GOVERNING THE VALUE JOURNEY

A PROFILE OF STRUCTURE, CULTURE, AND PRACTICES OF BOARDS IN TRANSITION

THE GOVERNANCE INSTITUTE'S 2013 BIENNIAL SURVEY OF HOSPITALS AND HEALTHCARE SYSTEMS

A service of NATIONAL RESEARCH Corporation

GOVERNING THE VALUE JOURNEY

A PROFILE OF STRUCTURE, CULTURE, AND PRACTICES OF BOARDS IN TRANSITION

THE GOVERNANCE INSTITUTE'S 2013 BIENNIAL SURVEY OF HOSPITALS AND HEALTHCARE SYSTEMS

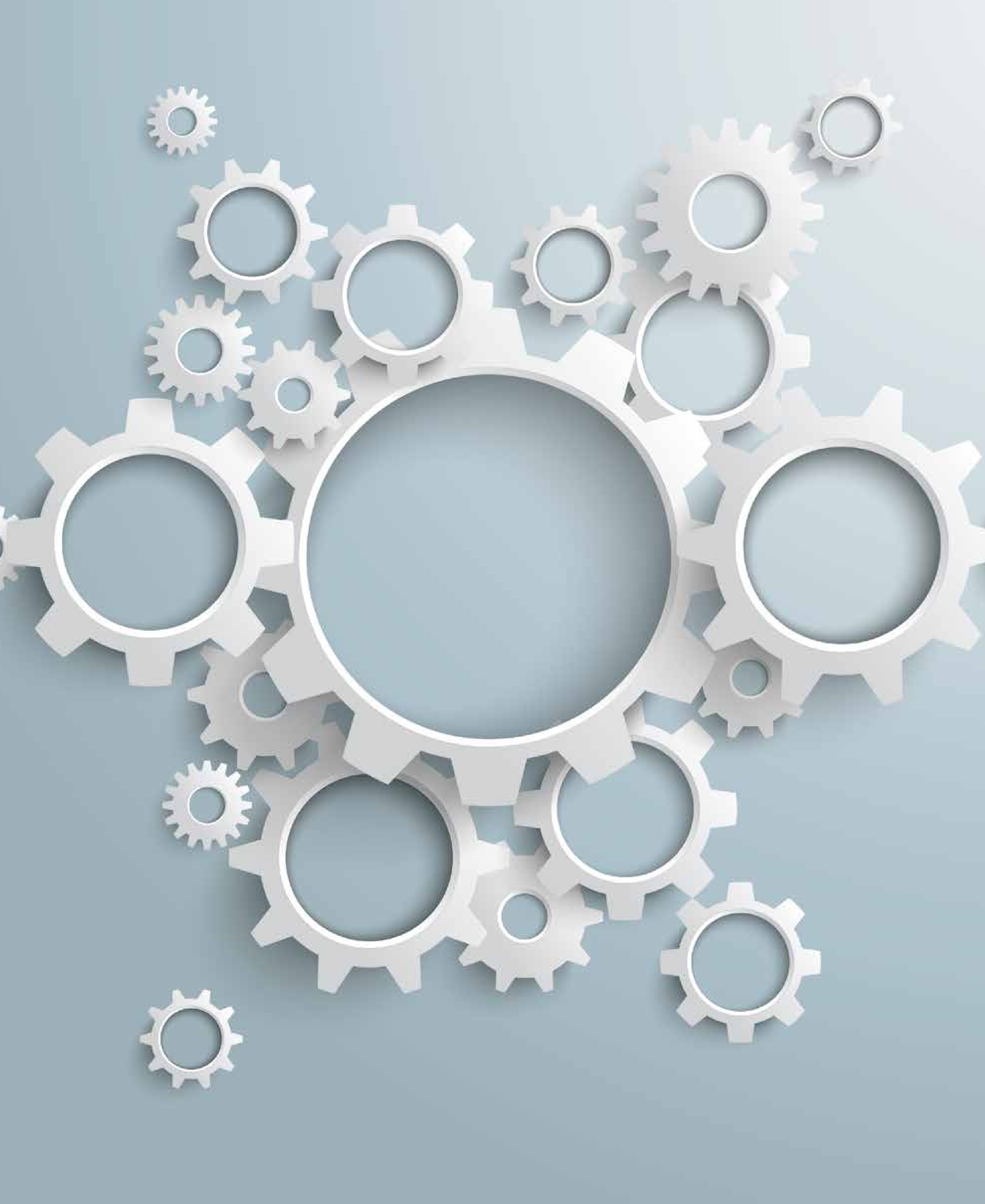
The Governance Institute®

The essential resource for governance knowledge and solutions®

9685 Via Excelencia • Suite 100 • San Diego, CA 92126

Toll Free (877) 712-8778 • **Fax** (858) 909-0813

GovernanceInstitute.com



ACKNOWLEDGEMENTS

THE GOVERNANCE INSTITUTE EXTENDS DEEP APPRECIATION TO governance advisors Don Seymour and Roger W. Witalis, FACHE; faculty members Guy M. Masters, M.P.A., David A. Shore, Ph.D., and Robert M. Wachter, M.D.; and Diana L. Smalley, FACHE. They contributed a significant amount of their time to reviewing the results and offering commentary on key areas for improvement.

Guy M. Masters, M.P.A., is a senior vice president with The Camden Group. With 20 years of healthcare experience, Mr. Masters focuses on strategic, business, and service line planning, and business advisory and competitive positioning strategies for hospitals/health systems, physicians, and payers. He has developed HMOs, PPOs, IPAs, MSOs, PHOs, medical groups, and direct contract relationships with employers. He is an experienced facilitator of board retreats, strategic planning processes, and business planning for healthcare services. He can be reached at (310) 320-3990 or gmasters@thecamdengroup.com.

Don Seymour, president of Don Seymour & Associates, provides advice to hospitals, healthcare systems, physicians, and healthcare associations throughout the U.S. His clients have included large, geographically diverse healthcare systems, academic medical centers, teaching hospitals, community hospitals, and critical access hospitals. He is the executive editor of *Futurescan*™, a faculty member for ACHE, and past president and faculty member of the Society for Healthcare Strategy & Market Development. Mr. Seymour has advised boards, CEOs, and physician leaders for over 25 years and is a frequent author, speaker, and retreat facilitator on governance, strategy, and hospital–physician alignment issues. He was named as one of The Governance Institute's advisors in 2008. He can be reached at (617) 462-4313 or don@donseymourassociates.com.

David A. Shore, Ph.D., is former associate dean of the Harvard School of Public Health (HSPH), faculty at Harvard University, and adjunct professor in the school of business at the University of Monterrey in Mexico. During his two decades as executive director of HSPH's Center for Continuing Professional Education, Shore founded and directed the flagship executive programs Forces of Change: New Strategies for the Evolving Health Care Marketplace; The Trust Initiative; and the Certificate Program on Launching and Leading Successful Change Initiatives. The latter program is based on the Project Activation Management System (PAMS), which he developed. He has consulted on six continents and regularly delivers keynote addresses and workshops to many industries in various national and international settings. He can be reached at shoredavida@gmail.com.

Diana L. Smalley, FACHE, is regional president of Mercy in Oklahoma and chairman of the American College of Healthcare Executives. She has served with Mercy since 2007, when she was appointed president and CEO. Prior to that, she served in various leadership roles with Alegent Health in Omaha, Nebraska. While at Alegent, she cofounded Avantas, an Omaha-based company nationally recognized for proven best-practice work strategies for the health industry. Ms. Smalley holds a master's in public health from the University of Minnesota and is a graduate of the Nebraska Methodist School of Nursing, Omaha, Nebraska. She can be reached at (405) 752-3756 or Diana.smalley@mercy.net.

Robert M. Wachter, M.D., is professor and associate chair of the Department of Medicine at the University of California, San Francisco, where he directs the 60-physician Division of Hospital Medicine. Author of 250 articles and six books, he coined the term "hospitalist" in 1996 and is generally considered the "father" of the hospitalist field, the fastest growing specialty in the history of modern medicine. He is past president of the Society of Hospital Medicine (1999–2000) and past chair of the American Board of Internal Medicine (2012–2013). In the safety and quality arenas, he has written two bestselling books on the subject, including *Understanding Patient Safety*, whose 2nd edition was published in 2012. For the past six years, *Modern Healthcare* has named him one of the 50 most influential physician executives in the U.S., the only academic physician to receive this recognition. He can be reached at (415) 476-5632 or bobw@medicine.ucsf.edu.

ACKNOWLEDGEMENTS (CONTINUED)

Roger W. Witalis, FACHE, is president of WITALIS & Company, Inc., a governance and management consulting firm serving tax-exempt hospitals and health systems throughout the U.S. He is a founding member of The Governance Institute's advisors. His expertise includes evaluation and improvement strategies for governance and management structures, practices, and performance; facilitation of board self-evaluation survey review and improvement sessions; individual board member performance evaluations; board education presentations; comprehensive governance assessments and restructuring; and governance designs for mergers and affiliations. He can be reached at (925) 330-8047 or roger@witalis.com.

The Governance Institute would also like to acknowledge the following people from National Research Corporation who conducted the data analysis for this year's report: **Sarah Fryda, M.S.**, senior research associate; **Katie Johnson, Ph.D.**, director of research and analytics; **Jessica Schwab**, data analyst; and **David Van Winkle, Ph.D.**, senior research associate. In addition, the following people from National Research Corporation helped facilitate the data reporting: **Juan Gomez**, manager of survey management; **Sheri Life**, client service manager; **Molly Murphy**, supervisor of survey management; and **Josh Vonfeldt**, survey operations manager.

THE GOVERNANCE INSTITUTE MEMBER EDITORIAL BOARD

The Governance Institute's member editorial board provides expertise and opinion to our research and publications. We consider this a "working editorial board," and members are asked to comment on our annual education and research agendas, provide input on specific research questions and member surveys, and offer commentaries for publications.

The composition of the member editorial board reflects Governance Institute membership overall: hospitals and health systems, varying sizes of organizations, private and public boards, children's hospitals, academic medical centers, secular and religious affiliation/sponsorship, geographic representation, physician CEOs, outstanding reputation, and a passion about governance.

Richard Afable, M.D., M.P.H.	President & CEO, Hoag Memorial Hospital Presbyterian, Newport Beach, California
Joel T. Allison, FACHE	President & CEO, Baylor Health Care System, Dallas, Texas
Linda Brady, M.D.	President & CEO, Kingsbrook Jewish Medical Center, Brooklyn, New York
Vincent G. Capece, Jr.	President & CEO, Middlesex Hospital, Middletown, Connecticut
James A. Diegel, FACHE	President & CEO, St. Charles Health System, Bend, Oregon
Norman Gruber	President & CEO, Salem Hospital, Salem, Oregon
M. Michelle Hood, FACHE	President & CEO, Eastern Maine Healthcare Systems, Brewer, Maine
Gary Meyer	President & CEO, Schneck Medical Center, Seymour, Indiana
Kevin J. Miller, FACHE	Chief Executive Officer, Hutchinson Regional Medical Center, Hutchinson, Kansas
Cynthia Moore-Hardy, FACHE	President & CEO, Lake Health, Painesville, Ohio
Thomas J. Sadvary, FACHE	President & CEO, Scottsdale Healthcare, Scottsdale, Arizona
Todd Sorensen, M.D., M.S.	President & CEO, Regional West Medical Center, Scottsbluff, Nebraska
Laureen K. Tanner, RN, M.S.N., FACHE	President & CEO, Ranken Jordan, A Pediatric Specialty Hospital, Maryland Heights, Missouri
Joseph Trunfio, Ph.D.	President & CEO, Atlantic Health System, Morristown, New Jersey
Chris D. Van Gorder, FACHE	President & CEO, Scripps Health, San Diego, California
Dennis Vonderfecht, FACHE	President & CEO, Mountain States Health Alliance, Johnson City, Tennessee

About the Author

Kathryn C. Peisert is managing editor of The Governance Institute. She has been in healthcare governance publishing for 10 years, and is responsible for all of The Governance Institute's publications in print and online, DVD/video programs, Webinars, and e-learning courses. Previously she served as permissions and copyright editor for Roxbury Publishing Company, now a division of Oxford University Press. She has a bachelor's degree in communications from UCLA and a master's degree from Boston University.

The Governance Institute®
The essential resource for governance knowledge and solutions®
9685 Via Excelencia • Suite 100 • San Diego, CA 92126
Toll Free (877) 712-8778 • **Fax** (858) 909-0813
GovernanceInstitute.com

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

THE GOVERNANCE INSTITUTE IS A MEMBERSHIP ORGANIZATION SERVING NOT-FOR-PROFIT hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

Charles M. Ewell, Ph.D.	Founder
Jona Raasch	Chief Executive Officer
Gregg Loughman	Vice President
Cynthia Ballow	Vice President, Operations
Kathryn C. Peisert	Managing Editor
Glenn Kramer	Creative Director
Kayla Wagner	Editor

The Governance Institute is a service of National Research Corporation. Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country. For more information about our services, please call toll free at (877) 712-8778, or visit our Web site at GovernanceInstitute.com.

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications, whether caused by The Governance Institute or its sources.

© 2013 The Governance Institute. Reproduction of this publication in whole or part is expressly forbidden without prior written consent.

TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

3 INTRODUCTION AND READER'S GUIDE
- 4 **Who Responded?**

5 GOVERNANCE STRUCTURE
- 5 **Board Size and Composition**
- 9 *Special Commentary: Diversifying Perspectives in the Boardroom: The Essential Voice of the Nurse Executive*
- 14 **Defined Terms of Service**
- 15 **Participation on the Board**
- 17 **Board Committees**
- 23 **Board Meetings**
- 27 *Special Commentary: Meetings and Committees: Current State and Future Opportunities for Higher Performing Boards*
- 30 **Board Member Compensation**
- 31 **Annual Expenditure for Board Member Education**
- 31 **Use of Board Portal or Similar Online Tool**
- 33 **Board Culture**
- 35 *Special Commentary: Emerging "Best" Practices in Culture and Structure*
- 38 **Governance Trends**
- 40 **System Governance Structure and Allocation of Responsibility**
- 41 **Subsidiary Hospitals: Allocation of Decision-Making Authority**

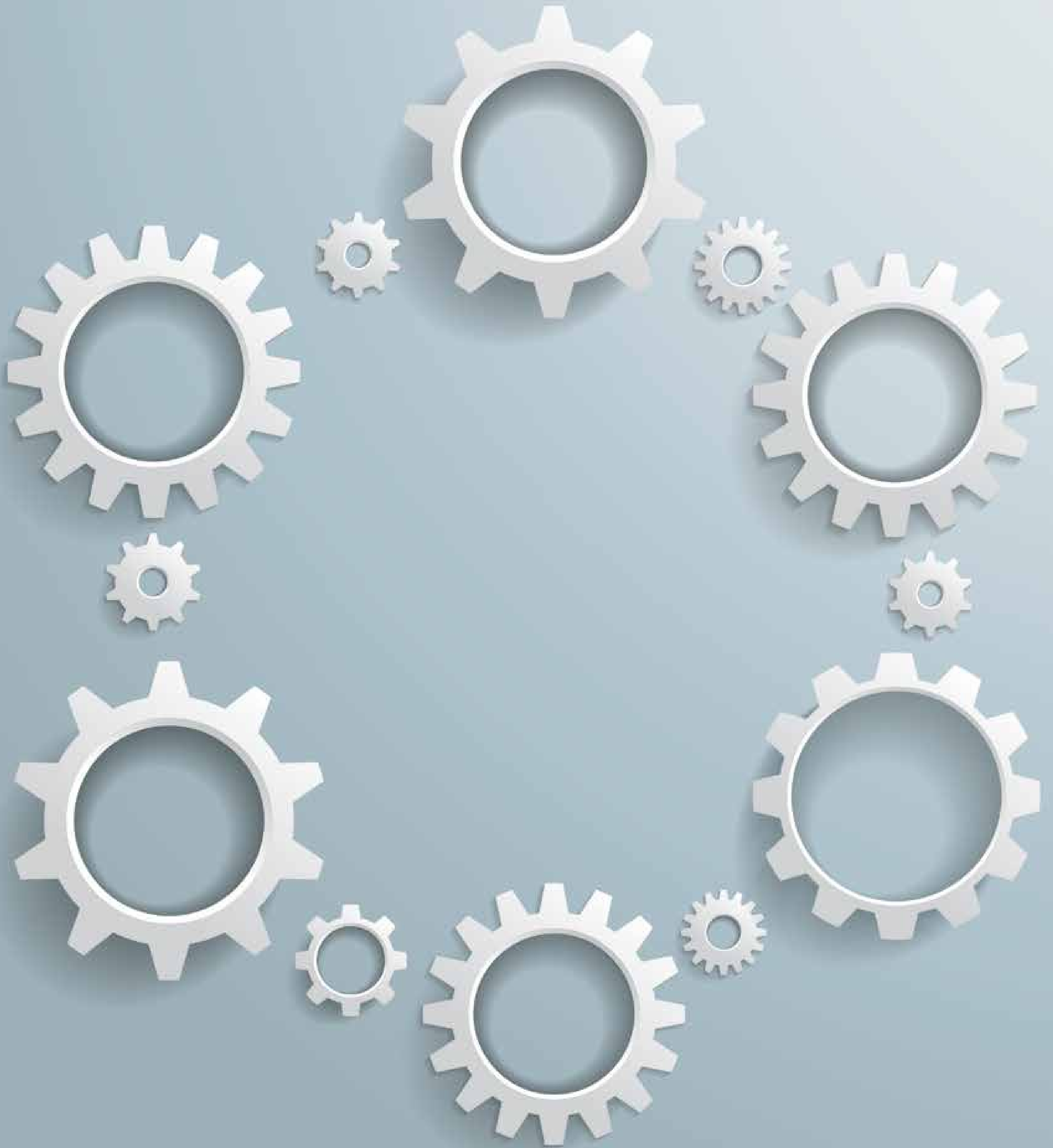
45 GOVERNANCE PRACTICES: FIDUCIARY DUTIES AND CORE RESPONSIBILITIES
- 45 **The Survey**
- 45 **Performance Results**
- 48 **Fiduciary Duties and Core Responsibilities**
- 48 **Recommended Practices**
- 49 **Overview of Results**
- 55 *Special Commentary: The Need for Transformation: Board Leadership in Quality, Safety, and Value*
- 59 *Special Commentary: Best Practices for a Strategically Oriented Board*
- 63 *Special Commentary: Board Development: Type of Organization Influences Adoption*
- 67 **Analysis of Results**

69 CONCLUDING REMARKS

73 APPENDIX 1. GOVERNANCE STRUCTURE (OVERALL AND BY ORGANIZATION TYPE, SIZE, AND CONTROL)

107 APPENDIX 2. GOVERNANCE PRACTICES

125 APPENDIX 3. GOVERNANCE PRACTICES: COMPARISON 2013 VS. 2011



EXECUTIVE SUMMARY

Since we last reported on governance structure and practices in 2011, the Supreme Court upheld the majority of the Patient Protection and Affordable Care Act (ACA) in June 2012, clearing the way for implementation. While there are still some roadblocks, questions, political and public disagreement about the law's benefits, and delays of some key aspects, we believe there are small signs in the data this year indicating that the healthcare industry is continuing to move forward with preparations for value-based payments and population health management with the understanding that the fee-for-service business model is not sustainable, regardless of action at the federal level. And providers will be seeing more insured individuals coming through their doors in states with expanded Medicaid programs, as well as in early 2014, as the health insurance exchange plans begin covering those formerly uninsured. This alone will have yet-to-be determined implications for healthcare leaders.

