

# ANALYSIS OF GOVERNANCE MODELS FOR ACADEMIC HEALTH CENTERS

*Prepared for The Center for Mississippi Health Policy*



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## EXECUTIVE SUMMARY

### PURPOSE

- Carry out the scope of work defined by the Center for Mississippi Health Policy<sup>1</sup> in order to assist Mississippi legislators in making highly informed, precedent-supported, and evidence-based decisions regarding the future of Academic Health Center (AHC) governance in the state

Note: While both effective governance and leadership are required in a high-functioning AHC, this study is focused on governance structures and practices for the University of Mississippi Medical Center (UMMC), and not UMMC leadership or management structure, competencies, or composition.

### PROCESS

- Describe the current state of governance at UMMC by interviewing representatives from all relevant stakeholder groups and reviewing UMMC governance structure and policies
- Provide national context on public state-based University and AHC governance - specifically, governance model alternatives and best practices - by conducting a comprehensive literature review and interviews with numerous AHC leaders from across the country
- Use national learnings to characterize UMMC relative to peers, and to identify potential governance options and key considerations for policymaker review

### FINDINGS & CONSIDERATIONS

- Disparate perceptions exist among State Institutions of Higher Learning (IHL), University of Mississippi, and UMMC stakeholders regarding the effectiveness of current UMMC governance
- Unlike the University of Mississippi and UMMC, the majority of state-based public universities with a medical school (and associated AHC) are not governed directly by the state (nor are their AHCs)
- Due to the complex demands on AHC leadership, as well as the fast pace of change and high degree of competition in the health care industry, effective AHC oversight requires health care specific expertise and the ability to make timely decisions
- A well-designed AHC governance structure alone cannot ensure sound and effective AHC governance; AHC governance should be examined holistically
- There is significant opportunity for AHC governance in Mississippi to approach national best practice
  - Capitalizing on this opportunity may mean substantial modification to governance structure, but structural change is not required to accrue incremental benefit
- Legislators should strive to achieve a balance between short-term risks and long-term reward, and between benefits derived from and difficulty to execute change, and should account for the cultural transformation needed to make and sustain any major change

<sup>1</sup> As defined in the Request for Concept Papers: Governance Structures for Academic Health Centers, May 2015.

## APPROACH AND METHODOLOGY OVERVIEW

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Below is a summary of the approach taken and methodologies employed to carry out the scope of work and achieve the objectives defined by the Center for Mississippi Health Policy<sup>2</sup>. Detail on methodologies can be found in Appendix A.

### STEP-BY-STEP APPROACH TO REPORT DEVELOPMENT

#### ***PART I : CURRENT STATE***

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- Define the rationale for undertaking this study of AHC<sup>3</sup> governance
- Gain deeper understanding of the historical and organizational context for UMMC governance
- Assess and characterize current UMMC governance

#### ***PART II: NATIONAL CONTEXT***

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- Evaluate governance models and policies of U.S. public universities and their related AHCs<sup>4</sup>
  - Perform a comprehensive review of the literature<sup>1</sup> and governance documents for all such universities and related AHCs, both at the University and AHC levels
  - Develop frameworks to classify governance models at each level
    - Conduct interviews with University and/or AHC representatives at select institutions<sup>5</sup> to ensure appropriateness of frameworks and to identify advantages and disadvantages of each model
- Identify key AHC governance best practices and commonly-held AHC governance guidelines
  - Perform comprehensive literature review<sup>6</sup> and conduct interviews with University and/or AHC representatives at select institutions<sup>4</sup> to better understand identified best practices

#### ***PART III: APPLICATION OF NATIONAL FINDINGS TO UMMC***

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- Compare UMMC governance to identified AHC governance best practices and guidelines
- Identify potential UMMC governance model options
- Discuss implications of proposed options
- Clarify considerations most relevant to Mississippi policymakers with regard to advancing AHC governance in the state

<sup>2</sup> As defined in the Request for Concept Papers: Governance Structures for Academic Health Centers, May 2015.

<sup>3</sup> For the purpose of this analysis the term AHC refers broadly to the following academic and clinical components: medical and other health professional schools, teaching hospital, and the associated faculty physicians.

<sup>4</sup> See Appendix B for a list of all Universities meeting stated criteria and organizational model of each.

<sup>5</sup> See Appendix A for indicators used to select institutions for interviews, the list of institutions included in the interview process, and Appendix C for the interview protocol and questions posed.

<sup>6</sup> Abbreviated citations throughout; see References, following the Appendices, for complete list of sources comprising the literature review.

## PART I: CURRENT STATE

### CONTEXT AND RATIONALE FOR UNDERTAKING REVIEW OF AHC GOVERNANCE

AHCs nationally are at a critical juncture in their history, facing dramatic decreases in state and federal funding, as well as grappling with transformative health care reform policy. These new challenges only exacerbate the traditional AHC dilemma of effectively and efficiently reconciling a tripartite mission.

Additionally, the tremendous growth and advancement achieved by AHCs has changed their dynamic with their respective Universities. In some cases, the budget of the academic health sciences enterprise approaches or exceeds that of the University overall. Despite this shifting dynamic, many AHCs have remained partly if not wholly governed by the broader University and/or the University's state-sponsored system.

As AHCs become larger, more complex, and more geographically dispersed, their leadership and governance structures and policies must evolve in kind. AHC governance models must continuously adapt to meet new challenges (Enders & Conroy, 2014).

At the core, effective AHC governance centers on the need to effectively balance multiple viewpoints and priorities (Wietecha, Lipstein, & Rabkin, 2009). This entails alignment of the broader educational perspectives of State-based and University boards with the health sciences-focused priorities, of which education is only one (fairly narrowly-focused) element.

The need to tailor governance practices to better address health care's unique issues and operating parameters has given rise to notable changes in AHC governance. These include the development of dedicated health sciences and AHC clinical enterprise (CE) governing boards, increased autonomy and authority of the AHC, and even wholesale separation of the AHC's CE from the University or state-sponsored system.

While the degree and pace of change facing AHCs in the last three to five years can be considered extreme, AHCs have of course historically faced and met new challenges. Further, albeit typically slow and cumbersome, AHCs have the capacity to evolve and adapt, overall and specifically with regard to governance and leadership.

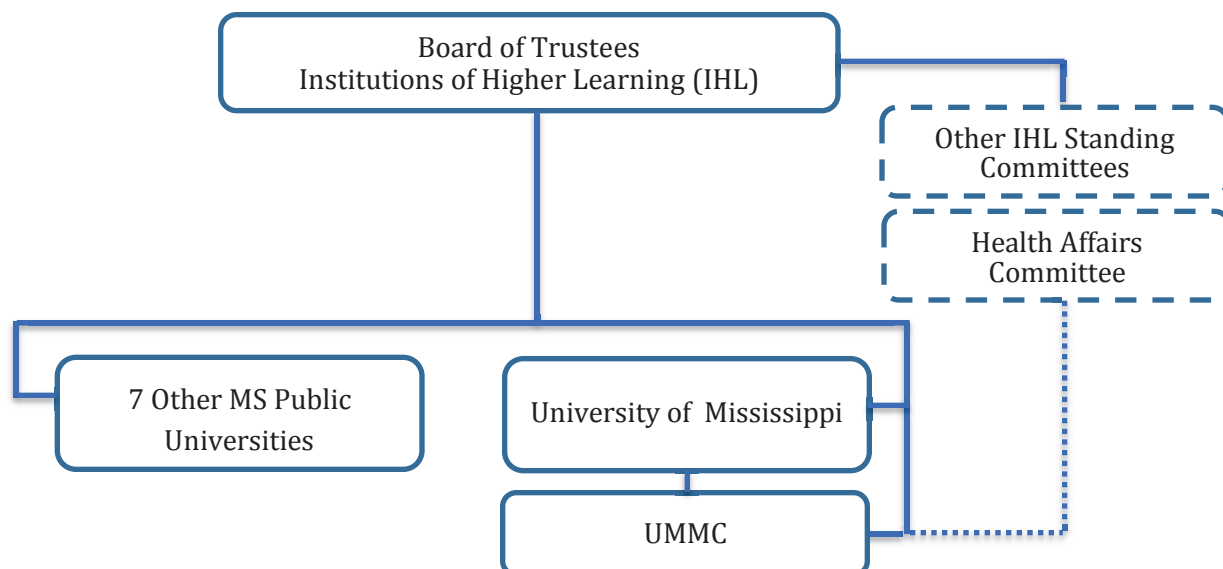
This AHC evolutionary process has tended to follow a similar pattern. It often begins with an event or set of circumstances that calls attention to the distinctive demands on AHCs relative to their counterparts within a University. It is subsequently recognized that AHC challenges are due in large part to the uniquely complex interrelationships that an AHC must balance. To foster mutual success of an AHC's academic and clinical components, an effort is made to better align the vision, strategy, finances, and/or operations within AHC entities<sup>7</sup> and between the AHC and its university and/or state. Often, realignment is sought by modifying governance, leadership, and/or operating structures and policies. These adaptations are iterative and build from each previous iteration to respond to new and different demands.

<sup>7</sup> E.g., University, medical and other health professional schools, faculty practice plan, teaching hospital(s).

UMMC's current governance challenges may reflect a relative lack of iterative adaptations made over time to address the unique demands faced by UMMC. As such, foundational alignment issues persist, between, the state and the University, UMMC and the University, and within the AHC itself. An all-encompassing collaborative effort must be pursued among all parties to tackle these underlying misalignments in order for UMMC to remain viable, and hopefully, for UMMC to achieve its potential as a premier AHC nationally.

Many important stakeholders, including the residents of the State of Mississippi, have an interest in ensuring UMMC can survive and thrive in this highly dynamic environment. This sincere interest in UMMC's sustainability and the strong desire for UMMC to achieve its full potential are the key precipitating factors for this study. The recent departure of key University executive leadership further underscores the need for thoughtful and deliberate consideration, collaboration, and action on UMMC's behalf.

## CURRENT UMMC GOVERNANCE MODEL

FIGURE 1: VISUAL REPRESENTATION OF THE CURRENT UMMC GOVERNANCE STRUCTURE<sup>8</sup>**Background on UMMC Governance Structure**

The Board of Trustees of the IHL is a constitutionally established body that oversees all degree-credit courses, research, public service activities, and educational programs across Mississippi's eight public universities, including the University of Mississippi and the state's only AHC, UMMC (see detailed UMMC overview in Appendix D). The IHL Board maintains legal authority and operating control over UMMC as the academic health sciences campus of the University of Mississippi. Therefore, UMMC is subject to the policies and procedures of the IHL Board.

**Background on UMMC Management Structure**

Day-to-day management and control of UMMC, however, is delegated by the Chancellor to the Institutional Executive Officer (IEO) of UMMC. The IEO of UMMC is the Vice Chancellor for Health Affairs who is responsible for:

- The overall strategic direction of UMMC
- Implementation of IHL Board policies
- Academic and administrative operations of UMMC's six health professional schools and clinical enterprise

**Relationships Between and Within Governance and Management Structures**

The Vice Chancellor for Health Affairs is also the Dean of the School of Medicine. Though the Vice Chancellor is responsible for day-to-day management, he/she reports to the University of Mississippi Chancellor who, as the head of the University, is ultimately responsible for oversight of UMMC. The

<sup>8</sup> Veralon interpretation of current structure as determined through interviews and document review, 2015.

Chancellor, appointed by and reporting directly to the IHL Board, is ultimately accountable for all aspects of the University of Mississippi. As such, together, the University of Mississippi Vice Chancellor, Chancellor, and IHL Board are collectively responsible for all facets of UMMC.

Despite this official reporting structure, UMMC is independently accredited (separate from the University) and is funded through a separate direct appropriation from the State Legislature. This separation is further enhanced by the natural barrier created by the distance between the University's main campus in Oxford and UMMC's campus in Jackson.

