AHA Trustee Services

National Health Care
Governance Survey Report

2019

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Executive Summary

Our nation's hospitals and health systems continue to adapt to an environment of transformation and pursue new strategies, structures and relationships to address the corresponding challenges and opportunities. The list of issues facing health care organizations are well-known—consumerism; disruptive innovation; providing greater value through new care delivery and payment models; addressing social, behavioral and environmental issues affecting the health and well-being of populations and communities; and others. What is now becoming clearer, however, is the magnitude of change these challenges are likely to have on where, when, how and from whom we receive care. They also are beginning to change how we define health and health care itself.

In this context, it is not surprising that the American Hospital Association's (AHA) 2019 National Heath Care Governance Survey Report describes a governance field in transition. Survey results often reflect how boards within systems are redefining roles, responsibilities and levels of decision-making authority to clarify and effectively integrate governance across multiple boards.

To provide a deeper longitudinal view of health care organization governance, the survey, conducted in 2018, continued to gather data on a variety of questions about board membership, structure and practices. Similar to the 2014 survey, this one also continues to examine findings across all respondents and by system, system subsidiary hospital and freestanding hospital boards.

This survey also includes some additional elements. New survey questions, displays of specific findings by subsidiary hospital boards with varying levels of decision-making authority, and commentary on survey findings from multiple governance experts and practitioners provide focus on contemporary governance issues and broad perspective and insight on survey results. Discussion questions, another new feature of this report, are included to help boards reflect on survey findings in the context of their own structure and practices.

This report includes several sections that can help readers better understand survey results and their implications for board work. They include:

- **Survey Methodology**, which describes survey design and process.
- **Board Composition**, which addresses board size, member voting status and member diversity, including participation of Millennials on boards.
- **Board Structure and Support**, which discusses data on board terms and term limits, board compensation, committees, governance restructuring and use of staff and technology support for governance.
- **Board Practices**, focusing on a range of issues related to board member selection, orientation, continuing education and performance evaluation and use of assessment results.
- **Performance Oversight**, including executive succession and leadership development, accountability and organizational performance.
- **Board Culture,** encompassing data about board meetings; use of, topics covered and attendance at executive sessions; and feedback about the time commitment required for board service.

Positive trends indicated by report findings include:

- Consistent growth in use of routine executive sessions over the past three years, considered a governance best practice.
- Some growth in racial and ethnic diversity of board members.
- A solid majority (about two-thirds) of all responding boards engaging in restructuring efforts to improve their governance.
- Increased use of board portals, also considered a governance best practice.
- Inclusion, by almost half of responding system boards, of board members from outside of communities served to add fresh perspective to board deliberations.

However, there are opportunities for improvement:

- Almost a third of all respondents did not use term limits.
- More than 75 percent either did not replace board members during their terms or continued to reappoint them when eligible during the past three years, resulting in low levels of board turnover.
- More than 70 percent of responding boards did not have a continuing education requirement for their members.
- Some 31 percent did not do board, board member or board or committee chair assessments in the past three years.
- Boards surveyed indicated a growing number of older members and fewer younger members.
- Almost half (49 percent) of respondents did not have a formal CEO succession plan.

Reflecting on the results of the 2018 survey and comparing their own structure and function with survey report findings can help boards gain insight into their own governance practices and performance. Survey results also provide a useful perspective on the state of health care governance in America. They raise important questions about boards and their governance: How are boards rising to meet the challenges of an evolving health care environment, and what key opportunities exist for them to further enhance their own performance and contributions?

Section 1

Survey Methodology

The 2018 national health care governance survey was developed by the AHA. It builds on the results of previous national governance surveys conducted by the AHA in 2005, 2011 and 2014.

The 2018 survey instrument, designed for completion by hospital and health system chief executive officers (CEOs), was sent via electronic mail and postal mail to the CEOs of 5,031 nonfederal community hospitals and health systems in the U.S. Specialty hospitals, such as eye-and-ear and psychiatric hospitals, were not included. Respondents were given the option to respond to the survey online or to complete the hard copy.

Survey responses were collected during spring 2018. A total of 1,316 CEOs responded to the survey (a 26.2 percent response rate). Overall, the respondents were generally representative of hospital bed size and geographic distribution in the U.S. (Figure 1.1). Not-for-profit organizations were somewhat overrepresented and investor-owned organizations underrepresented in the survey results, as were rural organizations.

Figure 1.1 – Survey Respondents Compared to All Hospitals

	Responders	Universe
Ownership		
Public	26%	24%
Not for profit	64%	50%
Investor owned	10%	27%
Total	100%	100%

	Responders	Universe
Location		
Urban	57%	67%
Rural	43%	33%
Total	100%	100%

	Responders	Universe
Bed size		
< 100	51%	56%
100 - 299	31%	30%
> 299	18%	14%
Total	100%	100%

	Responders	Universe
System		
System	58%	65%
Non-System	42%	35%
Total	100%	100%

	Responders	Universe
Region		
Northeast	14%	13%
Midwest	33%	27%
South	33%	41%
West	20%	19%
Total	100%	100%

Section 2

Board Composition

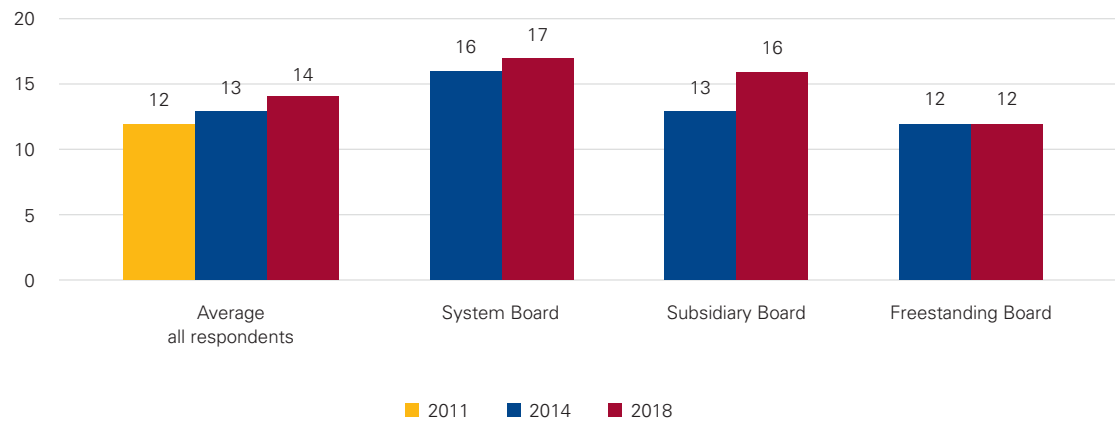
Data Points

Data from the AHA 2018 national health care governance survey indicate an increase in board size; inclusion of board members from outside the health care organization's service area, especially on system boards; and a slight increase in member diversity. At the same time boards are reporting a decline in clinician members and a higher percentage of older members. Survey respondents also indicate they are not taking specific efforts to attract Millennials to board service.

Board Size

- In 2018, the average board size overall was 14 members, compared to 13 in 2014 and 12 in 2011 (Figure 2.1).
- System boards, having 17 members on average, are typically larger than boards of system subsidiary hospitals or freestanding hospitals (Figure 2.1).
- Boards of system subsidiary hospitals have experienced the greatest change in size, averaging 16 members in 2018 and 13 members in 2014 (Figure 2.1).

Figure 2.1 – Board Size



Member Voting Status

- The number of nonvoting members across all boards increased from 2014 to 2018, with system subsidiary hospitals reporting triple the number of nonvoting board members in 2018 as they did in 2014, at 3 and 1, respectively (Figure 2.2).
- Of respondents overall in 2018 who reported having physician board members, on average a higher number of physician board members not employed by the hospital or system had voting privileges than those who were employed. On average, among all employed physician board members, more had voting privileges than those that did not (Figure 2.3).

Figure 2.2 – Non-voting Board Members

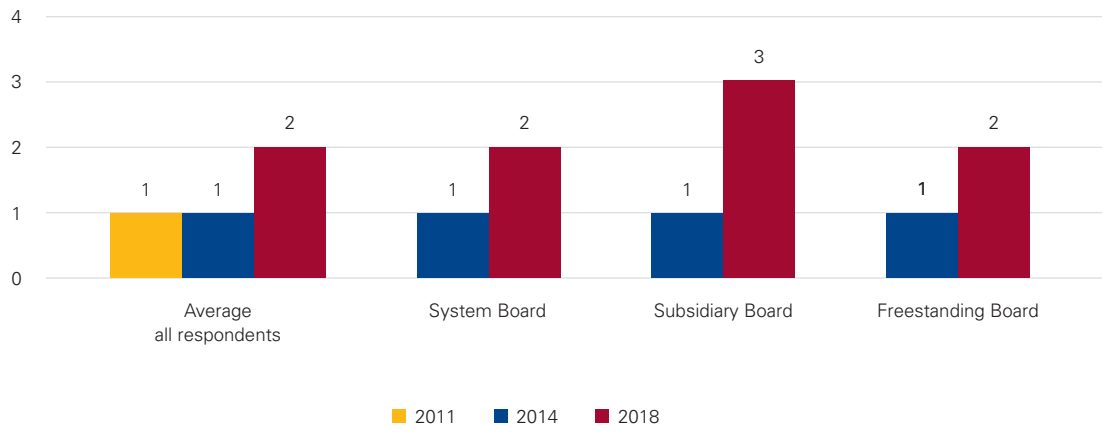


Figure 2.3 – Employment and Voting Status of Physician Board Members

	All	System Board	Subsidiary Board	Freestanding Board
Employed by your hospital/system a. Voting	2.00	2.00	2.00	1.00
Employed by your hospital/system b. Non - Voting	1.00	0.00	1.00	1.00
Not employed by your hospital/system a. Voting	3.00	3.00	3.00	2.00
Not employed by your hospital/system b. Non - Voting	0.00	0.00	1.00	0.00

- Overall, a higher percentage of respondents in 2018 reported their CEOs were not voting members of the board (54 percent) versus 46 percent who said their CEOs served on the board with vote. CEOs with vote were more common on boards in systems than on boards of freestanding hospitals (Figure 2.4).
- Some 10 percent of respondents overall included emeritus members in their governance (Figure 2.5).
- Of those overall respondents who included emeritus members, 37 percent said they can vote in board and/or committee meetings (Figure 2.6).

Figure 2.4 – CEO as a Voting Member

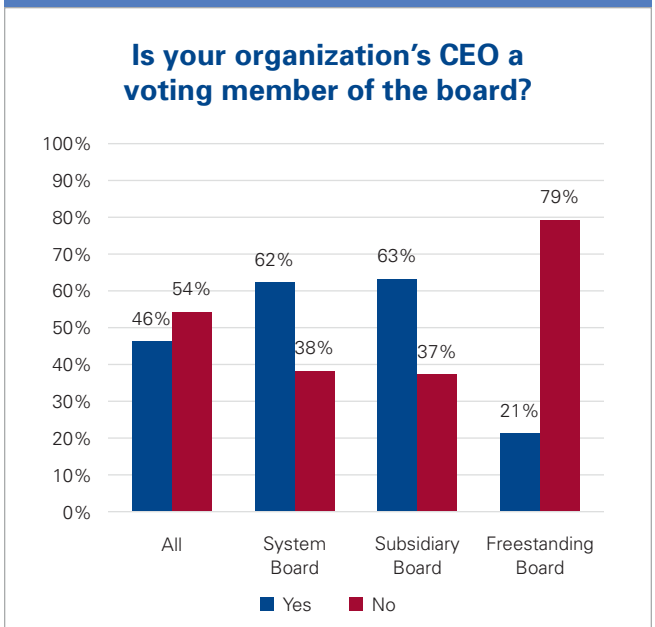


Figure 2.5 – Emeritus Board Members

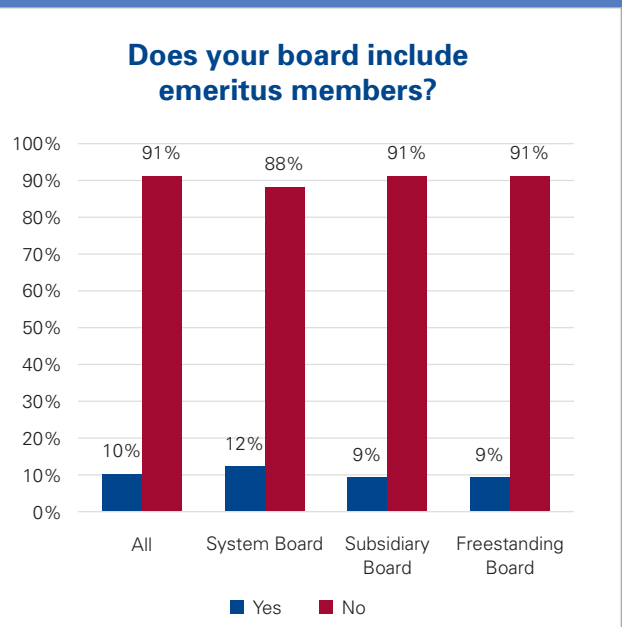


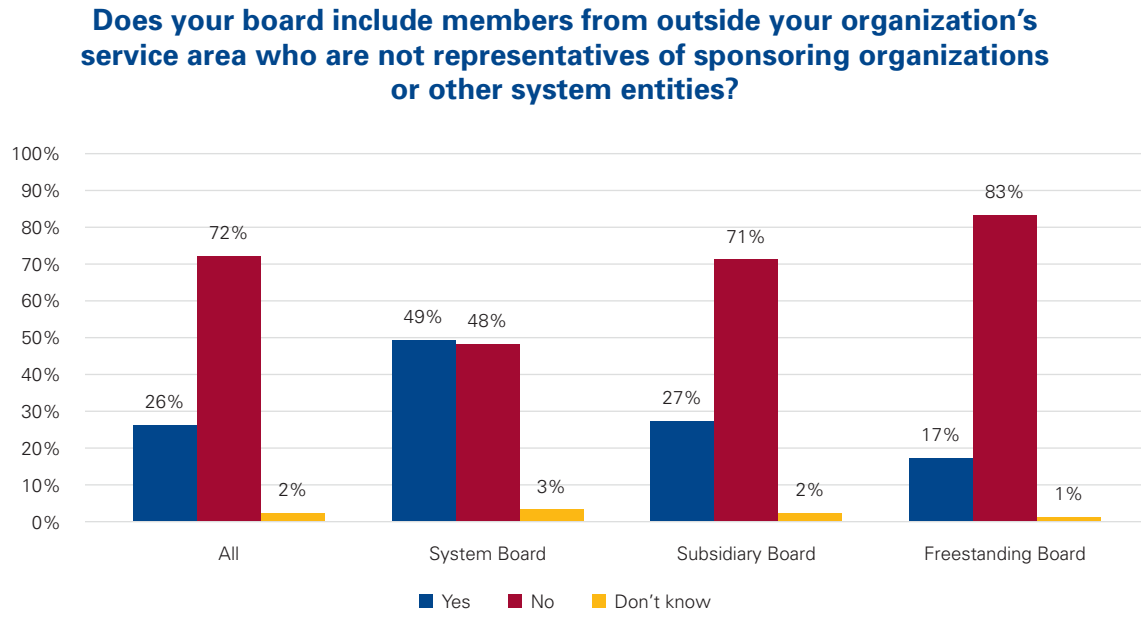
Figure 2.6 – Emeritus Member Voting Status

	All	System Board	Subsidiary Board	Freestanding Board
They can vote in committee meetings	24%	29%	25%	20%
They can vote in board meetings	13%	0%	18%	15%

Board Diversity

- Outside board members (those from outside the service area who are not from sponsoring organizations or other system entities) are most prevalent on system boards. Almost half (49 percent) of system boards reported including outside members, compared with 27 percent and 17 percent of boards of system subsidiary hospitals and freestanding hospitals respectively (Figure 2.7).

Figure 2.7 – Outside Board Members



- System boards report the highest level of diversity, with 17 percent of their membership being non-Caucasian in 2018, compared with 13 percent of system subsidiary hospital boards and 9 percent of freestanding hospital boards (Figure 2.8).

Figure 2.8 – Voting Board Member Demographics

	All	System Board	Subsidiary Board	Freestanding Board
Race/Ethnicity				
Caucasian	87%	83%	85%	91%
African American	6%	9%	6%	4%
Hispanic/Latino	3%	4%	3%	2%
Asian/Pacific Islander	2%	2%	2%	1%
American Indian	0%	0%	0%	1%
Other	2%	2%	2%	1%
Total	100%	100%	98%	100%
Gender				
Male	70%	72%	70%	70%
Female	30%	28%	30%	30%
Other	0%	0%	0%	0%
Total	100%	100%	100%	100%
Age				
35 or younger	2%	2%	2%	3%
36-50	20%	14%	22%	22%
51-70	66%	73%	64%	62%
71 or older	12%	11%	12%	13%
Total	100%	100%	100%	100%
Clinical Background				
Nurse	4%	3%	5%	4%
Physician	18%	18%	21%	15%
Other Clinician	3%	2%	3%	4%

- Survey data indicate that today's hospital boards are becoming slightly more ethnically/racially diverse, with 58 percent reporting at least one non-Caucasian member in 2018, compared with 53 percent in 2014 (Figure 2.9).
- Gender diversity on boards has increased over the past 13 years. In 2018, survey respondents reported 30 percent of their members were female; in 2005, survey respondents reported 23 percent of their members were female. However, gender diversity on boards did not increase at all between 2011 and 2014 (Figure 2.10).

Figure 2.9 – Systems and Hospitals with at Least One Non-Caucasian Board Member

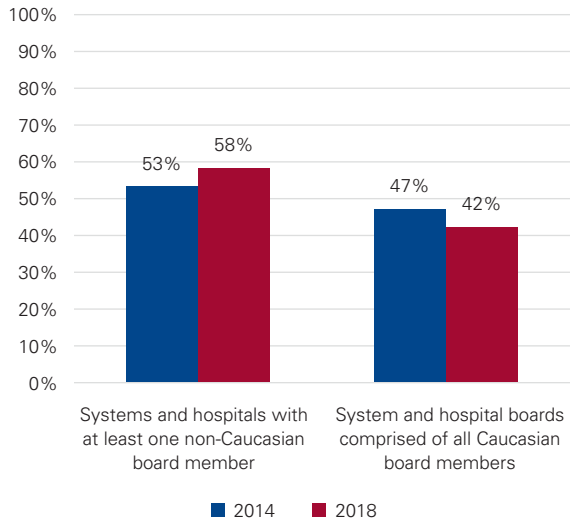
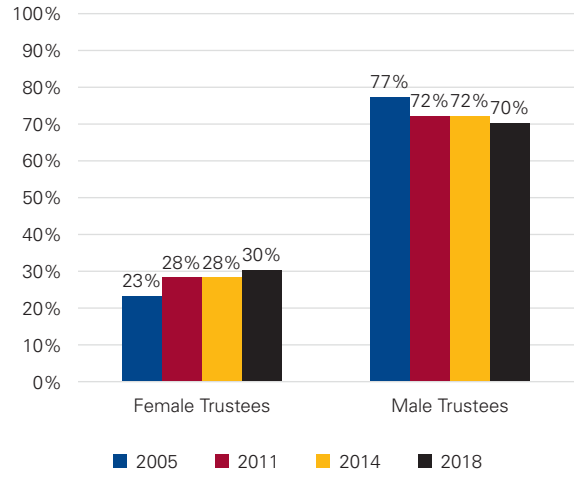
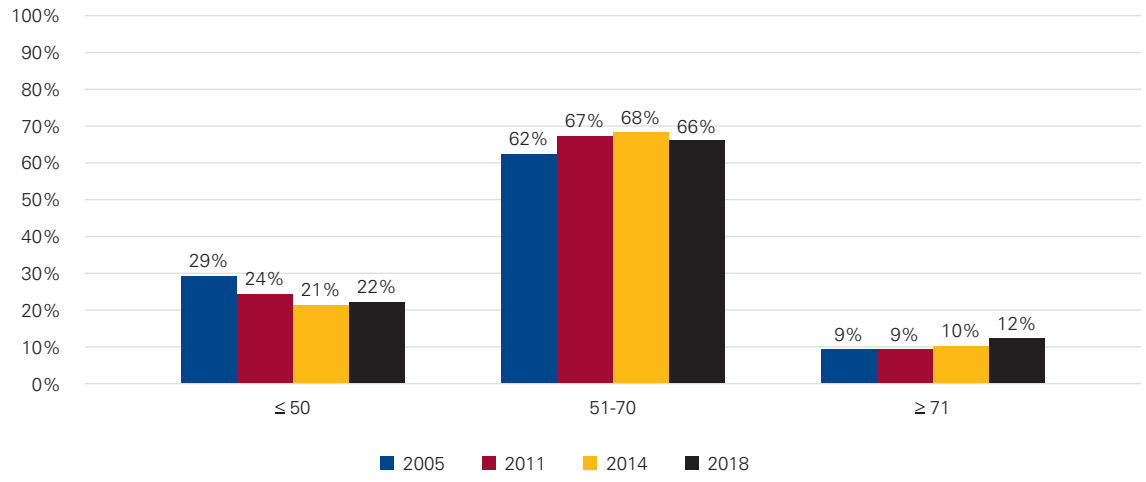


Figure 2.10 – Board Gender



- Boards overall in 2018 had a higher percentage of members age 71 or older than did boards in 2005, 12 percent versus 9 percent respectively (Figure 2.11).
- In 2018, boards overall reported a lower percentage of members age 50 or younger (22 percent) compared with 29 percent in 2005 (Figure 2.11).

Figure 2.11 – Board Age



- In 2018, 91 percent of all survey respondents reported not having an age limit for board service (Figure 2.12).
- Of those 2018 respondents overall that reported having an age limit, the majority (71 percent) indicated a maximum age of less than 75 years for all board members (Figure 2.13).
- 2018 survey data show the percentage of board members who are clinicians continues to decline overall and across individual categories (physicians, nurses and other clinicians). Respondents overall in 2018 reported their boards had 26 percent clinician membership, compared with 29 percent in 2014 and 31 percent in 2011 (Figure 2.14).

