



Emerging Standards for Institutional Integrity: A Tipping Point for Charitable Organizations

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The Governance Institute

This white paper was developed for members as part of The Governance Institute's service providing board development tools to continually improve the effectiveness of boards of directors in America's best healthcare organizations.

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The Governance Institute provides information services for boards and executives of healthcare organizations. Its purpose is to improve the effectiveness of hospitals and healthcare systems by continually strengthening their boards of directors, medical leadership, and management performance.





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Table of Contents

1	Introduction: Institutional Integrity
3	Passing Fad or Permanent Landmark?
	1. A Growing Voluntary Sector Faces Increased Scrutiny of Its Performance and Integrity
	2. Not-for-Profit Hospitals Are Experiencing Challenges to Their Tax-Exempt Status
	3. Initiatives to Make Providers' Clinical Quality Results and Prices More Transparent Are Gaining Traction
	A Preponderance of Evidence
	Taking the Initiative
11	Recommended Practices: Inoculating Your Organization
	Measuring and Demonstrating Community Benefit
	Financial Integrity, Transparency, and Corporate Compliance
	Oversight of Executive Compensation
	Conflicts of Interest and Director Independence
	Transparency of Quality, Safety, Customer Service, and Pricing Information
	Governance Practices and Board Culture
	Frequently Asked Questions
31	Choosing Your Board's Strategic Response
35	Conclusion: An Opportunity for Generative Governance
36	References

Introduction:

Institutional Integrity

Dictionary Definition of Integrity:

1. Firm adherence to a code of especially moral or artistic values, i.e., incorruptibility;
2. An unimpaired condition: i.e., soundness;
3. The quality or state of being complete or undivided, i.e., completeness.

One Institution's Definition:

"Faithful pursuit of the institutional mission, compliance with local, state, and federal laws and regulations, and responsiveness to the needs of students, faculty, staff, and other constituents are top priorities of the administration."

—*Iowa State University*

An Outside View:

"In my experience reviewing charities that have failed their mission, poor board governance unites them all."

—*Senator Charles F. Grassley, Chairman,
U.S. Senate Finance Committee*

In a Few Words:

"Do the Right Thing."

—*Spike Lee*

Board members of not-for-profit organizations can be excused for feeling like they are the victims of a bad April fool's joke. In return for devoting hundreds of hours of free time every year and donating generously to their institutions, boards face a skeptical public and doubting governmental officials who question their motives, community commitment, and even their competence. Once a source of pride, now serving on the board of a charitable organization is fast becoming a burden.

In recent years, the governing boards and executives of not-for-profit organizations have faced an onslaught of challenges to their legitimacy as tax exempt, charitable institutions. Some of this is an extension of the Sarbanes-Oxley Act, passed in 2002 to restore public and shareholder trust in the integrity of corporations' financial statements and business conduct. The act set new standards for governance accountability, independence, effectiveness, and transparency. Although most provisions apply to publicly owned companies, not charitable organizations, public officials are asking why much of Sarbanes-Oxley should not be extended to the not-for-profit sector.

Amidst heightened scrutiny of charitable organizations, hospitals have attracted a good deal of criticism—some deserved, much not. Hospitals and health systems have been

accused of gouging uninsured patients, scrimping on charity care, overpaying executives, engaging in self-dealing with trustees, building lavish edifices with community dollars, doling out perks to executives, and concealing their clinical quality, medical mistakes, and prices from public view. They've been sued, audited, surveyed, fined, and pilloried in the media. Some were pressured into making "payments in lieu of taxes" (PILOTs) to local governments. The good works of the many have been obscured by the well-publicized, alleged misdeeds of a few.

The first impulse of mission-driven executives and boards is to bristle with anger at critics who ignore the millions spent on charity care, community service, and health education. However, we believe it is wiser to follow the counsel of Max De Pree, former corporate executive turned leadership sage, who wrote "the first responsibility of a leader is to define reality."

Today's reality is both public companies and not-for-profit enterprises exist in an environment of increased public accountability and transparency. They ignore rising expectations at their own peril.

Passing Fad or

Permanent Landmark?

Untill, it's reasonable to ask just how seriously to respond to the attacks on not-for-profit hospitals. Are they a short-term phenomenon, or are these challenges the harbinger of new, higher performance expectations? The question is important because gearing up to meet uncertain accountability and transparency standards could be a costly proposition.

If the attacks on not-for-profits are just a fad—the byproducts of opportunistic politicians and sensation-seeking news media—then CEOs and boards may be safe to respond in a targeted fashion, double-checking compliance with current law and marshalling public relations strategies to tell their stories. After all, it's a good story: millions of dollars reinvested in community service, charity care, teaching, and research, with compassionate, high-quality care delivered 24/7 to the most vulnerable members of our society. What other institution is expected to deliver cutting-edge quality services equally to those who can and can't pay?

Until now, the challenges to tax exemption, external scrutiny of not-for-profit hospitals' conduct, and public disclosure of hospitals' quality and prices have been viewed as isolated developments. We believe they are connected. The common strand is institutional integrity.

On the other hand, if the attacks on hospitals' charity care policies, executive pay practices, and trustee conflicts of interest, and the demands for greater disclosure of quality, safety, and pricing information have staying power, they may signal a trend that is approaching a tipping point.

We think a compelling case can be made that the tax-exempt sector generally and hospitals specifically are seeing signs of a fundamental shift in societal expectations. We advance three reasons:

One

A Growing Voluntary Sector Faces Increased Scrutiny of Its Performance and Integrity

It's not just hospitals. All stripes of charitable enterprises are being questioned about how they use donations and other funds and fulfill their commitments to society.

The tax-exempt sector constitutes a large and growing component of the American economy. Charitable organizations deliver a wide range of social services ranging from education, housing, food programs, and safety net healthcare to offerings in the arts, recreation, and scientific research. For their good works, not-for-profit organizations are eligible to receive a tax exemption from the federal, state, and local governments under each entity's laws and regulations.

More than 1.6 million tax-exempt organizations in the U.S. accounted for \$7.3 trillion in total revenues or nearly 7 percent of the national income in 1998, according to Independent Sector's most recent Almanac. Not-for-profit organizations employ 11.7 million paid staffers, 9 percent of the entire national workforce and more workers than the finance, insurance, and real estate industries combined, according to Independent Sector.

In some communities without a broad industrial tax base, not-for-profits represent a double-edged sword: a valued source of jobs and community services on one hand, but also, land and assets that are exempt from taxation to support local government services. In addition, individuals make an estimated \$207 billion in contributions to charitable organizations; corporations and private foundations add another \$41 billion. Charitable contributions to health-care providers increased by a record 16 percent in fiscal year 2005 to \$7 billion, according to the Association for Healthcare Philanthropy.

Clearly, the federal and state governments have a legitimate obligation to oversee the appropriate use of tax-exempt status and charitable donations.

Every profession has its scoundrels and “wastrels.” Similarly, abuses or lax oversight in the voluntary sector are not new. Over the past 20 years, for example, the United Way lived through a scandal involving a high living CEO, the U.S. Olympic Committee weathered several scandals, and the New York State Board of Regents replaced almost all the trustees of Adelphi University for conflicts of interest and lax oversight of the president’s pay.

Since 2001, however, not-for-profits have faced more intense scrutiny and calls for tougher external controls. Consider:

- The 120-year-old American Red Cross had to defend itself for allegedly using targeted donations—after the terrorist attacks on September 11, 2001 and again after the Asian tsunami in 2004—for other programs and administrative costs. In 2005, after press reports charged that the Red Cross received \$568 million in donations for Asian tsunami relief but only spent \$167.6 million, the Senate Finance Committee asked for detailed information about the organization’s grant programs, executive compensation, and board practices.
- In 2003, a series of reports in *The Washington Post* charged the Nature Conservancy with improprieties in the organization’s land transactions and its dealings with trustees and supporters that allowed them to take allegedly inappropriate income-tax deductions. The Senate Finance Committee launched an investigation, and the Nature Conservancy—while arguing the newspaper articles were not entirely accurate—made extensive changes to strengthen its governance, accountability, and transparency.
- In 2004, California adopted the Non-Profit Integrity Act designed to minimize accounting abuse by charitable entities and to provide operational oversight for charitable entities similar to the Sarbanes-Oxley Act. Among its provisions, charitable organizations with annual gross revenues in excess of \$2 million dollars must make audited financial statements available to the public, have an audit committee that is separate from the finance committee, and have the compensation of the CEO and CFO approved by the board of directors.
- In 2005, the IRS tightened oversight of tax-exempt credit counseling agencies, which are supposed to help

individuals facing bankruptcy. Audits found many credit counseling agencies had become “a big business dominated by bad actors,” according to the IRS. “... These organizations have not been operating for the public good and don’t deserve tax-exempt status. They have poisoned an entire sector of the charitable community.”

- In 2005, American University in Washington, D.C. won unwanted national publicity over revelations it had paid for inappropriate expenses by its president, including a 13-course engagement dinner for his son. After the president was dismissed with a multi-million dollar severance payment, Senator Grassley called the university “the poster child” for why reform of not-for-profits is needed.
- In 2006, the California attorney general found that charitable funds given to the J. Paul Getty Trust were improperly used to pay the travel expenses of the foundation’s former chief executive and to buy artwork for retiring board members. The trust is the nation’s third largest foundation with assets of more than \$9 billion. Attorney General William Lockyer appointed a former state attorney general to independently monitor the trust for two fiscal years, “the first time in state history that someone will oversee the dealings of a charitable trust,” according to news reports.
- New York Attorney General Eliot Spitzer sued Richard Grasso, former chairman of the New York Stock Exchange (NYSE), in 2004 for receiving an exorbitant compensation and retirement package (at that time the NYSE was a not-for-profit corporation). In October 2006, the New York State Justice Charles E. Ramos, in a 73-page opinion, found Grasso had failed to fully disclose his \$187.5 million compensation package, which included \$80 million in supplemental retirement (SERP) benefits, to the NYSE’s board of directors. Ramos also criticized the board for lax oversight.
- Some public officials have questioned why not-for-profits shouldn’t face the same standards for financial integrity and accountability as public companies under Sarbanes-Oxley. The Senate Finance Committee and House Ways and Means Committee asked Independent Sector, a respected coalition of not-for-profits, to study the question. A landmark report called for a range of legislative changes and voluntary reforms in charitable organizations’ accounting, public reporting, and board practices.

