVERNANCE INSTITUTE
SPECIAL WHITE PAPER

2005

A Special Thanks to our Sponsor



The Governance Institute extends special thanks to Paul Gilbert and Waller Lansden Dortch & Davis for commentary and underwriting this white paper.

Based in Nashville, Tennessee, the healthcare practice group of Waller Lansden Dortch & Davis, PLLC was formed during the infancy of the investor-owner hospital and surgery center industries. Since that time, multidisciplinary teams of lawyers from their healthcare practice group have handled an unprecedented number of healthcare transactions throughout the United States on behalf of investor-owned, not-for-profit and governmental facilities, systems, and ventures. These transactions have included, for example, the acquisition, affiliation, sale, merger, joint venture, syndication, privatization, not-for-profit conversion, or development of acute care hospitals, psychiatric hospitals, specialty hospitals, ambulatory surgery centers, imaging centers, cardiac catheterization labs, radiation oncology centers, and medical device companies.

In addition to an extremely active healthcare transactional practice, Waller Lansden routinely advises healthcare industry clients on matters such as regulatory compliance, fraud and abuse compliance, Stark compliance, government investigations, intellectual property licenses, information services agreements, medical staff credentialing, and tax compliance. They also regularly advise boards of directors with respect to governance and fiduciary duty issues, including best practices.

Waller Lansden's healthcare practice group is comprised of more than 50 lawyers drawn from a number of legal disciplines including mergers, acquisitions, and divestitures; Federal and state healthcare regulation and compliance; Federal and state taxation; securities and corporate finance; employee benefits, compensation plans, and ERISA; employment and labor; real estate; and the environment. For more information, please visit www.wallerlaw.com.

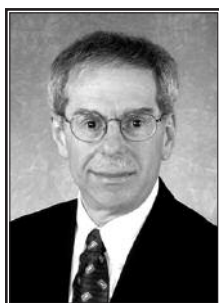
The Governance Institute

This white paper is developed for members as part of **The Governance Institute's** service providing board development tools to continually improve the effectiveness of boards of directors in America's best healthcare organizations.

The hospitals and healthcare systems that comprise **The Governance Institute's** membership include organizations and leaders who are the most respected in their communities, carefully picked for their ability to add to the strength of our service.

The Governance Institute provides information services for boards and executives of healthcare organizations. Its purpose is to improve the effectiveness of hospitals and healthcare systems by continually strengthening their boards of directors, medical leadership, and management performance.

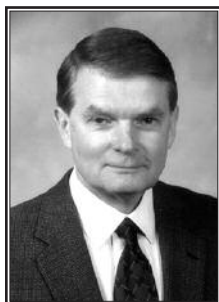
About the Authors



Barry S. Bader
Principal
Bader & Associates

Barry S. Bader is principal of Bader & Associates, based in Potomac, Maryland. Since founding Bader & Associates in 1980, Barry has conducted board retreats and consulted on governance restructuring and improvement initiatives throughout the U.S. and Canada. He previously served on the staff of the Maryland Hospital Association and with the nation's largest banking association. Barry was named one of The Governance Institute Advisors in

1999. He can be reached at (301) 340-0903 or bbader@GreatBoards.org.

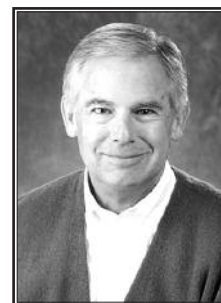


Edward A. Kazemek
Chairman & CEO
ACCORD LIMITED

Edward A. Kazemek is Chairman & CEO of **ACCORD LIMITED**, a Chicago-based firm specializing in healthcare governance, strategy, and management. Ed has more than 29 years of experience as a management consultant serving a variety of industries, with an intense concentration on not-for-profit healthcare. His practice is focused on assisting boards and senior executives in the areas of governance assessment, restructuring, board development, and strategic planning.

He has served as one of The Governance Institute Advisors since 1996, and is a long-time faculty member. He can be reached at (312) 988-7000 or ekazemek@accordlimited.com.

Roger W. Witalis is president of **WITALIS & Company** in Lafayette, California, and a founding member of The Governance Institute Advisors. Roger brings to his clients over 30 years of experience serving many of the leading health systems, hospitals, physician organizations, and professional associations throughout the United States. He has built an enviable reputation of respect and trust with chief executives, trustees, and physician leaders. Roger's sensitivity to client concerns and his ability to facilitate change have led to long-standing client relationships. He can be reached at (925) 945-1188 or roger@witalis.com.



Roger W. Witalis
President
WITALIS & Company

Carlin Lockee, M.P.H., is the managing editor for The Governance Institute. She has more than twenty years of experience in healthcare, including administration, financial management, development, reengineering, and medical marketing. She also holds degrees in journalism and literature.

III



The Governance Institute

Toll Free (877) 712-8778

Phone (858) 909-0811 • Fax (858) 909-0813

6333 Greenwich Drive • Suite 200

San Diego, CA 92122

governanceinstitute.com

Gordon R. Clark	<i>President & CEO</i>
Charles M. Ewell, Ph.D.	<i>Chairman</i>
James A. Rice, Ph.D., FACHE	<i>Vice Chairman</i>
Karma H. Bass, M.P.H., CHE	<i>Senior Research Executive</i>
Gary D. Aden, FACHE	<i>Senior Vice President, New Business Development</i>
Robbie Green, CMP	<i>Vice President, Conference Services</i>
Michele Saunders, CPA	<i>Controller</i>
Kevin R. Kantz	<i>Director, Technology</i>
Patricia-ann M. Paule, PHR	<i>Director, Operations</i>
Carlin Locke	<i>Managing Editor</i>
Kathryn Croom	<i>Editor</i>
Amy Soos	<i>Senior Researcher</i>
Glenn Kramer	<i>Graphic Designer</i>

Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country.

For more information about our services, please call toll free at **(877) 712-8778**, or visit our Web site at **www.governanceinstitute.com**.

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications whether caused by The Governance Institute or its sources.

©2005 The Governance Institute. Reproduction of this publication in whole or part is expressly forbidden without prior written consent.

Contents

Executive Summary	1
Introduction	3
Forces Driving Change	5
Health Systems in Transition	8
Changes in Governance Authority and Management Practices: A Look at “Systemness”	9
Decision-Making Authority: Who Decides—Corporate or Subsidiary?	9
Systemwide Strategies and Resources: Beefing Up to Add Value	11
The Shift to “Systemness”	13
Changes in Governance Structure and Practice	15
Subsidiary Boards in the Hot Seat	18
Evolution of Better Boards	18
Conclusion: Is a New, Corporate Enterprise Model Emerging?	21
Appendix: Study Design	23

Executive Summary

Background

Large health systems today lead change in an increasingly complex healthcare environment, and they also have been quick to respond to challenges imposed on them from both internal and external forces, according to a recent survey conducted by The Governance Institute. The survey, completed by over 50% of the large health systems in the U.S., showed that over the last five years these systems have been shifting their governance structures along a continuum from a holding company model to more of a corporate enterprise model. Some health industry experts attribute this shift to a natural “evolutionary” response to increasingly complex organizational dynamics as well as a necessity to keep up with increasingly restrictive regulations from external sources. However, the authors conclude there’s more—they see a fundamental change in the DNA of health system governance.

When The Governance Institute first started to examine the evolution of large healthcare system governance, we observed that many systems were streamlining their structures through reduction in the number, size, and levels of governing bodies. Several years later, we reported that systems seemed to undertake major restructuring efforts every few years, as their systems matured and trust grew among previously separate entities.

In 2000 we reported that many systems were moving toward a “value-added” governance model, wherein subsidiary boards were maintained only if they could make a distinct, non-duplicative, and *positive* contribution to the mission and performance of the system. Unnecessary boards were eliminated or consolidated. The mission focus of not-for-profit health systems remained a constant throughout these earlier reports. Health systems were not just health delivery corporations, they were *social* enterprises, adopting business tactics and pursuing financial margins to improve health and meet community needs.

In early 2004, a number of The Governance Institute’s larger, multi-hospital system members began reporting another wave of change affecting both systems’ management and governance models. Facing powerful financial and competitive threats to their financial viability and mission sustainability, systems were adopting structures and practices familiar in the corporate world. Some said they had instituted a single fiduciary board over all major facilities, tighter parent control of subsidiaries, and a “no excuses” approach to achieving financial operating targets. Some went so far as to say they were moving from a social enterprise model to a corporate enterprise model of governance.

This white paper outlines the results of a study we conducted to either confirm or refute this anecdotal evidence. We tested the following hypothesis with approximately 100 large multi-hospital health systems: governing boards of large health systems are adopting structures and practices, either by choice or forced by circumstances, that are consistent with those of public corporations. Governance Institute Advisors Barry S. Bader, Edward A. Kazemek, and Roger W. Witalis formulated the study, analyzed the results, and discussed the findings with seven large system CEOs, looking at forces driving change as well as changes actually seen in governance structure. They discuss their findings and offer their analysis in this white paper.

Findings

The survey results offer compelling evidence that significant changes are occurring not only in health system management, but also in governance. Further, these changes are not cosmetic or a natural evolution of a maturing, multi-faceted organization seeking tighter alignment among subsidiaries. The survey suggests fundamental changes are occurring in the DNA of health system governance.

Many of the changes occurring on boards represent the adaptation of the species to powerful and often threatening external forces. For example, the Sarbanes Oxley Act does not currently apply to not-for-profits, but the specter of financial penalties has driven tax-exempt hospital executives and boards to adopt new oversight practices and bolster board independence as if the law did apply.

In addition, unforgiving economics and relentless competition of the marketplace are driving system boards to focus on financial results much like the board of a Fortune 500 company facing Wall Street’s expectations. The overwhelming majority of survey respondents said they are deliberately operating “more along the lines of a corporate enterprise board by focusing on strategy, results, and financial integrity.” To do their jobs well, they are deliberately placing “increasing emphasis on corporate experience and/or business-related acumen when selecting new board members.”

While the data strongly suggest that health system *management* is looking and acting more like its private industry counterparts, the survey findings, our interviews, and our experience do *not* support the emergence of a new model of governance. They do, however, indicate that *fundamental changes are underway in health system governance at a quick pace*, and in the direction of more influence and control by the parent organization. However, labeling them a new

“corporate” model is premature at best and gives insufficient weight to the board’s accountability for the mission of not-for-profit organizations.

It may be that governance practices are converging among various sectors of society. As convergence intensifies, the distinction between not-for-profit and for-profit governance becomes moot, with one set of standards emerging for defining “good governance.”

