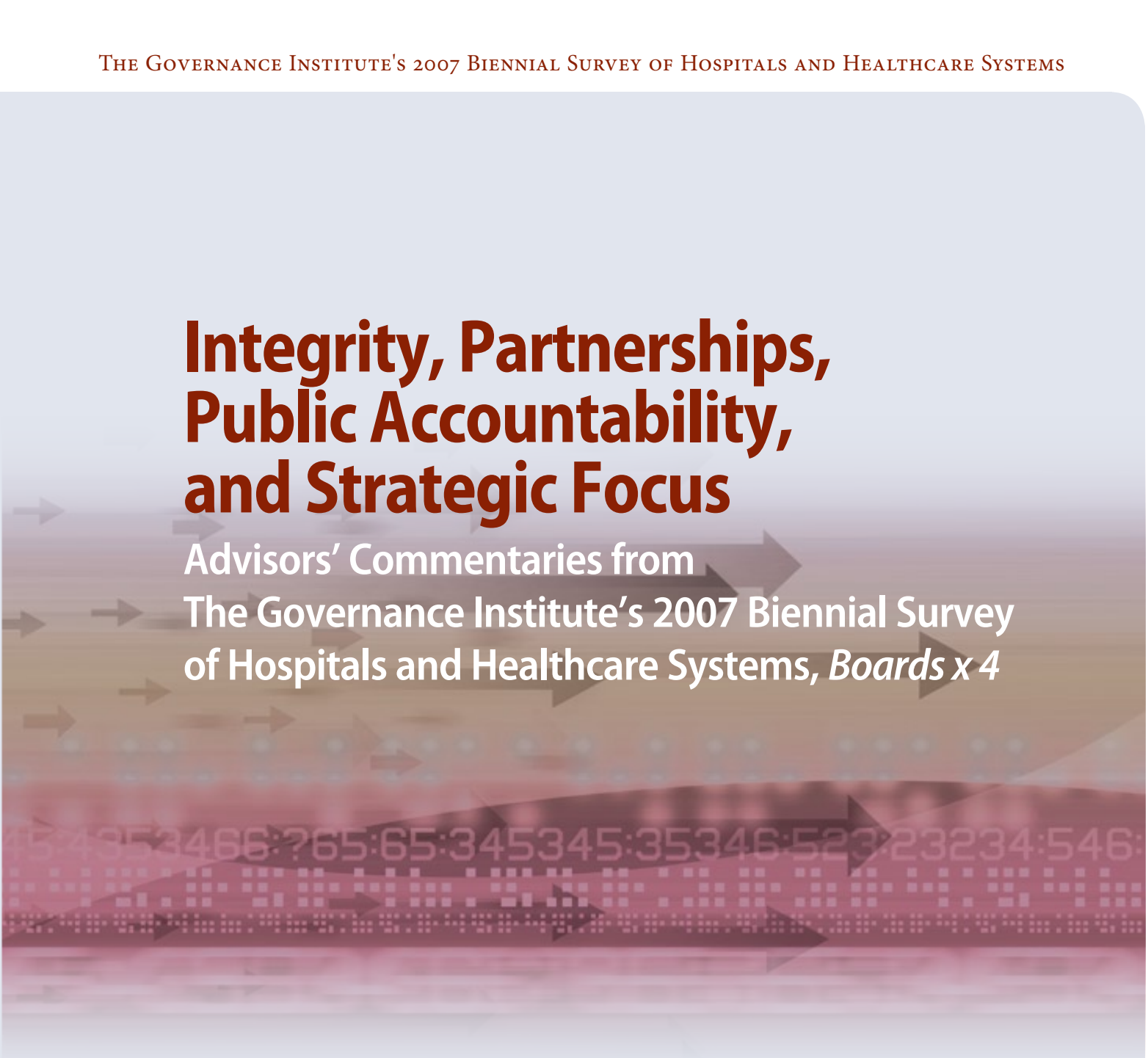
Integrity, Partnerships, Public Accountability, and Strategic Focus

Advisors' Commentaries from The Governance Institute's 2007 Biennial Survey of Hospitals and Healthcare Systems, *Boards x 4*



THE GOVERNANCE INSTITUTE

Acknowledgments

The Governance Institute extends deep appreciation to our four Governance Advisors, Barry Bader, Edward Kazemek, Pamela Knecht, and Roger Witalis, as well as Jim Rice, vice chairman of The Governance Institute, for their commitment to this survey. They contributed a significant amount of their time to identifying and refining the 85 governance practices presented in the survey, followed the analysis of the results, and offered commentary on key areas for improvement in each of the nine categories of fiduciary duties and core responsibilities. Their contributions have significantly helped make this report a rich learning document and valuable resource for healthcare boards.

