*The American Hospital Association's*

CENTER FOR HEALTHCARE GOVERNANCE™

# 2014 NATIONAL HEALTH CARE GOVERNANCE SURVEY REPORT

AHA Center for Healthcare Governance
155 North Wacker Drive, Suite 400
Chicago, IL 60606
Phone: (888) 540-6111
www.americangovernance.com

# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

Health care is undergoing a complex, uncertain and fast-paced transformation on many fronts. Hospitals and health systems are adapting to shifts in health care reimbursement that encourage greater provider coordination and integration (mergers, acquisitions, affiliations, joint ventures and other relationships) that will radically change the organizational landscape. In addition, evolving advances in information and medical technology, an emphasis on population health that requires organizations to reconsider how and with whom they can partner to best achieve their mission and vision, and a myriad of new laws and regulations are compounding the growing need for diligent, high-performance governance.

This 2014 National Health Care Governance Survey includes many questions from previous surveys that allow insightful comparisons of governance evolution over time. It also probes new areas to enable a better understanding about how hospital and health system boards are preparing for and responding to the transforming health care environment. For the first time, the survey examined the results of questions by types of boards, including independent hospital boards, subsidiary boards of health care systems and boards of health care systems. The survey results confirm the growing transition toward system boards holding greater fiscal and strategic responsibility than their subsidiary organizations; at the same time, however, local boards continue to offer a valuable purpose and essential connection and engagement link to local communities. Independent hospitals typically utilize more traditional board structures, including longer board member terms and term limits and more frequent meetings, while hospital systems and their subsidiary boards typically have shorter terms and term limits, and meet less frequently.

Despite the growth of increasingly diverse populations in communities across the nation, survey results indicate that little change in the racial and ethnic composition of board members has taken place. Gender and age gaps are not closing either; trustees are generally older (in 2014, only two in 10 board members were under age 50), and nearly three-quarters of board members are male. And while clinical representation is essential as hospitals strive to continually improve quality and patient safety, the percentage of clinical board members has declined. Despite this, board chairs and CEOs both report high levels of alignment among boards, medical staffs and nursing staffs.

One of the challenges boards face as health care experiences significant change is the need for greater evolution in composition. Diversity of background, life experience, gender and ethnicity are important and must be factored into board composition. At the same time, boards should have an intense focus on ensuring that they possess the competencies needed to lead their organizations successfully into the future. Clearly defined skills and competencies are being employed to a greater degree in new board member selection; however, they are employed less frequently for evaluations and re-nominations of existing board members.

Ensuring purposeful and highly productive hospital governance requires considering how leading governance best practices are carried out. About one half of hospitals reported conducting a full board assessment in 2014, a process that, when used properly, has been shown to be a major factor in continuous governance improvement.

When new trustees are selected for board service, a clear role description and a robust trustee orientation process can ensure that they have a deep leadership understanding of the organization, the environment in which it operates and the challenges and opportunities that will define its success. The goal is to enable board members to quickly become well-informed, active participants in governance strategic thinking, dialogue and debate. Currently, nearly one-half of surveyed CEOs report that their organizations do not have a role description for their trustees, board chairs and committee chairs. And while nearly all hospitals and health systems report conducting some form of new trustee orientation, they reportedly are primarily focused on educational basics, with limited mentoring by more experienced board members or "shadowing" of clinicians to gain insights about care delivery, quality and patient safety. The combination of limited-scope orientations and the decline in board education is concerning; now more than ever, governance education focused on continual board-wide knowledge-building is essential to ensure that boards are best prepared to make well-informed strategic decisions that successfully shape the future of their hospitals and the communities they serve.

While there is agreement by both CEOs and board chairs that boards are highly engaged in quality and patient safety, board chairs perceive greater levels of CEO accountability for quality than do CEOs. In addition, in the areas of executive performance and compensation, CEOs' perception of their accountability was lower in nearly every area compared to the views of board chairs. Future-focused boards should view this as an opportunity to enhance the board/CEO partnership through review of the CEO evaluation process, but also strengthened CEO retention and succession plans.

Boards have often struggled to find the balance between the board's role in affirming high-level strategic direction and management's role in plan implementation. As many of the ideas in today's health care transformation move from concept to reality, the concept of shared governance is gaining traction, encouraging trustees, senior leaders, and clinical leaders to challenge one another and complement one another's skills and roles in ways that most benefit the organization. Boards must continually focus on purposeful and productive efforts to lead strategic direction to improve quality and patient safety, strengthen financial viability, ensure executive performance, respond to community health needs and more. Just over 40 percent of hospital and health system boards reported that more than one-half of their governance time is spent in strategic, active discussion, deliberation and debate. At the same time, nearly one in five boards report spending less than one-quarter of their meeting time engaging in this manner.

Board chairs and CEOs are reportedly generally knowledgeable about emerging trends in health care as they prepare their organizations for success through health care transformation. Board chairs reported higher levels of engagement than did CEOs in embracing new practices to prepare them to govern successfully through transformation.

The dramatic transformation taking place in the way in which health care is financed and delivered in communities across the nation creates great challenge and opportunity for governing boards. The 2014 National Health Care Governance Survey provides unique insights that can assist boards, executive teams and clinical leaders to govern together for success.

SECTION 1

# INTRODUCTION

The 2014 National Health Care Governance Survey was developed by the American Hospital Association's (AHA) Center for Healthcare Governance. Building on the results of previous national governance surveys conducted by the AHA in 2011 and 2005, the 2014 survey also includes many new questions about different types of boards, board selection and evaluation, board culture and readiness for health care transformation.

Two survey instruments were developed, one designed for hospital chief executive officers (CEOs) to complete, and the other to be completed by hospital board chairs. The surveys were sent via electronic mail and postal mail to the CEOs of 4,806 nonfederal community hospitals and health systems in the United States. Specialty hospitals, such as eye-and-ear and psychiatric hospitals were not included. CEOs were requested to provide the appropriate survey to their board chairs. Respondents were given the option to respond to the survey online or to complete the hard copy.

Survey responses were collected during spring 2014. A total of 1,078 CEOs (a 22 percent response rate) and 710 board chairs (a 15 percent response rate) responded to the survey.

Overall, the respondents were generally representative of hospital bed size distribution and geographic distribution in the United States *(see Figure 1.1)*. Public hospitals and not-for-profit hospitals were somewhat overrepresented in the survey results, as were non-metro/rural hospitals. Metropolitan hospitals and health systems and investor-owned hospitals were somewhat underrepresented. AHA non-member systems were somewhat overrepresented, with less representation from AHA member hospitals.

The majority of the questions were asked of both CEOs and board members, allowing comparisons and contrasts throughout this report. Questions about board composition and structure were only asked of CEOs.

| Figure 1.1 – Survey Respondents Versus All Hospitals | | | |
|---|---|---|---|
| | **All Hospitals** | **CEO Respondents** | **Board Chair Respondents** |
| **Size** | | | |
| < 100 Beds | 52% | 53% | 47% |
| 100-299 Beds | 32% | 30% | 33% |
| >= 300 Beds | 16% | 17% | 20% |
| **Census Region** | | | |
| Northeast | 13% | 16% | 19% |
| Midwest | 30% | 37% | 35% |
| South | 39% | 28% | 28% |
| West | 19% | 19% | 18% |
| **Ownership** | | | |
| Public | 21% | 27% | 27% |
| Not-for-Profit | 58% | 64% | 66% |
| Investor-Owned | 21% | 9% | 7% |
| **Location** | | | |
| Metro | 60% | 53% | 55% |
| Non-Metro | 40% | 47% | 45% |
| **Multi-Hospital System** | | | |
| Non-AHA Member | 38% | 50% | 49% |
| AHA Member | 62% | 50% | 51% |

SECTION 2

# BOARD COMPOSITION AND THE COMMUNITY

Health care in America is transforming, and so are the communities that hospitals serve. As patients become more diverse, the diversity of hospital caregivers, leaders and board members must evolve to reflect changing community desires and needs. At the same time, the structure of America's hospitals is changing. While community hospitals remain the bedrock of most communities, hospitals and health systems are increasingly forging partnerships and alliances to better serve their communities. This 2014 survey is the first examination of the various types of boards, including freestanding hospital boards, hospital subsidiary boards and boards of system headquarters.

## Board Size

Over the past several decades, hospital boards have trended toward smaller sizes, which allow them greater flexibility and enable more in-depth, robust discussions and decision-making. However, as health care transforms and the complexity of the challenges faced by hospitals and health systems and their boards increases, board sizes may be shifting again.

The survey results indicate a slight increase in average board size, from 12 board members in 2011 to 13 board members in 2014 *(see Figure 2.1)*. System boards typically had the largest boards, with an average of 16 board members. System boards also had the least number of non-voting board members (on average less than one), and the largest average number of members. Both freestanding hospital boards and hospital subsidiary boards reported approximately one non-voting board member *(see Figure 2.2)*.

**Figure 2.1 – Board Size**

| | Average Numbers of Board Members |
|---|---|
| Freestanding Hospital Board | 12 |
| Hospital Subsidiary Board | 12 |
| System Headquarters Board | 16 |

2014 Average all respondents = 13
2011 Average all respondents = 12

**Figure 2.2 – Nonvoting Board Members**

| | Average Numbers of Nonvoting Board Members |
|---|---|
| Freestanding Hospital Board | 1 |
| Hospital Subsidiary Board | 1 |
| System Headquarters Board | 0.5 |

2014 Average all respondents = 1
2011 Average all respondents = 1

## Board Diversity

For many hospitals across the country, the racial and ethnic diversity of communities is changing and cultural disparities in health care are becoming more and more evident. It is trustees' role and responsibility to ensure that the hospital knows what the community's health needs are, and how to best deliver care that meets the needs of those served by the organization.

In 2011, the AHA, American College of Healthcare Executives, Association of American Medical Colleges, Catholic Health Association of the United States and America's Essential Hospitals stood together in a national call to action to eliminate health care disparities. The focus is threefold, including increasing the collection of race, ethnicity and language preference data; increasing cultural competency training; and increasing diversity in governance and leadership. The call to action for increased governance and leadership diversity is focused on leadership that is reflective of the communities served.

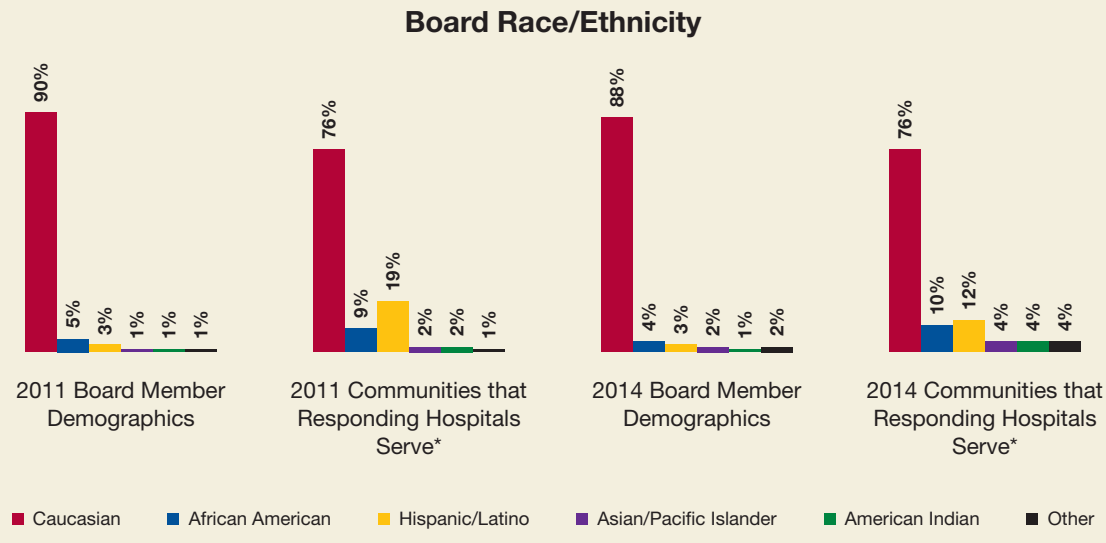
Despite this national call to action, the survey results highlight a lack of progress in board diversity of race or ethnicity, gender, age and clinical profession.

### *Race and Ethnicity*

Minorities currently comprise 37 percent of the U.S. population according to the U.S. Census Bureau. In the coming years the U.S. population's diversity is expected to grow significantly, with minorities comprising an estimated 57 percent of the population in 2060.[1] Despite this growing diversity, in most communities hospital boards are predominantly Caucasian.

The 2014 survey results indicate that little has changed in the racial and ethnic composition of hospital boards since 2011, with almost nine in 10 board members reportedly Caucasian *(see Figure 2.3)*. Slightly over half of all boards surveyed had at least one non-Caucasian board member; leaving 47 percent of all hospital boards in America with no

**Figure 2.3**




**Community diversity as reported by responding hospitals, may not reflect the actual demographics of the community.*

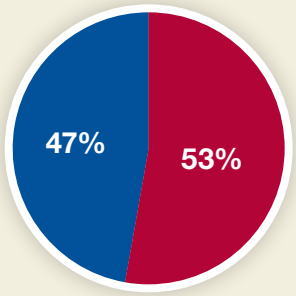
1 Source: https://www.census.gov/newsroom/releases/archives/population/cb12-243.html)

racial or ethnic minority representation in 2014 *(see Figure 2.4)*.

When asked whether their board's composition reflects the diversity of the community and stakeholders served by the organization, the average score was 3.5 (using a scale of 1 – Not at All, to 5 – Completely). Freestanding hospitals and hospital subsidiary boards reported that their board composition was more reflective of the community served, while system boards were less confident *(see Figure 2.5)*.

## Figure 2.4

### Hospitals with At Least One Non-Caucasian Board Member




- Hospitals with At Least One Non-Caucasian Board Member
- Hospital Boards Comprised of All Caucasian Board Members

** Percent of all hospitals that reported board composition, not the total of all survey respondents.*

## Figure 2.5 – Boards Reflective of Community Diversity

| | Average Score |
|---|---|
| Freestanding Hospital Board | 3.6 |
| Hospital Subsidiary Board | 3.4 |
| System Headquarters Board | 2.9 |
| Overall | 3.5 |

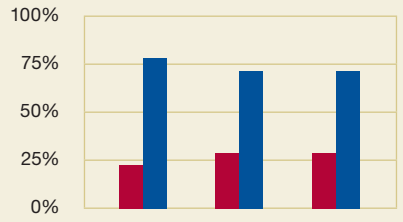
**Extent that the Composition Reflects Community Diversity**
Scale of 1 (Not at All) to 5 (Completely)

** Community diversity as reported by hospital, may not reflect the actual demographics of the community.*

### *Gender*

While the percentage of men and women is nearly equal in the U.S., according to the U.S. Bureau of Labor Statistics women comprise nearly 80 percent of the health care workforce. In recent years, the importance of women in leadership has been elevated, but there has been little shift in hospital board representation. In fact, the gender divide on hospital boards remained the same in 2014 as it was in 2011 *(see Figure 2.6)*. Just under three-quarters of all board members were male, while 28 percent were female.

## Figure 2.6 – Board Gender



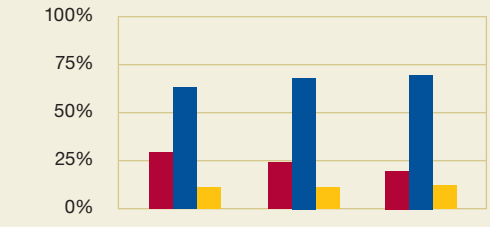

| | 2005 | 2011 | 2014 |
|---|---|---|---|
| Female Trustees | 23% | 28% | 28% |
| Male Trustees | 77% | 72% | 72% |

### *Age*

Four generations are now represented in the workforce, but not necessarily around the board table. Boards missing the diversity of age may also be missing the commitment, passion for service, and fresh thinking of their community's next generation of leaders. In addition to the benefits younger leaders can offer to boards, organizations may also be missing an opportunity to offer their communities a valuable leadership development experience for these future leaders.