Many not-for-profit hospitals and health systems are not waiting. They have already adopted relevant Sarbanes-Oxley practices. A study done by the American Hospital Association in 2004 found that 75 percent of health systems and 55 percent of hospitals had conducted a formal review of new rules under Sarbanes-Oxley and the Securities and Exchange Commission. Many had implemented new procedures, such as 70 percent that reported a new policy requiring the board or a board committee to engage and supervise the work of the external auditor.

Tina

Not-for-Profit Hospitals Are Experiencing Challenges to Their Tax-Exempt Status

Challenges to hospitals' fulfillment of their public accountability also are on the rise and are coming from a wide range of influential sources:

- Various rules in the Internal Revenue Code prohibit "private inurement," i.e., any portion of the value of a tax-exempt organization benefiting an individual. Not-for-profit hospitals that violate these rules risk losing their tax-exempt status.
- The Internal Revenue Service, which grants federal exempt status, has ramped up its oversight. In May of 2006, the IRS sent out "Compliance Check Questionnaires" seeking detailed information about hospitals' uncompensated care policies, community care programs, compensation practices, and board organization. The IRS is also broadening the information required on Form 990 on which not-for-profits report their activities—and which then becomes public information.
- The IRS also has tightened its requirements for oversight of executive compensation. The so-called "Section 4958 intermediate sanction rules" impose harsh penalties (short of loss of tax-exemption) if a not-for-profit abuses the public trust by sanctioning excessive pay or self-dealing by executives or trustees.
- State governments have cast an eye on whether not-for-profits deserve local tax breaks. Illinois officials revoked the tax exemption of a hospital (see Provena Loses Tax-Exemption Status on page 6), and a Massachusetts clinic lost its exemption over practices common in many hospitals, such as contracting hospital-based services to private physician practices.
- Minnesota's Attorney General Mike Hatch charged Allina Health System in 2001 with, among other things, over-spending on executive bonuses, benefits, and "perks" such as golf outings.
- Ohio's Attorney General has proposed new rules requiring not-for-profit organizations to file community benefit reports using standardized criteria. Hospitals and nursing homes would be required to disclose whether they follow "fair billing and collection practices." Those that don't adhere to recommended policies on conflict of interest and oversight of executive compensation would be required to explain why.
- Hospitals' charity care practices also have drawn fire. Class action lawsuits—a majority brought by Richard Scruggs, a lead plaintiffs' attorney in the tobacco litigations—have accused hospitals of overcharging poor patients and failing to advise them of charity care policies that would have reduced their bills. These actions are alleged to be a violation of hospitals' fiduciary duty to patients and state consumer fraud laws. While judges dismissed most of the suits as groundless, a few systems have signed costly settlements while not admitting guilt. For example, in 2004 a health system in Mississippi agreed to change its charity care policies, make refunds to patients, and adopt governance reforms and new conflict-of-interest rules modeled on Sarbanes-Oxley.
- In some states, local governments in financial duress have challenged the property tax exemptions of community hospitals or all not-for-profits. Some hospitals have agreed to make "payments in lieu of taxes" (see PILOT Programs Extract Taxes from Not-for-Profits on page 6).
- Some labor unions curry public favor by portraying hospitals as greedy corporations that misuse their tax status. In May 2006, a union-funded group won media coverage declaring Cook County hospitals received \$352 million in tax benefits from their charitable status but provided just \$105 million in charity care. The Illinois Hospital Association countered with an analysis valuing hospitals' community benefits at \$1.5 billion. In California, under prodding from the Service Employees International Union, San Francisco's Public Health Director alleged a large health system and one of its hospitals received 22 times more in tax breaks than it provided in charity care in 2003. The attack ignored the system's other community benefit services, which it valued system-wide at \$814 million in 2004.

PILOT Programs Extract Taxes from Not-for-Profits

Without much national notice, a number of not-for-profits have agreed to make “payments in lieu of taxes” (PILOTs) to support local governments and pay for services they benefit from. For example, despite fulfilling tax-exempt criteria in state law, a hospital in Erie, PA has paid more than \$3.5 million during the past six years to the city of Erie, Erie County, and the Erie School District under a voluntary PILOT agreement.

In Baltimore, Johns Hopkins Hospital and other non-profits agreed to make PILOTs in 2001 to stave off a city energy tax. They agreed to pay \$20 million over four years, of which Hopkins’ share was \$10.4 million. In 2004, Baltimore replaced new energy and phone levies using PILOTs that will cost Johns Hopkins \$2.1 million a year.

In Boston, a PILOT program began in the 1980s. It covers 43 entities—including public broadcast station WGBH, Boston University, and hospitals including Brigham and Women’s and Massachusetts General—that contribute more than \$12 million a year.

In September 2006, Senator Charles Grassley, chairman of the Senate Finance Committee, said legislation may be needed to set more specific standards for not-for-profits and require them to account for their good works. Grassley didn’t mince words:

“Non-profit doesn’t necessarily mean pro-poor patient. Non-profit hospitals may provide less care to the poor than their for-profit counterparts. They may charge poor, uninsured patients more for the same services than they charge insured patients. They sometimes give their executives gold-plated compensation packages and generous perks such as country club memberships.

All of this calls into question whether non-profit hospitals deserve the billions of dollars in tax breaks they receive from federal, state, and local governments. Unfortunately, it’s almost impossible to get an exact measurement of how much charity care and community benefit, such as vaccination clinics or cancer screenings, that non-profit hospitals offer to earn their special tax status. That’s because non-profit hospitals don’t have to report any kind of information about those activities to the IRS.”

Provena Loses Tax Exemption

Provena Covenant Medical Center in Urbana, Illinois is part of a 6-hospital Catholic health system, Provena Health. In late 2002, the Champaign County Board of Review rejected Provena Covenant’s application for renewal of its tax exemption under the Illinois Property Tax Code. The code requires charitable hospitals to be “actually and exclusively used for charitable and beneficent purposes.”

The Illinois Department of Revenue concurred, citing allegations that Provena overcharged uninsured patients and then aggressively pursued collection, that its charity care program was skimpy, and that it allowed outside companies (e.g. therapy services, pharmacy management, physician groups, and food service) to use hospital space for profit-making activities. Provena appealed, but as the case dragged on, Provena paid nearly \$5 million in taxes to Champaign. While appealing the decision, Provena increased no-cost and discounted services by 40 percent, revised its billing and collection techniques, and advertised the availability of financial assistance in local newspapers and within the hospital itself.

In October 2006, the Illinois Department of Revenue rejected Provena’s final appeal and affirmed the revocation of its property tax exemption. The department’s reasoning may be instructive for other hospitals because it compared Provena Covenant’s charity care with the value of its local tax exemption. The ruling calculated Provena Covenant’s charitable spending at \$832,000, or 0.7 percent of total 2002 revenues, compared to its property tax exemption, which it valued at more than \$1.1 million. In addition, the ruling said Provena failed to ensure that for-profit providers observed charity care policies when they provided services under contract for the laboratory, radiology, and so forth. Finally, the ruling faulted Provena’s sliding scale for discounts for the near-poor, saying that since discounts were calculated off “inflated” charges, impoverished families could still face huge bills.

William Foley, Provena Health’s CEO, adamantly defended Provena’s integrity. “This goes against over 100 years of legal precedent supporting non-profit hospitals as charitable institutions,” he was quoted as saying in the *Chicago Business* journal.



Three

Initiatives to Make Providers' Clinical Quality Results and Prices More Transparent Are Gaining Traction

Rising healthcare costs and concerns over medical errors and variances in quality have triggered a rising drumbeat for greater transparency of information about hospitals' and physicians' quality and prices. For example:

- Publicly available information on the quality of clinical care is growing geometrically. The Centers for Medicare and Medicaid Services (CMS), the Joint Commission, several state governments, and private companies such as Health Grades publish hospital outcomes data on the Internet. A recent California report ranked California hospitals on cardiac bypass surgery for the first time.
- CMS plans to begin publishing patient satisfaction scores.
- Legislation passed in 2005 would require hospitals to report medical errors to a national patient safety data-bank.
- In August 2006, President Bush signed an executive order requiring the Department of Health and Human Services, the Department of Defense, the Veterans Administration, and the Federal Employee Health Benefits Program to compile and share quality and price information. The order is intended to align federal agencies with the goal of providing information to help consumers make informed healthcare decisions.
- The black box of hospital billing is being opened. Proposed federal legislation would require hospitals to disclose their prices or charges and to estimate what patients with insurance would actually pay out of pocket. Sentiment is growing that hospitals ought to disclose their prices, give patients advance estimates of the bills, and make bills understandable, and the American Hospital Association has endorsed increased provider transparency.
- Some hospital associations, including South Dakota and New Mexico, are proactively launching price transparency initiatives.
- CMS has published what it pays for 30 common elective procedures and other hospital admissions, complementing its Hospital Quality Alliance, which publishes data on 17 clinical quality measures.

