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HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Charlotte Thompson
Deputy Director
Research and Methodology

May 3, 2010

Peter A. Hammen, Chairman
Health and Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, Maryland 21401

Dear Chairman Hammen:

On September 8, 2009, you requested the Health Services Cost Review Commission (HSCRC) undertake a study of hospital board governance and inform the General Assembly and the public regarding the stewardship of hospital resources.

I am pleased to present you with the enclosed "Maryland Survey of Nonprofit Hospital Board Governance: Report to the Maryland General Assembly". As requested, this report evaluates current board practices at Maryland nonprofit hospitals as well as board governance relative to identified best practice standards. The study focused on board composition, transparency, conflict of interest policies, self-governance functions, financial oversight, executive compensation and community benefits. Results reveal that most hospital boards in Maryland tend to be in line with national trends and best practices.

At your convenience I look forward to meeting with you to discuss the findings of this report.

Sincerely,

Robert Murray
Executive Director

Encl.

Maryland Survey of Nonprofit Hospital Board Governance: Report to the Maryland General Assembly

February 19, 2010

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Executive Summary

Introduction

Delegate Peter Hammen, Chairman of the House Health and Government Operations Committee, requested the Maryland Health Services Cost Review Commission (HSCRC) to undertake a study of hospital board governance policies and practices to inform the General Assembly and the public regarding the stewardship of hospital resources. Chairman Hammen asked that the study include the following: a review of existing literature on the principles for good governance of nonprofit entities, identification of best practice standards, a survey of Maryland hospital board governance, an examination of all of the HSCRC's trustee disclosure reports for a given year, and an evaluation of possible trustee conflicts of interest. The HSCRC contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to assist in this study.

Methods

The study involved three major tasks. First, Hilltop performed a review of the existing literature to identify recommendations for best practices in hospital governance. This literature review informed the second major task, development of a survey instrument on board governance practices and policies. The survey was distributed to Maryland's 45 nonprofit hospitals by the HSCRC, and all hospitals completed the survey and responded to follow-up questions. Finally, Hilltop reviewed the fiscal year (FY) 2008 trustee disclosure of interest statements submitted by Maryland's nonprofit hospitals and analyzed their content to evaluate the hospitals' legal compliance and the extent to which there might be conflicts of interest between trustees and the institutions they govern as board members.

Survey and Literature Review Findings

The survey and literature review addressed governance policies and practices in the following areas: governance structure, transparency, conflict of interest policy, financial oversight, executive compensation, quality oversight, community benefits, and self-governance. A brief summary of key findings in each of these areas follows.

Governance Structure: Board Size, Composition, and Committee Structure

- The composition of Maryland's hospital boards are aligned with national trends and best practices in many areas, including board size, physician representation, and recruitment of board members with core areas of expertise, such as health care quality and financing. Maryland's boards exceed national benchmarks in racial/ethnic minority and female membership.
- Maryland's boards exceed national benchmarks by almost universally establishing committees overseeing quality assurance/improvement and patient safety and establishing committees overseeing community benefits at a higher rate.

- Twelve hospitals reported difficulty in recruiting a sufficient number of desirable candidates for board membership.

Transparency

- Based on the availability to the public of 20 key hospital documents, it appears that Maryland hospitals maintain a level of transparency consistent with guidance from the Maryland Association of Nonprofit Organizations.
- Maryland hospitals rely heavily on disclosure through public information offices, rather than through hospital websites. This strategy requires that interested persons have a basic level of knowledge regarding the documents they seek in order to make a request for information.

Conflict of Interest Policy

- All but one hospital reported having a written conflict of interest policy.
- More than 90 percent of board policies contained the following key provisions: requirements for the disclosure of potential conflicts of interest, conditions when members must recuse themselves from discussions and voting, and guidance on what may constitute a conflict of interest. Maryland is comparable to national benchmarks in these areas.
- No Maryland board positions the CEO as the board chair and a voting board member, which is a rare practice nationally.

Financial Oversight

- Almost all of Maryland's boards have established whistle-blower policies and receive routine reports on many types of financial data.
- For most hospitals—independent and member hospitals alike—authority resides with the board to approve many or all of the financial transactions of concern to federal and state policy makers, including real estate transactions, creation of subsidiary entities, and joint ventures.
- All or all but one independent hospital boards: 1) are responsible for retaining and replacing the hospital's independent auditor; 2) have created a standing committee with audit oversight; 3) meet independently with the external auditor at least annually; and 4) require full board approval of long-range and annual capital and financial plans. Member hospitals conduct these practices infrequently.
- Practices that are followed by fewer than half of all hospitals—independent and system member hospitals alike—include: 1) adoption of policies that require replacement of the independent auditor every five years at a minimum; 2) review and approval of IRS Form 990 before submission to the IRS; 3) establish written policies

governing the investment of assets, internal accounting systems and control procedures, purchasing practices, and unrestricted current net assets.

- Many of the above from federal and state policy makers have not been tested in surveys, so we do not know how Maryland hospitals perform relative to national trends.

Executive Compensation Oversight

- Although the practice of full disclosure of executive compensation (salary and nonsalary) to the full board is recommended in the literature, few boards in Maryland conduct this practice. Because parent boards typically reserve oversight authority over compensation practices, full transparency to the local hospital boards may not be occurring.
- Maryland's hospital boards have CEO performance expectations similar to boards nationally, with more emphasis on financial performance and quality of care targets, and less emphasis on community benefits targets.

Quality Oversight

- Overall, Maryland hospital boards meet or exceed national benchmarks for quality oversight practice.
- Hospital boards in Maryland are nearly twice as likely as hospitals nationally to conduct periodic review of morbidity and mortality rates.

Community Benefit Program Oversight

- Maryland boards engage in formal community needs assessment at a higher rate than hospitals nationally.
- Maryland boards adopt measurable community benefit performance objectives at a lower rate than hospitals nationally. However, additional comments provided by the hospitals elaborated on new community benefits oversight initiatives, indicating that community benefits oversight practices in Maryland are continuing to evolve.

Self-Governance

- Maryland boards are generally structured for success as measured by board committee education/orientation and self-assessment.
- Almost all of Maryland's boards conduct formal self-assessment, and the majority does so at least every two years, which meets or exceeds national benchmarks.
- The majority of Maryland's boards engage in formal orientation and ongoing education, reflecting the recommendations in the literature.

Trustee Disclosure Findings

HSCRC regulations require a nonprofit hospital annually to submit a list of its trustees, their business addresses, and an indication of trustees who are "also an employee, partner, director, or beneficial owner of 3 percent or more" of a business entity that transacted business with the hospital worth $10,000 or more during the reporting period. Trustees, directors, and officers associated with such transactions are required to provide specified information about the transactions to the HSCRC. The HSCRC provides a template that may be used as a guide for making these disclosures, but its use is not mandatory. Hilltop analyzed FY 2008 trustee disclosure reports hospitals submitted to the HSCRC and found the following:

- For FY 2008, 44 of Maryland's 45 nonprofit hospitals submitted trustee disclosure reports with varying degrees of completeness.
- All 44 of the hospitals that reported provided a list of trustees, but only 38 (86 percent) provided trustees' addresses.
- Of the aggregate 908 trustees[1] these 44 hospitals listed, 38 indicated a total of 178 trustees with reportable interests (20 percent of all trustees).
- Of the 38 hospitals indicating one or more trustees with reportable interests:
    - 24 hospitals used the HSCRC's reporting template or provided required data in a similar manner.
    - Less than half (40 percent) of disclosure of interest statements the hospitals submitted were complete.
- The extent to which there may be conflicts of interest between trustees and the institutions they govern cannot be assessed solely on the basis of information provided in trustee disclosure of interest statements; these may, at most, indicate an *apparent* conflict of interest that is the hospital board's responsibility to investigate and, if appropriate, take action to address.

Further Considerations

Many hospitals in larger systems report contractual arrangements between local hospital boards and parent corporations in which the parent corporation, along with its board of trustees, holds "reserved powers." As a result, many boards of hospitals in larger systems retain limited authority across several domains of governance. This is certainly not the case across all systems. In some cases, local hospital boards appear to participate in both monitoring and decision-making functions.

[1] The term "trustee," when used in the context of trustee disclosure, should be understood to include hospital officers.

The Maryland Survey on Nonprofit Hospital Board Governance limited its scope to the practices of hospital boards, sought no detailed information regarding the practices of hospital and health *system* boards and did not collect any information regarding the dynamics between hospital boards. Therefore, the implications of "reserved powers" agreements for policy makers and regulatory bodies interested in enhancing public accountability and increasing the community benefit are arguably not well understood.

Several questions appear immediately relevant to the interests of policy makers, regulators, and the public interest:

1) Is the composition of system boards, in terms of representation from major stakeholders, including the community, adequate to ensure transparency in governance?
2) Are there some systems in which the local hospital boards serve in a capacity that is more advisory in nature relative to the authority exerted at the system level?
3) Even when local hospital boards are limited in their decision making authority because of system arrangements, are they provided adequate information regarding financial practices, compensation practices, and financial performance, to monitor the financial management of the hospital?
4) Are local hospital boards empowered to intervene in a meaningful way, if concerns arise in these domains?

Further exploration into governance structures of hospital and health systems in Maryland is recommended.

Maryland Survey of Nonprofit Hospital Board Governance

Introduction

In September 2009, Delegate Peter Hammen, Chairman of the House Health and Government Operations Committee, requested the Maryland Health Services Cost Review Commission (HSCRC) to undertake a study of hospital board governance policies and practices to inform the General Assembly and the public regarding the stewardship of hospital resources. The governance areas of concern to Chairman Hammen were board composition, transparency, conflict of interest, and financial oversight. Chairman Hammen asked the HSCRC to include the following in this study:

- "Review of existing literature and related informative articles on the principles for good governance of nonprofit entities
- Identification of best practice standards for nonprofit organizations
- Development of a survey tool to be submitted to each Maryland hospital inquiring about current board practices and requirements
- Compilation of completed survey tool data and evaluation of Maryland hospital board governance relative to identified best practice standards
- Examination of all of the HSCRC's Trustee Disclosure Reports for a given year to evaluate (a) the extent to which hospitals are complying with the Trustee Disclosure Requirements of the HSCRC statute; (b) the extent to which there may be conflicts of interest between trustees and the institutions in which they govern."

The HSCRC contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to assist in this study. The purpose of this report is to present the results of the study.

Methods

This study involved three major tasks. First, Hilltop performed a review of the existing literature to identify recommendations for best practices in hospital governance in the subject areas requested by Chairman Hammen. This literature review informed the second major task, the development of a survey instrument on governance practices. The survey was distributed to the hospitals by the HSCRC after review by the Maryland Hospital Association (MHA). Survey findings are presented in this report. Finally, Hilltop reviewed the annual trustee disclosure reports submitted to the HSCRC by Maryland's nonprofit hospitals in fiscal year (FY) 2008 and analyzed their content for compliance with statute, regulations, and the template provided by the HSCRC, as well as for the extent to which there may be conflicts of interest between trustees and the institutions they govern as board members. The methods for the literature review and survey are described in more detail below.

Literature Review

Hilltop reviewed the literature on best practices and principles of good governance for nonprofit organizations using industry reports, previous studies, journal articles, and state and federal policies related to the governance of nonprofit organizations. The review emphasized the governance of nonprofit hospitals and health systems in the subject areas requested by Chairman Hammen. The literature informed the survey design, and key articles were shared with MHA before the survey was fielded. The literature review also identified benchmarks from national studies to use as a comparison to Maryland's governance practices. A full list of references is available at the end of the report. A summary of the key literature follows:

- **The New Jersey Commission on Rationalizing Healthcare Resources Final Report (New Jersey Commission on Rationalizing Healthcare Resources, 2008):** Under the governor's executive order, this report studied the financial conditions of New Jersey's hospitals. Chapter 10 of this report outlined recommended best practices and suggestions for regulatory reform for the governance of New Jersey's hospitals. This report, in part, provided the impetus for Chairman Hammen's request.
- **Building an Exceptional Board: Effective Practices for Healthcare Governance: Report of the Blue Ribbon Panel on Healthcare Governance (Center for Healthcare Governance, 2007):** In 2005, the Health Research and Educational Trust (HRET) and the Center for Healthcare Governance convened a Blue Ribbon Panel of hospital chief executives, board members, governance researchers, and other experts to identify best practices and recommendations for exceptional board governance. This report provides a summary of these findings, as well as implementation tools to assist boards in adopting these practices.
- **Minority Staff Discussion Draft (Senate Finance Committee, 2004):** This draft report was released by Senate Finance Committee staff and includes recommended practices for financial oversight of tax-exempt organizations.
- **The Attorney General's Guide for Board Members of Charitable Organizations (Commonwealth of Massachusetts Office of Attorney General Martha Coakley, 2007):** This guide provides recommendations for board members of nonprofit organizations to ensure that they carry out their responsibilities for the organization's charitable mission. The report provides guidance on board member rights and responsibilities, board composition, executive evaluation and compensation, conflicts of interest, and financial oversight.
- **Strengthening Transparency Governance Accountability of Charitable Organizations (Panel on the Nonprofit Sector, 2006):** This report summarizes the findings of the Panel on the Nonprofit Sector, which was convened in 2004 to make recommendations for good governance and ethical conduct for charitable organizations. Relevant recommendations include transparency and disclosure of information, financial oversight, and executive compensation.

- **Standards for Excellence: An Ethics and Accountability Code for the Nonprofit Sector (Maryland Association of Nonprofit Organizations, 2009):** This report outlines 54 standards for responsible governance and performance benchmarks for determining how organizations are fulfilling their charitable obligations. These benchmarks are centered on guiding principles for eight subject areas, including mission and program, governing body, conflict of interest, human resources, financial and legal, openness, and public policy.
- **Report on Nonprofit Hospital Systems: Survey on Executive Compensation Policies and Practices (U.S. Government Accountability Office, 2006):** The United States Government Accountability Office (GAO) surveyed 100 hospitals and health systems on the methods used to determine executive compensation, the governance structures surrounding executive compensation, and internal controls over these practices. **Although this report does not provide recommendations, the survey results are used as benchmarks for comparison with Maryland's hospitals.**
- **Hospital Governance: Initial Summary Report of 2005 Survey of CEOS and Board Chairs (HRET 2005 Survey, Margolin et al., 2006):** This report presents the results of a survey of 4,865 CEOs of nonfederal acute care community hospitals on the structure and operations of the hospital board, including governance, board composition, committees, board management, board relationships, operations, and accountability. **The survey results are used as benchmarks for comparison with Maryland's hospitals.**
- **The Governance Institute's 2009 Biennial Survey of Hospitals and Healthcare Systems: Governance Structure and Practices: Results, Analysis, and Evaluation (The Governance Institute, 2009):** This report presents the results of a survey of 4,250 hospitals and health care systems on governance structure (board composition, committee structure, and board meeting time) and governance practices. The report measures the adoption of best practices selected for each survey fielding, and, in 2009, these practices were related to compliance, financial oversight, duties of care and loyalty, board self-assessment/development, and advocacy. **The survey results are used as benchmarks for comparison with Maryland's hospitals.**
- **Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives (Prybil et al., 2008):** This study presents the results of a survey of 201 community health systems regarding the structures, practices, and cultures of nonprofit, nongovernmental community health system governing boards and compares them with selected benchmarks of good governance. **The survey results are used as benchmarks for comparison with Maryland's hospitals.**
- **Governance in High-Performing Community Health Systems: A Report on CEO and Trustee Views (Prybil et al., 2009):** This report is a follow-up to the 2008 report described above. In addition to presenting the survey results, this report compares governance practices with the health systems' operating performance. **The survey results are used as benchmarks for comparison with Maryland's hospitals.**

Overview of Survey Methods

The survey instrument was developed in November and December 2009 and was derived from existing surveys of hospital and health system governance practices. In some cases where no existing survey had inquired about current practice related to a recommendation, survey questions were designed to directly compare to specific recommendations identified in the literature. A senior member from MHA reviewed the survey instrument, provided written comments, and participated in a 90-minute meeting to discuss these written comments. Many of MHA's comments were incorporated. The survey asked respondents to address the governance policies and practices of the hospital's board. It did not address the governance policies and practices of the board of a parent company or health system. In cases where the parent or system board met an oversight responsibility on behalf of the hospitals, the survey solicited information regarding the authority of the hospital board, not the system board. The details of governance practices and board composition of the parent or system board were not collected. In short, the scope of the survey did not obtain complete information about the governance practices of system boards. Further understanding of system-level practices is material to understanding the governance of nonprofit hospitals that belong to systems.

The survey questions addressed board composition, transparency, conflict of interest policies, self-governance functions, financial oversight, executive compensation, and community benefits. The survey instrument is included in Appendix I of this report.

The 2009 Maryland Survey of Hospital Governance was fielded to the CEO of each of the 44 nonprofit acute care hospitals in Maryland and one quasi-governmental entity, Garrett County Memorial Hospital Center. Southern Maryland Hospital Center is a for-profit hospital and was not asked to participate in the survey. The survey was distributed in December 2009 via emailed electronic documents by HSCRC staff. The HSCRC conducted follow-up with several hospitals for clarification on relationships between the hospitals and their parent companies/health systems. All hospitals completed the survey and responded to follow-up questions.

