I. General Structure

** Governing Board --** all HSO’s have a governing body/board, which retains decision-making authority (final) within the HSO. May be as simple as a single person/owner or as complex as a formally authorized governing board for a hospital system.

** Chief Executive Officer --** in corporate settings, selected by/approved by the governing board to carry out HSO operations for the purpose of accomplishing HSO strategic objectives. In non-corporate settings, may be called something different -- administrator, manager, etc.

** Clinical Staff --** persons who deliver health services within HSO’s. Most influential and unusual group of clinical staff for most HSO’s are the MD’s, due to their unique position of authority in the health system (independent contractors to HSO’s in most cases).

II. Legal Status of HSO’s

** HSO’s may legally exist as (1) sole proprietorships, (2) partnerships, or (3) corporations

** Sole proprietorships are the simplest legal form, with no special legal standing compared with other organizational forms. Solo practice MD’s are a common example. (Those that do not incorporate)

** Partnerships may be general or limited. General partnerships involve organization arrangements where all partners to the agreement are at virtually unlimited liability with respect to organizational performance. Common example would include group practice MD’s. Limited partnerships involve organizational arrangements where some of the partners are at unlimited liability for organizational performance (general partners) and some are only liable for organizational performance to the extent that they have personal assets invested in the organization (limited partners). Common example includes joint venture arrangements between hospitals (general partners) and MD groups (limited partners).

** Corporations are the most legally complex organizational form that an HSO may assume, and also the most common form by far. Legally established through application for incorporation in a given state. HSO’s may incorporate as either of several types: (1) for-profit; (2) not-for-profit; (3) professional corporation (PC). Many NFP are also tax-exempt (determined by IRS).
III. HSO Organizational Designs

** Bureauratic structures have been predominant organizational design for HSO’s, especially institutional HSO’s. The most common type of bureaucratic structure in HSO’s is the ‘dual pyramid’ structure:

** Governing Board (GB): serves two distinct roles in this structure -- (1) establish objectives and policies for the HSO; (2) monitor HSO performance. Primary governance mechanism within HSO.

** Principles of HSO Governance

** Governance has been defined as the fulfillment of the function of responsible ownership. Has also been defined (within the health services sector) as the responsible stewardship and allocation of health resources to produce a sustained benefit to the community (in the not-for-profit case) and/or the shareholder (in the for-profit case).

** The history of HSO governance has evolved since the founding of the first hospitals in colonial America. Early emphasis, from the mid 18th century to the mid-1960’s, of HSO governing bodies was primarily one of fund raising, or the ability to procure charitable/community resources to finance hospital operations.

** The year 1965 represents a watershed year with respect to a shift in emphasis of HSO governance emphasis – with the advent of governmental payment for health services (and the accompanying oversight/scrutiny that goes with it) and the landmark Darling v. Charleston Community Memorial Hospital case, where the governing body was found to be liable for the care provided by hospital-contracted MD’s. The combination of the two events ushered in a transition phase of HSO governance where governing boards of HSO’s began to become more active in terms of governance over HSO activities, incl. quality of care.

** The early 1980’s brought with it increased competitive pressures between HSO’s, reductions in HSO reimbursement by most payors, and increasing scrutiny of HSO activities by all parties. These environmental changes Ushered in the current phase of HSO governance, where governing boards Are not only actively involved with oversight of all HSO activities but have also begun to systematically evaluate their own effectiveness as a Governing body (JCAHO requirement).

** Most NFP-HSO GB’s are predominantly community based in terms of
board membership, due to practical as well as legal requirements for tax-exempt NFP’s. FP-HSO GB’s tend to have greater representation by major corporate shareholders and organizational MD’s. Both types of GB’s have internal and external members.

** In terms of other variables, governing boards for HSO’s can be characterized as follows:

** Average size: 13-14 members per HSO (over time, HSO board size has become smaller)

** Member Age: >90% of HSO board members between the ages of 31 and 70. (little change over time)

** Member Background: increasing number of board members with experience in health field, decreasing number of members from non-health fields. (relation to shifting emphasis of board governance over time)

** Member Gender: little change in female participation on HSO governing boards over time – still a small minority (16-18%).

** Member Term: trend over past 20-30 years towards limits placed on board member terms. (>50% of boards)

** HSO governing boards have a unique relationship with the CEO of the organization. Increasingly, organizational CEO’s also serve as a voting member of the governing board of the HSO, in some cases assuming the chairperson’s role as well (competitive rationale). Governing boards increasingly make use of written contracts to formalize the relationship between the board and the CEO, and also are more heavily involved in the formal evaluation of CEO performance.

** The relationship between the governing board of the HSO and the medical staff has evolved over time as well, as discussed previously. Such relationships are now more formally established vis-à-vis the presence of a direct reporting relationship between the medical staff and the governing board as well as increasing MD participation on the governing boards of the HSO. (>90% of HSO’s, average of 2-3 MD’s serving per board)

** Multiorganizational systems, discussed previously, present special challenges in terms of HSO governance. These multi-unit systems typically are comprised of multiple governing boards, usually one board per HSO within the system, as well as at least one parent governing board for the system as a whole. Questions that must be addressed in such situations are numerous (overhead).
The most common governing board structures employed within multi-organizational systems are as follows: parent holding company structure (53%), unit of government (23%), religious order (13%), other (11%).