Figure 2.12 – Board Member Age Limit

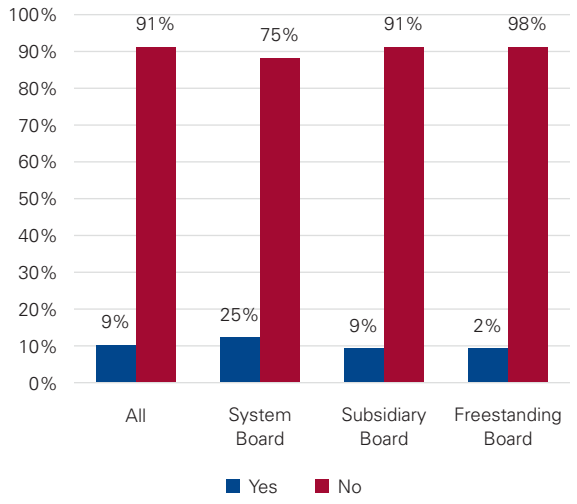


Figure 2.13 – Maximum Age for Board Members

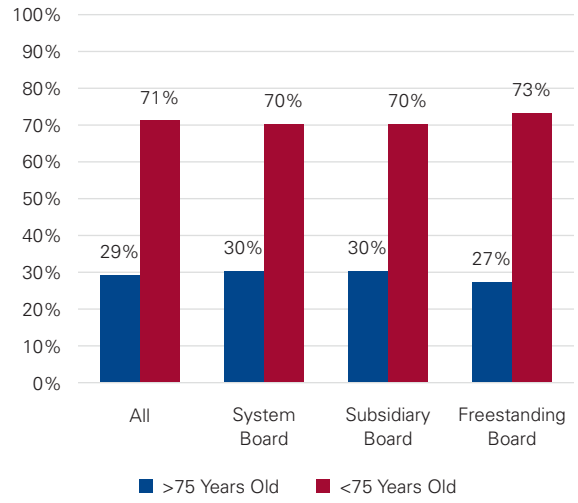
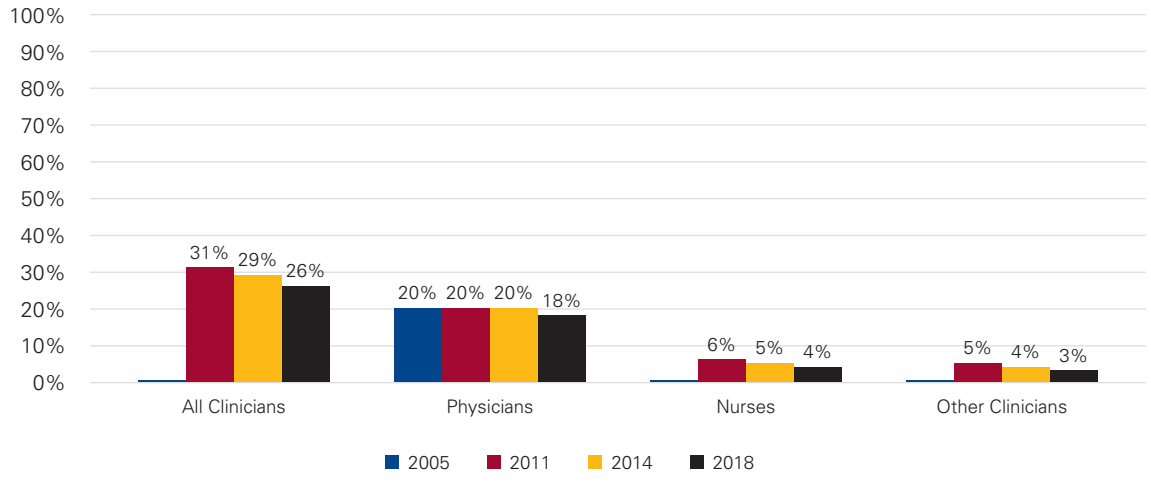
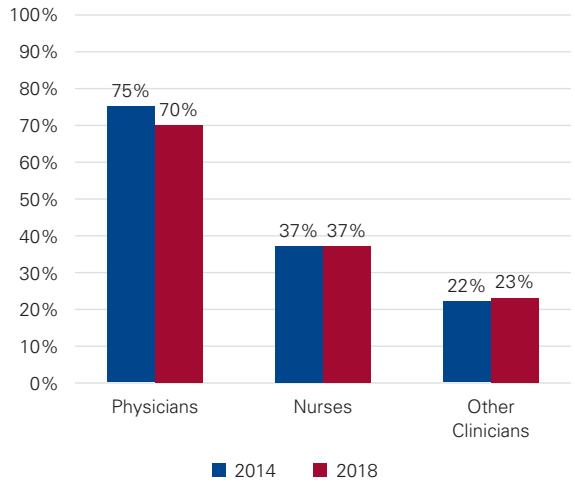


Figure 2.14 – Clinician Board Membership



- A lower percentage of hospitals and systems (70 percent) reported having physician board members in 2018, compared with 75 percent in 2014. The percentage that reported having at least one nurse on their board remained the same at 37 percent in 2018 and 2014 (Figure 2.15).

Figure 2.15 – Percentage of Systems and Hospitals with Clinician Board Members



- Boards of freestanding and system subsidiary hospitals in 2018 reported the greatest percentages of members age 50 or younger (25 percent and 24 percent respectively) compared with 16 percent for system boards (Figure 2.16).
- The proportion of clinician members on all types of boards from 2014 to 2018 has stayed the same or declined (Figure 2.16). Survey data for 2018 showed: nurses are more common on freestanding and system subsidiary hospital boards than system boards; physicians are more common on system boards and subsidiary hospital boards than on freestanding hospital boards.

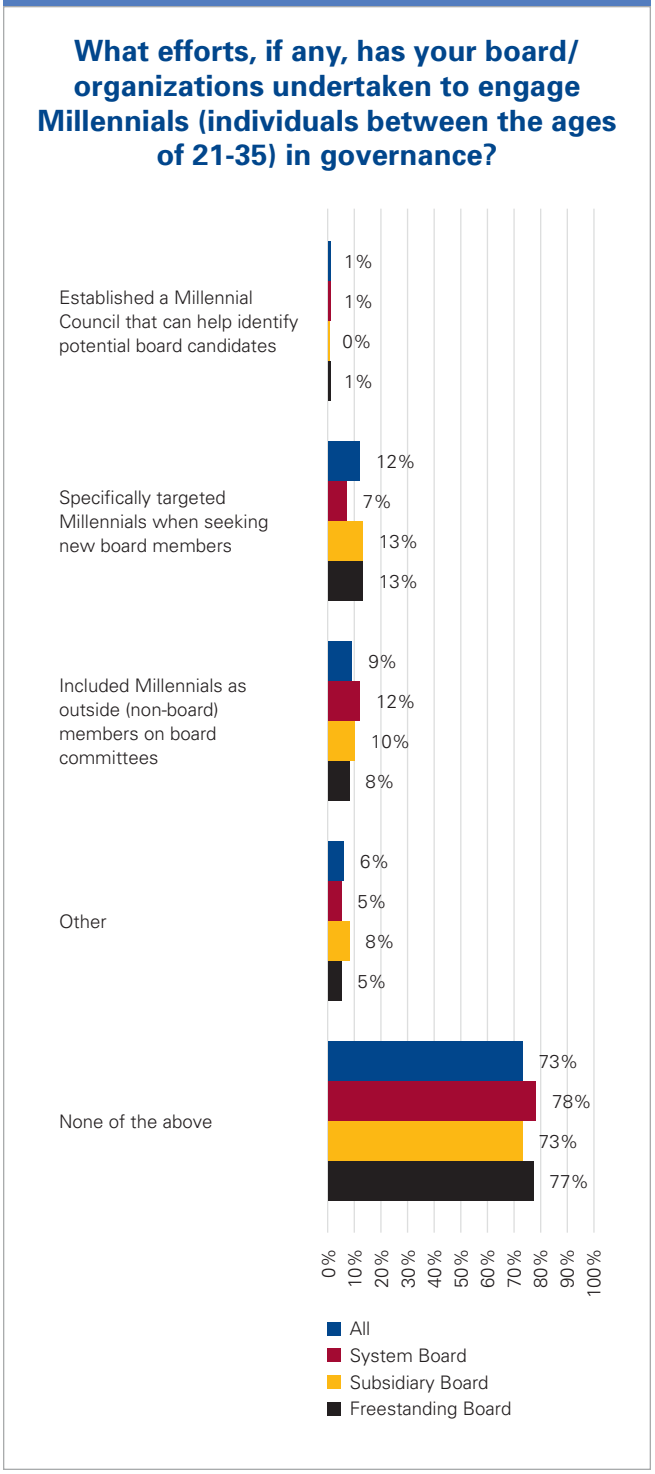
Figure 2.16 – Board Composition by Board Type by Year

	System Board		Subsidiary Board		Freestanding Board	
	2014	**2018**	**2014**	**2018**	**2014**	**2018**
Race/Ethnicity						
Caucasian	86%	83%	86%	85%	90%	91%
African American	7%	9%	6%	6%	4%	4%
Hispanic/Latino	3%	4%	3%	3%	3%	2%
Asian/Pacific Islander	2%	2%	2%	2%	1%	1%
American Indian	1%	0%	0%	0%	1%	1%
Other	1%	2%	4%	2%	1%	1%
Gender						
Male	76%	72%	69%	70%	72%	70%
Female	24%	28%	31%	30%	28%	30%
Other	–	0%	–	0%	–	0%
Age						
35 or younger	–	2%	–	2%	–	3%
36-50	12%	14%	19%	22%	17%	22%
51-70	81%	73%	70%	64%	63%	62%
71 or older	7%	11%	11%	12%	20%	13%
Clinical Background						
Nurse	4%	3%	6%	5%	4%	4%
Physician	26%	18%	22%	21%	17%	15%
Other Clinician	2%	2%	3%	3%	5%	3%

* In 2014 survey, the option was <=50

- The majority of overall respondents to the 2018 survey (73 percent) are not undertaking specific efforts to engage Millennials (individuals between the ages of 21 and 35) in governance. Hospital boards were more likely than system boards to target Millennials when seeking new board members; system boards were more likely than hospital boards to include Millennials as outside members on board committees (Figure 2.17).

Figure 2.17 – Efforts to Engage Millennials in Governance



Commentary

Commentary on Board Composition
by Nicholas Tejeda

Introduction

Psychologists often speak of the IKEA Effect — a cognitive phenomenon named after the Swedish behemoth that sells ready-to-assemble furniture. The IKEA Effect is defined as a bias in which consumers place disproportionately high value on products that they partially create. Put another way, people cherish what they help create. Similarly, every generation is inclined to believe that the path they forged and followed is to be cherished — whether it is culture, politics or the economy. Health care is no different.

Every decade — if not more often — administrators and physicians alike bemoan the sea change that confronts them. Whether it was the introduction of DRGs in the 1980s or the Affordable Care Act today, we lament a health care system that is going through a period of change like never before and yearn for a romanticized health care system of old.

Yet, the truth is something else. The health care system cannot remain what it was yesterday. While best intentions existed when we (and our predecessors) built that health care system, the patients we serve today have different demands and expectations. The employers of those patients have a different set of cost pressures. The technology that supports care delivery is rapidly advancing. And, younger employees within our organizations require a unique approach to motivation and reward systems.

It is with this in mind that governance of our organizations becomes so important. It is governance — and the trustees providing oversight — that are responsible for ensuring our organizations continually evolve to meet the demands of our environment.

While it is comfortable to cherish the health care system we have built, effective governance ensures we place the greatest value on a very simple principle: becoming better, every day, for our patients and for our communities.

This is certainly true in the organization I lead — The Hospitals of Providence in El Paso, Texas — a part of the Tenet Healthcare system. The Hospitals of Providence and its affiliates include seven distinct governing boards that maintain responsibility for our acute care hospitals, children's hospital, microhospitals and surgery centers.

The American Hospital Association 2018 governance survey demonstrates the extent to which governance of our nation's hospitals and health systems is prepared to build the foundation of a new reality that will be cherished for generations to come.

Observations About Survey Findings

To ensure that the organization's strategy is aligned with the current and future needs of the community, it is imperative that the governing board's composition be appropriately constructed. The 2018 survey reveals that boards are addressing this in a number of ways.

According to survey results, the size of the board is growing. Between 2011 and 2018, the average board size — including both system boards and subsidiary hospital boards — increased by some 16 percent. This significant increase demonstrates that boards seek to more deeply connect and engage with the community and its unique constituencies.

For this reason, it isn't surprising that subsidiary hospital boards have experienced the largest growth in board size. As has been often said, health care is local and, therefore, it may be beneficial to "build a big tent" within the local board.

Interestingly, this growth in board size has occurred at the same time that the average number of non-voting board members increased threefold on subsidiary boards. Whether emeritus or at-large members, these individuals can add value to the board through institutional and historical knowledge, notable influence in the community, and/or subject matter expertise that is not otherwise present. As an example, the board of our teaching hospital in El Paso includes the president and dean of the local medical school as a nonvoting, at-large member.

Emeritus members, who are on 10 percent of boards, are essential to navigating the Ikea Effect. In El Paso, our emeritus board members have served multiple terms as voting members on our boards, including leadership positions. They keenly value the institutions our health care system has built over the years. Yet, our emeritus board members maintain a desire to be progressive and find better ways to serve our community. This unique combination of experience and foresight is essential as we onboard and orient new board members.

It is instructive to learn that CEOs do not have voting rights on the majority of boards across the country that responded to the survey. The role of a chief executive officer is normally defined by positional authority. However, in this instance, the CEO must lead the organization and board through influence — a reality that we will incorporate into our future development of executives within our organization.

The survey also reveals a number of opportunities to strengthen the governance of our nation's health care system.

Surprisingly, the percentage of hospitals and systems with physician board members has declined significantly over the last four years, from 75 percent to 70 percent. Furthermore, the percentage of hospitals and systems with board members who are nurses remained at 37 percent over this same period, even though nurses represent the largest portion of a hospital's workforce. As has been said many times in many venues, the clinical and financial performance of health care organizations, particularly hospitals, are no longer separate. Clinical leadership — at all levels of the organization including governance — is absolutely necessary to meet the elevated expectations of all stakeholders (patients, families, purchasers and providers).

Most notably, since 2005, female membership on boards has increased from 23 percent to 30 percent, a significant increase. However, when considering that this increase occurred over 13 years, it seems we can do better to ensure our boards better represent the patients who come through our doors — consistently a 50/50 split between men and women. Considering that the majority of a hospital's workforce is female, we must focus our efforts to identify and develop women leaders for roles in governance.

Survey results reveal some striking findings regarding racial and ethnic diversity:

- While U.S. Census Bureau data indicate Hispanics comprise 18 percent of the total U.S. population, they represent only 3 percent of board members.
- Similarly, U.S. Census Bureau data indicate African Americans represent 13 percent of the U.S. population, yet they only comprise 6 percent of governing board membership.

These data reinforce the opportunity to leverage existing programs to match candidates with governance opportunities. As an example, the AHA's Institute for Diversity and Health Equity has established unique partnerships with the National Urban League and UnidosUS to match health care CEOs with governing board candidates across the country.

However, progress is being made. In 2018, 58 percent of systems and hospitals have at least one racial/ethnic minority on the board – a material increase from

53 percent in 2014. Such progress, now and in the future, will better enable health care organizations to understand and meet the expectations of the patients they serve.

Perhaps the most fascinating survey findings about board composition relate to the age of board members. The percent of board members age 71 or older has increased from 9 percent to 12 percent over the last 13 years. Similarly, board membership among individuals 50 years or younger decreased from 29 percent to 22 percent in the same time period. Despite this aging of board membership, only 27 percent of survey respondents indicated that they are taking specific efforts to engage younger individuals (ages 21 – 35) in governance. Succession planning is key to the long-term success of any organization, and governance is certainly no exception. Accordingly, The Hospitals of Providence established a Young Leader Advisory Group (formerly called the Millennial Advisory Group) to engage up-and-coming leaders regarding their health care perspectives while vetting these individuals for future governance roles. This group has already produced new members of our governing board — one of whom recently moved into a chair-elect position.

The AHA 2018 governance survey offers a revealing perspective on the state of governance of our nation's health care system. It is clear that progress is being made to better engage the communities we serve and the individuals we collectively care for every day. Equally clear is that much opportunity remains to further strengthen board membership, particularly with respect to age and diversity. Given the progress we have made and the challenges ahead, I have no doubt that our health care organizations' governing boards and leaders will succeed in building the foundation of a new reality that will be cherished for generations to come.

Nicholas Tejeda, FACHE (nicholas.tejeda@tenethealth.org) is the market chief executive officer, The Hospitals of Providence, El Paso, Texas, and chair, Institute for Diversity and Health Equity.

Discussion Questions on Board Composition

1. What aspects of today's health care system (changing patient expectations, cost pressures, advancing technology, a younger workforce with different needs, etc.) most affect the way we now deliver care to our patients and communities?
2. What actions are our board and organization taking to ensure we continue to meet the demands of an evolving health care environment?
3. How does our board's composition compare with the findings of AHA's 2018 governance survey? How might similarities and differences between our board and others around the country influence the effectiveness of our organization's governance?
4. What opportunities exist to strengthen our board's composition/membership to better serve our patients and communities?

Section 3

Board Structure and Support

Data Points

Survey data indicate a significant percentage (about a third) of respondents do not use term limits. The proportion of system boards that compensate their members has increased somewhat since 2014. About two-thirds of all respondents indicated participating in specific board restructuring activities during the past three years.

Term Limits

- Almost two thirds (66 percent) of all survey respondents reported having term limits for their board members. Term limits were most prevalent among system boards (78 percent) and least prevalent among boards of freestanding hospitals at 52 percent (Figure 3.1a).

Figure 3.1a – Term Limits

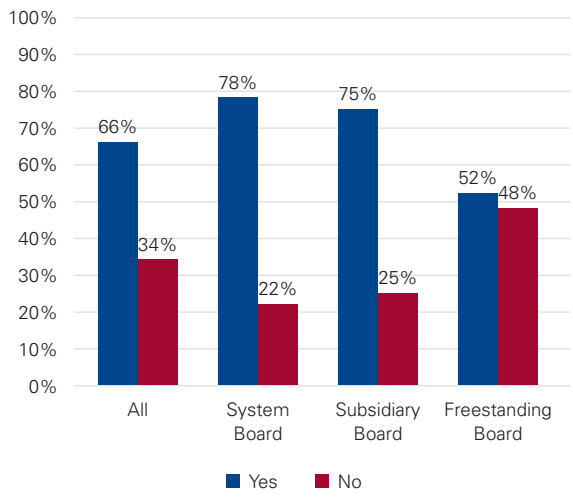
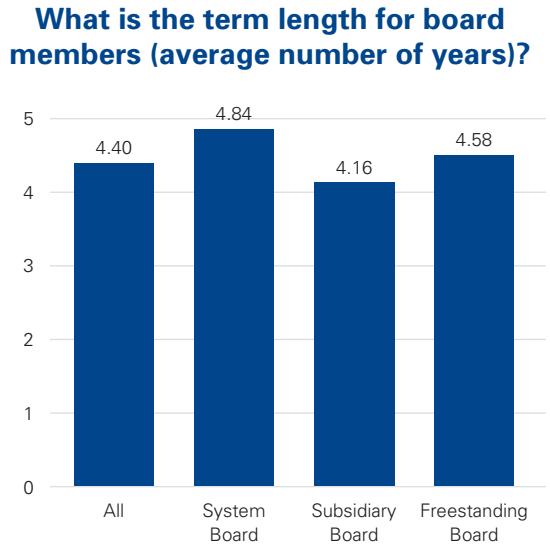


Figure 3.1b – Term Limits



- In 2018, system boards and freestanding hospital boards reported the highest average term length for board members (five years). Boards in systems indicated notable increases in term length, which averaged five years for system boards and four years for system subsidiary hospital boards in 2018, compared to three years for both system boards and system subsidiary hospital boards in 2014 (Figure 3.2).
- In 2018, system boards allowed their members to serve more consecutive terms than hospital boards, five on average for system boards compared to three for both freestanding and system subsidiary hospital boards (Figure 3.3).

Figure 3.2 – Average Board Member Term Length in Years (2011-2018)

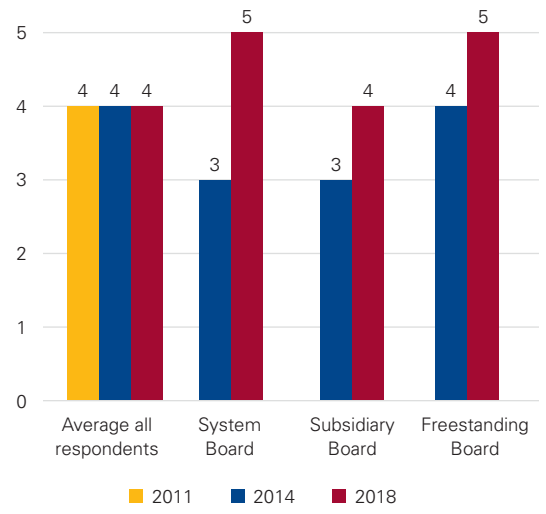
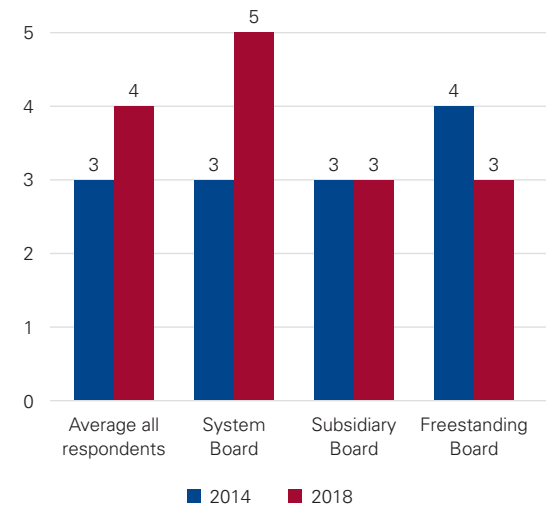


Figure 3.3 – Maximum Number of Consecutive Terms on Average by Year



Board Compensation

- The overall percentage of boards that compensate their members rose slightly in 2018. On average, about 13 percent of respondents overall in 2018 said they compensated their members, exclusive of reimbursement for out-of-pocket expenses, compared with 10 percent in 2014 and 13 percent in 2011 (Figure 3.4).
- Of those boards that reported compensating their members, system boards were most likely to do so at 25 percent, compared with 6 percent of system subsidiary hospital and 16 percent of freestanding hospital boards (Figure 3.4).
- Higher percentages of respondents to the 2018 survey reported providing per-meeting fees for board members versus annual fees (Figure 3.5).