The role of the healthcare board is now becoming more expansive as payments focus on patient outcomes based on multiple care episodes (provided in different care settings and by different providers). The board of directors of the (near) future will need to have the ability to oversee and improve the quality and value of care provided across the continuum, not just within the organization's walls. The concepts of "partnership" and "integration" will take on new meaning in this context. Thus, our list of "recommended practices"—fundamental board activities necessary to meet the fiduciary responsibilities and ensure fulfillment of the charitable mission—continues to evolve to help boards frame their work more effectively and enhance their ability to expand their oversight into new areas.

Governance Structure

Governance structure is an essential component of the effectiveness of a board, which affects culture (of both the board and the organization) and the board's ability to perform. This year we added governance structure questions related to system and subsidiary board structure, and whether boards are changing their structure or activities to prepare for population health and value-based payments.

Governance structure has remained relatively consistent over the past few surveys. A few differences this year are briefly summarized below.

Board composition: There was a slight decrease in representation on the board from medical staff physicians that are not employed by the organization. Employed physicians on the board remained about the same. Seventy-two percent (72%) of all responding organizations have zero voting nurses on the board, and the average percentage of nurses on the board is only 3% overall. Most boards (97%) have at least one female board member, but just over 50% have ethnic minorities represented on the board. There has not been significant movement in these two areas since 2007 (female representation has remained about the same; ethnic minority representation [at least one director] has increased from 47% in 2007 to 53%).

This year we added questions about the background of the chief executive and board chair. For both the CEO and board chair, the overwhelming majority indicated a business/finance background. We also asked about the average age of board members. The overall average age is 57.3 with a range of 40 to 70 years old.

Committees: The average number of committees decreased significantly from 8 in 2011 to 5 in 2013. The committees that have increased the most in prevalence are: quality, governance/nominating, executive compensation, and audit/compliance. Systems, independent hospitals, and subsidiary hospitals show a significant increase in the prevalence of a quality/safety committee since 2011 (85% vs. 74% for systems; 80% vs. 74% for independent hospitals; and 86% vs. 77% for subsidiaries).

The executive committee has about the same level of authority as it did in 2011, overall. However, only 49% of executive committees in systems have full authority to act on behalf of the board on all issues compared with 57% in 2011. The movement can be seen in the category "some authority": 40% of executive committees in systems this year have authority to act on behalf of the board on *some* issues; 28% had "some authority" in 2011.

Board meeting time: Boards continue to devote half of their meeting time to hearing reports from management and board committees. Systems have usually spent the lowest amount of time in this category, but this year subsidiary hospitals receive this distinction (46% of meeting time spent hearing reports). Forty-seven percent (47%) of health system board meeting time is spent hearing reports, which has risen from 40% in 2011. This year's analysis again shows a significant positive correlation between spending more than half of the board meeting time (over 50%) discussing strategic issues and respondents rating overall board performance as "excellent" in the various core areas of responsibility presented in the second half of this report.

Board member compensation: There was another slight increase in the percentage of respondents who compensate board members (16%, up from 15% in 2011). However, the

increase is due to the number of government-sponsored hospitals that compensate board members (35% compensate some or all board members vs. 28% in 2011); there was a significant drop in the percentage of health systems that compensate some or all board members (18% vs. 25% in 2011). For respondents who compensate, the amount of compensation is generally less than $10,000.

Use of board portal or similar online tool: Fifty-three percent (53%) of respondents use a board portal or similar online tool for board members to access board materials and for board member communication (a significant increase from 34% in 2011). Fifty-nine percent (59%) of respondents provide board members with laptops or iPads to access online board materials, compared with 30% in 2011.

Board culture: For the first time we asked questions related to board culture. There was relatively strong agreement with most of the statements related to culture; those with the lowest level of agreement (respondents who answered "strongly agree" and "agree") are:

- The board ensures appropriate physician/clinician involvement in governance (86%).
- The board has an effective system in place to measure whether strategic goals will be met (83%).
- The board is effective at setting appropriate short- and long-term goals for management and physician leaders in accordance with the strategic plan (82%).
- The board effectively holds management and physician leaders accountable to accomplish strategic goals (89%).

Preparation for population health management: Over half (58%) of respondents have added population health goals (e.g., IT infrastructure, physician integration) to the strategic plan. But 57% have not made any changes to the board or management team to prepare for population health management (21% have added physicians to the management team).

Preparation for value-based payments: About half (52%) of respondents have added value-based payment goals to strategic and financial plans, and 17% have added physicians to the management team (58% have not made any changes to the board or management team to prepare for value-based payments).

System–subsidiary governance structure: Most systems (44%) have a system board as well as separate local/subsidiary boards with fiduciary responsibilities. Seventy percent (70%) of system boards approve a document or policy specifying allocation of responsibility and authority between system and local boards, and 91% of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders.

We asked subsidiary hospitals to tell us whether they retain full authority, share authority, or whether the system board retains responsibility for various board activities. Significant increases in the rate of hospital consolidation activity since 2009 imply that systems are moving towards retaining more control at the corporate level. The 2013 results for these questions do not reflect this movement directly, although overall survey results indicate a strong relationship between system and subsidiary board performance/activities.

Governance Practices

This year, the list of recommended practices remained at 95, with some practices revised slightly, combined where applicable to reduce duplication/redundancy, or moved to other areas (community benefit and advocacy is the area with the most amount of change this year as a result of activities required by the ACA). As the list of practices grows and becomes more complete, we are careful to maintain consistency over reporting years for the sake of comparison, while still having the ability to reflect market changes and new governance responsibilities. Thus, the list includes both fundamental governance practices that are not likely to change, as well as leading-edge practices that reflect priorities for boards given the current environment.

This year's results show that adoption of the recommended practices continues to be generally widespread. However, adoption rates have not increased significantly; in most cases adoption has either remained stagnant or decreased slightly. Community benefit and advocacy is the only area demonstrating increases in practice adoption rates.

Overall performance composite scores for 2013 are slightly higher than in 2011. However, this is the first year since 2007 indicating a decline in the performance composite score for financial oversight. This area continues to score higher than most other areas in both performance and adoption and the decline is small; but given the impacts of tightening hospital reimbursement and increasing challenges related to reducing costs and preparing for value-based payment models, the decline may be due to boards becoming more accustomed to new financial metrics and essentially a new payment system. Community benefit and advocacy shows the most improvement between 2011 and 2013; duty of obedience also improved substantially.

Systems show a decline in performance ratings in the three fiduciary duties, board development, management oversight, and community benefit. However, systems show a significant improvement (and the highest score) in performance of quality oversight. Government-sponsored hospitals showed a decline in performance for the duties of care and loyalty, quality oversight, and financial oversight, but an improvement in board development and community benefit and advocacy.

INTRODUCTION AND READER'S GUIDE

Healthcare governance continues to evolve to meet the demands of individual organizations, their communities, and the legal and regulatory environment. The Governance Institute surveys U.S. not-for-profit hospitals every other year and, although the framework of the surveys remains similar, the information sought varies slightly from year to year. Given that providers are now moving slowly towards value-based payment models and more hospitals are becoming affiliated with systems, this year's survey sought information about how board structure and practices may be changing to prepare for a new healthcare business model.

This year's report presents results by topic. The first section of the report focuses on governance structure and offers comparisons with previous reporting years, as well as notable variations by organization type—systems, independent hospitals, hospitals that are part of a multi-hospital system ("subsidiary" hospitals), and government-sponsored hospitals.

The second section reports prevalence of adoption of recommended governance practices, and overall board performance for each area of board oversight responsibility. Variations by organization type that are notable are included here as well. This year, the number of recommended practices stayed at 95, although there were still some minor changes. This list has slowly been growing from a list of 50 practices in 2003. Some practices have been updated; others were added—primarily in the area of community benefit and advocacy. As the list of practices grows and changes, we are careful to maintain consistency over reporting years for the sake of comparison, while still having the ability to reflect market changes and new governance responsibilities. Thus, the list includes both fundamental governance practices that are not likely to change, as well as leading-edge practices that reflect priorities for boards given the current environment.

When reporting on governance structures, we use frequency tables (reported as a percentage of the total responding to specific questions). For governance practices, the body of this report shows results as composite scores, both practice adoption rates and overall performance in each oversight area.

The appendices in this report include 1) results by frequency (percentages) for governance structure, by organization type, AHA designation, and bed size; 2) results by frequency for governance practices, by organization type; and 3) a table of all governance practices, using composite scores to determine the rate of adoption of the practices; this table highlights the most and least observed practices and compares the scores to the 2011 results. (Additional appendices reporting board structure for each organization type are available online at GovernanceInstitute.com/2013biennialsurvey.)

For both governance structure and practices, the results reported here do not include those responding "not applicable" nor missing responses. Therefore, the "N" (denominator) is not fixed; it varies by question. For total number of responses for each question—overall and for the various subsets on which we report—see the appendices.

Table 1. Survey Responses

	2013		2011		2009	
	Respondents	**Population**	**Respondents**	**Population**	**Respondents**	**Population**
Organization	**N = 541**	**N = 4,199**	**N = 660**	**N = 4,250**	**N = 740**	**N = 4,250**
Religious (54)	10%	13%	11%	13%	12%	13%
Secular:						
Government (140)	26%	24%	25%	25%	24%	25%
Non-Government (401)	74%	63%	64%	62%	64%	62%
Number of Beds						
< 100 (197)	36%	43%	39%	46%	36%	45%
100–299 (180)	33%	29%	35%	31%	35%	32%
300+ (164)	30%	28%	26%	23%	29%	23%
System Affiliation (245)	45%	58%	35%	53%	35%	52%

Who Responded?

All U.S. not-for-profit acute care hospitals and health systems, including government-sponsored organizations (but not federal, state, and public health hospitals), received a copy of the survey—a total of 4,199. We received 633 responses (15%). Of those, 541 respondents had a fiduciary board (13%).[1]

In general, distribution of responding organizations matched those types of organizations in the surveyed population (see **Table 1**).

The largest group of responding organizations (36%) is hospitals with fewer than 100 beds (this is consistent with 2011). Government-sponsored hospitals represent 46% of those organizations—see detail in **Table 2**.

Almost half of all responding organizations (45%) are a system or affiliated with a system (this has increased from 35% in 2011, possibly corresponding with the reduced number of independent hospitals in the U.S. due to industry consolidation in the past two years).

Due to this increase in system affiliation, we looked at the percentage of subsidiary vs. independent hospital respondents over the last three reporting years:

Percentage of Total Respondents	2009	2011	2013
Subsidiary Hospitals	18.0%	23.2%	33.6%
Independent Hospitals	40.7%	39.7%	28.8%

We also looked at system type and size—Catholic and other church systems appear to be larger among our panel of health system respondents (see **Table 3**).

Comparison of Respondents 2013 vs. 2011

About half (46%) of the respondents in 2013 also completed and returned the survey in 2011 (see **Table 4**).

Table 2. Respondents with Fewer than 100 Beds (N = 197)

Government-Sponsored Hospitals (91)	46%
Subsidiary Hospitals (56)	28%
Independent Hospitals (49)	25%
Systems (1)	1%

Table 3. Health System Respondents by System Type and Size

	Number of Beds				
	100–299	300–499	500–999	1,000–1,999	2,000+
Catholic Systems (9)	0%	11%	22%	11%	56%
Other Church Systems (4)	0%	0%	25%	50%	25%
Other Systems (50)	8%	22%	24%	34%	12%

Table 4. 2013 vs. 2011 Respondents

	Number of Respondents in 2013	Number of Respondents in 2011	Number of Respondents Who Completed the Survey in both 2011 and 2013
Systems	63	81	34
Independent Hospitals	156	262	78
Subsidiary Hospitals	182	153	76
Government-Sponsored Hospitals	140	164	60
Total	541	660	248

1 About 22% of the 541 respondents are members of The Governance Institute.

GOVERNANCE STRUCTURE

Board Size and Composition

Summary of Findings

- Average board size: 13.5
- Median board size: 13
- Voting board members:
  - Medical staff physicians: average is 2.1; median is 1
  - "Outside" physicians: average is 0.4; median is 0
  - Nurses: average is 0.4; median is 0
  - Management: average is 0.7; median is 0
  - Independent board members: average is 8.8; median is 9
  - Female board members: average is 3.7; median is 3
  - Ethnic minority board members: average is 1.3; median is 1
- Board member age limits: 6.8% of boards have age limits; average age limit is 72.3; median is 72
- Average board member age: 57.3; median board member age: 58 (overall age range on the board: 40–70)

The average number of board members is about the same as that reported in 2011—13.5 vs. 13.3. The median remained 13. There has been only a slight shift in board composition from 2011 to this year; the most significant being that health systems have an average of one additional person on the board (the most significant increase of any organization type). **Table 5** shows the overall comparison; **Tables 6–9** show a comparison of board composition for each organization type.

Board size generally increases with organization size for all organization types. Systems and subsidiary hospitals have the largest boards in general, and government-sponsored hospitals have the smallest boards.

The average number of independent board members (i.e., those who do not have a material financial relationship with the organization and fit the definition of "independent" according to IRS guidelines)

Table 5. **2013 and 2011 Board Composition**

All Respondents	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Average # of Voting Board Members	13.5	13.3	0.7	0.7	2.1	2.3	8.8	9.9	1.8	0.4
Median # of Voting Board Members	13	13	0	0	1	1	9	10	2	1

*Includes employed physicians.
**Includes physicians who are not on the organization's medical staff/not employed and nurses who are not employed by the organization.
***Includes nurses who are employed by the organization.

Table 6. **System Board Composition**

Systems	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Average # of Voting Board Members	16.7	15.7	1.3	1.0	2.5	2.6	12.6	12.5	0.3	0
Median # of Voting Board Members	17	15	1	1	2	2	13	12	1	0

Note: Average and median board size increased, reflected in a slight increase in management and independent board members.

Table 7. **Independent Hospital Board Composition**

Independent Hospitals	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Average # of Voting Board Members	15.1	14.9	0.6	0.6	2.6	2.6	10.3	11.0	1.6	0.7
Median # of Voting Board Members	14	14	0	1	1	2	10	10	2	1

Note: Independent board members decreased slightly.

Table 8. **Subsidiary Hospital Board Composition**

Subsidiary Hospitals	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Average # of Voting Board Members	15.4	15.1	1.0	1.3	2.6	2.9	9.8	11.5	2.0	0
Median # of Voting Board Members	14	15	1	1	2	2	10	11	1	0

Note: Medical staff physicians decreased slightly and independent board members decreased significantly.

has decreased slightly for all organization types with the exception of systems, which remained about the same. Health systems again reported the highest average number of independent board members (12.6). When broken down by percentage, independent board members by organization type (as a percentage of total board members) is:

- All respondents: 65%
- Systems: 75%
- Independent hospitals: 68%
- Subsidiary hospitals: 64%
- Government-sponsored hospitals: 59%

See **Exhibit 1** for a breakdown of board members overall and by organization type for 2013.