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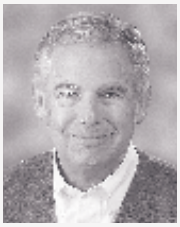

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Table of Contents

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Executive Summary

The Governance Institute published its biennial report on hospital and health system governance, Boards x 4, in November 2007. The report, based on responses from 718 U.S. hospital and health systems, covers board structures and practices—overall and by type of organization. A key component of the report is the special commentary by Governance Institute Advisors Barry Bader, Edward Kazemek, Pamela Knecht, and Roger Witalis. Their commentaries offer further insight into the survey results. We present these commentaries here. Specific topics covered by the advisors include:

- Public accountability for quality and community benefit
- Higher standards of integrity
- Ensuring strategic focus
- Reframing the board–executive partnership

The advisors highlighted areas of most progress and also most concern. For example, there has been an increase in the number of boards that report a board-level quality committee, and nearly all organizations use a formal method for measuring the organization's performance in quality. Boards appear to have made some positive movement in their oversight responsibilities for quality of care delivered by their hospitals, although more need to focus on specific oversight practices (when those practices are appropriate for their organizations).

Alternately, boards have a ways to go with respect to ensuring manageable levels of conflict-of-interest concerns on the board, as well as ensuring the organization's continued vitality by planning for changes in board leadership and also executive leadership (i.e., the CEO). More boards should take a look at their efforts regarding measuring and reporting community benefit, and should focus on their role in setting the organization's strategic direction. How boards assess themselves can be improved by considering, where appropriate, individual board member performance, the process for recruiting new board members, and board member performance requirements for reappointment. And boards should consider their advocacy responsibility—participation in public policy endeavors and making the organization's information "transparent" to its constituents, for example.

There are more areas of progress and concern in the full report. The advisors have selected only a few for their commentaries. For full results, please refer to *Boards x 4: Governance Structures and Practices* (for a quick review of the results, see Appendices 1 and 2 at the end of the report).

Alternate Ways to Interpret the Results

Readers may choose to review the results of the survey from the perspective of prevalence of practice adoption by respondents—the percentage of respondents who said their board generally follows the practice or is considering adopting the practice.* If you prefer this approach, please note that a majority of the 85 recommended practices in the survey are in place or under consideration by most of the respondents (more than 80 percent of the practices are being followed or are under consideration by at least 75 percent of the respondents).

