

Governance

in Nonprofit Community
Health Systems

AN INITIAL REPORT ON CEO PERSPECTIVES

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Foreward

Initial Report on Governance in Nonprofit Community Health Systems

Governance of not-for-profit healthcare organizations is one of the most important and talked about topics today, both in healthcare and in government. Healthcare leaders, government officials, the Internal Revenue Service (IRS) and the regulators, bond underwriters, Joint Commission, and the quality and patient safety advocates all are speaking out about the need for competent, engaged, committed healthcare trustees who govern our nation's healthcare organizations with well thought out governance structures, thoughtful and effective governance processes, and measurable outcomes for their healthcare organizations.

This research study, done by researchers at the University of Iowa led by Lawrence Prybil, Ph.D., focuses on three important areas of healthcare governance: board structure and composition; board practices and processes; and board culture. These three areas are often cited as areas of governance that governing boards need to focus on if they are to achieve a strong and effective governing board.

This body of work focuses on community health systems and is phase two of a three-part research study. The report is thorough and comprehensive. It very effectively utilizes and builds on previous research and reports on benchmarks of good governance in healthcare. Particularly impressive is the analysis and commentary that follows the report of findings. Readers will find helpful insights and analysis that can provide guidance into making a board a more effective governing body.

The methodology of the study is clear and has an amazing response rate to its survey of 61 percent. This response provides an excellent database from which the researchers provide very helpful analysis and commentary on the findings.

Important governance topics such as board education and development, community benefit programs and policies, patient care quality and safety are all addressed. Processes boards are using to carry out their governance are described and assessed, along with a very important section on board culture.

The study's recommendations are thoughtful and contain some very helpful ideas for continued healthcare governance improvement. They deal with important governance topics including board development programs, board evaluation processes, board room culture, and board composition. In particular, the study's recommendation regarding the importance of Community Benefit Plans and the board's role in establishing policy, community needs assessment, adopting a formal Community Benefit Plan, ensuring that reporting and accountability mechanisms are in place, and providing a thorough report on the organization's community benefits to their community is particularly impressive. As local, state, and federal governments focus more closely and question more seriously not-for-profit hospitals' commitment to community benefit, this study's research findings and recommendations are particularly helpful.

Phase III of this project, which involves site visits to selected systems, will delve deeper into many of these same topics but Phase II can stand alone as an excellent contribution to the healthcare field's understanding of issues in healthcare governance and how healthcare boards can improve their effectiveness.

Donald C. Wegmiller
Chairman, National Board of Advisors
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I. Introduction

At federal, state, and local levels, there is a growing call for more accountability, greater transparency, and better performance by the boards that govern our nation's investor-owned and nonprofit organizations. This has been heightened by a number of factors, including the visible consequences of governance failures in the business sector,¹ in higher education,² in foundations,³ and in the health field.⁴

These breakdowns have contributed directly to the enactment of stronger federal regulations including Public Law 107-240 (generally known as the "Sarbanes-Oxley Act") and revisions to the Federal Sentencing Guidelines in 2004 which increased the responsibilities of governing boards with respect to corporate compliance and ethics programs.⁵ They also have focused attention on the governance of nonprofit organizations including hospitals and health systems. As stated by James Wiehl:

*Recent events should serve as a lesson to directors of nonprofit organizations that they not only must be cognizant of corporate governance issues, but also must manage the additional responsibility of overseeing the organization's regulatory compliance mechanisms and tax-exempt status.*⁶

The Senate Finance Committee, the House Ways and Means Committee, the Internal Revenue Service, the General Accountability Office, a growing number of state legislatures, and bond rating agencies are among the bodies that are scrutinizing nonprofit healthcare organizations and their governing boards more closely than ever before. Governance oversight of charity care and other forms of community benefit, executive compensation, and the quality of patient care are among the issues that are receiving attention. In effect, the requirements for maintaining tax-exempt status and the expectations for governing boards of nonprofit healthcare organizations are becoming more stringent.⁷

Not surprisingly, growing interest in the performance of nonprofit organizations and their governing boards has resulted in serious examination of governance practices. There is general agreement that proper governance of hospitals and health systems is vital and, for a host of reasons, has become increasingly complex. It also is widely acknowledged that, on the whole, the governance of nonprofit organizations, including hospitals and health systems, should be improved.⁸ In recent years, these factors have stimulated reassessment of the

characteristics and practices of effective boards. Except for requirements established by state statutes, the Internal Revenue Service, and the Joint Commission, formal standards for governance of nonprofit healthcare organizations have not been adopted in the United States. However, in recent years substantial efforts have been made by voluntary commissions, panels, and others to describe good governance practices and provide guidance for boards and chief executive officers to consider as benchmarks in evaluating and improving governance performance.⁹ Some of these benchmarks are well-established and widely accepted; others are in their formative stages. Several of these well-established and some emerging benchmarks will be discussed in Section III of this report.

Concurrent with the growing cry for better performance by governing boards, America's healthcare delivery system has continued an evolution from mostly freestanding institutions into larger groupings.¹⁰ For example, the number of non-governmental, nonprofit healthcare systems increased from 311 in 2000 to 369 in 2005, an increase of 19 percent. By 2005, the proportion of non-governmental, nonprofit hospitals affiliated with these systems had increased to 56 percent and, according to the American Hospital Association, continues to grow.¹¹ Similar trends are occurring in other industrialized countries.¹²

One of the principal features of this transformation has been the development of various forms of community-based health networks or systems.¹³ They take many forms, from loose affiliations to highly integrated systems with centralized governance and management.¹⁴ These community-based networks or systems include a substantial and growing proportion of our hospitals and provide a substantial volume of inpatient and outpatient services. However, while the body of knowledge regarding governance in general has expanded substantially in recent years, there is relatively little information about governing boards and governance practices in community-based healthcare systems.¹⁵

These three patterns — heightened interest in the duties and performance of governing boards, advances in formulating benchmarks of good governance, and limited knowledge about governing boards and governance practices in a growing segment of healthcare organizations — provided the impetus for this study of governance in community health systems.

II. Purpose and Methodology

Purpose of the Study

This study examines selected aspects of governance in a set of nonprofit, community health systems. For this study, “community health systems” are defined as:

Nonprofit healthcare organizations that (1) operate two or more general-acute and/or critical access hospitals and other healthcare programs in a single, contiguous geographic area and (2) have a chief executive officer and a system-level board of directors who provide governance oversight over all of these institutions and programs.

Some community health systems that meet this definition are independent while others are part of larger, nonprofit parent organizations. This study includes both categories. The critical characteristic is that the system includes an integrated governance and management structure that has oversight responsibility for the system’s hospitals and other healthcare programs.

The overall purpose of this study is to examine the structures, practices, and cultures of community health systems’ governing boards and compare them to selected benchmarks of good governance. The intent is two-fold: first, to identify areas where, on the whole, governance of these systems could be improved and, second, to provide information that will assist the systems’ chief executive officers and board leaders in assessing and enhancing the boards’ effectiveness.

The overall study design involves three principal components: identifying a set of community health systems that meet the definition set forth above (Phase I); a survey of the chief executive officers to obtain their opinions and some descriptive information about governance in these systems (Phase II); and on-site visits to a subset of the systems to conduct interviews with the chief executive officers and board leaders (Phase III). This initial report provides summary information about the survey conducted in 2007. The on-site visits will be conducted early in 2008 and the final, comprehensive study report will be published later that year.

Research Methodology

The methodology for the first two phases of this study is detailed in Appendix A. In brief, Phase I involved working with the American Hospital Association (AHA), the Health Research and Educational Trust (HRET), and 21 regional and national healthcare organizations to identify community health systems that would meet the criteria stated in the previous section.¹⁶ This process was conducted between July 2006 and January 2007. It resulted in the identification of 210 nonprofit community health systems that appeared to meet the established criteria and a database with descriptive information about these systems and their hospitals.

Phase II involved a mail survey of the chief executive officers (CEOs) of the community health systems included in our preliminary study population. This survey had two aims: to verify that the systems met our established criteria and to obtain the CEOs’ input on certain aspects of their respective board’s structure, practices, and culture. The questions in the survey form were limited to those the team believed could be answered accurately by CEOs without extensive investigation. Draft versions of the survey form were pre-tested independently by three CEOs and refined on the basis of their input.

The survey forms with individualized cover letters and a one-page overview of the study were distributed in February 2007. A follow-up mailing was sent to non-respondents in March 2007. The second mailing included another copy of the survey form and offered the CEOs an optional procedure for completing the form electronically. Finally, follow-up phone calls were made in the April-June time frame to randomly selected non-respondents to encourage their participation in the study.

The overall purpose of this study is to examine the structures, practices, and cultures of community health systems’ governing boards and compare them to selected benchmarks of good governance.

TABLE 1

Profile of the Study Population

| | No. of Community Health Systems | No. of General-Acute and/or Critical Access Hospitals in These Systems | Average No. of General-Acute and/or Critical Access Hospitals in These Systems |
|---|---------------------------------|--|--|
| Independent Systems | 131 | 485 | 3.7 |
| Usable Responses to the Mail Survey | 79 (60.3%) | — | — |
| Systems That Are Part of 16 Regional or National Parent Organizations | 70 | 227 | 3.2 |
| Usable Responses to the Mail Survey | 44 (62.9%) | — | — |
| TOTAL STUDY POPULATION | 201 | 712 | 3.5 |
| TOTAL USABLE RESPONSES | 123 (61.2%) | — | — |

Table 1 shows the results of this data collection process. The final study population includes 201 nonprofit community health systems; 131 of these are independent organizations (65 percent), while 70 are part of larger regional or national organizations (35 percent). These 201 community health systems include 712 hospitals, or about 25 percent of the 2,958 non-governmental, nonprofit community hospitals in the United States.^{17,18} The number of hospitals in these systems ranges from two to nine, with an overall average of 3.5 general acute and critical access hospitals per system.

Usable survey forms were completed and returned from 123 of the 201 systems in the study population, a response rate of 61 percent. In general, these 123 systems are very representative of the study population (see Appendix A). The survey forms were quite complete, with little missing data. As part of the process of reviewing the survey responses in preparation for entering the data into an electronic spreadsheet, follow-up telephone calls were made to CEOs and/or their executive assistants in instances where a response was missing or unclear. The CEOs and their assistants invariably were helpful and, as a result, the survey data set is virtually complete.

III. Survey Findings

An important responsibility in designing any study is defining its scope and selecting the variables that will be examined. Previous work in the healthcare field has identified attributes that influence board performance. In recent years, considerable progress has been made in translating those learnings into benchmarks of good governance in healthcare organizations. Using a framework of three research objectives, this survey examines certain aspects of governance structures and practices in nonprofit community health systems and compares them to contemporary benchmarks. This phase of the study focuses on CEO opinions and basic descriptive information that can be obtained through mail survey methods. This initial report presents survey findings for community health systems that are part of regional or national organizations and compares them to the findings for independent systems that are not affiliated with a larger parent organization.

RESEARCH OBJECTIVE #1:

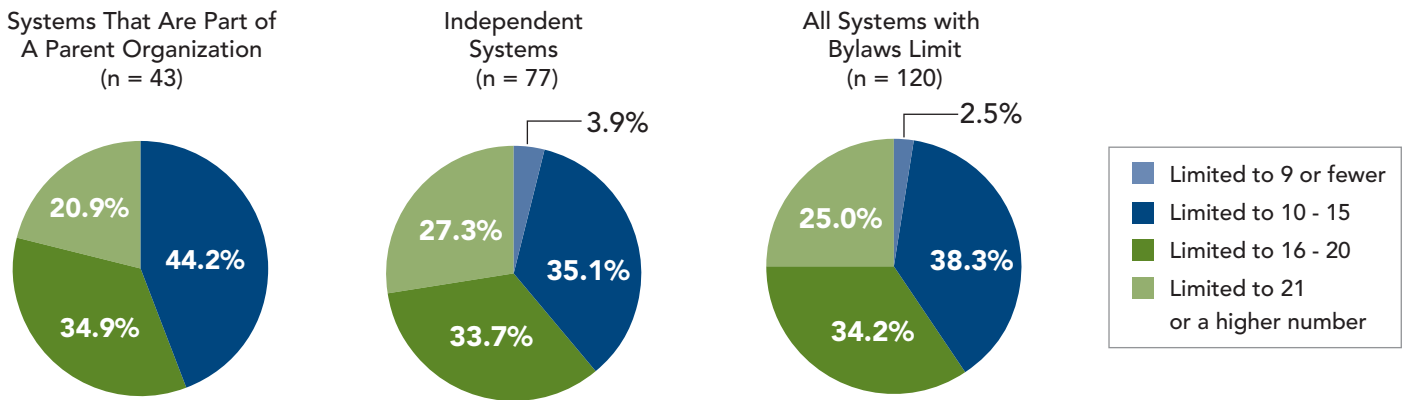
EXAMINE THE STRUCTURE AND COMPOSITION OF COMMUNITY HEALTH SYSTEM BOARDS

Bylaws Limits on Numbers of Voting Members

For many reasons, a basic benchmark of good governance is to establish a limit on the number of voting members who can serve on a governing board.¹⁹ Without clear boundaries and a need to balance new appointments with retirements of longtime directors, boards can become stale and/or too large. This survey found that systems that are part of larger parent organizations and independent systems predominantly comply with this benchmark. In both groups, 98 percent of the systems' bylaws establish limits. Table 2 shows what those limits are.

TABLE 2

Bylaws Limit on Number of Voting Members



Size of Boards

In general, the size of governing boards in hospitals and healthcare systems has grown smaller over the years but appears to be stabilizing.²⁰ It is increasingly acknowledged that large, unwieldy boards tend to be inefficient and do not contribute positively to governance effectiveness. For example, the recent report of the HRET Blue Ribbon Panel on Health Care Governance recommended a range of nine to 17 members for hospital and health system boards.²¹

This survey found that the average size of community health system boards falls within this range; the average number of voting members on the boards of systems that are part of parent organizations and independent systems is virtually identical: 16.5 for the former and 16.7 for the independent systems. This is somewhat larger than nonprofit hospital boards, which average 13 to 14 members.²²

It should be noted that the boards of nonprofit hospitals and health systems are considerably larger than the boards of America’s public companies. A 2006 study of 798 public

companies by the National Association of Corporate Directors (NACD) found that their average board size was nine members. It is worth noting that 80 percent of the CEOs and board members who participated in this NACD study expressed the view that their current board size is “just right.”²³

Board Composition

Table 3 shows the composition of community health system boards. In the aggregate, boards of systems that are part of larger parent organizations clearly have more clinicians — both physicians and nurses — as compared to independent systems. Recent national surveys have found that physicians constitute approximately 20 percent of hospital and health system boards.²⁴ The boards of independent community health systems have a similar physician component. However, boards of systems that are part of parent organizations include a somewhat larger proportion (over 25 percent) of physicians.²⁵

TABLE 3
Clinician Composition of System Boards

| | Systems That Are Part of a Parent Organization | | Independent Systems | | All Board Members | |
|--------------------------------|--|-------|---------------------|-------|-------------------|-------|
| | # | % | # | % | # | % |
| Physician Members | 183 | 25.2 | 270 | 20.5 | 453 | 22.1 |
| Nurse Members | 27 | 3.7 | 21 | 1.6 | 48 | 2.4 |
| Other Members | 517 | 71.1 | 1,028 | 77.9 | 1,545 | 75.5 |
| All Voting Members | 727 | 100.0 | 1,319 | 100.0 | 2,046 | 100.0 |
| X ² = 16.6; p < .01 | | | | | | |

It is worth noting that 80 percent of the CEOs and board members who participated in this NACD study expressed the view that their current board size is “just right.”