Largest Boards

- Independent hospitals with 300–499 beds: 20.2 (increase from 17.7 in 2011)
- Systems with 1,000–1,999 beds: 20.1 (increase from 17.2 in 2011)
- Subsidiary hospitals with 300–499 beds: 19.1

Table 9. Government-Sponsored Hospital Board Composition

Government-Sponsored Hospitals	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Average # of Voting Board Members	7.8	8.0	0.2	0.1	0.6	0.9	4.6	5.3	2.4	1.7
Median # of Voting Board Members	7	7	0	0	0	0	5	5	2	2

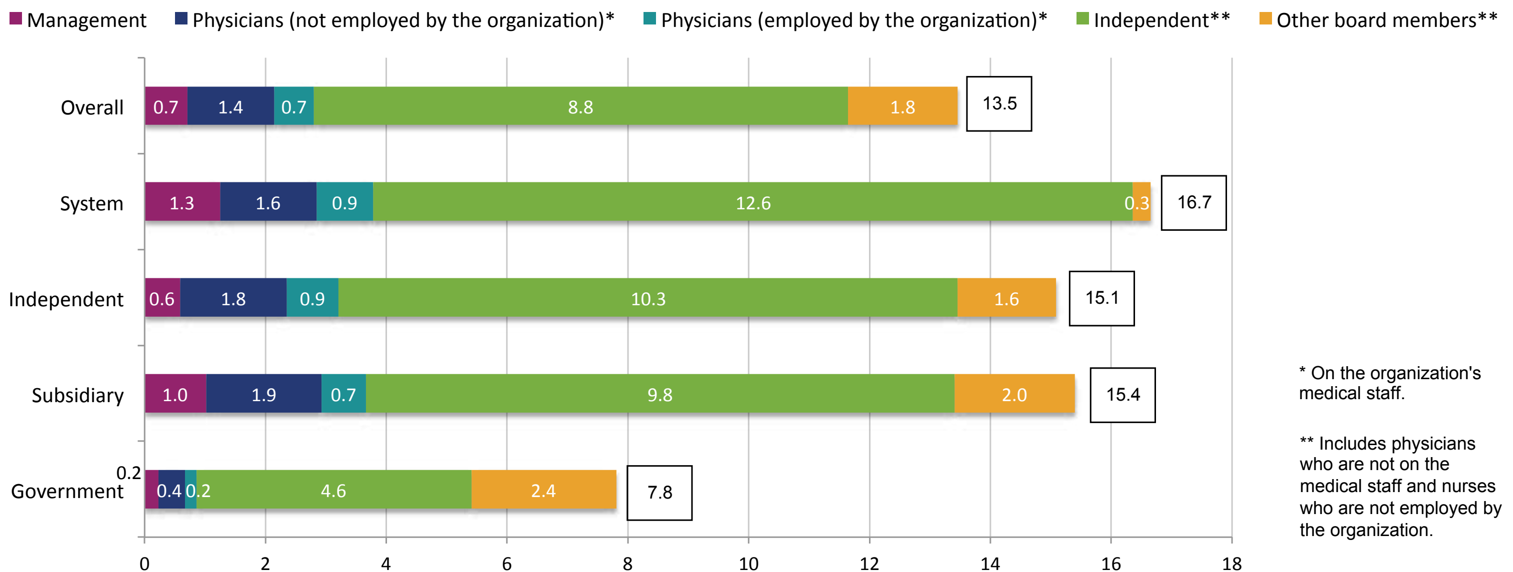
Note: Medical staff physicians and independent board members decreased slightly.

Table 10. Physicians on the Board 2013 vs. 2011

	On the medical staff but not employed by the organization		On the medical staff and employed by the organization		Not on the medical staff; not employed by the hospital ("outside")	
	2013	2011	2013	2011	2013	2011
Average	1.4	1.7	0.7	0.6	0.4	0.5
Median	1	1	0	0	0	0

Note: In 2011, health systems and subsidiary hospitals had more physicians on the board (average 3.31 and 3.41 physicians as voting members, respectively); this year the number of physicians is about the same for independent hospitals (3.0), systems (3.08), and subsidiaries (3.05). Government-sponsored hospitals again report the fewest physician board members (average 0.91, a decrease from 1.23 in 2011).

Exhibit 1. Average Number of Board Members



Physicians on the Board

Respondents noted physician board membership in the following categories:

- Physicians who are on the medical staff and not employed by the hospital
- Physicians who are on the medical staff and employed by the hospital
- Physicians who are on the medical staff and have contracts with the hospital (there may be some overlap here with physicians who are on the medical staff and not employed by the hospital)
- Physicians who are not on the medical staff (and qualify as "outside" board members)

The total average number of physicians on the board (all types of physicians including "outside" physicians; excluding medical staff physicians with contracts) is 2.5; the median is 1 (this represents a decrease from 2011—the average was 2.7 and the median was 2). The total average number of physicians on the board decreased from 2011 for all organization types with the exception of independent hospitals, which increased from 2.9 to 3.0. Overall, the breakdown for these categories is shown in **Table 10**.

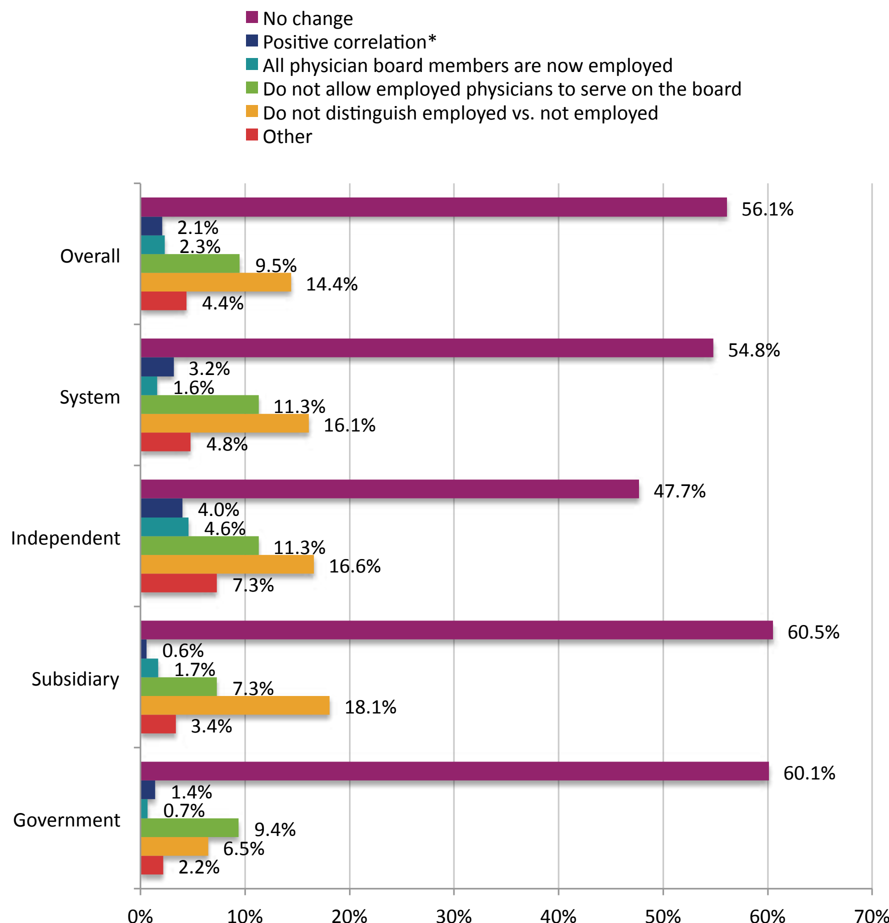
For every type of organization, there was a slight decrease in representation on the board from medical staff physicians who are not employed by the organization. Employed physicians on the board remained about the same (average 0.7 for all respondents).

For the second reporting year, we asked respondents to note if there have been any changes in physician representation on the board resulting from employing physicians. As in 2011, the vast majority of respondents again indicated that there has been no change (or, any changes in physician representation on the board have not been attributed to employing physicians). A breakdown of results by organization type appears in **Exhibit 2**.

Nurses on the Board

Overall, the average number of nurses on the board has remained constant since 2011 (the first year we asked about nurse participation on the board; average is 0.4).

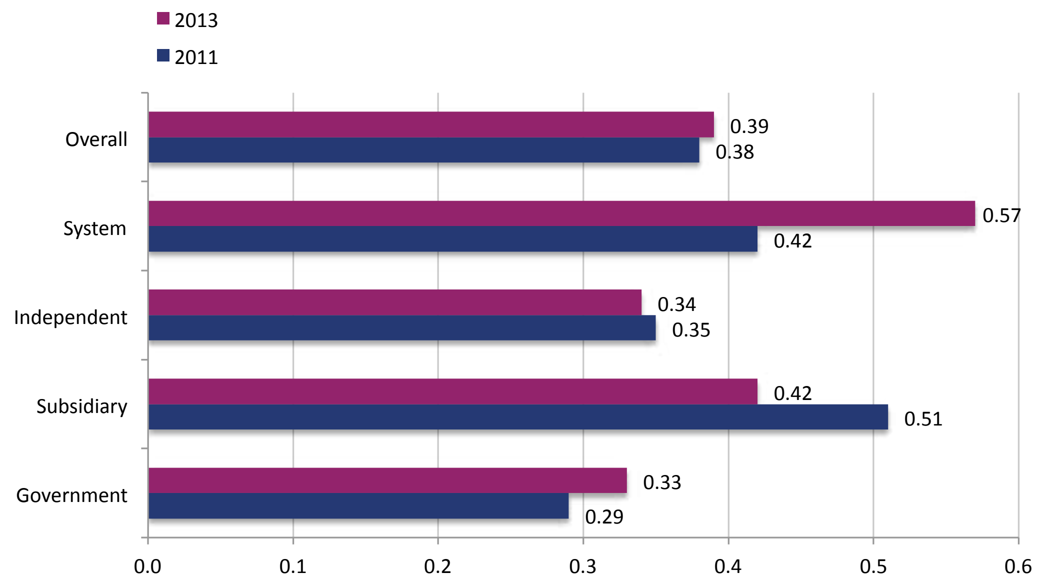
Exhibit 2. Changes in Physician Representation on the Board Resulting from Employing Physicians



* The number of employed physicians on the board corresponds with the percentage of physicians employed by the organization.

Seventy-two percent (72%) of all responding organizations have zero voting nurses on the board, and the average percentage of nurses on the board is only 3% overall (about the same since 2011). Twenty-eight percent (28%) of organizations have at least one voting nurse on the board, which is slightly lower than 2011 (31%). Systems have the highest average number of nurses on the board (0.6), which represents a significant increase from 2011 (0.4). Systems also have the highest percentage of respondents with at least one voting nurse board member (35%, up from 30% in 2011). The average number of nurses has also increased for government-sponsored hospitals (0.33 vs. 0.29 in 2011). However, subsidiary boards have slightly fewer nurses (0.4, down from 0.5 in 2011). (See **Exhibit 3**.)

Exhibit 3. Average Number of Board Members Who Are Nurses 2013 vs. 2011



DIVERSIFYING PERSPECTIVES IN THE BOARDROOM: THE ESSENTIAL VOICE OF THE NURSE EXECUTIVE

Diana L. Smalley, FACHE, *Regional President, Mercy in Oklahoma*

SPECIAL COMMENTARY

MANY BUSINESS DECISIONS ARE BASED ON DATA, like the discoveries in this year's biennial report. But, a lot of decisions in the boardroom are made as results of experience and "gut feelings," too. Boards will be dealing with a full agenda of challenges in the coming months and years as the healthcare payment and delivery system moves to a value-based model. We will be paying for wellness, rather than illness, combatting reimbursement decreases with innovative care models that focus on prevention. As our patient population increases, physician availability will be decreasing. We will be facing shrinking funding and increased costs, while being challenged to provide better care to our communities.

Because of these challenges, it is ever more important to diversify the voices in the boardroom, including the powerful perspectives nurse leaders can bring to the table.

It is ever more important to diversify the voices in the boardroom, including the powerful perspectives nurse leaders can bring to the table.

Thirty years ago, I wrote my master's thesis on the hypothesis that nurse executives who participated in board meetings and medical executive committee meetings and played active roles in their communities felt they had more control over their working environments than those who did not participate in leadership. In 1983, that hypothesis was true. When I revisited that hypothesis 10 years later, in 1993, it still held true. What alarmed me in 1993, however, was that the number of nurse executives who were afforded opportunities to participate in board meetings had decreased, rather than increased, over that time span.

We will be paying for wellness, rather than illness, combatting reimbursement decreases with innovative care models that focus on prevention. As our patient population increases, physician availability will be decreasing. We will be facing shrinking funding and increased costs, while being challenged to provide better care to our communities.

The 2013 biennial survey data shows that overall, the average number of nurses on the board has remained constant since 2011 (the first year The Governance Institute began reporting on this issue). Seventy-two percent (72%) of all responding organizations have zero voting nurses on the board, and the average percentage of nurses on the board is only 2.9% overall. Those organizations are missing valuable perspective.

Roughly 60% of the workforce in any U.S. hospital is in the nursing department, and I believe the importance of nurse leadership will increase in the coming years. One reason, among

many, is the increasing focus on (including reimbursement tied to) the patient experience—a domain that nurses have the primary power to change. Nurses need a voice at the leadership and governance levels now more than ever before in our industry. To that end, nurse executive "participation" in board meetings should not mean that he or she sits in the back of the room and listens to meeting discussions. "Participation" should mean that he or she establishes a relationship with the board that results in being viewed as a respected member of the executive team, whose opinions are valued and actively sought on relevant issues (ideally, as a voting or non-voting member of the board). That kind of relationship takes work on the part of the nurse executive and a strong sense of self-worth.

Healthcare leaders and board members need to see in themselves both what they lack and what they contribute. They need to recognize their own strengths and weaknesses, as well as the strengths and weaknesses of others on the board, and recruit additional members who fill gaps and bring diverse perspective.

As a nurse executive, it can be awkward to interject thoughts or opinions in a board meeting if the CEO is striving to hold the floor in terms of speaking for the executive team. Therefore, it is imperative that the CEO is comfortable with the nurse executive (and other members of the senior management present, for that matter) offering comments during the meeting, knowing that those comments will be supportive of the executive team's work and will only enhance the relationship between the board and the management team. When I was a nurse executive, I often found it helpful to review the board agenda with the CEO in advance of the meeting and suggest where my contribution might be helpful.

Healthcare leaders and board members need to see in themselves both what they lack and what they contribute. They need to recognize their own strengths and weaknesses, as well as the strengths and weaknesses of others on the board, and recruit additional members who fill gaps and bring diverse perspective.

Diversity also means diversity in age, gender, role, ethnicity, geography, community population, and experience. Diversity benefits us all—especially our patients. Who knows more about the real frontline issues in healthcare, than nurses? Nurses spend more time with patients than any other healthcare team member. Pull from their overflowing treasure chests of knowledge, by including nurse leaders on your board.

Today's healthcare boards need to recognize these challenges and opportunities, and strive for diversity among board members in order to address these diverse challenges in healthcare. It's a necessary balance to have the visionary, the logistical genius, the cultural expert, and the financial guru all at the table.

According to the data in this report, recruiting those voices of power shouldn't be difficult. Eighty-two percent (82%) of respondents stated their organization's chief nursing officer regularly attends meetings, but doesn't serve on the board. If the CNO is attending meetings regularly, unless there is some bylaw restricting his or her participation, he or she is a ready, engaged person who could make an excellent addition to the team. Sometimes a solution is sitting right there in the boardroom with you.

Today's healthcare boards need to recognize these challenges and opportunities, and strive for diversity among board members in order to address these diverse challenges in healthcare. It's a necessary balance to have the visionary, the logistical genius, the cultural expert, and the financial guru all at the table. Knowing my own strengths and weaknesses, without that diversity on my team I'm afraid I'd spend every single penny and work everyone to death!

Sensitivity to diversity in the healthcare industry is especially important because of the type of work we do. Having respect for and understanding religious, cultural, and ethnic differences as we deliver and explain healthcare to patients is part of providing compassionate care, a goal we all want to meet.

When leaders reflect the communities they serve, decision makers bring firsthand experience and sensitivity when addressing those differences respectfully and compassionately. No amount of study can replace the inherent knowledge of culture, so we must rely on other's experiences, in addition to our own, to provide better environments of care for our communities.

Females and Ethnic Minorities on the Board

Most boards (97%) have at least one female board member, but just over 50% have ethnic minorities represented on the board (see **Exhibits 4** and **5**). There has not been any significant movement in these areas since 2007 (female representation has remained about the same; ethnic minority representation on the board [at least one member] has moved from 47% in 2007 to 53%). Responses suggest that in general, as these organizations get larger, female and ethnic minority representation increases, with the exception of systems with 1,000–1,999 beds, which have a much higher representation of both females (average 7.8) and ethnic minorities (average 2.4). It should be noted that systems of this size also have larger boards. (See **Table 11** for detail by organization size.)

Table 11. Female and Ethnic Minority Representation on the Board—by Organization Size

	Females	Ethnic Minorities
	Average / Median	Average / Median
< 100 beds	2.9 / 3	0.6 / 0
100–299 beds	3.8 / 3	1.5 / 1
300–499 beds	4.2 / 4	1.7 / 1
500–999 beds	3.7 / 3	1.9 / 1
1,000–1,999 beds	7.6 / 4	2.4 / 2
2,000+ beds	5.1 / 3	2.3 / 2

For detail, see appendices.

Background of the Organization's Chief Executive and Board Chair

To gain a more complete profile of clinician participation in governance, administrative, and other leadership positions, this year we added questions about the background of the chief executive and board chair. For both the CEO and board chair, the overwhelming majority indicated a business/finance background (71% for the CEO and 68% for the board chair). (See **Exhibits 6**, **6a**, and **7**.) We will continue to track this in coming years to determine if there is a trend in any given direction.

We asked survey respondents to check all options that applied (with the understanding that people in these positions could have more than one background). For the board chair, the next largest category was "other non-clinical/non-healthcare" (21%); for the CEO, the next largest category was non-profit/not-for-profit experience (27%).

Clinical Expertise

- 13% of respondents have CEOs who are nurses; the same percentage have CEOs with other clinical expertise; and 5% have physician CEOs.
- 7% of respondents have board chairs who are physicians, 3% have board chairs who are nurses, and 4% have board chairs with other clinical expertise.