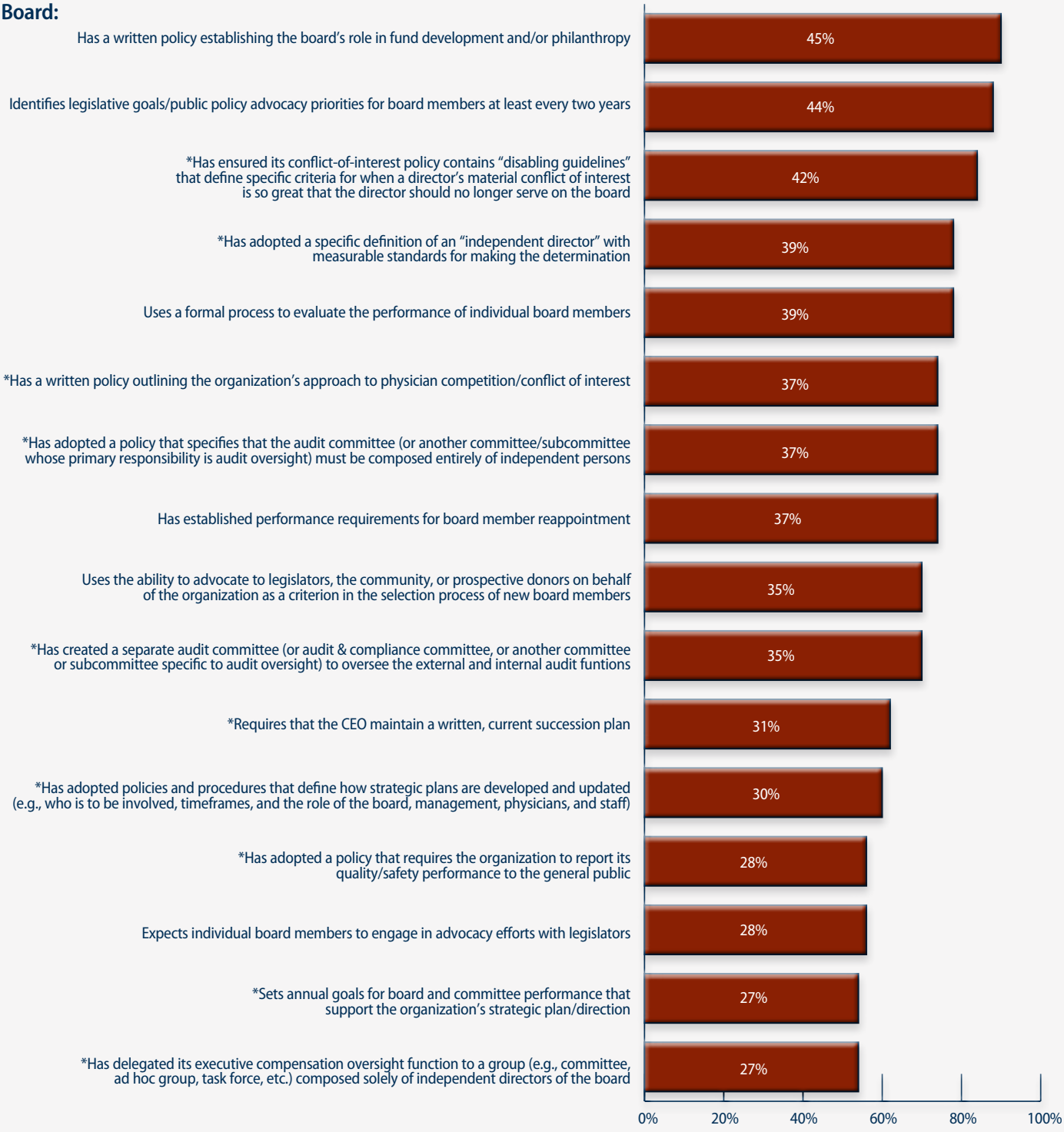
A different approach—endorsed by some improvement experts as a way to emphasize areas of work for improvement—focuses on looking at the percentage of organizations that have **not** adopted a practice, and are not even considering it. Some organizations have not adopted key practices, even when those practices *do apply* to their organizational structure and environment. From this perspective, it appears governance in hospitals/health systems, on a macro level, has room for improvement.

Fifteen of the 85 recommended practices covered in the survey have not been adopted by more than 25 percent of the respondents, and those practices are shown in the exhibit on the next page.

* **Special Note:** We have characterized the practices as "recommended" rather than "best" because, as many of our members have noted, each one has a specific application within each organization. Some are not even applicable to some organizations; some will not fit the organization's culture and there may be other practices—not listed here—that are more appropriate; some may work with a board in the future but not at the time of the survey; and so forth. This list represents a collapsing of the wide range of what we believe are important approaches to great governance and, as a result, something may be "lost in translation."

Percentage of Responding Organizations That Have Not Adopted and Are Not Considering Adopting Specific Board Practices—The Top 15

The Board:



*Specifically discussed in Advisors' Commentaries.

Higher Standards of Integrity

Edward A. Kazemek
Chairman & CEO, **ACCORD** LIMITED

The days when not-for-profit healthcare boards were presumed to be doing good works for unselfish motives and adhering to the highest standards of ethical conduct have come to an end. Today, the distinction between not-for-profit and for-profit boards has been blurred by spectacular scandals in both sectors (reported on regularly by the media), intense congressional attention, numerous investigations, lawsuits, and legislative proposals. Not-for-profit boards must now *demonstrate transparently* that they deserve the public's trust by functioning in a manner that exceeds what current laws and past practices require. The problem is a significant number of hospital and health system boards seem to have not gotten this message or have chosen to ignore this new reality. The survey results support this disturbing conclusion.

Independent Governance

As fiduciaries entrusted with the assets of the organizations they govern, boards are legally and morally expected to make independent decisions on what is best for the organization and the communities served and not be influenced by personal or competing agendas. The duty of loyalty requires nothing less. Most would agree that a board's independence is a critical requirement for developing a trusting relationship with the various stakeholders of a hospital or health system.

In his Berkshire Hathaway annual report, Warren Buffet is quoted as saying: "In selecting a new board director, we were guided by our long-standing criteria, which are that board members be owner-oriented, business-savvy, interested, and **truly independent** [emphasis added]." He goes on to criticize the loose standards that boards use to determine a board member's independence. It appears that the survey respondents can be faulted for the same deficiency. Only 34.1% have adopted a specific definition of an "independent director" with measurable standards for making the determination (with 27.1% considering it). It is astonishing that 38.8% of the respondents are not even considering developing such standards. Yet, 51.2% indicate that their audit committee must be composed entirely of independent persons. Obviously, the numbers don't add up, since only 34% have a clear definition for independence.

