

## Chapter 10: The Governance of New Jersey Hospitals

### Key Points

- **Nearly all New Jersey hospitals are non-profit institutions – while many of these non-profit boards have exercised effective oversight and governance, some have failed to keep pace with best practices for non-profit governance. This has negatively affected hospital performance in some instances.**
- **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.**
- **Transparency helps ensure community accountability. Hospital boards should maximize transparency of financial performance data and measures of clinical quality.**
- **Conflicts of interest can threaten the integrity of the governance process. Hospital boards should have strong and explicit conflict of interest policies.**
- **Effective oversight requires that hospital boards are adequately trained and engage in best practices for financial oversight. Hospital boards should establish effective training programs and follow best practices for hospitals in audit and compliance committees.**
- **General principles of fiscal responsibility and transparent governance may be derived from principles articulated in the Sarbanes-Oxley Act of 2002. The Department of Health and Senior Services should review those principles and require that hospitals adopt those practices appropriate to hospital governance.**

Many New Jersey hospitals are facing crises for reasons external to the institutions themselves. As the Commission discusses elsewhere in this Report, shifts in the structure of health care delivery and shortfalls in payment from important funding sources have created new burdens for hospitals nationally. Hospitals' problems are not always external. In some instances, the governance of hospitals may not have kept pace with changes in the industry or the broader economy; in others, hospital governance itself may be at fault for institutional distress and even failure. In his classic "Burning the Seed Corn" (1996) health policy analysts Jeff C. Goldsmith chronicled how during the 1990s many hospital Boards in California presided over the

spending of hospital reserves to prop up physician incomes and perpetuate redundant hospital capacity.<sup>95</sup> In their "The Fall of the House of AHERF: The Allegheny bankruptcy" (2000) Lawton R. Burns et al. offer as a lesson for Boards and managers a trenchant analysis of the rise and fall of one of America's largest non-profit health systems.<sup>96</sup> In their "Corporate Structure and Capital Strategy at Catholic Health Care West" (2006)

<sup>95</sup> Jeff. C. Goldsmith, "Burning the Seed Corn," *Healthcare Forum Journal* (March/April, 1996): 19-23.

<sup>96</sup> L R Burns, J Cacciamani, J Clement, and W Aquino, "The fall of the house of AHERF: the Allegheny bankruptcy," *Health Affairs*, January/February 2000; 19(1): 7-41.

James C. Robinson and Sandra Dratler conclude that “The ‘trust me’ era of nonprofit accountability is being replaced by an attitude of ‘trust but verify’.”<sup>97</sup>

Recognizing that most factors creating the dire position of many New Jersey hospitals are external, the Commission nevertheless determined that it must address the governance of our overwhelmingly nonprofit hospitals for two reasons:

- The management and long-term planning of nonprofit hospitals is governed by unpaid boards of directors, comprising community volunteers. A discussion of the health of New Jersey hospitals would be incomplete were these essential bodies ignored.
- Recent New Jersey history shows that communities may on occasion be ill-served when the nonprofit boards follow paths that drive their hospitals unnecessarily to significant fiscal difficulty. This history suggests that poor decision-making may be traceable to failures of institutions to ensure that board members have access to key information in a timely fashion, and to subversion of proper board oversight rules by the excessive empowerment of small cliques of board members or hospital management.

Many New Jersey hospital boards have adapted to recent decades’ transformation of the business of nonprofit hospitals. They are populated by dedicated members who are regularly provided with detailed information on their hospitals’ performance in patient care, financial stability, and community service. They have tracked the changes in hospital structure, payer reimbursement, and product line competition. In New Jersey, as elsewhere in the United States, this adaptation is not universal. Good governance is central to the success of New Jersey’s hospitals. The Commission recommends in some instances that all New Jersey hospital boards be encouraged to adopt “best practices” – methods of governance commensurate with their sophisticated range of obligations. In other instances, the Commission recommends that the adoption of methods

be made obligatory and that the Department of Health and Senior Services update its regulations to mandate certain governance measures.

## I. History

### A. Hospital Boards as Stewards of Local Charities

Fifty years ago, nonprofit hospitals operated as local community charities, and as workshops for local physicians. The scope of the operations of the hospitals was modest by modern standards. Boards of directors, made up of local businesspeople and professionals, served the important but relatively straight-forward roles common to the governance of other community charities. Directors raised charitable donations (then a more significant source of hospital revenue), encouraged volunteer participation in hospital life, and lightly oversaw the activities of a management that was lean and uncomplicated by today’s standards.

