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Subsidiary Hospital Boards: Window Dressing or Opportunity?

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A lot of hospital boards in health systems are confused or downright unhappy with what they perceive as a diminished role. "Why are we here," they ask, "since we have little to no authority, and the parent board makes most of the important decisions?"

Two years ago, we co-authored a white paper for The Governance Institute that found health systems are moving decision-making authority for financial and strategic matters to the parent corporate level to drive higher system-wide standards for performance and accountability. Some systems have eliminated hospital boards in favor of a single parent board with fiduciary authority for the entire system and each operating entity, but most have adopted some sort of shared governance model that splits authority and responsibility between parent and local boards. And there's the rub.

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When the system board calls the shots on the big financial, strategic and management decisions, local trustees question whether they have a meaningful role or are just there for their names and money.

In our experience, the reasons why boards of some hospitals and other operating entities feel disenfranchised and unhappy vary, and may include:

- Their position description is outdated or ambiguous, or they have no clear description of their role at all.
- They have important responsibilities such as quality oversight and medical staff relations, but haven't received sufficient training and tools for their roles.
- Local boards continue to recruit community leaders with business and financial skills and philanthropic potential, even though the board's responsibilities have shifted to quality oversight, medical staff and community relations.
- The local board is told its role includes reviewing and approving

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financial decisions and strategic plans, when in fact it has minimal influence on management-developed proposals for submission to the corporate board.

— The corporate board and management attempt to hold the local boards accountable for decisions that were imposed on them, including "unfunded mandates."

— Local trustees feel marginalized if the system board rejects their request for capital or new programs because other system entities have a higher priority.

— Local board members who served on the board when it had final fiduciary authority still mourn their loss of power.

— Some local hospital executives have less experience than their predecessors in how to work with boards and fully use their talents.

— The system consists of just one or two hospitals serving a single geographic area, so there's little rationale for having separate system and hospital boards.

The failure to address local board dissatisfaction can be costly. The ranks of local boards include smart, respected, influential leaders who can be enormously helpful. If local trustees feel their time and talents aren't well used, they will lose enthusiasm, resign, or worse, grow antagonistic toward the system.

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The core problems here are misaligned expectations and poor communications. As health systems have moved away from decentralized governance models in favor of shared governance and centralized governance models, they've paid too little attention to rethinking, clarifying and communicating the new roles that subsidiary boards are expected to play, and to adjusting board practices to the new roles.

One common failing is the unintended fiction that although hospital bylaws say the board "approves and recommends" budgets and plans to the system board, the real decisions are made between system and local management; local trustees are supposed to "bless" their recommendations with little fuss. That's none too fulfilling to hospital trustees who are passionate about wanting to put their stamp on important clinical programs, buildings and initiatives to serve their communities.

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Why System Boards Need Sufficient Authority to Optimize Performance

✳ A local hospital board recruited a group of star OB/Gyns away from another system hospital developing a women's and children's center of excellence, in order to develop its own OB program. It paid far more than system management felt was fair market value for the doctors' practices.

✳ A local hospital board worked hard to develop plans for a new patient care tower and engaged a local builder, but the system reversed plans when its analysis found it would get a better price through competitive bidding.

✳ A small hospital's board couldn't persuade local physicians to participate in national quality and safety programs until the system said participation was mandatory.

✳ A local hospital board would not shut down a marginal, money-losing sports medicine program for fear of upsetting a group of orthopedic physicians, until the system imposed the decision on them.

✳ A "cash cow" hospital balked at signing on to the system's Master Trust Indenture debt financing proposal, even though it would save the entire system over a million dollars a year in financing costs.

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What to do? One answer doesn't fit all situations, but there's a logical process leaders can engage in to choose the right solution for their systems.

1. Reaffirm and communicate the benefits of being part of the health system to local board members. Local trustees are typically less aware of the system's vision, activities and achievements than system leaders realize. It's easy to take for granted that everyone recognizes the economies of scale, branding advantages, enhanced capital access, better terms on managed care and other benefits that the system delivers. Restate why, in order to achieve these benefits, subsidiaries need to relinquish ultimate authority to a parent that makes decisions in the best collective interests of the system. Be frank about the need to drive out redundancies, inter-facility competition, and local pet programs that reduce system efficiency and profitability (see box on page 2).