The National Quality Forum, the Institute for Healthcare Improvement, and other prominent healthcare organizations have urged hospital and health system boards to engage clinical leaders in developing goals and strategies for improving the quality of patient care. For this and other reasons, involving capable, committed physicians on governing boards and board committees has become widely accepted as a good governance practice.²⁶ It is clear that, on the whole, the composition of community health system boards meets this benchmark.

Table 3 also provides data regarding the involvement of nurses on the boards of community health systems. As with physicians, the boards of systems that are part of parent organizations have a higher proportion of nurses as voting members (3.7 percent) than independent systems (1.6 percent). Engaging leaders in the nursing profession on hospital and health system boards has not yet become the norm or accepted as a benchmark of good governance. However, given the importance of nursing in the provision of patient care, it seems likely that the idea of engaging nurses on boards and board committees will receive growing consideration in the future. As Donald Berwick has stated,

*It is key that nurses be as involved as physicians, and I think boards should understand that the performance of the organization depends as much on the well-being, engagement, and capabilities of nursing and nursing leaders, as it does on physicians. I would encourage much closer relationships between nursing and the board.*²⁷

TABLE 4
Racial Composition of System Boards

| | Systems That Are Part of Parent Organizations | | Independent Systems | | All Board Members | |
|-------------------------------|---|-------|---------------------|-------|-------------------|-------|
| | # | % | # | % | # | % |
| Non-Caucasian Members | 102 | 14.0 | 141 | 10.7 | 243 | 11.9 |
| Caucasian Members | 625 | 86.0 | 1,178 | 89.3 | 1,803 | 88.1 |
| All Voting Members | 727 | 100.0 | 1,319 | 100.0 | 2,046 | 100.0 |
| X ² = 4.7; p < .05 | | | | | | |

Gender and Diversity Mix

In the healthcare field and other sectors, there is agreement that the membership of governing boards must include persons with a strong blend of pertinent experience and skills in order to perform their fiduciary duties effectively. Increasingly, it is recognized that the boards of nonprofit, tax-exempt organizations also should include members with diverse backgrounds including, but not limited to, ethnic, racial, and gender perspectives.²⁸

Table 4 shows the proportion of non-Caucasians serving on the boards of community health systems that are part of parent organizations (14.0 percent) collectively is higher than the corresponding figure for the boards of independent systems (10.7 percent). Similarly, Table 5 shows that the proportion of females serving on the boards of systems that are part of parent organizations (33.4 percent) is much larger than the corresponding figure for the boards of independent systems (18.7 percent). The differences in both areas are statistically significant.

These data show that 12 percent of the board members in these 123 community health systems are non-Caucasian, and 24 percent are female. By way of comparison, a national study of hospital boards in 2005 found that nine percent were non-Caucasians, and 23 percent were female.²⁹ In general, community health system and hospital boards are similar on these measures of diversity.

TABLE 5

Gender Composition of System Boards

| | Systems That Are Part of Parent Organizations | | Independent Systems | | All Board Members | |
|--------------------------------|---|-------|---------------------|-------|-------------------|-------|
| | # | % | # | % | # | % |
| Female Members | 243 | 33.4 | 247 | 18.7 | 490 | 24.0 |
| Male Members | 484 | 66.6 | 1,072 | 81.3 | 1,556 | 76.0 |
| Total Voting Members | 727 | 100.0 | 1,319 | 100.0 | 2,046 | 100.0 |
| X ² = 54.8; p < .01 | | | | | | |

The survey also found that 98.4 percent of these 123 community health systems have one or more female members; 77.2 percent include non-Caucasians. A recent study that examined the governing boards of 248 nonprofit organizations — including foundations, colleges and universities, and hospitals — had virtually identical findings: 98 percent of these organizations had females on their boards, and 77 percent had diverse membership in terms of racial and ethnic make-up; by way of comparison, a 2007 study of companies in the S & P 500 found that only 91 percent had one or more females on their boards.³⁰

So, the boards of community health systems as a whole are quite similar to the boards of other nonprofit organizations with respect to these measures of diversity. However, the board composition of systems affiliated with larger parent organizations is substantially more diverse as compared with the boards of independent systems.

TABLE 6

CEO Membership on System Boards

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Board Members (n=123) |
|-------------------------------|--|----------------------------|---------------------------|
| Voting Member and Board Chair | 0.0% | 0.0% | 0.0% |
| Voting Board Member | 90.9% | 79.7% | 83.7% |
| Non-Voting Board Member | 6.8% | 11.4% | 9.8% |
| Not a Member of the Board | 2.3% | 8.9% | 6.5% |
| | 100.0% | 100.0% | 100.0% |

CEO Membership on System Boards

In the investor-owned sector, there have been calls from numerous independent bodies to separate the positions of chief executive officer and board chairman or, alternatively, to designate a non-executive board member to serve as “lead director.” Non-executive lead directors preside over executive sessions of the non-executive directors and perform other leadership functions.³¹ Combining the board chair and CEO roles is uncommon among charitable, nonprofit organizations, including hospitals and health systems. However, over the past 20 years there has been a definite trend to provide hospital and health system CEOs with ex-officio voting membership on the board of the organization they lead.

These patterns are clearly reflected in the data presented in Table 6. None of the CEOs of the community health systems concurrently chair their system’s board of directors.

Among systems that are part of parent organizations, over 90 percent of CEOs are voting members of their boards; 80 percent of the CEOs who lead independent systems enjoy this status. These figures are higher than reported in a 2007 Governance Institute survey of hospitals and healthcare systems, which found only 48 percent of the CEOs were voting members of their respective boards.³² It is likely this is a reflection of the more diverse set of institutions included in the Governance Institute's study, including a large proportion (24 percent) of governmental facilities.

Board Oversight for Specific Governance Functions

The fundamental fiduciary duties of the governing boards of nonprofit healthcare organizations are well-codified and widely accepted.^{33,34} As stated in Section I, however, there is considerable concern about the effectiveness with which governing boards in nonprofit (and investor-owned) organizations are performing those duties.³⁵ Numerous studies and expert panels have suggested that boards that adopt a proactive role and are actively engaged in governance work are more likely to demonstrate effective performance than boards that are less involved.³⁶ As stated in the 2003 Report of the American Bar Association Task Force on Corporate Responsibility:

*... sound corporate governance [depends] upon the active and informed participation of independent directors and advisors who act vigorously in the best interests of the corporation. . . .*³⁷

It is widely agreed that a well-organized committee structure with knowledgeable, engaged members is one of the keys to effective governance.³⁸ Clear allocation of oversight responsibility for vital governance functions is a benchmark of good governance. In some situations, a board may choose to handle oversight for a particular governance function as a "committee of the whole." However, given the complexity of today's healthcare environment and the array of issues that boards must address, direct oversight responsibility for governance functions generally must be assigned to board committees working within parameters established by the

board and consistent with applicable law. Table 7 shows the CEOs' responses to the following question: "Regardless of its exact name, does your board have a standing committee with clear oversight responsibility for the following governance functions throughout your community health system?"³⁹ The findings with respect to five key governance functions are as follows:

Audit Functions. Inadequate auditing programs and poor governance oversight of audit functions have been instrumental in several corporate scandals in both investor-owned and nonprofit organizations.⁴⁰ It is now widely accepted that assuring the integrity of corporate auditing programs is a fundamental governance responsibility and that strong board oversight of external and internal audit functions is imperative.⁴¹ As stated in a recent report by the Panel on the Nonprofit Sector, established in 2004 with the encouragement of the Senate Finance Committee:

*Every charitable organization that has its financial statements audited, whether or not it is legally required to do so, should consider establishing an audit committee composed of independent members with appropriate financial expertise.*⁴²

The data in Table 7 show that a higher proportion of independent system boards have assigned oversight responsibility for external and internal audit functions to standing committees than systems that have parent organizations. The difference between the groups is statistically significant. It is possible, perhaps likely, that governance oversight of audit functions for systems that are part of parent organizations has been centralized at the corporate level. This question will be pursued in Phase III of this study, which will involve on-site visits to a selected subset of the community health systems that participated in this baseline survey.

TABLE 7

Proportion of Community Health System Boards That Have Assigned Clear Oversight Responsibility for Selected Governance Functions to Standing Committees*

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--|--|----------------------------|---------------------|
| External Audit X ² = 20.3; p < .01 | 63.6% | 94.9% | 83.7% |
| Internal Audit X ² = 5.0; p < .05 | 72.7% | 88.6% | 82.9% |
| Executive Compensation X ² = 30.6; p < .01 | 59.1% | 97.5% | 83.7% |
| Board Education and Development | 43.2% | 53.2% | 49.6% |
| Community Benefit Programs | 52.3% | 38.0% | 43.1% |
| Patient Quality and Safety | 86.4% | 88.6% | 87.8% |

* This table compares, on each variable, the proportion of positive responses for the two groups of systems.

Executive Compensation Programs. The importance of governance control over executive compensation programs is increasingly recognized.⁴³ The level of public interest in executive compensation is growing, and governmental rules and sanctions have become more demanding.⁴⁴

It is not surprising, therefore, to find that nearly all (98 percent) of the governing boards of independent community health systems have assigned “clear oversight responsibility” for executive compensation functions to a standing board committee. In contrast, this is true in only 59 percent of systems that are part of parent organizations. Again, the observed difference is statistically significant and, quite possibly, reflects centralization of governance oversight for executive compensation programs at the parent organization level.

Board Education and Development. The governance of healthcare organizations has become increasingly complex as a result of economic, environmental, legal, and technological changes. Accordingly, sustained commitment to a well-designed board education and development program has become a basic benchmark of good governance.⁴⁵ In this

context, it is surprising that fewer than half of all community health system boards have assigned clear responsibility for board education and development to a standing board committee. It is possible that the other boards have opted deliberately to guide and monitor governance development activities as a “committee of the whole” and that this is being done effectively. However, it also is possible that this important responsibility is being performed in an informal, ad hoc fashion. Board practices with respect to board education and development programs will be examined more fully in the next phase of this study.

Community Benefit Programs. In total, only 43 percent of these community health system boards have assigned oversight responsibility for their organizations’ community benefit programs to a standing board committee. Given the growing questions at the national, state, and local levels about the extent to which nonprofit healthcare organizations are providing community benefit and deserve tax-exempt status, it is clear that concerted board-level attention to this area is necessary and important. Board practices with respect to the systems’ community benefit programs are discussed more fully in a later part of this report.

Patient Care Quality and Safety. On a more positive note, nearly 90 percent of the community system boards have assigned oversight responsibility for their organizations’ patient care quality and safety functions to a standing board committee. Monitoring and evaluating the quality of patient care and ensuring the safety of patients, staff, and visitors is one of the governing board’s most important responsibilities. Strong, effective board oversight of patient care quality and safety programs is, without question, one of the most fundamental standards of good governance today.⁴⁶ Obviously, assigning oversight responsibility to a standing committee is only one step in meeting that standard.

Board-Approved Definitions of Committee Responsibilities

Assigning definitive oversight responsibility for a particular governance function to a standing committee (or explicitly deciding it will be performed by the board as a whole) is a good governance practice. However, when oversight responsibility is delegated to a board committee, the committee’s role and duties should be spelled out in a written form that will be clear to all parties.⁴⁷

Table 8 shows CEO responses to the following questions: “Do [your board’s] committees have clearly defined responsibilities that are spelled out in a written document (i.e., a ‘charter’) that has been formally approved by the system’s board of directors?” According to their CEOs, 71 percent of all community health system boards meet this standard for all of their board committees. Ideally, there would be this level of clarity in the role and duties of every committee that carries out important functions on behalf of the governing board.