The hospital was more charity than business. The law imposed few duties on the directors. They were not responsible for the quality of care delivered by the hospitals’ employed nurses or the competence of the private physicians who used the hospitals as extensions of their private practices. Hospitals required little in the way of legal counsel – an attorney serving on the board was generally sufficient to handle minor matters that arose. Hospitals often reflected their neighborhood, and community residents came to believe the hospital they used was in a very real sense “theirs.” This halcyon state of affairs was possible because medicine was genuinely simpler then, requiring less in the way of expensive equipment and specialized technical personnel. Perhaps most significantly, medicine, and therefore hospitals, occupied a small footprint in the economy; care was relatively cheap, structures of reimbursement were rudimentary (frequently involving patient self-payment), and finances of the operation were too minor to draw significant notice of government, business, or even the commercial payers – such as they were.

<sup>97</sup> James C. Robinson and Sandra Dratler, “Corporate Structure And Capital Strategy At Catholic Healthcare West,” *Health Affairs*, January/February 2006; 25(1): 134-147.

## B. From Charity to Big Business: Protecting Patients' and the Community's Interests

The surge in health care sophistication has brought many changes in hospitals, including increasing demands on nonprofit boards. With professional and technological advances – as, that is, medicine was capable of doing more for patients – came increasing prominence of third-party payment. Medicare, Medicaid, and the proliferation of commercial insurance brought more funding into hospitals. No longer just community charities, hospitals increasingly became big businesses. Even relatively modest community hospitals realized revenues of hundreds of millions of dollars a year. Larger hospitals and health systems generated billions of dollars each year. The scale of their business rendered hospitals even more significant engines of employment and commerce. As medicine, and therefore hospitals, could do more for patients, expectations for high-quality, technically proficient care increased.

With these changes have come increased demands on hospital boards. Recent events have focused attention on the quality of performance by hospital boards. The United States Senate,<sup>98</sup> IRS<sup>99</sup> and lenders have been particularly vocal in the last two years about nonprofit hospital boards' need to reform their governance practices. In addition, some state courts and Attorneys General have examined boards' conduct with increased scrutiny.<sup>100</sup> The passage of the Sarbanes-Oxley Act<sup>101</sup> focused significant attention on business enterprises which has trickled down to nonprofits, especially hospitals. Hospitals have been particularly in the

spotlight both because they are important to health and welfare and because they tend to be very large, complex enterprises. Many “best practice” recommendations for improved corporate governance have already been adopted by New Jersey hospitals, although this adoption has apparently not been universal. Taken together, these sources of guidance suggest several categories of structure that could be incorporated in New Jersey hospital regulation to ensure appropriate governance of these important community resources.

## II. Proposed Governance Reforms

Many New Jersey hospital boards are well-organized, well-run, and successful. It is clear, however, that there is a need to ensure that *all* of our non-profit hospital boards meet basic standards of competence, transparency, and community service. It may be that many boards already meet or exceed the standards set out below. Regulation of these important community resources is irresponsible, however, if it does not insist that *all* boards meet the minimum standards driving these recommendations.

Our concern in this regard finds resonance in the work of many governmental and professional voices that have recently expressed concern that too many members of nonprofit hospital boards are not serving their communities properly. One pithy set of recommendations has been provided by former Massachusetts Attorney General Tom Reilly.<sup>102</sup> It sets out guidelines in a thoughtful and useful manner, and we reproduce it below:

<sup>98</sup> Senate Finance Committee, Exempt Status Reforms, (Staff Discussion Draft 2006), available at [www.senate.gov/~finance/hearings/testimony/2004test/062204stfdis.pdf](http://www.senate.gov/~finance/hearings/testimony/2004test/062204stfdis.pdf) (last visited Oct. 20, 2007).

<sup>99</sup> Available at [http://www.irs.gov/pub/irs-tege/good\\_governance\\_practices.pdf](http://www.irs.gov/pub/irs-tege/good_governance_practices.pdf) (last visited Oct. 20, 2007) (the IRS opines that boards following good governance practices are more likely to pursue an exempt purpose, act for the public's interest, and avoid pursuit of private interests).