Figure 3.4 – Board Member Compensation

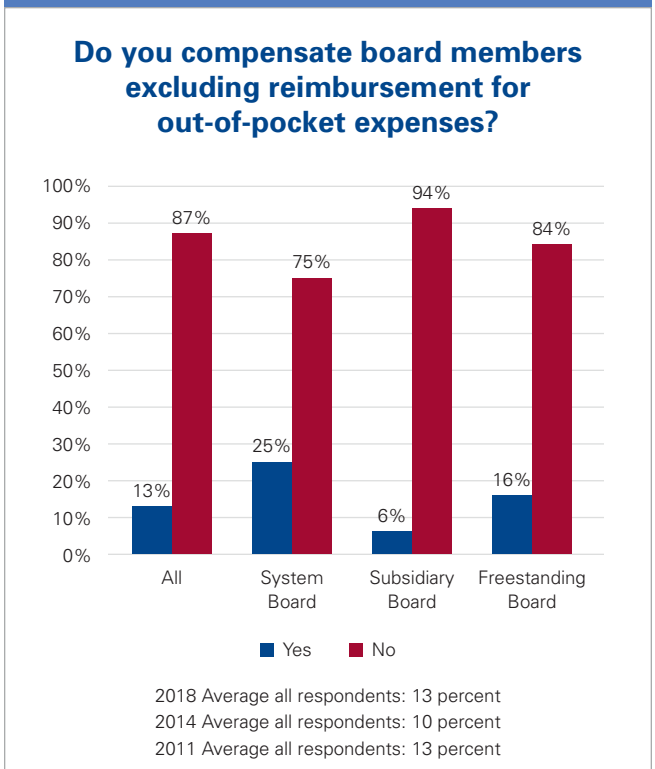
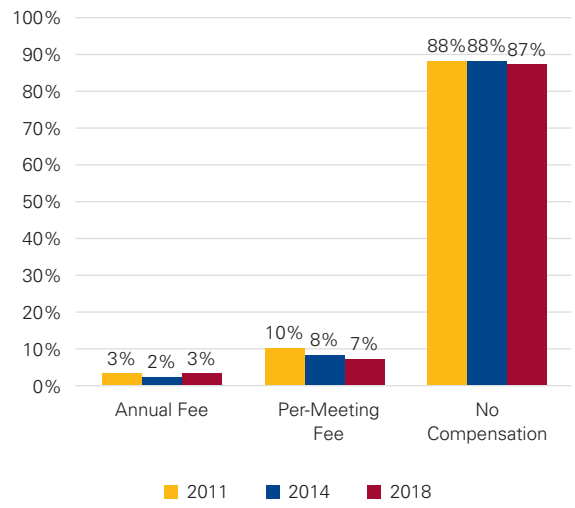


Figure 3.5 – Type of Board Member Compensation by Year

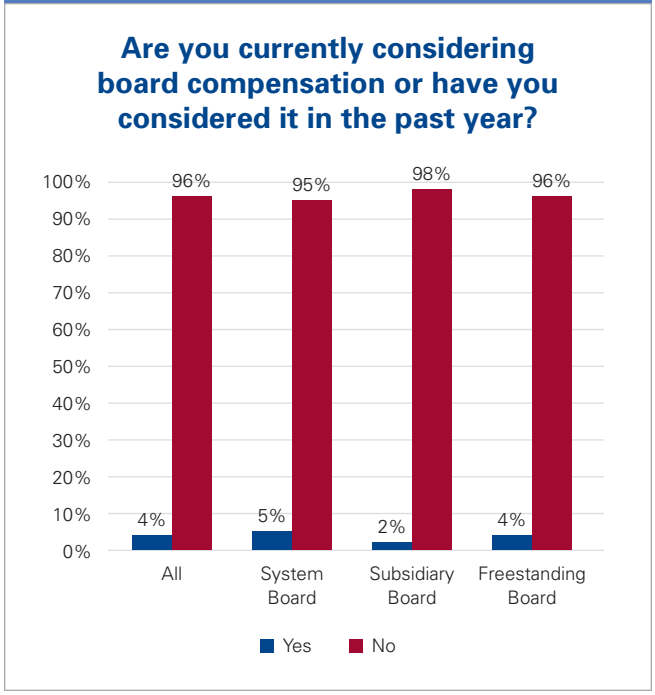


- In 2018, 75 percent of system boards reported they did not compensate their members, compared with 92 percent in 2014 (Figure 3.6).
- About 4 percent of respondents overall who did not provide board compensation in 2018 reported that in the past year they considered compensating their members (Figure 3.7).

Figure 3.6 – Forms of Board Member Compensation by Board Type by Year

	System Board		Subsidiary Board		Freestanding Board	
	2014	**2018**	**2014**	**2018**	**2014**	**2018**
A. Annual Fee	4%	3%	3%	2%	3%	2%
B. Per-Meeting Fee	4%	6%	6%	4%	12%	12%
C. No Compensation	92%	75%	91%	94%	85%	84%
D. Do Not Know Form of Compensation	1%	16%	0%	0%	0%	1%

Figure 3.7 – Boards Considering Compensation



Board Committees

- The most common standing committees across all boards responding to the 2018 survey were Quality (77 percent) and Finance (76 percent). System boards reported having the highest percentage of Quality Committees, 91 percent compared to 70 percent of freestanding hospital boards (Figure 3.8).
- Audit/Compliance Committees, Community Benefit/Mission Committees and Executive Compensation Committees were far more common among system boards than hospital boards. Workforce Committees and Strategic Planning Committees were more common among freestanding hospital boards than boards in systems (Figure 3.8).

Figure 3.8 – Standing Committees by Board Type

	All	System Board	Subsidiary Board	Freestanding Board
Quality	77%	91%	78%	70%
Finance	76%	90%	56%	90%
Executive	66%	78%	59%	66%
Governance/ Nominating	60%	78%	58%	54%
Audit/Compliance	47%	81%	30%	47%
Strategic Planning	35%	35%	28%	42%
Executive Compensation	31%	71%	12%	31%
Community Benefit/ Mission	21%	43%	22%	11%
Fundraising/ Development	12%	14%	12%	12%
Workforce	7%	6%	5%	10%
Enterprise Risk Management	5%	5%	5%	5%
Government Relations	4%	6%	3%	4%
Innovation	1%	1%	0%	1%

- A lower percentage of boards overall reported having Quality, Finance, Audit/Compliance, Strategic Planning, Executive Compensation, Fundraising/ Development and Government Relations Committees in 2018 than in 2014 (Figure 3.9).
- The percentage of Finance Committees among freestanding hospital boards increased to 90 percent in 2018 from 85 percent in 2014 (Figure 3.10).
- The percentage of system boards that reported having Audit/Compliance Committees increased significantly to 81 percent in 2018 from 21 percent in 2014. The percentage of system boards that reported having a Community Benefit/Mission Committee also increased to 43 percent in 2018 from 20 percent in 2014 (Figure 3.10).

Figure 3.9 – Standing Committees by Year

	2011	2014	2018
Quality	75%	82%	77%
Finance	83%	80%	76%
Executive	68%	66%	66%
Governance/ Nominating	60%	60%	60%
Audit/Compliance	51%	52%	47%
Strategic Planning	44%	42%	35%
Executive Compensation	36%	37%	31%
Fundraising/ Development	18%	19%	12%
Community Benefit/ Mission	14%	17%	21%
Government Relations	4%	6%	4%

Figure 3.10 – Standing Committees by Board Type by Year

	System Board		Subsidiary Board		Freestanding/ Independent	
	2014	2018	2014	2018	2014	2018
Quality	94%	91%	87%	78%	76%	70%
Finance	98%	90%	60%	56%	85%	90%
Audit/Compliance	21%	81%	20%	30%	13%	47%
Governance/ Nominating	88%	78%	56%	58%	54%	54%
Community Benefit/ Mission	20%	43%	21%	22%	18%	11%
Executive	86%	78%	34%	59%	51%	66%
Strategic Planning	80%	35%	58%	28%	66%	42%
Executive Compensation	52%	71%	33%	12%	44%	31%
Fundraising/ Development	62%	14%	20%	12%	39%	12%
Government Relations	14%	6%	7%	3%	4%	4%
Workforce*	–	6%	–	5%	–	10%
Innovation*	–	1%	–	0%	–	1%
Enterprise Risk Management*	–	5%	–	5%	–	5%

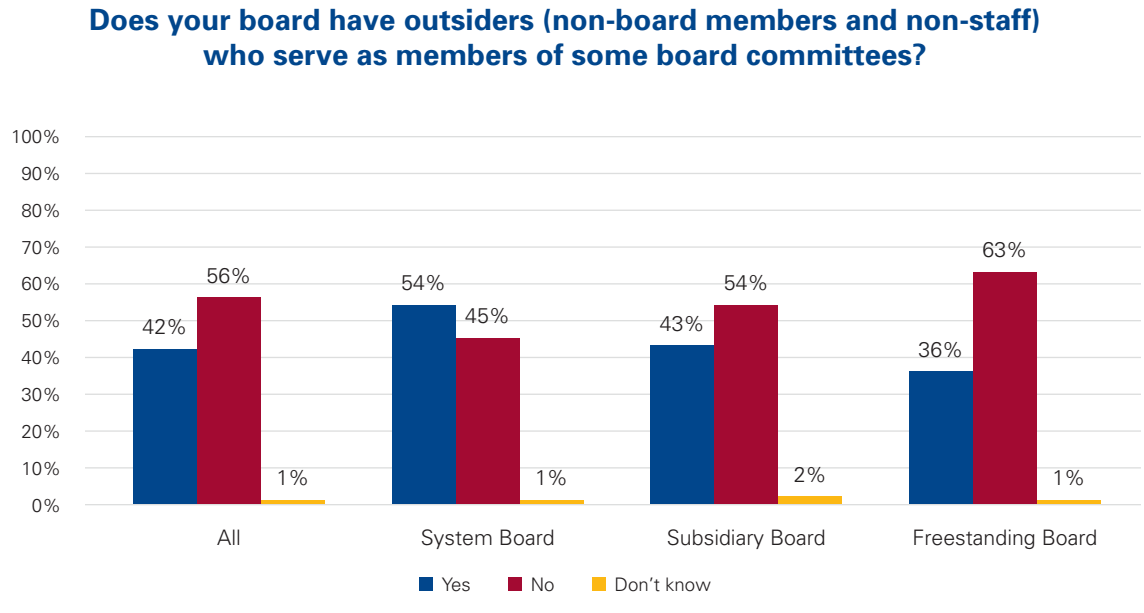
* Not asked in 2014

- Of the 65 percent of 2018 respondents overall that said their boards had Executive Committees, the percentage of system boards that allowed these committees to have broad decision-making authority on behalf of the full board (52 percent) was significantly higher than the percentages for hospital boards (Figure 3.11).
- A higher percentage of system boards (54 percent) reported having outsiders (non-board members and non-staff) as members of some board committees than did hospital boards (Figure 3.12).

Figure 3.11 – Executive Committee Authority

	All	System Board	Subsidiary Board	Freestanding Board
Has broad decision-making authority on behalf of full board	30%	52%	27%	24%
Has limited decision-making authority and primarily makes recommendations for action by the full board	35%	26%	31%	43%
Not applicable	35%	22%	42%	33%

Figure 3.12 – Outsiders on Board Committees



- The percentage of outsiders who serve as members of some board committees has declined overall: 42 percent in 2018 compared with 53 percent in 2014 (Figure 3.13).

Board Restructuring and Support

- About two thirds of all survey respondents in 2018 reported engaging in specific board restructuring activities in the past three years. A higher percentage of freestanding hospitals (45 percent) reported not engaging in specific restructuring activities than did boards in systems (Figure 3.14).

Figure 3.13 – Outsiders on Board Committees by Year

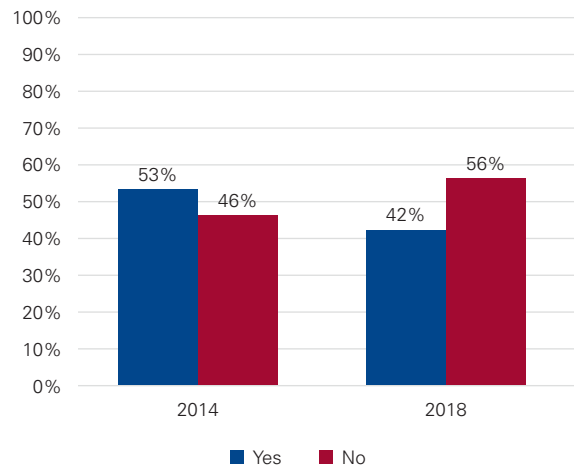


Figure 3.14 – Board Restructuring in the Past Three Years

	All	System Board	Subsidiary Board	Freestanding Board
Sought new board member skills/competencies	48%	61%	51%	40%
Added board committees	16%	21%	14%	16%
Reduced the number of board committees	12%	20%	15%	6%
Redefined authority among system and subsidiary boards	12%	16%	20%	2%
Reduced board size	11%	14%	15%	6%
Expanded board size	11%	8%	14%	10%
Eliminated all board committees	1%	1%	0%	1%
None of the above	33%	21%	25%	45%

- The highest percentages of respondents overall in 2018 reported that the CEO's executive assistant or another administrative assistant (71 percent) and/or the CEO (59 percent) supported board function. Higher percentages of system boards reported having the chief legal officer/general counsel and/or dedicated governance professional staff provide board support than did hospital boards (Figure 3.15).
- A majority of overall respondents to the 2018 survey (55 percent) said they used an electronic board portal. System boards reported the highest percentage of portal use at 85 percent (Figure 3.16).
- A higher percentage of overall respondents to the 2018 survey (55 percent) reported using an electronic board portal than did respondents in 2014 at 52 percent (Figure 3.17).

Figure 3.15 – Board Support Staff

Who supports the functioning of your board?

	All	System Board	Subsidiary Board	Freestanding Board
CEO's executive assistant or another administrative assistant	71%	59%	76%	72%
CEO	59%	41%	55%	71%
Chief legal officer/ general counsel	24%	37%	23%	19%
Dedicated governance professional staff member(s)	15%	39%	15%	4%

Figure 3.16 – Use of Board Portal

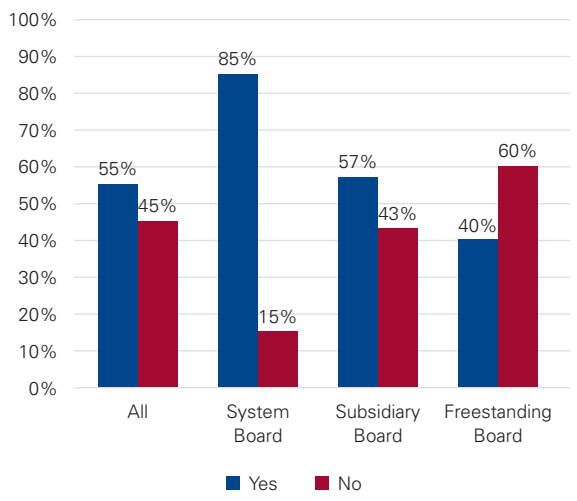
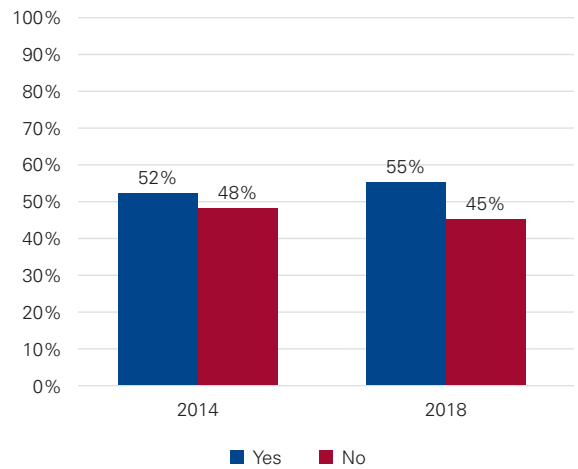


Figure 3.17 – Use of Board Portal by Year



Commentary

Commentary on Board Structure and Support
by Pamela R. Knecht

Introduction

This section of the survey report discusses data related to terms and term limits, board compensation, board committees and board restructuring and support. It discusses some results that are expected and some that are surprising. It also includes some results that may indicate the need for further examination or inquiry to understand them in greater detail and determine whether or not they may indicate some trends different from historical patterns of governance.

Observations about Survey Findings

The survey data regarding terms and term limits is both expected and unexpected. For instance, the percentage of boards with term limits (66 percent) is consistent with other governance surveys over the last decade. And, it is typical for a higher percentage of systems to have implemented term limits than freestanding hospitals.

However, the survey results regarding the average length of terms are surprising. According to the survey, the average term length for board members in systems was five years and for subsidiary hospital board members, four years. But, multiple sources over the years have reported that the average term length for all types of health care boards has been three years.

In addition, the data on term limits is highly unusual. According to the survey results, the average system board member's term length is five years and the maximum number of consecutive terms is five. If a system board is consistent with both the average term length and maximum number of terms, system board members would be serving for 25 years on average. This is almost three times longer than system board members usually serve (e.g., nine years).

These results are so different from prevailing experience that it is possible that respondents thought they were being asked how long, on average, each person had served on the board. That number would be higher than three years, since most board members serve for more than one, three-year term.

This topic should be studied further since all boards are looking for guidance on how best to balance the "competing goods" of ensuring sufficient institutional knowledge (from longer-tenured board members) with bringing in newer members with fresh perspectives and additional expertise.

The survey results regarding board compensation indicate that, over the last seven years, there has not been much change in the percentage of boards that compensate their members beyond reimbursement for out-of-pocket expenses (13 percent on average). This is an interesting finding because a growing number of trustees wonder if providing compensation would make it easier to attract and retain individuals with the expertise required to oversee a complex organization undergoing transformation. While the survey data indicate that on average this tactic for recruiting and retaining health care board members still has not been employed very often, survey data reported by type of board show that 25 percent of system boards, 16 percent of freestanding hospital boards and 6 percent of hospital subsidiary boards in systems are now compensating their members. Survey data reported by type of board appears to

provide a clearer picture that is more consistent with other feedback from the field.

These results are not surprising. Historically, trustees often have stated that their board service is an opportunity to serve their community. They say they are giving back to the organization that has taken such good care of their loved ones.

On the other hand, system boards often include members who are not from the community that the board oversees. They may be national experts who are traveling a great distance to provide their knowledge and perspective. In that way, they are more like the board members of publicly traded corporations whose board members are often highly compensated. Therefore, it is not surprising to learn that system boards are more likely to compensate their members than subsidiary or freestanding hospital boards.

The question of whether to compensate board members most likely will continue to be asked as health systems become more complex and board members' responsibilities continue to grow.

The data on board committees elucidates some of the differences among responsibilities of system boards, subsidiary boards and freestanding boards. For instance, according to this survey, subsidiary hospital boards are much less likely to have the following committees: Executive Compensation, Audit and Compliance, and Finance. These results are consistent with a key best practice — form should follow function. In other words, a board's form (e.g., committee structure) should be consistent with its function (e.g., authority). Since most system boards have final authority for executive compensation, audit, compliance and finance, it makes sense that those committees would be at the system board level, not at the subsidiary board level.

On a related note, it is common for subsidiary hospital boards to have authority for quality oversight. Therefore, it is somewhat surprising that the percentage of subsidiary boards with quality committees is only 78 percent. One would expect a higher percentage of those boards to use quality committees to help them with one of their key responsibilities. A possible explanation for the lower-than-expected percentage could be that some subsidiary boards are functioning as a Committee of the Whole regarding their quality oversight responsibilities. It would be interesting to explore that hypothesis in future surveys.

According to this survey, freestanding hospital boards do not as often use some of the key committees utilized by system boards. Granted, between 2014 and 2018, freestanding hospital boards have increased their use of an Audit and Compliance Committee from 13 percent to 47 percent. However, freestanding boards are still behind system boards' use of that committee and four others: Quality; Governance/Nominating; Executive Compensation; and Community Benefit/ Mission. Freestanding boards that typically have a level of authority similar to system boards could benefit from following the lead of system boards and ensure they have the complement of committees necessary to help them fulfill all their responsibilities.

Another best practice used more frequently by system boards than any other type is the inclusion of non-board members on their committees. Non-board members can bring needed expertise to committees, and therefore, to the board. Another benefit of adding non-board members to some committees is that they can become part of a pool of individuals who are potential board members. Committee service can help determine whether a specific individual would be a valuable board member.

The data regarding committee changes since 2011 highlight some governance trends. For example, the decline in the use of Strategic Planning Committees since 2011 (44 percent to 35 percent) is not surprising. Given the complexity of health industry transformation, most boards have chosen to engage their full board, not just a committee, in strategic direction-setting discussions. In this way, all board members are educated about and involved in critical discussions about the internal and external environments and possible strategic options.

The growth in Community Benefit/Mission Committees since 2011 (14 percent to 21 percent) is consistent with

boards' increased focus on population health improvement. It is also occurring in the time period when boards gained new responsibilities for community health needs assessments (CHNA). These committees can help the board assure that the organization understands the health care needs of the communities it serves and that management is developing programs and services to address the most problematic areas. The most effective Community Benefit Committees are also vehicles for strengthening relationships with community leaders to improve the community's overall health (e.g., public health agencies, social service agencies, employers, schools and churches).

The survey results on board restructuring underscore the importance of determining the correct committee structure for an organization's board. Interestingly, the percentage of boards that added or reduced the number of committees was about equal (e.g., 21 percent of system boards added committees, but 20 percent reduced the number of committees). The relationship between adding and reducing committees is the same for subsidiary boards (14 percent added, but 15 percent reduced). The main take away regarding these findings is that boards of all types are taking the time to determine how their committee structure can best support their board.

