# Governance

## in High-Performing Community Health Systems

A REPORT ON TRUSTEE AND CEO VIEWS

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# Foreward

## Governance in High-Performing Community Health Systems
## A Report on Trustee and CEO Views

With governance of all types of organizations being increasingly called into question, not-for-profit healthcare organizations are being scrutinized more closely than ever before. Further accenting that trend, reform of our entire healthcare system is likely to be hard upon us. Community health systems will need to deal with major organizational change, and their boards must be capable of understanding it, adapting to it, and monitoring its impact. To do so, chairs and CEOs will be responsible for their boards having the necessary structures, processes, and culture in place.

This research report examines the structures, practices, and cultures of community health system boards and compares them to several benchmarks of good governance. Its conclusions and recommendations get down to straightforward practical measures that a hospital or health system board can implement. Among others, they include blueprints for evaluation of the board's strategic and bread-and-butter performance, plus review of membership composition. Well-noted are recommendations for essential board development and attention to community benefits. These and other areas provide a roadmap for needed change in our boards plus the rationale for why this makes sense.

This study was not designed to analyze the statistical relationships between benchmarks of good governance and system operating performance. However, it's clear there is substantial variation in the extent to which current board structures, practices, and cultures meet these benchmarks. There are major gaps, and they are more evident in low-performing and mid-range performing systems. On-site interviews with board leaders and CEOs in ten high-performing systems documented their views on the key factors that have contributed to their systems' success — success that, in several instances, required a major turnaround. Whether these are simply coinciding factors or cause-and-effect, there is a very compelling argument for community health system boards to adopt the well-established principles for improvement that are presented here.

Having spent much of our professional careers in healthcare, as CEO and Trustee, we applaud the work of this dedicated team of researchers and urge careful reading of this report by all who are interested in governance, and in particular healthcare governance.

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# I. Introduction[1]

The corporate form of organization emerged in the 16th and 17th centuries, principally as vehicles for the large trading companies that were created in England, Holland, and other nations during this period. In the United States, investor-owned corporations began to emerge early in the 19th century as the organizational framework for large enterprises such as banking, insurance, manufacturing, and railroad construction.

The number, size, and power of corporate enterprises in the United States expanded greatly during the 19th and 20th centuries. With that expansion came growing separation of the *ownership* of organizational assets by shareholders from *control* of those assets by governing boards and managers.

Early in the 20th century, the potential problems related to separating ownership and control in corporate enterprises began to attract the attention of government officials, scholars, and shareholders.[2] These concerns led, in 1932, to publication of "The Modern Corporation and Private Property" by Adolf Berle and Gardiner Means, a groundbreaking analysis of organizational ownership and control in American society. A central thesis of their analysis was:

*As the ownership of corporate wealth has become more widely dispersed, ownership of that wealth and control over it have come to lie less and less in the same hands. Under the corporate system, control over industrial wealth can be and is being exercised [by boards and management] with a minimum of ownership interest. Conceivably it can be exercised without any such interest. Ownership of wealth without appreciable control and control of wealth without appreciable ownership appear to be the logical outcome of corporate development.*[3]

As predicted by Berle and Means, growth in the number and influence of corporate organizations continued in the following decades. With it came growing interest in the role, duties, and performance of corporate management and governing boards. For both investor-owned and nonprofit corporations, the state statutes under which corporations are chartered call for the board of directors to have overall fiduciary responsibility for the organization and the products or services it provides. Over the years, a large body of corporate law related directly or indirectly to boards and several theories of corporate governance have emerged, all with the general intent of explaining and guiding how boards carry out their duties.[4] However, a growing number of parties in both the public and private sectors continued to raise questions and concerns about the effectiveness of governing boards.[5] In 1992, Martin Lipton and Jay Lorsch stated that:

*Corporate governance in the United States is not working the way it should. The problem is not in the system of laws, regulations, and judicial systems which are the framework of corporate governance. It is the failure by too many boards of directors to make the system work the way it should. The most obvious sign of this failure is the gradual decline of many once great American companies.*[6]

In recent years these concerns have escalated in response to major governance breakdowns in the business sector,[7] higher education,[8] foundations,[9] and the health field.[10] The concerns have become even more pronounced in the past year due to the shocking collapse of major financial institutions such as Bear Stearns, Lehman Brothers Holdings Inc., and Merrill Lynch & Co. as well as long-established companies in other sectors. As stated by Winthrop Smith Jr., son of a Merrill Lynch founder, at that company's final shareholder meeting on December 5, 2008:

*Today is not the result of the subprime crisis or synthetic debt obligations. These are only the symptoms. . . Merrill's downfall reflects unprincipled leadership and the failure of a board of directors to understand what was happening to this great company and its failure to take action soon enough.*[11]

The management and governance leadership of investor-owned and nonprofit organizations are being placed in the "white-hot spotlight of public discourse."[12] Stakeholders are calling for more accountability, greater transparency, and better performance by the persons who manage and govern these organizations.

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*Nonprofit* healthcare organizations and their governing boards are being scrutinized more closely than ever before. The Internal Revenue Service (IRS), the General Accountability Office (GAO), the Senate Finance Committee, a growing number of state legislatures and attorneys general, and bond rating agencies are among the bodies that are looking closely at the governance of nonprofit hospitals and health systems. Governance oversight of charity care and other forms of community benefit, compliance issues, conflicts of interest, executive compensation, and patient care quality and safety are among the areas receiving attention. In effect, the expectations for boards of nonprofit healthcare organizations are becoming more stringent.[13]

There is general agreement that proper governance of hospitals and health systems is important and, for a host of reasons, has become increasingly complex. It also is widely acknowledged that, on the whole, the governance of nonprofit hospitals and health systems can and should be improved.[14] However, except for requirements established by state statutes, the IRS, and the Joint Commission, formal standards for governance of nonprofit healthcare organizations have not been adopted in the United States. In recent years efforts have been made by voluntary commissions, panels, and others to describe good governance practices and provide guidance for boards to consider as benchmarks in evaluating and improving governance performance.[15] Some of these benchmarks are well-established and widely accepted; others are in formative stages. These benchmarks of good governance have not yet been compiled into a single document, but a number of them will be discussed in Section III of this report.

Concurrent with growing interest in improving the performance of governing boards, America's healthcare delivery system continues to evolve from mostly independent institutions into larger groupings.[16] According to the American Hospital Association, the number of multi-unit health systems increased from 311 in 2000 to 390 in 2007, an increase of 25 percent. Well over half of our nation's hospitals presently are integrated into systems and this is growing.[17] Similar trends are occurring in other industrialized countries.[18]

One of the principal features of this transformation has been the development of various forms of community-based health networks and systems.[19] They take many forms, from loose affiliations to highly integrated systems with centralized governance and management.[20] These community-based networks and systems include a large 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 in recent years, there is relatively little information about governing boards and governance practices in community-based health systems.[21, 22]

These three patterns — heightened interest in the duties and performance of governing boards, advances in formulating benchmarks of good governance, and limited research-based knowledge about governing boards in nonprofit community health systems — provided the impetus for this study.

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# II. Purpose and Methodology

## Purpose of the Study

This study examines selected aspects of governance in a set of nonprofit community health systems. "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 tha t provides governance oversight over all of these institutions and programs.*

The community health systems that meet this definition vary in size and scope of services. Some are independent, others are part of larger, parent organizations. A key criterion 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 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 board leaders and chief executive officers in assessing and enhancing board effectiveness.

## Research Methodology

The methodology for this study included four phases: First, identifying the study population by locating community health systems that meet the criteria stated above; second, conducting a baseline survey of the systems' chief executive officers (CEOs); third, comparing the systems' performance on selected measures; and, fourth, making site visits to "high-performing systems" and interviewing several board members at each location.

The study methodology is detailed in Appendix A. In brief, the four phases included the following activities:

**Identifying the Preliminary Study Population.** The research team worked 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.[23] This process was completed early in 2007. It resulted in the identification of 210 nonprofit community health systems that seemed to meet the established criteria and a database with basic information about these systems and their hospitals.

**Conducting a Mail Survey of the CEOs of Systems Included in the Preliminary Study Population.** This mail survey had two aims: to verify that the systems met the established criteria and to obtain the CEOs' views on certain aspects of their respective boards' structure, practices, and culture. The questions in the survey form were limited to those the research team believed the CEOs could answer accurately without extensive investigation. Draft versions of the survey form were pre-tested independently by three CEOs whose healthcare organizations are not part of the study population; the form was refined with the benefit of their advice.

The survey form was distributed in February 2007, with a follow-up mailing to non-respondents several weeks later. 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 calls were made to non-respondents to encourage their participation in the study. Nine CEOs reported that their systems did not meet the team's criteria, resulting in a study population of 201 nonprofit community health systems.

Usable survey forms were completed and returned from 123 of the 201 systems, a response rate of 61 percent. As part of reviewing the survey responses, follow-up telephone calls were made to CEOs and/or their executive assistants in instances where a response was missing or unclear. After these calls were completed, the survey data were entered into the database and independently verified by another member of the research team.

The initial analysis of the survey data compared the findings for independent systems to those for systems that are part of larger parent organizations. A report on the results of this analysis was published in 2008.[24]

**Comparing the Performance of Community Health Systems.** The third phase of this study involved developing methods to compare the systems' performance. *Two* performance measures were used: the three-year operating performance of each system's hospitals and, based on the CEO survey findings, each system's governance structure, practices, and culture in relation to current benchmarks of good governance.

**System Operating Performance:** In cooperation with Thomson Reuters Healthcare staff, each system in the study population for which data were available (199 of the 201 systems) was scored and ranked on the basis of the operating performance of its respective hospitals during the past three years. Using the MEDPAR (Medicare Provider Analysis and Review) data set; the SAF (CMS Standard Analytical File) outpatient data set, and Medicare cost reports, the Thomson Reuters performance assessment protocol calculates composite scores for hospitals based on selected clinical, efficiency, and financial measures.[25] While imperfect, the research team concluded that the consolidated performance of a system's hospitals is a reasonable proxy for "system performance." For the systems included in this study, hospital operating expenses comprise, on average, 84 percent of the systems' total operating expenses. On the whole, hospitals constitute the bulk of system operations.[26]

Using this approach, Thomson Reuters Healthcare staff employed an algorithm to calculate for each *community health system* a composite systemwide score that expresses, in percentile terms, its hospitals' operating performance over the past three years in relation to peer institutions across the country. The composite percentile scores for the 199 systems for which data were available ranged from a high of 96 to a low of 7; the median was 53. (See Appendix A for details.)

**Governance Benchmarks:** As the second performance measure, the research team scored each system whose CEO participated in the mail survey in relation to 39 current benchmarks of good governance. Only benchmarks the team considered to be well-established and objectively measurable were scored. The systems' scores ranged from a high of 36 to a low of 9; the median score was 25.

Scores on system operating performance and governance benchmarks were computed for 121 of the 123 systems that participated in the mail survey. The systems whose scores on *both* measures were in the *bottom third* of the range are defined as "low-performing systems"; 11 systems are in this category. Those whose scores were in the *top third* of the range on both measures are defined as "high-performing systems"; 17 systems are in this category. The balance are termed "mid-range performers."

**Site Visits to Selected Systems Including Interviews with Board Members.** Studies regarding governance in both investor-owned and nonprofit organizations largely have been conducted from afar. Many experts have advocated more field work and closer engagement with executives and board members.[27] The basic intent of the site visits was to obtain trustees' views on selected aspects of their boards' structures, practices, and cultures. A structured interview guide was developed and pre-tested in the Spring of 2008. Where possible, the interview guide was designed to permit direct comparison of board members' views with those of CEOs obtained through the mail survey in 2007.

The W. K. Kellogg Foundation grant which provided the principal funding for this study encouraged efforts to learn about governance in community health systems in diverse locations whose operating performance has been strong. Available funding permitted ten site visits. The research team sought and secured permission to visit and interview board members at ten of the 17 "high-performing" systems as defined in the previous section. Eleven requests to make site visits were extended; only one was declined. The reason given was that this particular system was in the midst of a CEO transition. Ideally site visits also would have been made to some or all of the 11 "low-performing" systems. Having the views of board members of low-performing systems to compare with those of their counterparts in high-performing systems could provide useful insights and strengthen the comparative analysis that can be made based on other data. However, financial and time constraints did not permit site visits to low-performing community health systems as part of this study. This and other limitations of the study are discussed in Appendix A.

Site visits to ten high-performing systems were made in the late Spring and early Summer of 2008. The selection process is described in Appendix A. The principal investigator participated in all ten site visits and senior co-investigators participated in six of them. During all but one site visit,

TABLE 1

## Profile of the Overall Study Population and Systems That Participated in the Mail Survey and the On-Site Visits

| | Systems That Are Part of a Parent Corporation | Independent Systems | No. of Systems and No. of States in Which They Are Located | No. of General and Critical Access Hospitals in These Systems | Average No. of General and Critical Access Hospitals in These Systems |
|---|---|---|---|---|---|
| Total Study Population | 70 | 131 | **201** (43) | 712 | 3.5 |
| Systems That Participated in the CEO Mail Survey[A] | 45<br>(64.3%) | 78<br>(59.6%) | **123** (40)<br>**(61.2%)** | 425 | 3.5 |
| Low-Performing Systems | 1 | 10 | **11** (10) | 36 | 3.3 |
| Mid-Range Performing Systems[B] | 36 | 57 | **93** (37) | 324 | 3.5 |
| High-Performing Systems:<br>Visited by the Team | 3 | 7 | **10** (8) | 27 | 2.7 |
| Not Visited | 5<br>8 | 2<br>9 | **7** (5)<br>**17** (11) | 31<br>58 | 4.4<br>3.4 |
| TOTAL | 45 | 76[C] | **121**[C] (40) | 418 | 3.5 |

[A] Between the CEO survey in 2007 and the site visits in 2008, one system that originally was classified as independent was integrated into a larger parent organization.
[B] The "mid-range performing" group was constructed by excluding the 11 low-performing systems and all 17 high-performing systems.
[C] As stated earlier in this section, Thomson Reuters Healthcare was unable to provide operating performance data for two of the 201 systems in the study population. Both were independent systems and both participated in the CEO mail survey.

individual interviews using the standard interview guide were conducted with four board members: the board chair, the immediate past chair, a senior physician board member, and one member who had joined the system board within the past year.[28]

In total, 41 trustees were interviewed. The interviews were 1.5 to 2 hours in length. Team members also met with the CEOs to supplement input received from them through the mail survey conducted in 2007 and obtain documents requested in advance of the site visits. All who were interviewed were assured of confidentiality; they were consistently cooperative and cordial.

In reviewing the completed interview guides, follow-up phone calls were made to board members and/or CEOs when a response was missing or unclear. After these calls were completed, the interview data were entered into the database and independently verified by another member of the research team.

Table 1 displays the results of the data collection and performance scoring processes. As previously stated, the final study population included 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 24 percent of the 2,913 non-governmental, nonprofit hospitals in the United States in 2007.[29] The numbers of hospitals in these 201 systems range from two to nine, with an overall average of 3.5 per system.

Usable survey forms were received from 123 of the 201 systems in the study population (61 percent). The systems are quite representative of the study population (see Appendix A). As shown in Table 1, the low-performing, mid-range performing, and high-performing systems are similar in terms of the number of hospitals included in them. However, the ten high-performing systems where site visits were conducted are somewhat smaller on this measure than the seven that were not visited. Also, the low-performing group includes a substantially higher proportion of *independent* systems (91 percent) than the mid-range performing group (61 percent) or the high-performing group (70 percent).

# 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 attributes into benchmarks of good governance in healthcare organizations. Using information provided by their CEOs and trustees, this report examines certain aspects of governance structures and practices in low-performing, mid-range, and high-performing community health systems as defined in Section II and compares them to contemporary benchmarks of good governance.

**RESEARCH OBJECTIVE #1**

EXAMINE THE STRUCTURE AND COMPOSITION OF COMMUNITY HEALTH SYSTEM BOARDS

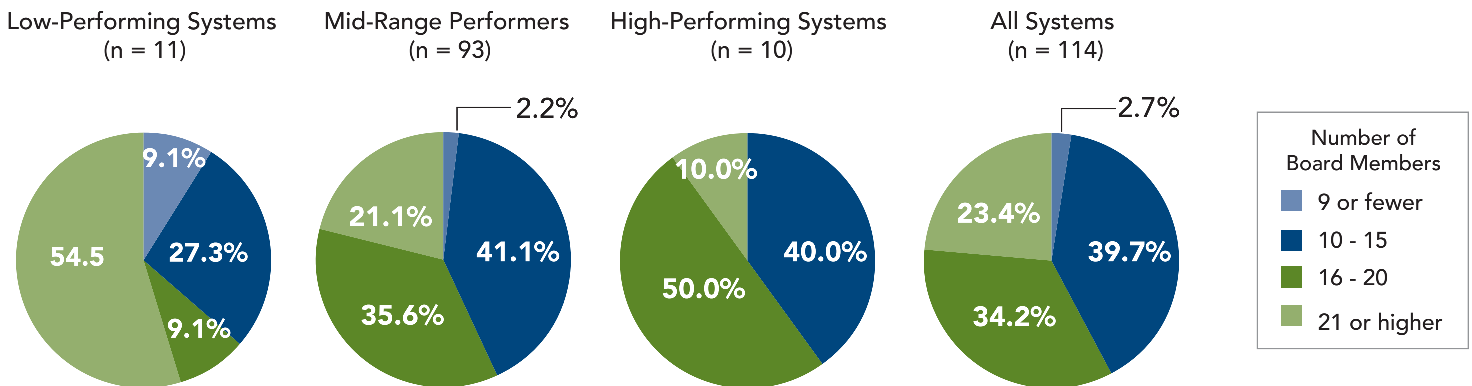
## Bylaws Limits on Number of Voting Members

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.[30] Without clear boundaries and a formal requirement to balance new appointments with retirements of longtime directors, boards can become stale and/or too large.