TABLE 8

Proportion of Community Health Systems Whose Standing Committees’ Responsibilities Have Been Spelled Out in a Written Document and Formally Approved by the System Board

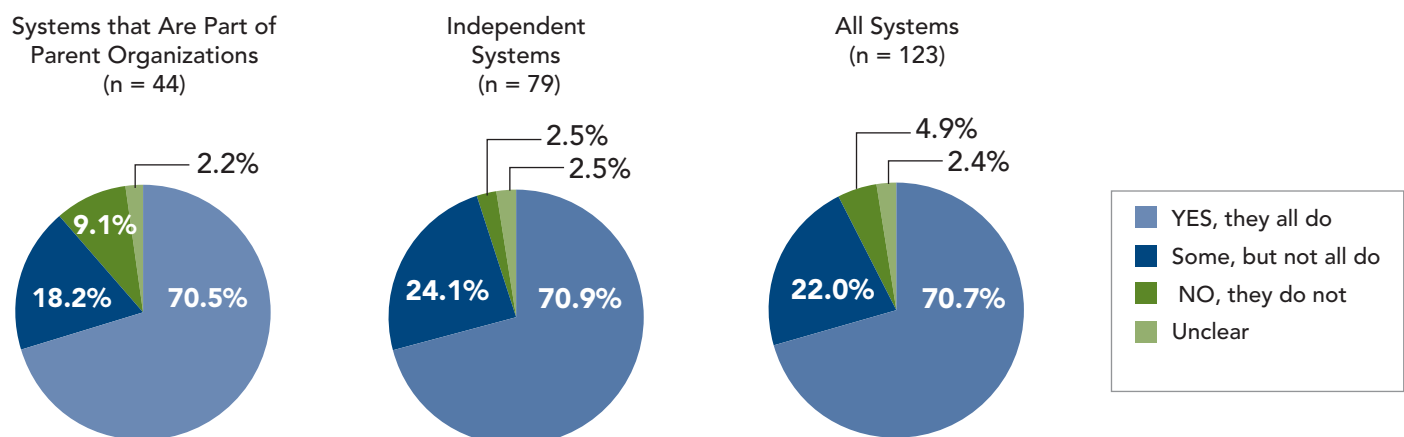
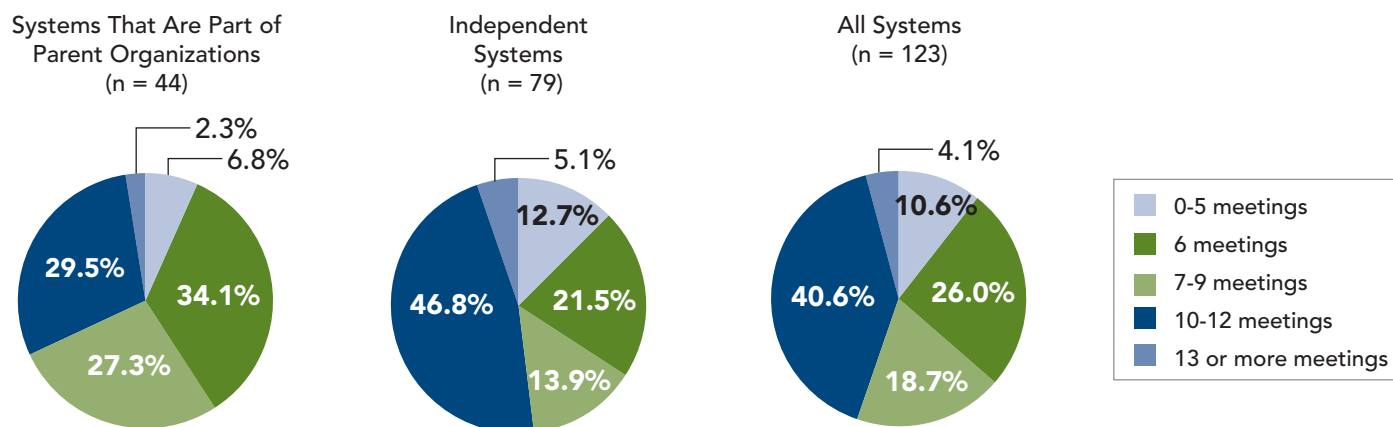


TABLE 9

Number of Times the Board Has Met in the Past 12 Months



RESEARCH OBJECTIVE #2:

EXAMINE SELECTED PRACTICES AND PROCESSES OF COMMUNITY HEALTH SYSTEM BOARDS

Board Meetings

Having a pre-established schedule of meetings is a good governance practice. There will be occasions that require special, called meetings, but this should be the exception. The CEOs of all 123 community health systems that participated in this survey reported that their boards have a predetermined, regular schedule of meetings. The frequency with which these boards meet is shown in Table 9. The overall pattern is very similar for systems that are part of parent organizations and independent systems. On the whole, the independent system boards meet a little more frequently (mean average of 8.8 meetings per year as compared to 7.8 for those that have parent organizations), but the differences are not statistically significant.

CEO Evaluation

For both investor-owned and nonprofit organizations, appointing the CEO, establishing his or her performance expectations, and assessing the CEO's performance in relation to those expectations are among a governing board's most fundamental and important duties. Evaluating the CEO's performance fairly, objectively, and regularly is beneficial for the CEO, the board, and the organization as a whole — and has become accepted as a fundamental benchmark of good governance.⁴⁸

National surveys suggest that a majority of governing boards now assess their CEO's performance using some form of pre-set criteria. For example, a 2007 study of hospitals and health systems found that 91 percent of the boards follow a "... formal process for evaluating the CEO's performance."⁴⁹ A 2006 survey of 798 public companies found that 73 percent of the boards have established "... specific and measurable goals for the CEO's performance."⁵⁰

There will be occasions that require special, called meetings, but this should be the exception.

The data in Table 10 show the proportion of community health system boards that have established written performance expectations for their CEO. Consistent with recent studies in several sectors, written performance expectations now are established for a large majority (over 90 percent) of the CEOs who participated in this survey, either by their community health system board or — for some of those who are affiliated with parent organizations — at the corporate level.

The 88 CEOs whose performance expectations are established by their community health system boards were

asked whether or not those expectations include targets in several specific areas. Their responses are shown in Table 11. As would be expected, of the 88 community health system boards that establish written performance expectations for their CEOs, 100 percent include specific financial targets. Given the importance of measuring, monitoring, and improving the quality of patient care and safety provided by these systems, it is good to see that performance expectations for 99 percent of these CEOs now include targets in this area.⁵¹ However, it is surprising that the performance expectations for only 68 percent of these CEOs address leadership team development.

TABLE 10

“Does the Community Health System Board Establish Written ‘Performance Expectations’?”
(e.g. specific objectives and/or criteria for the system’s CEO?)

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--|--|----------------------------|---------------------|
| Yes | 45.5% | 86.1% | 71.6% |
| No | 2.3% | 11.4% | 8.1% |
| Done by the System’s Parent Corporation, Not at the Community System Level | 52.2% | 0.0% | 18.7% |
| Unclear | 0.0% | 2.5% | 1.6% |
| $X^2 = 43.8; p < .01$ | 100.0% | 100.0% | 100.0% |

TABLE 11

Targets That Are Regularly Included in CEO Performance Expectations*

| | CEOs of Systems That Are Part of Parent Organizations (n=20) | Independent System CEOs (n=68) | All Responses (n=88) |
|----------------------------|--|--------------------------------|----------------------|
| Financial Targets | 100.0% | 100.0% | 100.0% |
| Patient Quality and Safety | 100.0% | 98.5% | 98.9% |
| Leadership Team Building | 60.0% | 70.6% | 68.2% |
| Community Benefit Targets | 90.0% | 48.5% | 58.0% |
| $X^2 = 10.9; p < .01$ | | | |

*This table compares, on each variable, the proportion of positive responses for the two groups of systems.

TABLE 12

CEOs' Opinions About Their Community Systems' CEO Evaluation Process

| | CEOs of Systems That Have Parent Organizations (n=20) | CEOs of Independent Systems (n=68) | All Responses (n=88) |
|---|---|------------------------------------|----------------------|
| The process is not well-organized and not very productive. | 0.0% | 1.5% | 1.1% |
| A process is in place and has been somewhat beneficial for the CEO and our organization. | 5.0% | 32.4% | 26.1% |
| The process provides clear performance expectations and assesses actual performance fairly. | 95.0% | 66.1% | 72.8% |
| X ² = 6.5; p < .05 | 100.0% | 100.0% | 100.0% |

With respect to community benefit programs, 90 percent of the CEOs who lead systems that are part of parent organizations have performance targets in this area as compared with only 49 percent of the CEOs in independent systems. This difference is statistically significant. It is possible, perhaps likely, that the parent corporations have encouraged (or required) their subsidiary system boards to establish specific expectations for their CEOs in this important area. In the current environment, establishing clear expectations for the CEO regarding community benefit programs is a good governance practice.

Nearly all of the CEOs — 100 percent of those who lead systems affiliated with parent organizations and 98 percent of those who lead independent systems — report that their community health system board formally evaluates their actual performance in relation to the established targets “. . . on a regular basis.” The vast majority of these CEOs also state that adjustments in their financial compensation “. . . are linked directly to the results of their performance evaluation” (100 percent of the CEOs in systems with parent organizations and 96 percent in independent systems).

The fact that a performance evaluation process is in place does not necessarily mean that it is done well or that it is perceived as beneficial by the employee. A recent survey of 2,000 employees in several large public companies found that only 39 percent believe their performance reviews are effective.⁵² With respect to CEO performance evaluations, numerous experts have raised serious questions about the rigor and efficacy of these processes.⁵³

The 88 CEOs whose community health system boards establish their performance expectations were asked their opinions about the effectiveness of the CEO evaluation process currently in place. Their views are shown in Table 12. It seems clear that, on balance, the CEOs of systems that are part of parent organizations are pleased with their boards' current CEO evaluation process. The CEOs of independent systems are much less sanguine, and the observed differences are statistically significant. Given the importance of the CEO evaluation to all parties, every community health system board of directors, in concert with its CEO and independent experts, should regularly assess and make improvements to its existing CEO evaluation policy and procedures.

In the current environment, establishing clear expectations for the CEO regarding community benefit programs is a good governance practice.

Board Evaluation

Serious examination of a board's structure, membership composition, and core practices on an ongoing basis — along with real commitment to make changes as a result of these examinations — are among the keys to improving governance effectiveness.⁵⁴ Studies have demonstrated that objective assessment coupled with proper development programs can improve board performance.⁵⁵

For these reasons, many bodies with regulatory or quasi-regulatory responsibilities in the healthcare field and other sectors (e.g., the Joint Commission and the New York Stock Exchange) have called for governing boards to conduct self-assessments on a regular basis. However, it is clear that the type of self-evaluation in which boards engage varies widely in rigor, results, and value. As stated by Beverly Behan:

*Rather than a robust and rigorous process that helps boards figure out whether they're doing the right work in the right way, we too often see a mechanical exercise in ticking off the boxes on a formulaic checklist often borrowed from another company. A board can get away with that and confidently report one more area where it complies with New York Stock Exchange rules. However, it will waste an opportunity if it does nothing to increase its effectiveness or value to the company and its stakeholders . . . almost every board could find ways to do its job better.*⁵⁶

So, good governance practice in this area is not merely to conduct some form of board self-assessment on a periodic basis. Instead, it is to invest the resources required to objectively assess the board and its performance against established benchmarks and, subsequently, to take action to make changes required to improve the board's structure, practices, and performance.⁵⁷

Tables 13 and 14 show that a large majority of the community health system boards meet the first part of this standard. About 90 percent do engage in “formal assessment” of how well they carry out their fiduciary duties; of those, nearly all conduct an assessment on a regular basis, either annually or every other year.

The second part of the standard — making changes based on the results of the assessment process — is a more stringent test. The data presented in Table 15 represent one probe of the community health systems' willingness to take action. Fifty-six percent of the CEOs whose boards conduct formal self-assessments state that these processes in the past two years resulted in actions that “substantially changed” their boards' practices.

The data suggest that, for well over 40 percent of system boards, their investment of time and other resources in assessment processes did not produce substantive changes or, presumably, improvements. It is possible that these assessment processes concluded there was no need for “substantial changes” in the boards' current structure, composition, or practices. However, the data raise questions about the extent to which assessment processes are making a meaningful impact in improving governance, at least in a substantial segment of these community health systems. The efficacy of board self-assessment processes will be studied more closely in Phase III of this study, the on-site visits to a subset of these community health systems.

Fifty-six percent of the CEOs whose boards conduct formal self-assessments state that these processes in the past two years resulted in actions that “substantially changed” their boards' practices.

TABLE 13

“Does the community health system board engage in formal assessment of how well it is carrying out its own duties?”

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|-----|--|----------------------------|---------------------|
| Yes | 90.9% | 89.9% | 90.2% |
| No | 9.1% | 10.1% | 9.8% |
| | 100.0% | 100.0% | 100.0% |

TABLE 14

“How frequently does the board engage in a formal, overall assessment of its performance?”

| | Boards of Systems with Parent Organizations That Assess Their Performance Regularly (n = 40) | Independent System Boards That Assess Their Performance Regularly (n = 71) | All Boards That Do Assess Their Performance Regularly (n = 111) |
|-----------------|--|--|---|
| Annually | 80.0% | 76.1% | 77.5% |
| Every Two Years | 17.5% | 19.7% | 18.9% |
| Other | 2.5% | 4.2% | 3.6% |
| | 100.0% | 100.0% | 100.0% |

TABLE 15

“Over the past two years, has the board assessment process resulted in actions that have substantially changed the board’s practices?”

| | Boards of Systems With Parent Organizations (n=40) | Independent System Boards (n=71) | All Boards (n=111) |
|-------|--|----------------------------------|--------------------|
| Yes | 62.5% | 52.1% | 55.9% |
| No | 32.5% | 47.9% | 42.3% |
| Other | 5.0% | 0.0% | 1.8% |
| | 100.0% | 100.0% | 100.0% |

Community Benefit Policies, Plans, and Reports

The landmark work of the Commission on Hospital Care during and after World War II led to the enactment of the Hospital Survey and Construction Act of 1946 (Public Law 79-725). This legislation, commonly referred to as the “Hill-Burton Act,” became Title VI of the Public Health Service Act. It represented the first large-scale policy instrument for shaping hospital and health services planning in the United States. To become eligible for hospital construction grants, states were required to establish hospital planning agencies, assess existing facilities and needs, and set statewide priorities. During the following decades, the Hill-Burton Act stimulated several thousand hospital construction and renovation projects, reshaped the nation’s health services delivery system, and introduced the concept that nonprofit, tax-exempt healthcare facilities should serve defined community needs.⁵⁸

Historically, tax-exempt status was accorded to nonprofit hospitals and health systems on the premise that the fundamental reason for their existence was to provide charity care to persons who needed healthcare services but were unable to pay for them. The original Hill-Burton legislation required facilities receiving grants to provide free care for 20 years to eligible individuals unable to pay for their services; facilities funded with grants under Title XVI in later years were required to provide uncompensated care in perpetuity.⁵⁹ In 1965, Congress enacted Public Law 89-97, which established the Medicare and Medicaid programs and significantly expanded health insurance coverage for elderly and poor Americans. In 1969, the Internal Revenue Service (IRS) issued a Revenue Ruling that embodied a broader rationale for granting tax-exempt status to nonprofit institutions: the so-called “Community Benefit Standard.”⁶⁰ In this Ruling, the IRS reasoned that providing healthcare services for the general benefit of the community is inherently a charitable purpose and spelled out the factors that would be considered in granting tax-exempt status.^{61, 62}

As time passed and the healthcare field experienced major economic, legislative, and structural changes, questions began to arise about the adequacy and appropriateness of the Community Benefit Standard as the basis for tax exemption.