The most striking data in the board restructuring section is related to seeking new board member skills and competencies. Over the last three years, most boards have actively sought individuals with needed expertise and perspectives. This is refreshing news, since the shift to value-based care means boards will want to include experts in public health, risk management, mergers and change management (among other areas).

Two other governance trends worth noting are related to board support. Over one-third of health system boards (39 percent) have a dedicated governance professional staff member to help the board become more effective and efficient. A very high percentage of system boards (85 percent) use an electronic board portal to keep their boards informed. Both practices should be considered by all other types of boards because they can make board service easier for busy individuals.

Pamela R. Knecht (pknecht@accordlimited.com) is president and CEO of ACCORD LIMITED, a national strategy and governance consulting firm based in Chicago.

Discussion Questions on Board Structure and Support

1. What, if any, changes should our board make to board member terms or term limits to ensure we retain needed expertise and organizational history while allowing for new board members with added expertise to join the board?
2. Should our board consider compensating our members? If so, what problems would we be trying to solve by this approach? Are we convinced that no other board practice could address those issues?
3. Do we have the committees our board needs to ensure appropriate governance oversight of each of our key responsibilities? Do we need to add or reduce the number of committees to better reflect our specific board's role and authority?
4. What, if any, skills, competencies and perspectives should we add to our board so we can appropriately oversee a complex health care organization?
5. Do we need to provide more support for our board and committees? For instance, would a dedicated governance professional staff person provide needed bandwidth and expertise?
6. Are we optimizing an electronic board portal to assist with initial orientation, provide continuing educational resources, and keep board and committee members sufficiently informed? If not, what changes should we make to our portal or our processes?

Section 4

Board Practices

Data Points

According to 2018 survey results, almost two-thirds of system boards use competencies in board member selection. Data also indicate some broadening and refinement of competencies used to select board members and chairs. More than 75 percent of all respondents indicated they did not replace or did not reappoint any members, when eligible, over the past three years. Slightly more than a third of respondents do not use job descriptions for board members and board and committee chairs. More than 70 percent of respondents have no continuing education requirement for members, and about three-quarters of all respondents said they had no formal orientation for the board chair.

Board Member Selection

Board Member Competencies

- In 2018, 42 percent of respondents overall reported that their selection committees used an approved set of competencies in selecting all board members. More than twice the percentage of system boards (64 percent) reported using competencies for board member selection than did boards of freestanding hospitals (Figure 4.1).
- Across all respondents, higher percentages of system boards reported using competencies as part of selection processes than did hospital boards (Figure 4.1).
- In 2018, a higher percentage of survey respondents overall used competencies to select board members than did respondents in 2014 and 2011 (Figure 4.2).

Figure 4.1 – Use of Competencies by Board Type

Does your board or board's selection committee use a set of approved knowledge, skills and behavioral competencies for selecting the following?

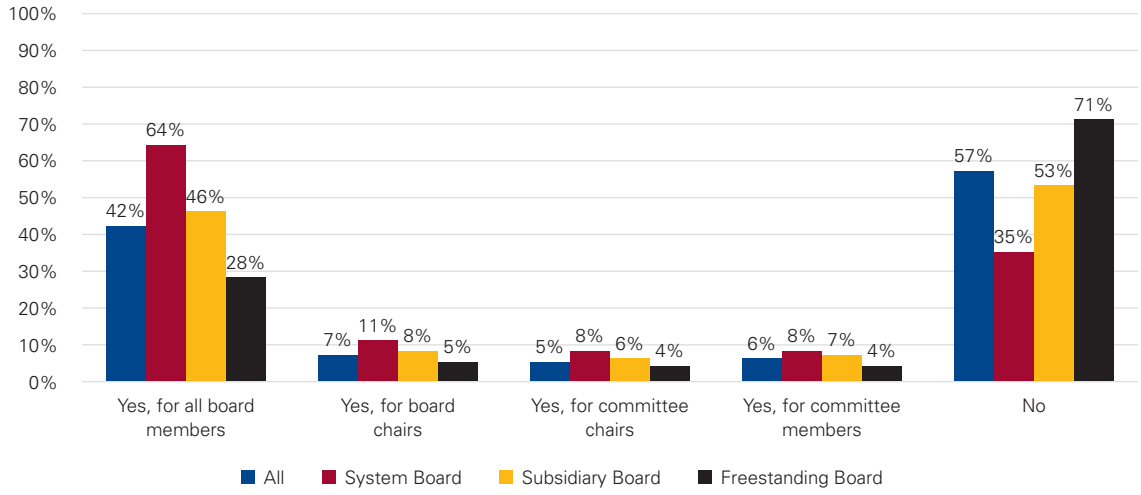
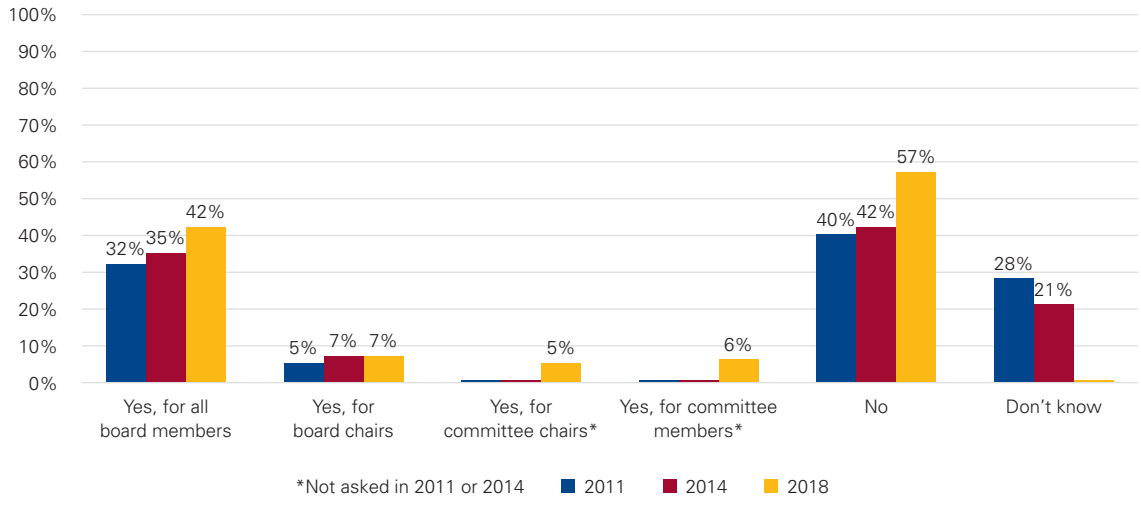


Figure 4.2 – Use of Competencies by Year



- As Figure 4.3 indicates, across all respondents to the 2018 survey, the top five knowledge, skills and behavior competencies used to select board members were: information seeking (80 percent); innovative thinking (73 percent); knowledge of business and finance (66 percent); knowledge of health care delivery and performance (62 percent); and community orientation (60 percent).
- Hospital boards included quality and safety expertise among their top five competencies; system boards did not (Figure 4.3).

Figure 4.3 – Top Five Competencies for Board Member Selection

Indicate below the top five essential knowledge, skills and behavior competencies you used most recently when selecting board members.

	All	System Board	Subsidiary Board	Freestanding Board
Information seeking	80%	93%	–	71%
Innovative thinking	73%	88%	66%	67%
Knowledge of business and finance	66%	–	67%	70%
Knowledge of health care delivery and performance	62%	69%	62%	–
Community orientation (understands the community needs and health)	60%	–	63%	66%
Organizational awareness (familiar with expectations, priorities, and values of health care stakeholders)	–	62%	–	–
Professionalism	–	65%	–	–
Quality and safety expertise	–	–	61%	88%

- Of the small percentage of hospitals and systems that use competencies to select board chairs, Figure 4.4 shows that the top five knowledge, skills and behavior competencies were: team leadership (78 percent); past governance experience (55 percent); complexity management (55 percent); achievement orientation (50 percent); and organizational awareness (49 percent).

Figure 4.4 – Top Five Competencies for Board Chair Selection

Indicate below the top five essential knowledge, skills and behavior competencies you used most recently when selecting board chairs.

	All	System Board	Subsidiary Board	Freestanding Board
Team leadership	78%	86%	75%	79%
Complexity management (balances, tradeoffs, competing interests and contradictions)	55%	68%	–	54%
Past governance experience	55%	57%	53%	55%
Achievement orientation (assures high standards, sets goals and priorities)	50%	–	–	–
Organizational awareness (familiar with expectations, priorities, and values of health care stakeholders)	49%	–	51%	52%
Accountability	–	53%	–	–
Change leadership (perceives and utilizes new information/ technology)	–	–	49%	–
Quality and safety expertise	–	69%	–	–
Strategic orientation (understands forces that shape health care over the next five to 10 years, helps shape mission and vision, policy and advocacy)	–	–	49%	–
Systems thinking	–	–	–	53%

Replacement

- Some 76 percent of 2018 survey respondents overall reported that no board member had been replaced or not been reappointed when eligible over the past three years (Figure 4.5).
- For those who did replace board members, higher percentages of system boards did so because of behavioral issues or because they were seeking new board member competencies than did hospital boards (Figure 4.6).

Figure 4.5 – Board Member Replacement in Past Three Years

Have any board members been replaced during their term or not been reappointed or re-elected when eligible for renomination in the past three years?

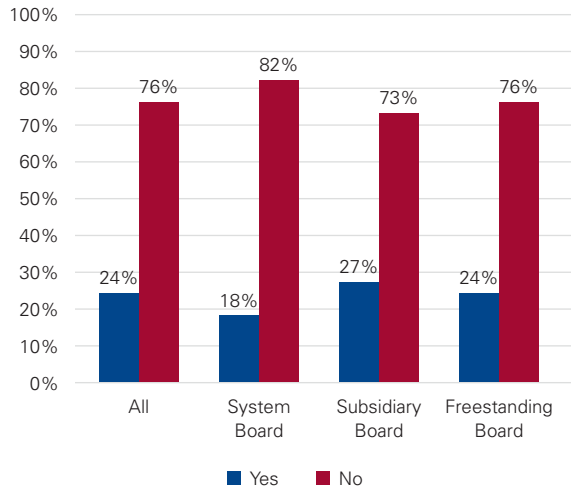
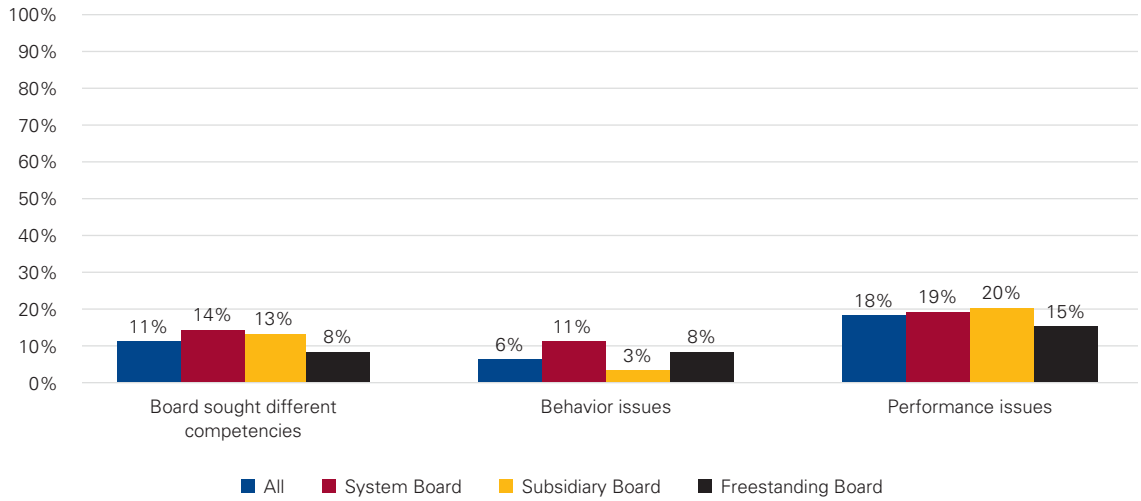


Figure 4.6 – Reasons for Board Member Replacement



Recruitment

- About a third (33 percent) of respondents overall in 2018 indicated that more effort is now required to recruit new board members compared with three years ago (Figure 4.7).
- About 62 percent of 2018 survey respondents overall reported that recruiting Millennials for board service requires the same or more effort than recruiting other age cohorts (Figure 4.8).

Figure 4.7 – Effort Required to Recruit New Board Members Compared to Three Years Ago

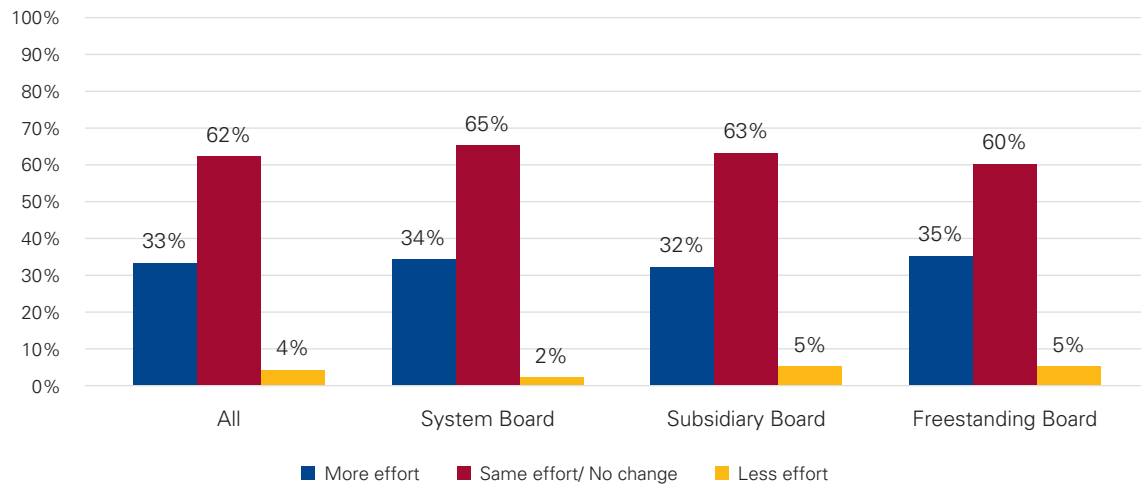


Figure 4.8 – Effort Required to Recruit Millennials Compared to Other Age Cohorts

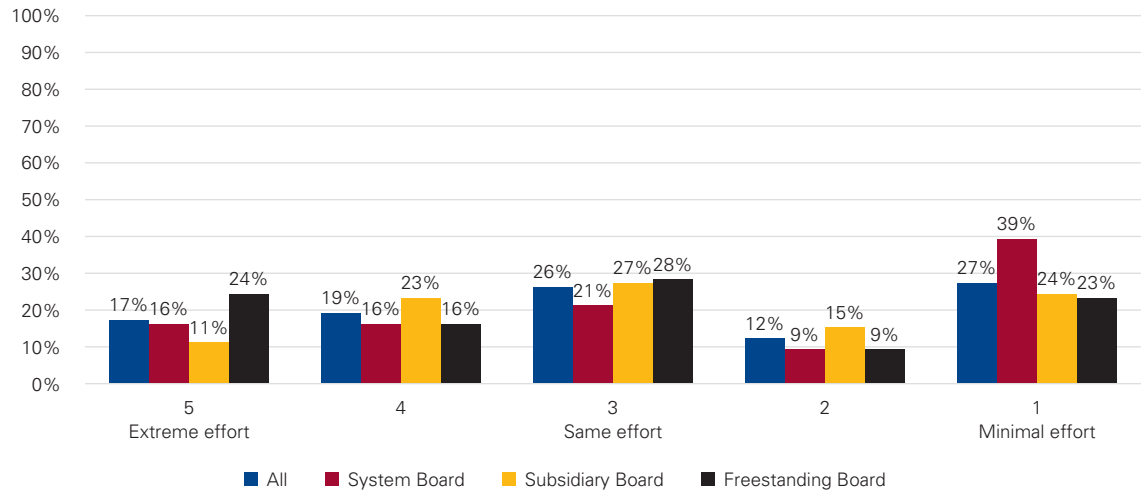
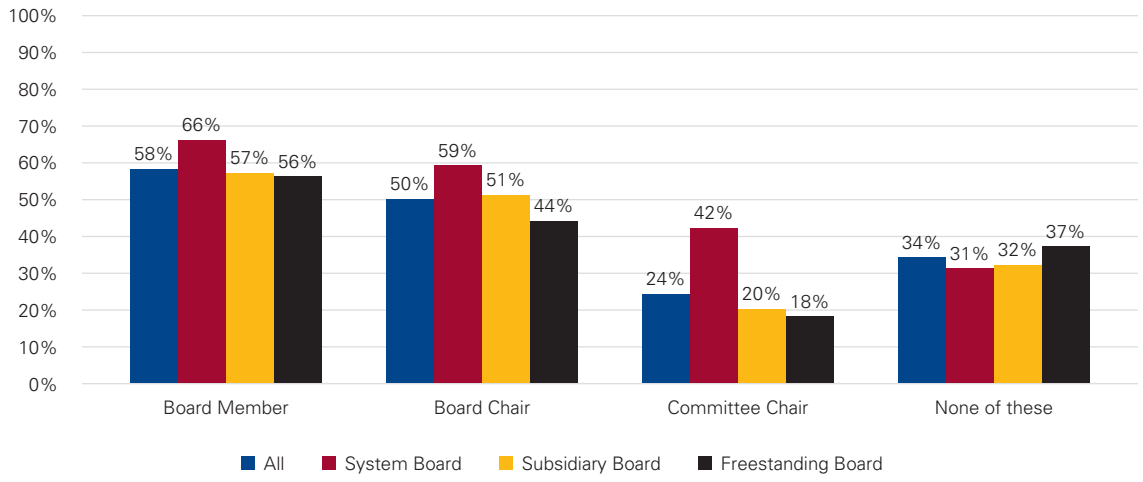


Figure 4.9 – Use of Job Descriptions by Board Type

For which of the following positions does your board have job descriptions?

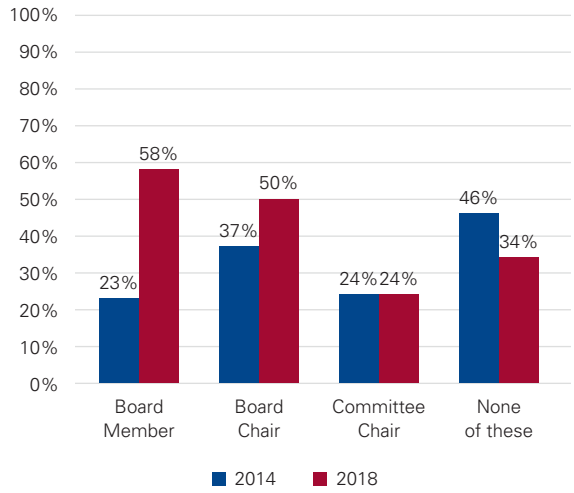


Board Orientation and Education

Job Descriptions

- Slightly more than a third (34 percent) of 2018 survey respondents overall reported they did not have job descriptions for board members, the board chair or committee chairs (Figure 4.9).
- Higher percentages of overall respondents to the 2018 survey reported having board member and board chair job descriptions than did respondents to the 2014 survey. Twenty-four percent (24 percent) of respondents to both surveys reported having job descriptions for committee chairs (Figure 4.10).

Figure 4.10 – Use of Job Descriptions by Year



Orientation

- Eighty-two percent (82 percent) of 2018 survey respondents reported having a formal orientation for new board members. This compares with 97 percent of overall respondents to the 2014 survey (Figure 4.11).
- As Figure 4.12 indicates, the highest percentages of respondents overall reported including the following activities in their formal board orientations: organization orientation (94 percent); meeting with the CEO and/or senior leadership team (94 percent); facility tour (81 percent); and health care governance orientation (80 percent).

Figure 4.11 – New Board Member Orientation

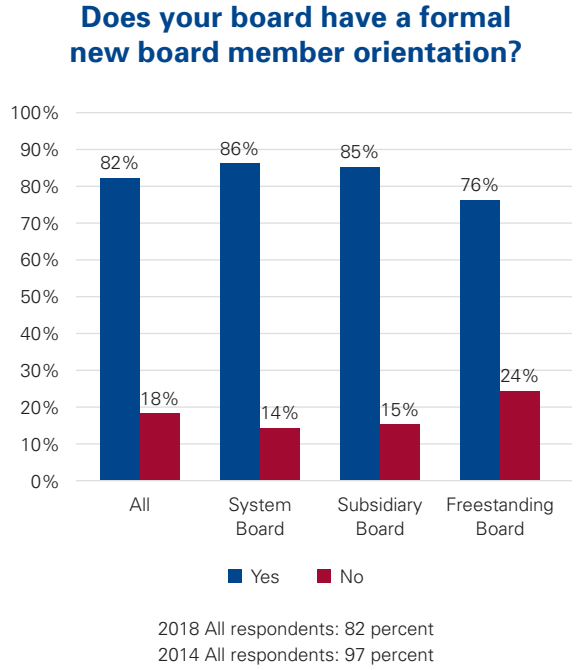


Figure 4.12 – Elements Included in New Board Member Orientation

	All	System Board	Subsidiary Board	Freestanding Board
Organization orientation	94%	97%	94%	93%
Meeting with the CEO and/or senior leadership team	94%	93%	93%	94%
Facility tour	81%	72%	77%	88%
Health care governance orientation	80%	83%	79%	81%
Health care orientation	74%	71%	70%	79%
Meeting with the board chair	59%	67%	64%	50%
Formal mentoring with a senior board member	21%	23%	19%	23%
Other	12%	13%	13%	10%

- Three quarters (75 percent) of respondents to the 2018 survey indicated they did not have a formal orientation for new board chairs. A higher percentage of system boards (33 percent) reported having a formal board chair orientation than did hospital boards (Figure 4.13).

Continuing Education

- A majority of overall respondents to the 2018 survey (71 percent) indicated they did not have a continuing education requirement for board members. (Figure 4.14).
- Of system subsidiary hospital boards, 76 percent of respondents who said they had significant decision-making authority indicated they did not have a continuing education requirement for their board members (Figure 4.15).