<sup>100</sup> See David M. Studdart *et al.*, *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 NEW ENG. J. MED. 625 (2007); Thomas L. Greaney and Kathleen M. Boozang, *Mission, Margin, and Trust in the Nonprofit Health Care Enterprise*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 1 (2005).

<sup>101</sup> Public Company Accounting Reform and Investor Protection Act of 2002 (“Sarbanes-Oxley Act”), P.L. 107-204, 116 Stat. 745.

<sup>102</sup> Attorney General Tom Reilly's 10 Practical Tips for Non-Profit Hospital Boards, available at <http://www.lawrenceassociates.com/Files/MA%20AG%20Tips%20for%20Hospitals.pdf>.



## 10 Practical Tips for Non-Profit Hospital Boards

- 1 **Hold management accountable.** The board should set benchmarks, and the board must ask about benchmarks not met, deadlines missed, and failure to meet budget projections. If the initial inquiry raises new questions, the board should pursue those new questions as well. The board needs full information in order to act decisively.
- 2 **Monitor the cash available to the hospital.** Scrutinizing an income statement is important, but to accurately track the financial health of the institution, particularly a distressed hospital, the board should also follow the cash.
- 3 **Include the entire board in key decisions.** The various constituencies within the hospital must work together and make decisions together; the board should not be dominated by a single person or a small group of insiders. Providing for a diverse board and implementing term limits for trustees will, in most cases, aid efforts to create a wholly engaged, fully active board that can better deal with the ever-changing array of challenges facing hospitals.
- 4 **Establish a strong conflict of interest policy and follow it.** A majority of the board should not have conflicts, even if those conflicts are disclosed and properly dealt with upon board votes.
- 5 **Provide meaningful orientation and continuing education programs.** New trustees need effective, comprehensive, and up-to-date orientation programs and materials. All trustees need broad information about the hospital's current situation, history, environment, and strategic plan in order to make informed decisions.
- 6 **Hold regular meetings focused on setting policy** in areas such as safety, quality, and strategic concerns.
- 7 **Establish a three to five year strategic plan with a three to five year budget.** The board needs to know where it is going, establish benchmarks to measure progress toward its goals, review whether it is meeting those benchmarks, and have contingency plans ready in case progress falters.
- 8 **Do not approve a budget that results in an operating deficit,** except in very unusual circumstances. When a hospital does fall into a deficit situation, the board and management should develop plans to regain profitability as soon as possible, and almost always within three years. Financially distressed hospitals must also develop short-term (monthly or quarterly) recovery plans, budgets, benchmarks, and contingency plans.
- 9 **Focus on the performance of the organization,** rather than on proposed transactions with external parties. The board needs to concentrate on internal steps that the organization can take to improve its efficiency, cut its costs, and improve its quality and safety. This focus is most important for financially distressed hospitals. The board should begin by improving what it can at home, and then look to outside opportunities.
- 10 **Do not expect the institution to grow its way out of problems.** The strategic plan must look beyond growth to find other ways to strengthen performance.

Many of these points are quite properly framed as recommendations. Members of boards are people of good will, often devoting many hours each month to their institutions. We recommend, however, that the New Jersey Department of Health and Senior Services impose regulatory obligations on hospital boards in three areas: board composition and education; required board activities; and public disclosure/transparency.<sup>103</sup>

### A. Board composition and education

Hospital boards must be efficiently functioning bodies. Board members have trouble functioning effectively or engaging wholeheartedly when boards are too large. The recent trend in board membership is to limit the size of boards. In addition, extremely long-term board membership limits member effectiveness, reduces independence from management, and constrains the power of innovation. We therefore recommend:

#### Recommended Best Practices:

- Hospital boards should be limited in size proportionate to the scope of its enterprise, but ordinarily to no more than 20 members.
- Members should serve fixed terms of three years.
- Members should be limited to three consecutive three-year terms, and may be reappointed to another term only after a three year period off the board.
- The terms of board members should be staggered to foster continuity.

