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The Governance Institute

GOVERNANCE OF HIGH-PERFORMING NONPROFIT HOSPITAL SYSTEMS

Survey of Key Characteristics
and Best Practices

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Larry S. Gage, Alston & Bird LLP

Mark Finucane, Jamal Brown, Sheridan Kelly, Eliza Medearis, Ethan Smith and Linda Tran,
Alvarez & Marsal Healthcare Industry Group

Foreword

The Governance Institute has been surveying U.S. hospital and health system boards on structure and best practices since 1999. The best practices in our survey were built upon qualitative experience and expertise from governance experts in the field who devoted significant hands-on time with hospital and health system boards observing, learning, and evolving what effective governance looks like in practice. The recognition that healthcare boards needed to function differently came out of several significant industry events around that same time—in particular, the seminal Institute of Medicine reports on the state of quality of care and patient safety in our nation's hospitals. As boards began grappling with how lay board members can effectively improve quality and safety, a few short years later the Sarbanes-Oxley legislation was passed and the Senate Finance Committee began focusing its scrutiny on nonprofit hospitals' tax-exempt status. In less than a decade, the job of a healthcare board became something different entirely, with more weight, importance, and influence. These building blocks spurred the evolution of governance and the best practices that we know today.

The stalwarts of best practice healthcare governance that have greatly influenced the work of The Governance Institute and others have included the very people who originated the work this report is based on: Dr. Larry Prybil, and Dr. James Rice. Larry Gage and his team have continued this valiant effort, and I and The Governance Institute have had the honor and benefit of collaborating with and learning from each of these stalwarts along the way.

This 2023–2024 Governance Survey shows broad consensus with The Governance Institute's research. The participating health systems have embarked on important work to assess and improve their governance structures and overall effectiveness of their governance function, while still being in varying positions along an integration spectrum. There is wide recognition that, while every system requires its own unique and nuanced governance framework, ensuring alignment, having a unified strategic direction, clarifying board roles, and eliminating duplication are the goals to be attained and there is more work to do. Most importantly, it reminds us of the critical importance of an effective system board and system-wide governance structure that enables complex organizations to make bigger, bolder, more difficult, and essential decisions that will sustain our mission-driven, nonprofit healthcare institutions into the future so that the high-quality, complex care desperately needed by Americans will be there for them when it is called for.

The Governance Institute supports this report and its findings and recommendations, and we are honored to have had the opportunity to review and provide feedback to pre-publication drafts.

Kathryn C. Peisert
Editor in Chief & Senior Director
The Governance Institute



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Introduction and Executive Summary

Background: Purpose of Report

The purpose of this report is to provide a current overview of the key characteristics and best governance practices of high-performing nonprofit health and hospital systems, based on a survey of 17 such systems. This Executive Summary provides a snapshot of those best practices and other key takeaways. The second section of this report provides an overview of our methodology and of the surveyed systems. The middle sections provide a more detailed discussion of the results of our survey, including examples and insights taken from our interviews and literature search. The final sections of our report address a number of specific governance challenges that face some, but not all, of the survey respondents. Appendix 1 provides a brief “primer” on the key elements of nonprofit governance, as requested by several participants to assist in educating new board members who may not be familiar with nonprofit organizations. Finally, Appendix 2 provides a detailed list of the references consulted in our review of the evidence-based literature.

In July 2015, our firms were asked by the Board of Trustees of the Henry Ford Health System (now known as Henry Ford Health or HFH) to assist the Board with an evaluation of HFH’s governance and structure. This is an evaluation HFH has a tradition of conducting approximately every ten years since the early 1980s. At the time, HFH consisted of four hospitals, a large integrated physician group, a 600,000-member health plan, a foundation, and approximately 15 to 20 other formal or informal entities, some of which were wholly owned and some of which consisted of joint ventures with third parties. Each entity within the HFH system had its own separate governance structure, with a mix of formal and informal, fiduciary, advisory, and internal and external boards. The expressed goal of the system at the time was to determine whether or not the consideration of evidence-based “best practices” in nonprofit health system governance could lead to the adoption of improvements and reforms that would contribute to the ability of HFH to achieve the system’s strategic growth, clinical integration, financial and community health improvement goals and initiatives.

In conducting this assessment for HFH we initially pointed out that their tradition of carefully evaluating their governance structure at least once every ten years was itself a “best practice” that should be emulated by other systems.

In order to assist HFH, we conducted a nationwide survey of a select group of ten nonprofit hospital systems that could be considered “peers” of HFH, in order to gain insights from the governance structures and practices of such systems. The peer survey consisted of an online survey followed by interviews with each system. At the same time, we also undertook a literature search of recently published articles, reports, and other surveys to identify evidence-based best practices.

Governance Best Practices

Conduct an assessment of your systemwide governance at regular intervals.

The period since we conducted our first survey has been momentous for the health industry. From the impact of the pandemic on the nation’s health system to the growth of cyber-attacks, health worker burnout, the behavioral health crisis, rising costs, artificial intelligence—the list goes on. Some of the original survey participants had begun to ask whether we planned to update the survey. Ultimately, in 2023, our two firms agreed to determine whether there was interest in doing so. As we had done in 2015, we reached out to a number of high-performing nonprofit hospital systems, and we were gratified when 17 systems agreed to participate in an updated survey. While this updated survey was not conducted under the sponsorship of any particular hospital system, it was done with the blessing of its original sponsor Henry Ford Health and of Wright Lassiter III, the then-CEO of HFH, who has since moved on to become the CEO of CommonSpirit Health.

When we decided to update the survey, we soon discovered that the surveyed systems had grown from 241 hospitals in 2015 to over 375 in 2024, while also adding hundreds of other subsidiaries and services. Revenues for the 17 systems grew from \$77B to \$155B during that period. As one survey participant put it: “We have about 250+ subsidiary companies and over 50% of our revenue is earned outside of hospitals. As a consequence, we have had to develop a governance structure that reflects the complex functioning of the health system and at the same time balance fiduciary oversight with agility in decision making and execution of strategy.” This report represents an effort to highlight the governance practices that can best enable nonprofit systems to achieve such a balance.

Summary of Key Findings and Best Practices

Our updated literature review and survey provide a wide range of important insights. There was significant consistency across the data obtained, which has allowed us to make a number of key findings and describe a number of “best practices” for nonprofit health system governance. Those findings and practices are briefly summarized in this Executive Summary and discussed in more detail in the remainder of this report.

- **Size of System Board:** A system board needs to be large enough to ensure there are sufficient individuals to accomplish the board’s workload but not so large as to impede effective discussion or prevent all board members from having meaningful input. On average, a board with 11 to 18 members is within the range identified as a “best practice” in the literature for nonprofit health systems. This finding was confirmed by responses of the systems surveyed. The majority of systems (nine systems) have board sizes ranging from 11 to 18 members. Five systems reported having 19 to 22 board members, while three systems were notable outliers with 25, 34 and 41 voting members, respectively. The outliers, even within the 19- to 22-member range, largely reported that their boards had grown in recent years due to mergers or acquisitions, while others reported that their boards were large for historic reasons. Most expressed the goal of downsizing. Recent mergers have also led to some systems absorbing additional legacy board members as they have expanded into new markets. Other systems attributed their somewhat larger size and complexity to the need to accommodate “sponsor” organizations in faith-based systems.
- **Composition of System Board:** There is abundant evidence that board effectiveness has substantial impact on organizational performance and that board composition is a principal determinant of board effectiveness. A well-designed board succession planning process can be instrumental in creating and maintaining excellence in board composition. Unfortunately, available evidence shows that formal board succession planning occurs in only about half of America’s hospitals and systems. Surveyed boards assess governance expertise, skills, availability, and capabilities of their members and identify gaps in needed expertise and other criteria (including gaps in diversity). Several system boards use their subsidiary, local or foundation boards to identify and recruit new system board members. As a general matter, we believe that “best practices” in recruiting board members should include the following:
 - Take great care in selection of board members.
 - Multi-hospital health systems should consider using professional recruiters.
 - Build a coherent transition and succession process so future trustees are identified and groomed for leadership.
 - A governance and/or nominating committee should be appointed to identify, interview, and nominate board members.

Governance Best Practices: Board Culture

Building and sustaining a proactive and interactive board culture directly impacts effective governance. Four board practices can have a significant impact on shaping board culture:

- *Identifying the right mix of people for effective governance.*
- *Attracting, recruiting, and appointing them.*
- *Setting board and committee objectives; evaluating performance.*
- *Establishing effective board education and development programs.*

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- **Skills and Experience of Board Members:** The range of skills and experience considered desirable for health system trustees has expanded in recent years to include a number of new areas of expertise. Given the trend toward streamlining system boards, adding trustees with the desired additional expertise can be challenging for health systems. While nonprofit boards will continue to seek members with traditional board member skillsets, such as finance, business, real estate and law, effective succession planning must also reflect the importance of other “21st century” professions, such as enterprise risk management, cybersecurity, digital health, telehealth, and population health. It is important to acknowledge that not every quality that is required or desired will come from a specialized skill. Experience in general areas is also important, as is diversity.
- **Ex Officio Board Members:** One way to meet the challenge of achieving a well-balanced board among surveyed systems has been to limit the number of “*ex officio*” or “constituency-based” board members. Having a large number of *ex officio* trustees raises the question of whether a board is representational rather than strategic. Sixteen of the surveyed systems include the CEO as an *ex officio* member, with 14 of these CEOs having voting rights. However, only six systems include other voting *ex officio* members, with total *ex officio* counts ranging from one to seven across 16 of the 17 systems surveyed. Two systems reported having additional non-voting, *ex officio* members, and one of these systems expressed an intention to reduce the number of *ex officio* members in the future. Several of the systems surveyed include ex-officio board members due to merger agreements combining two organizations, because of the need for representation from “sponsor” organizations in faith-based systems, or attributable to relationships between the systems and medical schools or other academic organizations.
- **Clinical Experience on System Boards:** Access to experienced physician and nursing leadership for integrated health system boards is considered essential as systems strive for expanded clinical integration, population health, and excellence in quality and patient safety. However, while clinical leaders can serve as effective board members, some systems surveyed expressed caution at the potential conflict of interest presented by active system clinicians serving in board positions. Several of the systems surveyed have tended to look for clinical expertise from outside the system, while relying on the system’s own clinical leadership to provide advice and expertise through participation on committees, through the organized medical staff structure, and through new clinical entities such as accountable care organizations, clinically integrated networks, etc., rather than serving as system trustees. One organization that has surveyed the literature found that physicians play multiple roles in health system governance:
 - Increased physician involvement in the governance of U.S. private acute-care hospitals leads to higher bed occupancy and operating margins.
 - Increased physician involvement in governance roles yields higher performance ratings for nonprofit hospitals compared to their private sector counterparts in overall profitability.
 - Boards with more clinician representation have significantly better financial performance than boards without any physician participation, studies show.
- **Use of National Experts on Boards:** As noted above, it is important to have the necessary range of expertise to make well-informed decisions in the rapidly changing health care environment. There is substantial evidence that a new range of skills and experience, beyond the traditional skill set, will be desirable for all health system boards in order to meet the challenges of the future. Health system boards should support and augment the current expertise of their members by engaging experts in a variety of additional skills. A majority of systems surveyed (10 systems) have “outside” or “national” experts serving on their system boards, and an even larger proportion (11 systems) includes such experts on their committees. One system reported the absence of national experts, attributing this to its board being composed of highly accomplished individuals from within their community (a large metropolitan area). Also, most of the CEOs of peer systems surveyed have themselves served as “national experts” on the boards of other health care entities.

- **Compensation of Board Members:** Three of the surveyed systems compensate their board members. In our 2015–2016 survey, two different respondents reported compensating their board members. The amount of compensation paid to board members was also somewhat higher this year than in the previous survey. Coupled with reports in the literature, we believe there is a modest trend towards recognizing the increasing demands on board members of large, complex nonprofit health systems. These demands include the expertise and experience required, as well as the significant time and attention needed once appointed.
- **Terms and Term Limits:** Three-year terms seem consistently to be standard at a majority of the hospitals we surveyed, but an argument can be made for four-year terms since it can take up to a year for board members to understand the many complexities and intricacies of their health system in order to be an effective contributor. Whichever approach is adopted, we believe a nine-year term limit and a maximum of three three-year terms with application of rigorous criteria for reappointment should be considered a “best practice.”
- **Duration and Frequency of System Board Meetings:** Eleven surveyed systems meet quarterly and six of those systems meet for a full day or for multi-day board meetings. The other six systems reported five to nine regularly scheduled meetings per year. Eight systems reported that their board meetings lasted two to four hours (four of which also met five to nine times rather than quarterly). The trend since our last survey has been toward longer but fewer meetings, and it appears that quarterly meetings that last for most of a day or longer should be considered a “best practice.” All but one surveyed system also typically convene annual or biennial retreats for board members.
- **Agendas/Content of System Board Meetings:** Most systems surveyed make extensive use of consent agendas for board meetings, with much of the work on consent issues taking place in committees. This enables system boards to devote substantial meeting time to critical topics like patient care quality, strategy, and planning, rather than focusing on past operating performance, short-term issues, or issues that should be addressed by committees. All systems reported spending board meeting time on financial and operational performance, and 12 of the 17 systems indicated that they spend more than 25% of board meeting time on financial performance. Eleven systems reported spending at least 25% of their time on strategic growth and competition, while eight spent more than 25% of their time on operational performance. However, only three systems reported spending at least 25% of their time on quality, safety, and patient experience.
- **Committees:** There appears to be a trend toward streamlining the use of committees by hospital system boards. Only five committees appeared to be common to most or all of the systems surveyed. All 17 surveyed systems reported having a Finance and Investments Committee, an Audit and Compliance Committee and a Governance/Nominating Committee. All but two systems reported having a Patient Care Quality and Safety Committee and an Executive Committee, and all but three reported having an Executive Compensation Committee. However, fewer than half of the systems reported having Board Education, Community Benefit, Strategic Planning, System Strategy or Credentialing Committees. Some of the expected functions of these committees were instead delegated to other committees or (in some cases) to subsidiary hospital or regional boards. While most systems have Executive Committees, their role appears to have been somewhat diminished in recent years, as the size of system boards has been reduced. Eleven systems reported that their Executive Committees only met “as needed,” while five systems reported that they met “as or more frequently than” the full board. (These tended to be the systems with larger boards.) Ten systems reported that they make use of ad hoc committees to address specific issues as needed.
- **Executive Sessions:** Eight respondents indicated that the CEO or other management participated in executive sessions, but only for a portion of the meeting, while eight responded that management participated for all of the meeting. Only one indicated that the CEO and management did not participate in executive sessions. Boards should adopt an explicit policy statement regarding the use of executive sessions and should regularly schedule executive sessions as part of every board meeting, with an agenda with specific issues and limit discussions to those issues. If the executive session includes a period in which board members may raise new concerns or suggest agenda items, boards should reserve substantive discussion for future meetings.

- **System Information, Education and Support for System Boards**: Most of the surveyed systems disseminate board materials electronically through a web-based board portal instead of hard copy materials sent by mail or provided at the meeting. In addition, most surveyed systems have administrative staff specifically dedicated to board matters, including the systems' general counsel, governance officers and external governance consultants. Most systems also assign C-suite officials to support board committees in their areas of expertise.
- **Regular Evaluation of Boards and Board Members**: Most system boards have their members conduct annual individual self-evaluations, and some systems also ask board members to evaluate their peers. Almost all systems have explicit expectations for attendance, preparedness, and other kinds of involvement for system board members.
- **Evaluation of CEO and Executive Staff Performance by Board**: Board evaluation of the CEO is standard, while evaluation of other leadership is less frequent. Effective boards continuously improve board and CEO performance using leadership performance evaluations, which include setting clear goals and expectations, conducting objective evaluations, and taking follow-up actions.
- **Governance of Subsidiary or Owned Hospitals**: Most effective multi-hospital system governance models place clear limitations on the authority, accountability and decision-making responsibility allocated to local hospital boards in the system. In several of the systems surveyed, owned hospitals either do not have their own boards or are part of a governance structure with regional or "market" boards that are responsible for several hospitals. In those systems that do have local hospital boards, the role of those boards has been redefined in recent years to focus on a more limited (but essential) set of duties and responsibilities, with particular emphasis on maintaining and improving linkages to their local communities, monitoring local quality of care and patient and employee satisfaction, and credentialing local medical staff. System boards are taking on more fiscal and strategic responsibilities for owned hospitals. However, affiliated, or managed (but not owned) hospitals still tend to have their own fiduciary boards. "Best practices" identified for subsidiary hospital boards include the trend toward making local boards primarily advisory, with fiduciary duties (if any) limited to certain matters. Local boards should be streamlined by minimizing committee use and meeting time. Where geographically feasible, systems should consider mirror boards for subsidiaries, which could meet concurrently with the system board.
- **Ownership or Other Relationships with Health Plans**: While there is some variation due to compliance with state-specific laws governing health plan governance, integrated systems that own health plans have moved toward health plan boards that are identical or largely parallel to the system board. This is done to improve communication and coordination with other components of the system and to maintain a system governance structure that is as efficient as possible.
- **Use of Written Governance Policies/Philosophies**: High-performing health system boards rely on written and web-based portals to enable easy access to policies that clearly define board authority and accountability and set out the decision-making responsibility allocated to local boards in their system. Several systems have published formal governance policies and procedures in manuals, which are provided to all board members. This can be especially important when it comes to policies related to such matters as conflicts of interest. It is also important for conflict of interest policies (and other board policies) to be considered "living documents," which are constantly monitored, implemented and updated as needed.
- **Diversity**: High-performing health systems strive to reflect in their boards the demographics of the populations they serve. Boards are looking for diversity in their composition and consider gender, age, race, and ethnicity in combination with competency when recruiting new members to their boards and committees.
- **Transparency**: High-performing health system boards make a strong commitment (in policy) to communicate transparently with key internal and external stakeholders (including the public and media) regarding system-wide performance in such areas as quality, safety, pricing, patient experience, and customer service.

- **Academic Health Systems:** Surveyed systems with ownership by or close affiliation with universities reported an ongoing challenge in integrating academically-oriented medical staff with community-based independent physicians. Seven of the surveyed systems have direct relationships with medical schools and serve as the schools' principal teaching hospital(s). Most systems that serve as primary teaching hospitals for a medical school report maintaining separate academic advisory boards or system board committees to oversee academic activities including teaching and research. Successful AMCs are typically organized as highly integrated and multifaceted health systems, with effective business management, a shared commitment to common goals, and meticulous attention to the academic, competitive, and regulatory demands of today's health system. Success does not necessarily correlate with a particular legal structure or governance model. The most effective systems studied have succeeded in a range of legal structures in aligning business, clinical, and academic performance to meet the diverse, and sometimes conflicting, needs of the modern academic health center. Regents (or Trustees) are still in charge of most universities that include medical schools, even where there has been some separation of direct system governance. However, most successful university systems have created boards to directly govern their health systems and have delegated considerable authority to those boards. The components of high-performing systems are fully aligned and integrated (hospitals and physicians) through common or shared governance, common ownership or strong (and longstanding) affiliations, even extending across multiple hospitals and broad geographic areas.
- **Faith-Based Systems:** Four of the 17 systems responding to our survey consider themselves "faith-based" Catholic systems (in whole or in substantial part). In each case, the hospitals forming these systems are guided in their healing mission by a fairly wide range of Catholic sponsoring ministries. Surveyed hospitals have adopted different approaches to balancing the requirements of their faith-based ministry sponsors with the expectations of payers, patients, and the rest of the health system. One system surveyed has a ministry sponsor board composed entirely of representatives of the religious ministries that oversee their faith-based obligations. This system also has a separate operating board that includes some sponsor representatives nominated by the faith-based board, but which also includes a majority of independent lay directors. Another survey respondent recently doubled in size when it acquired a regional Catholic system. Their solution was to continue to operate the Catholic system as a separate corporate entity with its own governing board, so that it could include representatives of the sponsoring ministries. The acquiring system continued to maintain its pre-existing, non-religious board. A third survey respondent, a result of mergers and acquisitions among several faith-based systems, has taken steps to incorporate itself as a non-religious (secular) nonprofit corporation, while maintaining liaison with the various ministries that have sponsored the merged and acquired systems. This system, which has also acquired a number of non-Catholic hospitals, continues to respect Catholic policies in its Catholic hospitals. However, this system has also created an informal category of "Community Hospitals" within their system—non-Catholic hospitals that have been acquired but do not have to follow the religious guidelines for most services.
- **Legacy Governance Issues following Mergers or Acquisitions:** Several surveyed systems have recently undertaken integration efforts that have impacted the structure of their governing boards. The predominant challenge encountered when merging with or acquiring another system, or even a large hospital, involves instilling a system-wide mindset among legacy or constituent board members. Systems that have successfully navigated this challenge have credited a proactive strategy involving creating a consensus among both management and the merging entities' boards prior to integration. While responses varied and some systems have a high number of legacy members, several surveyed systems have been working to reduce or even eliminate legacy board members and instead institute procedures that ensure governing boards are working effectively from a more system-wide point of view. In general, it should be considered a "best practice" to avoid appointing system board members who will see their role as representing (and protecting) a particular constituency, rather than governing for the good of the entire system.