Higher Standards: The full board should develop an operational definition of the requirements for independent directors that includes measurable parameters for allowable financial relationships and other limitations. At least a majority (some are using 75% as the standard) of the board members should meet the requirements to be considered independent.

Conflicts of Interest

Almost all boards ensure that they do not violate the laws pertaining to conflicts of interest. While the majority of boards allow board members to do business with the hospital or be involved in conflict situations from time to time as long as the board members adhere to policies and procedures for disclosing and handling such conflicts, there appear to be some gaping holes in today's practices. Only one third of the survey respondents have ensured that their conflict-of-interest policy contains "disabling guidelines" that specify criteria for when a director's material conflict of interest is so great that the director should no longer be allowed to serve on the board. Almost 42% are not even considering developing such guidelines. In effect, these respondents are saying no matter how conflicted board members' interests may be with the hospital, they are welcome to continue serving on the board. This can be damaging to an institution's reputation if the perception develops that board members are using their positions for personal gain.

Approximately 15% of the respondents do not treat **deliberate** violations of conflict-of-interest policies as grounds for removal from the board.

Finally, boards have been slow to address the issue of how to deal with physician conflicts of interest (especially physicians who serve on the board). Only 28.3% (34.4% considering it) have developed a written policy outlining an approach to dealing with these matters. Given the increased competition between hospitals and their active medical staff, not addressing this phenomenon proactively, especially as it relates to physician board or committee service, is equivalent to putting one's head in the sand and hoping things will take care of themselves.

Higher Standards: The full board should develop a set of "disabling guidelines" and include them in its conflict-of-interest policy. Willful violations of the conflict-of-interest policy and procedures should be grounds for removal from the board and included in the disabling guidelines. Working with medical staff leadership, the board and management should establish policies for dealing with physician conflicts of interest and material competition that threatens the hospital's mission.

Executive Oversight

Boards appear to have upgraded their executive oversight practices, especially in terms of CEO performance evaluation and compensation. Since the 2005 survey, there has been a 50% increase in the number respondents reporting the use of an executive compensation committee. And, the vast majority of organizations seem to have formalized their processes for linking compensation to executive performance. Clearly, Sarbanes-Oxley practices have been embraced by the not-for-profit healthcare industry.

However, boards seem reluctant to embrace three other important practices that have become the norm in the private sector. Only 28.9% require that the CEO maintain a current succession plan, with 31.2% not even considering it. Approximately 38% of the respondents do not convene executive sessions periodically without the CEO in attendance to discuss CEO performance. And, almost 33% of the respondents do not ensure that oversight of executive compensation is handled solely by

independent directors. Boards that follow these practices are those striving to ensure executive leadership continuity, candid discussion concerning CEO performance, and executive compensation decisions that are above reproach in all respects.

Higher Standards: Develop a board policy on holding executive sessions periodically without the CEO in attendance to discuss any issues that the board would feel more comfortable discussing among themselves. Approve a written executive succession plan that covers all of the C-suite executives. And, ensure that the full board is appropriately involved in all aspects of the CEO performance goal setting/review process and approves the compensation decisions recommended by a board committee composed entirely of independent directors.

Finances

Most boards spend a disproportionate share of board meeting time focused on financial matters. Financial oversight is the one area that all boards recognize as an extremely important responsibility and often consider (erroneously) the word "fiduciary" to mean financial oversight. Therefore, it is no surprise that survey respondents consistently rank financial oversight performance at the top.

In spite of the attention paid to this core responsibility, the survey reveals some vulnerabilities. Almost 32% of the respondents indicate that the board does not ensure that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy. In fact many board members have never seen the Form 990 filed by their hospital. The IRS expects the full board to review the document and the new Form 990 proposed by the IRS requires the document filer to attest that the board has reviewed it.

Another vulnerability and somewhat surprising finding is that almost 49% of the respondents have not adopted a policy requiring that the audit committee (or another committee/subcommittee whose primary responsibility is audit oversight) must be composed entirely of independent directors. And, almost 25% do not require that board members responsible for audit oversight meet with the external auditors at least annually without management present. These two practices are followed by most of the larger system respondents to the survey but less so by independent and government-sponsored hospitals.

Higher Standards: Educate the full board on the components of the Federal Form 990 and ensure that the board reviews it thoroughly before it is filed with the IRS. Adopt a policy that requires that the board members who handle audit oversight meet the board's independence standards and that they meet with the external audit firm to discuss the audit findings without management present. Additionally, consider forming a separate audit committee with delegated authority to oversee this sensitive responsibility.