In 1991, the House Ways and Means Committee held hearings on proposed legislation designed to make a hospital’s tax-exempt status contingent upon providing a defined level of charity care, and the IRS initiated a series of audits to examine the charitable activities of several large healthcare organizations. During the same period, prompted in part by growing need for revenues, several states and local governmental bodies began to challenge hospitals’ exemption from property and other taxes.⁶³ As stated in 1994 by J. David Seay:

This public policy debate has led us to the point where nonprofit hospitals must either concede their tax-exempt status or articulate in clear and convincing terms why they should retain this socially important and fiscally significant form of social approbation.⁶⁴

In subsequent years, the debate about the Community Benefit Standard and requirements for maintaining tax-exempt status has escalated. Various forms of community benefit requirements (such as a specific level of charity care) and/or standard reporting of community benefit activities have been established in at least 22 states.⁶⁵ However, while it is vague and lacks the force of law, the Community Benefit Standard remains the principal federal guidance for nonprofit healthcare organizations regarding community benefit requirements. In 2005, the General Accountability Office (GAO) issued a report that critically assessed the level of charitable services provided by the nation’s non-governmental healthcare institutions. It concludes, in part, that:

... current tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred. If these criteria are articulated in accordance with desired goals, standards could be established that would allow nonprofit hospitals to be held accountable for providing services of benefit to the public commensurate with their favored tax status.⁶⁶

In mid-2007, the national dialogue about charity care and other forms of community benefit was informed by substantive reports issued by the IRS and the Senate Finance Committee.⁶⁷ In brief, these included:

- On June 14, 2007, the IRS issued a proposed revision of Form 990 that must be submitted annually by all tax-exempt organizations, including hospitals and health systems. The proposed form, specifically Schedule H, called for much more information about several topics including charity care and other components of community benefit, executive and board compensation, and certain aspects of organizational governance. The IRS received voluminous comments about the proposal and, on December 20, 2007, published the version that will be used in the 2008 tax year. The IRS intends to issue instructions to assist in completing the updated Form 990 “early in 2008.”⁶⁸
- On July 17, 2007, Senator Charles Grassley (ranking minority member of the Senate Finance Committee) released a “minority staff discussion draft” containing a host of potential changes to the standards currently applied to tax-exempt healthcare organizations, including the existing Community Benefit Standard.
- On July 19, 2007, the IRS issued an interim report on its Hospital Compliance Project that studied community benefit activities in 487 hospitals. Among the principal observations set forth in the interim report is that 97 percent of these hospitals state they have a written policy on “uncompensated care.” However, the IRS found no uniform definition of this term and, in addition, found wide variation in the activities and level of expenditures that hospitals report as “community benefit.”⁶⁹

A number of voluntary associations such as the AHA, the Alliance for Advancing Nonprofit Healthcare, the Catholic Health Association (CHA), the Health Research and

Educational Trust (HRET), the Public Health Institute, and the VHA have encouraged healthcare organizations to better document the services they provide and how they benefit the communities they serve. Historically, however, there have been no federal-level regulatory guidelines to be used by healthcare organizations to measure and report the full range of services that constitute “community benefit.” For the most part, nonprofit providers have been reluctant to adopt and implement uniform definitions and guidelines on a voluntary basis.⁷⁰ The lack of comprehensive, comparable data has been a cause of consternation for the Senate Finance Committee and other Congressional committees for some time.⁷¹ The updated Form 990, specifically the revised Schedule H, is intended to address this problem and provide more complete and consistent information for governmental officials, healthcare organizations, and the public at large.⁷²

Just as the long debate about requirements for tax-exempt status is beginning to yield more uniform definitions and reporting expectations, it also appears that some basic benchmarks for governance practices are beginning to emerge. The survey findings in relation to several of these emerging benchmarks are as follows:

Engagement. Proactive engagement and transparency are hallmarks of good governance. The Coalition for Nonprofit Health Care has called for trustees to be “. . . more vigorous in exercising their oversight responsibilities” and “. . . more inquisitive on matters requiring their attention.”⁷³ The American Bar Association Task Force on Corporate Responsibility has stated that boards must engage in “. . . active, independent, and informed oversight of the corporation’s business and affairs. . . .”⁷⁴ Given the increasing pressure on nonprofit healthcare organizations to demonstrate how their community benefit activities justify tax-exempt status, it seems clear that serious, ongoing dialogue by governing boards about community benefit issues is becoming a necessary and important governance practice.⁷⁵

Just as the long debate about requirements for tax-exempt status is beginning to yield more uniform definitions and reporting expectations, it also appears that some basic benchmarks for governance practices are beginning to emerge.

TABLE 16

“Does the community health system board have formal discussions on a regular basis about the system’s community benefit responsibilities and programs?”

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--------------------------------|--|----------------------------|---------------------|
| Yes | 93.2% | 58.2% | 70.7% |
| No | 6.8% | 41.8% | 29.3% |
| X ² = 15.0; p < .01 | 100.0% | 100.0% | 100.0% |

In this context, the CEOs of community health systems were asked whether or not their boards engage in “. . . formal discussions on a regular basis about their system’s community benefit responsibilities and programs.”⁷⁶ The data in Table 16 indicate that 93 percent of CEOs who lead systems that are part of larger, parent organizations respond affirmatively as compared to 58 percent of independent system CEOs. This difference is statistically significant. It appears that, on the whole, the boards of community health systems affiliated with larger parent organizations are more actively engaged in dialogue about their community benefit responsibilities and programs than the boards of independent systems. It is possible, perhaps likely, that the parent corporations are encouraging or requiring the leadership of their subsidiary units to place this important subject on their governance and management agendas.

Formal Policy. Active board-level dialogue is a necessary ingredient but, in itself, is insufficient to provide clear direction and priorities for the organization and its management team. To govern effectively, board deliberations must produce sound, well-constructed policies regarding vital areas of the organization’s structure and functions. Given the importance of maintaining tax-exempt status and the increasing attention being given to community benefit issues, it seems evident that adopting policies that provide guidance for programs and services is emerging as a benchmark of good governance for all nonprofit healthcare organizations, including community health systems.⁷⁷

In this survey, CEOs were asked if their community health system board has adopted “. . . a formal written policy that defines overall guidelines for the system’s community benefit programs.” As shown by the data in Table 17, in community health systems that are part of larger, parent organizations, 82 percent of the system boards have adopted formal written policies to guide the system’s community benefit programs. In contrast, less than half (49 percent) of the independent system boards have taken this step. This difference is statistically significant and indicates that a substantial segment of our nation’s nonprofit community health systems currently are operating without formal board direction and guidance for their community benefit programs and services.

Community Needs Assessment. For years, many organizations, including the AHA,⁷⁸ the CHA,⁷⁹ the Public Health Institute,⁸⁰ HRET, and others, have encouraged hospitals and health systems to institute formal processes to assess community needs — preferably in partnership with other community agencies — to provide a solid foundation for setting priorities and allocating resources. As stated in the CHA’s Guide for Planning and Reporting Community Benefit:

Meeting the access and community health needs of our communities requires an assessment of community needs and assets and prioritization of needs and problems. A well-thought-out and systematic planning process is critical to having a community benefit program that builds on community assets, promotes collaboration, and improves community health⁸¹

TABLE 17

“Has the community health system board adopted a formal, written policy that defines overall guidelines for the system’s community benefit programs?”

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|-----------------------|--|----------------------------|---------------------|
| Yes | 81.8% | 49.4% | 61.0% |
| No | 18.2% | 50.6% | 39.0% |
| $X^2 = 11.2; p < .01$ | 100.0% | 100.0% | 100.0% |

The Finance Committee “minority staff discussion draft” regarding potential community benefit reforms and proposed amendments to the existing Community Benefit Standard released on July 17, 2007, call for assessing community needs on a regular basis. The AHA has made a similar recommendation to the nation’s hospitals.⁸² It seems apparent that board-level insistence on systemwide involvement in community needs assessment, preferably in collaboration with other community agencies, as a basis for setting community benefit priorities and allocating resources is an emerging benchmark of good governance for nonprofit hospitals and health systems.

The CEOs who participated in the survey were asked if their community health system “. . . engages in a formal assessment process designed to determine community needs in the system’s area to which system resources should be allocated.” The data in Table 18 show that more than half of these community health systems (54 percent) conduct formal assessments of community health needs on a regular basis, either independently or in collaboration with other organizations. Collaborative approaches are more common among systems that are part of larger, parent organizations (41 percent) than among independent systems (23 percent).

TABLE 18

“Does the system engage in a formal assessment process designed to determine community needs to which system resources should be allocated?”

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|---|--|----------------------------|---------------------|
| YES, the system conducts <u>its own</u> formal community needs assessment process on a <u>regular</u> basis. | 18.2% | 27.8% | 24.4% |
| YES, the system <u>collaborates</u> with other local organizations in a community needs assessment process on a <u>regular</u> basis. | 40.9% | 22.8% | 29.3% |
| YES, the system <u>periodically</u> engages in community needs assessment but not on a <u>regular</u> basis. | 25.0% | 25.3% | 25.2% |
| NO | 15.9% | 24.1% | 21.1% |
| | 100.0% | 100.0% | 100.0% |

A quarter of all systems engage in assessing community health needs “periodically” but not on a regular basis; one in five is not involved at all. It seems apparent that the absence of formal, board-approved policies regarding community benefit programs in 39 percent of these community health systems is reflected in the lack of attention to formal assessment of community needs paid by a substantial proportion of them.

Formal Community Benefit Plan. For all organizations, resources are limited and good stewardship by governance and management is imperative. As stated by Michael Porter and Mark Kramer, “No business can solve all of society’s problems or bear the cost of doing so.”⁸³ For nonprofit hospitals and health systems, adoption by the governing board of a formal plan for the organization’s community benefit program is becoming a benchmark of good governance.⁸⁴ These community benefit plans should set direction and provide benchmarks against which performance can be assessed.

The CEOs were asked if their community health system’s governing board has adopted a formal “community benefit plan” that provides measurable objectives for their system’s community benefit program. The data presented in Table 19 show that on an aggregate basis, only 36 percent of these

systems have a formal, board-adopted community benefit plan in place. Another 40 percent of the boards have established some “priorities” for their systems’ community benefit programs but have not developed or adopted formal plans. Of the community health systems that are affiliated with larger parent organizations, well over half (55 percent) have formal, board-adopted plans versus 25 percent of the independent systems. The difference is statistically significant. The adoption of a formal plan is a good governance practice; however, it is certainly possible that some systems without formal plans have robust community benefit programs.

Performance Reports. As with other facets of system operations, adopting a plan is important but, in and of itself, does not fulfill the governing board’s oversight responsibility. Boards also should receive regular reports regarding the system’s community benefit program, including performance data regarding progress in relation to established objectives.⁸⁵

The findings presented in Table 20 show that 68 percent of community health boards regularly receive performance data regarding progress toward systemwide objectives established for their organizations’ community benefit programs. Consistent with the pattern found on other community

TABLE 19

“Has the community health system board adopted a formal community benefit plan that spells out measurable systemwide objectives for the organization’s community benefit program?”

| | Systems That Are Part of a Parent Organization (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--|---|----------------------------|---------------------|
| YES, there is a formal, board-adopted community benefit plan of this nature in place. | 54.5% | 25.3% | 35.8% |
| The system board has established some <u>priorities</u> for the system’s community benefit program, but, at this point, there is not a <u>formal plan</u> of this nature in place. | 31.8% | 44.3% | 39.8% |
| NO, not yet. | 11.4% | 30.4% | 23.6% |
| Other | 2.3% | 0.0% | 0.8% |
| X ² = 14.0; p < .01 | 100.0% | 100.0% | 100.0% |

TABLE 20

“Is the community health system board regularly presented with performance data on measurable systemwide objectives regarding its community benefit programs?”

| | Systems That Are Part of a Parent Organization (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|----------------------|---|----------------------------|---------------------|
| Yes | 86.4% | 58.2% | 68.3% |
| No | 13.6% | 41.8% | 31.7% |
| $X^2 = 9.1; p < .01$ | 100.0% | 100.0% | 100.0% |

benefit issues, the figure for systems that are part of a larger, parent organization is much higher than the independent systems (86 percent versus 58 percent). This difference is statistically significant. Without measurable objectives and evidence-based progress reports, it is difficult (if not impossible) for a board to fulfill its oversight responsibilities for its organization’s community benefit program or to hold the management team accountable for results.

In general, the survey findings regarding community health system board oversight with respect to community benefit programs suggest there is a considerable gap between current practices and emerging benchmarks of good governance. The gap is significantly greater for the boards of independent systems as compared with systems affiliated with larger, parent organizations. There has not been extensive research regarding this subject; however, these findings are consistent with the results of previous work by Shouou-Yih Lee, Jeffrey Alexander, and Gloria Bazzoli:

With few exceptions, a significantly greater involvement of system and network hospitals was found in providing community health services and inpatient services to Medicaid patients relative to freestanding hospitals ... In general, affiliation with health systems and health networks appears to be positively related to community responsiveness in community hospitals.⁸⁶

Monitoring and Assessing the Quality of Patient Care

In healthcare organizations, ensuring that organizational standards for the quality of patient care are established and that continuous improvement processes are in place are among the board’s most fundamental responsibilities. Based on evidence provided in a series of landmark reports by the Institute of Medicine and numerous other studies, it is clear that the overall quality of clinical care provided by our nation’s hospitals and health systems is uneven and needs to be improved.⁸⁷ To accomplish this, proactive board leadership will be necessary. However, available evidence suggests that the levels of board knowledge and engagement in quality assessment and improvement processes are often inadequate.⁸⁸ As Donald Berwick has stated:

I would like to see more boards feel as committed and as responsible to quality as they do to finances. I think we have a leadership gap, a board gap. I’m awaiting the moment when boards decide that, if care is going to get better on their watch, they are going to have to do something, instead of just observing it.⁸⁹

It is vital for health system boards to understand the quality of patient care their organizations provide, engage proactively with management and clinical leadership in quality improvement processes, and establish metrics for monitoring progress. In today’s environment, these are basic benchmarks of good governance practices.⁹⁰

The CEOs of community health systems were asked their opinion about their boards' current role with respect to the quality of patient care. The data in Table 21 indicate that 59 percent of these boards formally adopt core measures and standards for quality of patient care within their systems while 28 percent delegate this responsibility to a board committee. In the balance of these systems (14 percent), measures and standards for the quality of patient care are not set at the system level at all. In these cases, it is unclear how the boards address their systemwide responsibilities with respect to patient care quality and safety.

Accurate, concise, and timely information is essential to enable effective governance in every sector of American enterprise. For hospital and health system boards, receiving formal reports regarding organizational performance in

relation to established quality targets on a regular basis has become a benchmark of good governance.⁹¹ The data presented in Table 22 suggest that current board practices in community health systems are consistent with this benchmark. Ninety-six percent of the CEOs report that their boards receive formal, written reports about systemwide and hospital-specific performance in relation to established quality targets on a regular basis. The responses from independent systems and those from systems that are affiliated with a larger parent organization are very similar. It is likely there is great variation in the form and content of the quality reports these boards receive. This will be examined in Phase III of this study. However, it appears that the majority of nonprofit community system boards are beginning to heed Donald Berwick's call to embrace "stewardship of quality" as a fundamental board duty.⁹²

TABLE 21

"Which statement best describes (your) community health system's role in the quality of patient care?"