Methodology

System Selection Criteria

The project team sought to develop a survey instrument that would identify best practices among high-performing nonprofit health systems. A number of integrated health and hospital systems were identified as offering a potential basis for comparative evaluation of governance practices. Seventeen systems agreed to participate in a web survey and follow-up interviews.

As with the original 2015–2016 survey, healthcare systems were selected based on several criteria. The project team sought to identify integrated delivery systems which were more than just hospital systems. While all the selected systems include multiple hospitals, it was considered important that the systems also included large, employed physician groups along with independent physicians and other practitioners as well as different kinds of subsidiaries. Systems were identified that covered large regional, statewide, or multi-state catchment areas and showed evidence of recent growth through acquisitions, affiliations, and partnerships. Ownership of or close affiliation with one or more health plans was considered desirable, as well as provision of or participation in major academic programs, including medical education and research. Not every system selected met all these criteria, but all invited participants met a majority of them.

Survey Participants

The project team would like to acknowledge and thank the 17 integrated healthcare systems that agreed to participate in this “best practices” governance survey. These systems, which responded to a detailed online survey and participated in follow-up interviews with members of the project team, are as follows:

- Baylor Scott & White Health
- Baystate Health
- BJC HealthCare
- Brown University Health
- CommonSpirit Health
- Henry Ford Health
- Intermountain Health
- MemorialCare Health System
- Northwell Health
- Northwestern Medicine
- Providence St. Joseph Health
- SSM Health
- Stanford Health Care
- Tufts Medicine
- UChicago Medicine
- University of Kentucky - UK HealthCare and UK King's Daughters
- University of Maryland Medical System (UMMS)

Structure of the Surveyed Systems

Most of the systems in our survey reported that their boards were considered operating boards rather than holding company (or other type of) boards. There are sometimes special circumstances to take into account with academic medical centers that are owned by or closely aligned with universities, as well as with faith-based hospital systems, which often share governance responsibilities with sponsoring ministries. Challenges faced by these types of entities are also addressed in our survey results below.

The systems surveyed for this report were larger than in our 2015–2016 survey. Their number of hospitals ranged from three to 140, with nine systems reporting owning or managing over 10 hospitals. (Several surveyed systems have grown through additional mergers or acquisitions even since responding to our survey.) Twelve systems reported annual revenues greater than \$4 billion, while the rest reported revenues of \$1–4 billion. Ten surveyed systems operate in a single state, while seven operate in multiple states. Four systems operate in four or more states and one in 19 states. Together these systems have over 700,000 employees and 100,000 physicians, or 200,000 more employees and 35,000 more physicians than in 2015.

The 17 surveyed systems were asked to categorize their structure and that of their boards. Nine systems elected to characterize themselves as “a fully integrated, multi-faceted health system,” while the other eight described themselves as “a hospital system with other components.”

The characterization of most of these systems as “fully integrated” is underscored by their integration of medical staff. Surveyed systems provided estimates of the total number of physicians practicing in their system, which totaled to over 100,000. Twelve of the surveyed systems reported directly employing over 1000 physicians, while only two employed fewer than 500. All of the systems, included major and minor teaching hospitals, and seven were either owned by or directly affiliated with one or more medical schools.

In general, since our 2015–2016 report, we have seen a change in the structural trends of nonprofit system-level boards away from holding companies and towards operating companies. This trend has also resulted in the retention of more fiduciary powers and responsibilities by system boards and the delegation of fewer to the boards of individual hospitals or hospital groups within the system. (This has not necessarily coincided with a retention of local operational responsibilities by system management, and indeed some systems have been engaged in revising their operational structure to delegate more operational powers and duties to regional hospital groups.)

Twelve systems reported having operating boards at the system level, while only two reported having holding company boards. One system reported that their board was simply a “governing board,” one characterized their board as “a strategic board,” and one said that they are “transitioning to an operating board.”

The majority of hospitals are owned by the systems, and six of the systems surveyed exclusively include owned hospitals. Another five systems reported having just one non-owned hospital in their systems. The other systems reported combinations of owned hospitals and those affiliated through other arrangements, such as leases, management contracts and joint ventures.

The surveyed systems operate hospitals and other components in a total of 22 states. Other identified system components included employed physician organizations, affiliated physician organizations, health plans, long-term care facilities, home health agencies, pharmacies, ambulatory care facilities, real estate holding companies, and other for-profit and nonprofit subsidiaries. Most of the peer systems indicated their system includes most, if not all, of these other components.

Health Systems Participating in the Original 2015–2016 Survey

- Banner Health
- Baylor Scott & White Health
- BJC HealthCare
- Carolinas HealthCare System
- Geisinger Health System
- HealthPartners
- Henry Ford Health
- Mercy Health
- Methodist Le Bonheur Healthcare
- Northwestern Memorial HealthCare



Survey Design

For the initial 2015–2016 survey, questions were developed, structured, and organized to both provide an overview of the governance structure of each system and to identify the governance-related aspects of each system’s integrated components and subsidiaries. With respect to the latter, there was a specific focus on how each system’s governance structure has evolved and is planned to evolve further. The survey was also designed to determine the extent to which current governance enhances or hinders communication and avoids duplication or lack of clarity in the responsibilities and powers of subsidiary boards. Because this updated report is intended to reflect the changes that have occurred in this sector of the hospital industry in the last decade, we elected to use the original survey questions. However, we augmented those questions with a new section of the survey that is intended to assess the extent to which health system governing boards are devoting time and attention to new developments that have occurred over the course of the last decade. The questions were organized into the following general categories:

- System overview (size, revenues, hospitals, medical staff, foundation, other components).
- System board size and composition.
- System board terms and term limits.
- Recruitment and education of system board members.
- Powers and duties of system board.
- Use of committees.
- System board meetings.
- Evaluation of board and board member performance.
- Board evaluation of management.
- Governance of hospitals, regions, and other subsidiaries.
- Board attention to recent issues and future challenges.

The results of our survey are summarized in the Executive Summary above and discussed in more detail in the remainder of this report. Also included throughout the report are a number of charts and figures illustrating some of our key findings. The raw survey data (redacted of system-specific identifiable information) can be made available upon request.

Literature Search

In both 2015–2016 and for the current report, the Project Team reviewed numerous studies, articles and other publications written within the five- to 10-year period prior to each report. We also carefully consulted the websites of each of the surveyed systems as well as other similar systems and drew on our firms’ own work for numerous health system clients. We have also drawn on our literature search to identify case studies that illustrate some of our findings. Where specific sources are cited, a summary reference is included. Full references may be found in Appendix 2.

Interview Process

In parallel with the survey format from the 2015–2016 survey, the 2023 survey was conducted online using the online platform, SurveyMonkey. After survey responses were completed and compiled, follow-up interviews were scheduled with the survey responders and/or system leadership to clarify responses and obtain additional information. The survey responses and interviews provided invaluable insight into the governance practices of the systems surveyed and enabled the project team to identify a range of “best practices.”

After 17 system responses were collected and organized, the follow-up interviews were conducted virtually, in order to develop a more holistic understanding of the system responses and obtain any additional, relevant information. These interviews shed light on pressing concerns and key areas of focus for each peer system, providing insights into the developments of previously identified best practices and uncovering additional best practices that have been described in the literature in more recent years. Results of our interviews are shared throughout this report, both in the text of the report and in “Interview Insight” sidebars including quotes from interview subjects on various topics.

Key Characteristics and Best Practices of Effective System Boards: *Selecting the Right Board*

Size of Board

In a landmark 2012 survey of governance practices of 14 large nonprofit systems, Professor Lawrence Prybil of the University of Kentucky School of Public Health and his co-authors compared the size of nonprofit system boards to the boards of large (Fortune 100) business corporations. As a general matter, Prybil found that business corporations tended to have smaller boards (averaging eight to nine members) than nonprofits and called attention to a 2007 AHA study that “advocated a range of nine to 17 voting members for hospital and health system boards.”

This nearly 20-year-old recommendation continues to hold true today and is borne out by our present survey. The recent trend among high-performing nonprofit hospital and health system boards has been to streamline membership, which often requires downsizing. Whereas many nonprofit hospital boards at one time consisted of large numbers of members, in part to promote philanthropic fundraising and ensure broad community support, the trend recently has been toward smaller numbers of carefully selected board members. While none of the systems we surveyed had fewer than nine members, the majority of systems (nine systems or 53%) have board sizes ranging from 11 to 18 members. Five systems reported having 19 to 22 board members, while three systems were notable outliers with 25, 34 and 41 voting members, respectively.

Only two systems reported having fewer voting members than total board members. The outliers, even within the 19- to 22-member range, largely reported that their boards had grown in recent years due to mergers or acquisitions, while others reported that their boards were large for historic reasons. Recent mergers have also led to some systems absorbing additional legacy board members as they have expanded into new markets. Other systems attributed their somewhat larger size and complexity to the need to accommodate “sponsor” organizations in faith-based systems. (These and other factors are discussed in more detail below.)

Over the last five to 10 years, nine of the surveyed systems have modified their board sizes primarily through reductions in size. A representative of one of the outlier systems, which has grown significantly through mergers and acquisitions in recent years, reflected in an interview on its even more substantial size less than 10 years ago: “Around 2015–2016, we were sitting with what I absolutely knew was the largest hospital board in the Northern hemisphere. We found only one board larger than ours in the entire Western hemisphere, which was located in Brazil.”

The representative of this system went on to describe the challenges of reducing the size of its board: “Our system is currently restructuring the board to remove historic commitments to antecedent boards in an effort to reduce by three to four members. On the other hand, we probably also need to add four members from a new merger which will retain its separate board, if approved. Their new board will exist for roughly four years before transitioning to a community advisory board.”

Currently, most systems are maintaining their existing board sizes, though five anticipate adjustments in the future. Interviews highlight that balancing best practices with appropriate board representation continues to be a focus for many health systems as they expand.

A range of 11 to 18 voting members is considered best practice for health system boards. Nine of the peer systems surveyed fell within this range, with six at the upper end (15 to 18). The other systems with larger boards indicated that the size of their boards had been dictated in part by recent mergers and acquisitions, or by the need to include representatives of religious organizations, and two of these expressed the intention of downsizing in the future.

Governance Best Practices: Board Size

Board size: The board needs to be large enough to ensure there are sufficient individuals to accomplish the board’s workload but not be so large as to impede effective discussion or prevent some board members from having meaningful input.

Governance in Transformational Times

INTERVIEW INSIGHTS

Board Size

"There is a dilemma with a board over a certain size—are there wallflowers in the room? Six or eight trustees tend to dominate board meetings. We see a very strong learning curve for newbies which causes them to be shy about participating."

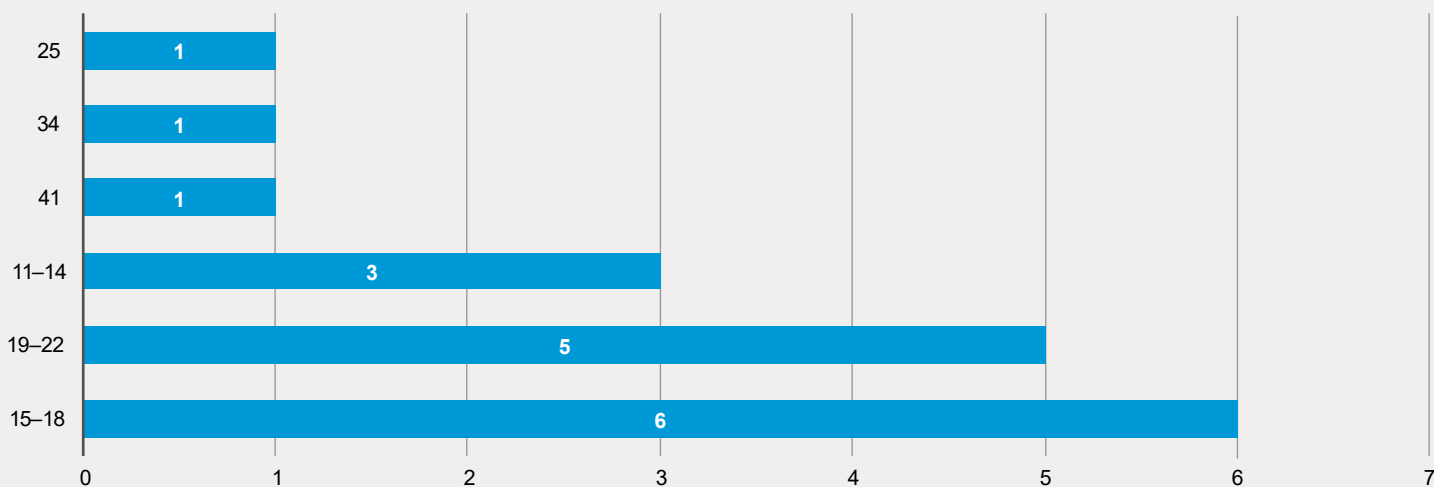
"In 2015–2016 we had largest board in Northern Hemisphere—135 members. At this size, the Board was a liability, there was no way to determine if the board fulfilled its fiduciary duty. Most work was done in committees (executive committee had 20 members and six key members that really controlled the board). The board chair at the time decided a change was needed; we brought in a firm to negotiate board reduction. The board ultimately voted itself out of existence; the executive committee became the fiduciary board, and all other individuals would return to their constituent institutions and become members of a community advisory board. All the delegated powers would reside at the system board."

"We need fewer board members, greater role clarity—local boards should be focused on quality and credentialing; in all other areas they should be advisory. The system board manages such things as financial matters, capital planning."

Note: Interview insights reflect systems' perspectives and are not necessarily endorsed as best practices.

Figure 1. Size of System Board

How many voting members are on the system board?



Case Study: Mayo Clinic (Part 1)

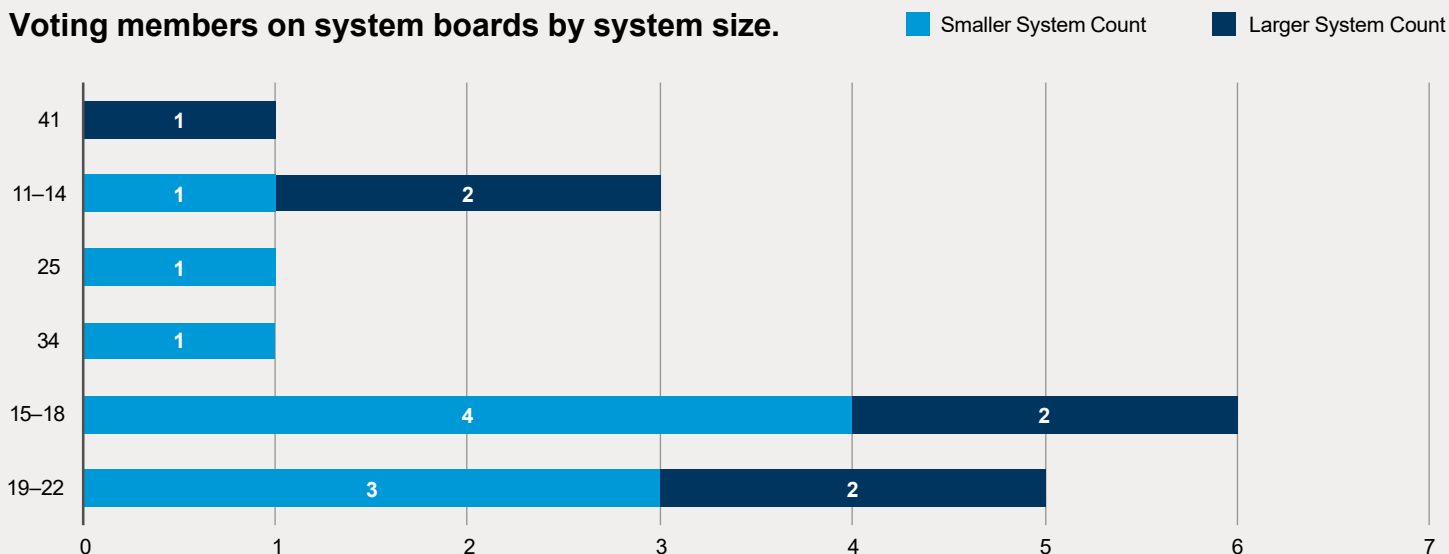
In updating our literature search, we came across a number of governance practices of the Mayo Clinic which we felt would be relevant to our inquiry (despite the fact that Mayo was not a survey participant). Systems with larger boards may want to consider the model adopted by the Mayo Clinic, which has a 31-member Board of Trustees. The size of their Board of Trustees appears to be intended to satisfy a number of internal needs through their governance structure, including ensuring representation from each of their distinct national regions, allowing for sufficient participation of independent board members (including several national experts) and incorporating the leadership of many of their medical specialties, in what is a decidedly physician-driven organization.

Mayo therefore divides governance responsibilities between their Board of Trustees and what they call their “Board of Governors,” a smaller group that includes members of the Board of Trustees, a number of internal managers who serve “*ex officio*” and select non-Trustee physician leaders from across their system who are elected to serve four-year terms. The Board of Governors also serves as the Executive Committee of the Board of Trustees. Mayo also meticulously describes (and regularly updates) a detailed overview of the relative powers and duties of the two boards, which is available to the public on their website. The current overview, which is summarized in more detail in Part 2 on page 40, was last approved by their Board of Governors in 2023.

Mayo Clinic: Governance and Management Structure

Figure 2. Voting Members on System Board

Voting members on system boards by system size.



Note: Only two systems reported having fewer voting members than total board members. The majority reported 15 to 18 voting members with four of the six systems in this group being smaller, single-state systems.

Three systems plan to increase the current size of their system governing board. Twelve systems plan to maintain the current size; however, the majority of these currently have 15 to 18 member boards. Two systems plan to decrease size; they are also the two systems which indicated that they had increased board size in the recent years due to mergers or acquisitions.

Composition (Qualifications, Diversity, Expertise, Metrics)

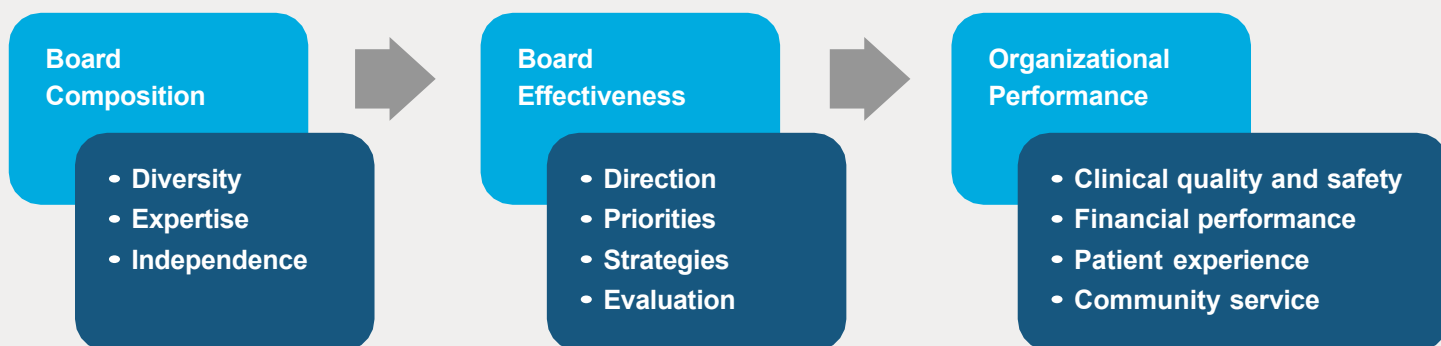
As described in a recent Governance Institute online publication, there is abundant evidence that *board effectiveness* has substantial impact on *organizational performance* and that *board composition* is a principal determinant of board effectiveness (Prybil and Gage, 2020). This is depicted in Figure 3. Given the importance of board composition in this equation, it is surprising that board succession planning—the process through which the needs for board talent are determined and future board members are selected—is not given more attention and priority, both in organizational policies and practices and in governance studies.

Governance Best Practices: Appointment Process

- *Take great care in selection of trustees.*
- *Multi-hospital health systems should consider using professional recruiters.*
- *Build in coherent transition and succession process so future trustees are identified and groomed for leadership.*
- *A governance and/or nominating committee should be appointed to identify, interview and nominate board members.*

Best Practices in Board Succession Planning

Figure 3: Linkage Among Board Composition, Board Effectiveness, and Organizational Performance



Source: *The Governance Institute, Prybil & Gage, 2020.*

A majority of systems surveyed (10 systems) have “outside” or national experts serving on their system boards, and an even larger proportion (11) includes such experts on their committees. One system reported the absence of national experts, attributing this to its board being composed of highly accomplished individuals from within their community (a large metropolitan area). However, systems headquartered in smaller cities or rural areas may experience greater difficulty attracting the range of skills and diversity of experience that is considered desirable. One such system noted difficulties in recruiting board members with national expertise.