Cynics say all this transparency has little impact, arguing medical care is too complex for consumers to pick hospitals and doctors the way they comparison shop for cars or televisions. Consumers can't evaluate quality, they say, so patients must rely more on advice from doctors, family, and friends to select a provider than on outcomes data. Skeptics add that consumers lack financial incentives to shop around for lower-priced, high-quality providers or to use comparative pricing data to negotiate a lower fee.

On the other hand, the breadth and precision of quality and pricing data are better than ever. Quality data are easier for consumers to understand. Health insurance plans with cost-saving incentives are growing, albeit slowly, and some employers are helping workers access and interpret quality data. CMS pioneered the use of the Internet to help Medicare patients estimate their drug costs. Some providers are publishing their quality scores and prices on their Web sites, putting pressure on competitors to follow suit.

Nothing is more important than one's health, and health costs are often a family's largest expenditure after housing. It is hard to believe educated consumers will not avail themselves of every resource they have to make better informed choices. The growing transparency of quality and pricing information may or may not revolutionize healthcare, but it already has required providers to ramp up their internal improvement and public communication strategies.

A Preponderance of Evidence

When a few seemingly isolated events take hold and spread new ideas like a contagious epidemic, they have tremendous power to alter traditional rules, writes Malcolm Gladwell in *The Tipping Point*. “Little causes can have big effects,” he writes. “That one dramatic moment in an epidemic when everything can change all at once is the tipping point.”

Until now, the challenges to tax exemption, external scrutiny of not-for-profit hospitals’ conduct, and public disclosure of hospitals’ quality and prices have been viewed as isolated developments. We believe they are connected. The common strand is institutional integrity.

We believe that, viewed in their totality, the progression of litigation, hearings, media reports, regulations, Web sites, and industry best practices form a preponderance of evidence that more explicit standards of institutional integrity have arrived as permanent obligations in an era of public accountability and transparency.

Tax exemption and community trust can no longer be taken for granted. Hospitals and health systems must be prepared to demonstrate that they re-earn the public trust every day. Not-for-profit leaders need to deepen their understanding of the forces at work and frame a proactive strategic response.

Taking the Initiative

Many respected not-for-profit organizations have concluded that a proactive strategy is superior to circling the wagons or ignoring external challenges.

In July 2004, a survey of the nation’s 101 largest health systems by The Governance Institute found that 86 percent had adopted changes consistent with the Sarbanes-Oxley Act. In a research poll administered by The Governance Institute and published in September 2006, among 117 responding hospitals and health systems:

- 90 percent say they conduct a regular calculation of the community benefit provided by the organization.
- 65 percent have “increased their charity care eligibility level.”
- 72 percent advertise the availability of financial assistance with posters in the emergency or admitting areas.

- 74 percent say the full board receives detailed information about executive compensation in either executive or open session.
- 51 percent say they publicize their quality results to the general public.

The sample size was small, and may have been biased by self-selection of early adopters to new standards for institutional integrity. However, we think the results show that at least some hospitals and health systems are responding to calls for a proactive institutional integrity strategy.

The Governance Institute has long recommended the use of best practices to promote effective, transparent, and accountable governance, as well as reduce potential liability from external scrutiny. As a recent compilation of highly recommended practices by The Governance Institute states, “adoption of and adherence to best practices may reduce a non-profit corporation’s exposure to potential state and federal corporate, charitable trust, and tax challenges.”¹

Two respected alliances of not-for-profit organizations—BoardSource and Independent Sector—recommend that “(N)on-profit leaders should look carefully at the provisions of Sarbanes-Oxley, as well as their state laws, and determine whether their organizations ought to voluntarily adopt best governance practices, even if not mandated by law.”²

The American Hospital Association has established model guidelines for billing and collection policies. The Catholic Health Association and VHA developed standards for defining, measuring, and reporting community benefit that have been widely embraced by hospitals and endorsed by Senator Grassley.

Many hospitals have used the new environment as an opportunity to tighten procedures and publicize their good works. Over the past year, The Governance Institute asked its member CEOs how they are experiencing and dealing with accountability and transparency, and what they’d like to know to help them respond.

Candidly, some CEOs are angry at how much it’s costing to defend unsubstantiated lawsuits, complete lengthy, “voluntary” government surveys, and respond to public officials who don’t appreciate the community services the hospital provides. Others are just realistic. One called news stories about executive pay “today’s news and tomorrow’s fish wrap,” but he adds, his entire board knows his compensa-

¹ *Best Practices: Non-Profit Corporate Governance*, Elements of Governance™, The Governance Institute, 2005.

² BoardSource and Independent Sector, “The Sarbanes-Oxley Act and Implications for Nonprofit Organizations,” revised January 2006.

tion, which is recommended by a compensation committee of independent directors who are advised by a third party consultant. “I’ve stopped apologizing for my compensation,” he says.

The CEO of a suburban Chicago hospital said he’s on a bank board and is familiar with Sarbanes-Oxley, which he thinks levies “a tremendous tax on the nation’s economy for those that have to fully comply.” Hospitals should proceed cautiously before embracing some costly provisions, such as Section 404 requirements for internal financial controls. However, he thinks “hospital boards should realize Sarbanes-Oxley has essentially arrived for our industry,” along with recommendations for more independent, effective governance from bond rating agencies including Moody’s Investors Service and Fitch Ratings.

Many members told us of positive steps they are taking, such as revising charity care policies, hiring experts to assess their compliance with the provisions of Sarbanes-Oxley, and adopting more stringent standards to ensure

only “independent directors” oversee executive compensation, financial audit, and corporate compliance. The CEO of a small Wisconsin system said his board has discussed Sarbanes-Oxley and decided to adopt “about 40 percent” of the items on a 100-point voluntary checklist from its auditing firm. The CEO of a Pennsylvania hospital thinks the outside scrutiny is merited because some not-for-profits “have lost their way and adopted the accoutrements, style, and manner of big business and forgotten their roots.”

Many also say their boards are looking for direction. They want to know what the law really requires, and what the best practices are.

Institutional integrity, public accountability, and transparency standards are moving targets. Amidst these changes, we will try to answer the most common questions our members raised. Equally important, we will suggest board practices in the form of a series of self-assessments intended to stimulate board self-evaluation, education, and discussion.



Recommended Practices:

Inoculating Your Organization

The governing board is an organization's central instrument of accountability to its shareholders or stakeholders. The board, therefore, is the first stop for assessing and demonstrating the organization's institutional integrity.

Governing boards need to see that their not-for-profit hospitals and health systems are prepared to demonstrate to the public and government agencies that they are meeting or exceeding their community benefit and institutional integrity responsibilities as tax-exempt organizations.

Management and the board's committees for audit oversight and executive compensation need to be transparent in informing the full board of their work. In turn, the board needs to ensure the organization is prepared to demonstrate transparency with external regulators and the public—either proactively or in response to inquiries.

However, we believe that public accountability and institutional integrity should not be viewed as just another compliance requirement. Rather, we believe that mission-driven boards and executives can use external forces as the motivation to assess and reaffirm their community benefit commitments, independent oversight mechanisms, and connections with their communities and primary constituencies.

In this section, we discuss practices that can help boards assess and ensure that their organizations are prepared to demonstrate their institutional integrity. We have grouped the practices around these major headings:

- Community benefit
- Financial integrity, transparency, and corporate compliance
- Oversight of executive compensation
- Conflicts of interest and director independence
- Transparency of quality, safety, customer service, and pricing information
- Governance practices and culture

What follows are the policies and practices we recommend institutional boards examine and tailor to their circumstances. One size will NOT fit all.

We present the practices in a self-assessment format to encourage boards to examine their present policies and activities and identify opportunities for improvement.

Measuring and Demonstrating Community Benefit

In 1969, believing that the recently enacted Medicare and Medicaid programs would make uncompensated care passé, the Internal Revenue Service adopted Revenue Ruling 69-545. It set a broad and somewhat vague "community benefit standard" for hospitals to qualify for tax exemption. In 1991, several House members introduced legislation to set minimum charity care and community service requirements, but the bills went nowhere. Technically, charity care is not a requirement for federal tax exemption.

However, in the last few years, federal as well as state and local officials have upped the ante in a crazy quilt of local tax rulings (e.g., Provena case), legal settlements (e.g., Scruggs lawsuits), Congressional hearings, IRS audits, and media coverage. In the absence of a clear definition and measures of community benefit, hospitals were hard-pressed to defend their good works.

In June 2006, the Catholic Health Association and VHA, Inc. filled the gap with a 142-page report, *A Guide for Planning and Reporting Community Benefit*. The CHA/VHA guidelines say the definition and calculation of community benefit should include:

- Actual costs (not charges or list prices) for charity care and Medicaid shortfalls, but not for bad debt and Medicare shortfalls (the American Hospital Association disagrees on Medicare shortfalls but overall endorses the guidelines)
- Community health education programs such as caregiver training, consumer health libraries, health fairs, and web-based consumer health information
- Healthcare support services such as information and referral services, Ask-a-Nurse, or cab vouchers for low income patients
- Many disease screening and prevention programs

By contrast, the CHA/VHA guidelines say community benefit tallies should not include health education

classes designed to increase market share, earn a profit, or drive referrals only to the sponsoring healthcare organization. Routine discharge planning or enrollment assistance programs designed to increase facility revenue also shouldn't be counted.

"If we say something is a community benefit, we want it to truly be our gift to the community, with no padding. We want these guidelines to be extremely conservative," says Julie Trocchio, CHA's senior director for continuing care ministries.