The CEO survey found that a large majority of systems in all three groups comply with this benchmark. In total, 111 of the 114 systems' bylaws establish limits on the number of voting board members. Table 2 shows what those limits are. Over half of the low-performing systems' bylaws allow their boards to have 21 or more members, a higher figure than the mid-range (21 percent) and high-performing systems (10 percent).

TABLE 2

### Bylaws Limit on Number of Voting Board Members[A]




[A] Throughout this report, test results are shown only when the observed differences were found to be statistically significant.

## 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.[31] 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 – Center for Healthcare Governance Blue Ribbon Panel on Health Care Governance advocated a range of nine to 17 members for hospital and health system boards.[32] Several other authorities have offered similar recommendations.[33]

As shown in Table 3, the CEO survey found that the average number of voting members for both mid-range performing and high-performing systems falls within this range, while the average size of low-performing system boards (both median and mean) exceeds it somewhat. On the whole, the boards of these nonprofit community health systems are larger than nonprofit *hospital* boards, which average 13 to 14 members.[34] One possible explanation for this disparity is that community health systems are larger, more complex organizations than hospitals and are likely to have more stakeholders who have a valid basis for involvement in system governance. In some cases, systems created by bringing together formerly separate organizations may have involved an agreement to create a relatively large system board, at least for a period of time, to enable substantial "representation" by the newly-affiliated institutions.

In the interviews with board members of high-performing systems, the members were asked their opinion on the current size of the boards. Thirty-six of the 41 interviewees (88 percent) expressed the opinion that the current size is "just about right." Four (10 percent) felt the current size was too large and only one felt the size should be expanded.

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.[35]

TABLE 3

### Number of Voting Members on System Boards

| | Low-Performing Systems (n = 11) | Mid-Range Performers (n = 93) | High-Performing Systems (n = 10) | All Systems (n = 114) |
|---|---|---|---|---|
| Range | 6 – 35 | 7 – 33 | 5 – 23 | 5 – 35 |
| Median | 19.0 | 16.0 | 17.0 | 16.0 |
| Mean | 18.0 | 16.3 | 16.1 | 16.4 |

[A] Test results are shown only when the observed differences were found to be statistically significant.

## Board Composition

Table 4 shows the composition of community health system boards. The proportion of clinicians — both physicians and nurses — on the boards of low-performing, mid-range performing, and high-performing systems is quite similar. Recent national surveys have found that physicians constitute around 20 percent of hospital and health system boards.[36] The boards of community health systems have a slightly larger physician component, particularly the high-performing systems.

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.[37] On the whole, the composition of community health system boards meets this benchmark.

With respect to the involvement of nurses, the relatively low proportion of nurses on these boards (two percent) is consistent with previous studies.[38] Engaging leaders in the nursing profession on hospital and health system boards has not yet become the norm, nor has it been 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 relationship between nursing and the board.*[39]

Of the ten high-performing systems where site visits were conducted in mid-2008, three already had one or more nurses as voting members of their boards. Through interviews with board members and CEOs, it was learned that two additional boards had made a *formal decision* to add a nurse leader(s) to their boards and were engaged in the process of selecting these new board members. These appointments are expected to be completed shortly and, at that point, half of these ten boards will include one or more nurses as voting members.

TABLE 4

### Composition of System Boards[A]

| | Low-Performing Systems | | Mid-Range Performers | | High-Performing Systems | | All Systems | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Physician Members | 45 | 22.7 | 337 | 22.3 | 41 | 25.5 | 423 | 22.6 |
| Nurse Members | 5 | 2.5 | 34 | 2.2 | 4 | 2.5 | 43 | 2.3 |
| Other Members | 148 | 74.8 | 1,143 | 75.5 | 116 | 72.0 | 1,407 | 75.1 |
| | 198 | 100.0 | 1,514 | 100.0 | 161 | 100.0 | 1,873 | 100.0 |

[A] Test results are shown only when the observed differences were found to be statistically significant.

## Diversity and Gender Mix

In the healthcare field and other sectors, there is general 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.[40]

Table 5 shows the proportion of non-Caucasians serving on the boards of community health systems. The proportion is similar for the low-performing, mid-range performing, and high-performing groups. Table 6 shows the gender mix. The boards of both mid-range performing and high-performing systems include a substantially higher proportion of women (24 percent and 30 percent respectively) than the low-performing systems (14 percent). The difference is statistically significant, indicating that high-performing systems include a higher proportion of women on their boards. This is consistent with studies that suggest the presence of women on corporate boards is associated positively with long-term corporate success.[41]

These tables show that, in the aggregate, 12 percent of the board members in the 114 community health systems are non-Caucasian and 24 percent are women.[42] By way of comparison, a national study of hospital boards in 2005 found that nine percent were non-Caucasians, and 23 percent were women. On the whole, community health system and hospital boards are similar on these measures of diversity.

The survey also found that 87 of these 114 boards (76 percent) include non-Caucasians; 113 of them (99 percent) include women. A recent study that examined the governing boards of 248 nonprofit organizations — including foundations, colleges and university, and hospitals — had nearly identical findings: 77 percent had diverse membership in terms of ethnic and racial make-up and 98 percent included women.[43]

TABLE 5

### Racial composition of System Boards[A]

| | Low-Performing Systems | | Mid-Range Performers | | High-Performing Systems | | All Systems | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Non-Caucasian Members | 22 | 11.1 | 174 | 11.5 | 22 | 13.7 | 218 | 11.6 |
| Caucasian Members | 176 | 88.9 | 1,340 | 88.5 | 139 | 86.3 | 1,655 | 88.4 |
| | 198 | 100.0 | 1,514 | 100.0 | 161 | 100.0 | 1,873 | 100.0 |

[A] Test results are shown only when the observed differences were found to be statistically significant.

TABLE 6

### Gender composition of System Boards[A]

| | Low-Performing Systems | | Mid-Range Performers | | High-Performing Systems | | All Systems | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Women | 28 | 14.1 | 370 | 24.4 | 49 | 30.4 | 447 | 23.9 |
| Men | 170 | 85.9 | 1,144 | 75.6 | 112 | 69.6 | 1,426 | 76.1 |
| $X^2 = 14.4; p < .01$ | 198 | 100.0 | 1,514 | 100.0 | 161 | 00.0 | 1,873 | 100.0 |

[A] A In this report, test results are shown only when the observed differences were found to be statistically significant. This is the first table where this is the case.

TABLE 7

CEO Membership of System Boards[A]

| | Low-Performing Systems (n = 11) | Mid-Range Performers (n = 93) | High-Performing Systems (n = 10) | All Systems (n = 114) |
|---|---|---|---|---|
| Voting Member and Board Chair | 0.0% | 0.0% | 0.0% | 0.0% |
| Voting Board Member | 90.9% | 82.8% | 100.0% | 85.1% |
| Non-Voting Board Member | 9.1% | 11.8% | 0.0% | 10.5% |
| Not a Member of the Board | 0.0% | 5.4% | 0.0% | 4.4% |
| | 100.0% | 100.0% | 100.0% | 100.0% |

[A] Test results are shown only when the observed differences were found to be statistically significant.

## 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.[44] Combining the board chair and CEO roles is uncommon among charitable, nonprofit organizations, including hospital 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 organizations they lead. These patterns are clearly reflected in the data presented in Table 7. None of the CEOs of community health systems chairs his or her system's board of directors. Among the high-performing systems, *all* of the CEOs are voting members of their boards. Within the low-performing and mid-range performing groups, smaller but still predominant proportions of their CEOs 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.[45] 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.

## Committee Oversight of Specific Governance Functions

The fundamental fiduciary duties of the governing boards of nonprofit healthcare organizations are well-codified and widely accepted.[46, 47] As stated in Section 1, however, there is considerable concern about the effectiveness with which governing boards in nonprofit (and investor-owned) organizations are performing those duties. Numerous studies and expert panels suggest 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.[48] 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. . .*[49]

It is widely agreed that a well-organized committee structure with knowledgeable, engaged members is one of the keys to effective governance.[50] 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 critical governance functions generally should be assigned to standing board committees working within parameters established by the board and consistent with applicable law. As Barry Bader and Elaine Zablocki have stated, "Working committees are the engine that powers effective boards."[51]

Table 8 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?"[52] The findings with respect to several basic 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.[53] 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.[54] As stated in a recent report by the Panel on the Nonprofit Sector, established in 2004 with the support 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.*[55]

Table 8 shows that about 83 percent of these community health system boards have assigned oversight responsibility for external and internal audit functions to a standing committee. Compliance with this benchmark of good governance is strong by the boards of high-performing systems; it is less consistent by the boards of mid-range and low-performing systems.

TABLE 8

## Proportion of Community Health System Boards That Have Assigned Clear Oversight Responsibility for Selected Governance Functions to Standing Committees[A]

| | Low-Performing Systems (n = 11) | Mid-Range Performers (n = 93) | High-Performing Systems (n = 10) | Total (114) |
|---|---|---|---|---|
| External Audit | 90.9% | 80.6% | 100.0% | 83.3% |
| Internal Audit | 63.6% | 83.9% | 90.0% | 82.5% |
| Executive Compensation | 90.9% | 81.7% | 100.0% | 84.2% |
| Board Education and Development | 27.3% | 48.4% | 60.0% | 47.4% |
| Community Benefit Programs | 18.2% | 41.9% | 50.0% | 40.4% |
| Patient Care Quality and Safety | 100.0% | 84.9% | 100.0% | 87.7% |

[A] Tests comparing the proportion of positive responses by the three groups of system CEOs on these six items found the observed differences were not statistically significant.

**Executive Compensation Programs.** The importance of governance control over executive compensation programs is increasingly recognized.[56] The level of public interest in executive compensation is growing, and governmental rules and sanctions have become more demanding.[57]

It is surprising, therefore, to find that the boards of several mid-range and low-performing systems have not yet assigned "clear oversight responsibility" for executive compensation functions to a standing committee. It is clear that, in every sector, governing boards will be held directly accountable for ensuring that their organizations' executive compensation policies, programs, and practices are appropriately structured and closely monitored.[58]

**Board Education and Development.** Because governance of healthcare organizations has become increasingly complex as a result of economic, environmental, legal, and technological changes, sustained commitment to a well-designed board education and development program has become a basic benchmark of good governance.[59] 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. This is inconsistent with good governance practice.

It is possible that some 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.

**Community Benefit Programs.** In total, only 40 percent of these community health system boards have assigned oversight responsibility for their organizations' community benefit programs to a standing board committee. Given growing concerns at national, state, and local levels about the extent to which nonprofit healthcare organizations are providing community benefit and deserve tax-exempt status, 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.** Community health systems appear to be more proactive with respect to patient care quality and safety than community benefit. Nearly 90 percent of the 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 benchmarks of good governance today.[60] Obviously, assigning oversight responsibility to a standing committee is only one of *many* steps that boards must take to meet 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 practice. However, when oversight responsibility is delegated to a board committee, the committee's role and duties should be spelled out by the board in a written form that will be clear to all parties. This is a basic benchmark of good governance.[61]

Strong, effective board oversight of patient care quality and safety programs is, without question, one of the most fundamental benchmarks of good governance today.

TABLE 9

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

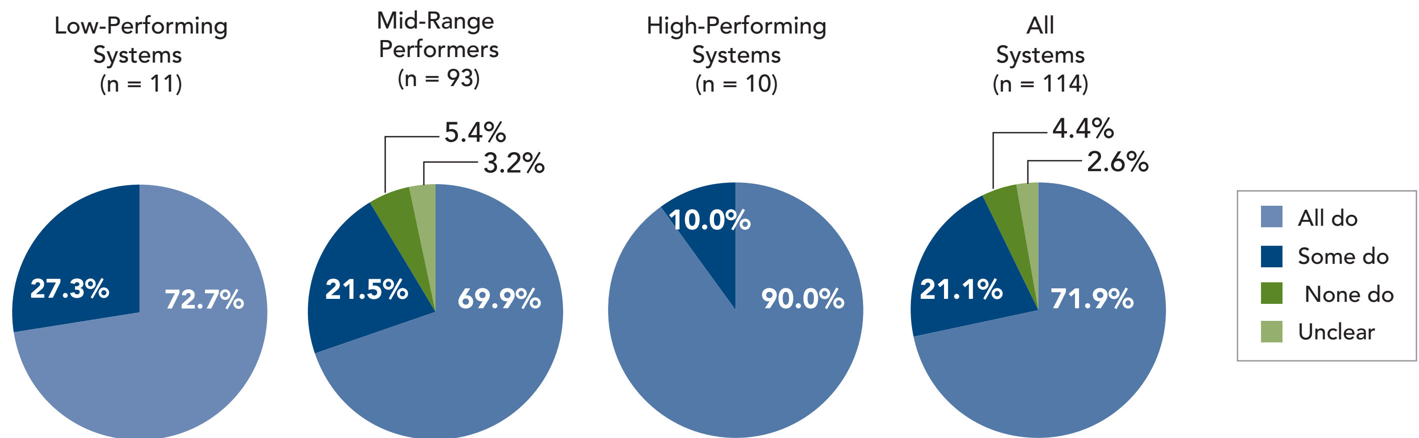



Table 9 shows CEO responses to the following questions: "Do [your board's] committees have clearly defined responsibilities that are spelled out in a written document (i.e., a 'charter') that has been formally approved by the system's board of directors?" According to their CEOs, 72% of community health system boards meet this standard. For the boards of high-performing systems, this proportion is 90%; the difference among the categories of systems is statistically significant. Ideally, there should be clarity in the role and duties of *every* committee that carries out important functions on behalf of the governing board.

## Board Executive Committees in High-Performing Community Health Systems

In both nonprofit and investor-owned organizations, it is quite common for governing boards to have "executive committees" as part of their governance structure. For example, a 2007 survey of nonprofit organizations (health related and non-health related) conducted by Grant Thornton LLP found that 88 percent of the boards had executive committees.[62] A 2006 study of 798 public companies by the National Association of Corporate Directors found that 97 percent of the boards had standing "executive/nominating" committees.[63]

The specific role and responsibilities of board "executive committees" vary widely. Some meet often and perform substantial functions; others meet on rare occasions and have very limited duties. If a board decides to establish an executive committee, it is imperative to clearly define the committee's role and authority in board bylaws and monitor the committee's actions to ensure those parameters are honored.[64]

During the site visits to ten high-performing systems, it was learned that eight system boards have standing executive committees. As part of the interview process, members of those eight boards were asked: "In your opinion, how important is the Executive Committee in ensuring the board fulfills its overall responsibilities and why?" Of the 33 interviewees, 21 (64 percent) felt their board's executive committee is "Very Important" and the balance felt it is "Somewhat Important"; none said their executive committee is "Unimportant." In subsequent discussions, nearly all mentioned the need to clearly define the scope of an executive committee's duties and authority. The importance of maintaining a *clear distinction* between the role of the executive committee and role of the board was well-understood. Providing the CEO with a "sounding board" and serving as a platform to prepare for board discussions on major issues often were cited as key functions of executive committees.

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 community health systems that participated in this study reported that their boards have a predetermined, regular schedule of meetings. The frequency of board meetings is shown in Table 10. The overall pattern is fairly consistent among the three groups. Very few of these boards (and *none* of the high-performing system boards) meet less than six times or more than 12 times per year.

