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Governance in Large Nonprofit Health Systems: Current Profile and Emerging Patterns

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Foreword

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Nonprofit healthcare organizations are not exempt from good governance. In fact, more today than ever, the hospitals and health care systems of this country must have the discipline and commitment to organize their governance structures and practices to provide forward-thinking leadership and stand up to scrutiny from any type of evaluation and review. As we move from "sick care" organizations to "health care" organizations with accountability for the health of the population of our communities from birth to end-of-life, the role of governance becomes even more critical.

Fourteen of the largest and most notable health care systems in this country have been included in a research study to examine their governance structures and practices in relation to nine benchmarks. The CEOs and board members of these organizations were interviewed about their structures, processes and cultures, and then compared to national best practices. The study also included close review of pertinent system documents.

This report is a must read for hospital and health care system CEOs and boards. It provides evidence-based outcomes that will assist an organization in advancing its governance practices. This study outlines critical success factors for governance structure and performance. It answers many questions that boards may be struggling with today and provides advancing actions. The research methodology is thorough and reliable with specific outcomes that provide high-performance opportunities.

Each CEO who participated in the research study has written about a best practice in his or her respective organization that advances governance responsibility. These insights add a personal dimension to this report.

Sharing has always been a part of community-based, nonprofit healthcare. This report is a true example of that commitment to learn from others. As one who has been blessed to be a part of this remarkable "space" known as health care, I congratulate the research team who dedicated themselves to this important work. As clinical, operational and financial performance continue to converge in health care organizations, quality and high-performing governance practices, structures and culture must prevail.

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Chief Executive Officer
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I. Introduction[1]

In the United States, the healthcare field and society-at-large are in the midst of enormous turbulence. An aging and increasingly diverse population, global and nationwide economic problems of unprecedented complexity, a federal government beset with political conflicts that harm its ability to address important issues, growing evidence of major disparities in healthcare access, affordability, and quality,[2] and the continuing explosion in medical science and technology are among the powerful forces that are affecting healthcare providers, payors, and consumers.

These forces create daunting challenges for the clinical, governance, and management leadership teams in America's hospitals, health systems, and other health-related organizations. The healthcare needs of the communities they serve are growing while, at the same time, available resources are increasingly constrained. Meanwhile, the public's satisfaction and trust in healthcare organizations have declined.[3]

With respect to governance, the public's unrest with the cost and quality of services they receive from healthcare organizations is accompanied by concerns about the effectiveness of their governing boards. Public and private organizations with oversight responsibilities for nonprofit hospitals and systems including the Internal Revenue Service (IRS), payors, rating agencies, and other parties recognize that governance plays an important role in shaping organizational performance, and they are scrutinizing the practices of governing boards more closely than in the past. As in other sectors, the boards of healthcare organizations are being placed in the "white-hot spotlight of public discourse."[4] Stakeholders are calling for more accountability, greater transparency, and better performance by the persons who manage and govern these organizations.

In recent years, the governance of nonprofit hospitals and health systems has received particular attention. It is widely acknowledged that the governance of these organizations has become more complex and that, on the whole, the caliber of governance can and should be improved.[5] Except for basic requirements established by the IRS, the Joint Commission, and state statutes, universal standards for the governance of nonprofit healthcare organizations have not been adopted. However, over the past several years significant efforts have been made by governmental agencies, voluntary commissions and panels, and other parties to identify what they believe to be the core features of effective governance for boards and CEOs to use as benchmarks in efforts to assess and improve governance performance.[6] Some of these benchmarks are well-established and widely accepted; others are in formative stages. In Section III of this report, a number of the benchmarks will be discussed, and current board structures, processes, and cultures will be compared to them.

According to the American Hospital Association, the total number of multi-unit health systems (governmental and private) increased from 311 in 2000 to 427 in 2010, an increase of 37% in a decade.

Concurrent with growing interest in improving governance, America's healthcare delivery system has continued to evolve from mostly independent institutions into larger groupings. According to the American Hospital Association, the total number of multi-unit health systems (governmental and private) increased from 311 in 2000 to 427 in 2010, an increase of 37% in a decade. Meanwhile, the proportion of the country's nongovernmental hospitals affiliated with nonprofit systems increased from 53% in 2000 (1,602 of 3,003) to 65% in 2010 (1,876 of 2,904).[7]

It is clear that consolidation of America's hospitals into various forms of health systems is occurring and for many reasons — including the hospitals' needs for access to capital and the support larger organizations can provide — this trend is likely to continue.[8] One of the striking features of this transformation has been the development of big, geographically-dispersed health systems. In 2010, 83 health systems (governmental and private) had annual operating expenses of at least $1.5 billion and included a total of 2,109 hospitals.[9]

These large health systems include a large and growing proportion of the USA's healthcare facilities 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, little research has been focused specifically on governing boards and governance practices in the nation's largest health systems.[10] This is especially the case for nonprofit systems as compared to investor-owned systems for which public reporting requirements are somewhat more extensive.

The confluence of these developments — growing interest in the responsibilities and performance of governing boards in all sectors, advances in formulating benchmarks of effective governance, and limited research-based knowledge about governance in large nonprofit health systems — provided the impetus for this study.

II. Purpose and Methodology

Purpose and Objectives of the Study

The overall purpose of this study is to examine board structures, processes, and cultures in a set of the USA's largest private, nonprofit health systems and compare them to several benchmarks of effective governance. The study's objectives are to:

- Increase knowledge and understanding of governance in large health systems;
- Identify and describe some examples of "exceptional governance features" that are in place in these systems;
- Identify areas where, on the whole, the governance of health systems could be improved; and
- Produce information that can assist CEOs and board leaders in assessing and enhancing board effectiveness.

Research Methodology

The methodology for this study includes four phases. First, defining the study population and securing agreements by systems to participate; second, based on previous studies and expert panel reports, formulating a composite listing of benchmarks of effective governance; third, collecting comparable information regarding board structures, processes, and cultures from interviews with CEOs and board leaders using a structured interview guide and from system documents; and fourth, comparing this information to benchmarks of effective governance and examining the findings using selected variables and analytical tools.

These four phases can be described as follows:

Defining the study population and securing the systems' participation. From its inception, the intent of this study was to focus on a set of the country's largest private, nonprofit health systems. Working with the American Hospital Association (AHA) in 2010, all of the country's private, nonprofit systems were ranked using a blend of three measures of size: annual operating expenses for the systems' hospitals, the number of hospitals in the system, and the number of counties in which these facilities are located.

It was found that the 20 largest nonprofit health systems collectively included 31% (573 of 1,876) of all nongovernmental hospitals affiliated with systems and, in addition, encompassed a broad array of other healthcare programs such as medical groups, health plans, and diverse health-related services. AHA staff and the research team agreed these 20 organizations represent the USA's largest private, nonprofit health systems.

The next step was to extend invitations to participate in this study. Starting with the largest system on the list of 20, the team presented the research proposal to chief executive officers and invited their systems' involvement in the study. In some instances, supplemental information and/or conversations with other system officials were required.

The research proposal that provided the basis for grant support anticipated that at least 10 of the nation's largest private, nonprofit systems would participate in the study. Ultimately, 14 of the 15 largest systems agreed to participate and did so.[11] Thus, these 14 systems comprise the study population. They are:

- Adventist Health System Sunbelt Healthcare Corporation, Altamonte Springs, Florida
- Ascension Health, St. Louis, Missouri
- Banner Health, Phoenix, Arizona
- Carolinas HealthCare System, Charlotte, North Carolina
- Catholic Health East, Newtown Square, Pennsylvania
- Catholic Health Initiatives, Englewood, Colorado
- Catholic Health Partners, Cincinnati, Ohio
- Christus Health, Irving, Texas
- Kaiser Foundation Hospitals and Health Plan, Oakland, California
- Mayo Clinic, Rochester, Minnesota
- Mercy Health, Chesterfield, Missouri
- Providence Health & Services, Renton, Washington
- Sutter Health, Sacramento, California
- Trinity Health, Novi, Michigan

Of the 14 systems, eight are sponsored or controlled by Roman Catholic entities. Three (Catholic Health East, Catholic Health Partners, and Christus Health) are sponsored by several religious communities and five (Ascension Health, Catholic Health Initiatives, Mercy Health, Providence Health and Services, and Trinity Health) have adopted the public juridic person model. This is an organizational arrangement that enables religious communities to transfer control of health care organizations to a new entity that, with substantial laity involvement, operates in the name of the Catholic Church and sustains the health ministry.[12]

One of the health systems in the study population is affiliated with the Seventh-Day Adventist Church (Adventist Health System), and one is operated by the Charlotte-Mecklenburg Hospital Authority (Carolinas Healthcare System). The other four systems (Banner Health, Kaiser Foundation Hospitals and Health Plan, Mayo Clinic, and Sutter Health) are independent, nonprofit entities that do not have parent organizations.

Collectively these 14 systems include 460 of the 1,876 nongovernmental hospitals affiliated with private, nonprofit systems (25%), an average of 33 hospitals per system. In all instances, their organizational mission and services include but extend beyond operating acute-care hospitals. For many, their hospital divisions are only one important component of an increasingly broad and diversified spectrum of health-related programs and services: e.g., the Mayo Clinic, Mercy Health, and Kaiser systems include four of the 11 largest medical group practices in the United States.[13] In various fashions, all 14 systems are at present or are on the pathway to becoming comprehensive, integrated healthcare organizations.

Formulating a composite listing of contemporary benchmarks of effective governance. Based on review of previous studies, current literature in the healthcare field and other sectors, and consultation with several experts in this realm, the research team formulated nine contemporary benchmarks of effective governance, and several basic indicators for each. In the selection process, they were reviewed with current and former executives in health systems that are not part of the study population as an independent check on their appropriateness and relevance. The benchmarks that were adopted are pertinent to the governance of large health systems, and the related indicators are considered to be reasonably well-established and measurable. Certainly there are other benchmarks and indicators of effective governance; they are beyond the scope of this study.[14]

Site visits to systems in the study population. Studies regarding governance in both investor-owned and nonprofit organizations largely have been conducted from afar. Several experts have advocated more field work and closer engagement with executives and board members.[15] The intent of the site visits to the 14 systems in the study population was to supplement information obtained in advance and learn at first-hand the views of senior trustees and CEOs regarding their respective board's structures, processes, and culture.

In preparation for the site visits, a standard set of documents was requested and received from each system; e.g., corporate articles of incorporation and bylaws; organization charts; listings of system-level board members and biographical information about them; listings of board committees and their "charters"; selected system-level policies pertinent to this study; position descriptions for the board chair and CEO; information about the system's mission, vision, and goals; copies of a system-wide "balanced scorecard" recently prepared for the system board; and other documents.

Baseline information about each system obtained from its documents and publicly-available sources was entered into a Data Collection Guide prior to the site visits. This tool was designed as a framework for recording comparable information from official documents and from interviews with the CEOs and board leaders regarding the benchmarks of effective governance and related indicators. The team's experience in conducting previous studies of governance in nonprofit hospitals and community health systems was helpful in creating an efficient and workable tool.[16]

The team conducted site visits in the latter part of 2010 and 2011. The principal investigator participated in all 14 site visits and senior co-investigators participated in some of them. Individual interviews were conducted with all 14 CEOs and a total of 57 board members. In all but one instance, interviewees included the current board chair and at least three other senior board members. Because of scheduling factors, six interviews were conducted entirely or in part via conference call. The interviews were 1.5 to 2.0 hours in length. Team members also met with senior staff personnel to augment information obtained from system documents and interviews. All interviewees were assured of confidentiality, and consistently were cooperative and cordial.

In the process of reviewing the completed Data Collection Guides after the site visits, follow-up contacts were made with board members, CEOs, and/or system staff when a response was missing or unclear. Subsequently, the interview data were entered into a Project Database and independently verified by another member of the research team.

Comparing the data collected before, during, and after the site visits to selected benchmarks of effective governance. The data obtained from system documents, interviews with the CEO and board members, and discussion with system staff leaders were compiled by the research team and tabulated. In doing so, the "data" about the systems' governance structures, practices, and culture were transformed into "information." In Section III, this information is compared to the benchmarks of effective governance and related indicators to determine where they are being met and where gaps exist. In addition, this information also is examined in relation to the system's operating performance using various analytical tools. Information regarding limitations of the methodology used in this study is provided in Appendix A.

III. Study Findings

An important responsibility in designing any study is defining the variables that will be examined. Previous work in the healthcare field and other sectors has identified attributes that influence the performance of governing boards. In recent years, considerable progress has been made in translating them into benchmarks of effective governance in healthcare organizations. Using information provided by board members, CEOs, and staff members and from system documents, this report examines board structures, processes, and culture in the health systems included in our study population and compares them to nine benchmarks of effective governance and related indicators.

BOARD STRUCTURE

With respect to board structures, this study focuses on two key benchmarks of effective governance. They are:

1. **Effective boards insist on governance policies and structures that facilitate their efforts to perform the board's functions and fulfill its responsibilities.**

2. **Effective boards are comprised of highly dedicated persons who collectively have the competencies, diversity, and independence that produce constructive, well-informed deliberations.**

Indicators that relate to these two benchmarks include:

Formal Limits on the Number of Consecutive Terms a Member Can Serve

Establishing limits on the number of terms a person can serve has become widely-accepted as a sound governance practice in all types of organizations.[17] Some take the position that term limits may deprive the board of valuable experience and institutional memory. However, without clear limits and a formal requirement to balance new appointments with retirements of longtime directors, boards can become too large and/or stale. It also becomes difficult to develop and implement a meaningful board succession plan. As stated in a recent Center for Healthcare Governance report, term limits enable the introduction of "…fresh thinking, expertise, and perspectives."[18] It is understood that careful attention must be devoted to the timing of term expirations to guard against losing an overly large proportion of experienced board members in any particular year. This typically is managed through the use of staggered terms.

Eleven of the 14 large systems in this study population (79%) have embraced the concept of term limits and incorporated this provision into corporate bylaws or policies. This compares to 64% for our country's hospitals and health systems as a whole, as determined by a national survey conducted by the Governance Institute in 2011.[19]

Among the 14 large systems that participated in this study, the length of term appointments and the number of consecutive terms a member can serve vary somewhat from system to system. A common provision is three-year terms with a limit of three consecutive terms for a maximum of nine years on a board.

Formal Limits on the Number of Voting Board Members

Traditionally, the boards of private, non-profit hospitals and systems have been larger than the boards of public companies. While the gap has narrowed over the years, there continues to be a substantial difference. For public companies, the average board size has remained in the eight to nine range for several years.[20] For hospitals and health systems as a whole, the average size consistently has been between 12 and 14 from 2005 to 2011.[21]

One mechanism for maintaining control of board size is to establish formal limits on the number of voting members. Establishing and honoring formal size limits is widely accepted as a sound policy. The basic logic is to ensure that the size is appropriate to meet the particular needs of the organization. As expressed recently by the IRS:

"Very small or very large governing boards may not adequately serve the needs of the organization. Small boards run the risk of not representing a sufficiently broad public interest and of lacking the required skills and other resources required to effectively govern the organization. On the other hand, very large boards may have a more difficult time getting down to business and making decisions. If an organization's governing board is large, the organization may want to establish an executive committee with delegated responsibilities or advisory committees."[22]

All 14 systems in this study population have adopted limits on the number of voting members for their boards, either in bylaws or corporate policies. Further, in all cases the actual number of voting members is consistent with their particular provisions.

Board Size

Neither in the healthcare field nor other sectors is there an exact answer to the question of "how large a board of directors should be." The 2007 report of the HRET-Center for Healthcare Governance Blue Ribbon Panel on Healthcare Governance advocated a range of nine to 17 voting members for hospital and health system boards.[23] Several other authorities have offered similar recommendations.[24]

As stated previously, the prevailing norm of America's public companies is considerably below this range — averaging in the range of eight to nine voting members — and some authorities advocate even smaller boards. For example, Robert Pozen recently proposed that public companies move to what he terms "professional directorship." Pozen argues for boards composed of seven voting members including the CEO and six independent directors, all with "…extensive experience in the company's lines of business" and with commitment to devote "…at least two days a month on company business beyond the regular board meetings."[25]

Table 1 shows the distribution of the 14 system boards by number of members. For 10 of the 14 systems, their board size is consistent with the Blue Ribbon Panel's recommendation. Three boards have between 18 and 28 voting members; one board has 60 members. The median size is 15 members, excluding the outlier with 60 voting members.

By any measure, the boards of these 14 health systems are larger than the boards of America's hospitals and health systems as a whole and the boards of our country's public companies. In 2011, 83% of America's Fortune 500 boards had 12 or fewer voting board members.[26] Only one of the 14 boards in this study population meets this criterion.

TABLE 1

Size of System Boards

	Number	Percent
Fewer than 9 voting members	0	0%
9 to 17 voting members	10	72%
18 to 28 voting members	3	21%
More than 28 voting members	1	7%
Total	**14**	**100%**

TABLE 2

Board Members' and CEOs' Views about the Size of Their Boards*

	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
It's somewhat too large to be efficient.	15%	26%	24%
The present size is just about right.	71%	63%	65%
We should expand its size to provide broader input.	7%	4%	4%
Other	7%	7%	7%
Total	**100%**	**100%**	**100%**

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

Table 2 shows the opinions of the systems' board members and CEOs about the current size of their boards. There is virtually no interest in expanding the size of their boards. In combination, 24% of the CEOs and board members believe their board is somewhat too large, and several boards are considering some degree of downsizing. However, a majority are reasonably comfortable with the current size of their boards.

Senior board members who serve on the 60-person board recognize clearly that it is exceptionally large and somewhat unwieldy, but believe that — for their faith-based system with multiple sponsors — the benefits of broad-based engagement in governance at the corporate level outweighs the downside of having a very large board. As would be expected, this board's "executive committee" (which includes 25 members) has substantial responsibility.

Board Composition

Independence. The Sarbanes-Oxley Act of 2002 made the definition of "independence" more stringent and increased the requirements for independent board members on the boards of public companies. Other regulatory and advisory bodies have adopted similar positions; for example, the New York Stock Exchange (NYSE) Listing Standards require a majority of a company's board members to be independent.

The overall impact on the composition of public company boards has been striking. The proportion of independent directors on the boards of Fortune 500 companies increased from 22% in 1987 to 84% in 2011.[27] In fact, some authorities have cautioned that this shift could have an adverse impact on board effectiveness by reducing the number of non-independent directors with great familiarity with the company and its sector.[28]

While the Sarbanes-Oxley Act currently applies only to public companies, many of its key provisions have been adopted voluntarily by nonprofit hospitals and health systems. The Panel on the Nonprofit Sector has taken the position that "… [a] substantial majority of a public charity, usually meaning at least two-thirds of the members, should be independent."[29] Several authorities including the Coalition on Nonprofit Health Care and the IRS (using somewhat different criteria) have called for a *majority* of board members in nonprofit organizations to be independent.[30] In the contemporary environment, this can be considered as a basic standard for nonprofit healthcare boards.

For the purpose of this study, the term "independent board member" was defined as persons who are "Not a member of a sponsoring body such as a religious congregation, not a full or part-time system employee, and not directly affiliated with the system in any way except serving as a voting board member." Table 3 shows that, in total, 60% of the members of the 14 system boards in this study population meet these criteria.

TABLE 3
Independent vs. Non-Independent Board Members

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in all Systems (n = 274)
Independent	49%	82%	60%
Non-Independent	51%	18%	40%
P < .01*	100%	100%	100%

*The chi-square test demonstrates significantly different proportions of independent board members in faith-based vs. secular systems.

However, 82% of board members in the six *secular* health systems meet the criteria for independence — virtually identical to the current composition of America's public companies — while only 49% of *faith-based* system board members meet those criteria. The difference is statistically significant, and mainly reflects that the composition of most faith-based system boards still includes a substantial proportion of persons who are affiliated with the previous or current religious sponsors. The range of *independent* member composition varies from 18% for one faith-based system to 100% for one secular system, the single system in the study population where the CEO is not a voting member of the board.

__Diversity.__ 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. It is increasingly recognized that the boards of nonprofit organizations also should include members with diverse backgrounds including, but not limited to, ethnic, racial, and gender perspectives.[31]

A coalition of major healthcare associations including the American Association of Medical Colleges, the American College of Healthcare Executives, the American Hospital Association, and the Catholic Health Association are collaborating in a new initiative — "A National Call to Action" — to eliminate healthcare disparities in the United States. One of this initiative's three core components is to increase diversity in governance and management leadership.[32]

Table 4 shows the proportion of non-Caucasians serving on the boards of the 14 large systems in this study population. In total, 17% of the systems' board members are non-Caucasians; the proportion of those serving on faith-based vs. secular boards is virtually identical. This proportion is somewhat higher than the comparable figure (10%) for hospitals that participated in a 2011 survey conducted by the AHA.[33] The *median* proportion of non-Caucasians on the boards of the 14 systems was 17%; however, the proportion varied from no non-Caucasians on one system's board to 25% on another.

TABLE 4
Racial Composition of Large System Boards*

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in <u>all</u> Systems (n = 274)
Non-Caucasian Members	17%	18%	17%
Caucasian Members	83%	82%	83%
	100%	100%	100%

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

Table 5 shows the gender mix of the 14 systems' boards. While there is substantial variation from board to board, the overall proportion of women serving on the boards of the nine faith-based systems (40%) is significantly higher than the corresponding figure for the secular systems (21%). For the hospitals and health systems that participated in a nationwide survey by the Governance Institute in 2011, 26% of their board members were women.[34]

As compared to America's Fortune 500 companies, the boards of these 14 large, nonprofit health systems are more diverse, both in racial and gender composition. In 2011, only 14% of Fortune 500 board members were non-Caucasians and only 16% were women.[35] It is notable that 12% of Fortune 500 boards still included no women.[36] The boards of all 14 systems in this study include several (two to 10) women.

Since eight of the 14 systems were established by one or more congregations of religious women and all 14 are considered to be progressive, it is not surprising that the composition of their boards are more diverse than the boards of both America's hospitals and health systems as a whole *and* public companies. It appears that our nation's largest nonprofit health systems are responding to what is, on balance, a compelling case for diversity in board composition. This includes a growing body of evidence that suggests organizations and groups with more diversity in board make-up and perspectives will out-perform others.[37]

With respect to executive leadership, during the period of time this study was being conducted (2010-2012), only one of the system's CEOs was a woman (7%). This is somewhat lower than the corresponding figure for America's hospitals and health systems as a whole (12%) and somewhat higher than the figure for Fortune 500 companies (4%).[38] It is clear that disparity still exists in this segment of organizational leadership, both in the healthcare field and in other sectors.

TABLE 5
Gender Composition of Large System Boards

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in all Systems (n=274)
Women	40%	21%	33%
Men	60%	79%	67%
P < .01*	100%	100%	100%

*The chi-square test demonstrates significantly different proportions of women board members in faith-based vs. secular systems.

Clinician Engagement. The National Quality Forum, the Institute for Quality Improvement, and many other prominent healthcare organizations have urged hospital and health system boards to engage clinical leaders in developing goals and strategies for improving patient care quality and safety. For this and other reasons, involving highly-qualified physicians who are committed to the organization's mission has become accepted as necessary and effective governance practice.[39] As stated by Barry Bader et al:

"…a board's membership should include independent, creative, strategic thinkers who bring a broad range of relevant skills to the table. It is difficult to imagine those skills excluding medicine."[40]

Recognition of the importance of physicians' involvement in healthcare governance is reflected in the results of several national studies showing that they constitute approximately 20% of hospital and health system board membership.[41] In contrast, engaging leaders in the nursing profession in the governance of healthcare organizations traditionally has not been a common practice. Studies conducted in 2004-2005 and 2008-2009 found that nurses comprised only about 2% of nonprofit hospital and community health system boards.[42] Recognizing the vital role of nursing in providing patient care and in determining the quality and cost of care, a growing number of respected organizations including the Robert Wood Johnson Foundation have urged hospital and health system officials to consider the appointment of highly-qualified nurse leaders to their boards. As Donald Berwick has stated:

"It is key that nurses be as involved as physicians, and I think boards should understand that the performance of the organization depends as much on the well-being, engagement, and capabilities of nursing and nursing leaders as it does on physicians. I would encourage much closer relationships between nursing and the board."[43]

Table 6 shows that, in combination, 14% of the study populations' board members are physicians and 6% are nurses. Physicians are somewhat more prominent on the boards of secular systems (18%) as compared to faith-based systems (11%); nurses comprise a larger proportion of the faith-based system boards (9%) than the secular system boards (2%). In both groups, clinicians *collectively* constitute 20% of the systems' voting board membership.

The finding that 6% of large system board members are nurses is exactly consistent with the results of the AHA's 2011 survey of American hospitals.[44] These findings appear to represent a shift in the direction that Dr. John Combes, Dr. Susan Hassmiller, and others believe is "… long overdue."[45] The finding that the overall proportion of physician membership on these boards (14%) is somewhat lower than the proportion on the boards of America's hospitals and community-based systems (approximately 20%) may be due, at least in part, to the more direct responsibilities of *local* healthcare organization boards for oversight of patient care quality and safety.

Board Member and CEO Views on the Current Composition of Their System's Board Composition. In the one-on-one interviews with senior board members and CEOs, all were asked to identify their *principal* viewpoint regarding their board's current composition from among the four options shown in Table 7.

Thirteen percent of the CEOs and trustees felt the current composition of their board was "just about right." One in five expressed the opinion that their board's deliberations would benefit from more *racial and ethnic diversity* around the board table and at the committee level.

TABLE 6
Clinician Composition of Large System Boards

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in all Systems (n = 274)
Nurses	9%	2%	6%
Physicians	11%	18%	14%
Other	80%	80%	80%
P < .05*	**100%**	**100%**	**100%**

*The chi-square test demonstrates significantly different proportions of nurses in the board compositions of faith-based vs. secular systems.

TABLE 7
"What is your overall opinion about the current composition of your Board?"*

	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
The Board's deliberations would benefit from additional <u>expertise</u>.	50%	61%	59%
The Board's deliberations would benefit from greater <u>diversity</u> in perspectives.	29%	20%	21%
The Board's deliberations would benefit from having more <u>independent directors</u> around the table.	7%	7%	7%
The present composition is just about right.	14%	12%	13%
	100%	**100%**	**100%**

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

In combination, 59% of the CEOs and board members expressed the view that their board composition and dialog would benefit from additional *expertise* in one or more areas. Two needs emerged as especially prominent: 20 of 71 CEOs and board members identified and discussed the importance of adding more clinical expertise. Eight spoke to the potential benefits of adding one or more persons with extensive experience in working with the executive and legislative branches of the federal government; that is, as one senior trustee expressed it, "persons who know how Washington DC really works in today's world." Later sections of this report will address, in more detail, the systems' current status and plans with respect to succession planning for board members and senior management.