CHA says more than 90 percent of its member hospitals have formally adopted the guidelines, and Senator Grassley commended CHA's efforts. It is likely that government agencies and courts will use the CHA/VHA guidelines and other sources to sharpen rules for tax-exempt hospitals.

The best defense is a good offense. Boards are the connection between the hospital and its community owners, and directors need to be knowledgeable and exert leadership on community benefit issues. Boards need to be sure the hospital or health system is doing the right things, that it can measure and compare its activities to evolving norms, and is prepared to communicate all that it does clearly and accurately. Although no gold standard yet exists, boards should consider requiring that community benefit services exceed the value of the organization's tax exemptions.

The Community Benefit Self-Assessment includes practices boards should consider to get ahead of the curve.



Table 1

Self-Assessment of Community Benefit Practices

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. The board is educated on evolving standards for community benefit and the organization's activities. (See Questions for a Board Education Session on Community Benefit on page 14.)					
2. The board has adopted a policy on community benefit, including a statement of its commitment, a definition, and a process for board oversight.					
3. The board periodically reviews and, if necessary, revises the organization's mission statement.					
4. The board considers stakeholders' needs during strategic planning discussions, including how proposed programs and transactions would benefit the mission.					
5. The board reviews a community health needs assessment every few years and ensures its findings are incorporated into the organization's strategic planning and community benefit activities.					
6. The board approves an annual or multi-year community benefit plan, including measurable goals.					
7. The board requires management to provide a dashboard-style report to facilitate setting goals and monitoring performance for community benefit.					
8. The board assesses community benefit performance against goals, including whether activities exceed the value of the organization's tax exemption.					
9. The board formally reviews a written assessment of the organization's community benefit or mission-focused activities at least annually.					
10. The board reviews the organization's communications strategy to ensure its community benefits are effectively conveyed to patients, news media, public officials, regulators, opinion leaders, and the general public.					
11. The board documents its discussions of community benefit activities in its minutes.					

Questions for a Board Education Session on Community Benefit

- How do we define and calculate community benefit?
 - How much is spent annually on community benefit, in dollars and as a percentage of net revenues?
 - Do we spend more on community benefit activities than we gain from our tax exemption?
 - How does our community benefit budget compare with other, similarly situated hospitals in our state or region?
 - Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan? Is the plan based on a community health needs assessment? Does the board discuss the assessment? Does the plan target specific, evidence-based areas of community need?
 - Who was involved in developing the community benefit plan? Were community leaders included?
 - How does the hospital participate in community partnerships and/or joint efforts to plan and implement community benefits activities? Are we viewed as a good partner dedicated to community service?
 - How do we keep the community, legislators, regulators, and key opinion leaders informed about our community benefit work? Do we know their perceptions of our efforts?
 - Who on staff directs and monitors community benefit activities, and does this person have the authority and resources needed to do so effectively?
 - How should we as a board monitor community benefit activities? Do we need a community benefit dashboard? Should we review regular progress reports?
 - What can we do to improve our community benefit performance and monitoring activities?
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Financial Integrity, Transparency, and Corporate Compliance

A not-for-profit organization's obligations with regard to financial integrity are derived from its duty of obedience to charitable purpose. The board has an obligation to see that the organization is directing its financial resources to its charitable mission. It therefore must have confidence in the accuracy of its financial statements and compliance with generally accepted accounting principles and ethical standards. It also should have an effective oversight process for the organization's corporate compliance program.

The Sarbanes-Oxley Act, as well as requirements set by the Securities and Exchange Commission and New York Stock Exchange, have raised the bar for public company governance and fueled pressures for parallel changes in the not-for-profit sector. Many not-for-profits have reviewed and decided to adopt practices conforming to some aspects of Sarbanes-Oxley, particularly requirements for independent audit committees and director independence. At least a few large health systems also are following Section 404, which requires a costly process to test and document internal financial controls, but most have determined Section 404 would incur huge costs that outweigh the benefits.

For the time being, not-for-profits can refer to the rules for public companies as a guideline but not an absolute standard in determining appropriate governance practices. However, as external scrutiny builds and more charitable organizations embrace the spirit of Sarbanes-Oxley, a de facto standard for more independent governance of not-for-profits is emerging and intersecting with the requirements for public companies.

Table 2

Financial Integrity and Transparency Practices Self-Assessment

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. The board has created an audit committee comprised entirely of independent directors. (See page 24 for the definition of an independent director.)					
2. The chair or at least one member of the audit committee is a financial expert, ideally with an auditing background.					
3. The audit committee (or other board committee) oversees the external financial audit process, the adequacy of internal control systems, the internal audit function, and if it exists, an enterprise risk management program.					
4. The audit committee's responsibilities are defined in a written charter that the full board updates and approves annually.					
5. The board authorizes the audit committee to engage the outside auditors and if necessary other independent advisers, or to recommend hiring or termination to the board, and to approve the terms of the outside auditor's or other advisers' engagements.					
6. The audit committee meets at least annually with the external auditor, without other management present for a candid discussion of the audit report findings.					
7. The appropriate board committee meets at least annually with the internal auditor, legal counsel, and corporate compliance officer, respectively.					
8. The audit committee recommends, for board approval, policies to provide for the independence of the audit process, including: <ul style="list-style-type: none"> • A policy limiting non-audit services provided by the outside auditor to the organization that could be perceived to compromise the auditor's independence • Policies addressing audit partner rotation, proper accounting treatment of material correcting adjustments, off-balance sheet arrangements, and related party transactions • Policies prohibiting executive interference with the audit process 					
9. The board has approved a code of ethics or code of conduct for directors and officers, including a procedure to protect employees who report ethics violations or concerns to the committee.					
10. The board has adopted a policy requiring it, or a board committee with delegated authority, to approve loans, credit extensions, and incentive compensation arrangements extended to directors and officers of the organization.					
11. The audit committee or another board committee oversees a process to ensure compliance of fund raising practices and the use of charitable funds with governmental rules. (See Audit Committee Models on page 17.)					
12. The board has adopted and monitors a policy requiring that financial information is prepared in accordance with generally accepted accounting principles.					

Table 3

Corporate Compliance Practices Self-Assessment

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. The board is educated about its corporate compliance responsibilities, including the guidelines set by the Office of the Inspector General, U.S. Department of Health and Human Services, for compliance with Medicare and Medicaid payment regulations.					
2. The board has developed and communicated its philosophy and core values on matters of corporate ethics and the expectation that the organization's culture will be based on these principles.					
3. The board is knowledgeable about the organization's compliance plan and its systems for detecting, reporting, and addressing potential violations of law and payment regulations.					
4. The board has established a mechanism composed of independent directors, such as a board compliance committee or an audit and compliance committee, to provide oversight of the implementation and effectiveness of the compliance plan and to perform any other functions delegated by the board.					
5. The compliance committee approves the annual corporate compliance plan, including designation of high risk areas to be audited (e.g., laboratory billing, compliance with HIPAA requirements, information security).					
6. The compliance committee assures that a senior member of management has direct, overall responsibility for the compliance function (i.e., corporate compliance officer) and reports to the compliance committee as well as within the senior management structure.					
7. The compliance committee meets with the corporate compliance officer at least annually without other management present. The compliance committee also has access to general counsel and internal auditors.					
8. The compliance committee ensures that document retention policies and procedures are in place and being followed.					
9. The compliance committee monitors "whistleblower" protections for employees who disclose possible legal violations.					
10. The compliance committee makes an annual report to the full board to keep it apprised of compliance matters affecting the corporation.					

Audit Committee Models

Audit committees should be composed of directors who meet the board's guidelines for independence, i.e., no material economic or other relationship with the organization. There are three common structural models for an audit committee:

- **Combined finance and audit committee.** This model is used by smaller organizations that lack a sufficient number of directors with appropriate expertise to populate both a finance committee and an audit committee. The main drawbacks are that audit oversight work may receive insufficient attention from an already busy finance committee, and that directors who approve financial decisions may lack the objectivity that an audit mindset needs.
 - **Audit committee.** A separate audit committee overcomes the drawbacks of a combined committee, but it creates an additional board committee and requires additional members. Some boards address this by creating an audit subcommittee of the finance committee with a different chair who has audit expertise.
 - **Audit and compliance committee.** In this model, one committee oversees external audit, internal audit, and corporate compliance. Because the committee is comprised of independent directors, it also may be responsible for review of the conflict-of-interest policy, ethical issues involving board members, and transactions with disqualified persons, which are discussed later. Although this model brings a significant workload that may entail four or more meetings a year, we believe that for many organizations, it represents the most effective deployment of board time and talents.
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Oversight of Executive Compensation

For better or worse, executive pay has become a high-visibility issue. In some places, newspapers publish hospital CEOs' salaries using publicly available data from a hospital's own Form 990. Senate Finance Committee Chairman Charles Grassley has criticized the independence of hospitals' board compensation committees, their lax oversight of personal entertainment expenses, and the use of supplemental executive retirement plans (SERPs).

Under IRS regulations, a board is responsible to see that executive pay and benefits are reasonable compared with fair market value and consistent with the organization's charitable mission. In addition, a board is responsible for

Oversight of Fund Raising

Healthcare attorney Michael Peregrine recommends several practices to ensure the organization's fund raising activities comply with IRS and other relevant laws and regulations:

- The board should oversee a periodic review or audit to ensure that donated funds are used in a manner consistent with laws and regulations, the organization's charitable solicitations, and the instructions of donors.
 - The board, or a delegated foundation board, investment committee, or audit committee, should ensure fundraising expenses are consistent with industry standards.
 - The board should ensure that the accumulation of reserves not needed for current activities is consistent with the organization's projected, long-term capital needs and could not be reasonably perceived as excessive hoarding of donated funds.
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attracting and retaining a highly qualified chief executive and senior management team.