Scrutiny of how not-for-profit boards carry out their fiduciary duties and core responsibilities is intense today. Will this pressure subside any time soon? Perhaps, but the pressure is not likely to lessen until new standards for ethical board performance have taken hold throughout the healthcare industry. The questions for board members to ask themselves are: Do we wait until we are forced to adopt some of the new practices being embraced by boards that are taking the lead on these issues and run the risk of damaging our reputation? Or do we focus on the issue of integrity now and adopt proven practices that demonstrate to the communities we serve that their trust in us is well deserved?

Reframing the Board–Executive Partnership

Roger W. Witalis, FACHE
President, **WITALIS** & Company

The non-profit voluntary healthcare corporation has traditionally been led by a seasoned, highly experienced CEO and executive management team working in concert with a governing board composed of socially prominent citizens committed to "doing good" for their community. This board–executive partnership has worked well for decades with little, if any, external accountability or performance expectations. Recently, however, the rules of the game began to change. Today, because of demands for higher levels of operating performance, quality outcomes, capital accumulation, and institutional integrity, contemporary hospitals and health systems are reframing the board–executive partnership much in line with what is occurring in corporate America. Structures, policies, accountabilities, and relationships are all being clarified or redefined.

The "New" Director

It is no longer acceptable for individuals to acquire hospital or system board seats solely through large financial donations or social prominence. "New" board members must, first and foremost, bring competencies and experiences expected from directors of billion-dollar corporations. Socially prominent individuals—who may be feeling anxious about the increased responsibilities and demands required of fiduciary board members, but who still want to contribute in some way—can be freed of the *fiduciary* responsibilities and risks of governing the corporation by contributing their time and efforts to the hospital's/system's philanthropic foundation.

The "new" director is often a senior executive of a large corporation who, in his or her own industry, has experienced many of the challenges facing hospitals and systems: Sarbanes-Oxley compliance, labor relations issues, peak performance management, Baldridge, Six Sigma, lean quality and performance culture building, brand risk protection, and the like.

These new directors can provide valuable insights in the boardroom and guiding counsel to executives. However, their time availability is limited and their tolerance for process is slim to none. These individuals want to get to the "meat," deal directly with issues, and discuss strategy, not be passive recipients of reports from management.

The "New" Executive

As the board reframes itself from passive process tolerance to active engagement, the CEO and executive team must be prepared to address the challenges, questions, behaviors, and style of "new" directors. Control of board agendas and meeting management become critical. Timely, accurate, and relevant information is imperative and must be available well in advance of meetings. The dynamic tension between both partners (board–executive) must be kept in check and a balance maintained; otherwise a painful and counter-productive board–executive clash of wills erupts. The check on tension is the responsibility, if not the duty, of the board chair and CEO working as a solidly-welded team.

The "New" Chair–CEO Relationship

Managing a board of highly competent, experienced individuals will not be easy. Having been successful in their own careers, "new" directors will be eager to solve the problems or issues themselves, without listening or considering the wisdom of others around the table. The chairperson now takes on the meeting management role, controlling discussion and director behavior, moving toward consensus, all the while mindful of agenda and time. The CEO takes on the information management role, ensuring that the executive team has prepared and distributed a clean, crisp, and focused board packet. Working closely together, the chair and CEO can ensure a successful meeting if they agree on the agenda, prepare the right material, and manage the meeting with statesmanship and discipline.

The "New" Need for Succession Planning and Recruitment

Historically, succession planning has focused on the succession of one CEO to another CEO. Even so, our current survey shows that only 29 percent of boards require a CEO succession plan. In addition, just 45% report they have an explicit process of succession planning for board leaders. The "new" board-executive partnership model goes way beyond the CEO. It becomes critical that succession considerations be focused on all key leadership positions: board officers and committee chairs as well as executive management positions. With chairpersons serving an average two years, boards need to carefully think out loud, in advance, about the series of individuals who will lead the board two, four, or six years ahead. Criteria for chairpersons should include group management, facilitation, and consensus building skills rather than a particular technical skill such as finance, medicine, or law. In many respects a leadership succession plan for the board is more critical than a succession plan for the CEO. Both, however, should be in place as a piece of the "new" board–executive design.

Equally important, boards that reflect the diversity of their communities are better equipped to understand and shape policies that are responsive to community needs. Recruiting a qualified, diverse board is easier said than done at a time when a board seat demands more time than ever and when highly qualified ethnic minorities and women—as well as mid-career professionals of all backgrounds—are hotly pursued by many community organizations and corporate boards.

The place to start is with clear recruiting guidelines. Yet, only 54% of respondents said they use competency-based criteria when selecting new board members; another 23% are considering the practice.