As a result of this study, we are now able to describe more clearly elements of a new “corporate governance model” that appears to be emerging for not-for-profit profit health systems. While we do not find the corporate, operating company model emerging everywhere in every aspect, health systems can use the model to ask several important questions about their system governance:

- Where are we on the continuum from a holding company model to an operating company of management and governance? Are we where we need to be?
- Have we addressed the hard questions of whether to have subsidiary boards and, if so, what do we expect of them?
- Are we demanding enough of governance at all levels to discharge our responsibilities as directors and to help the organization thrive?
- Are we maintaining the right balance between finances and mission—remembering the board is accountable for both in equal measure? Failing the test for either one means the organization fails.
- As system management moves toward the operating model, with greater standardization and centralization of core processes and decision making, does it follow that governance must move in parallel, and just as much on the continuum? Or—if healthcare truly has important local elements—does local governance, through the shared governance model, provide a check and balance to corporate power as well as a valuable connection to local stakeholders?

Introduction

Over the past decade, The Governance Institute has conducted a series of research studies examining the structure and practices of governance in not-for-profit, multi-hospital health systems. The studies show not a static governance design but a work in progress.

Most health systems were formed through mergers, acquisitions, and strategic affiliations of previously autonomous hospitals. In systems' early years, subsidiary boards not only remained, but they enjoyed substantial autonomy and often had a number of seats on the parent board—a model called “representational governance.”

In the early 1990s, we observed that many systems were streamlining overly bureaucratic structures through reduction in the number, size, and levels of governing bodies. Several years later, we reported that systems seemed to undertake major restructuring efforts every few years, as their systems matured and trust grew among previously separate entities. Systems began to emphasize the importance of the parent board having sufficient authority over subsidiaries to achieve system synergies—but many maintained a subsidiary board structure.

In our 2000 study, we found that many systems were moving away from representational governance and toward a “value-added” governance model, wherein subsidiary boards were maintained only if they could make a distinct, non-duplicative, and positive contribution to the mission and performance of the system. Unnecessary boards were eliminated or consolidated. The mission focus of not-for-profit health systems remained a constant throughout the studies. Health systems were not just health delivery corporations, they were social enterprises, adopting business tactics and pursuing financial margins to improve health and meet community needs.

In early 2004, a number of The Governance Institute's larger, multi-hospital system members began reporting another wave of change affecting both systems management and their governance model. Facing powerful financial and competitive threats to their financial viability and mission sustainability, systems were adopting structures and practices familiar in the corporate world. Some said they had instituted a single fiduciary board over all major facilities, tighter parent control of subsidiaries, and a “no excuses” approach to achieving financial operating targets. Some went so far as to say they were moving from a social enterprise model to a corporate enterprise model of governance.

To determine whether these anecdotal reports represented a trend, The Governance Institute engaged its three Governance Advisors, Barry S. Bader, Edward A. Kazemek,

and Roger W. Witalis, to lead a new study of health system governance. Carlin Lockee, managing editor of The Governance Institute, directed the study.

We framed a hypothesis:

The governing boards of large, not-for-profit, multi-hospital health systems are adopting structures and practices (by choice or forced by circumstances) normally associated with boards of publicly traded corporations.

To test the hypothesis, we identified a number of possible characteristics of a more “corporate” model of governance, and we administered a mail survey to approximately 100 large, multi-hospital health systems. The Advisors also conducted telephone interviews with a subset of system CEOs to explore the findings. Our survey looked at both the forces stimulating change and well as the types of changes underway in health systems' governance. Board governance cannot be examined in isolation from an organization's management structure and practices. So, in addition to examining the relationship between the parent and subsidiary board levels, we also considered whether systems were centralizing or standardizing certain core management processes across all subsidiaries.

This white paper presents the study's findings and an analysis by our Governance Advisors. We found, in short, clear evidence of a transformation in system management and governance, but neither the emergence of a single new model nor a full acceptance of the so-called “corporate model.” We consider this study a snapshot, and plan to follow up with detailed examinations in the future.

The Governance Institute thanks all those who responded to the survey and, in particular, the following CEOs for their contributions to the study:

- Joel T. Allison, FACHE, President & CEO, Baylor Health Care System, Dallas, TX
- Barry S. Arbuckle, Ph.D., President & CEO, Memorial Health Services, Long Beach, CA
- David P. Blom, President & CEO, OhioHealth, Columbus, OH
- Michael D. Connelly, M.A., J.D., President & CEO, Catholic Healthcare Partners, Cincinnati, OH
- Peter Fine, President & CEO, Banner Health, Phoenix, AZ
- Robert V. Stanek, CHE, President & CEO, Catholic Health East, Newtown Square, PA
- Richard J. Umbdenstock, President & CEO, Providence Services, Spokane, WA

Forces Driving Change

In the fall of 2004, The Governance Institute published *Environmental Scan: Trends and Responses for Great Governance 2005–2010*. This comprehensive document describes in detail the complexity and enormity of forces converging on healthcare organizations throughout the United States. Never before in its history has U.S. health-care been presented with such a menu of challenges.

Caught in the vortex of change are the large, multi-hospital, not-for-profit health systems that serve broad and diverse geographic, demographic, economic, and political communities and constituencies. As a result, large systems are especially positioned to feel the pressures of a disproportionately larger array of forces than smaller, local market systems or stand-alone institutions.

In preparation for this white paper, we selected 10 specific forces we consider to hold high potential for stimulating change in governance and management in larger systems. These include:

- **Sarbanes-Oxley Act of 2002:** Perhaps the single most important piece of legislation affecting corporate governance, financial disclosure, and the practice of public accounting in for-profit corporations since the U.S. securities laws of the early 1930s.
- **Executive Compensation:** The spillover effect of the failure and in some cases corruption of publicly traded corporate boards to halt runaway CEO compensation and IRS interest in the issue of not-for-profit organizations.
- **Performance Targets:** The continued pressure placed on operating units to strengthen operating margins in light of growing demands for capital.
- **Divestiture/Closure:** The necessity of eliminating underperforming assets or services from system operating portfolios to free up capital for more productive uses.
- **Quality Reporting:** The disclosure of information relative to quality and safety indicators by health systems voluntarily, by contract, or by law to payers, employers, regulators, or the public at large.
- **Labor Relations:** The extent of unionization activity experienced or anticipated at operating units in a variety of professions and employee categories.
- **Pricing:** Similar to quality reporting, the disclosure of information relative to pricing by health systems voluntarily, by contract, or by law to a variety of organizations and agencies.

- **Physician Competition:** The growing issue of physician-owned single-service facilities coming into direct competition with operating units of health systems.
- **Tax-Exempt Status:** The powerful challenges to tax exemption of not-for-profit systems coming from federal, state, and regional legislative bodies, special interests, and advocacy groups.
- **Disaffiliation:** The decision by an operating unit (e.g., hospital) to legally separate from a system and/or the decision of the system to release the operating unit from system connectivity and responsibility.

Respondents to the survey noted their boards' actual experiences with these 10 forces; that is, whether their board had addressed or whether they anticipate it will address each force directly (See **EXHIBIT 1**, next page). Of the 10 forces listed, four stand out as areas of significant activity—nearly 75 percent or more of the respondents have addressed these factors, and up to 12 percent anticipate their organizations will have to address these in the future.

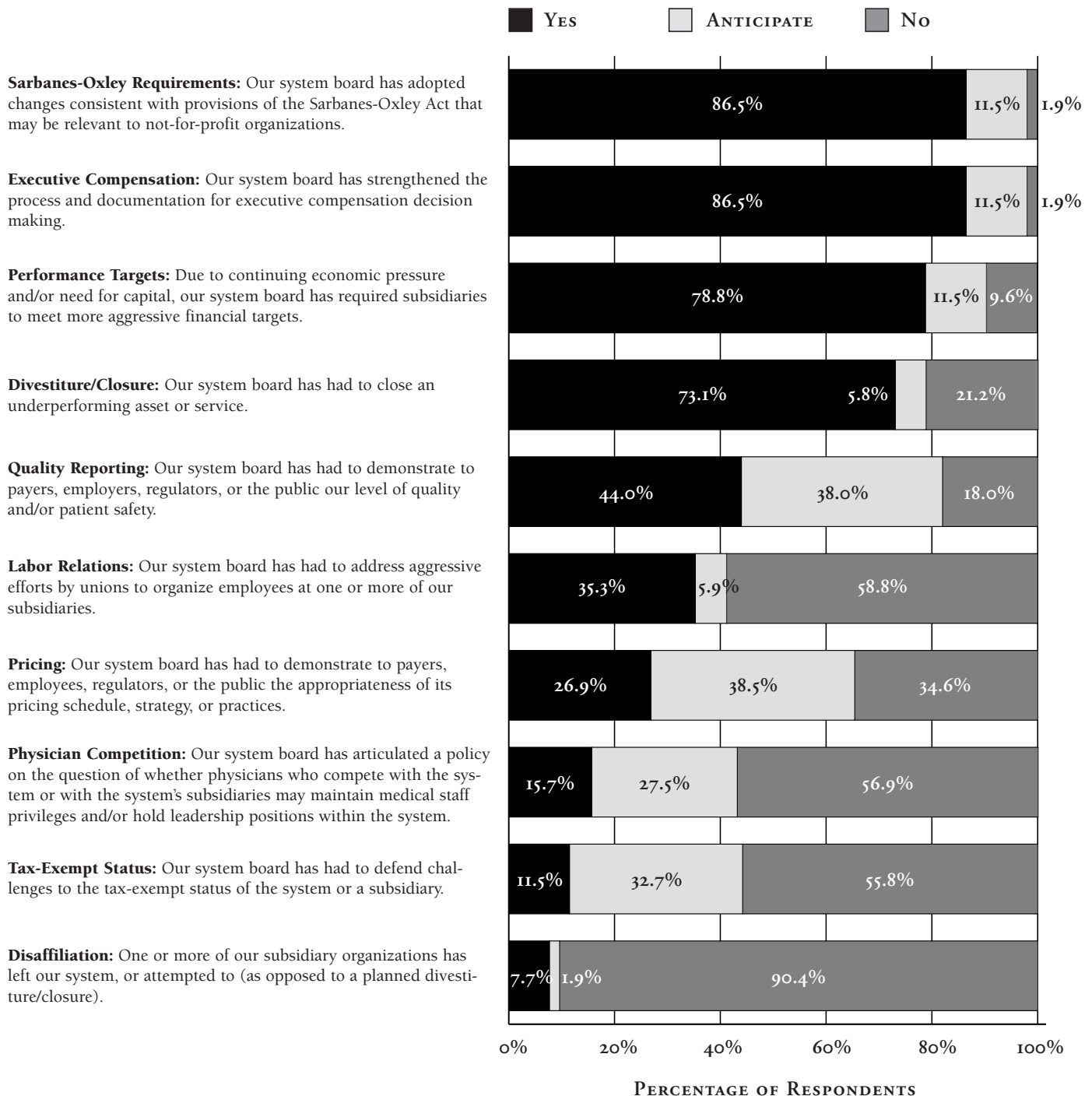
Adopting Sarbanes-Oxley requirements that may be relevant to not-for-profit organizations. Eighty-six percent (86 percent) of the survey respondents have already adopted changes consistent with provisions of the Sarbanes-Oxley Act of 2002 that may be relevant to or could be required of not-for-profit organizations in the future.

