Hospital Governance in the U.S.: An Evolving Landscape

by Mary K. Totten

In 2010-2011 the Center for Healthcare Governance and the Health Research & Educational Trust (HRET), in partnership with the American Hospital Association and Health Forum, surveyed hospital CEOs and board chairs of non-federal community hospitals in the United States. The survey built on three previous surveys of CEOs and trustees conducted in 1989, 1997 and 2005 and examined:

- board composition and structure,
- selection,
- orientation and education,
- evaluation, and
- stakeholder engagement.

The survey and report of its findings also explored new areas such as the relationship between board composition and the demographics of the communities boards serve; the role of competencies in board selection, education and evaluation; quality oversight and board culture. Survey findings provide insight about the state of hospital and health care governance today, with information gathered from 1,052 hospital CEOs and 468 board chairs.

The results of this survey show three significant findings:

1. Board chairs feel a greater sense of accountability for quality and patient safety.
2. Board chairs feel a greater sense of accountability for community and population health.
3. Boards still have work to do to better reflect their community’s demographics.

This article summarizes study report highlights. For more information about the complete report, visit www.americangovernance.com.

Quality Oversight

A majority of boards have developed precise and quantifiable hospital quality and safety objectives in the areas of clinical quality, patient safety, and service quality/patient satisfaction as shown in the Quality and Safety Objectives figure below. More board chair respondents indicated the existence of these objectives than CEO respondents.

Overall, board chairs and CEOs indicated that their boards are highly engaged in quality and safety issues. Most board chairs (75%) and CEOs (69%) said their board holds the CEO ac-
countable for defined quality objectives during the CEO performance evaluation process.

Internal and External Stakeholders

Findings showed relatively high levels of alignment between the board and medical and nursing staff related to pursuing the organization’s goals and vision. Board-nursing alignment was reported as especially high even though relatively few nurses serve on boards.

Strong variation exists between board chair and CEO responses regarding review of community health needs, with significantly more board chairs (57%) than CEOs (31%) indicating that the board formally reviews and/or considers the health status/needs of the communities it serves at least once a year.

Board Composition and Structure

Overall, survey data indicate that boards often do not reflect their community demographics. Seventy-eight percent of responding CEOs said their boards are less diverse than their communities. African Americans, Latinos, Asian/Pacific Islanders, and American Indians are all underrepresented on boards, as shown in the figure titled Race/Ethnicity. While women also are still underrepresented (28% of board members), 2011 data showed a significant increase from 2005 (23%). Study results also indicate that since 2005, boards have become less diverse by age.

Hospital boards today have an average of 12 members, with the majority of boards (68%) ranging from six to 18 members. Most board member terms are either three or four years. Only about half (52%) of boards have limits on the number of consecutive terms their members can serve.

The most common standing committees on today’s boards are finance and quality. More than half of hospitals also have executive, governance/nominating, and audit/compliance committees.

Strategic planning, previous board experience, patient safety/quality knowledge, conflict management, and public relations skills are seen as differentiating competencies for board chairs (more important for chairs than for regular members). Educational background and human resources development also are viewed as important for both board members and board chairs.

Ninety-five percent of respondents indicated that their hospitals have an orientation process. The process typically includes the following topics:

- overall organizational orientation (92% of respondents),
- health care governance orientation (80%), and
- broader health care orientation (79%).

The majority of survey respondents indicated that position-specific charters are reviewed during the orientation process for new board members and new board chairs. However, less than one-third indicated that position charters are reviewed with members assuming other board officer positions, such as committee chairs. See the figure titled Board Assessments.

### Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Board Member Demographics</th>
<th>Communities that Responding Hospitals Serve</th>
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<tbody>
<tr>
<td>Caucasian</td>
<td>90%</td>
<td>76%</td>
</tr>
<tr>
<td>African American</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>American Indian</td>
<td>&lt;1%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
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</table>

According to both CEOs and board chairs, more than nine out of the last 10 decisions their boards made were unanimous. (For more on board deliberation and decision-making, see the Fall 2011 issue of the Great Boards newsletter at www.greatboards.org.)
According to survey findings, the most common methods of board member continuing education are access to board-oriented publications, onsite speakers at board meetings and destination education events, such as trustee leadership conferences.

Board and Executive Evaluation

Survey results indicate that common forms of board assessment include full board assessment and individual board member self-assessment. Very few boards perform peer-to-peer or 360-degree assessments, in which the entire board evaluates the performance of each board member.

CEOs and board chairs differed in their understanding of the types of assessments used by the board. CEO respondents were more likely than board chair respondents to indicate that the board used a broader full board assessment. Board chairs were more likely than CEO respondents to indicate their boards used more granular assessments, such as individual board member self-assessments, board chair assessments, and committee assessments.

Sixty percent of board chairs indicated that individual board member assessment results are used to create an action plan to improve the performance/contribution of each board member; 42% of board chairs indicated that these assessment results are used in the process of reappointing trustees for additional terms of service.

Only 14% of board members indicated that a board member had been replaced during his or her term or was not reappointed because of a failure to demonstrate proper board member competencies over the past three years. Board chair respondents indicated that the most important criteria when evaluating CEO performance are:

- financial performance,
- vision or other leadership qualities,
- patient satisfaction,
- physician relations/integration/satisfaction,
- strategic plan fulfillment,
- clinical quality of care/outcomes, and
- legal and regulatory compliance.

Overall, there are statistically significant differences between CEO and board chair perceptions of CEO accountability for all criteria except financial performance. The biggest gaps between CEO and board chair perceptions of CEO accountability were found in areas outside traditional executive evaluation criteria: finances, strategic plan fulfillment, patient satisfaction, and physician relations. In 2011, these gaps occurred in areas such as community health improvement, risk management, legal and regulatory compliance, and system/network performance. In 2005, community health improvement represented the largest gap between CEO and board chair perceptions.

According to board chair respondents, 60% of boards have a CEO succession/transition plan, and 56% of boards have a CEO retention plan.

Some Observations

While the data show some improvements in governance in recent years, such as more women serving on boards, survey findings suggest more work needs to be done in areas such as expanding the diversity of board membership to better reflect the communities served and achieving greater clarity among boards and hospital leaders about performance objectives, evaluation and accountability.

As hospitals and their boards move toward new models of care delivery and payment in an environment of greater performance transparency, ongoing education and communication and clear objectives and expectations and a common understanding of them will be critical for all boards and leaders to work effectively together to meet the challenges ahead.

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<table>
<thead>
<tr>
<th>Board Assessments</th>
<th>CEO</th>
<th>Board Chair</th>
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<tbody>
<tr>
<td>What type of assessments does your board currently use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular Full Board Assessment</td>
<td>64.27%*</td>
<td>46.29%</td>
</tr>
<tr>
<td>Individual Board Member Self-Assessment</td>
<td>24.1%</td>
<td>34.78%*</td>
</tr>
<tr>
<td>Board Chair Assessment</td>
<td>7.16%</td>
<td>13.04%*</td>
</tr>
<tr>
<td>Peer-to-Peer Assessment to evaluate the performance of each board member</td>
<td>2.56%</td>
<td>1.79%</td>
</tr>
<tr>
<td>360 Assessment (Every board member is evaluated by the entire board)</td>
<td>1.79%</td>
<td>1.28%</td>
</tr>
<tr>
<td>Committee Assessments</td>
<td>8.18%</td>
<td>15.09%*</td>
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<tr>
<td>None of the Above</td>
<td>17.9%</td>
<td>21.99%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1.79%</td>
<td>1.53%</td>
</tr>
<tr>
<td>Not applicable</td>
<td>5.63%</td>
<td>6.39%</td>
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* = p < .05