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--|--|----------------------------|---------------------|
| The system board formally adopts the core measures and standards for quality of patient care. | 54.6% | 60.8% | 58.6 % |
| A board <u>committee</u> adopts the core measures and standards and shares them with the board, but the board does <u>not</u> formally adopt them. | 31.8% | 25.3% | 27.6% |
| Measures and standards for quality of patient care are <u>not done at the system level</u> ; this function is handled by the hospitals and other healthcare organizations within the system. | 13.6% | 13.9% | 13.8% |
| | 100.0 % | 100.0% | 100.0% |

Accurate, concise, and timely information is essential to enable effective governance in every sector of American enterprise.

TABLE 22

“Does the community health system board regularly receive formal written reports on systemwide and hospital-specific performance in relation to established measures and standards for the quality of patient care?”

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--|--|----------------------------|---------------------|
| YES, it does. | 97.7% | 95.0% | 96.0% |
| NO, this information is received and handled by a board committee. | 2.3% | 2.5% | 2.4% |
| NO, reporting and monitoring the quality of patient care is a function that is handled by the hospitals and other health-care organizations within our system. | 0.0% | 2.5% | 1.6% |
| | 100.0% | 100.0% | 100.0% |

RESEARCH OBJECTIVE #3:

EXAMINE GOVERNANCE CULTURE IN COMMUNITY HEALTH SYSTEMS

Effective boards understand their role and fiduciary responsibilities, are actively engaged in the work of governance, and accept accountability for their performance and the performance of the organization they govern. Over time, either deliberately or not, every board of directors creates a governance culture — a pattern of beliefs, traditions, and practices that prevail when the board convenes to carry out their duties. Each board is responsible for shaping its own culture. As stated by JoAnn Reed:

Good governance is hard work. Boards must develop a culture of accountability and engagement. Board leaders should pay strict attention to how much board time is spent passively listening to reports and how much time is spent discussing strategic issues and the duties of care and loyalty. Active and vigorous board discussion, debate, and questioning is not only a sign of a good

*board, it is the sign of an engaged board. Board members should not allow a “don’t-ask-questions” culture to thrive and become the norm. An open culture of cooperation and transparency is healthy and will attract skilled board members.*⁹³

In too many cases, boards are insufficiently committed, the governance culture is passive, and the result is underperformance.⁹⁴ There is a growing belief that effective governance requires a proactive culture of commitment and engagement that drives both the board and the organization it governs toward high performance.⁹⁵

In recognition of the importance of governance culture on performance, the HRET Blue Ribbon Panel — composed of senior board leaders, CEOs, governance consultants, and university faculty members with experience in governance research and service — recently examined board culture. Based on previous studies and their collective experience, the panel identified the features the members believe characterize an “effective board culture.” The panel selected 11 key characteristics.⁹⁶

Community health system CEOs were asked to indicate the extent to which their systems' boards of directors demonstrate these characteristics. Their opinions are presented in Table 23. There are no established benchmarks against which to assess the CEOs' responses. However, the data show that a large majority of the CEOs (over 89 percent) believe their boards always demonstrate commitment to their community health systems' mission. On the other hand, less than half of all CEOs believe their boards always review core governance

processes on a regular basis (43 percent), systematically define their needs for expertise and recruit new board talent to meet those needs (41 percent), recognize the importance of ongoing board education (45 percent), and hold board members to high standards of performance (46 percent). With respect to these and other characteristics, it is clear that there is plenty of room to improve governance culture within these community health systems.

TABLE 23

CEOs' Opinions on the Extent to Which Their Boards Demonstrate the HRET Blue Ribbon Panel's Characteristics of Effective Board Culture

| | Systems That Are Part of Parent Organizations (n=44) | | Independent Systems (n=79) | | All Systems (n=123) | |
|---|--|-----------|----------------------------|-----------|---------------------|-----------|
| | ALWAYS | SOMETIMES | ALWAYS | SOMETIMES | ALWAYS | SOMETIMES |
| (a) The board's actions demonstrate commitment to our organization's mission. | 90.9% | 9.1% | 88.6% | 11.4% | 89.4% | 10.6% |
| (b) The board's core governance processes (e.g., ongoing oversight of financial performance, CEO evaluation, etc.) are reviewed regularly to identify ways to improve them. | 50.0% | 50.0% | 39.2% | 60.8% | 43.1% | 56.9% |
| (c) The board systematically defines its needs for expertise and recruits new board members to meet these needs. | 50.0% | 50.0% | 35.4% | 64.6% | 40.7% | 59.3% |
| (d) Our organization's performance (financial and clinical) is tracked closely by the board and actions are taken when performance does not meet our targets. | 79.5% | 20.5% | 69.6% | 30.4% | 73.2% | 26.8% |
| (e) The board places high priority on addressing long-range strategic issues that confront our organization. | 61.4% | 38.6% | 67.1% | 32.9% | 65.0% | 35.0% |
| (f) Board meetings are characterized by high enthusiasm. | 52.3% | 47.7% | 50.6% | 49.4% | 51.2% | 48.8% |
| (g) There is an atmosphere of mutual trust among the board members. | 72.7% | 27.3% | 70.9% | 29.1% | 71.5% | 28.5% |
| (h) Board members clearly recognize the importance of ongoing board education. | 52.3% | 47.7% | 40.5% | 59.5% | 44.7% | 55.3% |
| (i) Board leadership holds board members to high standards of performance. | 52.3% | 47.7% | 41.8% | 58.2% | 45.5% | 54.5% |
| (j) Constructive deliberation is encouraged at board meetings. | 63.6% | 36.4% | 72.2% | 27.8% | 69.1% | 30.9% |
| (k) Respectful disagreement <u>and</u> dissent are welcomed at board meetings. | 52.3% | 47.7% | 58.2% | 41.8% | 56.1% | 43.9% |

*For each characteristic, the figure in **bold** type indicates which group of CEOs (those who lead community health systems that are part of larger parent organizations or those who lead independent systems) rated their boards higher. The differences in their responses were not statistically significant. The 11 characteristics, with some abbreviations, were adopted from *Building an Exceptional Board: Effective Practices for Health Care Governance*, op cit, p. 14.

TABLE 24

“Over the past 12 months, how would you characterize your system board’s approach to making decisions on important issues?”

| | Systems That Are Part of a Parent Organization (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|--|---|----------------------------|---------------------|
| The board tends to be passive and reactive in its approach to decision-making. We need to find ways to get the board much more engaged. | 0.0% | 1.3% | 0.8% |
| The board is involved in <u>some</u> issues, but its level of engagement is inconsistent. The board’s decision-making process would benefit from more dialogue and debate. | 22.7% | 29.1% | 26.8% |
| The board tends to be <u>actively</u> engaged in discourse and decision-making processes. Most board members are willing to express their views and constructively challenge each other and the management team. | 77.3% | 69.6% | 72.4% |
| | 100.0% | 100.0% | 100.0% |

The differences between the opinions expressed by CEOs who lead systems affiliated with larger parent organizations versus those who lead independent systems are not statistically significant. However, on eight of the 11 characteristics, the CEOs of systems that are part of parent organizations assess their boards’ culture more positively than the CEOs of independent systems. This finding may suggest a pattern that can be pursued in Phase III of this study. It will include on-site interviews with board members regarding boardroom culture and other matters.

The fiduciary role and responsibilities of governing boards require them to make many decisions that shape organizations and their direction. The manner in which the board approaches and conducts its decision-making processes is a fundamental component of its culture and has a major impact on the organization’s performance.⁹⁷ As one way to gauge this dimension of the community health systems’ board culture, the CEOs were asked to characterize their systems’ approach to making decisions on important issues. Table 24 presents their responses. From the CEOs’ perspectives, over 72 percent of these boards tend to be “. . . actively engaged in

discourse and decision-making” and most of the board members “. . . are willing to express their views and constructively challenge each other and the management team.” The balance (28 percent) view their boards of directors to be either passive or inconsistent in their level of engagement in decision-making processes. To the extent that the assessment of these CEOs is correct, the performance of these boards in their decision-making role does not meet a fundamental benchmark of good governance.

Another indicator of governance culture is how a board allocates its meeting time. The time that board members devote to their governance duties is a valuable asset that is not always used well. As expressed by Sydney Finkelstein and Ann Mooney:

. . . if a board deems a matter important and strategic enough to require their involvement, they must make the effort to address that decision comprehensively. The problem is, however, that boards often tackle problems in a less than comprehensive manner; they often address decisions with little depth, avoid seeking help from experts, and limit their exploration of decision alternatives.⁹⁸

TABLE 25

“Over the past 12 months, what is your best estimate of how the meeting time of your community health system’s board (not board committees) has been allocated among the following subjects?”

| | Systems That Are Part of Parent Organizations (n=44) | Independent Systems (n=79) | All Systems (n=123) |
|---|--|----------------------------|---------------------|
| Strategic planning (including updating the system’s strategic plan, reviewing progress reports, etc.) | 26.5% | 27.6% | 27.2% |
| Oversight of patient care quality | 24.1% | 22.3% | 23.0% |
| Oversight of financial performance | 23.9% | 25.9% | 25.2% |
| Oversight of community benefit program | 7.7% | 6.9% | 7.2% |
| Monitoring the CEO’s performance in relation to established expectations | 7.6% | 6.6% | 6.9% |
| Board development (including board succession planning, recruitment, education, performance evaluation, etc.) | 10.2% | 10.7% | 10.5% |
| | 100.0% | 100.0% | 100.0% |

Table 25 displays the CEOs’ estimate of how their boards have allocated their meeting time over the past 12 months. Perhaps the most striking feature of these data is the similarity of how boards that are part of larger parent organizations and boards that govern independent systems allocate their time. Their CEOs’ estimates of how the boards employ their time are, on the whole, very consistent between these two groups.

A second finding is that the community health system boards, on a combined basis, have devoted 23 percent of their meeting time to patient care quality and safety issues during the past year. The Institute for Healthcare Improvement and others have urged hospital and health system boards to spend 25 percent or more of their meeting time on quality and safety issues, so these boards are fairly close to this benchmark.⁹⁹

According to their CEOs, community system boards currently are allocating around a quarter of their meeting time respectively to strategic planning issues, quality and safety issues, and financial issues. These three subjects — all vitally important — collectively consume over 75 percent of community health system board meeting time.

Phase III of this study will examine more fully the reasons why these boards choose to allocate meeting time as they do and how it reflects governance culture in these organizations.

Examining and trying to understand the culture of any organization or group is difficult terrain. This survey of community health system CEOs tried to gain some initial insight into the boards’ cultures on a short set of questions. More detailed inquiry will be required to understand the cultures of these boards and how they may differ by size, type, and other characteristics.

Examining and trying to understand the culture of any organization or group is difficult terrain.

IV. Conclusions and Recommendations

Exhibit 1 summarizes the survey findings presented in Section III. At this point in their evolution, many benchmarks of good governance are not expressed in quantitative terms so the precise degree to which organizations meet them cannot be determined. Still, overall patterns emerge from the findings and provide a foundation for the following conclusions.

1. On the whole, governance in community health systems appears to be substantially consistent with current benchmarks in 11 areas. In the same sequence that the findings are presented in Section III and in Exhibit 1, these areas include:

- Clear limits on the number of voting board members
- Board size is consistent with the range (nine to 17 members) recommended by the HRET Blue Ribbon Panel on Health Care Governance
- Substantial involvement of physicians in governance roles
- Inclusion of CEOs as voting members of the board
- Pre-established and regular schedules for board meetings
- Written performance expectations for CEOs with respect to financial targets and quality of patient care targets (though not consistently in other areas)
- Formal and regular evaluation of CEO performance in relation to established targets
- Direct linkage of CEO compensation adjustments to results of CEO evaluation processes
- Formal and regular evaluation by boards of how well they are performing their duties
- Receiving formal and regular reports on system performance with respect to quality of patient care
- Demonstrated commitment to the system's mission

2. The governance of community health systems that are part of larger parent organizations is more consistent with current benchmarks as compared with independent systems in several areas, including:

- Greater racial and gender diversity in board composition
- Providing written performance expectations for CEOs
- Conducting CEO evaluation processes that set clear performance expectations and fairly assess actual performance
- Taking actions that substantially change governance practices on the basis of board assessment processes
- Proactive engagement regarding the system's community benefit programs including regular boardroom dialogue, collaboration with other local organizations in community needs assessment, adoption of systemwide policies and plans, and formal reports on the system's performance in relation to established objectives

3. The governance of independent systems is more consistent with current benchmarks than systems affiliated with parent organizations in one area: i.e., their boards are significantly more likely to have standing board committees with clear oversight responsibility for three governance functions: internal audit, external audit, and executive compensation. As stated in Section III, it is likely that governance oversight of these functions for systems that have parent organizations has been centralized at the corporate level. This question will be pursued in the next phase of the overall study.

4. However, as shown by the findings presented in Section III and summarized in Exhibit 1, there are gaps between present reality and current benchmarks in a majority of the dimensions of governance addressed in this report. This is to be expected because benchmarks are targets to which organizations should aspire; they evolve over time, and perfection is an ideal that is unlikely to be attained.

At this time, the gaps are somewhat greater for independent systems than for those affiliated with parent organizations, but they are evident in both groups. All of the benchmarks of good governance addressed in this report are attainable. According to information provided by the CEOs, each of the benchmarks is being met by many systems at this time. If community health system boards wish to improve their performance, and we believe most if not all do, this report suggests a number of areas where attention can and should be directed.

Recommendation #1

The governing boards of community health systems and their CEOs are encouraged to take a close look at their existing board development programs and, on the basis of that review, adopt a strong commitment and a concrete plan for improving them.

According to their CEOs, fewer than half of the community health system boards have a standing committee with assigned oversight for ongoing board orientation, education, and development, even though this is a fundamental board duty. Every board of directors should build and maintain a solid, comprehensive development program (See End Note #45 for a list of key components) as a core strategy for improving their effectiveness. A standing board committee — perhaps a new “Governance Committee” — should be assigned oversight responsibility for it. One of the principal priorities of these programs should be ensuring that the entire board membership is very familiar with current and emerging benchmarks of good governance. Boards are responsible and accountable for understanding and meeting these benchmarks; those that do not are remiss.

Recommendation #2

The governing boards of community health systems and their CEOs are encouraged to initiate an overall review of their traditional “board evaluation” process, objectively assess the value it has provided for the organization, and determine how its effectiveness can be improved.

Over 90 percent of the community health system boards included in this study conduct a form of board evaluation on a regular basis. However, only 56 percent of the CEOs report that these processes have led to substantial changes and, presumably, improvements in board practices. These findings are consistent with other studies that have found board evaluation processes often become pro forma exercises that involve filling out questionnaires, summarizing the answers, and presenting the board with a report that is accepted with minimal deliberation and little or no action. This is a recipe that perpetuates the status quo and does not improve board structures, practices, or culture. It is time for board chairs and CEOs to lead a candid, overall review of their board’s

evaluation approach and, based on the results, transform it into a vibrant process that brings about continual improvement in all aspects of governance. Retaining knowledgeable external parties to bring fresh perspectives and facilitate discussions may be very helpful in this initiative.