Strengthening the process and documentation for executive compensation decision-making. Eighty-six percent (86 percent) said they have strengthened their processes and documentation for executive compensation decision making. Although the issue of executive compensation has assumed varying levels of importance over the last few decades, this time it is being presented within the context of charity care and tax exemption.

Requiring subsidiaries to meet more aggressive financial targets. Seventy-nine percent (79 percent) of the respondents require their subsidiaries to meet more aggressive financial targets, and another 12 percent anticipate doing so in the near future.

Closing an under-performing asset or service. Nearly 80 percent of the respondents said they have had to or anticipate having to close an under-performing asset or service, and some experts predict the frequency of closures will increase as access to capital continues to tighten.

EXHIBIT I FORCES DRIVING CHANGE



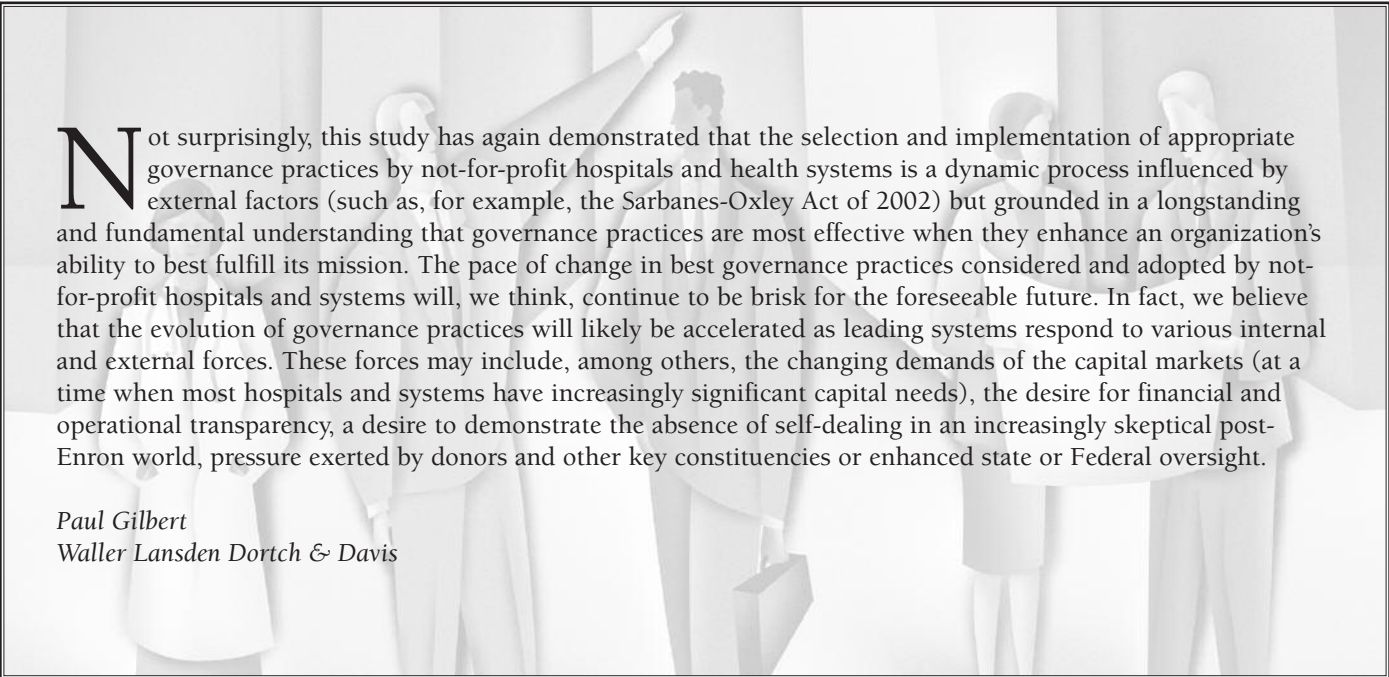
Two additional areas of significance—quality reporting and pricing disclosure—stand out due to the magnitude of current experience and because of their significant anticipated experience. With respect to disclosure and transparency, fewer respondents have undertaken steps to demonstrate the appropriateness of their pricing strategy or practices (27 percent) or their level of quality and/or patient safety (44 percent). However, in both of these areas, 38 percent of the respondents said they anticipate they will have to demonstrate their practices and results to payers, employees, regulators, or the public at some point in the future. We expect the number of systems anticipating board attention to public disclosure of quality and pricing is likely to hold up because of strong external pressures from Medicare, state agencies, large purchasers, and empowered consumers.

External forces that appear to have generated board activity for significantly fewer respondents include:

- Articulating a policy on physician competition, specifically with respect to medical staff privileges and/or leadership positions within the system
- Defending challenges to the tax-exempt status of the system or a subsidiary
- Unplanned disaffiliation with the system by one or more subsidiaries

Here, between 8 and 16 percent have already addressed these issues. However, nearly 28 percent said they anticipate they will work on a policy with respect to physician competition, and 33 percent expect they will have to defend challenges to their tax-exempt status. Only 2 percent anticipate disaffiliation activity.

Finally, 35 percent said they have had to address aggressive unionization efforts at one or more of their subsidiaries, and only an additional 6 percent said they expect they will have to deal with this in the future.



Not surprisingly, this study has again demonstrated that the selection and implementation of appropriate governance practices by not-for-profit hospitals and health systems is a dynamic process influenced by external factors (such as, for example, the Sarbanes-Oxley Act of 2002) but grounded in a longstanding and fundamental understanding that governance practices are most effective when they enhance an organization's ability to best fulfill its mission. The pace of change in best governance practices considered and adopted by not-for-profit hospitals and systems will, we think, continue to be brisk for the foreseeable future. In fact, we believe that the evolution of governance practices will likely be accelerated as leading systems respond to various internal and external forces. These forces may include, among others, the changing demands of the capital markets (at a time when most hospitals and systems have increasingly significant capital needs), the desire for financial and operational transparency, a desire to demonstrate the absence of self-dealing in an increasingly skeptical post-Enron world, pressure exerted by donors and other key constituencies or enhanced state or Federal oversight.

Paul Gilbert
Waller Lansden Dortch & Davis

Health Systems in Transition

The survey findings and follow-up interviews with system CEOs confirm that the changes buffeting large health systems have reached the boardroom and executive suites. “These are the forces we are dealing with,” said Banner Health System CEO Peter Fine. What’s more, system executives believe these forces will gain momentum over the next several years.

Quality reporting and meeting performance targets will take center stage as a governance issue. “The quest for the ‘clinical enterprise’ and its seamless standards of clinical excellence will be a top priority and driver of change,” predicted Joel Allison of Baylor Health System. Richard Umbdenstock of Providence Services added that, “quality and payment will be linked in some form and fashion, crudely at first and refined over time.”

“As consumers have more information and choice, the ability to demonstrate quality will be critical,” said Robert Stanek of Catholic Health East. “The next wave will have to be the electronic medical record because it allows measurement and management of all aspects of care.” Information technology investments pose critical questions for governance about allocating resources and transforming the culture.

The push to improve financial performance and expand access to capital also will continue to be prominently displayed on boards’ “radar screens.” Allison noted that continued demand for and access to capital will subject organizations to rigorous pressure for reimbursement and operating income performance. “The demand for performance is being driven by the markets, especially the capital markets

and the rating agencies, as well as the payers,” said Umbdenstock. “The need for capital has never been higher,” agreed Stanek. “Consequently, financial performance has to be superb, and systems need a very robust process of capital planning, allocation, and spending.”

The greater focus by boards on governance accountability driven by Sarbanes-Oxley, according to Michael Connelly of Catholic Healthcare Partners, shows that “we need to be more conscientious about how we do things, such as handling conflicts of interest and confidentiality.” Barry Arbuckle, Memorial Health Services, predicted that Sarbanes-Oxley will continue to drive boards of not-for-profit systems to adopt and monitor compliance policies and practices.

Several CEOs agreed that systems will have to be more transparent in demonstrating how they meet the needs of communities, price their services fairly, and “earn” their tax-exempt status. Dave Blom of OhioHealth called this “the value equation,” clearly communicating to business, government, and the community at large the tangible benefits the system provides.

As noted earlier, we did not expect the 10 forces driving change in the survey to be an exhaustive list and, in fact, the CEOs we interviewed identified other issues they believe will have a major impact on governance and management for their organizations. For example, Dave Blom noted continued and varied challenges to public accountability and emphasized the need for advocacy. Peter Fine said he worries about the consequences of intervention and regulation at the federal level in areas such as class action lawsuits, claims disputes, investigations, and executive compensation.

Changes in Governance Authority and Management Practices: A Look at “Systemness”

The survey data reported in this section strongly support the proposition that large health systems are moving fairly quickly away from a holding company governance and management model and in the direction of functioning more like a corporate enterprise, with greater influence and outright control over system assets, governance, management, and quality at the top. What is also clear from the data is that health systems are finding their own paths toward “systemness.”

What does systemness mean? Although definitions are evolving and vary among systems, leaders generally use the term to define looking and acting more like a single integrated organization rather than a collection of independently functioning pieces. Systemness means being more tightly-knit, shifting decision-making responsibility and authority away from the subsidiary operating units to the corporate level, and centralizing or standardizing key management systems and processes. Systemness is consistent with the corporate enterprise model of governance.

Because systemness involves both governance and management, our survey looked at both of these areas.

Decision-Making Authority: Who Decides—Corporate or Subsidiary?