Exhibit 4. Female Board Members *(All Respondents)*

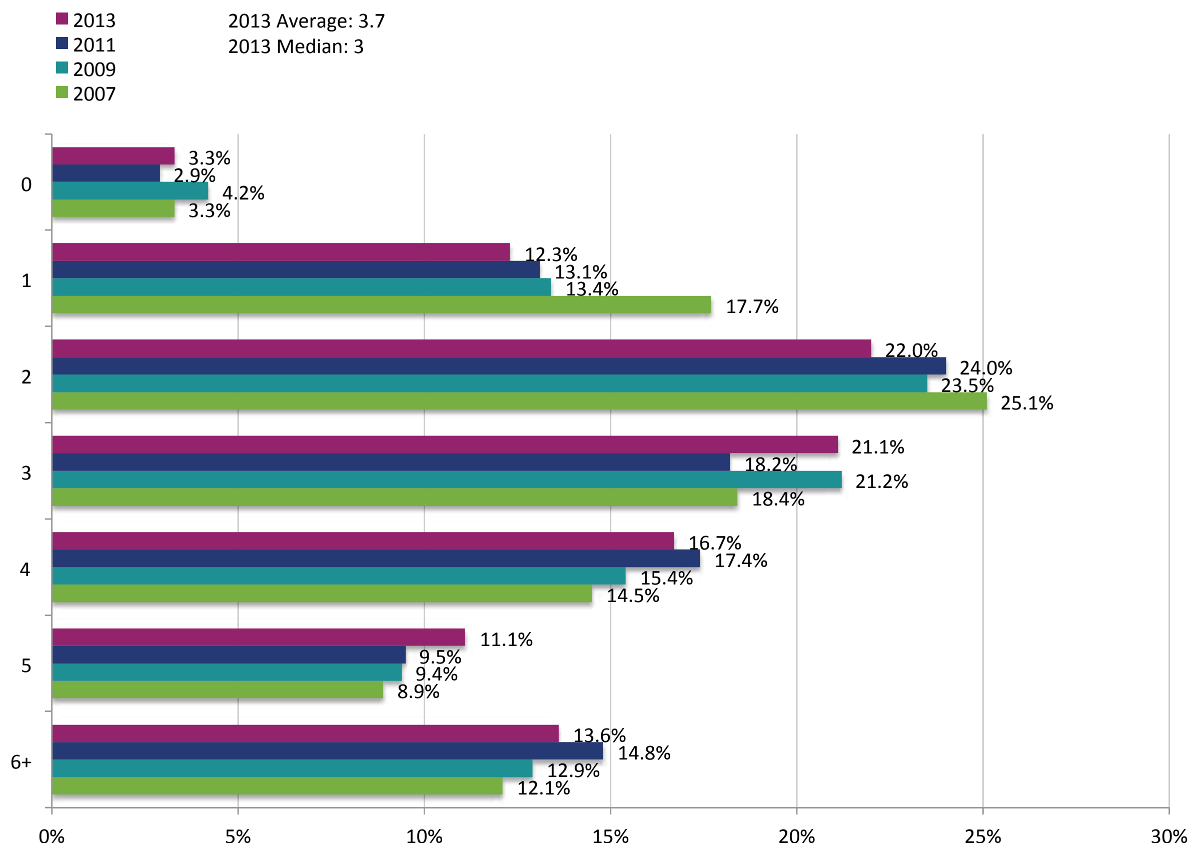


Exhibit 5. Ethnic Board Members *(All Respondents)*

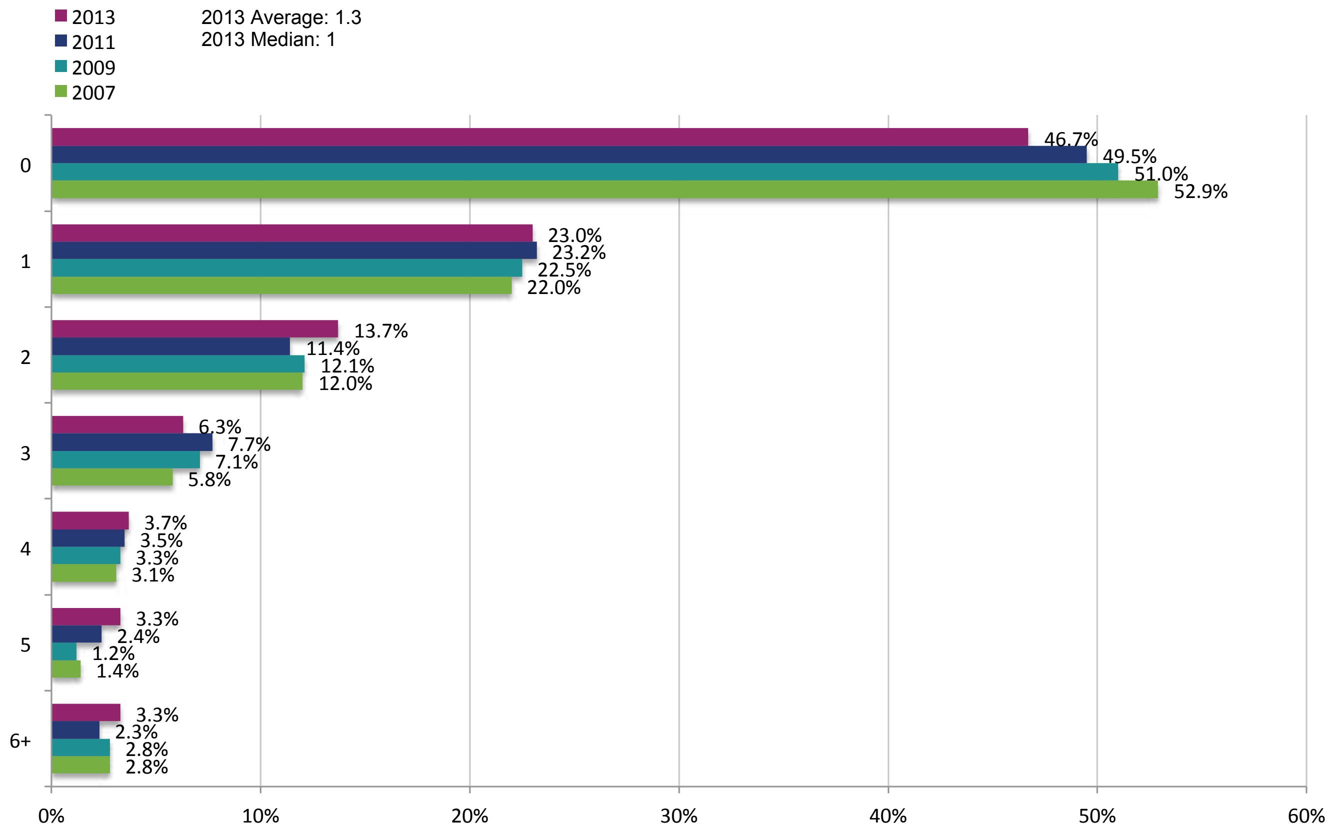
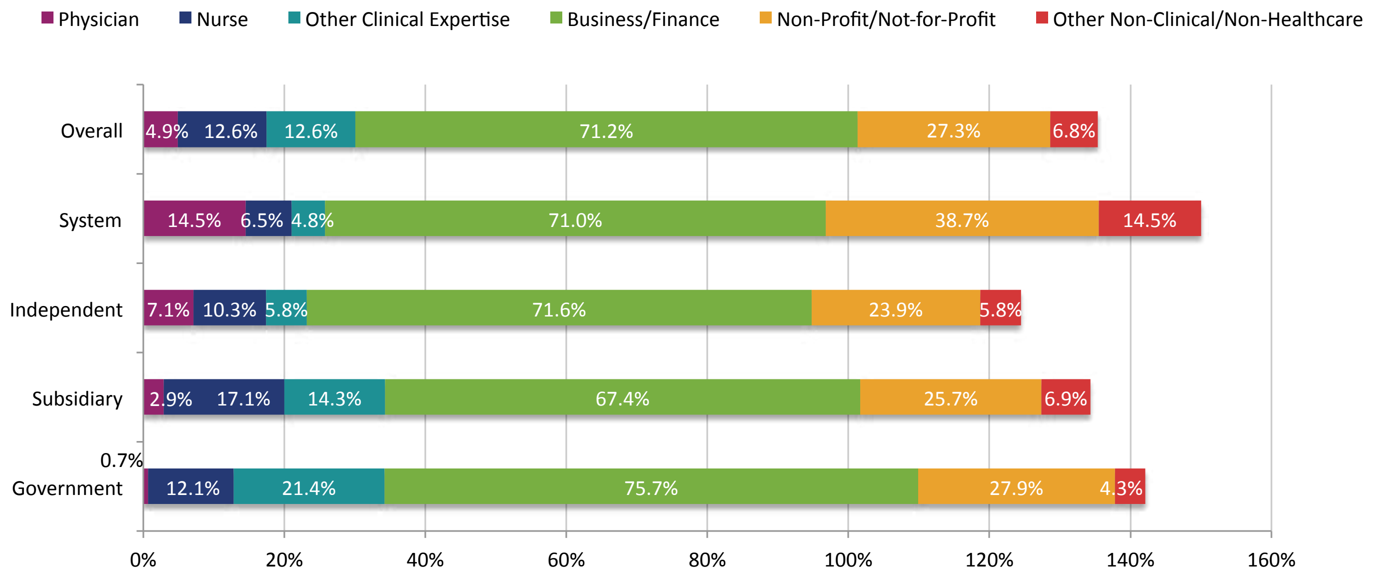


Exhibit 6. Background of the Organization's Chief Executive



Expertise by Organization Type

- Health systems were the most likely to have a physician CEO (15%), a CEO with non-profit/not-for-profit experience (39%), and other non-clinical/non-healthcare experience (15%).
- Subsidiaries were the most likely to have a nurse CEO (17%).
- Government-sponsored hospitals were the most likely to have a CEO with other clinical expertise (21%) and a business/finance background (76%).

Age Limits and Average Board Member Age

The number of organizations that have specified a maximum age for board service has continued to decrease (6.8% of boards have age limits this year; 7.6% had age limits in 2011 and 8.1% did in 2009). The median age limit for the 36 respondents to this question is 72 years (down from 75 years in 2011).

We also asked this year about the average age (estimated) of board members. The overall average age is 57.3 (median 58). The range was 40 to 70 years old. Catholic systems have the oldest board members (average 62.5; median 63).

Exhibit 6a. Background of the Organization's Board Chair and Chief Executive *(All Respondents)*

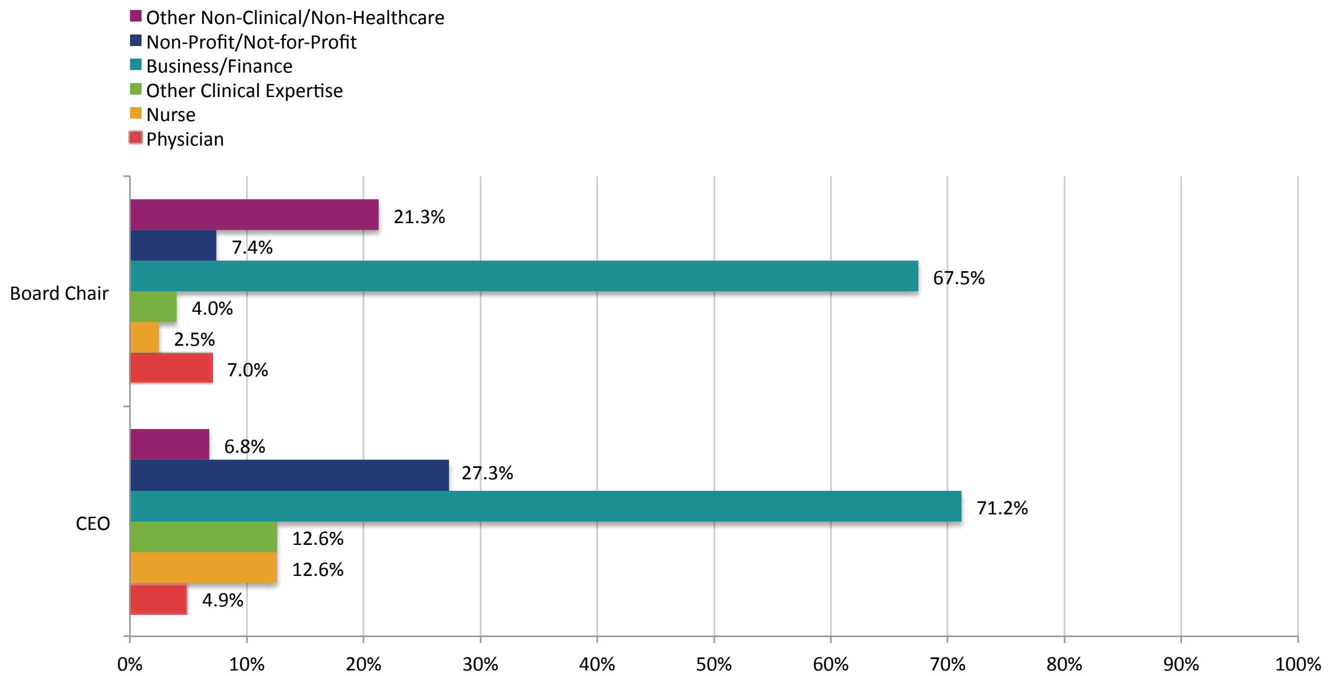
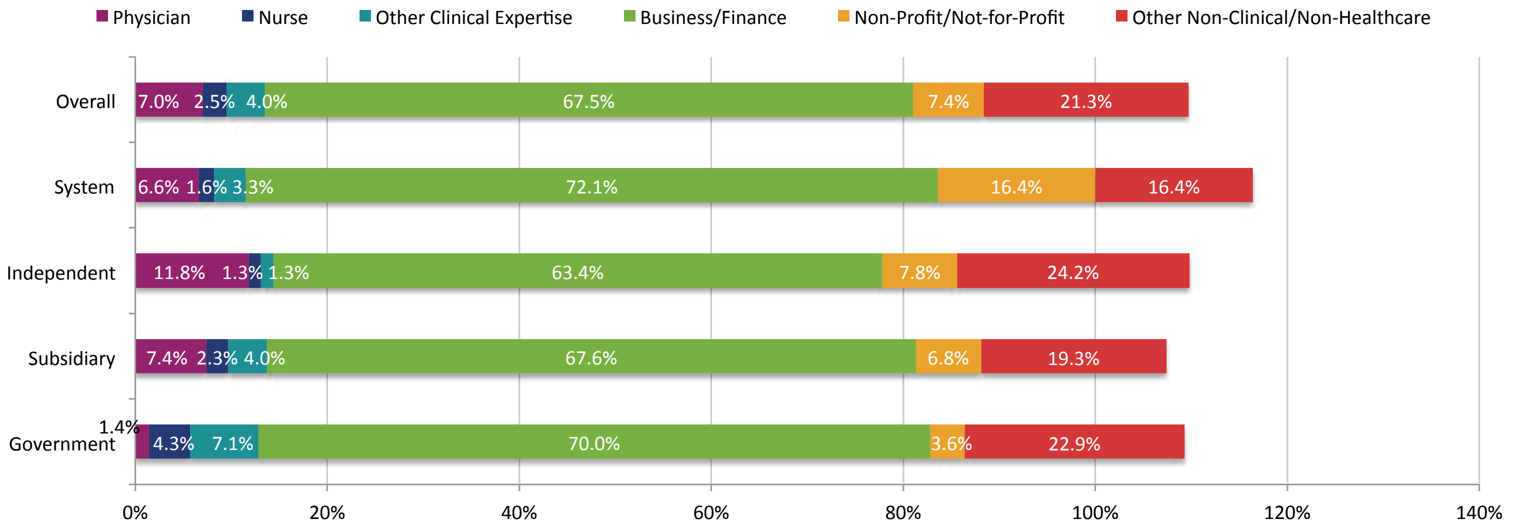


Exhibit 7. Background of the Organization's Board Chair



Defined Terms of Service

Summary of Findings

66% of boards limit the number of consecutive terms; median maximum number of terms is three. (This is up slightly from 64% in 2011.) All organizations increased with the exception of government-sponsored hospitals, which decreased significantly.

By type of organization:

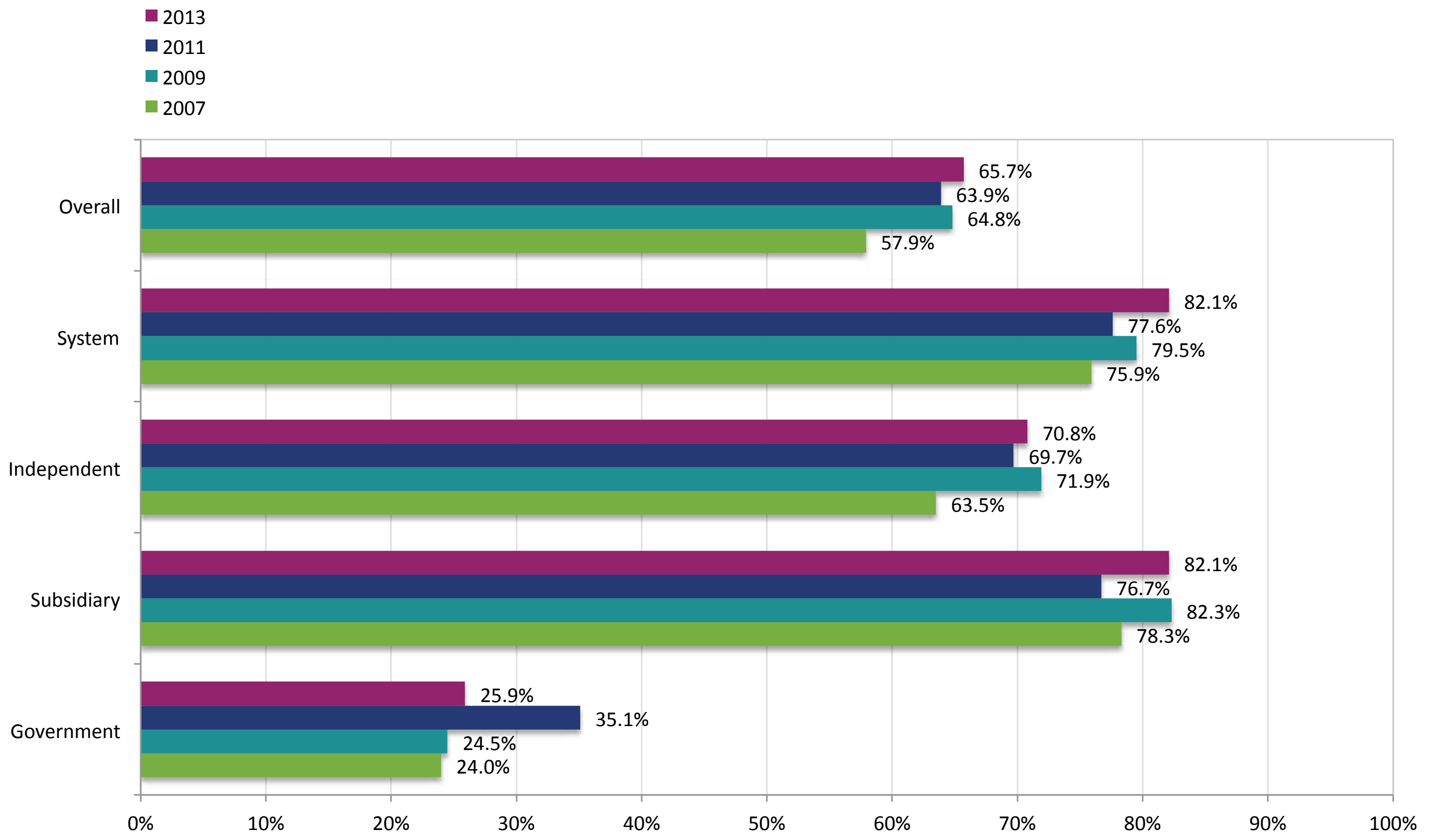
- Systems—82% (up from 78% in 2011)
- Independent hospitals—71% (up from 70% in 2011)
- Subsidiary hospitals—82% (up from 77% in 2011)
- Government-sponsored hospitals—26% (down from 35% in 2011)

Most respondents (89%—down from 91% in 2011) have defined terms for the length of elected service. The median term length has remained three years. The median term length for government-sponsored hospitals is four or five years. A significantly lower percentage of respondents has defined limits for the maximum number of consecutive terms (the deciding factor in "term limits")—66% (up from 64% in 2011). Most organizations limit board members to three consecutive terms; government-sponsored hospitals that have term limits allow only two consecutive terms (given that their terms are one to two years longer).