Boards should be populated with two considerations in mind: representation of key stakeholders, and access to expertise necessary to accomplish board business. Target stakeholders should include community members, physicians, employees, and patients. Targeted expertise should include health care quality and delivery, financial and accounting, legal, and patient advocacy. Many boards' director nomination procedures are entirely internal and closed, and are not likely to surface

<sup>103</sup>The implementation of many of these recommendations is within the current authority of the Department. If the Department lacks current authority to regulate in these areas, we recommend that the New Jersey Legislature empower the Department to do so.

candidates not already known to current board members. To serve representational and expertise goals, and to provide opportunities for community involvement in the composition of the hospital's governing body, the Department's regulations should be amended to require boards to adopt the following procedures:

**Recommended Regulatory Adoptions:**

- The board should 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.
- Potential board members should complete an application that identifies the extent to which the candidate meets the criteria set by the board; assures the candidate's commitment to the hospital's mission; provides references; and identifies any possible conflicts that may interfere with the candidate's board service.
- The candidate may not be, or have a conflicted relationship with, the hospital's auditor.<sup>104</sup>
- The board should explore the feasibility of including an employee as a member.

The nominating committee should clearly convey to candidates what the service expectations will be. The Commission recommends that boards adopt practices providing the following information:

<sup>104</sup>Accountants are ethically prohibited by their own code from serving on the boards of entities for which they perform audits. The Code of Professional Conduct of the American Institute of Certified Public Accountants [hereinafter AICPA] rule on independence prohibits transactions, interests, and relationships that impair the member's independence; directorships are expressly prohibited under the rule. The NYSE precludes from service as a director one who is "affiliated with or employed by . . . a present or former internal or external auditor of the company . . . until three years after the end of the affiliation or the employment or auditing relationship." Listed Company Manual § 303A.02(b)(iii)(A) available at: [http://www.nyse.com/Frameset.html?nyseref=http%3A//www.nyse.com/regulation/listed/1182508124422.html&displayPage=/lcm/lcm\\_secti\\_on.html](http://www.nyse.com/Frameset.html?nyseref=http%3A//www.nyse.com/regulation/listed/1182508124422.html&displayPage=/lcm/lcm_secti_on.html). See generally, *Developments in the Law, And Now, the Independent Director: Have Congress, the NYSE, and NASDAQ Finally Figured Out How to Make the Independent Director Actually Work?*, 117 HARV. L. REV. 2181, 2190 (2004).

**Recommended Best Practices:**

- Attendance at a general orientation on nonprofit governance (as required by New Jersey law<sup>105</sup>) as well as an orientation specific to the entity s/he will be serving;
- Number of hours per month required to prepare for and attend meetings;
- That the board member will be automatically terminated upon
  - absence from a certain percentage of meetings, or
  - failure to comply with the conflict of interest policy;
- Directors are often required to contribute financially to the hospital as a condition of service. Such a requirement should not be a necessary condition of membership on a hospital board.

Upon appointment, and prior to orientation, directors should be provided with information necessary for their successful service in a properly organized board book or similar mechanism (e.g. dedicated webpage). This information is listed below.

**Recommended Best Practices**

- The entity's most recent annual report to the Secretary of State, audited financial statement and Form 990.
- An organizational chart, the names and contact information for every corporate member, director and officer, the identity and contact information for the board "staff person", and the composition of each board committee.
- The articles of incorporation and corporate bylaws.
- The medical staff bylaws.
- The charters for each committee to which the director is assigned, as well as the Joint Commission standards that apply to that committee's work.
- The prior year's board minutes as well as the minutes of each committee to which the board member is assigned.
- The names of hospital and medical staff leadership as well as general descriptive information including the number of beds and available services.
- The hospital's code of ethics.
- The hospital's corporate compliance and whistleblower protection policy.

<sup>105</sup>N.J.S.A.26:24-12.34.

The Commission considered whether nonprofit board members should or may be compensated for their services. The IRS's draft Good Governance Guidelines, which takes the position that "charities should generally not compensate persons for service on the board," has been criticized in some quarters. The Independent Sector's recently-published Principles of Good Governance and Ethical Practice also discourages director compensation. In addition, New Jersey nonprofit corporate law weakens director immunity from liability for directors receiving compensation.<sup>106</sup> On the other hand, some have urged that compensation of directors is appropriate in certain circumstances in which the board needs access to a scarce pool of experts, who may be unwilling to serve without compensation. It is estimated that only two percent of nonprofits nationally compensate board members. Health care organizations (particularly larger organizations) are more likely to compensate directors, although even in that setting the practice is rare. A recent Urban Institute Survey found no correlation between director compensation and board engagement.<sup>107</sup> At this time, the Commission was not ready to recommend payment, although the issue might be explored further.

