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# **The Evolving Accountability of Nonprofit Health System Boards**

Monograph Series

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## Introduction

More than 17 percent of the United States' gross domestic product currently is devoted to health care, far more than other industrialized countries for which the median figure is less than 10 percent. Health care expenditures per capita in the U.S. are about \$8,000 per year, more than twice the median figure for other industrialized nations (Commonwealth Fund, May, 2012). However, despite our large and growing investment of resources, the U.S. lags behind on many indicators of population health such as infant mortality and life expectancy, and there is abundant evidence of wide disparities in access, cost, and quality of health care services (Wennberg, 2010).

While a broad array of factors—economic, environmental, lifestyle, political, and social—contribute to this vexing paradox, much attention is being focused on the performance of non-governmental, nonprofit health systems, which are growing in numbers and provide a large proportion of all inpatient and outpatient services. Nonprofit hospitals and health systems in the private sector are regulated and/or influenced by local, state, and federal government requirements, accrediting commissions, bond rating agencies, payers, and many other external parties. Governing boards, with the assistance of their management teams, are responsible for staying abreast of this complex web of ever-changing expectations and overseeing enterprise-wide compliance with them.

As the number and size of health systems continue to grow, an increasing share of overall governance responsibility is coming to rest with the system or parent boards of these health systems. According to the American Hospital Association, more than 60 percent of our nation's community hospitals (3,007 of 4,973) are part of non-governmental, nonprofit health systems, and the proportion is growing steadily (American Hospital

Association, AHA Hospital Statistics, 2012). Moreover, an increasing share of physicians are employed or contractually integrated into systems, adding a new dimension to their complexity. According to a recent study by Accenture, Inc., the proportion of physicians in independent practice decreased from 57 percent in 2000 to 39 percent in 2012; and this trend is expected to continue (Creswell and Abelson, November 30, 2012).

We are in an era where government, the media, and society at-large are scrutinizing all nonprofit organizations more closely. In such an environment, governing and managing large, complex health care organizations poses many challenges and requires high levels of expertise. It also demands greater performance transparency, a clear understanding of accountability at all levels, and specific mechanisms for demonstrating how accountabilities are being fulfilled.

This monograph addresses the multiple accountabilities of nonprofit health system boards for the cost, quality, and safety of the services their facilities provide, the manner in which these accountabilities are being fulfilled, and issues we believe warrant attention by system leadership in order to retain and build public confidence, respect, and trust.

## Board Accountability in a Changing Environment

Broadly speaking, in organizational settings accountability involves an on-going requirement for boards and executive leaders to perform specified responsibilities properly and provide parties who have oversight responsibility with objective information regarding the extent to which these responsibilities have been accomplished and a full explanation whenever they have not. Clarity about responsibilities and mechanisms for demonstrating accountability are essential components of the foundation for effective organizational governance and management.

Lack of clarity in defining responsibilities and/or demonstrating how they have been fulfilled leads to misunderstanding and erosion of trust on the part of the internal and external stakeholders that health care boards and management serve.

Governing boards have broad accountabilities as well as specific fiduciary duties they must fulfill. For example, the state statutes under which both investor-owned and nonprofit corporations are chartered call for the governing board to have overall responsibility for the organization and the services and/or products it provides. In *all* sectors—due in part to a series of recent governance breakdowns in organizations such as British Petroleum, Hewlett-Packard, J.P. Morgan Chase, Pennsylvania State University, and Rutgers University—there is increasing interest by regulators and the public in how effectively boards are both performing their specific fiduciary duties and fulfilling their broader accountabilities to owners, stakeholders, and society at-large (Pozen, 2010; Bhaget, et. al. 2013; Morgenson, 2013).

In the health care field, the call for accountability to the public is not new. In 1918, as the number and social roles of hospitals were expanding, the American College of Surgeons stated “All hospitals are accountable to the public for their degree of success ... if the initiative is not taken by the medical profession, it will be taken by the lay public” (Bulletin of the American College of Surgeons, 1918). In the contemporary environment, the call for more transparency and fuller accountability by the governing boards of nonprofit health care organizations is becoming stronger. One reason has been growing evidence from authoritative studies showing large variations in the quality and cost of health care services from community-to-community and from institution-to-institution (Institute of Medicine, *Better Care at Lower Cost*, 2012; U. S. Department of Health and Human Services, *National Healthcare Quality Report*, 2013). The

variation is substantial, well-documented, and troublesome.