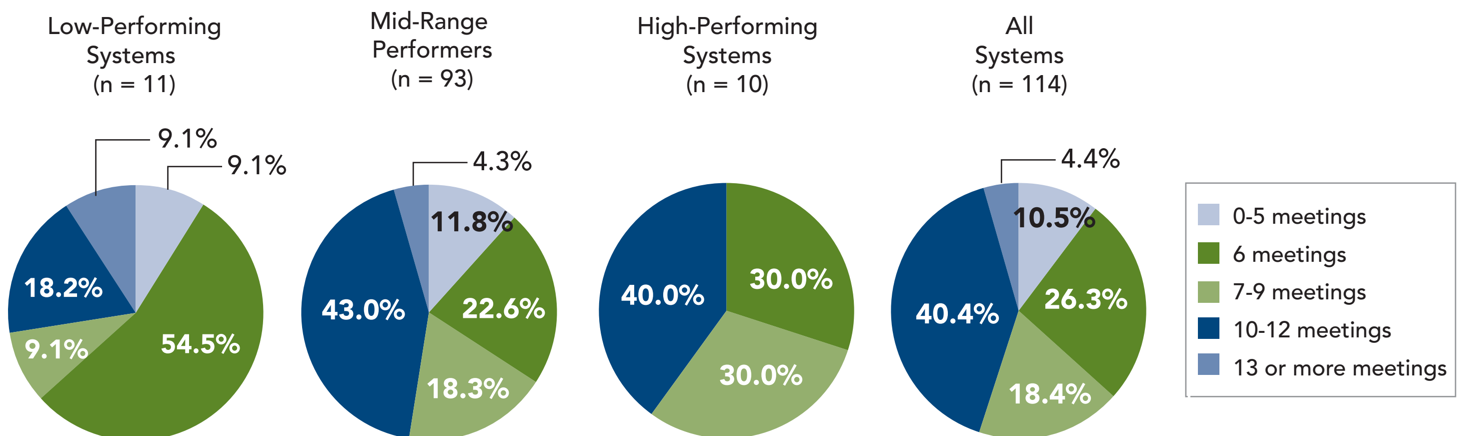
## CEO Evaluation

For both nonprofit and investor-owned 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. Studies in several fields show that having clear goals tends to enhance performance.[65] Evaluating the CEO's performance against pre-established expectations objectively and regularly is beneficial for the CEO, the board, and the organization as a whole. This has become accepted as a fundamental benchmark of good governance.[66]

National surveys suggest that a large majority of governing boards formally assesses their CEOs' performance in some manner. 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."[67] A 2006 survey of public companies found that 73 percent of the boards have established ". . .specific and measurable goals for the CEO's performance."[68]

TABLE 10

Number of Times the Board Has Met in the Past 12 Months[A]




[A] Test results are shown only when the observed differences were found to be statistically significant.

TABLE 11

## "Does the Community Health System Board Establish Written 'Performance Expectations' (e.g., specific objectives and/or criteria) for the System's CEO?"[A]

| | Low-Performing Systems (n = 11) | Mid-Range Performers (n = 93) | High-Performing Systems (n = 10) | All Systems (n = 114) |
|---|---|---|---|---|
| Yes | 72.7% | 71.0% | 90.0% | 72.8% |
| Done by the System's Parent Corporation, Not at the Community System Level | 0.0% | 21.5% | 10.0% | 18.4% |
| No | 27.3% | 7.5% | 0.0% | 8.8% |
| | 100.0% | 100.0% | 100.0% | 100.0% |

[A] Test results are shown only when the observed differences were found to be statistically significant.

TABLE 12

## Targets That Are Regularly Included in CEO Performance Expectations[A]

| | Low-Performing Systems (n = 8) | Mid-Range Performers (n = 66) | High-Performing Systems (n = 9) | All Systems (n = 83) |
|---|---|---|---|---|
| Financial Targets | 100.0% | 100.0% | 100.0% | 100.0% |
| Patient Care Quality and Safety | 100.0% | 98.5% | 100.0% | 98.8% |
| Leadership Team Building | 75.0% | 63.6% | 77.8% | 66.3% |
| Community Benefit Targets | 25.0% | 60.6% | 55.6% | 56.6% |

[A] Tests comparing the proportion of positive responses by the three groups of system CEOs on these four items found the observed differences were not statistically significant.

The survey data in Table 11 show the proportion of community health system boards that have established written performance expectations for their CEOs. Consistent with recent studies in several sectors, written performance expectations now are established for a large majority (91 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 83 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 12. As would be expected in the present healthcare environment, of the 83 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 provided by these systems, it is encouraging to see that performance expectations for 99 percent of these CEOs now include targets in this area. However, it is surprising that the performance expectations for only 66 percent of these CEOs address leadership team development. Even a smaller proportion of the CEOs — 57 percent — report that they have written performance expectations with respect to their organization's community benefit programs. In the contemporary environment, establishing formal expectations for the CEO regarding community benefit programs is becoming a good governance practice.

Nearly all (98 percent) of the 83 CEOs for whom formal performance expectations are established by community health system boards report their board "...formally evaluates their performance in relation to those expectations on a regular basis." The vast majority of these CEOs (96 percent) also state that adjustments in their financial compensation "... are linked directly to the results of their performance evaluation."

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.[69] With respect to CEO performance evaluations, numerous experts have raised serious questions about the rigor and efficacy of these processes.[70]

The 83 CEOs whose boards formally evaluate their performance in relation to pre-established objectives were asked their opinions about the effectiveness of the evaluation process that was in place at the time of the 2007 survey. During the on-site visits to ten high-performing systems in 2008, board members were asked the same question. Table 13 presents the responses of the CEOs and trustees. It is clear that the CEOs of low-performing systems are less satisfied with their current evaluation process than the CEOs of mid-range and high-performing systems. The difference is statistically significant. The CEOs of all high-performing systems consider the existing evaluation systems to be effective; their assessment is somewhat more positive than that of their board members. It should be noted that five of the 41 trustees who were interviewed (12 percent) joined their boards recently and were not in a position to provide a considered opinion on the current CEO evaluation process.

In total, these data suggest there is ample room to enhance the effectiveness of the CEO evaluation process in community health systems. 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 review and make improvements to its existing CEO evaluation policy and procedures.

TABLE 13

## CEO and Trustee Views on the Overall Effectiveness of Their System's Current CEO Evaluation Process[A]

| | Low-Performing Systems (n = 8) | Mid-Range Performers (n = 66) | High-Performing Systems (n = 9) | All Systems (n = 83) | High-Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| The process provides clear performance expectations and assesses actual performance fairly. | 37.5% | 72.7% | 100.0% | 72.3% | 72.3% |
| A process is in place and has been somewhat beneficial for the CEO and our organization. | 62.5% | 25.8% | 0.0% | 26.5% | 26.5% |
| The process is not well-organized and not very productive. | 0.0% | 1.5% | 0.0% | 1.2% | 1.2% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| $X^2 = 8.9$; $p < .05$[B] | 100.0% | 100.0% | 100.0% | 100% | 100% |

[A] This is the first table that includes the responses of trustees in high-performing systems. Tests comparing their responses to the responses of CEOs of high-performing systems found the differences were not statistically significant; this is a sign of agreement between trustees and their CEOs.
[B] The observed differences among the three groups of system CEOs are statistically significant.

## Board Evaluation

Serious examination of a board's structure, composition, and core practices on an ongoing basis — along with real commitment to make appropriate changes as a result of these examinations — are among the keys to improving governance effectiveness.[71] Studies have demonstrated that objective evaluation coupled with proper board development activities can improve board performance.[72]

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 assessments which are done vary 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.*[73]

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 and make changes* that will improve the board's structure, practices, and performance.[74]

In the 2007 survey of CEOs and during the site visits to ten high-performing systems, the following question was asked: "Does your community health system board engage in *formal* assessment of how well it is carrying out its duties?" The data presented in Table 14 indicate that nearly all boards of mid-range and high-performing systems do engage in "formal assessment" of how well they carry out their fiduciary duties; these assessments predominantly are done on an annual or biennial basis. According to their CEOs, only 64 percent of the boards of *low-performing* systems formally assess their performance.

TABLE 14

### "Does Your Community Health System Board Engage in Formal Assessment of How Well It Is Carrying Out Its Own Duties?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performance (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High-Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| Yes | 63.6% | 91.4% | 100.0% | 89.5% | 95.2% |
| No | 36.4% | 8.6% | 0.0% | 10.5% | 0.0% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 4.8% |
| $X^2 = 9.3$; $p < .05$[A] | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the high-performing systems also were compared; the observed differences are not statistically significant.

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 boards' willingness to take action. These data indicate that over 40 percent of the CEOs believe the investment of board members' time and other resources in board evaluation exercises did *not* produce substantial changes or, presumably, improvements. It is possible these evaluation processes concluded there was no need for "substantial changes" in the boards' current structure, composition, or practices. However, these data raise serious questions about the extent to which assessment processes are making a meaningful impact on improving governance, at least in a large segment of these community health systems.

With respect to the high-performing systems, 70 percent of the CEOs and trustees agree that their board evaluation processes have resulted in substantial changes in board practices and/or structures. In the on-site interviews, most trustees were able to give specific examples of actions taken by the board as a result of board self-evaluation efforts during the past two years, e.g., clarifying committee duties and authority, reducing the size of the board, adding more clinicians to the board, adding post-board meeting "executive sessions" as a standard practice, enhancing the board energy devoted to setting standards and monitoring the quality of patient care provided by the system's hospitals and clinics.

TABLE 15

## "Over the Past Two Years, Has the Board Assessment Process Resulted in Actions That Have Substantially Changed the Board's Practices?"[A]

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High-Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| Yes | 28.6% | 56.4% | 70.0% | 55.8% | 70.7% |
| No | 71.4% | 41.2% | 30.0% | 42.2% | 12.2% |
| Other | 0.0% | 2.4% | 0.0% | 2.0% | 17.1% |
| | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] Test results are shown only when observed differences were found to be statistically significant.

With respect to the high-performing systems, 70 percent of the CEOs and trustees agree that their board evaluation processes have resulted in substantial changes in board practices and/or structures.

In the CEO survey and on-site visits to high-performing systems, CEOs and trustees were asked to share their *overall* opinions on the effectiveness of their systems' current board evaluation process. Their responses, summarized in Table 16, suggest that all three categories of CEOs and the board members in high-performing systems have reservations about the effectiveness of their current board evaluation processes. The CEOs of high-performing systems are more positive than the CEOs affiliated with the low-performing and mid-range systems. They also are slightly more sanguine about these processes than their own board members.

On the whole, however, the CEOs' and board members' views indicate clearly that board evaluation processes need attention and improvement. This is important work. As David Nadler stated after a study of 200 large corporations:

*Board building is an ongoing activity, a process of continual improvement, which means boards must keep coming back to the same questions about purpose, resources, and effectiveness. The best mechanisms for doing that are annual self-assessments. According to our survey, conducting and acting on such assessments are among the top activities most likely to improve board performance overall.*[75]

TABLE 16

## "Which of the Following Statements Most Accurately Describe Your Overall View on the Effectiveness of Your Board's Current Evaluation Process?"

| | Low-Performing System CEOs (n = 11) | Mid-Range System CEOs (n = 93) | High-Performing System CEOs (n = 10) | All Systems (n = 114) | High-Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| Our board evaluation process is thorough and has resulted in substantial improvements in board performances. | 0.0% | 27.1% | 60.0% | 28.4% | 41.5% |
| A process is in place and has been somewhat beneficial for the board and organization. | 71.4% | 68.2% | 40.0% | 65.7% | 41.5% |
| The process is not well-organized and not very productive. | 14.3% | 3.5% | 0.0% | 3.9% | 2.4% |
| Other | 14.3% | 1.2% | 0.0% | 2.0% | 14.6% |
| $X^2 = 14.9$; $p < .05$[A] | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the *high-performing* systems also were compared; the observed differences are not statistically significant.

The CEOs of high-performing systems are more positive than the CEOs affiliated with the low-performing and mid-range systems.

## Community Benefit Policies, Plans, and Reports

The landmark work of the Commission on Hospital Care during and after World War II led to 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.[76]

Historically, tax-exempt status was accorded to nonprofit hospitals and health systems on the premise that a 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.[77] 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 IRS issued guidance in the form of a Revenue Ruling that embodied a broader rationale for granting tax-exempt status to nonprofit institutions: the so-called "Community Benefit Standard."[78] 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.[79, 80]

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.[81] 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.*[82]

In subsequent years, debate about the Community Benefit Standard and requirements for maintaining tax-exempt status has escalated. A number of voluntary healthcare organizations such as the AHA, the CHA, the HRET, the Public Health Institute, and the VHA have encouraged hospitals and health systems to document the services they provide and how their services benefit the communities they serve.[83] However, in the absence of definitive federal-level guidance beyond the vague Community Benefit Standard, nonprofit providers were reluctant to voluntarily adopt uniform definitions, standards, and public reporting practices. Consequently, several major studies by the GAO and other organizations documented wide variability in terminology, in the amount of "uncompensated care," and in other forms of community benefit provided by nonprofit hospitals and systems.[84, 85]

The growing evidence of this variability together with the lack of comparable information about community benefit provided by nonprofit hospitals and systems became a growing source of consternation for the Senate Finance Committee and other Congressional committees. It also has contributed to the adoption of various forms of community benefit requirements (such as a specific level of charity care) and/or standard reporting rules in at least 25 states.[86]

In the Summer of 2007, the IRS issued a report on its Hospital Compliance Project that studied community benefit activities in 487 hospitals. Like earlier studies, it found broad variation in definitions, activities, and the level of expenditure that hospitals report as "community benefit." In that year, the IRS also instituted a process that led to substantial revision of Form 990 that must be submitted annually by all tax-exempt organizations, including hospitals and health systems. The updated 990 form, specifically Schedule H, calls for much more information including charity care and other components of community benefit. The IRS has issued instructions, and the new reporting rules will be phased in beginning in 2008.[87] This is the first major revision to the 990 form since 1979.

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 regarding board oversight of community benefit are beginning to emerge. The findings of this study in relation to several of these emerging benchmarks are as follows:

**Board 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.[88] 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. . ."[89] 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 ongoing by governing boards about community benefit issues is becoming a necessary and important governance practice.[90]

In this context, CEOs in the 2007 survey and trustees of high-performing systems in the 2008 interviews were asked whether or not their boards engage in ". . . formal discussions on a regular basis about their systems' community benefit responsibilities and programs." As shown in Table 17, over 90 percent of the CEOs *and* trustees of high-performing systems responded affirmatively to this question. Only 36 percent of the CEOs of low-performing systems and 72 percent of mid-range performing systems indicated that their boards *regularly* discuss community benefit responsibilities and programs. The difference is statistically significant.

TABLE 17

## "Does the Community Health System Board Have Formal Discussions on a Regular Basis About the System's Community Benefit Responsibilities and Programs?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High-Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| Yes | 36.4% | 72.0% | 90.0% | 70.2% | 97.6% |
| No | 63.6% | 28.0% | 10.0% | 29.8% | 0.0% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 2.4% |
| $X^2 = 8.0; p < .05$[A] | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the *high-performing* systems also were compared; the observed differences are not statistically significant.

**Formal System Policy.** Ongoing dialog is a necessary ingredient but, in itself, is insufficient to ensure clear direction and priorities for the organization and its management team. To govern effectively, board deliberations must produce sound, well-constructed *policies* regarding key aspects of the organization's structure, functions, and strategies. 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.[91]

In the 2007 survey, the CEOs of community health systems were asked if their system board had adopted ". . .a formal written policy that defines overall guidelines for the system's community benefit programs." As shown by the data in Table 18, nearly all (90 percent) of the CEOs of high-performing systems answered affirmatively. Considerably smaller proportions of the CEOs of mid-range systems (60 percent) and low-performing systems (27 percent) said their boards had adopted a formal written policy on community benefit. The difference is statistically significant.

On-site interviews with board members at ten high-performing systems provided the opportunity for nuanced conversations about system policies. Nearly 80 percent of the board members stated that their board has, in fact, adopted a formal written policy. About half of them say their policies provide clear direction and guidelines for their system's entire community benefit program; the other half feel their current policies are mainly focused on their systems' charity care commitments and should become more comprehensive.

On-site review of the systems' community benefit policies confirmed that they vary considerably in scope and content. The main point that the CEO survey and trustee interviews reveals is that a large proportion of our nation's nonprofit community health systems currently are operating with limited or no formal board direction and guidance for their community benefit programs and services.

**Community Needs Assessment.** For years, many organizations, including the AHA,[92] the CHA,[93] the Public Health Institute,[94] 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 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 strategy that builds on community assets, promotes collaboration, and improves community health . . .*[95]

TABLE 18

"Has the Community Health System Board Adopted a Formal, Written Policy That Defines Overall Guidelines for the System's Community Benefit Programs?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) |
|---|---|---|---|---|
| Yes | 27.3% | 60.2% | 90.0% | 59.6% |
| No | 72.7% | 39.8% | 10.0% | 40.4% |
| $X^2 = 8.6; p < .05$ | 100.0% | 100.0% | 100.0% | 100.0% |

The AHA has made similar recommendations to the nation's hospitals.[96] It is apparent that board-level insistence on systemwide involvement in objectively assessing community health needs — preferably in cooperation with other community agencies — as a foundation for setting priorities for community benefit programs is an emerging benchmark of good governance for nonprofit hospitals and health systems.

The CEOs in the 2007 survey and trustees of high-performing systems in the 2008 on-site interviews were asked if their community health system ". . .engages in a *formal assessment process* designed to determine community needs to which system resources should be allocated." Table 19 shows that, according to the CEOs, about half of the community health systems (51 percent) conduct formal assessments of community health needs on a regular basis, either in collaboration with other local organizations or independently.

However, the pattern of engagement varies substantially among the low, mid-range, and high-performing groups. The difference is statistically significant. Collaborative approaches to assessing community needs are far more common among high-performing systems than the other groups, from the viewpoint of both their CEOs and board members

The *overall* picture that emerges from these data is that more than 27 percent of all systems engage in assessing community health needs "periodically" but not on a *regular basis*; one in five systems is not involved at all in formal assessment processes. It seems the absence of formal, board-approved policies regarding community benefit programs in over 40 percent of these community health systems (see Table 18) is reflected in lack of attention to formal assessment of community needs by a substantial proportion of them.