This year's survey results reiterate that the governance age gap is not narrowing. Hospital trustees are getting older. Since 2005, the percentage of board members under the age of 50 has continued to decline. In 2014, only two in 10 board members were under age

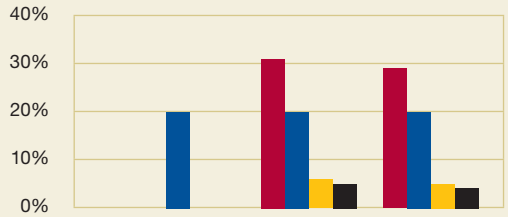
## Figure 2.7 – Board Age




| | 2005 | 2011 | 2014 |
|---|---|---|---|
| <= 50 | 29% | 24% | 21% |
| 51-70 | 62% | 67% | 68% |
| >= 71 | 9% | 9% | 10% |

## Figure 2.8

### Clinical Professions Serving on Boards




| | 2005 | 2011 | 2014 |
|---|---|---|---|
| All Clinicians | | 31% | 29% |
| Physicians | 20% | 20% | 20% |
| Nurses | | 6% | 5% |
| Other Clinicians | | 5% | 4% |

**2011 was the first survey to ask about clinicians other than physicians.*

50. The majority of hospital trustees were ages 51-70, with the remainder over age 71 *(see Figure 2.7)*.

### *Clinical Representation*

Expertise is required on hospital boards in a variety of areas, but as hospitals and health systems continue to strive for excellence in quality and patient safety the need for a strong clinical voice on the board is essential. Clinical expertise may come from a variety of professions, including physicians, nurses, pharmacists, and other clinical specialties. Despite their essential perspective, the percentage of clinical board members declined from 31 percent in 2011 to 29 percent in 2014 *(see Figure 2.8)*. Overall, the percentage of physician trustees remained the same from 2011 to 2014, but the percentage of board members that were nurses or other clinicians declined.

Of all survey respondents, three-quarters had at least one physician serving on their board. More than one-third (37 percent) had at least one nurse on their board, and 22 percent included at least one other clinical profession as a board member *(see Figure 2.9)*.

## Figure 2.9 – Percentage of Hospitals with Nurses, Physicians and Other Clinicians on the Board

| | Percentage |
|---|---|
| **Physician** | 75% |
| **Nurse** | 37% |
| **Other clinician** (e.g., pharmacist, therapist) | 22% |

### *Diversity Varies by Board Type*

There are sizeable differences in board composition by type of board. System boards had slightly greater African American representation, more males, and more trustees in the 51–70 age range. System boards also tended to have greater physician representation. Hospital subsidiary boards included more females and a greater percentage of younger trustees. Freestanding hospital boards had the highest percentage of Caucasian board members. Freestanding hospital boards also had the largest percentage of trustees over age 71, more nurses and the smallest percentage of physician representation *(see Figure 2.10)*.

As health care organizations grow and evolve, the various types of boards used throughout systems and their subsidiaries serve a unique role. While system boards are typically responsible for finance, strategic

## Figure 2.10 – Board Composition by Type of Board

| | Freestanding Hospital Board | Hospital Subsidiary Board | System Headquarters Board |
|---|---|---|---|
| **Race/Ethnicity** | | | |
| Caucasian | 90% | 86% | 86% |
| African American | 4% | 6% | 7% |
| Hispanic/Latino | 3% | 3% | 3% |
| Asian/Pacific Islander | 1% | 2% | 2% |
| American Indian | 1% | 0% | 1% |
| Other | 1% | 4% | 1% |
| Unknown | 0% | 0% | 0% |
| **Gender** | | | |
| Male | 72% | 69% | 76% |
| Female | 28% | 31% | 24% |
| **Age** | | | |
| <=50 | 17% | 19% | 12% |
| 51-70 | 63% | 70% | 81% |
| >=71 | 20% | 11% | 7% |
| **Clinical Background** | | | |
| Physician | 17% | 22% | 26% |
| Nurse | 4% | 6% | 4% |
| Other Clinician ( e.g., pharmacist, therapist) | 5% | 3% | 2% |

direction and rigorous oversight of performance and risk, local or subsidiary boards are responsible for understanding community needs and perceptions and relaying those needs to the system board, as well as local quality, patient safety and physician credentialing. Local boards should be more reflective of the community served, while system boards may be more focused on professional expertise and experience.

## Section Highlights

- The average board size was 13 trustees
- 47 percent of all hospital boards in America had no racial or ethnic minority representation in 2014
- No progress has been made since 2011 in gender diversity
- Hospital trustees are getting older
- The percentage of clinical board members declined from 31 percent in 2011 to 29 percent in 2014
- There are sizeable differences in board composition by type of board

SECTION 3

# BOARD STRUCTURE

Highly effective boards ensure that their governance structure and operational practices are designed for maximum governance effectiveness and successful achievement of the organization's mission. When they govern at peak performance, the board and individual trustees play an important role in helping to ensure that the organization gains strength and new capacity to sustain success through the change ahead; doing so requires a clear understanding of the requirements for governing excellence.

Boards set the tone for successful governance by ensuring that clear policies and procedures clarify expectations for board term limits, board meeting frequency, board committee roles and participation requirements and board compensation.

## Term Limits

Board term limits offer a formal process that enables longtime board members to leave the board. Term limits also provide a way for trustees to leave the board who may no longer be a good fit for the organization's governing body. At the same time, board terms ensure consistency of board composition to prevent continuous turnover.

The complexity of health care brings unique challenges to board term limits. Hospital and health system boards must balance the value of experienced board members with the opportunity to bring fresh thinking and perspectives to governance dialogue and strategic direction setting.

In 2014, the average board term was 3.9 years, up slightly from the average of 3.5 years in 2011. Freestanding hospital boards had longer board terms (more than four years) than hospital subsidiary boards or system boards *(see Figure 3.1)*.

**Figure 3.1 – Term Length for Board Members**

| | Average Number of Years |
|---|---|
| **Freestanding hospital board** | **4.4** |
| **Hospital subsidiary board** | **3.1** |
| Local hospital board with limited authority | 2.9 |
| Local hospital board with no fiduciary duties | 3.1 |
| Local hospital board with significant authority | 3.4 |
| **System headquarters board** | **3.1** |

2014 Average all respondents = 3.9
2011 Average all respondents = 3.5

The maximum number of consecutive terms in 2014 was 3.3 terms. Like the average board term length, the number of consecutive terms allowed was highest for freestanding hospitals (3.5 terms), and lower for hospital subsidiary boards and system boards *(see Figure 3.2)*.

When combined, if a board member served the maximum number of consecutive terms, the average length of board service would be nearly 13 years. For freestanding hospital boards, the average maximum length would be over 15 years, while the average for hospital subsidiary boards would be 9 years and the average for system headquarters boards would be nearly 10 years.

| Figure 3.2 – Maximum Number of Consecutive Terms | |
|---|---|
| | **Average Number of Consecutive Terms** |
| **Freestanding hospital board** | **3.5** |
| **Hospital subsidiary board** | **3.0** |
| Local hospital board with limited authority | 2.9 |
| Local hospital board with no fiduciary duties | 2.9 |
| Local hospital board with significant authority | 3.1 |
| **System headquarters board** | **3.2** |

Average all respondents = 3.3

| Figure 3.3 – Number of Regularly Scheduled Board Meetings Annually | |
|---|---|
| | **Average Number of Board Meetings** |
| **Freestanding hospital board** | **11** |
| **Hospital subsidiary board** | **8** |
| Local hospital board with limited authority | 7 |
| Local hospital board with no fiduciary duties | 8 |
| Local hospital board with significant authority | 9 |
| **System headquarters board** | **8** |

Average all respondents = 9

## Board Meeting Frequency

The frequency with which hospital and health system governing boards meet varies depending on the scope of the governing board's responsibilities, board composition, travel requirements and a variety of other factors. Some system boards with wide-ranging representation may only meet four times a year with longer board meetings, while other boards may meet more frequently but for a shorter duration.

In 2014, boards reported holding an average of nine board meetings annually. Freestanding hospital boards averaged the highest frequency of board meetings, with 11 meetings annually. Hospital subsidiary boards and system headquarters boards met on average eight times a year. Within hospital subsidiary boards, governing bodies with limited authority met less frequently, while governing bodies with significant authority met more frequently *(see Figure 3.3)*.

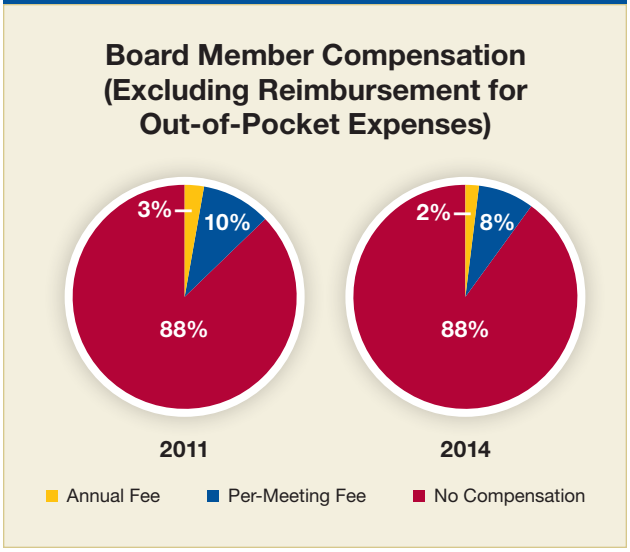
## Board Compensation

Serving on a hospital or health system board is increasingly complex, requiring a significant time commitment and dedication from board members. As hospital trustee responsibilities grow, there is no doubt that their expertise is valuable and their personal and professional time is at a premium. Compensation rewards trustees' valuable contributions, and some believe it may result in improved governing performance, or may contribute to a better ability to recruit future trustees. At the same time, compensating trustees may raise questions about trustees' motives and incentives to serve and act on the board. Compensation may also increase the board's liability, and may have the potential to hinder advocacy clout.

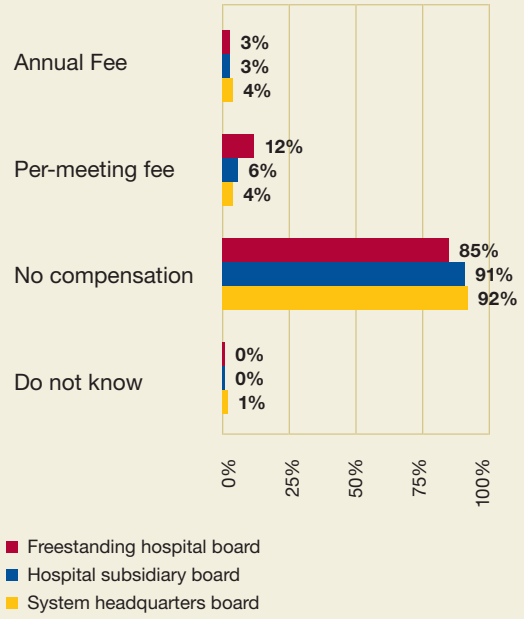
While some believe that the growing complexity and demands of not-for-profit trustees merits compensation, others believe that trustees are motivated by non-financial benefits, including the opportunity to serve the local community and provide value to the local hospital or health system. Despite some debate, compensating trustees for their important leadership work is uncommon.

The overall percentage of hospital and health system boards that compensate their members has not changed since 2011. While 12 percent of hospital and

## Figure 3.4




## Figure 3.5 – Forms of Board Member Compensation by Type of Board




health system boards provided some form of compensation, 88 percent offered no compensation outside of reimbursement for out-of-pocket meeting-related expenses *(see Figure 3.4)*.

Freestanding hospitals were most likely to compensate trustees, with the most common reported compensation in the form of a per-meeting fee (12 percent of all freestanding boards do this). Hospital subsidiary boards that provided compensation were also most likely to provide a per-meeting fee (6 percent), followed by an annual fee (3 percent). System headquarters boards were least likely to provide trustee compensation; those that did were equally divided between compensating trustees through an annual fee or a per-meeting fee (4 percent each) *(see Figure 3.5)*.

### Board Committees

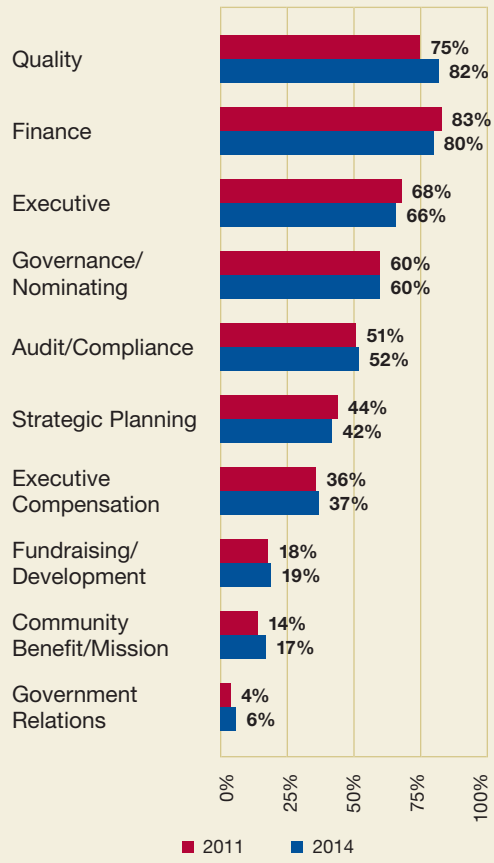
Board committees are an essential component of effective hospital governance and leadership. They form the "substructure" that enables the full governing board to focus on larger issues of policy, strategy and vision. Many boards utilize a combination of standing board committees as well as ad hoc committees and task forces that address specific, short-term issues or needs.

Successful boards use committee to maximize their governance time and energy, enhance their effectiveness and understand their position, progress and performance in key areas. When effective, substructure groups provide the analysis and recommendations necessary for effective and well thought-out full board decisions.

The most common standing committees were quality and finance. Over half of all boards also reported having a standing executive committee, governance/nominating committee and audit/compliance committee *(see Figure 3.6)*.

The prevalence of a standing quality committee has markedly increased in the last decade; fewer than six in 10 boards reported having a quality committee in 2005, compared to more than eight in 10 boards reporting a quality committee in 2014. The 2014 survey also revealed a slight decrease in the overall use of standing finance committees, down to 80 percent

## Figure 3.6 – Standing Committees




compared to 83 percent in 2011; however, that decrease may be attributed to the centralization of finance responsibilities at system boards resulting in a decline in finance committees at the subsidiary board level.

### *Changing Board Structures*

As health systems grow in size, the responsibilities of the system and subsidiary boards are shifting to complement one another. This change is reflected in the typical standing committees utilized by each type of board. System boards typically hold significantly more responsibility for finance than do hospital subsidiary boards, which is reflective in the near certain use of finance committees on system boards (98 percent) compared only six in 10 on hospital subsidiary boards *(see Figure 3.7)*. System boards were also more likely than their subsidiary boards to have standing committees in the areas of quality, audit/compliance, governance/nominating, executive, strategic planning, and executive compensation.