Thirteen systems conduct annual evaluations to identify gaps in board expertise, while one system performs this assessment semi-annually. Two systems evaluate their board expertise every two to three years, and one system does so every five years. All systems actively recruit new board members based on the expertise or representation needed. However, one system reported challenges in recruiting qualified individuals for its health system board, citing the industry's complexities and the additional layers of complexity introduced by subsidiaries and other business units.

Governance Best Practices

Board Composition:

Board candidates should demonstrate the ability to deal with complex situations, lead effectively through change, and think and act strategically.

Governance in Transformational Times

Some governance experts have found that “structures alone” do not necessarily lead to effective decisions and policymaking. Leadership—the quality of board leadership and the ability to generate trust and respect can play an equal role (Kezar, Adrianna 2004). Several respondents indicated that leadership qualities of key board members (as well as of the CEO and other key managers) has contributed greatly to the success in particular of major mergers and acquisitions.

Discussions with surveyed systems also highlighted a strong commitment to diversity, aimed at ensuring their boards mirror the communities they serve and are strategically prepared for the future. Board membership diversity was not included in the original survey. However, in the 2015–2016 survey, a brief follow-up questionnaire was sent to the surveyed systems. All of the respondents to that follow-up survey gave important consideration to diversity in board composition and consider gender, age and race in combination with competency when targeting new board members. In the 2023 survey, one system identified diversity and the advanced age of key board members, several of whom are 85 years old or older, as its primary challenges. Another system pointed out that it prioritizes diversity over expertise, which is currently deemed less urgent.

Succession Planning

Succession planning is an essential component of effective nonprofit governance. It is important for boards to make room for new members who may have skills, experiences and capabilities needed to meet new challenges and prepare adequately for the future. Boards that lack term limits, or do not effectively engage in succession planning, can find that they are dominated by a few senior members who discourage newer or younger members from investing the time and commitment to become future leaders.

Effective succession planning must consist of more than simply tapping into the same traditional “old friend networks” whenever a board vacancy occurs. Boards must take account of the full range of skills, experiences and personal characteristics needed on a successful governing board. This, in turn, requires attention both to the qualifications of each potential board member and the needs of the board as a whole. In a high-performing board, each board member should be expected to possess integrity, passion for the hospital’s mission, willingness to provide independent counsel and ask probing questions, and sufficient dedication to attend board meetings, serve on committees and be both educated and prepared.

Hospitals and health systems experienced great strain during the pandemic. In this post-pandemic era, a great deal of reflection has occurred on health systems and operations as a whole. Planning for the future also means planning to appropriately transition out of one phase and into another while ensuring that the necessary tools and people are in place for all areas. A healthy governance board environment can be

INTERVIEW INSIGHTS

Board Composition

“Challenges for board member recruitment and education lie in our diversified portfolio, not regional variation. Board members with financial backgrounds don’t necessarily understand health care finance, and complexity grows when you consider subsidiaries and other business units.”

“We have made a list of qualities we want to see in board members but haven’t implemented it effectively yet. We aren’t as rigorous as we should be in bringing in new members. Diversity is a big issue but easier said than done.”

“We have over a dozen ex officio board members. It is sometimes a struggle to keep discussion of fiduciary duties alive in the boardroom. This is an ongoing challenge to allow active participation. Ten members are engaged and work well together, but we have 20 others who are mostly wallflowers.”

“Permitting ex officio membership on the system board by the chairs of subsidiaries means that we have six members of the 11-member system board who are out within two years. This is simply not enough time to become an effective system board member. We have now added two new board members and would like to move away from this board composition setup.”

“The challenge of getting our board down to 15 members is filling out the competency matrix. Even at 21, we sometimes feel that they are light on certain competencies.”

maintained through appropriate recruitment efforts and succession planning. In the 2023 survey results, all but one system leverages a skills and capabilities matrix. The details of this matrix vary from respondent to respondent with ten systems building their internal matrix whereas three systems leverage external evaluations. Notably, one system now uses a field for “diversity” to explicitly identify gaps to work toward building a more representative board. The majority of systems evaluate gaps in expertise or skills needed on an annual basis or at least every two or three years. One system practices board evaluation every five years or longer. This system is unique in their process since they are the only volunteer-sourced board and do not recruit members or work to identify gaps in needed expertise.

One of the surveyed systems reported that they had been slow in moving toward term limits because some of their longstanding trustees had been major donors and had also participated vigorously in leading the system through a period of rapid and successful growth. However, these trustees were now all in their 80s, and with the system “in the middle of a potential leadership transition, a succession plan was being developed for senior board members who have served for many years in our health system.”

Ten of the surveyed systems employ a nominating process for selecting board officers, with one of these systems also open to volunteers. Four systems have implemented succession plans for their board officers. One system described a selection process where internal executives and leaders choose new board members. Another system mentioned that their religious sponsor appoints members of the system corporation, who in turn become board members and are responsible for selecting additional board members. One system conducts annual elections, influenced both by succession planning and nominations from the governance committee. Meanwhile, another system adheres to a specific selection process governed by the university's Governing Regulation and state regulations.

Governance Best Practices: Succession Planning

- *Board-approved statement of the basic qualifications for all board appointees and a position description for board members.*
- *Standing board committee with responsibility to lead board succession planning.*
- *Assessing the board's evolving needs for talent.*
- *Creating and maintaining an inventory of highly qualified candidates as a foundation for identifying nominations.*
- *Interviews with selected candidates for board appointments.*
- *Limiting the number of ex officio board members.*
- *Planning for clinical experience on system boards.*
- *Building a process for identifying candidates for board leadership roles.*

Best Practices in Board Succession Planning

Physicians (and Other Clinicians) as Board Members

With respect to physicians, all of the systems indicated they employ physicians, and 12 indicated their system and subsidiaries employ more than 1,000 physicians. In addition, all of the surveyed systems indicated they also have affiliated physicians within their system.

The recent trend in most high-performing health systems has been to offer a full continuum of care. To that end, most systems indicated they utilize accountable care organizations (ACOs) and/or clinically integrated networks (CINs) and other arrangements to integrate employed and independent physicians. Additional methods of clinical integration identified by surveyed systems include:

- Creation of a risk assumption contracting company.
- Creation of a separate physician corporation.
- Membership of open (non-contracted) physicians on the medical staff of various hospitals in each system.
- Platform integration plans which include soliciting input from open staff physicians.
- Medical staff presidents serving as liaisons with open staff physicians and management.
- Regularly scheduled opportunities to discuss clinical and cultural issues between employed and independent physicians.

INTERVIEW INSIGHTS

Clinical Expertise on Boards

"The current CEO is an MD and prioritizes clinical expertise for the board. The Chair of the quality committee is an MD and former executive at another system. We would not recruit an active physician due to time constraints. We recruited a Chief Nursing Officer and have her serving on the board. There are also a couple of academic PhDs on the board."

"We have no doctors on our board because we have 5,000 physicians and we had trouble early on—they couldn't drop their constituency point of view. Doctors come to board meetings, can ask questions, serve on committees. We also have no nurses on board because they are all unionized."

Governance Best Practices: Role of Physicians in Health System Governance

- *Greater doctor involvement in the governance of US private acute care hospitals leads to higher bed occupancy and operating margins.*
- *Non-profit hospitals outperform the private sector counterparts in terms of overall profitability when doctor involvement in governance roles is higher.*
- *Many studies have found that boards with clinicians have significantly better financial performance than boards without any doctor participation.*
- *However, some scholars have found evidence of a negative impact of doctor involvement in hospital management, resulting in lower efficiency.*
- *Board culture improves with the number of physicians on the board—data shows a positive relationship up to six physicians.*

Clinical Leadership and Hospital Performance: Assessing the Evidence Base

Think Bold: Looking Forward with a Fresh Governance Mindset

Effective succession planning should include ensuring that the board has access to experienced clinical leadership, including nurse leaders as well as physicians and other clinicians. However, while clinical leaders can serve as effective board members, some systems expressed caution at the potential conflict of interest presented by active system clinicians serving in board positions. Such systems looked for board level clinical expertise from outside the system. These systems relied on their own clinical leadership to provide advice and expertise to the board through participation on committees, through the organized medical staff structure and through the formation of new clinical entities such as ACOs and CINs, rather than serving as system trustees.

Only one system surveyed does not have a physician on its system board, citing previous challenges with physicians maintaining a constituency perspective as the reason for transitioning away from clinician membership. However, physicians still participate on committees in this system. In contrast, the remaining systems have between one and seven physician board members, with an average of three; seven systems have included physician membership in their bylaws. Additionally, one system noted that while it includes physicians on the board, it does not recruit active physicians due to the significant time commitments required by board service. Another system emphasized that apart from the Dean of the affiliated medical school, who served *ex officio*, physicians were included among "outside experts" on the board to avoid potential conflicts of interest that might arise if a physician board member also provided services in one of the system hospitals.

Use of *Ex Officio* Members

Given the trend toward streamlining nonprofit hospital boards, effective succession planning that includes ensuring the board has the desired diversity of skills and expertise can be challenging. One way to meet this challenge is to limit the number of "ex officio" or "constituency-based" board members. Having a large number of *ex officio* trustees raises the question of whether a board is representational rather than strategic.

Sixteen of the surveyed systems include the CEO as an *ex officio* member, with 14 of these CEOs having voting rights. However, only six systems include other voting *ex officio* members, with total *ex officio* counts ranging from one to seven across 16 of the 17 systems surveyed. Two systems reported having additional non-voting *ex officio* members, and one of these systems expressed an intention to reduce the number of *ex officio* members in the future.

While there are advantages to having some *ex officio* members on a system board, it is important to understand that many *ex officio* appointees (with the exception of system leadership such as the CEO and the Chief Medical Officer) are going to have potentially conflicting loyalties. Several of the systems surveyed include *ex officio* board members due to merger agreements combining two organizations, because of the need for representation from “sponsor” organizations in faith-based systems, or attributable to relationships between the systems and medical schools or other academic organizations (see discussion of each of these situations below).

However, even in such cases, it is important to bear in mind that all board members, including *ex officio* trustees, are subject to the same duties, responsibilities, and liabilities (including requirements related to conflicts of interest and confidentiality), and should also be provided as any other director and therefore should be subject to the same mandatory orientation and education and are asked to disclose potential or real conflicts of interest in the same way as other directors.

It is also important that the number of *ex officio* members not “crowd out” independent members or trustees, such as at-large board members who bring a needed range of skills, experiences, and personal capabilities to the board.

Compensation of Board Members

Three of the surveyed systems compensate their board members. This is approximately the same percentage as in the 2015–2016 survey, where two respondents reported compensating their board members. However, we note that the systems reporting compensating board members in this survey are not the same as in the 2015–2016 survey. Taken together with a few reports in the literature, we believe there is at least a modest trend toward the recognition that the demands on board members of large, complex nonprofit health systems, both in terms of the expertise and experience required of board members today, and the demands on their time and attention once appointed.

A representative of one system that does not yet compensate trustees pointed out that they were considering doing so because they were having a more difficult time recruiting high-quality members who also have options for well-compensated board membership in large, public business corporations. Even when they were able to recruit a member who also served on business company boards, they heard anecdotally that the board member devoted less attention to the nonprofit board. “We were told that he never missed a corporate board meeting, while he missed several of our meetings over the course of a few years.” Compensating board members can also make it possible to broaden the diversity and experiences of the board membership.

Governance Best Practices: Use of Ex Officio Members

Some governance experts recommend a maximum of two ex officio board members; typically, the CEO and medical staff Chief of Staff, to help ensure that insider perspectives or interests do not dominate the board.

A Guide to Good Governance

Governance Best Practices: Compensation of Board Members

While nonprofit board members are much less likely to receive compensation than directors of business corporations, in large, complex hospital systems, paying board members a limited stipend for their expertise and commitment should be considered one tool in the tool-bag. If a system elects to compensate trustees, it should take into account ways to accommodate directors who do not wish to accept such compensation (such as the opportunity to donate it back to the system) while being sensitive to not putting undue pressure on trustees who could benefit from a stipend.

Of course, some nonprofit board members serve for a combination of prestige in their communities, the opportunity to “give back” and because they also are prepared to donate funds—sometimes substantial sums—to the organization. Such members are unlikely to be motivated by compensation, and some may even be offended. Some nonprofit organizations (not just hospitals) that compensate board members make it voluntary, although one of the surveyed systems that considered that approach decided it should be mandatory to avoid undue pressure on members who may appreciate it. Still, nothing prevents a compensated trustee from donating a similar amount to the organization.

Within the survey group, two systems also offer additional compensation for their board Chair and national experts, while one system provides remuneration for other officers. The remaining fourteen systems do not offer compensation to their trustees or board chairs. One system, which recently started compensating its trustees, explained in an interview that the decision was made to prevent board members from feeling overworked and underappreciated. However, trustees at this system do have the option to decline the compensation if they wish.

On balance, we have come to believe that some form of compensation for board members could be considered an emerging “best practice” for large, complex systems, as long as there are appropriate mechanisms for taking into account differences among members.

INTERVIEW INSIGHTS

Board Compensation

"We went to an AHA conference and asked the question, 'how many of you pay trustees?' The answer was 'quite a few.' We use a comp consulting firm to pay board members an 'appreciation stipend.' We pay the Chair a flat \$50K. All board members get \$30K and the chairs of committees get an additional \$5K."

"Board compensation is considered a stipend. We pay more to committee chairs (\$50K) and the board chair (\$75K) than to board members who are not board or committee chairs (\$40K)."



Terms and Term Limits

The survey results show that 14 systems operate with three-year terms for board members. Among the other systems, one maintains one-year terms, another has five-year terms, and one features four-year terms for elected members and six-year terms for appointed members. There is greater variability in term limits: 10 systems enforce a three-term limit, three systems allow up to four terms, one system permits up to nine terms, one has a two-term limit, one has a one-term limit, and one system does not impose any term limits. Regarding exceptions to these term limits, six systems reported that there are no exceptions, whereas eight systems make allowances for *ex officio* members and six for officers.

Governance Best Practices: Terms and Term Limits

Currently, consensus on good governance practice is that directors should serve for terms of at least three years with a maximum limit of nine years. Board officers and Committee chairs should also be subject to term limits, although we agree that those can be somewhat longer than three years. Reasonable but carefully limited exceptions can be made.

Think Bold: Looking Forward with a Fresh Governance Mindset

Length of terms and term limits represent a balancing act on the part of health system boards. On the one hand, as systems grow over time, familiarity with the structure, operations, finances, and short-and-long-term goals of the system are important assets. Acquiring such knowledge represents a steep learning curve and an investment of time and resources, especially as the health care system itself becomes increasingly complex. It can also take time and considerable education for members to be ready to ascend to Board or Committee chairs or assume other leadership responsibilities, as well as to be able to serve as mentors to newer board members.

INTERVIEW INSIGHTS

Term Limits

"We have an 'old fashioned' approach to term limits – we need turnover. We have recently staggered the board at one to three years – now all 16 legacy board members will rotate off. New CEO is driving the goal to get experts on board – until now the board was viewed as parochial, with members recruiting their friends. They were not philanthropic."

"All current board members have far exceeded term limits. Board members agreed that they wanted to have term limits but when push came to shove they did not actually want to give up their board seat."

Most surveyed systems that have terms and term limits do make exceptions for officers and committee chairs, who often also have limited terms that do not necessarily coincide with the length of their terms as board members. In such case, officers and committee chairs are permitted to serve out the length of their term in that position.

On the other hand, if term limits are excessively long, or as in one surveyed system, non-existent, it may prove harder to recruit new members in the community who may see a long path to being able to make meaningful contributions.

In sum, three-year terms seem consistently to be standard at the hospitals we surveyed, and we believe a nine-year term limit should also be considered a best practice.

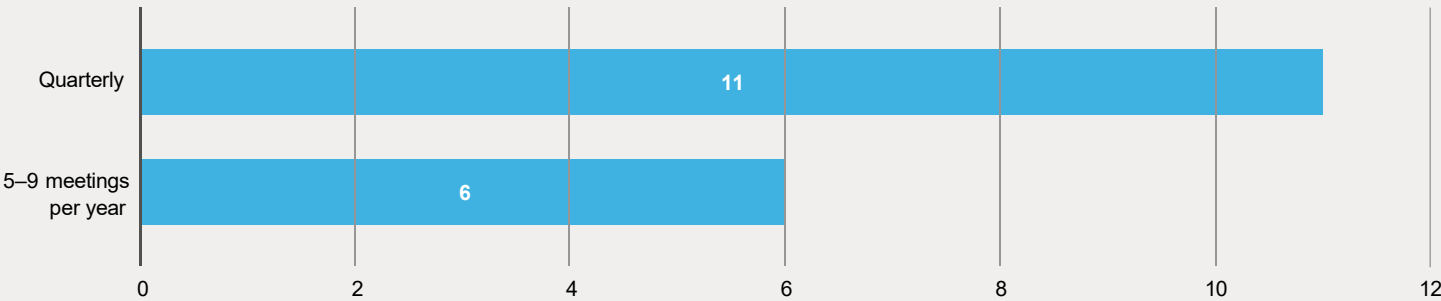
Key Characteristics and Best Practices of Effective System Boards: *Effectiveness in Conducting the Work of the Board*

Board Meetings – Frequency & Length

All of the system boards meet at least quarterly, with 11 of the 17 systems surveyed reporting quarterly meetings. The remaining six systems meet five to nine times per year. When system boards meet, eight meet for a full day or longer, eight meet for two to four hours, and one meets for two hours or less. Survey results show that 12 survey respondents use a consent agenda.

Figure 4. Frequency of System Board Meetings

How frequently does your system board have regularly scheduled meetings?

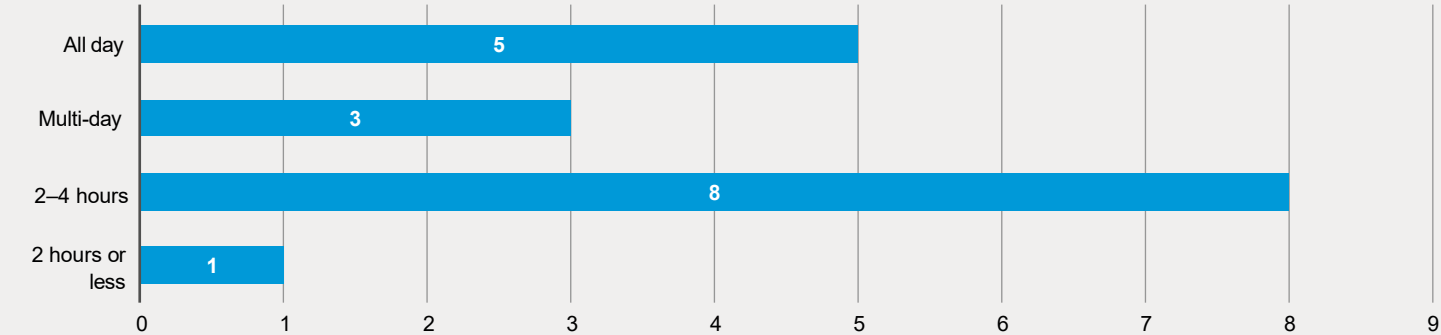


Note: The majority (65%) of systems hold quarterly board meetings.

Interview findings show that participants found full or multi-day board meetings to be most beneficial due to the amount of content to cover and to also allow enough time for debate in decision making.

Figure 5. Duration of System Board Meetings

How long are regular system board meetings?



Note: 8 surveyed systems hold board meetings for 2-4 hours, while the same number allocate a full day or more.



During the follow-up discussions, one health system commented on their move from a 90-minute meeting to a two-day meeting:

Prior to the two-day system, we would meet for only 90-minutes with no exceptions. In this forum, we would move directly into the next topic without allowing time to reflect, debate, and fully understand the topic at hand in a productive way. We now have a two-day system. In this forum, we have management reports for Quality, Finance, CEO and COO reports. About half the time is taken up by the CEO and staff reporting. We now have an executive session held for 10 minutes at the end of each session. Sometimes the CEO stays, but this changes each time. We have found the two-day sessions far more productive.

In conversations with other health systems, it was apparent that the preference to host meetings for day-long sessions and to host these sessions in person maximized these sessions. As part of the go-forward plan, one health system is working toward re-instating the requirement to host all meetings in person claiming, “There is something to be said about being in the room. By 2025, we will have all boards meeting in person. We feel most productive in person. With an in-person environment, we can dig deeper into each topic and truly discuss pressing issues on a more intimate level.”

At the same time, with longer meetings it is important to guard against “meeting fatigue” on the part of board members. The use of read-ahead board materials (carefully crafted for direct and succinct communication) and consent agendas for routine decisions is important. Also, breaking up the day among topics of interest or concern (other than when addressing a crisis or a strategic decision that demands the board’s full time and attention) is important. While boards should guard against meetings where they are largely being read to (or spoon fed) by management, in a day long setting or longer, it is helpful to break up the day with the occasional outside speaker or educational session. Similarly, if a board meeting includes a reception or dinner the night before or the day of a board meeting, this should be considered genuinely valuable time for board members to socialize and get to know one another.