Figure 4.13 – New Board Chair Orientation

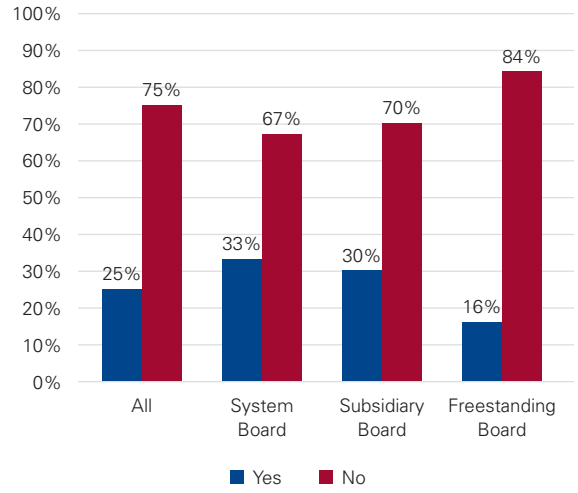


Figure 4.14 – Board Member Continuing Education Requirement

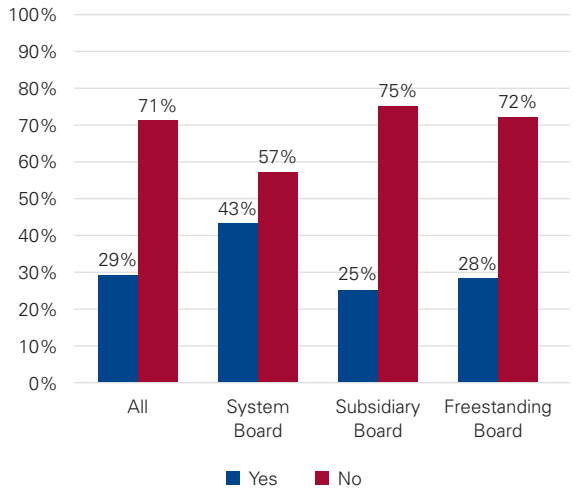
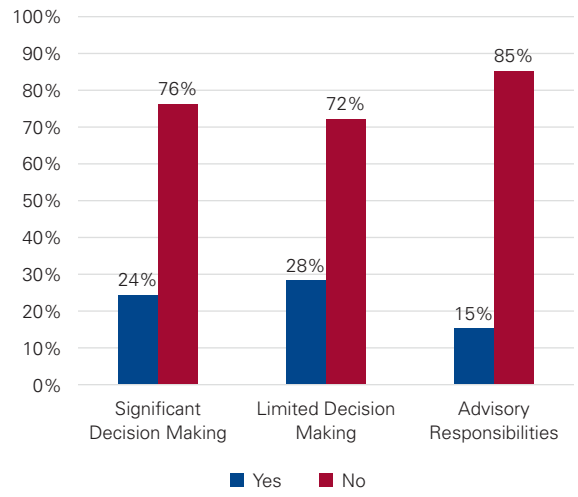
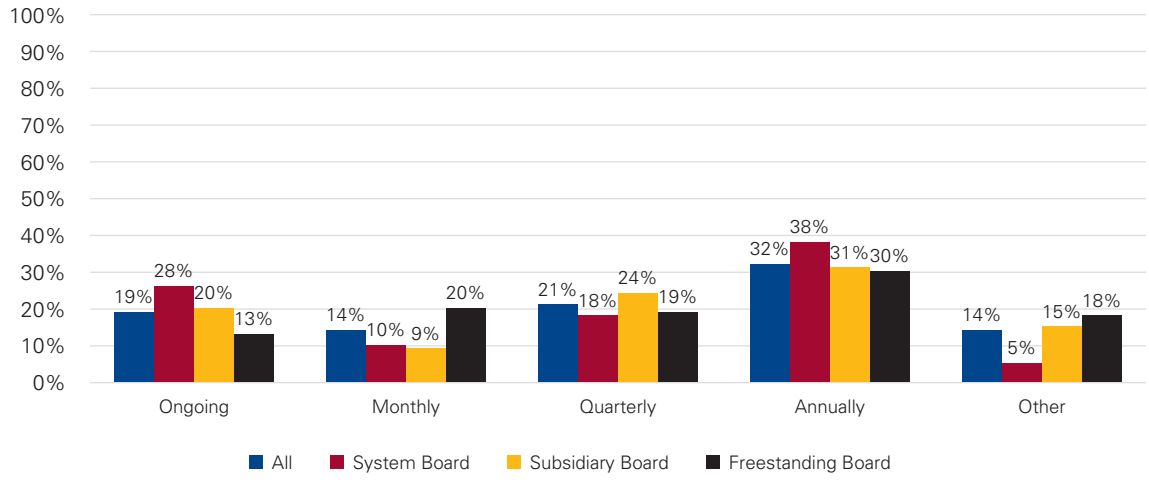


Figure 4.15 – Subsidiary Boards with Continuing Education Requirement by Authority Level



- When asked about frequency of organized education activities, the highest percentage of 2018 survey respondents overall (32 percent) and within each board category (system, subsidiary hospital and freestanding hospital) reported that their boards participated in organized education activities annually (Figure 4.16).

Figure 4.16 – Frequency of Organized Board Education Activities



- The highest percentage of 2018 survey respondents overall (75 percent) and within each board category reported that continuing education for their boards is delivered at board/committee meetings (Figure 4.17).
- The highest percentage of 2018 survey respondents overall (85 percent) reported receiving an educational briefing on compliance issues from legal counsel, followed by briefings on trustee conflicts of interest/ independence at 75 percent (Figure 4.18).

Figure 4.17 – Delivery of Board Education

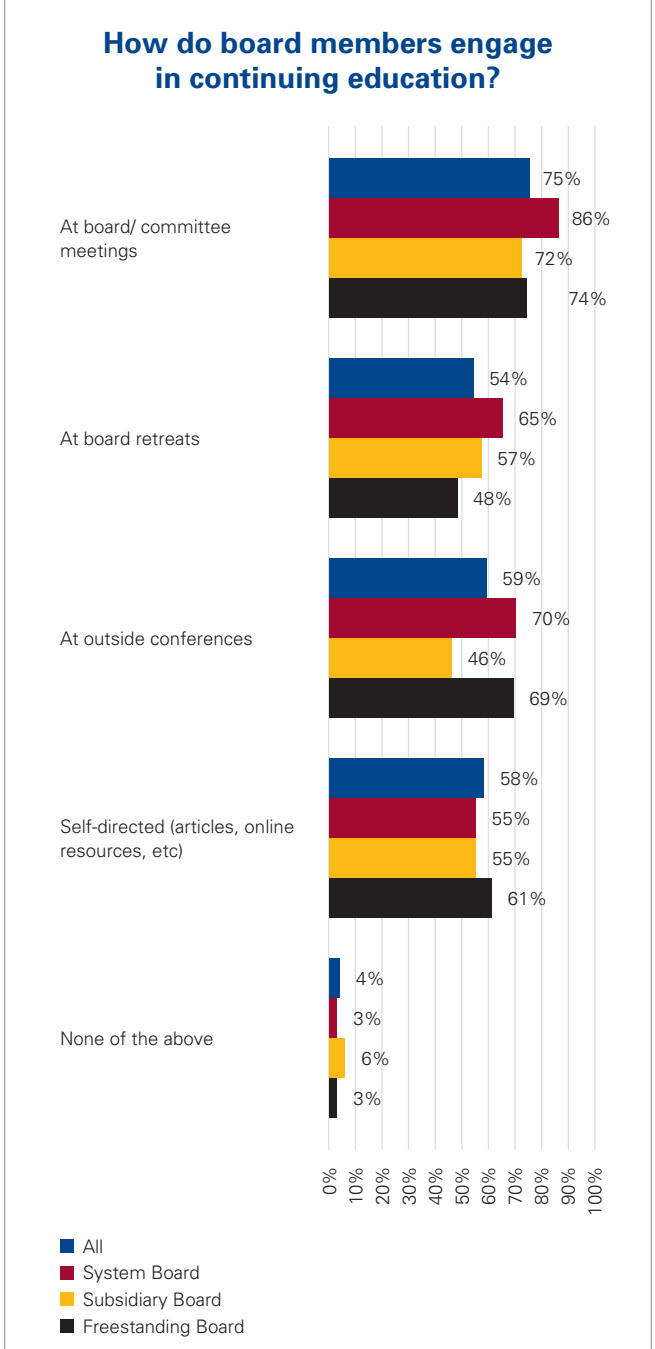
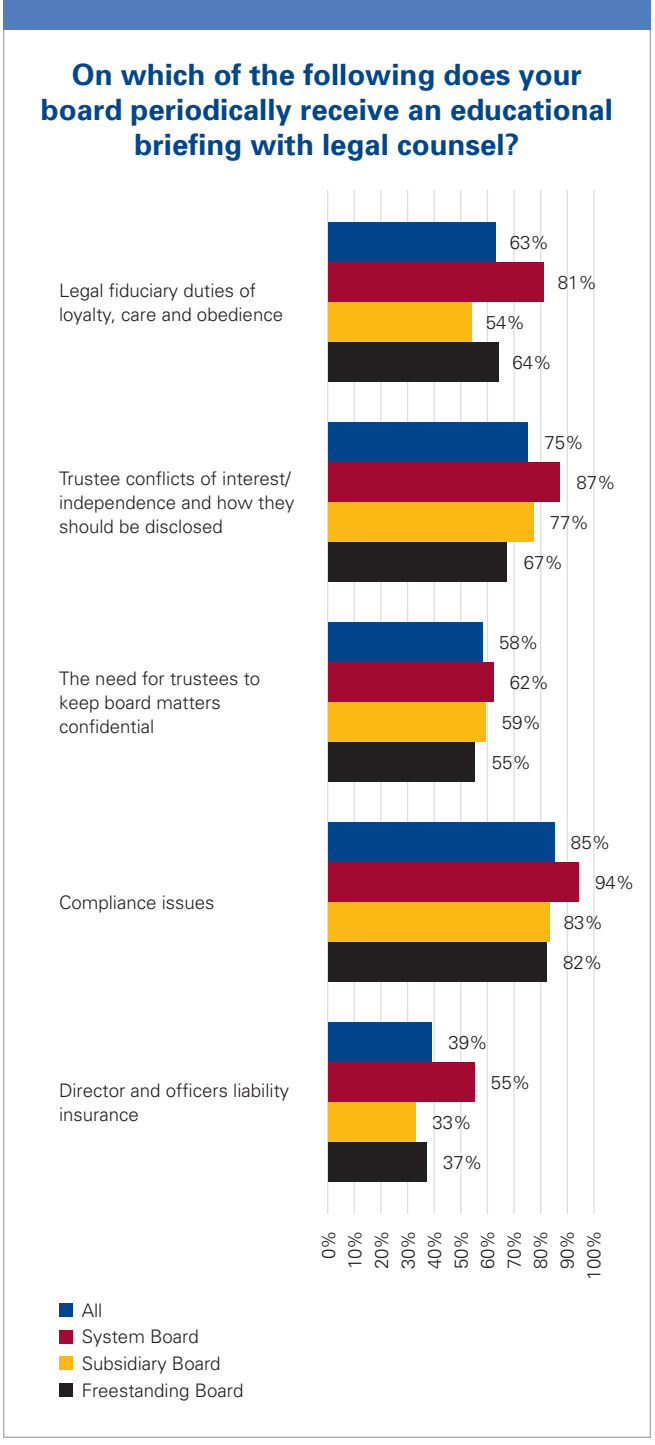


Figure 4.18 – Legal Counsel Briefing Topics by Board Type



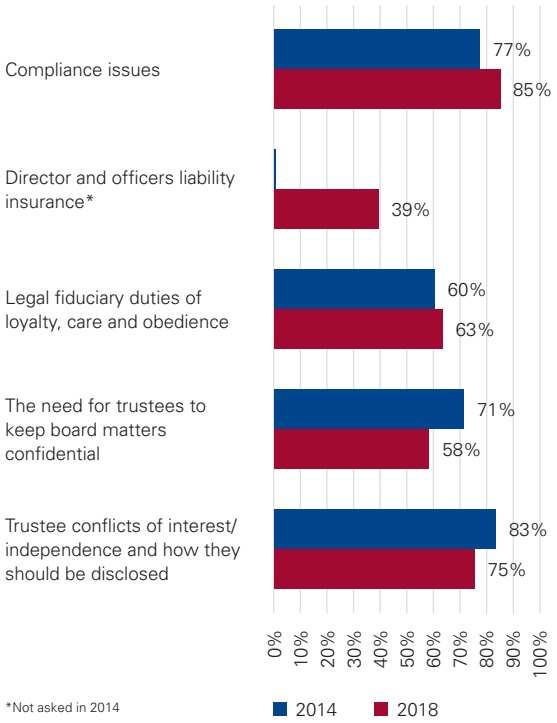
- Higher percentages of respondents overall in 2018 reported receiving briefings from legal counsel on compliance issues and fiduciary duties than in 2014 (Figure 4.19).

Board Evaluation

Assessment Types and Focus

- Some 31 percent of 2018 survey respondents overall reported not using, in the past three years, any of the following types of board assessments: full board, board member, board chair or board/ committee meeting (Figure 4.20).

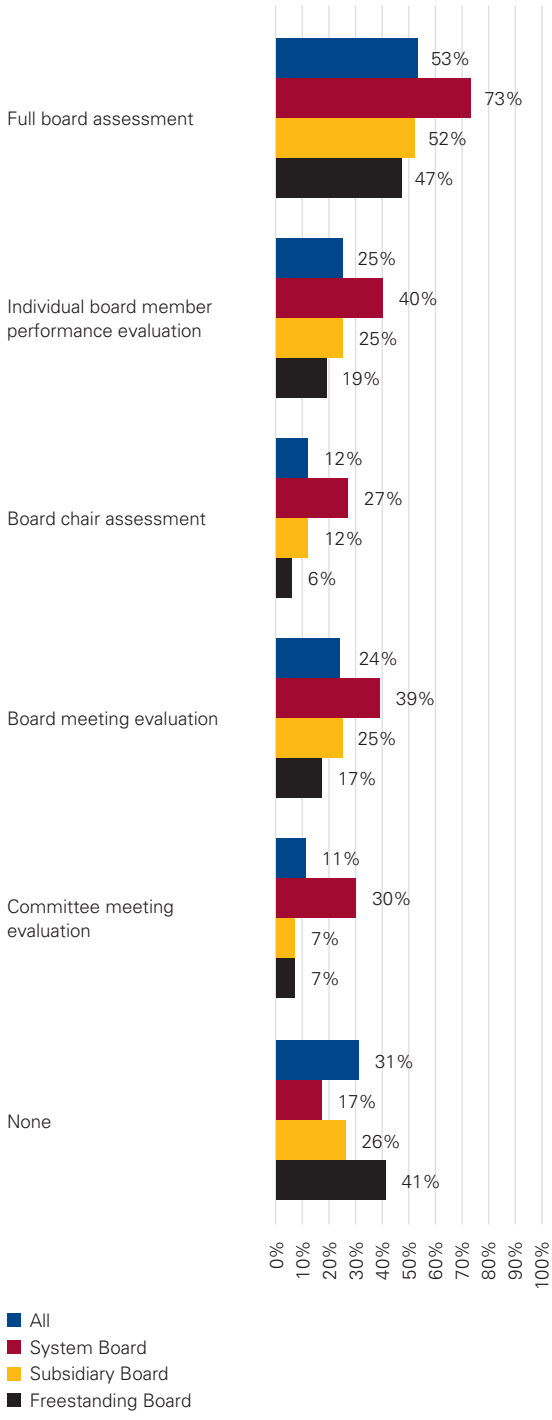
Figure 4.19 – Legal Counsel Briefing Topics by Year



*Not asked in 2014

Figure 4.20 – Use of Governance Assessments by Board Type

Which of the following types of assessments has your board used in the past three years?



- Lower percentages of respondents to the 2018 survey reported conducting both board member and full board evaluations than did respondents to the 2014 survey (Figure 4.21).
- As shown in Figure 4.22, of 2018 respondents overall that conducted a full board assessment, the highest percentages said the assessment focused on understanding of board structure, roles and responsibilities (78 percent) and achievement of board goals/work plan (71 percent).

Figure 4.21 – Use of Governance Assessments by Year

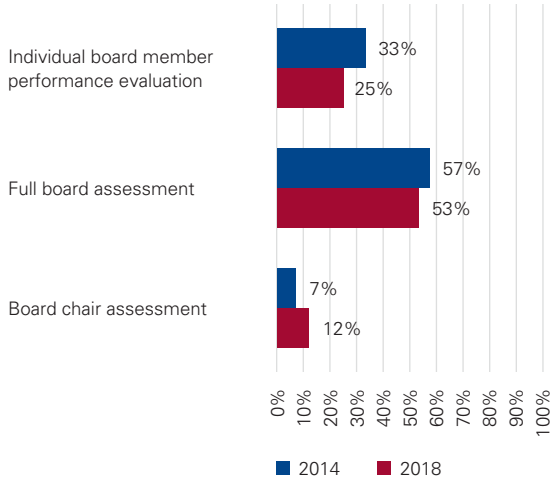
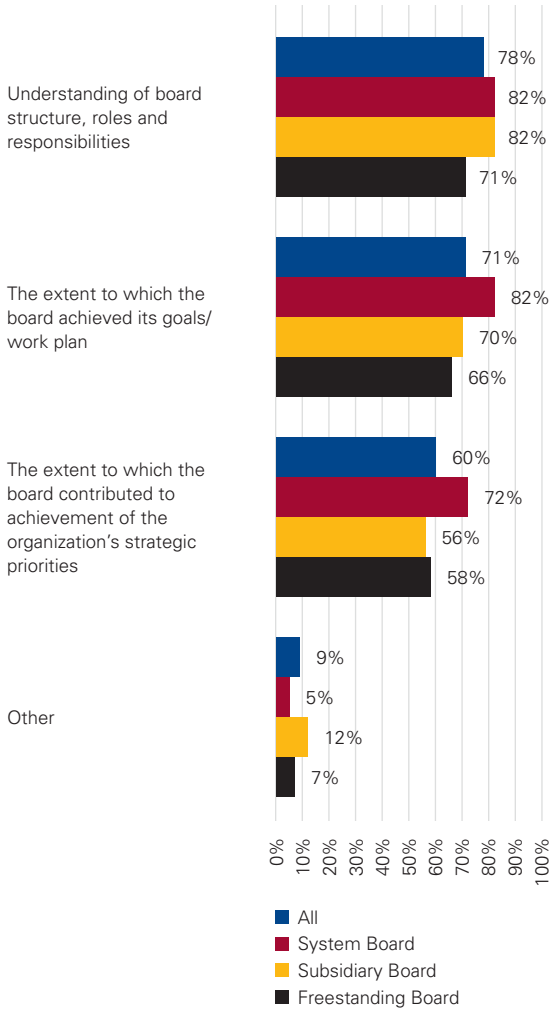


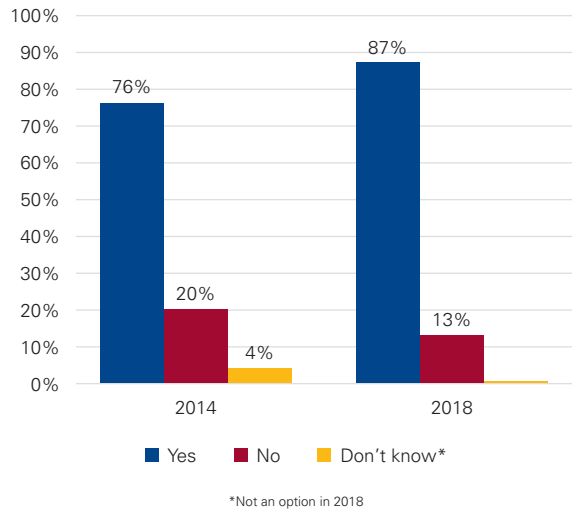
Figure 4.22 – Focus of Full Board Assessment



Assessment Results and Criteria

- The majority of overall respondents to the 2018 survey (87 percent) indicated they used assessment results to create an action plan or provide feedback to improve board performance (Figure 4.23).
- A higher percentage of 2018 survey respondents overall (87 percent) reported using assessment results to improve board performance, compared to respondents to the 2014 survey (Figure 4.24).
- About two-thirds (68 percent) of overall respondents to the 2018 survey did not use performance assessment results for reappointment of board members, board chairs or committee chairs (Figure 4.25).

Figure 4.24 – Use of Assessment Results to Improve Performance by Year



*Not an option in 2018

Figure 4.23 – Use of Assessment Results to Improve Performance by Board Type

Are assessment results used to create an action plan and/or provide feedback to improve performance?

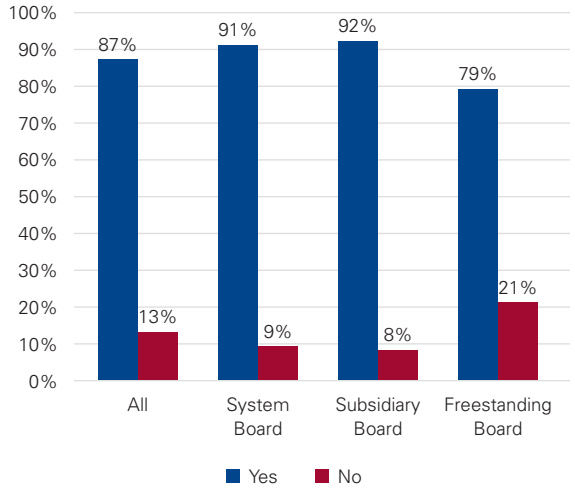
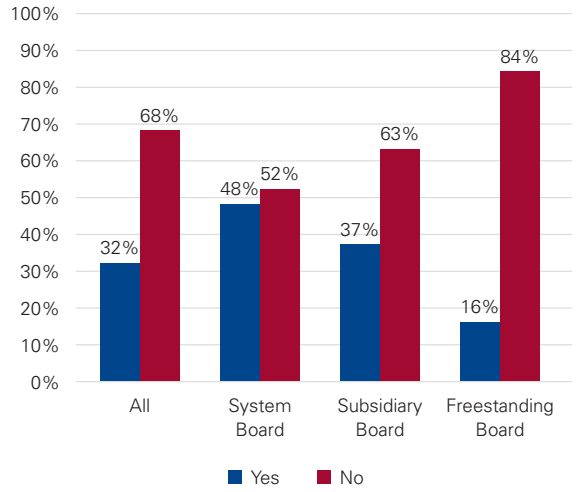


Figure 4.25 – Use of Assessment Results for Reappointment by Board Type

Are assessment results used in the process for reappointment to additional terms of service for board members, board chairs, or committee chairs?