Hospital System Characteristics and Classification Method

Appendix II provides a complete list of hospitals responding to the survey and their system characteristics. Two changes to hospital structures occurred in 2009. Braddock and Cumberland hospitals merged to become a single hospital, Western Maryland Health System. Previously a multi-hospital system, this entity is now a sole-hospital system with one governing board. Western Maryland is classified as an independent hospital. The University of Maryland Medical System (UMMS) merged with the Upper Chesapeake Health System, which includes Harford Memorial and Upper Chesapeake Medical Center. These hospitals are therefore shown in Appendix I as part of the UMMS system.

Thirty-five acute care hospitals in Maryland belong to a larger system with a separate parent board. The relationship between governing boards varies based on the type of system. Systems can be characterized as multi-hospital systems or sole-hospital systems. Twenty-nine hospitals in Maryland are members of a multi-hospital system. Moreover, hospitals may belong to a system

headquartered in Maryland, or a system with out-of-state system headquarters. Three hospitals are the only in-state member of their system with headquarters out-of-state. Finally, the system may have a parent or corporate board that is a separate entity from the hospital board, meaning that the parent board is composed of a separate group of individuals than the hospital board membership. This is predominantly the case. Five hospitals reported membership in a larger health system, but also indicated that the parent board is composed of the same individuals that comprise the local hospital board. In these cases, the hospital is the dominant entity. For the purposes of this analysis, hospitals with this structure were classified as independent hospitals rather than as part of a system. They are listed under "Health Systems" in Appendix II.

System membership affected responses to several survey topics. Most member hospitals that are part of larger systems, led by a parent corporation, explained that the system or parent corporation board holds certain "reserved powers."In general, reserve powers refer to powers that otherwise would be exercised by the hospital board (also referred to as the "local" board). Powers that a system board reserves to itself typically include, for example: approval of major transactions, large capital expenditures, or changes to the affiliated hospital's corporate bylaws (Bader et al., 2007).

Member hospitals did not systematically elaborate on the details of the scope of authority reserved by their parent corporations, and among those that did, explanations varied widely. Respondents commonly indicated that parent corporations reserved powers in the area of executive compensation and audit oversight. Some additional examples are provided below:

> "[Parent corporation] serves as the sole member [comparable to a shareholder of a for-profit corporation] of [the local hospital] corporation and… has reserved certain powers to itself...[including] appointment of members of [the local hospital's] board of directors; appointment and retention of the President; approval of operating and capital budgets; borrowing and issuance of debt instruments; management and investment of assets; approval of [local hospital] strategic and operating plans; review and approval of executive compensation plans; appointment and retention of independent auditors; oversight of internal audit and compliance functions; and review and approval of 'significant transactions' (e.g., mergers, acquisitions, dissolution)."
>
> * * *
>
> "The parent company, [name], maintains some system level oversight over most governance functions, but most decisions are made locally."
>
> * * *
>
> "Because of the allocation of responsibilities between the [local] Hospital and its parent organization, the survey seems unlikely to provide a complete and accurate picture of the way in which the Hospital's activities are overseen. The Hospital's parent organization has a robust governance process, and … many important

governance functions are performed by the Board of Directors and Board-level committees of the parent organization."

According to research conducted by the Center for Healthcare Governance (2007), hospitals that are members of a system will operate within a "hierarchical governance" structure, in which multiple boards relate. Parent boards are likely to oversee and coordinate functions of member boards (Center for Healthcare Governance, 2007). Typically, certain authorities may be centralized at the parent or system level, whereas other aspects of decision making are decentralized to the members. This hierarchical oversight structure recognizes that standards (such as quality policy) and goals (such as strategic plans and certain performance targets) are best established at the system level.

The shared oversight responsibilities established within these hierarchical governing structures has implications for interpreting the Maryland survey results. One of the primary concerns of Chairman Hammen was financial oversight, which is typically a shared responsibility between the system board and its local hospital member boards. Local hospital boards reported almost unanimously that parent boards determined audit oversight practices and executive compensation practices. In these sections of the report, survey results reflect the practices of the local boards and not parent boards. Where the survey solicited information about the role of the parent board, these results are incorporated. A complete picture of governance practices that impact local hospitals requires that additional information be collected from parent companies and parent boards regarding their governance practices.

One hospital has a unique governance structure that affects its classification. This hospital reported that the governance structure of its sole hospital health system included a local hospital board, a parent board composed of the same individuals, and a separate corporate board. This structure is unique to the health systems present in Maryland. This hospital was classified as a system member because it has a corporate board separate from the hospital board.

Based on this understanding of board governance structures, the analysis classified hospitals into the following categories based on system board structure: (1) independent hospitals (n=15), (2) member hospitals (n=30), and (3) all hospitals (n=45).

The "member" category includes all hospitals reporting ownership by a parent company or health system that also indicated existence of a separate parent board composed of different individuals than the individuals comprising the hospital board (n=30). The "independent" category includes hospitals not reporting system ownership (n=10). In addition, this category includes hospitals that indicated belonging to a larger health system in which the parent board was composed of the same individuals as the hospital board (n=5).

Report Structure

This report is divided into five chapters. The first four chapters present the results of the Maryland Survey of Hospital Governance. Chapter I discusses board size, composition, committee structure, terms of service for board members, and member recruitment. Chapter II

discusses public transparency, primarily public access to pertinent governance documents. Chapter III discusses conflict of interest polices. Chapter IV includes the following governance practices: financial, executive compensation, quality, community benefits, and self-governance. Each section includes a brief review of the literature, recommendations from the literature, and industry-selected best practices. This is followed by presentation of Maryland survey results, and, finally, a listing of national benchmarks. The final chapter describes some governance issues for further considerations. The results of the trustee disclosure report analysis are included in Appendix III of this report.

Chapter I. Governance Structure: Board Size, Composition, and Committee Structure

"All boards should consider enriching their membership with greater racial and gender diversity; they also should consider the appointment of highly-respected and experienced nursing leaders as voting members of the board to complement physician members and strengthen clinical input in board deliberations (Prybil et al., 2009, p. 41)."

"The composition of hospital boards helps ensure that the hospital is responsive and accountable to the community. Hospital boards should ensure that they are representative of key stakeholders complemented by adequate technical expertise in key areas of oversight. (New Jersey Commission on Rationalizing Health Care Resources, 2008, p. 150)."

Board Size and Composition

Hospital boards face challenges in trying to balance board size, diversity in membership, representation from core constituents, inclusion of members with core areas of expertise, and members free of conflicts of interest. Different sized hospitals (e.g., based on operating revenue or number of beds) may require different-sized boards. Although there has been a trend toward decreased board size (Prybil et al., 2008), the size of a board should be evaluated in relation to its composition and other board bylaws and practices.

Public accountability is facilitated through the inclusion of members who represent key community constituents, such as local minority/ethnic and immigrant communities, women, and community members generally. Constituent representation and diversity in membership should be balanced by the inclusion of key hospital stakeholders (e.g., officials and staff), board members with core expertise in oversight responsibilities, and independent membership. Core areas of expertise identified by industry experts include health care quality and delivery, financial, and legal expertise (Center for Healthcare Governance, 2007). Not all constituents can be served through direct representation on the board, so boards must have a process to prioritize stakeholder interests.

In health care systems, board composition at the level of the parent company is geared to serve system-wide strategies. In contrast, representation of stakeholders and constituents is perceived as a priority for member boards at the local level (Center for Healthcare Governance, 2007).

Recommendations and Best Practices

Recommendations for best practices related to board size and composition, as found in the literature, include the following:

- Voting membership should be between 9 and 17 members (Center for Healthcare Governance, 2007).

- Representation from physicians and nurses that can represent the broader medical staff community and advance the hospital's mission is encouraged (Center for Healthcare Governance, 2007).
- Representation from nursing staff is encouraged to counterbalance other hospital stakeholders often represented (e.g., physicians) (New Jersey Commission on Rationalizing Health Care Resources, 2008).
- Nursing representation is not recognized as a benchmark of good governance, but "given the importance of nursing in the provision of patient care," increased engagement of nurses on boards is anticipated in the future (Prybil et al. 2009, p. 8).
- Good governance is supported by substantial gender diversity (at least 21 percent) and substantial racial diversity (at least 9 percent) in board composition (Prybil et al., 2009).

Maryland Survey Results

The Maryland survey found the following:

- Forty-nine percent of hospital boards are composed of a voting membership between 9 and 17 members, including vacancies. Boards of member hospitals tend to be larger than boards of independent hospitals. Board sizes range from 9 to 44 (see Table 1).
- The number of physicians on the board ranges from 0 to 6 physicians (2.9 on average), not including the medical staff president, who is also typically a voting member (see Table 1). Thirty-one boards include at least three physicians. These are virtually all physicians without hospital privileges.
- Most hospital boards (69 percent) have no nurse representation (see Table 2).
- Boards tend to be dominated by members representing the community (i.e., general public), who comprise 72 percent of voting board membership, on average (see Table 2). Sixty percent of boards include 11 or more community leaders (see Table 2).
- On average, Maryland boards include four female members. Sixty percent of boards include at least four female members (See Table 2).
- On average, Maryland boards include two leaders representing local ethnic or minority communities (these members might also be women) (See Table 2).
- Thirty-three Maryland hospitals (73 percent) reported that board membership included members with three core areas of expertise, including 7 independent hospitals and 24 member hospitals (See Table 3).

Table 1. Maryland: Total Number of Voting Board Members, Including Vacancies

Number of Voting Board Members, Including Vacancies	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
	N (%)	N	N
1 to 8	0	0	0
9 to 17	22 (49%)	9	13
More than 17	23 (51%)	6	17
Average	18	15.9	19.1
Range (Min. to Max.)	9-44	9-24	11-44

Table 2. Maryland: Composition of Voting Board Membership

Composition of Voting Board Membership	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Physicians[1]			
Average	2.9	2.4	3.1
Range	0-6	0-5	0-6
Average percentage of all members[2]	17%	15%	18%
Nurses (staff and other)			
Average	0.4	0.3	0.4
Range	0-3	0-1	0-3
Average percentage of all members	2%	2%	2%
Community members/leaders			
Average	12.5	10.3	13.6
Range	2-41	2-15	4-41
Average percentage of all members	72%	70%	72%
Local minority/ethnic leaders			
Average	2.1	1.3	2.5
Range	0-10	0-10	0-7
Average percentage of all members	13%	10%	15%
Females			
Average	4.2	4.2	4.1
Range	0-11	1-9	0-11
Average percent of all members	24%	28%	22%

[1] Includes physicians with or without admission privileges. Excludes Chief Medical Officer and Medical Staff President.
[2] Calculated as the average percentage of all voting members.

Table 3. Maryland: Inclusion of Members with Core Areas of Expertise

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Core Areas of Expertise	N (%)	N	N
Board currently retains members with the following expertise:			
Health care quality and delivery	44 (98%)	14	30
Legal	35 (78%)	11	24
Health care financial and accounting	43 (96%)	13	30
If no financial expertise (n=2):	2		
Board contracts with an independent financial advisor	2 (100%)	2	

National Benchmarks

National benchmarks related to board size and composition include the following:

- Eleven percent of nonprofit hospital boards had fewer than 6 members, and 11 percent had 21 or more board members, with an average of 13 members (HRET 2005 Survey, Margolin et al., 2006). No benchmark survey provided data on the percentage of boards that met the recommended size of 9 to 17 members.
- Independent hospitals and member hospitals, respectively, reported an average of 14.4 and 14.5 voting board members (including vacant positions). Larger hospitals reported larger boards (The Governance Institute 2009 Biennial Survey, 2009).
- Physicians comprise about 20 percent of hospital board membership nationally (Prybil et al., 2008).
- Less than 3 percent of boards nationally (independent and systems) have nursing representation (Prybil et al, 2008).
- Female board members comprised on average 23 percent of nonprofit hospital board membership nationally, including vacancies (HRET Survey 2005 Survey, Margolin et al., 2006).
- On average, member boards had 4 female and 1 ethnic minority voting members, and independent boards had 3 female and 1 ethnic minority voting members (The Governance Institute 2009 Biennial Survey, 2009).
- High-performing system boards include a substantially higher proportion of women (30 percent) compared with low-performing boards (14 percent) (Prybil et al., 2009).

Board Member Recruitment

Some hospitals may find it challenging to secure competent membership that balances all of these interests—size, expertise, representation, and independence—on an ongoing basis. The challenge may be even greater in rural areas or for hospitals that are in financial distress. Small boards may have more difficulty meeting composition standards that support good governance and public accountability: representation of core stakeholders, retention of core expertise, and a sufficiently independent membership. Such limitations could be offset by other board practices, such as the retention of expert consultants.

Recommendations and Best Practices

Recommendations for best practices in board member recruitment, as found in the literature, include the following:

- Conduct a stakeholder analysis to identify emerging stakeholders and provide clarity and focus to the board's priorities (Center for Healthcare Governance, 2007).
- Adopt written criteria specifying areas of knowledge, skills, and perspectives needed on the board, and then use these criteria when recruiting and re-electing board members (The Governance Institute, 2009).
- "Publish a notice of board membership openings at a time and in a manner calculated to generate meaningful community input (e.g., local newspapers, hospital website, and other forms of outreach that would be expected to reach target representational constituency). The notice should identify the target representational constituency and/or expertise category, as relevant, that the board seeks to satisfy with the noticed appointment (New Jersey Commission on Rationalizing Health Care Resources, 2008, p.154)."

Maryland Survey Results

The Maryland survey found the following:

- Overall, 12 of 45 Maryland hospitals reported difficulty in recruiting members to their respective boards.
- Of the 12 citing difficulties, 8 cited difficulties recruiting minority members, and 3 said they were unable to find qualified community representatives. Two hospitals reported a need for qualified members in quality control, legal, or banking. Two hospitals reported either rural location or general instability as factors in recruitment difficulty.

The Maryland survey asked about the publication of notices of board membership openings (1) on the hospital website and (2) in other public media, such as local newspapers, hospital publications, or other forms of outreach expected to broadly reach target representational constituencies. The Maryland survey found the following:

- Only six hospitals (13 percent) published a notice of board membership openings through public media other than the hospital website. None of the boards used its website to recruit new members.
- A very small number of hospitals conducted other forms of targeted outreach.
- Of the 12 boards citing difficulty recruiting members, only 2 used public media to publish notices of board membership openings.

Terms of Service

How terms of service are established and limited may influence board culture broadly. Bylaws that do not establish terms of service may give the CEO or board chair too much influence over the board composition. Term limits reinforce the integrity of the full board, rather than place individual members in charge (Center for Healthcare Governance, 2007). An absence of staggered terms may undermine board continuity (New Jersey Commission on Rationalizing Healthcare Resources, 2008). Although hospitals may face external constraints that make it difficult to meet compositional standards for good governance, standards related to terms of service and continuity can be met by any hospital.

Maryland Survey Results

The Maryland Survey found the following:

- Most Maryland boards (93 percent) stagger the terms of board members.
- All Maryland board members are limited to a fixed term.
- The majority of board member terms (78 percent) are limited to three consecutive terms of three years each.

Table 4. Maryland: Board Member Terms of Service

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Terms of Service	N (%)	N	N
Terms of board members are staggered	42 (93%)	15	27
Board members are limited to a fixed term	45 (100%)	15	30
Terms are limited to 3 consecutive terms of 3 years	35 (78%)	11	24

National Benchmarks

National benchmarks related to board terms of service include the following:

- Eighty-five percent of nonprofit hospital boards limited board members (other than board officers) to a fixed length, and 67 percent limited the number of consecutive terms (HRET 2005 Survey, Margolin et al., 2006).
- Ninety-two percent and 94 percent of independent and member boards, respectively, have defined terms for the length of elected service (The Governance Institute 2009 Biennial Survey, 2009). The median length of term was 3 years for both board types (The Governance Institute 2009 Biennial Survey, 2009).
- Approximately 65 percent and 77 percent of independent and member boards, respectively, have bylaws that limit the maximum number of consecutive terms (The Governance Institute 2009 Biennial Survey, 2009).

Standing Committees

There is consensus in the literature that boards should have standing committees for specific governance functions, such as finance and audit (Center for Healthcare Governance, 2007; The Governance Institute, 2009; Prybil et al., 2008; Prybil et al., 2009).

Recommendations and Best Practices

Recommendations for best practices in board committee structure, as found in the literature, include the following:

- Boards should have standing board committees with clear oversight responsibility for the following functions: external audit, internal audit, executive compensation, board education and development functions, community benefit programs, and patient care quality and safety (Prybil et al., 2008).
- Standing committee responsibilities should be clearly defined in a written document (Center for Healthcare Governance, 2007).
- Each standing committee should have a charge, annual objectives, an annual work plan, and a mechanism for evaluating its performance (Center for Healthcare Governance, 2007).

Maryland Survey Results

The Maryland survey inquired generally regarding whether or not boards have standing committees with clearly defined responsibilities and, more specifically, about committee functions. The Maryland survey found the following:

- Nearly all boards (93 percent) have clearly defined, written responsibilities for standing committees.

- The five most frequently reported board committees are quality assurance/improvement (96 percent), patient safety (91 percent), executive (76 percent), finance/budget (76 percent), and ethics/compliance (71 percent).
- The least frequently reported board committee is community benefit (40 percent).