The survey identified seven areas of authority that could be assigned to either the parent board or subsidiary boards, or could be shared by both. We looked to see if authority was in fact shifting to the corporate level for these responsibilities:

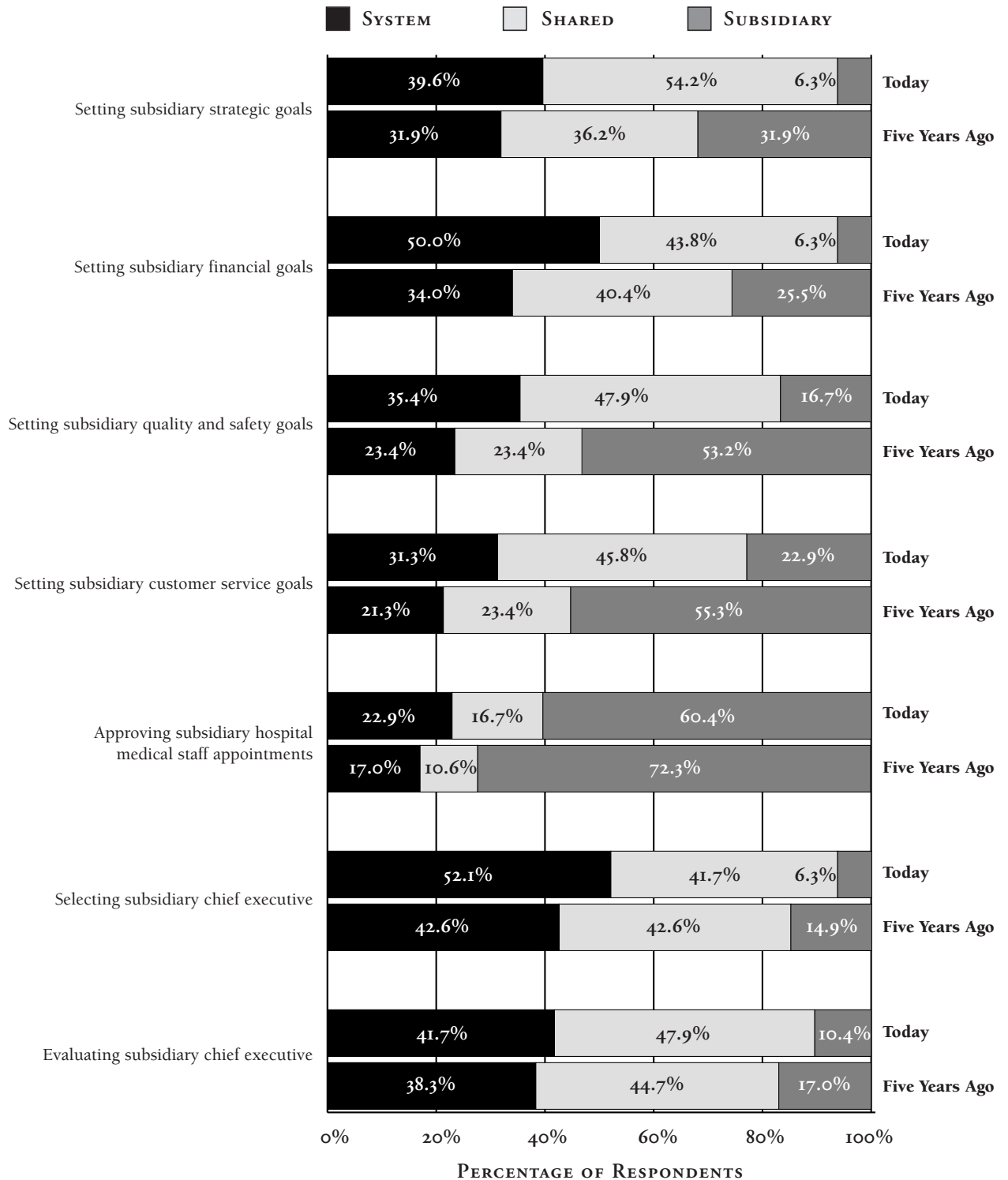
- Setting subsidiary strategic goals
- Setting subsidiary financial goals
- Setting subsidiary quality and safety goals
- Setting subsidiary customer service goals
- Approving subsidiary hospital medical staff appointments
- Selecting the subsidiary chief executive
- Evaluating the subsidiary chief executive

Based on responses, it appears that, overall, fewer systems delegate decision-making responsibility to subsidiary hospitals today than they did five years ago. In each of the seven specific activities, the percentage of subsidiaries with sole rights to make decisions decreased. With the exception of the responsibility for selecting the subsidiary chief executive, what subsidiaries lost in responsibility was picked up relatively equally in the “shared responsibility” category and the system category. It appears that more of the responding systems have shifted the responsibility for selecting the CEO to the system than have decided to share this responsibility between system and subsidiary. (See **EXHIBIT 2**, next page).

In only two areas did 50 percent or more respondents say the system has sole responsibility today: setting subsidiary financial goals (50 percent) and selecting the subsidiary CEO (52.1 percent). And in only one area did 50 percent or more say the responsibility today is shared by the system and the subsidiary: setting subsidiary strategic goals (54.2 percent). Subsidiaries have, however, retained control over decisions about hospital medical staff appointments—60.4 percent of the respondents today said the subsidiary has this responsibility. Even here, fewer respondents place that responsibility with the subsidiary today than they did five years ago.

Two areas indicate a dramatic decrease of subsidiary responsibility: setting subsidiary quality and patient safety goals (from 53.2 percent five years ago to 16.7 percent today) and setting subsidiary customer service goals (from 55.3 percent five years ago to 22.9 percent today). Both of these areas are related to quality of services, and both have moved along the spectrum to more of a shared responsibility, as systems work toward a consistent and higher level of excellence wherever the organization’s flag flies. (A caution: the survey asked about authority to *establish goals* for quality, patient safety and customer service. It did not ask about responsibility for *monitoring performance and overseeing implementation*. These responsibilities remain important for many subsidiary boards.)

EXHIBIT 2 SYSTEM–SUBSIDIARY HOSPITAL RESPONSIBILITY DISTRIBUTIONS



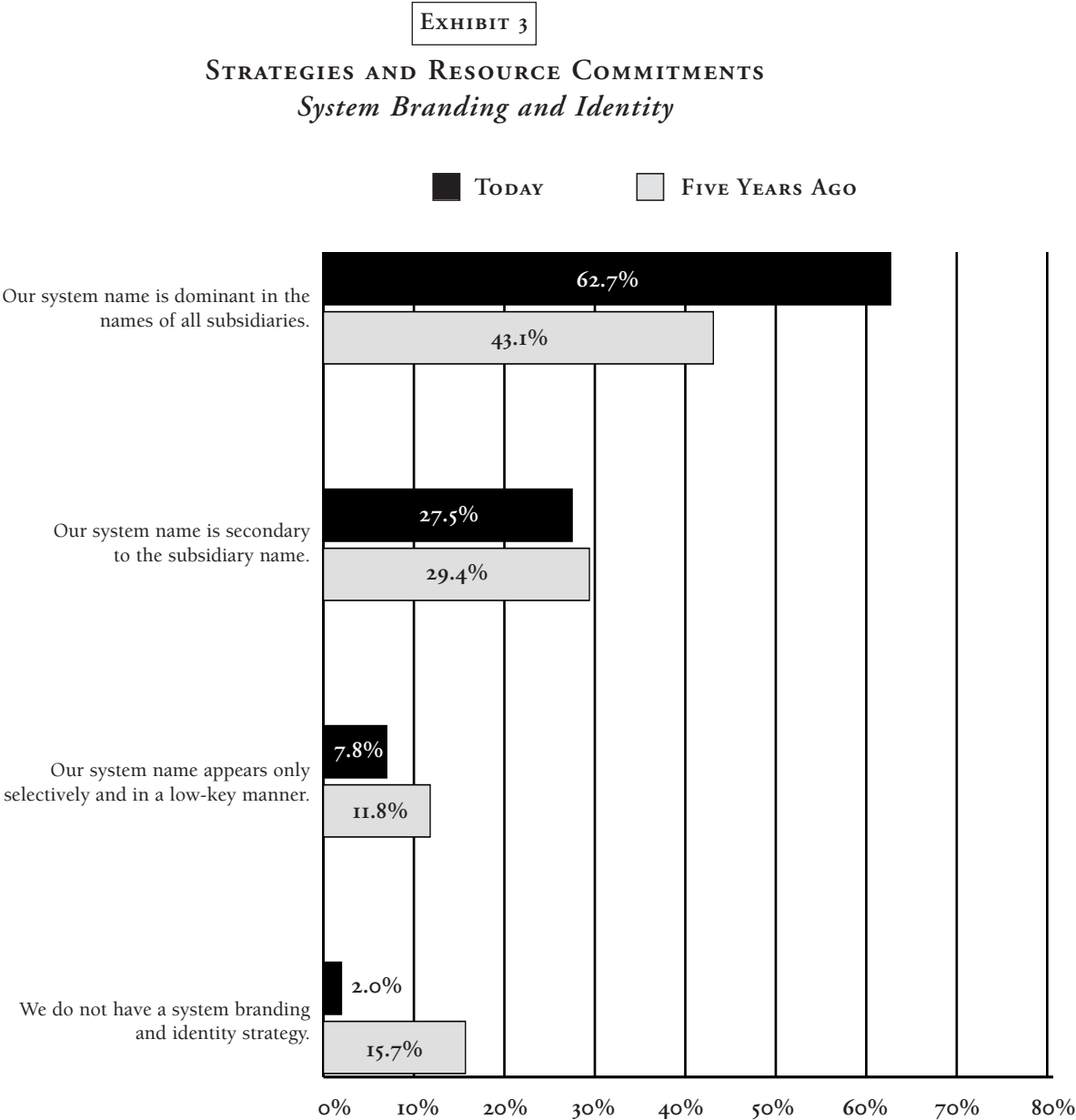
Systemwide Strategies and Resources:
Beefing Up to Add Value

Governance experts have identified a number of strategies and resource commitments that signal the shift from a decentralized model of system operations and governance to a more centralized model. In the survey, CEOs were asked about their organization’s activities in three of these specific areas: system branding and identity, centralized information systems, and standardized patient care management systems. If one accepts that these three strategies

indicate a move toward centralization, then based on the responses, the majority of organizations are, in practice, becoming more centralized.

System Branding and Identity

A majority of respondents (62.7 percent) said their system name is dominant in the names of their subsidiaries, an increase of nearly 20 percentage points over this strategy five years ago. Only 2 percent said they do not have a system branding and identity strategy. (See EXHIBIT 3.)

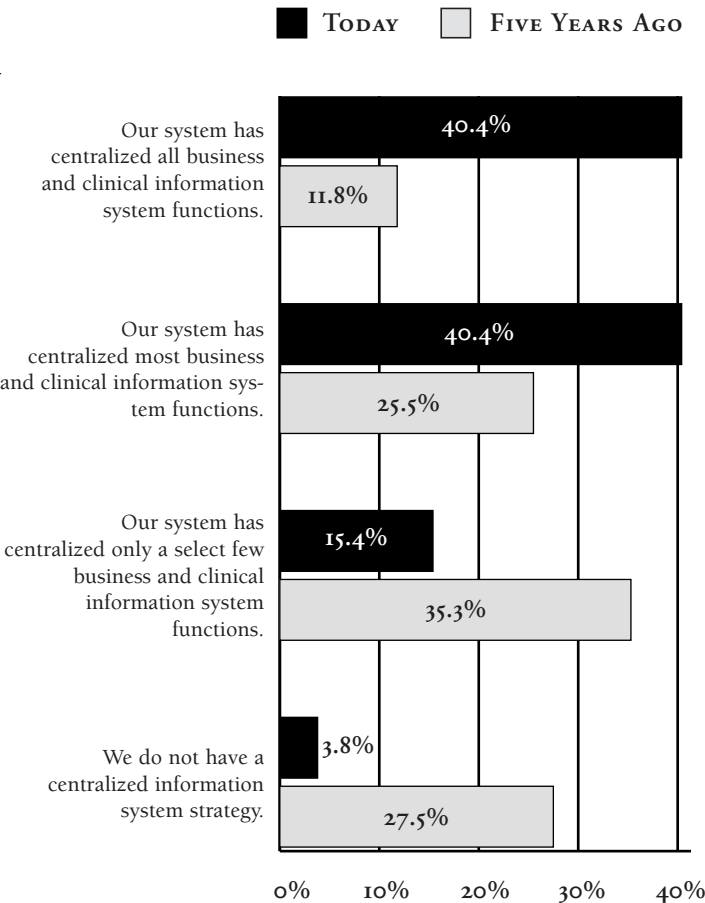


Centralized Information System Function

More than 80 percent of the respondents said that in the last five years their system centralized all or most business and clinical information system functions. Five years ago, 37 percent had centralized all or most of these functions. Again, only 4 percent do not have a centralized information system strategy today, but this is significantly fewer than five years ago (27.5 percent). (See EXHIBIT 4.)