- Percentages of 2018 survey respondents that reported using assessment results for reappointment were similar to 2014 results (Figure 4.26).
- Some 91 percent of 2018 respondents overall reported "meets the board and committee attendance requirement" as a criterion used to evaluate individual board member performance. "Actively engages in board discussion" (75 percent) and "fosters a culture of mutual respect" (67 percent) were the criteria with the next highest percentages of reported use (Figure 4.27).

Figure 4.26 – Use of Assessment Results for Reappointment by Year

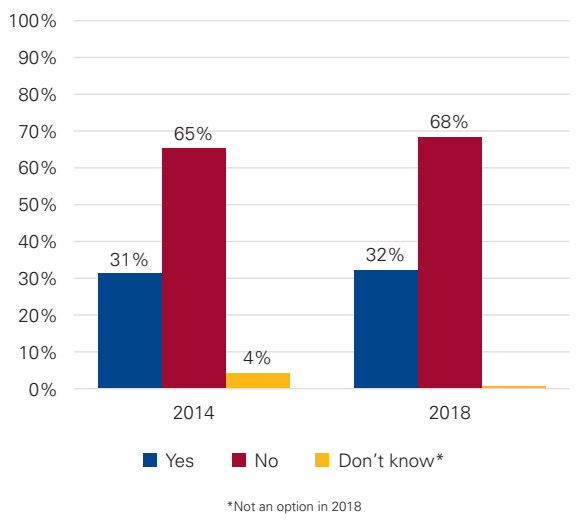
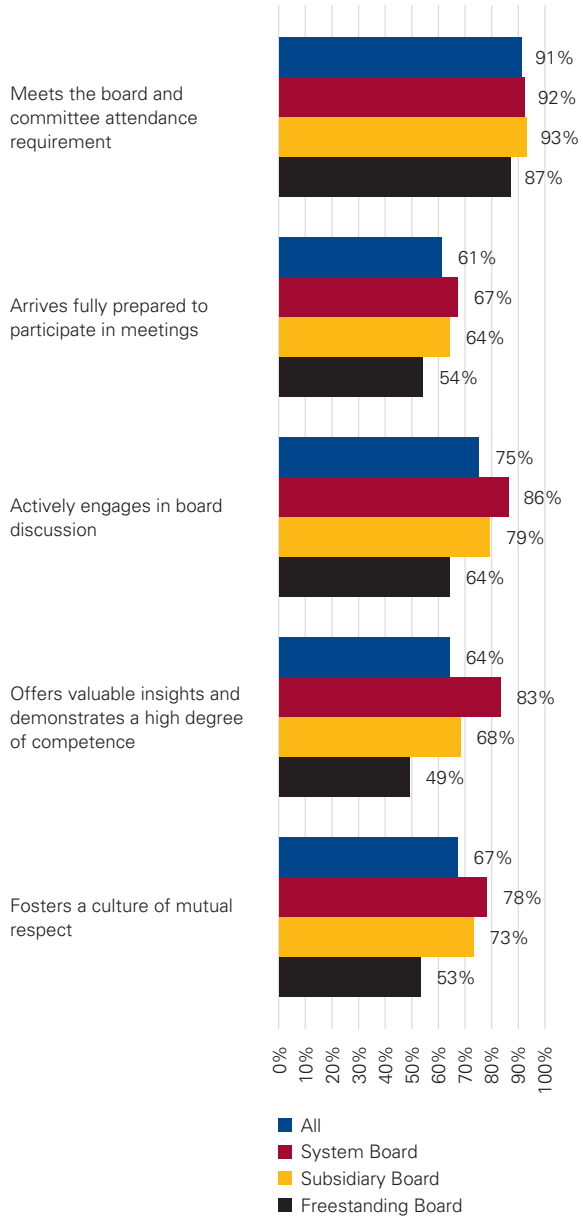


Figure 4.27 – Criteria for Board Member Performance Evaluation



Commentary

Commentary on Board Practices
by Luanne R. Stout

Introduction

Findings from the AHA's 2018 governance survey about how system, system subsidiary and freestanding hospital boards conduct a variety of governance practices appear to reflect a field in transition. For example, while use of competencies for board selection processes seems to be growing, with the type and prioritization of competencies becoming more refined, 2018 data show a lower percentage of boards offering new members a formal orientation than in 2014. Data from the 2018 survey also indicate that despite encouraging gains in use of some board practices designed to support good governance, much opportunity for improvement still exists.

Observations about Survey Findings

The 2018 AHA survey results confirm the growing use of defined competencies in board selection processes. When compared with data from 2011 and 2014 surveys, 2018 data reflect increased use of competencies in board member selection and the same or increased use in board chair selection. Survey data from 2018, however, indicate fewer boards use competencies in selecting committee chairs and members than they do in board member or board chair selection.

The 2018 survey findings also indicate an increase in both complexity and refinement of the competencies identified and ranked as important in board member and board chair selection. While the top competencies listed by survey respondents for selecting a board chair are critical (team leadership, past governance experience, complexity management, achievement orientation and organizational awareness), additional competencies such as attaining a level of knowledge and understanding about the health care field; the organization's competitive environment; relationships with physicians; and other industry-specific competencies also are beneficial in leading a health care board.

The AHA and others have contributed to a growing literature that helps health care boards better define needed competencies, assess the competencies of current members and establish a refined recruiting process to select the right candidates. Board leaders are encouraged to engage their boards in studying and discussing the extensive literature available on health care governance competencies toward the goal of adopting competency-based selection processes that are consistently used and continuously refined to reflect the board's and organization's needs.

According to survey findings, the majority of health care governing boards (76 percent) either did not replace or continued to reappoint board members during the past three years. When board members were replaced, higher percentages of system boards did so because of behavioral issues or seeking new competencies than did hospital boards.

Term limits (usually three or four consecutive, three-year terms) are helpful in accomplishing board turnover; however, some boards are reluctant to adopt term limits for fear of losing highly valued board members. Boards that annually review board member attendance, performance and contribution can achieve desired levels of rotation and competency enhancement without utilizing term limits.

The 2018 survey findings indicate some increase in efforts to recruit board members across all age groups, with boards of freestanding hospitals spending the most effort to recruit Millennials. This represents hard work by boards to move beyond an historic trend toward recruiting members who are predominantly male, white and over age 65. As communities across the country are becoming increasingly diverse in gender, ethnicity, race, religion, age and perspective, it will be critical that boards continue to strive to reflect this diversity mix in their board selection.

One of the most common ways to clarify board roles, responsibilities and expectations for a single board or among different governing bodies is to provide a job description for each, and a chart that compares roles across boards for each key responsibility. Committee charters are similarly beneficial.

The 2018 survey data indicate that about two-thirds (66 percent) of all survey respondents reported having a job description for board members, the board chair and/or committee chairs. The percentage of boards using job descriptions for board members and board chairs has increased since the 2014 survey. Both 2018 and 2014 survey data indicated the same percentage of boards having job descriptions for committee chairs (24 percent).

It is unlikely that individuals would be content in a job where their duties, reporting relationships, boundaries, expectations and hierarchical structure were unclear. Therefore, it is not difficult to understand why board members, many of whom volunteer their time, would feel the same way about their board service. Board member satisfaction and board functionality improve dramatically in organizations that provide job descriptions and clarify comparative system/subsidiary board roles and responsibilities.

Survey data indicate a notable decrease in the percentage of boards that provide a formal orientation to their members (82 percent in 2018, down from 97 percent in 2014). It is possible responses to this question may be influenced by the length of time since the orientation occurred and/or that some board members do not feel the orientation they received was either formal or adequate. Nonetheless, the significant decrease is troubling. Similarly, about two-thirds (67 percent) of system boards reported including a meeting with the board chair in their new board member orientation process; however, the same percentage of system boards does not provide a formal orientation for new board chairs.

While it is encouraging that the vast majority of board members indicate they receive orientation, my experience with a number of boards indicates key orientation elements are often lacking while others are presented in an overwhelming fashion. A manual three or four inches thick containing numerous documents without accompanying explanation of key takeaways is largely ineffective.

A 40- to 50-page orientation manual that explains what board members need to know on day one is critical. The manual should plainly describe the key facts about the organization, board service, strategic objectives, and the health care field. Orientation should be supplemented by a plan for ongoing education.

The highest percentage of respondents across all board types reported receiving board education annually. The majority (75 percent) indicated continuing education is largely delivered at board and committee meetings. System boards reported a higher use of outside conferences for board education, while freestanding hospitals reported more self-directed learning.

While outside conferences can help board members understand the health care industry and the issues it faces, they often do not offer sessions that sufficiently correlate with the system's and/or hospital's strategic plan objectives and challenges. Annual education may afford an opportunity for a strategic deep dive session; however, this opportunity alone is not sufficient. Board education should be ongoing and continuous, utilizing a variety of mechanisms such as: board and committee meeting presentations and discussions, web portals, distribution of industry or internal articles, board newsletters, annual reports, and system and/or board retreats or internal conferences.

The complexity of the health care field dictates that ongoing education should focus on strategic plan components, field structure and challenges, market competitive picture, relationships with physicians and allied health professionals, reimbursement challenges, elements of effective board performance, and other timely topics that are generative and forward-looking. In addition to education, ample opportunities and time should be provided for board members to engage in meaningful interactive discussion.

More than two-thirds (69 percent) of all boards responding to the 2018 survey utilized an assessment survey within the past three years. Fifty-three percent used a full-board assessment, followed by 25 percent that employed board member assessment. Survey results indicated a decline in both board member and full board evaluations from 2014 to 2018.

Use of a full board evaluation often helps identify governance strengths and weaknesses, as well as performance compared to that of similar boards. Individual board member assessments can be more controversial: some boards find them either too subjective or potentially hurtful to board members, many of whom volunteer their time. However, there is always value in periodic assessment of individual board members, whether accomplished through formal individual surveys or by alternative mechanisms.

The majority (87 percent) of 2018 survey respondents indicated their self-assessments were utilized to create an action plan or provide feedback to improve board performance. A higher percentage of respondents to the 2018 survey reported using assessment results to improve performance than did respondents to the 2014 survey. Some two-thirds of respondents to the 2018 survey (68 percent) do not use performance assessment results in their reappointment process for board members, board chairs, and committee chairs; however, percentages were comparable to 2014.

In my experience, boards that conduct performance assessments, full board or individual board member, and then merely report the results without utilizing them to develop action plans that drive performance improvement tend to experience lower survey participation and diminished perceived value of assessments by board members in future years. If survey results are not used in a meaningful way, performance assessments are largely viewed as a waste of time.

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Discussion Questions on Board Practices

1. Has your board developed the competencies (skills, attributes, expertise, and behaviors) that would be most beneficial to governance? Do these include core competencies that each board member should possess, as well as secondary competencies that may be demonstrated by the board as a whole?
2. Does your board, possibly with the help of a committee, annually review the attendance, contributions and competencies of the full board? Is the board able to make hard decisions about replacing board members? If not, would term limits be beneficial, if they are not already in place?
3. Do(es) your board(s) have a job description and a chart of comparative responsibilities in key areas? If not, should these resources be developed to improve clarity and understanding for board members?
4. Does your board have a formal orientation program that is efficient and focused? Does your board have a sufficient program of ongoing board education that incorporates a variety of approaches, including the opportunity for generative discussion?
5. Does your board have a full and/or individual performance assessment for board members and chairs, as well as committee members and chairs? If so, are the results used to drive performance improvement?

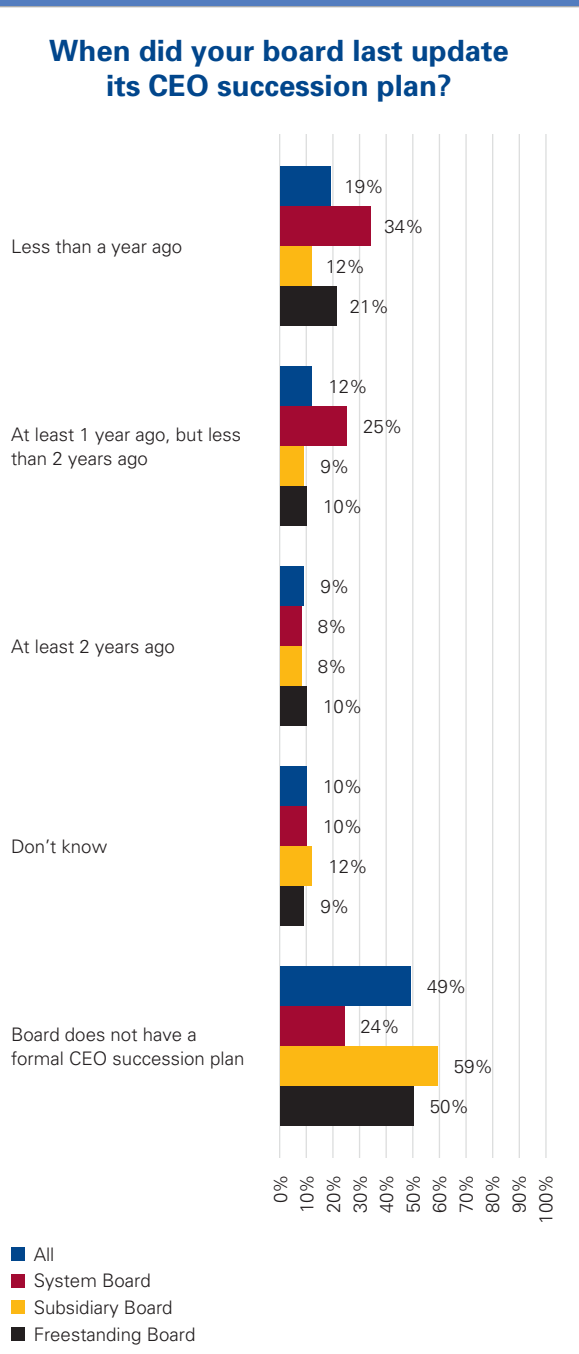
Section 5

Performance Oversight

Data Points

A formal CEO succession plan is not in place for almost half of 2018 survey respondents. Sixty-nine percent of respondents said they have an authority matrix or policy delineating management versus board authority for specific decisions. Some 89 percent or more of respondents said they use clinical quality, service/satisfaction, patient safety and financial metrics to evaluate organizational performance. Higher percentages of boards in systems indicated use of these metrics than did boards of freestanding hospitals.

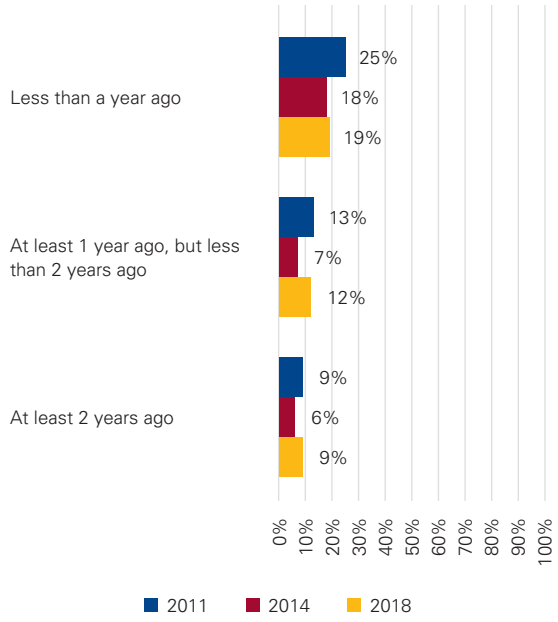
Figure 5.1 – Timing of CEO Succession Plan Update by Board Type



Executive Succession and Leadership Development

- Almost half (49 percent) of all respondents to the 2018 survey indicated their board does not have a formal CEO succession plan (Figure 5.1).
- Thirty-one (31) percent of 2018 survey respondents overall reported updating their CEO succession plan within the past two years, compared with 25 percent in 2014 and 38 percent in 2011 (Figure 5.2).

Figure 5.2 – Timing of CEO Succession Plan Update by Year



- When asked how their board oversees executive leadership development, 59 percent of 2018 survey respondents overall reported that the board ensured executive leadership development was a key priority for the CEO (Figure 5.3).

Accountability

- The majority of 2018 survey respondents overall (69 percent) indicated that their boards had an authority matrix or policy delineating management versus governance oversight and accountability for various types of decisions (Figure 5.4).

Figure 5.3 – Executive Leadership Development Oversight

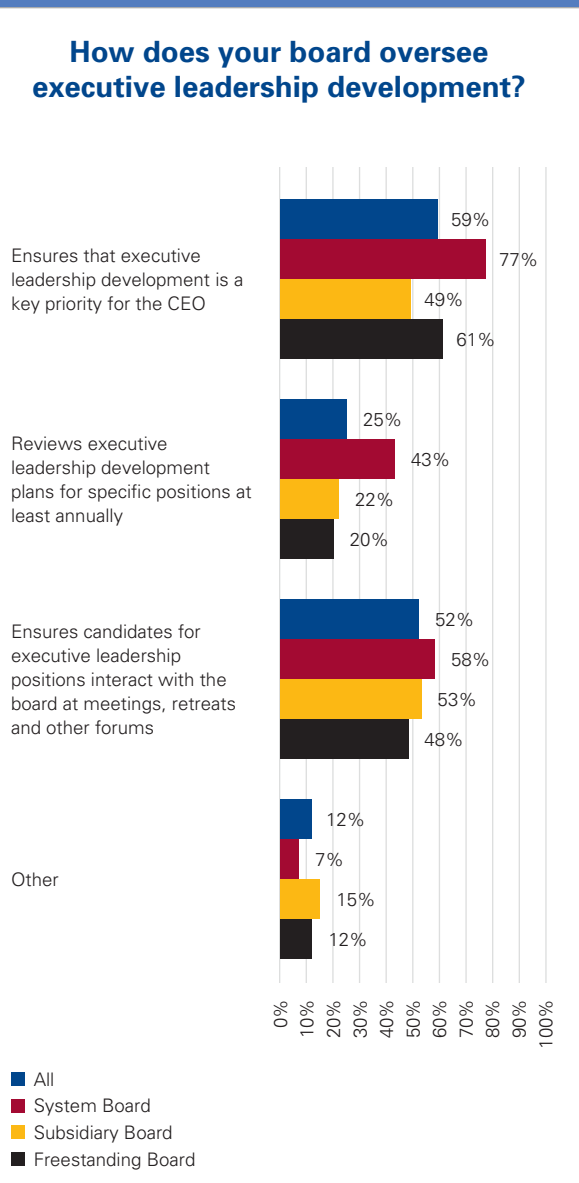
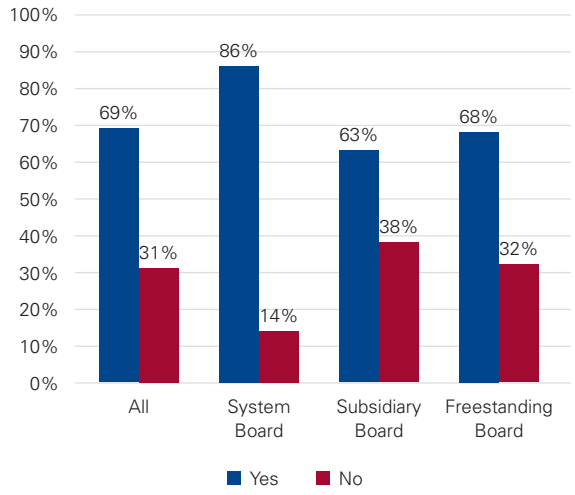


Figure 5.4 – Use of Authority Matrix Delineating Governance Versus Management Accountability



- Some 77 percent of system subsidiary hospital boards that reported having significant decision-making authority said they had an authority matrix or policy delineating accountability for various types of decisions (Figure 5.5).

Organizational Performance

- When asked which types of metrics and objectives the board uses to evaluate organizational performance (Figure 5.6), the highest percentages of 2018 survey respondents overall cited the following: clinical quality (93 percent); service quality/patient satisfaction (91 percent); patient safety (89 percent); and financial performance (89 percent).
- Use of community/population health metrics and objectives represented the lowest percentage of responses overall and for hospital boards, as Figure 5.6 indicates.

Figure 5.5 – Use of Authority Matrix or Policy by Subsidiary Boards with Varying Levels of Authority

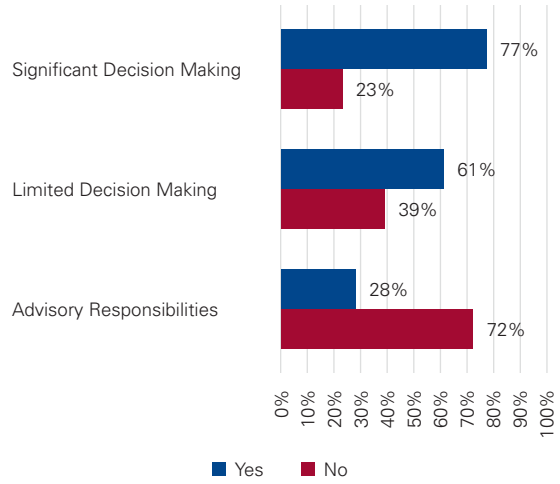
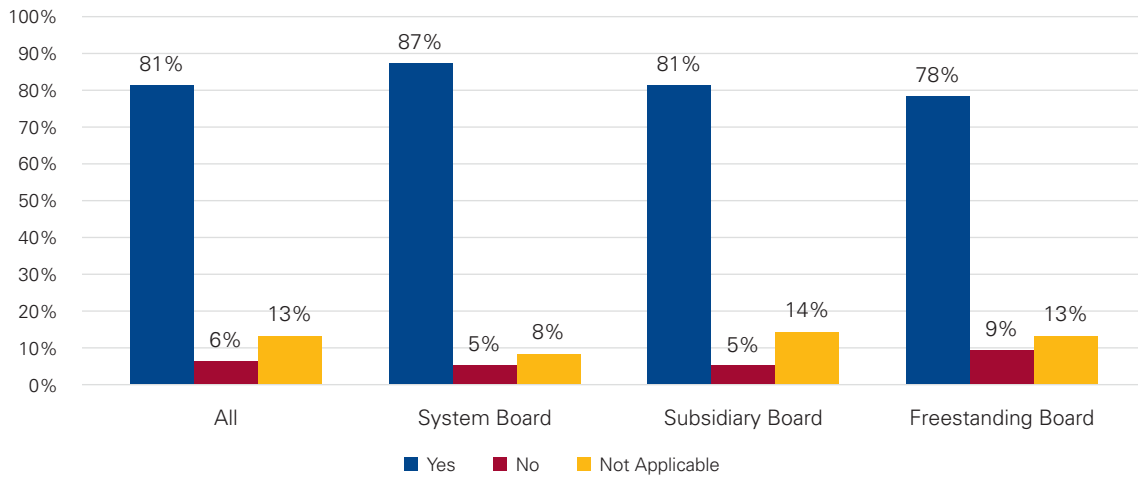


Figure 5.6 – Use of Metrics/Objectives to Evaluate Organization Performance

Does your board use precise and quantifiable metrics and objectives to evaluate organizational performance in the following areas?