Recommendation #3

As a basic outcome of formal board evaluation processes and routine, ongoing review of their performance, all community health system boards should establish clear priorities for improving their structure, practices, and boardroom culture.

Vigorous board development activities and solid self-assessment processes will surface many ways to strengthen existing governance structures, practices, and culture. All boards, even the very finest, have ample opportunities for improvement. It is vitally important for board leadership and the CEO to set clear priorities for making changes, provide sufficient resources to support these efforts, and set crisp timetables for their accomplishment. Responsibility and accountability for each priority should be established with reporting mechanisms back to the full board. Having these ingredients in place will increase the likelihood that intended changes will be implemented effectively. Ongoing evaluation and continuous improvement is the pathway to excellence.

Recommendation #4

Community health system boards and their CEOs are encouraged to give careful attention to the boardroom culture that currently prevails within their organization and determine steps that can and should be taken to make it healthier and more effective.

In both the public and private sectors, there is growing evidence that organizations whose boards have a proactive, interactive culture and are actively engaged in governance work are more likely to perform well than those whose boards are less involved. The findings of this survey show that, in general, community health system boards consistently demonstrate commitment to their respective system’s mission. However, as shown in Section III and summarized in Exhibit 1, their performance with respect to other key characteristics of an effective board culture is uneven. Objective appraisal of

existing boardroom culture is likely, in every situation, to identify steps that can strengthen the culture and, in doing so, improve the board's performance.

Recommendation #5

Community health system boards and their CEOs should re-examine their present composition. The boards of independent systems, in particular, should consider enriching their membership with greater racial and gender diversity; all boards should consider the appointment of highly respected and experienced nursing leaders as voting members of the board to complement physician members and strengthen clinical input into board deliberations.

The findings presented in Section III and summarized in Exhibit 1 show that, as compared to systems affiliated with larger parent organizations, the boards of independent systems generally have less racial and gender diversity. Efforts to further diversify the composition of boards are encouraged. With respect to nurses, given the magnitude of the nursing workforce and its impact on patient care quality and cost, it seems apparent that community health system board deliberations and decision-making processes would benefit from the perspectives of expert leaders in the nursing profession. Candidates could be affiliated with institutions within the system and/or serving in leadership roles in other organizations. As with physician trustees, for nurses who are affiliated with the system where they serve on the board, the potential for conflicts of interest must be recognized and addressed.¹⁰⁰

Recommendation #6

All community health system boards and their CEOs should devote concerted attention and resources to meeting the emerging benchmarks of good governance with respect to their systems' community benefit responsibilities. The boards are urged to (a) adopt a systemwide policy regarding their systems' roles and obligations in providing community benefit, (b) collaborate actively with other organizations in ongoing community needs assessment, (c) adopt a formal community benefit plan that states the systems' objectives in clear, measurable terms, (d) ensure that reporting and accountability mechanisms to monitor progress are in place, and (e) provide thorough reports to the communities served on a regular basis, at least annually.

The information presented in Section III suggests that basic benchmarks of good governance are emerging for nonprofit healthcare organizations that wish to maintain tax-exempt status and that, at this time, a substantial proportion of community health systems are not meeting them. The gap is somewhat greater for independent systems than for those that are affiliated with larger parent organizations, but it exists across the board. The emerging benchmarks are reasonable and attainable. All community health system boards and their CEOs are urged to make a shared commitment to ensure their systems meet them as soon as possible. The systems' policies, plans, and reporting procedures should be designed in a manner that will enable them to comply fully with pertinent federal, state, and local reporting needs and expectations.

All six of these recommendations call for community health system boards — in concert with senior management and clinical leadership — to reflect, engage in dialogue about the status quo, and then take action. These deliberations will challenge current structures and practices, and will generate new ideas and perspectives. This can and should be beneficial; healthy boards and management teams welcome dialogue, the open exchange of views, and constructive dissent. However, these recommendations really are a call to action. The active support and leadership of CEOs will be essential in this work. Boards that are committed to continuous improvement and have the courage to make needed changes will enhance governance effectiveness and improve their systems' contributions to the communities they serve.

Exhibit 1

Summary of Findings Regarding Community Health System Board Structures, Practices, and Culture in Relation to Selected Benchmarks of Good Governance

| Brief Statement of Current or Emerging Standard of Good Governance *An asterisk indicates that the observed difference between figures for systems that are part of a larger parent organization versus independent systems is statistically significant. | Boards of Systems That Are Part of Parent Organizations | Boards of Independent Systems |
|---|--|--------------------------------------|
| Board Structure and Composition: | | |
| 1. Board bylaws establish clear limits on the number of voting members | 98% | 98% |
| 2. Board size is consistent with HRET Blue Ribbon Panel on Health Care Governance recommendations (9-17 members) | 16.5 members | 16.7 members |
| 3. Substantial involvement of physicians in governance roles | 25% of members | 21% of members |
| 4. Substantial racial diversity in board composition* | 14% non-Caucasian | 11% non-Caucasian |
| 5. Substantial gender diversity in board composition* | 33% female | 19% female |
| 6. CEO is a voting member of the board | 90% | 80% |
| 7. Standing board committees have clear oversight responsibility for key governance function; i.e.: | | |
| • External audit* | 64% | 95% |
| • Internal audit* | 73% | 89% |
| • Executive compensation* | 59% | 98% |
| • Board education and development functions | 43% | 53% |
| • Community benefit programs | 52% | 38% |
| • Patient quality and safety | 86% | 89% |
| 8. The role and responsibilities of <u>all</u> standing board committees are spelled out in a written document (a "charter") and formally adopted by the community health system board. | 71% | 71% |
| Selected Board Practices and Processes: | | |
| 9. Board has a pre-established schedule of meetings | 100% | 100% |
| 10. Written performance expectations are provided for the CEO by the community health system board or its parent corporation* | 98% | 86% |
| 11. CEO performance expectations include specific targets in key areas; i.e.: | | |
| • Financial targets | 100% | 100% |
| • Patient quality and safety targets | 100% | 99% |
| • Leadership team-building targets | 60% | 71% |
| • Community benefit targets* | 90% | 49% |
| 12. Board formally evaluates its CEO's performance in relation to established targets on a regular basis | 100% | 98% |
| 13. Adjustments in CEO compensation are linked directly to results of the CEO evaluation process | 100% | 96% |
| 14. CEO evaluation process establishes clear performance expectations and assesses the CEO's actual performance fairly* | 95% | 66% |
| 15. Board formally assesses how well it is performing its duties | 91% | 90% |

| Brief Statement of Current or Emerging Standard of Good Governance *An asterisk indicates that the observed difference between figures for systems that are part of a larger parent organization versus independent systems is statistically significant. | Boards of Systems That Are Part of Parent Organizations | Boards of Independent Systems |
|--|--|--------------------------------------|
| 16. Board assessment process results in actions that substantially change board practices | 63% | 52% |
| 17. Board regularly engages in formal discussions about its system's community benefit responsibilities and programs* | 93% | 58% |
| 18. Board adopts formal, written policy that defines overall guidelines for the system's community benefit programs* | 82% | 49% |
| 19. Board requires systemwide collaboration with other local organizations in community needs assessment on a regular basis* | 41% | 23% |
| 20. Board adopts a formal plan that spells out measurable, systemwide objectives for the system's community benefit program* | 55% | 25% |
| 21. Board regularly receives formal reports on the system's community benefit program, including performance data in relation to established objectives* | 86% | 58% |
| 22. Board is proactively engaged in quality assessment and improvement processes, including: <ul style="list-style-type: none"> <li data-bbox="142 1045 1096 1108">• Board or designated board committee adopts core measures and standards for quality of patient care within the system <li data-bbox="142 1119 1096 1171">• Regularly receives formal reports on system performance in relation to established measures and standards | 86% | 86% |
| Board Culture: | | |
| 23. Board consistently demonstrates proactive culture of commitment and engagement including: | | |
| • Commitment to the system's mission | 91% | 89% |
| • Reviewing and improving core governance processes | 50% | 39% |
| • Defining needs for board expertise and recruiting new members to meet them | 50% | 35% |
| • Tracking system's performance (clinical and financial) and taking action when performance doesn't meet targets | 80% | 70% |
| • Addressing long-term strategic issues | 61% | 67% |
| • High enthusiasm at board meetings | 52% | 51% |
| • Mutual trust among board members | 73% | 71% |
| • Recognizing the importance of board education | 52% | 41% |
| • Holding board members to high performance standards | 52% | 42% |
| • Encouraging constructive deliberations at board meetings | 64% | 72% |
| • Welcoming respectful disagreement and dissent at board meetings | 52% | 58% |
| 24. Board is actively engaged in discourse and decision-making, with most board members willing to express their views and constructively challenge each other and the system's management team | 77% | 70% |

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Appendix A

Methodology for the Study of Governance in Community Health Systems

A. Selection of Nonprofit, Non-Governmental, Community Health Systems

This research intends to identify and study the population of nonprofit, non-governmental community health systems in the United States that meet the following criteria:

Nonprofit healthcare organizations that (1) operate two or more general-acute and/or critical access hospitals and other healthcare programs in a single, contiguous geographic area and (2) have a chief executive officer and a system-level board of directors who provide governance oversight over all of these institutions and programs.

Initial identification of community health systems was based on the American Hospital Association's (AHA) Annual Guide Issue and output from the AHA database on hospitals and health systems.¹⁷ This information was supplemented by information obtained from 21 multi-unit healthcare organizations. Discovery and validation of Medicare identification numbers was accomplished through personnel at the AHA, as well as through the staff of Thomson Healthcare. Questionable and/or missing information on systems was clarified by phone with the systems. The combination of these methods resulted in the finding and removal of additional facilities and systems.¹⁹

The final study population includes 201 nonprofit community health systems. Seventy of these systems are part of larger regional or national nonprofit healthcare organizations. The remaining 131 systems are considered independent systems, as they do not have a parent organization affiliation.

B. Data Collection and Compilation

Initial survey and follow-ups were accomplished over three main waves as discussed in the main text. Of the 123 responses received, 85 responded at the first wave, 26 responded at the second wave, and 12 responded after phone call follow-ups. Four CEOs responded using the electronic web-based option resulting in an overall response rate of 61 percent.

The responses that were received were coded by a two-person team. One person entered each data point and the other

validated the entry. The data were then validated by a third member of the research team who independently ensured the accuracy of the data entered using the original survey responses. All missing data were pursued through community based healthcare system contacts, often the executive secretary and/or the system CEO. Any data that appeared to be erroneous or inconsistent was pursued through the same mechanism. At final review, a response option for one question was removed due to the prevalence of missing or incomplete data across respondents. The other six response options for that question were retained. The end result was a virtually complete survey based data set.

C. Statistical Analysis

For the purpose of this initial report, data were analyzed in terms of independent systems versus systems that are part of larger parent organizations. The chi-square test was used to examine the difference between these groups at the various levels of the survey variables. In instances where the asymptotic behavior of the chi-square distribution may not hold, the Fisher exact test was used to carry the test of significance. Four survey questions yielded continuous variables. On these variables, non-parametric methods were used in order to test the two systems.

D. Response Bias Analyses

Analyses were conducted to assess the potential for a response bias among the study population. Covariates included system performance (high, medium, low), whether or not the system was part of a larger parent organization, the number of hospitals in the system, the number of states in which the system operated, and the census region in which the system resided. Performance was calculated using an algorithm developed by Solucient that is not discussed in this report. Independent analyses were conducted on response for each set of covariates (performance, parent membership, number of hospitals, number of states, and census region). Results were consistent across analyses (Table A-1).

Only one covariate demonstrated significance in any of the independent analyses or the full model analysis. Census

TABLE A-1: Full Model Response Bias Analysis

| Covariate | B | S.E. | Sig. | Exp(B) | 95.0% C.I. for EXP(B) | |
|---|--------|------|------|--------|-----------------------|-------|
| | | | | | Lower | Upper |
| High Performance | .218 | .461 | .636 | 1.244 | .504 | 3.072 |
| Mid-Range Performance | .414 | .388 | .286 | 1.513 | .707 | 3.238 |
| System Part of Parent | -.250 | .342 | .465 | .778 | .398 | 1.523 |
| Number of Hospitals in System | -.104 | .089 | .239 | .901 | .757 | 1.072 |
| Number of States in Which the System Operates | .170 | .702 | .809 | 1.185 | .300 | 4.689 |
| Northeast Region | -1.598 | .533 | .003 | .202 | .071 | .575 |
| Midwest Region | .230 | .444 | .604 | 1.259 | .527 | 3.008 |
| Southern Region | -.135 | .438 | .759 | .874 | .370 | 2.063 |

Note: Reference categories: low performance and Western Region.

Region 1 (Northeast) was significant ($p=.003$) in the full model and the model that included only census regions as predictors of response ($p=.001$). In both the independent and full model analyses, community based health systems in the Northeast Region appeared to have roughly 20 percent lower odds of response than those in the Western Region (reference category). Only 28 percent of systems in the Northeast Region responded to the survey as compared to response rates of at least 63 percent in all other regions. However, it is not likely, given an overall 61% response rate, that the difference in response by region represents a practical survey response bias.

E. Limitations of the Study

There are several limitations to this study. First, there is the potential for a regional response bias. However, the study has a 61 percent response rate that appears to be very representative of the nonprofit community health systems in the study population. The regional bias is unlikely to influence results. There is no a priori reason to believe that community based healthcare systems in the Northeast are appreciably different in terms of survey response data than the other three regions, aside from their lower response rates.

Second, the team endeavored to identify and include as many nonprofit community health systems that met the criteria outlines in Section II as possible. We believe a large majority were captured and included in the study population. However,

we are sure some were missed and, therefore, the study population is not totally inclusive.

Third, the survey that provided the basis for this initial report focused on current governance practices in relation to a selected set of established or emerging benchmarks of good governance. There are many other benchmarks that are important and warrant attention by board leaders but, due to various constraints including the mail survey methodology used to collect data in this phase of study, are not addressed in this report.

Fourth, this report presents the opinions of community health system CEOs regarding certain aspects of their boards' structure, practices, and cultures. The research team made substantial efforts to clarify questions that arose in reviewing the CEOs' responses and to obtain any missing data elements. However, the data represents the CEOs' perceptions and may or may not be factually correct. Further, while the research team was careful throughout the data collection and analysis process, there are bound to be some inaccuracies in our summarization and interpretation of the survey data. The opinions of community health system board members regarding several topics addressed in the mail survey will be obtained through on-site visits in Phase III of this study. The report on Phase III will compare the board members' views to those of CEOs' on those topics.