EXHIBIT 4

STRATEGIES AND RESOURCE COMMITMENTS
Centralized Information System Function

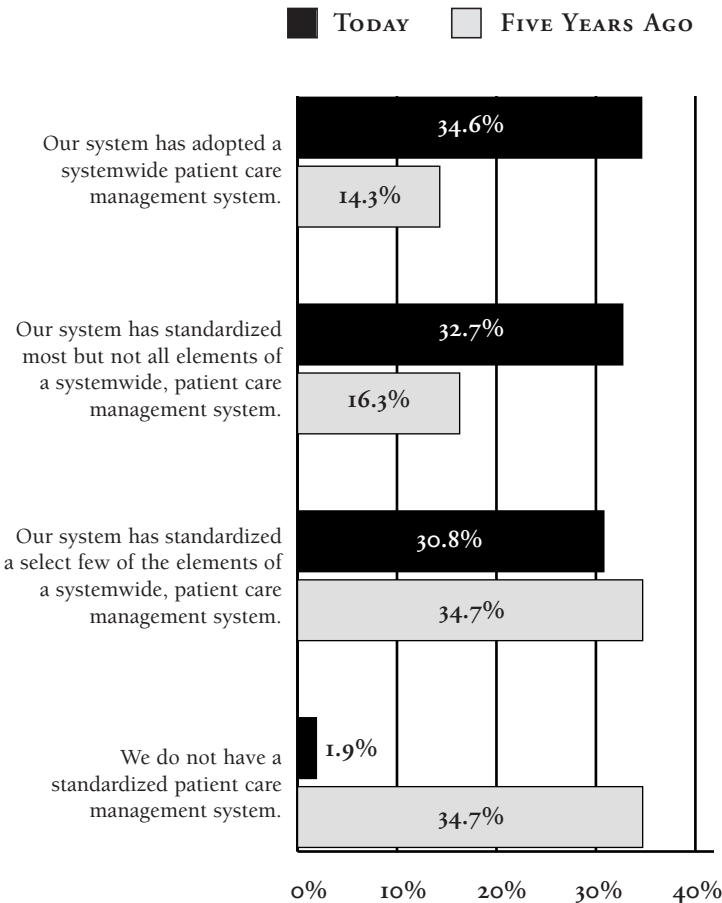


Standardized Patient Care Management System

Although the numbers here are not as dramatic, the differences between practice today versus five years ago are significant. Nearly 35 percent of the respondents said their system has adopted a systemwide patient care management system in the last five years—only 14.3 percent said they had done this five years ago. Another 33 percent said they have standardized most (but not all) elements of systemwide patient care management. Very few (2 percent) said they do not have a standardized system. (See EXHIBIT 5.)

EXHIBIT 5

STRATEGIES AND RESOURCE COMMITMENTS
Standardized Patient Care Management Function



The Shift to “Systemness”

For over 20 years, larger not-for-profit healthcare organizations have been on a journey to become systems. Unfortunately, there is no “yellow brick road” for them to follow. And, to make the quest even more challenging, what it means to be a system means different things to different people and is dependent on the history and local circumstances of each system. Hence, today’s larger healthcare systems are in a constant state of “becoming,” without a clear end state shared by all. As Joel Allison put it, “the results [of the survey], while not surprising, validate that it takes significant time to evolve to ‘systemness,’ especially when there is uncertainty about what ‘systemness’ really means.”

The system movement gained traction as a response to legal, competitive, and economic forces. Today, the forces described in the previous section, combined with even more intense financial, governmental, and societal pressures, have accelerated the pace on the journey to systemness. Enabling a group of healthcare entities to work together for greater effectiveness and efficiency, and requiring more influence and control at the system or corporate level have gradually become accepted as common features of being a system. For many, it has become a question of greater or lesser centralization of power and authority.

Most not-for-profit health systems began using a holding company model of governance and management. In a relatively short time span, many shifted to a shared governance/influence model. Robert Stanek sees “clear evidence of a shift away from the holding company model, with minimal parent authority, to more of a shared governance model where the parent sets the expectations for subsidiaries, but shares with local governance responsibility for customizing how the expectations will be met in plans and budgets, according to local needs.”

More recently, a number of systems have made the transition to functioning more as an operating company. Peter Fine views large health systems as “moving from the holding and shared governance models to becoming operating companies of large businesses.”

Clearly, health systems today are on varying points on this continuum from holding company to operating company. (See **TABLE 1** on page 14 for a typology of models.) The same is true in the private sector of the economy. All of the models have proven to be successful in the private sector.

Berkshire Hathaway is a classic holding company that has achieved outstanding results for decades. The disparate array of businesses that make up Berkshire Hathaway would receive little benefit from a centralized decision-making process dominated by a corporate headquarters. Thus, the holding company model is ideal for ensuring that control and authority is at the right level and that corporate bureaucracy does not get in the way.

Starbucks and Barnes & Noble are on the other end of the continuum and epitomize successful operating companies. Their focus on standardization, efficiency, and consistently high-quality customer service, requires strong direction and control over systems, purchasing, policies, and operating decisions.

Somewhere in between these extremes is a company like Gap, Inc., which has chosen to centralize those functions that add value for the various brands that comprise Gap, Inc. but with a fair amount of control and influence over strategic and operating decisions at the brand level.

D*ecisions to centralize or integrate are based on performance considerations and whether they add value for the people served.*

Large health systems’ movement away from the holding company approach seems to belie the popular adage that “all healthcare is local.” While healthcare is delivered locally, larger systems have recognized the benefits of greater standardization, coordination, and

centralization of various functions with more control and authority shifting to the corporate headquarters. This is especially true with regard to eliminating duplication among administrative support functions, developing a common information systems platform, leveraging economies of scale, enhancing access to capital, and achieving consistent levels of clinical quality and customer service.

What appears to differentiate the evolution of not-for-profit health systems from large private companies is that mission is one of the motivations behind the shift to systemness. Most of the CEOs interviewed for this publication emphasized their commitment to a common mission to better meet the needs of the communities they serve; they say the decisions to centralize or integrate are based on performance considerations and whether they add value for the people served. There is also growing awareness that large systems are serving more than a single local community and have to elevate their perspective beyond individual facilities and constituencies.

TABLE I

THREE MODELS OF HEALTH SYSTEM GOVERNANCE AND MANAGEMENT

Holding Company	Shared Governance	Operating Company
<ul style="list-style-type: none"> • Goal setting, oversight, and decision making are decentralized • Local boards retain significant fiduciary authority and responsibility • Parent has limited reserved powers or rarely exercises them • Parent board composition often based on representation governance • Local executives have considerable power • Little standardization or centralization of key business functions; few or no platforms to share best practices • Very lean corporate staff • Common to have large and multiple boards composed of stakeholders • Governance processes can be cumbersome because of desire to involve many stakeholders and achieve consensus • High priority placed on fulfilling mission and meeting local/market needs 	<ul style="list-style-type: none"> • Goal setting, oversight, and decision making are shared with local fiduciary boards • Premium placed on local input into systemwide decision making • Parent applies influence in key strategic areas and uses reserved powers sparingly • Standardization, centralization and sharing of best practices implemented where they add value • Alignment promoted by enterprise-wide strategic planning, capital planning, systemwide policies, and accountability for performance targets • Moderate sized corporate staff • Parent board composition not based on representational formula • Local executives are evaluated by parent CEO with local board input • Governance structures and processes are streamlined • Mission and meeting local/market needs is balanced with financial requirements 	<ul style="list-style-type: none"> • Goal setting, oversight, and decision making are centralized at corporate level • Authority shift from subsidiary to parent level • Elimination of local boards or conversion to advisory status • Business functions centralized, intense standardization, mandatory use of best practices • Strategic planning and capital planning are driven from the top • Large corporate staff to manage key functions • Local executives are evaluated by parent • Flatter governance and management structures • Corporate financial performance takes priority over subsidiary considerations • Lean board size and committee structure
<p style="text-align: center;">Corporate Control, Capability, Coordination, and Centralization</p> <p style="text-align: center;">Less ←————→ More</p>		

Changes in Governance Structure and Practice

When our survey and interviews drilled down further into changes in health system governance, we found the shift toward systemness and a more corporate way of governing was evident in many ways. Specifically, we examined changes in system-subsidary board relationships, adoption of specific system policies, changes in board structure, and selected governance practices often associated with stronger corporate control.

Changes in system-subsidary board relationships. Quite a few health systems have reexamined their approach to governance following large financial losses in one or more hospital subsidiaries. A frequent contributor in these situations was passive local governance—boards of committed volunteers who thought somebody else was minding the store. It turned out nobody was. As a result—or to avoid the scenario—systems have taken various steps to tighten up their structures and alignment with subsidiaries. We wanted to see if systems were redesigning subsidiary boards out of existence.

The study looked at three specific changes in the relationship between system and subsidiary boards over the past five years. As shown in **EXHIBIT 6** (next page):

- More than a third (38.5 percent) have changed or are considering changing their subsidiary hospital boards from fiduciary to advisory.
- More than half (52 percent) of the respondents said they have consolidated or are considering consolidating two or more subsidiary boards into one board, and/or merging the system and hospital boards. (The consolidation of system and hospital boards into one is especially common when a system serves a single geographic market and has trimmed back its strategic plan of the '90's to become a regional, integrated delivery system with multiple subsidiaries along the continuum of care.)
- Some (39.2 percent) have eliminated or are considering eliminating overlapping board membership between the system and subsidiary boards.

At the same time, subsidiary boards are not going away everywhere. Half the systems responding have subsidiary boards and have no plans to change their responsibilities to advisory. (See **EXHIBIT 6**.)

Adoption of System Policies. Another way a corporation keeps subsidiaries aligned with system goals and priorities is through systemwide policies. Earlier in their history, many health systems were reluctant to remove local boards' authority over key policy areas, but the survey suggests this hesitance is evaporating.

As **EXHIBIT 7** (next page) shows, more than 80 percent of the respondents said they have adopted systemwide policies for external audit, quality of care standards, and conflict of interest, and adding those who are considering these policies, the percentage increases to more than 90 percent.