Currently, there is no established forum where the IHL Board, the University, and UMMC come together to discuss the triple mission of the AHC. However, the relationship between the University and UMMC has evolved over the last decade through increased collaboration and communication between the University and UMMC. Specifically, the Chancellor of the University of Mississippi and the Vice Chancellor for Health Affairs meet at least once a week to discuss issues related to UMMC. Additionally, the Chancellor participates in the IHL Board's Health Affairs Committee meetings and is therefore directly involved in the interactions between the IHL and UMMC.

The Health Affairs Committee, a standing committee of the IHL Board, provides further UMMC oversight at the Board level and facilitates direct communication between the Board and UMMC. Committee meetings are held to specifically discuss all aspects of UMMC, (e.g., strategic initiatives, projects and priorities, compliance, and the financial state of UMMC). The Committee meets at least eight times a year and is chaired by the Vice President of the IHL Board. All IHL Board members serve on the Health Affairs Committee and the IHL Board comes together for another 2-hour open forum session the day prior to the regularly scheduled board meeting to discuss all UMMC-related matters.

### ***OVERVIEW OF THE STATE INSTITUTIONS OF HIGHER LEARNING BOARD OF TRUSTEES***

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The IHL Board is a constitutionally established 12-member board, with authority over Mississippi's public universities:

- Alcorn State University
- Delta State University
- Jackson State University
- Mississippi State University
- Mississippi University for Women
- Mississippi Valley State University
- The University of Mississippi and UMMC
- The University of Southern Mississippi

Board members serve nine-year terms and are appointed by the Governor with the advice and consent from the Senate, chosen from each of the three Mississippi Supreme Court districts (with the goal of having four members from each district). Current IHL board members include a lawyer, accountant, three private practice physicians, a dentist, and six business owners and executives from various industries (e.g., financial services, energy, telecommunications, farming and agriculture). The IHL system mission is



to operate a strong public University system with eight distinct, mission-driven universities, and enhance Mississippians' quality of life by meeting their diverse educational needs<sup>9</sup>.

A primary responsibility of the IHL Board is to appoint the Commissioner and the Institutional Executive Officers (IEO) of each member institution. The Commissioner serves as the member University system's executive officer and assists in the administration of Board bylaws and policies. Each IEO is delegated with the management and control over the member institution and reports directly to their Commissioner, who reports to the IHL Board.

Other primary responsibilities of the board include:

- Contracting with faculty and staff members
- Terminating the contract of any employee for malfeasance, inefficiency, contumacious conduct, or financial exigency
- Making any adjustments as needed between the various institution departments and schools, or between multiple institutions

The IHL Board also has the responsibility to review and the authority to evaluate and modify: existing or proposed new undergraduate and graduate academic programs; infrastructure and physical property; supervision of all buildings and grounds; need for expansion or reduction of all institutions; contracting terms; terms related to the sale or purchase of public property; terms related to construction projects. All member institutions must comply with policies and procedures set by the IHL Board.

### ***KEY INTERNAL INTERVIEW FINDINGS REGARDING CURRENT STATE OF GOVERNANCE***

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#### ***Timeliness and ability to be nimble***

Decisions impacting UMMC are perceived as occurring too slowly and in too cumbersome of a manner, particularly those impacting day-to-day operations at UMMC. Given the \$250,000 threshold triggering IHL intervention, nearly all contracting decisions – even those related to necessary and routine supplies for patient care operations – require IHL review and approval. This threshold is perceived as unusually low for an entity with the size and scale of UMMC<sup>10</sup>. Additionally, IHL must review and approve all proposed partnerships for clinical programs or services, even those with a very limited scope. These review and approval processes are perceived as drawn out and limiting to UMMC's ability to effectively sustain and compete.

In addition to the relatively low dollar amount threshold (given UMMC's \$1.6B size), decision-making timeliness is also perceived as negatively impacted due to limited accessibility of IHL Board members to UMMC leadership. Regularly scheduled, open forum meetings of the IHL Board and Health Affairs Committee provide the only opportunities for direct UMMC leadership contact with the Board. If these meetings are not held monthly, (some months are deferred due to holidays), there is no other established forum to address time-sensitive UMMC issues or other critical agenda items. As an example, when the September Health Affairs Committee meeting was canceled, it took significant time and resources to

<sup>9</sup> IHL Board of Trustees – Policies and Bylaws, Section 102.01, State Institutions of Higher Learning (IHL System) Authorization.

<sup>10</sup> This issue further explored in the best practices section.

request and convene an urgent and last-minute ad hoc meeting to approve expiring contracts and renew standard purchase orders.

It has been suggested that in general, the volume and scope of issues for which the IHL Board is responsible are excessive, and that timeliness and agility concerns represent the downstream impact of these overwhelming duties. Further, the structure and operating parameters of the IHL Board were not designed to govern a health care enterprise, but rather institutions of higher learning. The latter, relative to the former, typically have more controllable and predictable operations and requirements. This mismatch between IHL governance model and style and the needs of UMMC as a health care provider is a key driver of the types of inefficiencies reported by interviewees.

### ***Board member expertise***

Competencies generally considered crucial to AHC governance include healthcare industry expertise, knowledge of AHC management and operations, current trends in the healthcare industry, and the impact of recent policy developments such as the Affordable Care Act. While trustees certainly are aware of and have a fundamental understanding of these issues, interviewees note that the Board lacks the depth of knowledge and experience required for UMMC governance, particularly in order to be timely, proactive, and strategically sound in decision-making.

Unlike corporate boards, whose members are typically chosen based on their expertise in a specific area, IHL Board members are appointed by the Governor with the qualifications that they “reside in the district from which each is appointed, and who are at least twenty-five years of age, and of the highest order of intelligence, character, learning, and fitness for the performance of such duties, to the end that such board shall perform the high and honorable duties thereof to the greatest advantage of the people of the state and of such educational institutions, uninfluenced by any political considerations”<sup>11</sup>.

This appointment process, coupled with the broad demands on the board’s time, likely limits trustees’ ability to develop in-depth knowledge and understanding of the healthcare industry. Interviewees noted that although the IHL Board includes various physicians with knowledge of the health care field generally, these private practice physicians do not have experience specific to AHCs. AHC experience was perceived as critical due to the inherent complexities within AHC operations (e.g., general breadth and scope of operation) in addition to the complex relationship between the teaching, research, and patient care components of the shared AHC/University mission. This issue is further explored in the national best practices identified in Part II of this document.

### ***Board Focus with regard to UMMC***

Interviewees noted that Board agenda time is focused on operational issues rather than having broader, more forward-looking strategic perspective. Multiple factors may contribute to this tendency, a primary factor being time. Given the Board’s volume and scope of responsibilities, the board has a limited amount of time to address any one agenda item. The IHL Board governs all eight of Mississippi’s public higher education institutions – each possessing its own specific mission and needs. Considering the complexity and size of UMMC’s operations, there are always a number of operational and strategic items the IHL

<sup>11</sup> IHL Board of Trustees – Policies and Bylaws, Section 201.01, Members and Qualification, Constitutional Organization, General Powers and Duties.

board must discuss, in addition to the needs of the other seven institutions over which the IHL has responsibility. As a result, there is often an inadequate amount of time at IHL Board meetings to engage in strategically-focused discussions related to UMMC, given the need to prioritize time sensitive operational issues or contract approvals.

Secondly, the IHL Board must review all UMMC-related items in its meetings, and the agendas and subsequent discussions are a matter of public record. Public viewing/knowledge of selected strategic discussions pertaining to competitive positioning of the medical center, (e.g., opening a new location of service near a competitor) is detrimental to UMMC's ability to compete in the marketplace, as competitors have access to this information.

The combination of the Board's extremely broad responsibilities, their relative inaccessibility to UMMC leadership, and need to review and approve a vast majority of matters related to UMMC has necessitated the board's historical focus on operational and urgent matters, rather than strategic issues and long-term positioning of the medical center.

## PART II: NATIONAL CONTEXT

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### REVIEW OF UNIVERSITY AND AHC GOVERNANCE MODELS

Veralon was charged with conducting an independent and unbiased assessment of national University and AHC governance models to provide an informed basis for Mississippi policymaker decision-making regarding UMMC governance. Please refer to Appendix A for detail on the approach, information used to develop the frameworks featured below, and sources of information referenced.

A multitude of governance models exist, and no two University or AHC governance models are identical (Hyatt, 2015), even if they share key characteristics. That is, two AHCs may be very similar in terms of governance structure and policy, but will work within their structures differently or apply documented policies in a different way. Please refer to [Appendix E](#) for a case study on University of Iowa Health Care, an AHC similar to UMMC with regard to governance structure and policy. Further, it should be noted that a governance model alone does not determine financial or operational success of an AHC (Enders & Conroy, 2014). Many factors contribute to organizational efficacy and success that are not explored in this analysis.

There is nonetheless value in identifying the defining attributes of University and AHC governance models, broadly classifying organizations based on these attributes, and analyzing the patterns that emerge. This analysis uses the degree of authority and autonomy retained or delegated at the State or University level, and at the AHC level, as the defining attributes of the governance model. Frameworks were developed to classify governance models based on these attributes at all U.S. state-based public Universities with medical schools<sup>12</sup>.

There are two frameworks, one for each of the levels of governance impacting the AHC, as referenced above. The first framework defines the governance relationship between the State and University, and the second addresses the governance relationship between the State or University and the AHC. Frameworks are described in detail below, and findings are provided regarding the national prevalence of each model defined by the frameworks. Notable advantages and disadvantages are described for Framework II.

#### ***FRAMEWORK I: RELATIONSHIP BETWEEN STATE AND UNIVERSITY***

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Framework I [see **Table 1**] classifies the governance relationship between the State and the University. Two primary models were identified: **Model 1 – Direct State Authority**, wherein the State directly governs the University, and **Model 2 – Indirect State Authority**, wherein the State has delegated substantive governance authority to the University.

A secondary element – ownership status of the AHC clinical enterprise (hospital and other patient care entities = clinical enterprise) – was layered on to Models 1 and 2, denoted as **Sub-Models 1.1 and 2.1**. Universities identified as Sub-Model 1.1 or 2.1 have a separate clinical enterprise, that is, not owned or operated by the State or University.

<sup>12</sup> See Appendix B for a list of Universities meeting stated criteria.