Table 5. Maryland: Board Committee Structure

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
	N (%)	N	N
Standing committees have clearly defined responsibilities that are spelled out in a written document (i.e., charter) that has been approved by the board	42 (93%)	15	27
Board has a standing committee with clear oversight responsibility for the governance function			
Executive	34 (76%)	10	24
Finance/budget	34 (76%)	15	19
External audit	27 (60%)	15	12
Internal audit	23 (51%)	12	11
Strategic planning	28 (62%)	10	18
Executive compensation	23 (51%)	14	9
Patient safety	41 (91%)	13	28
Quality assurance/quality improvement	43 (96%)	14	29
Ethics or compliance	32 (71%)	14	18
Community benefits program	18 (40%)	8	10
Board governance (i.e., self-governance)	28 (62%)	12	16
Board education and development	24 (53%)	10	14

National Benchmarks

National benchmarks related to committee structure include the following:

- Frequently reported committees in the 2005 HRET Survey include finance/budget (75 percent), executive (72 percent), and quality assurance (59 percent) (Margolin et al., 2006).

- The 2009 Biennial Survey found that 78 percent of independent hospitals and 83 percent of member hospitals have standing committees for quality assurance (The Governance Institute, 2009).
- Eighty-three percent and 76 percent of independent and member boards, respectively, had an executive committee in the 2009 Biennial Survey (The Governance Institute, 2009).
- Only 10 percent of independent and 23 percent of member hospitals had standing committees for community benefits in the 2009 Biennial Survey (The Governance Institute, 2009).

Summary

In many respects, the composition of most nonprofit hospital boards in Maryland tends to be in line with national trends and best practices. Areas where Maryland hospitals are aligned with national trends and best practices include board size, physician representation, and recruitment of board members with core areas of expertise, such as health care quality and financing. Both independent and member hospitals significantly surpass national practices in some areas. Maryland boards tend to be weighted more heavily with racial/ethnic minority community leaders and female voting membership; and exceed national benchmarks in terms of service practice. As could be expected given the wide variation in corporate structures across hospitals in Maryland, there is also considerable variation in the number and choice of board committees in Maryland. However, Maryland hospitals exceed national benchmarks by almost universally establishing committees overseeing quality assurance or quality improvement and patient safety, and establishing committees overseeing community benefits at a far higher rate (40 percent of Maryland boards have community benefit committees compared with 10 to 23 percent of boards nationally).

Survey results raise two outstanding questions. The literature review did not find consensus regarding the role nurses should play in board governance. On the one hand, several sources strongly recommended representation by nurses on hospital boards, acknowledging nurses as a key constituency, a resource for quality oversight, and as a counterbalance to physician interests. On the other hand, industry sources did not identify nursing representation as a best practice, and few hospitals nationally appear to include nurses as board members. Maryland hospitals fall in line with these national practices. The outstanding question is whether or not an enhanced role of nurses in board governance could enhance quality oversight or provide other advantages in board governance.

Finally, twelve hospitals reported difficulty in recruiting candidates for board membership with certain desirable qualities or qualifications, although the types of candidates sought varied. Maintaining a board composed of qualified members and representing diverse stakeholder groups may be particularly challenging for hospitals in rural areas or hospitals facing chronic financial distress or instability. Given the limited outreach many hospitals in Maryland appear to engage in, enhanced public awareness campaigns in targeted communities or assistance with targeted outreach by the HSCRC might improve the pool of qualified candidates seeking board member service.

Chapter II. Transparency

"Transparency helps ensure community accountability. Hospital boards should maximize transparency of financial performance data and measures of clinical quality (New Jersey Commission on Rationalizing Health Care Resources, 2008, p.22)."

Openness is one of eight guiding principles promoted by the Maryland Association of Nonprofit Organizations (Maryland Association of Nonprofit Organizations, 2009). As this association indicates in its preamble, although nonprofits may be private corporations, they operate for "public purposes with public support" (Maryland Association of Nonprofit Organizations, 2009, p.8). Generally, a nonprofit should be "accessible and responsive to members of the public who express interest in the affairs of the organization" (Maryland Association of Nonprofit Organizations, 2009).

The principle of transparency has been interpreted more broadly by the New Jersey Commission on Rationalizing Health Care Resources as openness between multiple agents of the organization: between management and the board, board committees and the entire board, and between the hospital and community (2008). Within the board, transparency involves committees reporting decisions and recommendations to the full board. Between the board and the community, it involves activities such as the consideration of confidentiality provisions in bylaws, sufficient notice of closure or financial stability, and public accessibility of information through hospital websites and public information offices (New Jersey Commission on Rationalizing Health Care Resources, 2008). Similarly, the Massachusetts Attorney General notes the importance of transparency within the board because board members need access to appropriate information in order to carry out their duties (Office of Attorney General Martha Coakley, 2007).

The principle of transparency is more than documenting organizational performance to the public. It is about the commitment to earning and maintaining the public's trust in the institution generally. According to the Blue Ribbon Panel on Health Care Governance, this commitment is demonstrated through "understanding traditional and emerging stakeholders and constituents," and "promoting transparency in reporting to stakeholders about the organization's performance" (Center for Health Care Governance, 2007, p.12)."

Recommendations and National Benchmarks

Transparency has not recently been selected by national surveys as a focus. Industry sources provided virtually no benchmarks in this area. The following is one available benchmark on the subject:

- Forty-three percent of independent boards and 55 percent of member boards (48 percent of system boards) reported adoption of a policy that requires reporting of quality/safety performance to the general public (The Governance Institute Biennial 2009 Survey, 2009).

- Several sources recommend that nonprofits should also make available to the public:
  - A mission statement; articles of incorporation; lists of board members, their terms, and biographies; bylaws; three most recent U.S. Internal Revenue Service (IRS) form 990s and annual reports; management compensation; and conflict of interest policies (New Jersey Commission on Rationalizing Health Care Resources, 2008).
  - Information about the organization's "mission, program activities, and finances" (Maryland Association of Nonprofit Organizations, 2009).
  - Tax-exemption application, annual tax return (must be available for 3 years after the due date in the return), and all schedules, attachments, and supporting documents associated with the tax return made available for public inspection and copying upon request (IRS, 2009).
  - Financial reports to stakeholders such as rating agencies, medical staff, and department heads, as well as an account of the level of community benefits provided, clinical quality reports, patient safety outcomes, and patient satisfaction surveys to the public (Center for Healthcare Governance, 2007).

Maryland Survey Results

The Maryland survey provided a list of 20 documents and asked each hospital to indicate whether it makes each document available to the public, either through the hospital website or through the public information office upon request (Table 6).

The Maryland survey found the following:

- Documents most commonly made available *on hospital websites* were the names of board members, clinical quality measures (other than patient safety), and the level of community benefits the organization provided in the most recent year.
- *Most* hospitals made *most* of the 20 documents available at least through the public information office upon request.
- Virtually all hospitals made available the articles of incorporation and mission statement, the three most recent IRS 990 forms, the hospital's financial assistance and/or debt collection policies for under-and uninsured patients, and the level of community benefits through at least one venue.
- The documents hospitals were *least likely* to make available were the audit letters of IRS Form 990 and the hospital's charge master.

Table 6. Maryland: Documents Made Available to the Public

	Maryland Survey		
	All Maryland Hospitals (N=45)		
	Document is Available Through		
Document or Information	Website N (%)	Public Information Office N (%)	At least one of these N (%)
Articles of incorporation, including corporate mission statement	7 (16%)	37 (82%)	40 (89%)
Names of members of the Board	22 (49%)	31 (69%)	40 (89%)
Board member terms in office	1 (2%)	30 (67%)	31 (69%)
Brief biography of each board member	2 (4%)	28 (62%)	29 (65%)
Board bylaws	0 (0%)	30 (67%)	30 (67%)
Medical staff bylaws	3 (7%)	27 (60%)	28 (62%)
Most recent IRS Form 990	1 (2%)	42 (93%)	43 (96%)
Three most recent IRS Forms 990	0 (0%)	43 (96%)	43 (96%)
Audits of IRS Form 990	0 (0%)	20 (44%)	20 (44%)
Both salary and nonsalary compensation of the top four executives (other than the CEO)	0 (0%)	26 (58%)	26 (58%)
Most recent annual report	15 (33%)	28 (62%)	36 (80%)
Three most recent annual reports	7 (16%)	32 (71%)	33 (73%)
Board's conflict of interest policy	2 (4%)	33 (73%)	33 (73%)
Strategic plans (board approved)	9 (20%)	20 (44%)	25 (56%)
Hospital's charge master	0 (0%)	15 (33%)	15 (33%)
Hospital's financial assistance and debt collection policies	17 (38%)	37 (82%)	44 (98%)
Any patient safety measures (i.e., medication errors)	16 (36%)	18 (40%)	26 (58%)
Any clinical quality measures (not patient safety)	20 (44%)	19 (42%)	31 (69%)
Level of community benefits the organization provided in the most recent year	20 (44%)	34 (76%)	43 (96%)
Identity and location of out-of-state corporate parents (relevant for three hospitals)	3 (7%)	0 (0%)	3 (7%)

Summary

Based on the availability to the public of 20 key hospital documents, it appears that Maryland hospitals maintain a level of transparency in line with the principle of openness promoted by the Maryland Association of Nonprofit Organizations. Maryland hospitals appear to make available quality/patient safety measures at rates comparable to the related national benchmark regarding adoption of policies requiring public disclosure of these measures. However, Maryland hospitals rely heavily on disclosure through public information offices, rather than through hospital websites. This strategy requires that interested persons have a basic level of knowledge regarding the documents they seek in order to make a request for information, and thus may limit access to members of the general public. Websites provide a venue that is searchable, and therefore is logically a more accessible venue for public disclosure than public information offices. Because there is no benchmark data on the content of hospital websites nationally, we do not know how Maryland hospitals compare with national trends in this respect.

Chapter III: Conflict of Interest Policy

"Conflicts of interest among nonprofit insiders have led to substantial litigation, embarrassment, and statutory reform for nonprofit boards. Every external agency—public and private—having authority over nonprofit organizations has expressed concern about the effects of conflicts and dualities of interest, especially in healthcare (Bryant et al., 2007, p.7). "

The IRS defines a conflict of interest as a situation in which "a person in a position of authority over an organization, such as a director, officer, or manager, may benefit personally from a decision he or she could make (IRS Form 1023[2] Instructions, 2009, p. 9)." Although adopting a conflict of interest policy is not required by the IRS, it does recommend that nonprofit organizations adopt such policies to protect the organization from "impropriety involving officers, directors, or trustees" (IRS, 2009, no page number). By doing so, the board demonstrates its intent to fulfill a nonprofit corporation's duty to the community and helps to ensure that the tax-exempt organization operates within its charitable mission (IRS, 2009). There is also consensus in the industry literature that nonprofits should have a written conflict of interest policy (Bryant et al., 2007; The Governance Institute, 2009; Maryland Association of Nonprofit Organizations, 2009; New Jersey Commission on Rationalizing Health Care Resources, 2008).

Structural elements also may create an opportunity for hospital directors or officers to have undue influence on board activities and decisions. Boards have to balance the demands for expertise and leadership with sufficient representation from persons free of conflicts of interest. Finally, positioning the hospital CEO as the board chair and voting member of the board may create an opportunity for undue influence by the CEO, and typically among charitable, nonprofit organizations, the CEO and board chair are separate positions (Prybil et al., 2009).

Recommendations and Best Practices

The literature on best practices recommends that conflict of interest policies include several common elements:

- Procedures for the disclosure of interest (The Governance Institute, 2009; IRS, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007; Wiehl, 2004)
- Procedures for handling the disclosed interests (The Governance Institute, 2009; IRS, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007; Wiehl, 2004)

[2] IRS Form 1023 is the Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code.

- Procedures for violations of conflict of interest policies (The Governance Institute, 2009; IRS, 2009)
- Disclosure of all interests (IRS, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007)

There appears to be near consensus that nonprofit trustees should disclose all interests that may potentially give rise to an actual conflict of interest or even create a perception that a conflict exists. Conflicts of interest that should be disclosed do not have to be monetary or involve a tangible benefit and instead could include situations in which a board member holds positions in organizations with conflicting goals (Wiehl, 2004). The disclosure of an interest does not necessarily constitute a conflict of interest, and an acknowledged conflict does not necessarily require corrective action. Once a potentially conflicting interest is disclosed, noninterested board members should discuss and vote on how to proceed with the transaction (IRS, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007; Wiehl, 2004).

Less often adopted but recommended practices include:

- Adopting disabling guidelines "that define specific criteria for when a director's material conflict is so great that the director should no longer serve on the board (The Governance Institute, 2009, p.30)."
- Adopting a definition of an independent director with measurable standards (The Governance Institute, 2009).

Maryland Survey Results

Table 7 displays the results of survey questions regarding conflict of interest policies. The Maryland survey found the following:

- All but one hospital board reported having a written conflict of interest policy.
- Forty-one boards (91 percent) reported including three recommended elements in the conflict of interest policy: 1) requirements for the disclosures of potential conflicts of interest, 2) conditions when members must recuse themselves from particular discussions and voting, and 3) guidance on what may constitute a conflict of interest.
- Three quarters of the boards required disclosure of conflicts of interest to the entire board, though only half of the boards require that prospective new members be screened for actual or potential conflicts of interest.

Table 7. Maryland: Conflict of Interest Policies

	Maryland Survey		
Conflict of Interest Policies	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Board has a *written* conflict of interest policy that covers all members of the board	44 (98%)	15	29
Board has a *written* conflict of interest policy that covers members of the Executive Compensation Body	33 (73%)	10	9*
Written conflict of interest policy:			
(1) Requires disclosures of potential conflicts of interest	44 (98%)	15	29
(2) Outlines conditions when members must recuse themselves from particular discussions and voting	41 (91%)	13	28
(3) Provides guidance on what may constitute a conflicting situation	43 (96%)	14	29
(4) Requires at least the *annual written disclosure* of all actual and potential conflicts of interest by *each officer and director*	44 (98%)	14	30
(5) Requires that all disclosed conflicts and/or dualities of interest be disclosed *to the entire board* and not just to the chair, the CEO, and/or legal counsel	34 (76%)	13	21
(6) Requires that prospective members first be screened or questioned regarding actual or potential conflicts or dualities of interest before being formally invited to stand for election to the board	22 (49%)	6	16

* Only nine member hospitals reported having an executive compensation committee. All of these hospitals reporting having a written conflict of interest policy for this body. The survey did not collect information on the conflict of interest policies at the parent board level.

With respect to the independence of board membership, the Maryland survey found the following:

- Based on the total voting membership and independent membership reported by Maryland hospitals, 44 of 45 hospitals reportedly met the standard that at least one fifth of voting members are independent, based on one industry definition.[3]

Table 8 presents data on the official capacity of the hospital CEO in relation to the hospital board. The Maryland survey found the following:

- None of the boards position the CEO as both the board chair and a voting member of the board, but most boards (80 percent) include the CEO as a voting board member.

Table 8. Maryland: Official Capacity of Hospital CEO to the Hospital Board

Official Capacity of Hospital Chief Executive Officer (CEO) on the Hospital Board	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
	N (%)	N	N
Voting member and board chair	0 (0%)	0	0
Voting board member	36 (80%)	12	24
Nonvoting board member	7 (16%)	1	6
Not a member of the board	2 (4%)	2	0

National Benchmarks

National benchmarks related to conflict of interest include the following:

- The GAO report found that all hospital systems surveyed reported having a conflict of interest policy, and this policy also covers members of the executive compensation body and requires disclosure of potential conflicts (GAO, 2006)

[3] Independence of membership was measured in the Maryland survey using the 2007 definition by the Panel on the Nonprofit Sector: "Independent members should not (1) be compensated by the organization as employees or independent contractors, (2) have their compensation determined by individuals who are compensated by the organization, (3) receive, directly or indirectly, material financial benefits from the organization except as a member of the charitable class served by the organization, and (4) be related to anyone described (as a spouse, sibling, parent, or child) or reside with any person so described" (Panel on the Nonprofit Sector, 2007, p. 23)

- The GAO report found that almost all conflict of interest policies included the three core provisions discussed above (GAO, 2006).
- The 2009 Biennial Survey found that 50 percent and 73 percent of independent and member hospitals, respectively, position the CEO as a voting board member. The survey did not ask about chairmanship (The Governance Institute, 2009).
- The HRET 2005 Survey found few nonprofit hospital boards that positioned the CEO as the chair, president, or vice chair of the board (6 percent). Instead, boards predominantly positioned the CEO as a full voting member (45 percent) and not a board officer (Margolin et al., 2006).

Summary

Maryland hospital boards meet or exceed most national benchmarks measured in the Maryland survey pertaining to conflict of interest policies. All but one hospital reported having a written conflict of interest policy, and more than 90 percent of board policies contained three key provisions, a finding that is comparable to the findings from the GAO survey. No Maryland board positions the CEO as the board chair and a voting board member, a very rare practice nationally as well. All but one hospital reported that at least one-fifth of the board membership was independent, or free of conflicts of interest, based on one industry definition applied in the Maryland survey from the Panel on the Nonprofit Sector.

This examination of conflict of interest policies did not examine other provisions that are considered important by industry leaders, including adoption of a "disabling" guideline that specifies when a conflict of interest is so great that severance from board service is warranted. As part of the survey fielding in Maryland, a copy of all conflict of interest policies was collected. Based on survey responses, it appears that conflict of interest policies are typically established at the system level for hospitals that are part of multi-hospital systems. Thus, further examination of policy content is possible.