TABLE 19

## "Does the System Engage in a Formal Assessment Process Designed to Determine Community Needs to Which System Resources Should be Allocated?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High-Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| YES, the system collaborates with other local organizations in a community needs assessment process on a regular basis. | 9.1% | 26.9% | 70.0% | 28.9% | 65.7% |
| YES, the system conducts its own formal community needs assessment process on a regular basis. | 9.1% | 23.7% | 20.0% | 21.9% | 9.8% |
| YES, the system periodically engages in community needs assessment but not on a regular basis. | 18.2% | 30.0% | 10.0% | 27.2% | 9.8% |
| NO | 63.6% | 19.4% | 0.0% | 21.9% | 9.8% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 4.9% |
| $X^2 = 21.3$; $p. < .01$[A] | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the *high-performing* systems also were compared; the observed differences are not statistically significant.

**Formal Community Benefit Plan.** Particularly in America's current economic environment, organizations in all sectors of society including the healthcare field face resource constraints. 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."[97] 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.[98] These community benefit plans should set direction and provide benchmarks against which performance can be assessed.

The CEOs were asked if their systems' governing boards have adopted a formal "community benefit plan" that provides measurable objectives for their systems' community benefit programs. To provide a common framework, the CHA's definition of "community benefit activities" was included on the survey form. The data presented in Table 20 indicate that, in the CEOs' opinions, only 34 percent of these systems — one in three — had a formal, board-adopted community benefit plan in place in 2007. Another 41 percent of the boards had established some "priorities" for their systems' community benefit programs but had not developed or adopted formal plans.

Once again, these survey data reveal wide variation among the low, mid-range, and high-performing groups. Half of the CEOs of the high-performing systems reported that their systems had a "formal community benefit plan" in place; 44 percent of their board members expressed the same view. In general, however, the board members tended to be somewhat more self-critical of their systems' progress-to-date in developing strong, comprehensive community benefit plans. A large proportion of the board members — even those with formal plans in place — expressed, in one way or another, the view that "Our board has only begun to focus on our community benefit responsibilities" and that "We and our management teams have lots of work to do" in the community benefit area.

TABLE 20

## "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?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High- Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| YES, there is a formal, board-adopted community benefit plan of this nature in place. | 9.1% | 35.5% | 50.0% | 34.2% | 43.9% |
| The system board has established some priorities for the system's community benefit program, but, at this point, there is not a formal plan of this nature in place. | 18.2% | 43.0% | 50.0% | 41.2% | 24.4% |
| NO, not yet. | 72.7% | 20.4% | 0.0% | 23.7 % | 29.3% |
| Other | 0.0% | 1.1% | 0.0% | 0.9% | 2.4% |
| $X^2 = 18.7; p < .01^A$ | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the *high-performing* systems also were compared; the observed differences are not statistically significant.

It certainly is possible that some nonprofit healthcare organizations without formal, board-adopted plans have robust community benefit programs in place. However, it is clear that board-level attention and adoption of a solid plan based on serious assessment and prioritization of community health needs is becoming a good governance practice.

**Performance Reports.** As with other basic components of system operations, adopting a community benefit 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.[99]

The CEO survey data presented in Table 21 indicate that 68 percent of community health boards regularly receive performance data regarding progress toward objectives established for the organizations' community benefit programs. Consistent with the pattern found on other community benefit issues, the figure for high-performing systems (90 percent) is substantially larger than the mid-range systems (70 percent) and low-performing systems (36 percent). The difference is statistically significant.

The views of board members at high-performing systems interviewed in 2008 coincide closely with the views of their CEOs: 80 percent say their boards routinely receive reports on progress in relation to systemwide community benefit targets; only 10 percent say they do not. A large proportion of the board members say the most complete information they receive relates to their systems' *charity care* targets; many express the view that their community benefit objectives and performance reports represent "work-in-progress." They anticipate substantial improvement in target-setting and performance reports in the coming months and years. Naturally, the revised IRS 990 form, especially the new Schedule H, is one of the factors that will stimulate these efforts and board-level attention.

In general, the findings regarding board oversight of community benefit programs suggest there is a considerable gap between current practices and emerging benchmarks of good governance. The gap is substantially greater for the boards of low and mid-range performing systems as compared with high-performing systems.

TABLE 21

## "Is the Community Health System Board Regularly Presented with Performance Data on Measurable Systemwide Objectives Regarding Its Community Benefit Program?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High- Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| Yes | 36.4% | 69.9% | 90.0% | 68.4% | 80.4% |
| No | 63.6% | 30.1% | 10.0% | 31.6% | 9.8% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% | 9.8% |
| $X^2 = 7.5$; $p < .05$[A] | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the *high-performing* systems also were compared; the observed differences are not statistically significant.

## Monitoring and Assessing the Quality of Patient Care

In hospitals and health systems, ensuring that organizational standards for patient care quality 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.[100] 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.[101]

As Caldwell, Butler, and Grah stated recently:
*. . .boards of trustees often are ill-equipped to fulfill their obligations to ensure that quality strategies, metrics, infrastructures, professionals and oversight align. For instance, boards are rarely involved in detailed quality discussions, opting to allow the medical director, quality professionals or executive team to propose the final strategy for board approval.*[102]

In the contemporary environment, it is essential for community health system boards to understand the quality of patient care their organizations provide, engage proactively with management and clinical leadership in quality improvement processes, establish metrics for monitoring performance in relation to these metrics, and ensure that appropriate and timely corrective actions are taken by executive and clinical leadership when the quality of care does not meet established standards. These have become basic benchmarks of good governance.[103]

In this context, the Centers for Medicare and Medicaid Services (CMS), the Department of Justice, and other regulatory bodies increasingly are holding the governing board accountable if a healthcare institution is not providing patient care that meets established quality standards and the board ". . .knew or should have known about it, yet did nothing while the institution continued to submit claims to Medicare and other payers . . ."[104] If there is evidence this has occurred, the organization's leadership, including the board of directors, can be considered to have committed "quality fraud."[105]

TABLE 22

### "Which Statement Best Describes Your Community Health System's Role in the Quality of Patient Care?"[A]

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High- Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| The system board formally adopts the core measures and standards for quality of patient care. | 54.5% | 57.0% | 80.0% | 58.7% | 87.8% |
| A board committee adopts the core measures and standards and shares them with the board, but the board does not formally adopt them. | 45.5% | 26.9% | 20.0% | 28.1% | 12.2% |
| Measures and standards for quality of patient care are not done at the system level; this function is handled by the hospitals and other healthcare organizations within the system. | 0.0% | 16.1% | 0.0% | 13.2% | 0.0% |
| | 100% | 100% | 100% | 100% | 100% |

[A] Test results are shown only when the observed differences were found to be statistically significant.

TABLE 23

## "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?"[A]

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High- Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| YES, it does. | 90.9% | 96.7% | 100.0% | 96.5% | 100.0% |
| NO, this information is received and handled by a board committee. | 9.1% | 2.2% | 0.0% | 2.6% | 0.0% |
| NO, reporting and monitoring the quality of patient care is a function that is handled by the hospitals and other healthcare organizations within our system. | 0.0% | 1.1% | 0.0% | 0.9% | 0.0% |
| | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] Test results are shown only when the observed differences were found to be statistically significant.

In the 2007 survey, the community health system CEOs were asked to characterize their boards' current role with respect to the quality of patient care. The data in Table 22 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 rest of these systems (13 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.

During the on-site visits to ten high-performing systems in 2008, board members also were asked to express their view on which of the statements in Table 22 best represents their board's role with respect to patient care quality. On the whole, the trustees responses are congruent with those of their CEOs: 88 percent of the trustees and 80 percent of the CEOs indicate that their boards formally adopt core measures and standards for the quality of patient care within their systems.

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 basic benchmark of good governance.[106] The data presented in Table 23 suggest that current board practices in community health systems are consistent with this benchmark. In the aggregate, 97 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. *All* of the CEOs and *all* of the board members affiliated with the high-performing systems responded affirmatively to this question.

It is likely there is great variation in the form and content of the quality reports these boards receive. This certainly is the case with the ten high-performing systems where interviews with board members and CEOs were conducted in mid-2008. However, with virtually no exceptions, these trustees and CEOs conveyed realization of their board's responsibility for patient care quality and commitment to continuous improvement in the performance of their oversight functions. Based on the 2007 CEO survey findings *and* these 2008 interviews, it appears that the majority of nonprofit system boards are beginning to heed Donald Berwick's call to embrace "stewardship of quality" as a fundamental board duty.[107]

RESEARCH OBJECTIVE #3

### EXAMINE GOVERNANCE CULTURE IN COMMUNITY HEALTH SYSTEMS

Effective boards understand their role and fiduciary duties, 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 its duties. Each board is responsible for shaping its own culture. As stated by Barry Bader:

*A governing board's culture may be passive or assertive, complacent or diligent, accepting of rationalizations or demanding of results. The board may be inclined to accept average performance or to challenge management to achieve stretch goals. Hospitals and health systems today need a board culture in which directors do their jobs with rigor, challenge management to pursue benchmark performance, give frank advice, heed red flags and demand accountability. They need a culture that allows board members to carry out their responsibilities respectfully but also to put organizational good before friendships and professional relationships.*[108]

However, boards too often are insufficiently committed, the governance culture is passive, and the result is underperformance.[109] 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.[110]

## Characteristics of Effective Board Culture

The Center for Healthcare Governance and HRET recently convened a Blue Ribbon Panel including senior board leaders, CEOs, governance consultants, and university faculty members with experience in governance research and service. The panel was asked to ". . . examine [five] critical issues facing health care boards and practices that lead to exceptional performance." One of those five issues was "Building and sustaining a proactive and interactive board culture."[111] Based on previous studies and their collective experience, this panel identified the 11 features they believe characterize an "effective board culture."[112]

CEOs of community health systems in the 2007 survey and board members at high- performing systems during on-site interviews in 2008 were asked to express their views on the extent to which their systems' governing boards demonstrate these 11 characteristics.[113] Table 24 displays the CEOs' and board members' views. The data indicate a large majority of all CEOs (89 percent) and all of the trustees who were interviewed believe their boards always demonstrate commitment to their community health systems' mission. On the other hand, *less than half* of the CEOs believe their boards always review core governance processes on a regular basis (42 percent), systematically define their needs for expertise and recruit new board talent to meet those needs (37 percent), recognize the importance of ongoing board education (43 percent), and hold board members to high standards of performance (42 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.

The views of the CEOs of low, mid-range, and high-performing systems differ statistically on only two of the 11 characteristics. However, on *all* of these characteristics, the CEOs of high-performing systems assess their boards' culture somewhat more positively than the other two groups.

With respect to the high-performing systems, *all* of the CEOs and *all* of the trustees who were interviewed believe their governing boards always demonstrate commitment to their system's mission. This congruence is striking. The trustees rate their boards somewhat more highly than the CEOs on eight of the other ten characteristics of effective board culture.

TABLE 24

## CEO and Trustee Opinions on the Extent to Which Their Boards Demonstrate the HRET – Center for Healthcare Governance Panel's Characteristics of Effective Board Culture [A, B]

| | CEOs of Low-Performing Systems (n = 11) | | CEOs of Mid-Range Performers (n = 93) | | CEOs of High-Performing Systems (n = 10) | | CEOs of all Systems (n = 114) | | High- Performing System Trustees (n = 41) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Always | Sometimes | Always | Sometimes | Always | Sometimes | Always | Sometimes | Always | Sometimes |
| (a) The board's actions demonstrate commitment to our organization's mission. | 72.7% | 27.3% | 89.2% | 10.8% | **100.0%** | 0.0% | 88.6% | 11.4% | 100.0% | 0.0% |
| (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. X2 = 8.5; $p < .05$ | 18.2% | 81.8% | 40.9% | 59.1% | **80.0%** | 20.0% | 42.1% | 57.9% | 63.4% | 34.1%[C] |
| (c) The board systematically defines its needs for expertise and recruits new board members to meet these needs. | 9.1% | 90.9% | 38.7% | 61.3% | **50.0%** | 50.0% | 36.8% | 63.2% | 58.5% | 31.7%[D] |
| (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. | 63.6% | 36.4% | 71.0% | 29.0% | **90.0%** | 10.0% | 71.9% | 28.1% | 95.1% | 4.9% |
| (e) The board places high priority on addressing long-range strategic issues that confront our organization. X2 = 6.8; $p < .05$ | 27.3% | 72.7% | 66.7% | 33.3% | **70.0%** | 30.0% | 63.2% | 36.8% | 92.7% | 7.3% |
| (f) Board meetings are characterized by high enthusiasm. | 36.4% | 63.6% | 50.5% | 49.5% | **60.0%** | 40.0% | 50.0% | 50.0% | 80.5% | 19.5% |
| (g) There is an atmosphere of mutual trust among the board members. | 54.5% | 45.5% | 71.0% | 29.0% | **80.0%** | 20.0% | 70.2% | 29.8% | 85.4% | 14.6% |
| (h) Board members clearly recognize the importance of ongoing board education. | 18.2% | 81.8% | 43.0% | 57.0% | **70.0%** | 30.0% | 43.0% | 57.0% | 63.4% | 34.1%[C] |
| (i) Board leadership holds board members to high standards of performance. | 18.2% | 81.8% | 41.9% | 58.1% | **70.0%** | 30.0% | 42.1% | 57.9% | 75.6% | 22.0%[C] |
| (j) Constructive deliberation is encouraged at board meetings. | 63.6% | 36.4% | 65.6% | 34.4% | **80.0%** | 20.0% | 66.7% | 33.3% | 90.2% | 7.3%[C] |
| (k) Respectful disagreement and dissent are welcomed at board meetings. | 54.5% | 45.5% | 51.6% | 48.4% | **70.0%** | 30.0% | 53.5% | 46.5% | 90.2% | 9.8% |

[A] For the responses of the CEOs of low, mid-range, and high-performing systems, this table compares the proportion of the groups whose response to this question was "Always." For each characteristic, the figure in **bold** type indicates which group of CEOs rated their boards higher.

[B] The 11 characteristics, with some abbreviations, were adopted from Building an Exceptional Board: Effective Practices for Health Care Governance, op. cit. p. 14.

[C] For these four characteristics, one trustee was unsure or chose to not provide a response.

[D] For this characteristic, four trustees were unsure or chose to not provide a response.

## Approach to Decision-Making

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.[114]

As one way to gauge this dimension of the community health systems' board culture, CEOs in the 2007 survey and trustees during individual interviews in 2008 were asked to characterize their respective board's approach to making decisions on important issues. Table 25 presents their responses. From the viewpoint of CEOs as a whole, over 70 percent of these boards tend to be ". . . actively engaged in discourse and decision-making" and most board members ". . . are willing to express their views and constructively challenge each other and the management team." The balance (30 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.

Table 25 indicates 100 percent of the CEOs of high-performing systems view their boards' approach to decision-making positively. This is higher than the CEOs of mid-range (69 percent) and low-performing systems (55 percent). The difference is statistically significant. The CEOs of high-performing systems also rate their boards somewhat higher on this characteristic than the trustees' self-assessment. Still, over 90 percent of the trustees believe their boards are "actively engaged" in decision-making processes and willing to "constructively challenge each other and the management team" in boardroom discourse.

TABLE 25

### "Over the Past 12 Months, How Would You Characterize Your System Board's Approach to Making Decision on Important Issues?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) | High- Performing System Trustees (n = 41) |
|---|---|---|---|---|---|
| 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. | 9.1% | 0.0% | 0.0% | 0.9% | 0.0% |
| The board is involved in some issues, but its level of engagement is inconsistent. The board's decision-making process would benefit from more dialog and debate. | 36.4% | 31.2% | 0.0% | 28.9% | 9.8% |
| The board tends to be actively 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. | 54.5% | 68.8% | 100.0% | 70.2% | 90.2% |
| $X^2 = 14.3$; $p < .05$[A] | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

[A] This is the result of a test that compared data for the three groups of system CEOs; the observed differences are statistically significant. Data for the CEOs and trustees of the *high-performing* systems also were compared; the observed differences are not statistically significant.

## Allocation of Board Meeting Time

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.*[115]

Table 26 displays the CEOs' estimates of how their boards have allocated their meeting time over the past 12 months. These data suggest that the boards of low-performing systems allocate substantially less time to oversight of community benefit programs and more time to oversight of their systems' financial performance as compared to the boards of mid-range and high-performing systems. The allocation of relatively more time to financial matters by the boards of low-performing systems may reflect their awareness and concern about their systems' operating performance. Otherwise, the CEOs' estimates of how the boards employ their time are, on the whole, fairly similar among the three groups.

A second finding is 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.[116]

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 about 76 percent of community system board meeting time.