2011 reflected a significant increase in the number of government-sponsored hospital respondents reporting term limits (see **Exhibit 8**). In 2011, 35% of the respondents from government-sponsored hospitals reported having term limits, up from 25% in 2009 and 24% in 2007. However, this percentage has decreased to 26% this year; this reverse trend line is an indication that the 2011 results may have been an anomaly. We will continue to track this trend in future reporting years. (We are particularly interested in results from government-sponsored hospitals in this area because term limits are not customary among this group, where board members usually are appointed by a government agency or elected by the general public. For district/authority hospitals, terms themselves may be determined by the public election cycle, and those elected may, in some areas, be "term limited." But this is not standard.)

For other hospitals and systems, more often than not, boards have chosen to adopt term limits. Systems and subsidiary hospitals both show a significant increase this year in the percentage of organizations with term limits (see **Exhibit 8**).

Exhibit 8. Limits on the Maximum Number of Consecutive Terms



For nearly all types and sizes of non-government-sponsored hospitals and systems, *more than 73% report term limits*. The exceptions are:

- Independent hospitals with fewer than 100 beds (66%)
- Independent hospitals with 500–999 beds (56%)

Ninety-six percent (96%) of subsidiary hospitals with 500–999 beds have term limits.

Participation on the Board

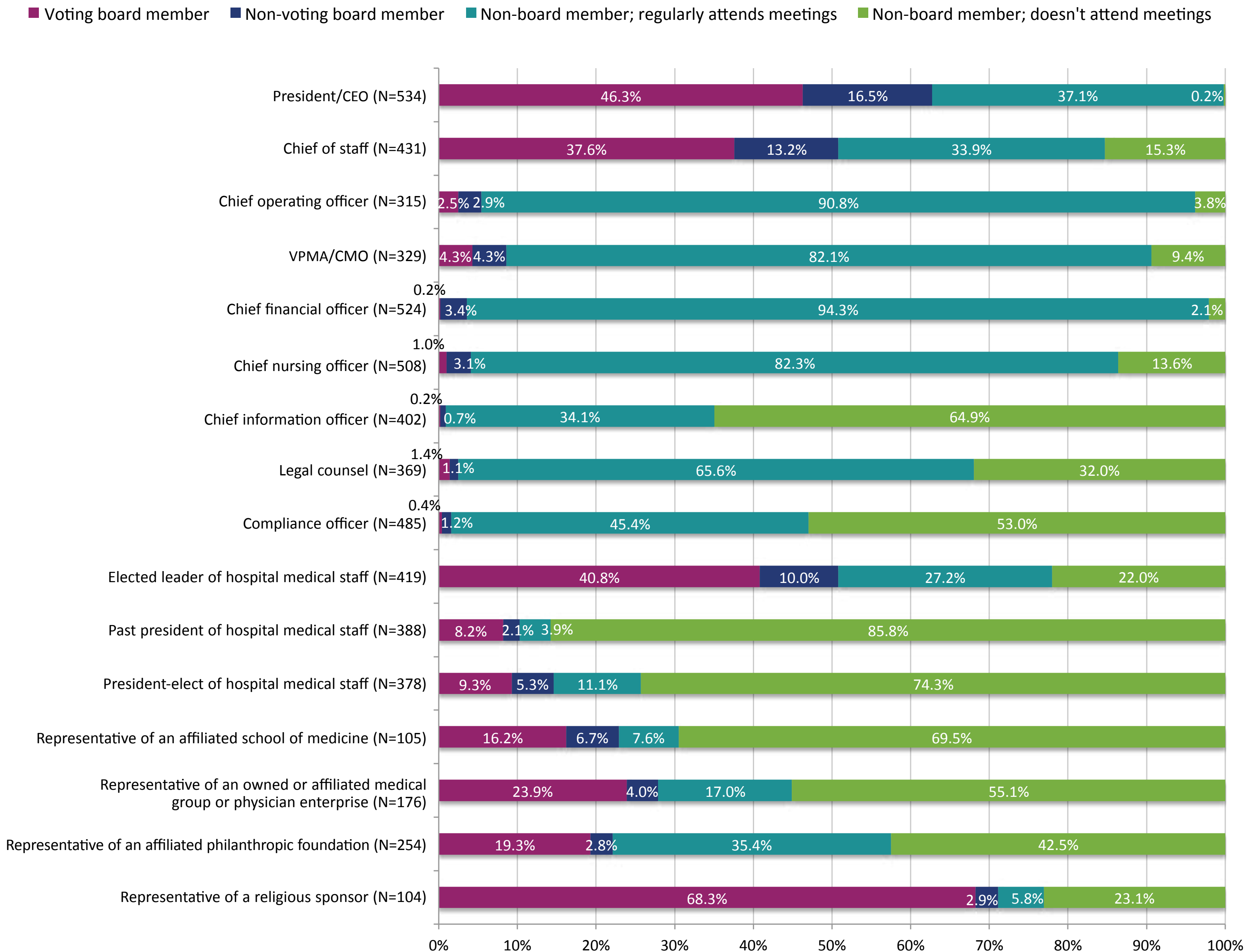
Summary of Findings

- President/CEO:
  - Voting board member: 46%
  - Non-voting board member: 17%
- Chief of staff:
  - Voting board member: 38%
  - Non-voting board member: 13%
- 14% said the chief of staff is a voting member of the board and the CEO is either a non-voting member or not a board member (same as 2011).

Respondents told us about executive and medical staff participation on the board—as voting or non-voting members, and as non-board members who regularly attend board meetings (see **Exhibit 9**). Board participation (voting vs. non-voting and non-members regularly attending board meetings) has remained generally the same overall since 2011.

Forty-six percent (46%) of respondents have an *ex-officio* voting CEO on the board. There has been a very slight decrease over the past two reporting periods (47% in 2011

Exhibit 9. Participation on the Board *(All Respondents)*
(Includes only organizations where specific job titles apply)



and 48% in 2009). Health systems again have the highest percentage of voting CEO board members: 82% (this has risen over time from 76% in 2009). In contrast, government-sponsored hospitals have the lowest percentage of voting CEO board members (4%, a significant decrease from 7% in 2011). For a large majority of government-sponsored hospitals (81%), the CEO is not a board member but regularly attends meetings.

Health systems are the least likely compared to other types of organizations to have a chief of staff at the system level (65% vs. 81%). In general, the larger the system, the less likely it is to have this position. Ninety-one percent (91%) of government-sponsored hospitals have a chief of staff, compared with 81% in 2011.

The chief of staff is a voting board member for 38% of respondents this year—about the same as in 2011 (39%). Independent and subsidiary hospitals are most likely to have a voting chief of staff on the board (51% and 48%, respectively), and government-sponsored hospitals are the least likely (14%), but the chief of staff regularly attends board meetings for 56% of government-sponsored hospitals.

There has been a significant increase in the percentage of respondents with typical C-suite positions, most particularly the increase in organizations with a compliance officer and a chief information officer (see Table 12). Their presence in the boardroom and board member status has remained about the same.

Most respondents said their executives, other than the compliance officer and the chief information officer, regularly attend board meetings. For the legal counsel, there were significant distinctions by organization type: legal counsel regularly attends board meetings for 93% of health systems, up from 81% in 2011 (in comparison, legal counsel attends boards meetings for 57% of independent hospitals, 66% of government-sponsored hospitals, and 59% of subsidiary hospitals). (For detail, see Appendix 1.)

Independent hospitals are more likely to have a representative of an affiliated school of medicine as a voting board member (24% vs. 15% for systems and subsidiaries and 7% for government-sponsored hospitals). For those organizations with an owned or affiliated medical group or physician enterprise (33% of respondents, up from 26% in 2011), 24% of those have a representative from this group as a voting member of the board. For those organizations that are sponsored by

a religious entity (10% of respondents), 68% have a representative from the religious sponsor as a voting member of the board (up from 63% in 2011).

Given the variation in board composition—specifically CEO and chief of staff board membership—we looked specifically at these two positions across types of organizations (see Table 13). There has been a significant decrease in boards with a voting chief of staff if they also have a voting CEO on the board.

Table 12. Frequency of Position and Board Participation 2013 vs. 2011

	% of respondents with this position		% of respondents noting presence in boardroom		% of respondents noting board member (voting and non-voting)	
	2013	2011	2013	2011	2013	2011
CFO	98.3%	83.9%	97.9%	96.2%	3.6%	3.2%
CNO	95.8%	80.3%	86.4%	85.3%	4.1%	3.6%
Compliance Officer	92.2%	72.9%	47.0%	45.2%	1.6%	1.7%
Legal Counsel	69.4%	58.4%	68.1%	65.0%	2.5%	2.8%
CIO	75.8%	56.7%	35.0%	31.2%	0.9%	1.0%
VPMA/CMO	61.7%	50.5%	90.7%	93.5%	8.6%	8.6%
COO	59.2%	46.8%	96.2%	95.0%	5.4%	5.5%

Table 13. CEO and Chief of Staff Board Participation by Organization Type 2013 vs. 2011

Number of Respondents	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013 N = 430	2011 N = 492	2013 N = 40	2011 N = 40	2013 N = 128	2011 N = 198	2013 N = 136	2011 N = 117	2013 N = 126	2011 N = 137
CEO=Voting board member AND Chief of Staff=Voting member	9.3%	24.8%	0.0%	30.0%	12.5%	28.8%	9.6%	42.7%	8.7%	2.2%
CEO=Non-voting board member AND Chief of Staff=Voting board member	5.1%	5.3%	2.5%	0.0%	10.9%	10.1%	3.7%	2.6%	1.6%	2.2%
CEO=Non-voting board member OR not a board member AND Chief of Staff=Voting board member	14.4%	14.4%	2.5%	0.0%	23.4%	23.7%	13.2%	9.4%	10.3%	9.5%
CEO=Voting board member AND Chief of Staff=Non-voting board member	4.0%	3.7%	10.0%	7.5%	3.9%	2.0%	5.9%	8.5%	0.0%	0.7%
CEO=Voting board member AND Chief of Staff=Not a board member	14.4%	13.4%	37.5%	40.0%	13.3%	13.6%	20.6%	16.2%	1.6%	2.9%
CEO=Not a board member AND Chief of Staff=Not a board member	28.8%	31.5%	12.5%	15.0%	16.4%	17.7%	10.3%	12.0%	66.7%	73.0%

Board Committees

Summary of Findings

- 6% of the respondents do not have board committees (up from 3% in 2011).
- Average number of committees decreased significantly from 8 in 2011 to 5 in 2013.
- Median: 5 (compared with 7 in 2011)
- Most prevalent committees (more than 50% of respondents): executive (77%), quality (77%), governance/nominating (77%), finance (76%), executive compensation (60%), and strategic planning (57%). All of these remained the same from 2011.
- The committees that have increased in prevalence most significantly are: quality (77%, up from 72% in 2011), governance/nominating (77%, up from 73% in 2011), executive compensation (60%, up from 56% in 2011), and audit/compliance (34%, up from 30% in 2011).

Most respondents (94%) noted their board has one or more committees, although this has decreased since 2011 (97%). More

importantly, the average number of board committees decreased significantly from 7.6 in 2011 to 4.97 in 2013. Health systems have the most committees (median of 7, down from 8 in 2011); the median for independent and subsidiary hospitals is 5 (down from 8 and 7 in 2011), and for government-sponsored hospitals the median is back to the 2009 level of 4 committees (down from 7 in 2011). (See **Exhibit 10**.)

Overall, there has been little change in the prevalence of specific types of board committees; interestingly, the frequency of community benefit, construction, and government relations/advocacy committees decreased slightly overall from 2011. Systems, independent hospitals, and subsidiary hospitals show a significant increase in the prevalence of a quality/safety committee since 2011 (85% vs. 74% for systems; 80% vs. 74% for independent hospitals; and 86% vs. 77% for subsidiaries).

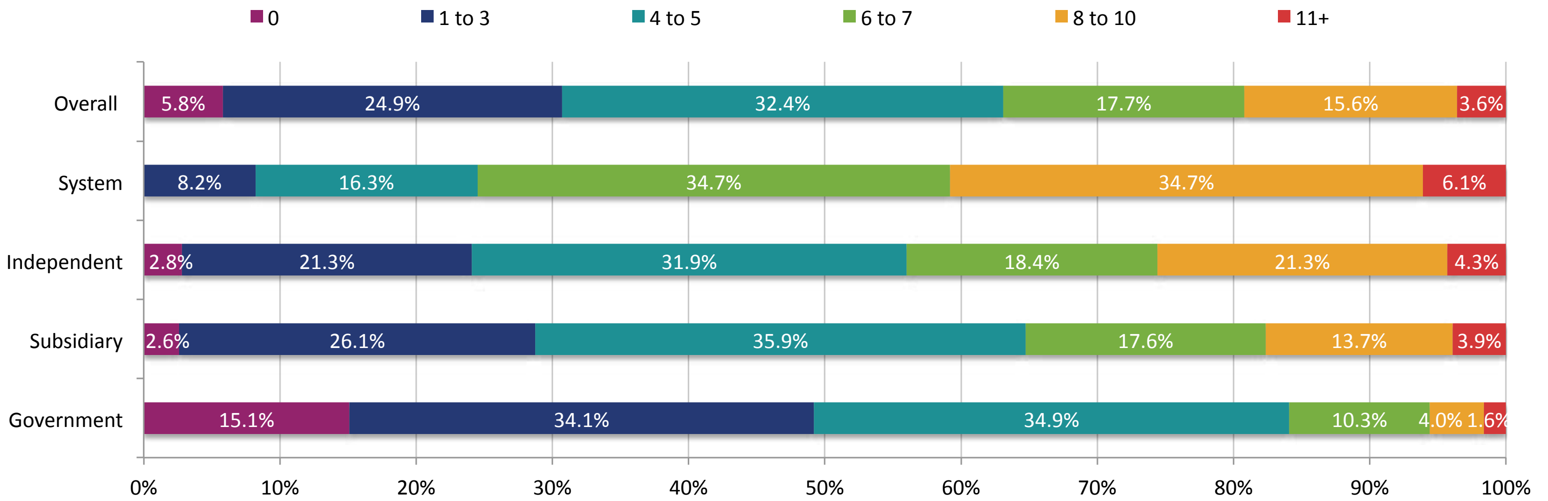
Systems have also shown a significant increase in the prevalence of the following committees:

- Governance/nominating (92% vs. 80% in 2011)
- Finance (86% vs. 79% in 2011)

Subsidiary hospitals also show significant increase in the prevalence of these committees:

- Executive compensation (58% vs. 45% in 2011)
- Audit/finance (39% vs. 29% in 2011)
- Audit (38% vs. 26% in 2011)

Exhibit 10. Number of Board Committees



Government-sponsored hospitals are least likely to have an executive committee (57% vs. 77% overall), quality/safety committee (60% vs. 77% overall), and a governance/nominating committee (51% vs. 77% overall). The prevalence of these committees for this type of organization has remained about the same or decreased slightly from 2011.

Table 14 shows prevalence of board committees over the last four reporting periods (2013, 2011, 2009, and 2007), and **Table 15** shows committees by type of organization (2013 vs. 2011).