Finally, it is not known what standard of independence is typically applied by governing boards in practice. One system commented on behalf of its member hospitals about the difficulty of meeting certain standards of an "independent director", citing the "economic realities of current physician reimbursement in Maryland," which has expanded the scope of physician contracting and increased the need for physician collaboration in hospital governance at the same time. Hospitals face two competing goals as a result: independence of directors and physician collaboration. Therefore, the definition of independence set forth by the Panel on the Nonprofit Sector might be less useful than other definitions that acknowledge the specific context of hospital governance.

Chapter IV: Governance Policies and Practices

This chapter of the report focuses on governance practices and policies, which refer to the board's fiduciary duties of care, loyalty, and obedience, as well as core responsibilities (The Governance Institute, 2009). The specific governance practices explored in the survey are financial oversight, executive compensation oversight, quality oversight, community benefit oversight, and self-governance. The subsequent sections of this chapter address each of these topics. The first section addresses the board's leadership role in overseeing the organization's finances, including audit oversight. The financial section is followed by a discussion of the board's role in determining, evaluating, and monitoring executive compensation, a key aspect of financial oversight. The quality section involves the board's responsibility for patient safety and the quality of care delivered. The community benefits section addresses the board's responsibilities for establishing and evaluating the organization's community benefit program. The final section discusses self-governance, which refers to policies the board puts in place to ensure effective functioning of its own activities.

This chapter reflects selected topics of interest to Chairman Hammen and the HSCRC, and should not be considered an exhaustive discussion of all board governance policies and practices. Other components of governance practices and policies not addressed in this report include advocacy efforts with legislators, donors, and other key stakeholders; board member compensation; and board culture.

Section 1: Financial Oversight

Financial oversight is a key duty of governing boards in both the nonprofit and for-profit sectors. Many of the recommendations and trends in practice related to financial oversight stem from scandals in the for-profit and non-profit arenas of corporate governance. Historical analysis of the collapse of the energy giant Enron pointed to multiple failings by the board of directors, among them the failure to carefully monitor significant financial transactions, heavy reliance on management controls and procedures that proved inadequate in hindsight; and failure to request and review information sufficient to understand financial transactions (Wiehl, 2004).[4]

Crises in corporate governance have also hit the nonprofit sector. In the case of Alleghany Health Education and Research Foundation, the failure to adequately oversee and monitor financial dealings resulted in bankruptcy (Wiehl, 2004). In the cases of Red Cross International and Washington, D.C. United Way, the impact was crises in public accountability and reputation more generally (Wiehl, 2004). In the case of Allina Health System, questions arose over executive compensation practices that were not pursuant to a charitable mission; the board of directors' inadequate review of executive compensation; and a lack of independence among

[4] William Powers, Jr., *Report of Investigation by the Special Investigative Committee of the Board of Directors of Enron Corp*. (Feb. 1, 2002), as summarized by Wiehl (2004).

financial consultants (Wiehl, 2004). As a result of these and other nonprofit scandals, accountability standards for nonprofit entities also have been questioned (Wiehl, 2004).

The federal response to several major for-profit corporate governance scandals involving publicly traded companies, including Enron, was enactment of the Sarbanes-Oxley Act of 2002 (Wiehl, 2004). Sarbanes-Oxley established sweeping changes in board oversight and accountability in the for-profit sector, including enhanced auditor oversight, certification of financial reports, and certain whistle-blower protections. Although this law does not apply to nonprofit corporations, debates over how best to assure nonprofit sector accountability have been anchored in the provisions of Sarbanes-Oxley that could be modified to apply to nonprofit corporations. In addition to a legislative response, the Internal Revenue Service has recently revised instructions for the IRS Form 990. Form 990 is the required information return for all tax-exempt nonprofit entities, filed annually.

Industry leaders now encourage boards of health care organizations to adhere to the principles outlined in the Sarbanes-Oxley Act (Center for Healthcare Governance, 2007), or at a minimum, to consider which elements of the Sarbanes-Oxley Act are worth pursuing (Bryant et al., 2007). Experts explain that regardless of specific procedures, the overarching objective of implementing a voluntary compliance program would be to eliminate the "ability of some individuals to control information in secret" (Bryant et al. 2007). Generally, provisions recommended by state and federal initiatives seek to "enhance the independence of governing boards from senior management; increase board accountability to communities and other key stakeholders; and reduce conflicts of financial interest between board members and the organization they govern" (Alexander et al. 2008, P. 200). How an organization interprets compliance and implements specific procedures and practices may vary based on the organization's governing structure or other characteristics.

At the state level, California, Massachusetts, New Hampshire, Maine, Connecticut, and Kansas have enacted legislation imposing stricter financial reporting requirements on nonprofit organizations (Baker, 2005). California's Nonprofit Integrity Act of 2004 appears to be the most comprehensive of this legislation, imposing numerous board requirements on all charitable corporations with gross revenues of $2 million or more (Lockyer, 2004). In addition, state Attorneys General, particularly in Massachusetts and Minnesota, have played a role in scrutinizing governance practices by nonprofit organizations and setting forth their own set of recommendations to ensure governance integrity (Office of Attorney General Martha Coakley, 2007; Wiehl, 2004).

Recommendations and Best Practices Related to Voluntary Sarbanes-Oxley Compliance

Voluntary compliance with Sarbanes-Oxley centers on audit oversight, audit committee structure, the certification of financial statements, and whistle-blower protections. Recommendations related to voluntary Sarbanes-Oxley compliance, as found in the literature, include the following:

- An independent auditor must be hired by the board and each such auditor may be retained only 5 years (Senate Finance Committee, 2004).

- The board's Audit and Compliance Committee should ensure replacement of the independent auditor at least every 4 years (New Jersey Commission on Rationalizing Healthcare Resources, 2008).
- All members of the board's audit committee should be independent (The Center for Healthcare Governance, 2007).
- The Governance Institute identifies the following as best practices for the board committee responsible for audit oversight, also recommended by the Senate Finance Committee:
    1) Excludes all members of senior management as voting members
    2) Meets independently with the external auditor at least annually
    3) Has sole authority to select and replace the external auditor
    4) Has sole authority to authorize independent reviews performed by another party if required. (Governance Institute, 2008; Senate Finance Committee, 2004, P. 12).
- The board, either directly or through its committees, should require that the hospital's financial statements be certified annually by both the CEO and CFO (Bryant et al., 2007).
- Boards should establish whistle-blower policies. (IRS, 2009; Senate Finance Committee, 2004). The Governance Institute also recognizes establishment of a whistle-blower policy as a best practice (The Governance Institute, 2009).

Maryland Survey Results Related to Voluntary Sarbanes-Oxley Compliance

Table 9 below presents findings related to voluntary Sarbanes-Oxley compliance by Maryland hospitals. Most member hospitals in Maryland (24 of 30) reported that the parent organization reserves authority for audit oversight functions, thus a complete picture of oversight practice requires further inquiry. Key findings from the Maryland survey include:

- More than half (56 percent) of Maryland's boards are responsible for retaining and replacing the hospital's independent auditor.
- Only one board requires auditor replacement every five years. (Policies regarding auditor replacement were collected from all but two member boards on behalf of the system where necessary).
- All 15 independent hospitals reported having an audit committee. Only 10 of 30 member hospitals reported having a standing committee that provides audit oversight.
- Of the 25 hospitals that have an audit committee, 14 (56 percent) met all four standards listed in Table 9, and all but one met at least one standard.
- Fifty-six percent of boards (25) require the hospital's financial statement to be annually certified by the CEO and CFO.
- All but one hospital reported that the board has established a whistle-blower policy.

Table 9. Maryland: Practices Associated with Voluntary Sarbanes-Oxley Compliance

Voluntary Sarbanes-Oxley Compliance	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Audit Oversight	N (%)	N	N
A. Board is responsible for retaining and replacing the hospital's independent auditor[1]	25 (56%)	15	10
Board policies regarding the independent auditor:			
(1) Require replacement every 5 years at a minimum	1 (2%)	1	0
(2) Require replacement less frequently	6 (13%)	0	6
(3) Re-bid required, not replacement	8 (18%)	2	6
(4) No requirement	28 (62%)	12	16
(5) Cannot ascertain; parent has sole authority	2 (4%)	--	2 (4%)
B. Board has a standing committee with audit oversight functions.	25 (56%)	15	10
The Audit Committee[2]:	Among boards with a standing committee with audit oversight (N=25)		
(1) Excludes all members of senior management (the CEO and other top four executives) as voting members	20 (80%)	12	8
(2) Meets independently with the external auditor at least annually	23 (92%)	14	9
(3) Has sole authority to select and replace the external auditor	18 (40%)	12	6
(4) Has sole authority to authorize independent reviews performed by another party (other than the external auditor) if required	18 (72%)	12	6
Meets all four standards above (1-4)	14 (56%)	9	5
C. Board Certification of Financial Statements	Among all boards (N=45)		
Board requires hospital's financial statements to be certified annually by both the CFO and CEO	25 (56%)	11	14
D. Establishment of Whistle-blower Policy			
Hospital has established procedures for employees to report in confidence any suspected financial impropriety or misuse of the charity's resources	44 (98%)	14	30

[1] Even though many member hospitals reported that the parent organization reserves authority for audit oversight functions, all but two hospitals provided information on the system's practice regarding the replacement of the auditor. Thus, data are provided for all 45 hospitals, with two not responding.

[2] Items regarding the audit committee are restricted to hospitals that reported creation of a standing committee with audit oversight functions.

National Benchmarks Related to Voluntary Sarbanes-Oxley Compliance

National benchmarks related to voluntary Sarbanes-Oxley compliance include the following:

- Eighty-four percent of independent hospital boards and 89 percent of member boards had a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight (The Governance Institute, 2009 Biennial Survey, 2009).
- Sixty-six percent of independent hospitals and 75 percent of member hospitals had created a separate audit committee (or committee by another name with audit oversight) to oversee external and internal audit functions (The Governance Institute 2009 Biennial Survey, 2009).
- Fifty-three percent of independent hospitals and 57 percent of member hospitals reported adoption of a policy that specifies that the audit committee must be composed entirely of independent persons (The Governance Institute 2009 Biennial Survey, 2009).
- Eighty-eight percent of independent hospital boards and 92 percent of member boards reported having approved a whistle-blower policy specifying certain protections (The Governance Institute 2009 Biennial Survey, 2009).

Recommendations and Best Practices Related to IRS Form 990 Review and Approval

At this time, the Internal Revenue Service does not require board approval of the Form 990 prior to filing. Two entities have provided recommendations regarding the board's role in the review and approval process:

- The New Jersey Commission on Rationalizing Health Care Resources recommends that boards review and approve the Form 990 before submission to the IRS (2008).
- The Senate Finance Committee recommends that the Form 990 require that the CEO declare under penalties of perjury that the CEO has put in place processes and procedures to ensure that the organization's federal information return and tax return (including Form 990T) complies with the Internal Revenue Code (2004).

Maryland Survey Results Related to IRS Form 990 Review and Approval

Maryland's results related to board review and approval of the IRS Form 990 include the following:

- All Maryland hospitals reported that they put in place processes and procedures to ensure that the organization's federal information return and tax return (including Form 990T) complies with the Internal Revenue Code (data not shown).
- Twelve hospital boards (27 percent) review and approve the Form 990 before submission to the IRS, and 36 percent review but do not approve the form. The review and approval

of Form 990 may take place at the system level if the hospital is a member of a system. The survey did not collect information on system level practice.

Table 10. Maryland: Review and Approval of IRS Form 990

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Review and Approval of IRS Form 990	N (%)	N	N
Board reviews but does not approve before submission	16 (36%)	4	12
Board reviews and approves before submission	12 (27%)	4	8
Provided a copy before submission	6 (14%)	1	5
Provided a copy after submission	9 (20%)	5	4
No response	1 (2%)	0	1
Government entity (does not submit Form 990)	1 (2%)	1	0

Recommendations and Best Practices for Other Financial Oversight Activities

Recommendations related to other financial oversight activities, as found in the literature, include the following:

- The Senate Finance Committee and the Maryland Association of Nonprofit Organizations recommend that boards should establish and approve 1) written policies for investment of the assets of the hospital; 2) internal accounting systems and control procedures; 3) purchasing practices; and 4) unrestricted current net assets (Senate Finance Committee, 2004; Maryland Association of Nonprofit Organizations, 2009).
- The Senate Finance Committee recommends that boards should review and approve the following: 1) the auditing and accounting principles and practices used in preparing the organization's financial statements; 2) significant investments, joint ventures, and business transactions; and 3) the organization's budget and financial objectives (Senate Finance Committee, 2004, p.12).
- The Massachusetts Office of the Attorney General Martha Coakley recommends that boards should require review and approval on 1) large and significant grants or contracts; 2) transactions involving real estate; 3) borrowing or sale/disposal of large assets (MA Office of Attorney General Martha Coakley, 2007).
- New Jersey Commission recommends that boards should review and approve the findings of the hospital's annual audit and long-range and annual capital and financial plans (New Jersey Commission on Rationalizing Health Care Resources, 2008). Full board approval of the findings of the hospital's annual audit and management letter is recommended by the Maryland Association of Nonprofit Organizations (2009).

Maryland Survey Results Related to Other Financial Oversight Activities

Table 11 provides a list of financial practices and transactions that the Senate Finance Committee recommends for board review and approval. The Maryland survey found:

- Half of the boards review or approve all of the financial practices listed in Table 11. Most of the boards that do not review or approve these practices are members of a larger system.

Table 11. Maryland: Approval (or Review) of Financial Practices and Transactions

Approval (or Review) of Financial Practices and Activities	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
	N (%)	N	N
Board approves the following:			
(1) Auditing and accounting principles and practices used in preparing the hospital's financial statements	24 (53%)	11	13
(2) Large or significant grants or contracts	30 (67%)	12	18
(3) Transactions involving real estate	33 (73%)	14	19
(4) Borrowing or sale/disposal of large assets	35 (78%)	15	20
(5) Creation of subsidiary entities	31 (69%)	15	16
(6) Joint ventures	30 (67%)	14	16
(7) Organizations' budget and financial objectives	35 (78%)	15	20
Approves all of the above	21 (47%)	9	12
Approves some of the above	14 (31%)	6	8
Reviews some of the above	2 (4%)	-	2
Reviews none of the above	8 (18%)	-	8

Table 12 lists four financial policies that the Senate Finance Committee recommends that boards establish and approve. The Maryland survey found that:

- Across all four policies in Table 12, only 8 hospitals (18 percent) include as board duties establishing and approving all four policies, while another 29 (64 percent) establish or approve at least some of the four policies.

- Eight (18 percent) hospital boards do not establish or approve any of these policies. These eight hospitals are all members of larger systems.

Table 12. Maryland: Board Establishment of Written Financial Policies

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Board Establishes Written Financial Policies Governing the Following	N (%)	N	N
(1) Investment of the assets of the hospital	24 (53%)	9	15
(2) Internal accounting systems and control procedures	21 (47%)	8	13
(3) Purchasing practices	8 (18%)	3	5
(4) Unrestricted current net assets	19 (42%)	8	11
Establish and approve all four above	8 (18%)	3	5
Establish or approve some of the above	29 (64%)	12	17
Do not establish or approve any above	8 (18%)	0	8

* The Maryland survey asked each board whether it established, approved, or did not establish or approve each policy. Where the board checked "establish" but did not check "approve," we counted that response as meaning "established and approved."

Table 13 lists two financial practices that are recommended for full board approval. The Maryland survey found:

- Fifty-one percent of boards approve the findings of the hospital's annual audit.
- Sixty-seven percent of boards approve long-range and annual capital and financial plans.

Table 13. Maryland: Full Board Approval of Certain Financial Practices

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Full Board Approves the Following	N (%)	N	N
Findings of the hospital's annual audit and management letter	23 (51%)	12	11
Long-range and annual capital and financial plans	30 (67%)	15	15
Full board approves both	21 (47%)	12	9
Full board approves neither	2(4%)	-	2
Parent company/system approves	11 (24%)	N/A	11

National Benchmarks Related to Full Board Approval of Financial Practices

National benchmarks related to full board approval of financial practices include the following:

- The Governance Institute 2009 Biennial Survey found that 100 percent of boards responding (all types) approved the organization's capital and financial plans (The Governance Institute, 2009).
- The HRET 2005 survey found that 95 percent of boards receive routine financial reports on budget performance and financial statistics, 94 percent receive routine reports on operating statistics, and 90 percent receive routine reports on capital planning (Margolin et al., 2006).

Maryland Survey Results Related to Financial Reporting

Table 14 lists four types of financial data that are recommended for routine review by the board or a standing committee. The Maryland survey found:

- Most Maryland hospital boards (87 percent) receive routine reports related to budget performance, financial statements, operating statistics, and capital planning, and 82 percent receive all four of these routine reports.(See Table 14).