### *Committee Meeting Frequency*

The frequency with which board committees meet varies, and is typically dependent on how frequently the full board meets, as well as the individual committee's responsibilities. For example, if a board meets 10–12 times a year, it is common for the finance committee to meet monthly. If a board meets quarterly, as system boards do, the committees may meet less frequently. At the same time, some committee responsibilities may only require quarterly meetings, while others may require monthly meetings to properly carry out the committee's responsibilities.[1]

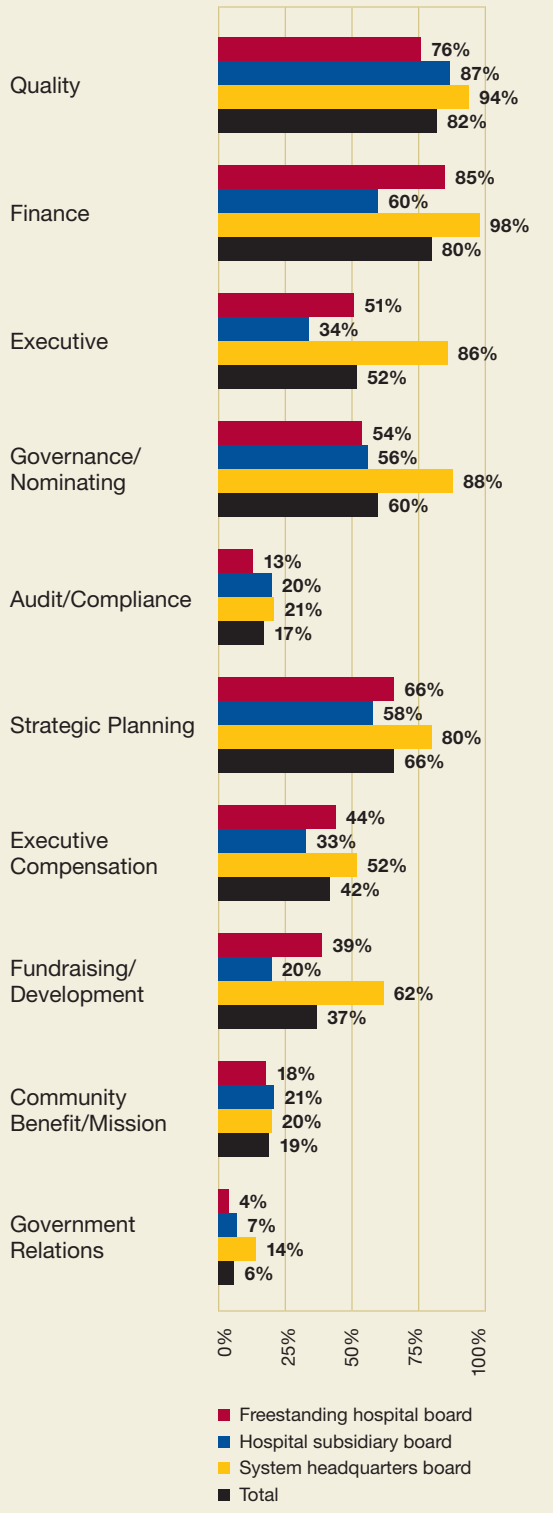
Nearly four in 10 standing board committees met monthly in 2014. The majority of the remaining standing committees reported meeting either bi-monthly (25 percent) or quarterly (28 percent). Few boards reported their committees meeting only semi-annually or annually *(see Figure 3.8)*.

### *Use of "Outside" Expertise*

If a hospital or health system is lacking in a particular competency or area of expertise, it may be beneficial to engage an individual from outside the service area to serve on a board committee. These individuals who serve on a board committee, but not on the full board, may provide unique and needed expertise and new perspectives. The practice of engaging external expertise may also serve as an effective "feeder" system for identifying competent individuals for future full board service. In 2014, over half of

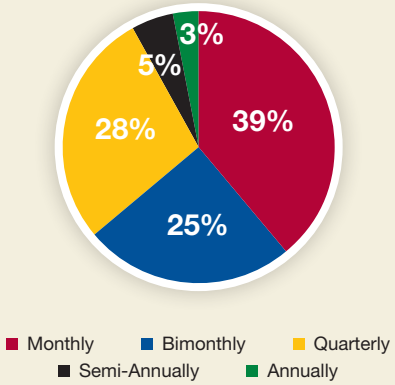
1 Adapted from the Summer 2013 Great Boards Newsletter, by Barry S. Bader and Pamela R. Knecht, entitled Most Commonly Asked Questions About Board Committees.

## Figure 3.7 – 2014 Standing Committees By Board Type




## Figure 3.8

### Average Number of Times a Year Committees Meet




hospitals and health systems reported using an "outsider" on at least one committee *(see Figure 3.9)*.

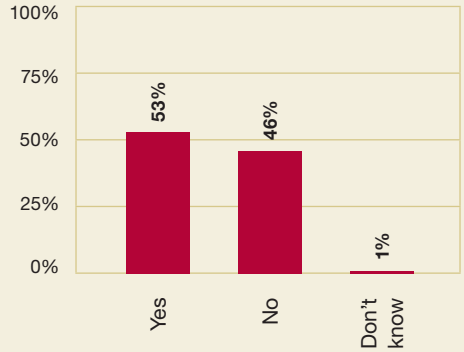
### *Audit Committees*

The governing board has a responsibility to engage external auditors to perform an annual audit of the hospital's financial records. This audit helps the board determine if the financial position and operations are accurately and fairly presented, and are in accordance with generally accepted accounting principles. Some boards fulfill this responsibility through the use of a standing audit committee, which assists the board in fulfilling its oversight responsibilities with respect to the independent auditor's qualifications and independence. Members of audit committees typically possess a strong understanding of finance and accounting practices, and at least one member should be a "financial expert."

About one-half of all hospital boards reported the use of a separate audit committee in 2014. Separate audit committees were generally comprised of independent or outside directors, and were overwhelmingly chaired by a board member with competencies or experience in accounting and/or managerial finance *(see Figures 3.10, 3.11 and 3.12)*.

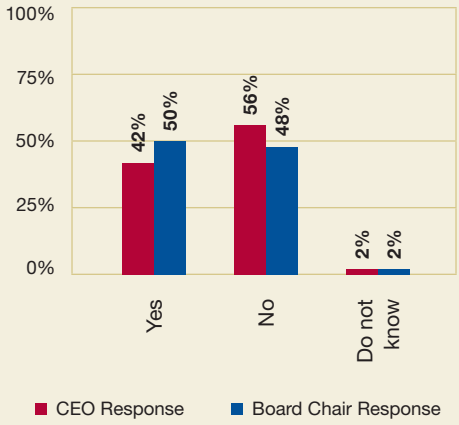
## Figure 3.9

### Use of "Outsiders" Who are Not Trustees But Serve as Members of Some Board Committees



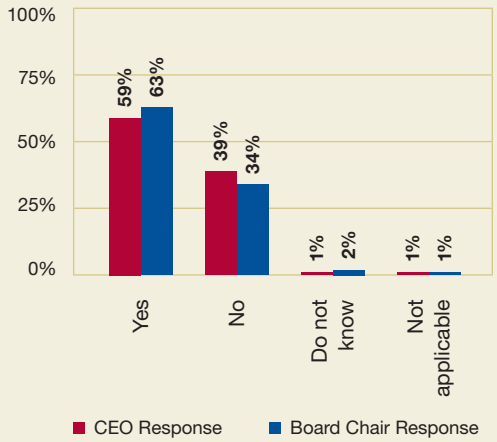

## Figure 3.10

### Use of a Separate Audit Committee



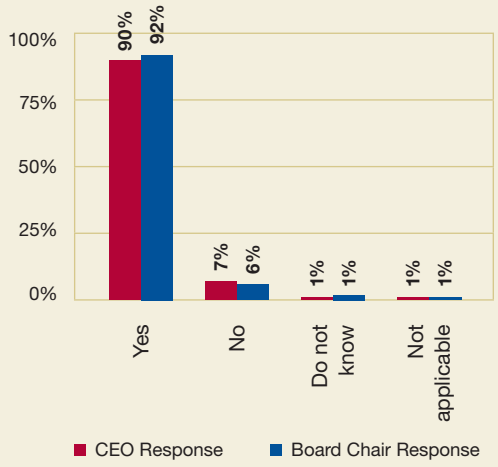

## Figure 3.11

### Audit Committee Comprised Solely of Independent/Outside Directors




## Figure 3.12

### Audit Committee Chaired by a Member with Competencies/Experience in Accounting and/or Managerial Finance



## Section Highlights

- The average board term was 3.9 years and the average number of consecutive terms was 3.3 terms, resulting in a maximum allowable board service of nearly 13 years
- Freestanding hospitals had longer terms and term limits than did subsidiary boards and system boards
- The average number of board meetings per year was 9
- Freestanding hospital boards met more frequently than did hospital subsidiary boards and system boards
- 12 percent of hospital boards offered board member compensation
- The most common standing committees were quality and finance
- System boards were more likely than subsidiary boards to have standing committees in the areas of finance, quality, audit/compliance, governance/nominating, executive, strategic planning and executive compensation
- Nearly four in 10 standing board committees met monthly in 2014
- Over half of boards reported using an "outsider" on a committee
- About 50 percent of all hospital boards had a separate audit committee in 2014
- Audit committees were generally comprised of independent directors, and were chaired by a financial expert

SECTION 4

# BOARD SELECTION

A growing body of research is beginning to connect competencies to both individual and organizational performance in many sectors, including health care. This link is motivating interest in competency-based selection and development of people serving on for-profit and not-for-profit governing boards. In the wake of calls for greater governance effectiveness and accountability, competencies are beginning to be applied to board work because of their capacity to improve performance.

In 2007 the AHA Center for Healthcare Governance's Blue Ribbon Panel on Health Care Governance identified essential board characteristics, skills and experience. In a 2009 follow-up Blue Ribbon Panel report, two sets of core competencies for board members of hospitals and health systems were identified. First, the Panel identified the knowledge and skills that all boards, regardless of the type of hospital or system they govern, should include: 1) health care delivery and performance; 2) business and finance; and 3) human resources. Second, the Panel recommended personal capabilities that should be sought in board members.

While critical competencies (skills and knowledge) are important, what differentiates excellent board members are characteristics that are more difficult to learn in board member education and orientation, including social roles, self-image, personality and motivation. How a trustee perceives the role of the hospital in the community, and his or her role on the board, impacts leadership style and decision-making. A trustee's self-image must be appropriately aligned with the new enterprise, and trustees must possess the personality and intrinsic motivation necessary to serve. The best trustees are motivated by achievement of the hospital's mission.[1]

## Competencies Considered for Board Selection

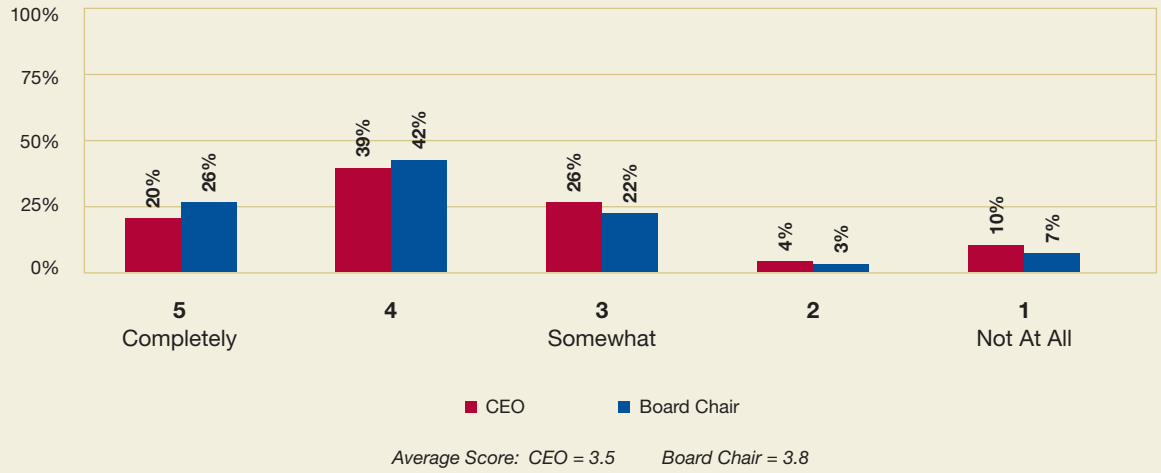
Boards should comprise individuals who display a diversity of opinions and independent thought and actions. Trustees should have demonstrated achievement in their career field and possess the intelligence, education and experience to make significant contributions to governance. They should also possess the personal attributes that will contribute to sound working relationships with other board members and the executive staff. Instead of a board composition that is simply representational, boards of trustees should seek to develop a composition that also reflects the overarching experience and expertise needed to successfully govern in today's era of transformation. The board should clearly define and recruit trustees with the skills, experience and personal characteristics that complement existing board members' resources and that result in a more well-rounded, competency-based board.

This is happening in many hospital boards, but there is room for growth. In 2014, board chairs reported that their board used knowledge/skill and personal capability competencies to select and evaluate board members at 3.8 on a scale of one (not at all) to five (completely). CEOs reported the use of competencies for new board member selection and existing board member evaluation less often, with an overall rating of 3.5 *(see Figure 4.1)*.

1 "Leadership Toolkit for Redefining the H: Engaging Trustees and Communities". American Hospital Association Committee on Performance Improvement and Committee on Research, 2014

## Figure 4.1

### Extent the Board Uses Knowledge/Skill and Personal Capability Competencies to Select and Evaluate Board Members




*Average Score: CEO = 3.5 Board Chair = 3.8*

### *Competency-Based Trustee Selection*

Compared to 2011, more hospitals are using competencies for their trustee selection process. In 2014, four in 10 board chairs reported using competency-based criteria for selecting new board members, and 13 percent reported using competencies for selection of new board chairs. CEOs rated the use of competencies for both new trustee selection and board chairs lower than did board chairs. Overall, approximately 40 percent of all hospitals did not use competencies at all in the selection process for new trustees or new board chairs *(see Figure 4.2)*.

### *Essential Core Competencies*

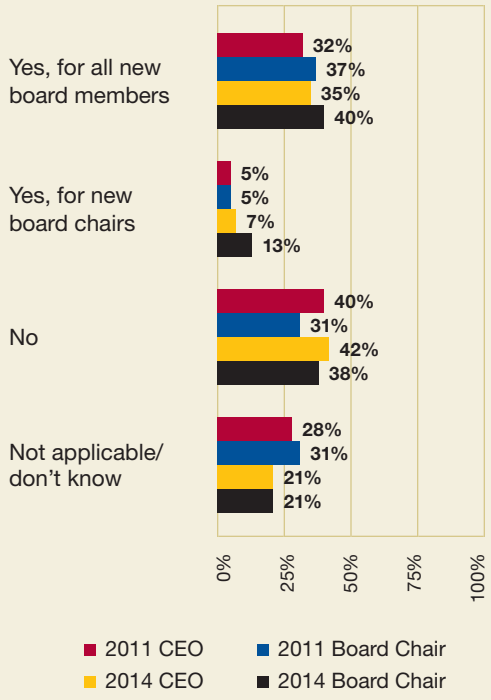
When selecting new board members and board chairs, board members and CEOs generally agreed that competencies in the area of finance and business, strategic planning and visioning were most important *(see Figure 4.3)*.

Other highly rated competencies for new board members included quality and patient safety and previous board experience. In addition, board chairs were more likely than CEOs to value a strong educational background as a core competency in new board members.

Previous board experience and quality and patient safety expertise were also rated as important for new board chairs; however, both board chairs and CEOs further believe that conflict management is an important skill for new board members to possess. In contrast, clinical practice experience, human resources/organizational development and legal expertise were viewed as more important in new board members than in new board chairs.

## Figure 4.2

### Competency-Based Trustee Selection (Use of Full Board-Approved Criteria/Competencies for Selecting New Board Members)




## Board Member Replacement

Defining essential core competencies is critical before selecting new board members and board chairs; however, equally important is using those core competencies to evaluate the performance of existing board members. Boards should conduct a self-assessment annually; the process should include a self-evaluation of individual trustees' performance, skills and competencies. Leading-edge boards also conduct a trustee peer evaluation in which board members anonymously evaluate one another's performance and make suggestions for ways their colleagues may strengthen their contribution to board leadership.

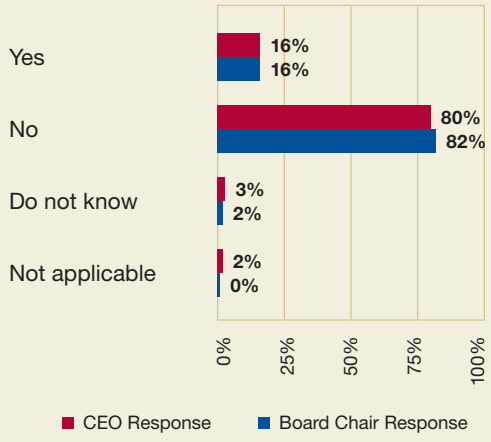
The annual evaluation process, as well as a re-nomination process when a trustee's term expires, is an opportunity to regularly compare the desired board competencies with the existing board composition, skills and experience to ensure that there are no gaps.