Table 14. Board Committees *(Overall)*

Committee	2013	2011	2009	2007
Executive	77%	78%	75%	74%
Quality and/or Safety	77%	72%	70%	62%
Governance/Nominating	77%	73%	72%	67%
Finance	76%	76%	73%	75%
Executive Compensation	60%	56%	54%	48%
Strategic Planning	57%	56%	54%	55%
Joint Conference	40%	39%	40%	38%
Audit/Finance	38%	39%	32%	23%
Investment	35%	36%	31%	25%
Audit/Compliance	34%	30%	28%	24%
Compliance	33%	31%	25%	19%
Audit	32%	32%	26%	29%
Facilities/Infrastructure/Maintenance	25%	25%	22%	19%
Human Resources	20%	22%	24%	22%
Physician Relations	19%	17%	16%	N/A
Community Benefit	18%	20%	15%	14%
Construction	9%	16%	14%	17%
Government Relations/Advocacy	9%	11%	10%	10%

Table 15. Committees by Organization Type 2013 vs. 2011

Committee	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Executive	77%	78%	75%	77%	88%	85%	85%	85%	57%	62%
Quality and/or Safety	77%	72%	85%	74%	80%	74%	86%	77%	60%	62%
Governance/Nominating	77%	73%	92%	80%	86%	84%	83%	77%	51%	51%
Finance	76%	76%	86%	79%	76%	76%	77%	75%	70%	74%
Executive Compensation	60%	56%	85%	83%	76%	71%	58%	45%	35%	43%
Strategic Planning	57%	56%	46%	47%	66%	59%	58%	61%	52%	52%
Joint Conference	40%	39%	26%	21%	43%	43%	36%	34%	50%	44%
Audit/Finance	38%	39%	26%	28%	45%	48%	39%	29%	35%	40%
Investment	35%	36%	70%	70%	40%	39%	31%	29%	18%	21%
Audit/Compliance	34%	30%	67%	49%	34%	29%	36%	33%	19%	19%
Compliance	33%	31%	24%	25%	38%	33%	34%	26%	30%	34%
Audit	32%	32%	40%	37%	34%	36%	38%	26%	21%	27%
Facilities/Infrastructure/Maintenance	25%	25%	9%	14%	21%	27%	26%	20%	34%	31%
Human Resources	20%	22%	27%	26%	17%	20%	19%	20%	22%	24%
Physician Relations	19%	17%	11%	11%	19%	18%	18%	14%	24%	21%
Community Benefit	18%	20%	21%	27%	17%	18%	20%	22%	14%	19%
Construction	9%	16%	4%	11%	6%	16%	7%	12%	19%	20%
Government Relations/Advocacy	9%	11%	9%	10%	8%	11%	9%	11%	9%	11%

Systems appear to have specific characteristics with respect to board committees; for example, the prevalence comparison is striking for quality/safety, governance/nominating, finance, executive compensation, investment, and audit/compliance (see shaded areas).

Note that 67% of the responding systems have combined audit and compliance rather than having a stand-alone audit committee (40%), a separate compliance committee (24%), or an audit/finance committee (26%).

The Quality Committee

The number of organizations reporting a board-level quality/safety committee continues to increase for all organization types except government-sponsored hospitals, jumping more substantially this year compared to previous years. Comparisons can be found in **Table 16**.

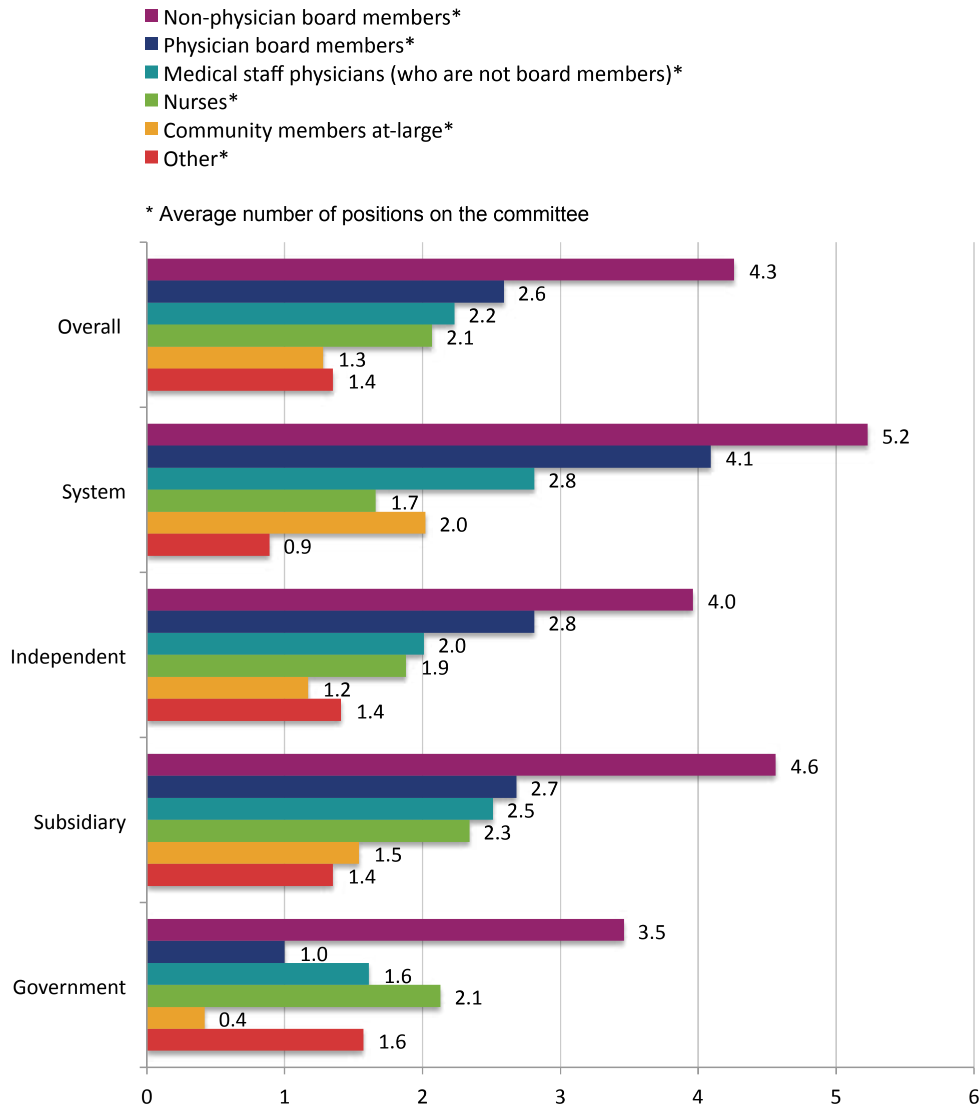
Quality committees generally meet monthly (for 56% of respondents); 21% meet bimonthly and 25% meet quarterly. Health system quality committees meet less frequently compared to other types of organizations (32% meet monthly, 36% meet bimonthly, and 30% meet quarterly). This has changed slightly from 2011 (46% of health system quality committees met monthly).

Table 16. Organizations with a Board Quality Committee

	2013	2011	2009	2007
Overall	77%	72%	70%	62%
Systems	85%	74%	78%	76%
Independent Hospitals	80%	74%	74%	64%
Subsidiary Hospitals	86%	77%	76%	70%
Government-Sponsored Hospitals	60%	62%	53%	46%

Note: In the governance practices section of this survey, we also ask whether the board has a standing quality committee as part of the list of recommended practices for quality oversight. The percentage for this question differs slightly from that reported in these tables for the quality committee due to a difference in the number of respondents for each question (N=396 for quality committee here in the structure section, and N=488 for quality committee in the practices section, in which 79% of the respondents reported a standing quality committee of the board). (See detail in Appendices 1 and 2.)

Exhibit 11. Representation on the Board-Level Quality Committee



The most frequently noted positions on the board quality committee are non-physician board members and physician board members (with one exception: for government-sponsored hospitals, the second most frequently noted position is nurses; physician board members are fourth, followed by medical staff physicians who are not board members). When compared to 2011, the primary difference is that in 2011 there were more medical staff/non-board physicians than physician board members on the quality committee; that has switched for 2013 (see **Exhibit 11**).

The Executive Committee

Seventy-seven percent (77%) of respondents said their board has an executive committee, and this committee meets "as needed" for 56% of those respondents (about the same since 2011). For more than half of those with an executive committee, responsibilities include advising the CEO (68%, up from 55% in 2011), emergency decision making (75%, up from 57% in 2011), and decision-making authority between full board meetings (75%, also up from 57% in 2011). Other responsibilities boards have delegated to the executive committee include strategic planning, quality/safety, physician compensation and other financial arrangements with physicians, compliance, CEO evaluation/compensation, and board assessment/development.[2] (For detail, see **Appendix 1**.)

This committee has generally the same level of authority as it did in 2011 (45% of respondents indicated the committee has full authority to act on behalf of the board

2 "Other" responses are too small in number to consider statistically significant and do not necessarily represent the sample population; they are mentioned here for informational purposes only.

on all issues). A few distinctions by organization type include:

- Subsidiary boards have the highest percentage of respondents indicating full authority of the executive committee (52%).
- Executive committees of government-sponsored hospitals have the least amount of authority (53% said all executive committee decisions must be ratified by the full board).
- The greatest difference from 2013 vs. 2011 was for health systems: this year, 49% of executive committees in systems have full authority; in 2011 57% had full authority.

The movement can be seen in the category "some authority": 40% of executive committees in systems this year have authority to act on behalf of the board on *some* issues; in 2011 28% had "some authority." (See **Exhibits 12** and **13**.)

Exhibit 12. Level of Authority of the Executive Committee

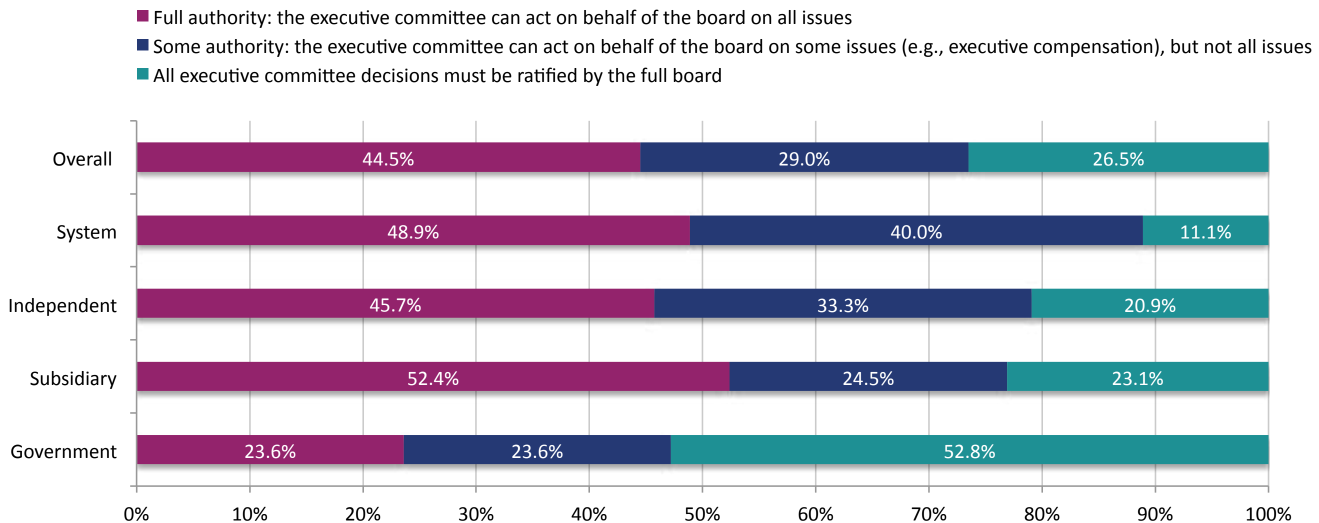


Exhibit 13. Responsibilities of the Executive Committee *(All Respondents)*

	2013	2011	2009
Executive compensation	40.5%	31.9%	41.3%
Board member nominations	24.9%	18.8%	19.7%
Board member selection	12.1%	12.7%	11.6%
Advising the CEO	68.3%	54.6%	67.2%
Emergency decision making	74.9%	56.6%	77.9%
Decision-making authority between full board meetings	74.6%	57.2%	74.1%
Other	6.0%	5.3%	8.0%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Fifty percent (50%) of independent hospitals also assign the executive committee responsibility for executive compensation decisions. Nearly 30% of subsidiary and government-sponsored hospitals with an executive committee use this committee for board member nominations (see **Appendix 1** for detail).

Committee Meeting Frequency

This year, most organizations reported similar meeting frequencies for each committee; results for health systems varied more significantly. For example, 61% of respondents overall reported that the finance committee meets monthly; however, only 33% of health system finance committees meet monthly—26% meet bimonthly and 41% meet quarterly. For respondents with a finance/audit committee, 31% meet monthly overall; only 8% of health system finance/audit committees meet monthly, with 39% meeting semi-annually or annually. For the strategic planning committee, most respondents indicated meeting quarterly (28%) or as needed (29%); in contrast, 40% of health system strategic planning committees meet quarterly, and 40% of government-sponsored hospitals reported that this committee meets as needed. (Meeting frequency for the executive and quality committees was reported on in the previous sections so those committees are not mentioned here.)

A few committees are meeting with different frequency compared with 2011:

- For health systems with finance/audit committees, more are meeting quarterly (31% in 2013 vs. 13% in 2011) and fewer are meeting monthly (8% in 2013 vs. 30% in 2011).
- More audit committees (all organizations) are meeting as needed (29% in 2013 vs. 18% in 2011).
- For government-sponsored hospitals, more audit/compliance committees are meeting as needed (48% in 2013 vs. 36% in 2011). This is in contrast with the overall results—most respondents with this committee meet quarterly (52% for both 2011 and 2013).
- This year, more health system compliance committees are meeting bimonthly or quarterly (75% vs. 55% in 2011); 0% of health systems reported that this committee meets monthly this year, compared with 25% meeting monthly in 2011. For this committee in independent hospitals, fewer are meeting quarterly (35% vs. 52% in 2011) and more are meeting bimonthly (16% vs. 6%) and as needed (22% vs. 13% in 2011).
- For the executive compensation committee, more subsidiary (47%) and government-sponsored hospitals (54%) are meeting as needed as opposed to annually.
- More community benefit committees are meeting quarterly (40% vs. 23% in 2011) for all organizations. Sixty-seven percent (67%) of health systems said this committee meets quarterly this year, compared with 41% in 2011 (fewer are meeting monthly, bimonthly, and as needed). More subsidiary hospital boards are having this committee meet quarterly in 2013 (47% vs. 12% in 2011) instead of bimonthly (11% vs. 27% in 2011).

For the following committees, many or most respondents noted meeting "as needed" (this remained the same since 2011):

- Physician relations (55%)
- Joint conference (62%)
- Facilities/infrastructure/maintenance (53%)
- Construction (87%)
- Government relations/advocacy (56%)

For detail on committee meeting frequency overall, by organization type, size, and AHA designation, see **Appendix 1**.

Board Meetings

Summary of Findings

- Most boards (67%) meet 10–12 times a year (90% of government-sponsored hospital boards meet 10–12 times per year). This has remained about the same from 2011.
- 48% of responding organizations' board meetings are two to four hours; 46% are one to two hours. This has also remained about the same since 2011.
- 71% of responding organizations use a consent agenda at board meetings (68% in 2011).
- 56% have scheduled executive sessions (same as 2011; up from 52% in 2009); of these, 68% said executive sessions are scheduled for all or alternating board meetings.
- 85% said the CEO attends scheduled executive sessions always or most of the time (down from 89% in 2011); 58% said physician board members attend scheduled executive sessions always or most of the time (compared with 53% in 2011).
- 50% of board meeting time is devoted to hearing reports from management and committees (about the same as 2011); 33% to discussing strategic issues/ policy (up one percentage point from 2011); 17% to board education (also up one percentage point from 2011).

Board Meeting Frequency and Duration

Most boards meet from 10 to 12 times per year (67% of the respondents; this has remained about the same since 2011). (See **Exhibit 14**.) Meeting duration tends to be concentrated in the two- to four-hour range (48%) and one- to two-hours (46%). (See **Appendix 1** for detail on meeting frequency and duration.)

Health systems again stand out from the rest of the organizations regarding board meeting frequency and duration:

- System boards have the longest board meetings generally (52% are from two to four hours and 18% are from four to six hours). Seven percent (7%) of system boards have meetings that last six to eight hours, and 5% of system boards have meetings that last more than eight hours (no other organizations fell into this category).
- Since their board meetings are longer, most system boards meet only four to six times per year (44%). This has remained about the same from 2011.

Consent Agenda and Executive Session

Almost three-quarters of respondents said the board uses a consent agenda (71%, which has risen steadily from 62% in 2007). (See **Exhibit 15**.) Frequency of scheduled executive sessions has remained constant at 56%. Again, a significant majority of systems said they have scheduled executive sessions. (See **Exhibit 16**.) Since 2009, most respondents continue to schedule executive sessions after or before every board meeting (see **Exhibit 17**).

