

WHOSE JOB IS IT? ANYWAY!

Governance Restructuring Clarifies Board Roles

“Exactly who has the authority to make this decision?” asks a trustee during a local hospital board meeting. The trustee, a prominent community leader, is new to the board. Her fellow board members, many of whom have served for years, shift uncomfortably in their seats. The new trustee rephrases her question: “Does our board or the system board have the ultimate authority to approve this \$5 million expansion project?” • Some of the trustees argue, “Of course, it’s our decision; we are the hospital board.” Others are less sure. They remember addressing this issue at the time of the merger. However, that was three years ago, and the trustees cannot now recall exactly what the revised bylaws said about capital expenditures of this size. Since the board cannot agree on an answer, the chair says that she will contact the system chair for clarification, and the discussion is tabled until the next month’s meeting.

BY PAMELA R. KNECHT AND EDWARD A. KAZEMEK

THE PROBLEM: CONFUSION AND INEFFICIENCY

This conversation highlights what is happening in many boardrooms today. The numerous mergers among health care providers over the last five to 10 years have produced many systems with multiple layers of governance, numerous boards and many committees. In one system, the corporate organizational chart grew to 16 boards and 57 committees, and spread across five layers, involving more than 200 people.

Confusion Regarding Authority. Even relatively small health care systems have ended up with separate boards for the hospital(s), the long-term care facility, the home health organization, the foundation, and other entities. All of these boards (and their committees) are supposed to report to a system or parent board. In many cases, this reporting relationship exists only on paper.

In reality, final decision-making authority may lie with any of a number of bodies within the governance structure. Sometimes the hospital board makes all the decisions for its own institution; sometimes the system board's finance committee is the final arbiter; at other times, the board's executive committee of the system's largest hospital has the most power. As a result, many new board and committee members become justly confused about their board's role in the decision-making process.

Slow Decision Making. The ungainly governance structures we have created also make for slow and arduous decisionmaking. Jeff Wendling, President/CEO of Northern Michigan Regional Health System, Petoskey, says that before their governance restructuring, some staff and board members served on as many as 13 governing bodies within the system. It took too long for decisions to work their way up through the multiple levels of committees and boards. In addition, trustees and managers became frustrated with hearing the same report over and over. Most felt that they were devoting an inordinate amount of time to governance.

Unmanageable Board Size. Merger and acquisition activity may also spawn unmanageably large system-level boards. In order to accomplish mergers and assuage the reservations of

trustees from previously independent hospitals, a certain number of seats may be reserved on the system board for the trustees of the acquired entities. We have seen system boards grow to more than 40 members as a result. Since experts in group dynamics believe the optimum size of a decision-making body is between eight and 10, these large boards are, by definition, inefficient. Either it takes a very long time to hear the opinions of 40 people, or, as is more often the case, the majority of trustees do not speak up for fear that the board meeting will last until midnight. The board, therefore, loses the opportunity to hear all of the relevant facts and opinions before it votes.

Underutilized Trustees. This situation leads to one of the worst consequences of governance confusion and inefficiency—the loss of talented board members. Board members check out (mentally and/or physically) because they do not believe they are making a significant contribution; because their roles are unclear; or because, as successful, busy community or business leaders, they cannot tolerate being part of an inefficient organization.

Given today's need for active boards, we cannot afford to squander this valuable resource. Without the total involvement of trustees, it's difficult for executives to understand the needs of the communities they serve and to determine how best to meet those needs while maintaining financial stability.

So what can and should be done about this situation?

A SOLUTION: GOVERNANCE RESTRUCTURING

The answer for many systems is governance restructuring.

According to The Governance Institute's 1999 *Biennial Survey of Health System Boards*, 53 percent of the 77 responding systems had conducted comprehensive governance assessments in the past two years. Of those, 63 percent had fundamentally restructured their governance model as a result.