Appendix B - End Notes

¹ See, for example, The Role of the Board of Directors in Enron's Collapse, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate, July 8, 2002; G. Morgenson, "10 Ex-Directors from WorldCom to Pay Millions," New York Times, January 6, 2005; and G. Colvin, "The Other Victims of Bernie Ebber's Fraud," Fortune, August 8, 2005.

² See, for example, A. Finder, "Senate Panel to Review American U. Board Actions on Spending," New York Times, December 3, 2005, p. A30; and R. Chait, "When Trustees Blunder," The Chronicle of Higher Education, February 17, 2006, pp. B6-B7.

³ See, for example, "Where's Oversight of Oversight Foundation?," Editorial, Des Moines Register, March 21, 2007.

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⁶ J. Wiehl, "Roles and Responsibilities of Nonprofit Health Care Board Members in the Post-Enron Era," Journal of Legal Medicine, Vol. 25, 2004.

⁷ See, for example, F. Entin, J. Anderson, and K. O'Brien, The Board's Fiduciary Role: Legal Responsibilities of Health Care Governing Boards, (Chicago: Center for Healthcare Governance, 2006), pp. 2-9; "Summer Months Bring Developments for Tax-Exempt Hospitals," DrinkerBiddleGardnerCarton, July 2007; and "Community Benefit Debate Escalates," McDermott, Will, & Emery, July 20, 2007.

⁸ See, for example, N. Ono, "Boards of Directors Under Fire: An Examination of Nonprofit Board Duties in the Health Care Environment," Annals of Health Law, Volume 7, 1998, pp. 107-138; M. Peregrine and J. Schwartz, "Revisiting the Duty of Care of the Nonprofit Director," Journal of Health Law, Spring 2003, pp. 183-211; G. Davis, "New Directions in Corporate Governance," Annual Review of Sociology, Volume 31, 2005, pp. 143-162; Not-for-Profit Governance Survey: 2006 (Washington D.C.:

National Association of Corporate Directors, 2006), esp. pp. 7-9; T. Thrall, "Building a Bolder Board and Learning to Like It," Hospitals and Health Networks, January 2007, pp. 81-84; and L. Mulligan, "What's Good for the Goose Is Not Good for the Gander," Michigan Law Review, Vol. 105, June, 2007, esp. pp. 1984-1992.

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¹⁰ As stated recently by Richard Umbdenstock, President and CEO of the American Hospital Association, "There are some hospital closures and there are some new hospitals in growing areas . . . But the bigger news is the continuing consolidation of hospitals into larger systems and larger learning networks. "Hospitals Must Show They Are Being 'More Open and Transparent' in Everything They Do", AHA News, pp. 4-5, October 1, 2007.

¹¹ Personal correspondence from Mr. Peter Kralovec, Director, Hospital Data Center, American Hospital Association (AHA), October 19, 2007. In 2000, 1,602 of the nation's 3,003 non-governmental, nonprofit hospitals were affiliated with nonprofit multi-unit systems (53.3%); in 2005, the corresponding figures were 1,662 of 2,958 (56.2%).

¹² F. Lega, "Strategies for Multi-Hospital Networks: A Framework," Health Services Management Research, Vol. 18, 2005, esp. pp. 86-88.

¹³ See, for example, R. Luke, "Local Hospital Systems: Forerunners of Regional Systems?" Frontiers of Health Services Management, Vol. 9, Winter, 1992, pp. 3-51; and A. Cuellar and P. Gertner, "Trends in Hospital Consolidation: The Formation of Local Systems," Health Affairs, Vol. 22, November-December, 2003, pp. 77-87.

¹⁴ See, for example, G. Bazzoli et al., "A Taxonomy of Health Networks and Systems: Bringing Order Out of Chaos," Health Services Research, Vol. 33, February, 1999, pp. 1683-1717.

¹⁵ See, for example, J. Alexander et al., "Governance Forms in Health Systems and Health Networks," Health Care Management Review, Vol. 28, July-September, 2003, pp. 228-242.

¹⁶ The AHA database on hospitals and healthcare systems is substantial and represents a great resource for operational and research purposes. However, the AHA employs a very general definition of the term "health system"; i.e., "A corporate body that owns, leases, religiously sponsors, and/or manages health provider facilities." The AHA database does not have the capability to precisely identify organizations that meet the definition of "community health system" established for the purpose of this study. Our research team is grateful to Mr. Peter Kralovec for his interest and invaluable assistance throughout the process of identifying our study population.

¹⁷ Personal correspondence from Mr. Peter Kralovec, *op cit*.

¹⁸ While the AHA database identifies the hospitals that are affiliated with multi-unit systems, it does not identify those that are organized into "community health systems" with an integrated management and governance structure within larger parent organizations. As indicated in Table 1, by working directly with system-level CEOs, we were able to identify 70 "community health systems" that meet the definition established for this study within 16 large non-governmental, nonprofit healthcare systems.

¹⁹ See, for example, A. Adams, "Quality of Board Governance in Nonprofit Healthcare Organizations," Internet Journal of Healthcare Administration (15312933), Vol. 2, Issue 2, 2003; and J. Orlikoff and M. Totten, "The New Board Chair," Healthcare Executive, January-February, 2008, pp. 56-58.

²⁰ The Governance Institute's 2005 biennial survey of hospitals and healthcare systems found that the average board size was 13.8; the 2007 survey found the average size was 13.3. Boards X 4: Governance Structures and Practices (San Diego: The Governance Institute, 2007), p. 1 and p. 5.

End Notes

²¹ Building An Exceptional Board: Effective Practices for Health Care Governance, op. cit., p. 13. Also see, for example, L. Larson, "Who Does It Better: The Corporate Versus The Nonprofit Governance Model," Trustee, May, 2005, pp. 15-16.

²² See F. Margolin, S. Hawkins, J. Alexander, and L. Prybil, Hospital Governance: Initial Summary Report of 2005 Survey of CEOs and Board Chairs, (Chicago: Health Resources and Educational Trust, 2005), p. 7; and Governance Forecast: Board Performance, Challenges, and Opportunities, (San Diego: The Governance Institute, 2004), p. 5.

²³ 2006 Public Company Governance Survey, (Washington D.C.: National Association of Corporate Directors, 2006), p. 23.

²⁴ Hospital Governance: Initial Summary Report of 2005 Survey of CEOs and Board Members, op cit, p. 7; and Governance Forecast: Board Performance, Challenges, and Opportunities, op cit, pp. 7-8.

²⁵ A recent study of governance in high-performing nonprofit hospitals in comparison with a matched set of mid-range performing institutions found that boards of high-performing hospitals had a higher percentage of physicians (30.3%) than the mid-range performing institutions (20.8%). L. Prybil, "Size, Composition, and Culture of High-Performing Hospital Boards," American Journal of Medical Quality, Vol. 21, No. 4, July-August, 2006, pp. 225-226.

²⁶ See, for example, J. Oliva and M. Totten, A Seat at the Power Table: The Physician's Role on the Hospital Board (Chicago: Center for Healthcare Governance, 2007), esp. p. 3 and pp. 19-24; and D. Pointer and J. Orlikoff, Board Work: Governing Health Care Organizations (San Francisco: Jossey-Bass Publishers, 1999), esp. pp. 177-179. Of course, board leaders must be mindful of regulatory constraints. Current Internal Revenue Service (IRS) rules permit nonprofit, tax-exempt hospital boards to have no more than 49% of their memberships as "interested persons." In IRS terminology, "interested persons" include any employee of the organization as well as physicians who treat patients in the organization or who "conduct business with or derive any financial benefit from the organization."

²⁷ D. Berwick as quoted in "Great Boards Ask Tough Questions: What to Expect from Management on Quality," Boardroom Press, April 2005, p. 7. Also see L. Prybil, "Nursing Involvement in Hospital Governance," Journal of Nursing Care Quality, Vol. 22, January-March, 2007, pp. 1-3; and P. Betzebe, "The New Rainmakers," HealthLeaders, December, 2007, pp. 55-56.

²⁸ See, for example, Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations, (Washington D.C.: Panel on the Nonprofit Sector, 2007), pp. 14-15.

²⁹ Hospital Governance: Initial Summary Report of 2005 Survey of CEOs and Board Members, op cit, p. 7.

³⁰ 2006 Not-for-Profit Governance Survey, (Washington D.C.: NACD, 2006), p. 14; and "Women on Boards (Not!)," Fortune, October 19, 2007, p. 105.

³¹ See, for example, The Conference Board Commission on Public Trust and Private Enterprise, (Pew Charitable Trusts, 2003); "Report of the ABA Task Force on Corporate Responsibility," The Business Lawyer, November 2003; and TIAA-CREF Policy Statement on Corporate Governance, (New York: TIAA-CREF, 2004).

³² Boards X 4: Governance Structure and Practices, p. 7.

³³ See, for example, F. Entin, J. Anderson, and K. O'Brien, The Board's Fiduciary Role: Legal Responsibilities of Health Care Governing Boards, (Chicago: Center for Healthcare Governance, 2006); S. Kaput, "Expanding the Scope of Fiduciary Duties to Fill A Gap in the Law: The Role of Nonprofit Hospital Directors to Ensure Patient Safety," Journal of Health Law, Winter 2005; and M. Peregrine and J. Schwartz, "Revisiting the Duty of Care of the Nonprofit Director," Journal of Health Law, Volume 36, Spring 2003.

³⁴ It is recognized that these fundamental responsibilities differ somewhat for boards of hospitals that are part of multi-level systems as compared to the boards of independent, freestanding entities. See, for example, L. Prybil, "A Perspective on Local-Level Governance in Multiunit Systems," Hospital and Health Services Administration, Spring 1991; and Value-Added Governance: New Insights into Old Challenges, (San Diego: The Governance Institute, 2001), esp. pp. 19-26.

³⁵ See, for example, Building an Exceptional Board: Effective Practices for Health Care Governance, op cit, esp. pp. 5-8; C. Montgomery and R. Kaufman, "The Board's Missing Link," Harvard Business Review, March 2003; and "Revisiting the Duty of Care of the Nonprofit Director," op cit.

³⁶ See, for example, C. Molinari et al, "Hospital Board Effectiveness: Relationships Between Governing Board Composition and Hospital Financial Viability," Health Services Research, 28 (August, 1993); I. Milstein and P. MacAvoy, "The Active Board of Directors and Performance of the Large, Publicly-Traded Corporation," Columbia Law Review, 98 (1998); C. Sundaramurthy, "Control and Collaboration: Paradoxes of Governance," Academy of Management Review, 28, 2003; and L. Prybil et al, Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-for-Profit Hospitals, (Chicago: Health Research and Educational Trust, 2005).

³⁷ "Report of the ABA Task Force on Corporate Responsibility," op cit, p. 151.

³⁸ See, for example, D. Pointer and J. Orlikoff, Board Work: Governing Health Care Organizations, (San Francisco: Jossey-Bass Publishers, 1999), esp. pp. 135-150; and Building An Exceptional Board: Effective Practices for Health Care Governance, op cit, esp. pp. 22-23.

³⁹ The research team recognized at the outset that the specific names of committees would vary from system to system. Therefore, the team focused on identifying and learning about the standing committees to whom *oversight responsibility* was assigned.

⁴⁰ For example, in an examination of the HealthSouth breakdown, Ernst and Young cited a lack of effective oversight by the board of directors and its audit committee and found that the company's internal audit program was "... understaffed, undertrained, and lacking in independence." A. Stuart, "Keeping Secrets: How Five CFOs Cooked the Books at HealthSouth," CFO, March 2005, p. 62. Also see J. Wiehl, "Roles and Responsibilities of Nonprofit Health Care Board Members in the Post-Enron Era," op cit, esp. pp. 414-417 and pp. 435-436.

⁴¹ See, for example, "Good Governance Practices for 501(c)(3) Organizations," Internal Revenue Service, February 2, 2007; and "50 Practices of Top-Performing Boards," op cit., p. 3.

⁴² Principles of Good Governance and Ethical Practice, op cit, p. 20.

⁴³ See, for example, "Compensation Oversight: Is Your Board Doing Enough?" 2007 National Board Governance Survey for Not-For-Profit Organizations (Grant-Thornton, LLP, 2007), p. 11; Is the Job Getting Harder? Updated Guidance for the Board's Executive Compensation Committee (San Diego, The Governance Institute, Summer, 2006); and M. Peregrine and R. DeJong, "Update on Executive 'Comp': What the Regulators and Boards are Focusing On," Health Lawyers News, December, 2004.

⁴⁴ See, for example, "Our View: ATC Compensation Investigation is Appropriate Move," Editorial, Iowa City Press-Citizen, January 2, 2008; "Report on Exempt Organizations Executive Compensation Compliance Project – Parts I and II," Internal Revenue Service (IRS), March 1, 2007; and "GAO Examines Executive Compensation Issues at Tax-Exempt Hospitals," Gardner, Carton & Douglas, April, 2006. The Taxpayers Bill of Rights II authorizes the IRS to apply "intermediate sanctions" including taxes and penalties on individuals receiving "excess benefits" and anyone who knowingly approves an excess benefits transaction. Section 4938 of the Internal Revenue Code defines steps that the governing boards of tax-exempt organizations should take to ensure compensation provided to executives is reasonable. Under the "rebuttable presumption" safe harbor, compensation is considered to be "reasonable" if requirements specified in Section 4938 are met.