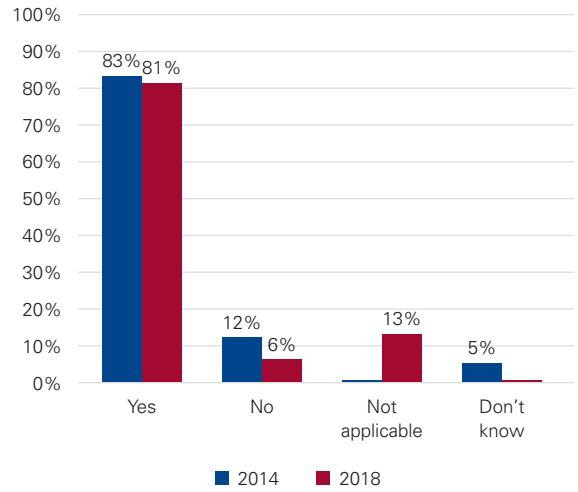
	All	System Board	Subsidiary Board	Freestanding Board
Clinical quality	93%	95%	97%	89%
Service quality/patient satisfaction	91%	92%	95%	87%
Patient safety	89%	93%	95%	81%
Financial/ capital allocation / investment performance	89%	94%	90%	86%
Employee satisfaction	79%	90%	87%	66%
Achievement of strategic priorities	70%	77%	71%	65%
Physician engagement/ satisfaction	58%	60%	72%	43%
Community/ population health	52%	71%	57%	38%
Other	3%	3%	4%	2%

Figure 5.7 – Use of Community Health Needs Assessment Results in Strategic Plan Development by Board Type



- The majority of respondents to the 2018 survey overall (81 percent) indicated they considered results of the organization's community health needs assessment (CHNA) in developing the strategic plan (Figure 5.7).
- Some 81 percent of overall respondents to the 2018 survey reported using CHNA results in strategic plan development, compared with 83 percent in 2014 (Figure 5.8).

Figure 5.8 – Use of Community Health Needs Assessment Results in Strategic Plan Development by Year



Commentary

Commentary on Performance Oversight
by Mary K. Totten

Introduction

Overseeing the performance of the organization and its executives is one of the board's core responsibilities. Data from the 2018 governance survey provides insight into executive succession and leadership development, board versus management accountability for specific decisions, use of metrics and objectives to evaluate performance and use of Community Health Needs Assessment (CHNA) data in developing the organization's strategic plan. Survey findings suggest that in some areas boards may be changing their practices more slowly than is optimal for a sector facing rapid, transformational change.

Observations about Survey Findings

Changing an organization's leaders results in significant impact, sometimes positive and sometimes less so. If well-focused and planned, succession at the top can bring fresh skills and perspectives and new, energized leadership, while at the same time creating stability, continuity and excitement about the organization's future. On the other hand, lack of a plan for leadership transition, especially at the CEO and C-Suite levels, can result in significant costs. These include lost productivity and departure of top talent looking for better opportunities to use their skills and experience.

Survey data indicating that almost half of respondents do not have a formal CEO succession plan raises questions about how or whether boards are addressing this key oversight responsibility. In times of rapid change, sometimes imposed upon health care organizations by external forces, ensuring there is a robust, up-to-date CEO succession plan gives a board an opportunity to manage one of the most significant changes its organization is ever likely to experience.

Similarly, a CEO's key responsibilities should include ensuring that a strong leadership development process is working to create a pipeline of ready leaders. Survey data show that the highest percentage of all respondents (59 percent) said this was among the ways their boards oversee executive leadership development. While tasking the CEO to ensure the organization is developing future leaders is a key element of board oversight, boards themselves can play a more active role. Interestingly, only 25 percent of respondents overall said they review leadership development plans for specific positions at least annually. System boards seem to be taking a more active role in development plan review, with 43 percent reporting involvement, compared with some 20 percent of freestanding hospital boards. Data regarding leadership development clearly indicates significant opportunities for further board work in this area.

Defining management versus governance oversight and accountability for key decisions brings clarity and efficiency to the board/management partnership. Using an authority matrix or policy that clarifies relative roles for decisions such as spending limits, signature authorities and other actions requiring board approval is one way to achieve this goal. Survey data indicate that a solid majority (about 69 percent) of survey respondents overall use a matrix or policy for this purpose. Further, some 86 percent of system boards and 77 percent of subsidiary boards with a significant level of decision-making authority also report that

these tools are in place in their organizations. These data appear to indicate that boards in systems understand the importance of role clarity when it comes to making key decisions and are using tools designed to efficiently support execution.

The survey asked respondents to indicate if they used precise and quantifiable metrics and objectives in eight categories to evaluate organizational performance. It's not surprising that performance related to clinical quality, service quality/patient satisfaction, patient safety and financial performance were the top four categories identified by respondents overall. It is refreshing to see that quality- and safety-related measures represented three of the four top categories, perhaps reflecting societal expectations for high-quality care and service as part of efforts to improve overall value in health care. Notably, higher percentages of system subsidiary hospital boards reported using the above quality and safety measures in performance evaluation than did system or freestanding hospital boards. This may reflect a movement among some systems to focus the role of subsidiary hospital boards largely on overseeing quality at the local level and on relationships with the communities they serve.

Interestingly, use of employee and physician satisfaction metrics appears to be higher in system and system subsidiary hospital boards than in freestanding hospital boards. The highest percentage of respondents reporting use of employee satisfaction metrics and objectives were system boards; and the highest percentage reporting use of physician engagement/satisfaction metrics and objectives were system subsidiary hospital boards. Use of these metrics and objectives by boards in systems may reflect the evolving division of governance responsibilities among these boards.

Not surprisingly, the lowest percentage of respondents overall (52 percent) reported using community/population health metrics and objectives to evaluate organizational performance. However, a much higher percentage of system boards (71 percent) reported using metrics and objectives of this type in performance evaluation. These findings may relate to the relatively recent focus on the significant impact that community/population health-related initiatives can have on health outcomes and quality of life in the communities health care organizations serve. It also may reflect the growing focus on delivering greater health care value by applying consistent care protocols and standards across larger groups of patients with similar diagnoses and treatment needs.

Eighty-one percent of overall respondents to the 2018 survey reported their boards considered the results of the organization's CHNA in developing their organization's strategic plan. This finding is consistent with 2014 survey results.

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Discussion Questions on Performance Oversight

1. If our organization does not have a CEO succession plan, what steps should our board take to ensure it focuses on this key governance responsibility?
2. How does our organization prepare future leaders? How does our board oversee this process?
3. Does our organization use an authority matrix or policy to clarify decision-making authority among our board(s) and management?
4. Have the metrics and objectives our board uses to oversee performance continued to evolve to reflect the changing structure and work our organization is undertaking?

Section 6

Board Culture

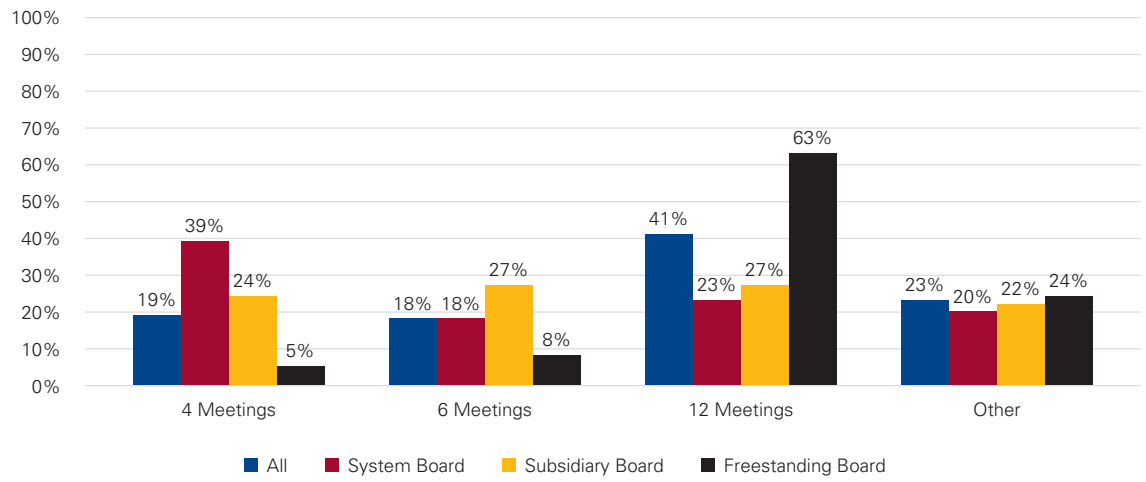
Data Points

Despite the tumultuous and challenging health care environment, a significant majority of respondents to the 2018 survey indicated they have not increased the number or length of their meetings in the past three years. A majority, some 70 percent, report spending 50 percent or less of their board meeting time in active discussion, deliberation or debate. Slightly more than half of hospitals and health systems reported including an executive session on the agenda of every board meeting.

Board Meetings

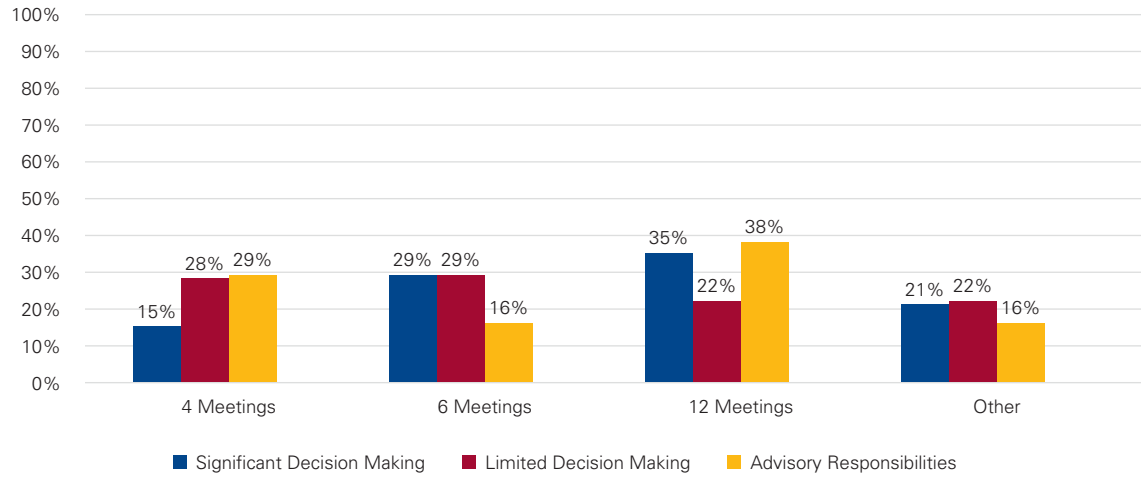
- As Figure 6.1 indicates, the highest percentage of system boards (39 percent) reported holding four regularly scheduled meetings each year. The highest percentages of system subsidiary hospital boards reported holding either six or 12 meetings a year. The majority of freestanding hospitals, 63 percent, reported their board held 12 regularly scheduled meetings each year.

Figure 6.1 – Number of Regularly Scheduled Board Meetings Annually by Board Type



- Among system subsidiary hospital boards with significant decision-making authority, the highest percentage (35 percent) reported holding 12 regularly scheduled meetings each year (Figure 6.2).

Figure 6.2 – Number of Regularly Scheduled Board Meetings Annually for Subsidiary Boards with Varying Levels of Authority



- The vast majority of overall respondents to the 2018 survey (94 percent) reported that in the past three years they did not increase the number of times the board met annually (Figure 6.3).
- The majority of overall respondents to the 2018 survey (84 percent) reported not increasing the length of board meetings in the past three years. Of those respondents that did increase board meeting length, system boards represented the highest percentage at 19 percent (Figure 6.4).
- The highest percentages of system subsidiary hospital boards across all levels of decision-making authority reported not increasing the length of board meetings in the past three years. (Figure 6.5).

Figure 6.3 – Increase in Past Three Years in Number of Board Meetings Annually

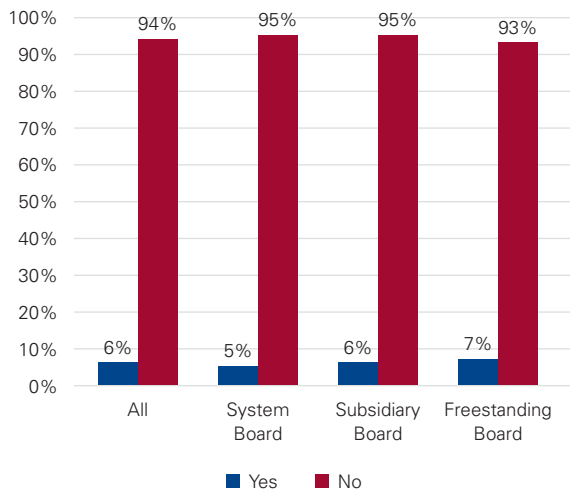


Figure 6.4 – Increase in Board Meeting Length in Past Three Years

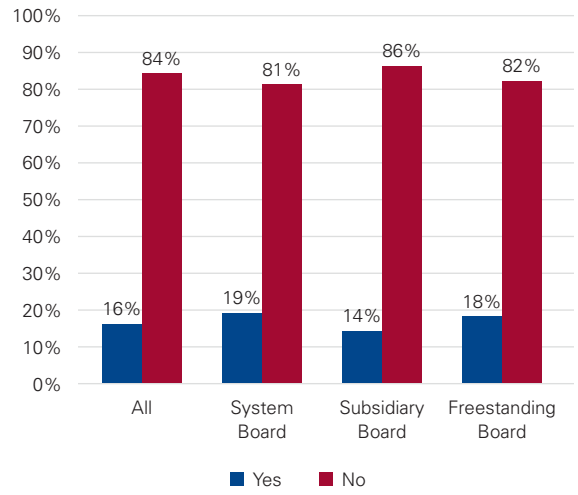
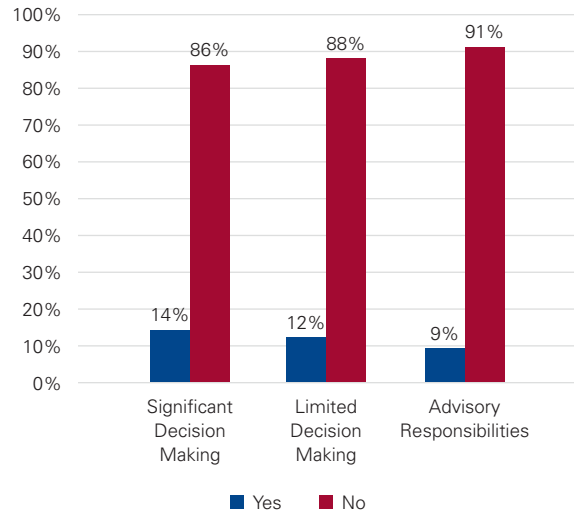
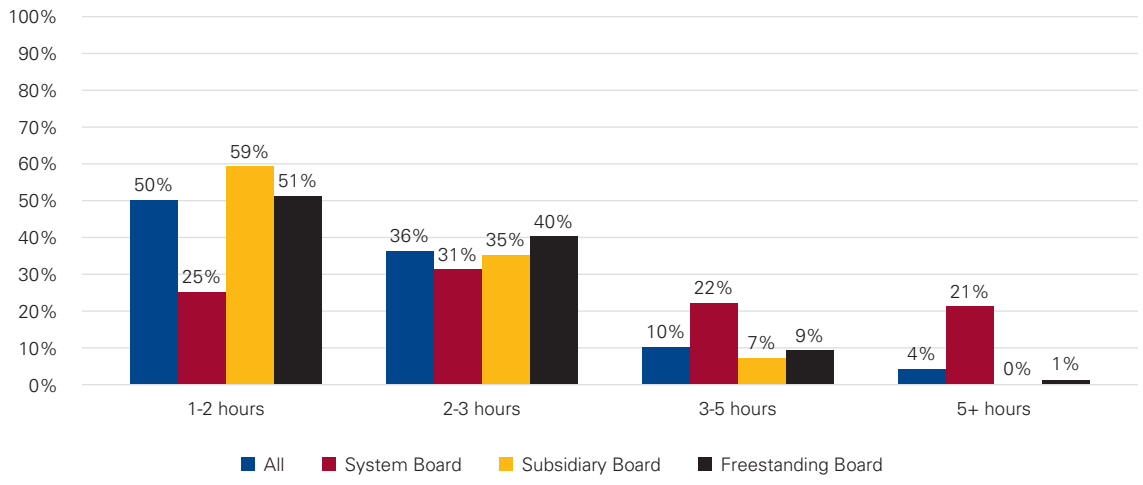


Figure 6.5 – Increase in Board Meeting Length for Subsidiary Boards with Varying Levels of Authority



- The highest percentages of hospital boards (both system subsidiary and freestanding) reported a typical board meeting lasts one to two hours. The highest percentage of system boards (31 percent) reported a typical board meeting lasts two to three hours (Figure 6.6).

Figure 6.6 – Length of Typical Board Meeting by Board Type



- The highest percentages of 2018 survey respondents overall and across all board types reported that they spent greater than 25 percent but less than or equal to 50 percent of board meeting time in active discussion, deliberation and debate at each board meeting (Figure 6.7). The same was true of system subsidiary hospital boards across all levels of decision-making in 2018 (Figure 6.8) and for overall respondents to the 2014 and 2011 surveys (Figure 6.9).

Figure 6.7 – Board Meeting Time Spent in Active Discussion, Deliberation and Debate by Board Type

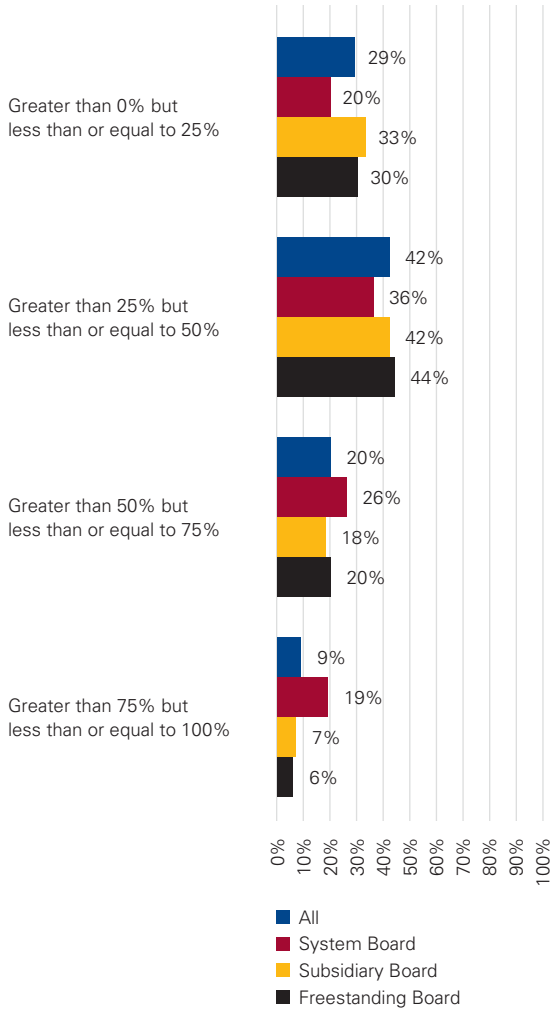


Figure 6.8 – Board Meeting Time Spent in Active Discussion, Deliberation and Debate for Subsidiary Boards with Varying Levels of Authority

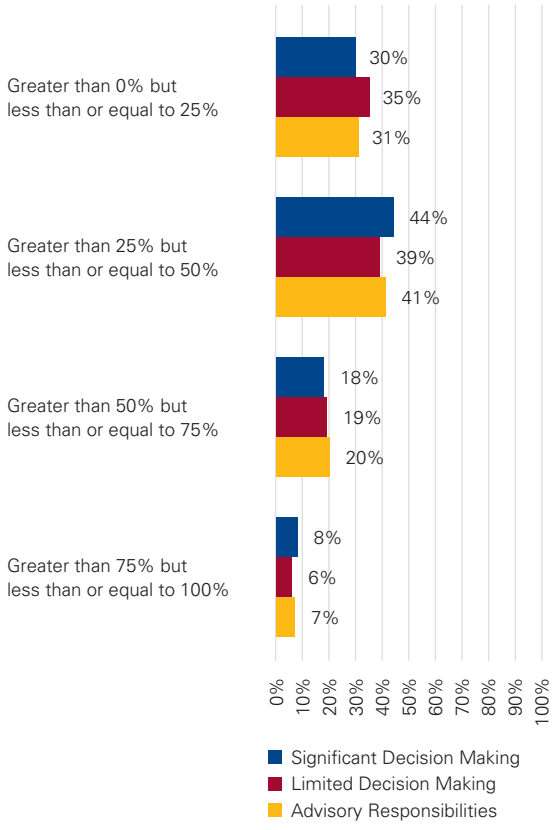
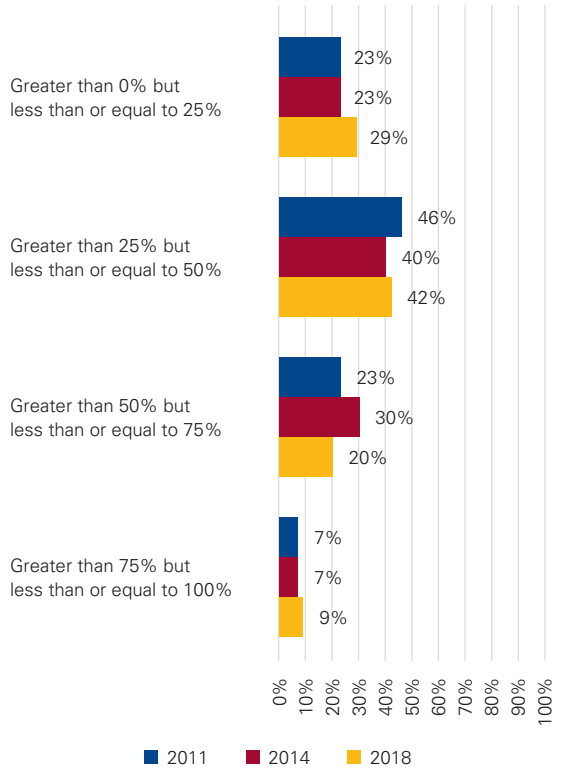


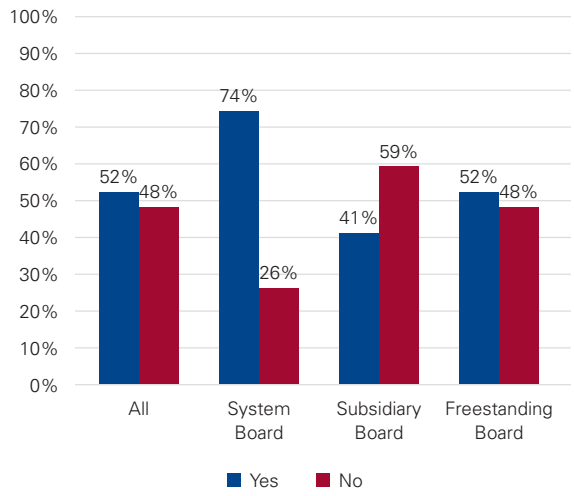
Figure 6.9 – Board Meeting Time Spent in Active Discussion, Deliberation and Debate by Year



Executive Sessions

- The highest percentage of overall respondents to the 2018 survey (52 percent) said they routinely included an executive session in the agenda of every board meeting. System boards, at 74 percent, represented the highest percentage of boards that reported this approach to executive sessions (Figure 6.10).