Restructuring looks different for each organization, but it generally entails a comprehensive assessment of:

- The corporate structure (e.g., the "boxes" on the organizational chart representing each board and committee)

GOVERNANCE DESIGN PRINCIPLES

Here are some principles a system may want to use to evaluate the appropriateness of various structural options. The new organizational structure must:

- **Help create a successful health care delivery system.**
- **Ensure effective resource allocation throughout the system as needed.**
- **Clarify the locus of power and authority.**
- **Clarify roles and relationships among the various entities.**
- **Enable governance to hold management accountable for its performance.**
- **Provide more opportunities for physician input and governance participation.**
- **Increase community input and involvement.**
- **Allow more strategic thinking at the board level.**
- **Expand the diversity of those serving in governance.**
- **Use board members' time wisely.**
- **Ensure that future governance leaders are knowledgeable about and prepared to deal with the changing health care industry.**
- **Be legally sound, factoring in regulatory and reimbursement issues.**

- Board and committee composition (i.e., the number and types of skills of members)
- Governance functioning (i.e., roles, responsibilities, and authority; meeting effectiveness, decision-making processes; orientation and education)

Although on the surface this seems like a straightforward process, governance restructuring can be fraught with difficulties.

An Organizational Change Initiative.

When Sister Gretchen Kunz, president and CEO, and Bill McGee, board chair, of the St. Joseph Health System in Bryan, Texas, decided to initiate a governance restructuring effort, they were concerned that their trustees would be uncomfortable with the discussion. In fact, they thought that talking about changing board members' roles, responsibilities, and authority would create fear and uncertainty and could lead to resistance to governance restructuring. In other words, they recognized that the restructuring must be viewed in the context of an organizational change initiative.

Start with Education. To counteract this potential reaction, St. Joseph began the restructuring process with a multi-day, systemwide governance retreat. Everyone who served on boards throughout the system was invited to this event, where board and committee members participated in a highly interactive educational session about national health care trends, governance best practices, and organizational change dynamics. One hundred and twenty people—trustees, physician leaders, and senior managers—participated in the retreat.

Engage Key Stakeholders. Next, St. Joseph used a participatory approach to its governance restructuring. Many of the system's key stakeholders (e.g., board members, physicians, and senior administrators) provided input into and feedback on the process. They identified obstacles to effective governance, and offered suggestions for needed changes. As a result, the key stakeholders strongly supported the final recommendations to streamline the structure and to change other aspects of their functioning because they had been involved in defining the problems and creating the solutions. Their fears had been allayed through education and conversation.

Be Participative and Efficient. To succeed as it did, the St. Joseph restructuring process not only needed to be highly participatory, it had to be efficient. No one had the time or the desire to make a career out of governance restructuring.

To balance the "competing goods" of participation and efficiency, a small task force was created. This group of 10 board members, physicians, and senior administrators met a few times to analyze the information gathered during the input and feedback sessions, to review the options presented by the facilitators/consultants, and to make recommendations to the system board. In this way, St. Joseph got the best of both worlds: involvement from a large number of stakeholders, and an effective, efficient decision-making process (see above for a graphic depiction of this process).

COMMON CHANGES

What kinds of organizational changes occur as a result of governance restructuring?

The Corporate Structure. Although there are many different ways of organizing governance, the ultimate goal is for "form to follow function." In other words, the structure should be aligned with, and support, the system's mission and vision.

Generally, governance restructuring results in a more streamlined corporate chart. By consolidating and/or eliminating legal entities, there are fewer layers, fewer boards, and fewer standing committees. For example, the system that started with 16 boards and 57 committees was able to decrease its structure to one system board, two hospital boards, and 12 advisory entities.

However, decreasing the total number of boards and committees does not necessarily result in fewer individuals serving in governance. In the above example, boards of subsidiary organizations were converted to advisory boards and committees. In this way, the system retained community input, but it clarified decision-making authority among governing bodies.