Despite this, eight in 10 hospitals reported that no board member has been replaced or not been re-nominated because of failure to demonstrate the needed competencies for governance effectiveness *(see Figure 4.4)*. While commitment to serving on a hospital board is an honor and a valuable contribution to the community, hospital boards must implement a true competency-based approach when evaluating trustees to ensure that hospital boards are best positioned to lead their organizations successfully in the future.

| Figure 4.3 – Essential Core Competencies When Selecting New Board Members and Chairs (Select Top Five) | | | | |
|---|---|---|---|---|
| | CEO Response | | Board Chair Response | |
| | Importance in New Board Members | Importance in New Board Chair | Importance in New Board Members | Importance in New Board Chair |
| Finance/Business | 17% | 17% | 17% | 15% |
| Strategic Planning/ Visioning | 16% | 17% | 17% | 17% |
| Education | 7% | 5% | 10% | 8% |
| Patient Safety/ Quality | 11% | 10% | 10% | 9% |
| Previous Board Experience | 9% | 15% | 10% | 14% |
| Public Relations | 6% | 7% | 7% | 9% |
| Human Resources/ Organizational Development | 6% | 4% | 6% | 7% |
| Clinical Practice | 6% | 2% | 5% | 2% |
| Legal | 6% | 3% | 4% | 3% |
| Conflict Management | 3% | 12% | 3% | 10% |
| Fundraising | 4% | 4% | 3% | 3% |
| Health Insurance/ Managed Care | 3% | 2% | 2% | 2% |
| Health Information Technology | 3% | 1% | 2% | 1% |
| Medical/Scientific Technology | 3% | 5% | 2% | 1% |

## Figure 4.4

### Board Members Replaced or Not Re-nominated in the Past 3 Years Because of Failure to Demonstrate Proper Competencies




## Section Highlights

- Nearly 40 percent of all hospitals surveyed did not use competencies in the selection process for new trustees or new board chairs
- Board chairs reported using competencies for trustee selection and evaluation more than CEOs did
- Finance/business and strategic planning/ visioning were viewed as the two most important board member competencies
- Quality/patient safety and previous board experience were also top-rated new trustee competencies
- Board chairs valued a strong educational background
- Conflict management was important for new board chairs
- Eight in 10 hospitals reported that no board member has been replaced or not been re-nominated because of failure to demonstrate the necessary competencies
- There is an opportunity to expand the use of competency-based approaches when selecting and evaluating trustees

SECTION 5

# BOARD ORIENTATION AND EDUCATION

Hospital board service has never been more challenging, as trustees today are expected to know and understand more and take on greater responsibility than they have in the past.

The increased expectation for trustees' knowledge and understanding underscores the critical work of the board and the importance of well-planned trustee selection, orientation, and ongoing education. While orientation is essential to integrating new trustees and maximizing their potential, ongoing education is equally important for all board members. Trustee knowledge-building must take place continuously, and through a variety of venues.

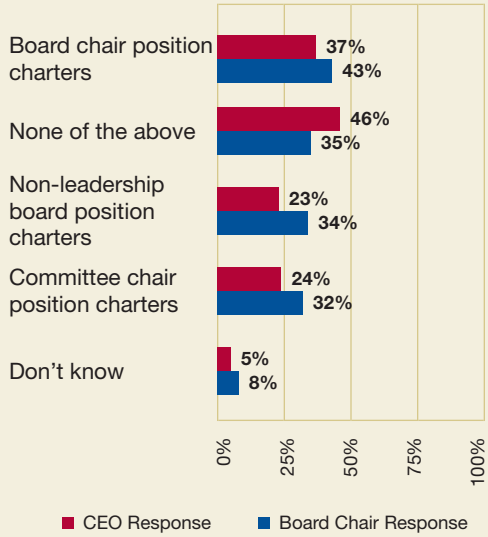
## Charters and Job Descriptions

A clearly articulated description of trustee roles and responsibilities is essential for all board positions, including board membership, board committees, and board leadership, including the board chair. The charters, or job descriptions, should first be used in the trustee recruitment process where potential candidates are given a written description of board and trustee roles and responsibilities to ensure they have a clear understanding of the accountabilities they will be assuming and a readiness to commit the time required to carry out those responsibilities. A comprehensive description of board roles and responsibilities should include a summary of fiduciary duties, a list of essential board functions, and a summary of the skills, attributes and commitments expected from trustees. The charters are equally important for ensuring that all board members understand and fulfill their responsibilities, and should be tested as a part of the board's annual self-assessment process.

In 2014, nearly half of all CEOs surveyed reported that their hospital did not have a job description or position charter for board positions. Board chairs reported a higher presence of position charters (only 35 percent reported having none, compared to 46 percent of CEOs). Board chairs were more likely to have a position charter than were non-leadership board positions or committee chairs. In all types of board positions, CEOs reported fewer position charters than did board chairs *(see Figure 5.1)*.

**Figure 5.1**

**Position-Specific Charters (Job Descriptions) Hospitals Have for Board Members**



## New Board Member Orientation

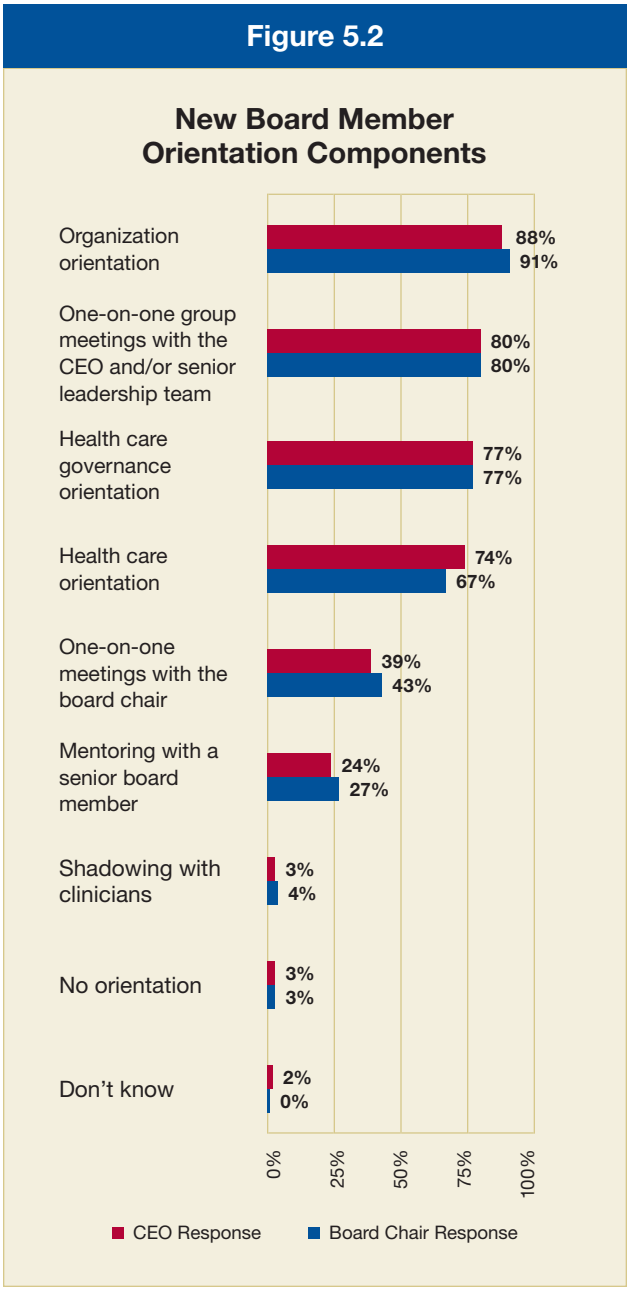
The board should have a well-thought out program for "onboarding" new trustees to ensure they have the foundation for effective and rewarding board service.

Trustee orientation should be considered a key component of a broader "onboarding" process that spans a trustee's first months on the board. The process is an opportunity to assist a new trustee to more rapidly assimilate information and issues, and become an engaged and contributing member of the board.

In addition to providing basic organizational and governance information and an overview of current market trends and challenges, a comprehensive trustee orientation process includes mentoring for new trustees with little or no prior board experience or health care expertise. A strong orientation program and warm welcome to the board are critical to trustees' success, as well as to the board's success as a cohesive governing body. Mentors play a key role in welcoming a new trustee to the board, and ensuring a rewarding opportunity for him or her to contribute to the success of the organization. Mentoring also provides an opportunity to learn new behavioral-based competencies such as asking probing questions respectfully and building consensus around the board table. New trustees with little or no experience in health care may also benefit from shadowing clinicians and/or additional meetings with the CEO or senior leadership team.

Nearly all hospitals and health systems reported having some form of new trustee orientation in 2014 (97 percent), which typically emphasized educational basics but did not typically include mentoring or shadowing of clinicians. Approximately nine in 10 organizations reported that their orientation included an introduction the organization, and eight in 10 included one-on-one group meetings with the CEO and/or senior leadership team. A strong majority also included health care governance orientation (77 percent) and general health care orientation (although CEOs reported 74 percent while board chairs reported 67 percent). About four in 10 new trustees engaged in one-on-one meetings with the board chair. Only about one-quarter of hospitals and health systems reported that their new trustee orientation process includes mentoring with a senior board member, and less than five percent included shadowing with clinicians in their orientation process *(see Figure 5.2)*.

**Figure 5.2**



## Continuing Board Education

Governance education is a continual process, not an end result. Education is the vehicle for improved governance knowledge. The end result and benefit of governance education is greater knowledge and heightened leadership intelligence that ensures trustees are fully-prepared to engage around critical issues, and make evidence-based decisions. Well-planned and well-focused governance education builds the "knowledge capital" the board needs to ensure that the right decisions will be made, using meaningful information and data.

Boards should commit to ongoing knowledge building, with a clearly articulated list of issues and topics most critical for board members to understand in order to make critical decisions. A basic education strategy should be set, with objectives and outcomes; success should be evaluated periodically; and new opportunities should be incorporated into the educational development effort as changes occur in the market. Education should not be a one-time event, but should instead be an institutionalized commitment to ensuring that the governing board has the knowledge resources necessary to make strategic decisions and to be a highly-effective leadership body.

A well-planned and financially well-supported trustee education effort will result in better decisions based on better knowledge and insights; an improved capacity to be a well-informed advocate for the hospital and its community; increased capacity to engage in challenging and productive governance dialogue; and an ability to think beyond "conventional wisdom."

Despite the importance of continuing education, in 2014 respondents reported a decline in nearly all types of board education compared to 2011 *(see Figure 5.3)*. The growth of webinars and podcasts may account for some decline in other traditional forms of education.

**Figure 5.3 - Types of Education Included in the Board's Continuing Education Process**

| | 2011 | 2014 |
|---|---|---|
| Publications | 83% | 76% |
| On-site speakers | 76% | 75% |
| Destination educational events | 72% | 72% |
| Webinars and podcasts | N/A | 33% |
| Membership in an outside governance support organization | 36% | 33% |
| Online education | 35% | 31% |
| Other | 10% | 10% |

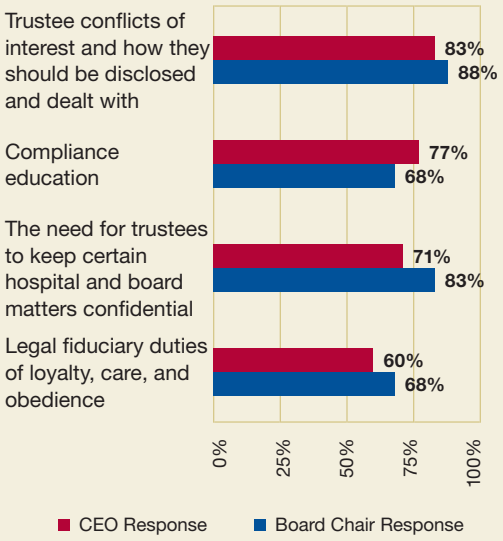
## Briefings from Legal Counsel

Hospital trustees have legal requirements that may be covered in a comprehensive trustee orientation process and general ongoing education, or may require targeted education from legal counsel. The basic fiduciary duties of loyalty, care and obedience are critical for trustees to understand. In addition, trustees should receive education about legal compliance, confidentiality requirements, preventing and responding to conflict of interest, and any pending legal proceedings, investigations, compliance issues, or other contingent liabilities that could have a significant impact on the hospital.

Most survey respondents reported that they periodically received educational briefings on conflict of interest and how they should be dealt with (83 percent for CEOs and 88 percent for board chairs), as well as board confidentiality (71 percent for CEOs and 83 percent for board chairs). Fewer reported receiving compliance education (68 percent of board chairs compared to 77 percent of CEOs), and even

## Figure 5.4

### Periodic Educational Briefings from Legal Counsel Provided to Boards




## Section Highlights

- In 2014, nearly half of all CEOs surveyed reported that their hospital did not have a job description or position charter for board positions
- In all types of board positions, CEOs reported fewer position charters than did board chairs
- Nearly all hospitals and health systems reported having some form of new trustee orientation in 2014
- Trustee orientations typically emphasized educational basics but did not include mentoring or shadowing of clinicians
- Despite the importance of continuing education, in 2014 respondents reported a decline in nearly all types of board education compared to 2011
- Most trustees periodically received educational briefings on conflict of interest and confidentiality
- Only six in 10 CEOs reported that trustees received a periodic briefing on the board's legal fiduciary duties of loyalty, care and obedience

fewer reported a periodic briefing on the board's legal fiduciary duties of loyalty, care and obedience (68 percent of board chairs compared to 60 percent of CEOs) *(see Figure 5.4)*.

SECTION 6

# BOARD EVALUATION

The AHA has coined the phrase "redefining the H" as hospitals consider what it means to be a hospital in today's transforming health care environment. In order to be successful in this endeavor, hospital trustees must also redefine their expectations of governance, including the board's roles, responsibilities, and composition. An annual board evaluation is an important starting point boards can take to ensure that they are well-poised to carry their organizations into the new health care world.

A board self-assessment is an organized evaluation of board members' satisfaction with all aspects of board performance in fulfilling the board's governance responsibilities. Governance assessments generally use a combination of quantitative and qualitative measurements of board, committee and individual performance.

Successful assessments enable boards to identify "governance gaps," or areas in which the board has the greatest potential for improvement. The assessment process identifies these gaps, and facilitates the development and implementation of initiatives and strategies to improve leadership performance.

Through an effective, well-developed board evaluation process growth opportunities can be realized, education can be pinpointed to unique governance needs, recruitment of new trustees can be undertaken with increased confidence, and long-range planning can be conducted within a consensus-based framework with everybody on the same page.

## Types of Board Evaluations

A successful board assessment engages the board in a wide-ranging evaluation of its overall leadership performance, focused on the full board as well as the responsibilities of individual board committees. At the same time, it provides trustees with an opportunity to gauge their personal performance as vital contributing members of the board of trustees, as well as the leadership performance of the board chair.

An individual performance assessment is a critical piece of a quality board evaluation process. Trustees may have one view of the overall board's performance, and have an entirely different view of their own individual performance, and that of their colleagues. A personal, introspective look at individual leadership enables trustees to focus on the essentials of good leadership and their personal impressions of their individual performance.

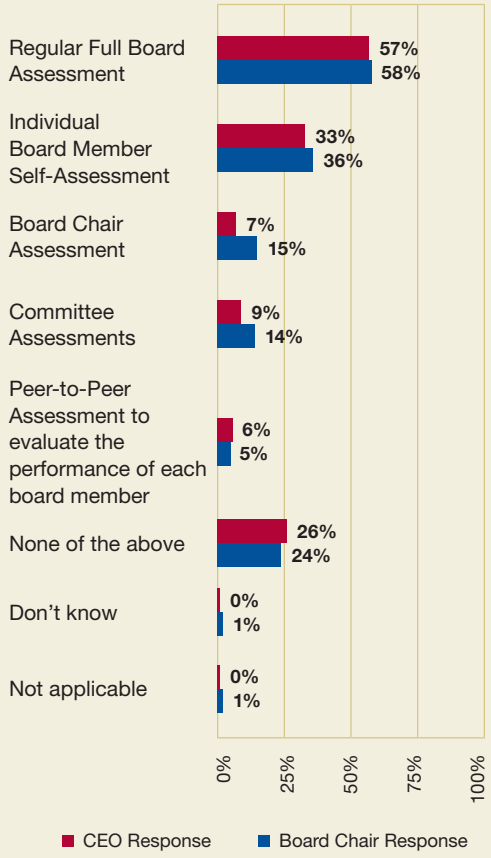
Just over one-half of all hospital and health systems reported conducting a full board assessment in the past three years (reported by 57 percent of CEOs and 58 percent of board chairs); however, only about one-third of hospitals reported conducting an individual board member self-assessment *(see Figure 6.1)*. While neither board chair assessments nor committee assessments were widely used, board chairs reported a higher use of both than did CEOs, with 15 percent of board chairs reporting use of a board chair assessment (compared to 7 percent of CEOs) and 14 percent reporting the use of committee assessments (compared to 9 percent of CEOs). The percentage of boards conducting a peer-to-peer assessment is not a practice used by many.