The central regulatory guidance for oversight of executive compensation is Section 4958 of the IRS Code. On one hand, it authorizes "intermediate sanctions" in the form of penalties and excise taxes if the IRS finds excessive compensation or self-dealing and misuse of charitable resources by trustees or officers. On the other hand, Section 4958 describes practices for boards to create a "rebuttable presumption" that executive pay is reasonable. These include using third party information on comparable industry compensation and requiring that directors who make compensation determinations are not in a position to benefit personally from these decisions. For example, a director whose law firm is selected by the CEO as counsel for the organization should not serve on the compensation committee.

Executive compensation is a critical, complex, and heretofore confidential matter. In the past, many boards delegated executive pay decisions to either the chairman or a compensation committee. Other directors were unaware of the CEO's compensation and benefits. Some boards were concerned that some trustees—especially physicians—would violate confidentiality and leak the CEO's salary, creating misunderstanding and dissension among those who don't understand the rationale for seemingly high salaries.

Times are changing. In just the last year, two major universities—Vanderbilt University in Tennessee and American University in Washington, D.C.—were embarrassed by national media coverage that found many trustees oblivious to their compensation committees authorizing excessive or questionable compensation for their presidents.

In an era of increased accountability and transparency, many boards are asking if the full board should know and approve the salaries of top executives, or if it may delegate this responsibility to a committee. The full board first should approve a compensation policy or philosophy statement and a compensation/incentive plan that have been developed by the executive compensation committee. These documents may one day be held up to outside scrutiny. They merit more attention than many boards give them.

In The Governance Institute's white paper, *Is the Job Getting Harder? Updated Guidance for the Board's Executive Compensation Committee*, published in October 2006, the authors recommend that the executive compensation philosophy statement should articulate the organization's long-term policy on executive compensation, promote consistency year-to-year, mandate a process that qualifies for the rebuttable presumption of reasonableness under the IRS intermediate sanctions rules, and support the organization's charitable purposes.

Without this context to educate the board, salary figures are orphan data that leave the board ill-equipped to assess whether compensation is reasonable and competitive with the market among comparable organizations. The compensation philosophy should articulate how the compensation

and incentive program furthers the tax-exempt mission and charitable purposes of the organization.

With regard to annual compensation decisions, we believe the compensation committee can bring a recommendation, but the full board should know and approve compensation at the top. A fiduciary board is responsible for and should know the compensation of its top executives. The board may delegate the details of compensation plans, salaries, incentive awards, and contract terms to an executive compensation committee, but it ultimately must oversee the committee's work and review/approve its recommendations. Except in rare circumstances, the full board does not rehash or redo the executive compensation committee's work.

For some boards, this is business as usual—for others, it will be a difficult change. Greater transparency opens a cloistered process to the risks of inappropriate tinkering and breaches of confidentiality. Board education, clear policies, and rigorous enforcement of confidentiality can mitigate the risks. Gradual implementation may be appropriate.

We recognize some will disagree with this recommendation, but we believe a board of directors deserves information that will in short order be in the public domain, available to the press and accessible to regulators and legislators. In an age of accountability and transparency, the board needs to know. With charitable tax status under scrutiny, it's time to open a window to the full board on the work of the executive compensation committee.³

³ For the most recent and detailed information on executive compensation, see The Governance Institute's white paper, *Is the Job Getting Harder? Updated Guidance for the Board's Executive Compensation Committee*, published in October 2006.

Table 4

Executive Compensation Practices Self-Assessment

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. The board is educated about its executive compensation responsibilities, including IRS Section 4958.					
2. The board has created a committee comprised of independent directors to oversee executive compensation, and has established a policy specifying its authority and any decisions that require approval/ratification by the board.					
3. The board approves the charter of the executive compensation committee annually, so that all members are aware of how the committee engages in its work.					
4. The CEO is a non-voting member or attends meetings of the compensation committee to participate in deliberations concerning the senior team, but is not present when his or her compensation is discussed, except to hear the results of the committee's evaluation of the CEO.					
5. This committee engages an independent compensation firm to provide education, advice, and comparability data. The committee also has access to legal counsel and other experts as it deems necessary.					
6. The compensation committee meets periodically in executive session (that is, outside the presence of the chief executive officer) with its independent advisors.					
7. The committee is not a rubber stamp—it is informed and engaged, raising tough questions and exercising rigorous oversight.					
8. The committee recommends to the full board for approval a compensation philosophy and incentive plan that provide a framework for determining executives' base pay, incentives, and benefits.					
9. All elements of the compensation program are fully disclosed to the committee, including the maximum cost of each compensation element.					
10. The compensation committee seeks independent assurances that deferred compensation arrangements, other benefit programs, and any "executive perks" such as automobiles, spouse travel reimbursement, and country club memberships, are consistent with current IRS rules.					
11. The full board reviews and approves the committee's recommendations.					
12. The compensation committee considers the how the public and public officials may interpret its compensation decisions in the context of its community benefit mission.					

Conflicts of Interest and Director Independence

A director has a duty of loyalty to the organization on whose board he or she serves. A conflict of interest occurs when a board member has direct or indirect professional or personal interests that compete with the interests of the corporation on whose board the person serves. For example, a conflict of interest occurs when a director, or a director's immediate family member, employer, or business partner has an economic or other relationship with the organization, a competitor, or another company with which the organization does business.

A conflict of interest can create an appearance of impropriety that can undermine confidence in the ability of that person to act properly in his/her position. No matter how insignificant the conflict may be, it must be acknowledged as a conflict. The board cannot determine that an actual conflict of interest does not exist simply because of its insignificance, or because some members say the conflict wouldn't affect the director's independent judgment. A conflict is a conflict—period.

Having a conflict does not disqualify a person from serving on a board, so long as:

- The conflicts are disclosed.
- The board (or a board committee composed of independent directors) reviews the conflicts and determines that they would not interfere with the director's exercise of his or her duties.
- The organization reviews any business transactions with the director and determines it could not with reasonable effort obtain better terms from a non-conflicted person.
- The board member does not vote nor attend meetings during a vote of such transactions or related matters.
- The board documents all the above in its minutes.

Conflict of Interest Terminology

Disabling guidelines. These guidelines describe conflicts that are so significant that an individual should not be elected to the board, or should be asked to resign if they occur during a director's term. (See Sample Disabling Guidelines on page 25.)

Direct and indirect conflicts. A direct conflict involves the director; an indirect conflict involves his or her family member, employer, business partner, or corporation in which the director is an owner or investor.

Duality of interest. Another way of saying conflict of interest. Lawyers seem to use both phrases interchangeably.

Insiders and outsiders. "Insider" is an IRS term that refers to employees of the organization, such as the CEO, as well as any physicians who treat patients in the hospital or derive financial benefit from the hospital. IRS rules allow not-for-profit boards to up to 49 percent of their membership to consist of insiders.

Interested person. An interested person has a direct or indirect financial interest, or intends to acquire a direct or indirect financial interest at any time during the life of a proposed transaction or business arrangement. A director who is an interested person has a conflict of interest.

Independent board member. An independent director has no direct or indirect, material conflict of interest with the corporation. An independent director has no conflicts or has a conflict of such insignificance (*de minimis*) that it would not be perceived to exert an influence on the director's judgment. What constitutes a *de minimis* and material conflict, respectively, must be defined precisely and in quantifiable terms. (See further definition on page 24.)

The vast majority of hospitals and health systems have written conflict-of-interest policies, usually embedded in the corporate bylaws and separate policy statements. Practically all of them were developed with legal counsel and do not knowingly violate the law.

That's the good news. The "bad" news is that simply following the advice of counsel and complying with the letter of the law, as the board understands it, is not keeping pace with rising public and governmental expectations for director independence as well as new types of conflict-of-interest situations that are emerging.

The Governance Institute's research throughout 2006 uncovered the fact that many boards and CEOs lack the precise understanding of the shifting legal and regulatory concepts related to conflicts of interest and the duty of loyalty. In a research poll conducted in March 2006, The Governance Institute found the following responses:

- Has the board adopted a written definition of an "independent director"?
 - Yes: 23.6 percent
 - No: 62.6 percent
 - Considering/in progress: 13.8 percent
- Has the board developed a written set of "disabling guidelines" that would cause a board member to step down if not met?
 - Yes: 17.7 percent
 - No: 70.2 percent
 - Considering/in progress: 12.1 percent

It is fair to say, "confusion is the norm." Here are a few examples of the situations we are seeing in which the absence of a current, comprehensive conflict-of-interest policy, a definition of an independent director, disabling guidelines, or a procedure for independent review, is causing confusion or putting CEOs in an awkward position:

- A physician who is a principal investor in an outpatient surgery center that competes with the hospital is elected medical staff president, and the bylaws give the president an *ex-officio*, voting seat. The conflict-of-interest policy does not define an economic relationship with a competitor as a conflict.
- An administrative position of vice president opens up, reporting to the CEO, and a director tells the CEO she wants to apply, but doesn't want to resign from the

board for fear of tipping her employer off that she's job-hunting. The CEO checks the conflict-of-interest policy and finds it's vague on whether this potential employment situation is defined as a conflict, and also whether the policy requires the director to resign before applying for the job.