The roles of board officers and committee chairs are too important to be left to seniority alone. Not every long-serving trustee has skills required in a chairperson. Boards must select and prepare those best suited to assume leadership roles.

Orientation, Education, and Evaluation

A final construct of the "new" board–executive partnership is the mindset of continuous improvement. Three specific tools are essential to facilitate the mind-set:

Thorough orientation: director candidates and new directors should be thoroughly oriented to the roles, responsibilities, duties, performance expectations, and time requirements of being a board member. Each candidate should sign a pledge of commitment prior to final consideration.

Constant education: It goes without saying that directors new to the industry need to become quickly educated on the issues. Not withstanding a basic foundation of learning, all directors, rookie or senior, should stay on top of the issues, be expected to read publications outside of the board packet, attend relevant educational conferences, and participate in annual board retreats.

Continuous evaluation: Most boards of directors conduct annual or bi-annual board self-evaluations. A far fewer number actually implement change as a result of the results. Even fewer evaluate the performances of individual board members (just 26% of boards are doing this today, although an encouraging 35% are considering it). The CEO and executive team members are always individually evaluated and their compensation set accordingly. It is therefore essential that to continuously improve, both partners (board and CEO) need to be evaluated and, more importantly, counseled to improve—or be asked to leave. Having the right partners "on the bus" can only be accomplished through continuous and critical evaluation.

Public Accountability for Quality and Community Benefit

Barry S. Bader
President, Bader & Associates

Over the past year, the IRS has ramped up its attention to not-for-profit organizations—especially hospitals and health systems—focusing on issues such as board conflicts of interest, executive compensation, and community benefit. State attorneys general have targeted a growing number of not-for-profit boards over alleged failings of oversight, including high-profile cases involving The Getty Trust and Allina Health System. The Joint Commission has announced stronger standards for organizational leadership.

The changing environment was captured by Stephen T. Miller, commissioner of the Tax-Exempt and Government Entities Division of the IRS before a House Ways and Means Oversight Committee: "…it is important for the IRS to act as the 'cop on the beat' to ensure that charities behave in accordance with their charter and the privilege of tax exemption. As the tax-exempt sector grows larger, wealthier, and structurally more complex, the line between charities and the commercial sector blurs, as businesses try to act like charities in order to reap the benefits of tax exemption and as charities engage in businesslike activities in order to raise funds for their activities."

The financial and competitive pressures facing hospitals make the balancing act between mission and financial viability more difficult than ever. Yet, an increasingly demanding public, backed by a growing army of regulators, public policymakers and the news media, is watching to hold voluntary hospitals accountable for their legal and moral obligations to the community.

Boards in the Spotlight

When a corporation or not-for-profit organization stumbles on the public stage, the first question is always, "Where was the board?" Clearly, governing boards of hospitals and health systems will occupy a highly visible role as the primary overseer of the organization's public accountability and quality of care in the future. As independent representatives of the public, trustees need to take their fiduciary duties of loyalty and due diligence very seriously and be transparent in reporting to the public.

Survey results suggest that hospitals and health systems have put into place many necessary oversight policies and mechanisms. But adopting a policy or creating a committee are just first steps. Boards must follow their policies rigorously with a keen sense of the organization's public accountability. Boards that have not yet adopted certain leading-edge practices need to rethink what they are doing.

Quality Oversight

In recent years, boards have clearly enhanced their knowledge of, direction, and oversight of quality and patient safety activities. The survey shows that the number of respondents reporting they have a board-level quality committee rose to 64% in 2007 from 56% in 2005. Most quality committees meet monthly or every other month. More than 90% of boards are using quality performance measures such as dashboards and balanced scorecards to track organizational performance and highlight areas needing corrective action.

More than 70% of boards are participating in the development of criteria for medical staff selection and reappointment, are reviewing quality related performance criteria before they approve new clinical programs or services, and are evaluating their CEO's performance based in part on the achievement of goals for clinical improvement or patient safety.

In the face of research showing that spending at least 25% of board time on quality is associated with higher organizational performance on quality indicators, some 67% of boards say they are devoting a significant amount of board meeting agendas to discussion of quality issues, and another 26% are considering increasing the time they spend.

Beyond these baseline practices that virtually every board with quality oversight responsibilities should follow, the survey shows that a number of other practices appear to be underutilized. For example:

Taking charge of the quality agenda. Only about half of the respondents said the board and the medical staff are at least as involved or more involved than management in setting the agenda for the board's discussion of quality. Although governance work should be supported by management, the board cannot be passive and reactive. Board and clinical leaders must play an equal role with management in setting the organization's priorities.