**TABLE 1: UNIVERSITY GOVERNANCE MODELS**

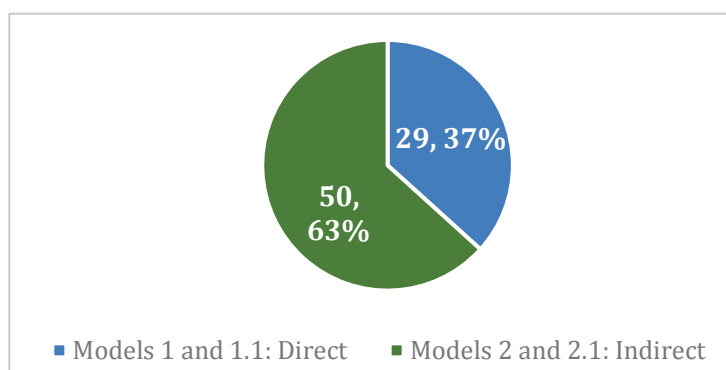
MODEL	MODEL DESCRIPTION	UNIVERSITY GOVERNANCE AUTHORITY
1	Direct State Authority with Owned CE	Largely held at the state level
1.1	Direct State Authority with Separate CE	Largely held at the state level
2	Indirect State Authority with Owned CE	Largely delegated from the state to the University
2.1	Indirect State Authority with Separate CE	Largely delegated from the state to the University

*UNIVERSITY GOVERNANCE MODEL PREVALENCE BY MODEL TYPE*

A total of 79 public state-based Universities with medical schools were included in the analysis<sup>13</sup>. 29 of the 79 (37%) were classified as having Direct State Authority (Models 1 and 1.1). 50 of the 79 (63%) were classified as having Indirect State Authority (Models 2 and 2.1). **[Figure 2]**

**FIGURE 2: PREVALENCE OF DIRECT AND INDIRECT PUBLIC UNIVERSITY GOVERNANCE MODELS**

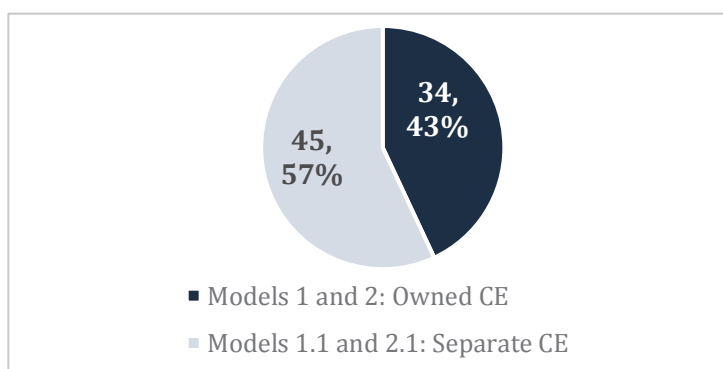
N = 79



45 of the 79 (57%) Universities analyzed were classified as having separate clinical enterprises and 34 of the 79 (43%) Universities were classified as having owned clinical enterprises. **[Figure 3]**

**FIGURE 3: PREVALENCE OF UNIVERSITY OR STATE OWNERSHIP OF CE**

N = 79



13 See Appendix B for a list of all Universities meeting stated criteria and organizational model of each.

An overall breakdown by model type for Framework I is provided below [Table 2].

**TABLE 2: FRAMEWORK I FINDINGS SUMMARY**

N = 79

MODEL	MODEL DESCRIPTION	NUMBER/PERCENT OF UNIVERSITIES
1	Direct; Owned CE	15/19%
1.1	Direct; Separate CE	14/18%
2	Indirect; Owned CE	19/24%
2.1	Indirect; Separate CE	31/39%

**FRAMEWORK II: RELATIONSHIP BETWEEN STATE/UNIVERSITY AND AHC**

Framework II [see Table 3] classifies the governance relationship between the State or University (whichever serves as the primary governance body per Framework I) and the AHC. Two primary models were identified: **Model A – Direct Authority**, wherein the State or University Board directly governs the AHC, and **Model B – Indirect Authority**, wherein the State or University has delegated authority to the AHC. The degree of authority and autonomy conferred to the AHC is further clarified by **Sub-Models B.i and B.ii**. AHCs identified as **Sub-Model B.i** have been delegated **significant authority and autonomy** whereas those identified as **B.ii** have **limited authority and autonomy**.

**TABLE 3: FRAMEWORK II - AHC GOVERNANCE MODELS**

MODEL	MODEL DESCRIPTION	AHC GOVERNANCE AUTHORITY
<b>A</b>	Direct	Held by the State or University governing body
<b>B</b>	Indirect	Delegated by the State or University to the AHC
	↓ AND THE AHC GOVERNING BODY HAS ↓	
	<b>B.i</b>	Significant authority and autonomy
	<b>B.ii</b>	Limited authority and autonomy

*AHC GOVERNANCE MODEL PREVALENCE BY MODEL TYPE*

**Please note:** As indicated in the description and findings for Framework I, 34 of the 79 AHCs are owned. Of the 45 designed in Framework I as having a separate CE, 20 were further designated (for the purposes of Framework II) as having a “Separate but Aligned” CEs (see description below). Therefore, a total of 54 of the 79 Universities analyzed and classified in Framework I were subsequently able to be classified in Framework II.

**Description of Further Classification in Framework II for Universities Identified with Separate CEs in Framework I**

The 45 Universities with a separate CE can be further classified as:

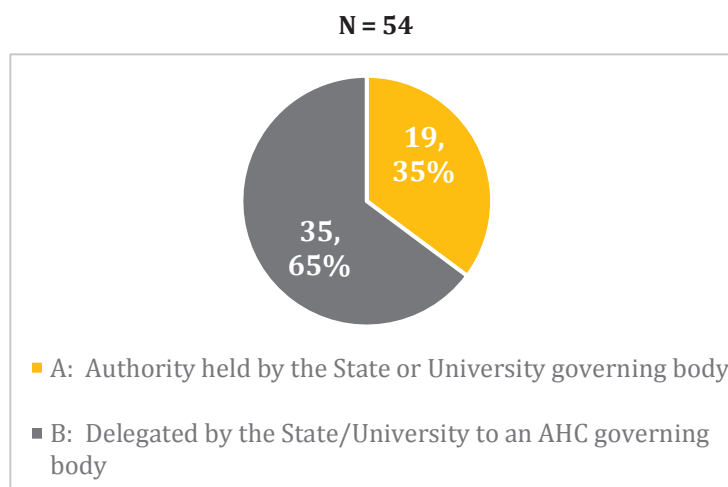
- **Truly separate:** The University has multiple contractual relationships with hospitals in the region to carry out resident or fellow training programs. Faculty from the University School of Medicine (SOM) support teaching activities at these hospitals. There are no governance ties between the University (or the State) and the teaching hospital(s).

- **“Separate but Aligned”**: The CE is not wholly owned by the University, but, most commonly, has a tight contractual relationship with a single non-academic health system, a county or district hospital, or a hospital authority. The University (or the state, in certain instances) typically has representation and some degree of authority on/over the governing board of AHC.

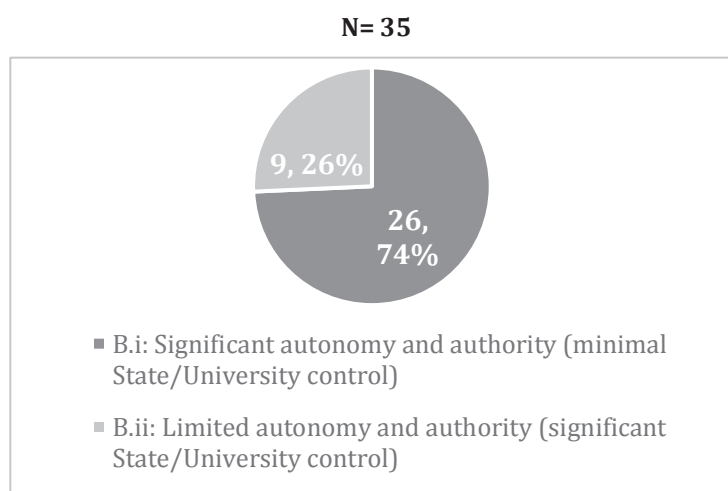
Only those fitting the latter description were analyzed in Framework II.

65%, of the 54 Universities able to be classified in Framework II delegated governance authority to an AHC governing body [Figure 4].

**FIGURE 4: PREVALENCE OF AHC GOVERNANCE MODELS IN OWNED AND SEPARATE BUT ALIGNED CEs**



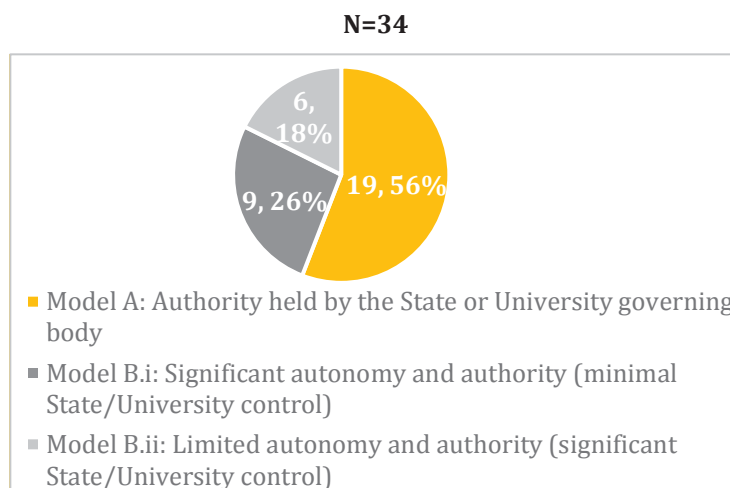
**FIGURE 5: PREVALENCE OF DELEGATED AHC GOVERNANCE MODELS IN OWNED AND SEPARATE BUT ALIGNED CEs BY DEGREE OF AUTHORITY DELEGATED**



Of the 35 Universities that delegated authority to the AHC, 74% delegated significant authority and autonomy to the AHC while 26% delegated limited authority and autonomy [Figure 5].

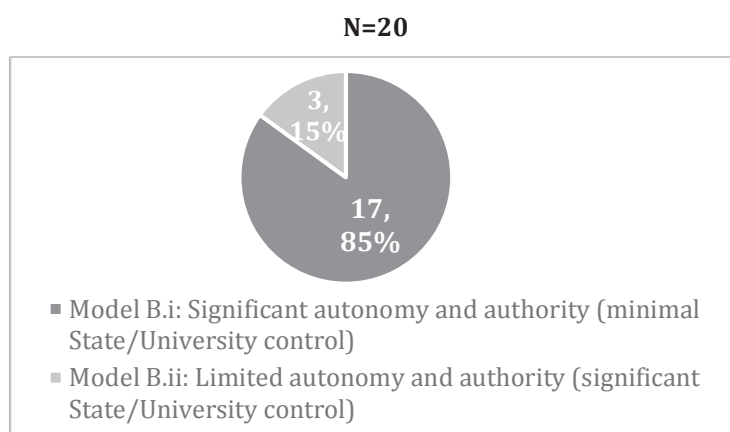
Of the 54 Universities analyzed in Framework II, 34 have owned CEs. 56% of these owned CEs were identified as **Model A**, 26% were identified as **Model B.i.**, and 18% were identified as **Model B.ii.** [Figure 6]

**FIGURE 6: PREVALENCE OF AHC GOVERNANCE MODELS FOR OWNED CEs ONLY**



The remaining 20 Universities analyzed in Framework II are “separate but aligned” CEs. 85% of these were identified as Model B.i., and 15% were identified as Model B.ii. [Figure 7]

**FIGURE 7: PREVALENCE OF AHC GOVERNANCE MODELS FOR SEPARATE BUT ALIGNED CEs ONLY**



The prevalence of each model described is notable in context of Mississippi’s current governance structure. In each Framework described, the current structure in Mississippi has a low prevalence, with its State AHC governance structure employing Model 1 (Direct) in Framework I, coupled with Model A (Direct, Authority held at the State/University level), relative to other national models.

**FRAMEWORK I: DESCRIPTIONS OF EACH MODEL**

**FRAMEWORK I, MODEL 1: DIRECT STATE GOVERNANCE, OWNED CE**

This model is characterized by expansive and direct state oversight of the University. The majority of the most impactful governance authorities - such as those referenced below [Figure 8] – are held by the State rather than the University (Horn, Isaak, Johnson, & Kamata, 2013). The mechanism by which powers are reserved to the State can vary. Most states define the terms of higher education governance through statutes, some use constitutional provisions (Hutchens, 2010).



**FIGURE 8: EXAMPLES OF COMMON RESERVED POWERS**

Election/removal of Board Trustees
Hiring, discharge, and evaluation of University leaders
Approval of any amendments to the Articles of Incorporation or Bylaws
Approval for adoption of/amendments to the strategic plan
Approval of annual operating and capital budget
Approval of expenditures, loans, or contractual arrangements in excess of established threshold
Creation of long-term obligations and debt guarantees (included creation of obligated group)
Merger or consolidation, change of control, ownership, capital structure or creation or acquisition of any entity
Sale or transfer of major assets
Discontinuance or major modification to a major activity, program or service
Approval of new or additional members or subsidiaries
Issuance of notes, bonds, or other debt
Approval of investment policies
Approval of faculty tenure policies and employee benefit policies

In this model, the State may not only govern the University in question, but also all public Universities in the state, or a sub-set of the state's public Universities. A University may retain a local board, though powers are limited to comment and review on major decisions.