The parent holding company model, by far the most common governance structure, typically includes one governing board for each facility within the system, with a system-wide board at the level of the parent holding company. As is typically the case, the individual HSO board primarily serves in an advisory role with the system board possessing reserved powers that give it ultimate decision-making authority on certain issues of system-wide importance.

As should be intuitive, one key to effective governance within multiorganizational systems possessing multiple governing boards is to formally and explicitly clarify and communicate the roles, responsibilities, accountabilities, and scope of authority of each of the respective boards, as well as to specify the key relationships between each.

**Governance Roles, Responsibilities, and Functions**

The legal duties of HSO governing boards include the fulfillment of their fiduciary responsibility to act as the financial overseer of the HSO. Consistent with this duty, they are required to exercise loyalty to the HSO as well as exercise responsible action on behalf of the HSO. The GB fulfills this legal duty by approving financial goals within the HSO, monitoring management progress toward achieving those goals, establishing financial policies and monitoring adherence to those policies, as well as monitoring the HSO’s systems of control to safeguard its financial resources and to ensure compliance with regulations.

GB’s also have the responsibility to select, monitor, and evaluate the performance of the CEO of the HSO. In terms of CEO selection, the GB establishes search criteria for CEO selection, the methods to be employed during the search, the mechanisms for applicant review, etc. In terms of monitoring and evaluation of CEO performance, the GB is responsible for establishment of the performance evaluation criteria that will be used to evaluate CEO performance.
Another key responsibility of the GB is to establish, monitor, evaluate, and articulate the mission of the HSO, which provides the conceptual basis for organizational strategic planning, of which the GB is also heavily involved with from a governance/oversight responsibility. The GB also is responsible for the periodic evaluation of the organizational strategic plan to continuously assess its relevance and currency.

The GB also is significantly involved, along with its handpicked CEO, with the effective management of relationships with the various stakeholders to the HSO. (stakeholder management)

Largely as a result of the Darling case mentioned before, GB’s are also involved to a significant extent with the management of service quality within the HSO. This involvement includes: (1) active monitoring of the HSO’s quality improvement program(s); (2) periodic assessment of the quality of services provided within the HSO; (3) oversight of medical staff credentialing activities within the HSO.

As mentioned previously, the recent emphasis in terms of GB philosophy has been towards GB self-evaluation in terms of governance effectiveness. This shift in emphasis is associated with other GB roles and responsibilities such as board development activities (new member recruitment and orientation, continuing education for current members, and the development of board self-evaluation methods).

GB’s are also responsible for coordinating their own activities, including selection of a chairperson to oversee GB activities, determining the size of the GB, establishing and assigning GB members to various committees of the GB, as well as scheduling GB/committee meetings.

Most larger HSO GB’s make significant use of committees for the purpose of fulfilling the GB’s responsibility to the HSO. Most important committees of a typical GB are (1) executive committee -- responsible for making recommendations to full board with regard to HSO decision-making; (2) professional staff committee -- responsible for making recommendations to board with respect to HSO relationships and issues with the medical staff primarily.

CEO: highest level of internal HSO management; basic responsibility is to manage organizational inputs and conversion processes to achieve organizational objectives.

CEO tends to be most involved with GB and external relations/issues
as it applies to HSO operations, and has a more strategic focus. CEO
delegates much of the remaining organizational responsibilities with
respect to day-to-day operations to a COO or VP(s) of operations and
day-to-day financial operations to a CFO and his/her support staff.

** Professional Staff Organization (PSO): formal organization of the
professional staff within an HSO, mostly comprised of MD’s/DO’s and
other medical staff with practice privileges within the HSO.

** Most highly developed as an organizational unit within hospitals and
other institutional types of HSO’s (managed care organizations).

** Characterized to a large extent by self-governance, each typically
having its own unique organizational design, charter, and bylaws
which are required for legal and regulatory purposes.

** PSO’s may be open (all qualified MD’s allowed to join) or closed
(PSO membership limited based on GB-approved criteria for inclusion).
Many PSO’s will be a combination of the two (open for primary
care MD’s, closed for specialty care MD’s).

** PSO’s (especially larger ones) also make use of committees for the
purpose of accomplishing the administrative objectives of the PSO.
Most important PSO committees are typically the executive and
credentials committees. Some PSO committees are unique or
peculiar to the professional staff as a result of their clinical
emphasis (e.g. P&T committee, UR, QA committees).

** All PSO’s (by regulatory requirement) must actively establish and
periodically monitor the credentials of all of its members. Such
a credentialing process involves (1) establishing category of
membership within the HSO (attending, associate, provisional, etc.);
(2) assessment of clinical competence of prospective member --
extension of commensurate practice privileges. Recommendations
to the PSO with regard to the above processes are the responsibility
of the credentials committee. Final approval is the responsibility of
the PSO executive committee.

** Most common type of credentialing that PSO’s undertake is
traditional clinical credentialing, based solely on education, experience,
input from clinical peers, etc. Economic credentialing, though much
less common, additionally involves credentialing of prospective PSO
members based on economic criteria -- utilization, cost, etc.