TABLE 26

### "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?"

| | CEOs of Low-Performing Systems (n = 11) | CEOs of Mid-Range Performers (n = 93) | CEOs of High-Performing Systems (n = 10) | All Systems (n = 114) |
|---|---|---|---|---|
| Strategic planning (including updating the system's strategic plan, reviewing progress reports, etc.) | 22.2% | 28.3% | 24.2% | 27.4% |
| Oversight of financial performance | 34.8% | 24.6% | 23.7% | 25.5% |
| Oversight of patient care quality and safety | 24.4% | 22.7% | 25.2% | 23.1% |
| Board development (including board succession planning, recruitment, education, performance evaluation, etc.) | 11.0% | 10.1% | 9.6% | 10.1% |
| Oversight of community benefit program | 2.1% | 7.4% | 9.5% | 7.1% |
| Monitoring the CEO's performance in relation to established expectations | 5.5% | 6.9% | 7.8% | 6.8% |
| $X^2 = 109.2$; $p < .01$ | 100.0% | 100.0% | 100.0% | 100.0% |

## Dimensions of Board Culture

In all sectors of society, there is growing interest in the duties and effectiveness of the boards that govern America's investor-owned and nonprofit organizations. There is general accord that governance is important and that it should be improved.

As stated in Section I of this report, the American people recently have witnessed numerous examples of the adverse impact that poor governance can have on organizations. Inadequate board performance has contributed to an array of corporate debacles for organizations such as Allegheny Health, Education and Research Foundation (AHERF), Enron, HealthSouth, Merrill Lynch, Morgan Stanley, and WorldCom.[117]

In these and other cases, poor governance has been shown to contribute substantially to poor organizational performance and, at times, failure. Common sense would suggest the inverse also should be true: i.e., that *effective* governance should contribute in some degree to organizational success. Examining this thesis is complicated by many factors, particularly the difficulty of defining and measuring "effective governance" and "organizational performance" in an objective, consistent fashion. The historical evidence has been mixed.[118] However, there is a growing body of empirical studies supporting the general proposition that there is a positive relationship between the caliber of governance and organizational success.[119]

With respect to board culture, the CEO survey yielded comparable data on 12 variables: the 11 characteristics of effective board culture listed in Table 24 and the boards' approach to decision-making (see Table 25). Through exploratory factor analysis, three of these 12 characteristics were removed because their statistical association with the other variables was insufficient.[120] When taken together, the nine remaining variables form a reliable (coefficient alpha = .78) and valid scale. These nine variables group together statistically into three distinct yet moderately related clusters that appear to represent *basic dimensions of board culture*. These three dimensions, their factor loadings, and the terms selected by the research team are presented in Table 27. The correlations among these three dimensions are shown in Table 28.

Examining and trying to understand the culture of any organization or group is difficult terrain. This study has tried to gain some insight into board culture in community health systems and how that culture is perceived by system leaders. A future phase of research will examine associations between selected facets of board structures, practices, and cultures and measures of health system operating performance, including but not limited to the one employed in this study. These three dimensions of board culture are among the variables that can and should be considered in designing the next phase of study.

As stated in Section I of this report, the American people recently have witnessed numerous examples of the adverse impact that poor governance can have on organizations.

TABLE 27

## Three Dimensions of Board Culture Identified Through Exploratory Factor Analysis

| Clusters of Culture-Related Variables | Factor Loadings | Descriptors for These Three Dimensions of Board Culture |
|---|---|---|
| Board meetings are characterized by high enthusiasm. | .482 | **Robust Engagement** |
| Constructive deliberation is encouraged at board meetings. | .818 | |
| Respectful disagreement and dissent are welcomed at board meetings. | .832 | |
| The board consistently is actively 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. | .646 | |
| The board's actions demonstrate commitment to our organization's mission. | .837 | **Mutual Trust and Willingness to Take Action** |
| Our organization's performance (financial and clinical) is tracked closely by the board and actions are taken when performance does not meet our targets. | .734 | |
| There is an atmosphere of mutual trust among the board members. | .743 | |
| The board systematically defines its needs for expertise and recruits new board members to meet these needs. | .918 | **Commitment to High Standards** |
| Board leadership holds board members to high standards of performance. | .557 | |

Factor loading represents correlation ($r_{xy}$) between the variable and that dimension of board culture.

TABLE 28

## Correlations Among the Three Dimensions of Board Culture

| Board Culture Dimensions | Robust Engagement | Mutual Trust and Willingness to Take Action | Commitment to High Standards |
|---|---|---|---|
| Robust Engagement | 1.000 | .0.313 | 0.192 |
| Mutual Trust and Willingness to Take Action | 0.313 | 1.000 | 0.256 |
| Commitment to High Standards | 0.192 | 0.256 | 1.000 |

**RESEARCH OBJECTIVE #4**

EXAMINE THE PERCEPTIONS OF HIGH-PERFORMING SYSTEM BOARD MEMBERS REGARDING KEY FACTORS THAT INFLUENCE SYSTEM OPERATING PERFORMANCE

The 41 board members who were interviewed during on-site visits were informed that the operating performance of their systems ranked in the top tier of the study population and, after the structured portion of the interview, each was asked two open-ended questions:

- From your perspective, what are the key factors that have contributed to this high level of operating performance?"
- "In your opinion, was there a particular event or development in the system's history (an 'inflection point') from which the system's operating performance began to change and improve?"

This section of the report provides an overview of the trustees' views regarding key factors that have contributed to organizational excellence, as well as their views regarding precipitating events which effected dramatic change in the institutions.

## Key Factors in Achieving High Operating Performance

There are, of course, numerous factors that influence the operating performance of complex healthcare organizations. These include internal factors such as management and clinical staff capabilities and external factors such as the economic environment and payer mix. In these confidential interviews, several board members at ten high-performing health systems were asked to reflect and identify the "short list" of factors they felt have been *most important* in contributing to their system's strong operating performance.

The greater majority of interviewees were articulate and spoke with conviction in expressing their perceptions. Six principal factors or themes emerged from the interviews.

**Strong, Values-Based CEO Leadership.** Not surprisingly, many interviewees at nine of the ten systems commented on the vital importance of effective CEO leadership in achieving and maintaining a high level of system operating performance. Among the specific attributes mentioned frequently were commitment to the system's mission and values, excellent communications and relationships with the board and medical staff(s), expertise in financial management and cost controls, passion for improving the system and its services, and strategic vision.

At seven of the ten systems, the importance of the system's overall management *team* was emphasized by many — in some systems, nearly all — of the trustees. There was broad-based recognition that strong, effective teams with expertise in the full range of management functions are essential to successful system operations in the contemporary healthcare environment. Further, the ability to attract talent and develop strong, effective management teams is widely recognized by these trustees as an essential characteristic of successful CEOs.

Board members at several systems acknowledged that former CEOs exhibited characteristics and relationships which impeded progress and exerted an adverse impact on performance. In one instance, a CEO was said to have "ruled with an iron fist." A substantial number of the interviewees volunteered the opinion that their boards had been slow in replacing a poorly functioning CEO. A majority of interviewees underscored the importance of their CEO as the primary organizational leader in driving the system's operating performance to high levels and doing so in a fashion consistent with the organization's core values. Most were in accord that their current CEO has had a positive and often dramatic impact on their community health system.

**Well-Understood Mission, Vision, and Values**. Interviewees at eight of the ten community health systems emphasized — sometimes using different terms — the importance of having a meaningful systemwide mission statement, a compelling vision for the system's future, and a clearly-stated set of core values that are understood and supported by key stakeholder groups, both internal and external. There appeared to be a general consensus that expressions of organizational mission, vision, and values can be powerful in unifying the stakeholders and galvanizing energy toward established goals and standards *if* they are consistently reinforced by organizational leaders throughout the system. Several board members recalled earlier periods in their system's history when such statements were "spoken" but not "lived." They spoke with conviction about how this has changed and the positive impact this change has had on the organization's culture and success. They also recognize that building the understanding and support of key constituencies within the system and in the communities it serves is a great challenge and requires continuous attention by governance and management leadership.

**Committed and Engaged Board of Directors.** The existence of a highly-committed, well-informed, and proactive governing board that works collaboratively with the CEO and physician leadership was identified by trustees at eight systems as being highly important in attaining and maintaining organizational success. As will be discussed below, a substantial number of these interviewees had vivid memories of a previous period when their system's board was relatively passive and unaware of environmental, strategic, and operational issues that eventually led to problems that threatened the system's future. These trustees often spoke with pride about the transformation of their board into a more effective body and conveyed eloquently their commitment to seeing this continue in the future.

Many board members stressed the importance of well-organized and staffed board committees, the leadership role of the board chair, and a mutually-supportive relationship between the board chair and the CEO. In this context, it is noteworthy that, in the *structured* portion of the interview process, all 41 trustees were asked, in their opinion, "Is there general agreement [within your organization] on the distinctions between the board chair's role and the CEO's role?" *All* of the interviewees responded affirmatively to this question suggesting once again that role clarity is an important contributor to effective working relationships.

In discussing the contributions that effective boards can make to organizational success, trustees at most of these systems addressed, in various ways, the importance of a *trust-based relationship* between a board of directors and its CEO. As will be discussed later in this section, CEO changes have been made in a majority of these systems in recent years. A lack of confidence and/or trust in the former CEOs contributed to most of these changes. Many trustees in a majority of these systems discussed the high level of trust and respect they and their board colleagues have for their current CEO. They also appreciate their CEO's commitment and contributions to building a strong, well-informed, and engaged board.

**Strong Clinical Leadership and Capabilities.** At least one senior physician trustee was interviewed at all ten systems. At eight systems, they and other trustees underscored the vital importance of committed, competent clinicians as a critical determinant of operational performance. It is their opinion that, without strong physician leadership, no hospital or health system can achieve enduring success. Several also spoke about the importance of excellent nursing leadership.

Both physician and lay trustees in four locations stressed the importance of building strong, mutually-beneficial *partnerships* between the system or its hospitals and physicians. At one system, all of the interviewees underscored the development of a series of joint ventures with physician groups as a principal contributor to steady improvement in the system's operating performance in recent years. Another system is the product of an asset merger between a large, well-established multi-specialty group practice and a major regional hospital. This merger was accomplished after a long planning process during which the leadership of both

organizations concluded the changing healthcare environment demands more fully integrated healthcare delivery models and new forms of collaboration between physicians and healthcare institutions. This integrated system is succeeding, and the board members and CEO believe it can and should be replicated in other communities.

**Clearly-Defined Organizational Objectives, Targets, and Metrics.** In one way or another, interviewees in six of the ten community health systems stressed the importance of having well-defined organizational "targets" together with evidence-based metrics that enable board, executive, and clinical leadership to monitor actual performance in relation to established standards in key aspects of system operations, including but not limited to community benefit, financial performance, and patient care quality. From the viewpoint of many trustees, the development of clearer targets, higher standards, and better metrics presented to system leadership on a regular basis has been a major contributor to achieving and maintaining high levels of performance — and in prompting swifter corrective action when established standards are not being met. In the area of patient care quality and safety, there is general recognition that precision in setting proper standards and in measuring performance remains elusive. However, consistent with their responses to structured questions (see Tables 22 and 23), interviewees largely express the view that their systems have made and continue to make progress in quality measurement and reporting.

**Healthy Organizational Culture.** Until recent years, the concept of a healthy organizational culture had not emerged as a salient force which can enhance progress toward strong performance outcomes. Although ambiguous and difficult to define, this concept is gaining significant traction in the health arena and is finding its place in the administrative lexicon. Momentum has been building to understand the complex culture of healthcare organizations through research and to adopt new approaches to performance improvement that incorporate cultural change. It is clear that hospitals and systems can be seen as an agglomeration of cultures, each with its own strengths and weaknesses.

The concept of organizational culture and its importance to organizations was mentioned specifically by trustees at six of the ten high-performing systems. A unifying theme, expressed in different ways, was that the prevailing culture within their system has come to include broad-based *commitment to excellence* in patient care and operating performance. Most emphasized that this commitment has not always existed but has been built through collaboration by clinical, governance, and management leadership in more recent years, either in response to serious organizational difficulties and/or as a core strategy for improving operating performance, esprit de corps, and competitive edge. In various ways, the interviewees expressed awareness of the complexity *and* the importance of shaping the organizational culture of their system to embrace its core values and commitment to high performance.

The interviews with trustees surfaced a number of other factors that, in their opinion, have contributed to their system's strong operating performance, e.g., population growth, improved payer mix, strategic mistakes by competitors, and so on. However, on the whole, the six factors outlined above emerged as the most influential in the opinion of these trustees. Table 29 shows the systems where trustees indentified these as the most important factors.

A unifying theme, expressed in different ways, was that the prevailing culture within their system has come to include broad-based *commitment to excellence* in patient care and operating performance.

TABLE 29

## CEO and Trustee Opinions on the Extent to Which Their Boards Demonstrate the HRET – Center for Healthcare Governance Panel's Characteristics of Effective Board Culture [A, B]

| | Strong, Values-Based CEO Leadership | Well-Understood Mission, Vision, and Values | Committed and Engaged Board | Strong Clinical Leadership | Clearly-Defined Objectives, Targets, and Metrics | Healthy Organizational Culture |
|---|---|---|---|---|---|---|
| System #1: In Southwest; Part of a Larger Parent Organization | X | X | | X | X | |
| System #2: In Southwest; Part of a Larger Parent Organization | X | X | X | | | X |
| System #3: In North Central; Independent System | X | X | X | | X | X |
| System #4: In Midwest; Independent System | X | | X | X | X | X |
| System #5: In Midwest; Independent System | X | X | X | X | | |
| System #6: In East; Independent System | X | X | X | X | | X |
| System #7: In Midwest; Independent System | X | X | X | X | X | X |
| System #8: In North Central: Independent System | X | X | | X | X | |
| System #9: In Northwest; Part of Larger Parent Organization | X | X | X | X | X | |
| System #10: In North Central: Independent System | | | X | X | | X |
| | 9 | 8 | 8 | 8 | 6 | 6 |

## Pivotal Events or Developments in the System's History That Proved To Be a Turning Point to Higher Operating Performance

Many organizations, perhaps most, move through cycles of progress and decline. It is difficult to maintain high-performing status over long periods of time. All ten community health systems where site visits were made have demonstrated strong operating performance in *recent years*. However, interviews with board members and subsequent discussions with the CEOs indicated most of these systems have experienced in the not-too-distant past environmental changes and/or operational difficulties that required awakening of the governing board and leadership changes to "right the ship" and drive performance improvement. In brief:

- In three situations, a combination of poor management leadership and passive governance had resulted in a gradual decline in operating performance and, eventually, a financial crisis that seriously threatened the system's survival. In all three, a stark examination by an external consulting firm and/or a special board-led work group led to the appointment of a new, energetic CEO, renewed commitment and more proactive engagement by the board, a series of operational changes, and fresh vision and strategic direction for the system.
- In four other situations, major developments in the healthcare environment dictated the need for dramatic action by system boards. In brief, these developments included a failed merger with the only other healthcare provider in the region after a long process that had immobilized both organizations; aggressive moves by a strong competitor to seize control of a community health system's primary service area; changes in third-party reimbursement, medical technology, clinical practice patterns and other factors that created a compelling case to consolidate a multi-specialty group practice and a regional hospital into a single, integrated delivery organization; and a unique opportunity in a large and rapidly-growing metropolitan area for a community health system to accept responsibility for the region's publicly-owned charity hospital and clinics and, in the process, fundamentally transform and enlarge its mission, vision, and role in the region. In three of these four situations, the magnitude of the environment developments and the leadership challenges associated with them led to the appointment of new CEOs who, in concert with their boards, charted the new direction and new strategies for the system.
- In two situations, systems experienced neither a crisis nor a major environmental development which demanded prompt action, but, instead, arrived at a point where CEO retirement or resignation required the selection and appointment of a new CEO — and this person brought great energy, stronger leadership skills, and foresight that has generated systemwide enthusiasm, a new vision, an enlivened organizational culture, and community pride in their health system.

So, in nine out of these ten systems, board members clearly recognized a particular event and moment in time — a severe crisis, a major environmental development, or, simply, the appointment of a new CEO — that proved to be a *pivotal* inflection point in the organization's history. From these events came strategic, operational, and cultural changes which have provided the foundation for significant improvement in the systems' operating performance and success. In eight of these cases, the appointment of a new and more effective CEO has been a vital ingredient in performance improvement. In many, new board members and a higher level of board commitment and engagement have been critically important.

At the tenth community health system — a highly-respected organization whose operating performance consistently has been exceptional for over 30 years — the board chair expressed the view that ". . . we are at our system's inflection point *right now*." In his opinion, shared by other board members and the CEO, the combination of serious economic woes in this system's local and statewide economy, demographic changes that are affecting their patient and payer mix, aggressive moves by competitors, and major capital commitments to new ambulatory centers, information technology, and medical education programs place this system at a decisive moment. How well the system's board, executive management team, and clinical leadership deal with these issues in the coming months will, in the board chair's view, ". . . determine our system's survival and success."

# IV. Conclusions and Recommendations

The purpose of this study is to examine the structure, practices, and cultures of community health system boards and compare them to several benchmarks of good governance. The intent is two-fold: first, to identify areas where, on the whole, the governance of these systems could be improved and, second, to provide information and recommendations for consideration by board leaders and CEOs in their ongoing efforts to enhance board effectiveness.