An alternative form of direct State authority is a dedicated University board for which all members are appointed directly by the Governor and include the Governor as the ex-officio and voting board chair.

#### ***FRAMEWORK I, MODEL 2: INDIRECT STATE GOVERNANCE, OWNED CE***

In an indirect governance model, the state or state coordinating body delegates authority (as defined by a majority of the reserved powers noted above) to the University Board and University executive leadership (e.g., president, chancellor, or other) (Horn, Isaak, Johnson, & Kamata, 2013).

#### ***FRAMEWORK I, MODELS 1.1 AND 2.1: DIRECT AND INDIRECT, SEPARATE CE***

Designation as model 1.1 means that the primary characteristic of the State to University governance model is Direct, but the CE is not owned. The same concept for CE ownership applies for model 2.1, with the primary characteristic being an Indirect governance model. Below we briefly explore the advantages and disadvantages of having a separate CE, regardless of whether or not the State to University governance model is Direct or Indirect.

##### ***Advantages of the Separate CE Approach***

- Allows CE to operate quasi-autonomously, which can increase competitive advantages in the marketplace (e.g., increased speed of decision-making due to limited number of approvals needed)
- Would limit or eliminate public meeting rules, contract limitations (e.g., competitive bidding processes), and other rules required by parent organization
- Allows for enhanced leadership and governance focus on healthcare-specific issues (vs. University or higher education issues)
- Financial relationships and reporting are clearer and cleaner

##### ***Disadvantages of the Separate CE Approach***

- Less inherent collaboration between State, University, and health sciences enterprise for research, teaching, and other CE efforts that incorporate the academic missions

- May negatively impact efficacy and efficiency of joint-decision-making when required
- May limit or even eliminate direct state funding for the CE
- May necessitate attainment of other funding sources for school of medicine and other colleges, (healthcare revenues supplement SOM activities in other models)
- May complicate philanthropic or alumni-program ties to the University, resulting in less support for the AHC or CE
- Often complicates funds flow model(s), which can create silos and competition for resources

## ***FRAMEWORK II: DESCRIPTIONS AND ADVANTAGES AND DISADVANTAGES OF EACH MODEL***

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### ***FRAMEWORK II, MODEL A: DIRECT***

In a direct model, reserved powers (and therefore, key governance authorities) of the AHC are held at the University level (note from Framework I, University authority may be held at the state level). In this model, the AHC does not have a separate governing board from University, but rather the University (and in turn, in some cases, the state) directly governs the AHC, either as a full board, or as part of a healthcare sub-committee or special University task force on health care (Wietecha, Lipstein, & Rabkin, 2009).

#### ***Advantages of Direct AHC Governance Model***

- University and/or AHC can be the recipient of direct funding or appropriation from the state
- Assurances of aligned State/University and AHC/CE priorities and vision
- Minimal ambiguity with regard to delineation of authorities
- Positive CE revenue streams can directly bolster University financial position
- Integrated University/AHC/CE financials may simplify and streamline financial reporting

#### ***Disadvantages of Direct AHC Governance Model***

- Significant proportion of State or University board time and energy may be monopolized by health care related issues
- May be inappropriately sensitive to the need for AHC/CE-specific decision-making expediency
- State or University board often populated by political appointees with minimal health care-specific expertise and in some cases, conflicts of interest related to the AHC or CE
- May be unable to be appropriately sensitive to competitive issues specific to health care due to open public meeting requirements applicable to the University or State board
- Requires time-intensive legislative action if it is determined that an a dedicated AHC board with delegated authority is required

### ***FRAMEWORK II, MODEL B: INDIRECT***

The State or University delegates authority to an AHC governing body that is separate from the primary State/University governance structure (Wietecha, Lipstein, & Rabkin, 2009). This AHC governance body could have *significant* or *limited* governance authorities delegated to it, and advantages and disadvantages and other key model details depend on the degree of delegated authority and autonomy. For example, the process by which AHC governing body members are appointed often includes selection by the chair of the

University board of trustees (and may include University board members) and a ratification process by the University board. In other models with limited delegated authority, the governor may appoint a selection of AHC board members directly, though this is less common. In short, no single mechanism exists for board member appointment within an indirect model.

#### ***Advantages of Indirect Model***

- Provides AHC-specific expertise and focus but can be structured to maintain integration and effective funds flow between the AHC and the University or State
- Promotes State and University board(s) that are appropriately focused on decisions and oversight impacting higher-education issues
- Mitigates challenges associated with state-based political appointees (i.e., lack of health-care specific expertise, conflicts of interest)
- Decision-making processes may be expedited relative to Direct model
  - Enables relatively quick response to changing market conditions and competitive threats

#### ***Disadvantages of Indirect Model***

- Limited State or University oversight of AHC/CE and resulting separation of financial and operational authority may be undesirable from perspective of State and/or University
- Specific delegation of powers is dependent on legislative language which could leave room for interpretation, resulting in unclear governance purview and associated authorities/accountabilities
- AHC board could subsequently decide (if it has the authority to do so) to delegate substantial authority and autonomy to AHC/CE executive leader, which would make oversight effectiveness dependent largely on leadership selection vs. governance

#### ***FRAMEWORK II, MODEL B.i.: INDIRECT - SIGNIFICANT AUTHORITY AND AUTONOMY***

In this model, the high degree of governance authority and autonomy delegated to the AHC may allow the AHC to function as a separate entity within the University or State governance framework. The AHC is empowered to make many strategic and financial decisions without approval from the State or University, though typically the State or University retains powers related to approval of financial decisions that exceed a high dollar amount threshold, as well as other major high-impact decisions with long-term implications.

#### ***Advantages of Indirect Model with Significant Delegation of Authority and Autonomy***

- Allows AHC to operate as a quasi-autonomous body, enabling quick response to changing market conditions and competitive threats
- Parent board(s) are appropriately focused on decisions impacting higher-education
- AHC board typically populated almost entirely by those with a high degree of health care expertise
- Requires very clear delineation of authority between AHC board and Parent board(s), which improves efficacy of all boards
- Provides AHC-specific expertise, focus, and high degree of decision-making power and autonomy, but can be structured to maintain integration and effective funds flow between the AHC and the University or State

***Disadvantages of Indirect Model with Significant Delegation of Authority and Autonomy***

- Structure alone does not necessarily solve alignment issues within the AHC/University structure, (e.g., if AHC and SOM report to different leaders, such as the University president and provost, respectively)
- AHC growth may outpace the University in revenue generation, having unintended consequences on relationships between faculty and leadership (e.g., cultural perceptions of issues of tenure and programmatic funding)

***FRAMEWORK II, MODEL B.ii.: INDIRECT - LIMITED AUTHORITY AND AUTONOMY***

This model is most similar to a direct model despite being classified as indirect. While there is a separate AHC board, it generally has very limited authority which often includes oversight of issues related to maintenance of quality standards and accreditation, physician recruitment, hiring and credentialing, and other narrowly-defined issues. For all issues regarding strategy or finances of the enterprise (e.g., budgeting, strategic planning, contracting) this local board may recommend or provide input or information to the University board, who will ultimately give approval.

This model was not commonly observed in practice due to its similarity with the direct model and limited authority. However, it is often used as a transition phase between a direct model and an indirect model with more oversight. This transition allows a local board to be formed and function with some autonomy as a trial period, with the potential for increased autonomy pending the success in oversight of the new board.

Additionally, it can be noted that this model may in practice operate with more autonomy or authority than is evident in the bylaws. For example, significant powers may be reserved to the State or University, and many issues may require State or University approval, however, the State or University may typically defer to AHC executive leadership or an AHC advisory board for the majority of decisions.

***Advantages of Indirect Model with Limited Delegation of Authority and Autonomy***

- Promotes somewhat more appropriate focus of State or University board
- May serve as an effective a “trial approach” to transitioning to more substantial authority/autonomy for an AHC board
  - Allows State/University board to fully vet implications of a change in model or powers

***Disadvantages of Indirect Model with Limited Delegation of Authority and Autonomy***

- Adds additional layer of governance without substantial delegation of authority and autonomy, which may be inefficient and in some cases, ineffective
- May create unnecessary friction between governance levels without yielding substantial additive value
- May be perceived as a disingenuous attempt to improve governance efficacy of the AHC

## REVIEW OF NATIONAL AHC BEST PRACTICES

Key best practices for AHC governance were developed via a comprehensive literature review and interviews with leaders at public AHCs across the country. The following best practices represent key elements of effective AHC governance.

### KEY BEST PRACTICES

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#### 1. **DISTINCT GOVERNING BODY – “AHC BOARD” – CHARGED WITH AND EMPOWERED TO HAVE OVERSIGHT OF THE ACADEMIC HEALTH CENTER**<sup>14,15</sup> (WIETecha, LIPSTEIN, & RABKIN, 2009)

*DETAIL: CHARACTERISTICS OF HIGH-FUNCTIONING AHC BOARDS*

##### A. Focus

- i. Clearly defined primary function(s) and delineation of oversight scope (which is differentiated from that of “Parent” Board, whether State or University)<sup>16</sup>
  - a. AHC Board scope: clinical, financial, and strategic performance of the AHC
  - b. Parent Board scope: linkages between academic mission of University, its Medical School, and the AHC; long-term sustainability and strategic direction of the AHC
  - c. Mutual understanding regarding roles of governance vs. executive clinical enterprise leadership

##### B. Composition

- i. Clinical and/or Operational Executive Leadership
  - a. Hospital President/CEO (often ex-officio) (Szekendi, Marilyn, et al., 2014)
  - b. Other “C-Suite” level hospital leaders (e.g., CFO, CNO), as appropriate
  - c. Faculty practice plan CEO (optional; if unified faculty practice plan exists)
- ii. Academic Executive Leadership
  - a. Health Sciences Vice Chancellor (often ex-officio)
  - b. Dean of the School of Medicine (optional)
  - c. State and/or University Board Representatives
  - d. Chair of State and/or University Board
  - e. University Chancellor (optional)
- iii. Experienced subject matter experts (The American Hospital Association’s Center for Healthcare Governance, 2012) (Enders & Conroy, 2014)

<sup>14</sup> Including the “Clinical Enterprise” referring primarily to the hospital and other patient care entities.

<sup>15</sup> A distinct governing body is ideal, though an AHC focused sub-committee of the Parent Board (State Board or University Board) can provide incremental benefit over direct Parent Board oversight if appropriately structured and operated.

<sup>16</sup> In the State of Mississippi, the Parent Board is the IHL Board.