Board Committee Oversight of Specific Governance Functions

The basic functions of the boards of nonprofit hospitals and health systems are well-codified and widely accepted.[46,47] However, as stated in Section I, of this report, there is considerable concern about the *effectiveness* with which governing boards in nonprofit (and investor-owned) organizations are performing those functions. Numerous studies and expert panels suggest boards that adopt a *proactive* role are more likely to demonstrate effective performance than boards that are less involved.[48]

It is widely agreed that a well-organized committee structure with knowledgeable, engaged members is one of the keys to effective governance.[49] As Barry Bader and Elaine Zablocki have stated, "Working committees are the engine that powers effective boards."[50]

Based on their experience in serving on and studying boards in a broad array of healthcare organizations, the research team realized the specific *names* of committees would vary from system to system. Therefore, in reviewing system documents and interviewing board members and CEOs, the team focused on identifying and learning about the standing committees to whom oversight responsibility was assigned.

Based on information obtained from system documents and interviews with board members and CEOs, Table 8 shows the number and proportion of boards in this study population that assigned *oversight responsibility* for seven core governance functions to standing board committees. The table also provides comparable information from the AHA's 2011 national survey of hospitals and systems.[51]

Given their complexity and importance, there is general accord that — in the contemporary healthcare environment — the audit and compliance,[52] executive compensation,[53] and financial functions[54] warrant close oversight by standing board committees. This has become a basic indicator of effective governance, and *all* 14 of the study population's boards meet this standard.

TABLE 8

Boards that have Assigned Oversight Responsibility for Selected Governance Functions to Standing Board Committees

Governance Function	Large Systems in this Study Population (n = 14)	All Hospitals Included in AHA 2011 Survey (n = 1,052)*
Audit and Compliance**	100%	51%
Executive Compensation**	100%	36%
Finance and Investments	100%	83%
Patient Care Quality and Safety	93%	75%
Board Education and Development	86%	60%
System Strategy and Planning**	79%	44%
Community Benefit**	43%	14%

*2011 AHA Health Care Governance Survey Report, op. cit., pp. 14-15.
**The P-value for the two-sample test of binomial proportions demonstrates significantly higher proportions of committees with oversight responsibility for these governance functions in large systems vs. hospitals.

Similarly, strong governance oversight of patient care quality and safety programs,[55] board education and development,[56] and system-wide strategy and planning functions[57] are widely recognized as fundamental duties of healthcare organization boards in the contemporary environment. Nearly all of the study population's boards have assigned clear oversight responsibilities for these key functions to standing board committees; the other boards, up to the present time, have chosen to perform these governance functions as a "committee of the whole." The board of the sole system which, at the time of the research team's site visit, did *not* have a standing committee with assigned responsibility for oversight of patient care quality and safety was in the process of establishing a new committee devoted to this governance function.

In contrast, only six of the 14 system boards (43%) have standing committees with clear oversight responsibility for system-wide community benefit policies, programs, and services. Given growing concerns at national, state, and local levels about the extent to which nonprofit healthcare organizations provide community benefit, meet community health needs, and deserve tax-exempt status, concerted board-level attention to this area clearly is necessary and important for governance and management leaders, both at the local and system levels.[58] The study population's governance policies and processes with respect to community benefit programs are discussed in a later section of this report.

Written, Board-Approved Definitions of Committee Responsibilities

Assigning oversight responsibility for specific governance functions to standing committees in lieu of explicitly deciding to perform those functions by the board as a whole, is commonly accepted as a standard practice, both in the healthcare field and other sectors. 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 fundamental indicator of effective governance.[59]

Based on system documents and interviews with CEOs and board members, Table 9 shows that the standing board committees of all 14 systems in the study population have clearly-defined responsibilities that are spelled out in a written document (i.e., a bylaws provision, a policy statement, or a formal committee charter) that has been formally adopted by the system's board of directors. As shown in Table 9, a recent study of governance in a group of 114 nonprofit community health systems found that only 72% of their boards met this standard.[60]

TABLE 9

Proportion of Health Systems Whose Standing Committees' Responsibilities have been Spelled Out in a Written Document and Formally Approved by the System Board

Response	Large Systems in this Study Population (n = 14)	Nonprofit Community Health Systems (n = 114)*
Yes, there are such documents for <u>all</u> standing Board committees.	100%	72%
Some, but not all, committees have such documents.	0%	21%
Other	0%	7%
P < .05**	100%	100%

*L. Prybil, et al, <u>Governance in High-Performing Community Health Systems</u>, pp. 12-13.
**The Fisher's exact test demonstrates a significantly larger proportion of committees with responsibilities spelled out in a written document in large vs. community-based systems.

Board Executive Committees

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 2009 survey of nonprofit organizations (health related and non-health related) conducted by Grant Thornton LLP found that 88% of the boards had executive committees.[61] A 2011 study of public companies by the National Association of Corporate Directors found that, in these organizations, board executive committees now are "nearly universal."[62]

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 define clearly the committee's role and authority in board bylaws and monitor the committee's actions to ensure those parameters are honored.[63]

The boards of 13 of the 14 large systems in this study population have executive committees in place. As part of the interview process during on-site visits, the CEOs and board members of the 13 systems that have board executive committees were asked "In *your* opinion, how important is the Executive Committee to the overall effectiveness of your Board?"

Table 10 shows the responses of CEOs and board members in the 13 systems whose boards presently have executive committees. Eighty-two percent of these CEOs and board members think their board's executive committee is "Somewhat Important"; none believes it is "Unimportant." From the perspectives of these CEOs and board members, their board executive committees have a limited and clearly-defined role which principally involves two basic functions: first, to act on routine, non-strategic matters that require formal board action between meetings of the full board, and, second, to serve as a "sounding board" for the CEO regarding topics on which he or she wishes to have informal governance input and counsel, e.g., board meeting agenda priorities. These CEOs and board members do *not* view the executive committee as a decision-making body on substantive issues.

Not surprisingly, two of the three CEOs and nearly all of the board members who believe their board's executive committee plays a "Very Important" role are affiliated with the two *largest* boards in the study population, one with 60 members and one with 28 members. Examination of the corporate bylaws and committee "charters" for these two systems support these CEO and board member assessments. In these two instances, the boards' executive committees operate with substantial responsibility, and thus their performance clearly has *considerable* impact on the overall effectiveness of the systems' boards.

TABLE 10

"In your opinion, how important is the Executive Committee to the overall effectiveness of your Board?"*

Response	CEOs (n = 13)	Board Members (n = 53)	Total Responses (n = 66)
Very Important	23%	17%	18%
Somewhat Important	77%	83%	82%
Not Important	0%	0%	0%
	100%	100%	100%

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

Perceived Effectiveness of Board Committees

As part of the interview process, all CEOs and board members were asked to share their personal assessment of the *overall effectiveness* of their respective board's committees. As shown in Table 11, a majority of both the CEOs and board members believe that, on the whole, their board committees are well-organized and effective. As a group, the CEOs' views about the committees are more sanguine than the trustees' assessment.

In four of the 14 systems, 60% or more board members believe the effectiveness of their committees' performance varies considerably, and that "…there is plenty of room for improvement." In two of these four systems, the CEOs agree with this assessment. It is likely this will lead to a serious review of those systems' board committees' roles, composition, and practices in the near future.

TABLE 11

"Based on your <u>personal</u> involvement and experience, how would you assess the <u>overall</u> effectiveness of your Board's committees?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
On the whole, our Board committees are <u>highly</u> organized and perform their duties <u>very</u> effectively.	86%	58%	63%
For the most part, our Board committees do a good job, but this varies from committee-to-committee, and there is plenty of room for overall improvement.	14%	39%	34%
I'm not sure.	0%	3%	3%
	100%	100%	100%

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

BOARD PROCESSES

With respect to board processes, this study focuses on five basic benchmarks of effective governance. They are:

3. **Effective boards have clear definitions of their authority and accountability *and* the decision-making responsibility they have allocated to local operating units in their system.**

4. **Effective boards require mutual understanding regarding the respective roles of governance vs. management, skillful board leadership, *and* excellent board-management relationships.**

5. **Effective boards continuously improve board and CEO performance by setting clear expectations, conducting objective evaluation, and taking follow-up actions.**

6. **Effective boards are committed to establishing and continually updating succession plans for the board, board leadership positions, and, in concert with the CEO, senior management positions.**

7. **Effective boards insist on meetings that are well-organized, focus principally on system-wide strategy and key priorities such as patient care quality and community benefit, and employ board members' time and energy wisely.**

Indicators that relate to these process-oriented benchmarks include:

Board Accountability

In the USA, there is growing interest in the relationship between large-scale organizations and their stakeholders. Clarity in corporate responsibility and accountability is a fundamental component in the foundation for effective organizational governance.

"Corporate responsibility sets the terms of an implicit contract between companies and society. This contract … is enormously valuable to all parties. It establishes the shared expectations on which people place their trust in companies, and sets the ground rules within which companies compete legitimately to provide the goods, services, jobs, and wealth on which modern economies depend."[64]

The state statutes under which both investor-owned and nonprofit corporations are chartered call for their governing boards to have overall responsibility for the organization and the services or products it provides. A large body of corporate law and several theories of corporate governance have developed over the years, all with the general intent of explaining how boards should carry out their duties.[65] In recent years, how effectively governing boards perform those duties and fulfill their accountability to shareholders, corporate sponsors, and society at-large has become the subject of increasing scrutiny.[66] In the nonprofit sector, the tradition of substantial autonomy is being reduced by increasing demands for more information by governmental bodies with oversight responsibility such as the IRS, public and private payors, the media, and other stakeholders.[67]

In this context, it is imperative for the boards of all nonprofit organizations to have a clear sense of the parties to whom — as the stewards of the organization — they are accountable and the ways in which their accountability is fulfilled. As part of the interview process, all board members and CEOs were asked "To whom, in your opinion, is your Board accountable?"

TABLE 12

"Is there a formal, written document that lists the specific powers that are reserved to the party or parties to whom your Board is accountable?"*

Response	Faith-Based Systems (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
Yes	100%	60%	86%
No	0%	40%	14%
	100%	**100%**	**100%**

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

For the board members and CEOs of *faith-based* systems, the initial response to this question was prompt and consistent. They believe their board's principal accountability is to the system's religious sponsors or the legal entity the sponsors have established to direct and control the system and its local organizations; e.g., a "sponsors council" of some type or, for the several Catholic systems that have shifted to this organizational arrangement, a public juridic person.[68] For those affiliated with *secular* systems, the most common view is that their board's principal accountability is to the "patients and populations" their healthcare institutions, health plans, and other programs serve. A substantial portion of the trustees and CEOs of faith-based systems also believe the organizations they govern are accountable to the communities they serve.

In addition, many board members and CEOs express the belief that — because a large and growing proportion of their system's revenues are provided by Medicare, Medicaid, and other public programs — there is de facto accountability to federal and state government. Nearly all of these persons express the view that this is very likely to become more pronounced in the coming years.

As a follow-up question, the board members and CEOs were asked if there is a *formal document* that specifies the powers that are reserved to the body or group to whom their system's board is principally accountable. As would be expected, the board members and CEOs in the nine faith-based systems, all of which have direct accountability to a particular religious body or entity, are well-aware of that relationship and the corporate bylaws or other legal documents that codify it. In the secular systems, four of which are independent entities that do not have a parent organization or sponsor, the responses were less uniform. However, these discussions and subsequent review of corporate documents demonstrated that all but two of the 14 systems in this study population have formal statements of some nature that address their board's basic duties and accountability to another party or parties (see Table 12).

In most instances, however, the boards' accountability to the "people, communities, and populations the systems serve" — while easy to profess — is not spelled out in a detailed fashion. The precise nature of the boards' accountability in this realm and the specific *mechanisms* by which their accountability is fulfilled generally are not codified. Many board members and CEOs agree this is a facet of their present governance model that requires more attention and development.

Allocation of Responsibility and Authority to Local Organizations

In all complex, multi-level organizations, clarity in the allocation of responsibility and decision-making authority is imperative. A lack of clarity, misunderstanding, and/or uncertainty will create operational problems and adversely affect organizational performance. In the world of health systems, especially those whose hospitals and other delivery organizations are geographically dispersed, a clear definition of the respective roles, responsibilities, and authority between system-level and local leadership is a fundamental indicator of effective governance.[69]

Twelve of the 14 health systems in this study population presently have an organizational model that includes a system-level board with overall governance authority and, for their major community-based or regional organizations, "local" boards that function with some degree of decision-making authority. In two instances, there are no local boards, and the system-level boards directly exercise governance authority over operating units. [70]

In 13 of the 14 systems, there is a written, board-approved document that specifies the allocation of responsibility and decision-making authority between system and local governance and/or management leadership. The form of these documents varies; some are incorporated in corporate bylaws, some are corporate policies, and some take the form of an "authority matrix." Only one system, at this time, has not formulated its practices into a formal board-approved document.

As part of the interview process, all board members and CEOs were asked to characterize their views on how their system's current allocation of authority between system and local leadership is viewed within the organization. Table 13 shows their responses.

Their perceptions vary slightly, but most CEOs and trustees felt their systems' current policies and practices on allocation of authority are reasonably well (not perfectly) understood and accepted by board and management leaders throughout the system; very few believe there is substantive discord or problems in this area. However, nearly all of these trustees and CEOs are in accord that the allocation of responsibility and authority within large, geographically-dispersed organizations requires continuous efforts to build understanding and on-going evaluation to identify opportunities for improvement.

TABLE 13

"Which of the following, in your opinion, most accurately characterizes the present allocation of authority between system-level and local leadership within your organization?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
The current allocation of authority is widely accepted by both local and system level leadership.	57%	39%	42%
The level of acceptance is generally good, but it can and should be improved.	43%	54%	52%
The level of acceptance is uneven and warrants system-wide attention.	0%	5%	4%
Not sure.	0%	2%	2%
	100%	100%	100%

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

Board Chair - CEO Relationships

Creating and maintaining strong, trust-based relationships among the CEO, the board chair, and the board as a whole is universally recognized as a critical factor in organizational performance and success. Clear, distinct, and mutually-understood definitions of roles and responsibilities are foundational to developing such relationships.[71]

As a key ingredient in creating clear definitions and mutual understanding, having formal descriptions of the CEO's and board chair's duties has become a basic hallmark of effective governance. Well-constructed position statements that are approved by the board — and reviewed and updated periodically — are a helpful tool for all parties. Vague and/or out-dated position descriptions are useless and potentially troublesome.

All of the 14 large systems in this study population have formal, written descriptions of the CEO's position that have been adopted by the board. Twelve of the 14 boards have adopted formal position descriptions for the board chair; in one system (Kaiser Foundation Hospitals and Health Plan), the CEO also chairs the board of directors.

This level of compliance compares very favorably with the findings of other studies.[72] Naturally the position descriptions vary substantially, both in form and content. Some are incorporated into corporate bylaws or policy statements; others are free-standing documents. Some are quite thorough and comprehensive; others are more succinct with less detail. All, however, have been reviewed and formally approved by the system's board of directors.

As one way to gauge role clarity, all CEOs and board members were asked to express their opinion on the extent to which there is agreement among their board colleagues on distinctions between the CEO's and board chair's respective roles. As shown in Table 14, a large majority of both CEOs and board members concur that those distinctions are well-understood with their boards.

TABLE 14

"In your opinion, is there solid agreement among board members on the distinctions between your CEO's role and the Board Chair's role?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
Yes	86%	91%	90%
No	7%	2%	3%
Not Applicable**	7%	7%	7%
	100%	100%	100%

*Test results are shown only when the observed differences were found to be statistically significant.
**In one system, the CEO also chairs the board of directors.

TABLE 15

"How would you describe the working relationship between your CEO and Board Chair? That is, how does it work?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
Our CEO-Board Chair relationship is consistently excellent.	86%	91%	90%
Our CEO and Board Chair generally work together, but the relationship could be better.	7%	4%	4%
Our CEO and Board Chair relationship can and should be improved.	0%	0%	0%
Not Applicable**	7%	5%	6%
	100%	100%	100%

*Test results are shown only when the observed differences were found to be statistically significant.
**In one system, the CEO also chairs the board of directors.

As a way to get a sense of how systems' CEOs and board chairs work together, interviewees were asked to express their views on their CEO-board relationship. As shown in Table 15, the predominant view among both board members and CEOs is that these relationships are "consistently excellent."

Board Evaluation Process

On-going assessment of its structure, processes, and culture is a fundamental duty of every board of directors. Numerous 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 boards to conduct self-assessments on a regular basis. Accordingly, engaging in some type of formal board evaluation — with or without assistance by an external, independent party — has become the norm. A 2011 study of public companies by the National Association of Corporate Directors found that nearly all companies (91%) regularly conduct full board evaluations and a very large proportion perform committee evaluations (83%).[73] A 2011 survey conducted by the Governance Institute found that 92% of health system boards "…engage in a formal process to evaluate its own performance at least every two years."[74] However, board evaluation processes vary greatly in rigor 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 the effectiveness or value to the company and its stakeholders … almost every board could find ways to do its job better." [75]

In short, there are two basic indicators of effective board evaluation in all organizations: serious, on-going examination of the board and its performance and demonstrated commitment to make actual changes as a result of the evaluation process.[76] Studies have found that objective evaluation together with follow-up board development steps can improve board performance.[77]

The 14 systems' board members and CEOs were asked if, in their opinion, their boards engage in formal board evaluation activities. Table 16 presents their responses compared to findings from a 2009 study of governance in 114 nonprofit community health systems. Consistent with other recent studies, these data affirm that around 90% of the boards in both groups conduct some type of formal board evaluation on an annual or biennial basis.

Two of the 14 large systems in this study population do not, at this time, perform formal, overall board evaluation on a regular basis. However, these two systems — and most of the other 12 — do employ other, less formal types of "board evaluation" activities such as post-board meeting reviews in executive sessions. One of these two boards presently is considering the establishment of a more formal board evaluation protocol.

The second part of the benchmark — actually making *changes* based on findings from the board evaluation process — is a more stringent test. The information displayed in Table 17 represents one probe into the willingness of boards in large, geographically-dispersed health systems and the boards of smaller, community health systems to take such actions.

In both groups, slightly over half of the board members and CEOs believe their board evaluation processes have resulted in *substantive* changes in board composition, practices, and/or dynamics. Most of these leaders were able to give specific examples of actions taken by their boards as a direct or indirect outcome of board assessment efforts during the past two years; e.g., re-allocating some board meeting time from routine reports to long-range strategic issues; upgrading board education programs; and modifying board committee structures through adding, deleting, or consolidating committees.

TABLE 16

"Does your system Board regularly engage in formal evaluation of how well it carries out its duties?"*

Response	Directors and CEOs of 14 Large Systems (n = 71)	CEOs of 114 Community Health Systems (n = 114)**
Yes, either annually or biennially	86%	90%
No	14%	10%
	100%	100%

*Test results are shown only when the observed differences were found to be statistically significant.
**L. Prybil, et al, Governance in High-Performing Community Health Systems, op. cit., pp. 17-18.

TABLE 17

"Over the past two years, has the Board evaluation process resulted in <u>actions</u> that have <u>substantially</u> changed the Board's size, composition, or practices."*

Response	Directors and CEOs of 14 Large Systems (n = 71)	CEOs of 114 Community Health Systems (n = 114)**
Yes	52%	56%
No	32%	42%
Not Sure or Did Not Answer	16%	2%
	100%	**100%**

*Test results are shown only when the observed differences were found to be statistically significant.
**L. Prybil, et al, <u>Governance in High Performing Community Health Systems</u>, op. cit., pp. 18-19.

However, about a third of these board members and CEOs clearly believe their investment of time and other resources in board evaluation exercises during the past two years did *not* result in substantial changes; several others "were not sure." It is possible that, in some instances, the evaluation processes simply concluded there was no need for changes in the board's structure, processes, or practices; that is, everything was fine as is. However, these data do raise serious questions about the extent to which the current board evaluation practices actually are improving governance, at least in a large segment of these health systems.

Each of the board members and CEOs in the 14 large systems also were asked to share their *personal* viewpoint on the effectiveness of their board's formal board evaluation process. Their responses, shown in Table 18, suggest that a large proportion of both board members and CEOs have reservations about their current board evaluation processes. In combination, *only 30%* of these system leaders believe their current board evaluation processes are "thorough" and have produced "substantial improvements in board performance." Their responses to this question reinforce concerns about the present state of board evaluation in these systems surfaced by the findings presented in Table 17. (As previously stated, at the time the site visits were conducted, two of the 14 systems did not have a formal, overall board evaluation program in place; one of the boards is engaged in considering the possibility of establishing one.)

TABLE 18

"Which of the following statements most accurately represents your view regarding the overall effectiveness of your Board's current evaluation process?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
Our Board evaluation process is excellent and has resulted in substantial improvements in Board performance.	36%	28%	30%
A process is in place and has been somewhat beneficial.	50%	54%	54%
The process is not well-organized and not very productive.	0%	2%	1%
We do not have a formal board evaluation process in place at this time.	14%	16%	15%
	100%	**100%**	**100%**

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

CEO Evaluation Process

For all corporate organizations, appointing the CEO, establishing performance expectations and evaluating his or her success in meeting those expectations are among a governing board's most essential duties. Numerous studies have shown that — for organizations, teams, and individuals — having clearly-defined goals tends to enhance performance.[78] For the CEOs of any organization, large or small, evaluating their performance against pre-established expectations in a fair, objective fashion is beneficial for the CEO, the board, and the organization as a whole. Doing this well is widely accepted as a basic hallmark of effective governance.

National studies in the healthcare field and other sectors indicate that a large majority of boards formally evaluate their CEOs' performance in some fashion. For example, a 2011 survey of public companies by the National Association of Corporate Directors found that approximately 70% of boards collaborate with their CEOs in setting financial and non-financial goals.[79] A 2011 Governance Institute study showed that 91% of the participating hospital and health system boards have adopted and utilize "…a formal process for evaluating their CEOs' performance."[80]

On-site interviews with the CEOs and board members in the 14 large systems found that all of the boards regularly evaluate their CEOs' performance in relation to pre-established expectations or criteria on a regular basis. As shown in Table 19, in seven of the 14 systems, the boards' compensation committees are charged with leading the evaluation process; in all seven instances, the board chair either serves on the compensation committee or works closely with it in the evaluation process. In four systems, the current CEO evaluation protocol calls for the board chair personally to lead the CEO evaluation process; in all four of these systems, the board chair engages other board members in the process.

All of the board members and CEOs also were asked to express their opinion on the *overall* effectiveness of their system's current CEO performance evaluation process. As shown in Table 20, a strong majority of both the CEOs and board members believe the current process "…produces clear performance expectations and assesses actual performance fairly."

Unfortunately, this is not the case in many organizations in the healthcare field and other sectors. A recent study by the American College of Healthcare Executives found that 82% of CEOs were not given performance expectations when they initially were employed, and 66% reported that no formal evaluation process was conducted at the end of their first year in the position.[81] Numerous experts have expressed serious questions and concerns about the rigor and efficacy of CEO evaluation in both nonprofit and investor-owned organizations.[82]

TABLE 19

"Who has lead responsibility for leading the CEO evaluation process?"*

Response	Faith-Based Systems (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
Board Chair	3	1	4
Board Executive Committee	0	1	1
Board Compensation Committee	5	2	7
Ad hoc group appointed by the Board Chair	1	1	2
Total	**9**	**5**	**14**

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

TABLE 20

"Which of the following statements most accurately describe your overall view of the
effectiveness of your Board's current CEO evaluation process?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total Responses (n = 71)
The process produces clear performance expectations for the CEO and assesses actual performance fairly.	79%	74%	75%
A process is in place and has been somewhat beneficial for the CEO and our organization.	21%	24%	24%
The process is not well-organized and not very productive.	0%	0%	0%
Has not yet participated in our CEO evaluation process	0%	2%	1%
Total	**100%**	**100%**	**100%**

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

Succession Planning Processes

In the organizational context, "leadership succession planning" should address the needs for clinical, governance, and management leadership talent. Having highly-dedicated and skillful leaders in key roles in all three realms with capable persons in line to succeed them when needed is essential to sustain organizational success in our rapidly changing and increasingly challenging societal environment.

The concept of "leadership succession planning" includes several basic components: on-going efforts to define leadership needs and how those needs are evolving as the organization's internal and external environment changes; assessing existing talent in relation to the organization's current and projected needs; building a strong leadership development program to enhance the existing talent base and recruit additional talent where required; and systematic planning to identify well-prepared individuals who have the competencies and motivation to step into key positions and perform effectively when they are called upon.

The concept is straight-forward, and the potential benefits for the organizations which embrace and execute it effectively are clear. This is why organizations such as the Securities Exchange Commission, rating agencies, and other bodies with oversight responsibilities in many sectors are devoting more scrutiny to leadership succession planning.[83] Ensuring that well-designed leadership succession programs are in place and functioning well has become a fundamental indicator of effective governance.

Unfortunately, the evidence suggests that many boards, both in the healthcare field and other sectors, fall short. To illustrate, a 2011 survey by the National Association of Corporate Directors found that only one third of America's public companies had a formal CEO succession plan in place.[84] A 2010 study by the American College of Healthcare Executives found that only 44% of hospitals had succession plans for their CEO, 39% for their chief nursing officer, and 36% for the chief financial officer.[85] A 2011 Governance Institute study showed that only 41% of the participating hospitals and health systems employ "…an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs."[86]

In the on-site interviews, all board members and CEOs were asked about the current status of succession planning for board and senior management positions within their systems. As shown in Table 21, these interviews and subsequent conversations with system staff indicate that six of the 14 systems (43%) have *some form* of succession plans in place, both for board leadership and senior management positions, including the system CEO. Another four systems (29%) have succession plans in place for the CEO and other senior management positions, but *not* for board leadership. In general, the development of succession planning is somewhat more advanced in the secular systems than in faith-based systems. However, virtually *all* of the board members and CEOs in systems that have initiated board and/or management succession planning programs express the view that their current programs are in "early stages of development" and will require much more work during the coming months and years. They also are in accord that leadership succession planning is critically important to the long-term success of their systems.

Board Oversight of Patient Care Quality and Safety

Extensive efforts to improve patient care quality and safety are being made by national organizations such as the Institute for Healthcare Improvement, the Hospital Quality Alliance, and the National Quality Forum as well as by health system leaders at the local level. There is evidence that improvements in some areas are being made.[87]

However, a series of studies by the Institute of Medicine, the Commonwealth Fund, and other authorities show that the overall quality of clinical services provided by healthcare institutions continues to be uneven and needs to be improved.[88] In March 2011, the U.S. Department of Health and Human Services promulgated a National Quality Strategy intended to "… promote quality health care in which the needs of patients, families, and communities guide the actions of all those who deliver and pay for care."

TABLE 21
"Has your board adopted formal succession plans for Board and senior management positions?"*

Response	Faith-Based Systems (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
Yes, for Board chair, for Board committee chairs, for the CEO, <u>and</u> for other senior management positions.	33%	60%	43%
For <u>Board</u> leadership positions but <u>not</u> for senior management positions.	11%	0%	7%
For the CEO and other senior management positions but <u>not</u> for Board positions.	23%	40%	29%
We have not yet adopted any formal succession plans.	33%	0%	21%
	100%	**100%**	**100%**

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

The governing boards of America's hospitals and health systems have a special role in meeting these challenges. Ensuring that organizational standards for patient care quality and safety are adopted and that processes for monitoring and improving clinical services are in place clearly are among the boards' most fundamental duties.[89] It is imperative for boards to understand their legal and moral responsibility in this realm; engage with clinical and management leadership in establishing policies, standards, and metrics for patient care quality and safety; and monitor the organization's performance in relation to them. Boards also must ensure that appropriate actions are taken by clinical and management leadership when performance does not meet the established standards.