The existence of these variations is increasingly visible to state and federal regulatory authorities, payers, the media, and the public at-large. Events such as a special edition of *Time* devoted to health care costs and quality of care (March 4, 2013), books that challenge the transparency and accountability of America’s health care organizations (Makary, 2012; Gage, 2012), and the national release of comparative Medicare data by the Centers for Medicare and Medicaid Services (CMS) in May, 2013 have brightened the spotlight on the performance of America’s hospitals and health systems and on those who are responsible for them. All hospital and health system boards—in concert with their clinical and executive leadership teams—must understand national trends and the performance of the organization for which they are responsible and ensure processes are in place within their organization to continuously measure, monitor, and improve its performance.

Another factor is that growing interest in America’s health care organizations is part of a wider public concern about the effectiveness of large institutions in all sectors, such as banking, the federal government, and others. Clearly there is declining trust and growing concern about the performance of large institutions and their governance and executive leadership (Kirby, July-August, 2012). In the business sector, these developments are being translated into new challenges for boards (National Association of Corporate Directors, 2012) including, for example, legislation and regulations that put somewhat more power in the hands of shareholders to influence the election of board members, levels of executive compensation, and other corporate decisions (e.g., the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010).

In the health care field, calls for greater accountability also have become more frequent and explicit. For example, the National Association for Healthcare Quality—in conjunction with several other national associations—recently urged the leaders of America’s health care organizations to “... implement protective structures to assure accountability for integrity in quality and safety evaluation and comprehensive, transparent, accurate data collection and reporting to internal and external oversight bodies” (National Association for Healthcare Quality, 2012). The Patient Protection and Affordable Care Act of 2010 also should prompt hospital boards and their parent systems to heighten their focus on their responsibility and accountability for developing and maintaining effective quality control processes (Belmont, et. al., July, 2011).

Failure to address these issues is likely to result in closer scrutiny of nonprofit hospitals and health systems and could result in additional regulatory controls. For example, it may not be too great a stretch to envision that growing concerns about the performance of nonprofit health care organizations and their priorities could expand to reviewing the benefits they are providing to the communities they serve, ultimately leading to increasing challenges to tax-exempt status or pressures to establish “payment in lieu of taxes” requirements (e.g., “Profit Motive: The City’s UPMC Suit will Turn on One Key Factor,” *Pittsburgh Post Gazette*, March 27, 2013).

### **Categories of Board Accountabilities**

As social institutions chartered to serve the needs of their patients and communities, nonprofit hospitals and health systems and the boards that govern them have a broad array of accountabilities. These range from specific fiduciary duties and obligations to broader ethical and moral responsibilities. Governing boards have a responsibility to understand these accountabilities and, with

the advice and support of their CEOs, ensure they are met.

Accountabilities that hospital and health system boards with fiduciary responsibility must ensure are fulfilled fall into three broad categories. The first category includes accountabilities that are *mandated* by parties with financial, ownership, and/or regulatory authority. These parties—some in the private sector, some governmental—have the power to specify requirements and standards that health care organizations must meet *and* apply sanctions if they fail to do so. One form of mandated accountability involves health care institutions with a parent organization that holds ultimate legal control. For instance, in many faith-based health systems, the boards of local or “market-based” organizations are accountable to and controlled by a parent system board which, in turn, may be directly accountable to a sponsoring body such as a religious congregation or federation.

Other examples of parties to whom hospitals and health systems have mandated accountability include CMS, which establishes Conditions for Participation in the Medicare program and payment rules; state agencies with licensure and regulatory authority; and the Internal Revenue Service (IRS), which has the authority to prescribe requirements that nonprofit hospitals and systems must meet to obtain and maintain tax-exempt status. Revisions made in 2007 to the IRS Form 990, “Return of Organizations Exempt from Income Tax,” and related schedules have expanded substantially the information that must be submitted by nonprofit health care institutions and now is publicly available (Prybil and Killian, July-August, 2013).

A second category of accountabilities, while important and often essential, includes those that are *voluntary* in nature. For example, to be accredited by the Joint Commission or another accrediting body, hospitals must meet the prescribed requirements and standards, provide extensive information, and

submit to review processes, all of which can consume substantial resources. However, the vast majority of nonprofit hospitals conclude that the benefits of accreditation outweigh the costs and, therefore, elect to be accountable to the accrediting body for meeting its requirements. Similarly, hospitals that want to offer medical residencies, advanced nursing certification, and/or other formal educational programs must accept accountability to the various bodies that review and certify these programs. In the health care field, there are numerous voluntary programs of this nature, each with its own requirements, standards, and accountability protocols.