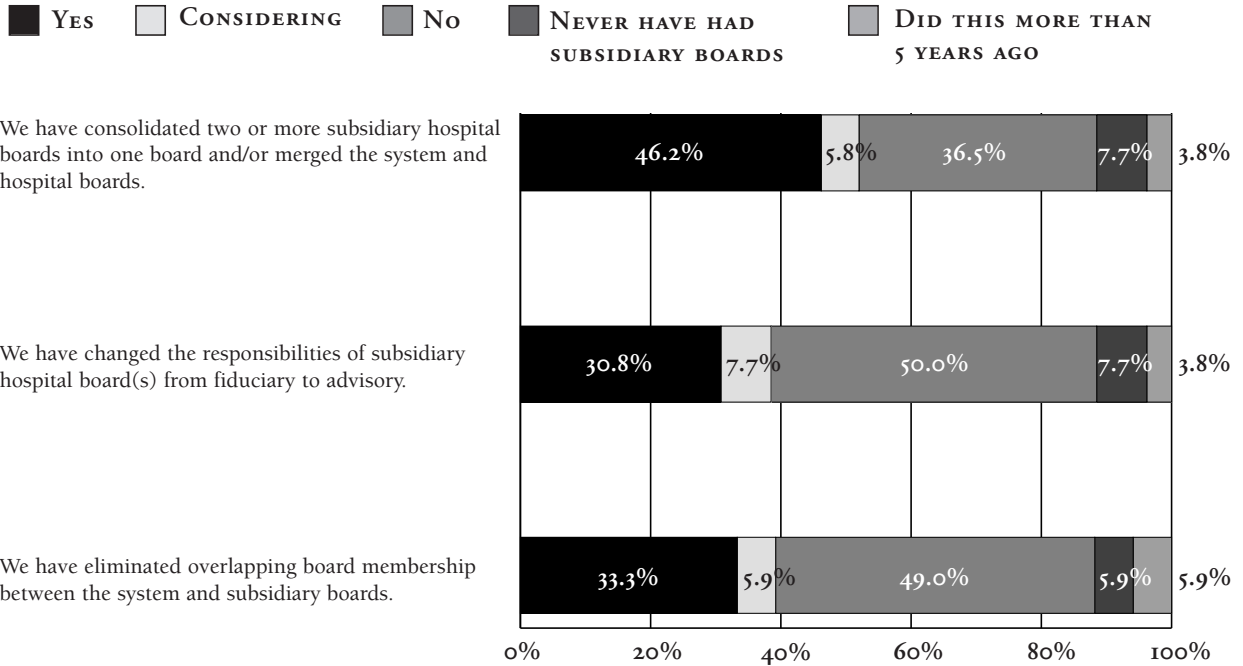
Nearly two-thirds of respondents have system policies in place for evaluation and improvement of governance structure and practice and quantifiable measures of community benefit—65.4 percent and 61.5 percent respectively. Combined with those who are considering these policies, the percentage jumps to more than 82 percent. (See **EXHIBIT 7**.)

Changes in System Governance Structure. We also looked at changes on system boards themselves—were they following the “corporate model” of smaller boards and a lean committee structure? Evidence is sketchy.

EXHIBIT 8 (page 17) shows that 25 percent of respondents have reduced the size of their system board or reduced the number of system board committees (23.1 percent). An additional 12 percent are considering whether they will reduce board size, and nearly 6 percent are considering cutting the number of committees. However, these findings have limited analytic value because the survey did not ask about the actual size of parent boards nor about the number of board committees. These elements are worthy of attention in subsequent research.

Governance Practices. It is in the area of board governance practices where evidence emerges of a shift toward a more corporate model. As **EXHIBIT 9** (page 17) shows, more than 92 percent of health systems responding now purposefully try to function more like a corporate enterprise board. More than 80 percent of the respondents said they are placing increased emphasis on corporate experience/business-related acumen when selecting board members, and they have assigned oversight of key business functions systemwide to system-level board committees.

Fifty-two percent (52 percent) have adopted a succession plan for the CEO of the health system, and nearly 33 percent currently are considering this. However, a succession plan for the system board chair did not fare as well—52 percent currently have a plan, but only about 10 percent of those that don't are considering it. A significantly lower percentage of respondents (11.5 percent) have an evaluation mechanism for individual board members' performance, and only an additional 25 percent are considering this. (See **EXHIBIT 9**.)

EXHIBIT 6
CHANGES IN SYSTEM/SUBSIDIARY BOARD RELATIONSHIP


16

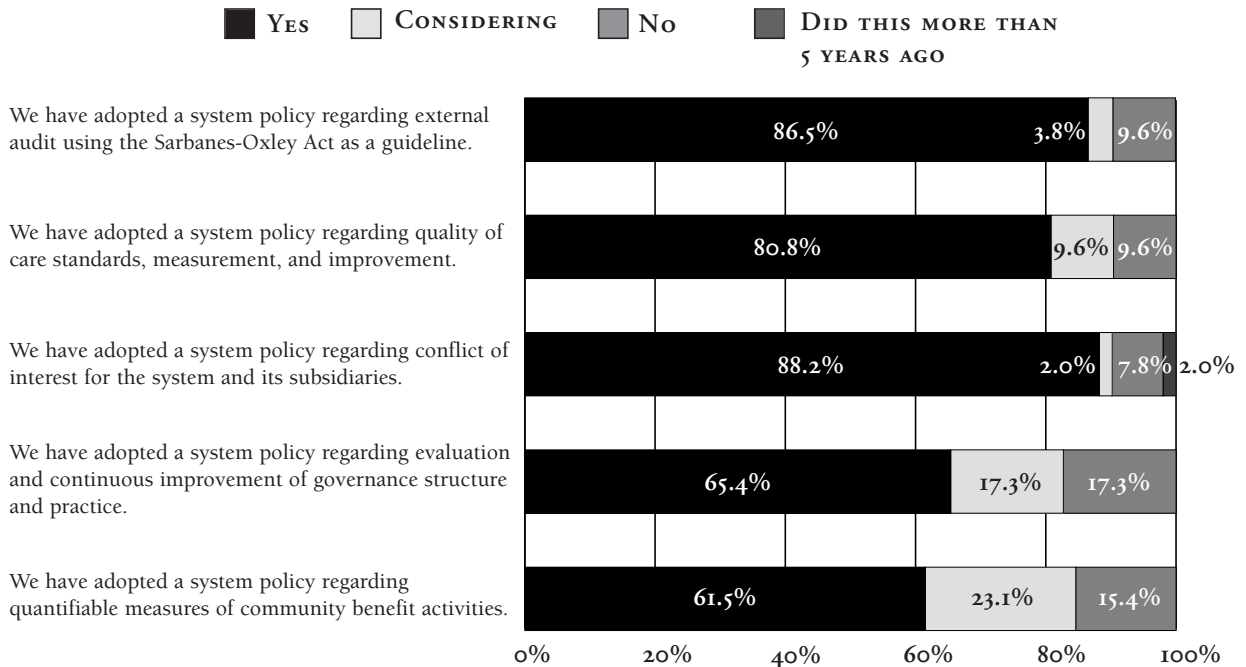
EXHIBIT 7
ADOPTION OF SYSTEM POLICIES


EXHIBIT 8 CHANGES IN GOVERNANCE STRUCTURE

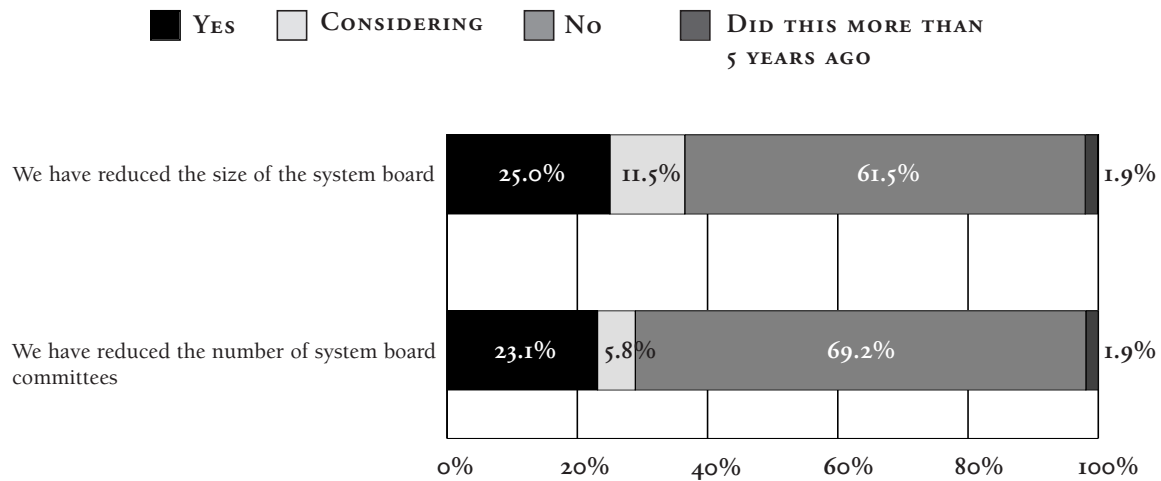
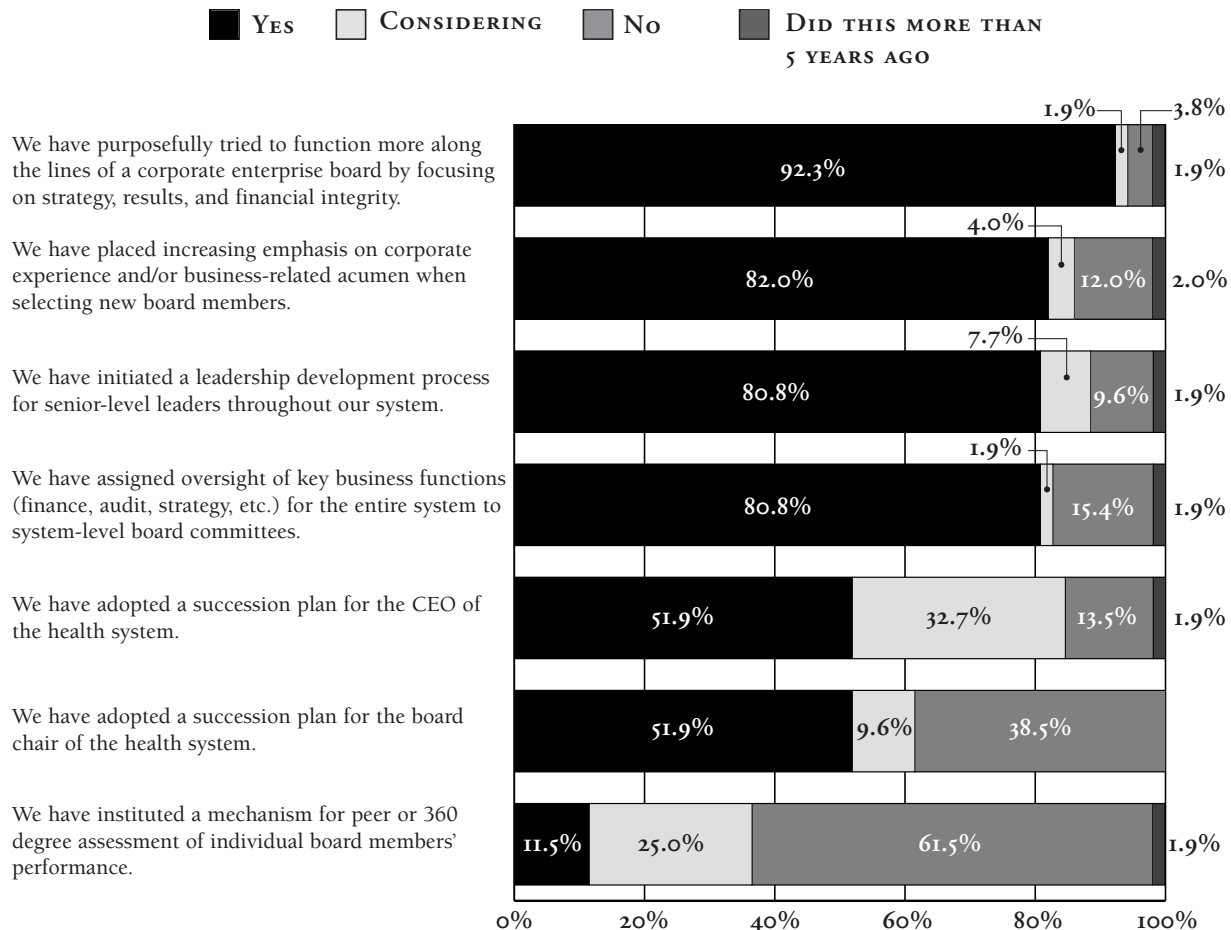