In the contemporary healthcare environment, meeting these obligations has become a basic expectation for hospital and health system boards. This has been reinforced by new leadership standards set forth by the Joint Commission in January, 2009, and by provisions of the Affordable Care Act of 2010.

"The [Affordable Care Act's] aim is to achieve optimal results in terms of the overall quality of care as well as its efficiency, cost, safety, and timeliness … boards, which are legally accountable for the quality of care their institutions provide, need to develop and implement effective quality oversight processes to achieve these objectives …"[90]

It seems likely that the Centers for Medicare and Medicaid Services (CMS), the Department of Justice, and other regulatory bodies will hold the board of directors accountable if a healthcare institution is not providing patient care services that meet 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 …"[91] However, some studies have raised concerns about the extent to which hospital and health system boards are focused on patient care quality and safety. For example, a study conducted by Ashish Jha and Arnold Epstein in 2007-2008 found that only half of the board chairs in a nationally representative sample of nonprofit hospitals identified clinical quality as one of their board's two top priorities for governance oversight.[92] A 2011 Governance Institute survey found that only 74% of health system boards have standing committees on quality and/or safety.[93]

This study of governance in 14 large systems examined several aspects of the board's oversight of patient care quality and safety and found evidence of substantive engagement. As shown in Table 8 and discussed earlier in this report, nearly all of the boards (93%) have established a standing committee with oversight responsibility for patient care quality and safety. Through interviews with senior board members and CEOs and review of system documents, this study examined the boards' current role with respect to setting the system core measures and standards for patient care quality. Table 22 shows the findings. In 11 of the 14 systems, the board of directors formally adopts system-wide measures and standards. In two cases, the board's standing committee on quality has been delegated responsibility to adopt the measures and standards and present them to the full board. During the period of time when this study was being conducted, the remaining board was engaged in re-examining its role and practices with respect to oversight of patient care quality and safety.

TABLE 22

The System Board's Role with Respect to System-Wide Measures and Standards for Patient Care Quality*

Response	Faith-Based Systems (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
The Board <u>formally adopts</u> core measures and standards for quality of patient care.	78%	80%	79%
A Board <u>committee</u> adopts the core measures and standards and shares them with the Board, but the Board does not formally <u>adopt</u> them.	11%	20%	14%
Measures and Standards for quality of patient care are <u>not established at the system level</u>; this function is handled by local organizations in our system.	11%	0%	7%
	100%	100%	100%

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

TABLE 23

"Has your system's Board adopted <u>specific action plans</u> in the past 12 months directed at improving system performance with respect to patient care quality and safety?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total (n = 71)
Yes	79%	80%	80%
No	14%	18%	17%
I'm not sure	7%	2%	3%
	100%	100%	100%

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

In the one-on-one interview process, all board members and CEOs were asked if their system board "…regularly receives written reports on system-wide and hospital-specific performance in relation to established measures and standards for the quality of care." All 14 CEOs and all 57 board members independently responded affirmatively. Their opinions were verified by examining "scorecard" reports and other system documents that are prepared for and presented to these boards.

Finally, as a test of the boards' willingness to address issues or problems that are surfaced by reports they receive, the board members were asked if, in the past 12 months, their system's board had "…adopted specific action plans directed at improving system performance in patient care quality and safety." Table 23 presents their responses to this question. The congruence between the views of board members and CEOs on this important issue is striking: among both groups, four out of five respondents stated that their boards had adopted one or more "action plans" within the past year. Many were willing and able to give concrete examples. Predictably, these "action plans" varied widely. They ranged from asking the CEO and system staff to address a specific quality of care issue at an institution in their system and prepare a special report for consideration at an upcoming board meeting to directing the board's quality committee and staff to "take a fresh look" at certain quality measures and targets adopted in the past.

Contrary to some other studies, the input provided directly by these board members and CEOs — in combination with system documents such as quality committee charters and board scorecard reports — suggest high levels of interest and engagement in addressing their responsibilities for oversight of patient care quality and safety. Nearly all of the board members and CEOs readily acknowledge the complexity of these responsibilities and the shortfalls they perceive in their current policies and practices. They view these policies and practices as "work-in-process" and recognize the need for continuous assessment and improvement in them. However, based on these findings, it certainly appears that the boards of these large nonprofit systems are heeding Donald Berwick's call to embrace "stewardship of quality" as a fundamental board duty.[94]

Board Oversight of Community Benefit Policies and Programs[95]

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 termed the "Hill-Burton Act," became Title VI of the Public Health Service Act. It represented the first major policy instrument for shaping hospital and health services planning in the United States. To become eligible for federal grants for hospital construction projects, states were required to establish hospital planning agencies, assess existing facilities in relation to current and projected community needs, and set priorities on a statewide basis. In the decades that followed, the Hill-Burton Act enabled thousands of hospital construction and renovation projects, reshaped America's health services delivery system, and introduced the concept that nonprofit, tax-exempt healthcare facilities should serve defined community needs.[96]

Historically, nonprofit hospitals and health systems were accorded tax-exempt status on the premise that a fundamental reason for their existence was providing charity care to persons who required healthcare services but were unable to pay for them. The original (1946) Hill-Burton legislation required facilities receiving grants to provide charity 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.[97]

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 Revenue Ruling 69-545 which shifted the rationale for granting tax-exempt status to nonprofit healthcare institutions from providing charity care to providing "community benefits." In Revenue Ruling 69-545, the IRS reasoned that providing healthcare services for the general benefit of the community *inherently* is a charitable purpose, outlined the factors that would be considered in granting tax-exempt status, and, in doing so, created the so-called "Community Benefit Standard."[98]

As time passed and the healthcare field and society as a whole experienced major economic, demographic, and political changes, many parties in both the public and private sectors began to raise questions about the adequacy and appropriateness of the Community Benefit Standard as the basis for providing tax-exempt status for nonprofit healthcare institutions.[99] A number of voluntary healthcare organizations including the American Hospital Association, the Catholic Health Association, the Health Research and Education Trust, the Public Health Institute, and the VHA have encouraged hospitals and health systems to document the services they provide and how those services benefit the communities they serve.[100] However, several studies by the IRS, the General Accounting Office, and other organizations documented wide variability in definitions and amounts of "uncompensated care" and other forms of community benefit provided by nonprofit healthcare institutions.[101,102] These studies — in combination with a series of hearings by legislative bodies including the House Ways and Means Committee and the Senate Finance Committee at the federal level and growing need for revenues at the state and local levels — generated serious questions about nonprofit hospitals' exemptions from income, property, and other taxes.

These issues have contributed to the adoption of various forms of community benefit requirements (such as a specific level of charity care and/or standard reporting rules) for nonprofit healthcare institutions in about half of the states.[103] In some locales, hospitals' traditional exemptions from property taxes are being challenged on the basis of their levels of charity care.[104]

At the federal level, continuing concerns about the utility of the IRS Community Benefit Standard, the absence of agreed-upon "community benefit" definitions, and wide variation in the amounts of uncompensated care and other community benefits provided by nonprofit

hospitals and systems led, in 2007, to substantial revisions to the IRS Form 990, "Return of Organization Exempt from Income Tax," and corresponding instructions. The redesigned form consists of a common document that must be completed by all applicable tax-exempt organizations and a series of schedules that organizations may need to complete depending upon their particular roles and activities. Phased in beginning with the 2008 tax year, this was the first major revision to Form 990 since 1979.

For healthcare institutions, the revised Form 990 and the new Schedule H require significantly more details about charity care, other types of community benefits provided by the organization, the expenses related to these services, and other information than in the past. According to the IRS, Schedule H was intended to " … combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care."[105]

Since its adoption in 2007, the Form 990 and related schedules have been refined somewhat but basically remained intact since then. However, the Patient Protection and Accountable Care Act (the "Act") adopted by Congress in 2010 amended the IRS code by adding Section 501(r)(3). It requires every hospital facility operated by a 501(c)(3) organization to conduct a "community health needs assessment" with input from interested parties in the community at least once every three years, develop an implementation strategy to address community needs identified through that process, and make the results widely available to the public. Hospitals with a July 1- June 30 fiscal year are required to complete a community health needs assessment, set priorities, and adopt implementation plans by June 30, 2013.[106] Details remain to be worked out, but if the Patient Protection and Affordable Care Act and IRS Code Section 501(r)(3) remain in place, they will have substantial impact on the nation's nonprofit hospitals and systems.

TABLE 24

"Has the Board adopted a <u>formal, written</u> statement that defines overall goals and guidelines for the system's community benefit program?"*

Response	Faith-Based System (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
Yes	78%	40%	64%
No	11%	60%	29%
Not Clear	11%	0%	7%
	100%	**100%**	**100%**

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

While recognizing the Act was new and federal guidance regarding Code Section 501(r)(3) would not be available for some time, the interviews with system board members and CEOs did include several questions regarding their particular system's community benefit programs as they exist at this time. The first was "Has your board adopted a formal, written statement that defines overall goals and guidelines for your system's community benefit program?" In combination, 61% of the trustees and CEOs answered affirmatively; many were able to discuss the genesis and content of their system's policy and position in some detail. A review of system documents support these finding and indicate that, at this time, nine of the 14 systems (64%) have board-approved policy statements regarding their community benefit programs in place. CEOs and board leaders in several of the remaining systems are giving consideration to developing and adopting policy statements of this type.

Among the basic aims of the Act are improving patient care quality and safety, reducing the growth in healthcare costs, and improving coordination among providers of healthcare services. As one strategy for achieving these aims, the Act promotes the development of "accountable care organizations" ("ACOs") which, as a general construct, can be defined as " … groups of providers who are willing and able to take responsibility for improving the overall health status, care efficiency, and health care experience for a defined population."[107] Implicit in the ACO and other provisions of the Act is encouragement to improve communication and coordination between healthcare providers in the private sector and public health agencies. This theme also has been affirmed by the Institute of Medicine's 2012 report, "Primary Care and Public Health: Exploring Integration to Improve Population Health" and a recent report by the Urban Institute.[108]

As one way to gauge the participating systems' current policy positions on coordination between their local delivery organizations and public health agencies, the board members and CEOs were asked if their system's board requires (not just "encourages") their local organization to collaborate with local public health agencies in their vicinities. The information presented in Table 25 shows that, at this time, such requirements are not common. Only four board members and one CEO, all affiliated with a single secular system, indicated that collaboration with local public health agencies in assessing community health needs and setting community benefit priorities is a system-wide requirement for their local organizations. However, in recognition of the nationwide need for greater focus on prevention and population health, many board members and CEOs expressed support for the idea of promoting stronger communication and coordination between their local institutions' leadership teams and local public health agencies.

In the contemporary environment, organizations in virtually all sectors of society face resource constraints and must set resource allocation priorities carefully. As stated by Michael Porter and Mark Kramer, "No business can solve all of society's problems or bear the cost of doing so."[109] For America's hospitals as a whole, uncompensated care (charity care and bad debt) increased from $21.6 billion in 2000 to $39.3 billion in 2010, an increase of 82% in that decade. This trend clearly has affected the availability of resources for other categories of community benefit activities.[110] For this and other reasons, developing and adopting formal plans and setting clear priorities for community benefit programs has emerged as a basic indicator of effective governance in healthcare organizations.[111]

TABLE 25

"Does your Board <u>require</u> your local organizations to collaborate with <u>local public health agencies</u> in assessing community needs and setting community benefit program priorities?"*

Response	CEOs (n = 14)	Board Members (n = 57)	Total (n = 71)
Yes	7%	5%	6%
No	93%	93%	93%
Not Sure	0%	2%	1%
	100%	100%	100%

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

In this study of governance in large nonprofit systems, all board members and CEOs were asked if, in their opinion, their system's board has required their local organizations to develop and adopt a formal community benefit plan that identifies specific priorities for its community benefit program. Nearly half of the board members and CEOs responded affirmatively. A review of system documents supports their opinions and, as shown in Table 26, seven of the 14 systems (50%) in this study population — principally but not exclusively faith-based systems — have directed their local leadership teams to develop formal plans with priorities, strategies, and metrics for their community benefit programs. In several instances, these expectations specify that the process of developing local plans must consider and address certain system-wide priorities. If the provisions of IRS Code Section 501(r)(3) go into effect and resources become further constrained, the development and adoption of formal community benefit plans at both the system and local levels of nonprofit health systems will become increasingly prevalent.

Allocation of Board Time and Effort

The time its board members are able and willing to devote to governance functions is one of an organization's most important assets. The manner in which board meetings are organized and how time is allocated is a key determinant of board effectiveness in all types of organizations.[112]

The board members and CEOs who were interviewed as part of this study were asked to estimate the proportion of board (not board committee) time allocated to two critical topics in meetings of their system board during the past twelve months. Those topics were, first, patient care quality and safety and, second, strategic thinking and planning.

TABLE 26

"Does your Board require your local organizations to adopt a formal community benefit plan that identifies specific priorities and strategies for its community benefit program?"*

Response	Faith-Based System (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
Yes	67%	20%	50%
No	33%	60%	43%
Not Clear	0%	20%	7%
	100%	**100%**	**100%**

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

As reported earlier in this report, 13 of the 14 boards in this study population have established standing committees on patient care quality and safety; virtually all of the board members and CEOs interviewed in this study view setting direction and providing oversight of their systems' performance in this area as one of their most important duties. With respect to allocation of board meeting time to reports and deliberations regarding patient care quality and safety during the past year, the combined estimates by board members and CEOs of the 14 boards ranged from a low of 10% to a high of 35%. The median estimate for the 14 boards was 23%; the mean estimate was 22%.

Governing boards in all types of organizations frequently are criticized for focusing on current operating performance and short-term issues as compared to the major strategic problems and opportunities that confront the organization.[113] In surveys of boards in both public companies and nonprofit organizations, directors often rank "strategic planning and oversight" as one of their boards' top priorities.[114] Many authorities have urged boards to devote more time and attention to strategic or "generative" thinking and deliberations; however, recent studies do not demonstrate that this shift is occurring.[115]

In this study, board members and CEOs were asked to give their best estimates of board meeting time devoted to strategic thinking and planning during the past year. The combined estimates by board members and CEOs of the 14 boards ranged from a low of 15% to a high of 53%. The median estimate for the 14 boards was 32%; the mean estimate was 30%.

Perhaps the most striking insight from these discussions with board members and CEOs was the consistent expressions of interest and commitment by both board members and CEOs to increase their boards' focus on strategic thinking and deliberations. Virtually all recognize the importance of this governance responsibility in our increasingly volatile healthcare environment; many discussed steps their boards already have taken and/or are planning to take to re-align their traditional board meeting agendas and practices to create more time for various forms of strategic assessment and deliberations. These include, for example, adopting a formal board policy to commit at least half of every board meeting to long-term strategic thinking and planning. Another board now blocks at least two hours of every board meeting to focus on a particular strategic issue or opportunity their system needs to address.

It must be recognized that the data regarding allocation of board meeting time simply represent the "best estimates" of board members and CEOs, not actual measurements, and longitudinal data are not available for comparison. However, these estimates in combination with narrative comments provided by the board members, CEOs, and system staff members are congruent and clearly suggest two conclusions: first, on the overall basis, these 14 system boards over the past year have devoted approximately half of their board (not committee) meeting time to deliberations regarding quality and safety and to strategic thinking and planning. Second, virtually all of these boards and their CEOs are making intentional efforts to re-balance their board meetings to provide more time for engagement in active deliberations with less time devoted to routine reports and presentations.

BOARD CULTURE

With respect to board culture, this study focuses on two basic benchmarks of effective governance. They are:

8. **Effective boards intentionally create a culture that nurtures enlivened engagement, mutual trust, willingness to act, and high standards of performance.**

9. **Effective boards expect their CEOs to demonstrate exceptional leadership and management skills, high personal and professional standards, and strong support for the role of governance.**

Over time, either deliberately or not, every board of directors creates a governance culture — a pattern of beliefs, traditions, and practices that come to prevail when the board meets to perform its duties. As stated by Barry Bader:

"Like their organizations, governing boards have a culture too. The pivotal importance of culture in distinguishing the effective from the ineffectual board has been apparent at least since the downfall of the Enron Corporation. Observers attributed Enron's collapse in part to a passive, management-driven board of directors. Despite talented members and a well-defined structure, directors failed to ask hard questions or display the independence needed to detect egregious accounting irregularities and unethical conduct by senior executives." [116]

Some boards, like Enron's and many others, are insufficiently dedicated with a passive culture and low performance standards. This combination generally results in ineffective governance. [117] In both the healthcare field and other sectors, there is growing conviction that effective governance requires a healthy board culture with commitment to proactive engagement, high performance standards, and rapt attention to making and executing decisions. [118]

Healthy Board Culture

Examining and trying to understand the culture of any organization or group is quite challenging.   Based on the work of a panel including senior board leaders, CEOs, governance consultants, and university faculty members with experience in board service and research convened by HRET in 2007 and other studies, the research team selected seven features that, if present, indicate the existence of a healthy, effective board culture. [119] Board members and CEOs of the 14 large systems who participated in this study were asked to express their views on the extent to which their system's board demonstrates these seven characteristics. [120] Table 27 displays their responses in comparison to the views of CEOs who participated in a recent study of governance in 114 nonprofit community health systems.

These data suggest that nearly all trustees and CEOs in these 14 large systems believe their boards consistently demonstrate commitment to their system's mission and honor their conflict of interest and confidentiality policies. However, less than 60% of them feel their board leaders "hold board members to high standards of performance" or that "robust engagement and respectful disagreement consistently are encouraged." In combination, only one-third of the trustees and CEOs feel their systems' board meetings consistently are "well-organized and focus principally on strategic deliberations rather than receiving information." This finding is consistent with Section III (B) of this report which documents the commitment by many board members and CEOs to shift a larger proportion of board time and effort from reports on routine operations to strategic thinking and deliberations. In general, the views of the CEOs of these 14 large systems on these indicators of effective board culture are similar to the view of community health system CEOs. None of the observed differences are statistically significant.

TABLE 27

Board Member and CEO Opinions on Whether or Not their Boards Demonstrate Selected Indicators of Effective Board Culture*

Indicators of Healthy, Effective Board Culture	Board Members of 14 Large Systems (n = 57)	CEOs of 14 Large Health Systems (n = 14)	CEOs of 114 Community Health Systems (n = 114)**
The Board's actions always demonstrate deep commitment to our organization's mission.	93%	93%	89%
There always is a strong focus on honoring Conflict of Interest and Confidentiality policies.	93%	86%	n/a
There always is an atmosphere of mutual trust among the Board members.	75%	71%	70%
Our system's performance (financial and clinical) always is tracked closely by the Board and actions are taken when performance does not meet our targets.	74%	93%	72%
Board leadership always holds Board members to high standards of performance.	58%	57%	42%
Robust engagement and respectful disagreement always is encouraged.	51%	50%	54%
Board meetings are well-organized and focus principally on strategic deliberations, rather than receiving information.	32%	43%	n/a

*Test results are shown only when the observed differences were found to be statistically significant.
**Prybil, et al, Governance in High-Performing Community Health Systems, pp. 28-29.

Approach to Decision-Making

The role and responsibilities of a governing board requires it to make decisions that shape the organization and its future direction. The manner in which a board approaches and conducts its decision-making processes is a fundamental indicator of its culture and has major impact on the organization's performance.[121]

As one way to probe this dimension of the boards' cultures, board members and CEOs were asked to characterize their board's overall approach to "… making decisions on important issues over the past 12 months." Table 28 displays their opinions, again in comparison with the views of 114 community health system CEOs who responded to the same question as part of a previous study.

TABLE 28

"Over the past 12 months, how would you characterize your system Board's approach to making decisions on important issues?"*

Overall Approaches to Decision-Making on Major Issues	Board Members of 14 Large Systems (n = 57)	CEOs of 14 Large Health Systems (n = 14)	CEOs of 114 Community Health Systems (n = 114)**
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.	63%	57%	70%
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.	35%	43%	29%
The Board tends to be passive and reactive in its approach to decision-making. We need to find ways to get the Board much more engaged.	0%	0%	1%
Other	2%	0%	0%
	100%	**100%**	**100%**

*Test results are shown only when the observed differences were found to be statistically significant.
**L. Prybil, et al, Governance in High-Performing Community Health Systems, op. cit., p. 30.

These data show that a substantial majority of board members (63%) and CEOs (57%) view their respective board's current approach to decision-making positively. On the whole, board members are slightly more sanguine about their approach than CEOs, but the difference is modest and not statistically significant. The CEOs of 114 community health systems studied in 2008-2009 view their boards' approach to making major decisions somewhat more positively than the CEOs of the 14 large systems in this study population, but, again, the observed difference is not statistically significant.

CEO Commitment to Board Development

As part of the interview process, all board members were asked to describe their CEO's level of commitment to developing a governing board whose culture has the characteristics shown in Table 27. Virtually without exception, the board members' responses to this question were positive and highly complimentary. It is clear that this group of CEOs — and their commitment to assist in building a strong, healthy board culture — is recognized and greatly appreciated by their board members.

Senior Staff Support for the Board

Table 29 provides another indicator of CEO commitment to strong governance. Because solid staff support for boards is a critical determinant of their effectiveness, board members were asked if all standing board committees are staffed by senior members of their system's leadership team. Ninety-one percent of the board members replied affirmatively to this question. Their opinions were verified by reviewing system documents and through discussions with the system CEOs and staff members. In only one system did board members express the view that the overall caliber of staff support for board committees — and for the board as a whole — was somewhat less than satisfactory.

In combination, these findings indicate that the CEOs of these 14 systems are strongly committed to effective governance and, on the whole, provide excellent support for their board and board committees.

TABLE 29

"Are the standing committees staffed by senior members of your system's leadership team?"*

Response	CEOs (n = 14)	Board Members (n = 57)
Yes, all standing committees have senior staff support.	100%	91%
Some, but not all, do.	0%	9%
No, they do not.	0%	0%
	100%	100%

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

Executive Sessions of the Board

Over the past twenty years, the practice of having "executive sessions" of the board has evolved from being rare to becoming commonplace, both in the healthcare field and other sectors. Among public companies, this practice now is virtually universal.[122] A 2011 survey conducted by the Governance Institute found 73% of the health systems that responded now schedule executive sessions before or after every board meeting.[123]

Executive sessions organized into two segments, one part without the CEO or other management team members present and one part with the CEO present, have become widely accepted as a standard practice of effective boards.[124]

Executive sessions of this nature provide an opportunity for board members to candidly exchange views on governance issues such as board succession planning while still ensuring solid communications and coordination between the board and the CEO. Establishing the tradition of executive sessions of this nature as part of every board meeting with the understanding and support of the CEO is an effective governance practice. It also becomes an important feature of the board culture and reflects mutual trust and respect between the board and the CEO.

Table 30 shows that nine of the 14 system boards in this study population (64%) hold executive sessions as part of every board meeting; the balance (36%) have such sessions sometimes, but not always.

TABLE 30

Does the Board Hold an Executive Session at the End of Board Meetings Without the CEO or Other Management Staff Present?*

Response	Faith-Based System (n = 9)	Secular Systems (n = 5)	All Systems (n = 14)
Yes	67%	60%	64%
Sometimes, but not always	33%	40%	36%
No	0%	0%	0%
	100%	100%	100%

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

This section of the report has two parts: first, an overview of several overall patterns or "themes" that emerged from this study of governance in 14 large, nonprofit health systems and, second, a synopsis of one particular feature of the governance model currently in place in each of these systems.

Emerging Governance Patterns

Each of the 14 health systems that participated in this study is unique in certain respects. Their genesis, their evolution over the years, the particular set of communities and populations they presently serve, their current mission, and their vision and goals for their future all differ in various respects. However, from this study of their governance structures, processes, and cultures including interviews with their senior board leaders and CEOs, several common patterns of governance emerge. These overall patterns appear consistently in all or most of the systems and in all parts of the country. These emerging patterns include the following:

1. Our nation's economic, political, and social environment is demanding major changes in all of these systems.

Virtually all of the systems' board leaders and CEOs recognize that the rapidly changing environment will require fundamental changes in their system's organizational structure, policies, programs, and, in many cases, their traditional mission and current vision. As one CEO stated during the interview process:

"The healthcare environment is changing dramatically and will continue to do so, but our system has been successful and comfortable with the status quo. The question is, can our system change — really change — to better address the changing needs of an aging population and a much greater emphasis on prevention and health promotion? Can we re-invent ourselves as a system to focus on improving community health status as well as providing acute care services much more efficiently?"

Healthcare in the USA is in the midst of turbulent change, and healthcare providers are facing difficult issues and great uncertainty. All of these large systems are engaged in various forms of transformational change; e.g.: re-designing their corporate structures to facilitate large-scale diversification; aligning closely with physicians and other providers to create a more integrated continuum of care; investing in for-profit ventures; and partnering with insurers to form new "accountable care organizations." The boards and CEOs realize that making major changes is imperative; making those changes while preserving their system's core values clearly is one of their fundamental challenges.

2. Increasing focus by boards on system-wide strategy and strategic issues

In all of the systems that participated in this study, the boards and CEOs are engaged in a distinct shift in governance focus and allocation of time. The pattern that clearly is emerging involves a growing emphasis on strategic issues, deliberations, and decision-making. All of the systems are in the midst of reforming their board structures, processes, and practices to accelerate that shift. In addition to now-standard practices such as board retreats and the use of a "consent agenda" format for board meetings, some examples of steps being taken by the systems' boards to enable greater attention to system-wide strategy and strategic issues include:

- A policy decision by one board to devote 50% of every board meeting to strategic issues and deliberations.
- Blocking at least two hours of every board meeting to a specific challenge or opportunity felt to have major implications for the organization's future direction.
- Re-structuring the board agenda to place items requiring board decisions and strategic issues that call for board deliberations as the first segment of every board meeting. Routine committee and management reports are distributed in advance of the board meetings, with the understanding that the information therein will not be replicated in verbal presentations.
- Requesting every board committee, as a standing agenda item at every committee meeting, to devote concerted time to identifying issues in their realm of responsibility (e.g., quality and safety) that could have major, long-term strategic impact on the system; then — with appropriate explanation and information — proposing such items for strategic deliberations at a future board meeting.

Proper board oversight of their system's operations in relation to established goals and targets is obviously essential. However, it is clear that — in the contemporary environment — it is increasingly important for boards to devote attention to strategic thinking and deliberations. In various ways and at differing speeds, the boards of all 14 systems are in the process of making this shift. As a board chair of one faith-based system stated in the interview process:

"As a system, what can and should we become in the future? What is the best direction for our health ministry? What should be our vision for the future and what strategies should we adopt for getting there? These are the issues our board and management colleagues must focus on."