For nonprofit hospitals and health systems, these two categories of accountability involve (1) complying with many sets of requirements and standards, often duplicative and sometimes contradictory, (2) submitting large amounts of information to numerous external parties, and (3) dealing with formal sanctions, penalties, and/or criticism when any of these parties believe the hospital or health system has not fully met their particular requirements or standards. Further, these accountabilities are often fulfilled separately without any coordinating mechanism that would provide a clear picture of the full range of accountabilities and their influence on health care cost and quality or impact on meeting community needs.

Few hospital or health system boards have ready access to a complete list of the external parties to whom the organization they govern has some form of accountability, much less a solid understanding of the multiplicity of requirements those parties expect the organization to meet. Yet, in order to fulfill their stewardship responsibility on behalf of the communities their health care organizations serve, governing boards need to understand the range of voluntary accountabilities and requirements their organizations have agreed to meet in order to ensure that organizational resources are being allocated and used prudently and effectively.

The third category of board accountabilities does not relate to oversight and control by organizational entities, but rather to relationships with the community or communities the hospital or health system serves. Nonprofit hospitals and health systems are created and exist principally to serve communities by providing health care services to those in need. As noted above, the governing board, working in concert with the organization's management team, acts in a stewardship capacity to ensure that the organization's resources—which the board holds in trust for the community and other stakeholders—are employed prudently to meet the health care needs of the people the organization is chartered to serve. The challenge is that—unlike regulatory agencies, accrediting bodies, payers, and other organizational entities to which nonprofit hospitals and systems are accountable—the community or communities served generally have not established formal requirements or expectations for nonprofit health organizations. Therefore, solid mechanisms or procedures typically are not in place to demonstrate the health care organization's accountability to the community.

This reality is reflected in a recent study of governance structures, processes, and practices in 14 of this country's 15 largest nonprofit health systems (Prybil, et. al., 2012). Nine of these 14 systems are controlled by and accountable to a particular religious body or entity. In each of these faith-based systems, the nature of that relationship and the mechanisms through which the system boards are required to fulfill their accountability are spelled out in corporate bylaws and/or other legal documents. This study found the board leaders and CEOs of these nine systems are well-aware of these provisions and mechanisms. Four of the five secular systems in this study population are independent organizations that do not have a parent organization or entity to whom they are accountable. The fifth is a state-chartered hospital authority model in which the board is

essentially independent of governmental controls.

In nearly all of these large health systems, both faith-based and secular, their bylaws, mission statements, and/or corporate policies express commitment to *identifying and meeting the health care needs of the communities and/or populations their institutions serve*. While the wording varies from system to system, these documents consistently reflect corporate responsibility for fulfilling this commitment. This was affirmed by a large proportion of the systems' trustees and CEOs interviewed during site visits. However, in almost every case, the precise nature of the systems' accountability to the communities they serve and the protocols by which their accountability should be fulfilled are not codified in any formal fashion. In the interview process, many board members and CEOs acknowledged this is a gap in their current corporate model which warrants attention.

Comparable information regarding the current policies and practices of other nonprofit health systems is not available. However, based on the authors' collective experience in working with numerous systems throughout the country, it is our view that, at this time, few have clearly defined the nature and extent of their accountability to the communities or populations they serve or established formal protocols for fulfilling that accountability. Their absence invites questions and criticism by the media and the public at-large.

### **Enhancing Board Accountability to the Communities They Serve**

In the world of investor-owned companies, there is growing debate about the role of shareholders, the investors who hold an ownership position. The box on the right suggests several questions now being raised about their role and influence.

In the large and growing sector of non-governmental, nonprofit organizations, similar questions are being raised (see box on page 10).

It is clear that the American public wants more transparency and accountability from the large institutions, both public and private, in which they are stakeholders or shareholders. In the health care field—with or without leadership by nonprofit hospitals and health systems—the availability of information about the cost, price, and quality of services is growing. The public availability of the increasingly detailed IRS Form 990 and related schedules; the ground-breaking work of Dr. John Wennberg and his colleagues in creating the Dartmouth Atlas Project and establishing the Foundation of Informed Medical Decision Making; the recent release of extensive Medicare pricing data by CMS; and investigative reporting by media around the country are among the developments dramatically expanding the volume of information available to the public at-large.