## Using Assessment Results

Conducting the governance assessment is the first step in improving governance leadership performance. The key to success of the full process is not simply the measurement of trustee viewpoints, but is instead the actions that are taken as a result of a careful examination of trustee viewpoints.

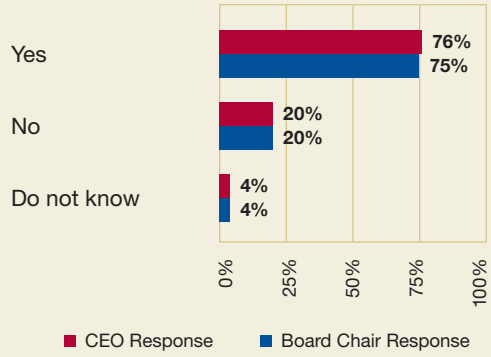
## Figure 6.1

### Assessments Boards Have Used in the Past Three Years (2011-2013)




## Figure 6.2

### Assessments Used to Create an Action Plan to Improve Board, Trustee, or Committee Performance




The assessment results should be a catalyst to engage trustees in a wide-ranging discussion of findings that highlight performance gaps and areas where trustees may lack consensus about the board's performance.

A full review of trustees' viewpoints should stimulate the board to discuss their opinions and ideas for improving board success, and result in the development of a governance improvement action plan with clearly defined responsibilities, time frames and projected outcomes. Boards should then monitor their progress to ensure that projected outcomes are achieved, and revise the governance improvement action plan when necessary.

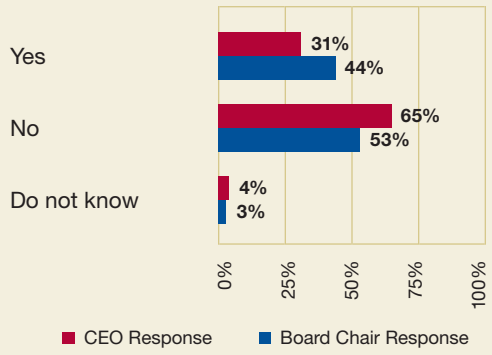
Three-quarters of hospitals and health systems reported that self-assessment results were used to create an action plan to improve board, trustee or committee performance; however, that leaves nearly one-quarter of boards that did not use the results for improvement or did not know how they use the results *(See Figure 6.2)*. Most hospitals did not use their assessment results when determining whether trustees should be reappointed for additional terms *(See Figure 6.3)*. This finding corresponds with earlier findings indicating that board members are typically not replaced or not re-nominated because of failure to demonstrate the needed competencies for governance effectiveness *(See Figure 4.4, earlier)*.

## Competency-Based Evaluations

Board evaluations should use pre-established, objective criteria to assess board effectiveness in improving hospital performance. The criteria should correlate with the board's defined roles and responsibilities, as well as individual trustee performance expectations. As hospital boards increasingly strive for a membership that possesses needed critical competencies, board evaluations should test the presence of those competencies in the annual self-evaluation process.

## Figure 6.3

### Assessment Results Used for Reappointment to Additional Terms




When evaluating the performance of individual board members, the most important competencies identified were community orientation, strategic orientation, accountability, knowledge of business and finance, and organizational awareness. At the same time, community orientation and collaboration were both rated as less important in 2014 when compared to 2011 by both board chairs and CEOs *(see Figure 6.4)*.

Board chairs and CEOs differ in their opinions about which competencies were most important when evaluating individual board member performance. Board chairs generally valued community orientation, achievement orientation, knowledge of health care delivery and performance, innovative thinking, and team leadership as most important. CEOs ranked the

## Figure 6.4 – The Most Important Competencies Board Members Consider When Evaluating the Performance of Individual Board Members

| | 2011 | | 2014 | |
|---|---|---|---|---|
| | CEO | Board Chair | CEO | Board Chair |
| Community Orientation | 74% | 79% | 62% | 66% |
| Strategic Orientation | 55% | 52% | 54% | 54% |
| Accountability | 56% | 47% | 47% | 49% |
| Collaboration | 58% | 45% | 41% | 38% |
| Knowledge of Business and Finance | 50% | 41% | 46% | 44% |
| Organizational Awareness | 31% | 41% | 40% | 42% |
| Professionalism | 36% | 39% | 36% | 36% |
| Achievement Orientation | 31% | 35% | 20% | 27% |
| Knowledge of Health Care Delivery and Performance | 25% | 29% | 29% | 32% |
| Innovative Thinking | 26% | 28% | 26% | 32% |
| Relationship Building | 26% | 23% | 29% | 21% |
| Complexity Management | 16% | 22% | 14% | 15% |
| Team Leadership | 13% | 22% | 11% | 14% |
| Impact and Influence | 21% | 20% | 30% | 21% |
| Information Seeking | 18% | 15% | 15% | 6% |
| Change Leadership | 9% | 7% | 12% | 10% |
| Knowledge of Human Resources Development | 5% | 3% | 1% | 3% |

competencies of collaboration, impact and influence, relationship building, and change leadership as more important evaluation competencies than did board chairs.

## Section Highlights

- Just over one-half of all hospital and health systems reported conducting a full board assessment in 2014
- The percentage of boards conducting a peer-to-peer assessment was not a practice used by many boards
- Nearly one-quarter of boards did not use their self-assessment results for improvement or did not know how they used the results
- Most hospitals did not use their assessment results when determining whether trustees should be reappointed for additional terms
- When evaluating the performance of individual board members, the most important competencies identified were community orientation, strategic orientation, accountability, knowledge of business and finance and organizational awareness
- Community orientation and collaboration as a board competency were both rated as less important in 2014 when compared to 2011 by both board chairs and CEOs
- Board chairs and CEOs differed in their opinions about which competencies were most important when evaluating individual board member performance

SECTION 7

# EXECUTIVE PERFORMANCE AND COMPENSATION

The board of trustees is responsible for ensuring that the CEO is appropriately and fairly compensated, which includes both a regular performance evaluation as well as compensation tied to that evaluation. The compensation and performance review process plays a critical role in building leadership loyalty and commitment, and ensuring leadership success and continuity. The process is about more than simply evaluating the CEO's compensation — it is an opportunity to strengthen the board/CEO relationship, and ensure that both the board and CEO have mutually agreed upon goals and expectations.

## CEO Performance Evaluation

The CEO evaluation sets specific direction on board expectations for the CEO and overall organizational performance. It ensures a consistent focus by the CEO, and continuous leadership accountability, renewal, focus and success. It defines the essential CEO functions and personal attributes required by the board, and encourages two-way communication between the board and CEO as they determine those functions and attributes, and discuss how they will be measured.

In addition, the CEO evaluation identifies performance areas requiring increased attention by the CEO, and defines the leadership competencies most critical to organizational success.

Board chairs reported that the most important criteria in CEO evaluations in 2014 were financial performance, patient satisfaction, vision or other leadership qualities, and clinical quality of care/outcomes. While CEOs and board chairs agreed on the weight given to financial performance in the CEO evaluation, CEO's perceptions of CEO accountability were lower in every other area when compared to board chairs. The biggest gaps between CEO and board chair perceptions of CEO accountability were risk management, community health improvement, system/network performance and legal and regulatory compliance *(See Figure 7.1)*. There was little difference in CEO evaluation criteria in 2014 when compared to 2011.

## CEO Compensation

Board oversight of CEO compensation is a responsibility examined by the Internal Revenue Service (IRS), and any failure may be subject to penalties, as well as potential media attention and other unwanted public scrutiny. The CEO's compensation must be reasonable and rewarding of performance, yet not "excessive." The CEO's compensation must be approved by the board or by a compensation committee whose members have no conflict of interest. In addition, the board or compensation committee must use relevant data to establish fair market compensation levels when approving executive compensation. Resources for comparability data include compensation surveys or studies, use of an independent compensation consultant, or review of Form 990 filings by similarly sized and/or structured organizations.

It is important that board actions and decisions about CEO compensation are supported with solid evidence, and that evidence is adequately documented in the board's written or electronic records. The board must have a clearly established process for determining compensation, use reliable comparative compensation information in evaluating the CEO's compensation plan, evaluate the CEO's specific skills and accomplishments in carrying out board-approved plans and priorities, and ensure that the CEO's total

| Figure 7.1 – Weight Given to Criteria in the Most Recent CEO Evaluation | | | | |
|---|---|---|---|---|
| | 2011 | 2011 | 2014 | 2014 |
| | CEO | Board Chair | CEO | Board Chair |
| Financial performance | 4.3 | 4.4 | 4.3 | 4.4 |
| Patient satisfaction | 4.0 | 4.2 | 3.9 | 4.3 |
| Vision or other leadership qualities | 3.8 | 4.3 | 3.9 | 4.3 |
| Physician relations | 3.9 | 4.2 | 3.8 | 4.1 |
| Cost reduction/efficiency | | | 3.8 | 4.1 |
| Strategic plan fulfillment | 3.9 | 4.1 | 3.8 | 4.1 |
| Clinical quality of care/outcomes | 3.8 | 4.1 | 3.8 | 4.2 |
| Employee Satisfaction | 3.6 | 3.9 | 3.6 | 3.9 |
| Legal and regulatory compliance | 3.5 | 4.1 | 3.5 | 4.0 |
| System/network performance | 3.1 | 3.6 | 3.3 | 3.8 |
| Risk management | | | 3.1 | 3.7 |
| Community health improvement | 2.5 | 3.3 | 2.7 | 3.3 |

** Respondents indicated how much weight the criteria had in the most recent CEO evaluation, on a scale from 1 (no weight) to five (absolutely critical).*

compensation package is commensurate with his or her responsibilities and performance.

Approximately eight in 10 hospitals reported that they use comparative data to ensure that CEO compensation reflects full market value. About one-half of respondents used a compensation committee comprised of independent members, or used an outside compensation consultant when determining CEO compensation *(See Figure 7.2)*. Boards not using a separate compensation committee may rely on their executive committee or full board when making compensation decisions.

## CEO Retention and Succession Planning

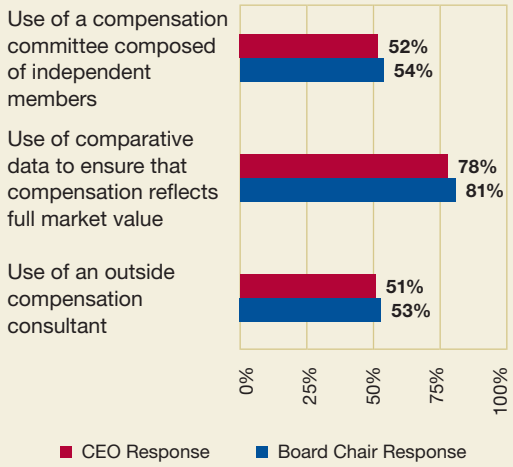
One of the principal accountabilities of the board of trustees is to ensure that the organization has consistently effective executive leadership at the top. The board is responsible for recruiting, motivating and retaining the chief executive officer. This responsibility is a continuing, evolving process of ensuring that leadership succession is planned and coordinated in a meaningful way to ensure a seamless transition from one executive leader to another.

According to the American College of Healthcare Executives, hospital CEO turnover is currently 20 percent, the highest rate since it was first calculated in 1981.[1] The need for clear retention and succession

1 Hospital CEO Turnover 1981 – 2013. American College of Healthcare Executives. March 10, 2014. www.ache.org.

## Figure 7.2

### Board Oversight of Executive Compensation




plans are clear. Yet in 2014, only one-quarter of CEOs reported having a CEO retention plan in place that had been updated in the past year. More board chairs (37 percent vs. 26 percent) reported the presence of a CEO retention plan that was updated within the last year. Both board chairs and CEOs reported an increase in the updating of CEO retention plans in 2014 when compared to 2011 *(see Figure 7.3)*.

Even hospitals with strong CEO retention plans should prepare for CEO turnover. The aim of succession planning is not necessarily to identify a specific individual or individuals in the organization to groom as potential successors, or to determine specifically ahead of time who the next chief executive should be. Instead, a responsible succession planning process consists of guidelines and options for the organization to utilize in the event of a need

## Figure 7.3 – Updating CEO Retention and Succession/Transition Plans

| | When did your board last update its CEO retention plan? | | | |
|---|---|---|---|---|
| | 2011 | 2011 | 2014 | 2014 |
| | CEO | Board Chair | CEO | Board Chair |
| Less than 1 year ago | 22% | 35% | 26% | 37% |
| At least 1 year ago but less than 2 years ago | 6% | 10% | 11% | 14% |
| At least 2 years ago | 6% | 4% | 10% | 10% |

## Figure 7.4 – Updating CEO Retention and Succession/Transition Plans

| | When did your board last update its CEO succession plan? | | | |
|---|---|---|---|---|
| | 2011 | 2011 | 2014 | 2014 |
| | CEO | Board Chair | CEO | Board Chair |
| Less than 1 year ago | 25% | 35% | 18% | 31% |
| At least 1 year ago but less than 2 years ago | 13% | 13% | 7% | 10% |
| At least 2 years ago | 9% | 9% | 6% | 8% |

to recruit or appoint a new CEO, whether the CEO leaves abruptly, or whether the leave is well planned and organized in advance.

Unlike the increase in CEO retention planning efforts, the frequency with which CEO succession plans are updated has declined when compared to 2011. In 2014, both board chairs and CEOs reported updating their CEO succession plan less frequently in 2014 when compared to 2011, with only 18 percent of CEOs reporting an updated succession plan within the last year *(see Figure 7.4)*.

## Section Highlights

- Board chairs reported that the most important criteria in CEO evaluations in 2014 were financial performance, patient satisfaction, vision or other leadership qualities, and clinical quality of care/outcomes. There was little difference in 2014 when compared to 2011
- CEO's perceptions of CEO accountability were lower in every area except financial performance when compared to board chairs
- Approximately eight in 10 hospitals reported that they used comparative data to ensure that CEO compensation reflects full market value
- About one-half of respondents used a compensation committee comprising independent members, or used an outside compensation consultant when determining CEO compensation. Boards not using a separate compensation committee may rely on their executive committee or full board when making compensation decisions
- Only one-quarter of CEOs reported having a CEO retention plan in place that had been updated in the past year
- Both board chairs and CEOs reported an increase in the updating of CEO retention plans in 2014 when compared to 2011
- The frequency with which CEO succession plans are updated has declined when compared to 2011
- Only 18 percent of CEOs reporting an updated succession plan within the last year

SECTION 8

# QUALITY AND STRATEGY OVERSIGHT

Boards of trustees are responsible for ensuring the quality of care and patient safety provided by their organizations, and must take strong, organized action to establish and ensure an organizational culture that continually strives to improve quality and patient safety.

A "culture of safety" should be ingrained in the hospital, a responsibility that begins with the board. The board sets the tone for the hospital, and ensures the resources necessary for employees and others to carry out the quality and patient safety vision. The board then regularly measures and monitors quality and patient safety progress to ensure success.

## Use of Quality Objectives and Benchmarks

An effective method for monitoring quality performance is through quality benchmarks, usually implemented through a quality "dashboard." The dashboard should be reviewed regularly at board meetings, ensuring that trustees are aware of the hospital's actual quality performance, and are empowered to make decisions based on hard facts and evidence.

Quality dashboards assist hospitals in accomplishing the goal of regular trustee review and assessment of patient quality and safety measures. Dashboards are presented in the same easy-to-read format at every board meeting, ensuring that all trustees understand the reports and can make informed decisions about whether the hospital is "on track" with its quality and patient safety goals.

Compared to 2011, more boards have developed precise and quantifiable hospital quality and safety objectives, although the reporting varies between hospital CEOs and board chairs. More than nine in 10 board chairs reported the presence of precise and quantifiable quality and safety objectives, while just over eight in 10 CEOs reported their presence. When asked about specific components, board chairs reported more widespread use of precise and quantifiable measures in the areas of patient safety, service quality/patient satisfaction, and clinical quality when compared to CEOs *(see Figure 8.1)*.