- a. Clinical aspects of academic health care delivery (including but not limited to quality)
- b. Health care finance and other health care delivery business disciplines
- c. Medical education
- d. Clinical faculty affairs and relationships
- e. Relevant health sciences research

### C. Size

- i. Minimum number of trustees/members able to meet composition requirements
  - a. Intent is to maximize efficiency of Board oversight; facilitate timely decision-making and action in order to keep pace with dynamic health care environment
  - b. Typically between 10 and 15 trustees/members

### D. Rights and Responsibilities

- i. Specific voting rights of each Trustee vary by institution, but best practice intent is to effectively empower most, if not all, Trustees via voting privileges on key matters
- ii. Delegation of **select approval authorities**<sup>17</sup> from Parent Board to the AHC Board; clear definitions of authority, accountability, and decision-making responsibility should be outlined in documents approved by Parent Board (The Blue Ribbon Panel on Health Care Governance, 2007)
  - a. Set strategic vision and goals for the AHC, and hold senior leadership responsible for clinical and financial outcomes with clear expectations, objective evaluation, and follow-up actions
  - b. Establish annual budgets
  - c. Process AHC funding requests under a certain reasonable dollar amount threshold; this may cause the AHC dollar threshold to differ from that of the university, given size, scope, and budget
  - d. Ensure CE regulatory/legal compliance
- iii. Responsibility of the AHC Board to **review and recommend** course of action to Parent Board for proposals related to<sup>18</sup>
  - a. Significant partnerships, including but not limited to, any proposed acquisitions
  - b. Substantial capital expenditures (over specified dollar amount threshold), including any proposed major construction projects or significant real estate transactions
  - c. Divestiture of major assets

### E. Interaction/Inter-Relationships with Parent Board

<sup>17</sup> Select examples of delegated authorities; not intended to be an exhaustive list.

<sup>18</sup> Select examples of review and recommend responsibilities; not intended to be an exhaustive list.

- a. Established mechanisms for communication and collaboration between the AHC Board and Parent Board (e.g., selective overlapping membership, quarterly briefings)

**2. FORMAL INITIAL ONBOARDING AND ONGOING TRAINING AND EDUCATION** (*THE AMERICAN HOSPITAL ASSOCIATION'S CENTER FOR HEALTHCARE GOVERNANCE, 2014*) (*SZEKENDI, MARILYN, ET AL., 2014*)

- A. Ensures comprehensive understanding of role, duties, authorities, and accountabilities
- B. Ensures appropriate and up-to-date knowledge of health care delivery policy and industry trends

**3. METRICS-BASED GOVERNANCE**

- A. Use of standard set of performance metrics
  - i. Most effective when performance is presented relative to appropriate benchmarks and shown over time
  - ii. Metrics included related to teaching and research support (e.g., amount of grant funding)
  - iii. Indicators should reflect clinical and care experience outcomes, inpatient/outpatient and medical/surgical volumes, access, cost, financial operating performance, balance sheet position
  - iv. Facilitates accountability - both of the AHC with respect to the AHC Board, and the AHC Board with respect to its Parent Board
  - v. Provides objective basis for delegation of authorities and responsibilities to the AHC Board

**4. ROUTINE EVALUATION OF GOVERNANCE EFFICACY AND EFFICIENCY**

- A. Process to compare actual efficacy and efficiency against defined expectations (*The American Hospital Association's Center for Healthcare Governance, 2012*) (*Szekendi, et al., 2014*)
- B. Fosters awareness, transparency, and targeted modifications

In addition to the above best practices deemed as key to AHC governance efficacy, the following practices were identified in the literature and by interviewees as important to success.

**GENERAL BEST PRACTICE GUIDELINES FOR AHC GOVERNANCE**

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**1. ACKNOWLEDGED AND DEMONSTRATED TRUSTEE COMMITMENT OF TIME AND ENERGY REQUIRED FOR SERVICE** (*THE BLUE RIBBON PANEL ON HEALTH CARE GOVERNANCE, 2007*)

- A. Trustee willingness to continuously expand base of content knowledge and develop new or evolve existing capabilities

**2. ADEQUATE BOARD STAFFING**

- A. Size and skill-mix of Board staff should not limit Board efficacy or efficiency

**3. SUFFICIENT NUMBER OF FORMAL AND PRE-SCHEDULED SESSIONS THROUGHOUT THE YEAR TO EFFECTIVELY GOVERN**  
(SZEKENDI, ET AL., 2014)

- A. Pertains to AHC Board meetings and reporting sessions to Parent Board
  - i. Monthly is most common for AHC Board; quarterly is most common for Parent Board

**4. ABILITY (AND ESTABLISHED PROCESS/PROTOCOL) TO CALL AD-HOC SESSIONS FOR TIME-SENSITIVE ISSUES**

**5. ABILITY (AND ESTABLISHED PROCESS/PROTOCOL) TO CONVENE SUB-COMMITTEES, TASK FORCES, ADDRESS COMPLEX OR OTHERWISE RESOURCE-INTENSIVE ISSUES** (THE AMERICAN HOSPITAL ASSOCIATION'S CENTER FOR HEALTHCARE GOVERNANCE, 2012) (THE AMERICAN HOSPITAL ASSOCIATION'S CENTER FOR HEALTHCARE GOVERNANCE, 2014)

- A. All standing committees should have written charters that have been formally adopted by the AHC Board (and approved by the Parent Board, as necessary)

**6. USE OF SPECIFIC CRITERIA FOR AHC BOARD AND/OR PARENT BOARD SUB-COMMITTEE APPOINTMENTS<sup>19</sup>** (SZEKENDI, ET AL., 2014)

- A. Critical to success given the unique, dynamic, and highly competitive nature of health care system governance
- B. Selection and nomination processes and policies must guarantee that each trustee/sub-committee member and the trustees/sub-committee overall has/have:
  - i. The right mix of health care delivery experience and expertise (The American Hospital Association's Center for Healthcare Governance, 2014)
  - ii. No potential conflicts of interest

**7. BALANCE OF TRANSPARENCY AND SENSITIVITY TO COMPETITIVE ASPECTS OF HEALTH CARE GOVERNANCE**

- A. Compliance with all clauses related to public access to meetings/minutes while ensuring that decision-making with potential competitive implications can be conducted effectively

**8. APPROPRIATE LIMITS ON TERM LENGTH AND ALLOWABLE NUMBER OF CONSECUTIVE TERMS** (THE AMERICAN HOSPITAL ASSOCIATION'S CENTER FOR HEALTHCARE GOVERNANCE, 2014)

- A. Both should be formally established in Bylaws
  - i. Term limits: three years is most typical but acceptable range is two to five years
  - ii. Consecutive terms: two is most common
    - a. Need to balance the value of experience and knowledge gained during tenure with the value of introducing new perspectives, competencies, and capabilities

**9. PROACTIVE SUCCESSION PLANNING**

<sup>19</sup> Applicable to non-ex-officio Trustees.



- A. Mechanisms in place to identify replacement needs in terms of bodies and competencies/capabilities (The American Hospital Association's Center for Healthcare Governance, 2012) (Szekendi, et al., 2014)

### ***ADDITIONAL INSIGHT ON BEST PRACTICES***

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Identified key best practices gleaned from interviews were corroborated by the literature. The best practice stressed most often by interviewees and in the literature was a well-designed and distinct AHC governing body or focused AHC sub-committee populated by individuals with health care specific expertise. The complexity of AHC strategy and operations, as well as the rapid pace of change in the health care industry, were the primary rationale given to support this need. It was further noted that a smaller executive committee of the AHC board is helpful to a consistent focus on high-impact strategic issues. Although more a leadership rather than governance issue, a related common sentiment was that the AHC board/sub-committee has a high degree of trust in and delegates a fair amount of operational autonomy to the AHC executive management team. Finally, importance of adequate accessibility to the governing body or decision-making authority in order for the AHC to make timely decisions as needs arise.

## PART III: APPLICATION OF NATIONAL FINDINGS TO UMMC

### ASSESSMENT OF UMMC RELATIVE TO BEST PRACTICES

UMMC governance was compared to the above identified key AHC governance practices. The degree to which current UMMC governance aligns with identified key best practices and overall best practice guidelines (denoted as low, moderate, or high) is summarized below [Table 4 and Table 5].

**TABLE 4: DEGREE OF UMMC ALIGNMENT WITH KEY BEST PRACTICES**

KEY BEST PRACTICES	CURRENT ALIGNMENT WITH BEST PRACTICE	RATIONALE
1. Distinct Governing Entity	Low	Health Affairs Committee but not distinct entity; all Trustees are on Committee
A. Clearly Defined Primary Functions and Delineation of Oversight Scope	Low	No defined charter for Health Affairs Committee; no clear delineation of scope and authority between IHL Board and Health Affairs Committee
B. Composition	Low	Board member appointees are selected as Trustees over a statewide system of education, not as members of an AHC-specific governing body
C. Size	High	Size of Health Affairs Committee aligns with best practice
D. Rights and Responsibilities	N/A	All IHL Board members are members of the Health Affairs Committee
E. Interaction/Interrelationships with Parent Board	N/A	All IHL Board members are member of the Health Affairs Committee
2. Formal initial onboarding and training and education	Low	Lack of formal onboarding, training, or continuing education processes
3. Metrics-based governance	Low	No defined or routinely used metrics
4. Routine evaluation of governance efficacy and efficiency	Low	No defined process or criteria for routine governance evaluation

**TABLE 5: DEGREE OF UMMC ALIGNMENT WITH BEST PRACTICE GUIDELINES**

GENERAL BEST PRACTICE GUIDELINES	CURRENT ALIGNMENT WITH GUIDELINE	RATIONALE FOR RATING
1. Acknowledged and demonstrated trustee commitment of time and energy required for service	High	Interviewees indicated that IHL Trustees are committed to their duties and responsibilities
2. Adequate board staffing	Moderate	Board staffing noted as generally sufficient to support Board functionality though staff spends significant time focused on UMMC vs. all other IHL needs
3. Sufficient number of formal and pre-scheduled sessions throughout the year to effectively govern	Moderate	Interviewees cited too few meetings as hindrance to decision-making efficacy
4. Ability to call ad-hoc sessions for time-sensitive issues	Low	Many interviewees noted difficulty in accessing the IHL Board or Health Affairs Committee outside of scheduled meetings
5. Ability to convene task forces or sub-committees to address complex or otherwise resource-intensive issues	Low	No clear policy stated in Bylaws
6. Use of specific criteria for clinical enterprise board and/or AHC sub-committee board appointees	Low	While a physician is usually appointed as a member of each entering class of board appointees, members are not appointed using AHC governance-specific criteria
7. Balance of transparency and sensitivity to competitive aspects of health care governance	Low/Moderate	Out of balance – heavily favors transparency over competitive concerns
8. Appropriate term limits and number of consecutive terms	Low	IHL Board members serve 9-year terms; Bylaws do not specify consecutive term limits
9. Proactive succession planning	Low	Minimal transparency re: the succession planning process; unclear whether succession planning is based on evaluation or criteria

## OPTIONS AND CONSIDERATIONS REGARDING UMMC GOVERNANCE

### ***OPTION 1: MODIFICATION WITHIN EXISTING STRUCTURE (I.E., STATUS QUO +)***

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This model would not fundamentally change the current governance structure, but would somewhat modify scope, composition, and orientation of the current Health Affairs Committee of the IHL Board of Trustees. (The recently Health Affairs Committee is a sub-committee of the IHL Board developed to oversee UMMC's patient-care delivery and other operations. This sub-committee is comprised of the entire IHL board.)

#### ***Composition***

In this alternative, the Health Affairs Committee would include fewer IHL Trustees, and add a select number of external members including health care business leaders, physicians with AMC experience, and others (see "Key Best Practices" section regarding key areas of expertise).

#### ***Orientation and Scope***

The revamped Health Affairs Committee would carry out its defined charter more effectively and expeditiously than today due to enhanced expertise and more manageable size. Additionally, it is proposed that IHL increase the approval threshold to \$750,000, allowing the Health Affairs Committee and UMMC executive leadership to execute the majority of routine contracts and purchases. These relatively minor modifications would enable the IHL Board to better focus on the highest-level strategic and educationally-oriented issues facing UMMC.