#### **Sidebar**

##### **The Evolving Role of Shareholders**

- How should shareholder voices be heard by those who govern and manage investor-owned organizations?
- What level of influence should shareholders have in the appointment and re-appointment of board members, the selection and retention of CEOs and other corporate decisions?
- What are the merits of quarterly earnings and current stock prices as key metrics for judging board and CEO effectiveness in relation to longer-term performance metrics?

*Sources: Protes and Lewis, June 8, 2012; Iannelli, April 18, 2013.*

In addition, the Patient Protection and Affordable Care Act amended the IRS Code by adding Section 501(r). It requires every hospital operated by a 501(c)(3) organization to conduct a “community health needs assessment” with input from those who represent the broad interests of the community or communities it serves (including those with public health expertise) at least every three years, develop implementation strategies to address the community needs identified through that process, and make the results widely available to the public. The IRS rulemaking process will not be completed until the autumn of 2013 or later, but it is clear the outcome will be new requirements to strengthen hospital collaboration with public health agencies and others in the community; increase the public visibility of hospital priorities and plans for addressing community health needs; and, at least indirectly, provide a new and potentially important mechanism for hospitals’ accountability to the

communities they serve. The identification, prioritization, and publication of community health needs and strategies for addressing them will provide a basis for community leaders and citizens at-large to ask for regular progress reports, if they are not already receiving them. For this and other reasons, it is highly advisable for nonprofit hospitals and health system boards to have a standing committee with oversight responsibility for the organization’s community benefit policies and programs (Prybil, et. al., 2012).

It seems certain that the trend toward these and other forms of involuntary transparency will continue (Rivkin and Seitel, 2011). However, the mere availability of more information—particularly information about complex subjects such as the cost and quality of health care services, the impact these services are having on population health, and the community benefit provided by health care organizations—is insufficient to build public understanding or provide a solid basis for organizational accountability to the community or communities the organization exists to serve. For many citizens, this information can be difficult to interpret and comprehend without advice and assistance. Availability of information does not readily translate into good understanding of that information.

Yet, the growing body of evidence demonstrating wide variation in the cost, prices, and quality of health care services across the U.S. coupled with rapidly increasing availability of information about these patterns clearly is contributing to public concerns about the efficiency of America’s health care organizations and the effectiveness of their clinical, executive, and governance leadership. Reports by prestigious institutions that conclude a substantial portion of our nation’s health care expenditures is spent on services that are unneeded and/or inappropriate (Institute of Medicine, *Better Care at Lower Cost*, 2012) and highly critical reports on the cost and pricing of these services (e.g., “The Murky World of Hospital Prices”, *The New York*

## Sidebar

### Accountability to the Community

- What information should be provided to the communities that nonprofit health care organizations are chartered to serve? By whom, and in what form?
- What mechanisms should exist to enable communities to understand the policies, priorities, and performance of nonprofit organizations?
- What degree of transparency is appropriate and what ability, if any, should the communities have to influence these policies and priorities?

Sources: Schlesinger and Gray, 2006; Birk, 2010.

*Times*, May 17, 2013) are contributing directly to public concerns and distrust of our nation's health care institutions. No one can understand why prices for the same procedures for similar patients, adjusted for differences in cost of living in various locations, should vary by 100 percent or, in many cases, even more.

These developments create both challenges and opportunities for the governing boards of America's nonprofit health systems, the systems that provide a large and growing share of hospital and medical services to the American public. The challenges include, first, the need to become more intentional, forthright, and proactive in sharing information about their priorities and performance with the communities they serve, the media, and other stakeholders. If they haven't already done so, the governing boards of nonprofit health systems, with the support of their CEO and clinical leaders, should develop policies and programs that deliberately and strategically increase their level of transparency with external and internal constituencies. These policies and programs should be designed to build their stakeholders' understanding, support, and trust. Several health systems already have taken such actions. For example, Norton Healthcare, a nonprofit health system based in Louisville, Kentucky, for several years has posted comprehensive, system-wide information—including clinical and financial targets and operating performance—on a website which is publicly available (<http://www.NortonHealthcare.com>). Kaiser Foundation Hospitals and Health Plan, a large nonprofit health system based in Oakland, California, has developed pace-setting community benefit policies and programs for which a standing board committee provides direction and oversight; Kaiser's board and executive leadership have insisted on full transparency of the system's community benefit programs and performance at a publicly available website (<http://www.kp.org/communitybenefit>). Health systems that do not adopt a proactive stance on transparency are, in effect, allowing the

media and other external parties to take the leadership role in informing and educating their key stakeholders and the community at-large. For many reasons, this is a risky strategy (Rivkin and Seitel, 2011).