- The board approves a charter for the executive compensation committee requiring that all members are "independent," but it has not defined guidelines for "independence." Some directors whose firms or family members do business with the hospital ranging from \$10,000 to hundreds of thousands of dollars a year say they can be independent.
- Members complete their annual disclosure forms, which are sent to the board chairperson, who himself has a conflict in that his firm does substantial business with the hospital. He says he would not permit directors to vote on transactions in which they have a conflict, but the rest of the board has no idea whether other directors have a conflict or not.
- The CEO would like to get independent legal advice on handling several conflict-of-interest situations involving directors, but the board chairperson herself is conflicted: her law firm is the hospital's general counsel.
- Some directors are uncomfortable that the CEO sits on the board of another not-for-profit organization whose executive director is a member of the CEO's board and compensation committee. The CEO doesn't see this as a conflict because he's uncompensated and the hospital has no economic ties to the other organization.
- A board member is concerned the chairperson may have an undisclosed conflict but doesn't know where to take this concern.
- A director is a partner in a physician group that has an exclusive contract for radiology. She is an excellent director and is elected board chair—which makes her chair of the executive compensation committee. The CEO thinks this is inappropriate but is silent, fearing it will offend her.

We couldn't make up these scenarios—sticky situations are occurring with increased frequency.

Mere compliance with current law and regulations may not be good enough anymore. The long-term damage to the reputation of an institution resulting from an "exposé" in the local or national media focused on the appearance of a board that is self-dealing can affect everything from the ability to maintain philanthropic support to sparking

a disruptive, expensive investigation by the state attorney general.

The recent experience of the Cleveland Clinic (Ohio) offers a cautionary tale. In that case, the number of significant conflicts of interest among many of the clinic's board members triggered government investigations and were reported on the front pages of the local papers, *The Wall Street Journal*, *New York Times*, and the health industry press.

The practices in our self-assessment for conflict of interest and director independence on the following page set the bar fairly high. Some boards may have difficulty following

some practices immediately, such as the requirement for the entire compensation committee to meet the definition for an independent director. Others may quarrel that some practices are not appropriate for reasons unique to the organization. For example, we are aware of one health system that wants to have several employed physicians on its board because it is building an integrated delivery system with its owned physician groups; directors believe giving the doctors a voice on the board has built good relationships. One size, as we've said, does not fit all, but we believe the practices we suggest are an appropriate reference point.



Table 5

Conflict of Interest/Director Independence Practices Self-Assessment

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. The board's conflict-of-interest policy, procedures, and disclosure are reviewed and updated annually, with the advice of legal counsel.					
2. The conflict-of-interest policy and procedures include the following practices: <ul style="list-style-type: none"> Identifies all individuals covered by the policy, including physician directors Defines "actual" and "potential" conflicts of interest, with examples, to ensure that board members are clear about the criteria for reporting current and potential business matters involving the organization Treats both economic and non-economic benefits as potential conflicts Spells out the duty to fully disclose conflicts both annually and immediately if a new conflict arises Includes a definition of an "independent" board member with measurable standards for making the determination (See Sample Definition for Independent Director on page 24.) Contains "disabling guidelines" that define specific criteria for when a board member's material conflict of interest is so great that he or she should no longer serve on the board (See Sample Disabling Guidelines on page 25.) Spells out that intentionally or repeatedly failing to adhere to the conflict-of-interest policy is grounds for removal from the board Provides a safe procedure for any board member, including the CEO, to raise questions concerning an actual or potential conflict situation they are aware of that is not reported on the disclosure forms 					
3. At least a majority of the board members meet the board's definition for "independent" persons.					
4. The composition of the audit and corporate compliance committee is restricted to independent directors, as is the executive compensation committee.					
5. Physicians nominated to serve on the board with a vote receive a thorough briefing from legal counsel on their fiduciary responsibilities, especially with regard to the duty of loyalty, the conflict-of-interest policy and procedures, and the reason why, as "inside" directors, they should not serve on the executive compensation committee.					
6. The board or a board committee composed of disinterested or independent directors (e.g., audit and compliance committee) reviews all disclosures and any other reported instances of a potential conflict of interest, and makes a determination as to the appropriate course of action in each case.					
7. The board requires that all directors receive a summary of members' disclosure forms and any action taken to address the reported conflicts.					
8. The board is educated on Form 990, including the requirements for disclosure of conflicts of interest.					
9. The board has adopted a policy concerning Form 990 reporting and its use as a mechanism for being more transparent with stakeholders concerning its activities					
10. The board approves and monitors a strict confidentiality policy to safeguard proprietary information, corporate assets and business interests.					
11. The board requires management to include governance information on the corporate Web site to facilitate easy public access to the names of board and committee members, the bylaws, structural relationships among legal entities, Form 990, and key board policies, e.g., audit oversight, conflict of interest, management oversight, quality oversight, and so forth.					
12. The board or a board committee conducts a thorough, annual review of the board's policies and procedures concerning conflict of interest and independence of board members.					

A Sample Definition for an Independent Director*

All directors must exercise independent judgment. This definition is intended to help determine which directors who may have a disclosed conflict of interest may serve on the audit/compliance and executive compensation committees, respectively, and for ensuring that the board is composed of at least 50 percent “independent” directors.

To be considered independent, the board of directors must determine that a director does not have any material relationship with the corporation or its subsidiaries, either directly or as an immediate family member, partner, shareholder, or officer of an organization with which the corporation or its subsidiaries has a relationship.

“Immediate family” includes a person’s spouse, parents, children, siblings, mothers- and fathers-in-law, sons- and daughters-in-law, brothers- and sisters-in-law, and anyone (other than domestic employees) who shares such person’s home.

The board will consider the following as guidelines to assist it in determining director independence. Independent directors will:

- a) Not have been employed by the corporation or any of its subsidiaries, nor have an immediate family member who is or has been an executive officer of the corporation or a subsidiary, within the last three years.
- b) Not have been the recipient of, or have an immediate family member who received, more than \$60,000 in direct compensation from the corporation or its subsidiaries, excluding any pension or other deferred compensation for prior services, during any 12-month period within the last three years.
- c) Not be, or not have been in any of the past three years, a board member, partner, executive officer, or employee, or have an immediate family member who is a board member, partner, or executive officer of another organization that makes payments to, or receives payments from the corporation or its subsidiaries, or for property or services in an amount that exceeds the greater of \$60,000 or 1 percent of the other company’s consolidated gross revenues.
- d) Not be an active member of the medical staff, nor have an immediate family member who is an active member of the medical staff.
- e) Have no other direct or indirect relationship with the corporation, a subsidiary, a vendor, another charitable organization or government agency, or a competitor that could reasonably be perceived as a material conflict of interest.

*This sample is a composite drawn from various organizations. Each organization must consider its particular community culture and determine which provisions and dollar thresholds would be most appropriate.

Sample Disabling Guidelines*

Under the following circumstances, a director should consider resigning, or may be asked to resign in the best interests of the organization:

- Repeated, intentional failure to disclose a conflict of interest
- A single but significant, intentional failure to disclose a conflict of interest
- Intentional violation of the organization's confidentiality policy or code of conduct
- Engaging in any external conduct that the board construes may adversely impact the organization
- Serving as a board member, partner, investor, or senior executive of a direct competitor to the corporation or its subsidiaries (not to be construed as barring physicians whose practices offer routine services, such as in-office laboratories)
- Speaking publicly against positions of the board or the best interests of the hospital
- Serving as an employee of the organization, or having an immediate family member who is a senior executive officer for the organization
- Receiving direct compensation for ongoing services provided to the organization (i.e., serving as a "de-facto employee")
- Serving as an owner, partner, employee, board member, or investor of a vendor (professional services, financial institution, or other business) receiving a substantial amount of revenue from the organization—which we define as the greater of \$200,000 or 2 percent of the annual revenues of that vendor in the preceding or current year

*This sample is a composite drawn from various organizations. Each organization must consider its particular community culture and determine which provisions and dollar thresholds would be most appropriate.

Transparency of Quality, Safety, Customer Service, and Pricing Information

The board should ensure that the organization provides consumers and patients with access to information that helps them understand how to access hospital services, obtain financial assistance, and make informed provider choices based on understandable information about quality of care, patient safety, customer service, and prices.

In the September 2006 research poll by The Governance Institute, of 117 responses:

- 48 percent said their organization has seen an increase in requests for pricing information from the general public or private individuals.
- 81 percent attribute this increase to an increase in individuals or families with high deductible health insurance plans.
- 74 percent are taking steps to help the public understand that a listing of prices does not represent their final payment obligation.
- 52 percent are providing patients—before care is delivered to them—with an estimate of what may be due from them after their insurance coverage.
- 58 percent are satisfied that their pricing is rational.
- 46 percent are comfortable and 13 percent are very comfortable explaining their pricing system to the public.
- 51 percent said their organization publicizes its quality results directly to the general public. Of those:
 - 61 percent report quality results from specific initiatives (such as the 100,000 Lives Campaign interventions, CMS core measures, and/or National Quality Forum indicators).
 - 64 percent report patient satisfaction scores.
 - 43 percent report the organization's infection rate, and 39 percent report the mortality rate.

There are no external standards with regard to the transparency of information on quality, patient safety, customer service, and pricing. This presents the board with an opportunity to work with management to develop transparency policies and practices that are consistent with the hospital's mission and values.

Table 6

Transparency Practices Self-Assessment

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. The board is educated about current trends and external requirements for information transparency, including Web sites that provide information to consumers.					
2. The board has approved a policy declaring its commitment to transparency and explaining to the public in understandable terms its performance on measures of quality, safety, and customer service; a reasonable estimate of the prices patients can expect to pay for common services; and the organization's policies and programs for financial assistance.					
3. The board periodically reviews a community perceptions survey and other assessments of the effectiveness of the hospital's initiatives to inform the public about its services, quality, safety, customer service, and prices.					
4. The board has created an effective mechanism, such as a board quality committee, to oversee quality improvement activities.					
5. The committee regularly reviews publicly available information about the organization's quality, safety, customer service and pricing both on its Web site and on Web sites of other organizations, including JCAHO and CMS.					