EXHIBIT 9 CHANGE IN GOVERNANCE PRACTICE



Subsidiary Boards in the Hot Seat

Taken as a whole, the results document that health system governance is paying closer attention to subsidiaries' operating performance: system board committees are overseeing key business functions systemwide at more than 80 percent of the health systems responding. While some system boards have taken control of oversight functions themselves—eliminating local boards or reducing their responsibilities—other systems have taken the opposite tact, launching board development programs to strengthen local governance and hold local directors accountable. As previously noted, **EXHIBIT 2** (page 10) shows an increase in the number of system boards that set strategic goals, financial goals, and even quality, patient safety, and customer service goals for subsidiaries. More than 80 percent of system boards have adopted policies setting forth expectations for external audit, quality of care, and conflict of interest for the system and subsidiary boards. Even in the area of community benefit, traditionally light on quantitative measures, 60 percent of boards have adopted policies and another 24 percent are considering it, probably driven by both mission and the looming presence of IRS and other external agencies demanding evidence that tax-exempt status is being earned.

18

Some health systems that were formed through mergers and co-sponsorships were initially reluctant to impose highly centralized, corporate control over once-autonomous operating units. But when red ink at a few operating units drains resources from other system facilities, local autonomy is an unaffordable luxury.

Catholic Health East's Robert Stanek says such situations mandate that the corporate parent exercise its accountability—but he doesn't think that requires eliminating local boards. Instead, he envisions a shared governance model in which parent boards will set higher expectations and standards than local boards traditionally have, and parents will also institute strong oversight processes to hold subsidiaries accountable for results.

Although leaders like to debate whether local boards are worthwhile or a historical hangover, the right structure is likely to depend less on philosophy than on the geographic makeup of the organization. A case in point is OhioHealth. Dave Blom said that in the Columbus market, OhioHealth reorganized into one board instead of individual facility boards, but outside the Columbus area, it maintains separate hospital boards that are still subject to OhioHealth reserved powers. However, one thing is common and paramount: "We have the same performance expectations for all boards," said Blom.

In fact, OhioHealth recently subjected itself voluntarily to a corporate responsibility audit of its governance practices. An outside law firm evaluated the board against relevant parts of the Sarbanes-Oxley Act and other "good governance" practices, such as having executive sessions without the CEO present to promote board independence. Even a law that doesn't apply to not-for-profit health systems is driving the renewed focus on governance accountability.

Evolution of Better Boards

Nonetheless, Darwinian evolution is not the sole driver of changes in health system governance. Many of the changes are proactive and come out of the belief that better boards help build better organizations. According to the survey, 80 percent of the respondents have initiated a leadership development program for senior-level leaders throughout the system. At least some of these systems also are investing in long-term development of directors. For example, Catholic Healthcare Partners offer both a Governance Academy and a Governance Retreat annually to board members. The retreat provides nationally known speakers in a spiritual retreat format while the academy offers educational modules tailored to subject area needs and strategic issues. "The retreat feeds the soul and the academy feeds the mind," said Michael Connelly.

Following Jim Collins' advice to "get the right people on the bus," (from his book *Good to Great*), many health systems are adopting explicit, criteria-based approaches to board member selection. "We use a very disciplined approach to ensure that we have the right blend of skills," said Blom. Using a matrix, board members are analyzed against 16 specific criteria to identify gaps that are then filled with appropriate people.

Similarly, more than half of the health systems have adopted formal succession plans for the CEO and for board leaders, and another 31 percent are thinking about formalizing CEO succession planning.

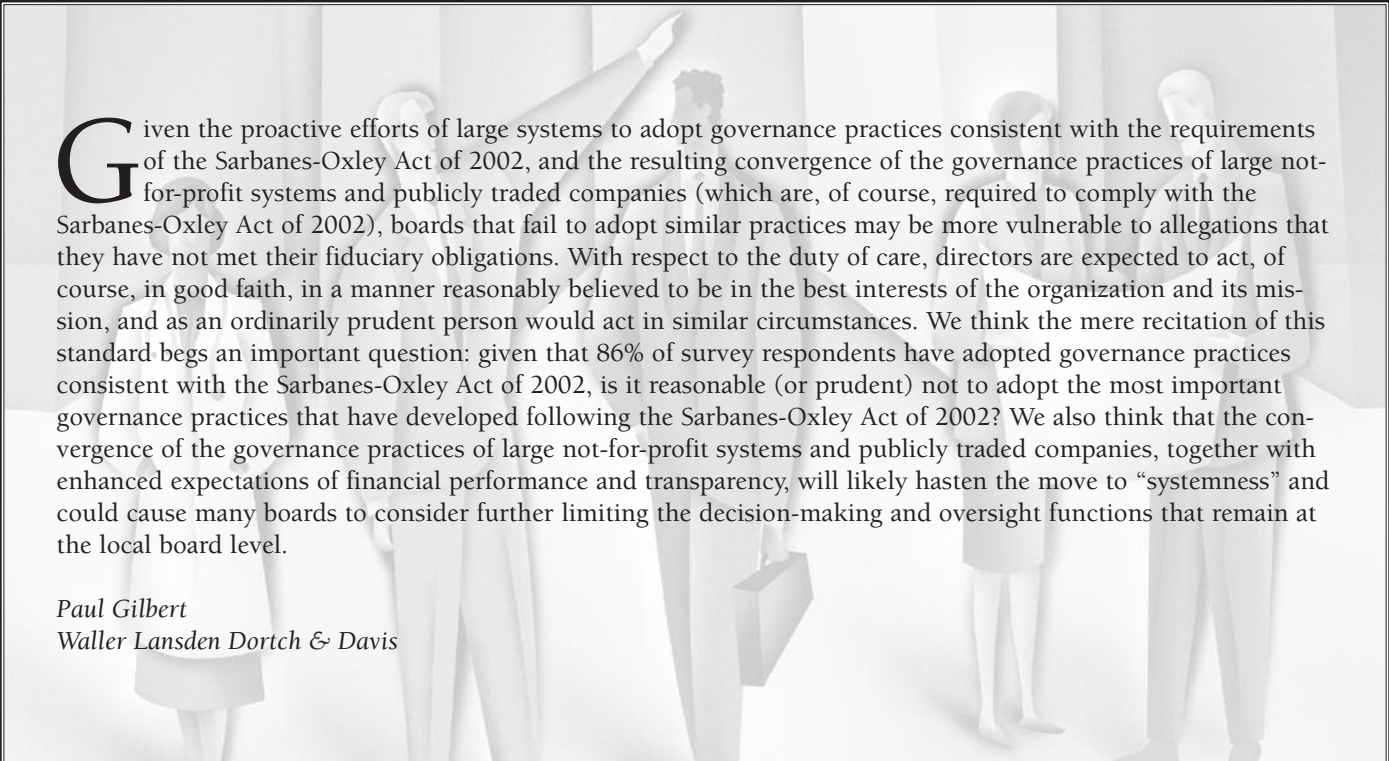
On the other hand, the survey shows that more than one-third of health systems have no succession planning process in place for the board chair, and don't contemplate adopting one. What are they thinking? The chair is the leader of the board, the CEO's strategic partner, and his or her chief evaluator. It is difficult to fathom why a large health system would lack such a basic board process.

Another forward-looking governance practice, peer or 360 degree evaluation, has gained surprising traction. Just a few years ago, corporate management and governance expert Ram Charan wrote that few corporate boards had adopted this practice, which he advocated but likened to “walking on eggshells.” Corporate board members are not eager to expose their ego’s to peer criticism, he said. We believe that is even more the case on a board of volunteers serving out of a sense of mission.

Yet, some 12 percent of system boards have instituted peer evaluation, and another 25 percent are considering it. That’s a clear reflection of a sense of increased accountability for boards and individual directors. Catholic Healthcare Partners, for instance, implemented a peer assessment

process in which the board first identified key competencies of individual directors. Then, the board engaged a third party to design and administer a peer assessment survey and share the results confidentially with each director. The response was positive, and the board plans to repeat the process every two years.

Many boards have adopted less structured but still important approaches to individual accountability, such as attendance policies, written performance expectations, codes of conduct, and formal reviews of director performance by the Governance Committee prior to reappointment. OhioHealth, for instance, recently removed two board members for not performing up to agreed upon standards.



Given the proactive efforts of large systems to adopt governance practices consistent with the requirements of the Sarbanes-Oxley Act of 2002, and the resulting convergence of the governance practices of large not-for-profit systems and publicly traded companies (which are, of course, required to comply with the Sarbanes-Oxley Act of 2002), boards that fail to adopt similar practices may be more vulnerable to allegations that they have not met their fiduciary obligations. With respect to the duty of care, directors are expected to act, of course, in good faith, in a manner reasonably believed to be in the best interests of the organization and its mission, and as an ordinarily prudent person would act in similar circumstances. We think the mere recitation of this standard begs an important question: given that 86% of survey respondents have adopted governance practices consistent with the Sarbanes-Oxley Act of 2002, is it reasonable (or prudent) not to adopt the most important governance practices that have developed following the Sarbanes-Oxley Act of 2002? We also think that the convergence of the governance practices of large not-for-profit systems and publicly traded companies, together with enhanced expectations of financial performance and transparency, will likely hasten the move to “systemness” and could cause many boards to consider further limiting the decision-making and oversight functions that remain at the local board level.