INTERVIEW INSIGHTS

Board Meetings

“We had previously been wedded to the idea of 90-minute board meetings. This spring, we are implementing spring and fall meetings which will be 100% in person and will occur over the span of two days.”

“We lost synergy during the virtual years—we lost the engagement with our various boards. There is something to be said about being in the room. It is more productive. Now we meet quarterly, in a two day cycle, six hours per day, with committees on the first day.”

“Board meetings are on a two-day cycle. The Board carves out time to talk about disruptive issues in the industry, including issues where it may be imperative to behave differently.”

“Board presentations must have a six-slide limit (except for financial presentations). Presentations must last no more than 30 minutes and that must set aside ten for questions and discussion.”

“Historically meetings were 85% presentation (aside from annual retreats). In the last two years, we put more information into pre-read materials, and we now operate with the principal that only 25-33% of meeting should be presentation, and no more than six slides per presentation. Board dialogue has been of more emphasis in recent years.”

“We don’t use a consent agenda, but I wish we would.”

- Eleven of the 17 systems surveyed report quarterly meetings.
- Eight systems meet for a full day or longer, while eight systems meet for two to four hours.
- Interview findings show that participants found full or multi-day board meetings, held quarterly, to be most beneficial due to the amount of content to cover and to allow enough time for debate in decision-making.
- With longer meetings it is important to guard against “meeting fatigue.” The use of read-ahead board materials (carefully crafted for direct and succinct communication) and consent agendas for routine decisions is important.
- There appears to be consensus that in-person meetings are more effective than virtual meetings. While CEO, management and committee reports in key areas are important, boards should guard against meetings where they are largely being read to by management.
- No more than half of the meeting should be devoted to management reports, and a best practice identified by one respondent is to limit presentations to no more than six slides.
- An executive session should be on the agenda at the end of each meeting, with an agenda set in advance. At least part of the session should be scheduled without the CEO present, to encourage candor and confidentiality, and the involvement of other managers should be limited to those necessary for the consideration of specific topics.
- In a day-long setting or longer, it is helpful to break up the day with the occasional outside speaker or educational session.
- Fifteen of the surveyed systems hold either an annual or biannual one- to two-day retreat.

Board Meetings – Meeting Agendas

Survey results show that 12 survey respondents use a consent agenda. Twelve systems also reported spending more than 25% of their meeting time on “Financial Performance,” which three systems spend over 50% of their time discussing. Eleven systems indicated that they spend more than 25% of their time on “Strategic Growth and Competition,” with two systems noting they spend more than 50% of their time on this subject. Other priority topics considered by peer systems in board meetings include Operational Performance, Quality & Patient Satisfaction, and Payment/Delivery System Reform. Research shows a significant correlation between use of a consent agenda and boards spending 40% or more of their meeting time in active discussion. Additionally, as the amount of time spent in active discussion about strategic priorities increases, boards are more likely to report “excellent” performance in their fiduciary duties and core oversight responsibilities (Peisert & Wagner, 2023).

Board Meetings – Read-Ahead Materials (the “Board Book”)

Most of the surveyed systems disseminate the board materials electronically through a web-based portal instead of hard copy materials sent by mail or provided at the meeting. Only one system hands out board meeting materials prior to the meeting via a hard copy form by mail or courier. One other system reported providing materials at the meeting instead of sharing prior to the meeting.

Dedicated Board Staff Support

Governance has become more sophisticated due to market challenges, regulatory environment, a wide range of serious litigation and security threats and the increasing sophistication of healthcare. Most surveyed systems have administrative staff specifically dedicated to board matters, such as delegating responsibility to the general counsel or governance officer. One system said that “We have a very strong and separate governance department, which does not report to the general counsel. It reports straight up to a Senior Vice President who reports to the CEO.” Others rely on their Chief Legal Officer to play this role or oversee a governance specialist. Two systems leverage the use of external governance consultants. Fifteen of the systems surveyed have dedicated administrative staff to support the board, and 14 systems indicate that there is a specific designated role for the system’s general counsel. One surveyed system maintained that, “Our Chief Legal Officer has created a governance office focused on intentional governance practices and adopted a ‘One [System] Governance Plan’ with ten standards for governance.”

Use of Executive Sessions

The use of executive sessions is widely misunderstood and continues to be debated even by governance experts. As a result, it is a practice that can be subject to misuse, which can cause mistrust and bad feelings amongst board members, and between boards and management.

However, as a recent Governance Institute publication pointed out, executive sessions can serve several core purposes. (Prybil & Gage, 2023). These sessions:

- Assure candor and confidentiality for board members in discussing sensitive matters.
- Create a mechanism for board independence and oversight.
- Provide an opportunity for all board members, not just a select few, to participate in governance.
- Allow board members frankly and honestly to assess their own performance and that of the board as a whole.
- Permit the board to raise and discuss sensitive issues related to the performance of the CEO or other C-suite staff.
- Foster discussion of the relationship between the CEO and the board and discuss difficult or controversial issues that the board and CEO may not wish to share with staff when the CEO is included.

INTERVIEW INSIGHTS

Executive Sessions

"Usually following the segment of an executive session without the CEO, the Chair and Vice Chair come directly to the CEO's office to to explain what was discussed and what is needed."

"If an Executive session is scheduled every time, then the board is very comfortable giving feedback to and receiving it from the CEO."

"Executive sessions are always held for ten minutes at the end of each session. This is different each time in terms of having the CEO there or not."

All but one of the surveyed systems reported the use of executive sessions. Most of the systems reported regularly scheduling such sessions, both with and without the CEO present. No systems reported including other staff in such sessions except to serve as subject matter experts on specific topics discussed.

Interviews with survey participants and our review of the relevant literature suggests the following can be considered "best practices" when it comes to executive sessions:

- Boards should adopt an explicit policy statement regarding the use of executive sessions.
- Regularly schedule executive sessions as part of every board meeting.
- Except in emergency situations, never call executive sessions on the spur of the moment.
- Have an agenda with specific issues and limit discussions to those issues.
- If the executive session includes a period in which board members may raise new concerns or suggest agenda items, reserve substantive discussion for future meetings.
- Conduct some portion of each executive session with the presence of the CEO (and possibly other staff, such as the General Counsel, Chief Compliance Officer, or Chief Medical Officer, if needed to discuss specific issues).
- Issues discussed without the CEO present should be shared with the CEO by the board chair (or other designated board member) as soon as possible following the session.

Use of Committees

Results varied in terms of member involvement in standing and ad hoc committees. Only six systems report having all board members participating in standing committees. Other committees typically involve a committee chair and then voluntary board members participating as active members.

There appears to be a trend toward streamlining the use of committees by hospital system boards. Only five committees appeared to be common to most or all of the systems surveyed. All 17 surveyed systems reported having a Finance and Investments Committee, an Audit and Compliance Committee and a Governance/Nominating Committee. All but two systems reported having a Patient Care Quality and Safety Committee and an Executive Committee, and all but three reported having an Executive Compensation Committee. However, far fewer than half of the systems reported having a Board Education, Community Benefit, Strategic Planning, System Strategy, or Credentialing Committee. Some of the expected functions of these committees were instead delegated to other committees or (in some cases) to individual hospital or regional boards. While most systems have Executive Committees, their role appears to have been somewhat diminished in recent years, as the size of system boards has been reduced. Eleven systems reported that their Executive Committees only meet “as needed,” while five systems reported that they met as or more frequently than the full board. (These tended to be the systems with larger boards.) Ten systems reported that they make use of ad hoc committees to address specific issues as needed.

Executive Committee

While most systems have Executive Committees, their role appears to have been somewhat diminished in recent years, as the size of system boards has been reduced. Eleven systems reported that their Executive Committees only meet “as needed”, while five reported that they met as or more frequently than the full board. (These tended to be systems with larger boards.)

Ten systems appear to give the system board Executive Committee full authority to act on behalf of the board on all issues between board meetings. Others limited the scope of the Executive Committee actions to emergencies, time-sensitive issues or “Matters that cannot reasonably await action by the full board of directors,” as one system put it. One system reported delegating specific powers in three areas: 1) advice and counsel for the CEO in sensitive matters, 2) authority to act on behalf of the board in case of emergency and 3) provide continuity in progress and communications pertaining to evolving business activities between regularly scheduled board meetings.” On the other hand, another system reported that “because of Zoom, we never had to convene the Executive Committee since the board was reorganized.”

Figure 6. Standing Committees

System Committees	Count
Audit and Compliance	17
Finance and Investments	17
Governance/Nominating	17
Executive	15
Patient Care Quality and Safety	15
Executive Compensation	14
Other	9
Credentialing	6
System Strategy and Planning	4
Community Benefit Finance	3
Strategic Planning	2
Board Education and Development	0

Note: Board education is part of the charter of most governance/nominating committees.

INTERVIEW INSIGHTS

Committees

"We have had too many committees—we have gone from eight to five. We eliminated the Quality and Behavioral Health Committees and moved the investment committee to a subcommittee of Finance."

"We have tried to reduce the size of the board and board committees. Our children's hospital now has a nine to 11 member board and has eliminated all committees. The full system board only has Patient Experience, Quality, and Financial Health Committees and has recently added Employee Engagement."

"We only have five committees, which allows all members to serve on two committees. Committees always meet virtually, with a quarterly cadence for all."

"Committees have been added as market dynamics have changed (we have added a Tech and Innovation Committee and a Public Issues Committee)."

"The Executive Committee has a charter but in fact does not meet frequently—only once in 24 months. We feel we need a sense of teamwork and trust among all trustees."

Key Characteristics and Best Practices of Effective System Boards: *Governance of Subsidiaries and Affiliates*

Governance of Individual Hospitals or Regions

There is considerable variation within surveyed health systems with regards to the governance of individual hospitals or regions within the system. Nine systems reported that “Some owned hospitals and/or systems have fiduciary boards,” whereas six reported that “Some owned hospitals and/or systems have advisory boards,” and only three reported that “No owned hospitals or regional systems have boards.” However, it appears that the trend is in the direction of eliminating local or regional boards or moving toward advisory rather than fiduciary governance at the local or regional level.

Survey results greatly varied amongst all respondents regarding the governance of individual hospitals within the system. From interview findings, common feedback revolved around the desire to revise current processes for setting up and running advisory and fiduciary board structures. There is a general interest in moving away from fiduciary board structures at the local and regional level because the boards interviewed commented often on the need to ensure alignment across the system. Systems have had issues with alignment of interests and strategic direction due to having many boards with conflicting voices. Overall, survey responses trended heavily toward having some type of fiduciary board structure over advisory board structures.

For systems with both fiduciary and advisory boards, it was apparent that these structures existed due to the provisions of a merger or acquisition agreement. Three system structures do not include any subsidiary boards at all; instead, these boards deploy mirror boards in which the system trustees are also trustees of other licensed entities. One of these systems has a non-fiduciary advisory council at each of their community hospitals.

One system’s response indicated that regional and community boards have advisory roles as well as some limited fiduciary responsibilities. These responsibilities are particularly for patient quality, safety, and experience. Nine systems have subsidiary boards that are organized under the system board: seven of these boards report directly to the system board, one board only has all fully owned or controlled subsidiary boards appointed and directly reporting to the system board while the grandchild entities have members appointed by and reporting to their direct parents. Six subsidiary boards are organized locally or regionally. One of these boards is organized locally but is appointed by the system board; yet they do not report directly to the system board.

Several systems reported that they have moved, or plan to move in the future, from independent local hospital boards to “mirror” boards, in which the system board also serves as the hospital or regional board. In such cases, the local mirror board meets at the same time as the system board.

Some systems are committed by the terms of mergers or acquisitions to maintain local or regional boards within the system, although such boards are often time-limited, which can create a delicate political situation when the period for maintaining a local board expires.

Where local hospital boards do retain some fiduciary responsibility, it is increasingly limited to a few areas, such as maintaining community relations, overseeing the delivery of community benefits, monitoring quality, safety and patient and employee satisfaction, and credentialing the local medical staff.

Most of the local/subsidiary boards are about the same size as the system board. Most systems do not have plans to change the size of local/subsidiary boards, but those that do maintain the size of the local/subsidiary boards say that they plan to reduce the size. None of the systems plan to increase the size of local/subsidiary boards.

Nine of the systems that have local boards indicate that those boards are appointed by and directly report to the system board; whereas four systems stated that local or regional boards are organized locally or regionally but report to the system board. Only one system reported that local hospital boards were appointed locally and did not report to the system board, while one system said that local boards were appointed by, but did not report to, the system board.

Within 12 systems, the regional/local boards only have a reporting representation at the level of the system board. Only three systems reported that local boards were entitled to representation on the system board, while one system reported that “Some, but not all, local boards are entitled to membership on the system board.”

Because governance of local or regional hospitals is an area which appears to be in a state of flux, we requested narrative comments from system representatives. One system responded to this section of the survey by noting, “By restructuring our hospital boards to just local advisory boards and doing away with fiduciary boards, we have a sense of system thinking across all hospitals. Our relationship between management and board governance is stronger than ever.” Another system CEO stated, “We have recently reduced our [local] hospital board by half (nine to 11 members) and have eliminated all committees. We want to streamline and minimize duplicity across the system.”

A third system representative told us, “Our board is no longer a constituent board. There is no fiduciary board over anything in the health system. Each hospital has a community advisory board. We have a disciplined management structure. We have a reverse hub and spoke model. The board members realized the most important thing they could do to serve their community was to relinquish their independence to join the system board. Once they joined, they realized the benefit their hospital would have if they adopted a system-wide mindset instead of the individual hospital that they represent. This cultural shift allows management to be moved seamlessly between facilities, gives the ability to constantly curate staff, and provides opportunities to invest heavily in community health.”

And finally, a fourth system official said, “We are collapsing our regions and turning these into divisions. It has gotten too confusing with having secular hospitals with fiduciary boards that operate independently. We also have different states that operate differently than others too. [State] is actually our first group of regional boards that will be collapsing this structure and putting up one regional board for [the entire State].”

INTERVIEW INSIGHTS

Subsidiary Boards

“We have concurrent (mirror) boards for our hospitals except where otherwise legally required (e.g., health plan). We don’t keep separate minutes. Two hospitals are still separate corporations from prior to their acquisition, but we want to do away with this status. Four hospitals have advisory boards with three committees—Nominating, Quality and a third committee of their choice. The system board has most reserved powers.”

“We need fewer board members, greater role clarity—local boards should be focused on quality and credentialing—in all other areas they should be advisory.”

“We have a true self-perpetuating system board, and the system board serves as a mirror board for four of our licensed entities. In a board meeting, they will convene each of the entity boards for required items.”

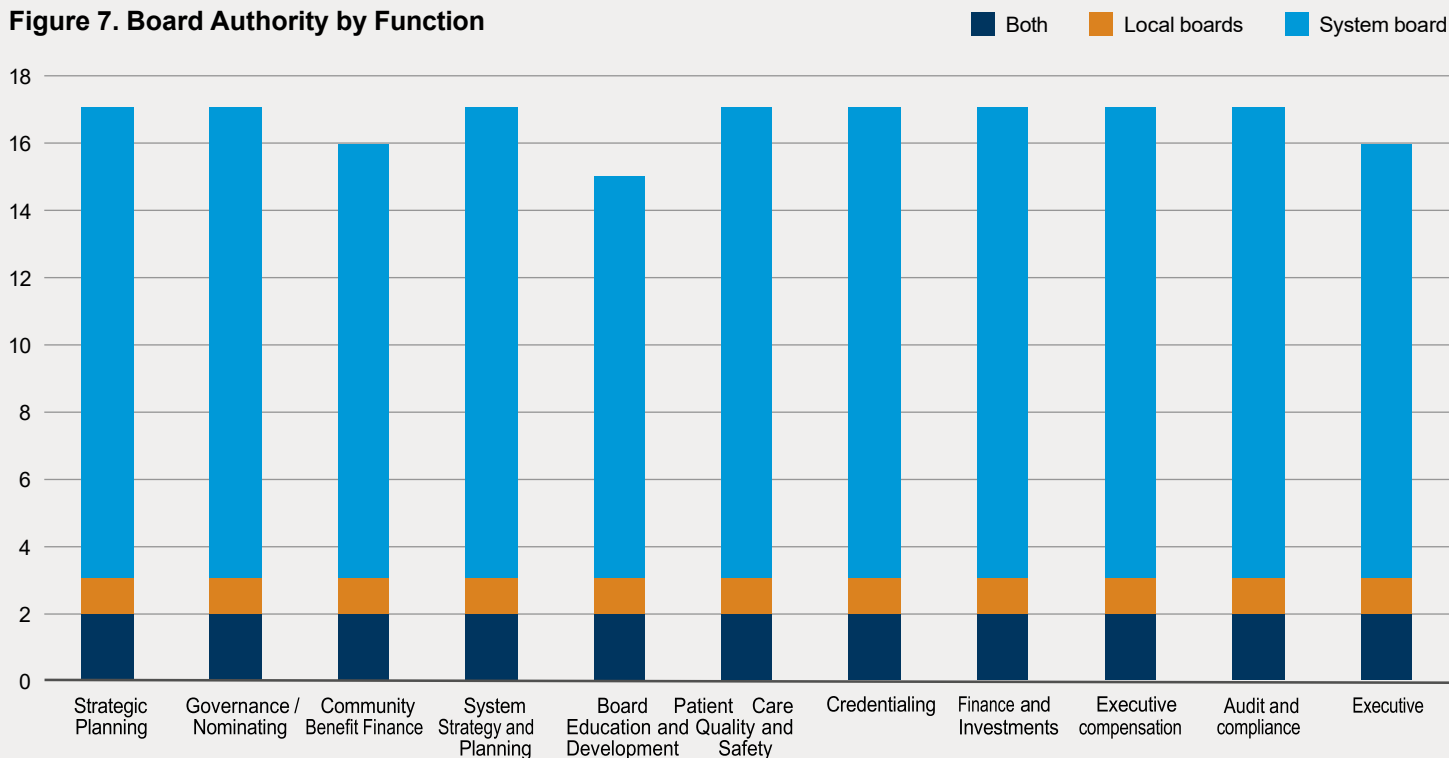
“We are more like a confederation of boards from among the various components that formed the system. However, we have a goal of integrating and aligning as a system over the next three to five years.”

“Of our 11 hospitals, nine have boards that meet concurrently with system board. Spring and fall meetings involve all hospital board members, who meet over two days and get to know each other.”

“Our hospitals do not have fiduciary boards, but they do have Community Advisory Councils.”

“Regional fiduciary boards have been streamlined so the system board retains full authority with two regional operating boards beneath it. Each regional board oversees all hospitals in their area.”

Figure 7. Board Authority by Function



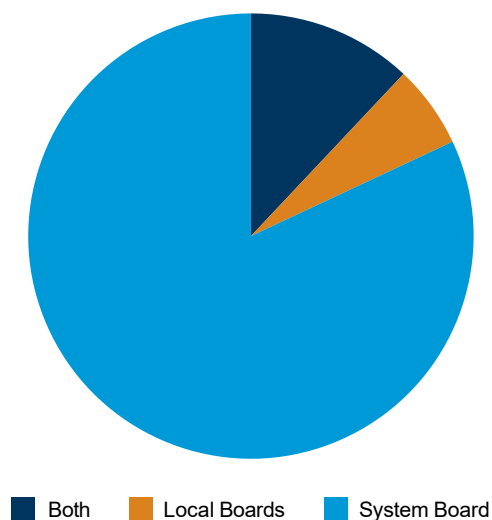
Note: A majority of systems reported that authority by function lies with the system board.

Figure 8. Governance Responsibility of Subsidiaries

Local/Subsidiary Committees	Count
Patient Care Quality and Safety	12
Governance / Nominating	10
Other	8
Executive	7
Finance and Investments	5
Executive Compensation	2
Community Benefit Finance	2
Strategic Planning	1
Board Education and Development	1
System Strategy and Planning	1

Note: A majority of systems reported that the Patient Care Quality and Safety (71%) and Governance/Nominating (59%) committees are committees of local or subsidiary boards. Only one system indicated that strategic planning was a committee at the local or subsidiary level. Systems that responded "Other" included local or subsidiary committees for Credentialing, Physician Compensation, Medical Executive Staff, Development, Community Benefit (no financial component), and Community Relations.