3. Patient care quality and safety has risen to become a principal board priority.

The board leaders in these 14 health systems clearly recognize their board's fiduciary and moral responsibility for quality and safety. Thirteen of the 14 boards now have standing committees to provide direction and oversight and all of the boards now routinely receive written reports on system-wide and hospital-specific performance in relation to quality measures. The interviews with senior board members and CEOs as well as conversations with system staff associates consistently reflect that patient care quality and safety has become a high governance priority. As stated by the CEO of one of these systems:

"Getting ready for 'value-based purchasing' which is emerging in many forms across the country is one of our system's greatest challenges. To be successful in the future, all providers of healthcare services must make dramatic advancements in improving quality and reducing costs. Multi-state providers such as we are will have special challenges because private and governmental payors in different states will adopt a variety of approaches and requirements."

The findings of this study suggest their oversight responsibility for patient care quality and safety has the boards' attention. However, many of the boards and CEOs are wrestling with the best approaches and methods for fulfilling this responsibility. What are the proper quality and safety measures against which boards should set targets and monitor performance? What is the most appropriate approach to articulate the respective roles of the board as a whole, the board committee on quality and safety, the system CEO and his or her management team, and local leadership? These are among the questions that the boards of health systems and other providers of healthcare services throughout the country are addressing.

The array of quality and safety measures being disseminated by CMS, the National Quality Forum, and other parties is large and growing constantly. As stated recently by Michael Wagner:

"Current health care leaders are finding it increasingly difficult to make progress in the quality terrain as the answer to the question, 'What is quality?' is an expanding and moving target."[126]

It seems apparent that the leadership of many health systems, large and small, would benefit from clear, pragmatic guidance in this complex realm.

4. Defining or re-defining the systems' key stakeholders and accountability protocols

As these systems become larger and more complex, many board leaders have identified the need to revise their organizational models and re-think their definitions of key "stakeholders" and traditional mechanisms for accountability. For example, as discussed earlier in this report, several Roman Catholic systems have adopted the Public Juridic Person model which enables religious congregations to transfer control to a new Catholic entity with substantial laity leadership. This has involved major changes in their traditional accountability to former religious sponsors and new forms of accountability to the Vatican. Other systems, both faith-based and secular, have made or are contemplating organizational changes that alter their traditional forms and practices with respect to accountability. For example, one large secular system recently eliminated hospital-level boards and replaced them with "regional" boards that now have defined levels of responsibility and decision-making authority for the system's hospitals and other healthcare programs in their geographic area. Among the implications of this organizational change is that the system no longer can expect its hospital boards to be a primary link for communications with and accountability to the particular communities and populations those hospitals serve.

For many faith-based and secular health systems, a fundamental question that emerges is this: In an increasingly complex healthcare environment where public and private payors and the public at-large are demanding healthcare providers to enhance access to services, improve quality, and reduce costs, to whom are nonprofit health systems and their boards accountable for their performance, and what are the best mechanisms for fulfilling that accountability? What are the best methods for ensuring proper accountability to the communities and populations these systems exist to serve? These are among the questions that are emerging and which a growing number of boards and CEOs are now addressing.

5. Increasing board focus on system-wide community benefit programs and community health needs

The boards of nine of the 14 large systems in this study population have adopted policies or some other formal statement that define overall goals and guidelines for their systems' community benefit programs; others are considering such action. About half of the systems now require their local organizations to develop and adopt formal plans that identify specific priorities and strategies for their community benefit programs. Moreover, discussions with the systems' board members and CEOs reflect board awareness of the national spotlight on what nonprofit organizations are doing in this area. It is apparent their awareness has been heightened by passage of the Patient Protection and Affordable Care Act which, among its many provisions, places several new requirements on tax-exempt hospitals related to their community benefit plans and programs. As stated in Section III (B) of this report, these new requirements include conducting community health needs assessments in concert with public health and other interested parties in the community, prioritizing these needs, developing implementation strategies, and making these strategies and results available to the public.

While the regulatory details remain to be developed, it seems clear these new requirements will have considerable effects on tax-exempt hospitals and their parent systems. As Richard Umbdenstock, President and CEO of the American Hospital Association, stated recently "… it's important to identify critical interfaces between public health and acute care and open a new, mutually-beneficial chapter in dialog and collaboration between the hospital and public health communities."[127]   The boards and CEOs of America's health systems will serve a key role building these linkages.

6. Succession planning for board and senior management is becoming a governance priority

Identifying and developing future leaders for the board of directors and the management team in a systematic fashion is critically important in all organizations. Unfortunately, there is abundant evidence that leadership succession planning in the healthcare field as well as other sectors traditionally has been — and continues to be — spotty at best.

This study provides evidence that leaders of many health systems in this study population have recognized the importance of succession planning and now are devoting attention and resources to it. Six of the 14 systems now have some form of succession plans in place, both for board and senior management positions; five others have instituted succession planning processes for either management or board leadership positions but not both. Most of the CEOs and board leaders who were interviewed acknowledge that developing and sustaining solid succession plans is essential, that the programs they presently have in place need a lot of improvement, and express commitment to ensuring this happens in the near future.

7. Boards and CEOs in most of these large systems are giving priority attention to board development and culture

Every board of directors, over time, develops 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, and the culture that exists will have a major impact on the board's performance.

Among the large health systems included in this study, the board cultures are varied and, in all cases, there are some gaps between the cultures that presently prevail and key indicators of effective board culture. However, among the board leaders and CEOs of all 14 systems, there is substantial agreement that healthy, high-performing boards are characterized by clear understanding of their role and responsibilities, active engagement in their governance duties, mutual trust, and willingness to take decisive actions. Further, as a whole, these board leaders and CEOs express strong commitment to board evaluation and development, including on-going attention to cultural characteristics.

8. High level of CEO support for the role of governance and solid, trust-based board-CEO relationships

When asked to describe their respective CEO's commitment to developing strong system-level governing boards with a healthy culture, nearly all board members expressed the view that their CEO's support is consistently high and greatly appreciated by them and their board colleagues. All of the boards have adopted a formal description of their CEO's and board chair's duties and believe that, at this time, their respective roles are well-understood, both by the board and the management team. With very few exceptions, the members believe their board of directors and board committees receive solid staff support from senior members of the management team. Ninety percent of the board members characterize the working relationship between their board and CEO as "consistently excellent."

In brief, the prevailing pattern is clear: the CEOs of these 14 large health systems understand and respect the role of governance, provide strong support for their board and board committees, and enjoy excellent, trust-based respect in their board-CEO relationships. These ingredients are vitally important in building and maintaining effective governance.

Selected Governance Features

Early in the process of conducting site visits to the corporate offices of systems in this study population and visiting with senior board leaders, CEOs and staff associates, it became clear to the research team that all of their governance models were distinctive in various ways. In addition, the systems' board and management leaders demonstrated clear understanding of particular strengths of their current governance model, as well as areas where they believe improvements are needed.

These conversations prompted the following question to each system's leadership team: "Would you please identify and describe one feature of your system's current governance model — its structure, policies, practices, or culture — that you believe has proven, over time, to be particularly beneficial?" All agreed to do so. Subsequently, guidelines with respect to length and format were provided to the systems and, during the fall of 2011, all of the systems prepared concise descriptions of the governance features they selected to showcase.

The research team greatly appreciates the support of the systems' CEOs and leadership teams in selecting and describing these features of their governance models. All have proved to be valuable for their particular organizations; the system leaders and our research team hope the readers of this report also will find them to be useful.

Those descriptions are presented in Appendix B: In alphabetical order by system they include:

Health System	The Governance Feature They Selected to Describe
Adventist Health System Sunbelt, Altamonte Springs, Florida	System Compensation Philosophy
Ascension Health, St. Louis, Missouri	Integrated Strategic, Operational, and Financial Plan
Banner Health, Phoenix, Arizona	Board Culture
Carolinas HealthCare System, Charlotte, North Carolina	Competency-Based Board Selection
Catholic Health East, Newtown Square, Pennsylvania	Development of Lay Leaders
Catholic Health Initiatives, Englewood, Colorado	CHI Discernment Process
Catholic Health Partners, Cincinnati, Ohio	System Scoreboard and Executive Evaluation
Christus Health, Irving, Texas	Generative Governance
Kaiser Foundation Hospitals and Health Plan, Oakland, California	Board Committee for Community Benefit
Mayo Clinic, Rochester, Minnesota	Building Mayo Clinic's Vision for 2020
Mercy Health, Chesterfield, Missouri	Physician Integration Policy and Strategy
Providence Health & Services, Renton, Washington	Board "Checking In and Checking Out" Practice
Sutter Health, Sacramento, California	Restructuring Governance to Enable Strategic Alignment
Trinity Health, Novi, Michigan	Founding Principles

SYSTEM PERFORMANCE

This section of the report addresses two dimensions of the health systems' performance: First, their scores in relation to the indicators of effective governance addressed in this study; and second, their operating performance using a Thomson Reuters assessment protocol that uses a blend of eight measures.

Governance Scores

This study examines board structures, processes, and cultures in a set of large, nonprofit health systems in relation to basic benchmarks of effective governance and related indicators. Table 31 displays the nine benchmarks, 34 indicators which the research team considered to be reasonably well-established and measurable, and the manner in which those indicators were scored. By meeting all of these indicators, a system could receive a maximum score of 48.

TABLE 31

Benchmarks and Related Indicators of Effective Governance Against Which the Health Systems were Scored

Benchmarks and Related Indicators	Scoring Basis*	Possible Score
1 Effective boards insist on governance policies and structures that facilitate their efforts to perform the board's functions and fulfill its responsibilities		
1.1 Board bylaws establish clear limits on the number of consecutive terms a voting member may serve	Yes	1
1.2 Board bylaws establish clear limits on the number of voting board members	Yes	1
1.3 Board size is consistent with Blue Ribbon Panel on Health Care Governance recommendations (9-17 members)	Yes	1
1.4 Standing board committees have clear oversight responsibilities for the following governance functions: (a) Audit and compliance (b) Board education and development (c) Community benefit (d) Executive compensation (e) Finance and investment (f) Patient care quality and safety (g) System-wide strategy and planning	Yes (one point for each function for which there is a standing oversight committee)	7
1.5 The responsibilities of all standing board committees (not just some) are spelled out in a written document or documents ("charters") and formally adopted by the health system board	Yes	1
1.6 The board has an "executive committee" that is authorized to act on behalf of the full board between its meetings	Yes	1
1.7 Board members perceive their board's committees to be highly organized and very effective	Yes	1

TABLE 31 (continued)

Benchmarks and Related Indicators of Effective Governance Against Which the Health Systems were Scored

Benchmarks and Related Indicators	Scoring Basis*	Possible Score
2 Effective boards are comprised of highly-dedicated persons who collectively have the competencies, diversity, and independence that produce constructive, well-informed deliberations		
2.1 Board composition includes at least a majority of voting board members who are "independent" (i.e., not a member of a sponsoring body such as a religious community, not a full- or part-time employee, and not directly affiliated with the system in any way other than serving as a board member)	At least a majority of voting board members are independent	1
2.2 Substantial racial diversity in board composition	At or above the median % of all 14 systems (17%)	1
2.3 Substantial gender diversity in board composition	No objective basis for scoring at this time	–
2.4 Substantial engagement of voting members have clinical (medical and nursing) education and experience	At or above the median % of all 14 systems (20%)	1
3 Effective boards have clear definitions of their authority and accountability and the decision-making responsibility they have allocated to local operating units in their system		
3.1 Where the board is accountable to a higher body, there is a formal, written document that specifies the powers reserved to that body	Yes	1
3.2 Where the board is accountable to a higher body, there are specific, well-established mechanisms through which the board fulfills its accountability to that body	No objective basis for scoring at this time	–
3.3 There is a board-approved document that specifies the allocation of responsibility and authority between the system and local organizations	Yes	1
3.4 The association of responsibility and authority is widely understood and accepted both by local and system-level leaders	Yes	1
4 Effective boards require mutual understanding regarding the respective roles of governance vs. management, skillful board leadership, and excellent board-management relationships		
4.1 The board has adopted written descriptions of <u>both</u> the board chair's <u>and</u> the CEO's role and duties	Yes (both questions)	1
4.2 There is solid agreement among board members and the CEO on the distinctions between the chair's and CEO's role	Yes	1
4.3 The working relationship between the board and the CEO is consistently excellent**	Yes	1

TABLE 31 (continued)

Benchmarks and Related Indicators of Effective Governance Against Which the Health Systems were Scored

Benchmarks and Related Indicators	Scoring Basis*	Possible Score
5 Effective boards continuously improve board and CEO performance by setting clear expectations, conducting objective evaluation, and taking follow-up actions		
5.1 The board formally evaluates how well it is fulfilling its responsibilities annually or every other year	Yes, annually or every other year	1
5.2 During the past two years, the board evaluation process resulted in specific actions that substantially changed board size, composition, or practices	Yes	1
5.3 Board members believe their board's current board evaluation process is excellent and has resulted in substantial improvements in board performance	Yes	1
5.4 CEO's performance is evaluated in relation to established expectations annually	Yes	1
5.5 CEO evaluation process produces clear performance expectations for the CEO and assesses their actual performance fairly	Yes	1
6 Effective boards have clear definitions of their authority and accountability and the decision-making responsibility they have allocated to local operating units in their system		
6.1 The board has adopted formal succession plans for board and senior management positions	Yes, for board and management positions	2
	Yes, for board or management positions	1
7 Effective boards insist on meetings that are well-organized, focus principally on system-level strategy and key priorities such as patient care quality and community benefit, and employ board members' time and energy wisely		
7.1 The board formally adopts system-wide core measures and standards for quality of patient care	Yes	1
7.2 The system board regularly receives written reports on system-wide and hospital-specific performance in relation to established measures and standards for the quality of patient care	Yes	1
7.3 Within the past 12 months, the board has adopted specific action plans directed at improving the system's performance in patient care quality and safety	Yes	1
7.4 The board has adopted a formal written statement that defines overall goals and guidelines for the system's community benefit program	Yes	1

TABLE 31 (continued)

Benchmarks and Related Indicators of Effective Governance Against Which the Health Systems were Scored

Benchmarks and Related Indicators	Scoring Basis*	Possible Score
7.5 The board requires its local organizations to collaborate with local public health agencies in their vicinity in assessing community needs and setting community benefit program priorities	Yes	1
7.6 The board requires its local organizations to develop and adopt a formal community benefit plan that identifies specific strategies and priorities for its community benefit activities	Yes	1
7.7 Well-organized board meetings focused principally on strategic deliberations, rather than "receiving information"***	Yes	1
8 Effective boards intentionally create a culture that nurtures enlivened engagement, mutual trust, willingness to act, and high standards of performance		
8.1 The board consistently demonstrates a healthy and proactive culture including: (a) Deep commitment to the system's mission (b) Well-organized board meetings focus principally on strategic deliberations, rather than "receiving information"*** (c) Tracking system's performance (clinical and financial) and taking action when performance doesn't meet targets (d) Encouraging robust engagement and respectful disagreement at board meetings (e) Atmosphere of mutual trust among board members (f) Holding board members to high standards of behavior and performance (g) Strong focus on honoring Conflict of Interest and Confidentiality policies	Always	7
8.2 The 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 management team	Yes	1
9 Effective boards expect their CEOs to demonstrate exceptional leadership and management skills, high personal and professional standards, and strong support for the role of governance		
9.1 The CEO demonstrates strong commitment to board development and on-going improvement in governance effectiveness	Consensus of the system's board members	1
9.2 The working relationship between the board and the CEO is consistently excellent**	Yes	1
9.3 All standing board committees (not just some) are staffed by senior members of system leadership team	Yes	1
9.4 The board routinely holds an executive session at the end of board meetings without the CEO and other management staff present	Yes	1
Total Possible Score		**48**

*For items where the scoring is based on the opinions of board members and the CEO, there must be at least 80% agreement on a particular response to identify it as the "system position" on that item. Where only outside board member data is applicable (i.e., excluding the CEO), there must be at least 75% agreement on a particular response to identify it as the "system position." To obtain a copy of the Data Collection Guide, send a request to Lawrence Prybil at Lpr224@uky.edu
**This indicator relates to Benchmarks #4 and #9
***This indicator relate to Benchmarks #7 and #8

Table 32 shows the governance scores for each health system. They ranged from a high of 42 to a low of 26; the mean score was 33.9, and the median score was 35.[128]

Table 33 displays consolidated information about all 14 systems. For each benchmark it shows the number of scorable indicators, the total possible score a system could receive, the range of the systems' actual scores, and — for the 14 systems as a whole — their collective mean score.

As with each system's individual scores, this information demonstrates there is considerable variation in the extent to which the systems' board structures, processes, and cultures collectively meet contemporary benchmarks of effective governance. On the whole, the systems score high (over 80% of total possible score) on three benchmarks:

- **Benchmark #1:** "Effective boards insist on governance policies and structures that facilitate their efforts to perform the board's functions and fulfill its responsibilities."

TABLE 32
Total Governance Scores for All 14 Systems

	Score	% of Total Possible Points (48)	Rank
System A	42	88%	1
System B	40	83%	2
System C	39	81%	3
System D	38	79%	4
System E	36	75%	5
System F	36	75%	5
System G	36	75%	5
System H	34	71%	8
System I	31	65%	9
System J	31	65%	9
System K	30	63%	11
System L	28	58%	12
System M	28	58%	12
System N	26	54%	14

- **Benchmark #4:** "Effective boards require mutual understanding regarding the respective roles of governance vs. management, skillful board leadership, and excellent board-management relationships."
- **Benchmark #9:** "Effective boards expect their CEOs to demonstrate exceptional leadership and management skills, high personal and professional standards, and strong support for the role of governance."

As a group, the systems scores were relatively low (60% or less of total possible score) on three benchmarks:

- **Benchmark #6:** "Effective boards are committed to establishing and continually updating succession plans for the board, board leadership positions, and, in concert with the CEO, senior management positions."
- **Benchmark #7:** "Effective boards insist on meetings that are well-organized, focus principally on system-wide strategy and key priorities such as patient care quality and community benefit, and employ board members' time and energy wisely."
- **Benchmark #8:** "Effective boards intentionally create a culture that nurtures enlivened engagement, mutual trust, willingness to act, and high standards of performance."

Continuous evaluation and improvement is the pathway to great performance in all endeavors. The system-specific and consolidated information presented in Tables 32 and 33 shows that _all_ of these excellent health systems have opportunities to further improve their governance models and suggests some possible areas that warrant collective attention.

TABLE 33

The Systems' Collective Scores for the Indicators Related to Each Benchmark

Benchmark	No. of Scorable Indicators Related to this Benchmark	Total Possible Score	Range of the 14 Systems' Scores	The Systems' Collective Mean Score	The Mean as % of Total Possible Score
1 Effective boards insist on governance policies and structures that facilitate their efforts to perform the board's functions and fulfill its responsibilities	7	13	8-13	11.4	88%
2 Effective boards are comprised of highly-dedicated persons who collectively have the competencies, diversity, and independence that produce constructive, well-informed deliberations	3	3	1-3	1.9	63%
3 Effective boards have clear definitions of their authority and accountability and the decision-making responsibility they have allocated to local operating units in their system	3	3	1-3	2.1	70%
4 Effective boards require mutual understanding regarding the respective roles of governance vs. management, skillful board leadership, and excellent board-management relationships	3	3	0-3	2.5	83%
5 Effective boards continuously improve board and CEO performance by setting clear expectations, conducting objective evaluation, and taking follow-up actions	5	5	2-5	3.4	68%
6 Effective boards are committed to establishing and continually updating succession plans for the board, board leadership positions, and, in concert with the CEO, senior management positions	1	2	0-2	1.2	60%
7 Effective boards insist on meetings that are well-organized, focus principally on system-level strategy and key priorities such as patient care quality and community benefit, and employ board members' time and energy wisely	7	7	2-6	3.8	54%
8 Effective boards intentionally create a culture that nurtures enlivened engagement, mutual trust, willingness to act, and high standards of performance	2	8	0-7	4.3	54%
9 Effective boards expect their CEOs to demonstrate exceptional leadership and management skills, high personal and professional standards, and strong support for the role of governance	4	4	2-4	3.4	85%

Operating Performance

As Peter Drucker and many other experts have noted over the years, hospitals and health systems are among the most complex organizations that exist. A myriad of inputs contribute to determining the cost, quality and volume of services they provide for the patients, populations, and communities they serve.

Other than standard financial indicators, no universally-accepted methods for assessing the overall performance of hospitals or multi-unit health systems exist. As the Medicare Program and other payors move toward "value-based payment systems" that provide incentives for excellence in patient care and efficiency in cost control, major efforts are being made by providers, voluntary organizations such as the National Quality Forum, the Centers for Medicare and Medicaid Services (CMS),

and many other parties to develop performance measurement systems that are fair, practical, and reliable. This is complex terrain. Lots of time and effort already have been invested; much more work remains to be done.

Methodologies for measuring the overall performance of multi-unit health systems are even less developed than methodologies for measuring the performance of hospitals, and thoroughly examining the operating performance of the 14 large systems in this population is beyond the scope of this study. However, as one indicator of the performance of the systems' hospitals, the team obtained the results of a 2012 study conducted by Thomson Reuters.[129] That study examined the performance of private and investor-owned health systems using a combination of eight patient care measures. These measures and sources of data are shown in Table 34.[130]

TABLE 34

Performance Measures and Data Sources for 2012 Thomson Reuters Health System Performance Study

Measure	Data Source and Time Period
Risk-adjusted mortality index	MedPAR FY2009 and 2010
Risk-adjusted complications index	MedPAR FY2009 and 2010
Risk-adjusted patient safety index	MedPAR FY 2009 and 2010
Core measures mean percent	CMS Hospital Compare, second quarter 2011 release (October 1, 2009-September 30, 2010 dataset)
30-day mortality rates (AMI, heart failure, pneumonia)	CMS Hospital Compare, second quarter 2011 release (July 1, 2007-June 30, 2010 dataset)
30-day readmission rates (AMI, heart failure, pneumonia)	CMS Hospital Compare, second quarter 2011 release (July 1, 2007-June 30, 2010 dataset)
Severity-adjusted average length of stay	MedPAR FY 2010
HCAHPS score	CMS Hospital Compare, second quarter 2011 release (October 1, 2009-September 30, 2010 dataset)

Of the 83 health systems with over $1.5 billion in operating expenses in 2010, 71 were independent, nonprofit organizations. Thomson Reuters was able to obtain data for 13 of the 14 systems in this study population. Based on their composite scores on the eight measures outlined in Table 34, the rankings of these 13 systems among the total group of 71 large, nonprofit systems ranged from a high of Number 2 to a low of Number 52. The median rank of the 13 systems was 28. On this set of measures, the health systems in this study population on the whole perform well in comparison to other large nonprofit systems.

Governance Impact of Organizational Performance[131]

In recent years there have been graphic illustrations of the adverse impact that ineffective governance can have on organizations. Inadequate board direction and/or oversight have been factors in major problems encountered by numerous organizations such as Allegheny Health, Education, and Research Foundation (AHERF), Enron, HealthSouth, Merrill Lynch, British Petroleum, and, recently, J.P. Morgan Chase.[132]

In these and other situations, poor governance has been shown to contribute substantially to poor organizational performance and, in some instances, abject 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 including the myriad of variables, both internal and external, that affect organizational operations and the difficulty of defining and measuring "organizational performance" in a consistent, meaningful, and valid manner. This is especially difficult in *nonprofit* healthcare organizations for which classic financial performance measures are important but not sufficient and patient care outcomes and impact on community health are paramount.

The historical evidence of governance impact on organizational performance in various sectors is mixed.[133] However, a growing body of empirical studies supports the general proposition that, in the long term, there is a positive relationship between the caliber of governance and organizational success.[134]

This study of governance in large, nonprofit health systems was not designed to determine the impact of their boards' structures, processes, and cultures on the systems' operating performance. The size of the population (14 of the country's 15 largest nonprofit health systems based on 2010 information) is not sufficient to enable robust analysis of this complex topic and, as stated earlier, there are no universally-accepted methods for measuring the *overall* performance of health systems including their financial, patient care, and community service results.

While recognizing and respecting these constraints, the research team did explore the relationships between the systems' scores on the benchmarks of effective governance and related indicators shown in Tables 31-33 and their performance scores on the performance measures listed in Table 34. This analysis did not find a statistically significant correlation between the systems' total governance scores displayed in Table 32 and their *aggregate* scores on the eight patient care measures included in the Thomson Reuters study. Positive and statistically significant correlations between the systems' total governance scores and some *individual* patient care measures were identified. These data are not sufficiently meaningful or statistically robust to warrant solid conclusions; however, they underscore the need for further examination regarding the long-term effect of governance on organizational performance — and, thus, steps that can be taken to ensure that impact is positive.

IV. Concluding Remarks and Recommendations

As stated in Section I, the purpose of this study is to examine board structures, processes, and cultures in a set of our country's largest nonprofit health systems and compare them to several benchmarks of effective governance and related indicators. The objectives of the study are to:

- Increase our understanding of governance in large health systems;
- Identify and describe some examples of "exceptional governance features" that are in place in these systems;
- Identify areas where, on the whole, the governance of these systems could be improved; and
- Produce information that can assist CEOs and board leaders — in these systems and other healthcare organizations — to assess and enhance their boards' effectiveness.

These are turbulent and challenging times for those with leadership roles in hospitals, health systems, and other healthcare organizations. For many reasons, the need for healthcare services is growing and resource constraints are becoming more stringent. Clinical, executive, and governance leaders are being asked by public and private payors and many stakeholders to improve access, quality, and operational efficiency in ways that can be measured and documented. In the near future, "value-based" purchasing programs of various forms are likely to predominate, and payment methods will be evidence-based with increasingly stringent standards and requirements. Hospitals and health systems increasingly will be expected to focus on preventing illness and injuries and improving the health of the communities and populations they serve.

In this environment, the duties of governing boards have become more complex and demanding. In recent years, organizations with oversight responsibilities for nonprofit, tax-exempt hospitals and health systems — including bond rating agencies, the IRS, the Joint Commission, the Office of the Inspector General, and others — have focused increasing attention on governing boards. With varying degrees of rigor and specificity, they are expecting distinct improvements in board performance, transparency, and accountability.

The process of formulating the nine benchmarks of effective governance and related indicators addressed in this study considered these expectations as well as information from other sectors. The findings of this study provide solid evidence that the boards and CEOs of the systems in this study population are highly committed to the organizations they lead and dedicated to improving governance and organizational performance. However, the findings clearly show some gaps between current practices and contemporary benchmarks of effective governance. A number of other studies regarding governance in hospitals and health systems cited in this report reach similar conclusions.

To meet society's increasing needs and rising expectations, it is apparent that substantial changes will be required in healthcare organizations *and* how they are governed. Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

1. Conduct an overall review of their board's role and responsibilities in the context of recent and anticipated changes in the healthcare environment and in the communities they serve. They must ensure all board members clearly understand the impact of these changes on their individual and collective duties.

The 14 health systems that participated in this study are progressive and, as one illustration, their boards clearly have made deliberate efforts to increase the energy and time they devote to strategic deliberations and decision-making. *All* of these boards are in the midst of reforming their board agendas and practices in this direction while still providing proper oversight of system operations and performance.