Board and Committee Composition. The next stage of governance restructuring reconfigures board and committee composition. Generally, 12–15 trustees serve on each fiduciary board and five to nine people on each committee. Many systems have also instituted the "rule of three," in which no one individual can serve on any more than three boards or committees. To fill the seats, non-board members are included on committees. This increases the number of community members serving the organization, creates a pool of potential future board members, and decreases the likelihood of trustee burnout.

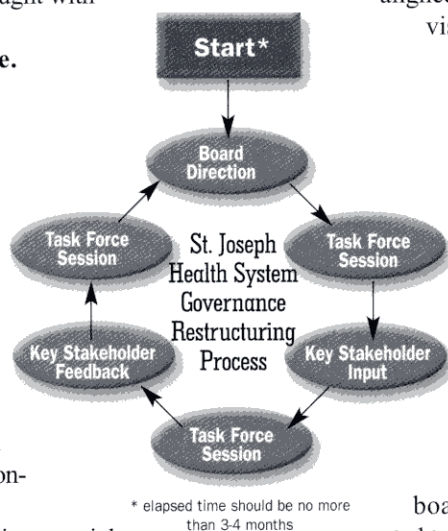
After restructuring, many systems begin to use selection criteria as well as term limits for board and committee members. Selection criteria ensure that people with the right skills and perspectives are included. The use of term limits (e.g., three three-year terms) helps boards and committees recruit new people with energy and fresh ideas.

Governance Functioning. As a result of a comprehensive restructuring, many of the following changes may be included in the board-approved recommendations:

- Quicker and more effective decision making
- Improved communications across the system
- Mandatory orientation and education sessions
- Annual goal setting for the board
- Annual evaluation of board and committee members
- Increased focus on strategic and policy issues

TIPS FROM THE TRENCHES

St. Joseph Health System and other systems that have restructured their boards recommend the following as critical compo-



nents of successful initiatives:

- The chair of the system board must fully agree with the need for the process and champion it. Otherwise, it will be a meaningless exercise, whose recommendations will not get implemented. Even worse, negative feelings among trustees could be dredged up, leaving the organization in worse shape than before the restructuring began.

- Because governance restructuring is a complex organizational change, it is helpful to have an experienced, external consultant/facilitator to assist with the design of the whole process, to facilitate the task force meetings, and to act as a coach to the CEO and board chair.

- A restructuring effort should include all the key stakeholders in the process (i.e., sponsors, system boards, subsidiary boards, senior administrators, and medical staff leaders). Strong, influential individuals who feel they have not been included in discussions can cause the initiative to fail by stimulating conflict and resistance to the changes among board members.

- In some cases, governance restructuring efforts have been initiated by physicians who want greater involvement in and/or access to the board. At one system, the medical staff had taken a vote of no confidence in the CEO and wanted to deal directly with the board. A highly inclusive governance restructuring process provided the forum for the physicians, board, and administrators to discuss the physicians' concerns and work out a series of structural and functional changes that have significantly

improved relations and enhanced governance efficiency.

- When presented with governance structure options, it is difficult to know which one would serve the organization best. Creating and using a set of design principles to guide the restructuring effort can help a task force determine which of various alternatives are most appropriate for the system (see "Governance Design Principles" on page 2 for examples).

- The governance structure should be aligned with the system's purpose and strategic intent. If necessary, the boards and CEO should clarify the system's mission and vision before embarking on, or as part of, the restructuring effort.

The ultimate benefit of governance restructuring is an enhanced ability to perform the key roles and responsibilities of the board. Restructuring enables everyone connected to governance to better focus on the future, ensure high-quality clinical care and patient satisfaction, protect the financial health of the organization, ensure effective executive leadership, reflect the communities served, strengthen relationships with key stakeholders, and perpetuate effective governance. The ultimate goal for systems is to improve the health of those living in our communities. And isn't that why you agreed to serve as a trustee? **T**

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