Figure 9. Authority of Boards



Note: Aggregate of Responses on Authority by Function, System, vs. Local Board

Figure 10. Governance Relationships with Health Plans and Other Non-Hospital Subsidiaries

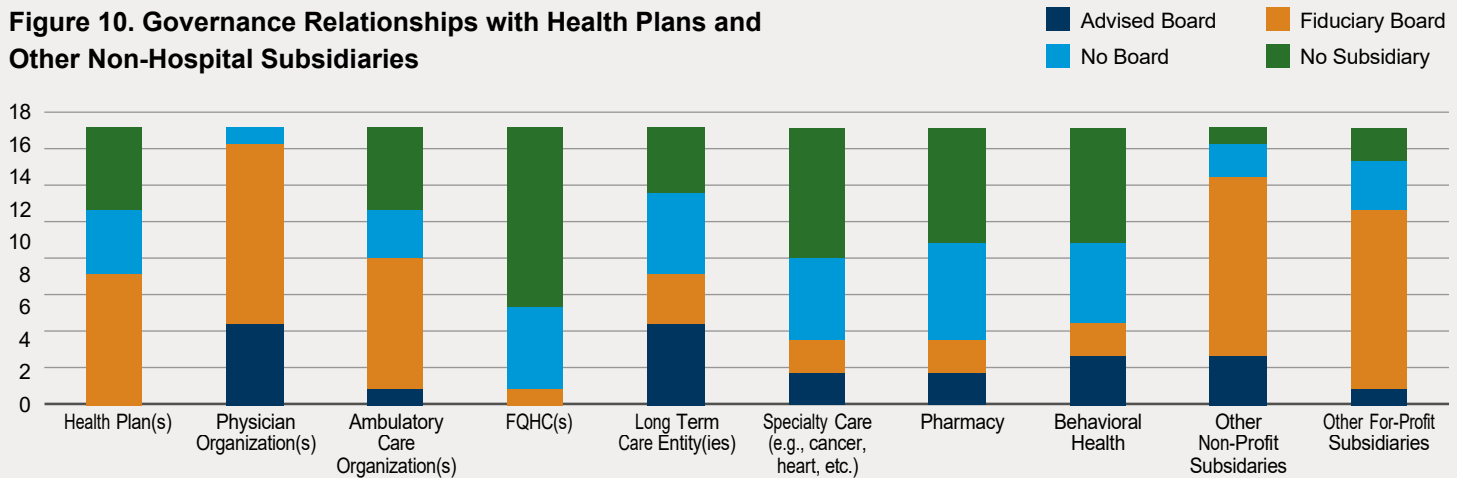


Figure 11. Separate Governing Boards by Subsidiary

	Advisory Board	Fiduciary Board	No Board	No Subsidiary
Health Plan(s)	0	8	4	5
Physician Organization(s)	5	11	1	0
Ambulatory Care Organization(s)	1	8	3	5
FQHC(s)	0	1	5	11
Long Term Care Entity(ies)	5	3	5	4
Specialty Care (e.g., cancer, heart, etc.)	2	2	5	8
Pharmacy	2	2	6	7
Behavioral Health	3	2	5	7
Other Non-Profit Subsidiaries	3	11	2	1
Other For-Profit Subsidiaries	1	11	3	2

Note: Each system component had at least one fiduciary board reported, with the highest number of fiduciaries (11 each) assigned to Physician Organizations, Other Non-Profit Subsidiaries, and Other For-Profit Subsidiaries.

Governance Best Practices: Subsidiary Boards

- Restructure boards to ensure alignment exists across the health system.
- Local boards should be primarily advisory.
- If they are delegated fiduciary duties, those should relate to such matters as credentialing, community benefits and engagement, and monitoring quality and patient/workforce satisfaction.
- Minimize committee use by local advisory boards.
- If statewide or regional subsidiary boards are created, it may be possible to grant them more fiduciary duties, such as proposing (but not approving) future capital expenditures and potential local expansions.
- Where geographically feasible, consider mirror boards for subsidiaries, which could meet concurrently with the system board.
- Build separate meeting minutes for concurrent boards. Be sure to be specific about which items discussed pertain to which corporations.

Legacy Governance in Merged Systems

Several surveyed systems have recently undertaken integration efforts in structuring their governing boards. The predominant challenge encountered when acquiring another system, or even a large hospital, involves instilling a system-wide mindset among legacy or constituent board members. Systems that successfully navigated this challenge credited a proactive strategy involving both management and the board prior to integration.

One system detailed their post-merger process, noting: "There was alignment of leadership on both management and governance sides, and we had a board to board working group doing what was best for both systems. Our board Chair changed after the merger so there was no legacy carryover in that regard, and the new Chair prioritized culture and bringing the board together."

While responses varied and some systems have a high number of legacy members, a few systems have been working to eliminate legacy board members and instead institute procedures that ensure governance boards are working effectively from a more unbiased point of view. One system commented: "We only have a few members remaining from a legacy board. These members helped design the new look of the board. When succession planning, we work to ensure that the board is not comprised of internal foundation members and close friends. Rather, we leverage a national search tool to ensure we are acquiring talent from across the nation for the right needs at the time."

Philanthropic Foundations

When surveying and interviewing systems, it was clear that fundraising methods for philanthropy looked different at every system. Some university-affiliated systems ran their philanthropic endeavors on the school-end and did not involve the health system in their pursuits. There were also instances where the school dean collaborated with the health system leadership to partner with their endeavors, although specifications of this collaboration were not commented on. In other instances, systems did not invest in their fundraising as they have generous donors that consistently supply the health system with funding. One university-affiliated system noted being fearful that their University would be threatened in their philanthropic efforts if the health system established a foundation board and expanded beyond their smaller Philanthropy Committee, putting a hinderance on the relationship overall.

Eight systems reported having a system-wide fundraising foundation, with boards ranging from "15 or fewer" to more than 25 members. For seven of the systems, the foundation board members are appointed by the system board. In addition, six have fundraising foundations for their subsidiary/local hospitals. Interestingly, almost half of the surveyed systems do not appear to have a system-wide foundation.

INTERVIEW INSIGHTS

Legacy Board Members

"We have affiliation agreements with our various hospitals, which includes the guarantee that a certain number of board members would serve on the system board for a term (three to five years). All such terms are now completed but we are still representative of our legacy systems. Board members are interested in the hospital where they live."

"Our merger went smoothly because we selected a collaborative chair with national expertise, and leadership on both sides were committed to success for both systems. Everyone set aside their egos and prioritized culture and bringing the board together. We selected members for their engagement, excellence and diversity, not simply because they were legacy members of the merged boards."

"Several years ago, the system replaced its entire board due to ineffective enforcement of conflict of interest policies. The system did feel that it needed some continuity, but it retained just three former members (Finance and Quality Committee Chairs and Board Vice Chair.)"

"Following a major merger five years ago, we now only have a few members left of the legacy boards. This resulted from a committee early on that designed the new look of the board. Only the current Chair and Chair of the Quality Committee are now legacy members. We use a board search tools to identify new members to make sure they have the right talent from across the nation."



On the opposite end of the spectrum, there were systems that have established departments with a lead over philanthropy. Some of these systems are new in integrating this position and department into their system and others have a designated portion of their budget attributed to community investment. In general, philanthropy appeared to be out of scope for our governance correspondents as this was handled at the management level.

INTERVIEW INSIGHTS

Foundations

"Our Foundation is a subsidiary of the parent corporation—only one Foundation that raises money for everyone, with 55 to 60 board members."

"The University does all fundraising. They are very successful, so it is not a problem for the health system. At my first board meeting as CEO, a board member announced a very large gift to the health system."

"As a University system, we struggle without a Foundation. We have been able to rely on the University for capital investments, but we also have many grateful patients who would contribute to the health system."

"We have five foundations within the system, which are streamlined from a management perspective via a Chief Foundation Officer that all foundations report to but have separate boards mainly due to geography."

"Foundations are all over the system and many of them are ministry-specific (individual hospital boards). Boards are more entity-focused due to donors tending to give to a specific place. The system foundation board is nascent, mainly consisting of the senior leadership team as a way to process systematic donations or grants to distribute across the system. We consolidated operational philanthropy functions two to three years ago."

"Many of the hospitals in our system have strong local philanthropic support, including foundations that predate the system itself. They raised over \$300 million last year."

"Fundraising is done at the hospital level; each founding hospital has its own foundation and they're all very productive (no need to have one at system level, which would also be competing with our university)."

Key Characteristics and Best Practices of Effective System Boards: *Understanding, Measuring and Improving Board Performance*

Board Operating Budget and Orientation

There was a large degree of variation reported in terms of system board operating budgets. Three systems indicated a budget greater than \$100,000, one responded with a budget of \$50,001–\$100,000, two responded with a budget of less than \$50,000, and two others besides HFH responded with zero. Similarly, only two respondents reported an educational budget of greater than \$30,000, two systems indicated budgets of less than \$30,000 and the remaining systems reported no education budget or did not reply. Based on interviews, however, it is clear that this variation is more likely to be a result of the way expenses are recorded within the systems and not of the lack of resources devoted to governance.

Only two systems reported having national experts serving on their board, and in both situations, experts also serve on System committees. One additional system has experts on system committees. It should be noted that interviews indicated that some additional board members have national health policy expertise although they were recruited from within the system's market. Most systems reported considering the addition of national experts to their boards, particularly in new areas like population health, performance improvement and integrated care management.

Governance Best Practices: Board Education

CEOs/senior executive staff should regularly provide the board with a deep dive into strategic initiatives and future challenges.

Governance in Transformational Times

There is no reported consistency in terms of the frequency and duration of new board member orientation: two systems conduct the orientation prior to appointment; five other systems conduct orientation in the first few months; one does it in the first year; one reported orienting new board members prior to their first board meeting; and four indicated orientation is ongoing. All systems indicated there is board member education, with seven systems responding that existing board member education occurs on an ongoing basis, one does it semiannually, and the other does it annually.

Onboarding New Members/New Officers

All of the surveyed systems reported some form of orientation and onboarding education for new members. Nine systems reported conducting orientation of new board members prior to their appointment, while 10 reported doing so in the “first few months” of a member's tenure. Several systems reported assigning mentors to new members from among longer-term members, which two systems (independently) referred to in interviews as “Board Buddies.”

Ongoing Board Education

No health systems reported having standing committees dedicated to board education in the survey results. However, all but two of the 17 systems reported conducting board member education on either an ongoing basis or annually. One system reported that “every meeting has an educational component about strategic issues that the organization will have to confront in the years ahead.” In one interview, a health system noted that they now have added “educational sessions” to each board meeting. Even if it is a short segment, they have learned that “it is not just the words and rules, but following through on our actions to establish a healthy culture.” They find that they are “rooted in values that contribute to life-long learning, as many health-based jobs require.”

Governance Best Practices: Board Orientation and Education

- *New members should receive detailed initial board education and orientation.*
- *Boards should assign experienced mentors or “board buddies” to new members.*
- *Board should hold regular retreats and ongoing educational sessions for all members.*

Evaluation of Board and Management Performance

Results varied when assessing the frequency of board member evaluations of the board as a whole; but the vast majority of participants reported performing a self-evaluation either every two years (three systems), annually (seven systems), or on an as-needed basis (two systems). Thirteen surveyed systems conduct a self-evaluation of the performance of the board as a whole; only three reported that they do not. Two systems replied that they conduct a self-evaluation following every board meeting.

In interviews with the participating health systems, it was discovered that one health system utilizes a tool at the end of each board meeting to evaluate the board and the board meeting as a whole. They explain, “We find annual board reviews to be insufficient by waiting to hear how the board is doing. Instead, we prefer a fluid and actionable environment. At the end of each meeting, we take the last ten minutes in a judgment-free space to use this tool to collect feedback on what board members find to be working well and to also identify areas to improve upon. There is also open discussion in this session. This discussion takes place with the management lead present in the room to facilitate.”

While most systems reported that board members evaluate the board as a whole, only two health systems conduct a board self-evaluation following each meeting. One system leverages a “Plus/Delta” exercise. In this exercise, the board is able to receive immediate feedback about identifying areas that were successful (Plus) and raising other areas to the surface for places of improvement (Delta). This health system not only engages in this free-response feedback review, but also participates in a more formalized self-evaluation of the board on an annual basis through The Governance Institute’s BoardCompass Survey.

Unlike assessments of the board as a whole, only 58% of the health systems surveyed evaluate their board members at the individual level. Ten of the health systems surveyed reported that they evaluate their board members at the individual level. Five health systems conduct an annual assessment, while the rest of the survey respondents indicate that they largely only perform these individual assessments either periodically or prior to an election/term renewal. When conducting a self-evaluation, seven systems report leveraging a pre-established, objective board effectiveness criteria format. Three organizations engage with external consultants for trustee and board member evaluations. It was reported that only 6 participants reported engaging a trustee skills and competencies portion on their assessments. Out of all systems surveyed, only two systems report evaluating their peers. Ten systems also conduct evaluations of individual board member performance, which is most commonly done annually, but one indicated that they conduct such evaluations only at the time of reappointment.

Several of the boards include additional evaluations with their self-evaluations, but the responses were mostly unique: one seeks to identify and update trustee skills and competencies; another also conducts anonymous trustee peer performance evaluations; another uses external consultants; and three utilize pre-established, objective board effectiveness criteria.

INTERVIEW INSIGHTS

Evaluation of Boards and Members

“We now use self-assessment tools and ask board members to evaluate one another—we are trying to do this in connection with reappointment.”

“Our board sets a priority of transitioning to value-based care and achieving the culture of a high-performing board. The board is also focused on governance vs. management. Committees can have non-trustees as members—they are also evaluated and considered a “farm system” for board membership.”

“We did not want to wait until the end of our annual process to evaluate how we were doing—we ask for responses in the last ten minutes of each meeting for all boards, then Governance specialist gets the report.”

“It has been a while since we have conducted a self-evaluation of board members.”

All of the surveyed systems evaluate the CEO's performance, and four boards also review C-suite performance generally and conduct compensation oversight of several members of system management. A Compensation Committee is responsible for the CEO executive performance and compensation oversight for 14 of the 17 systems. In the case of one, this responsibility instead resides with the Human Resources Committee, and two systems reported using their Executive Committee to perform this function. The respective group responsible for executive compensation oversight is composed solely of independent directors of the board for 13 of the systems surveyed.

Responses indicate that most boards consistently use a formal process for evaluation of leadership with written performance goals. The CEO's compensation package is typically based on the performance evaluation and appropriate consideration of IRS "fair market value" mandate, independent information on industry comparables, and ensuring compliance with regulatory requirements. In addition, all but one of the respondents discuss CEO performance in an executive session without the CEO in attendance.

In all systems, the board sets annual goals/objectives for the CEO; and, in ten systems, the board sets annual goals/objectives for the entire C-suite. In addition, seven systems set annual goals/objectives for SVPs and in five systems this goal-setting reaches down to the level of VPs.

All but one system review the major oversight responsibilities of the board annually.

Fulfillment of the organization's mission is formally assessed at least every two years by 11 systems. In 16 of the 17 systems, the board chair has a clear position description that identifies individual and shared responsibilities. 11 systems have a clear position description of the vice chair, and 13 systems have clear position descriptions for committee chairs. One indicated this also exists for the Secretary, another for board members, another for all board officers, and another is currently reviewing the fact that it has duties and responsibilities in their corporate bylaws but not separate position descriptions.

Key Characteristics and Best Practices of Effective System Boards: *Making Effective Use of Board Members' Time and Experience*

How Does the Board Spend Its Time?

Budget and Finance

Survey results showed that financial performance was discussed at board meetings in the last two years more than 50% of the time at three of the 17 surveyed health systems. However, nine of the surveyed systems discussed financial performance 25 to 50% of the time, and five systems discussed financial performance 25% or less of the time. This highlights that financial performance was of relatively great importance to a majority of surveyed health system boards. Ultimately, surveyed system boards spent, on average, 38% of their meeting time devoted to financial performance. This was the highest average percent of all surveyed discussion topics.

Quality of Care and Patient Satisfaction

Fourteen of 17 surveyed health system boards focused on quality and patient satisfaction approximately 10 to 25% of their total meeting time. One system board discussed this topic 25 to 50% of the time and only two systems spent more than 50% of their time devoted to patient satisfaction and quality.

Governance Best Practices:

Key areas of board member responsibility:

- *Strategic Orientation*
- *Management Oversight/Accountability*
- *Public Accountability*
- *Financial Oversight*
- *Quality Assurance*
- *Advocacy*
- *Board Development*

Long-Range Strategic Planning

Four out of the seventeen surveyed system boards currently have System Strategy and Planning committees. Many system boards have strategy as a point of focus during their new member orientation sessions as well as during their retreats. This is viewed as an appropriate opportunity for board members to get aligned on organizational goals and direction. Additionally, some boards identified that not all board members are healthcare savvy or fully understand the ramifications or long-term effects of strategic decisions. One board reports that they are currently evaluating how to be thoughtful and engage in discussions about where the organization needs to be in the future and where it may be more suitable for other groups (i.e., management, outside experts, etc.) to engage in these discussions with reports to the board.

Governance Best Practices: Governance and Quality

Engaged hospitals boards can affect quality:

- *High-performing hospital systems typically have one board overseeing all activities.*
- *Clinical quality is one of the top two priorities for board oversight in high-performing hospitals.*
- *High-performing hospital chairs are significantly more likely to report familiarity with Joint Commission core measures or HQA measures.*

Hospital Governance and the Quality of Care

Figure 12. Agendas/Content of System Board Meetings

Board Topic	Less than 10%	10 to 25%	25 to 50%	More than 50%
Financial performance	1	4	9	3
Strategic growth and competition	0	6	9	2
Operational performance	3	6	6	2
Quality and patient satisfaction	0	14	1	2
All other subjects	4	6	1	2
Payment and delivery system reforms	8	6	2	0

Figure 13. Agendas/Content of System Board Meetings

Board Topic	Average Percentage
Financial performance	38%
Strategic growth and competition	35%
Operational performance	29%
Quality and patient satisfaction	25%
All other subjects	24%
Payment and delivery system reforms	14%

Note: Over the past two years, systems spent the most time discussing financial performance (38%) and strategic growth and competition (35%). Less emphasis was placed on payment and delivery system reforms (14%). Average Percentage: Estimated based on mid-points of response ranges.

Understanding the Difference Between Governance and Management

A key element of the most effective use of board member time and expertise is for the board to have a clear understanding of the difference between governance and management. Clearly the board needs to have an understanding of the responsibilities and job performance of the CEO and other senior managers. Its job is to articulate the mission and vision of the hospital system, set policies, goals and priorities for the board and management, and provide oversight (and evaluation) of the performance of the CEO and, as needed and appropriate, other senior managers. However, it is not the role of the board to become directly involved in implementing goals and policies, or in the direct operations of the system—just as it would not be a non-physician board member’s role to step in and perform surgery or treat patients.

The general rule to guide an effective board in working with management is “noses in, fingers out.” It means that board members should be sufficiently knowledgeable to provide oversight but should not micromanage: they should be aware of what’s happening in the business, including risks, trends, issues, and wins. They should understand the system’s market and capabilities, and what’s working and not working. They should also attend and participate in meetings, ask questions, and respond promptly in crises. They should not try to tell managers how to do their jobs. Instead, they should leave implementation to management, while setting strategic direction, reviewing, and listening to what’s happening, and providing resources to help management achieve its goals.

All the surveyed systems reported that they conduct an annual evaluation of the health system CEO. However, only four systems conduct evaluations of C-Suite members beyond the CEO. When discussing the lines between governance and management, one system expands on this concept: “Over the past few years, we have learned a great deal about the power of partnership between governance and management. We joined The Governance Institute to gain a repository of best practices and standards and began to actionably institute them. To date, we have instituted 18 policies for board responsibilities and for responsibilities as oversight of senior management. Through this process, clear lines were re-established which restored confidence in the ability of our board to stay out of conflicts of interest.”

Another surveyed system suggested that because their system board included several prominent, high-powered individuals, they sometimes “have a hard time understanding the line between governance and management. We are looking for better guidance here on where to draw the line.”

One prominent health system (the Mayo Clinic) that is not among the systems surveyed has articulated a clear statement of their policies with regard to the relationship between governance and management.

INTERVIEW INSIGHTS

Recognizing the Line Between Governance and Management

Board Challenges: How are we balancing the fiduciary oversight with current strategic realities? How do you do it responsibly and maintain the line between board and management? How do you continue to develop a board?

“We now have a strong emphasis on the power of the relationship between the board and management. Board members had previously lost sight of their fiduciary duties.”

“Our board has a healthy dissatisfaction with the status quo, but it does not necessarily have a market understanding of healthcare. They come from other industries, and several are self-made billionaires. It requires educating the board on market trends and where/how our system fits in. There is a jockeying back and forth among board members and they sometimes step over the line between board and management.”

Case Study: Mayo Clinic (Part 2)

The Mayo Clinic, whose unique two-part governance structure is discussed at p.16 above and described in detail in a publication on their website, also includes a clear delineation of the division of powers and duties between their Board of Trustees and Board of Governors, on the one hand, and the CEO and management, on the other.

Among other duties and responsibilities:

The Board of Trustees maintains responsibility for such matters as:

- monitor, provide oversight, and evaluate the affairs of Mayo Clinic in the best interest of Mayo Clinic, the community it serves, and its employees;
- ensure that the President and CEO leads Mayo Clinic in a manner that is lawful, prudent, and consistent with its corporate compliance plan and with ethical business and professional practices;
- execute the responsibilities of the standing Committees of the Board of Trustees;
- ensure the President and CEO meets operating plans and causes all activities to be conducted in compliance with their IRC 501(C)(3) status; and
- reviews the periodic performance evaluation of the President and CEO conducted by the Mayo Clinic Board of Governors.