However, the findings indicate that even this group of boards and their CEOs believe they must continue and accelerate the shift toward a greater focus on system-wide strategy and strategic thinking. Evidence from other studies in the healthcare field and other sectors suggest many boards still spend large portions of board meetings listening to reports and discussing operational issues as compared to active engagement in constructive

dialogue about strategic challenges and opportunities. Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

2. Candidly re-examine their board and board committee agendas and practices, with a focus on how the meetings are structured, how topics are selected, expectations regarding the distribution and review of materials in advance of meetings, and pragmatic steps that can and should be taken to enable the board to devote more time and energy to strategic deliberations. The effectiveness of changes that are made should be evaluated on an on-going basis with strong commitment to continual improvement.

Achieving excellence in any endeavor requires commitment to on-going evaluation and improvement. Particularly in a dynamic environment, forthright assessment and timely changes are essential to organizational survival and success. Evidence from many studies indicate that board evaluations often become a formality, a pro forma exercise that involves completing standard questionnaires and leads to reports that are accepted with little deliberation and produce little or no action. This is an approach that wastes time, perpetuates the status quo, and does not improve board structures, practices, culture, or performance. Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

3. Engage in a thorough assessment of their existing "board evaluation" processes and practices with the intent of either improving them or, depending on the findings, totally replacing them with better, more progressive models. The goal is to have vibrant, outcome-oriented evaluation processes — formal and informal — that consistently generate action and improve the effectiveness of boards, board committees, and board leadership. Retaining expert, independent parties to facilitate the re-examination of current board evaluation protocols may be helpful in this initiative.

Societal realities are demanding fundamental changes in the mission and goals of public and private health organizations and the services they provide to their communities. Stakeholders want assurance that nonprofit hospitals and health systems deserve tax-exempt status and are meeting high-priority community needs and that public health agencies are performing essential functions efficiently and effectively. Concurrently, the historic roles of hospitals and health systems and public health agencies are evolving as all parties recognize that prevention of illness and injuries, early detection and treatment, and intentional promotion of wellness in all sectors of the population are imperative. Better communication and closer collaboration among health systems and public health agencies increasingly are essential. Therefore, if they haven't already done so, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

4. Charge a standing board committee with oversight responsibility for system-wide community benefit policies and **programs** *and* **the organization's role and priorities in the realm of population health. It is time for a fresh look at traditional practices and relationships — and for new approaches that will serve our communities better and more efficiently.**

The idea of building stronger, more durable linkages between the private and public sectors of the health field and instituting new models for promoting population health has important implications for traditional practices in both sectors. Among them are the need to re-think the organizations' fundamental roles and accountabilities. It has been customary for many nonprofit hospitals and health systems to declare a principal accountability to the "community or communities they serve." This clearly is appropriate; however, the mechanisms, methods, and metrics for fulfilling that accountability often are under-developed and imprecise. In an era where governmental bodies with regulatory and/or oversight responsibilities and society at-large are scrutinizing nonprofit organizations more closely than ever before, the question

of these organizations' accountability — to whom, for what, and how it can be fulfilled effectively — warrants attention. Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

5. Collaborate with professional associations and legal experts in developing better methods and practices to enable their organizations to be properly accountable to the communities and populations they are chartered to serve. This process can and should be open to new definitions and protocols that provide greater transparency and new metrics.

Strong, effective oversight of patient care quality and safety is, without question, one of the most fundamental duties of hospital and health system boards. Among clinical, governance, and management leaders, there now is broad recognition that the overall quality of services provided by our country's hospitals and health systems is uneven and needs to be improved. During recent years, this realization — coupled with the movement toward evidence-based medicine and value-based purchasing programs — has produced enormous growth in quality improvement programs and metrics. This trend is important and necessary; however, one consequence is that hospital and health system boards often are presented with reports on patient care quality and safety that include an extensive array of highly-detailed metrics and data that, for many board members (including executives and clinicians) are too voluminous and difficult to comprehend.

The boards and CEOs of the large systems in this study population clearly are focused on meeting their oversight responsibilities with respect to patient care quality and safety. However, along with their counterparts in other health systems, they would benefit from improvements in the content and form of information they receive as the basis for deliberation. Too many boardrooms are awash in quality and safety "*data*"; what the boards need is more concise and understandable *information*.

Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

6. Mount concerted initiatives — in partnership with their clinical leadership teams, other health systems, voluntary associations, and independent experts in this area — to define more clearly the roles that boards and board committees can and should play in today's environment with respect to patient care quality and safety. In that context, the information (volume, content, and format) that will facilitate board members' understanding and ability to perform their duties effectively should be identified and provided.[135]

A large proportion of the board leaders and CEOs in the health systems in this study population recognize the tremendous importance of thoughtful, well-organized leadership succession planning programs for boards, board leadership positions, and system management positions. Most of these systems already have some type of succession planning programs in place — and, thus, appear to be somewhat ahead of most healthcare organizations. However, nearly all of these board leaders and CEOs view their present programs as "work-in-progress" that need further development. Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations:

7. Make the development of top-notch leadership succession planning programs for boards, board leadership, and senior management a system-wide strategic priority. The basic components of comprehensive succession planning programs are identified in Section III of this report.

In the healthcare field and other sectors, there is growing evidence that boards with a culture that consistently demonstrates commitment to high standards, mutual trust among board members and management leadership, robust engagement in the work of the board, and willingness to take action are more likely to perform well than other boards. As stated recently by Pamela Krecht and Karma Bass, "A healthy culture at the very top of an organization can create a spillover effect to the organization as a whole. With all the changes facing [healthcare] organizations today, a healthy culture can be a key differentiator in facilitating an organization's success."[136]

The findings of this study show the system boards and CEOs are highly committed to their organization and its mission. However, with respect to several other core characteristics of a healthy culture, many senior board leaders and CEOs perceive their boardroom cultures as uneven.

For these boards — and the boards of most other healthcare organizations — frank, objective appraisal of their existing boardroom culture is likely to identify practical steps that, if taken, will strengthen the culture and, in doing so, improve the board's performance. Therefore, the team recommends that board leaders and CEOs of nonprofit health systems and other organizations:

8. Undertake an objective appraisal of 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.

It is the team's belief that these eight recommendations are evidence-based and warrant consideration by the systems that participated in this study and by other healthcare organizations. It is our view that devoting some time and energy to considering them will prove to be a good investment that will pay long-term dividends for each board, the organization it governs, and the population and communities it serves.

After some consideration and reflection, it is paramount for boards to *identify and prioritize* the particular issues they believe are most important, assign responsibility, and set a timetable for taking action. Focusing on carefully-established priorities will enable prudent use of board and staff time and increase the likelihood of solid improvement in board practices and performance.

V. Acknowledgements

Many individuals and organizations contributed to this study. Our research team included Samuel Levey, PhD, Distinguished Professor of Health Management and Policy, College of Public Health, University of Iowa; Rex Killian, JD, President, Killian & Associates, LLC; David Fardo, PhD, Assistant Professor, Department of Biostatistics, College of Public Health, University of Kentucky; Richard Chait, EdD, Research Professor, Graduate School of Education, Harvard University; David Bardach, BA, Graduate Research Assistant, Department of Biostatistics and Department of Epidemiology, College of Public Health, University of Kentucky; and William Roach, JD, a retired partner of McDermott, Will, and Emery, LLP and current Chair, National Board , American Heart Association. As the principal investigator for this two-year study, I thank this team for their collegiality, commitment, and contributions.

My teammates and I wish to express appreciation to:

- The 14 CEOs, 57 senior board members, and many staff members at the large health systems who participated in this study. We appreciate their interest, the time they devoted to this project, and their cooperation at every point in the process. These are exceptional organizations, and we are very grateful to their leadership teams.

- Kathryn McDonagh, PhD, and her associates at Hospira, Inc, and Anne McGeorge and her partners at Grant Thornton LLP for encouraging us to initiate this study and for the major grants that were instrumental in enabling it to be conducted. We also are grateful to Thomas Giella and his partners at Korn/Ferry International; Terry Heath, JD, and his partners at Hall, Render, Killian, Heath, and Lyman, PC; and Tim Cotter and his colleagues at Sullivan, Cotter, and Associates for their grants which were essential and for their support all along the way.

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- Donna Wachman, National Marketing Manager-Health Care Industry, Grant Thornton LLP, and her staff for their splendid work in designing and printing this report.

Acknowledgements

Appendix A – Limitations of the Study

The methodology employed in this study has several limitations. They include:

- The study population was limited to 14 of the country's 15 largest private, nonprofit health systems in 2010 using AHA data and a blend of three measures of size: total annual operating expenses for the system's hospitals, the number of hospitals in the system, and the number of counties in which those facilities are located. The findings and conclusions relate directly to exceptionally large, nonprofit systems; they cannot be generalized to systems of all types and sizes.

- The study has focused on comparing board structures, processes, and cultures in a set of very large health systems to nine benchmarks of effective governance and 34 related indicators. These benchmarks are pertinent to the governance of large systems, and the indicators are considered to be reasonably well-established and measurable. There certainly are other benchmarks that merit attention by CEOs and board leaders but, due to constraints including the unavailability of measurable metrics and/or objective scoring techniques, these are not addressed in this study.

- This report presents the views of system CEOs and board members regarding their particular board's structure, selected processes and practices, and cultures. A structured interview guide was employed, and there were substantial follow-up communications after the site visits to clarify questions and obtain any missing data elements. Also, information obtained from system documents and staff members were employed to supplement and, where possible, verify the interview data. However, those data represent the participants' perceptions and may or may not be factually correct in some instances. Opinion data have inherent limitations, and there are bound to be some inaccuracies in the team's interpretation and summarization of those data.

- The tests employed in this report to determine the statistical significance of observed differences (chi-square test, two-sample test of binomial proportions, and Fisher's exact test) and correlations (Pearson's product-moment and Spearman's rank correlation coefficient) are appropriate for this data set. However, due to the relatively small size of the study population, some of the testing procedures do not have sufficient power to detect and precisely estimate actual differences and correlations.

- This study examined certain aspects of board structures, processes, and cultures in a set of large nonprofit health systems and compared them to nine benchmarks of effective governance and related indicators. Clearly there is great need and opportunity for more research regarding the governance of both nonprofit and investor-owned healthcare organizations. As one example, we would encourage studies designed specifically to examine relationships between selected features of board structures, processes, and cultures and measures of organizational performance.

Appendix B – Selected Features of the Participating Systems' Governance Models

Adventist Health System
Altamonte Springs, Florida

Compensation Philosophy

The current philosophy of Adventist Health System in compensation dates from the mid 1990's. Prior to that time, our system did not even use a market-based approach, but had an extremely conservative wage structure tied to some Church approved principles.

When it was agreed the time had come to adopt a market-based approach, our System's governance and management leadership team was determined to have a program that met all of the requirements that could be expected of a 501(c)3 organization, but also wanted the philosophy, while market-based, to be conservative. Attachment A is a statement of our System's Board-approved compensation philosophy.

Also, governance and management leadership decided the Compensation Committee should take actions that would generate confidence in and support for the compensation system by establishing processes and procedures that went beyond the IRS standards for obtaining the rebuttable presumption of reasonableness.

A governance practice we started at the time, and even up to the current day has never been required by external parties, is to have the System's external auditor annually review the actual implementation of the compensation program to ensure management has carried out the instructions of the Compensation Committee without exception. That practice has now been in place for several years. To date there has never been an instance where a compensation action has been out of line with the Committee's instructions or a variance that was inconsistent with the authority given by the Committee to the CEO of the company.

The fact that the actual administration of wage and benefit practices is independently audited, we believe is, a very beneficial practice that may not be employed by some health systems. It gives our Board and its Compensation Committee additional comfort and protection and, in addition, protects management from any chance of being criticized for doing something which is not authorized by the Compensation Committee.

Donald Jernigan, Ph.D.
President and CEO, Adventist Health System

Executive Compensation Philosophy and Practices

1. COMPENSATION PHILOSOPHY

The compensation philosophy of Adventist Health System (AHS) rests on two fundamental beliefs. First, the primary motivation of professionals who choose to join AHS is not financial but the realization of mission. AHS intentionally recruits executive leaders who choose to devote their professional and personal skills to advance the medical ministry of the Seventh-day Adventist Church (SDA). Because executives believe themselves to be agents of the church's medical ministry, wages are more conservative by market standards. Second, the demand for highly competent and experienced SDA healthcare executives makes it necessary for AHS, working with the support of church leadership, to set wages at market levels. These market levels will be based on principles and guidelines which have met standards of the AHS board officers and the North American Division of SDA.

2. ROLE OF BOARD STRATEGY AND COMPENSATION COMMITTEE

The role of the Board Strategy and Compensation Committee (Committee) is to review and approve all components of the executive compensation plan and to assure that the guidelines and principles agreed upon with the church will be incorporated in the compensation plan.

3. COMPENSATION STANDARDS

Executive wage ranges, bonus levels, and the Flex Benefit percentage are established by the Committee based upon a report by a nationally-recognized independent compensation advisor (Advisor). The Advisor reviews market competitive compensation for similar positions. Rangers are based on the annual net revenue of the employing organization as well as a careful review of each executive's core responsibilities.

Salary maximums are established using the following principles:
- The AHS CEO base salary shall not exceed the 40th percentile of comparable CEO positions nationwide.
- Other leadership base salary shall relate to the 50th percentile of national market data.
- Small hospitals may exceed the 50th percentile as necessary.
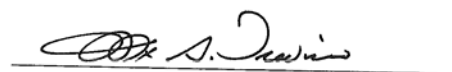- Geographic adjustments may be approved where necessary.

Other compensation:
- Flex Benefit percent at market median
- Incentive bonus opportunity at market median for the respective position

Attachment A

4. COMPENSATION PROCESS

- The committee will select their Advisor from qualified professionals who specialize in healthcare executive compensation. The Committee shall provide direction to the Advisor with regard to AHS compensation philosophy and practices which will form the basis for a compensation study and then commission the review of all executive wage ranges, benefit and bonus levels by their Advisor.
- The compensation study for all AHS executive positions will be performed every other year.
- Once the study is completed, the Advisor shall submit an advance report to the committee chair for review.
- The Committee chair shall review the proposed ranges for compliance with AHS and North American Division Guidelines as identified in "compensation standards" above.
- The AHS CEO will provide recommendations to the Committee for each executive's salary for the ensuing year.
- The Committee will receive the CEO's recommendation, approve accordingly and establish a date for implementing the new base salaries.
- For years when a full wage study is not performed, the Committee shall approve an annual adjustment to base salary based upon a report from the Advisor.
- Individual studies will be performed for new positions as needed. Individual studies will also be performed, as they are needed, for positions where major changes in responsibilities have occurred.
- In addition to reviewing and approving new base salaries, the Committee will annually approve the Accountability program performance objectives and the awarding of incentive payments.
- As necessary, the Committee will review and approve any changes to the executive Flex Benefit and Accountability plans.

The Chair of the Committee will report committee actions to the full board.

Chair, AHS Board
Chair, Board Strategy and
Compensation Committee

Approved: April 2000
Affirmed: December 5, 2007
Revised: September 17, 2009

Integrated Strategic, Operational and Financial Plan

A key governance feature for Ascension Health is the annual Integrated Strategic, Operational and Financial Planning (ISOFP) process. Ascension Health senior leaders and Board of Trustees utilize the ISOFP as a vehicle to ensure that the System is generating the resources required to sustain the national health ministry and its mission into the future and is implementing strategies that will ensure the accomplishment of Ascension Health's Strategic Direction. The Strategic Direction (Figure 1) calls the national health ministry to fulfill its promise to those it serves by providing Healthcare That Works, Healthcare That Is Safe, and Healthcare That Leaves No One Behind, for Life through a clarified focus on a person-centered approach that fosters the potential for continuous, dynamic relationships with those served. This will be made possible by four Enabling Strengths: Inspired People, Trusted Partnerships, Empowering Knowledge and a Vital Presence in meeting the evolving needs of the communities served.

In their annual Integrated Strategic, Operational and Financial Plans (ISOFP), each of Ascension Health's Health Ministries describes their strategic, operational, financial and capital plans and highlights their current and planned participation in the components of Ascension Health's Strategic Direction over a five-year period. The ISOFP utilizes the seven components of Ascension Health's Strategic Direction as the organizing construct. Figure 1 highlights how certain Health Ministry strategic initiatives fit with the components of Ascension Health's Strategic Direction.

Figure 1

Current Work / Initiative	Fit with Strategic Direction Component
Create an Exceptional Patient Experience	Healthcare That Works
Implement Physician Engagement Strategies	Healthcare That Is Safe
Build Community Coalitions that Address Public Health Issues (e.g., childhood obesity)	Healthcare That Leaves No One Behind
Implement Initiatives to Optimize Associate Health	Model Community
Forge Partnerships With Post-Acute Care Providers	Trusted Partnerships
Deploy Electronic Health Records	Empowering Knowledge
Develop Unique Health Services for Seniors	Vital Presence

As an integrated plan, the ISOFP connects Health Ministry strategic plans to capital requirements, operational plans, financial plans and budgets, and therefore is a collaborative effort among Health Ministry finance, operational and strategy leaders. In addition, the ISOFP process incorporates a set of principles that create the foundation for Ministry stewardship, including strategic relevance, operational excellence and financial health.

Strategic relevance is the ability to pursue strategies that ensure accomplishment of the Strategic Direction, appropriate services are provided by the Health Ministry or in partnership with others, programmatic development is relevant to the current and future needs of the communities served and a vital presence is maintained in the community. Stewardship of the Mission and its long-term preservation calls each Health Ministry to be **operationally excellent** and ensure that high quality, safe clinical services are provided in the most efficient manner, productivity is maintained at or better than benchmark levels and high-value support services are provided to operations.

Financial health is the ability of leadership to optimize Health Ministry financial performance to fund care for persons who are poor and vulnerable, short-term capital needs, replacement of the long-term assets, sufficient resources for programmatic development, resources for investing in transformational opportunities and resources during economic downturns.

Ascension Health's Ministry Market Leaders[1] assume shared accountability for assessing the strategies and quality of the ISOFPs and hold review meetings with each of the Health Ministries in their market prior to ISOFP submission to the System Office. The objectives of these meetings are to:

1. Confirm that the ISOFP was developed with a high level of rigor.
2. Assess the level of collaboration between finance, operations and strategy leaders.
3. Validate that mechanisms are in place to monitor ISOFP progress and close gaps in performance.
4. Ensure that Health Ministry leaders are committed to the achievement of the ISOFP.

The consolidated System ISOFP is eventually presented to the Ascension Health Board Finance Committee and full Board of Trustees each June for approval and serves as a key input to Ascension Health's Developmental Model (Attachment A) which supports the tracking of Strategic Direction initiatives from early development to full operations. Ascension Health's senior leaders and Board of Trustees also utilize an Integrated Scorecard to set annual goals, align incentives and measure the progress that each Health Ministry is making in delivering on the System's Strategic Direction commitments.

Anthony R. Tersigni, Ed.D.
President and CEO, Ascension Health Alliance

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[1]Ascension Health's Health Ministries are organized into eight regional Ministry Markets (e.g., New York/Connecticut, Gulf Coast/North Florida). Each Ministry Market is led by an executive, the Ministry Market Leader.

Ascension Health's Strategic Direction

Ascension Health's Developmental Model
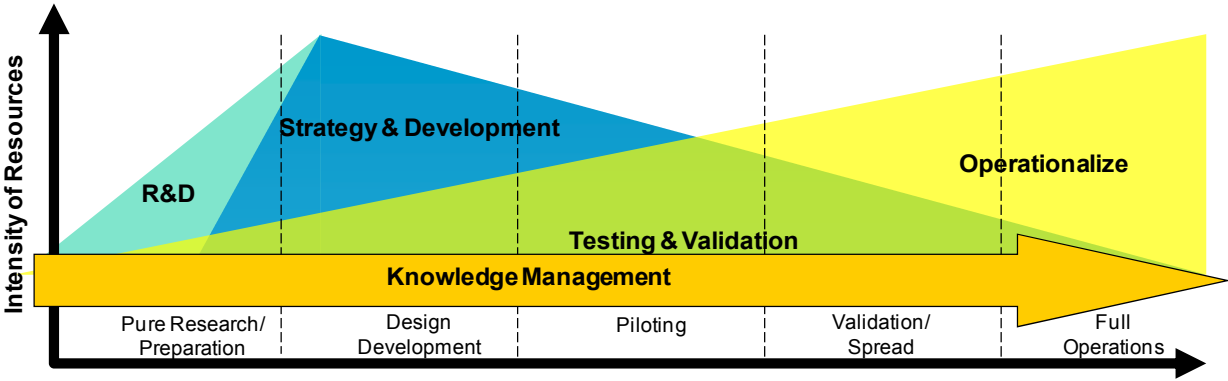
Banner Health
Phoenix, Arizona

Culture Trumps All Other Variables for Success

The success of the Banner governance model really focuses on a few key behavioral approaches that have driven organizational success and demonstrate that culture supports behaviors which drive organizational performance. First, it has become clear that our operating company model, both at a management level and at a governance level, is quite complementary. The focus is on a willingness to challenge conventional truths and each other fearlessly without making the issue personal. This has allowed the board to feel a sense of freedom in debating and considering those organizational variables associated with long term success as it relates to strategy, financial stability and clinical performance — both with the management team and with themselves. This has created a safe environment to engage and has created clarity around what is a management responsibility and what is a governance responsibility. This clarity of role and responsibility has maximized the use of skills. Banner Health's "2020 Vision" is depicted in Attachment A.

Second, while Banner Health was originally created by consolidating two previously separate organizations, the company was designed and built in a manner that left no opportunity in the future to deconstruct. That forced a focus on future success and viability rather than old traditions and past loyalties. Therefore from a behavioral perspective, the desire or need to maintain a constituency behavior model disappeared. It has enabled system leaders to recognize they are here to create a new company and lead it rather than defend the wishes and desires of past constituencies. The original board, which was created in September 1999 when the organizations came together, was made up of several members from each of the prior organizations (Samaritan Health System and Lutheran Health System) and they jointly recruited a fifteenth member from outside of their respective organizations.

Third, the board developed a behavior that calmly considers difficult issues thoughtfully and candidly. This enables them to confront issues quickly without emotion but with logic. It also creates an environment that limits things from going unsaid and creates a healthy, engaged and productive culture.

Fourth, the structure of board meetings has created a behavior that emphasizes focus and preparedness. The board meets four times a year and the meetings span 2-3 days. Because of this concentrated time period and the fact that the committee meetings occur in the early part of the 2-3 day meetings, there is no opportunity for relaxation time. The days are very packed which requires board activities to be focused. As a result, if someone is not well-prepared ahead of time, there is little opportunity to catch up during the educational program, committee meeting, or full board meeting. As a result, board members are highly engaged and participate actively.

Organizational success starts with the Board and the members' ability to work together in an efficient and effective manner focusing the organization on key critical success factors. By doing that properly, management will stay focused on what they do best and the Board will stay focused on what it does best — and, at the same time, making sure that they are meeting all of their fiduciary responsibilities and guiding the organization forward. As stated by Mr. Wilford Cardon, long-time Board chair:

"The Banner Board is successful because no board member represents a particular constituency which allows us to openly debate without fear of reprisal. We disagree without being disagreeable. We encourage differing opinions defended with facts. However, because the Board understands that the only authority of the Board is in our collective decision not in our individual opinions, after a robust discussion and a vote, we all coalesce around the collective decision of the Board and unite with management to implement our collective decision in support of our mission."

Peter Fine
President and CEO, Banner Health

Banner's 2020 Vision
"Our Steps to the Future"

LEAD IT — Industry Leadership 2016 - 2020
CHANGE IT — Innovation 2011 - 2015
GROW IT — Growth 2007 - 2010
DO IT — Performance 2003 - 2006
FIX IT — Turnaround 2000 - 2002
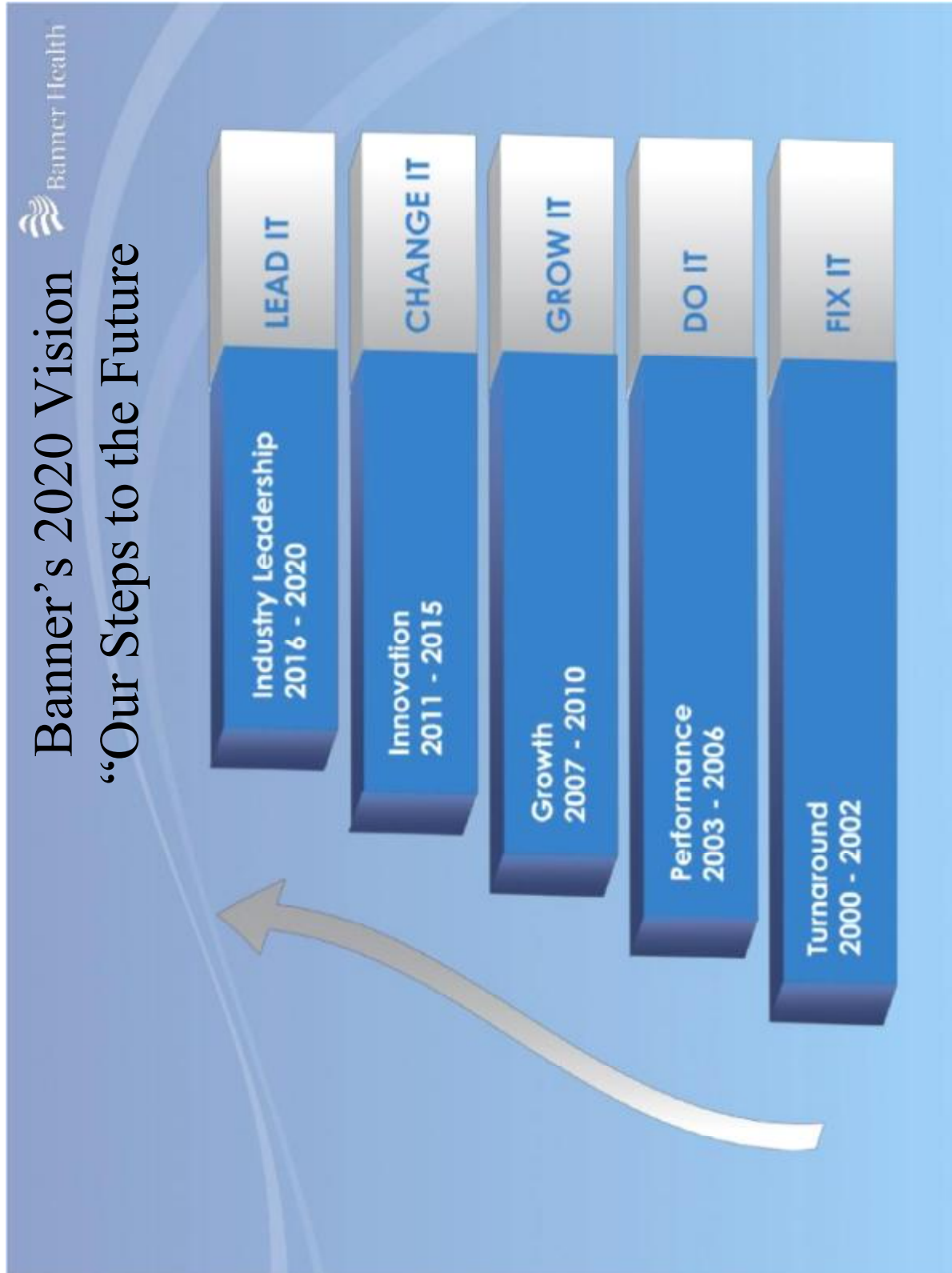
Attachment A

Carolinas HealthCare System
Charlotte, N.C.