Examples of Increased Transparency

- Community benefit report: St. Joseph Health System, Orange, CA (www.stjhs.org)
 - Governance information: Getty Trust (www.getty.edu/about/governance/)
 - Quality and safety: University of Oregon (www.ohsuhealth.com/)
 - Executive compensation transparency: Lehigh Valley Health System (PA) (www.lvh.org)
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Governance Practices and Board Culture

An intentional and systematic approach to governance unites all the foregoing practices. Effective governance practices are particularly important in an era of increased public accountability, transparency, and institutional integrity.

A periodic self-evaluation and improvement process using a comprehensive survey instrument, such as The Governance Institute's Board Compass™, is the best way to encourage effective governance. We highlight some of the more important practices in the Effective Governance Self-Assessment.

Table 7

Effective Governance Practices Self-Assessment

To what extent does your board follow the suggested practices below?

Practices	Completely	Partially	A little/ not at all	Don't know	N/A
1. Every director receives an orientation and continuing education on the board's fiduciary duties, core responsibilities, policies, and current legal trends.					
2. The board recruits members based on specific criteria describing the backgrounds, skills, and personal characteristics needed. The criteria include the ability to exercise independent judgment.					
3. The board has a well-defined and objective process for leadership succession planning.					
4. The board, led by its chair and united by a passion for the mission, promotes a culture of accountability, respect, candor, transparency, education, teamwork, and engagement.					
5. The board adopts annual goals, incorporates them into a work and education plan, and develops effective meeting agendas.					
6. The board approves the charters and goals of its committees annually, and it oversees their performance but does not redo their work.					
7. The board reviews a dashboard or balanced scorecard of key performance measures at every meeting.					
8. The board engages in a self-assessment and improvement process at least every two years.					
9. The board routinely evaluates performance of committees, the board chair, and individual directors.					
10. Periodically, the board engages an independent governance expert to assess its policies, practices, structure, and culture.					

Frequently Asked Questions

What are most boards doing in response to the Sarbanes-Oxley legislation?

Many hospitals and health systems have reviewed thoroughly and adopted certain aspects of the Sarbanes-Oxley legislation that applies to publicly traded, for-profit companies. Thus, without being forced to do it, many provisions of Sarbanes-Oxley have become “best practices” in the not-for-profit healthcare industry, such as a stand-alone audit committee, independence requirements, executive compensation oversight, and so forth. It is likely that these provisions will become standard practice in the near term, if they have not already.

Do board policies and procedures pertaining to conflict of interest and standards for independence apply to non-board members who serve on board standing committees?

The short answer is “yes.” This is especially true for those committees that have board delegated decision-making powers. In that case, the non-board committee members should be bound by the same fiduciary duties and board policies that apply to all board members. Furthermore, it is sound practice to instill this expectation in all committee members who do not sit on the board even if the committee is purely advisory in nature.

How should a board deal with the sensitive issue of a board member who has a conflict but has not reported it on the disclosure form?

The best way to address this issue is to distribute a summary report or a set of the conflict disclosure forms to all board members so they know everyone else’s conflicts (if any). Also, the board chair should create the expectation that, if any board member is aware of or has a question concerning another board member’s situation of an actual or potential conflict of interest that was not reported, he or she should raise the question during the board meeting. An alternative would be for the board member to share his or her concerns with the board chair or the chair of the governance committee so one of them can raise the issue.

What does “recusal” mean? Absent from the vote or absent from both the discussion and vote?

It all depends on the matter being considered by the board. In some cases, it is best for the conflicted board member to leave the boardroom at the time the matter comes up on the agenda and not be there for any of the discussion. In some cases, the conflicted board member may have information to share or may be the most appropriate person to answer questions concerning the matter. If this is the case, the conflicted board member can stay for that part of the discussion but not be allowed to “sell” the board on the decision they have to make. In all cases, the conflicted board member should physically leave the boardroom for all or part of the agenda item and the minutes of the board meeting should reflect that the board acknowledged the board member’s conflict and that the conflicted member recused him or herself.

Are hospitals and health systems moving toward a “zero tolerance” conflict-of-interest policy, excluding anyone who does business with the organization from serving on the board?

Most not-for-profit organizations maintain they draw strength from having a board with members drawn from the community or constituencies they serve. To bar all members with conflicts would deprive the organization of directors’ skills in finance, business, human resources, and other fields. Thus, most boards have chosen to upgrade and enforce their conflict-of-interest policy and procedures.

However, a relatively small but growing number of institutions are moving in the direction of banning all conflicts, according to recent research polls done by The Governance Institute. In March 2006, approximately 10 percent of the poll respondents had taken that approach to eliminating any issues surrounding board member conflicts of interest. Interestingly, while a small percentage, that number doubled over the past year, and many more boards are at least discussing the matter.

Are not-for-profit hospitals and health systems obligated to seek competitive bids from vendors, and what role should the board play in selecting vendors?

Unlike units of government, there is no legal requirement to solicit competitive bids from vendors. However, the

board has the authority to create a policy on this issue, if it so desires. The board's role in selecting vendors ultimately depends on the nature and magnitude of the decision. The board usually selects the executive search firm to be used to handle CEO search, and the audit and executive compensation committees usually select the professional firm to assist those committees, respectively. Boards will also get involved in vendor selection if the project represents a large investment for the facility, e.g., replacement hospital architect and contractor, significant information systems investments. The board needs to be careful, however, not to step over the line and meddle in management decisions. Therefore, it is good practice to discuss the kind of vendor decisions that the board feels it should be involved in with the CEO on a routine basis.

If the board follows its conflict-of-interest policies and procedures carefully, how concerned should it be about the appearance of how the board makes its decisions, especially with regard to board members doing business with the organization?

Developing and adhering to a rigorous conflict-of-interest policy and procedures that are based on current recommended practices (not mere compliance with minimal legal requirements) is a must for all boards. Unfortunately, this may not be sufficient to prevent both internal and external publics from being critical of how the board conducts its business. In the current environment of demanding greater accountability and transparency from boards, the board should be extremely sensitive to how a decision "looks" to someone not on the board. The appearance of a conflict can be just as damaging as an actual conflict to the board's reputation. A good question for the board to ask itself when making a decision that entails a conflict of interest is: "If our governance practices were reported in the local newspaper, would we be proud, uncomfortable, or embarrassed?"

Given the rapidly changing and increasingly competitive nature of the relationship between physicians and hospitals/ health systems, how can the board keep physicians involved in governance without compromising on the board's fiduciary duties of care, loyalty, and obedience to mission?

Many boards are dealing with these issues largely in a reactive or haphazard manner. The best practice is for the board to proactively develop a clear set of policies pertaining to physician participation in board and board committee service. Some of the key policy questions that need to be answered are:

- Should physicians be allowed to serve on the board if they have invested in a significant competing business (e.g., specialty hospital, imaging center, etc.)?
- Is it desirable to "manage through" this type of situation with a physician board member or better to not have the person serve on the board?
- Should we allow employed physicians to serve as voting board members?
- Should we consider any private practice physicians who serve on the board to be "independent" board members for purposes of populating the audit or executive compensation committees, or achieving a desirable quota of independent board members?

In our opinion, the best and safest answer to all these questions is "no."

Active physicians on the medical staff are viewed by the IRS as insiders or interested parties which precludes them from being considered independent. Any board member who is an investor/owner of a competing business should be covered by the board's "disabling guidelines" and not allowed to serve in a governance capacity. The same applies to physicians who are employed by the institution. Employed physicians can serve as non-voting board members and on board committees and in some cases, boards have "imported" physicians to serve on their boards from outside the service area.

While the above answers seem clear cut, the process of getting the active medical staff to understand the unique situation they are in vis-à-vis the fiduciary duties of a not-for-profit health care board is of the utmost importance. Boards are advised to begin the education and dialogue with their medical staff leaders sooner rather than later.



Choosing Your Board's *Strategic Response*

The Governance Institute's research conducted earlier this year in surveys and individual interviews found that its members are responding to the challenges of public accountability and institutional integrity in a variety of ways.

Some are doing little, taking a "wait and see" position, hoping that "this too shall pass." These members are concerned that the cry for more accountability and transparency will diminish, and they do not want to disrupt their organizations and expend resources needlessly.

Others have become very aggressive in responding to the issues raised in this white paper and are defining for themselves what "best practice" means without being told by the government or other outside parties.

Most of The Governance Institute's members are somewhere in between the two extremes.

We think that public accountability and institutional integrity are here to stay, but it is not clear how far and how fast these forces will progress. What's more, because some of the pressures come from states and local governments, the pace of change will vary across the country.

Our recommendation is for boards to assess their environment and consider two interrelated variables before deciding what course of action to take:

1. First, the board should assess its risk. How much pressure is the organization experiencing to demonstrate its public accountability and institutional integrity? Is there an activist attorney general? Does the state have a community benefit reporting law? Has any hospital's tax-exempt status been challenged? Do the local media run stories on executive pay? Was the hospital targeted by the Senate Finance Committee or the IRS in their various studies and audits? Are payers driving greater use of publicly available quality and pricing information by consumers? What is the likelihood that these pressures will increase in the next 3–5 years? A candid review of the origin of the pressure (i.e., local government, state attorney general, the community at large, physicians, sponsoring body or parent organization, or the board's sense of integrity) and the intensity of the pressure will help the board decide how proactive it

needs to be in its effort to enhance the integrity profile of the institution.