Table 14. Maryland: Data Routinely Reported to the Full Board or Standing Committee

Data that Are Routinely Reported to the Full Board or Standing Committee	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Subsidiary Hospitals (N=30)
Budget performance	39 (87%)	15	24
Financial statements	39 (87%)	15	24
Operating statistics	39 (87%)	15	24
Capital planning	39 (87%)	15	22
All four types of data reported	37 (82%)	15	22
Some of four reported	8 (18%)	0	8

Summary

Financial oversight is one area of governance where independent hospitals and members of larger systems tend to diverge in practice. Only two policies are almost universally practiced by both independent and member hospitals: establishment of whistle-blower policies and routine reporting to the board of certain financial data, although fewer member hospitals are receiving all types of financial data compared to independent hospitals. In addition, most hospitals—independent and member hospitals alike—approve many or all of the financial transactions of concern to federal and state policy makers, including large and significant grants and contracts,

real estate transactions, borrowing or sale of large assets, creation of subsidiary entities, and joint ventures.

In some other areas, practices diverge. Independent hospitals perform well against some recommended practices and national benchmarks where they exist, while members of larger systems engage in the practice very infrequently. All or all but one independent hospital boards:

1) are responsible for retaining and replacing the hospitals' independent auditor;
2) have created a standing committee with audit oversight;
3) meet independently with the external auditor at least annually;
4) require full board approval of long-range and annual capital and financial plans.

In contrast, no more than half of the system member hospitals engage in these recommended practices. Where national benchmarks are available — creating an audit committee is one example—system members in Maryland fall far short of national trends among system members. Less than half of system members require annual certification of financial statements by the CEO and CFO, a practice recommended by the Maryland Association of Nonprofit Organizations.

Financial oversight practices by Maryland boards are not aligned with some of the recommended practices. Practices that are followed by fewer than half of all hospitals—independent and system member hospitals alike—include:

1) adoption of policies that require replacement of the independent auditor every five years at a minimum (one hospital meets the practice);
2) review and approval of IRS Form 990 before submission to the IRS (12 hospitals meet this practice);
3) establish written policies governing the investment of assets, internal accounting systems and control procedures, purchasing practices, and unrestricted current net assets (8 hospitals establish and approve all four).

The above recommendations from the Senate Finance Committee and the New Jersey Commission on Rationalizing Health Care Resources have not been tested against national practices in other surveys, so we do not know how Maryland hospitals perform relative to national trends.

As previously mentioned, member boards do not typically play a significant role in audit oversight functions, functions that are cited as a reserve power held by some system boards, according to hospital feedback. Other member hospitals appear to have substantial audit oversight authority, so contractual relationships between parent and local boards clearly varies by system. The full extent of governance practices that affect system member hospitals is not known, because the scope of the Maryland survey did not examine the specifics of system level practices. Where survey respondents provided clarification regarding system practices, some system boards did engage in recommended practices on behalf of member hospitals, thus further information about system practices would be useful to determine the extent of practice variation.

Section 2: Executive Compensation Oversight

"The importance of governance control of executive compensation programs is increasingly recognized. The level of public interest in executive compensation is growing, and governmental rules and sanctions have become more demanding" (Prybil et al., 2008, p. 9).

Background

Insufficient board oversight of executive compensation can have major consequences. One example was the Minnesota Attorney General's investigation of Allina, a nonprofit organization formed through the merger of the state's largest health maintenance organization (HMO) and numerous health care facilities (Wiehl, 2004). The Attorney General's investigation found that the organization had spent millions of dollars on executive benefits that did not further the organization's mission, and the board of directors did not adequately review compensation nor monitor executives' activities (Wiehl, 2004).

Executive compensation practices have also been scrutinized by Congress and the IRS. In response to a request from the Chairman of the Congress's House Ways and Means Committee, the GAO conducted an extensive survey of executive compensation practices in 2005 and found that hospitals commonly reported certain policies: having committee or full-board responsibility for determining executive compensation, having conflict of interest policies that include executive compensation, and the use of market data in determining executive compensation (GAO, 2006).

State-level policies regarding nonprofit executive compensation are limited. One exception is California's Nonprofit Integrity Act of 2004, which requires the governing board or a board committee to review and approve the compensation of the president/CEO and treasurer/CFO (Lockyer, 2004). This review and approval must occur at the initial hiring, whenever the executive's term is renewed, and whenever compensation is modified (Lockyer, 2004). The Massachusetts Attorney General has also issued guidance on executive compensation in charitable organizations. This guidance recommends that all board members should be aware of the compensation of the CEO and other members of senior management, including nonsalary benefits; the full board should vote on executive compensation; and compensation should be based on the executive's performance, comparable compensation in the field, and other factors, such as the impact on the organization's mission (Coakley, 2007).

Recommendations and Best Practices

Recommendations and best practices found in the literature review include:

- The full board should be provided information about the complete compensation package for the CEO and other senior managers, including salary, and the value of any non-salary compensation; and authority to approve the compensation of senior managers should reside with the full board (Massachusetts Office of Attorney General Martha Coakley, 2007).

- All members of the executive compensation body should be independent, and where executives are assigned to support the work of this committee, they should not drive the work (Center for Healthcare Governance Blue Ribbon Panel).
- CEO compensation should be linked to performance, and performance should be evaluated annually. The board and CEO should engage in 360-degree evaluations, where both provide comprehensive input into the evaluation (Center for Healthcare Governance Blue Ribbon Panel).
- Boards should be informed of all aspects of executive compensation, including cash (base salary, bonuses, severance, paid time off, and other cash), benefits (health, life, social security, unemployment, pension, etc.), and supplemental executive benefits (supplemental executive retirement plans, supplemental life insurance, additional paid time, etc.), and perquisites (club memberships, legal assistance, car allowance, etc.) (Cohn, 2008; Healthcare Financial Management Association [HFMA]).
- Use an "executive compensation tally sheet" to review compensation components such as supplemental retirement plans, determine what portion of an executive's salary is paid as a bonus or incentive, and what portion comes from employer-provided contributions. Quantifying these liabilities to include future and potential costs, not just current-year costs, can aid financial managers with financial planning and budgets (Cohn, 2008).
- The board requires that the CEO's compensation package is based, in part, on the CEO performance evaluation and that quality-related goals are included in the incentive compensation plan for senior executives (The Governance Institute).
- The board or a board committee routinely reviews the compensation for executives to ensure appropriateness and alignment with statutory and regulatory guidelines (The Governance Institute).

Maryland Survey Results Related to Monitoring and Approving Executive Compensation

- Seventeen of 45 Maryland hospital boards (38 percent) receive information about the CEO's complete compensation package, including 9 independent hospitals and 8 member boards (See Table 15).
- Twelve hospital boards (27 percent) receive information about the compensation packages for the other top four executives (See Table 15).
- Nine hospitals (seven independent and two members) reported that compensation of the CEO is approved by the full board (rather than a committee or a parent board) (See Table 15).

Table 15. Maryland: Monitoring and Approving Executive Compensation

Monitoring and Approving Executive Compensation	2009 Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Subsidiary Hospitals (N=30)
	N (%)	N	N
Full board is provided with information about the complete compensation package for:			
CEO	17 (38%)	9	8
Other top four executives	12 (27%)	6	6
Full board approves:			
Compensation of the CEO	9 (20%)	7	2
Compensation of the other top four executives	6 (13%)	5	1

Maryland Survey Results Related to Setting Executive Compensation Standards

Virtually all hospitals in Maryland that belong to larger systems indicated that executive compensation was set by the parent board and not the local hospital boards. Thus we do not have complete data on the use of performance expectations and targets for these hospitals or systems, where such practices are set. These data are presented only for independent hospitals (Table 16).

Among independent hospitals (see Table 16), the Maryland survey found:

- All 15 independent hospital boards reported that the board had established written performance expectations with clear objectives or criteria for the CEO.
- All 15 independent hospital boards regularly included performance expectations related to financial performance; all but 1related to clinical quality, whereas fewer boards (10) reported targets related to community benefits.
- In setting compensation for the CEO, all 15 independent hospital boards formally considered data on comparable hospital CEO compensation and performance targets, whereas all but one considered the mission of the hospital.

Table 16. Maryland: Setting Executive Compensation Standards

Setting Executive Compensation Standards	**Maryland Survey**
	Independent Hospitals (N=15)
	N
Board has established written performance expectations with clear objectives or criteria for the CEO	15
Performance expectation regularly includes targets related to:	
(1) Financial performance	15
(2) Clinical quality	14
(3) Community benefits	10
In setting compensation for the CEO, the following are formally considered:	
(1) Data on comparable hospital CEO compensation	15
(2) Performance targets	15
(3) Mission	14

National Benchmarks Related to Setting Executive Compensation Standards

National benchmarks related to setting executive compensation standards include the following:

- Ninety-two percent of independent boards and 89 percent of member boards nationally routinely have the full board, or a board committee, review the compensation for executives to ensure appropriateness and alignment with statutory and regulatory guidelines (The Governance Institute 2009 Biennial Survey, 2009).
- All responding hospital systems surveyed by the GAO reported reliance on comparable market data of total compensation and benefits before making compensation determinations for the hospital CEO (GAO, 2006). Ninety percent of independent boards and 93 percent of member boards relied on market data in a national benchmark survey (The Governance Institute 2009 Biennial Survey, 2009).
- Ninety percent of independent boards and 93 percent of member boards required that compensation be linked to performance (The Governance Institute 2009 Biennial Survey, 2009).

- About half (49 percent) of independent systems and 90 percent of systems with parent organizations regularly included community benefits targets in CEO performance expectations (Prybil et al., 2008). All systems included financial and virtually all included patient quality/safety targets in performance expectations (Prybil et al., 2008).

Maryland Survey Results Related to Composition of the Executive Compensation Body

The data in Table 17 is limited to boards with a standing committee with executive compensation oversight functions. The Maryland survey found the following:

- Of all 45 nonprofit hospitals, 23 have a standing committee with executive oversight functions. Only 9 of 30 member hospitals reported having such a committee. One independent hospital explained that these functions were conducted by the full board.
- Of the 23 hospitals boards with an executive compensation committee, 19 (83 percent) do not include the CEO as a member, and only 2 (both member hospitals) include the CEO as a voting member.
- Almost all independent hospitals (13 of 15) and member hospitals with an executive compensation committee (20 of 23) indicated that all members of the executive compensation body are independent. We do not have complete information about the independence of oversight bodies at the parent company level.

Table 17. Maryland: Composition of the Executive Compensation Body

Composition of the Executive Compensation Body	Maryland Survey		
	All Hospitals	Independent Hospitals	Subsidiary Hospitals
	N (%)	N	N
Board has a standing committee responsible for executive compensation oversight	23	14	9
Official capacity of hospital CEO on the executive compensation body[1]	Among boards with a standing committee with executive compensation oversight[2]		
Voting member	2 (9%)	0	2
Nonvoting member	2 (9%)	2	0
Not a member	19 (83%)	13	7
All voting members of the executive compensation body hospital are independent	20 (87%)	13	7

[1]The executive compensation body is equivalent to the committee that provides executive compensation oversight among all respondents with the exception of one independent hospital for which the full board conducts oversight of this function.

Responses in this table are restricted to hospitals with executive compensation committees.

[2]Only nine member hospitals reported having an executive compensation committee. Data in table reflect composition of these committees at the local hospital level. We did not collect information on the composition at the parent board level.

National Benchmarks Related to the Composition of the Executive Compensation Body

National benchmarks related to the composition of the executive compensation body include the following:

- Eleven of 65 responding hospital systems surveyed by the GAO indicated that either the CEO or one of the other top four executives was a voting member of the executive compensation body. However, no system indicated that such executives with voting privileges attended meetings when his or her own compensation was being discussed (GAO, 2006).[5]

- Eighty-one percent of independent boards and 74 percent of member boards had delegated its executive compensation oversight function to a body composed solely of independent directors of the board (The Governance Institute 2009 Biennial Survey, 2009).

Summary

Although the practice of full disclosure of executive compensation (salary and nonsalary) to the full board is recommended by the HFMA and the Massachusetts Attorney General, few boards in Maryland conduct this practice. Because parent boards typically reserve oversight authority over compensation practices, full transparency to the local hospital boards may not be occurring. It is an outstanding question as to whether this is a concern of public interest. Further understanding of the composition of parent boards and their executive compensation bodies is warranted to explore this question. Maryland's hospital boards have similar CEO performance expectations to boards nationally, with an emphasis on financial performance and quality of care targets, and less emphasis on community benefits targets. Compensation oversight even by independent hospital boards appears to be a responsibility reserved for committees. There are insufficient data from national survey data to ascertain how Maryland hospitals are performing relative to national trends in this respect.

Section 3: Quality Oversight

Beginning in the 1960s, numerous court cases have established that hospitals have an obligation to oversee the quality of care they provide (Kaput, 2005). A series of Institute of Medicine reports issued between 1999 and 2003 show that the quality of care delivered at hospitals viewed nationwide is uneven and needs improvement (Prybil et al., 2009). It since has become widely

[5] Senator Charles Grassley (R-IA), chairman of the Senate Finance Committee, identified these voting privileges as an area of concern (Sonnenschein, Nath, & Rosenthal, July 31, 2006).

accepted that the hospital board is the natural choice for quality oversight because of its responsibility to assure quality and its authority over medical staff and administration (Gautam, 2005). Further, the Joint Commission, a hospital accreditation body, stresses in its guidance on hospital leadership that "the governing body is ultimately responsible for the safety and quality of care, treatment and services" (Joint Commission, 2007). In addition, boards of nonprofit hospitals have the responsibility to ensure the board's own high-level performance in its duties (Gautam, 2005).

Recommendations and Best Practices

Recommendations for best practices related to quality oversight, as found in the literature, include the following:

- Boards should facilitate the institution of quality standards and benchmarks and should establish an overarching quality-improvement committee to assure the quality of patient care (Gautam, 2005).
- Boards should participate at least annually in education regarding issues related to its responsibility for quality of care (The Governance Institute, 2009).
- Boards should receive formal, written, quality reports on a regular basis (Prybil et al., 2008).
- Boards should routinely review a performance "dashboard" or "balanced scorecard" of critical quality indicators that highlights significant trends and variances that may require corrective action or follow-up reports (The Governance Institute, 2009).

Maryland Survey Results

Table 18 provides the results related to quality oversight practices. The Maryland Survey found:

- One hundred percent of Maryland hospitals have a standing committee responsible for quality oversight.
- Nearly 100 percent of Maryland hospitals have adopted all best practices in quality oversight that hospitals were asked to report on in the survey.
- Boards, either through a standing committee or through full board review, are less likely to review mortality rates than other types of quality-related data.

Table 18. Maryland: Quality Oversight Practices

Quality Oversight Practice	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
	N (%)	N	N
Board has a standing committee responsible for quality oversight	45 (100%)	15	30
Board or a standing committee establishes annual objectives and goals in relation to clinical quality	44 (98%)	14	30
Board annually participates in opportunities for board member education and training regarding its quality responsibilities and issues	44 (98%)	14	30
Does the board regularly receive formal written reports on performance in relation to established measures and standards for the quality of patient care?	45 (100%)	15	30
Data that are routinely reported to the full board or standing committee			
Patient satisfaction surveys	45 (100%)	15	30
Quality indicators	45 (100%)	15	30
Patient safety	45 (100%)	15	30
Morbidity rates	43 (96%)	13	30
Mortality rates	41 (91%)	13	28

National Benchmarks

National benchmarks related to quality oversight include the following:

- Nearly 90 percent of hospital boards had a committee dedicated to quality and patient safety (Prybil et al., 2008).
- Just less than 83 percent of independent boards and slightly less than 93 percent of member boards participate at least annually in education regarding issues related to its responsibility for quality of care (The Governance Institute 2009 Biennial Survey, 2009).

- About 97 percent of hospital boards regularly receive formal written reports on system-level, hospital-specific performance in relation to established measures and standards for the quality of patient care (Prybil et al., 2009).
- More than 96 percent of both independent and member boards (and 97.6 percent of system boards) routinely review a performance dashboard and review these measures at least quarterly (The Governance Institute 2009 Biennial Survey, 2009).

Summary

Overall, Maryland hospital boards meet or exceed national benchmarks for quality oversight practice. One notable achievement by Maryland hospitals relative to their national peers is the near universal periodic review of morbidity and mortality rates. Hospital boards in Maryland are nearly twice as likely to review these data as hospital boards nationally.

Section 4: Community Benefit Program Oversight

Maryland's 45 nonprofit hospitals are required to submit annual community benefit reports to the HSCRC. The specific obligations are set forth in Health General Article, §19-303 Annotated Code of Maryland, which requires each nonprofit hospital to: (a) identify the community health care needs in its service area (drawing upon resources such as needs assessments and consultations with local leaders, health officers, and physicians); and (b) submit a community benefits report that documents the hospital's various community benefits initiatives, its expenditures on each, the objective of each initiative, and the efforts taken by the hospital to evaluate the effectiveness of each initiative.

Maryland's community benefit reporting statute is silent on what role, if any, the hospital's board should have in this process. The law places a duty on each nonprofit hospital to submit an annual community benefit report to the HSCRC, but it does not specify the extent to which the board should be involved. The survey sought to learn the extent to which the hospital boards participated in the process of fulfilling the hospital's duties under community benefit reporting law.

Recommendations and Best Practices

Recommendations for best practices related to community benefit oversight, as found in the literature, include the following:

- Boards should require a periodic community health needs assessment to understand the health issues of the communities served (The Governance Institute, 2009).
- As a system-level practice, boards should regularly discuss their community benefit responsibilities and programs, and have a formal written policy that defines overall guidelines for the system's community benefit programs (Prybil et al., 2009).
- Boards should have a community benefit plan that spells out measurable system-wide objectives for the organization's community benefit program (Prybil et al., 2009).