## B. Board Functions

Many of the board's most essential functions – assuring the quality of patient care – are already codified in regulations and standards of the Department of Health and Senior Services, the Centers for Medicare and Medicaid Services, and the Joint Commission. Some additional financial and ethical standards have been recommended in recent years. Many New Jersey hospital boards have adopted most or all of these recommended procedures; all should do so. Hospital boards should be required to:

### **Recommended Regulatory Adoptions:**

- Establish and adopt a written conflict of interest policy and procedure for board members.
- Create and disseminate to all employees a written whistleblower policy.
- Create and adopt a written document retention and destruction policy.
- Review and approve the Form 990 prior to its submission to the IRS.

There has been much discussion recently regarding the benefits of State involvement in ensuring that hospitals in New Jersey are operating with reasonable financial security. This Report discusses a proposed State role in creating and implementing an "early warning system" that would engage hospital boards in situations in which key indicators suggest severe financial distress. This "early warning system" is described in detail in Chapter 15 of this Report. All members of the board should be informed of this system, and information on this system should be included in the orientation of new board members.

Board bylaws should provide for the creation and operation of an Audit and Compliance Committee. In particular, the regulations should require the following structure:

### **Recommended Regulatory Adoptions:**

- Audit and Compliance Committee<sup>108</sup>
  - Comprised of independent (non-employee) members.
  - Governed by a charter enumerating its duties to oversee and ensure the existence of reliable internal financial controls, receive complaints or concerns from the internal auditors, and oversee the annual independent audit.<sup>109</sup>
  - Vested with the authority to select an independent auditor, receive the audit letter at the conclusion of the audit, and retain its own legal counsel.<sup>110</sup>
  - Ensures rotation of the audit partner or firm every four years.
  - Meets with the audit firm in executive session to, at a minimum, discuss the audit letter.
  - Ensures that the Compensation Committee has reviewed key officers' compensation packages, including (non-qualified) deferred compensation

<sup>106</sup>N.J. STAT. ANN. § 15A:6-14 provides that trustees who serves without compensation shall "not be personally liable to the corporation or its members for damages for breach of duty as a trustee," irrespective of the protections enumerated in the certificates of incorporation.

<sup>107</sup>Francie Ostrower, *Nonprofit Governance in the United States: Findings on Performance and Accountability from the First National Representative Study*, The Urban Institute Center on Nonprofits and Philanthropy at 11, available at [http://www.urban.org/Uploaded PDF/411479\\_Nonprofit\\_Governance.pdf](http://www.urban.org/UploadedPDF/411479_Nonprofit_Governance.pdf) (last visited July 8, 2007).



and income from other sources for hospital work, as well as non-taxable fringe benefits and expense reimbursements over certain amounts.<sup>111</sup>

- 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.

The retention of experts essential to assist the board in decision-making is a core function of a governing board. New Jersey law insulates board and committee members from liability “if, acting in good faith, they rely on the opinion of counsel for the corporation or upon written reports setting forth financial data concerning the corporation and prepared by an independent public accountant or certified public accountant or firm of accountants...”<sup>112</sup> The legislature’s conferral of protection in such circumstances signals that directors should oversee the selection of these individuals or firms to ensure quality and independence, and to ensure that such experts do not serve dual roles as directors. Such governance norms should include requiring that:

**Recommended Best Practices:**

- The board should review and approve management’s recommendation of legal counsel to the hospital.
- Management should fully discuss the process for retention of the hospital’s legal counsel when seeking board approval.

<sup>108</sup>See generally, Ellen P. Aprill, *What Critiques of Sarbanes-Oxley Can Teach about Regulation of Nonprofit Governance* 8 available at <http://ssrn.com/abstract=952563> (Jan. 2007) (surveying the recommendations of various entities).

<sup>109</sup>California, for example, requires nonprofit entities with annual revenue in excess of \$2 million to undergo annual audits by an independent accountant, overseen by a board audit committee. The audit must be disclosed to the public and the California attorney general. Nonprofit Integrity Act, Cal. S.B. 1262. See also, MASS. GEN. LAWS ANN. Ch. 12, § 8F (West 2006) (public charities whose annual revenues exceed \$500,000 to file audited financial statements with the Public Charities Division); N.H. REV. STAT. ANN. § 7:28 (2006) (requires charities with an excess of \$500,000 revenues to file audited financial statements with attorney general). In 2005, four states, Arizona, Colorado, Connecticut and Kansas enacted legislation addressing charitable organization financial disclosure and auditing. Ariz. S.B. 156; Colo. Legis. Serv. Ch 290 (2005) (S.B. 05-205); 2005 Conn. Legis. Serv. P.A. 05-101 (S.B.946); 2005 Kan. Sess. Laws Ch. 83 (S.B. 121).