A second major challenge for the governing boards of nonprofit health systems is to examine and re-define the nature of their accountability to the communities their institutions serve and how, in the contemporary environment, they should fulfill that accountability. For years, it has been customary for many, perhaps most, nonprofit hospitals and health systems to declare that they are accountable to the "communities and populations they serve" in their bylaws, mission statements, and other corporate documents. However, it is clear that methods for reaching out and systematically defining community expectations *and* mechanisms and metrics for accountability often are under-developed and imprecise. For instance, annual reports in the form of free-standing documents made available to external and internal constituencies and/or special sections in local newspapers can be useful tools for disseminating information and increasing transparency, but have limited value as a mechanism for meeting an organization's commitment to be "accountable" to the communities or populations it serves.

For geographically dispersed health systems, growth and structural changes can complicate the challenges inherent in striving to be accountable to the communities they serve. Expansion into new locations through acquisition or start-ups creates a need to establish communication channels, identify and address community needs and expectations, and build mutual understanding and trust. The governance model for most multi-unit health systems traditionally included multiple governing boards with defined duties. Governing boards at the local level retained some decision-making authority and were largely composed of members from the communities served. These boards were

typically viewed as an important source of community input and linkage to the community. There are many strategies and tools for building communications, understanding, and trust between health care organizations and the communities they serve. Having a governing board composed of community members, establishing advisory councils and conducting community forums for two-way communication are some examples. However, when health systems move toward “operating company” models and eliminate or substantially diminish governance presence at the local hospital level, the system can no longer rely upon the local hospital boards to be a primary link for communications with and accountability to the particular communities and populations those institutions serve. The impact of new health system operating models on the governance of these systems and on linkages and accountability to local communities served is beginning to be discussed more broadly in the health care governance literature (AHA’s Center for Healthcare Governance, 2012) and deserves careful consideration by health system leaders and boards as operating models change and evolve.

So, for the governing board and CEO of a nonprofit health system, fundamental questions include: In an increasingly complex health care environment with escalating demands for health care providers to improve the quality of patient care and control costs:

- What is the nature and scope of the system’s accountability to the communities and populations it exists to serve?
- What mechanisms are in place to fulfill that accountability, and are they sufficient to build and maintain the public’s understanding, trust, and support?
- How can these mechanisms be improved?

Some health care organizations have addressed these issues and developed new accountability models and mechanisms. For example, Inova Loudoun Hospital has created

a “Quality Compact”—a formal, written commitment signed by the CEO, the board chair, the medical staff president, and the chief nurse executive—that expresses a *public commitment* to the community regarding actions that will be taken to improve the institution’s performance with respect to patient care quality and safety. This document has been posted on the institution’s website (<http://www.inova.org/upload/docs/Quality/ILH/Inova-Loudoun-Hospital-Quality-Compact.pdf>), along with progress reports. This Quality Compact and transparency in sharing the institution’s quality targets and its performance in relation to them reflect the board’s commitment to being accountable to the community the institution serves (Pophal, 2013). Inova Loudoun Hospital’s Quality Compact and a sample “Board Accountability Policy” developed by the authors in concert with AHA’s Center for Healthcare Governance staff (see Model Policy on pages 14 and 15) can be useful as background material for board discussion.

## Conclusions

We are in an era where governmental bodies with regulatory and/or oversight responsibilities, the media, and society at-large are scrutinizing all nonprofit organizations more closely than ever before. In this context, nationwide concerns regarding access, cost, and quality of health care services are focusing attention on the performance of nonprofit health systems, systems which are growing in numbers and size and are providing an increasing proportion of these services. These health systems have a broad array of mandated and voluntary accountabilities that collectively comprise an uncoordinated mosaic of requirements and reports, the overall impact of which boards themselves and certainly the communities they serve may be largely unaware.

The governing boards of America's nonprofit health systems are responsible for examining the cost, prices, and quality of the services their facilities provide, understanding how their performance compares to comparable organizations and contemporary standards, and insisting on continuous evaluation and improvement. It is our belief that these nonprofit boards have an ethical accountability to demonstrate to the communities and populations their systems serve how they are meeting these responsibilities, how the organizations they govern are performing, whether or not their performance is improving, and why or why not. We further believe that, at this time, the mechanisms for fulfilling this accountability largely are underdeveloped and inadequate.