#### ***Potential Advantages***

- Does not require [substantive] legislative action as IHL retains direct authority over UMMC
- Incorporates select key AHC governance best practices
- May expedite certain UMMC operations-related decisions

#### ***Potential Disadvantages***

- Does not fully address key issues identified by internal stakeholders (e.g., speed of decision-making, ability to be nimble) nor competitive sensitivities (e.g., board member conflicts/independence, public nature of some board meetings)

*NOTE: INCLUSION OF EXTERNAL EXPERTS, STRATEGIC AND EDUCATIONAL FOCUS OF IHL BOARD, AND INCREASED APPROVAL THRESHOLD SHOULD BE ASSUMED AS A BASELINE IN ALL SUBSEQUENT OPTIONS.*

### ***OPTION 2: DISTINCT UMMC OPERATIONS BOARD WITH LIMITED DELEGATED AUTHORITY***

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IHL creates a new UMMC Operations Board to replace the Health Affairs Committee structure and advise the IHL Board directly. If desired, the Health Affairs Committee could remain in place and operate alongside the new Operations Board, but this is likely to generate unnecessary redundancies.

**Composition**

The new UMMC Operations Board would be populated by UMMC executive leadership, physicians with academic experience, other experts, Chair of the IHL Health Affairs Committee (or other IHL representative(s), as delegated), and University representation (e.g., Chancellor).

**Orientation and Scope**

As the name suggests, the new Board's focus would be primarily operational, enabling a more appropriate focus of the IHL board. The Operational Board may have review and recommend responsibilities related to select strategic and financial decisions. The new Board's delegated authorities would include oversight of clinical operations issues, such as quality management, physician credentialing, and others of a similar nature.

**Potential Advantages**

- Allows IHL Board to focus on high-level strategic issues and those most relevant to their educational mission
- Places UMMC operations under direct oversight of health care experts
- Enhances effectiveness and efficiency of UMMC's operational decision-making

**Potential Disadvantages**

- A fair number of UMMC decisions are still subject to IHL board timeline and structure
- Continued public accessibility to UMMC strategic decisions
- The Operations Board may request or require additional autonomy in the future
- Legislative action required

***OPTION 3: DISTINCT UMMC BOARD WITH SIGNIFICANT DELEGATED AUTHORITY***

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IHL would create a UMMC Board of Trustees with delegated authority for a majority of strategic and financial decisions in addition to daily operations.

**Composition**

Board comprised mostly of health system leadership, physicians with academic experience, and other health care experts. Could include IHL and University representation (e.g., Chancellor). In this model, the IHL Health Affairs Committee would disband.

**Orientation**

Both strategic and operational, allowing IHL board to focus only on issues unable to be resolved at the campus level or issues of a significant strategic nature. IHL Board has final authority and approval but is mostly ratifying decisions recommended by the UMMC Board.

**Scope**

All aspects of operations and strategy, with limited oversight by IHL board (e.g., final budget or selected other approvals). UMMC Board would be able to preliminarily approve all operational processes, including contracting for services, without requirement of IHL approval.

**Potential Advantages**

- Allows a majority of health care decisions to be decanted from IHL, allowing IHL focus on higher education, rather than healthcare issues
- Allows continued (or new) collaboration with a variety of universities and/or health care systems across the state
- Opportunity for focused governance with academic health care expertise/experience
- Does not include members appointed by legislature with the potential for conflicts of interest or presence of other political influence

**Potential Disadvantages**

- Significant legislative action required
- Less direct IHL oversight than current state (from perspective of state)

**OPTION 4: CREATION OF BIFURCATED MODEL - HOSPITAL AUTHORITY MODEL**

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A distinct governance structure is created outside of the current State/University structure.

**Composition**

Hospital Authority Board is populated by University of Mississippi and UMMC leadership. The board could have IHL representation but this would not be required.

**Orientation and Scope**

Hospital Authority Board authorities and oversight scope would encompass operational and strategic decision-making.

**Potential Advantages**

- Enables IHL to focus primarily on decision-making with higher-education implications, allowing it to better fulfill its primary purpose/role
- Insulates the University (and/or State) from the potential financial implications of a distressed medical center (e.g., impact on bond rating if medical center operations do not perform well)
- Allows confidential board discussions and communication outside of IHL board structure (e.g., outside of the Mississippi Open Meetings Act<sup>20</sup>) allowing increased strategic and competitive advantage than current state
- Creates distinct entity to lead and govern the AHC, ensuring health-care focus and significant health care expertise
- Opportunity to foster greater integration of academic and clinical missions by having representatives from both the University and health-care specific UMMC representatives representation

<sup>20</sup> Current IHL Policy 301.0505 "It is the policy of the Board to conduct its meetings pursuant to the provisions of the Mississippi Open Meetings Act".

***Potential Disadvantages***

- Would remove the IHL from direct UMMC clinical enterprise oversight role
- Would make it more challenging and complex to allow the University and/or State to share in AHC revenue surpluses
- May limit or impede ability to transfer funds between UMMC and University of Mississippi, as the organizations would be separately owned (e.g., operationally difficult)
- Significant legislative impact and hurdles

***OTHER CONSIDERATIONS***

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***Balance between the need for and difficulty of change implementation***

Legislators should consider the need for policy solutions to achieve short-term wins while also establishing a the foundation for a governance structure that will can be a sustainable, long-term solution. Both short-term and long-term solutions should be considered. For example, selected changes may be benign from a policy standpoint but would have immediate operational impact to the AHC (e.g., raise in cap for contracting, change in board committee structure). Conversely, selected governance models (e.g., AHC separation from state oversight) would require significant state policy, funding, and operational changes and result in significant impact to University and UMMC employees. In this case, the proposed model and structure would afford significant advantages, however policymakers should weigh these against the significant effort, time needed, and impact of those changes.

**CONCLUSION**

As noted in the introduction, this analysis is intended to provide information to assist legislators with decision-making regarding AHC governance in Mississippi. As such, this report does not specifically recommend pursuit of any of the above presented options, but rather clarifies the options available and the potential implications of each.

The analysis does identify the opportunity for UMMC to better align with national best practice. However, several key best practices identified could be pursued in the current governance framework, though a modified governance model is likely to enable more substantive improvement.

When contemplating which best practice initiatives to pursue and how to pursue them, the primary focus should be on how reimagined governance structure and policy could improve UMMC viability and future growth potential. A thoughtful balance should be struck between the likely degree of benefit yielded from governance modifications and the associated challenges and investments. Finally, all risks associated with pursuing change efforts should be compared against the risk of doing nothing in a fast-paced and increasingly competitive and complex academic health care marketplace.

## APPENDICES

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Appendix A: Methodologies and Study Limitations

Appendix B: Categorization of Governance Models by School

Appendix C: Interview Protocol

Appendix D: UMMC Overview

Appendix E: UIHC Case Study

References



## APPENDIX A: METHODOLOGIES AND STUDY LIMITATIONS

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The processes used to complete the study were unbiased, independent, and included comprehensive internal and external sources. This study is not meant to recommend one specific model or structure to the legislature, UMMC, or its stakeholders. Rather, it is meant to give an unbiased view of the multitude of governance options available to UMMC, and implications of each model for stakeholders involved, should a change be perceived as warranted by members of the legislature.

### Literature Review

The study commenced with a national literature review from publically-available sources (see References), including peer-reviewed and non-peer-reviewed literature. Topics included AHC, University, and state governing/coordinating body governance structures and effectiveness, leadership, finance, operations, and others.

To further refine research and conclusions pertaining to AHCs most similar overall to UMMC, a phased approach was used to identify, classify, and further assess AHCs nationally.

This study's focus was on publically-funded AHCs, as the governance, authority, and therefore implications arising from changes in governance of publically-funded entities differs fundamentally than those of their private or semi-private counterparts. Additionally, AHCs were only included in the study if they were associated with an allopathic medical school<sup>21</sup>. The relationship between the medical school and the academic medical center, whose primary purpose is to fulfill the teaching (and often research) component of the University's mission via the medical school, is critical at multiple levels of AHC governance.

A governance documentation review was performed on the 79 publically-funded AHCs, which were then categorized into distinct governance models based on factors including direct or delegated authority (both from the state and University to the health enterprise) and level of integration/ownership of the AHC (details on each model can be found in next section).

### Framework I

Governance models were classified first by determination if governance authority was largely held at the state level, through direct state legislation or statewide governing/coordinating body deriving authority through legislation, state appropriation or other (direct state authority) or, if authority was delegated, either in whole or in part, from the state to the University (indirect state authority).

Further, these models were subcategorized based on CE ownership by the University, (e.g., University owned CE or separate CE from the University). A summary of these models is presented as Table 1 in the main body of the paper<sup>22</sup>.

**Please note:** As indicated in the description and findings for Framework I, 34 of the 79 AHCs are owned. Of the 45 designed in Framework I as having a separate CE, 20 were further designated (for the purposes of Framework II) as having a "Separate but Aligned" CEs (see description below). Therefore, a total of 54

<sup>21</sup> Osteopathic medical schools were excluded from the study.

<sup>22</sup> A detailed description of each model type, including benefits, drawbacks, and other organizational implications, is detailed in the body of the report.

of the 79 Universities analyzed and classified in Framework I were subsequently able to be classified in Framework II.

### ***Description of Further Classification in Framework II for Universities Identified with Separate CEs in Framework I***

The 45 Universities with a separate CE can be further classified as:

- **Truly separate:** The University has multiple contractual relationships with hospitals in the region to carry out resident or fellow training programs. Faculty from the University SOM support teaching activities at these hospitals. There are no governance ties between the University (or the State) and the teaching hospital.
- **“Separate but Aligned”:** The CE is not wholly owned by the University, but, most commonly, has a tight contractual relationship with a single non-academic health system, a county or district hospital, or a separate hospital authority. The University (or the state, in certain instances) typically has representation and some degree of authority on/over the governing board of AHC.

Only those fitting the latter description were analyzed in Framework II.

### **Framework II**

The second framework categorized the relationship between the University and the CE, and further clarified the nuanced and varying degrees of governance and integration that exist, even within CEs that are not wholly owned by the University. This phase considered AHC governance models where the CE was wholly owned by the University and those CEs that are not wholly owned, but are aligned with the University through relationships including a hospital authority/separate corporation model, county or district hospital, or if the CE is a partnership with and/or owned and operated by a single, non-academic health system.

U.S. public medical schools with multiple hospital or health system affiliates, largely for teaching purposes, were excluded from this phase of the analysis, as governance authority of the clinical enterprise of these teaching institutions is not integrated, dependent on, or otherwise directly related to the governance of the public University and/or the state.

These owned or otherwise aligned CEs were classified according to governance authority held at or delegated from the University level, and the degree to which the CE has authority and autonomy over its daily affairs.

### **Internal and External Interviews**

Organizations with owned or aligned CEs were contacted and interviews were performed with University or AHC leadership to further delineate characteristics of governance model employed, best practices and areas of opportunity within the current model, and other ideal governance components from the perspective of national leaders. For complete interview protocol, see Appendix C.

Organization excluded from the interview process included:

- States with three or more publically-funded AHCs; a rationale that governance involving an AHC that is the only, or among one of two AHCs in a state is vastly different than in a state where multiple AHCs exist

- AHCs associated with medical schools who have not yet graduated a class
- AHCs that had a separate clinical enterprise governance structure; for the purposes of completeness, this structure is reviewed in the models identified nationally and as a consideration; the vast amount of literature on this model (and experience with this model by others interviewed), resulted in the conclusion to limit comprehensive interviews to organizations with structures more similar to UMMC's current state

Additionally, interviews were completed with leadership and physicians of Mississippi institutions, as noted below. Organizational documents and data provided by each were subsequently analyzed. An assessment and gap analysis were conducted on the current governance structure employed within Mississippi and compared to the best practices identified in other organizations/states nationwide.