In addition, the Department should mandate the following through regulation:

**Recommended Regulatory Adoptions:**

- Any contribution received from a vendor or contractor to the hospital should be reported to the hospital board.
- Legal counsel may not also serve as a director<sup>113</sup>.

**C. Transparency**

Transparency is essential to successful governance and service to the community. Transparency norms should address openness between management and the board, between board committees and the board as a whole, between the nonprofit hospital and the community which it serves, and between relevant agencies and stakeholders and the nonprofit hospital. Non-profit governance is most accurately described as one governed by confidentiality rather than transparency – regulations seeking to transform governance should transform this tradition.

Transparency reforms should begin at the board and management level. All committees, including the executive committee, should report all of its decisions, actions, and recommendations at every board meeting; the board should retain the ultimate power to reverse a

<sup>110</sup>See National Association of College and University Business Officers, *Advisory Report: The Sarbanes-Oxley Act of 2002: Recommendations for Higher Education* (November 20, 2003) available at <http://www.nacubo.org/Documents/news/2003-03.pdf> (last visited December 21, 2007).

<sup>111</sup>Sarbanes-Oxley principles require that the compensation committees of boards of non-profit firms perform this function; the Audit and Compliance Committee should merely be charged with confirming that the Compensation Committee’s report in this regard has been accepted by the board.

<sup>112</sup>N.J.S.A. 15A:6-14.

<sup>113</sup>Such service is not precluded by the Rules of Professional Responsibility. ABA Comm. on Ethics and Professional Responsibility, Formal Op. 410 (1998). See, also, Ellen B. Kulka, *Attorneys Services as Trustees of Nonprofits*, 189 N.J. LAW. 14 (Feb. 1998) (observing without approbation that directors sometimes also act as legal counsel (frequently pro bono); discussing the possibility of a higher standard of care for the trustee-attorney).

committee decision.<sup>114</sup> Directors should be given the opportunity to submit meeting agenda items. The board should have a staff person assigned directly to it, with the attendant right of any director to request that this “staffer” collect information, prepare a report, or obtain the presence of any senior or middle manager, all without the necessary mediation of the CEO or other top manager. Any director should be able to call a meeting, or request the presence of the board’s legal counsel at a meeting. Some part of every meeting should be outside of the presence of management. Many boards likely operate in this fashion already. Transparency with the community at large is a less common practice. Boards should revisit the confidentiality provisions contained in their bylaws or committee charters, to narrowly circumscribe them to be consistent with this more liberal notion of transparency.

A hospital’s dire financial straits, and the strategic solutions under board consideration, should come as a surprise to neither the community (including patients and employees) nor the State. Rather, sufficient notice of an impending closure should facilitate the planned replacement of services to the community and the opportunity for employees to find alternative employment. Notice of financial instability at an appropriately early time may enable bondholders and/or the State to help the hospital develop strategies to salvage all or some of the hospital’s services, or to expedite closure, thereby avoiding further dissipation of assets. Elsewhere in this Report, the Commission sets out a series of “early warning” indicators and a series of steps to be taken when the conditions signaled by those indicators arise (see Chapter 15).

<sup>114</sup>The Revised Model Act does anticipate and permit board actions without a board meeting by unanimous written consent. REV. MODEL ACT § 8.21. The ALI draft Principles represent a significant step forward in this area, and could be further improved through the enhancement of transparency obligations. The comments to the draft ALI principles observe that “In general, the executive committee acts for the board between regular board meetings, and may exercise all powers of the board unless expressly limited by statute or the organizational documents.” Comment b.2 to § 325 at 173. The comments further elaborate that the executive committee should not usurp the board, may be reversed by the board, and should not be allowed inordinate power. *Id.* at 174.

<sup>115</sup>Other documents to be posted might include medical staff bylaws, audited financial statements, key committee charters, record retention policies, information on bond covenant violations.

<sup>116</sup>These might include outcomes of significant legal actions, Joint Commission inspection reports, health and safety code violation reports.