**Figure 8.1 – Areas Where Boards Have Developed Precise and Quantifiable Hospital Quality and Safety Objectives**

| | 2011 | 2011 | 2014 | 2014 |
|---|---|---|---|---|
| | CEO | Board Chair | CEO | Board Chair |
| Service quality/patient satisfaction | 71% | 83% | 73% | 89% |
| Patient safety | 68% | 86% | 70% | 88% |
| Clinical quality | 71% | 86% | 74% | 87% |
| No precise and quantifiable objectives have been developed | 24% | 10% | 19% | 8% |
| Don't know | 2% | 2% | 3% | 2% |

| Figure 8.2 - Board Benchmark Used When Evaluating Hospital/System Performance | | | | |
|---|---|---|---|---|
| | 2011 | 2011 | 2014 | 2014 |
| | CEO | Board Chair | CEO | Board Chair |
| Financial performance | 96% | 96% | 94% | 92% |
| Patient/family satisfaction | 90% | 95% | 92% | 96% |
| Human resources | 73% | 80% | 67% | 71% |
| Clinical outcomes | 74% | 75% | 78% | 82% |
| Clinical quality | 60% | 65% | 62% | 72% |
| Efficiency or cost of care measures | 52% | 68% | 56% | 69% |
| Market share | 42% | 48% | 43% | 51% |
| Community health | 19% | 44% | 26% | 47% |
| Other | 6% | 2% | 3% | 2% |

When evaluating the hospital or system's performance, the most common benchmarks used by boards in 2014 were patient/family satisfaction, financial performance, and clinical outcomes. Board chairs placed greater emphasis on community health, efficiency or cost of care measures, and clinical quality than did CEOs when evaluating overall organizational performance *(see Figure 8.2)*.

## Board Engagement and Accountability for Quality

Quality is not a one-time agenda item. Instead, quality and patient safety should be at the forefront in board discussions and decisions on virtually any agenda topic. In addition to tracking progress in achieving hospital quality and safety objectives and comparing the organization's performance to benchmark data, boards should receive executive reports of medical staff quality meetings, information about quality and patient safety improvement plans and general information about health care quality trends. Boards should also receive information about grievances, adverse events, "near misses," and potential liabilities, as well as progress reports on correction action plans to address known challenges.

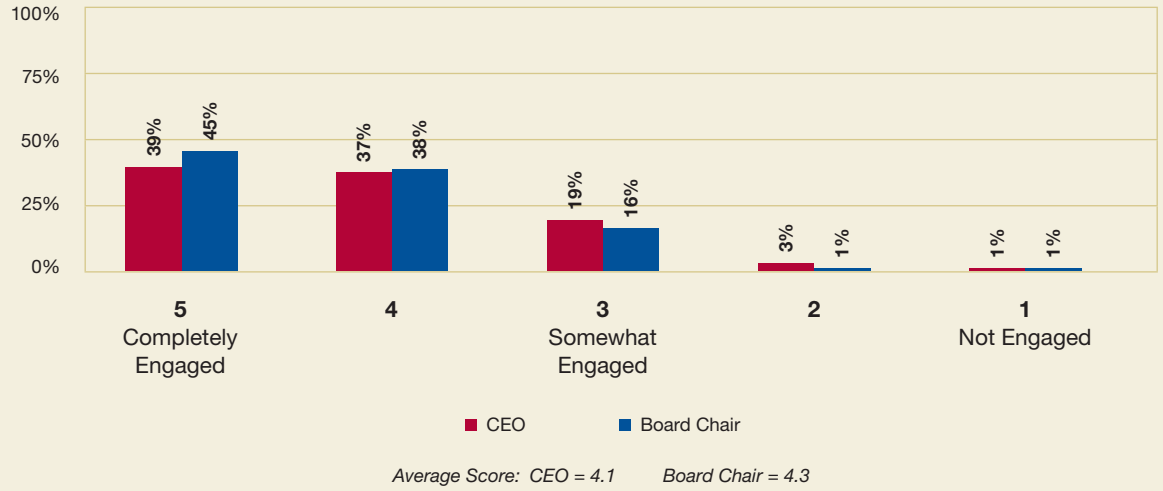
When asked about their overall board's engagement in quality and safety issues, both board chairs and CEOs indicated that their boards are highly engaged (4.3 and 4.1 respectively on a five-point scale) *(see Figure 8.3)*. The majority of hospitals also reported that their CEO is held accountable for defined quality objectives during the performance evaluation; however, 78 percent of board chairs reported that the CEO is accountable for quality, while only 68 percent of CEOs reported this accountability *(see Figure 8.4)*.

## Tracking Strategic Performance

One of the board's primary responsibilities is setting long-term and high-level strategic direction; however, the process cannot stop there. Hospital boards must know whether the strategies and objectives adopted and implemented are achieving the desired outcomes. Being able to engage in a continuous analysis and

## Figure 8.3

### Board Engagement in Quality and Safety Issues (Scale of 1-5)



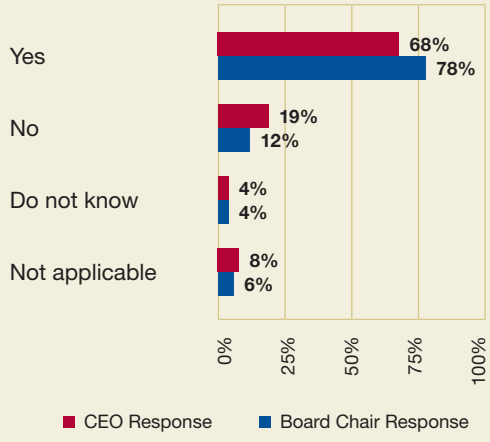

*Average Score: CEO = 4.1 Board Chair = 4.3*

dialogue about strategic progress and performance requires a set of key performance indicators that tell the board where current strategic gaps exist, and where potential strategic gaps may be on the horizon. With the input of the CEO and management team, the board should track performance and progress using a set of metrics, a periodic review process, and an incentive system to reward management for meeting organizational objectives.

Nearly nine in 10 board chairs, and 85 percent of CEOs, reported that their board assesses at least annually the hospital's strategic performance using measures established at the beginning of the year. At the same time, 14 percent of CEOs reported that their board did not review the hospital's strategic performance at least annually, and a small percentage of CEOs and board chairs did not know whether this review took place.

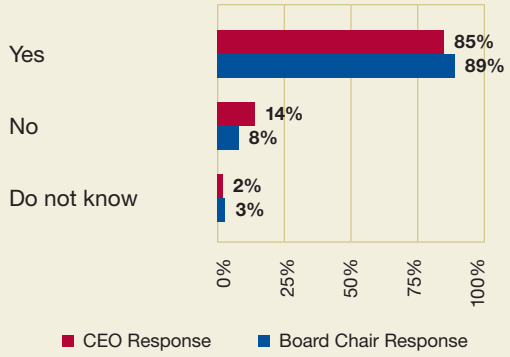
## Figure 8.4

### CEO is Held Accountable for Defined Quality Objectives During Performance Evaluation



## Figure 8.5

### Board Assesses the Hospital's Strategic Performance Using Measures Established at the Beginning of the Year (At Least Annually)




## Section Highlights

- Compared with 2011, more boards have developed precise and quantifiable hospital quality and safety objectives, although the reporting varies between hospital CEOs and board chairs
- Board chairs reported more widespread use of precise and quantifiable measures in the areas of patient safety, service quality/patient satisfaction and clinical quality when compared to CEOs
- The most common benchmarks used by boards in 2014 were patient/family satisfaction, financial performance and clinical outcomes
- Both board chairs and CEOs indicated that their boards are highly engaged in quality and safety issues (4.3 and 4.1 respectively on a five-point scale)
- Seventy-eight percent of board chairs reported that the CEO is accountable for quality, while only 68 percent of CEOs reported this accountability
- Nearly nine in 10 board chairs, and 85 percent of CEOs, reported that their board assesses at least annually the hospital's strategic performance using measures established at the beginning of the year
- At the same time, 14 percent of CEOs reported that their board did not review the hospital's strategic performance at least annually

SECTION 9

# INTERNAL AND EXTERNAL STAKEHOLDERS

Hospital boards play a role in facilitating strong and trusting partnerships both internally and in the community. Boards play a pivotal leadership role in ensuring that their organizations have a workplace culture that will attract and retain a high-quality workforce and medical staff prepared to meet both today's and tomorrow's community needs. At the same time, hospital boards have a unique opportunity to ensure that their organizations consistently engage in meaningful ways with a broad range of community stakeholders.

## Alignment with Physicians and Clinical Staff

Health care transformation encourages more than hospitals, physicians, nurses and other clinical caregivers to cooperate to care for patients. It requires hospitals and clinicians to provide integrated care —care that is coordinated, uses seamless technology, and involves providers across the spectrum working together to care for each patient as an entire "episode of care."

This is a necessary shift in thinking for many health care trustees. Hospital trustees should be preparing for that shift now, working jointly with their medical staff, nurses and other providers in the community to develop shared solutions and forge partnerships that will provide better care and prepare all health care providers for a successful future.

Overall, both CEO and board chair respondents indicated relatively high levels of alignment between the board and the medical staff and nursing staff *(see Figure 9.1)*. Despite this reportedly high alignment, clinical board representation has declined from 31 percent in 2011 to 29 percent in 2014 *(see Figure 2.9, earlier)*.

## Understanding Community Health Needs

A comprehensive community needs assessment provides the hospital with first-hand information about the health care needs of the community it serves. With this "snapshot" of the community's health, organizations can identify the most pressing community health care needs, populations of individuals in need, gaps in care and services, barriers and challenges to receiving services, and information about other organizations that may already be working to meet specific needs. This information provides the foundation needed to build strategic and operational plans that will advance the hospital's mission of service to the community.

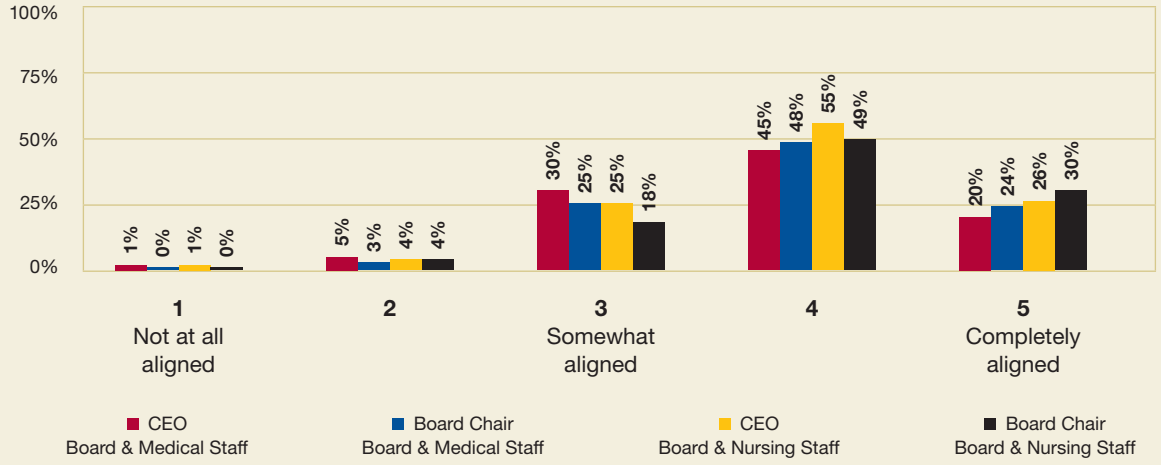
In 2014, boards overwhelmingly reported that they consider the results of their organization's community health needs assessment when developing their strategic plan *(see Figure 9.2)*. Although the majority of board chairs and CEOs both reported considering the needs assessment as a part of the strategic planning process, 12 percent of CEOs reported not using a community needs assessment when developing the strategic plan, in contrast to only five percent of board chairs reporting the needs assessment was not considered.

## Board Receipt of the IRS Form 990

IRS revisions to the Form 990 and the addition of the form "Schedule H" have resulted in trustees being held to greater accountability for oversight of the hospital's financial and community benefit reporting. A broader scope of information is now required to be collected and reported, allowing more transparency into hospitals' actions and their community benefit contributions. With this additional reporting and increased transparency there is opportunity for greater scrutiny; however, the revisions also give hospitals and

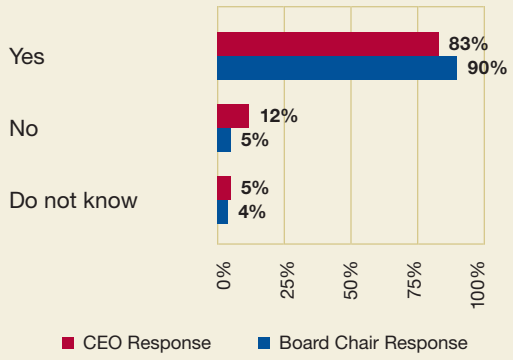
## Figure 9.1

### Alignment of Hospital/System Board and Medical Staff/Nursing Staff in Pursuing the Organization's Goals and Vision




## Figure 9.2

### Board Considers the Organization's Community Health Needs Assessment When Developing the Strategic Plan



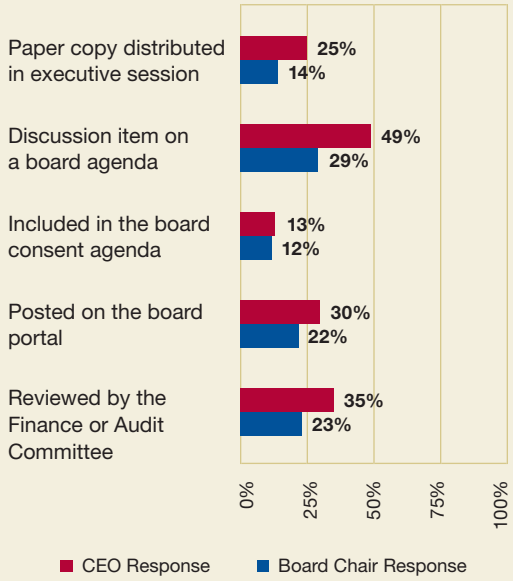

trustees a greater opportunity to tell their story, and to build strong public trust and confidence.

While the core Form 990 asks whether a complete copy of the Form was provided to all members of the governing body before its filing, there can be a variety of methods for accomplishing this requirement.

In 2014, there was a disconnect between the CEO and board chair responses about how boards are receiving a copy of the organization's IRS Form 990 Schedule H. While approximately one-half of CEOs reported that the Form 990 is a discussion item on a board agenda, less than one-third of board chairs provided the same response. Similarly, 25 percent of CEOs reported that the Form 990 is distributed in executive session, and only 14 percent of board chairs reported the form's distribution in that forum. More CEOs also reported the Form 990 being reviewed by the Finance or Audit Committee than did board chairs *(see Figure 9.3)*.

## Figure 9.3

### How Boards Are Provided a Copy of the Form 990 Schedule H




## Section Highlights

- Overall, both CEO and board chair respondents indicated relatively high levels of alignment between the board and the medical staff and nursing staff. Despite this reportedly high alignment, clinical board representation has declined
- In 2014, boards overwhelmingly reported that they consider the results of their organization's community health needs assessment when developing their strategic plan
- There are a variety of methods for providing a complete copy of the IRS Form 990 to the board prior to its filing. There was a disconnect between the CEO and board chair responses about how boards are receiving a copy of the Form 990

SECTION 10

# BOARD CULTURE

Effective, high-performance boards spend most of their time on important strategic and policy issues. They engage in rich discussion and dialogue, assess outcomes and participate in ongoing learning and gathering of new ideas and perspectives. Whether in a full board meeting or executive session, they focus on the issues that are most critical to the organization, and where they can have the greatest impact.