Competency-Based Board Selection

The board of commissioners of Carolinas HealthCare System ("CHS") uses a competency-based board selection process and a robust system for continuing education to build and maintain a stable, high-functioning board. The board devotes substantial effort to identifying potential candidates for board membership and clearly articulates to each candidate that the board considers board membership to be a long-term commitment on both sides. This dedicated focus on board development and succession planning has been consistent for decades.

The process for selection as a member of the board starts with the ongoing review of the collective competencies of the board and an examination of what competencies should be developed or supplemented. The nominating and governance committee (the "committee") looks to identify and recommend potential board members who will contribute to the mix of skills of the board and who will approach board service as a long-term commitment. The committee evaluates each prospective nominee's demonstrated interest in the health and welfare of the general public, strength of character, mature judgment and relevant technical skills. Further, the committee considers the performance of incumbents in determining whether to nominate them for re-election or re-appointment. The practice of approaching board development with a view to the long-term is a major factor in the stability and quality of the CHS board. At its last regularly scheduled meeting of each year, the board receives and acts upon the committee's recommendations for a new class of commissioners to replace those whose terms will expire at the end of the year.

In addition to having a board of commissioners, CHS has a board of advisors that advises the CEO, the chairman, and the board of commissioners concerning matters relating to CHS's facilities. Members of the board of advisors are appointed by the chairman of the board of commissioners, based on recommendations from the nominating and governance committee, and from residents of communities served by CHS who have demonstrated an interest in the health and welfare of the general public. In some respects, the board of advisors serves as a training ground for potential members of the board of commissioners. The board of advisors meets concurrently with the board of commissioners and members of the board of advisors participate with members of the board of commissioners on board committees and board educational sessions and conferences. This structure affords members of the board of advisors an outstanding "on-the-job" opportunity to learn about CHS and the healthcare sector prior to joining the board of commissioners.

The board utilizes a robust committee structure that allows board members and management to devote appropriate time to explore together specific areas where board oversight is desirable; e.g., strategic planning committee; finance and compliance committee; and quality care and comfort committee. The board attempts to rotate board members among the several committees over time, taking into account individual board member preferences and each committee's needs. In other words, a board member might serve several years on the quality care and comfort committee and then rotate off that committee to spend several years on the finance and compliance committee. Board members may also serve on more than one committee simultaneously depending upon expertise, interest and time available. This practice of rotating board members among the board committees provides board members the opportunity to learn more about specific areas of the organization and to develop, over time, a comprehensive picture of the organization.

The CHS board of commissioners relies on thoughtful, intentional selection of board candidates, utilization of a board of advisors and an organized approach to board committee service to build and maintain an excellent governing board. These structures and practices have helped CHS enjoy stability, clinical excellence and financial strength.

Michael C. Tarwater, FACHE
President and CEO, Carolinas HealthCare System

Development of Lay Leaders in Catholic Healthcare

Like most Catholic health care organizations nationwide, Catholic Health East (CHE) has been focused for some time on ministry formation - the grounding and development of lay leaders in the healing ministry of Jesus Christ and the foundations of Catholic health care – in order to secure the future leaders of our organizations.

Following a fairly recent CEO transition and newly appointed Senior Leadership Team, all of whom were internal candidates, it became apparent that an entire new bench of lay leaders would need to be developed for senior-level management positions across the system. To help make this happen, leadership development became a top priority for the organization. This function transitioned from the human resources department to the president's office, and gained both board and CEO level sponsorship of a sustained focus on succession planning.

Building on foundational ministry formation work that was firmly established in the organization, it was decided that integrating ministry formation, classic leadership development and succession planning efforts would expedite building the needed leadership bench strength. To achieve this integration, the CHE Ministry Leadership Academy was established. Its purpose is to:

- Continue the development a cadre of committed well-formed lay leaders into servant leaders who are transformative stewards of their health care ministries – the "sweet" spot where ministry, transformational and operational leadership overlap, and
- Facilitate smooth succession of Regional Health Care Corporation (RHC) CEOs and CHE-level senior management teams positions in the near-term future.

The curriculum framework is predicated on integrating three forms of leadership (see Attachment A), which are expressed in three learning objectives:

1. Ministry Leadership – integrate the core elements of ministry formation into policies, structures and the organization's culture so that Catholic identity explicitly informs the work of the ministry and directs its daily operations.
2. Transformational Leadership – establish leadership capabilities essential to a ministry's ongoing agility, innovation and growth.
3. Operational Leadership – determine how to define, align and integrate core functions effectively throughout the organization.

The first cohort is comprised of 20 individuals who have been identified as "top talent", either as part of our annual talent review process or strongly recommended by local leadership. Top talent is defined as individuals who currently exceed expectations in terms of the CHE Leadership Competencies, CHE Core Values and performance at the RHC-level. They act like leaders and demonstrate the capability of advancing to a significantly broader or more complex role within the next two to three years. Participants were also required to have actively participated in and completed Excellence in Ministry - CHE's executive-level ministry formation program. Lastly, they needed to have a track record of leadership effectiveness and career aspirations consistent with CHE's organizational and strategic needs. Each cohort's engagement is two years in duration. The current plan is to form three cohorts which will provide us 50 "ministry-ready" leaders within the next five years.
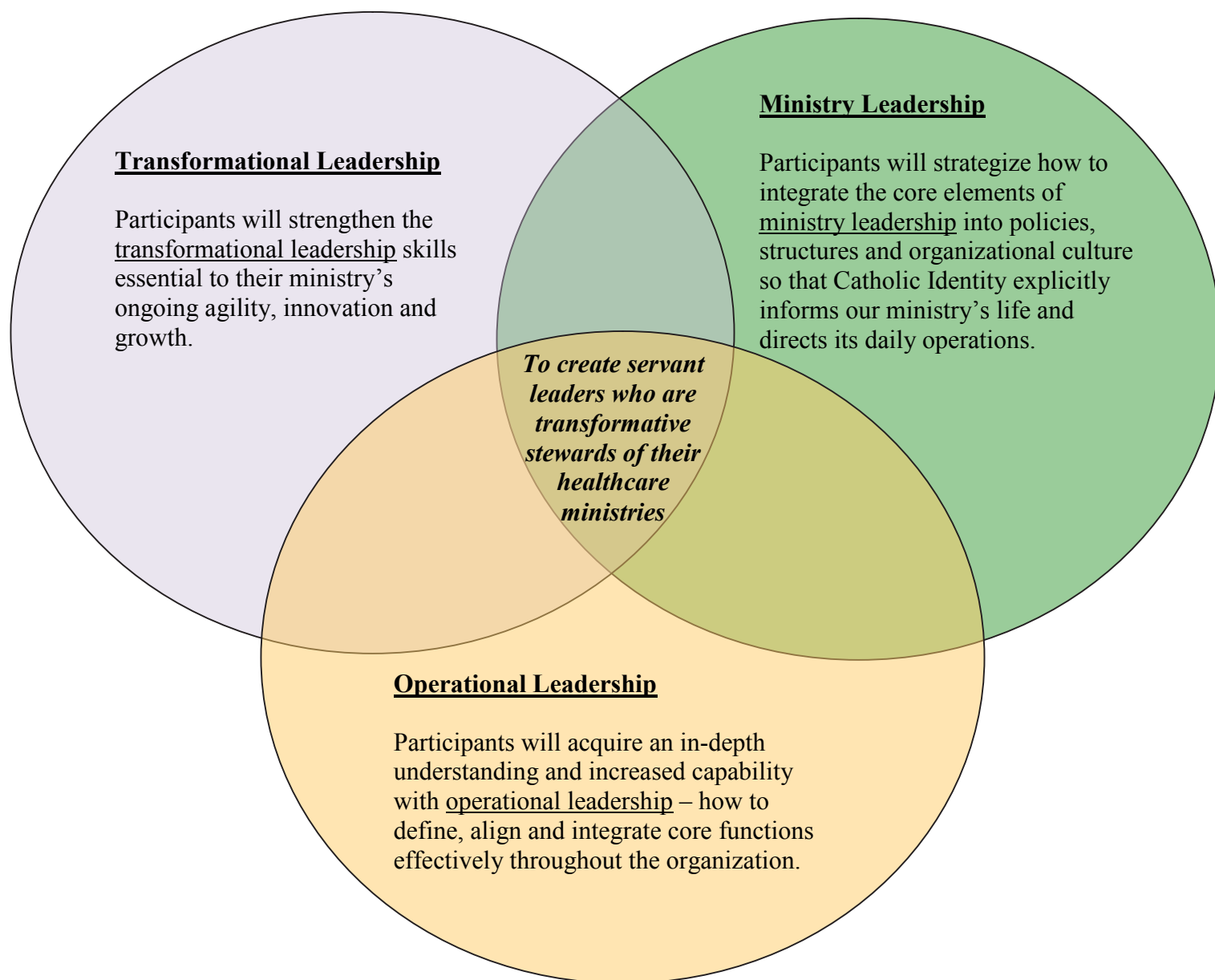
Catholic Health East established a partnership with Seton Hall University to develop and deliver the program. Seton Hall is providing faculty from their Institute of Catholic Studies and Schools of Theology, Healthcare Sciences, Theology, Business & Law. We also involve adjunct faculty from other notable institutions and organizations. Because of the affiliation with Seton Hall, participants earn a leadership certificate upon completion that will be recognized in the broader Catholic community.

The design is highly interactive, and responsive to current organizational challenges and opportunities. The established expertise of the academy participants is actively incorporated while simultaneously encouraging them to deepen their understanding of the essence of Catholic health care and how it should influence their leadership identity. The faculty sit with the participants and all share responsibility for the learning environment and the content. "Real" organizational work is brought into the various learning platforms — classroom sessions, exposure opportunities, inter-organizational rotations and inter-session contacts — in an Action Learning approach. This ensures the learning occurs in the context of real-life issues and situations and advances the "real" work of the organization at the same time.

Prior to inviting an individual into the Academy, there are conversations confirming his/her career aspirations, identifying the specific CHE position(s) they will be prepared for during their Academy experience and an individual development plan is outlined that specifies everything required to ensure their readiness upon completion. Review of the Academy's content and the participant's growth is a standing agenda item for the Board's Leadership & Compensation Committee. We also will measure the Academy impact by the number of "ministry-ready" individuals who are available to fill key positions when we need them, as well as the degree to which the participants can articulate how they have internalized and evolved into servant leaders who are transformative stewards of their health care ministries.

Judith Persichilli
President and CEO, Catholic Health East

CHE Ministry Leadership Academy
Curriculum Framework

Transformational Leadership

Participants will strengthen the <u>transformational leadership</u> skills essential to their ministry's ongoing agility, innovation and growth.

Ministry Leadership

Participants will strategize how to integrate the core elements of <u>ministry leadership</u> into policies, structures and organizational culture so that Catholic Identity explicitly informs our ministry's life and directs its daily operations.

To create servant leaders who are transformative stewards of their healthcare ministries

Operational Leadership

Participants will acquire an in-depth understanding and increased capability with <u>operational leadership</u> – how to define, align and integrate core functions effectively throughout the organization.

<u>Attachment A</u>

The Catholic Health Initiatives Discernment Process

Leading and governing Catholic health care ministries call us to balance key principles and values as we make critical decisions in the best interests of those we serve.

Catholic Health Initiatives has developed a comprehensive discernment process to guide leaders and boards in making crucial operational and strategic decisions (<u>Attachment A</u>). The Catholic Health Initiatives (CHI) Discernment Process focuses on the questions, "What is God calling us to do in light of our mission, vision and core values?" "How do our decisions best translate our ministry into the future?" Discernment respects the presence of God's Spirit and creates an environment conducive for the Spirit to act among us. It empowers participants to speak their truth courageously, in deep reverence for each person; listen attentively to the perspective of those whose viewpoints may differ from their own; and open their hearts carefully to hear God's deepest wisdom in the voices of those around the table.

The CHI Discernment Process is rooted in a values-based decision-making process that guided the health system through its first decade of development. While many of the steps in the discernment process are found in other significant business decision-making models, CHI's process is distinctive in how it incorporates prayer and quiet reflection at key intervals throughout the process, and how it guides participants to reach, implement and evaluate decisions based on the system's mission and core values. The process calls for careful consideration of who will be impacted by the decision and who will own the decision. It acknowledges the potential conflict among competing values and engages participants in identifying what values are affirmed and negated in potential actions.

The CHI Discernment Process begins with focused prayer and guides participants to analyze a situation by defining the issue thoroughly, framing different perspectives and implications, and identifying and weighing possible alternatives. The process guides participants to reach a resolution based on balancing core values and how the decision will uphold the system's mission and vision. Once the decision is reached, the process calls participants to define how the decision will be implemented, communicated and evaluated.

The CHI Discernment Process provides a comprehensive, consistent framework to evaluate strategic and operational actions in light of the system's mission, core values and ethics. Every leader in CHI reviews and practices the discernment process at a leadership orientation session. Board members at national and local levels across the system are also introduced to the process during their orientation sessions. It is expected that the CHI Discernment Process is used for making critical decisions that impact the ministry. These are decisions that have far-reaching effects on those served by the ministry today and well into the future, including acquisitions, divestitures, partnerships, mergers and capital allocations.

A *CHI Discernment Process workbook* outlines the steps of the process and includes a resource directory to support teams in their discernment process. The workbook enables participants to align their notes and resources with the steps of the process, thereby increasing the ease of thoughtful reflection as they deliberate the decision. The process details steps that, oftentimes, take place over time rather than any one moment. Perspectives emerge only as questions are asked and decisions are made when participants are ready to commit to a course of action in the name of Catholic Health Initiative's mission and core values.

Kevin Lofton
President and CEO, Catholic Health Initiatives

Discernment Process Overview

Begin with Prayer/Discernment	Define the Issue	Frame the Perspectives	Identify Alternatives

A N A L Y S I S   S P A C E

Begin with Prayer/Discernment
- Lead an opening prayer for God's guidance and wisdom in decision making.

Define the Issue
- Identify key facts, factors and stakeholders.
- Establish the facts of the issue: e.g., who, what, where, when, why and how.
- Clarify who will own the decision.

Frame the Perspectives
- Identify your own perspective and appreciate the perspectives of others.
- Identify who will be affected by the decision.

Identify Alternatives
- Identify all possible alternatives at stake.
- Brainstorm options.
- Determine the pros and cons of each option, including doing nothing.

Discernment Process Overview

R E S O L U T I O N   S P A C E

Analyze the Values
- What values are at stake?
- What are the significant value conflicts?
- What values are being affirmed?
- What values are being negated?

Conduct Prayerful Discernment
- Pause for a few minutes of silence.
- Review your notes.
- Reflect upon the alternatives in light of CHI's mission and values.
- What is the right thing to do?

Make a Decision
- Which option best advances CHI's mission, values and core strategies?
- Choose a path among the possible alternatives.

Implement the Decision
- Develop a process for carrying out the decision.
- How and when will the decision be communicated to all stakeholders?

Evaluate the Decision: Evaluate whether the solution addresses the defined problem. What are the desired outcomes?

Attachment A

Catholic Health Partners
Cincinnati Ohio

System Scorecard and Executive Evaluation

Creating a System Scorecard to measure strategic progress, while simultaneously integrating this tool into the Executive Evaluation Process, has been an important tool for advancing CHP's culture and strategy. Over the past 13 years this Scorecard has focused our culture to emphasize quality and performance results. It has also created a healthy balance between team work and individual performance while advancing the System's Mission through prioritized strategic objectives.

CHP has evolved a balanced evidence-driven scorecard benchmarked to top quartile results across a spectrum of strategy-driven quality, human resources, and stewardship measures. The Scorecard is a by-product of the System's Strategic Plan and is used to evaluate the corporate office team and the regional teams in our System by their respective Boards (Attachment A).

Ultimately, the Scorecard determines gain sharing awards for all of CHP's 35,000 associates. The Scorecard consists of four distinct parts and approximately 20 individual measures. Part 1 of the Scorecard focuses on outcome measures for quality, human resources and stewardship. Part 2 of the Scorecard measures progress on system wide strategic initiatives and is more process oriented (i.e. implementing a standard digitized health record throughout CHP). Part 3 of the Scorecard focuses on individual objectives related to the leader's particular position. Finally, Part 4 is a threshold or a screen that determines the eligibility for incentive compensation for the entire team. There are three thresholds (community benefit, quality and financial) or screens that must be achieved before the incentive compensation is offered to associates. The Part 1-3 results then determine the level of incentive compensation for the individual and the team. Fundamentally, the Scorecard has driven our Board conversations – markedly moving those conversations from financial issues to quality and talent management issues.

The Scorecard creates teamwork because the top 600 leaders in CHP have it incorporated into their individual evaluations. The Scorecard creates focus because it forces management and the boards to identify, define and measure the key strategic objectives for the year. The structure of the Scorecard allows results to be customized for regional team performance and also consolidates results for the corporate office leaders. Part II of the Scorecard allows for promotion of system-wide initiatives across all Regions and Part III of the Scorecard allows for a focus on individual performance priorities.

The Scorecard as a whole creates concrete measures for living our Mission that are approved by our boards each year.

Since inception, the Scorecard has had almost 50% of the objectives devoted to quality. The attached Scorecard has 9 quality-focused objectives: preventable harm, inpatient mortality, readmission rate, LOS, inpatient experience, diabetes measures in physician practices, CarePath implementation, CMS core measures and patient safety culture survey results from AHRQ. This commitment to excellence and quality helps bring our values to life in our evaluations.

At year end, the System's Scorecard results are compared to both targets and top quartile national benchmarks. Each Board member then assesses these results and individually scores each objective. These Board scores are then used by the full Board to complete the Executive Evaluation Process.

The Scorecard is the core of our executive evaluation process and drives our culture and Mission by explicitly defining and measuring our priorities. That process also incorporates a rigorous 360 assessment (colleagues and direct reports) and behavioral assessment (CHP Board members and Regional Board members).

As part of the CHP executive compensation process, independent auditors perform a review of the CHP Incentive Compensation Plan to validate the accuracy of data reported on the System Scorecard, as well as the reported system thresholds. Additionally, an audit to validate the accuracy of CHP Board evaluation scores, as summarized for the Compensation Committee review is provided. Attachment B is a diagram of the CHP Executive Performance Evaluation Model.

Michael Connelly
President and CEO, Catholic Health Partners

2011 Annual Plan
CHP System Scorecard
as of 1/20/2012

CATHOLIC HEALTH PARTNERS

PART 1 OPERATIONAL PERFORMANCE MEASURES (KRA)	2010 (Latest Available)	2011			STATUS	COMMENT
		TARGET	BENCHMARK	CURRENT		
Preventable Harm (Quality)	0.24%	0.19%	0.22% Harm Measures, by definition, are usually preventable. "Benchmark" is Premier Top Quartile. Benchmark includes hospitals with preventable harm events	0.17% (284 patients harmed)	★★ December YTD	Through December, there has been a 56% reduction in harm from our 2008 baseline and a 29% reduction compared to last year in the five (5) harm measures used for the Part 1 objective. Current performance, at 0.17%, is exceeding the 2011 target of 0.19%. Year-to-date, 284 patients have experienced one or more of the five harm events used in the Part 1 definition. During the year we report seven (7) stage 3 or 4 pressure ulcers, down 74% from 2010. Falls and trauma, which had been a challenge in 2010, have declined 20% since last year. Post-op deep vein thrombosis/pulmonary embolisms did not decrease in 2011, but are down 52% since 2008; post-op sepsis is down 21% since 2010, and central venous catheter related bloodstream infections are down 42% since last year.
Inpatient Mortality (Quality)	0.49 (1.46% unadjusted)	0.55	0.55	0.54 (1.47% unadjusted)	★ December YTD	Through December, the risk adjusted mortality observed to expected (O/E) ratio is better than target and has performed better than top decile in 8 of the last 12 months. Unadjusted mortality rates finished the year at 1.47%.
Readmission Rate (Quality)	2010 Jun - Nov Baseline: Acute Care: 21.0% Home Care (Risk Adjusted): 24.4%	Acute Care: 20.7% Home Care: 19.1%	Acute Care: 19.6% Home Care: 15.0%	Acute Care: 21.7% Home Care: 24.5%	⬤ Acute Care: Nov YTD Home Care: Dec YTD	Raw rates increased; acute O/E ratio declined to 0.95. System OE ratio is better than expected (target </=.99). Monthly rates demonstrate a decrease in variation. Decreased variation seems to indicate two things: (1) the readmission population does appear to be "sicker" and (2) teams have had success in tackling low-lying opportunities -- stronger discharge planning for those readmitters who are less acutely ill, more reliable assessment and discharge processes, more cross-continuum collaboration and alignment. All facilities have detailed action plans. CHP home office staff is conducting readmission system tracers to provide additional feedback and identify barriers. For 2012, the readmission metric will move from a raw rate to an OE ratio and count readmitted patients only once, rather than serial readmissions to better matches CMS' method. **Benchmark: Acute care based on CMS Hospital Compare top quartile for readmission to any US hospital; Home care based on Strategic Health Partners database top quartile.**
LOS (Quality)	1.07	1.04	1.00	1.04	★ December YTD	Through December, the geometric mean length of stay (GMLOS) O/E ratio has outperformed prior year, and is at the 2011 target; the O/E ratio is 1.04 compared to prior year ratio of 1.07. YTD unadjusted LOS is 4.09 days compared to prior year of 4.23 days. This equals an approximately 22,000 day reduction from prior year, representing an $11M reduction at $500 per day.
Inpatient Experience (Quality)	26%	35%	46% Top Quartile (VBP Attainment Rate)	26%	✓ December YTD	Through December, the patient experience composite score is continuing to rebound following poor 1st quarter performance; overall performance is 26%, **slightly higher than in 2010 performance.** Performance remains well below our target of 35%. November performance was 35%. **Monthly value based purchasing (VBP) points have been at or above 30% of total points for 6 of the past 7 months.**
Minority Retention Rate (Human Potential)	86.5%	87.2%	88.2%	85.4%	⬤ 2011	Minority Retention Rate declined 1.1% in 2011 while All Associate Rate declined 0.8%. However, Minority Engagement (Gallup) reached parity with all associates, and both the absolute number and the percentage of minority associates increased in 2011. The 2012 objective will focus on % diverse in SLT.
Associate Engagement (Human Potential)	3.93	4.02	4.00	3.97	✓ 2011	System improvement was broad-based, with six facilities achieving meaningful improvement (Mercy Tiffin, St. Vincent, St. Rita's, St. Charles, St. Elizabeth and Community Mercy) and two experiencing a statistically significant decline (St. Joseph and Marcum and Wallace). **Minority engagement increased more than overall engagement; and at 3.91 it is statistically at parity with overall engagement.** Benchmark is Gallup Organization Grand Mean for healthcare 50th percentile. Database contains 511 hospitals with 1.5 million workers.
Primary Care Provider Recruitment (Physician Engagement & Growth)	55 (Target: 37)	37	N/A	45	★ December YTD	Target is 90% of the 2011 plan for family practice, internal medicine, general pediatrics and their associated mid-level professionals. 2011 Target excludes MHP-NEPA and TN recruitment plans. Regional targets are set at 90% of their plans on each region's respective Part 1. Recruitment is defined as "new to the community", not employment.
Net/Net Patient Revenue/Provider FTE (Physician Engagement & Stewardship)	$324,073	$345,750	N/A	$341,627	✓ December YTD	Net/net patient revenue is based on all employed providers--physicians and mid-level providers. Year-end 2011 was 5.4% higher than 2010 baseline, but trailed 2011 Target by 1.2%. The largest cause for this variance was due to the unmet employment goals of several high revenue producing specialist physicians. Target is based on 2011 OFP budgeted revenue.
Operating Margin (%) (Stewardship)	2.9%	3.1% (Stretch)	2.7%	3.3%	★★ December YTD	3.1% is the operating margin adding back the contingency. **Benchmark and Target are consistent with the 5 Year Strategic Financial Plan, rather than the 2011 OFP (the "budget").**

TARGET: set annually based on baseline measure, benchmarks, and current/prior performance with input from the appropriate EMT committees (Quality, Mission, HR, etc.), RCEOs and LTM. Targets are set to insure steady progress towards achieving top quartile within a specified time frame (or to maintain/improve performance at top quartile).

BENCHMARK: represents the "best practice" known for a specific metric. CHP uses as many top quartile national measures from external sources as are available. Benchmark data in health care can vary widely by level of maturity.