We believe it is time for America's nonprofit health systems to review, renew, and strengthen their social contract with the communities and populations they exist to serve. We recommend that governing boards of all nonprofit health systems—as a strategic priority—devote attention to a truly objective assessment of their present philosophy, policies, and practices regarding accountability to those communities and populations. Issues the board should consider in this assessment are listed in the sidebar on the right.

Discussing these questions will illuminate the board's current views and the system's current practices regarding accountability to the communities and populations it serves. The answers will guide the future development of system-wide policies and assist in improving the system's mechanisms for fulfilling its accountability to them. Done well, these actions will help to build public understanding, trust, and support for the system, its mission, and its leadership. Without these actions, we fear nonprofit health care organizations will be vulnerable to greater external scrutiny, erosion of public confidence, and more regulatory requirements and controls by governmental agencies.

## Sidebar

### Accountability Questions for Boards

- How does the system and its local organizations determine the needs and expectations of the people in their service areas?
- How are these needs and expectations prioritized and by whom? Is the board involved in this process and are the outcomes employed in shaping the system's strategic plans?
- Are these priorities and plans made available to the public and, if so, are feedback and questions sought and welcomed?
- Has the board and its management team considered and adopted the use of contemporary social media to strengthen the bonds of communication and understanding with key stakeholders? If not, why not?
- Are the system's quality and cost targets and its performance in relation to these targets and to external benchmarks shared and explained in a transparent manner?
- Does the board understand it is accountable to the communities and populations its system serves? If so, has the board adopted a formal policy statement on its accountability to these communities and populations and has it established system-wide policies and mechanisms to meet its commitments? If not, why not?

## **Model Policy Statement on Nonprofit Health System Board Accountability**

It is the policy of the board of \_\_\_\_\_ (insert Name) to be accountable to the public, communities it serves, patients and the organization it governs. This accountability is essential to preserve and build organizational and public trust. This covenant between the board and the public is established to help insure that the system and its hospitals are serving the public good.

The board will be intentional and diligent in maintaining its accountability. The board recognizes its accountability to the following constituents:

### **To Communities We Serve**

For governing with commitment, diligence and integrity to further the purposes for which the system was created and to achieve the mission and vision

For understanding the overall health needs of the communities we serve, establishing long range plans for meeting those needs and providing access to care within the resources available

For acting as a responsible corporate citizen to further the overall welfare of the communities we serve, to maintain community benefit programs and to be good stewards of community resources

For providing transparent communication on the plans, programs, and performance of the system and for enabling effective community input to the board

For improving the health of the communities served through services, advocacy, communications, education, planning and collaboration with partners

### **To Patients We Serve**

For accessible, safe, science-based, efficient, respectful and culturally competent patient and family-centered care

For coordinating patient care and educating and informing patients through the network of providers treating and supporting the patient and their family

For respecting the role of patients in decision making about treatment choices and recognizing all the rights of patients as spelled out in A Patient's Bill of Rights adopted by this board

For engaging and supporting individuals and families in their quest for optimal health through proactive prevention, wellness and community health programs

## **To The Organization**

For always acting in good faith to protect the system's assets, improve its performance, and provide the communities it serves and sponsors with accurate, complete, and timely information about the state of the organization and plans for the future

For assuring the board's composition represents the diversity of the communities served

For conducting board business in a culture of openness, trust, debate and respectful dissent, forthright examination of all relevant issues and to strive for a consensual approach to decision-making

For adhering to the system's philosophy and values and ensuring all matters of the corporation are conducted with integrity and avoidance of fraud, and for being transparent about any board conflicts of interest

For conducting regular assessments of the board and its performance, to take action based on the assessment and make changes that will improve the board's performance, and to conduct on-going board education and development

For appointing a highly committed and capable system CEO, ensuring that an effective management team is in place throughout the system, and administering compensation programs that are fair, justified and transparent

For providing to employees, physicians, researchers, students and volunteers an environment that supports and enables collaboration, productive relationships and the highest quality performance and outcomes for patients

## **To the Regulatory Bodies, Media, Payers and The Public At-Large**

For governing the organization in accordance with the Articles of Incorporation, bylaws and policies of the corporation

For assuring the governance and operation of the organization is in compliance with applicable law and regulation at the national, state, and local levels

For transparency in reporting how patient safety, clinical service quality, pricing and cost of care compare with known regional and national quality and cost performance standards, to explain performance variation from standards and to report on efforts to improve performance of the system

For effective use of funds provided by payers for services rendered and provided by donors

For collaboration and leadership in developing value-based payment and care delivery systems that will enhance appropriate, effective and efficient care

Chair-Board of Trustees

Chief Executive Officer

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