For this report, community health systems were scored on two performance measures: their hospitals' operating performance for a three-year period using Thompson Reuters Healthcare data and, based on information provided by CEOs in a 2007 survey, the extent to which their boards' structure, practices, and culture meet 39 benchmarks of good governance. The systems whose scores on *both* measures were in the bottom third of the range are defined as "low-performing" systems; 11 systems located in ten different states are in this category. Those whose scores were in the top third of the range on *both* measures are defined as "high-performing" systems; 17 systems located in 11 states are in this category. The balance are defined as "mid-range" performers.

Section III of this report presents findings from the CEO survey and on-site interviews with board members and CEOs at ten of the 17 high-performing systems. These findings provide the foundation for the following conclusions:

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

- Clear limits in their bylaws on the number of voting board members
- Substantial involvement of physicians in governance roles
- Inclusion of CEOs as voting members of the board
- Existence of board committees with clear oversight responsibility for several governance functions; i.e., audit, executive compensation, and patient care quality and safety
- 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)
- Some form of regular evaluation of CEO performance in relation to established targets
- Direct linkage of CEO compensation adjustments to results of CEO evaluation processes
- Boards regularly receive formal reports on system performance with respect to the quality of patient care
- Board actions demonstrate commitment to the system's mission

2. In several, but not all, areas, the governance of high-performing systems as defined in this study is more consistent with current benchmarks than the mid-range and low-performing systems. Areas where the differences are particularly clear and statistically significant include:

- The proportion of systems where the role and responsibilities of standing board committees are spelled out in written, board-approved documents
- The proportion of systems whose CEOs believe their boards' present processes for setting their job expectations and assessing their performance is effective
- The proportion of systems whose boards engage in formal assessment of how well they are carrying out their fiduciary duties
- The proportion of systems whose CEOs believe the existing process for evaluating board performance is effective
- The proportion of systems that regularly engage in formal discussions about their organizations' community benefit responsibilities and programs
- The proportion of systems that collaborate regularly with other local organizations in community needs assessment
- The proportion of systems whose boards have adopted a system-level policy and a formal system-level plan with measurable objectives for the organizations' community benefit programs
- The proportion of systems whose boards regularly receive reports on the organizations' performance in relation to the established objectives for their community benefit programs

- The proportion of systems whose boards are actively engaged in discourse and decision-making processes, and whose members are willing to express their views and constructively challenge each other and the systems' management team

In addition, while most of the observed differences are not statistically significant, the findings presented in Table 24 suggest that the cultures of high-performing system boards may be more consistent with the characteristics of "effective board culture" as defined in a HRET – Center on Healthcare Governance report in 2007 than the boards of mid-range and low-performing systems.

3. On the whole, the views of CEOs and trustees of high-performing community health systems about their boards' structures, practices, and cultures are consistent. While the data were collected by different methods (mail survey vs. on-site interviews) at different times (2007 vs. 2008), there are no statistically significant differences between the aggregate views of the CEOs and trustees on a series of questions. On most questions, the views of the CEOs and trustees are not identical, but they are congruent; this congruence adds a degree of confidence to the validity of the findings presented in Section III and the conclusions stated above.

4. Of the ten high-performing systems where site visits were made, nine experienced in recent years a decisive moment in their history — a serious crisis that threatened the organization's survival, a major environmental challenge or opportunity, or the need to replace the system CEO due to retirement or resignation. At these inflection points, it seems clear that all of these boards — sometimes with the advice and assistance of external consultants — recognized the key issues and made a decision or series of decisions that, over time, have contributed to moving the system toward sustained, successful performance. In eight cases, the board's selection of a new and more effective CEO has proved to be a vital ingredient in this improvement. Recruiting, selecting, and supporting the CEO's professional development are critical governance duties. It is evident that these boards have pride in the performance of their CEOs and systems, and have maintained a proactive stance with respect to their fiduciary responsibilities.

The tenth system — an organization whose performance has been consistently stellar for decades — presently is facing a combination of major environmental and strategic challenges. Board leaders believe this may prove to be a pivotal inflection point for their system.

5. A *multitude* of factors contribute in varying degrees to organizational performance. According to trustees at ten high-performing community health systems, six factors have been especially influential in their organizations' success in recent years. In brief, they are:

- Strong, values-based CEO leadership
- Well-understood systemwide mission, vision, and values
- A highly committed and engaged board of directors
- Strong clinical leadership and capabilities
- Clearly-defined organizational objectives, targets, and metrics
- Healthy organizational culture

6. Finally, and most important, it is clear that — for the *entire* set of community health systems — there are substantial gaps between present reality and current benchmarks in a majority of the dimensions of governance addressed in this report. At least in part due to the selection criteria, the gaps are somewhat smaller for systems in the high-performing systems, but they are evident in all three groups. With respect to several basic benchmarks, the gap is large and troubling; e.g., the findings suggest that nearly all boards routinely assess how well they are carrying out their duties but, in most cases, these exercises apparently did not lead to substantial changes in board structures, composition, practices, or culture.

*All* of the benchmarks addressed in this report are attainable. Each one was being met by several systems when data presented in this report was collected in 2007 and 2008. If community health system boards wish to improve their performance, and we believe most do, there are a number of areas where attention can and should be directed.

## Recommendation #1

The governing boards of all community health systems are encouraged to devote time and energy to serious reflection and dialog about their fundamental role, responsibilities, and the overall caliber of their performance in recent years — and then make a shared commitment and develop a concrete strategy for becoming a better, more proactive, and more effective board.

Most boards do some things well, but universally there are gaps between board structures, practices, and culture and contemporary benchmarks of good governance. The healthcare environment is more challenging and less forgiving than in past years. Hospitals and health systems must address a host of economic, operational, and strategic issues. Governing boards must be alert and engaged. Every board can and should be more effective and should aspire for excellence. Every board has the responsibility and the power to make the decisions and take the actions that will lead in that direction. Virtually all of the high-performing systems where site visits were made have demonstrated this.

Boards can create their own inflection point. They can improve their structures, composition, and practices — and create a more vibrant board culture. In doing so, they will improve their effectiveness and the leadership they provide for their organizations. To be passive, mediocre, and content with the status quo is irresponsible governance.

## Recommendation #2

Community health system boards and their CEOs should re-examine their current size and composition. A substantial number of community health system boards — particularly the boards of low-performing systems — have well over twenty voting members and should consider bringing this number into line with the HRET – Center for Healthcare Governance guidelines of nine to 17 members. *All* boards should consider enriching their membership with greater racial and gender diversity; they also 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 in board deliberations.

The boards of high-performing community health systems (and, as studies have shown, *other* successful organizations) have more gender diversity than mid-range and low-performing systems. For many reasons, efforts to further diversify the gender and racial 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, when nurses are being considered for board appointments in systems where they are employed, the potential for conflicts of interest must be recognized and addressed.

## Recommendation #3

The governing boards of community health systems and their CEOs are encouraged to take a hard 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.

The findings of this and other studies show that "board development" as a core governance function is weak in many, perhaps most, healthcare organizations. According to their CEOs, fewer than half of the community health systems have a standing committee with oversight responsibility for board recruitment, orientation, education, and evaluation even though these are critically important activities. *Every* board of directors should build and maintain a solid, comprehensive "board development program" (see End Note 59 for a list of the key components) as a basic strategy for improving their effectiveness. A new or existing standing committee of the board should be given oversight responsibility for the board development program, and adequate staff and other resources should be allocated to it. One of the priorities should be ensuring that the entire board membership is 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 #4

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

Continuous evaluation and improvement is the pathway to excellence in any organization. The findings in this report are consistent with other studies that have found annual or biennial 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 traditional evaluation protocol 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 helpful in this initiative.

## Recommendation #5

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 be and should be taken to make it healthier and more effective.

In both the public and private sectors, there is growing evidence that boards with a healthy culture that demonstrates commitment to high standards, mutual trust, robust engagement in the work of the board, and willingness to take action are more likely to perform well than other boards. The findings of this study show that, in general, community health system boards consistently demonstrate commitment to their respective systems' mission. However, as shown in Section III, their performance with respect to other key characteristics of 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 #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. All boards that have not already done so 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 benchmarks of good governance are emerging for nonprofit hospitals and health system boards regarding their community benefit responsibilities and that, at this time, a large proportion of community health system boards are not meeting them. The gap is somewhat less for the high-performing systems than the others, 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 these benchmarks 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 ongoing 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 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.

## Recommendation #7

Current and emerging benchmarks of good governance for nonprofit hospitals and health systems — including but not limited to those addressed in this study — should be reviewed, refined, and compiled into an authoritative, consolidated document. This document should explain the basis for these benchmarks and provide guidance for trustees and CEOs as they strive to meet them.

Except for requirements established by state statutes, the IRS, and the Joint Commission, formal "standards" for the governance of nonprofit hospitals, health systems, and other healthcare organizations have not been adopted in the USA. As stated in Section I of this report, attention is being focused on governance in all sectors of American society including the healthcare field, and numerous individuals and groups have published articles and reports on "benchmarks" or "standards" of good governance. (For a partial list of these publications, see End Note 15.)

Some of these publications and the information they present are solid, but they are scattered and not readily accessible to board leaders and CEOs. When located, they often are not packaged in a user-friendly manner. To the extent that meaningful "standards" or "benchmarks" exist, they are not available in a form that makes it easy for boards and CEOs to use in assessing and improving board effectiveness.

It is time for leading healthcare organizations with a strong stake in hospital and health system governance such as the AHA, the ACHE, the CHA, the Joint Commission, and others — in collaboration with experts in healthcare governance, law, management, and policy — to address this issue. It is time for voluntary associations and healthcare leaders to provide hospital and health system boards, CEOs, and the field at large with a truly authoritative and integrated source of information about contemporary benchmarks of good governance and pragmatic guidance for boards about how they can and should be met. Further, this will be an ongoing responsibility that will require continuous updating and improvement in clarity, content, and format.

This will not be an easy or simple task, but it can and should be done. It probably will require solid and enduring commitment by a *formal consortium* of interested organizations; it definitely will require strong leadership and adequate funding support, perhaps from a major foundation which recognizes the importance of effective governance.

# V. Acknowledgements

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# Appendix A - Methodology

## Methodology for the Study of Governance in Community Health Systems

### A. IDENTIFYING NONPROFIT COMMUNITY HEALTH SYSTEMS

This study focuses on non-governmental, nonprofit 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 nonprofit community health systems was based on the AHA's Annual Guide Issue and information from the AHA database on hospitals and health systems. This was supplemented by information obtained from 21 regional and national healthcare systems. The process of locating and validating Medicare identification numbers was accomplished with the assistance of AHA and Thomson Reuters Healthcare staff. Questionable and/or missing information regarding particular community health systems was clarified through discussions with system staff members.

The final study population includes 201 nonprofit community health systems; 70 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

### CEO Baseline Survey

Initial survey and follow-ups were accomplished over three main waves of data collection. 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 of these CEOs responded using the electronic Web-based option. The overall survey response rate was 61 percent.

The survey responses were coded by a two-person team. One person entered each data point and the other independently verified them. All missing, unclear, or apparently inconsistent data were pursued with community health system contacts, usually the CEO and/or the CEO's executive assistant. At final review, a response option for one question was removed due to the prevalence of missing or incomplete data across respondents. Other response options for that question were retained. The end result was a virtually complete survey data set.

### On-Site Interviews

As described in Section II of this report, the research team used two measures to score and compare the community health systems' performance: the three-year operating performance of systems' hospitals using Thomson Reuters Healthcare data and, based on the CEO survey findings, the systems' governance structure, practices, and culture in relation to current benchmarks of good practice. The research team was able to compute scores on *both* measures for 121 of the 123 systems that participated in the CEO survey. The systems whose scores on both measures were in the *bottom third* of the range are defined as "low-performing" systems; 11 systems are in this category. Those whose scores on both measures were in the *top third* of the range on both measures are defined as "high-performing" systems; 17 systems are in this category. The balance of the systems are termed "mid-range performers."

The W. K. Kellogg Foundation grant which provided the principal funding for this study encouraged efforts to learn about governance in high-performing community health systems in diverse locations. Available funding permitted ten site visits. The research team extended requests to make site visits to 11 systems in the high-performing group; only one was declined.[A]

[A] The reason given was that this system was in the midst of a CEO transition. The team listed the 17 high-performing systems in rank-order based on their scores on both performance measures. The team's basic protocol was to extend invitations in the sequence of this ranking. The outcome was that site visits were made to ten of the 13 top-performing systems.

During the site visits in the late spring and early summer of 2008, individual interviews using a pre-established interview guide were conducted with at least four board members. At all but one location, these included the current board chair, the immediate past-chair, a senior physician board member, and one member who had joined the board within the past year.[B] Team members also met with the CEOs to augment input obtained through the mail survey.

The trustees' responses to interview questions were coded by two-person teams. One team focused on the responses to questions where the trustee selected a response from pre-defined options read to them by the interviewer; one person entered each data point and the second independently verified it. The second team compiled all supplemental, narrative comments offered by the trustees on those questions and, in addition, summarized the trustees' responses to two open-ended questions; again, one person summarized the narrative information in a standard format and the second independently verified it. Any missing, unclear, or apparently inconsistent data were discussed with the interviewer and, when necessary, with community health system board members and/or CEOs. The end result was a nearly complete interview data set.

## C. CEO SURVEY RESPONSE BIAS ANALYSES

Analyses were conducted to assess the potential for a response bias within the study population. Covariates included system operating performance (low, mid-range, high), 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. System operating performance was calculated using an algorithm developed by Thomson Reuters Healthcare (see Section D). Independent analyses were conducted on responses for each set of covariates (performance, membership in a larger organization, 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 Region One (Northeast) was significant ($p < .01$) in the full model and the model that included only census regions as predictors of response ($p < .01$). Community health systems in the Northeast Region are under-represented in the survey response. Only 28 percent of systems in the Northeast Region responded to the CEO survey as compared to a combined response rate of 63 percent for the other census regions. Given the high overall response rate for this survey (61.2 percent, it is unlikely that low response from one census region represents a material response bias.

### TABLE A-1: Full Model Response Bias Analysis

| Covariate | Adjusted Odds Ratios [CI] | Sig. |
|---|---|---|
| High-Performance | 1.244 [.504, 3.072] | .636 |
| Mid-Range Performance | 1.513 [.707, 3.238] | .286 |
| System has a Parent Organization | .778 [.398, 1.523] | .465 |
| Number of Hospitals in System | .901 [.757, 1.072] | .239 |
| Number of States in Which the System Operates | 1.185 [.300, 4.689] | .809 |
| Northeast Region | 202 [.071, .575] | .003 |
| Midwest Region | 1.259 [.527, 3.008] | .604 |
| Southern Region | .874 [.370, 2.063] | .759 |

Reference categories are Low Performance and Western Region.

[B] One of these systems had been formed through a merger in recent years and, as of mid-2008, a single person has served as the board chair. There is no "immediate past-chair" so, instead, another senior board member was interviewed. At another location, the team interviewed five (rather than four) trustees.

## D. THOMSON REUTERS HEALTHCARE ANALYSIS OF COMMUNITY HEALTH SYSTEM OPERATING PERFORMANCE

As stated in Section II, Thomson Reuters Healthcare uses three primary data sources to score hospital performance. They are the MEDPAR (Medicare Provider Analysis and Review) data set; the SAF (CMS Standard Analytical File) outpatient data set, and Medicare cost reports. The Thomson Reuters methodology calculates composite scores for hospitals based on selected clinical, efficiency, and financial measures. Three years of data (2004-2006) were used in the analysis described in this section. The measures in use when this analysis was completed were:

- Risk-adjusted mortality index
- Risk-adjusted complications index
- Risk-adjusted patient safety index
- Core Measures Score (based on heart attack, heart failure and pneumonia)
- Severity-adjusted average length of stay
- Expense per adjusted discharge, case mix- and wage-adjusted
- Profitability (operating profit margin)
- Cash to total debt ratio
- Growth in patient volume (percent change in patient volume year-to-year in inpatient emergency, outpatient surgery, and major outpatient diagnostic and therapeutic)[C]

As defined above, for the purpose of this study nonprofit community health systems include ". . . two or more general-acute and/or critical access hospitals *and other healthcare programs*." Ideally, the methodology for measuring and comparing the systems' operating performance would include its general hospitals and all other operating units; e.g., specialty hospitals, long-term care facilities, home health agencies, etc. In the absence of a comprehensive methodology such as this, the research team explored plausible alternatives and concluded that the consolidated performance of a system's general-acute and critical access hospitals would serve as a reasonable, albeit imperfect, proxy for "system performance." This decision was based in part on a special study of the 123 community health systems that responded to the CEO survey. In 2008, the CEOs of these systems were asked to provide information for the most recent fiscal year regarding the operating expenses of their general-acute and critical access *hospitals* in relation to *total*, *systemwide* operating expenses. Based on usable responses from 70 of the 123 systems (57 percent), hospital operating expenses comprise, on average, 84 percent (median figure) of the systems' total operating expenses. (The range was 36.8 to 100 percent; the standard deviation was 15.4). So, on the whole, hospitals constitute the bulk of most systems' operations.