*Paul Gilbert
Waller Lansden Dortch & Davis*

Conclusion: Is a New, Corporate Enterprise Model Emerging?

Clearly, the survey shows that large health systems are adopting the management practices of well-run, successful private enterprises. They are implementing centralized and standardized business and information systems to drive increased efficiency and productivity. They're applying branding strategies and measurement systems to define their value and measure their performance. In so doing, they're convinced they'll do a better job of fulfilling their mission.

The survey offers compelling evidence that significant changes are occurring not only in management, but also in governance. Further, these changes are not cosmetic or a natural evolution of a maturing, multi-faceted organization seeking tighter alignment among subsidiaries. The survey suggests fundamental changes are occurring in the DNA of health system governance.

"Clearly our system and hospital boards are responsible for responding to changes in the environment. These changes, while not revolutionary, are evolving in a common direction, the corporate/enterprise model of governance," said Barry Arbuckle.

"It's inevitable that systems will organize themselves and adopt more disciplined, business-like practices to better serve the community," agreed Dave Blom.

Many of the changes occurring on boards represent the adaptation of the species to powerful and often threatening external forces. The Sarbanes-Oxley Act doesn't currently apply to not-for-profits, but the specter of financial penalties and orange jumpsuits has driven tax-exempt hospital executives and boards to adopt new oversight practices and bolster board independence as if the law did apply.

In addition, unforgiving economics and relentless competition of the marketplace are driving system boards to focus on financial results much like the board of a Fortune 500 company facing Wall Street's expectations. The overwhelming majority of survey respondents say they are deliberately operating "more on the lines of a corporate enterprise board by focusing on strategy, results, and financial integrity." To do their jobs well, they are deliberately placing "increased emphasis on corporate experience and/or business-related acumen when selecting new board members."

Richard Umbdenstock noted an "increased focus on performance and accountability—the market and availability of information are leading the changes."

"The responsibility shift apparent in the data supports the hypothesis you are testing," namely, the emergence of the corporate or enterprise board, said Peter Fine. In fact, Fine was surprised that subsidiaries still have as much responsibility as reported. He said he views systems as "moving from the holding company mindset to becoming operating companies of large businesses." Banner has eliminated local boards, and he questions the cherished notion that a local board is necessary to interpret healthcare needs and connect with local communities.

"Can a local board truly represent the whole community where a particular hospital is located?" he asked. Fine said he believes that a single board like Banner's, if equipped with the right information about population needs, customer perceptions, and health trends, is better able to objectively look out for the interests of the diverse array of communities they serve than local community hospital boards.

Robert Stanek agreed that the holding company model is fading fast, but he doesn't buy the argument that local boards ought to join the junk heap. "I do not believe the corporate model is a good model for a geographically dispersed, multi-organizational, not-for-profit health system," said Stanek. "If you're serving a close knit area, it works well, but not when you serve communities up and down the East Coast the way Catholic Health East does. Healthcare is truly local. I may be a dinosaur, but I think local boards are still important."

While the data strongly suggest that health system *management* is looking and acting more like its private industry counterparts, the survey findings, our interviews, and our experience do not support the emergence of a new model of governance. They do, however, indicate that fundamental changes are underway in health system governance at a quick pace, and in the direction of more influence and control by the parent organization. However, labeling them a new "corporate" model is premature at best and gives insufficient weight to the board's accountability for the mission of not-for-profit organizations.

"The word model makes it sound like a major change or new direction. I see something less dramatic," Richard Umbdenstock said.

It is worth noting that governance in the private sector is also changing quickly to enhance corporate accountability and transparency, but private corporations are incorporating some of the age old practices used by the not-for-profit sector, such as separation of the chair and CEO roles, board

self-evaluation, term limits, conflict-of-interest policy enforcement, and a majority of the board composed of independent directors.

“The increase in accountability and discipline is happening to all governance, not just non-profit or healthcare non-profits,” said Michael Connelly. “Independence, transparency, and the other mechanics of increased accountability are happening with all types of boards.”

It may be that governance practices are converging among various sectors of society. As convergence intensifies, the distinction between not-for-profit and for-profit governance becomes moot, with one set of standards emerging for defining “good governance.”

“I always chuckle when people say, ‘hospital boards have to be more like corporate boards,’” Umbdenstock said. “If corporate boards had done some of the things non-profit hospitals have done for years, like board self-evaluation, many would be better off.”

“But,” he quickly added, “our governance is changing. There’s definitely less tolerance, less acceptance of so-so results by saying, ‘but [in non-profit healthcare] we’re different, we have a mission.’ If that means health system boards are more like corporate boards, that’s probably right.”

“The trick is to keep in touch with who you really are, your mission, and also not to accept inadequate performance,” he said.

Utility of the model. We began this study with a hypothesis that a new “corporate governance model” was emerging among not-for-profit health systems. In the course of the study, we have been able to describe the elements of that model more clearly, and particularly in **TABLE 1** (page 14), showing the differences among the holding company, shared governance, and operating company models.

The expression, “All models are wrong, some models are useful,” comes to mind. In this case, while we do not find the corporate, operating company model emerging everywhere in every aspect, health systems can use the model to ask several important questions about their system governance:

- Where are we on the continuum from a holding company model to an operating company of management and governance? Are we where we need to be?
- Have we addressed the hard questions of whether to have subsidiary boards and, if so, what do we expect of them?
- Are we demanding enough of governance at all levels to discharge our responsibilities as directors and to help the organization thrive?
- Are we maintaining the right balance between finances and mission—remembering the board is accountable for both in equal measure? Failing the test for either one means the organization fails.
- As system management moves toward the operating model, with greater standardization and centralization of core processes and decision making, does it follow that governance must move in parallel, and just as much on the continuum? Or, if healthcare truly has important local elements, does local governance, through the shared governance model, provide a check and balance to corporate power as well as a valuable connection to local stakeholders?

The Governance Institute will continue to track the evolution of health system governance in future research and publications.

Appendix

Study Design

The Governance Institute mailed a 4-page survey to 101 CEOs of large, not-for-profit U.S. health systems in late July 2004. The survey focused on four specific areas:

1. Forces Driving Change

CEOs responded to 10 forces driving governance change by noting their actual experience; that is, whether their board has addressed each force directly, or whether they anticipate having to address each force.

2. System-Subsidiary Hospital Responsibility Distributions

Specific responsibilities for decision making were listed, and respondents were asked to designate whether these responsibilities were reserved to the system board, shared between the system and subsidiary hospital boards, or delegated to the subsidiary hospital board. They noted the division of responsibilities five years ago and who holds those responsibilities today.

3. System Strategies and Resource Commitments

A number of strategies and resource commitments have been connected with the reported shift to a corporate/enterprise governance model—system branding and identity, a centralized information system, and a standardized patient care management system. Respondents described their approach five years ago as well as their approach today.

4. Changes in Governance Structure and Practice

CEOs were asked to indicate whether their system has implemented in the last five years, or is considering implementing, a number of changes in governance structures, policies, and practices.

Who Responded

Fifty-two organizations (51 percent) responded to the survey. Secular, non-governmental systems represented 50 percent of the responses; Catholic systems were 30 percent of the respondents; and 12 percent were other church-affiliated systems.

More than half of the responding systems (58 percent) have hospitals in one state only. Twenty-five percent (25 percent) have hospitals in 2–3 contiguous states, and 17 percent have hospitals in more than three states.

EXHIBIT A

SYSTEM SPONSORSHIP

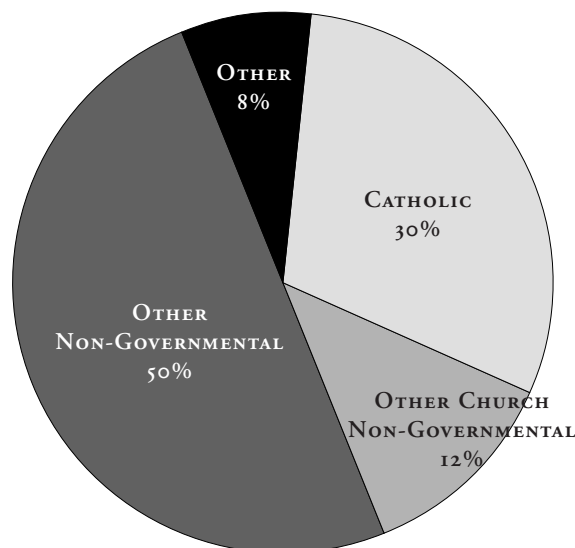
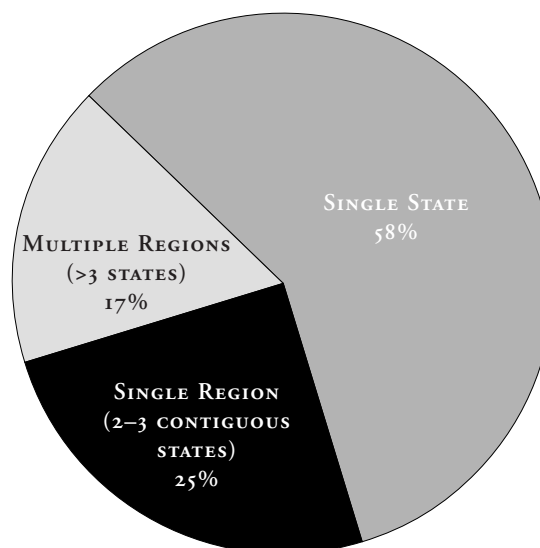


EXHIBIT B

GEOGRAPHIC DISPERSION OF SYSTEM HOSPITALS



Follow-Up Interviews

Seven CEOs who responded to the survey were interviewed to determine their reaction to the survey findings. The Advisors specifically asked:

1. What key findings caught their attention? Did any results surprise them? Did any results prompt major insights?
2. Did they accept or reject the basic hypothesis of the survey? Do they believe the trend is real, a passing fad, or non-existent?
3. What are the two or three driving forces that have and will continue to have the greatest impact on large, multi-hospital system governance over the next five years?

Two CEOs interviewed represented single-state systems with “other” church sponsorship. An additional CEO from a single-region system with Catholic sponsorship was interviewed, and another CEO from a single-state system with secular sponsorship. Finally, a secular multiple-region system CEO was interviewed, as well as two Catholic multiple-region system CEOs.



The Governance Institute

Toll Free (877) 712-8778
6333 Greenwich Drive • Suite 200
San Diego, CA 92122
governanceinstitute.com