Requiring transparency. Only about 40% of boards have adopted a policy that requires the organization to report its quality and safety performance to the general public. In an era of greater transparency and consumer-driven purchasing based on both price and quality, boards must ensure their hospitals openly report their results and tell their stories to their community.

Perfection, not incrementalism. The fact that a hospital reduced preventable errors by 10% over the prior year is little solace to the patient suffering from a drug error or preventable injury this year. Yet, only 61% of boards say that they require management to base at least some of the organization's quality goals on the "theoretical ideal," not just incremental improvement. Some hospitals that have targeted "perfection," such as "*zero* central line infections" and "*zero* bloodstream infections," are in fact achieving those results. By adopting stretch goals, leadership challenges the organization to reject mediocrity. Using such methodologies as Six Sigma, Toyota's Lean Production System, and IHI's best practice bundles, these hospitals are eliminating root causes of chronic errors and nearing "perfect performance."

Community Benefit

America's hospitals provided more than $27 billion in uncompensated care and served as a safety net for more than 46 million uninsured people in 2005, according to the American Hospital Association. Yet, not-for-profits are under unprecedented scrutiny over charity

care, billing practices, and the fulfillment of their community benefit obligations.

Governing boards have responded by paying more attention to community benefit, but these efforts are just beginning. Significant increases are needed with regard to the following board practices:

Community benefit policies. Just 43% of respondents have adopted a policy on community benefit that:

- Clearly states the organization's commitment to the community
- Clearly defines community benefit and describes a publicly understandable methodology for measuring it
- Establishes a process for board oversight of community benefit

Formal evaluation. Just 41% of respondents assess the organization's community benefit performance against goals, such as whether community benefit activities exceed the value of the organization's tax exemption or represent a reasonable share of the organization's expenses. Not-for-profit hospitals' performance on community benefit varies widely: the IRS released an interim report in 2006 on community benefits provided by almost 500 tax-exempt hospitals. The mean (average) community benefit expenditure, as a percentage of the individual hospital's total revenues, was 9%, and the median was 5%. In all, the 500 hospitals reported some $9.3 billion in benefits, no small sum. However, about 22% of hospitals reported 1.9% or less of their total revenue spent on community benefit, while another 27% hospitals reported 2% to 4.9%.

Annual reporting. Some hospitals do a great job for their communities but are bit too humble about it for their own good. Just 56% of boards have adopted a policy requiring management to make an annual report on the value of community benefit services provided to the general public. In addition, requiring public disclosure tends to spur efforts to enhance performance and look as good as possible.

Public Transparency

It's clearly time to raise the curtain on what not for profit boards themselves are doing to fulfill their fiduciary duties. Only 32% of boards have adopted a policy on information transparency, requiring that the organization report to the public in understandable terms about its quality, safety, pricing, and customer service. The choice is clear: the board can allow the government, private Web sites, and the media to assess its performance based on publicly available data, or the board can instruct management to take the initiative. The better choice is to communicate accurately and comprehensively with the public and use public transparency as a motivator for internal improvement.

Showcasing Governance on Your Web site

One of the most encouraging not-for-profit organization practices, although it wasn't measured in the survey, is the use of the organization's Web site to make governance itself more transparent. Some hospital and health system Web sites tell the public who's on the governing board, their qualifications, and how the board's processes work to oversee financial audit, executive compensation, community benefit, and board conflict of interest. Web sites increasingly include and explain the organization's IRS Form 990 as well as its quality and patient safety performance results and community benefit activities of health promotion, disease prevention, medical and health professional education, community development, and charity care.

Organizations that tell their story on the Internet clearly "get" what the new era of public accountability and transparency is all about. The time of not-for-profit boards toiling effectively but silently is over. If your organization is doing the right thing but not *demonstrating* transparently to the public that it is, it's tantamount to not doing it at all.

Governing boards of hospitals and health systems have a lot to be proud of. They need to adopt the policies and practices that put their best foot forward.

Ensuring Strategic Focus

Pamela R. Knecht
Vice President, **ACCORD** LIMITED

According to the fiduciary duty of oversight, every board is responsible for formulating strategy and then monitoring the organization's performance vis-à-vis that strategy. And yet, recent governance improvement efforts at many not-for-profit organizations have not paid sufficient attention to this crucial responsibility. This assertion is supported by the results of The Governance Institute's 2007 biennial survey. Over 25% of the survey respondents rated their board's overall performance in setting strategic direction as only 'Good,' 'Fair,' or 'Poor.' In fact, the only areas in which they scored themselves lower were board self-assessment/development and advocacy. This is an unacceptably low level of performance for such an important board responsibility.