★★ **Superior** - Current performance is ≥ 5% better than benchmark (external only)
★ **Excellent** - Current performance is at Benchmark or Target
✓ **Progress** - Current performance is better than prior year but not at Target
⬤ **Poor** - Current performance is < Prior Year

Attachment A

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<table>
<tr><td colspan="5">**2011 Annual Plan**
CHP System Scorecard
as of 1/20/2012</td></tr>
<tr><th>PART 2: STRATEGIC OBJECTIVES</th><th>TARGET</th><th>CURRENT</th><th>Status</th><th>Comment</th></tr>
<tr>
<td>Identify and track quality indicators for owned physician practices.
(Quality & Physician Engagement--Grossbart; Copeland)</td>
<td>~ All employed PCPs report the Diabetes 5 (D5)
~ Create infrastructure for collecting and reporting readmissions</td>
<td>Completed</td>
<td>★</td>
<td>~All employed PCPs report the Diabetes 5 (D5): Physician level reports are now available on CHP's internal web site and have been shared with regional physician leadership.
~D5 performance score: 19%
~Readmissions: Healthspan's Infomed data warehouse has been redesigned to identify hospital readmission rates by attributed PCP and available in Q4 2011. Humana has provided hospital readmission rates by attributed PCPs.
~CHP readmission rate for patients attributed to CHP Physicians: 15%</td>
</tr>
<tr>
<td>Complete Year 2 milestones of CarePATH strategy.
(Quality--Sykes)</td>
<td>~ Go-Live at HMHP (3), Jewish and all identified owned physician practices.
~ Expanded metric set</td>
<td>HMHP - August 21st
Toledo (Ambulatory) - October 24th
CMHP - November 13th</td>
<td>★</td>
<td>The November 13th Springfield implementation was successful and completes the scheduled installs for 2011. The Toledo ambulatory implementation on October 24th completed the ambulatory implementations for 2011. We attested for meaningful use and are receiving 26.1 M.</td>
</tr>
<tr>
<td>Address associate health claims and cost of health care claims.
(Human Potential--Gage)</td>
<td>~ Standardize and improve CHP's management of associate health plans
~ Reduce rate of increase to ≤10%</td>
<td>3.6% increase
(Nov. YTD 2011 vs. 2010)</td>
<td>★</td>
<td>3.6%, like last year's result (2.3%), sets CHP's trend far below the U.S. average. CHP's effective cost control is due in part to changes in plan design, vendor management, and in-sourcing stop loss to the CHP captive.</td>
</tr>
<tr>
<td>Strengthen infrastructure of employed physician practices.
(Physician Engagement--Copeland; Gravell)</td>
<td>~In-source and standardize employed physician business office (CBOs) by 12/31/11
~Conduct pilot in 10 CHP program practices to continue transformation to Patient Centered Medical Home.</td>
<td>~CBO/CPBC on target with addition of Lima & Lorain in Q3. Pre-Service Centers (PSCs) established in all regions.
~PCMH on target.</td>
<td>★</td>
<td>The Corporate Physician Business Center is successfully expanding back-office support. NO & SWO are targeted for consolidation into the CPBC Q1 2012. PSC's in place and expanding functionality. Transforming CHP employed practices into NCQA recognized PCMH's is advancing with each region developing a specific 2012 rollout plan.</td>
</tr>
<tr>
<td>Advance the quality and efficiency of the emergency services provided in each CHP Emergency Department.
(Growth--Copeland; Grossbart)</td>
<td>Decrease by 5% median time for emergency department arrival to ED departure for admitted patients among faciliies above the national median.</td>
<td>Selected Emergency Departments have decreased Median LOS from 320 to 303 minutes against a target of 303.</td>
<td>★</td>
<td>Among the 9 facilities identified with opportunity for improvement, the overall admitted median LOS though September has improved at 6 of 9 facilities and 3 of 9 have achieved target. Overall, median admitted LOS for these nine facilities hospitals has declined from 320 minutes in 2010 to 303 minutes against a target fo 303.</td>
</tr>
</table>

2011 Annual Plan
CHP System Scorecard
as of 1/20/2012

PART 3: CONNELLY	TARGET	CURRENT	Status	Comment
Complete transaction for sale of assets in MHP-NEPA region. (Starcher - Growth)	Transaction successfully negotiated and closed.	Complete	★	Sale of Northeast PA assets to Community Health System complete effective May 1, 2011. Distribution of proceeds complete to all parties. Sisters of Mercy, Mid-Atlantic Community Foundation and Scranton Civic Foundation formed and operational. Re-named Regional Hospital of Scranton, Tyler Memorial Hospital and Nantikoke Hospital running under ownership of CHS.
Implement preferred strategic option for MHP-TN region. (Starcher - Growth)	Transaction successfully negotiated and closed.	Complete	★	Sale of East Tennessee assets to Health Management Associates complete effective October 1, 2011. Distribution of proceeds complete to all parties. Remainder Mercy Foundation, Trinity, and new diocesan foundation, St. Mary's Legacy Foundation, formed and will be operational by January 2012. Former Mercy Health Partners and all affiliates now running under Tennova banner for Health Management Associates.
Increase perception of patient safety as measured by AHRQ Survey on Patient Safety Culture. (Grossbart - Quality)	2011 target: 64% 2009 Score: 61.1% 2007 Score: 58.3	62%	✔	AHRQ Patient Safety Culture Survey: The survey results identify a small improvement in 2011, to 62% from 61% in 2009 and 58% - 2007. OB, error reporting, and select facilities showed significant improvement.
Foster development of ACOs with Medicare or other payers in selected regions. (Copeland - Growth)	~ Complete CHP market assessments in each region	All Region Market Assessments completed	★	Market assessment in each region to assess our readiness for payment reform, including participating in the Medicare ACO progam and other Payer's risk sharing agreements.
Strengthen CHP ability to invest in health care redesign. (Gravell - Stewardship)	Days Cash On Hand ≥170	226	★ December YTD	Target is a stretch goal above 2011 OFP budget of 167 Days Cash on Hand.
Advance CHP's talent management strategy. (Gage - Human Potential)	Initiate formal Mission formation program/process for leaders	Complete New 2012 Part 2 will standardize leadership and formation program/process across CHP	★	Standard guiding principles developed and adopted. New Leader Orientation re-designed, CHP Leadership Video produced and introduced at LDI. New 2012 Part 2 will standardize adoption of these plus a day of renewal for RN leaders (successfully piloted in 3Q 2011) and RISEN for front-line employees.

2011 Annual Plan
Incentive Thresholds
as of 1/20/2012

Annual Incentive Metrics	Threshold	CURRENT	Status	Comment
Affordability as measured by Net Income margin % (excluding interest rate swap, impairment and loss on advanced refunding of debt)	2%	2.1%	★ December YTD	Investment losses in 3rd and 4th quarters affected metric.
Community Benefit	$294.3M	$345.7M	★ December YTD	
Overall ACM Score	85.0%	94%	★ October 2010 - September 2011	Data harvested through November 17, 2011.

Background and Definitions:
Incentive Compensation Thresholds are established as minimum affordability and performance levels for executives to be eligible for incentive compensation each year. At the December 2010 Compensation and Evaluation Committee meeting the Committee will review and recommend 2011 incentive metrics to the CHP Board of Trustees for final approval. Management will be recommending the following metrics:

Net Income Margin % - Excess revenue before discontinued operations divided by total net operating revenue + total non-operating revenue (excluding interest rate swap, impairment and loss on advanced refunding of debt). *Proposed Threshold* is 2% Net Income.
Community Benefit - Expenses identified as benefits to the underserved and/or community at large. *Proposed Threshold* is 90% of budgeted community benefit.
Overall ACM Score - Overall ACM score measures total percentage of patients who received all appropriate care for heart attack, heart failure, pneumonia, or surgical care. *Threshold* is 90% of the top quartile benchmark for the overall appropriate care measure. *Proposed threshold is 83.8%.*

Executive Evaluation Performance Model

Eligibility for Incentive Compensation has 3 Thresholds:

90% Budgeted Community benefit
2% Net Income
90% Quality Score

Incentive Compensation Stretch Objectives:

The actual level of compensation is based on CHP System Scorecard performance and limited to board approved ranges. At least 75% of Part 1, 2, and 3 objectives on CHP System Scorecard must be achieved to be considered for targeted incentive compensation

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Factors Used to Adjust Base Compensation

- Current position in the pay range
- Years of experience at current level and tenure with CHP
- Leadership (leading system initiatives or representing the system on national/regional level)
- 360 Review by colleagues

Attachment B

CHRISTUS Health
Irving, Texas

Generative Governance

As CHRISTUS Health neared its tenth anniversary, having been formed by the joining of two 140-year-old Catholic health systems, its governance process and structure were common: an engaged group of health care professionals and women and men religious focused on their fiduciary and mission-oriented duties of guidance and oversight. Indeed, this had served the system well after the merger by creating a focus on developing culture, creating new processes and a greater focus on operations to ensure a return to stability and strength.

As the system's second decade dawned, the governing board began to increase its focus on governance itself — its makeup, role, and ultimate purpose — with the intent to create even greater board engagement beyond the oversight of operations and monitoring of finances so critical in the early years and challenge members to shift to other approaches.

Guided by the work of Chait, Ryan and Taylor in *Governance as Leadership: Reframing the Work of Nonprofit Boards*, the CHRISTUS board chair embarked upon a process that would embrace the authors' three levels of governance: fiduciary, strategic and generative.

Fiduciary **Governance Leadership** **Strategic**

Generative
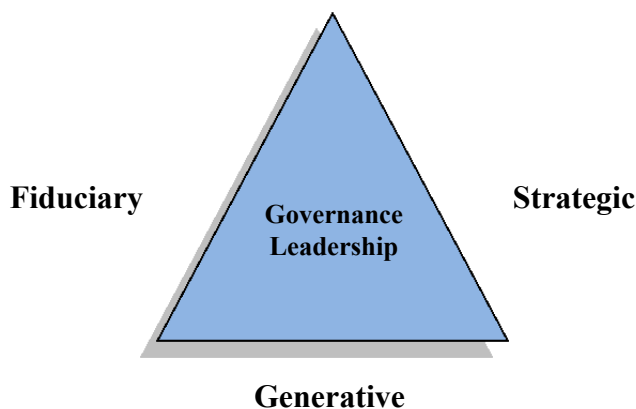
The CHRISTUS board, like most, typically worked within a preferred position on the triangle. Their work shortly after the merger tended toward fiduciary — embracing the "familiar" board work of financial oversight; legal responsibility of accountability to the sponsors, members and other key stakeholders; and providing policy guidance to the newly-formed system. This focus was appropriate as CHRISTUS worked to bring two health systems of over 20 hospitals in 11 markets into one system. During this phase, the system stabilized operations and finance with the board through facility divestments, consolidation of markets and ending relationships with some physicians and insurance companies.

After the first formative years, however, the board more clearly shifted its focus to a greater emphasis on strategic thinking and decision making. This focus involved more problem solving, an immersion in strategic planning, and critical strategic decision-making by board members. For CHRISTUS, this resulted in some significant, longer-range visioning and planning, and let to its first "Futures Task Force, " an 18-month process of research, learning, visioning and strategic discussion that set a course for its next 10 years. The board engaged with management in developing specific scenarios of future states of health care, from those gleaning the directions that would form the base for the annual strategic planning process.

The results of the strategic thinking at the board level resulted in CHRISTUS entering the international health care arena by forming a partnership to create the CHRISTUS Muguerza Health System in Mexico, originally a two-hospital system which has since grown to seven hospitals and a network of clinics and ancillary services.

The true governance "breakthrough" occurred in recent years as the CHRISTUS board added the third mode of governance – the generative mode – to its work, purposefully examining opportunities and challenges from a broader perspective. Using the knowledge and data gleaned from the fiduciary and strategic modes, the board uses its insight to create fresh understanding of complex and ambiguous situations. At CHRISTUS, this is done by asking generative questions to flesh out different perspectives and viewpoints; by noticing clues, trends and patterns; and by seeking different frames of reference. It is evidenced when board members ask the questions, "What is this telling us about or organizational story or direction," "How does this underscore our visioning and take us to the future," or simply, "What is the underlying question we are really discussing?"

CHRISTUS Governance Principles

The CHRISTUS Health Principles of Governance, adopted in 2010, provide a frame for the health system's board to guide its pursuit of governance excellence and innovation:
- Commitment to integrity in Mission, Vision, Core Values and Catholic identity which reflects incarnational spirituality in governance policies and procedures.
- Commitment to simplicity in governance structures and practices.
- Commitment to communication among sponsors, governance to governance and governance to management.
- Commitment to systemness in governance.
- Commitment to continued Catholic and faith-based formation and development for governance leaders.

This mode of thinking allows a board to make sense of the facts and bring a different value than just reacting to them. It creates discussion and ideas that then can be translated into specific strategies, policies, plans and tactics.

At CHRISTUS, this drew the board to consider and ponder the underlying focus of "incarnational spirituality" for the system. CHRISTUS' mission — to extend the healing ministry of Jesus Christ — undergirds its vision's ultimate purpose of providing services so that all "might experience God's healing love." As the basic charism of the founding congregations, the Sisters of Charity of the Incarnate Word of Houston and San Antonio, this incarnational spirituality, then, calls the board to ponder how every decision represents God among us.

In practice, the CHRISTUS board embraced the generative mode to ask those compelling questions, but also to develop a better governance process and structure. The governance committee took on a new role and led the board to develop specific principles (see sidebar) and generated the second Futures Task Force for the system. In this task force, board members embarked upon a more experiential learning, immersing themselves in environments such as high-tech health care companies in Silicon Valley, New Orleans shortly after hurricane Katrina, and even touring the poorest of the poor areas in need of reliable health care — all to inform those underlying questions that would provide direction for the future. The result was solid strategic focus and parameters around which to lead the system to meet the challenges and responsibilities of the future.

The new health care environment we live in calls us to develop new models of care and meet expanding needs in new ways with fewer or different resources, and requires our boards to continue to challenge themselves to bring those generative questions and ideas forward. It brings a deeper meaning to their board service, and provides invaluable insight that we look to our boards to offer. Ultimately, it encourages the healthiest complimentary relationship with management and fulfills the intended purpose of a board.

Ernie Sadau
President and CEO, CHRISTUS Health

Kaiser Foundation Hospitals and Health Plan
Oakland, California

Board Committee for Community Benefit

The Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals Boards of Directors exercise oversight responsibility for the nation's largest private, nonprofit health care system, commonly known as Kaiser Permanente. That system consists of the 9 million-member Kaiser Foundation Health Plans, operating in eight regions covering nine states and the District of Columbia, as well as Kaiser Foundation Hospitals, which owns hospitals or contracts for hospital services in each of the program's regions. The Kaiser Permanente Medical Care Program also includes the eight regional Permanente Medical Groups, which are independent physician partnerships or professional corporations with their own governance structure.

In 2001, the Board and the program's outgoing CEO ordered an in-depth review of the program's community benefit activities. The internal study concluded that the community benefit work, then managed by a small staff within the public affairs department, should be strengthened to enhance its internal and external visibility as well as its strategic focus and leadership. When a new CEO, George Halvorson, arrived in 2002, one of his first actions was to endorse the hiring of a senior executive-level leader for a separate community benefit program, Raymond J. Baxter, PhD, and to create a standing Board committee solely responsible for community benefit. The new committee, which was (and remains) a rarity among boards of health care organizations, was deemed one of the Board's two "heart" committees, along with the Quality and Health Improvement Committee, in contrast to the two "head" committees, Finance and Audit and Compliance. Each Board member was expected to sit on one "head" committee and one "heart" committee.

In 2003, Cynthia Telles, PhD, of the UCLA School of Medicine, became chair of the Board's Community Benefit Committee. Under her leadership, a committee charter was drafted and approved setting out the committee's responsibilities. These included strengthening the community benefit program and activities; regularly reviewing its strategies, policies and performance; monitoring related internal control systems and risk assessment and management; reviewing the design and management of major initiatives; overseeing related legal and regulatory compliance; and increasing public recognition of community benefit activities.

The new committee soon approved a new funding policy setting a minimum threshold on annual community benefit contributions by each region, resulting in greater program predictability and the sustainability of multiyear initiatives. It also approved a strategic approach to community benefit funding that targeted four specific areas of activity: charitable care and coverage, support of the health care safety net; community health initiatives (primarily focused on healthy eating and active living); and development and dissemination of new health knowledge, focused on Kaiser Permanente's large health care research and health professions education program.

From the beginning, committee members have been actively and deeply involved in oversight of the community benefit department's work. At each quarterly Board meeting, the committee receives an in-depth organization-wide review of one of the strategic focus areas, and once or twice a year it visits a specific region to review its entire portfolio of activity. In addition, it receives detailed quarterly reports, for its approval, on each of hundreds of grants exceeding $100,000 dollars a year, as well as regular reports on internal and external audits and federal and state compliance issues, plus the annual Form 990 IRS reports relating to community benefit. A comprehensive annual report, originally prepared only for the Board, is now also distributed to external stakeholders in print and in electronic format on the department's content-rich website.

Over the past decade, the committee has proved to have a powerful and direct impact on the scope, effectiveness, and visibility of Kaiser Permanente's community benefit work, which has grown to $1.8 billion in total investment as of 2010. For example, beginning with the onset of the recession, the committee was directly responsible for driving a significant shift in community benefit programming that focuses resources on helping people who have lost their jobs and health care coverage to obtain healthy foods and to qualify for public health care coverage programs. It has also served as a powerful advocate for program performance measurement and evaluation.

Today, the department and its community initiatives and partnerships are widely understood and strongly supported among Kaiser Permanente's 170,000 employees and 15,000 physicians, and they are featured in extensive media coverage in support of the program's reputation and brand. At the leadership level of the organization, the existence and work of the Board committee has underscored the message that the community benefit work is no less central to Kaiser Permanente's governance and mission than that of other standing committees, including Governance, Accountability and Nominating, Audit and Compliance, and Finance.

In 2009, just seven years after it was created, the committee participated in another Kaiser Permanente governance innovation that was as unusual in corporate boardrooms as the committee itself. It underwent a comprehensive audit of its performance against its charter-defined authorities and duties, performed not by outside consultants but by Kaiser Permanente's own Internal Audit Services. The exercise was part of a unique ongoing series of internal audits of board committees that began in 2008 with an audit of the board's Governance, Accountability and Nominating Committee.

The auditors interviewed the committee chair, the Board chair, the Governance committee chair, and community benefit program management. They reviewed over a year of committee materials, and they observed three committee meetings. The only hitch in the audit process came when auditors attempted to compare the committee's activities to best practices among the community benefit committees of other health care organizations. As the final audit report noted, the only source identified for best practices for Board community benefit committees was the 2009 initial report on *Governance in Nonprofit Community Health Systems*, by Prof. Lawrence Prybil and others.

"We heard from several sources outside Kaiser Permanente," wrote the auditors, "that they looked to the Kaiser Permanente community benefit program and the Community Benefit Committee for guidance on good governance practices in nonprofit health systems…."

The audit concluded with a "Meets Expectations" opinion, the auditors' highest possible rating, and a recommendation to update one section of the charter, which was quickly implemented.

George Halvorson
Chairman and CEO, Kaiser Foundation Hospitals and Health Plan

Mayo Clinic
Rochester, Minnesota

Mayo Clinic's Vision for 2020

In November of 2007, the Mayo Clinic Board of Trustees asked "Does Mayo Clinic have a plan for 2020?" The resulting initiative undertaken by the Board of Governors was a study dubbed the 2020 Initiative. The purpose of the initiative: "To develop a tangible construct to describe what Mayo Clinic should/must/will look like in 2020."

As this project was begun, internal reflection revealed Mayo Clinic as an unrivaled health care leader, poised with strength and confidence, founded on sound principles, having proven success in many clinical areas, with an unmatched legacy of excellence and humanitarian achievement. A number of strategic initiatives were already underway, including a focus on quality, research into individualized medicine and the science of health care delivery, and integration plans within the organization were well under development. The strategic plan had not been refreshed for a number of years, and the development of a longer-term action plan was needed. At this same time, there were concerns with environmental, regulatory, and reimbursement pressures. There was also concern that external influences could force change to the way care is delivered, or restrict access only to the insured, the wealthy or the favored patient. There were also acute concerns with the pressure being placed on resources, a shrinking labor force, and, most importantly, the strain on staff.

The 2020 Initiative sought individual and group-based input from more than 250 Mayo Clinic physicians, leaders, educators, and researchers, and found an unwavering confidence in the primary value that "the needs of the patient come first", unyielding support for Mayo's principles, and energy and enthusiasm for defining what Mayo Clinic would become. Mayo Clinic found that the vision statement "*Mayo Clinic will be the premier patient centered academic medical organization*" had been achieved and no longer reflected the full range of aspiration and organizational intents.

In late 2008, the insights of the 2020 Initiative were brought to the forefront as the strategic plan was refreshed, and the vision, mission and core business statements of Mayo Clinic were updated. The 2020 Initiative was the primary source of input for the new plan, and was an activity which drove the organization to reflect not only on the past, but also on the future.

In 2008, a reorganized Mayo Clinic with a single governing board, a single mission, single vision, single strategic plan, and a single operating plan brought alignment and purpose to the planning efforts.

The 2020 Initiative was used as an anchor of vetted ideas that described Mayo Clinic as more than a place, more than a research center, and more than an educational institution. The 2020 goals were bigger than ever before, and the reach to patients and people needed to be greater as well. A construct that guided the concepts of our thinking was patients here (within our facilities), patients there (with other providers or at home), and people everywhere (recognizing our commitment to those who are not currently patients). This construct has since been modified to highlight that we can run, grow, or transform what we do across the spectrum of here, there and everywhere.

The new vision, "Mayo Clinic will provide an unparalleled experience as the most trusted partner for health care," guides the course to 2020. The Board of Trustees has embraced the vision and strategic plan. This support has been demonstrated through dialogue, discussion, approval of resource allocations and through interaction in many spheres of influence.

The new strategic plan has empowered the organization to think more broadly than Mayo Clinic's walls. A new affiliation strategy was announced and provider groups around the nation are joining forces. Mayo has expanded beyond health care to transform the health care and information delivery process. Engagement in health and wellness services has been encouraged through a location at the Mall of America, and staff are developing and implementing new ways to improve the health of people.

The refreshed plan highlights bringing solutions and hope to patients. Innovative practice techniques, new discoveries and ongoing research in regenerative medicine, individualized medicine and the dissemination of the learnings from these initiatives are essential. This spreading of best practices and best knowledge allows Mayo Clinic to continue offering the best outcomes, safety and service possible while being affordable.

Mayo Clinic sees great challenges ahead, yet the board, the physicians, scientists and allied health staff are guided by the words of our founders, and our future is clear.

"I look through a half-opened door into the future, full of interest, intriguing beyond my power to describe, but with a full understanding that it is for each generation to solve its own problems and that no man has the wisdom to guide or control the next generation."
Dr. William J. Mayo on his 70th birthday

John H. Noseworthy, M.D.
President and CEO, Mayo Clinic

Mercy Health
**Chesterfield, Missouri**

Physician integration

In 1992, Mercy Health had the opportunity to enter into an "integration arrangement" with a 110-member multi-specialty group, the Smith-Glynn-Callaway Clinic, located in Springfield, Missouri. Mercy made the decision to proceed with integration, and to offer other physicians on the medical staff of St. John's Regional Health Center, the same integration opportunity. Mercy firmly believed that it was imperative for physicians and institutions to work closely together in planning for the future, in an environment in which both the cost and the quality of healthcare were to become major national issues. We believed that an organization structure, in which a large physician clinic and a hospital were operated as sister corporations, was the appropriate structure to achieve the organization's mission over the long term.

Subsequent to that decision, the Mercy Clinic in Springfield has grown into a 505-member integrated group. In years following that decision, integration arrangements were successfully completed in Northwest Arkansas and Kansas. During this period, the Board of Directors and leadership of Mercy made a long-term commitment to physician integration as a key strategy of the organization. Whenever physicians were ready in a regional market, Mercy resolved to pursue integration in that location.

Over a ten year period, Mercy developed a reputation for their approach to physician integration. In the recent past, there has been a significant interest in the integration process in all of Mercy's regional markets, and an integration structure is in place in each of their regional communities. Some are more established than others, but all are growing and developing a culture that brings physician leaders and lay leaders together in managing the enterprise of Mercy Health.

In each regional market, the corporate structure under which the integration relationship is operated entails a physician clinic structure that is operated as a 501(c)3 organization and a sister hospital corporation. Both entities have governing bodies with fiduciary responsibilities for their operations. Both report to a regional Mercy holding company, which is the Corporate Member of each. The relationship is depicted as follows:
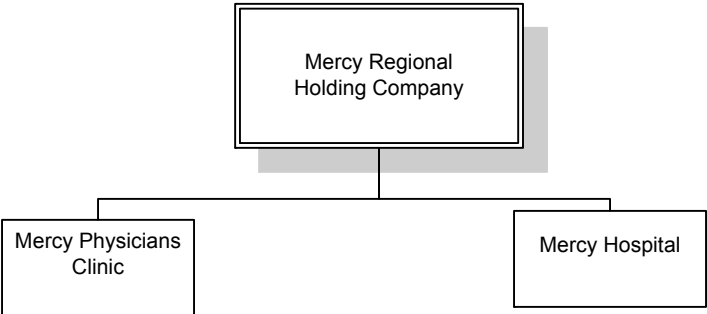
In June, 2009, the Board of Directors made the decision to charter a Board Committee on Physician Engagement (see Attachment A). The committee's basic role is to assess and monitor progress of the strategy for integration as set by the Board, and to recommend appropriate Board action concerning the development of integration in each of their regional markets. The Board Committee undertook the responsibility of reviewing the integration arrangements that were being proposed in the markets in order to make appropriate recommendations to the Board. They also are reviewing the work that is being done to develop leaders – both physician leaders and lay leaders working together to further the strategic aspects of the organization.

Today, the Board Committee on Physician Engagement meets prior to each Board of Directors meeting. It consists of 6 individuals, including: the Board Chair; the President/CEO; a Sister of Mercy; a physician leader who is President/CEO of a regional health system; the President/CEO of a northeastern health care system; and a business leader in one of our Arkansas communities who had previously chaired a regional health system in that area. The Committee reviews quarterly reports on the status of integration in Mercy's markets, reports on leadership development, and other key issues brought to their attention. They recommend action when necessary to the Board of Directors, and report on the status of integration across Mercy.

As integration has developed in each of the regional markets, regional compensation systems have been designed based upon the input of physicians and lay leaders in each of those markets. Today, several compensation systems exist. All have similarities but also differences. Consideration is now being given to developing a system-wide physician compensation design, with significant input from physician leadership throughout all the clinics. The Board Committee on Physician Engagement is assuming the responsibility for overseeing this process.

The Committee's activities are an important part of the Board's function, given the importance of the integration strategy throughout Mercy Health.

Today, integration is rapidly taking place throughout Mercy. At this date there are approximately 1550 physicians who have entered into an integration arrangement or 33% of the active medical staff members throughout the system. Mercy expects this number to continue to grow.

Lynn Britton
President and CEO, Mercy Health

Charter
Board Committee on Physician Engagement

Adopted by the Board of Directors, Mercy Health System **June 3, 2009**

<u>**Purpose**</u>

The Committee on Physician Engagement will advise the Mercy Board of Directors on matters related to Mercy's integrated groups and strategy to pursue and cultivate integration in all of our markets. Generally, its focus will include:

- Integration
  - o Scope related to the total activity in the Region
  - o Review of arrangements involving the growth of the multi-specialty group
  - o Culture and its development

- Leadership development

- Compensation system

Ancillary to providing advice and input to the Mercy Board of Directors related to matters of integration, the Committee will provide an environment for Mercy physician leaders to interact with Mercy's leaders and gain insight as to their approach to our challenges and opportunities.

<u>**Membership**</u>

Chair Members:	Ron Ashworth, Chairman Board of Directors
	Lynn Britton, President and CEO SMHS
	Sister Padraic Hallaron, RSM
	Eric Jackson, General Manager, Oaklawn Jockey Club, Hot Springs, AR
	Ron Paulus, M.D., President/CEO, Mission Health System, Ashville, NC
	Ellen Zane, President and CEO Tufts-New England Medical Center
Staff:	Fred Ford, Senior Vice President Ambulatory Care
	Shannon Sock, Senior Vice President Business Development
	Donn Sorensen, Vice President Ambulatory Operations

<u>**Frequency**</u>

Committee will meet prior to each quarterly meeting of the Board. The Chairman may call ad hoc meetings as necessary provided a minimum of four members are available.

<u>**Form of Meeting**</u>

Meetings will be held in person as schedules allow. If necessary, meetings can occur via video conference, telephonic or other electronic formats.

<u>Attachment A</u>

Providence Health & Services
Renton, Washington

Board "Checking In and Checking Out" Practice

The simple yet profound statement "Know me, care for me, ease my way"™ has been adopted by Providence Health & Services to describe the experience we seek to provide for each patient we serve. It is likewise an underlying belief that all Providence people should recognize and model this behavior in their relationships within the system. An example of its presence beyond direct patient care can be found in the manner in which the members of the System Board of Directors enter into and close their quarterly meetings. The use of this tool for more than five years has served us well and we would suggest it as an "exceptional best practice" because of the way in which it has contributed to strengthening relationships and teambuilding among our system board members.