The Board of Governors has responsibilities for operational and financial oversight, such as:

- approval of strategic plans of individual sites including strategic priorities;
- annual capital and operating budget approval;
- physician, scientist, and senior administrator salary policy;
- employee benefits;
- incurrence of debt;
- approve each capital expenditure by item or aggregate program account in excess of \$5 million;
- any transfer of assets other than in the ordinary course of business;
- use of the “Mayo” and “Mayo Clinic” name; and
- actions that may impact the tax-exempt status of Mayo Clinic or any of its subsidiary entities.

The CEO and President has explicit financial, operational and strategic duties and responsibilities such as:

- define and coordinate Mayo Clinic’s vision, mission, and strategy;
- define enterprise market positioning and preserve the Mayo brand;
- provide financial stewardship;
- develop long-range financial models, to include cash flows and capital expenditures; and
- oversee annual operating budgets, including cash flows and capital expenditures.

Mayo Clinic: Governance and Management Structure

Meeting the Challenges of the Future

New Questions in 2023 Survey

Because our primary goal was to update our 2015–2016 survey report—to see what had changed in the course of eight years in health system governance—we purposely asked the same questions of respondents in the current survey. However, recognizing that many changes have occurred in the health industry, and in the nature of how we think of health itself, we added one set of questions asking health systems to estimate how much attention had been paid by their boards in recent years to new or emerging topics, as well as to challenges that are yet primarily in the future. We asked health systems to estimate whether their boards had “substantial,” “moderate,” or “little or no” engagement with the following issues in the last two years:

- Pandemic services for patients with COVID-19.
- Impact of patients with COVID-19 on non-COVID-19 patients.
- Rising costs of supplies and equipment.
- Supply chain disruptions.
- Rising costs of traveling nurses and other services.
- Rising costs of non-clinical employee wages.
- Recruitment, turnover, burnout of nurses.
- Recruitment, turnover, burnout of doctors and other clinical staff.
- Impact of climate change.
- Changes in Medicare and Medicaid reimbursement.
- Negotiations with private insurers.
- Substance abuse/opioid epidemic.
- Access of patients to behavioral health services.
- Cyber-security.
- Regulatory compliance.
- Enterprise risk management.
- Telehealth.
- Hospital workplace violence and harassment.

Governance Best Practices

To achieve transformational governance, boards need the ability to respond to a near constant pace of change.

To evaluate the responses to these questions, we assigned numerical values to each of the three answers: 5 for “substantially engaged”, 3 for “moderately engaged” and 1 for “little or no engagement.” The results for the topics of greatest attention are displayed in Figures 14 and 19. Figure 14, for example, demonstrates that all surveyed systems, in the aggregate, spent significantly more time engaging with issues related to staff recruitment, burnout and costs, for both nurses, doctors and non-clinical employees. There was a fairly sharp cutoff at an average value of 3.7, and four of the nine topics which averaged an engagement of 3.7 or higher reflected concerns about staff. The other five topics scoring at or above 3.7 were the rising costs of supplies and equipment, supply chain disruptions, cyber-security, changes in Medicare and Medicaid reimbursement and pandemic services for patients with COVID-19. Figure 19 reflects the level of engagement reported by all survey respondents for each of the top five topics in terms of engagement.

Pandemics

In many respects, our national nightmare with COVID-19, while receding in memory as the virus becomes more endemic, is responsible for the extra attention survey respondents reported as having been paid to other issues, including nurse, doctor and staffing burnout and shortages, rising costs and supply chain disruptions. Pandemics have the potential to place great strain on the healthcare system. Effective pandemic preparedness requires the engagement of the entire health community and requires that healthcare assets from across the spectrum of care be prepared to meet the increased demands. Additionally, an effective healthcare response to a pandemic event requires an overall awareness of a health system’s capabilities and capacities. Healthcare facilities must be prepared to adjust to varying stressors on the system over time through collaboration with diverse partners, effective information sharing, and coordination of response activities. Figure 19 indicates that all surveyed systems reported at least moderate engagement on services to COVID-19 patients in the last two years, while 11 of the 17 systems surveyed report being substantially engaged on the topic.

In considering the lessons of the COVID-19 pandemic, it is important, as Tulane University Professor John M. Barry recently pointed out in a New York Times article, that “we need to be prepared to fight the next pandemic, not the last one.” Barry suggests that there were several assumptions about COVID-19 that may not be applicable to future outbreaks of (for example) viruses like Bird Flu or Mpox. For one, he reminds us that “COVID-19 primarily killed people 65 and older,” whereas “The five previous pandemics we have reliable data about all killed much younger populations.” (Barry, 2024).

INTERVIEW INSIGHTS

Impact of Pandemic

“Our board members go deep on operational understanding to process the depth of the pandemic impact. People are still concerned about making sure they are prepared and have what they need during flu season so they will be ready for the next pandemic. They talk a lot about what they learned about the pandemic.”

“The board’s finest moment was during the pandemic. We were the only health system that had permission to do lab testing for COVID-19. We lost \$1.5 billion but the board would not allow leadership to take pay cuts. The board met every week and management met every day with a reporter to publish a playbook for other health systems on how to lead through a pandemic.”

“In January 2020, we had seven financial systems with no common EMR or HR system—all of this was changed during COVID-19. We needed to include governance to achieve goals and to support the management team. Our board chair had been a former CEO and understood roles of board and management. We went from a representational board to a true system board. The balance between ex officio members representing doctors, on the one hand, and independent trustees, on the other, has shifted in favor of the latter.”

The Great Burnout of the Hospital Workforce

The erosion during the pandemic of the hospital workforce through resignation, illness, and sheer burnout also raises profound and ominous concerns that have clearly occupied the attention of many of the boards of our surveyed health systems. These factors are likely to continue to affect hospitals and health systems well into the future.

Throughout the pandemic, our essential health workers were appropriately considered heroes, caring for wave after wave of people suffering from COVID-19. At the same time, the role they played during the pandemic took a fearsome additional toll on the hospital workforce, both in terms of caring for hundreds of thousands of new patients and experiencing a dramatic increase in their own infections. And lurking beneath the surface is a profound and possibly permanent erosion of mental health on the part of overworked people in understaffed hospitals.

The problem is made worse by the fact that medical professionals often put off seeking help. About 62 percent of healthcare workers have said that COVID-19 has had a negative impact on their mental health, according to a Washington Post/Kaiser Family Foundation poll from March 2021, but only about 13 percent had received mental health services or medication because of the stigma attached.

As a Minnesota hospital official put it in an op-ed column: “Even before the pandemic, physicians had twice the risk of burnout as the general population and had an estimated 40 percent rate of depression and suicidality. Now, 60 to 75 percent of clinicians experience symptoms related to depression, sleep disorders, and PTSD. The numbers are likely higher in nurses.”



Other Emerging Issues

In contrast with COVID-19 and staffing concerns, five topics scored less than three in this part of the survey, meaning that boards were either unengaged or less than moderately engaged with these issues. They were telehealth, hospital workplace violence, negotiations with private insurers, substance abuse and climate change (which was dead last). It should be noted that all of these issues continue to be important for both health systems and the entire population—and some will likely become more important in the future. This set of questions and the topics at the bottom of the engagement scale could well serve as agenda items for future board education sessions.

To take one example, “telehealth,” which became a far more prominent component of our health system during the pandemic, is really just shorthand for many different ways in which we have moved away from institutionalization and hospitalization to a more dominant role for remote care or virtual health. These changes will only accelerate as the health system becomes more confident in the ability to use artificial intelligence to inform or augment remote care.

Some of the respondent systems indicated that they are already focusing on these issues. One system reported that its board was having discussions around topics that could transform or disrupt healthcare in the future. Others reported that their boards had asked for educational sessions on artificial intelligence. Another system said that “Our board views AI as an ‘anchor topic’ and something that they need to get smart about” as their system continues to grow and digitize. That system reported that they start the year by identifying a “parking lot list” of topics that teams are prepared to present on to the board. “The idea is to educate all members on areas affecting the system and our health plan. We conduct all of these talks in house and do not yet utilize outside people to teach on these topics.”

Cyber-security, and the broader topic of enterprise risk management, are other issues that have become more prominent (and concerning to health systems) in the last couple of years. As the “engagement” score for these issues illustrates, hospitals and health systems are still far behind other kinds of businesses in our economy (banking, insurance, etc.) who have maintained robust ERM policies for years. With the recent rise in cyber-attacks and the shift to digital domains, cyber-security has become an increasingly important focus area for health systems across the United States. While some surveyed systems indicated that this is now an area of focus during new board member orientation and that they are now actively assessing anticipated needs across the health system, those systems are still in a minority among survey respondents.

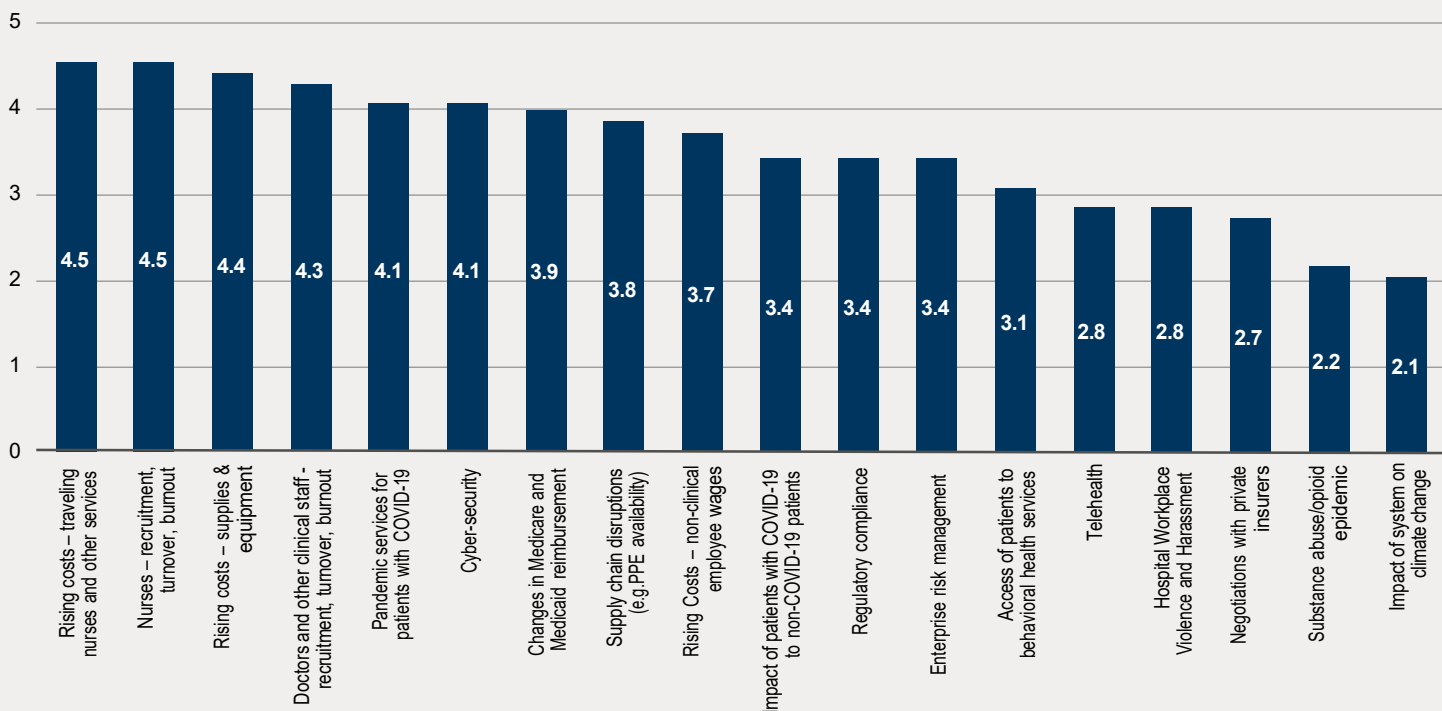
New Skillsets for Board Members

While nonprofit boards will continue to seek members with traditional board member skillsets, such as finance, business, real estate and law, effective succession planning must also reflect the importance of other “21st century” professions, such as:

- Enterprise risk management
- Cybersecurity
- Digital health and telehealth
- Epidemiology
- Population health
- Operational improvement (Lean, Six Sigma)
- Social media communication
- Robotics
- Nanotechnology
- “Big Data”

Figure 14. Time Spent on System Board Topics

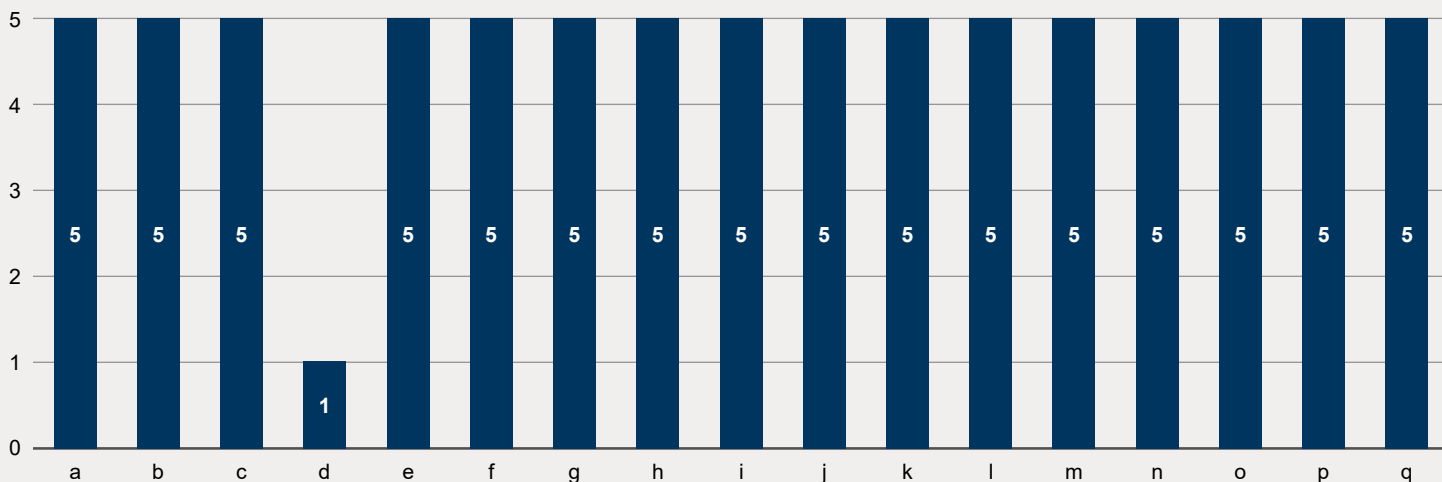
Please estimate how much time your System board has spent per year (or in the past two years) engaging in each of the following subjects.



Note: On average, all systems dedicated more time to discussing COVID-19 impacts, rising costs/supply chain disruptions, and workforce recruitment and turnover as compared to other topics. Legend: (1 = little or no engagement, 3 = moderate engagement, 5 = substantial engagement).

Figure 15. System Board Activity – Rising Costs

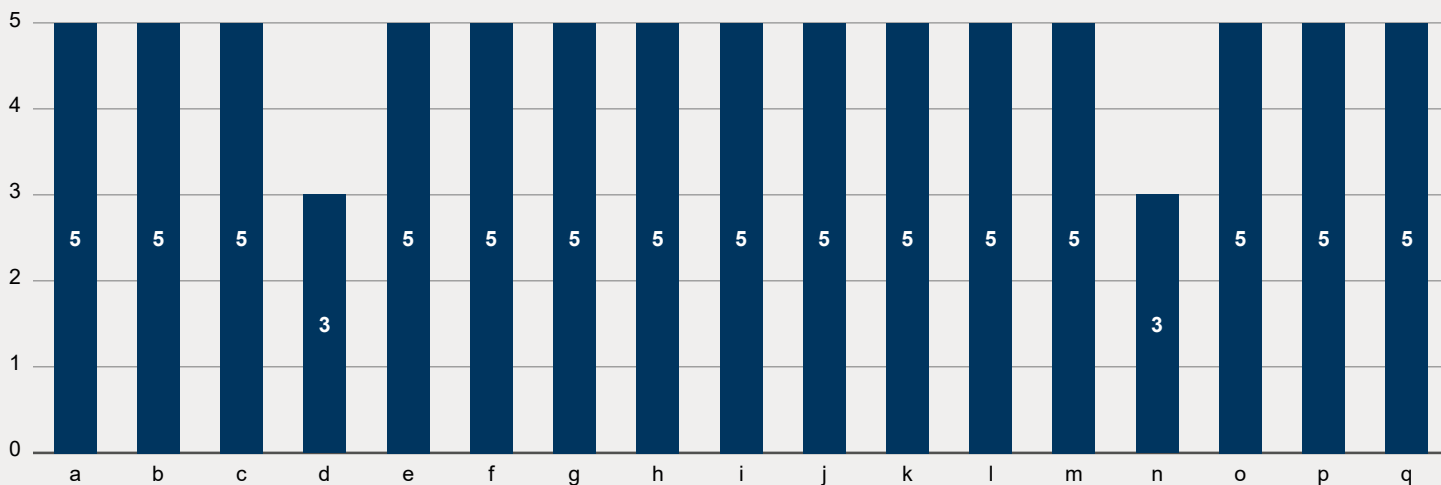
1. Please estimate how much time your System board has spent per year (or in the past two years) engaging in rising costs for traveling nurses and other services?



Note: 16 systems reported spending substantial engagement (more than 15 minutes at two or more Board meetings per year or past 2 years) on rising costs for traveling nurses and other services. Legend: (1 = little or no engagement, 3 = moderate engagement, 5 = substantial engagement).

Figure 16. System Board Activity – Nursing Recruitment

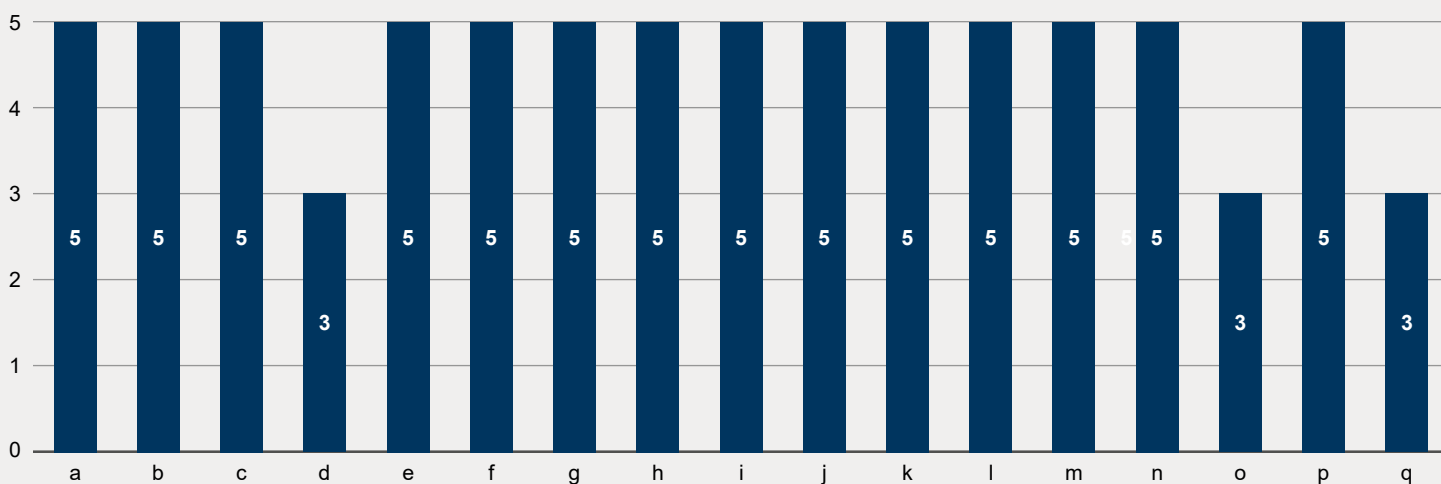
2. Please estimate how much time your System board has spent per year (or in the past two years) engaging in nursing recruitment, turnover, and burnout?



Note: 15 systems reported spending substantial engagement (more than 15 minutes at two or more board meetings per year or past 2 years) on nursing recruitment, turnover, and burnout. Legend: (1 = little or no engagement, 3 = moderate engagement, 5 = substantial engagement).