### **Organizations Interviewed**

#### ***External***

- The University of Tennessee Health Science Center
- University of Alabama at Birmingham (UAB) Health System
- University of Arkansas for Medical Sciences
- University of Illinois Hospital & Health Sciences System
- University of Iowa Health Care
- University of Kentucky HealthCare
- University of New Mexico Health Sciences Center
- University of North Carolina Health Care
- University of South Alabama Health System
- University of Utah Health Care

#### ***Internal***

- Mississippi Institutions of Higher Learning
- University of Mississippi
- University of Mississippi Medical Center
- The Bower Foundation

Finally, governance model options are presented, with implications, for legislative consideration. These options aim to elucidate specific governance changes to address the organizational gaps identified by the assessment.

### **Limitations of this study**

Reiterating points made in the process section above, several key limitations should be noted regarding methodologies, data, and results in this study:

- Initial list of state-based public universities was developed through the Association of American Medical Colleges (AAMC) database of the nation's public medical schools; relationships between the medical school, University, and health enterprise were determined through further research and

review of applicable bylaws. However, it should be noted that that basis of the report's list of schools is dependent on the reliability of the initial database used.

- Governance categorizations were based on review of publically-available documentation regarding the current state. These documents do not account for any ongoing or upcoming changes in governance structures if planned or not yet executed.
- Select best practices and subsequent benefits and drawbacks or commentary were summarized from research and interviews completed, findings biased by experience and perspective of individuals interviewed
- Detailed interviews completed only on a sub-selection of AHCs with two or fewer publically-funded AHCs in the state; analysis did not consider governance structures of larger states with multiple AHCs

## APPENDIX B: CATEGORIZATION OF GOVERNANCE MODELS BY SCHOOL

<b>Framework I Analysis: State to University Governance Model</b>	
<b>MODEL 1:</b>  <b>Direct State Authority Owned CE</b>	Medical College of Georgia at Georgia Regents University
	Medical University of South Carolina College of Medicine
	State University of New York (SUNY) Downstate Medical Center College of Medicine
	SUNY Stony Brook University School of Medicine
	SUNY Upstate Medical University
	University of Arkansas for Medical Sciences College of Medicine
	University of California, Davis, School of Medicine
	University of California, Irvine, School of Medicine
	University of California, Los Angeles, David Geffen School of Medicine
	University of California, San Diego, School of Medicine
	University of California, San Francisco, School of Medicine
	University of Iowa Roy J. and Lucille A. Carver College of Medicine
	University of Mississippi School of Medicine
	University of New Mexico School of Medicine
University of Utah School of Medicine	
<b>MODEL 1.1:</b>  <b>Direct State Authority Separate CE</b>	East Tennessee State University James H. Quillen College of Medicine
	Louisiana State University School of Medicine in New Orleans
	Louisiana State University School of Medicine in Shreveport
	Marshall University Joan C. Edwards School of Medicine
	Rutgers New Jersey Medical School - Newark
	Rutgers, Robert Wood Johnson Medical School
	University at Buffalo SUNY School of Medicine & Biomedical Sciences
	University of Kansas School of Medicine
	University of Nevada School of Medicine
	University of North Dakota School of Medicine and Health Sciences
	University of South Carolina School of Medicine
	University of Vermont College of Medicine
	Virginia Commonwealth University School of Medicine
	West Virginia University School of Medicine
<b>MODEL 2:</b>  <b>Indirect State Authority Owned CE</b>	Ohio State University College of Medicine
	Oregon Health & Science University School of Medicine
	The University of Toledo College of Medicine
	University of Alabama School of Medicine
	University of Cincinnati College of Medicine
	University of Connecticut School of Medicine
	University of Florida College of Medicine
	University of Illinois College of Medicine
	University of Kentucky College of Medicine
	University of Michigan Medical School
	University of Missouri Columbia School of Medicine
	University of Nebraska College of Medicine
	University of North Carolina at Chapel Hill School of Medicine

	University of Oklahoma College of Medicine
	University of South Alabama College of Medicine
	University of Texas Medical Branch School of Medicine
	University of Texas Southwestern Medical School
	University of Virginia School of Medicine
	University of Washington School of Medicine
<b>MODEL 2.1:</b>	Central Michigan University College of Medicine
<b>Indirect State Authority</b>	Charles E. Schmidt College of Medicine at Florida Atlantic University
<b>Separate CE</b>	Eastern Virginia Medical School
	Florida International University Herbert Wertheim College of Medicine
	Florida State University College of Medicine
	Indiana University School of Medicine
	Michigan State University College of Human Medicine
	Northeast Ohio Medical University
	Southern Illinois University School of Medicine
	Texas A&M Health Science Center College of Medicine
	Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
	Texas Tech University Health Sciences Center School of Medicine
	The Brody School of Medicine at East Carolina University
	The University of Texas School of Medicine at San Antonio
	University of Arizona College of Medicine
	University of Arizona College of Medicine, Phoenix
	University of Central Florida College of Medicine
	University of Colorado School of Medicine
	University of Hawaii John A. Burns School of Medicine
	University of Louisville School of Medicine
	University of Maryland School of Medicine
	University of Massachusetts Medical School
	University of Minnesota Medical School
	University of Missouri, Kansas City School of Medicine
	University of South Dakota, Sanford School of Medicine
	University of Tennessee Health Science Center College of Medicine
	University of Texas Medical School at Houston
	University of Wisconsin School of Medicine and Public Health
	University of South Florida Health Morsani College of Medicine
	Wayne State University School of Medicine
	Wright State University Boonshoft School of Medicine

**Framework II Analysis: Relationship Between the University and AHC where the *CE is Owned by the University*<sup>23</sup>**

<p><b>MODEL A:</b></p> <p><b>Direct</b> – Authority held by the State/University</p>	Medical University of South Carolina College of Medicine
	Oregon Health & Science University School of Medicine
	The University of Toledo College of Medicine
	University of Arkansas for Medical Sciences College of Medicine
	University of California, Davis, School of Medicine
	University of California, Irvine, School of Medicine
	University of California, Los Angeles, David Geffen School of Medicine
	University of California, San Diego, School of Medicine
	University of California, San Francisco, School of Medicine
	University of Connecticut School of Medicine
	University of Illinois College of Medicine
	University of Iowa Roy J. and Lucille A. Carver College of Medicine
	University of Kentucky College of Medicine
	University of Mississippi School of Medicine
	University of Nebraska College of Medicine
	University of Oklahoma College of Medicine
University of Texas Medical Branch School of Medicine	
University of Texas Southwestern Medical School	
University of Utah School of Medicine	
<p><b>MODEL Bi:</b></p> <p><b>Indirect</b> – Authority is delegated by the State/University to an AHC governing body; the <i>AHC-specific governing body has significant autonomy and authority</i></p>	Medical College of Georgia at Georgia Regents University
	Ohio State University College of Medicine
	University of Alabama School of Medicine
	University of Cincinnati College of Medicine
	University of Florida College of Medicine
	University of Michigan Medical School
	University of New Mexico School of Medicine
	University of North Carolina at Chapel Hill School of Medicine
University of Washington School of Medicine	
<p><b>MODEL Bii:</b></p> <p><b>Indirect</b> – Authority is delegated by the State/University to an AHC governing body; the <i>AHC-specific governing body has limited autonomy and authority</i></p>	SUNY Downstate Medical Center College of Medicine
	SUNY Stony Brook University School of Medicine
	SUNY Upstate Medical University
	University of Missouri, Columbia School of Medicine
	University of South Alabama College of Medicine
	University of Virginia School of Medicine

23 Ownership in whole or in part by the University. University ownership and control will in some cases also correlate to state ownership/control.

<b>Framework II Analysis: Relationship Between the University and the AHC where the <u>CE is Not Owned but is Aligned</u></b>	
<p><b>MODEL Bi:</b></p> <p><b>Indirect</b> – Authority is delegated by the University/state to an AHC governing body; the <b>AHC-specific governing body has <u>significant autonomy and authority</u></b></p>	Indiana University School of Medicine
	Louisiana State University School of Medicine in New Orleans
	Louisiana State University School of Medicine in Shreveport
	Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
	Texas Tech University Health Sciences Center School of Medicine
	The Brody School of Medicine at East Carolina University
	University at Buffalo SUNY School of Medicine & Biomedical Sciences
	University of Arizona College of Medicine
	University of Arizona College of Medicine, Phoenix
	University of Colorado School of Medicine
	University of Louisville School of Medicine
	University of Maryland School of Medicine
	University of Massachusetts Medical School
	University of Vermont College of Medicine
	University of Wisconsin School of Medicine and Public Health
	Virginia Commonwealth University School of Medicine
West Virginia University School of Medicine	
<p><b>MODEL Bii:</b></p> <p><b>Indirect</b> – Authority is delegated by the University/state to an AHC governing body; the <b>AHC-specific governing body has <u>limited autonomy and authority</u></b></p>	Rutgers New Jersey Medical School, Newark
	Rutgers Robert Wood Johnson Medical School
	University of Kansas School of Medicine



## APPENDIX C: INTERVIEW PROTOCOL

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### ***Interviews with National Academic Health Centers***

Telephone interviews were performed with leaders from national AHCs as part of this study. Leaders of the university and/or AHC were selected for the interview based on which individual the organization identified as most able to speak to the governance structure (both state to university and university to AHC) of the institution and impact the governance structure has on the effectiveness of AHC operations.

The interviews were confidential and intended to gain perspectives on governance processes within the organization. Depending on the availability of the individual interviewed, interviews lasted between 30 – 60 minutes.

### ***Interviews with University of Mississippi Stakeholders***

In addition to the national organizations, internal interviews were completed with organizations and institutions within Mississippi (list above). These interviewees were asked similar questions as national interviewees, but asked to elaborate on historical context relevant to Mississippi's current state/history to the extent that this context assisted in development of an accurate representation of governance in the state.

### ***Interview Protocol/Questions***

Below is the interview protocol used to guide each interview:

Introduction: Veralon is partnering with the Center for Mississippi Health Policy in a national study of governance structures for Academic Health Centers. The goal of this study is to identify various governance models and best practices within each. This interview is confidential and intended to gain perspectives on best practice governance processes within your organization and will be compiled with other national interviews completed to identify trends.

#### ***Questions:***

- Describe your current role and history within the organizational governance structure
- Describe your governance model, specifically your relationship with the university and applicable state governing bodies
- What are the advantages of this model? Disadvantages?
- What aspects of this governance structure do you consider a “best practice” or process that works particularly well (e.g., process for building consensus, vetting issues, particular operational aspects, members sitting on more than one board within an organization, specific accountabilities)
- What aspects of this model do you perceive to be unique?
- Describe the powers reserved to the university or state (to the extent you are able); how are these powers enforced in practice (e.g., only in extreme circumstances, or are powers build into specific organizational processes and culture)?
- Have these powers caused issues or tension between boards?
- How are these (or other) issues resolved between boards?

- Does the organization, and specifically the clinical enterprise of the organization, feel it has sufficient access to the board to discuss time-sensitive issues in a timely manner?
- What is the size of the board? How are your board members selected or appointed (e.g., AHC, University, or State governing body)?
- Are there any selection requirements or qualifications?
- What, if any, direct financial relationship/funds flow model(s) exist between the AHC and the state? University?
- How is transparency achieved?
- Describe the board/leadership culture of the board(s); how does this culture contribute to success? What could be improved?
- How are strategies developed? (e.g., brought forth by committees, top-down or bottom-up, other)
- Have you discussed these issues with your peers (either statewide or nationally)? Would they agree with your identified issues, above?
- Would you change how your organization is governed? Why/why not? If so, how?
- Given what you have learned from your organization's journey, if you could be the architect of a new governance structure for your organization, what would be the ideal structure, in your opinion? Why?

## APPENDIX D: UMMC OVERVIEW

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The University of Mississippi Medical Center (UMMC), a \$1.6 billion clinical enterprise, is the health sciences campus of the University of Mississippi, located in Jackson, MS, and is the state's only AHC. UMMC was created by law in 1950 by the Mississippi legislature and subsequently opened on July 1, 1955. The core mission of UMMC is to pursue the "triple mission" of patient care, research, and medical education in support of the University's mission.