- Boards should be regularly presented with performance data on system-wide objectives for the organization's community benefit program (Prybil et al., 2009).
- Boards should adopt community benefit policies that include a statement of commitment, oversight process, definition of community benefit, measurement goals and methodology, financial assistance policy, and commitment to transparency (The Governance Institute 2009 Biennial Survey, 2009).

Maryland Survey Results

Table 19 presents findings related to community benefits oversight practices. The Maryland Survey found the following:

- Most of Maryland's boards (84 percent) engage in formal community needs assessments in order to allocate resources.
- Twenty-nine percent of boards have formal, written policies that define overall guidelines for the community benefit program, and 24 percent have a formal community benefit plan with measurable objectives.
- Half of Maryland's boards are regularly presented with performance data on their community benefits program.

Table 19. Maryland Community Benefits Oversight Practices

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (n=15)	Member Hospitals (n=30)
Community Benefits Oversight Practice	N (%)	N	N
Board has adopted a formal, written policy that defines overall guidelines for the system's community benefit program	13 (29%)	2	11
Board (or a standing committee) is regularly presented with performance data on measurable objectives regarding its community benefit program	22 (49%)	11	11
Board (or its parent company/system) has adopted a formal community benefit plan that spells out measurable objectives for the organization's community benefit program	11 (24%)	2	9
Board (or its parent company/system) engages in a formal assessment process designed to determine community needs to which system resources should be allocated	38 (84%)	14	24

National Benchmarks

Only two benchmarks related to community benefits oversight were identified from surveys of hospital boards:

- Sixty percent of independent boards and 75 percent of member boards require a periodic community health needs assessment to understand the health issues of the communities served. Between 15 and 26 percent of the remaining boards reported considering this practice, suggesting this is an emerging best practice (The Governance Institute 2009 Biennial Survey, 2009).
- Forty-six percent of independent boards and 76 percent of member boards had adopted community benefit policies that included a statement of commitment, oversight process, definition of community benefit, measurement goals and methodology, financial assistance policy, and commitment to transparency (The Governance Institute 2009 Biennial Survey, 2009).

Most national benchmarks related to community benefit oversight are from surveys of system boards. These include the following:

- All (100 percent) high-performing system boards engage in a formal assessment process to determine the best way to allocate system resources to different community needs, though this varies by frequency of assessment and whether or not the system collaborates with other local organizations. Only 36 percent of low-performing systems met this best practice (HRET 2005 Survey, Margolin et al., 2006).
- Ninety percent of high-performing systems reported that their community health system board has a formal written policy that defines overall guidelines for the system's community benefit programs. Only 27 percent of low-performing systems met this best practice (Prybil et al., 2009).
- All (100 percent) high-performing systems reported having a community benefit plan that spells out measurable system-wide objectives for the organization's community benefit program, though it varies regarding whether or not the plan is formal or informal. Only 27 percent of low-performing systems met this best practice (Prybil et al., 2009).
- According to the CEOs of systems, 90 percent of high-performing systems regularly discuss their systems' community benefit responsibilities and programs, as compared with 36 percent of low performers (Prybil et al., 2009).
- Ninety percent of high-performing systems reported that they regularly present the community health system board with performance data on measurable system-wide objectives for the organization's community benefit program. Only 36 percent of low-performing systems met this best practice (Prybil et al., 2009).

Summary

Maryland's board oversight practices of community benefits programs are similar to hospitals nationally in some areas, but there is room for improvement in others. Maryland boards engage in formal community needs assessment at a somewhat higher rate, compared to hospitals nationally. Two potential areas for improvement in Maryland are the development of a written policy that defines overall guidelines for community benefit programs and adoption of measurable community benefit performance objectives. Less than one-third of Maryland's boards have adopted each these practices, a far lower rate of adoption compared to boards nationally. Benchmark data suggest that establishing performance objectives is a system-wide practice recommendation, and so survey results may not reflect all activity occurring at the system level. However, both independent hospitals and members of larger systems fall short on these two benchmarks.

Section 5: Self-Governance

Self-governance refers to activities that ensure effective functioning of the board and includes structural choices and practices, such as board self-assessment (of the full board and performance evaluation of individual board members), orientation of new board members, and ongoing education.

Recommendations and Best Practices

Recommendations for best practices related to self-governance, as found in the literature, include the following:

- Boards should have a formal self-assessment process to support effective governance (Center for Healthcare Governance, 2007; The Governance Institute, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007).
- New members should receive a formal orientation (Center for Healthcare Governance, 2007; The Governance Institute, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007).
- Boards should provide formal, ongoing education (Center for Healthcare Governance, 2007; The Governance Institute, 2009; Maryland Association of Nonprofit Organizations, 2009; Office of Attorney General Martha Coakley, 2007).
- Boards should periodically review bylaws and other policies (The Governance Institute, 2009).
- The board education plan should be included in the budget (The Governance Institute, 2009).

Maryland Survey Results

Table 20 presents the survey results for self-governance practices. The Maryland survey found:

- All but one of Maryland's hospital boards have engaged in a formal assessment of how well it is carrying out its own duties within the past five years. Nearly half engage in this process annually.
- Most Maryland boards (90 percent) require periodic review of bylaws and other policies.
- Ninety-three percent of boards have a formal orientation and education program, 71 percent develop annual education plans, and 81 percent include this education plan in their budget.

Table 20. Maryland: Self-Governance Practices

	Maryland Survey		
	All Hospitals (N=45)	Independent Hospitals (N=15)	Member Hospitals (N=30)
Self-Governance Practices	N (%)	N	N
Board engages in formal assessment of how well it is carrying out its own duties:			
Annually	20 (44%)	6	14
Every 2 years	12 (27%)	5	7
Less frequently than every 2 years	12 (27%)	3	9
Has not engaged in formal assessment in past 5 years	1 (2%)	1	0
Standing committees have clearly defined responsibilities that are spelled out in a written document (i.e., charter) that has been approved by the board	42 (93%)	15	27
Board requires that its bylaws and other important board self-governance policies be reviewed periodically for recommendations regarding enhancements	40 (89%)	14	26
Board has a formal program for its own orientation and ongoing education	42 (93%)	14	28
Board develops an annual board education plan	32 (71%)	13	19
Board education plan is reflected in the organization's budget for board activities and support (provided board develops an annual board education plan)	26 (81%)	11	15

National Benchmarks

National benchmarks related to self-governance include the following:

- The 2009 Biennial Survey found that most independent boards (81 percent) and member boards (86 percent) engage in a formal process to evaluate its own performance at least every 2 years. System boards are more likely (90 percent) to adhere to this practice. Most other responding hospitals indicated that they were considering it (The Governance Institute, 2009).
- The 2007 Survey of Nonprofit Health Systems reported that 90 percent of all community health system (and similar results by system status) boards engage in formal assessment of how well it is carrying out its own duties, with most of these boards conducting this assessment annually (Prybil et al., 2008).
- Findings on high-performance boards found that 100 percent of high-performing systems reportedly formally evaluate their own performance compared with 91 percent of mid-range–performing systems and 64 percent of low-performing systems. Of those systems that reported evaluating their own performance, most do so on an annual or biennial basis. Overall, 95 percent of high-performing system trustees reportedly evaluate their own performance (Prybil et al., 2009).

Summary

Maryland boards are generally structured for success as measured by board committee education/orientation and self-assessment. Almost all of Maryland's boards conduct formal self-assessment, and the majority does so at least every two years, which meets or exceeds national survey results. The majority of Maryland's boards engage in formal orientation and ongoing education, reflecting the recommendations in the literature.

Chapter V. Further Considerations

Several observations and questions arise from this report. A principle observation is that nonprofit hospital governance structures are complex and diverse in Maryland, reflecting national trends. We found in Maryland that many systems report contractual arrangements between local hospital boards and parent corporations in which the parent corporation, along with its board of trustees, holds "reserved powers." As a result, many boards of hospitals in larger systems retain limited authority across several domains of governance, including limited decision making authority over financial matters generally, and specifically more limited participation in audit functions and in establishing executive compensation. This is certainly not the case across all systems. In some cases, local hospital boards appear to participate in both monitoring and decision-making functions by: establishing standing committees with finance/budget, audit, and executive compensation oversight; approving many of the practices that govern hospital management; and receiving information routinely regarding many financial matters and executive compensation. Again, this reflects diversity both in governance structures and in strategic choices.

In other respects, local hospital boards universally appear to play an integral role in quality oversight, with standing committees overseeing patient safety and clinical quality/quality assurance, and following most of the best practices identified in the literature. In fact, both independent and member boards exceed national trends in reviewing an array of patient safety, quality, and morbidity measures on a routine basis. Thus, it appears that systems have made strategic choices about how to best utilize local hospital board members skills and input. In some domains, local hospital boards participate fully. In other domains, they do not.

The Maryland Survey on Nonprofit Hospital Board Governance limited its scope to the practices of hospital boards, sought no detail regarding the practices of hospital and health *system* boards, and did not collect any information regarding the dynamics between hospital boards and system boards in hierarchical governance structures. Therefore, the implications of "reserved powers" agreements for policy makers and regulatory bodies interested in enhancing public accountability and increasing the community benefit are arguably not well understood.

Several questions appear immediately relevant to the interests of policy makers, regulators, and the public interest:

1) Is the composition of system boards adequate to ensure transparency in governance, through representation from major stakeholders, including the community?
2) Are there some systems in which the local hospital boards serve in a capacity that is more advisory in nature relative to the authority exerted at the system level?
3) When local hospital boards are limited in their decision making authority because of system arrangements, is it in the public interest that local boards have greater involvement in monitoring financial management practices of the hospital? If so, which practices are most critical that member hospital boards adhere?

4) Are local hospital boards empowered to intervene in a meaningful way, if concerns arise in these domains?

Additional information would be helpful to better understand the governance strategy of systems that establish a parent and local hospital boards that are composed of the same persons:

5) What are the advantages or disadvantages of structuring boards using this "dual membership" in terms of both system efficiency and public accountability?
6) How do the bylaws and committee structure of parent boards and local hospital boards differ?

Further exploration into governance structures of hospital and health systems in Maryland is recommended. The objective of this inquiry would be:

- To document system board structures and board composition, and directly compare these to the structures and composition of member hospital boards;
- To document the specific governance practices by system boards that were inquired about in the Maryland survey and for which member hospitals reported the parent company or system holds "sole authority."
- To understand more broadly the dynamics in authority, decision making, monitoring, and exchange of information between hospital officers, member hospital boards and their committees, and system boards.

The overarching concern of this continued line of inquiry would be to better understand the implications for exercising appropriate policy and regulatory oversight of nonprofit hospitals.

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Appendix I. Survey Instrument

Instructions for Completing This Questionnaire

In response to a request dated September 8, 2009, from Del. Peter Hammen, Chairman of the House Health and Government Operations Committee, the Health Services Cost Review Commission (HSCRC) is conducting a survey related to non-profit hospital governance in Maryland. In the process, we expect to educate the industry, and our Commission, about best practices in hospital governance. We hope this will begin a dialogue about how we can work together to enhance good hospital governance in Maryland.

As the CEO of a Maryland hospital, HSCRC is requesting your full participation to coordinate completion of this questionnaire on behalf of your hospital.

All questions relate to the governance policies and practices of your hospital's Board of Trustees, not its parent company or health system. All questions that refer to the Board refer to your hospital's Board, its by-laws, charter, and governance policies and practices.

Most survey questions require detailed knowledge of board policies and practices. To ensure the most accurate response to survey questions, we ask that you forward a copy of the survey to your hospital's **Board Chair** now and consult with the Chair where necessary.

Please provide the contact information for your Board Chair below so that we may contact them to clarify any responses, if necessary:

Name of Hospital: ___
Name of Board Chair: _____
Phone number: _____
Email: _____

Most of the questions in this survey can be answered easily by checking boxes or filling in blanks, which are shaded gray. A few questions require entry of numbers.

- Please use your mouse to navigate throughout the survey by clicking on the field or check box you wish to answer. Do not use the "Tab" or "Enter" keys as they may cause formatting problems.
- To select a check box, simply click on the center of the box.
- To change or deselect a response, simply click on the check box and the "X" will disappear.
- The survey provides space for comments after many questions and at the end of the survey. Please use this space to clarify your responses or provide other feedback. Please note that these blanks expand to fit your answer.

Any questions about the survey should be submitted to Amanda Greene (agreene@hscrc.state.md.us) by **December 22, 2009**. We will compile questions from all hospitals and distribute to all survey participants via e-mail.

If your hospital has a parent company or is part of a health system, the Board of this company or system may meet certain oversight responsibilities on behalf of your hospital. To better understand shared oversight responsibility with parent companies and systems, we may follow up with your parent company or health system to ask for clarification on specific items. Please check here if this describes your organizational structure. ☐

Please provide the name of the parent company or health system, its CEO, and Board Chair.

Name of Parent Company or Health System_____

CEO Name:	Board Chair Name:
Mailing Address:	Mailing Address:
Email:	Email:
Phone #:	Phone #:
Name of Assistant:	Name of Assistant:

In certain cases, survey responses allow you to indicate if your parent company or health system meets an oversight responsibility on behalf of your hospital. Please feel free to provide additional clarification regarding shared oversight responsibility in the comment area below.

COMMENTS: _____

Submission Instructions

Please submit a completed copy of this questionnaire by **January 15, 2010**. When you have completed the survey, simply save this file to your computer desktop or hard drive as a Word 2003 or Word 2003-2007 Compatible file. Return the completed questionnaire via e-mail by attaching the file as part of your e-mail message. Please e-mail a copy of your written conflict of interest policy as an attachment to your e-mail, or you may fax a copy. Submit to:

Amanda Greene
Program Manager
Health Services Cost Review Commission

Email: agreene@hscrc.state.md.us
Fax number: 410-358-6217
Phone: 410-764-2597

Definitions for terms used in this survey

Independent - Free of financial conflict of interest. Independent persons (1) are not compensated by the organization as employees or independent contractors; (2) do not have their compensation determined by individuals who are compensated by the organization; (3) do not receive, directly or indirectly, material financial benefits from the organization except as a member of the charitable class served by the organization; and (4) are not related to anyone described above (as a spouse, sibling, parent or child), and do not reside with any person so described. As defined by the Panel on the Nonprofit Sector, 2007. Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations.

Executive Compensation Body –The executive compensation body refers to the hospital system's Board of Trustees, executive compensation committee, finance committee, Board or Board committee chairperson, or other appropriate authorized body or person of the hospital system with primary responsibility for compensation matters. As defined by the U.S. Government Accountability Office.

Other Top Four Executives – Refers to the four most highly compensated executive officers of the hospital system other than the CEO. As defined by the U.S. Government Accountability Office.

Board Governance – Refers to the self-governance of the hospital Board. Board governance functions would include routinely assessing the Board's bylaws and making recommendations for improvement or best practices in structure, composition, and performance of the Board. As defined by the Governance Institute.

Section I. Hospital Board Composition

1. In the columns below please provide the number of **voting** and **non-voting** members of the Board. Do not include vacancies in these counts. Indicate vacancies separately.

	Voting Member(s)	Non-Voting Member(s)	Total Members
A. Number of Board members (do not include vacancies)			
B. Number of **independent** members (do not include vacancies)			
C. Number of current vacancies			

2. In the table below, use the appropriate box to indicate the **number** of Hospital Board Members who represent each of the following persons or communities as **Voting Members** or **Non-Voting Members**. If Board Membership does not include representation of that person or community, please check the column "**No Members**".

For members representing Minority/Ethnic Communities (Item I) and Patients (Item J), count only the Board members recruited to serve as representatives of the community (Item H). Do not include members who represent hospital staff, employees, or officers. For Female members (Item K), include all female members, regardless of affiliation.

Composition of Board Membership	Number of Members		Check here if No Members
	Voting Member(s)	Non-Voting Member(s)	
A. Chief Medical Officer			☐
B. Medical Staff President			☐
C. Physicians with active medical staff privileges (other than A or B)			☐
D. Physicians without active medical staff privileges (other than A or B)			☐
E. Nursing staff			☐
F. Other Nurses (not staff)			☐
G. Hospital employees (not nurses)			☐
H. Community members/leaders			☐
I. Local minority/ethnic (any in H)			☐
J. Patients (any in H)			☐
K. Female members (any in A-H)			☐

3. Has your Board had difficulty recruiting members to sufficiently represent certain constituencies, or that retain certain expertise? If so, please elaborate on these difficulties**:**

COMMENTS: ___

For the following question(s), please check the appropriate response.

4. Indicate type of CEO Membership on Board:	**Check ONE**
A. Voting member and Board chair	☐
B. Voting Board member	☐
C. Non-voting Board member	☐
D. NOT a member of the Board	☐
5. Indicate type of CEO Membership on Executive Compensation Body *(See definitions on page 3)*:	**Check ONE**
A. Voting member of the Executive Compensation Body	☐
B. Non-voting member of the Executive Compensation Body	☐
C. Not a member of the Executive Compensation Body	☐

For the following question(s), please check the appropriate response.