Strategic Meetings

One would think that if a board rated itself low in strategic direction-setting, it might attempt to spend more time discussing strategic issues in its meetings. However, only 32% of board meeting time is spent discussing strategy and policy, virtually the same result as the 2005 survey (31%). Boards continue to spend 53% of their meeting time listening to reports from management and committees.

Another way to look at this issue is that 74% of the responding organizations spend 40% or less of the time in their board meetings on strategy. The percentage is even higher for government-sponsored hospitals—81%. (City/county/district hospitals may spend less time in their board meetings on strategy because of an open meeting forum.)

The real conundrum is that again this year, as in 2005, survey results confirm that the more time a board spends discussing strategic issues, the better the board itself performs. It seems that more boards should be connecting the dots—boards perform better if they spend more time on strategic discussions, so change the board meeting agenda.

Boards should take the bold step of developing a master board calendar that identifies the strategic issues or decisions that need to be addressed at each point during the year. They should then ensure that they receive education on that topic one or two months before the decision is to be made. At least a week prior to the board meeting, they should receive a packet that includes the relevant background material as well as an executive summary that frames the strategic issues/decisions. The packet should also contain an agenda that states that at least half of the meeting time will be spent in discussion related to the relevant strategic issues.

An effective technique for freeing up time on the agenda for these strategic conversations is to use a consent agenda. Interestingly, 62% of the respondents use a consent agenda. The relevant question may be how has the "found" time been utilized? Are more verbal reports from management added? Or has the time been reallocated for strategic and policy discussions?

Boards should use consent agendas to handle routine matters with one vote, so that more time is available for discussions about strategy and policy issues. They should also spend a majority of their time in discussion and debate, as opposed to listening to reports. Ideally, verbal reports of packet materials should be forbidden.

Engagement in Strategic Planning

Almost all respondents (95%) said the board "is actively involved in establishing the organization's strategic direction, such as creating a longer-range vision, setting priorities, and developing/approving the strategic plan." This statistic is promising—in this day of increased board transparency and accountability, it no longer seems sufficient for a board to simply "approve" a plan.

Boards should be actively engaged in helping management to develop the components of the strategic plan, which describe what will be achieved (e.g., mission, values, vision, and strategic goals). Boards should then allow management to determine how the vision and strategic goals will be accomplished.

Many boards use a strategic planning committee as a means of becoming engaged in strategy development. According to the survey, over 57% of respondents now have such a committee. That is a significant increase since the 2005 survey, when the number was 44%. This could be a sign that boards are becoming increasingly aware of their need to become more focused on and engaged in strategic planning.

Boards should be careful not to become overly dependent on a strategic planning committee to do their work. It may be better to ask the strategic planning committee to function as a steering committee that oversees the entire process and ensures that key stakeholders (including the full board) are appropriately engaged in making strategic decisions. This would ensure that all board members, not just some, understand the critical strategic issues and support the final decisions about resource allocation.

It seems that too few boards take the time to thoroughly discuss and document exactly how and when they will be involved in the strategic planning process. Only 40% of respondents have adopted policies and procedures that define how their strategic plans are developed and updated. Not only is this indicative of boards' lack of clarity about their own role, it throws into question whether boards are providing sufficient oversight regarding management's development of the strategic plan. Even more frightening is the fact that 30% of respondents are not only without such a policy; they are not considering developing these written expectations.

Boards should take their strategic direction-setting oversight role seriously and create a formal, written board policy that clearly articulates their expectations of the strategic planning process and outcomes. This practice helps the existing players clarify their roles and ensures that when there is a change

in board or management leadership, the approved approach to strategic planning will be retained.

Strategic Alignment

One key factor in the successful implementation of the final strategic plan is total alignment between that plan and all other plans in the organization. Therefore, it is heartening to learn that 91% of boards require that the organization's strategic and financial plans are aligned; that 96% of boards consider whether new projects adhere to the organization's strategic plan before approving them; and that 98% of boards reject proposals that put the organization's mission at risk.

Boards should continue this level of rigorous oversight of plan alignment and attention to the mission.

However, it seems that too many boards are viewing alignment as management's job, not theirs. Only 44% of respondents set annual goals for board and committee performance that support the organization's strategic plan. Another 29% are considering or working on this practice, but over a quarter of the responding organizations are not even considering setting goals for themselves in support of the strategic plan.

If boards are going to be serious about fulfilling their legal duty to help management accomplish the mission and vision of the organization, they must put some skin in the game. Boards must set goals for management and themselves and then have the courage to hold everyone accountable for achievement of the agreed-upon strategy.

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