2. Communicate the tremendous importance of board oversight of quality and patient safety, and the board's role in overseeing the hospital's mission, especially with regard to addressing unmet community healthcare needs. Some hospital trustees perceive that the quality-related responsibilities delegated to many hospital boards are a demotion from their previous authority over financial and business matters. *Nothing could be further from the truth!* What could be more important than quality and safety, overseen by people from the community who actually receive the care and know how to relate with local physicians? The Institute for Healthcare Improvement, the Joint Commission, and other respected organizations all recognize the potential of the board to improve and ensure quality and safety.

3. Engage system and local board leaders in a process to clarify how much authority and responsibility subsidiary hospital boards should have. The responsibilities need to be meaningful and enable local trustees to make a contribution that adds value above and beyond what the parent board can do. Local hospital boards typically fall into one of four categories depending on the relative shares of advisory and

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Table 1. Continuum of Local Hospital Board Roles

Less ← Authority of Local Hospital Board → More

Responsibilities	Type I Purely Advisory Board	Type II Quality-focused Board	Type III Shared Authority Board	Type IV Operating Board
Finance	None	Advisory	Makes recommendations and monitors performance	Approves decisions subject to reserved powers
Strategy	None	Advisory	Makes recommendations and monitors performance	Approves decisions subject to reserved powers
Quality and patient safety	None	Fiduciary responsibility	Fiduciary responsibility	Fiduciary responsibility
Medical staff credentials and relationships	None	Fiduciary responsibility	Fiduciary responsibility	Fiduciary responsibility
CEO selection, evaluation and compensation	None	Has input	Has input and a major voice	Has final authority subject to system guidelines and approval
Audit oversight	None	None	Informed	Chooses and oversees auditor subject to system approval
Philanthropy	Advises and participates in efforts	Advises and participates in efforts	Provides leadership for fund raising efforts	Has final authority subject to system reserved powers

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fiduciary responsibility they have, as shown in a continuum in Table 1:

• Type I - Purely advisory board. The board has no fiduciary responsibilities or formal authority, but is asked for its counsel on programs and community relationships, and assists with fund-raising, community outreach and advocacy.

• Type II - Quality-focused board. The board has delegated fiduciary responsibility for the quality and safety of patient care and medical staff credentialing, is kept informed about organizational performance, and is consulted as management develops strategic plans, budgets and other major decisions.

• Type III – Shared Authority board. The board has fiduciary responsibility for quality, safety and medical staff relations, monitors hospital performance, and the system board gives considerable deference to its review and recommendations on strategic plans, budgets and other major decisions.

• Type IV - Operating board. This board is delegated significant responsibilities for oversight and decision making, subject only to the system's reserved powers, such as approval of large capital expenditures and major transactions.

Develop and communicate a clear position description for the roles and responsibilities of hospital and other operating entity boards. Choose the language with care and precision. Customize - don't rely on a consultant's boilerplate or another system's document.

4. Develop and communicate a clear position description on the roles and responsibilities delineating hospital and other operating entity boards. Choose the language with care and precision. Don't say the hospital board "approves" the budget if it really makes recommendations subject to system approval. Customize – don't rely on a consultant's boilerplate or another system's document. Communicate the roles and responsibilities in new director orientation and reinforce them through board education and evaluation.

5. Align board practices with the real roles of hospital boards. For example, if a hospital is a Type II board focused on quality-related responsibilities, develop recruitment criteria weighted toward persons with backgrounds in industrial quality, safety, or customer service; consultants in quality management; attorneys who can understand complex technical matters; and physicians and nurses with training in quality measurement and management. Consider retired physicians, corporate medical directors, and professors of healthcare management or quality improvement from local universities. Focus board orientation, education, meetings, and evaluation on the board's quality-related responsibilities, and provide the board with the dashboards and other tools to facilitate oversight and goal-setting. If the board is a Type III, be sure to recruit trustees who are comfortable with the fact that they don't have final authority. Look for a blend of business, community, and quality backgrounds.

Successful multi-hospital systems all have at least one thing in common – a team ethos. They understand that the whole is potentially greater than the sum of its parts, but only if all elements of the system accept and support the team effort. Like any successful team, the players need to be clear on their roles and understand how their efforts contribute to the team's success. They also accept the fact that not everyone can be the leader of the team. The support role players on a winning team experience far greater satisfaction than those who resist and resent a subsidiary role, only to end up losing the game.

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