6. Indicate if the Board currently retains members with the following expertise:	**Check all that apply**	
A. Health care quality and delivery	☐	
B. Health care financial and accounting	☐	
C. Legal	☐	
D. Patient advocacy	☐	
	Check YES or NO	
7. If your Board does not retain members with financial expertise, does the Board currently contract with an independent financial advisor, other than your auditor? (Leave blank if you checked 5B)	☐ YES	☐ NO
8. Are the terms of Board members staggered?	☐ YES	☐ NO

9. Are Board members limited to serve a fixed term?	☐ YES	☐ NO
A. If YES, what is the fixed term? _____Years		
B. Are Board members limited to serving a certain number of consecutive terms?	☐ YES	☐ NO
C. How many consecutive terms may a member serve? _____		

Section II. Transparency

10. For each of the documents below, please check the box to indicate if the document is **posted on the hospital's website** and/or **available upon request through the hospital's Public Information Office**.

Document	**Posted on the Hospital's Website**	**Available upon request through the hospital's Public Information Office**
A. The articles of incorporation, including the corporate mission statement	☐	☐
B. Names of members of the Board	☐	☐
C. Board member terms in office	☐	☐
D. Brief biography of each Board member	☐	☐
E. The Board bylaws	☐	☐
F. The medical staff bylaws	☐	☐
G. The most recent IRS Form 990	☐	☐
H. The three (3) most recent Forms 990	☐	☐
I. Audits of Form 990	☐	☐
J. Both salary and non-salary compensation of the Other Top Four Executives *(See definitions on p. 3).*	☐	☐
K. The most recent annual report	☐	☐
L. The three (3) most recent annual reports	☐	☐
M. The Board's conflict of interest policy	☐	☐
N. Strategic plans approved by the Board that significantly affect the provision of services in the community	☐	☐

Document	Posted on the Hospital's Website	Available upon request through the hospital's Public Information Office
O. Hospital's charge master	☐	☐
P. Hospital's financial assistance and debt collection policies for under- and uninsured patients	☐	☐
Q. Any patient safety measures (ie. medication errors)	☐	☐
R. Any clinical quality measures (not patient safety)	☐	☐
S. The level of community benefits the organization provided in the most recent year	☐	☐
T. Identity and location of out-of-state corporate parents *(leave blank if not applicable)*	☐	☐

For the following question(s), please check YES or NO.

11. Does the Board publish a notice of Board membership openings?	Check YES or NO	
A. On the hospital website?	☐ YES	☐ NO
B. In other public media, such as local newspapers, hospital publications, or other forms of outreach expected to broadly reach target representational constituencies?	☐ YES	☐ NO

Section III. Conflict of Interest Policy

For the following question(s), please check YES or NO.

	Check YES or NO	
12. Does your hospital Board have a written conflict of interest policy that covers all members of the Board? *If Yes, please submit a copy with your completed survey.*	☐ YES	☐ NO
13. Does your hospital Board have a written conflict of interest policy that covers members of the Executive Compensation Body (see definition on page 2)? *If Yes, please submit a copy with your completed survey.*	☐ YES	☐ NO
14. If your Board has a written conflict of interest policy (for the full Board or the Executive Compensation Body), does this policy:	**Check all that apply**	

A. Require disclosures of potential conflicts of interest?	☐	
B. Outline conditions when members must recuse themselves from particular discussions and voting?	☐	
C. Provide guidance on what may constitute a conflicting situation?	☐	
	Check YES or NO	
15. Does the Board require at least the annual written disclosure of all actual and potential conflicts of interest by each officer and director?	☐ YES	☐ NO
16. Does the Board's conflict of interest policy require that all disclosed conflicts and/or dualities of interest be disclosed to the entire Board?	☐ YES	☐ NO
17. Does the Board's conflict of interest policy require that prospective members first be screened or questioned as to actual or potential conflicts or dualities of interest before being formally invited to stand for election to the Board?	☐ YES	☐ NO

Section IV. Governance Policies and Practices

For the following questions, check the appropriate response.

18. How many prescheduled meetings does the Board calendar during a 12 month period?	**Check ONE**
A. 0-3 meetings	☐
B. 4-5 meetings	☐
C. 6 meetings	☐
D. 7-9 meetings	☐
E. 10-12 meetings	☐
F. 13 or more meetings	☐
19. How often does the Board engage in formal assessment of how well it is carrying out its own duties?	**Check ONE**
A. Annually	☐
B. Every two years	☐
C. Less frequently than every two years	☐

D. The Board has not engaged in formal assessment in the past 5 years	☐

For the following question(s), please check YES or NO

	Check YES or NO	
20. Do standing Board committees have clearly defined responsibilities that are spelled out in a written document (i.e. charter) that has been approved by the Board?	☐ YES	☐ NO
21. Does the Board require that its bylaws and other important Board self-governance policies be reviewed periodically for recommendations regarding enhancements?	☐ YES	☐ NO
22. Does the Board have a formal program for its own orientation and ongoing education?	☐ YES	☐ NO
23. Does the Board develop an annual board education plan?	☐ YES	☐ NO
A. If YES, Is this plan reflected in the organization's budget for board activities and support?	☐ YES	☐ NO

24. Check the appropriate column to indicate which of the following data are routinely reported (at least semi-annually) to the **full Board**, **a standing committee only**, or **not reported**.

Routine Data Reports	Full Board	Standing Committee	Not Reported
A. Budget Performance	☐	☐	☐
B. Financial Statements	☐	☐	☐
C. Operating Statistics	☐	☐	☐
D. Capital Planning	☐	☐	☐

25. Listed below are a number of governance functions. Check YES next to the governance function if the Board has a standing committee, regardless of its exact name, with clear oversight responsibility for the function. Check NO if no standing committee has clear oversight responsibility. One committee could oversee more than one of these functions. If the hospital's Parent Company/System holds sole authority for this function on behalf of your hospital, check the column "**Parent Company/System**."

Governance Functions	Standing Committee? (Check YES or NO)		Parent Company/System
A. Finance/Budget	☐ YES	☐ NO	☐

B. External Audit	☐ YES	☐ NO	☐
C. Internal Audit	☐ YES	☐ NO	☐
D. Executive	☐ YES	☐ NO	☐
E. Strategic Planning	☐ YES	☐ NO	☐
F. Executive Compensation	☐ YES	☐ NO	☐
G. Patient Safety	☐ YES	☐ NO	☐
H. Quality Assurance/Quality Improvement	☐ YES	☐ NO	☐
I. Ethics or Compliance	☐ YES	☐ NO	☐
J. Community Benefits Program	☐ YES	☐ NO	☐
K. Board Governance (i.e. self-governance) *(See definitions on page 3).*	☐ YES	☐ NO	☐
L. Board Education and Development	☐ YES	☐ NO	☐

COMMENTS: _____

The following questions seek to determine whether the hospital board DUTIES related to FINANCIAL oversight include any of the following. These duties may be carried out by the full Board or a standing committee.

	Check Any That Apply		
26. Indicate whether the Board (or a standing committee) reviews or approves the following:	**Review**	**Approve**	**Neither**
A. Auditing and accounting principles and practices used in preparing the hospital's financial statements	☐	☐	☐
B. Large or significant grants or contract	☐	☐	☐
C. Transactions involving real estate	☐	☐	☐
D. Borrowing or sale/disposal of large assets	☐	☐	☐
E. Creation of subsidiary entities	☐	☐	☐
F. Joint ventures	☐	☐	☐
G. Organizations' budget and financial objectives	☐	☐	☐

	Check YES or NO	
27. Is the Board (or a standing committee) responsible for retaining and replacing the hospital's independent auditor?	☐ YES	☐ NO
28. Do Board policies require the replacement of the independent auditor?	☐ YES	☐ NO
27A. If YES, how often?	___	
27B. If NO, do Board policies require a re-bid of the independent auditor every five years, at a minimum?	☐ YES	☐ NO
29. Does the Board require that the hospital's financial statements be certified annually by both the CEO and CFO?	☐ YES	☐ NO
30. Is the Board (or a standing committee) empowered to receive reports on the contracting and compensation processes for the hospital's most significant independent contracts, including those receiving more than $100,000 in compensation in any year?	☐ YES	☐ NO
31. Has the Board or CEO put in place processes and procedures to ensure that the organization's Federal information return and tax return (including Form 990) complies with the Internal Revenue Code?	☐ YES	☐ NO

	Check Any That Apply		
32. Indicate whether the Board (or a standing committee) establishes or approves written financial policies governing the following:	**Establish**	**Approve**	**Neither**
A. Investment of the assets of the hospital	☐	☐	☐
B. Internal accounting systems and control procedures	☐	☐	☐
C. Purchasing practices	☐	☐	☐
D. Unrestricted current net assets	☐	☐	☐

The following questions refer to the standing committee responsible for AUDIT OVERSIGHT, regardless of its name. If these responsibilities reside with your parent organization and NOT with your hospital Board, please check the box in Question #33 below and SKIP TO QUESTION #35 ON THE NEXT PAGE.

	If YES,

	Check here
33. Responsibility for AUDIT OVERSIGHT resides with our parent company/system and NOT our hospital Board (SKIP TO Question 35)	☐

For the following question(s), please check YES or NO

34. Does this Board have a Board Auditing Committee that:	Check YES or NO	
A. Excludes all members of senior management (the CEO and Other Top Four Executives) as voting members?	☐ YES	☐ NO
B. Meets independently with the external auditor at least annually?	☐ YES	☐ NO
C. Has sole authority to select and replace the external auditor?	☐ YES	☐ NO
D. Has sole authority to authorize independent reviews performed by another party (other than the external auditor) if required?	☐ YES	☐ NO

COMMENTS:

_____

35. Check the appropriate column to indicate which entity, the **full Board**, a **standing committee**, the **parent company/system**, or **other entity**, approves the following.

	Check ONE			
Which entity approves:	**Full Board**	**Standing Committee**	**Parent Company/System**	**Other**
A. Findings of the hospital's annual audit and management letter?	☐	☐	☐	☐
B. Long-range and annual capital and financial plans?	☐	☐	☐	☐
C. Compensation of the CEO?	☐	☐	☐	☐
D. Compensation of the Other Top Four Executives?	☐	☐	☐	☐

The following questions relate to the filing of the **Internal Revenue Service Form 990**.

36. Please select the response that best describes the review and/or approval by the Board of the Form 990:	**Check ONE**

A. The Board reviews but does not approve the Form 990 prior to submission	☐
B. The Board reviews and approves the Form 990 prior to submission	☐
C. The Board is provided a copy of the Form 990 prior to submission but does not review or approve the Form 990	☐
D. The Board is provided a copy of the Form 990 after submission	☐

37. Does the Board require that the Form 990 be reviewed by an independent auditor for conformity to established Form 990 filing standards?	**Check ONE**
A. **YES**, independent audit is conducted of Form 990	☐
B. **NO**, only an internal audit is conducted of Form 990	☐
C. **NO**, no audit, independent or internal, is conducted.	☐

	Check YES or NO	
38. Has your hospital established procedures for employees to report in confidence any suspected financial impropriety or misuse of the charity's resources? *(This policy is sometimes referred to as a whistleblower policy)*	☐ YES	☐ NO

The following questions relate to EXECUTIVE COMPENSATION oversight.

	Check YES or NO	
39. Does the Board establish written performance expectations with clear objectives or criteria for the CEO?	☐ YES	☐ NO
38a. If YES, does the performance expectation regularly include:	**Check all that apply**	
A. Financial performance target?	☐ YES	☐ NO
B. Clinical quality target?	☐ YES	☐ NO

C. Community benefits target?	☐ YES	☐ NO
40. In setting compensation for the CEO, indicate which of the following are formally considered:	**Check all that apply**	
A. Data on comparable hospital CEO compensation	☐ YES	☐ NO
B. The hospital's mission	☐ YES	☐ NO
C. Performance targets (any financial, quality, or community benefits targets)	☐ YES	☐ NO
D. Other written objectives or expectations about CEO performance	☐ YES	☐ NO
41. Is the full Board provided with information about the complete compensation package for the CEO, including salary, and the value of any non-salary compensation, such as use of an automobile, retirement funds, and/or incentive bonuses?	☐ YES	☐ NO
42. Is the full Board provided with the same information (salary and non-salary) for the Other Top Four Executives?	☐ YES	☐ NO
43. Are all voting members of the Executive Compensation Body hospital independent? *(See definitions on page 3).*	☐ YES	☐ NO

The following questions relate to QUALITY oversight.

	Check YES or NO	
44. Does the Board or a standing committee establish annual objectives and goals in relation to clinical quality?	☐ YES	☐ NO
45. Does the Board annually participate in opportunities for board member education or training regarding its quality responsibilities and issues?	☐ YES	☐ NO

46. Does the Board regularly receive formal written reports on performance in relation to established measures and standards for the quality of patient care?	Check ONE
A. YES, it does	☐
B. NO, this information is received and handled by a parent company/system.	☐
C. NO, this information is received and handled by a board committee.	☐
D. NO, reporting and monitoring the quality of patient care is a function that is handled by hospital officers.	☐

47. Check the appropriate box to explain which of the following data are routinely reported (at least annually) to the **Full Board, Standing Committee**, or **Not Reported Routinely (at least annually)**.

Routine Reports of Data	Full Board	Standing Committee	Not Reported Routinely
A. Patient Satisfaction Surveys	☐	☐	☐
B. Quality Indicators	☐	☐	☐
C. Patient Safety Indicators	☐	☐	☐
D. Morbidity Indicators	☐	☐	☐
E. Mortality Indicators	☐	☐	☐
F. Community Health Status Measures	☐	☐	☐
G. Other Clinical/Outcomes Indicators*	☐	☐	☐

*To help us understand what types of data are reported, please list examples of other clinical/outcomes indicators routinely reported here: _____

The following questions relate to oversight of the hospital's COMMUNITY BENEFITS program.

48. Has the Board (or its Parent Company/System) adopted a formal community benefit plan that spells out measurable objectives for the organization's community benefit program?	**Check ONE**
A. YES, there is a formal, board-adopted community benefit plan that spells out measurable objectives for the organization's community benefit program?	☐
B. NO, the Board has established some priorities for the community benefit program, but, at this point, there is not a formal plan of this nature in place.	☐
C. NO, not yet	☐

49. Does the Board (or its Parent Company/System) engage in a formal assessment process designed to determine community needs to which system resources should be allocated?	**Check ONE**
D. YES, the Board conducts its own formal community needs assessment process on a regular basis	☐
E. YES, the Board collaborates with other local organization in a community needs assessment process on a regular basis	☐
F. YES, the Board periodically engages in community needs assessment but not on a regular basis	☐
G. NO	☐

COMMENTS:

_____

For the following question(s), check YES or NO.

	Check YES or NO	
50. Has the Board adopted a formal, written policy that defines overall guidelines for the system's community benefit programs?	☐ YES	☐ NO
51. Is the Board (or a standing committee) regularly presented with performance data on measurable objectives regarding its community benefit programs?	☐ YES	☐ NO

52. Does the Board review and approve financial assistance and credit collection policies?	☐ YES	☐ NO
53. Is the Board presented with any routine data (eg. monthly, annually) related to the hospital's credit and collection and financial assistance activities?	☐ YES	☐ NO
52a. If YES, how often? _____		

COMMENTS:

Is there anything else that you would like to add about your hospital's governing Board or practices?

_____

Is there anything you would like to say about the survey?

_____

This completes the survey. We appreciate your full participation and acknowledge the burden of responding to this survey. Please record here the approximate amount of time taken to complete this survey by your

CEO: _____
Board Chair: ___
Staff: ___

Does your Board have a written conflict of interest policy? ☐ Yes ☐ No

Please attach a copy of your policy to your email or fax a copy of this policy along with your completed survey.

Respondent Information

Please provide the following information for the individual who coordinated the completion of this survey so that we may contact them to clarify any responses.

Name: ___
Title: ___
Hospital Name: ___
Telephone Number (___) ___ - ___, Ext: ___
Email: ___@___

Upon completion of the survey, please check the box that best describes how the survey was completed by your institution:

- ☐ A copy of this survey was sent to our Board Chair.
- ☐ I consulted with the Board Chair regarding responses to this survey.
- ☐ I completed this survey and the Board Chair reviewed my responses.
- ☐ The Board Chair completed this survey and I reviewed it.

Thank you very much.

Appendix II. Maryland Nonprofit Hospitals

Name of parent company or health system Name of hospital	Part of Multi-hospital system?	Has a separate parent board?
System Member Hospitals		
Adventist HealthCare, Inc.		
Shady Grove Adventist Hospital	Yes	Yes
Washington Adventist Hospital	Yes	Yes
Ascension Health (Headquarters in St. Louis, MO)		
Saint Agnes HealthCare[6]	Yes	Yes
Bon Secours Health System, Inc.		
Bon Secours Baltimore Health System	Yes	Yes[7]
Catholic Health Initiatives (Headquarters in Denver, CO)		
Saint Joseph Medical Center	Yes	Yes
Dimensions Healthcare System		
Laurel Regional Hospital	Yes	Yes
Prince George's Hospital Center	Yes	Yes
LifeBridge Health		
Northwest Hospital Center	Yes	Yes
Sinai Hospital of Baltimore	Yes	Yes
MedStar Health, Inc.		
Franklin Square Hospital Center	Yes	Yes
Good Samaritan Hospital	Yes	Yes
Harbor Hospital	Yes	Yes
Montgomery General	Yes	Yes
Saint Mary's Hospital	Yes	Yes
Union Memorial Hospital	Yes	Yes
Mercy Health Services		
Mercy Medical Center	No	Yes
The Johns Hopkins Health System Corporation (JHHSC)		
Howard County General, Inc.	Yes	Yes

[6] Member of a multi-hospital system with only one hospital located in Maryland. System headquarters is located out-of-state.