Figure 17. System Board Activity – Rising Costs

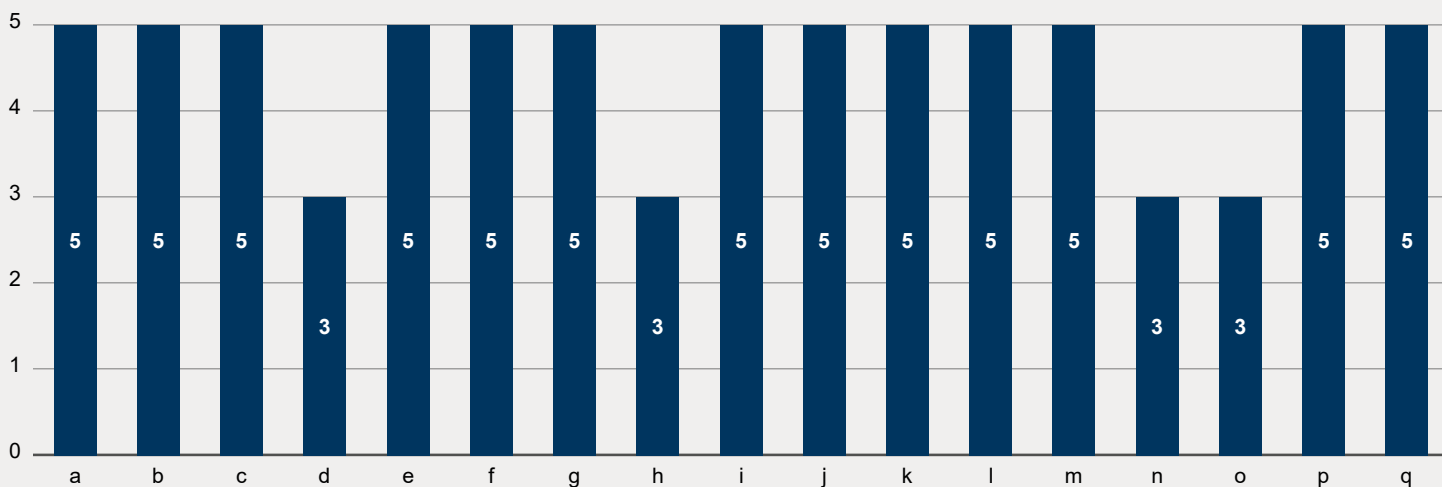
3. Please estimate how much time your System board has spent per year (or in the past two years) engaging in rising costs for supplies & equipment?



Note: 14 systems reported spending substantial engagement (more than 15 minutes at two or more board meetings per year or past 2 years) on rising costs for supplies & equipment. Legend: (1 = little or no engagement, 3 = moderate engagement, 5 = substantial engagement).

Figure 18. System Board Activity – Staff Recruitment

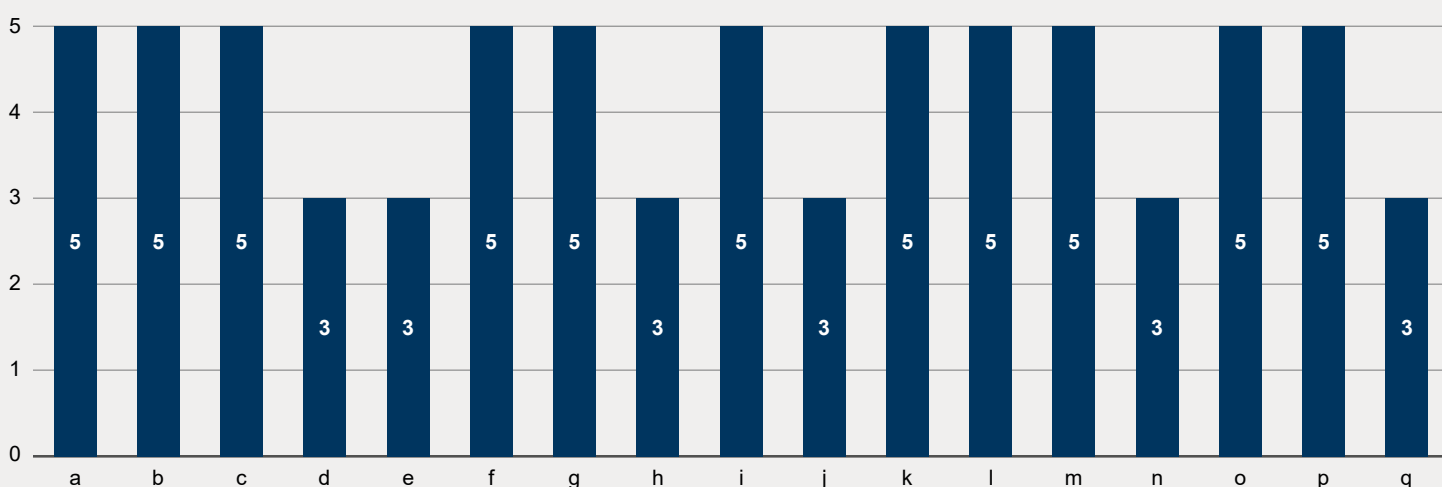
4. Please estimate how much time your System board has spent per year (or in the past two years) engaging in physician and other clinical staff recruitment, turnover, and burnout?



Note: 13 systems reported spending substantial engagement (more than 15 minutes at two or more board meetings per year or past 2 years) on physician and other clinical staff recruitment, turnover, and burnout. Legend: (1 = little or no engagement, 3 = moderate engagement, 5 = substantial engagement).

Figure 19. System Board Activity – COVID-19 Services

5. Please estimate how much time your System board has spent per year (or in the past two years) engaging in pandemic services for patients with COVID-19?



Note: 11 systems reported spending substantial engagement (more than 15 minutes at two or more board meetings per year or past 2 years) on pandemic services for patients with COVID-19. Legend: (1 = little or no engagement, 3 = moderate engagement, 5 = substantial engagement).

Unique Governance Challenges

University-Owned or Affiliated Academic Health Systems

Seven systems responding to our survey are either owned by or closely affiliated with universities, comprising three university-owned and four university-affiliated systems. Interviews revealed that some respondents whose university partners are significantly involved in the governance of their hospital systems expressed a desire to reduce university involvement to enhance engagement and achieve greater autonomy.

This involvement is particularly detailed in situations where the university owns and operates the hospital system, and where the university board also serves as the governing board of the system. There can be benefits to such a close relationship, including the ability to function as a fully-integrated system with university faculty (often spread across several different schools of medicine, nursing, public health, etc.). The University can also provide access to capital, both through bonds and grants as well as through philanthropic fund-raising. At the same time, however, there can be impediments to effective hospital system governance in such relationships, including in the ability to recruit health system board members with the skills and experience needed by complex systems, as well as the ability to engage in more specialized fundraising needed by health care facilities. One system noted that its board does not perform the typical functions expected of a hospital system board, primarily due to its size and the fact that its purview extends over the entire university. Additionally, major decisions involving capital, lending, and executive committee membership are reserved for the University board.

Governance Best Practices

Key factors affecting mergers of academic health systems:

- *Understand that some academic health systems have not had great success with acquiring or integrating assets into their existing clinical organizations.*

***Academic Medical Centers:
Transformational Imperatives to
Succeed in the New Era***

The governance and legal structure of academic medical systems (AMCs) take many different forms across the country. For over 50 years, universities that own or operate AMCs have engaged in a quest for the “optimal” governance structure. That quest has never been more important than it is today. AMCs are generally financially more successful than non-AMC hospitals, but they are also more costly; and financial pressure on health costs continues to build from patients, payers and the government. In a broader sense, universities themselves are confronted with major challenges to their future success, including recent political challenges. As a result, many universities are once again revisiting past AMC governance reforms and rethinking their governance structure.

A substantial majority of universities with medical schools have built or acquired teaching hospitals over the course of their existence, in support of what has come to be known as the classic “tripartite mission” of research, education, and patient care. As early as the 1970s, out of concern that the costs of delivering health care would swallow an increasing proportion of their resources, many universities sought to identify more effective (and less risky) structures for governing their hospitals, which often led to restructuring and even divesting their AMCs.

Many public and private universities either created new non-profit corporations for their hospitals and faculty practice groups in the last quarter of the last century, while others went so far as to merge their teaching hospitals and physician organizations with other nonprofit (and even occasionally for-profit) organizations. The public Universities of Maryland, West Virginia, Florida, Arizona, Nebraska, Colorado, Oklahoma, Massachusetts, Cincinnati, Vermont, Minnesota and the Medical College of Georgia (among others) all took one or another of these steps.

Private universities also adopted various mechanisms aimed early on at shielding themselves from potential uncontrollable costs and losses from the provision of health care.

However, some public and private universities have doubled down on direct ownership and operation, and there have been notable success stories in this category (including at least one of the surveyed systems owned by a public university and two systems owned by private universities). In these cases, the structure has consistently dictated that the board of the university itself has served for all practical purposes as the health system board with the reservation of all significant powers and duties to the “mother ship.” Representatives of some of those systems have told us in interviews that the universities have been very supportive of the hospital systems but that they would welcome an opportunity, for example, to do some of their own philanthropical fundraising, apart from the university.

Perhaps left in the middle are those hospital systems who serve de facto, under arms-length affiliation agreements, as the hospitals (and in some cases the medical staff) of university medical schools. In some cases, this has resulted in representatives of the university sitting on their governing board *ex officio* (such as the Dean of the Medical School, Chancellor, University President, etc.). This can sometimes raise delicate issues and even conflicts, but in general survey respondents in this position told us that they were able to overcome those challenges and collaborate with their university partners on major new education, research, and patient care infrastructure.

Another group of public universities went even further in privatizing their hospitals, by selling them to (or merging them with) pre-existing private, non-profit, or for-profit corporations. Early examples included the University of Massachusetts (UMass-Memorial Health), the University of Cincinnati, Indiana University, the University of Minnesota, and the University of Oklahoma.

The University of Massachusetts has merged successfully with a non-profit system to create the UMass Memorial Health System in central Massachusetts, and the University of Minnesota sold its University Hospital to the non-profit Fairview Health Services (now known as “M Health Fairview”).

This model is by no means limited to state university AMCs. Private universities like Georgetown, George Washington University, St. Louis University, Tulane, and Creighton have all sold or otherwise transferred their hospitals to other nonprofit or for-profit systems. Conversely, some of the most prominent nonprofit AMCs have expanded their networks by acquiring or affiliating with other hospitals across their region and in some cases around the country. They include the Partners Health System, Johns Hopkins Health, and the Mayo Clinic, among others.

Over a half-century of public teaching hospital restructuring initiatives has led to a wide range of governance structures across the country for such hospitals. In the last several years, however, many universities have begun to question their previous steps, pursuing new strategies. These strategies are intended to promote better integration and alignment of all the key components of what others have called the “virtuous cycle” that underlies the AMC’s tripartite mission. Recent trends in further restructuring AMC governance have stemmed in part from a broader recognition that each of the components of this virtuous cycle must work together in an integrated fashion in order for all of the elements of the “tripartite AMC mission” of education, research and clinical care to succeed.

INTERVIEW INSIGHTS

Academic Health Systems

“The hospital system and the University have had an affiliation agreement that has been renegotiated every 10 years. We recently came to terms on a new definitive agreement that is expected to be signed in June ’24 to become an integrated healthcare system, which will be a 45-year agreement instead of 10-year agreement.”

“The full board of our University-based system is too big to have meaningful discussions. The medical center was spun off by the University in 1986 as a separate corporation, but the board is still appointed by the University. It has 53 members, including ten ex officio trustees and ten emeritus “life trustees.” It is more of a philanthropy board, and actual governance takes place in the executive committee.”

“The trustees would agree the board is too big and they really prefer the committee work. They are taking a pretty hard look right now at their governance structure and system structure to make sure they are poised for growth in the future.”

“Members of our University-based board are appointed by the Governor. Our board is a subset of the University governance structure. The Governor’s appointees are considered board members for Joint Commission and CMS purposes—they are the only members with votes.”

“By ‘leaning in’ on our reliance on the University, we currently have a historic building campaign going on, building a new health sciences building, a cancer and advanced ambulatory building which will be as large as current hospital tower, and a new hospital tower as well.”

Case Study: State University of New York

The State University of New York (SUNY) operates four medical schools and three AMC campuses with no separate governing body apart from the SUNY Board of Trustees. SUNY convened a Task Force on Hospital Governance in 2019 to recommend potential governance reforms for the university's AMCs. SUNY had previously convened no fewer than four different commissions or task forces to consider governance concerns, dating back to the mid-1980s.

Steven Wartman, MD, a past President of the Association of Academic Health Centers, was a member of the 2019 SUNY Task Force. Dr. Wartman has written that “the traditional tripartite missions of education, research, and & patient care can no longer be seen as ends in themselves. Rather, they should be a means to fulfill the mission of improved health and well-being of their communities as efficiently as possible.... Recalibration of teaching, research, and patient care requires realignment—it will be a test of leadership because there are barriers at every level, including leadership, faculty, staff, governance, economics, and politics.”

In leading up to the work of the 2019 task force, SUNY's Chancellor, in a previous report to the Governor, stated that SUNY's hospitals are “severely hampered” by their inability to:

- Enter into contracts in a timely fashion.
- Participate in health-care networks.
- Contract with their employees (e.g., physicians) in response to the demand for managed care.
- Maintain adequate cash reserves.
- Access capital.
- Participate in the Dormitory Authority's equipment loan program.
- Independently purchase supplies and equipment.
- Attract and maintain qualified personnel due to civil service restrictions.
- Pay the true cost of fringe benefits.
- Negotiate labor contracts and manage labor issues at the local level.

SUNY Chancellor Reports, 1995 & 2019

Some universities that continue to directly operate their teaching hospitals without fiduciary or even advisory boards have taken to heart the desirability of at least some oversight and guidance from independent board members. Following a study by the Rand Corporation, the University of California Health system (composed of six medical schools and five hospital AMC campuses) developed an expanded Health Services Committee under the Board of Regents that includes several prominent independent health industry experts. The new, expanded UC Health Affairs Committee was delegated a number of specific powers and duties, in order to permit it to address a range of identified concerns:

- A highly competitive industry characterized by declining reimbursements, rapid consolidation, unpredictable policy environment, and growing patient/payer expectations.
- The new environment requires new, creative solutions, scale, system integration, agility, and rapid strategic growth.
- Current administrative and operational structure hampers and often prevents the development of these system changes required by the new environment.
- Many of the current systems and procedures with which the health system copes were designed for a policy and market era that no longer exists.
- The length of time from idea to plan to program, is far too long.
- Systems around it are growing larger, more competitive, and aggressive in the pursuit of its people, patients, and ideas.
- The proliferation of mergers and alliances makes it clear that system size, solid financial performance, and increasing emphasis on quality and accountability will be the key variables for continued success.

Case Study: University of California

Rand Corporation researchers identified seven criteria for evaluating UC Health's governance structures:

- Timeliness and efficiency of decision making.
- Ability to provide strategic guidance.
- Ability to take advantage of system-level efficiencies.
- Ability to maintain alignment across the triple mission.
- Responsiveness to local (market or community) conditions.
- Expertise (among board members).
- Feasibility (or the costs and perceived risks of transitioning to a new governance system).

Governing the University of California Health System: An Analysis of Issues and Options

In conclusion, a number of lessons can be learned from these recent efforts to revisit and further reform the governance and legal structure of university hospitals and health systems:

- Successful AMCs are typically organized as highly-integrated and multifaceted health systems, with effective business management, a shared commitment to common goals, and meticulous attention to the academic, competitive, and regulatory demands of today's health system.
- Success does not necessarily correlate with a particular legal structure or governance model. The most effective systems studied have succeeded in a range of legal structures in aligning business, clinical, and academic performance to meet the diverse, and sometimes conflicting, needs of the modern academic health center.
- Regents (or Trustees) are still in charge of most universities that include medical schools, even where there has been some separation of direct system governance. However, most successful university systems have created boards to directly govern their health systems and have delegated considerable authority to those boards.
- Physician leadership is essential. But effective governance combines strong physician leadership with effective and often non-physician, independent board members and AMC management.
- The components of high-performing systems are fully aligned and integrated (hospitals and physicians), through common or shared governance, through common ownership or strong (and longstanding) affiliations, even across multiple hospitals and broad geographic areas.
- Governance is specifically tasked with policy approval and oversight of quality, patient experience, and the constant improvement of care coordination.
- Both governance and management practices are consistent and based on commonly shared and understood principles.

Faith-Based Systems

Faith-based hospitals and hospital systems play a major role in our nation's health care system today. One observer, who, has written a new book about Catholic health care, reports that "four of the 10 largest U.S. healthcare systems are Catholic systems. In some states, more than 40% of the hospital beds are in Catholic hospitals. One of the largest Catholic systems claims that one in four Americans have access to healthcare in its system." (Gabow, 2024). With more mergers and acquisitions in the marketplace, it can be expected that this number will continue to grow with additional consolidation.

The Catholic church is not the only religious sponsor of hospitals and other health care services in the country. Other religions, including Seventh Day Adventists, Baptists, Methodists, Presbyterians, and Judaism also sponsor hospital systems, or have done so in the past. However, the Catholic church is the dominant faith-based sponsor of health care services, and that is true for the systems responding to our survey.

Out of the 17 system respondents to our survey, four systems identified as faith-based organizations, and they are all affiliated with the Catholic church. Three of these systems reserve seats on their system board for religious leaders. One system, which represents a recent “merger of equals” between a faith-based system and a secular system, maintains a separate board for the faith-based system with sponsor representation on that board. This reservation is either mandated by the bylaws or implemented by choice.

In general, the management and governing boards of faith-based systems have similar aspirations for quality, growth and change as non-faith-based system boards. For example, both non-faith-based and faith-based boards inquired about guidance on defining the lines between management and board roles. The responses varied in how faith-based systems approached achieving this balanced relationship, with some believing they have found the balance and others actively working to better determine the relationship between the board and senior management.

One major difference between Catholic systems and other nonprofit systems is their need to adhere to an additional, overarching set of rules that set them apart from other systems, known as the Ethical and Religious Directives for Catholic Health Care Services (ERDs). According to Dr. Gabow, the ERDs did not begin as a “do and don’t list.” Rather, their beginning stems from a Jesuit priest who “wanted assurance that Catholic hospitals were not falling behind in delivering modern healthcare.” Yet, they have evolved to prohibit a wide range of common reproductive health services, sterilization, abortion, gender affirming surgeries, and end of life care.

Surveyed hospitals have adopted different approaches to balancing the requirements of their faith-based ministry sponsors with the expectations of payers, patients and the local or regional non-faith-based hospitals who also serve the same populations. They have also sought to address the ERDs in providing day-to-day care to their patients, many of whom may not even be aware that they are being cared for in a Catholic facility.

One system surveyed has a [Ministry/Sponsor] board composed entirely of representatives of the religious ministries that has responsibility for oversight of faith-based obligations. The system also has a separate operating board that includes some sponsor representatives nominated by the faith-based board, but which also includes a majority of non-faith-based directors.

INTERVIEW INSIGHTS

Faith-Based Systems

"There are two separate boards. The religious board will convene when it is a big deal and will weigh in as needed on activities. Two sisters sit on the system board. They do traditional board work. They have a Sponsorship in Governance Committee that serves as a nomination committee for the system board."

"Some separate governance was retained for the Catholic part of our merged system. We have a “Catholic Sponsor” and 11 ministries are now consolidated as regional entities under a “Catholic Enterprise Board.” There are reserved powers for this part of the board to ensure compliance with ERDs."

"Each new board member goes through an intense mission training with the Chief Mission Officer, understanding the mission and the organization’s tie to the Catholic faith, especially if the new Board member is not Catholic."

"Our Catholic system has a separate sponsor board, and a whole separate authority matrix (e.g., if something costs over \$50M it goes to sponsor board, anything related to church property has to go to the sponsor board). The sponsor board meets more often than the system board. It almost meets monthly and has a mix of religious and lay members."

"As a Catholic system, we have a separate “Health Ministries” board, whose members all have connections to the Vatican and all are also members of the fiduciary board. We are actively discussing whether to reduce our total board size."

"Outsiders can serve on board committees. Mission, vision and values come from Rome and Assisi. All board members make a pilgrimage to Assisi. New board members are assigned a “board buddy” to mentor and provide orientation."

"A Catholic University is a part owner of one of our regions—they acquired the hospital and the practice plan."

Another of our survey respondents recently doubled in size when it acquired a medium-sized regional Catholic system. Their solution was to continue to operate the Catholic system as a separate corporate entity with its own governing board, so that it could include representatives of the sponsoring ministries. However, the acquiring system continued to maintain its pre-existing non-religious board.

A third survey respondent, a result of mergers and acquisitions among several faith-based systems, has taken steps to incorporate itself as a non-religious (secular) nonprofit corporation, while maintaining liaison with the various ministries that have sponsored the merged and acquired systems. This system, which has also acquired a number of non-Catholic hospitals, continues to respect the ERDs in its Catholic hospitals. However, this system has also created an informal category of “Community Hospitals” within their system – non-Catholic hospitals that have been acquired but do not have to follow the ERDs for almost all services.

One commonality among faith-based respondents is a need to revise the board structure between their regional or local hospitals and their national structure. A general sense of “realignment” was a common theme. One system reported they will be convening a focus group to begin the process for recognizing a fiduciary board and then deploy advisory boards at each local hospital. Given the size of some of these large, faith-based systems, building a rollup structure of regional boards that report to a national structure may be a best fit. When discussing fiduciary responsibilities, it was apparent that one system was actively debating how to operate their fiduciary oversight given the strategic realities of the present.