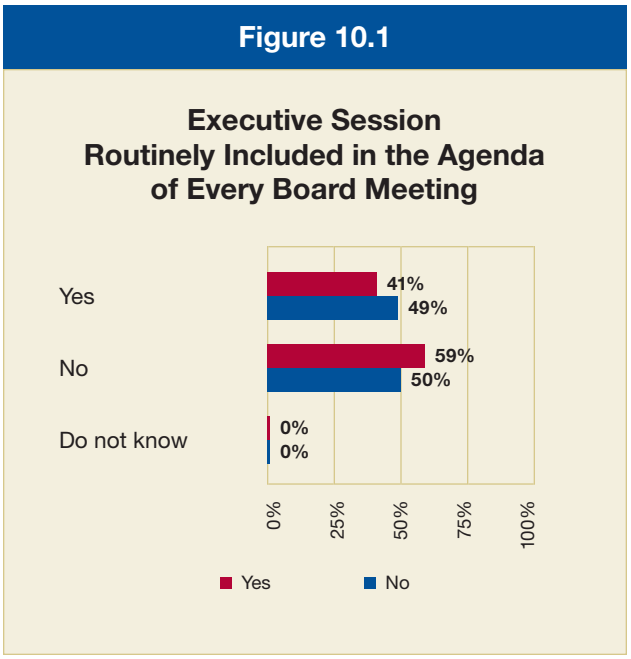
## Executive Sessions

One of the most productive places for candid and forthright board/CEO discussion to take place is in an executive session. Executive sessions are settings that allow the board to handle confidential matters behind closed doors, without staff present.

Appropriate topics for an executive session may include personnel matters, investigations or updates on alleged improper conduct, CEO performance assessment, legal negotiations and financial discussions with an auditor, or other topics that must remain highly confidential for a limited period of time. Items appropriate for executive sessions will vary if the organization is a public or private hospital, and depending upon state laws and regulations.

In addition, there are times when the board simply needs to have an opportunity to openly and confidentially share opinions among board members on a particular topic. In order to be effective and not misused with a "shadow-agenda," executive sessions should address only pre-determined issues and not delve into discussion and decision-making that could more appropriately be conducted in the regular board meeting. The executive session is not an excuse to avoid difficult topics and conversations, or inappropriately hide board deliberations behind closed doors.

**Figure 10.1**




In 2014, half of all hospitals reported that an executive session was routinely included in the agenda as a part of every board meeting, up from 41 percent in 2011 *(see Figure 10.1)*.

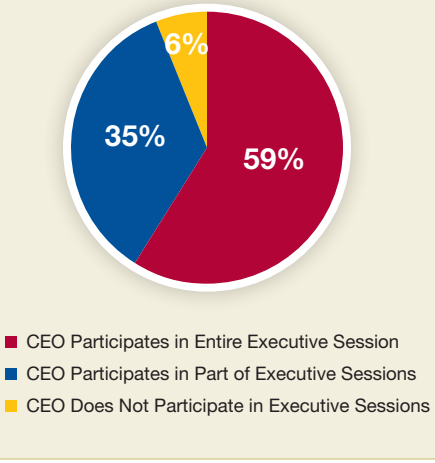
### *CEO Participation in Executive Sessions*

Holding regular executive sessions is a constructive way to build a strong sense of connection and communication between the board and the CEO. The executive session enables both to engage in the kind of dialogue that is oftentimes difficult during regular board meeting when staff members and, in the case of public hospitals, the press and members of the community, may be in attendance.

In 2014 CEOs participated in the entire executive session in 59 percent of hospitals, and in part of the executive session in 35 percent of hospitals. Few hospitals conducted an executive session without any CEO participation at all (six percent) *(see Figure 10.2)*.

## Figure 10.2

### CEO Participation in Executive Sessions




***Typical Topics Discussed***

The most common topics discussed at executive sessions in 2014 were executive performance and evaluation, followed by executive compensation, miscellaneous governance issues, general strategic planning and strategy with regards to mergers and acquisitions. Compared to 2011, it was reported that more executive sessions now focus on miscellaneous governance issues and strategy with regard to mergers and acquisitions *(see Figure 10.3)*.

There were differences between board chair and CEO respondents' perspectives on all topics, with the exception of executive performance and evaluation and executive compensation. In nearly all other areas, board chairs reported a higher prevalence of discussion topics than did CEOs.

## Figure 10.3 – Topics Typically Discussed at Board Executive Sessions

| | 2011 | 2011 | 2014 | 2014 |
|---|---|---|---|---|
| | CEO | Board Chair | CEO | Board Chair |
| Executive performance and evaluation | 82% | 84% | 77% | 78% |
| Executive compensation | 72% | 73% | 62% | 62% |
| Miscellaneous governance issues | 29% | 38% | 43% | 54% |
| General strategic planning | 36% | 51% | 41% | 53% |
| Strategy with regards to mergers and acquisitions | 40% | 44% | 46% | 51% |
| Financial performance of institution(s) | 28% | 49% | 32% | 47% |
| Clinical or quality performance measures | 28% | 47% | 33% | 45% |
| Board recruitment and selection | 28% | 42% | 24% | 41% |
| Succession planning | 37% | 37% | 32% | 39% |
| Board performance and evaluation | 29% | 35% | 31% | 38% |
| Government relations | 17% | 27% | 15% | 27% |
| Other | 21% | 16% | 17% | 12% |

## Board Meeting Dialogue and Discussion

Board and committee meeting time is limited, and should strive to be purposeful and productive. Board members must ensure their governance conversations are vibrant, vital and focused on purpose and outcomes. Through critical conversations, decisions are made by grasping with concepts, ideas and practical solutions, leading to informed and rational conclusions.

When boards experience a "dialogue deficit" they miss unique opportunities to explore alternative ideas, choices and courses of action. In many cases a lack of dialogue results in "proforma" decisions that are made with little insight or real understanding. In contrast, there are continual opportunities for board learning that occur when trustees engage in robust discussion, challenge one another's assumptions and work toward a consensus that is grounded in mutual knowledge, understanding and commitment.

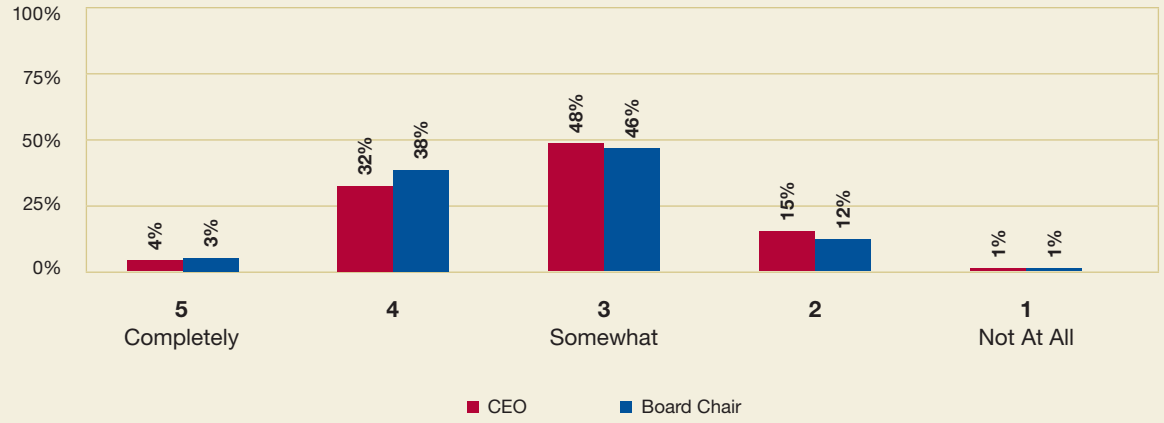
CEOs and board chairs reported that they are spending some board meeting time in active discussion, deliberation and debate about the strategic priorities of the organization (rather than listening to briefings, presentations, and reports). On a five point scale, board chairs reported 3.3 and CEO's 3.2 *(see Figure 10.4)*.

One way to ensure that meetings are focused on where the hospital is headed, rather than where it has been, is to design the agenda to ensure that the majority of governance attention and discussion is on issues in which the board has the greatest impact: planning, setting policy, making critical decisions and setting future direction.

Little progress has been made since 2011 with regard to the percentage of board meeting time that boards normally spend in active discussion, deliberation, and debate at each board meeting. While just over 40 percent of hospital boards reported spending more than 50 percent of their time in active discussion, deliberation and debate in 2014, 19 percent of board chairs reported spending less than 25 percent of their meeting time on such activities *(see Figure 10.5)*.

**Figure 10.4**

**Extent the Majority of Board Meeting Time Is Spent in Active Discussion, Deliberation and Debate about Strategic Priorities of the Organization**




*Average Score: CEO = 3.2 Board Chair = 3.3*

| Figure 10.5 – Approximate Percentage of Board Meeting Time the Board Normally Spends in Active Discussion, Deliberation and Debate at Each Board Meeting | | | | |
|---|---|---|---|---|
| | 2011 | 2011 | 2014 | 2014 |
| | CEO | Board Chair | CEO | Board Chair |
| Greater than 0% but less than or equal to 25% | 23% | 19% | 23% | 19% |
| Greater than 25% but less than or equal to 50% | 46% | 41% | 40% | 40% |
| Greater than 50% but less than or equal to 75% | 23% | 26% | 30% | 33% |
| Greater than 75% | 7% | 13% | 7% | 8% |

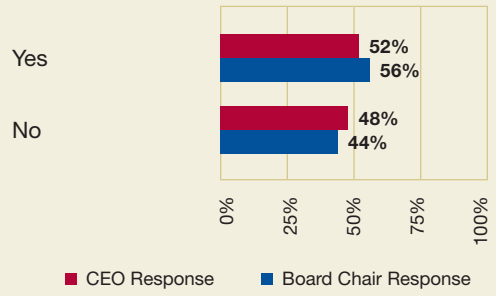
## Electronic Board Portals

Whether it is an everyday social interaction, patient-physician communication, or interaction between hospital leaders and board members, technology increasingly plays a role. Technology is an unparalleled tool for enhancing and strengthening communication, one that is rapidly changing our culture.

For hospital boards, an electronic board portal reduces waste and administrative time required to prepare for meetings and ensures that governance resource materials are always up to date. Board portals can also offer an ongoing way for trustees to access information anywhere from a mobile device or computer, including basic organizational information, ongoing education and resources, a board calendar, trustee and administration contact information and more.

Hospitals and health systems must be adept and innovative in leveraging the benefits that technology offers across a variety of settings and for any number of purposes. At the same time, hospital boards, physicians and senior leaders must be cautious to not replace the personal connections and face-to-face meetings that are essential to strong and effective governance leadership. In 2014, over half of hospitals reported using an electronic board portal (56 percent of board chairs and 52 percent of CEOs) *(see Figure 10.6)*.

**Figure 10.6**



## Section Highlights

- Half of surveyed hospitals reported that an executive session was routinely included in the agenda as a part of every board meeting
- CEOs participated in the entire executive session in 59 percent of hospitals, and in part of the executive session in 35 percent of hospitals
- The most common topics discussed at executive sessions in 2014 were executive performance and evaluation, and executive compensation
- CEOs and board chairs reported that they are spending some board meeting time in active discussion, deliberation and debate about the strategic priorities of the organization (rather than listening to briefings, presentations and reports). On a 5 point scale, board chairs reported 3.3 and CEO's 3.2
- Little progress has been made since 2011 with regard to the percentage of board meeting time that boards normally spend in active discussion, deliberation and debate at each board meeting
- Over half of hospitals reported using an electronic board portal in 2014

SECTION 11

# READINESS FOR HEALTH CARE TRANSFORMATION

The transformation from a fee-for-service to a value-based payment system is prompting hospitals to embrace population health management and promote care across the continuum, with goals to improve the health of the community, provide better access to primary care, reduce admissions and readmissions, and make meaningful and measurable improvements in outcomes of care. Hospitals are accountable to their communities, not only for the care provided inside the hospital, but also for improving the overall health of the communities they serve. Many are making that commitment by striving to achieve the goals of the Institute for Healthcare Improvement's Triple Aim: improving the patient experience of care, improving the health of populations and unparalleled patient outcomes, and providing care at an affordable cost.[1]

A recent survey by the AHA of more than 1,000 hospital CEOs, C-suite leaders and board chairs found a general agreement on the direction in which the health care field is heading. These leaders forecast that in five years there will be more hospitals aligned with health systems, greater hospital/physician affiliation, increased ownership of health plans by systems, and increased value-based and capitated payments.[1]

To better understand how well hospitals and their governing boards are preparing to make this shift, the 2014 survey included new questions focusing on board chair and CEO perceptions of board readiness to govern in the transforming health care delivery system.

## Knowledge of Health Care Transformation

The first step in preparing for health care transformation is ensuring that hospital and health system boards of trustees understand the factors driving health care transformation, as well as the potential implications on their organization and community. Trustees should continually seek information and education about changes in the environment, and engage in dialogue about the strategic implications for their organization. Boards need to ensure that a fundamental question is regularly asked and answered: "What do we know today that we didn't know at our last meeting, and how does that new information impact or reshape the assumptions that underpin our strategic direction?"

Both board chairs and CEOs reported that their boards were fairly knowledgeable about the coming changes, with scores of 3.9 and 3.8 respectively on a five point scale *(see Figure 11.1)*.

## Engagement in Transformational Governance Practices

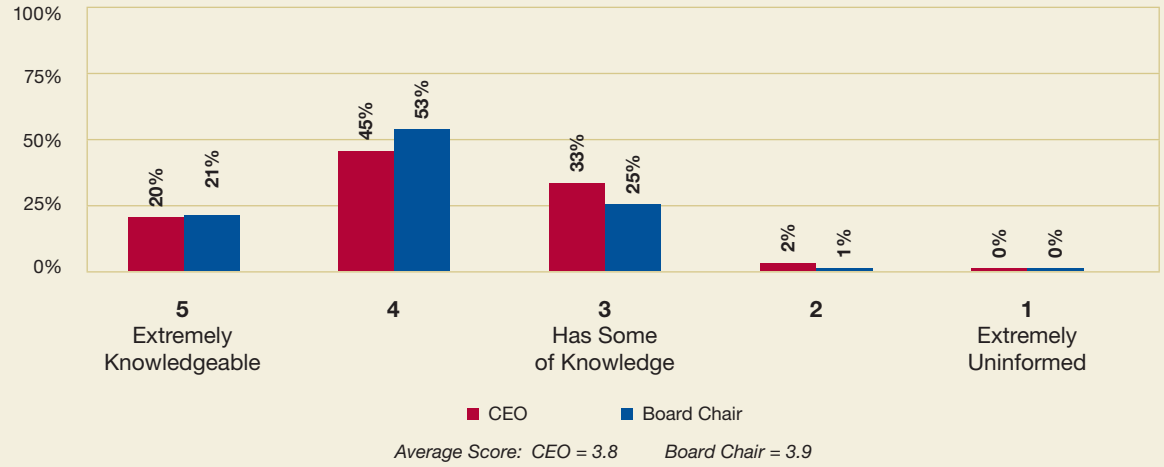
Engaging in transformational governance practices may be different for every board, but typically includes discussion and dialogue around key considerations for future board thinking, board competencies, and the origination's overall strategic direction. Areas explored in this area of the survey included board engagement in:

- examining emerging governance models and considering how they might apply to their organization;

1 "Leadership Toolkit for Redefining the H: Engaging Trustees and Communities". American Hospital Association Committee on Performance Improvement and Committee on Research, 2014

## Figure 11.1

**How Knowledgeable is Your Board About the Transformational Changes Occurring in Health Care?**




*Average Score: CEO = 3.8 Board Chair = 3.9*

- having a candid strategic discussion about what health care transformation means for their organization, and how to best deploy assets to meet community health needs;
- developing a new vision and strategy for transformational change for their organization;
- developing future-focused metrics that assess today's performance and shape future outcomes;
- strengthening board and organizational competencies to manage change and risk; and
- developing new or revised competencies required for board membership in a transformed environment.

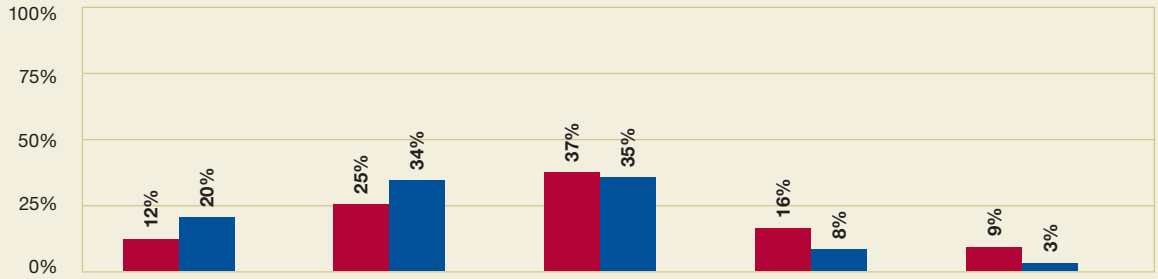
Overall, there were significant differences in the responses between board chairs and CEOs about the extent to which boards are currently engaged in new practices to prepare for governing in a transformed health care delivery environment, with the board chairs reporting much higher levels of engagement than CEOs.