With respect to measuring and comparing *hospital* performance, there are no universally accepted criteria and methodologies. After considering those that were available when this study was being designed, it was decided to employ the Thomson Reuters Healthcare performance assessment protocol. It had been in operation for several years, it included both clinical and financial measures, and information about the methodology was publicly available in journals and other publications and at the Thomson Reuters Web site.[D] The research team believed it was important for the systems we would ask to participate and for the readers of the study's findings to have ready access to detailed information about the protocol used to assess hospital performance.[E]

[C] The growth measure was in use for the first two of three-year period; it was not used in the third year.

[D] See Thomson Healthcare 100 Top Hospitals: National Benchmarks for Success, 2008, (Ann Arbor, MI: Thomson Healthcare, 2008), esp. pp. 13-22; and www.100tophospitals.com.

[E] It should be noted that two of the nine Thomson Reuters Healthcare measures were excluded for critical access hospitals (CAHs): the severity adjusted length-of-stay and the case-mix/wage-adjusted expense per discharge measures. These measures were excluded for CAHs because of a lack of adequate volume at CAH facilities, potential for systematic bias due to unique facility characteristics, such as a mean length of stay of 96 hours or less, and subsequent minimal variation. Sensitivity analyses of system performance rankings including and excluding CAH scores demonstrated no appreciable differences and no quartile changes among systems.

For two of the 201 community health systems included in the study population, no hospital performance data were available for the 2004-2006 period so, as stated in Section II, these two systems were excluded from the analysis. For the remaining 199 systems, data for the full three-year period were available for *73 percent* of the hospitals. For the other hospitals, performance scores were calculated using data for two years (17 percent) or for a single year (10 percent).

In assessing a system's performance, the performance scores for the system's hospitals were computed and compared to peer institutions. Thomson Reuters Healthcare staff then applied an algorithm that weights each hospital's data by patient discharges to balance their relative contributions to its system's performance and calculates, for each system, a *composite systemwide score*. The score expresses, in percentile terms, the consolidated performance of the system's hospitals over a three-year period in relation to peer institutions across the country. The composite percentile scores for the 199 systems for which data were available ranged from 96 to 7 ; the median was 53. The ranges for the low, mid-range, and high-performing groups are shown in Table A-2.

### TABLE A-2: System Operating Performance

| Cohort | Range of Percentile Scores | No. of Systems |
|---|---|---|
| High-Performing Systems | 70 to 96 | 17 |
| Mid-Range Performing Systems | 43 to 69 | 93 |
| Low-Performing Systems | 7 to 42 | 11 |

Highest Possible Score = 100

## E. SYSTEM BOARD STRUCTURE, PRACTICES, AND CULTURE IN RELATION TO BENCHMARKS OF GOOD GOVERNANCE

The second measure used in determining and comparing system performance was, based on the 2007 CEO survey, each system's governance structure, practices, and culture in relation to 39 current benchmarks of good governance. Only benchmarks the team considered to be reasonably well-established and objectively measurable were scored. These benchmarks and how they were scored are displayed in Table A-3. They included 13 benchmarks related to board structure, 14 related to board practices and processes, and 12 related to board culture. The systems scores ranged from a high of 36 to a low of 9; the median score was 25. The ranges for the low, mid-range, and high-performing group are shown in Table A-4.

## TABLE A-3: System Structures, Practices and Culture in Relation to Selected Benchmarks of Good Governance

| Benchmark | Scoring Basis | Possible Score |
|---|---|---|
| Board bylaws establish clear limits on the number of voting members (see Table 2) | Yes | 1 |
| Board size is consistent with Blue Ribbon Panel on Health Care Governance recommendations (9-17 members) (see Table 3) | 9-17 | 1 |
| Substantial involvement of physicians in governance roles (see Table 4) | At least 21% (median figure) | 1 |
| Substantial racial diversity in board composition (see Table 5) | At least 9% (median figure) | 1 |
| Substantial gender diversity in board composition (see Table 6) | At least 21% (median figure) | 1 |
| CEO is a voting member of the system board (see Table 7) | Yes | 1 |
| Standing board committees have clear oversight responsibility for key governance functions (see Table 8) | Yes | 1 |
| • External audit | Yes | 1 |
| • Internal audit | Yes | 1 |
| • Executive compensation | Yes | 1 |
| • Board education and development functions | Yes | 1 |
| • Community benefit programs | Yes | 1 |
| • Patient care quality and safety | Yes | 1 |
| The role and responsibilities of all standing board committees are spelled out in a written document and formally adopted by the community health system board (see Table 9) | Yes | 1 |
| Board has a pre-established schedule of meetings | Yes | 1 |
| Written performance expectations are provided for the CEO by the community health system board or its parent corporation (see Table 12) | Yes | 1 |
| Performance expectations for local hospital CEOs are set through a collaborative process involving system and local leadership | Yes | 1 |
| Board formally assesses how well it is performing its duties (see Table 15) | Yes | 1 |
| • Board self-assessment is done on a regular (annual or biennial) schedule | Yes | 1 |
| Board assessment process has resulted in actions that substantially change board practices (see Table 16) | Yes | 1 |
| Board self-assessment is thorough and has improved board performance (see Table 17) | Yes | 1 |
| Board regularly engages in formal discussions about its system's community benefit responsibilities and programs (see Table 18) | Yes | 1 |
| Board has adopted a formal, written policy that defines overall guidelines for the system's community benefit programs (see Table 19) | Yes | 1 |

| Benchmark | Scoring Basis | Possible Score |
|---|---|---|
| Board requires systemwide collaboration with other local organizations in community needs assessment on a regular basis (see Table 20) | Yes | 1 |
| Board adopts a formal plan that spells out measurable, systemwide objectives for the system's community benefit program (see Table 21) | Yes | 1 |
| Board regularly receives formal reports on the system's community benefit program, including performance date in relation to established objectives (see Table 22 | Yes | 1 |
| Board is proactively engaged in quality assessment and improvement processes, including: | | |
| • Board or designated board committee adopts core measures and standards for quality of patient care within the system (see Table 23) | Yes | 1 |
| • Board regularly receives formal reports on system performance in relation to established measures and standards (see Table 24) | Yes | 1 |
| Board consistently demonstrates proactive culture of commitment and engagement (see Table 25) including: | | |
| • Commitment to the system's mission | Always | 1 |
| • Defining needs for board expertise and recruiting new members to meet them | Always | 1 |
| • Tracking system's performance (clinical and financial) and taking action when performance doesn't meet targets | Always | 1 |
| • Addressing long-term strategic issues | Always | 1 |
| • High enthusiasm at board meetings | Always | 1 |
| • Mutual trust among board members | Always | 1 |
| • Recognizing the importance of board education | Always | 1 |
| • Holding board members to high performance standards | Always | 1 |
| • Encouraging constructive deliberations at board meetings | Always | 1 |
| • Welcoming respectful disagreement and dissent at board meetings | Always | 1 |
| 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 (see Table 26) | Yes | 1 |
| | Total Number of Possible Points | 39 |

## TABLE A-4: System Governance in Relation to Selected Benchmarks of Good Governance

| Cohort | Range of Scores | No. of Systems |
|---|---|---|
| High-Performing Systems | 28-36 | 17 |
| Mid-Range Performing Systems | 22-27 | 93 |
| Low-Performing Systems | 9-21 | 11 |
| Highest Possible Score | 39 | |

## F. STATISTICAL ANALYSIS

For this report, data were analyzed by (1) comparing responses to the 2007 survey by CEOs of low-, mid-range, and high-performing systems and (2) comparing the responses of CEOs of high-performing systems to the responses of their board members obtained through on-site interviews in 2008. Chi-squared test was used to examine heterogeneity between these performance groups at the various levels of the study variables. In instances where the asymptotic behavior of the chi-squared distribution may be questionable, the Fisher exact test was used to carry the tests of significance. The continuous study variables that may have violated parametric assumptions were analyzed using non-parametric methods.

## G. LIMITATIONS OF THE STUDY

There are several limitations to this study. These include: (1) With respect to the CEO survey, the response rate of community health systems in Census Region One (Northeast) was lower than the other census regions and, thus, there is some degree of regional bias in the survey findings. (2) The research team endeavored to identify and include as many community health systems that met the established criteria as possible. We believe a large majority were located and included in the study population; however, we know some were missed and, therefore, the study population is not totally inclusive.[F] (3) This study has focused on comparing board structures, practices, and cultures in relation to a selected set of established and 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 and interview methods employed in data collection, are not addressed in this report. (4) This report presents the views of community health system CEOs and trustees regarding their particular board's structure, practices, and culture. There were substantial follow-up communications after the survey and on-site interviews were completed to clarify questions and obtain any missing data elements. However, these data represent the participants' *perceptions* and may or may not be factually correct. (5) The survey data and the interview data were obtained at different points in time (2007 vs. 2008) and, while the research team was careful throughout the data collection and analysis processes, there are likely to be some inaccuracies in our summarization and interpretation of the information. (6) Financial and time constraints restricted on-site visits to ten of the 17 (59 percent) high-performing systems. It would have been desirable to conduct interviews with board members and CEOs at all 17 high-performing systems *and* some or all of the low-performing systems. Having the views of board leaders and CEOs in low-performing systems could provide useful insights and strengthen the comparative analysis that can be made based on other data.[G] Having data from board members at only 59 percent of the high-performing systems and the absence of comparative interview data from their counterparts in low-performing systems are limitations of this study's findings and conclusions. (7) At this time, there are no well-established, widely-accepted measures of health system operating performance. In this study, the three-year operating performance of the systems' general-acute and critical access hospitals using Thomson Reuters Healthcare data for 2004-2006 is employed as a proxy for "system operating performance." While clearly imperfect, the team considers it to be a reasonable proxy. A 2008 survey shows that, on the whole, the operating expenses of these community health systems' *hospitals* represent 84 percent of *systemwide* operating expenses and, therefore, encompass the bulk of system operations. However, this proxy is incomplete because it does not incorporate the operating performance of the systems' other operating units such as long-term care facilities, home health agencies, etc. (8) This study was not designed to analyze the statistical relationships between system performance and benchmarks of good governance. Examining the directional or causal nature of those relationships is beyond the scope of this study; it is a challenge that merits attention in a future phase of healthcare governance research.

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[F] As of December 1, 2008, the team had identified 14 community health systems that meet the established criteria but were not included in the study population of 201 systems. It is likely there are some more we have not yet located.

[G] See, for example, J. Denrell, "Selection Bias and the Perils of Benchmarking," Harvard Business Review, April, 2005, pp. 114-118.

# Appendix B - End Notes

[1] Some of the text in this and subsequent sections is excerpted from an earlier report written by this research team: L.Prybil, S. Levey, R. Peterson, D. Heinrich, P. Brezinski, J. Price, G. Zamba, and W. Roach. Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives (Chicago: Grant Thornton LLP, 2008).

[2] See, for example, C. Daily, D. Dalton, and N. Rajagopalan, "Governance Through Ownership: Centuries of Practice, Decade of Research," Academy of Management Journal, Vol. 46, April, 2003, pp. 151-158.

[3] A. Berle and G. Means, The Modern Corporation and Private Property, (New York: Harcourt, Brace, & World, Ins., Revised Edition, 1967) [1st Edition, 1932], p. 66.

[4] These include agency theory, resource dependence theory, shareholder/stakeholder theories, and various blends. See, for example, M. O'Sullivan, "The Innovative Enterprise and Corporate Governance," Cambridge Journal of Economics, Vol. 24, 2000, pp. 393-416; and C. Sundaramurthy and M. Lewis, "Control and Collaboration: Paradoxes of Governance," Academy of Management Review, Vol. 28, July, 2003, pp. 397-415.

[5] See, for example, R. Hamilton, "Corporate Governance in America: Major Changes But Uncertain Benefits," Journal of Corporation Law, Winter, 2000, pp. 349-373.

[6] M. Lipton and J. Lorsch, "A Modest Proposal for Improved Corporate Governance," The Business Lawyer, Vol. 48, November, 1992, p. 59.

[7] See, for example, "Citi's Taxpayer Parachute," Editorial, Wall Street Journal, November 25, 2008, p. A14.

[8] See, for example, "The Rutgers Mess," Editorial, New York Times, November 24, 2008, p. A22.

[9] See, for example, J. McCafferty, "Misgivings: Recent Studies Show an Uncharitable Question: Is Nonprofit Accounting Off the Track?" CFO, January, 2007.

[10] See, for example, L. Burns, "The Fall of the House of AHERF," Health Affairs, Vol. 19, January-February, 2000, pp. 7-41.

[11] W. Smith, Jr., as quoted in J. Papini and M. Eckblad, "It's a Done Deal: Merrill and B of A," Wall Street Journal, December 6-7, 2001, p. B3.

[12] J. Lorsch and R. Clark, "Leading from the Boardroom," Harvard Business Review, Vol. 84, April, 2008, p. 105.

[13] M. Peregrine, "The New Intermediate Sanctions Regulations: What Boards Need to Know," (Chicago: American Health Lawyers Association, April, 2008); "Update on 2008 Form 990 Draft Instructions," Internal Revenue Service, U. S Department of the Treasury, August 5, 2008; and L. Lerner, "Letter from the Director: Tax Exempt and Governmental Entities," Division of Exempt Organizations, Internal Revenue Service, U. S. Department of the Treasury, November, 2008.

[14] See, for example, G. Davis, "New Directions in Corporate Governance," Annual Review of Sociology, Vol. 31, 2005, pp. 143-162; 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; and E. O'Reilly, "Put Your Board on High Alert for Sarbanes-Oxley Creep," Hospitals and Health Networks, April, 2008, pp. 57-60.

[15] See, for example, "Best Practices: Nonprofit Corporate Governance," (Chicago: McDermott, Will, & Emery, 2004); D. Bjork and D. Fairley, "Strengthening Governance in Hospitals and Health Systems," (Boseman, Montana: American Governance and Leadership Group, 2004); "50 Practices of Top-Performing Boards," (San Diego, CA: The Governance Institute, 2005); B. Bader, E. Kazemek, and R. Witalis, Emerging Standards for Institutional Integrity: A Tipping Point for Charitable Organizations (San Diego, CA: The Governance Institute, 2006); E. Bryant and P. Jacobson, "Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards," Bulletin of the National Center for Healthcare Leadership, December, 2006, pp. 9-20; "Good Governance Practices for 501(c)(3) Organizations," Internal Revenue Service, February 2, 2007; Building An Exceptional Board: Effective Practices for Health Care Governance, (Chicago: Center for Healthcare Governance, 2007); Boards X 4: Governance Structures and Practices (San Diego, CA: The Governance Institute, 2007); "Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations," Panel on the Nonprofit Sector, October, 2007; T. Silk, "Good Governance Practices for 501(c)(3) Organizations: Should the IRS Become Further Involved?" The International Journal of Not-for-Profit Law, Vol. 10, December, 2007; and M. Peregrine, "Corporate Governance Update: IRS Updates Position on Corporate Governance," Memorandum to the Corporate Governance Task Force: A Joint Endeavor of HMOs and Health Plans; Hospitals and Health Systems; In-House Counsel; Tax and Finance; and Teaching Hospitals and Academic Medical Centers Practice Groups, February 28, 2008.

[16] As stated 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, October 1, 2007, pp. 4-5.

[17] In 2000, 1,602 of the nation's 3,003 non-governmental, nonprofit hospitals were affiliated with nonprofit health systems (53.3%); in 2007, the corresponding figures were 1,607 of 2,913 (55.2%). Personal correspondence from Mr. Peter Kralovec, Director, Hospital Data Center, American Hospital Association, October 19, 2007, and November 20, 2008.

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

[19] See, for example, R. Luke, "Local Hospital Systems: Forerunners of Regional Systems?" Frontiers of Health Services Management, Vol. 9, Winter, 1992, pp. 3-51; A. Cueller and P. Gertner, "Trends in Hospital Consolidation: The Formation of Local Systems," Health Affairs, Vol. 22, November-December, 2003, pp. 77-87; and J. Bentley, Senior Vice President for Strategic Policy Planning, American Hospital Association, as quoted in P. Betbeze, "Weaning Your Hospital Off Medicare," HealthLeaders, June, 2008, p. 31.

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

[21] See, for example, D. Pointer, J. Alexander, and H. Zuckerman, "Loosening the Gordian Knot of Governance in Integrated Health Care Delivery Systems," Frontiers, Vol. 11, 1995, pp. 3-37; and J. Alexander et al, "Governance Forms in Health Systems and Health Networks," Health Care Management Review, Vol. 28, July-September, 2003, pp. 228-242.

[22] Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives, op. cit., presents the results of one of the first studies to compare governance structures, practices, and cultures in community health systems that are part of larger regional or national health care organizations with structures, practices, and cultures in independent systems.

[23] The AHA database on hospitals and healthcare systems is substantial and is a useful 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 and providing other information needed by our research team.

[24] Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives, op. cit.

[25] See Thomson Healthcare 100 Top Hospitals: National Benchmarks for Success, 2008, (Ann Arbor, Michigan: Thomson Healthcare, 2008), esp. pp. 13-22; and www.100tophospitals.com.