Finally, in the area of philanthropy, all of the faith-based systems responding to our survey reported having many foundations throughout their systems, but not necessarily at the system-wide level. The consensus was that most of their local or regional hospitals had long-standing ties to the local community (and donors) that they did not want to disrupt. Some of these foundations are ministry-specific. Some of these systems did report having structured philanthropy departments to support the foundations across their system while recently (and cautiously) undergoing some consolidation. One system notes, “We recently consolidated our philanthropy two or three years ago. The system foundation board mostly has system leadership processing system donations at that level.”

In sum, the governing boards of faith-based hospital systems are faced with a number of challenges that do not necessarily confront secular systems, or even systems affiliated with other religions. They have adopted a number of approaches to addressing those challenges.

How High-Performing Boards Can Survive the Culture Wars

Finally, in the decades we, the authors, have been working with nonprofit hospital systems, we have never seen the level of anxiety and divisiveness that we are facing in the current environment. Wherever you turn, emotional and cultural battles are being fought over deeply felt differences over a wide range of issues.

Many of these battles are playing out in healthcare, and many of them involve issues that are now tied up in the courts or in Federal or state-by-state political battles. Controversial issues include vaccines, the use and misuse of artificial intelligence, the opioid epidemic, transgender and reproductive health, inadequate cyber-security, the behavioral health crisis, hospital staff burnout—the list goes on.

How can hospital system board members navigate all this as we move forward into an unknown political future? For starters, we recommend a new book by the New York Times columnist David Brooks. *How to Know a Person: The Art of Seeing Others Deeply and Being Deeply Seen* explores a range of communications techniques that can help address issues colored by even extreme cultural or ideological differences. In his book, Brooks offers the following advice: “There is one skill that lies at the heart of any healthy person, family, school, community organization, or society: the ability to see someone deeply and make them feel seen—to accurately know another person, to let them feel valued, heard, and understood.”

How can we accomplish this goal, especially when we are often dealing with people who profoundly disagree with us? In a recent interview, Brooks agreed that “We happen to live in a time that is not normal. We need to make connections under unfavorable circumstances.” He believes it is inevitable that we are going to run into hardcore viewpoints that differ from ours. But in those cases, it is all the more important to stand in another person’s place and try to truly listen to them, with civility and respect. “It is not naïve to lead with trust, with respect,” according to Brooks. “In every conversation, respect is like air. When it is present, nobody thinks about it. When it is absent, nobody thinks about anything else.”

Don’t let us leave you with the impression that we believe there are simple answers for every adversarial issue or encounter. We are not wearing blinders. Some people do hold extreme and intractable viewpoints on controversial issues and are likely beyond the reach of reasonable discourse. But we do believe that true extremists are far fewer than we might think from watching the nightly news.

As counterintuitive as it may seem, you might even take the U.S. Congress as an example. For while Congress appears at first glance to be full of extremists on both sides, when you look more carefully—when you take the time to “see” individuals—the superficial surface often drops away, and reasonable people who are not at either extreme have been able to pass several important bills in the last year on a bipartisan basis. In other words, you are able to discern what Brooks calls “the disagreement under the disagreement,” which may not be nearly as intractable as the rhetoric saved for the cameras.

This can be an important lesson for nonprofit board members. Despite the best efforts to recruit the highest quality directors and trustees, you will inevitably end up with a range of opinions on many issues important to the future of the institutions you govern. By truly seeing, engaging, and seeking to understand the viewpoints of those who may disagree with you, your boards will operate and govern far more effectively than if you don’t make such an effort.



Survey Conclusion: Self-Identified Best Practices

In conclusion, our survey confirms that a selection of high-performing nonprofit health systems has much to offer to the entire hospital industry in terms of best practices in nonprofit governance. By surveying the performance of these systems in a wide range of governance policies and practices, we believe we have been able to demonstrate that in many areas these systems are exercising leadership and innovation in governance, even as they continue to transform themselves through growth and an expanding range of services. To be sure, not every system surveyed performed at the highest level in every domain of our survey. But even those that did not do so exhibited an acute self-awareness of their shortcomings and evinced a sincere expectation of future improvement.

For this reason, rather than providing our own lengthy conclusion to this report, we will let some of the surveyed systems speak for themselves (as we have done in providing "Interview Insights" throughout the report). Surveyed systems were asked in the survey (and in follow-up interviews) to identify any additional governance practices that they consider being a "best practice" or provide us with any additional comments or clarifications. A sampling of their responses will conclude our report:

The operating company model with one board provides significant advantages in thoughtful and timely decision making.

Our board has adopted a Corporate Governance Policy, which includes independent director criteria based on independence from management. We hold an executive session for board members at the beginning of each board meeting and conduct an annual meeting of only independent directors, with the option to call such a meeting at any time. The Quality Committee of the board includes at least two members from the Patient and Family Council.

Our board is no longer a constituency board. Board members realized that the most important thing they could do to serve their community was to relinquish their independence to join the system board. Once joining, they realized the benefit their hospital would have if they adopted a system-wide mindset. Now, members advocate for the entire system instead of individual hospitals they represent. System-wide thinking is the strongest attribute of the board. The benefits of this culture shift allow management to be moved seamlessly between facilities, enable constant staff curation, and allow for heavy investment in community health.

We believe our board evaluation process is a best practice. We consider our best practices to include term limits, removal provisions for Directors, a revamped CEO report, and a newly formed Enterprise Risk Committee.

The [Redacted] Health System Scorecard was created to measure strategic progress while simultaneously integrating this tool into the Executive Evaluation Process. The scorecard has been an important tool for advancing [redacted system name] culture and strategy. It has focused [redacted system name] culture to emphasize quality and performance results. It has also created a healthy balance between teamwork and individual performance while advancing the System's mission through prioritized strategic objectives.

Initially, the system board was formed entirely of founding member hospital board members, which created dissonance on decisions that should have been made on behalf of the entire system instead of constituent hospitals. Individual hospital boards still handle medical staff credentialing, but transitioned system bylaws have changed founding hospital bylaws and dynamics. Subsidiary boards cannot approve projects for their own hospitals – authority to move forward must go through the system board. Individual hospitals cannot change their own bylaws – they can put forth recommendations, but the final decision lies with the system board.

Every entity in our system has a fiduciary board, though we have combined them over the years. Our health plan and foundation have separate boards. Each subsidiary has a seat on the system board. We recently added two new system board members, but our board is still on the smaller side. Our subsidiary boards need a clear understanding of the reserved powers of the system board.

Our system board has reduced the time spent on presentations from 75 to 80% to a quarter or a third of the meeting time. No presentation can have more than six slides.

There is great transparency on our website with principles of governance. We have a requirement of 15 hours of board education each year, with some portion tied to interaction with patients or members or safety rounds.

Our system is passionate about governance and is willing to share any information with anybody. We publish an internal governance report every year.

Appendix 1: Fundamentals of Nonprofit Governance

What is a “Nonprofit” Organization?

It is impossible to imagine how our society would look today without the hundreds of thousands of nonprofit organizations that provide a wide range of essential services. So important is the nonprofit sector to our success as a nation that it is sometimes hard to appreciate that it has only existed in its current form for barely more than half a century.

In its simplest terms, a nonprofit is a group or organization engaged in providing goods or services that are intended to improve the common good in some way rather than to generate income to increase wealth or for personal gain. Nonprofit organizations today exist in many fields, including education, the arts, social improvement, the environment as well as in healthcare.

In their earliest days, what we now know as nonprofit organizations largely consisted of non-governmental charities that undertook to provide a range of benefits to society. Many of these were benefits or services that might also be provided by governments but often were not due to inadequate taxpayer funding or for political or ideological reasons. It is important to understand that the word “private” often precedes “nonprofit” in describing most (though not all) of the systems surveyed for this report. Clearly, governmental hospitals also exist that are not organized for pecuniary gain, including those owned or operated by the federal government, state universities, cities, counties and hospital districts and authorities. The difference is that these entities are not governed by Section 501(c)(3) of the IRC, drawing their exempt status instead from their governmental status.

Many early charities were religious in nature and often focused their efforts and initiatives on particular services or segments of the population. Those efforts often centered around the provision of health services, and indeed In the U.S., healthcare today represents the largest segment of nonprofits, followed by education.

According to many observers, the first “nonprofit” of the modern era was most likely an English hospital – the Foundling Hospital in London, which was founded in 1741. On May 11, 1751, a charter was granted by the Pennsylvania legislature to Benjamin Franklin and Dr. Thomas Bond to establish a private hospital to care for the “Sick-poor and insane who wander the streets of Philadelphia.” The story of the Good Samaritan was chosen by Franklin as the official seal of the hospital, and “Take Care of Him and I will repay Thee” ushered in a new attitude of social responsibility. In the U.S., the Red Cross is generally considered the first prominent “modern” nonprofit, created in 1881, while the YMCA (founded in 1884) is the first nonprofit said to engage in widespread fundraising among private donors.

The world of the nonprofit corporations as we know it today has only existed for half a century. (Indeed, the very term “nonprofit” did not enter into our vocabulary until the mid-20th century.) Following World War II, the federal government became much more involved in social and cultural welfare programs. In 1969, in the same decade that saw the enactment of Medicare, Medicaid and the programs of the “War On Poverty,” Congress enacted a Tax Reform Act that gave us Section 501(c)(3) of the Internal Revenue Code (IRC). This new law said that every charity in the U.S. that meets certain requirements can be exempt from federal taxation, and donations to such entities would also be tax-exempt.

What Kind of Nonprofit Organization?

There are many different organizational models in the nonprofit sector:

- Membership organizations, in which directors are often selected by a vote of the members after being nominated by the existing board (or through some other process);
- Boards composed primarily of community leaders and/or wealthy individuals, which are more likely than other boards to be expected to financially support the organization;
- Constituency-based boards, in which multiple organizations have the right to designate board members;
- “Umbrella” organization boards (such as University regents or boards of elected officials), which are often responsible for multiple organizations and responsibilities of hospitals or hospital systems;
- Private foundations, which are primarily formed to oversee charitable expenditures by wealthy individuals, families, or other entities;
- Holding companies, which are responsible for a group of similar organizations or entities like hospitals and provide general guidance to, and share fiduciary responsibilities with, local or regional boards; and
- Operating boards, which have primary (and more direct) fiduciary and oversight responsibilities.

There are also many specialized nonprofit models organized under different sections of the IRC, such as private foundations, supporting organizations, trade associations (which, unlike most nonprofits, are permitted to lobby the government), etc.

Why Is Governance Important?

The unique role and status of nonprofit organizations extends to their governance. The requirements for obtaining tax-exempt status include the governance of exempt organizations by directors or trustees who had a duty to serve the public and community and who did not receive any of the financial benefits they would receive if they were directors of a business corporation organized for profit.

Much has been written about the duties and responsibilities of nonprofit governing boards. These responsibilities are also spelled out in the requirements for participation in government health programs, accreditation by the Joint Commission and other guidance in addition to the Internal Revenue Code.

When organizations found that they could legally have status as a charitable organization and offer tax exemptions to their donors, there was a surge in applications for 501(c)(3) status. With the development of an official “nonprofit sector” came the development of more rules, regulations and policies.

Need to tie to governance – with growth of nonprofit organizations (both number and size) came unique demands on governance – boards were to be composed of individuals who were not to profit from the activities of the organization – held to different standards than business corporations (which were obliged to focus primarily on profit).

After the Tax Reform Act in 1969, the number of non-profits in the U.S. increased rapidly over the years. By one estimate, as of 2016, there were 1,571,056 tax-exempt organizations in existence. At the same time, nonprofit organizations providing healthcare services have grown in size and complexity over the last several decades, demanding governance every bit as effective and professional as the largest business corporations.

Governance Best Practices

Building and sustaining a proactive and interactive board culture. The culture of the board has a lot to do with effective governance. Four board practices can have a significant impact on shaping board culture:

- *Identifying the right mix of people for effective governance.*
- *Attracting, recruiting, and appointing them.*
- *Setting board and committee objectives; evaluating performance.*
- *Establishing effective board education and development programs.*

Report of the AHA Blue Ribbon Panel on Health Care Governance

Nonprofit entities today draw heavily on government support, both directly (in the form of grants, governmental payment for services, etc.) and indirectly, through exemption from taxation for both the organizations and their donors. The IRS has been criticized in recent years for not sufficiently reviewing nonprofit hospitals' compliance with its Community Benefit requirement. "Community benefit" is described vaguely on the IRS's Form 990, but is generally understood to encompass unreimbursed Medicaid services, research, and subsidized health services. The IRS is required to review hospitals' community benefit activities at least once every three years, though a 2023 report by the Government Accountability Office found the agency's enforcement on that front has been lacking. Hospital tax exemptions were said to total nearly \$28 billion in 2020. In June 2024 the IRS announced that it will start to crack down on the failure of tax-exempt hospitals to provide adequate community benefits, initially by auditing 35 hospitals in the current fiscal year as part of a stepped-up focus on the sector (Racer, 2024).

What Does it Mean to be a Fiduciary?

The board of directors of a nonprofit has three primary legal duties known as the "duty of care," "duty of loyalty," and "duty of obedience." These duties have been articulated by many organizations that provide advice and assistance to nonprofit organizations generally. The National Council of Nonprofits describes them as follows:

- **Duty of Care:** Take care of the nonprofit by ensuring prudent use of all assets, including facility, people, and good will.
- **Duty of Loyalty:** Ensure that the nonprofit's activities and transactions are, first and foremost, advancing its mission; recognize and disclose conflicts of interest; make decisions that are in the best interest of the nonprofit corporation, not in the best interest of the individual board member (or any other individual or for-profit entity).
- **Duty of Obedience:** Ensure that the nonprofit obeys applicable laws and regulations; follows its own bylaws; and that the nonprofit adheres to its stated corporate purposes/mission.

It should be noted, however, that these are not the only responsibilities of the board of a nonprofit. Board members also advocate and often fundraise for an organization, as well as contribute to the organization's culture, strategic focus, effectiveness, and financial sustainability. Board members can also bring various kinds of skill and experience to an organization, including subject-matter expertise, community connections and the benefits of diversity.

There are a number of regulatory requirements related to a nonprofit hospital's ability to acquire and maintain tax-exempt status. The IRS, in its general requirements for tax exemption under Section 501(c)(3), states that to qualify as an organization described in Section 501(c)(3), a hospital must:

- Be both organized and operated for exempt purposes,
- Demonstrate that it provides benefits to a class of persons that is broad enough to benefit the community, and
- Operate to serve a public rather than a private interest.

In a subsequent Revenue Ruling, the IRS indicated that factors such as the following could demonstrate that the hospital was providing a community benefit:

- Operating an emergency room open to all, regardless of ability to pay.
- Maintaining a board of directors drawn from the community.
- Maintaining an open medical staff policy.
- Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare.
- Using surplus funds to improve facilities, equipment, and patient care.
- Using surplus funds to advance medical training, education, and research.

There are also other governance requirements imposed on nonprofit hospitals. For example, the Conditions of Participation for the Medicare program include requirements related to a hospital's governing body, such as: "There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body."

With respect to hospitals that are part of a multi-hospital system, Medicare gives the governing body of the healthcare system the option to act as the governing body of each separately certified hospital, unless doing so would conflict with State law. A hospital system also has the option to form several governing bodies, each of which is responsible for several separately certified hospitals.

Hospitals seeking accreditation from The Joint Commission must comply with additional governance standards, including a requirement to approve the hospital's written scope of services," "make sure that performance improvement activities reflect the complexity of the hospital's organization and services," and "approve the structure of the organized medical staff," among other duties.

Together with hospital management, the Joint Commission requires the governing body to "regularly evaluate the culture of quality and safety using valid, reliable tools," "develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety," and "develop and enforce a conflict-of-interest policy," among other requirements.

Conflicts of Interest & Checking Private Agendas at the Boardroom Door

Ultimately, to be a fiduciary means that board members are stewards of public trust and must act in good faith on behalf of the organization they represent, rather than to benefit themselves. Conflict of interest policies are among the most important policies that nonprofit boards can adopt.

There are several recent examples of situations with hospital or health system boards where some members violated or ignored the system's conflict-of-interest policies and appear to have lost sight of their fiduciary responsibility. As spelled out in a recent Governance Institute online publication, health system boards should evaluate their current conflict-of-interest and ethics policies, as applied to both the board and senior management. When were these policies adopted? Do they need updating? Are they routinely being followed by both the board and management? It may also be helpful to conduct an inventory of all hospital or system contracts or other relationships that benefit, or relate in any way to, board members and/or their businesses and immediate family. Boards should determine whether those contracts have been reviewed and approved by the board with sufficient transparency and accountability under the board's conflict-of-interest policies, and if necessary, reviewed by counsel with respect to relevant procurement and tax laws. If necessary, the board's conflict of interest policy should require appropriate remedial action, including submitting them to the board for approval (Gage, 2019).

It is also the responsibility of the board and its members to ensure that private agendas are left at the boardroom door. In one university hospital described in The Governance Institute publication, several board members felt that their primary responsibility was to the government entity that appointed them (Gage, 2019). In particular, one board member felt his/her role was to expand certain specific hospital services regardless of need or cost—even to the extent of (unsuccessfully) lobbying the state legislature to divert funds from the hospital into programs and services that were actually opposed by a majority of board members and the university. When the hospital CEO finally succeeded in convincing the legislature that the hospital opposed the board member's proposal, the board member turned his/her attention to disruptive efforts to convince the board to fire the CEO. (The board member's term ultimately expired and he/she was not reappointed; the CEO retained his job.)

Governance Best Practices

Board members are the fiduciaries who steer the organization towards a sustainable future by adopting sound, ethical, and legal governance and financial management policies, as well as by making sure the nonprofit has adequate resources to advance its mission.

National Council of Nonprofits

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About the Authors

Larry Gage is a Senior Counsel in Alston & Bird's Washington, D.C. office, and a Senior Advisor to Alvarez & Marsal's Healthcare Industry Group.

Larry founded the National Association of Public Hospitals (NAPH, now known as America's Essential Hospitals) in 1981 and served as its president for 30 years. Larry focuses his practice primarily on public sector and nonprofit health law and policy. During his tenure as president of NAPH, Larry developed and achieved enactment of Medicare and Medicaid reimbursement reforms that are the economic lifeblood of hospitals serving a disproportionate number of elderly and low-income patients. America's Essential Hospitals has, for the last decade, called its annual member recognition awards program the Gage Awards.

For most of his career, Larry has focused on the governance and legal structure of public and nonprofit hospitals and health systems, writing and lecturing extensively on the topic. In 2012 he was given the American Hospital Association's prestigious Trustees Award and has been named one of the 100 most powerful people in healthcare by Modern Healthcare Magazine. Along with his advocacy and health policy representation of NAPH, Larry's clients have included major teaching hospitals, medical schools, integrated health and hospital systems, and state and local governments across the country. He has assisted clients with mergers, reorganizations, conversion to other corporate structures, and negotiation of complex contracts, affiliation agreements, and joint ventures. He is a graduate of Harvard College and Columbia Law School.



Mark Finucane is a Managing Director with Alvarez & Marsal's Healthcare Industry Group in Los Angeles.

A major element of his work focuses on the relationship of his client senior executives to the governance structure. In multiple markets Mr. Finucane has assisted Academic Health Systems and other clients cope with policy developments, industry trends, internal pressures, market changes and trustee expectations. He has served on the founding board of the Integrated Health Association of California, the National Association of Public Hospitals and Health Systems, LA Care, the California Association of Hospitals and Health Systems, the Public Health Law and Policy Institute, and the University of Southern California Hospital System. This governance experience has been particularly valuable to the senior executives and leaders with whom he has worked.

The healthcare industry has recognized him for his leadership, executive capability and policy creativity. He is frequently asked to testify before state and federal legislative bodies on a variety of health policy and management topics, and has served on a number of policy study groups convened by various foundations and other deliberative policy organizations, such as the Commonwealth Fund, the New York Academy of Medicine, the Millbank Fund, the Robert Wood Johnson Foundation and the Institutes of Medicine.

Mr. Finucane earned a bachelor's degree from Wichita State University. He also studied at Trinity College in Dublin, Ireland. Mr. Finucane has attended a variety of senior executive development programs at Harvard University, IBM, the Transamerica Corporation and others throughout his career.

ALSTON & BIRD LLP



LARRY S. GAGE
SENIOR COUNSEL

+1 202 230 1500
larry.gage@alston.com

ALVAREZ & MARSAL HEALTHCARE INDUSTRY GROUP

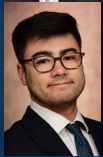


MARK FINUCANE
MANAGING DIRECTOR

+1 626 665 8167
mfinucane@alvarezandmarsal.com



SHERIDAN KELLY
ASSOCIATE



ETHAN SMITH
ASSOCIATE



JAMAL BROWN
ASSOCIATE



ELIZA MEDEARIS
SENIOR DIRECTOR

+1 646 344 9848
emedearis@alvarezandmarsal.com



LINDA TRAN
DIRECTOR

ALSTON & BIRD

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