On a scale of one to five, board chairs rated the board's level of engagement highest for having candid strategic discussion about what health care transformation means for the organization and how to best deploy assets to meet community health needs (4.0, *see Figure 11.3*), and developing a new vision and strategy for transformational change in their organization (3.9, *see Figure 11.4*).

CEOs rated the board's level of engagement lowest for examining emerging governance models and considering how they might apply to their organization (3.1, *see Figure 11.2*) and developing new or revised competencies required for board membership in a transformed environment (2.7, *see Figure 11.7*).

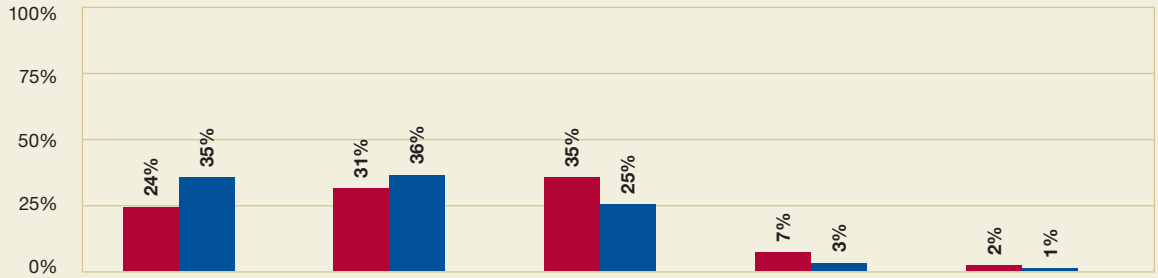
## Figures 11.2, 11.3, 11.4

### Board Engagement in Examining Emerging Governance Models and Considering How They Might Apply for Their Organization



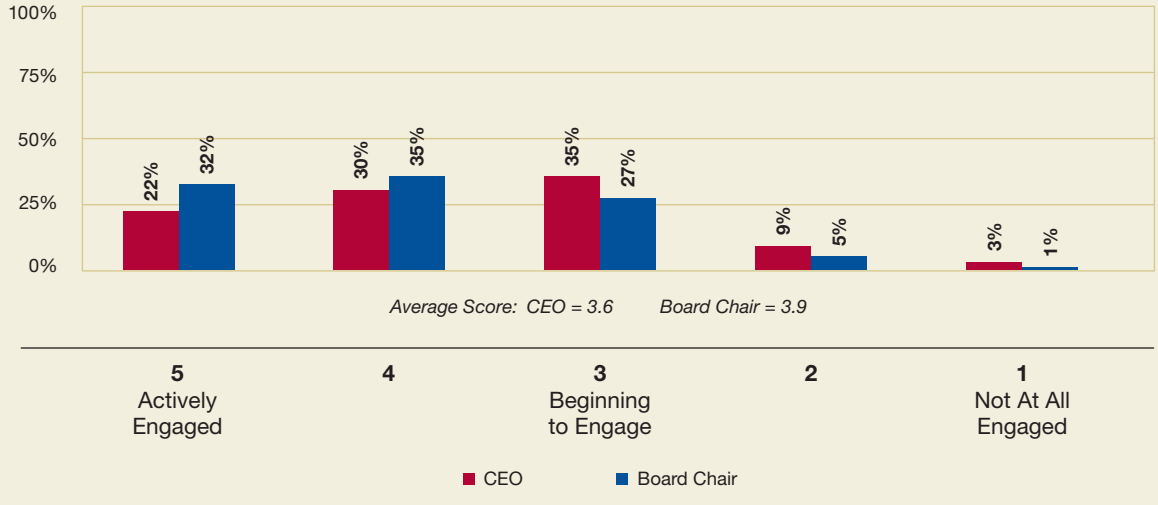

*Average Score: CEO = 3.1 Board Chair = 3.6*

### Board Engagement in Having a Candid Strategic Discussion About What Health Care Transformation Means for Their Organization and How to Best Deploy Assets to Meet Community Health Needs




*Average Score: CEO = 3.7 Board Chair = 4.0*

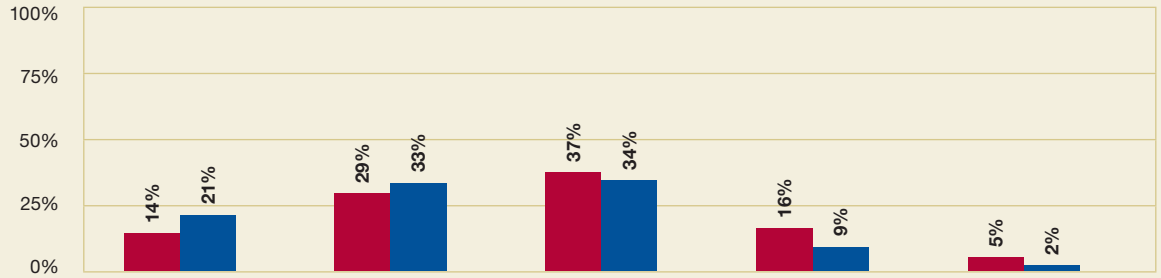
### Board Engagement in Developing a New Vision and Strategy for Transformational Change for Their Organization




*Average Score: CEO = 3.6 Board Chair = 3.9*

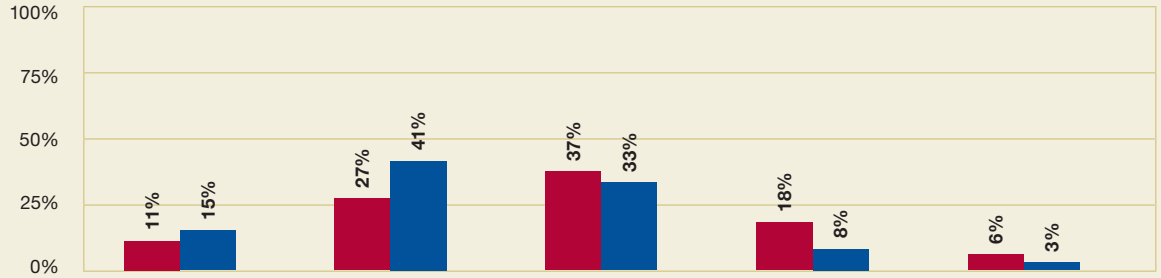
## Figures 11.5, 11.6, 11.7

### Board Engagement in Examining Emerging Governance Models and Considering How They Might Apply for Their Organization



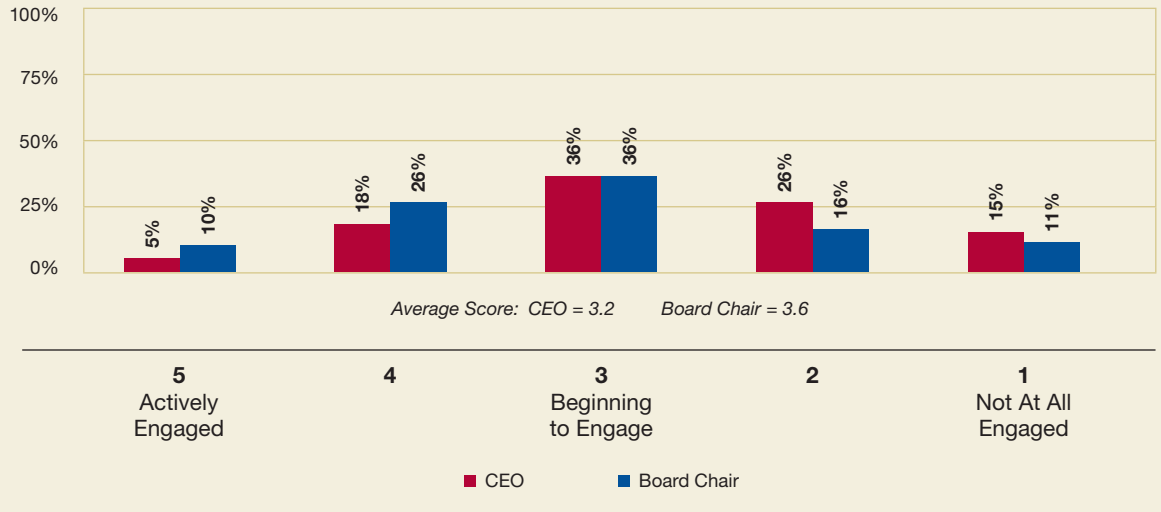

*Average Score: CEO = 3.3* *Board Chair = 3.6*

### Board Engagement in Strengthening Board and Organizational Competencies to Manage Change and Risk




*Average Score: CEO = 3.3* *Board Chair = 3.6*

### Board Engagement in Developing New or Revised Competencies Required for Board Membership in a Transformed Environment




*Average Score: CEO = 3.2* *Board Chair = 3.6*

## Information Technology Resources to Support Transformation

The goal of population health, or improving the overall health of a population, is closely aligned with hospitals' missions to improve the health of the community they serve. As hospitals and health systems foster partnerships with other providers and build community relationships to impact the overall health of the community, information technology is necessary to define, track and measure success, including using predictive modeling for population health management, as well as the use of data analytics for care management and operational management.

Both board chairs and CEOs expressed some concern about the adequacy of their organizations' information technology resources for supporting population health. On a scale of one to five, board chairs rated their IT adequacy for supporting population health at 3.5, while CEOs rated it as 3.0 *(see Figure 11.8)*.

## Progress in Transformation

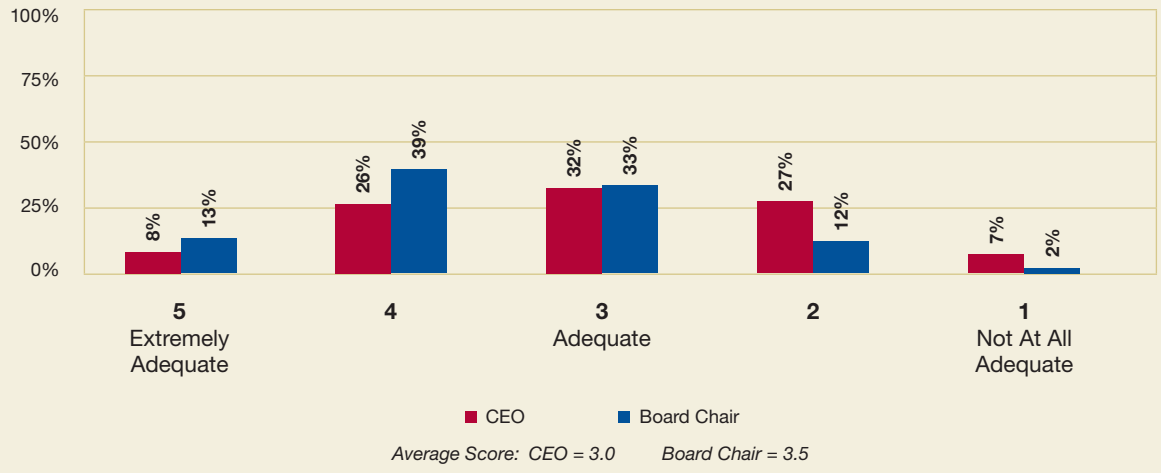
Transformation takes time and patience. Many hospital and health system boards reported that they are well on their way to creating a transformed health care organization, while board chairs reported that they are slightly further along than CEOs reported. Only 1 percent of respondents indicated that they have not yet begun the transformational process, and only 1 percent reported that they have completed the work; this leaves the vast majority of organizations in the process of transitioning toward a transformed health care organization *(see Figure 11.9)*.

## Willingness to Give Up Some Autonomy

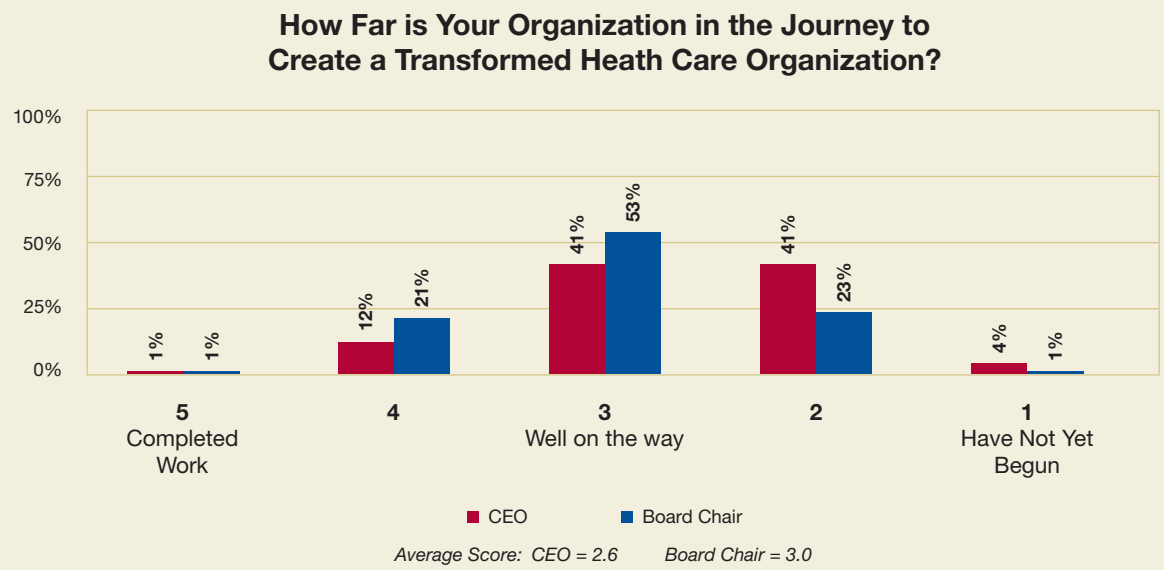
As organizations increasingly engage in collaborations, alliances, mergers and acquisitions, the structure of governance and the role of local boards may change. While no single governance model fits every organization, many larger systems are redefining the role of the larger, system board that results in a more limited, yet essential role for local governing bodies.

**Figure 11.8**

**How Adequate Are Your Organization's Information Technology Resources for Supporting Population Health?**

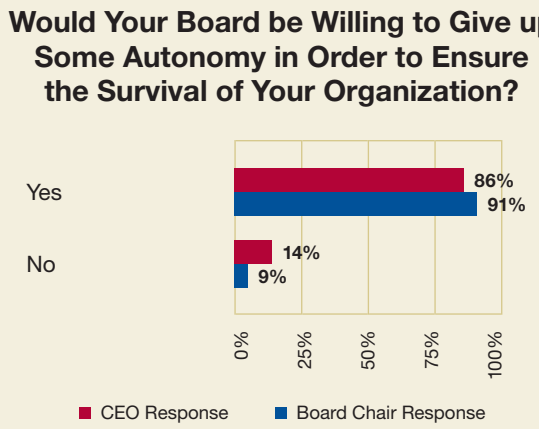


## Figure 11.9




When asked if their boards would be willing to give up some autonomy in to ensure the survival of their organizations, a strong majority of both board chairs and CEOs would agree to their boards having less autonomy. Responses between board chairs and CEOs differed slightly, with 91 percent of board chairs indicating a willingness on the part of the board to give up some autonomy, and with 86 percent of CEOs agreeing *(see Figure 11.10)*.

## Figure 11.10



## Section Highlights

- Both board chairs and CEOs reported that their boards were fairly knowledgeable about the emerging changes in health care delivery and financing, with scores of 3.9 and 3.8 respectively on a five point scale
- There were significant differences in the responses between board chairs and CEOs about the extent to which boards are currently engaged in new practices to prepare for governing in a transformed health care delivery environment, with the board chairs reporting much higher levels of engagement than CEOs
- Board chairs rated their IT adequacy for supporting population health at 3.5, while CEOs rated it lower at 3.0 on a five-point scale (extremely adequate to not at all adequate)
- Many hospital and health system boards reported that they are well on their way to creating a transformed health care organization
- When asked if their boards would be willing to give up some autonomy in order to ensure the survival of their organizations, a strong majority of both board chairs and CEOs would agree to having less autonomy in favor of survival

*The American Hospital Association's*

CENTER FOR HEALTHCARE GOVERNANCE™