UMMC strives to improve the lives of Mississippians by educating tomorrow's health care professionals, conducting health sciences research, and providing cutting-edge patient care. UMMC is comprised of six health science schools: medicine, nursing, dentistry, pharmacy, health related professions, and graduate studies in the health sciences. UMMC also includes University Hospitals and Health System (UHHS) and the University Physicians multispecialty physician practice plan.

As the state's only AHC, UMMC serves a critical role as the educational institution for the state's health professionals. UMMC is independently accredited and the sole provider for baccalaureate and professional degrees in disciplines such as medicine (allopathic), dentistry, physical therapy, occupational therapy, and dental hygiene. In an effort to supply the health professionals required to meet that state's health care needs, Mississippi residents are given priority admission. During the 2014-2015 academic year, 2,900 students were enrolled in 28 degree programs with approximately 600 residents and fellows receiving graduate medical training.

Since opening in 1955, UMMC has gained significant recognition for notable research achievements; UMMC's research programs and facilities have undergone considerable expansion, and extramural research funding has doubled in the past five years – particularly due to increased investments in infrastructure and in the recruitment of additional distinguished research faculty.

UMMC's health care services are divided into two entities: UHHS and University Physicians. UHHS provides wide-ranging patient care programs and houses the teaching hospitals for UMMC educational programs. UHHS includes the state's only Level 1 trauma hospital and serves as a 722-bed diagnostic, treatment and referral care system for the state of Mississippi. Inpatient admissions total approximately 28,000 annually, with more than 418,000 outpatient and emergency visits every year.

***UMMC's Jackson campus includes the following entities:***

- University Hospital: UMMC's 256-bed flagship hospital
- Batson Children's Hospital: Mississippi's only children's hospital
- Winfred L. Wiser Hospital for Women and Infants: Mississippi's only Level IV neonatal intensive care unit
- Wallace R. Conerly Critical Care Hospital: a 70-bed critical care hospital

***Additional UHHS entities include:***

- Holmes County Hospital and Clinics in Lexington, MS
- UMMC Grenada in Grenada, MS

- Jackson Medical Mall: teaching and subspecialty clinics, and the Cancer Institute

University Physicians is UMMC's multispecialty physician faculty practice plan including the state's largest medical group, representing more than 125 specialties. This network of physicians sees about 600,000 patients annually at various locations, including UMMC's hospitals, clinics, and private offices.

## APPENDIX E: UNIVERSITY OF IOWA HEALTH CARE CASE STUDY

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### Introduction

University of Iowa Health Care (UI Health Care), is an integrated health system comprised of UI Hospitals and Clinics (UIHC), the UI Roy J. and Lucille A. Carver College of Medicine, UI Children's Hospital, and UI Physicians. UI Health Care is involved in several innovative healthcare delivery initiatives, including the University of Iowa Health Alliance (UIHA). UIHA is a collaborative agreement between over 20 hospitals and 1,900 physicians to share best practices and strategies for delivering high-value patient care. Additionally, UI Health Care and MercyCare Service Corporation participate in the Medicare Shared Savings Program through a joint venture Accountable Care Organization.

As part of the University of Iowa, UIHC is governed by the Board of Regents, State of Iowa (Board of Regents).

### Key similarities between the UI Health Care and UMMC clinical enterprises include:

- Both enterprises are the sole AMCs of their respective states, serving as regional referral centers and providing critical tertiary and quaternary care services
- The clinical enterprises are similar in size:
- UIHC is a \$1.8B enterprise, including a 730-bed hospital and 32,000 inpatient visits; however, UIHC has significantly more emergency department visits (56,000) and outpatient clinic visits (914,300) than UMMC
- UMMC is a \$1.6B enterprise, with a 722-bed hospital, 28,000 inpatient admissions, and 418,000 total outpatient and emergency visits annually

### Key similarities between University of Iowa and University of Mississippi governance models include:

- The statewide governing board has authority over multiple institutions of higher education:
- The Board of Regents governs three institutions: The University of Iowa, Iowa State University, and University of Northern Iowa
- Mississippi's IHL Board governs eight institutions: Acorn State University, Delta State University, Jackson State University, Mississippi State University, Mississippi University for Women, Mississippi Valley State University, The University of Mississippi, and The University of Southern Mississippi
- The statewide governing board has a healthcare committee on which the entire board serves:
- The Board of Regents' University of Iowa Hospitals and Clinics Committee (UIHC Committee) is a standing committee of the Board, whose primary responsibilities include, but are not limited to:
  - Providing strategic direction and focus to the UIHC
  - Monitoring planning, opportunities, and achievements
  - Reviewing, monitoring, and recommending long-range capital plans
  - Assessing recommendations related to the UIHC
- The IHL Board's Health Affairs Committee is a standing committee providing further oversight over UMMC

- There are similar processes for board member appointments in each state:
- The nine members of the Board of Regents are appointed by the governor and approved by the Senate; members serve staggered six-year terms
- The twelve members of the IHL Board are appointed by the governor and approved by the Senate; members serve staggered nine-year terms

## Discussion

At first glance, the UIHC and UMMC governance structures are extremely similar. However, there are key differences in the way UIHC governance functions that results in highly effective governance over the clinical enterprise.

### 1. *THE UNIVERSITY OF IOWA HEALTHCARE FUNCTIONS AS AN INTEGRATED CLINICAL ENTERPRISE*

An integrated strategic plan guides UIHC, the UI Roy J. and Lucille A. Carver College of Medicine, UI Children's Hospital, and UI Physicians. The plan ensures alignment of strategic goals for clinical quality and service, research, education, people, diversity, and financial growth across all entities within UI Health Care.

### 2. *ESTABLISHMENT OF ADDITIONAL HEALTHCARE-SPECIFIC ADVISORY ELEMENTS*

The clinical enterprise is led by a senior management team headed by the Vice President for Medical Affairs, and the system has a single Chief Financial Officer. Leadership of UIHC, the faculty practice plan, and college of medicine all report to the Vice President of Medical Affairs<sup>24</sup>, and the senior leadership team meets weekly. Other aspects of the clinical enterprise, including Legal, Human Resources, and Information Technology are also integrated across UI Health Care.

The Iowa Board of Regents established a 13-member UI Health Care Board of Advisors (Board of Advisors), in addition to the Board of Regents' University of Iowa Hospitals and Clinics Committee. Comprised of UI Health Care Leadership, University of Iowa Leadership, Board of Regents members, and external independent members, this Board of Advisors advises the University of Iowa President and Vice President for Medical Affairs on policy issues, performance improvement and long-term planning. This Board of Advisors also has a robust sub-committee structure focusing on finance and strategy, audit and compliance, quality/safety and service, and human resources and workforce development for the clinical enterprise.

### 3. *THE FINANCIAL THRESHOLD FOR BOARD OF REGENTS APPROVAL IS SIGNIFICANTLY HIGHER*

A member of the State Board of Regents also serves as a Liaison between UI Health Care leadership and the Board of Regents UIHC Committee, which enhances the communication of UI Health Care-related issues to the Board of Regents.

<sup>24</sup> Components related to the clinical enterprise, including practice plan, hospital and relating teaching programs (staffed by faculty) report to the VPMA; academic components, including all faculty report to the Provost

**4. THE BOARD OF REGENTS LARGELY DEFERS TO THE EXPERTISE OF THE CLINICAL ENTERPRISE'S SENIOR LEADERSHIP TEAM**

The Board of Regents utilizes a tiered process for construction contracts, projects, and capital plans, requests and reports. While the Board Office will review and approve requests between \$250,000 and \$1,000,000, these items do not appear in the Register. Items over \$1,000,000 are submitted to the Board of Regents for review and approval, appear in the Register and receive discussion/consideration during Board of Regents meetings.

Similar to Mississippi, Board of Regents members in Iowa are appointed to govern a system of higher education, and are not chosen specifically for healthcare experience or expertise. As a result, UIHC spends a significant amount of time educating the Board of Regents on relevant healthcare topics and issues. The Board of Regents is accessible to UIHC leadership on a regular basis, outside of the UIHC Committee environment.

While the Board approves budgets, strategic planning initiatives, and building expansions<sup>25</sup>, Board members largely defer to UI Health Care leadership's expertise and experience to guide decisions regarding the CE<sup>26</sup>.

**Conclusion**

The key functionalities of UIHC governance described above culminate in a highly effective clinical enterprise, (as assessed by UIHC leadership). Senior leadership has adequate access to the appropriate governing bodies, and decisions regarding the clinical enterprise can be made in a timely manner. The Board of Regents provides effective and appropriate oversight and guidance for high-level strategic issues, though it defers to the senior leadership team of the CE to manage day-to-day operations. This high degree of autonomy delegated to the clinical enterprise is perceived by the Board of Regents and leadership team as advantageous for remaining innovative and competitive in the healthcare marketplace.

<sup>25</sup> Not intended to be an exhaustive list of Iowa Board of Regents powers.

<sup>26</sup> Per discussion during interview protocol.

## REFERENCES

- About The Board of Trustees.* (n.d.). Retrieved September 16, 2015, from Mississippi Public Universities Web Site: <http://www.mississippi.edu/board/>
- About UMMC.* (n.d.). Retrieved September 16, 2015, from <https://www.umc.edu/Overview.aspx>
- Colenda, C. C., Levin, S., Case, W. J., Murdock, G., Ross, A. J., McClymonds, B., & Charlton, J. F. (2013). *Achieving Alignment in an Academic Health Science System - Creating WVU Healthcare.* The Chartis Group.
- Enders, T., & Conroy, J. (2014). *Advancing the Academic Health Systems for the Future - A Report from the AAMC Advisory Panel on Health Care.* Association of American Medical Colleges.
- Haytt, J. A. (2015). *Restructuring Public Higher Education Governance to Succeed in a Highly Competitive Environment.* Berkeley: Center for Studies in Higher Education, University of California, Berkeley.
- Horn, A. S., Isaak, L., Johnson, A., & Kamata, T. (2013). *State Constitutional Provisions and Higher Education Governance.* Midwestern Higher Education Compact.
- Hutchens, N. (2010). Preserving the independence of public higher education: An examination of state constitutional autonomy provisions for public colleges and universities. *Journal of College and University Law*, 1-30.
- IHL Board of Trustees Policies and Bylaws. (2015, June 18).
- Nelson, C., O'Hanlon, C., Chari, R., Chen, P., Leuschner, K., & Wange, Y. (2015). *Governing the University of California Health System - An Analysis of Issues and Options.* RAND Health.
- SUNY Academic Medical Centers Governance Task Force. (2015, April 22). Governance of the SUNY Academic Medical Centers and their Hospitals.
- Szekendi, M., Prybil, L., Cohen, D. L., Godsey, B., Fardo, D. W., & Cerese, J. (2014). Governance Practices and Performance in US Academic Medical Centers. *American Journal of Medical Quality*, 1-6.
- Szekendi, Marilyn, et al. (2014). *A Study of Hospital Governing Boards and Factors Associated with High Performance in US Academic Medical Centers.* UHC.
- The American Hospital Association's Center for Healthcare Governance. (2012). *Governance Practices in an Era of Health Care Transformation.* Chicago.
- The American Hospital Association's Center for Healthcare Governance. (2014). *National Health Care Governance Survey Report.* Chicago.
- The Blue Ribbon Panel on Health Care Governance. (2007). *Building an Exceptional Board: Effective Practices for Healthcare Governance.* Chicago.
- Wietecha, M., Lipstein, S. H., & Rabkin, M. T. (2009). Governance of the Academic Health Center: Striking the Balance Between Service and Scholarship. *Academic Medicine*, 170-176.