Figure 6.10 – Executive Session on Every Board Meeting Agenda by Board Type



- A higher percentage of respondents to the 2018 survey (52 percent) reported routinely including an executive session in the agenda of every board meeting than did respondents in 2014 (49 percent) and 2011 (41 percent), as shown in Figure 6.11.
- Of 2018 survey respondents that did have executive sessions, the majority of all respondents and respondents across all board types said the CEO participated in at least a portion of these sessions (Figure 6.12).

Figure 6.11 – Executive Session on Every Board Meeting Agenda by Year

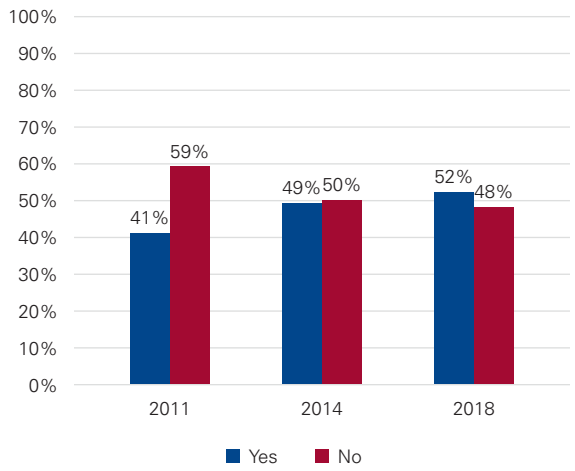
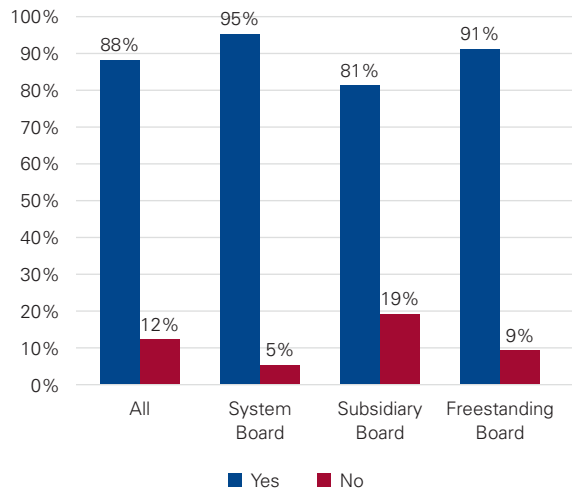


Figure 6.12 – CEO Participation in Any Portion of Executive Sessions



- Of those that reported CEO participation in executive sessions, the highest percentage of all respondents and respondents across all board types indicated the CEO participated in the entire executive session. Higher percentages of hospital boards reported CEO participation in the entire executive session than did system boards (Figure 6.13).
- Excluding executive performance evaluation and executive compensation, more than 85 percent of respondents reported that their CEOs were present for executive session discussions about all other topics reported in Figure 6.14.

Figure 6.13 – Level of CEO Participation in Executive Sessions

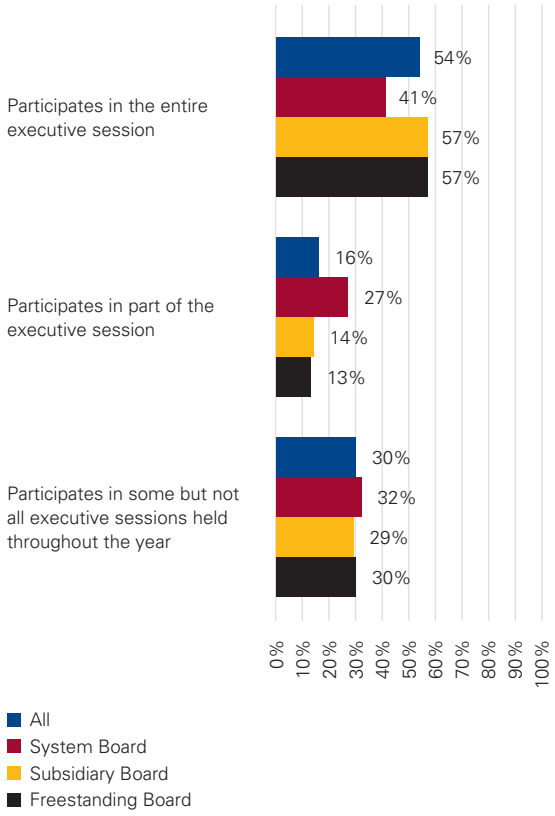


Figure 6.14 CEO Participation in Board Executive Sessions by Topic					
		All	**System Board**	**Subsidiary Board**	**Freestanding Board**
Clinical or quality performance measures	CEO Present	99%	99%	99%	98%
	CEO Not Present	1%	1%	1%	2%
Financial performance of the health system/ hospital(s)	CEO Present	98%	99%	99%	96%
	CEO Not Present	2%	1%	1%	4%
General strategic issues/ planning	CEO Present	98%	98%	98%	98%
	CEO Not Present	2%	2%	2%	2%
Board development	CEO Present	97%	97%	98%	97%
	CEO Not Present	3%	3%	2%	3%
Board recruitment and selection	CEO Present	95%	97%	97%	93%
	CEO Not Present	5%	3%	3%	7%
Board evaluation	CEO Present	91%	95%	92%	89%
	CEO Not Present	9%	5%	8%	11%
Board member performance evaluation	CEO Present	90%	93%	92%	86%
	CEO Not Present	10%	7%	8%	14%
Executive compensation	CEO Present	34%	35%	36%	32%
	CEO Not Present	66%	65%	64%	68%
Executive performance evaluation	CEO Present	31%	20%	30%	35%
	CEO Not Present	69%	80%	70%	65%

Time Commitment

- Compared to three years ago, the highest percentages of survey respondents overall and across all board types said there was no change in the amount of time spent on board work and related activities. Of those that reported spending more time, system boards, at 41 percent, represented the highest percentage (Figure 6.15).
- The highest percentages of system subsidiary hospital boards across all levels of decision-making authority reported no change in the time spent on board work and related activities (Figure 6.16).

Figure 6.15 – Time Spent on Board Activities Compared to Three Years Ago

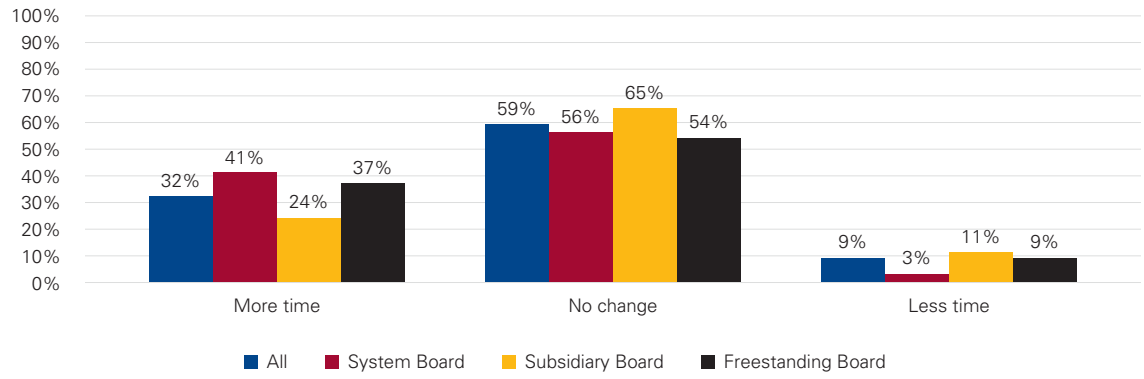
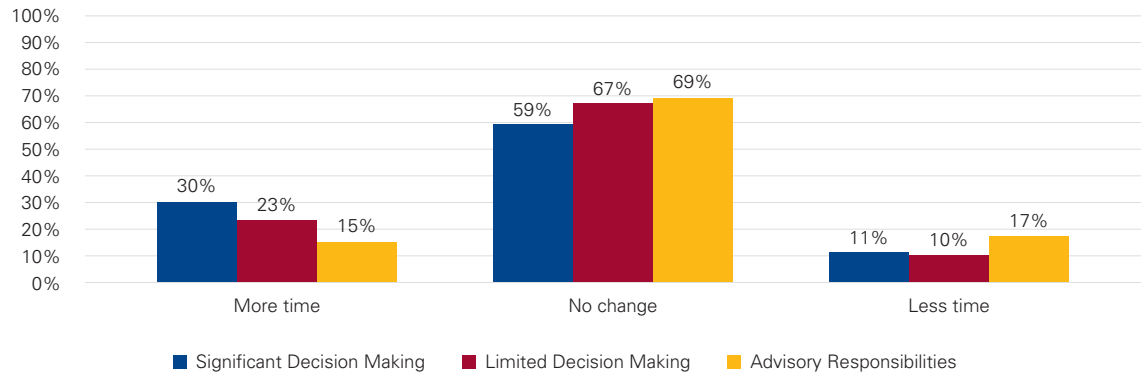


Figure 6.16 – Time Spent on Board Activities by Subsidiary Boards with Varying Levels of Authority



- Among 2018 respondents overall and across all board types, the highest percentages reported board members have not voiced concerns about time commitments associated with board service (Figure 6.17).
- Of system subsidiary hospital respondents to the 2018 survey, the highest percentages across all levels of decision-making authority reported that board members have not voiced concerns about time commitments associated with board service (Figure 6.18).

Figure 6.17 – Board Member Concern About Board Service Time Commitments

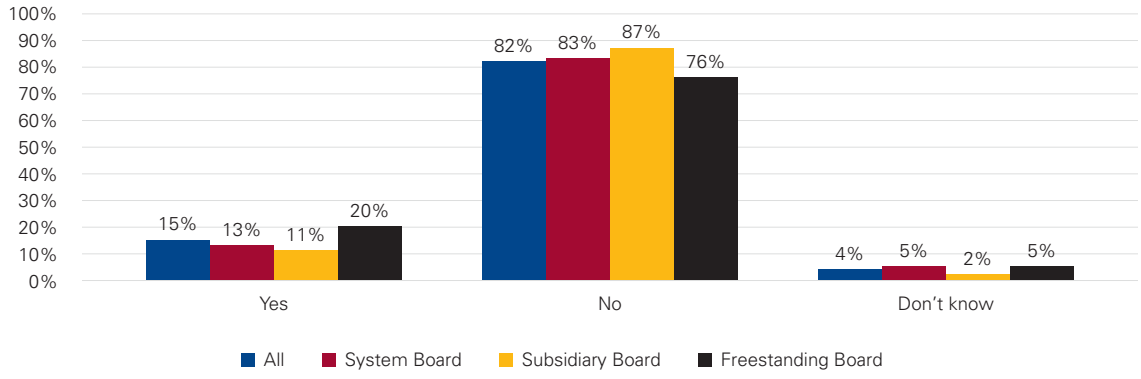
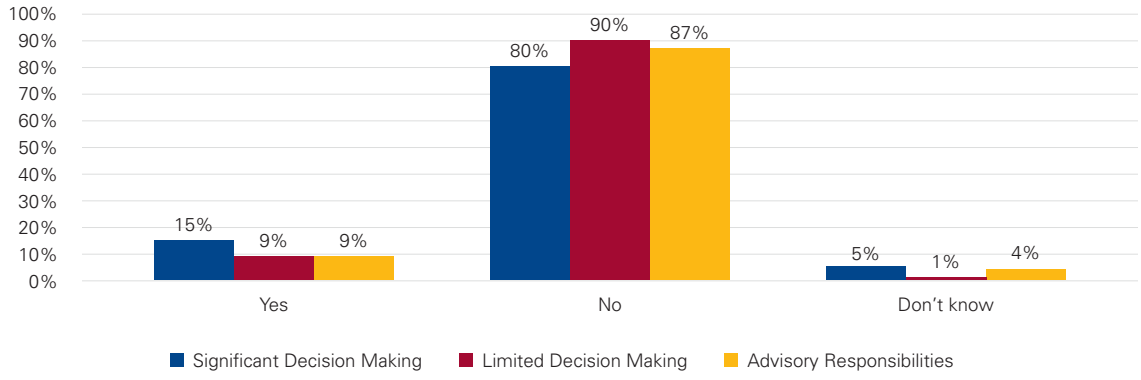


Figure 6.18 – Board Member Concern About Board Service Time Commitments by Subsidiary Boards with Varying Levels of Authority



Commentary

Commentary on Board Culture
by James E. Orlikoff

Introduction

Culture is most succinctly defined as "shared patterns of meaning" where the same event, phrase, situation or process has the same implicit meaning to all members of a board or other group. To grasp the unique culture of a board, one must focus on the underlying assumptions and the ever-present but unspoken expectations and unwritten rules that frame the behavior within and by a board and, therefore, define its function and effectiveness. With this as context, what can we glean from these survey results about the current national state of health care governance culture, and how it may be changing?

Observations about Survey Findings

A board only exists when it is meeting. Thus, the single most precious commodity a board possesses is its time together. As health care becomes more challenging and complex, it is reasonable to expect that governance will require more time. Yet, only 6 percent of all respondents increased the number of board meetings conducted annually in the past three years, and only 16 percent of all respondents increased the length of their board meetings.

However, in boards with ultimate governance authority and responsibility, 19 percent of system boards and 18 percent of freestanding boards increased the length of their board meetings. Further, 41 percent of system boards and 32 percent of all respondents reported that their board members were spending more time on governance-related activities than they did three years ago.

Perhaps the system boards that increased the length of their meetings had cultures robust enough to allow them to recognize that the growing complexity of health care requires more governance time, and were flexible enough to adapt by increasing the amount of time spent governing. Yet, this realization and flexibility were not demonstrated by the majority of either all respondents or system boards, both of which reported spending the same or less time governing than they spent three years ago. Perhaps their cultures facilitated an assessment of time spent on governance, but appropriately concluded that it was adequate and that no increase was necessary. Another interpretation is that many of the boards reflected in the majority of respondents had more limiting cultures that precluded both an honest assessment of time demands and any adjustment to time spent governing. Such "we have always done it this way so why should we change" board cultures are still common but hopefully diminishing. The survey results at least allow for this more optimistic interpretation of cultural governance trends.

The amount of time spent on governance is one thing; how a board spends that time is something else entirely. Boards must balance the need to spend their time on relatively minor but necessary custodial issues and tasks (receiving reports, approving minutes, satisfying regulatory requirements, etc.) with engaging in strategic and generative discussions and making impactful decisions. Seventy-one percent of all respondents reported that their board normally spends a maximum of 50 percent of their meeting time in active discussion, deliberation and debate. If accurate, this profile indicates a positive cultural governance trend.

Yet, other survey results challenge this assessment. For example, an astounding 50 percent of freestanding boards and 24 percent of system boards indicated their board does not have a formal CEO succession plan. How could such an abrogation of fundamental governance responsibility occur in boards with ultimate oversight of the CEO, especially if the vast majority of these boards are spending up to 50 percent of their meeting time in active discussion, deliberation and debate?

One answer can be found in the relationship of the board to the CEO, a relationship crucial to effective governance, but one difficult to assess in a broad survey. However, survey results relating to executive sessions may provide insight into this relationship. Executive sessions, where the board spends a portion of its meeting time with no executives or guests other than the CEO, and/or spends a portion of time with just board members present without the CEO, are a well-accepted governance best practice. Survey data corroborate this, with more than half of all respondents reporting that an executive session is routinely included in the agenda of every board meeting. This use of executive sessions also was reported by 74 percent of system boards and 52 percent of freestanding boards. Further, survey data show the practice of routine executive sessions has been growing consistently over the past seven years.

This positive trend notwithstanding, 26 percent of system boards and 48 percent of freestanding boards do not routinely include an executive session in the agenda of every board meeting. Further, and much more culturally concerning, is that the CEO participates in the entire executive session for 41 percent of system boards and 57 percent of freestanding boards.

Perhaps the fact that 50 percent of freestanding boards and 24 percent of system boards do not have a formal CEO succession plan is directly due to the fact that 48 percent of freestanding hospital boards and 26 percent of system boards do not routinely include an executive session in the agenda of every board meeting. Further, when executive sessions are held, the CEO participates in the entire executive session in 57 percent of freestanding hospital and 41 percent of system boards. While correlation does not mean causation, it is possible to conclude that the culture of a significant number of boards is inappropriately dominated by the CEO; and, that these boards are therefore not likely to meaningfully engage in the challenging, but critical discussion of CEO succession planning, nor to adopt a formal CEO succession plan.

Another important indicator of culture is board composition; and survey data indicate interesting trends, both positive and negative. First, an accepted best governance practice is recruiting a few board members who live and work outside the service area of the hospital or system (and who are not from sponsoring organizations or other system entities) to gain truly independent perspectives and needed expertise. Having one or more of these outside board members indicates a board's desire to challenge and improve its culture by having "disruptors" as colleagues who can challenge assumptions, call out "elephants in the room" and provide new context from which to examine strategic challenges or opportunities.

Survey data show that outside board members are most prevalent on system boards (49 percent), compared with 27 percent and 17 percent of boards of system subsidiary hospitals and freestanding hospitals respectively. If these 49 percent of system boards are leading a growing trend of having outside board members, then this is a positive direction in overall governance culture.

However, survey data indicate negative trends in board composition as well. Specifically, boards are getting older and no significant attempt to address this is reflected in the survey data. Overall respondents in 2018 had a higher percentage of board members age 71 or older than did boards in 2005, 12 percent versus 9 percent respectively. Further, only 22 percent of all boards and 16 percent of system boards reported having any members age 50 or younger. The clear trend is toward a growing number of older board members and fewer younger ones. This worrisome

trend is compounded by the survey finding that 73 percent of overall respondents and 78 percent of system board respondents are not undertaking specific efforts to recruit Millennials (individuals between the ages of 21 and 35) to their boards.

Other trends that stand out for having both positive and negative cultural implications include:

- Ethnic and racial diversity on boards is increasing, albeit slowly.
- Gender diversity on boards increased a bit, but seems to have stalled.
- More boards are joining the digital world by using board portals; but the number is growing slowly, from 52 percent of all boards in 2014 to 55 percent of all boards in 2018.
- The number of boards that use defined and approved sets of competencies to select all of their board members grew from 32 percent in 2011 to 35 percent in 2014 to 42 percent in 2018. However, this governance best practice is still only employed by a minority of health care boards.
- About two-thirds of all boards engaged in conscious efforts to implement governance restructuring to improve governance, but most of these efforts did not address the relationship of the board to the Executive Committee. Some 52 percent of system boards and 30 percent of all boards have Executive Committees with the authority to make broad decisions on behalf of the entire board. The potential negative cultural dynamic of dual power structures persists in many boards.

Culture is the most amorphous and, therefore, the most often neglected dimension of governance. Yet, culture is the strongest determinant of effective governance at any point in time. It drives the ability of a board to sustain and improve governance effectiveness, despite turnover in board members and leaders, changes in executive and clinical leadership, and a changing health care environment. Great governance cultures facilitate both honest assessment and drive necessary and timely change in governance.

Taken as a whole, the survey results indicate that governance culture is moving in a positive direction in response to the rapidly changing and radically challenging health care environment. The question is: is it moving fast enough?

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Discussion Questions on Board Culture

1. How would you describe your board's culture? How has it changed over the past three years?
2. How do the survey results discussed above compare with your board, and what do you think the comparison indicates about your board's culture?
3. What actions does your board take (ongoing assessment, periodic board discussions, etc.) to understand its culture and the impact it has on governance effectiveness?
4. Has your board recently taken any specific actions to strengthen aspects of its culture?
5. Does your board have a formal CEO succession plan? If not, why not?


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March 2019