Arriving at the meetings from several regions of the nation, having left busy schedules and demanding positions in order to give their time, experience, and talent in the governance of the system, the members need a way to "reconnect". The first item of business on the agenda of day one is relatively brief, but much valued. It is our "Checking In" session where each member brings the group up to date on what is going on in her/his life at present. Directors share a variety of events and activities which may be uplifting or sobering. Examples include recent vacation highlights, personal honors, the birth of grandchildren and the illness or death of loved ones. Each person concludes the update with the phrase "and I'm checking in" to signify that they are now fully engaged in the board meeting. This has become a way for us to stay current with and supportive of each other and to build long-lasting bonds. It also has proven to be the vehicle that allows us to focus as a team on the work ahead. Having shared with persons whom we value and respect what is uppermost in our minds when we arrive, we are then ready to let go and enter into the business before us. Moreover, the thoughts that are shared tend to ground us in what is really important in our lives and help us to focus together on our responsibilities as trustees of Providence Health & Services.

Equally important in this process is the ending session of the meetings. Having concluded the work of the days of the meetings and before departing from the board room, each member summarizes her/his experience of the meeting, its accomplishments and also makes suggestions for improvements or additions for future meetings. Each then concludes and signals a readiness to leave by merely saying to all "and I'm checking out".

Easy to accomplish and really relatively inconsequential as to time used, this practice has proven to be valued and effective in the development of the culture of our Board. It has also enabled members of the board to develop deeper and more personalized relationships and to enhance their overall effectiveness as a team.

In reflecting on the use of this practice, the Chair of the Board, Sister Lucille Dean, remarked "So appreciated is this short but personal manner of launching and concluding our meetings that when there has been an occasion to omit it, we can count on the fact that at least one member of the board will point out the omission and request that we be more diligent in following the practice. Our ability to work well together has been enhanced by the fact that we have come to know more about each other as persons in a very meaningful way."

John Koster, M.D.
President and CEO, Providence Health & Services

Sutter Health
Sacramento, California

Restructuring Governance to Enable Strategic Alignment

Sutter Health's history is one of change, evolution, and initiative. In 2007, a number of strategic imperatives compelled us to be proactive in evolving once again.

First, we recognized that several environmental trends threatened Sutter's current business model. As the population ages, health care costs accelerate, and reimbursements diminish, we face the business imperative and responsibility to consumers to be more affordable. Second, we were aware that the variation across our multiple affiliate organizations would not be acceptable in a new era of quality and cost transparency. To transform our processes across the system would require unprecedented integration, standardization, and new operating paradigms. Lastly, we realized that historical boundaries and definitions of community have expanded in today's health care environment. We need to act in a deliberate, coordinated manner to care for our patients across expanded geographies.

Sutter's future success depends upon our ability to coordinate closely among our affiliates and reform our cost structure. However, the overriding concern was that our organizational complexity would hinder our ability to execute our strategy.

Sutter evolved over several decades from mergers and acquisitions of 27 affiliate organizations, with governance fragmented across 55 separate corporations. To consider a system-wide strategic decision, it required a minimum of six to 12 months to move through 20 review steps and gain agreement. Consequently, 17% of Affiliate CEOs' and 35% of System Executives' time was spent on governance.

Acknowledging governance as a key enabler to strategic alignment, we decided to reassess our structures and processes. A Governance Assessment Steering Committee, consisting of board members from affiliates and the system, formed to oversee the assessment, evaluate options, and make recommendations. The year-long process involved internal interviews, case studies, and forums to promote transparent, two-way communication. The Committee evaluated approaches against the criteria of community benefit, financial sustainability, stakeholder responsiveness, system performance, philanthropy and concluded:

1) **We need to act in a more unified manner.** Consolidation of several functional areas and a regional approach to service planning and delivery would facilitate higher quality, lower costs, and smoother intra-system coordination. As stewards of community assets, the Sutter Board believed that not changing our governance would inhibit our ability to innovate and lead in the transformation of health care delivery.
2) **Merge affiliate organizations into five regions.** This structure would enable the advantages of region-wide planning but still keep strategy and communications close to local communities. However, philanthropy, community benefit, and quality assurance should continue as local functions.
3) **Regional board members should act as a single point of responsibility.** To achieve integrated governance of both our medical foundations and hospital corporations while maintaining two legally separate corporate entities (a requirement in California), the two corporations would have "mirror boards" with concurrent meetings, deliberations, and decision making (while subject to conflict of interest policies).
4) **Additional supporting steps are needed to reinforce local/regional/system decision-making.** Governance changes alone would not assure future success, but rather facilitate and complement other necessary changes.

The Governance Committee evaluated and ruled out alternative approaches ranging from a single system board to maintaining the status quo. The regional structure, on balance, was considered to be the best alternative to move the organization forward. After initial findings were presented, 85% of affiliate CEOs polled were "very willing to personally endorse these recommendations and be an advocate for regionalization." With Board approval, regional integration was executed over the next three years: five regional hospital and medical foundations merged with appointed boards, key executives were named to fill new regional roles, and support functions were consolidated regionally.

While Sutter Health acts as one entity in accessing capital and other select activities, the region is the core accountable business unit to implement strategy, service planning, and physician planning. We believe our new governance structure has enabled us to be more effective while maintaining sensitivity to our local communities. The Sutter Health board and management continue to monitor and assess the effectiveness of the regional governance model and believe that it has prepared us to be more efficient and flexible in the fulfillment of our not-for-profit mission as we enter the era of health care reform.

Pat Fry
President and CEO, Sutter Health

<u>Sutter Health Governance in 2007:</u>
- 55+ Corporations (including subsidiaries and 20+ joint ventures
- 40 Full Boards (26 Affiliate Boards, 1 Regional Board, 1 System Board, 12 Philanthropy Boards)
- 750+ Board Members (Affiliate, System and Philanthropy/Foundation)investing 39,597 hours annually
- 17,901 hours invested annually by management (estimated $4.1M in annual resource cost + opportunity cost)
- 20,782 hours invested annually by staff (estimated $1.9M in annual resource cost + opportunity cost)
- Affiliate CEOs spend ~325 hours annually or 17% of their time on governance
- System Executives spend ~683 hours annually or 35% of their time on governance

<u>Sutter Health Governance in 2012:</u>
- 1 System Management Team
- 1 System Board
- 5 Regional Management Teams
- 5 Regional Boards with local Committees
- Philanthropy Boards

Founding Principles

At the time Trinity Health was founded on May 1, 2000, the new entity formed to sponsor Trinity Health, Catholic Health Ministries, established guiding principles to direct the organization's mission and development. These fifteen principles are now referenced as the "Founding Principles" (Attachment A). These principles are based on Catholic Social Teaching, most notably the moral imperatives to care for people who are poor and underserved, the sacredness of human life, the common good of the communities we serve, stewardship of resources, and collaboration in decision making – all of which guide our performance as a Catholic health system.

The intent of the Principles was to give Trinity Health the foundation on which to build a strong and unified health system that drew strength from the legacies of its founding congregations. The founders understood that creating a strong and unified system, would, in turn, help strengthen each of the local Ministry Organizations (hospitals) as they strive to improve the delivery of health care in their local communities across the country.

The Founding Principles serve as a significant philosophical document outlining the expectations for the business enterprise. These Principles guided development of the Board role and responsibilities document, which includes the criteria and competencies for appointment to the Trinity Health Board of Directors. They also helped direct efforts to purposefully shape the organization's culture early in the formation of Trinity Health.

Twelve years after Trinity Health's founding, the Principles continue to frame the responsibilities for governance accountabilities, such as strategic planning engagement and a variety of stewardship responsibilities. The principles also continue to serve as an accountability tool for both governance and management in assessing faithfulness to our Mission and the congruence of the system's priorities and strategic direction. For example, as Trinity Health takes on new partners, the Principles serve as guideposts for integrating new organizations into the Trinity Health culture. Additionally, when major business decisions are being made that have a significant impact on the organization, the Principles are taken into account as part of the process used to determine the best course of action.

The members of Catholic Health Ministries, who also serve as the Trinity Health Board of Directors, have periodically reviewed the Principles to assess the system's faithfulness to them, and also their impact on Trinity Health and the communities served. One of the amazing outcomes of the formal reviews of the Founding Principles is their enduring quality. There has never been a single request or recommendation to delete or add to them. The Principles are experienced as a living document that provides counsel, direction and affirmation to the Board and management as they advance the ministry to carry out its Mission, Vision, and Values.

Joseph Swedish
President and CEO, Trinity Health

Founding Principles of Catholic Health Ministries and Trinity Health

Catholic Health Ministries, the entity formed to sponsor Trinity Health, established several guiding principles to direct the organization's mission and development. These principles have been integrated with the principles articulated as part of the system's organizational design and are now referenced as the "Founding Principles."

1. Trinity Health will be characterized by a demonstrated commitment to persons who are poor and underserved, with particular attention to the needs of women and children, working to assure access, recognition of health as a basic social right, and effective advocacy.

2. Trinity Health will be committed to the integration, assessment and development of mission in all of its activities, decisions and strategies.

3. In all of its actions and decisions, Trinity Health will recognize and respect the sacredness of all life, the dignity of all persons, and the needs of the whole person - spirit, body and mind.

4. Decision-making within Trinity Health will be characterized by the following attributes: social analysis and mission discernment, reflecting a commitment to meeting the needs of the communities it serves, promoting diversity, and locating decision-making at the most appropriate level.

5. Trinity Health's culture will be characterized by collegiality, interdependence and accountability, with respect for the traditions of the founding organizations while creating its own mission and culture.

6. Sponsorship in Trinity Health will be mediated through governance structures that enhance and promote a spirit of a community of persons committed to the mission, full partnership of religious and laity in governance, management and sponsorship, and continued reflection on the evolution of sponsorship.

7. The members of Catholic Health Ministries, our sponsor, will possess the competencies so required, will be committed to a personal and communal formation in sponsorship, and will be periodically assessed.

8. Trinity Health will be committed to partnering with physicians to assure quality outcomes, cost-effective, compassionate and accessible care.

9. Trinity Health will be an active collaborator consolidating and rationalizing services in its markets and partnering with Catholic and other health and social service organizations to improve the health and overall well-being of those communities.

10. Trinity Health will strive to be the employer of choice, committed to the development of its human resources and to creating workplaces that nurture the human spirit and respect diversity.

11. Trinity Health will leverage its strengths and geography in order to facilitate the sharing and adoption of best practices and learnings across the System as well as to assure its financial stability.

12. Trinity Health through its corporate structure, services, and collective actions will add value, synergy and bring economies to its members.

13. Trinity Health will act as a unified System, recognizing its interdependency in fulfillment of its mission and vision.

14. Trinity Health will develop and monitor standards for mission accountability, financial viability, patient and employee satisfaction, quality enhancement and stewardship of its resources - human, financial, environmental.

15. Trinity Health will faithfully attend to the recruitment, development and retention of governance, management, physician partners and staff.

Attachment A

Appendix C – End Notes

[1] Some of the text in this section is excerpted from an earlier report: L. Prybil, S. Levey, R. Peterson, D. Heinrich, P. Brezinski, G. Zamba, A. Amendola, J. Price, and W. Roach. Governance in High-Performing Community Health Systems (Chicago: Grant Thornton LLP, 2009), pp. 1-2.

[2] See, for example, G. Kenney et al, "Virtually Every State Experienced Deteriorating Access to Care for Adults Over the Past Decade," (Washington, DC: Urban Institute, 2012); J. Wennberg, Tracking Medicine: A Researcher's Quest to Understand Health Care (New York: Oxford University Press, 2010); and Why Not the Best: Results from the National Scoreboard on U.S. Health System Performance (New York: The Commonwealth Fund Commission on a High Performance Health System, October, 2011).

[3] See, for example, K. Getz, "Public Confidence and Trust Today," Monitor, September, 2008, pp. 17-21; and J. King and E. Moran, Trust Counts Now: Hospitals and Their Communities (Washington, DC: American Hospital Association, 2006).

[4] J. Lorsch and R. Clark, "Leading from the Boardroom," Harvard Business Review, Vol. 84, April, 2008, p. 105. Also, see Prepared Remarks by Lois Lerner, Director, Exempt Organizations, IRS, presented at Georgetown University Law School, April 19, 2012.

Transcript at http://www.irs.gov/pub/irs-tege/georgetown_04192011.pdf.)

[5] See, for example, 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; L. Prybil, et al, Governance in High-Performing Community Health Systems (Chicago: Grant Thornton LLP, 2009), esp. pp. 39-43; N. Kane, J. Clark, and H. Rivenson, "The Internal Processes and Behavioral Dynamics of Hospital Boards: An Exploration of Differences Between High- and Low-Performing Hospitals," Health Care Management Review, Vol. 34, January-March, 2009, esp. pp. 89-90; and "Governance and Management of Non-for-Profit Healthcare Organizations: A Key Driver of Ratings," (New York: Moody's Investors Service, December 20, 2010).

[6] See "Best Practices: Nonprofit Corporate Governance," (Chicago: McDermott, Will, & Emery, 2004); 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, 2008; M. Peregrine, "Corporate Governance Update: IRS Updates Position on Corporate Governance," Memorandum to the Corporate Governance Task Force: 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 29, 2008); "50 Practices of Top-Performing Boards" (Minneapolis: Integrated Healthcare Strategies, 2008); "Governance and Related Topics," Internal Revenue Service, December, 2009; L. Prybil, et al, Governance in High-Performing Community Health Systems (Chicago: Grant Thornton LLP, 2009); "Governance and Management of Not-for-Profit Healthcare Organizations: A Key Driver of Ratings" (New York, NY: Moody's

Investors Service, December 20, 2010); "NYSE's Commission on Corporate Governance Issues: 2010 Report Indentifying Ten Core Governance Principles," American Health Lawyers Association, January 2011; and D. Brown, S. Murphy, and L. Prybil, "Great Governance: A Practical Guide for Busy Boards and Executives of Nonprofit Health Care Organizations" (Washington, DC: Alliance for Advancing Nonprofit Health Care, 2011).

[7] Personal communications with Mr. P. Kralovec, Director, Data Center, American Hospital Association, November, 2008 and January-March, 2012.

[8] See, for example, "New Forces Driving Rise in Not-for-Profit Consolidation," (New York, NY: Moody's Investors Service, Inc., March, 2012); and T. Dolan, "Futurescan: Healthcare Trends and Implications: 2012-2019," Presentation at Center for Healthcare Governance National Symposium, Naples, Florida, January 24, 2012.

[9] Kralovec, op cit, February, 2012.

[10] Among the few studies that have focused principally on the governance of large health systems is Health System Governance Structures and Practices Survey (Seattle, Washington: ECG Management Consultants, Inc., 2006). The study examined governance structures and practices in eleven health systems,

eight of which were among the 40 largest systems in the country in 2005 when the authors' survey was conducted. Also see America's Leading Health Systems: Setting a New Standard (Alexandria: The Academy Advisors, 2011); and B. Bader et al, Pursuing Systemness: The Evolution of Large Health Systems (San Diego, CA: The Governance Institute, 2003).

[11] Catholic Healthcare West, recently re-named "Dignity Health," respectfully declined to participate due to pressing system priorities during the period of time when this study was being conducted.

[12] Ascension Health shifted to a public jurdic person model after the study team's site visit in the fall of 2010 and, early in 2012, an organizational re-structuring created a new parent company, Ascension Health Alliance which now includes Ascension Health (which focuses on hospitals and the delivery of healthcare services) and several other diversified, health-related companies as subsidiaries. According to Anthony Tersigni, President and CEO of Ascension Health Alliance, these organizational changes have had minimal impact on the structure, functions, or practices of the Ascension Health board as codified by the research team and reflected in this report. Personal communication with A. Tersigni, February 13, 2012.

[13] "By the Numbers: Largest Group Practices," Modern Healthcare, Vol. 42, April 23, 2012, p. 34.

[14] The research team wishes to extend special acknowledgement to the Alliance for Advancing Nonprofit Health Care and its President and CEO, Bruce McPherson, for their recent work regarding benchmarks of "great governance" which was very helpful in identifying and defining the benchmarks used in this study. See "Great Governance: A Practical Guide for Busy Boards and Executives," op, cit.

[15] 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; J. Collins, Good to Great (New York: Harper Business, 2001), Chapter one; 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.

[16] See, L. Prybil, R. Peterson, J. Price, S. Levey, D. Kruempel, and P. Brezinski, Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-for-Profit Hospitals (Chicago: Health Research and Educational Trust, 2005); 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); and L. Prybil, S. Levey, R. Peterson, D. Heinrich, P. Brezinski, G. Zamba, A. Amendola, J. Price, and W. Roach, Governance in High-Performing Community Health Systems (Chicago: Grant Thornton LLP, 2009).

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[19] Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry (San Diego, CA: The Governance Institute, 2011), p. 9. A 2011 Survey by the AHA found that only about half (52%) of hospital boards have limits on the number of consecutive terms that board members can serve. 2011 Health Care Governance Survey

Report (Chicago: Center for Healthcare Governance, 2011). P. 14.

[20] NCAD Public Company Governance Survey (Washington, DC: National Association of Corporate Directors, 2011), p. 11.

[21] Dynamic Governance: An Analysis of Board Structures and Practices in a Shifting Industry , op. cit., p. 5; 2011 AHA Health Care Governance Report, op. cit., p. 12; and 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.

[22] Internal Revenue Service, "Governance and Related Topics: 501(c)(3) Organizations," posted February 4, 2008, pp. 2-3

[23] Building an Exceptional Board: Effective Practices for Health Care Governance (Chicago: Center for Healthcare Governance, 2007), p. 13.

[24] See, for example, L. Larson, "Who Does it Better: The Corporate Versus the Nonprofit Governance Model," Trustee, Vol. 60, 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.

[25] R. Pozen, "The Case for Professional Boards," Harvard Business Review, Vol. 88, December, 2010,   p. 52.

[26] "Corporate Boards: Now and Then," Harvard Business Review, Vol. 89, November, 2011, p. 39.

[27] Ibid, p. 39.

[28] See, for example, C. Anderson, "NYSE's Commission on Corporate Governance Issues: 2010 Report Identifying Ten Core Governance Principles," American Health Lawyers Association, January, 2011, p. 8.

[29] "Principles for Good Governance and Ethical Practice," Panel on the Nonprofit Sector, op. cit, p. 15,

[30] "White Paper: Corporate Responsibility Proposals that could be Extended to Nonprofit Health Care Organizations," Coalition for Nonprofit Health Care, July 18, 2002; Internal Revenue Service, "Governance and Related Topics: 501(c)(3) Organizations," posted February 4, 2008; and IRS Revenue Ruling 69-545. While neither federal law not IRS regulations mandate that the governing boards of nonprofit hospitals and systems be composed of a majority of independent members, there are several guideposts that indicate the IRS is placing substantial importance on this principle. It is clear the IRS believes the presence of independent

members on a board is an important factor in evaluating whether an organization furthers an exempt purpose and adequately safeguards charitable assets.

[31] See, for example, "Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations," Panel on the Nonprofit Sector, op. cit., pp. 14-15; J. Carlson, "Measuring Inclusiveness: Study Looks at Hospitals' Cultural Competency," Modern Healthcare, Vol. 38, 2008, pp. 18-20; and S. Davidoff, "To Improve Corporate Boards, Add More Diverse Voices," New York Times, March 9, 2011, Business-Finance Section, p. 7.

[32] For detailed information, visit www.equityofcare.org

[33] J. Combes and B. Bader, "The State of Governance: Insights from AHA's 2011 Governance Survey," National Symposium on Leading and Governing Healthcare Organizations," Naples, FL, January 22-25, 2012; and 2011 AHA Governance Survey Report, op. cit, p. 12.

[34] Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry, op. cit, p. 5.

[35] "Corporate Boards: Then and Now," Harvard Business Review, op. cit., p. 39.

[36] L. Petrecca, "More Women on Tap to Lead Top Companies," USA Today, October 27, 2011, p. 3.

[37] See, for example, A. Woolley and T. Malone, "What Makes a Team Better? More Women," Harvard Business Review, Vol. 89, June, 2011, pp. 32-33; "To Improve Corporate Boards, Add More Diverse Voices," op. cit; N. Kristof, "Mistresses of the Universe," NY Times, February 8, 2009, Opinion Section, p. 12; R. Barnardi, S. Bosco, and 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 L. Hong and S. Page, "Problem Solving by Heterogeneous Groups," Journal of Economic Theory, Vol. 97, 2001, pp. 123-163,

[38] K. McDonagh and N. Saunders, "Clearing the Pathway," Trustee, Vol. 64, October, 2011, pp. 41-44; and "More Women on Tap to Leader Companies," op. cit.

[39] 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 that 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."

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[41] 2011 AHA Health Care Governance Survey Report op. cit., p. 13; Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry, op. cit, p. 5; and L. Prybil et al, Governance in High-Performing Community Health Systems, op. cit, p. 8.

[42] 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.

[43] D. Berwick as quoted in "Great Boards Ask Tough Questions: What to Expect from Management on Quality," Boardroom Press, April, 2005, p. 7.

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III, Summer, 2008. Also see L. Walker, "The Supporting Case: Strong, Focused Committees and Task Forces are Essential to Overall Governance Excellence," Trustee, Vol. 65, March, 2012, pp. 6-7.

[51] 2011 AHA Healthcare Governance Survey Report: 2011, op. cit., p. 5. It is recognized that the AHA data was collected through a mail survey without the benefit of reviewing system documents and that the AHA's committee terminology is somewhat different than what is employed in this study of 14 large systems. However, the research team concluded the data were sufficiently compatible to warrant this comparison.

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[60] L. Prybil, et al, Governance in High-Performing Community Health Systems, op. cit., pp. 12-13.

[61] 2009 National Board Governance Survey for Not-for-Profit Organizations, (Chicago: Grant Thornton, LLP, 2009), p. 9.

[62] NACD Public Company Governance Survey, op. cit., p. 11.

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

[64] "Rewarding Virtue: Effective Board Action on Corporate Responsibility," Insight Investment, Business in the Community, and the FTSE Group, November, 2005, p. 6.

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[98] In Revenue Ruling 69-545, 1969-2,C.B. 117, the factors that 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 institutional 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."

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[115] See. For example, Dynamic Governance: An Analysis of Board Structures and Practices in a Shifting Industry, op. cit., p. 24; and "Governance Since the Global Economic Crisis," op. cit.

[116] B. Bader, "Culture: The Critical But Elusive Component of Great Governance," in Governance Structures and Practices: Results, Analysis, and Evaluation (San Diego: The Governance Institute, 2009), p. 19.

[117] 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, not 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.

[118] In their recent study of best practices in multi-hospital systems, a HRET research team found that "Creating a culture of performance excellence, accountability for results, and leadership execution are [among] the keys to success." J. Yonek et al, A Guide to Achieving High Performance in Multi-Hospital Health Systems (Chicago: Hospital Research and Educational Trust, 2010), p. 1. Also see L. Prybil et al, Governance in High-Performing Community Health Systems, op. cit., esp. pp. 28-29; "Ten Best Practices for Measuring the Effectiveness of Nonprofit Healthcare Boards," op. cit., p. 15; K. McDonagh, J. Chenoweth, M. Totten, and J. Orlikoff, "Connecting Governance Culture and Hospital Performance Improvement," Trustee, Vol. 61, April, 2008; 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.

[119] Building an Exceptional Board: Effective Practice s for Health Care Governance, op. cit., esp. pp. 12-16.

[120] As a standard part of the individual interviews, the board members and CEOs were given a one-page sheet that listed the seven indicators of effective board culture. The research team member then highlighted each characteristic and asked the interviewees 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 71 persons who were interviewed.

[121] See, for example, M. 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.

[122] See, for example, D. Nadler, et al, Building Better Boards: A Blueprint for Effective Governance (San Francisco: Jossey-Bass, 2006), chapter 5.

[123] Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry, op. cit., p. 22. In the contemporary environment, it is widely accepted that boards periodically should meet in executive sessions with their executive compensation consultant, compliance officer, and external and internal auditors.

[124] See, for example, "The Case for Professional Boards," op. cit., p. 52.

[125] Some of the text in this section is excerpted from a preliminary report on this study: M. Totten and L. Prybil, "Governing Large, Nonprofit

Systems: A Preview of CEO, Trustee Perspectives," Trustee, Vol. 65, January, 2012., pp. 15-18.

[126] M. Wagner, "If You're Asking How to Measure Quality, You're Asking the Wrong Question," The Advisory Board Daily Briefing, April 27, 2012. For additional information on this vexing topic, see C. Damberg et al, An Evaluation of the Use of Performance Measures in Health Care, (Santa Monica, CA: Rand Corporation, 2011) and "Coordination Strategy for Post-Acute Care and Long-Term Care," (Measure Application Partnership – National Quality Forum, February, 2012).

[127] "Hospitals and Public Health: Collaborating for Communities," Keynote address by Richard Umbdenstock, President and CEO, AHA, at the University of Kentucky Keeneland Conference, Lexington, Kentucky, April 18, 2012. Also see "Managing Population Health: The Role of the Hospital (Chicago: Health Research and Education Trust, 2012).

[128] The systems also were scored and ranked for each of the nine benchmarks. Then each system's rank (1-14) for the nine benchmarks were added and the systems were ranked according to these totals. The ranking was found to be essentially the same as shown in Table 32. This indicates that the systems' status (and, thus, ranking relative to the other systems) were

generally consistent across all nine benchmarks.

[129] It is recognized that hospitals only comprise part of the organizational entities and services provided by the 14 large systems in this study population. Some, such as Kaiser Foundation Hospitals and Health Plan, include large health insurance operations; others, such as Mayo Clinic, include large medical groups. Looking at and comparing the performance of these systems' hospital divisions provides only a partial and imperfect picture; however, hospital data is at least available and comparable. As stated in Section III of this report, there are no universally-accepted methods for measuring and comparing the overall operating performance of these extremely large and diverse healthcare organizations.

[130] For details regarding the methodology and findings of the 2012 Thomson Reuters study of health system performance, see 15 Top Health Systems: Study Overview and Research Findings (Ann Arbor, MI: Thomson Reuters, 2012).

[131] Some of the text in this section is excerpted from an earlier report: L. Prybil et al, Governance in High-Performing Community Health Systems, op. cit., p. 32.

[132] See. For example, L. Burns, "The Fall of the House of AHERF," Health Affairs, Vol. 19, January-

February, 2000, pp. 7-41.; The Role of the Board of Directors in Enron's Collapse, Subcommittee on Investigations, Committee on Government Affairs, U.S. Senate, July 8, 2002; 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; J. Papini and M. Eckblad, "It's a Done Deal: Merrill and B of A," Wall Street Journal, December 6-7, 2008, p. B3; G. Colvin, "Who's to Blame at BP? Start with its Top-Notch Board, Which Let Safety Failings Slide," Fortune, Vol. 162, July 26, 2010, p. 60; and N. Schwartz and J. Silver-Greenberg, "JP Morgan Was Warned About Lax Controls," New York Times, June 4, 2012, pp. B1-B2.

[133] 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.

134 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, p. 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; ISS Corporate Governance Quotient, Institutional Shareholder Services, June 6, 2007; and N. Kane et al, "The Internal Processes and Behavioral Dynamics of Hospital Boards," op. cit., esp. pp. 85-89.

135 For one example of a well-developed "board scorecard" that includes a compact set of quality and safety metrics, see the Catholic Health Partners governance feature ("System Scorecard and Executive Evaluation") which is included in Appendix B.)

136 P. Knecht and K. Bass, "Why Board Culture Matters," Trustee, Vol. 65, May, 2012, p. 24.