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Governance Best Practices ... Fact or Fiction?

The context for interpreting contemporary industry standards.

In healthcare boardrooms across America, a familiar script unfolds: Trustees review dashboards, discuss finances and remind one another to “stay out of operations.” But what actually works? For decades, governance experts have issued proclamations of best practices, but few have asked the harder questions. Which of these practices are truly proven—and which are more faith than fact?

This article reorders six of the most-cited governance principles from most to least evidence-based, pairing each with examples of systems that thrive despite deviating from them. The pattern that emerges is less about rules than results. Boards succeed not because they follow orthodoxy but because they understand why certain disciplines matter—and where exceptions can serve the mission.

1. Quality First: When the Board Owns Safety, Patients Live Longer Among all governance practices,

one stands tallest among the data. When hospital boards put quality and safety at the top of their agenda, patients fare better—measurably so.

A 2015 *Health Affairs* study by Thomas Tsai and Ashish Jha, MD, found that hospitals whose boards paid greater attention to clinical quality had management that better monitored quality performance, including lower mortality rates. The Institute for Healthcare Improvement created a framework for effective board governance of quality that includes: Establishing quality as a core board responsibility, building trustee knowledge of improvement science and linking the CEO’s evaluation to quality, safety and patient outcomes.

Yet even here, the rule isn’t absolute. Some academic giants—fueled by brand, reputation and brilliant clinicians—sustained elite

outcomes long before their boards became fluent in quality dashboards. Their early success owed more to culture than structure. But when those organizations scaled up, that same culture couldn’t compensate forever; quality governance eventually had to catch up.

2. Trust but Verify: The Data Doesn’t Lie

If the first rule of modern governance is to make quality a board responsibility, the second is to measure it relentlessly. Transparent, accurate and timely data is the backbone of accountable leadership, and measurement extends beyond just quality.

Studies from IHI and the National Quality Forum show that boards who focus on performance data—risk-adjusted, trended and benchmarked—are associated with stronger results. When those metrics are linked to executive incentives, the improvement can compound.

Still, not every success story fits the mold. Some mission-driven systems, particularly those rooted in religious or academic traditions, maintained extraordinary reputations for decades without modern dashboards. Trust and culture filled the gap—until scale, payer pressure and public accountability made those invisible metrics untenable. Also, overreliance on data without considering context can be equally harmful.

Questions to Consider:

- What problem is this “best practice” meant to solve?
- What evidence tells us it is working here?
- If we choose a different path, how will we monitor risk, performance and unintended consequences?

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3. Who Sits at the Table:

Why It's Complicated to Decide

The modern mantra of “competency-based and diverse boards” has strong intuitive appeal and, increasingly, empirical support. A literature review of the research on this topic shows that boards with a mix of expertise—finance, digital, population health, clinical quality—and demographic diversity make more informed, less biased decisions.

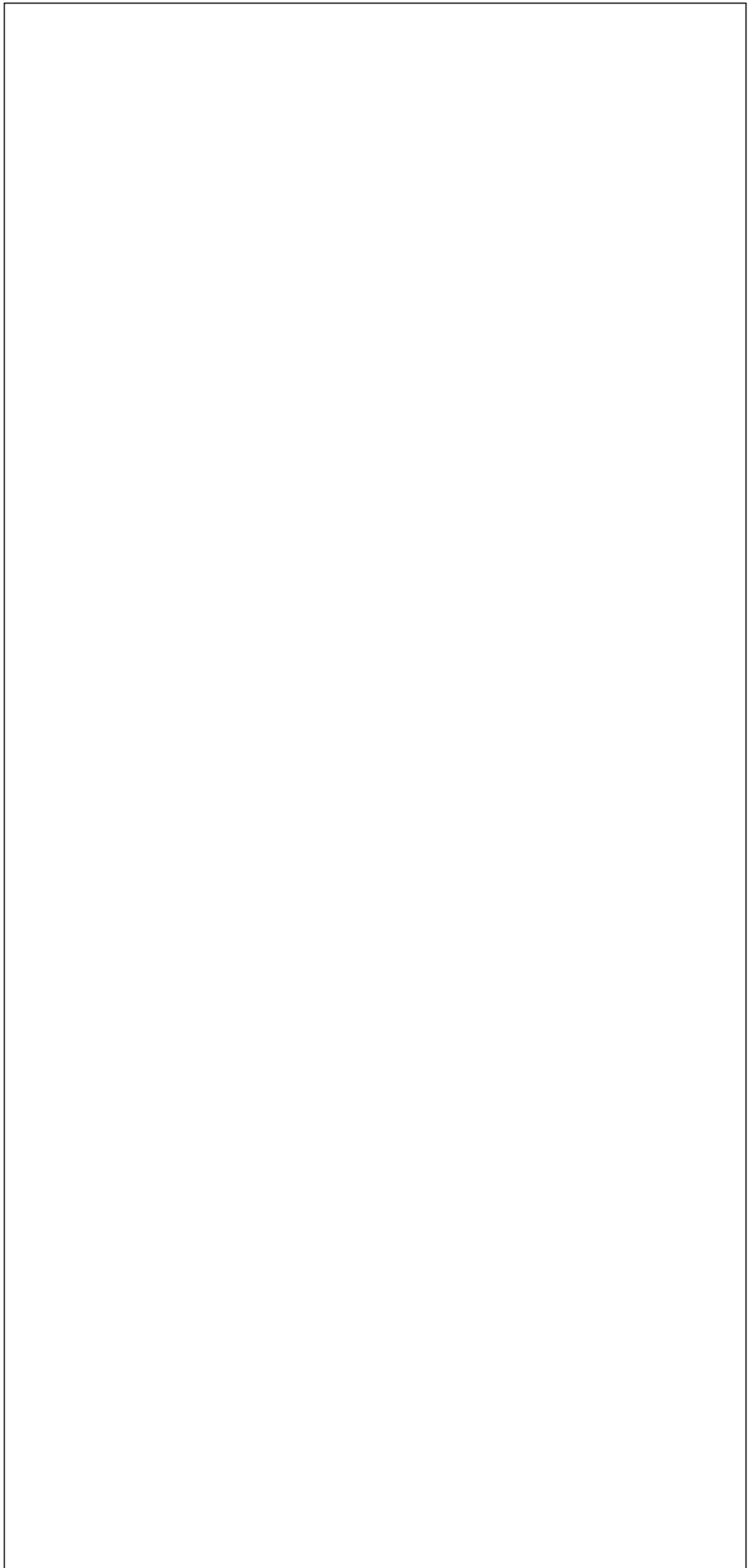
However, Mayo Clinic’s governance model offers a counterpoint. Its board of trustees is composed of one-third Mayo Clinic-employed physicians, and its board of governors includes a majority of physicians. This governance model for Mayo Clinic has consistently produced world-class results. Its key is not external diversity but internal cohesion—a culture that prizes peer accountability and continuous learning.