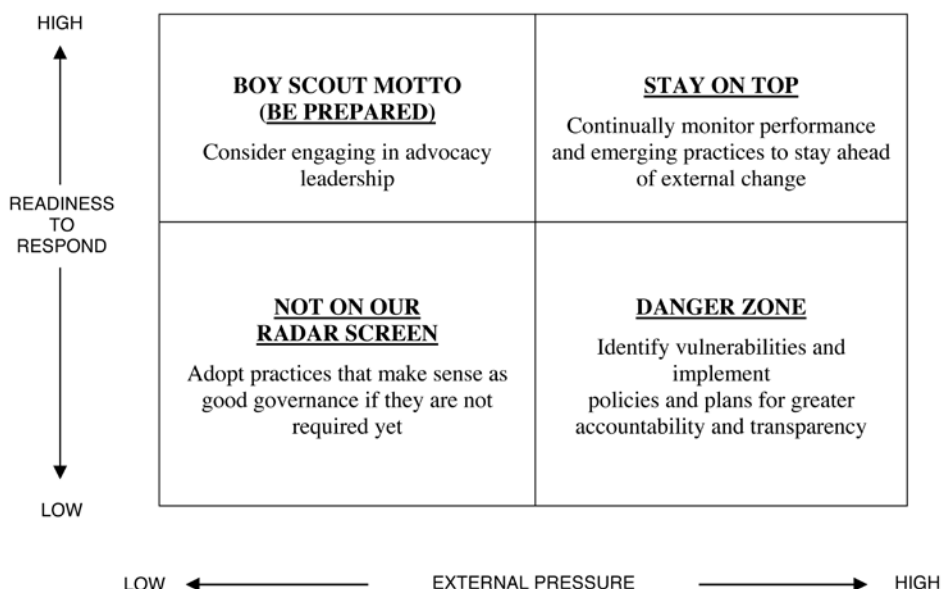
2. Second, the board should "confront its brutal facts" and determine how well the organization is performing in the areas of public accountability and transparency. This requires a candid, bare knuckles review of current practices in all of the areas discussed in this white paper, with a finding of current strengths and vulnerabilities. How would the organization fare in a comprehensive IRS audit or Congressional hearing on its community benefits, charity care, and conflict-of-interest enforcement? The outcome of this review should tell the board how prepared the organization is to demonstrate its good works or whether it needs to make significant changes in organizational and governance policies and practices.

By juxtaposing these two variables, the board will be able to assess its risks and readiness to respond. Figure 1 below illustrates four possibilities:

- **Low risk, low readiness.** An organization experiencing little external pressure for greater public accountability and transparency may decide to simply prioritize its greatest vulnerabilities and develop an implementation plan for gradually eliminating them.
- **Low risk, high readiness.** If your organization has developed sound practices and could withstand a stringent regulatory review, it may want to pursue advocacy efforts to influence the new rules governments are writing for not-for-profits.
- **High risk, low readiness.** This is a dangerous quadrant. These organizations are under great pressure for change and would be wise to accelerate a change process to adopt the practices we've discussed.
- **High risk, high readiness.** If you are in this quadrant, then the board has established effective mechanisms to oversee and demonstrate accountability and institutional integrity. It needs to monitor performance and keep testing its performance against emerging recommended practices.

Figure 1

Risk/Readiness to Respond Analysis



Clarifying the position your organization occupies currently is a good first step. However, developing a concrete strategy and related implementation plans also requires careful board deliberation. Given the fluid nature of the topics discussed in this white paper, boards have to be clear on the consequences of some of the governance and other policy

changes they may make. “Getting out front” of the industry and being very proactive or not is the key strategic decision the board must make. Knowing the pros and cons related to employing a proactive strategy is a must.

Pros & Cons of Being Proactive

Pros

- Prepared for anything the government or regulators can throw at you
- Reduced potential of any public embarrassment
- Clarifies an important dimension of your organization’s culture
- Attractive environment for future executives and board members
- Eliminates confusion, especially on physician board member issues
- Sleep at night

Cons

- More work/accountability on the board’s shoulders
- May lose some board members
- Resistance to change based on the “fad argument”
- Increased cost of doing business
- Can never be sure what future laws/regulations will require
- Possible board involvement in management

Figure 2
Charting a Strategy

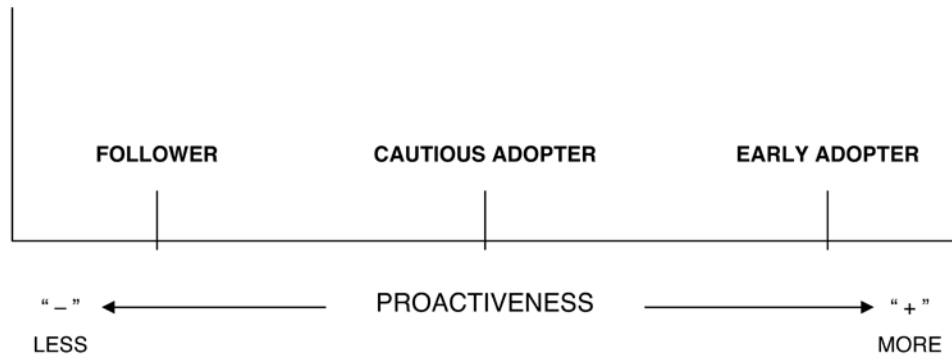


Figure 2 depicts three distinct institutional strategies dependent upon how proactive the board wants to be on addressing the public accountability and transparency issues. Some boards have decided that their institutions should become “early adopters” of most policies and best practices associated with a high degree of accountability and transparency (e.g., measuring and documenting community benefit, Sarbanes-Oxley compliance, few board conflicts allowed, precise definition of “independence,” rigorous executive compensation oversight, quality, and pricing transparency). These organizations have decided that they want to define the issues for themselves and provide public leadership on these issues in their communities and for the industry. They do not want to be put in a defensive position.

The other end of the continuum represents those institutions that have decided to be “followers” or “watchful waiters”—not be proactive until necessary and content to defend themselves against external attacks if and when they occur.

In the middle are those following the “cautious adopter” strategy. These institutions do not want to constantly be put on the defense but are not ready to plunge head long into a change process without a clearer understanding

of what is likely to be the result of the policy and legal debates occurring at various levels of government. These organizations are beginning to dialogue actively with local government and the public and are not resisting requests for more disclosure.

There are risks associated with each of the strategies. However, the “follower” strategy (being used by many organizations today—intentionally or not) could lead to greater damage to an organization’s reputation and tax-exempt status and trigger regulatory sanctions and legal actions more so than the other strategies, in the authors’ opinion. To mitigate against these consequences, those healthcare institutions that choose to be “followers” on the host of issues raised in this white paper should, at a minimum, make sure that the board is fully educated on these subjects, with contingency plans in place in the event that their institution becomes the target of an external challenge. Ignorance of the issues that have generated unprecedented public and governmental attention over the past five years or so will not be an acceptable defense.

Conclusion: An Opportunity for

Generative Governance

The genie is out of the bottle. There is no going back to the days when not-for-profit organizations and their boards could operate in the dark, employing practices open to question and communicating information on their own terms. The integrity of not-for-profit hospitals and systems can no longer be taken for granted. The public and other interested parties are demanding a higher level of performance, accountability, and transparency. Not-for-profits may debate how hard the wind is blowing but not its direction. The storm is here, the tipping point is near. Never before has the interest in governance—good governance—been so focused and intense. And the interest is coming from board members themselves.

So, how can the board and senior executives use this white paper to strengthen institutional governance and ensure that they are able to address the challenges in the new era of accountability and transparency?

Our colleague Richard Chait, professor of Higher Education at the Harvard University Graduate School of Education, has cautioned boards not to over-emphasize the fiduciary aspects of their role, but to also engage in strategic thinking and what he calls “generative governance.” Boards, Chait says, should use their outside perspective and intellectual capacities to generate challenging questions and provoke new thinking about the organization’s mission, values, vision and practices.

We think that the emerging standards for institutional integrity call for equal doses of fiduciary, strategic, and generative governance. This white paper has dwelled on the first two modes, but boards also should ask the generative questions: What does it mean to be not-for-profit? What does the community really think of us? Are the burdens of tax-exemption worth it?

Addressing the challenges of institutional integrity is a journey—how fast each board goes depends on its unique circumstances. Here are some practical steps to get moving:

1. Distribute a copy of this white paper to every board member and senior executive. Encourage them to read the document and discuss it at an upcoming meeting. You might consider having someone from The

Governance Institute conduct a special education session for your board on the contents of the white paper.

2. Assign to the governance or audit committee the task of completing the “Risk/Readiness to Respond Analysis” on your organization and use the findings to spur generative discussion at a board meeting or retreat.
3. Engage the full board in charting the appropriate strategy to pursue based on the risk/readiness analysis. The board must be committed to whatever strategy is selected and understand the implications of pursuing it in terms of time, effort and impact on the organization’s culture.
4. Once the board has determined how proactive it wants to be regarding the issues surrounding public accountability and institutional integrity, the governance committee can then proceed to review the self-assessment tools contained in the white paper to identify practices that represent priority areas for improvement. The governance committee can turn the practices selected into an organizational development plan that addresses both governance and other organizational policy changes.
5. Reengage the board, perhaps in a retreat-like setting, to thoroughly review, revise, and approve the changes recommended by the governance committee. Start with high priority practices/policies so as not to overwhelm the board and management with trying to “fix” everything at one time.
6. Convert the outputs from the above meeting into a detailed action plan, including accountability assignments, completion dates, and cost estimates (if any).
7. Incorporate the self-assessment tools from this white paper into the board’s overall self-assessment process to continue to push the envelope on matters pertaining to accountability, transparency, and institutional integrity.

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