- ⁴⁵ A comprehensive board development program should at least include: a continuous process for assessing the board's changing needs for expertise and diverse perspectives; a proactive recruitment effort to attract trustees who meet these needs; a well-planned orientation program for newly appointed trustees; a solid, needs-based board education program; a succession plan for board officers and committee leadership positions; an ongoing board evaluation process to assure ongoing appraisal of effectiveness and promote continuous improvement; and clear assignment of responsibility and accountability for oversight of all components of the board development program. L. Prybil, "Characteristics of Effective Boards," *Trustee*, March, 2006. Also see, "Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards," op cit, esp. pp. 11-12 and 14.
- ⁴⁶ See, for example, *Board Work: Governing Health Care Organizations*, op cit, esp. pp. 53-67; *Moving Toward Excellence in Quality*, The Governance Institute, 2001, esp. pp. 13-32; and J. Marren, "The Trustee's Responsibility for Quality Care," *Trustee*, July-August 2, 2004.
- ⁴⁷ See, for example, "Advancing the Public Accountability of Nonprofit Health Care Organizations," Alliance for Advancing Nonprofit Health Care (www.nonprofithealthcare.org), May, 2005, esp. pp. 4-6.
- ⁴⁸ See, for example, J. Conger, E. Lawler, and D. Finegold, *Corporate Boards: New Strategies for Adding Value at the Top*, (San Francisco: Jossey-Bass, 2001), esp. Chapter 6; and D. Nadler, B. Behan, and M. Nadler, *Building Better Boards: A Blueprint for Effective Governance*, (San Francisco: Jossey-Bass, 2006), esp. Chapter 8.
- ⁴⁹ *Boards X 4*, op cit, p. 24.
- ⁵⁰ *2006 Public Company Governance Survey*, op cit, p. 30.
- ⁵¹ See, for example, K. Gautam, "A Call for Board Leadership on Quality in Hospitals," *Quality Management in Health Care*, January-March 2005.
- ⁵² "How'm I Doing?" *CFO*, February, 2007, p. 21.
- ⁵³ See, for example, R. Beekun and G. Young, "Board Characteristics, Managerial Controls, and Corporate Strategy: A Study of U.S. Hospitals," *Journal of Management*, 24, 1998; and "Board Governance and Accountability," an interview with Edward E. Lawler, III, conducted by Robert Howie, Jr., Balanced Scorecard Report, Reprint No. B0301D, Harvard Business School Publishing Corporation, January-February, 2003, p. 3.
- ⁵⁴ See, for example, *Corporate Boards: New Strategies for Adding Value at the Top*, op. cit., esp. Chapter 7; and *Striving for Excellence: Health System Governance at the Dawn of the New Millennium*, The Governance Institute, 2002, esp. pp. 28-29.
- ⁵⁵ T. Holland and D. Jackson, "Strengthening Board Performance: Findings and Lessons from Demonstration Projects," *Nonprofit Management and Leadership*, 9 (1998), esp. pp. 128-133.
- ⁵⁶ B. Behan, "Board Assessment," in *Building Better Boards: A Blueprint for Effective Governance*, op. cit., p. 213.
- ⁵⁷ See, for example, *Advancing the Public Accountability of Nonprofit Health Care Organizations*, op. cit., p. 7.
- ⁵⁸ L. Abbe and A. Baney, *The Nation's Health Facilities: Ten Years of the Hill-Burton Hospital and Medical Facilities Programs, 1946-1956* (Washington DC: Public Health Service Publication 616, 1958); H. Somers and A. Somers, *Doctors, Patients, & Health Insurance* (Washington, DC: The Brookings Institution, 1961), pp. 57-61; A. Somers, *Hospital Regulation: The Dilemma of Public Policy* (Princeton, NJ: Princeton University, 1969), pp. 132-137; and S. Coleman, "The Hill Burton Uncompensated Services Program," Congressional Research Service, The Library of Congress, Order Code 98-968C, May, 2005, pp. 1-4.
- ⁵⁹ Coleman, op cit, p. 1.
- ⁶⁰ Rev. Rul. 69-645, 1969-2, C.B. 117.
- ⁶¹ These factors, which originally comprised the "Community Benefit Standard," included: maintaining an emergency room on a 24-hour per day basis; providing charity care to the extent of the institution's financial abilities; granting medical staff privileges to all qualified physicians in the community, consistent with the size and nature of the institutions; accepting payment from the Medicare and Medicaid programs on a non-discriminatory basis; and maintaining a community-controlled board comprised primarily of persons from the local community and not controlled by insiders. A later IRS ruling (Rev. Rul. 83-157, 1983-2 C.B. 94) stated that hospitals did not need to maintain and operate an emergency room to qualify for tax exemption if it showed that adequate emergency services existed elsewhere in the community and the hospital met the other requirements of the "Community Benefit Standard."
- ⁶² For excellent background information about the history and development of the "Community Benefit Standard" and Federal requirements for tax exemption, see "Nonprofit Hospitals: Better Standards Needed for Tax Exemption," General Accounting Office, May, 1990; G. Young, "Federal Tax-Exemption Requirements for Joint Ventures Between Nonprofit Hospitals Providers and For-Profit Entities," *Annals of Health Law*, 13, 2004, esp. pp. 329-335; "Hospital Charity Care in the United States," Missouri Foundation For Health, Summer, 2005; and "Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals," Joint Committee on Taxation, U.S. Senate Finance Committee, September 12, 2006.
- ⁶³ J. Kuchler, "Tax-Exempt Yardstick: Defining the Measurements," *Healthcare Financial Management*, February, 1992.
- ⁶⁴ J.D. Seay, "From Pemsel's Case to Health Security: Community Benefit Comes of Age," *Journal of Health Administration Education*, Vol. 12, Summer, 1994, p. 375.
- ⁶⁵ M. Evans, "Caution: More Scrutiny Ahead," *Modern Healthcare*, November 12, 2007, p. 46. For a recent summary of state laws and requirements, see *Health Care Community Benefits: A Compendium of State Laws* (Boston: Community Catalyst, Inc., November, 2007)
- ⁶⁶ "Nonprofit, For-Profit, and Governmental Hospitals: Uncompensated Care and Other Community Benefit," Testimony of David. M. Walker, Comptroller General of the United States, General Accounting Office, before the Committee on Ways and Means, U.S. House of Representatives, May 26, 2005, p. 19.
- ⁶⁷ For excellent summaries of these three documents, see "Community Benefit Debate Escalates," McDermott, Will, & Emery Newsletter, July 20, 2007; and "Summer Months Bring Developments for Tax-Exempt Hospitals," DrinkerBiddleGardnerCarton, Client Memorandum, July, 2007.
- ⁶⁸ "IRS Releases Final 2008 Form 990 For Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief," Internal Revenue Service, U. S. Department of the Treasury, December 20, 2007.
- ⁶⁹ In brief, "uncompensated care" generally is defined to include bad debt (i.e., hospital losses from unpaid bills for which they expected to receive payments) and charity care (i.e., the cost of services rendered to patients from whom no payment was anticipated). The term "uncompensated care" typically does not include underpayment (i.e., unreimbursed costs) from Medicare, Medicaid, and other publicly financed health care programs. However, as stated in the IRS Interim Report on its Hospital Compliance Project, hospitals presently employ a very wide range of definitions of "uncompensated care" and "community benefit."
- ⁷⁰ The Catholic Health Association, working in concert with other organizations, has played a strong leadership role in developing guidelines and tools for measuring community benefit in a consistent, objective manner. See, for example, *A Guide For Planning and Reporting Community Benefit* (St. Louis, MO.: Catholic Health Association, 2006); and *Community Benefit Planning: A Resource for Nonprofit Social Accountability* (St. Louis, MO: Catholic Health Association and the Coalition for Nonprofit Health Care with assistance from VHA, Inc., Premier, Inc., and The Alliance of Community Health Plans, 2002).

End Notes

⁷¹ See, for example, memorandum from Senator Charles Grassley, Senate Finance Committee, to Reporters and Editors, September 12, 2006.

⁷² The revised Form 990 will ask for “a full accounting” of community benefit provided by the reporting organizations. The new Schedule H will be phased in beginning with the 2008 tax year. Some sections will be optional that year; reporting organizations will be required to complete the entire Schedule in subsequent years. See “IRS Released Final 2008 Form 990 For Tax-Exempt Organizations,” op cit; “More Detailed Bad-Debt Reporting is Part of IRS’ New Form 990,” Modern Healthcare, December 24/31, 2007, p. 4; and “Top Eight Health Industry Issues for 2008,” PriceWaterhouseCoopers LLP, 2007, pp. 5-6.

⁷³ Corporate Responsibility Handbook, Coalition for Nonprofit Health Care, November, 2002, p. 9.

⁷⁴ “Report of the ABA Task Force on Corporate Responsibility,” The Business Lawyer, November, 2003, pp. 159-160.

⁷⁵ See, for example, “My Brother’s Keeper: Growing Expectations Confront Hospitals on Community Benefit and Charity Care,” PriceWaterhouseCoopers Health Research Institute, 2006, p. 7.

⁷⁶ To provide a common frame of reference, the survey form sent to CEOs in this study provided a definition of “community benefit” based on one developed jointly by the CHA and VHA; i.e., “Community benefit is a planned, managed, and measured approach to meeting identified community needs. It implies collaboration with a ‘community’ to benefit its residents by improving health status and quality of life. Community benefit responds to an identified community need and meets at least one of the following criteria: generates a low or negative margin, responds to the needs of special populations, and/or provides services or programs that would likely be discontinued if a decision were made on a purely financial basis.”

⁷⁷ M. Bilton, Director, Community Health Programs, HRET, “Community Benefit: A New Strategy,” Presentation at the Iowa Hospital Association’s Joint Board Retreat, Lake Okoboji, Iowa, August 11, 2006. Also see “My Brother’s Keeper: Growing Expectations Confront Hospitals on Community Benefits and Charity Care,” op cit, p. 2.

⁷⁸ See, for example, Strengthening Community Trust: Strategies for CEOs (Chicago: AHA, 2006) p. 5.

⁷⁹ A Guide to Planning and Reporting Community Benefit, op cit, esp. pp. 13-22.

⁸⁰ Advancing the State of the Art of Community Benefits (Oakland, California: Public Health Institute, November, 2004), p. 15.

⁸¹ A Guide to Planning and Reporting Community Benefit, op cit, p. 13.

⁸² “My Brother’s Keeper: Growing Expectations Confront Hospitals on Community Benefits and Charity Care,” op cit, p. 8.

⁸³ M. Porter and M. Kramer, “Strategy & Society,” Harvard Business Review, December, 2006, p. 44.

⁸⁴ See, for example, Advancing to State of the Art in Community Benefit, op cit, esp. pp. 40-43; and “50 Practices of Top-Performing Boards,” op cit, p. 4.

⁸⁵ See, for example, “My Brother’s Keeper: Growing Expectations Confront Hospitals on Community Benefit and Charity Care,” op cit, p. 2, and Advancing to State of the Art in Community Benefit, op cit, p. 43.

⁸⁶ S. Lee, J. Alexander, and G. Bazzoli, “Whom Do They Serve? Community Responsiveness Among Hospitals Affiliated With Health Systems and Networks,” Medical Care, Vol. 41, no. 1, 2003, p. 165.

⁸⁷ See, for example S. Levey et al, “Hospital Leadership and Quality Improvement: Rhetoric Versus Reality,” Journal of Patient Safety, Vol. 3, No. 1, March, 2007; J. DerGurahian, “Quality Better, Not Great” Modern Healthcare, November 19, 2007, pp. 10-11; “Hospital Leadership Summit – Moving from Good to Great: Summary of Conference Proceedings,” Center for Medicare and Medicaid Services, September 28, 2006, esp. pp. 1-2; and D. Nash and N. Goldfarb (Editors), The Quality Solution: The Stakeholder’s Guide to Improving Health Care, (Sudbury, Massachusetts: Jones and Bartlett Press, 2006).

⁸⁸ See, for example, M. Joshi and S. Hines, “Getting the Board on Board: Engaging Hospital Boards in Quality and Patient Safety,” Journal of Quality and Safety, Vol. 32, no. 4, April, 2006; “Boards of Top-Performing Hospitals Differ in Quality Oversight Practices,” Boardroom Press, August, 2006, p. 8; and B. Bader, “Quality and Patient Safety: Engaging Your Board to Take the Lead,” Healthcare Executive, March-April, 2006, p. 64.

⁸⁹ Donald Berwick, as quoted in an interview with John Diconsiglio, “Back-to-Basics Measures Change Lives,” Hospitals and Health Networks, November, 2006, p. 64.

⁹⁰ See, for example, “Improving Clinical Quality and Safety of Greater Importance to Not-For-Profit Hospitals,” Moody’s Investor Services, May, 2006, esp. pp. 1-2; “Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards,” op cit, esp. p. 16; and C. Vaughn, “Board on the Floor,” HealthLeaders, December 2007, pp. 23-29.

⁹¹ See, for example, “50 Best Practices of Top-Performing Boards,” op cit, p. 3; Board Work: Governing Health Care Organizations, op cit, esp. pp. 63-67; and “Hospital Governing Boards and Quality of Care: A Call to Responsibility,” National Quality Forum, December 2, 2004.

⁹² Donald Berwick, as quoted at a panel discussion facilitated by J. Molpus, “Roundtable Highlights: The State of Quality,” HealthLeaders, December 2006, p. RT2.

⁹³ J.S. Reed, “Ethics and the Not-for-Profit Board,” Boardroom Press, December 2003, p.7.

⁹⁴ Based on extensive work with many boards over a long period of time, William Ryan, Richard Chait, and Barbara Taylor recently concluded in part that “...the board is widely regarded as a problematic institution” and “...too many board members are disengaged. They don’t know what’s going on in their organizations, nor do they demonstrate much desire to find out.” W. Ryan, R. Chait, and B. Taylor, “Problem Boards or Board Problems?” The Nonprofit Quarterly, Winter, 2005, p. 80.

⁹⁵ See, for example, “Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards,” op cit, p. 16; and David Nadler, “Engaging the Board in Corporate Strategy,” in D. Nadler, B. Behan, and M. Nadler, Building Better Boards: A Blueprint for Effective Governance, (San Francisco: Jossey-Bass, 2006), pp. 129-148. As an illustration of the growing importance being placed on proactive board engagement, Moody’s Investors Services recently has called for hospital boards to strengthen their level of oversight over their institution’s investment strategies. “Moody’s Sharpens Focus on Board Oversight of Investment Management,” McDermott Hot Topic Newsletter, McDermott, Will, & Emery, November 14, 2007.

⁹⁶ Building An Exceptional Board: Effective Practices for Health Care Governance, op. cit., pp. 12-14.

⁹⁷ See, for example, W. Useem, “How Well-Run Boards Make Decisions,” Harvard Business Review, November, 2006, pp. 130-138; and D. Nadler, “Building Better Boards,” Harvard Business Review, May, 2004.

⁹⁸ S. Finklestein and A. Mooney, “Not the Usual Suspects: How to Make Boards Better,” Academy of Management Executive, Vol. 17, no. 2, 2003, p. 106.

⁹⁹ “Getting Started Kit: Governance Leadership How-To Guide,” Institute for Healthcare Improvement, December 12, 2006, p. 3. Also see T. Vaughn, et al, “Engagement of Leadership in Quality Improvement Initiatives: Executive Quality Improvement Survey Results,” Journal of Patient Safety, Vol. 2, No. 1, March, 2006, pp. 2-9.

¹⁰⁰ See, for example, L. LeGraw and D. Roble, “Physicians on the Board: Competitive Conflicts of Interest,” Trustee, January 2005; Emerging Standards for Institutional Integrity, op. cit; and C. Becker, “Getting Tough on Conflicts,” Modern Healthcare, November 13, 2007, pp. 8-9.