All community members should have access through a prominent section of the hospital’s web page (e.g. Community Relations), and upon request to the hospital’s public information office, to important institutional documents. The list of recommended information is listed below.

**Recommended Regulatory Adoptions:**

- The articles of incorporation, including the corporate mission statement;
- The members of the board of directors, their term of office, and a brief biography of each member;
- The board bylaws;
- The medical staff bylaws;
- The three most recent Forms 990;
- Management compensation, both direct and indirect;
- The three most recent annual reports;
- The board’s conflict of interest policy;
- Strategic plans approved by the board that significantly affect the provision of services in the community;
- The hospital’s charge master and its sliding fee provisions for the uninsured as well as the hospital’s billing and collection practices for the uninsured;
- Others.<sup>115</sup>

In addition, the web site should contain in readily accessible formats, health quality and price information, as the Department of Health and Senior Services deems appropriate. This information should be required to include:

**Recommended Regulatory Adoptions:**

- Reports on infection rates in formats approved by the Department;
- Quality measures and outcomes as approved by the Department;
- Information on sentinel events as approved by the Department;
- Pricing information for a sample of services approved by the Department;
- Information regarding the availability of charity care;
- Others.<sup>116</sup>

New Jersey hospitals are beginning to be acquired by multi-state systems whose parents are incorporated outside of New Jersey. This raises the policy question of the extent to which New Jersey stakeholders should have



access to information about these out-of-state “owners.” New Jersey law provides that every “domestic corporation and every foreign corporation authorized to conduct activities” in New Jersey must file an annual report with the Secretary of State.<sup>117</sup> Neither this report, however, nor the IRS Form 990 is required to disclose the identity and location of out-of-state corporate parents. This information should be disclosed in the hospital’s annual report, which should be posted on the hospital’s web page.

#### D. Additional Governance Reforms

The passage of the Sarbanes-Oxley Act caused an intensive examination of the state of corporate governance in the United States, and in particular an examination of the extent to which reforms mandated by that law should apply to nonprofit corporations.<sup>118</sup> Many of the recommendations in this chapter are drawn from Sarbanes-Oxley principles. Other reforms could be drawn from those principles, including requirements that:

- Hospital chief executive officers and chief financial officers personally certify the validity of key financial statements such as the Form 990;
- Hospitals not extend personal loans to officers and directors;
- Hospitals adopt a mandatory document retention program; and
- Hospitals adopt whistleblower policies that permit anonymous, confidential reporting of wrongdoing and protect employees from retaliation.

These and other additional governance reforms require further examination and discussion with interested parties. That process should be undertaken to identify other appropriate governance reforms.

<sup>117</sup>N.J.S.A. 15A:4-5.

<sup>118</sup>See Francie Ostrower, *Nonprofit Governance in the United States: Findings on Performance and Accountability from the First National Representative Study*, The Urban Institute Center on Nonprofits and Philanthropy, available at [http://www.urban.org/UploadedPDE/411479\\_Nonprofit\\_Governance.pdf](http://www.urban.org/UploadedPDE/411479_Nonprofit_Governance.pdf) (last visited December 21, 2007); Lumen N. Mulligan, *What’s Good for the Goose is not Good for the Gander: Sarbanes-Oxley-Style Nonprofit Reforms*, 105 Mich. L. Rev. 1981 (2007).

#### **Recommendation:**

The Department of Health and Senior Services should review guidance on the application of Sarbanes-Oxley principles to hospital governance, discuss possible reforms with interested parties, and adopt by regulation those additional requirements that will ensure the integrity and transparency of hospital governance in New Jersey.

### III. Conclusion

New Jersey’s hospitals have been buffeted by many market and regulatory forces out of their control. The Report discusses in Chapter 15 an “early warning system” that would assist board members in their obligation to respond to these forces. Some hospital problems are, however, within the control of its board. The Commission has concluded that inadequate attention to the relationship between hospital health and hospital governance may in some situations play a role in hampering the vital mission of our hospitals. We therefore conclude that steps should be taken – some in the form of recommended best practices and some in the form of mandatory regulation – to facilitate the maintenance of responsible board oversight of New Jersey’s hospitals. These recommended practices would increase accountability by improving the transparency and representativeness of hospital governance, ensure integrity of the process by limiting conflicts of interest, and enhance oversight of hospital finances and performance through board training and well-functioning oversight committees.