Competency-based governance, then, is less about representation of all the right skill sets. Diversity alone will not guarantee positive results. Rather, competency and diversity need to be considered in the context of the culture.

Competency has to include effective communication that’s relevant to the organization to ensure multiple perspectives are understood and considered. This is less about a formula and more about shaping culture.

4. The Architecture of Authority: Systems, Subsidiaries and Org Chart Limits

In the age of sprawling health systems, governance often resembles



federalism. Who decides what? The parent board or the local affiliate?

Here, evidence gives way to pragmatism. The Governance Institute, as well as the American Hospital Association's Center for Healthcare Governance, emphasize that systems with clear "reserved powers" and decision-rights maps report fewer conflicts and faster integration. Yet no single model outperforms across all settings.

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In today's world of mergers and acquisitions, finding the right governance model to ensure local needs are met is increasingly becoming a discussion point. This becomes complicated when there are multiple locations that have differing needs but must share limited resources. Centralized systems thrive with tight control and minimal local autonomy; federated systems excel with robust community boards. The success variable isn't structure—it's coherence. Clarity beats complexity, but flexibility beats rigidity.

5. The Perfect-Sized Board: Why There Is No Magic Number

Few topics inspire more consultant PowerPoint slides than board size. Many experts say to keep the number between 12 and 17, and to

simplify the committees. The logic feels right with the idea that smaller groups make faster decisions, and large boards drift toward ceremony.

In nonprofits, smaller boards may deliberate more efficiently, but hospital performance shows no consistent link. This is complicated as there are not great datasets to look at board sizes and outcomes with rigor. Some organizations have larger boards that excel. They likely have numerous mechanisms to manage the larger group to ensure they still have efficient and effective decision-making.

Consider New York-Presbyterian Hospital in New York City, the primary teaching hospital for Weill Cornell Medicine and Columbia University College of Physicians and Surgeons. Its board of trustees is well above the ideal size at nearly 100, yet it consistently ranks as a top 10 hospital by U.S. News and World Report. Process discipline and culture are more important than actual head count.

A small, unfocused board is still a poor one. A large, aligned board can govern a complex enterprise with grace. This does not mean you want a larger board. Instead, it means that if you have excellent performance with a large board, this may be a practice you can cautiously continue.

6. The Board Governs, Management Manages—and Other Comfortable Myths

Perhaps the most widely taught governance principle is also the least evidence-based: Boards set strategy, management executes it.

In theory, that division of labor protects against micromanagement. In practice, it can produce dangerous passivity. For example, during crises—from bankruptcies to COVID-19 surges—some of the most effective boards stepped directly into the operational fray, forming ad hoc task forces on staffing, supply chain or patient throughput. When the emergency passed, they stepped back.

The line between governance and management, it turns out, is less a wall than a membrane. The healthiest systems know how to flex it without tearing it.

Evidence Over Orthodoxy

The hierarchy of governance evidence tells a simple story: The closer a board's actions touch the patient—quality, safety, data, accountability—the stronger the research base. The further the practice drifts into structure and ritual—board size, committee count, formality—the more the evidence thins.

A health system can defy half these governance rules and still thrive if its board is engaged, self-aware and relentlessly focused on outcomes. In governance, as in medicine, best practice is never a substitute for good judgment. When boards consider departing from conventional wisdom, the burden should not be on whether a rule is being broken—but on whether performance is being strengthened. ▲

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