Exhibit 14. Number of Board Meetings Per Year

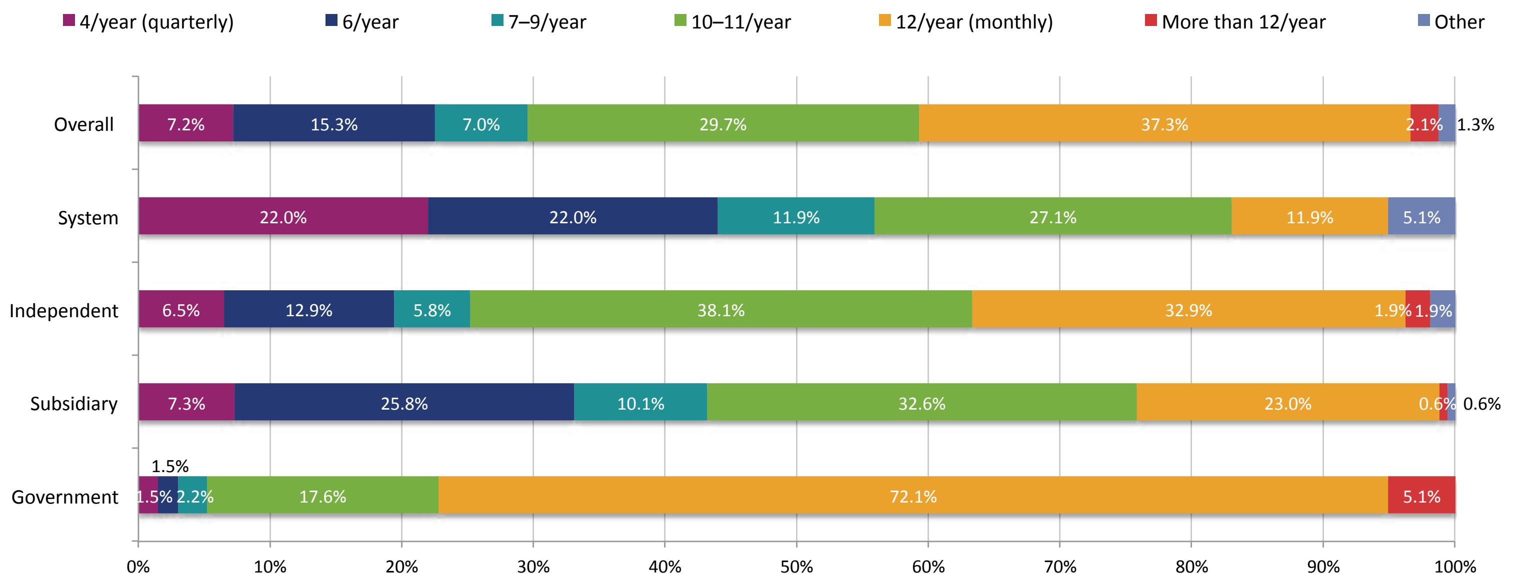


Exhibit 15. Use of Consent Agendas

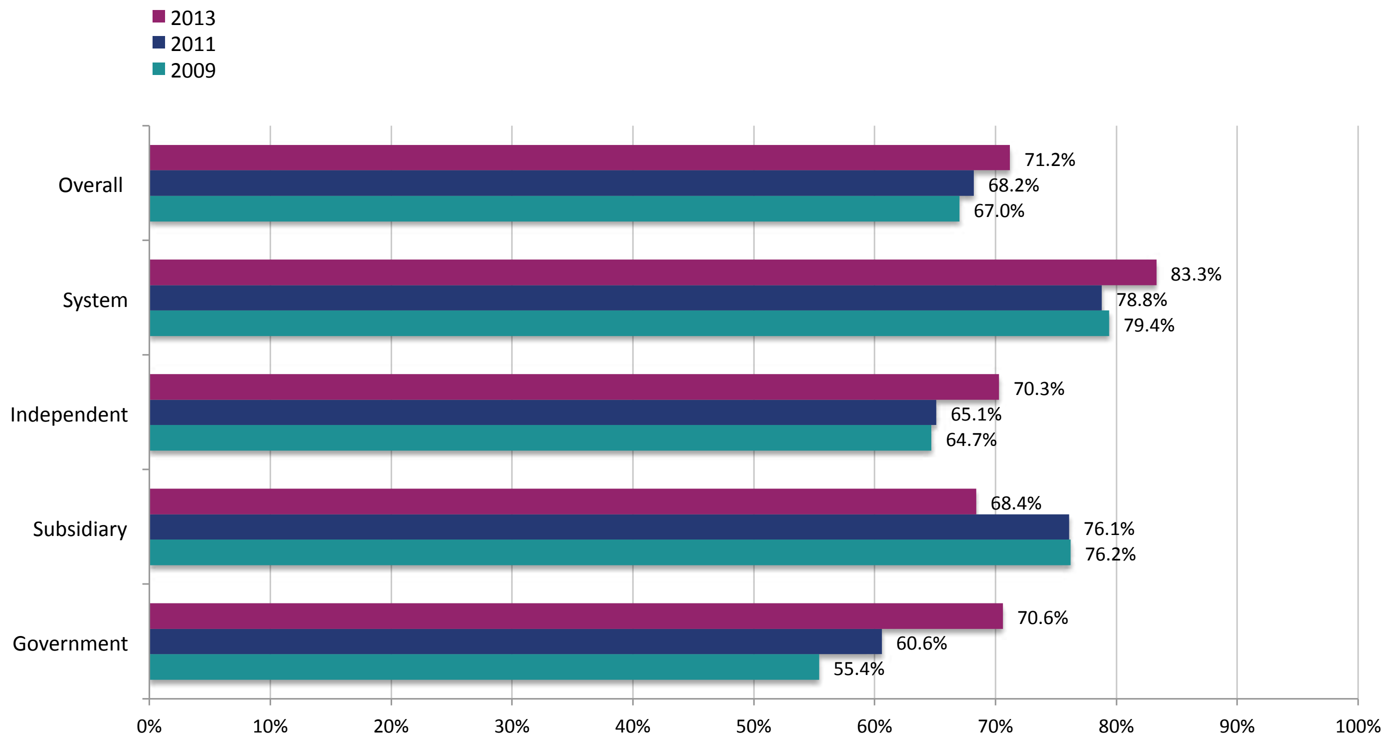


Exhibit 16. Scheduled Executive Sessions

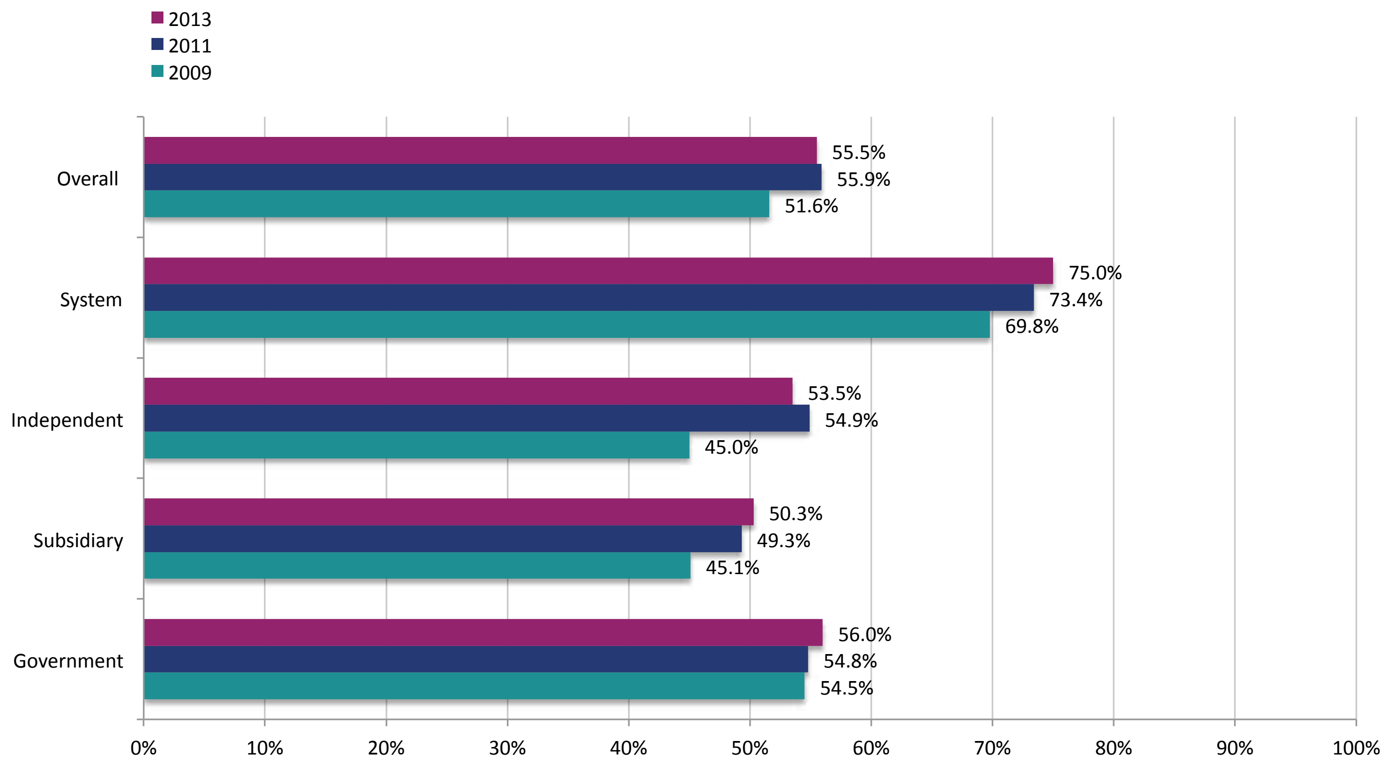
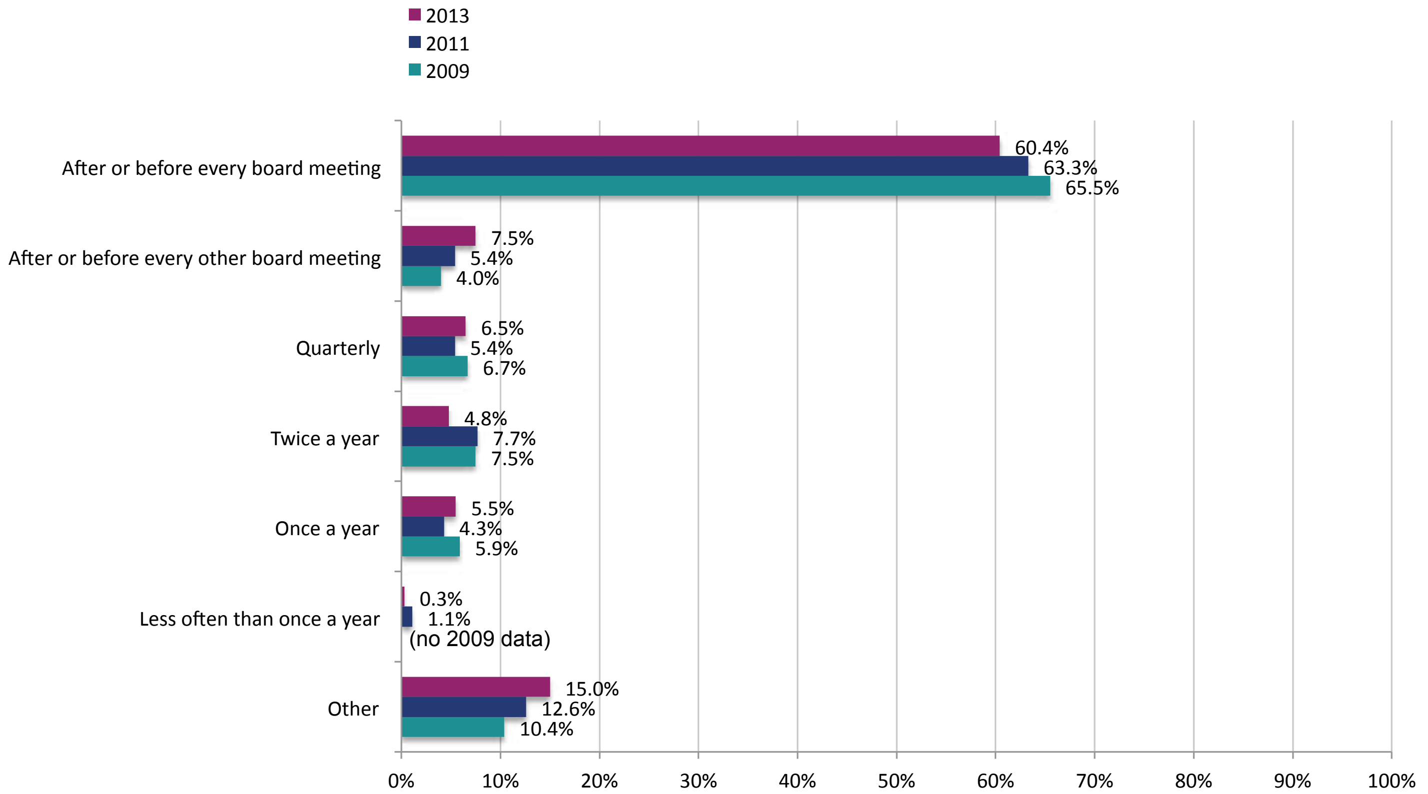


Exhibit 17. Frequency of Scheduled Executive Sessions



We asked who typically attends scheduled executive sessions. Eighty-six percent (86%) of respondents with scheduled executive sessions said the CEO attends always or most of the time (up from 82% in 2011); 58% said physician board members attend always or most of the time (down from 66% in 2011); and 38% said legal counsel attends always or most of the time (down from 42% in 2011). (See **Table 17**.)

Board Meeting Content

Boards continue to devote half of their meeting time to hearing reports from management and board committees. This percentage has decreased very gradually (i.e., gone in the "right" direction) from 55% in 2005 to 50% today. Systems have usually spent the lowest amount of time in this category, but this year subsidiary hospitals receive this distinction (46% of meeting time spent hearing reports). Forty-seven percent (47%) of health system board meeting time is spent hearing reports, which has risen from 40% in 2011.

Meeting time spent discussing strategy/setting policy has remained constant (33% of meeting time on average, vs. 32% in 2011 and 33% in 2009). Time spent on board member education continues to inch up one percentage point each year (17% this year vs. 16% in 2011 and 15% in 2009). (See **Exhibit 18**.)

System and subsidiary boards are the most likely to spend more than 50% of meeting time discussing strategy and setting policy (14% and 13% respectively). Government-sponsored hospitals are the least likely to spend more than half of meeting time discussing strategy and setting policy (6.8% of government-sponsored hospitals do so) and spend the highest percentage of meeting time receiving reports from management and committees (58% of meeting time).

Table 17. Who Attends Scheduled Executive Sessions 2013 vs. 2011

	Always		Most of the Time	
	2013	2011	2013	2011
CEO	47%	55%	39%	33%
Physicians on the Board	42%	36%	16%	17%
Legal Counsel	26%	23%	12%	11%

More government-sponsored hospitals said the CEO always attends scheduled executive sessions (64% compared to 47% overall, although this is about 10 percentage points lower than in 2011); and more government-sponsored hospitals said legal counsel always attends (41% compared to 26% overall; this is up from 33% in 2011).

For health systems, the CEO is more likely to attend "most of the time" (48%) rather than "always" (34%); the same is true for independent hospitals: 47% of CEOs attend "most of the time" rather than "always" (36%).

Exhibit 18. Average Percentage of Board Meeting Time Devoted to Reports, Strategy, and Education

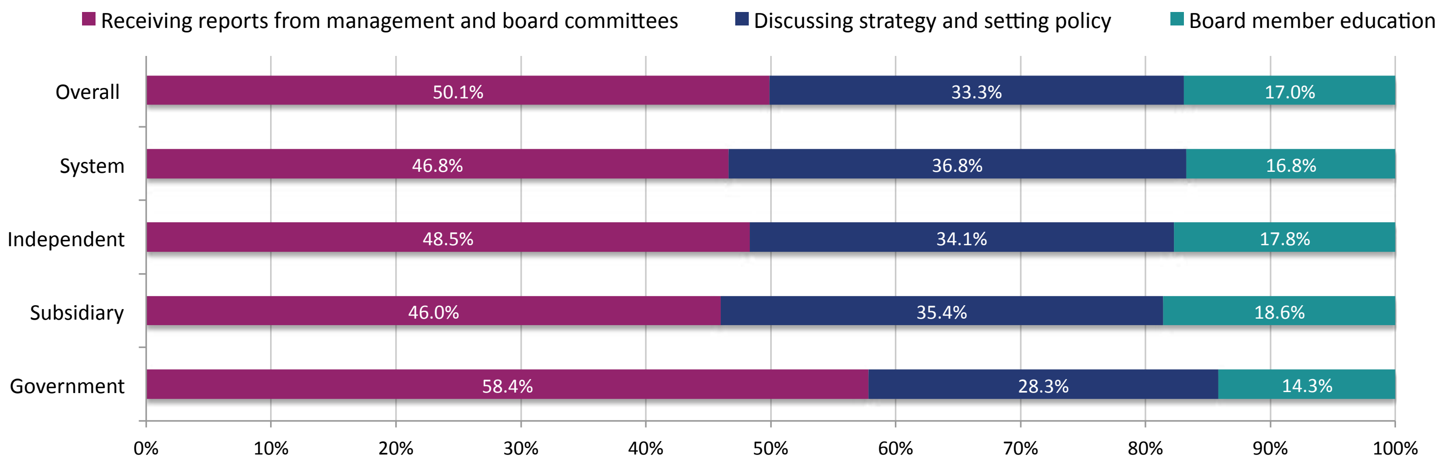
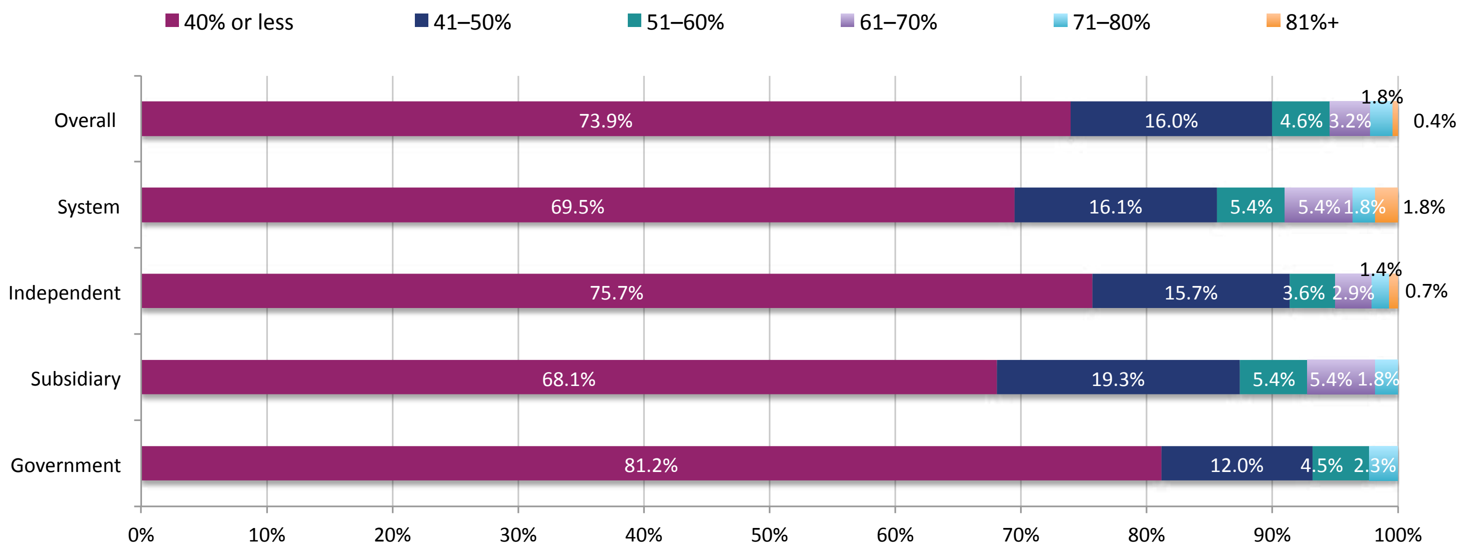


Exhibit 19. Percentage of Board Meeting Time Spent on Strategy/Policy



Overall, it appears that boards still have a way to go to bring about the recommended shift in board meeting content as there has not been significant movement in this area since 2005. This year, 74% of the responding organizations spend 40% *or less* of the time during their board meetings on strategy (see **Exhibit 19**).[3] This year's analysis again shows a significant positive correlation for all organization types between spending more than half of the board meeting time (over 50%) discussing strategic issues and respondents rating overall board performance as "excellent" in the various core areas of responsibility presented in the second half of this report.