[26] In the summer of 2008, the CEOs of the 123 community health systems who participated in the 2007 mail survey were asked to provide information about systemwide and hospital-specific operating expenses during the *most recent* fiscal year for which *audited* data were available. 70 of the 123 systems (57 percent) provided complete information. For these 70 systems, hospital operating expenses as a proportion of systemwide operating expenses ranged from a high of 100 percent to a low of 37 percent; the median figure was 84.3 percent.

[27] See, for example, S. Finkelstein and A. Mooney, "Not the Usual Suspects: How to Make Boards Better," Academy of Management Executive, Vol. 17, 2003, esp. p. 103; and A. Pettigrew and T. McNulty, "Sources and Uses of Power in the Boardroom," European Journal of Work and Organizational Psychology, Vol. 7, 1998, esp. p. 197.

[28] One of these systems had been formed through a merger in recent years and, as of mid-2008, a single person has served as the board chair. There is no "immediate past-chair" so, instead, another senior board member was interviewed. At another location, the team interviewed five (rather than four) trustees.

[29] Personal correspondence with Mr. Peter Kralovec, op. cit.

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

[31] 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, CA: The Governance Institute, 2007), p. 1 and p. 5.

[32] Building an Exceptional Board: Effective Practices for Health Care Governance, op. cit., p. 13.

[33] See, for example, L. Larson, "Who Does It Better: The Corporate Versus the Nonprofit Governance Model," Trustee, May, 2005, pp. 15-16; and Re-Vitalizing Governance in Not-for-Profit Hospitals and Health Systems (Chicago: Spencer-Stuart, HRET, and APM Management Consultants, 1997), Section III.

[34] 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 Research and Educational Trust, 2005), p. 7; and Governance Forecast: Board Performance, Challenges, and Opportunities, (San Diego, CA: The Governance Institute, 2004), p. 5.

[35] 2006 Public Company Governance Survey, (Washington, DC: National Association of Corporate Directors, 2006), p. 23.

[36] J. Justice, A. Kastel, K. Van Dyke, Creating a Healthy Board/Medical Staff Relationship: Current Trends and Practices, (Chicago, Illinois: Center for Healthcare Governance, 2008) pp. 6-7; 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.

[37] 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 Health Care 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 membership 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."

[38] See, for example, L. Prybil, "Size, Composition, and Culture of High-Performing Hospital Boards," American Journal of Medical Quality, Vol. 21, July-August, 2006, pp. 224-229; and L. Prybil, "Engaging Nurses in Governing Hospitals and Health Systems," Journal of Nursing Care Quality, Vol. 24, January-March, 2009, pp. 5-9.

[39] 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 P. Betbeze, "The New Rainmakers," HealthLeaders, December, 2007, pp. 55-56.

[40] See, for example, Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations, (Washington, DC: Panel on the Nonprofit Sector, 2007), pp. 14-15; and J. Carlson, "Measuring Inclusiveness: Study Looks at Hospitals' Cultural Competency," Modern Healthcare, Vol. 38, 2008, pp. 18-20.

[41] R. Barnardi, S. Bosco, K. Vassill, "Does Female Representation on Boards of Directors Associate with Fortune's '100 Best Companies to Work For' List?" Business Sociology, Vol. 45, June, 2006, pp. 235-249; and Z. Burgess and P. Tharenou, "Women Board Directors: Characteristics of the Few," Journal of Business Ethics, 2002, Vol. 37, pp. 39-49.

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

[43] 2006 Not-for-Profit Governance Survey, (Washington, DC: NACD, 2006), p. 14.

[44] See, for example, The Conference Board Commission of 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).

[45] Boards X 4: Governance Structure and Practices, op. cit., p. 7.

[46] 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); and S. Kapur, "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.

[47] It is recognized that these 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 Multi-Unit System," Hospital and Health Services Administration, Spring, 1991; and Value-Added Governance: New Insights into Old Challenges (San Diego: The Governance Institute, 2003), esp. pp. 19-26.

[48] See, for example, C. Molinari, et al, "Hospital Board Effectiveness: Relationships Between Governing Board Composition and Hospital Financial Viability," Health Services Research, Vol. 28 (August, 1993); I. Milstein and P. MacAvoy, "The Active Board of Directors and Performance of the Large, Publicly-Traded Corporation," Columbia Law Review, Vol. 98, June, 1998; C. Sundaramurthy, "Control and Collaboration: Paradoxes of Governance," Academy of Management Review, Vol. 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).

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

[50] See, for example, C. Elson, "Separation Anxiety," Harvard Business Review, October, 2004, p. 22; Building an Exceptional Board: Effective Practices for Health Care Governance, op cit., esp. pp. 22-23; and D. Pointer and J. Orlikoff, Board Work: Governing Health Care Organizations, (San Francisco: Jossey-Bass Publishers, 1999), esp. pp. 135-150.

[51] B. Bader and Elaine Zablocki, "Evaluating and Improving Board Committees," Great Boards, Vol. III, Summer, 2008. Also see B. McPherson, "The Failed Conversion of CareFirst Blue Cross-Blue Shield to For-Profit Status: Part 2, Lessons Learned," Inquiry, Vol. 41, Winter, 2004/2005, esp. p. 363.

[52] 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.

[53] 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," Journal of Legal Medicine, Vol. 25, 2004, esp. pp. 414-417 and pp. 435-436.

[54] 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.

[55] Principles of Good Governance and Ethical Practice, op cit., p. 20.

[56] 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; and Is the Job Getting Harder? Updated Guidance for the Board's Executive Compensation Committee (San Diego, CA: The Governance Institute, Summer, 2006).

[57] See, for example, M. Peregrine and E. Mills, "Advising the Compensation Committee Chair: New Developments," American Health Lawyers Association, Vol. 6, May 2, 2008; and "Report on Exempt Organizations Executive Compensation Compliance Project – Parts I and II," Internal Revenue Service (IRS), March 1, 2007. 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.

[58] See, for example, K. Scannell, "SEC Calls on Every Board to Review Pay," Wall Street Journal, October 22, 2008, p. C2.

[59] 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 J. Orlikoff and M. Totter, "Effective Board Development: Showing the Way Toward Exceptional Governance," Healthcare Executive, May-June, 2007, pp. 68-70; and "Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards," op cit., esp. pp. 11-12 and 14.

[60] See, for example, A. Gosfield and J. Reinertsen, "Avoiding Quality Fraud," Trustee, September, 2008, pp. 12-15; C. Vaughan, "Board on the Floor," HealthLeaders, December, 2007, pp. 23-29; Board Work: Governing Health Care Organizations, op cit., esp. pp. 53-67; and Moving Toward Excellence in Quality, The Governance Institute, 2001, esp. pp. 13-32.

[61] 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.

[62] National Board Governance Survey for Nor-for-Profit Organizations, (Chicago, IL: Grant Thornton LLP), p. 9.

[63] 2006 Public Company Governance Survey, (Washington, DC: National Association of Corporate Directors, 2006), p. 19.

[64] Building an Exceptional Board: Effective Practices for Health Care Governance, op cit, p. 24.

[65] See, for example, "You're Hired: Business Plus Brains Equals On-the-Job Success," University of Iowa Spectator, Vol. 38, Winter, 2005, p. 1; "The Link Tightens Between System Boards and Management Survey," Trustee, November-December, 2002, esp. p. 35; and S. Rynes, K. Brown, and A. Colbert, "Seven Common Misconceptions About Human Resource Practices: Research Findings Versus Practitioner Beliefs," Academy of Management Executives, Vol. 16, December, 2002, pp. 92-102.

[66] See, for example, J. Conger, E. Lawler, and D. Finegold, Corporate Boards: New Strategies for Adding Value at the Top, (San Francisco, CA: 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.

[67] Boards X 4, op cit., p. 24.

[68] 2006 Public Company Governance Survey, op. cit., p. 30.

[69] "How'm I Doing?" CFO, February, 2007, p. 21.

[70] 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.

[71] 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.

[72] T. Holland and D. Jackson, "Strengthening Board Performance: Findings and Lessons from Demonstration Projects," Nonprofit Management and Leadership, Vol. 9, 1998, esp. pp. 128-133.

[73] B. Behan, "Board Assessment," in Building Better Boards: A Blueprint for Effective Governance, op. cit., p. 213.

[74] See, for example, Advancing the Public Accountability of Nonprofit Health Care Organizations, op. cit. p. 7.

[75] D. Nadler, "Building Better Boards," Harvard Business Review, May, 2004, p. 104.

[76] 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 Regulations: 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.

[77] Coleman, op. cit., p. 1.

[78] Rev. Rul. 69-645, 1969-2, C.B. 117.

[79] 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."

[80] 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, Vol. 13, 2004, exp. 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.

[81] J. Kuchler, "Tax-Exempt Yardstick: Defining the Measurements," Healthcare Financial Management, February, 1992.

[82] 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.

[83] The Catholic Health Association, working in concert with the VHA and other organizations, has played a strong leadership role in developing guidelines and tools for measuring community benefit in a consistent, objective manner. See A Guide For Planning and Reporting Community Benefit, 2008 Edition (St. Louis, MO: Catholic Health Association of the United States, 2008).

[84] See, for example, "Nonprofit, For-Profit, and Governmental Hospitals: Uncompensated Care and Other Community Benefit," Testimony of David M. Walker, Comptroller General of the United States, U.S. General Accountability Office, to the Committee on Ways and Means, U.S. House of Representatives, May 26, 2005; and Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements, U.S. General Accountability Office, Report to the Ranking Member, Committee on Finance, U.S. Senate, September, 2008.

[85] 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."

[86] Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements, op. cit., pp. 16-18. For a summary of state laws and requirements, see Health Care Community Benefits: A Compendium of State Laws (Boston, MA: Community Catalyst, Inc., November, 2007).

[87] Internal Revenue Service, U.S. Department of the Treasury, "IRS Completed 2008 Form 990 Instructions and Background Documents," August 19, 2008.

[88] Corporate Responsibility Handbook, Coalition for Nonprofit Health Care, November, 2002, p. 9.

[89] "Report of the ABA Task Force on Corporate Responsibility," The Business Lawyer, November, 2003, pp. 159-160.

[90] See, for example, E. Barsi, "Accountability for Community Benefit," Trustee, Vol. 61, November-December, 2008, pp. 32-36; and "My Brother's Keeper: Growing Expectations Confront Hospitals on Community Benefit and Charity Care," PriceWaterhouseCoopers Health Research Institute, 2006, p. 7.

[91] 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.

[92] See, for example, Strengthening Community Trust: Strategies for CEOs (Chicago, IL: AHA, 2006), p. 1-9.

[93] A Guide to Planning and Reporting Community Benefit, op. cit., esp. pp. 65-78.

[94] Advancing the State of the Art of Community Benefits (Oakland, CA: Public Health Institute, November, 2004), p. 15.

[95] A Guide to Planning and Reporting Community Benefit, op. cit., p. 64.

[96] "My Brother's Keeper: Growing Expectations Confront Hospitals on Community Benefits and Charity Care," op. cit., p. 8. Also see E. Zablocki, "Compliance or Leadership: The Governance Role in Community Benefit," Great Boards, Vol. VIII, Spring, 2008, esp. pp. 3-4.

[97] M. Porter and M. Kramer, "Strategy & Society," Harvard Business Review, December, 2006, p. 84.

[98] See, for example, C. Evashwick and K. Gautam, "Governance and Management of Community Benefit." Health Progress, Vol. 89, September-October, 2008, p. 12; 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.

[99] See, for example, "My Brother's Keeper: Growing Expectations Confront Hospitals on Community Benefit and Charity Care," op. cit., p. 2; Advancing to State of the Art in Community Benefit, op. cit., p. 43; and A Guide for Planning and Reporting Community Benefit, op. cit., p. 211.

[100] See, for example, J. Wennberg et al., An Agenda for Change – Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration, The Dartmough Institute for Health Policy and Clinical Practice, December, 2008; and National Healthcare Quality Report – 2007, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, February, 2008.

[101] S. Levey, et al, "Hospital Leadership and Quality Improvement: Rhetoric Versus Reality," Journal of Patient Safety, Vol. 3, March, 2007; J. DerGurahian, "Quality Better, Not Great," Modern Healthcare, November 19, 2007, pp. 10-11; and "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.

[102] C. Caldwell, G. Butler, and J. Grah, "Breakthrough Quality: What the Board Must Do," Trustee, Vol. 61, June, 2008, p. 1.

[103] 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.

[104] A. Gosfield and J. Reinertsen, "Avoiding Quality Fraud," Trustee, Vol. 61, September, 2008, p. 12.

[105] Ibid., p. 12.

[106] See, for example, “Board on the Floor,” op. cit., pp. 27-28; “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.

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

[108] B. Bader, “Enron’s Real Lesson: Strengthen Board Culture,” Great Boards, Vol. II, November, 2002, p. 3.

[109] Based on extensive work with many boards over a long period of time, William Ryan, Richard Chait, and Barbara Taylor 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.

[110] See, for example, “Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards,” op. cit., p. 16; K. McDonagh, J. Chenoweth, M. Totten, and J. Orlikoff, “Connecting Governance Culture and Hospital Performance Improvement,” Trustee Workbook, April, 2008; M. Useem, “How Well-Run Boards Make Decisions,” Harvard Business Review, November, 2006, pp. 130-138; 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, op. cit., pp. 129-148.

[111] Building an Exceptional Board: Effective Practices for Health Care Governance, op. cit., p. 5.

[112] Ibid., pp. 12-14.

[113] As a standard part of the individual interviews, the trustees were given a one-page sheet that listed the same 11 characteristics that had been included in the CEO survey. The research team member then read each characteristic and asked the trustee to indicate which of the following most accurately represents how their board demonstrates that characteristic: “Always,” “Sometimes,” “Never,” or “I’m Not Sure.” The “Never” option was not chosen by any of the 41 trustees who were interviewed.

[114] 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.

[115] S. Finklestein and A. Mooney, “Not the Usual Suspects: How to Make Boards Better,” Academy of Management Executive, Vol. 17, 2003, p. 106.

[116] “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, March, 2006, pp. 2-9.

[117] See, for example, “The Fall of the House of AHERF,” op. cit.; The Role of the Board of Directors in Enron’s Collapse, Subcommittee on Investigations, Committee on Government Affairs, U.S. Senate, July 8, 2002; K. Eichenwald, “In String of Corporate Troubles, Critics Focus on Weak Boards,” Wall Street Journal, September 21, 2003, pp. 1 and 30-31; J. Piotrowski, “HealthSouth’s Most Wanted,” Modern Healthcare, November 10, 2003, esp. p. 6; S. Pulliam, “How Hazards for Investors Get Tolerated Year After Year,” Wall Street Journal, February 6, 2004, esp. p. 1; G. Morgenson, “10 Ex-Directors From WorldCom to Pay Millions,” The New York Times, January 6, 2005, p. A1; A David and R. Smith, “Delayed Reaction: At Morgan Stanley, Board Slowly Faced Its Purcell Problems,” Wall Street Journal, August 5, 2005, p. A1; J. Mantone and J. Zigmond, “Guilty in Rhode Island,” Modern Healthcare, October 16, 2006, pp. 6-7; P. Elkind, “UnitedHealth and the Ghost of Dr. McQuire,” Fortune, April 30, 2007, pp. 151-154; and J. Papini and M. Eckblad, “It’s A Done Deal: Merrill and B of A,” Wall Street Journal, December 6-7, 2008, p. B3.

[118] See, for example, J. Coles et al, “An Examination of the Relationship of Governance Mechanisms to Performance,” Journal of Management, Vol. 27, No. 1, 2001, pp. 23-50; C. Dailey et al, “Governance and Strategic Leadership in Entrepreneurial Firms,” Journal of Management, Vol. 28, No. 3, 2002, pp. 387-412; and C. Dalton and D. Dalton, “Boards of Directors: Utilizing Empirical Evidence in Developing Prescriptions,” British Journal of Management, Vol. 16, S1, 2005, pp. S91-S97.

[119] See, for example, P. Compers et al, “Corporate Governance and Equity Prices,” The Quarterly Journal of Economics, Vol. 118, February, 2003, pp. 107-155; N. Bradley, “Corporate Governance Scoring and the Link Between Corporate Governance and Performance Indicators: In Search of the Holy Grail,” Corporate Governance, Vol. 12, January, 2004, pp. 8-10; J. Eisenhofer and G. Levin, “Does Corporate Governance Matter to Investment Returns?” Corporate Accountability Report, Vol. 3, September 23, 2005, pp. 1-11; D. Durfee, “More Rules, Higher Profits?” CFO, August, 2006, p. 24; J. Alexander and L. Lee, “Does Governance Matter? Board Configuration and Performance in Not-for-Profit Hospitals,” The Milbank Quarterly, Vol. 84, No. 4, 2006; K. McDonagh, “Hospital Governing Boards: A Study of Their Effectiveness in Relation to Organizational Performance,” Journal of Healthcare Management, Vol. 51, November-December, 2006, pp. 377-391; and ISS Corporate Governance Quotient, Institutional Shareholder Services, June 6, 2007.

[120] The three variables that were removed as a result of exploratory factor analysis were (1) “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;” (2) “The board places high priority on addressing long-range strategic issues that confront our organization;” and (3) “Board members clearly recognize the importance of ongoing board education.”

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