[7] The hospital board of Bon Secours is composed of the same individuals as local parent board. In addition, a separate corporate board reserves oversight on several functions.

Name of parent company or health system Name of hospital	Part of Multi-hospital system?	Has a separate parent board?
Johns Hopkins Bayview Medical Center, Inc.	Yes	Yes
The Johns Hopkins Hospital	Yes	Yes
Suburban Hospital, Inc.	Yes	Yes
Trinity Health (Headquarters in Novi, MI)		
Holy Cross Hospital of Silver Spring, Inc.	Yes	Yes
University of Maryland Medical System (UMMS)		
Baltimore Washington Medical Center	Yes	Yes
Chester River Hospital Center	Yes	Yes
Dorchester General Hospital	Yes	Yes
Harford Memorial Hospital, Inc.	Yes	Yes
James Lawrence Kernan Hospital	Yes	Yes
Maryland General Hospital	Yes	Yes
Memorial at Easton	Yes	Yes
Upper Chesapeake Medical Center	Yes	Yes
University of Maryland Medical Center	Yes	Yes
Health Systems Classified as Independent Hospitals		
Anne Arundel Health System, Inc.		
Anne Arundel Medical Center	No	Same board[8]
Calvert Health System		
Calvert Memorial Hospital	No	Same board
Nexus Health Inc.		
Fort Washington Medical Center	No	Same board
Peninsula Regional Health System, Inc.		
Peninsula Regional Medical Center	No	Same board
Union Hospital of Cecil County		
Union Hospital of Cecil County	No	Same board
Independent Hospitals		
Atlantic General Hospital Corporation	N/A	No
Carroll Hospital Center	N/A	No
Civista Health, Inc.	N/A	No
Doctors Community Hospital	N/A	No
Frederick Memorial Healthcare System	N/A	No

[8] The parent board is composed of the same individuals as the hospital board.

Name of parent company or health system Name of hospital	Part of Multi-hospital system?	Has a separate parent board?
Garrett County Memorial Hospital	Government	No
Greater Baltimore Medical Center (GBMC)	N/A	No
McCready Memorial Hospital	N/A	No
Washington County Hospital	N/A	No
Western Maryland Regional Medical Center	N/A	No

Appendix III. Maryland Trustee Disclosure Requirements

Trustees, directors, and officers of Maryland nonprofit hospitals are required by law and regulation to disclose any interest in transactions with the hospital of over $10,000 (reportable interests). These requirements are meant to support transparency, disinterested governance, and accountability. They provide a basis upon which a hospital board can discharge its responsibility to monitor the appropriateness of trustee business dealings with the hospital, investigate apparent conflicts of interest, and, if appropriate, take action to address the conflict. The fact that a reportable interest exists, in and of itself, does not suggest a conflict between the interests of the hospital and those of the trustee. A conflict *may* be suggested, however, by information the law requires to be disclosed regarding the nature of the transaction and the relationship of the trustee to the firm involved.

Methods

FY 2008 disclosure of interest reports for trustees, directors, and officers were submitted by 44 of Maryland's 45 nonprofit hospitals. These reports (rather than survey responses) are the basis for quantitative observations made herein.

COMAR 10.37.01.06 (the reporting regulation) requires that nonprofit hospitals submit to HSCRC "a list of all trustees, directors, or officers." Although the terms "trustee" (or "director"), on the one hand, and "officer" on the other differ conceptually,[9] some hospitals responded to this requirement by providing lists that appear to combine trustees and officers without indicating the title or status of the listed individuals. This lack of distinction between trustees and officers in some hospitals' reports made it necessary to treat both trustees and officers as "trustees" for purposes of this analysis of trustee disclosure for FY 2008; hereinafter the term "trustee" will be used in this Appendix to refer to trustees, directors, and officers collectively.

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[9]COMAR 10.37.01.01B(10) defines "trustee or director" as:

> [A]any person serving on a governing board or committee of a nonprofit hospital or related institution who is empowered to vote on matters concerning the hospital's or related institution's governance or other matters generally concerning its policies.

The same regulation defines an officer of a nonprofit hospital as:

> (a) An individual who is elected to office pursuant to a resolution of the governing board of the hospital or related institution, to fill a position defined in the bylaws of the hospital or related institution; or
>
> (b) An individual who, although not specifically designated as an "officer" administers the policies of the hospital or related institution, and has the authority and performs the duties in the management of the property and affairs of the hospital or related institution as may be provided in the bylaws.

Trustee disclosure of interest reports for FY 2008 were reviewed for completeness and to assess compliance with the requirements of Health-General Article, §19-224, Annotated Code of Maryland (the reporting statute) and the reporting regulation.

Conflicts of Interest

The extent to which there may be conflicts of interest between trustees and the institutions they govern as board members cannot be assessed solely on the basis of information included in the disclosure reports, which may, at most, provide evidence of an *apparent* conflict of interest. As explained in Chapter III of this Report, investigation of a trustee's apparent conflict of interest is the responsibility of the hospital board, consistent with its adopted conflict of interest policy. This policy would properly include procedures for trustee disclosure of interests, the handling of disclosed interests, and for correcting violations of the hospital's conflict of interest policy. The trustee disclosure of interest reports required by the reporting statute and regulation serve two purposes: as a mechanism for alerting a hospital board that apparent conflicts of interest exist, so that it may investigate and take appropriate action, and as a mechanism for informing regulators who monitor that process.

Reporting Responsibility of Hospitals and Trustees

A Maryland nonprofit hospital must report to the HSCRC annually the names and business addresses of all trustees. No additional information is required (of either hospital or trustee) regarding trustees who have no interest in or relationship to a business entity involved in specified categories of transactions with the hospital. In the case of a trustee who does have such an interest or relationship, however, both the hospital and the trustee are required to report. The content of the report required of the hospital and disclosures required of the trustee differ, however. A hospital must indicate to the HSCRC which of its listed trustees, if any, is also an employee, partner, director, or has a beneficial interest[10] of 3 percent or more in an entity that has engaged, during the reporting period, in a transaction with the hospital of $10,000 or more (a reportable interest).

A trustee is responsible for reporting the name and address of a firm to which the trustee is related that engages in a reportable transaction, as well as the nature and extent of such transactions. In practice, trustees submit their disclosures to the hospital, which then submits them to the HSCRC as an indication of which of its listed trustees have reportable interests. In effect, hospitals assume responsibility for ensuring compliance with disclosure requirements

[10] A person has a "beneficial interest" in a business entity if the person "ultimately benefits or suffers losses from the operation of the firm or has a vested interest in it, and includes, but is not limited to, limited partners, beneficiaries of voting or other trusts, and limited term and remaindermen beneficiaries or owners." COMAR 10.37.01.01B(2).

applicable to trustees as a means of fulfilling the regulatory reporting responsibility of the hospital.[11]

It is clear, however, that individual trustees are personally responsible for failure to disclose their reportable interests. Unless the deadline is extended, a civil penalty of $25 per day may be assessed against a trustee whose disclosure of a reportable interest is filed more than 90[12] days after the end of the fiscal year. The reporting regulation goes on to specify that if a hospital reimburses or indemnifies its trustee for payment of the fine, that expense will not qualify as a "reasonable cost" to be considered by HSCRC in the context of setting the hospital's cost-based rates. The reporting statute makes a trustee who "willfully" fails to file a required disclosure report subject to a criminal penalty up to $500.[13]

Hospitals that fail to report to the HSCRC the names and business addresses of their trustees or identify those with reportable interests in a timely manner may be subject to a civil penalty of up to $250 per day the report is delayed (also expressly not a "reasonable cost" for rate-setting purposes), and may be refused a rate increase.[14]

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[11] *Compare* sections C and I of the reporting regulation (COMAR 10.37.01.06).

[12] Since 1992, the HSCRC has granted blanket 30-day extensions of the 90-day reporting deadline for trustee disclosure reports specified in regulation. See HSCRC Accounting and Budget Manual, Section 400 - 1 Reporting Requirements, at p. 1, posted at: http://www.hscrc.state.md.us/documents/Hospitals/Compliance/Accounting&BudgetManual/8-1-09/SECTION400_FINAL08.01.09.pdf (accessed 1/31/10)

[13] The reporting regulation's reference to "business transactions described in Health-General Article, §19-220" is meant to refer to the reporting statute (§19-224); the reporting regulation, promulgated in 1974, cites the reporting statute's then-current designation. (Section 19-220 was recodified as §19-224 in 1999; its content has remained unchanged.)

[14] These penalties apply to a hospital's failure to file a report "required under … Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland, or its regulations." COMAR 10.37.01.03N(1) and (3).

Compliance and Completeness

Of Maryland's 45 nonprofit hospitals, 44 submitted reports for FY 2008 that address, with varying degrees of completeness, the information required by the reporting statute and regulation. Section I of the reporting regulation requires a nonprofit hospital to (1) list its trustees, (2) their business addresses, and (3) to indicate which ones are "also an employee, partner, director, or beneficial owner of 3 percent or more" of a business entity that transacted business with the hospital worth $10,000 or more during the reporting period. Distinct from the three elements assigned as hospitals' reporting responsibility are additional reporting requirements, applicable to trustees, requiring more detailed information about such transactions. A template and instructions incorporated into the reporting regulation provide a tool for facilitating compliance.

Trustee Disclosure Statement Template and Instructions.

Timely submission to the HSCRC of a disclosure statement including all information the template requires, prepared in accordance with the instructions, satisfies *a trustee's* reporting responsibility under the reporting statute and regulation. A hospital's collection and submission of complete trustee disclosure statements from all trustees with a reportable interest (along with a list of trustee names and business addresses) satisfies the *hospital's* reporting responsibility as well.

Instructions accompanying the template characterize it as "a guide, not a form," but indicate that a trustee's disclosure of interest statement must include all required information in substantially the same manner. In addition to nine numbered items[15] (most of an administrative nature) the template features a table of six columns that represent six[16] of the seven key elements reviewed for this report's assessment of completeness (see fig.1). The seventh element reviewed for this analysis is the template's item "(7)," the trustee's signature, which appears adjacent to an oath or affirmation.[17]

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[15] These include: trustee name and address, hospital or related institution indicator, hospital name and address, date of statement, reporting period, oath or affirmation, trustee signature, assumption of responsibility for valuation, and appraiser qualifications and signature.

[16] The name and address of a trustee's firm (i.e., the business entity with which the hospital has done business amounting to $10,000 or more) are counted, for purposes of the completeness assessment, as two data elements. Because the instructions indicate that either column E or F are to completed (not both) columns E and F are counted as a single element.

[17] To the left of the template's signature line (item (7)), the following appears: "(6) Oath or Affirmation 1. Oath of Trustee before Notary Public that the Statement is true and correct to the best of the knowledge, information and belief of the Trustee OR 2. Signature of Trustee, under declaration that Statement is true and correct under the penalties of perjury." This, with the trustee's signature, apparently is intended to address the requirement that the trustee's statement be signed and verified, as required by the reporting statute and regulation.

Fig. 1.

COMPLETE EITHER COLUMN E OR F, BOTH COLUMNS NEED NOT BE COMPLETED

A	B	C	D	E	F
NAME AND ADDRESS OF TRUSTEE'S FIRM	MAJOR BUSINESS, PROFESSIONAL OR ACADEMIC ACTIVITY OF FIRM	TITLE, RELATIONSHIP OR POSITION OF TRUSTEE IN THE FIRM	TYPE OR NATURE OF BUSINESS, TRANSACTIONS DEALINGS OR SERVICES BY AND BETWEEN HOSPTIAL /INSTITUTION AND TRUSTEE'S FIRM HAVING AN ACTUAL OR IMPUTED VALUE OR WORTH TO THE FIRM OF $10,000 OR MORE	MONETARY VALUE OF BUSINESS OR TRANSACTIONS TO TRUSTEE'S FIRM	CONSIDERATION FOR OR PRICE OF GOODS AND/OR SERVICES RENDERED FROM HOSPITAL/INSTITUTION

As mentioned above, neither statute nor regulation require submission of a trustee disclosure of interest statement in precisely the format shown in Figure 1. Review of the disclosure statements submitted by hospitals for FY 2008 showed that only 24 of the 38 hospitals indicating one or more trustees with a reportable interest either used the HSCRC's template or provided the required data in a similar manner.

Results

For FY 2008, all 44 of the reporting hospitals provided a list of trustees, but only 38 hospitals (86 percent) provided trustees' addresses. In some cases it was unclear whether these were business addresses. Thirty-eight hospitals (86 percent of those reporting) indicated that one or more trustees had a reportable interest during FY 2008. Individual hospitals reported between 1 and 48 reportable transactions in FY 2008 attributable to hospital trustees. In the aggregate, 257 transactions of $10,000 or more in which trustees had an interest were reported by 38 hospitals. Of the aggregate 908 trustees listed by the 44 reporting hospitals, 38 hospitals indicated a total of 178 trustees with reportable interests,[18] representing 20 percent of all trustees.

[18] This number is not unduplicated; individuals who serve on more than one hospital board are counted for each hospital board on which they serve.

Table 20

	A_1 Name of trustee's firm	A_2 Trustee's firm's address	B Trustee firm's major activity	C Relationship of trustee to firm	D Nature of firm's & hospital's transaction ≥ $10,000	E or F Transaction value	(7) Trustee signature
Total reported	238	135	232	238	132	196	253
Total required	257	257	257	257	257	257	257
Compliance rate	93%	52%	90%	93%	51%	76%	98%

Table 20 (above) shows the aggregate number of each key information element provided by the 38 hospitals required to submit trustee disclosure statements. Of all (257) trustee interested transactions reported, 169 (66 percent) were from system-affiliated hospitals. Less than half of the disclosure of interest statements submitted by all hospitals were complete: only 104 (40 percent) included each of the seven key elements.

Trustee disclosure of interest reports (submitted for FY 2008 by 39 hospitals) reference transactions amounting in the aggregate to over $3.5 billion. Only 2.4 percent ($85 million) of this aggregate value was reported by trustees of independent hospitals. The magnitude of individual transactions ranged from $10,000 to almost $160 million. Transactions at the high end of this range may seem implausible unless the effect of statutory attribution rules is considered. If, for example, a hospital routinely engages in high-value transactions with another entity that is part of the same system (including, for example, another hospital, a corporation or partnership supplier of physician services, or a managed care organization) these transactions constitute reportable interests for any trustee who serves on the boards of both entities, regardless of whether the trustee has any direct or individual involvement in the transaction, and regardless of whether the trustee derives any personal benefit from it. Moreover, if the transaction is between two hospitals in the same system, the interest of a trustee who serves on the boards of both hospitals must be reported by both hospitals. The aggregate value of transactions attributed to interested trustees of all Maryland nonprofit hospitals is therefore misleadingly large because it includes values that have been multiplied by the number of trustees in common to the boards of entities on both sides of a transaction, and then doubled if both of those entities are nonprofit hospitals.

Federal Reporting Requirements for Tax-exempt Organizations – "Transactions with Interested Persons"

Organizations that are exempt from federal taxation (such as nonprofit hospitals) are required to file Federal Tax Form 990 with the Internal Revenue Service annually. Under Form 990, which was redesigned for tax year 2008, and its new Schedule L, nonprofit hospitals and other tax-exempt entities must report a broader range of business transactions by the organization with a broader range of persons and entities than formerly required. Some aspects of the new federal reporting requirements are also broader than reporting currently required by Maryland law and regulations.

Significant differences between the requirements of Form 990 and current Maryland trustee disclosure requirements include federal rules that:

- Require a tax-exempt organization to report transactions in which a trustee's only interest is through a family member;
- Include separate reporting thresholds for single and multiple transactions during a single reporting period;
- Include *former* trustees as potentially interested persons;
- Require the organization to indicate whether all trustees were provided a copy of the organization's final Form 990 prior to its filing; and
- Require a description of the extent to which trustees reviewed the completed form, the scope of the review (if any), and how it was conducted.[19]

[19] For a comprehensive discussion of Form 990's reporting requirements, see Peregrine, M. & Mills, E. 2008. Corporate Governance Emphasis in Final Form 990 Instructions, available at: http://www.greatboards.org/pubs/AHLA-MWE-Form-990-instructions-exec-summary.pdf (accessed 2/5/10)

Discussion

The magnitude of some trustee interests reported by Maryland nonprofit hospitals is not surprising considering the overstatement (for all practical purposes) that results from attribution rules and trustee membership on multiple boards, usually within the same hospital system. In many other cases, a trustee's preexisting relationship with a firm that does business with the hospital may be the reason for the trustee's initial identification by the board as a desirable trustee candidate. As discussed in chapter I of this report, effective governance requires that a hospital's board include members with certain core areas of expertise. It seems natural that boards seeking new members capable of providing such expertise would look for candidates among individuals with whom the hospital has existing business relationships, particularly when those relationships involve trust. Trustees in this category may well include individuals who are, for example, principals in firms that provide financial, legal, or other services for which the hospital, in the ordinary course of business, pays substantial consideration.