3 We recommend that boards spend 50% or more of their meeting time on strategic discussions due to the relationship between the amount of time devoted to strategic discussion and overall board performance.

MEETINGS AND COMMITTEES: CURRENT STATE AND FUTURE OPPORTUNITIES FOR HIGHER PERFORMING BOARDS

David A. Shore, Ph.D., *Former Associate Dean, Harvard University School of Public Health; Lecturer, Harvard University; Adjunct Professor of Organizational Development and Change, School of Business, University of Monterrey, Mexico*

SPECIAL COMMENTARY

Meetings have been around since before the invention of the printing press, and six centuries later, they do not appear much different. Likewise, despite the pending transformation of the healthcare industry, the 2013 biennial survey does not suggest any large shift in the patterns of board meetings. There was, however, a meaningful decline in the average number of committees from 7.6 in 2011 to 4.97 two years later.

Current State of Board Meetings and Committees

As in 2011, most boards continue to meet almost monthly (between 10–12 times per year); with two to four hours remaining the most frequent duration (see **Exhibit 14**). The average board has 13.5 members. To provide some context and scope, if we assume a three-hour board meeting, this would be a total of 40.5 hours of board time for each meeting (13.5 members x three hours). Of course this does not factor in the additional investment of time by board members, enterprise-wise leadership, and staff prior to, during, and after the board meeting for preparation and follow-up. The most conservative statistic we find based on experience working with healthcare organizations is that it cumulatively takes 22 hours of preparation time for every hour of board meeting time. If we now take that 40.5 hours of just board meeting time and multiply that by an average of 11 board meetings per year, we jump to 445.5 hours or 55.7 days per year that directors devote to regular board meeting time. To this we add the requisite 360-degree investment by board members, institutional leadership, and staff that surrounds these meetings. In addition, these groups of people devote an abundant amount of time to executive committee, standing committee, and subcommittee meetings.

As noted earlier, the results show a decline in the average number of committees from 7.1 in 2011 to 4.97 this year. With their targeted focus, committees can be a particularly efficient mechanism for doing business. The objective is to have the right people on the right committees discussing the right topics. A further analysis would illuminate whether boards that have reduced their committees determined that the topics under consideration by decommissioned committees were no longer necessary or whether their work was now being considered by the entire board.

From a broader perspective, with this view we can quickly appreciate the magnitude of board meetings. The Nobel Prize winning economist Milton Friedman is attributed with saying “the business of business is business.”

A review of the considerable amount of data from the 2013 biennial survey devoted to board and committee meetings might lead to the conclusion that a significant part of the business of boards is meetings. Indeed, from a legal standpoint, a board only exists and has the power to make decisions and actions when it meets.

As illuminating as it is to consider the size and scope of board meetings, it is perhaps more interesting to examine how boards spend their meeting time. After all, as the American author Annie Dillard reminds us, "how we spend our days is, of course, how we spend our lives." This year's data with regard to focus remains essentially stable from 2011, with a variation of no more than 1% in any category. Half of board meeting time is spent listening to reports from management and committees. Based on this alone, it is not unreasonable to conclude that, as such, boards continue to spend too much time in passive mode. The balance of time is spent discussing strategic issues/policy (33%) and board education (17%) (see **Exhibits 18–19**). One recommendation to consider is to work toward reversing these first two numbers so that 50% (or more) of the meeting time is spent on strategy/policy, with no more than one-third of meeting time spent on reports from management and committees. In addition to further leveraging the extraordinary talent and expertise of the board members by increasing time for strategic discussion, we have consistently found a positive correlation between time spent on strategy and board member satisfaction levels. Such a shift would therefore bode well for attracting and retaining the best and the brightest board members.

It may also be interesting to reflect on how boards differ. Here we look at a comparison of the United States and the United Kingdom. Specially, with regard to the U.K. we consider data from the National Health Service (NHS) on how boards differ in the way they spend their time with regard to quality and safety. Quality of care performance is on the agenda at every board meeting in 98% of English hospitals; while it is on the agenda at every board meeting in 68% of U.S. hospitals/systems. Eighty-three percent (83%) of NHS hospitals spend more than 20% of board meeting time on quality performance issues as compared to 42% that do so in the U.S. In terms of training in quality management for board chairs, in England the median is eight hours and among their U.S. counterparts it is three hours. Finally, when it comes to the top priority of board chairs for board oversight, 72% of English hospital board chairs choose either patient safety or clinical effectiveness as their top priority; while only 31% of U.S. board chairs chose clinical quality as their top priority. [4]

The Consent Agenda

Because the goal of committee and board meetings should be to permit boards to govern effectively and efficiently without wasting their time, it is encouraging to see the extensive use of consent agendas. Here we observe an increase from a respectable 68% of boards using consent agendas in 2011 to a more impressive 71% in 2013 (see **Exhibit 15**). The use of the consent agenda is an area where boards outpace other sectors of the healthcare delivery organizations.

The concept behind consent agendas is a simple but elegant one: bundle that which is routine, procedural, informational, and self-explanatory (items that are non-controversial and assumed not to be in need of a discussion before taking a vote). As such they can be presented collectively as a package in a single motion for an up or down vote. Items are placed on a consent agenda only if *all* board members agree—if one member considers a specific item warranting discussion, it must be removed from the package ahead of time and placed on the regular agenda of the meeting. Among other things, the appropriate use of a consent agenda frees up time for strategic and competitive thinking, decision making, and action items. We find the use of

4 Ashish K. Jha and Arnold M. Epstein, "A Survey of Board Chairs of English Hospitals Show Greater Attention to Quality of Care Than Among Their U.S. Counterparts," *Health Affairs,* Vol. 32, No. 4, April 2013.

consent agendas particularly well suited to standing committee meetings. While there has been limited study relative to the return on investment of consent agendas, the best data we have suggests that consent agendas can take between 25–50% of time out of a standard one-hour meeting, depending on a host of variables such as the meeting chair, organizational culture, and maturity of meeting (i.e., a long-standing meeting culture in which the issues are known and the agenda well established). The types of items that often appear on a consent agenda include: board and committee meeting minutes, committee and staff reports, information-only updates or background reports, staff appointments requiring board confirmation, routine contracts that fall within policies and guidelines, and dates for future meetings.

It is a myth in the time management field that we can get it all done—we can't! When boards wish to succeed in achieving something, time becomes an important constraint to realizing the objective. The board, and by extension the organization, that can think fast, respond quickly, and implement quickly has a tremendous advantage—this requires freeing up time and this is what a consent agenda does. Indeed, it is rare to find a healthcare delivery organization that does not acknowledge that time and human capital are their greatest rate-limiting factors.

Focus on People and Process

In recent years in the healthcare delivery sector, we have seen a dramatic rise in interest in continuous process improvement practices such as Lean and Six Sigma. With Lean, the objective is to eliminate waste (speed) and with Six Sigma the goal is standardization (eliminating or reducing variation). A hallmark of all process improvement techniques is measurement. It is also a hallmark of medicine. Consider this: in the spirit of continuous quality improvement, when board members and organizational leadership team members go to an event hosted by The Governance Institute, participants are asked to evaluate the effectiveness of all speakers as well as the event overall, and provide suggestions for improvement. The data from these surveys guide future planning and allow The Governance Institute to better meet the needs of its members. Yet, when it comes to the ubiquitous board and committee meeting, we rarely see such an evaluation instrument. If we measure what we value, should we not be measuring the effectiveness of meetings—the most common activity of all boards?

For a more extensive discussion of the role of meetings in healthcare, see David A. Shore and Douglas A. Shore, From "Wasteful" Meetings to Parsimonious Meetings Management: Preserving Human Capital in Health Care Delivery Organizations *(working paper), Harvard School of Public Health, 2013. This working paper is available from David A. Shore (shoredavida@gmail.com).*

Board Member Compensation

Summary of Findings

- 12% of respondents said their board chair is compensated (same as 2011), and 63% of these said compensation is less than $5,000.
- 16% said some or all other board members are compensated (a small increase from 15% in 2011), and 74% of these said compensation is less than $5,000.
- There was a significant increase in the number of government-sponsored hospitals that compensate board members (35% compensate some or all board members vs. 28% in 2011); there was a significant drop in the percentage of health systems that compensate some or all board members (18% vs. 25% in 2011, although this is still higher than the 2009 level of 14%).

This is the second reporting year showing an increase in overall board member compensation (16% of respondents compensate some or all other board members; from 2005–2009 the level remained constant at about 10% of boards compensating board members). Government-sponsored hospitals have shown the highest increase in board member compensation, affecting the overall increase (35% vs. 28% in 2011). (See **Exhibit 20**.)

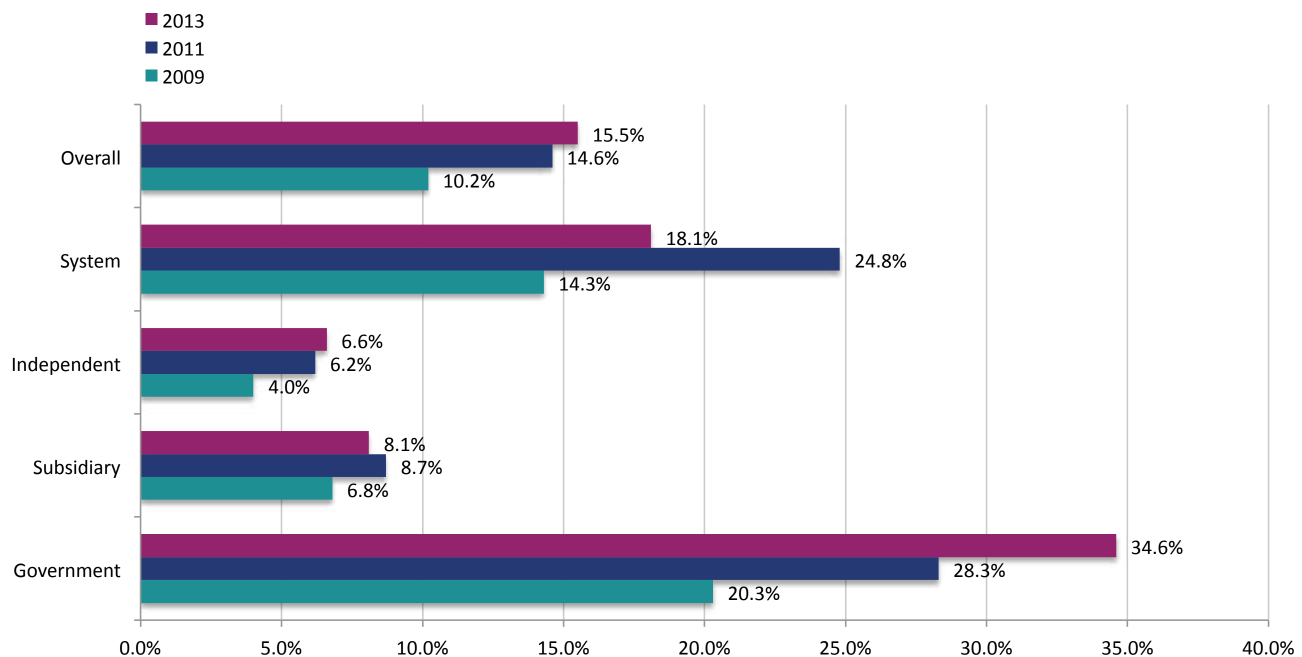
Compensation for the board chair has remained constant at 12%. Compared with 2011, fewer health systems compensate the board chair. Government-sponsored hospitals are the most likely to compensate the board chair (see **Table 18**).

Seventy-four percent (74%) of respondents said board chair compensation is less than $10,000 per year; 74% said compensation for other board members is less than $5,000. This year we also asked whether boards compensate board officers (10%) and board committee chairs (7%). Compensation for board officers was less than $5,000 (76% of respondents), and compensation for committee chairs was also primarily less than $5,000 (79% of respondents). Consistent with compensation for the board chair, government-sponsored hospitals were most likely to compensate board officers and committee chairs. (For detail, see **Appendix 1**.)

Table 18. Percentage of Organizations That Compensate the Board Chair

	2013	2011	2009	2007
Overall	**11.8%**	**12.0%**	**9.6%**	**9.5%**
Systems	17.5%	21.3%	12.7%	10.0%
Independent Hospitals	5.8%	5.2%	4.7%	3.9%
Subsidiary Hospitals	6.2%	7.1%	5.3%	8.5%
Government-Sponsored Hospitals	23.5%	22.9%	19.1%	19.9%

Exhibit 20. Percentage of Organizations That Compensate All or Some Other Board Members



Due to the variance in rates of board member compensation for government-sponsored hospitals vs. other types of organizations, we looked at overall compensation rates for systems, independent hospitals, and subsidiaries only from 2009–2013. For board chair compensation, the combined percentage (excluding government-sponsored hospitals) was 7.6% in 2009, 11.2% in 2011, and 9.8% in 2013. For compensation of some or all other board members, compensation rates were 8.4% in 2009, 13.2% in 2011, and 10.9% in 2013.

Thus, when government-sponsored hospitals are excluded from the calculation, the overall compensation rate *declines* for 2013 (although the rate is higher than 2009). So while the data shows an increase in compensation of board members overall, this increase is due to compensation in government-sponsored hospitals only.

Annual Expenditure for Board Member Education

Summary of Findings

- 42% of respondents spend $20,000 or more annually for board education (same as 2011).
- 2.5% said they don't spend any money on board education.
- Health systems generally spend more for board education than other types of organizations, although the dollar amount has decreased since 2011 (38% spent $50,000 or more in 2013 vs. 44% in 2011). The offset can be found in the $30,000–49,999 range (19% in 2013 vs. 14% in 2011) and the $20,000–29,999 range (14% in 2013 vs. 10% in 2011).
- Government-sponsored hospitals spend the lowest dollar amount for board education (54% spend under $10,000).

Use of Board Portal or Similar Online Tool

Summary of Findings

- 67% of respondents use a board portal or are in the process of implementing a board portal or similar online tool for board members to access board materials and for board member communication (a significant increase from 54% in 2011). Specifically, 53% of respondents in 2013 already use a board portal vs. 34% in 2011.
- 88% of health systems are using or in the process of implementing a board portal; and 76% of subsidiary hospitals are in this category (the two types of organizations most likely to use a board portal).
- 45% said the most important benefit of using a board portal is the reduction of paper waste and duplication costs (same as 2011). Thirty-three percent (33%) said it enhances board members' level of preparation for meetings.
- 59% of respondents provide board members with laptops or iPads to access online board materials, compared with 30% in 2011.

Exhibit 21. Approximate Total Annual Expenditure for Board Education

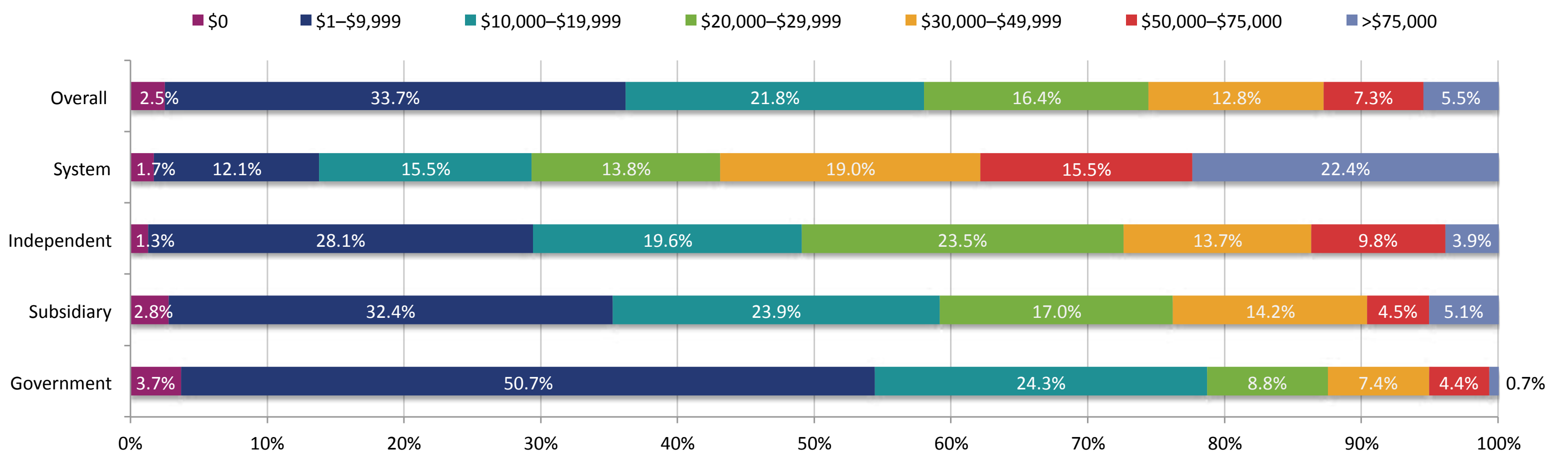


Exhibit 22. Use of Board Portal or Similar Online Tool

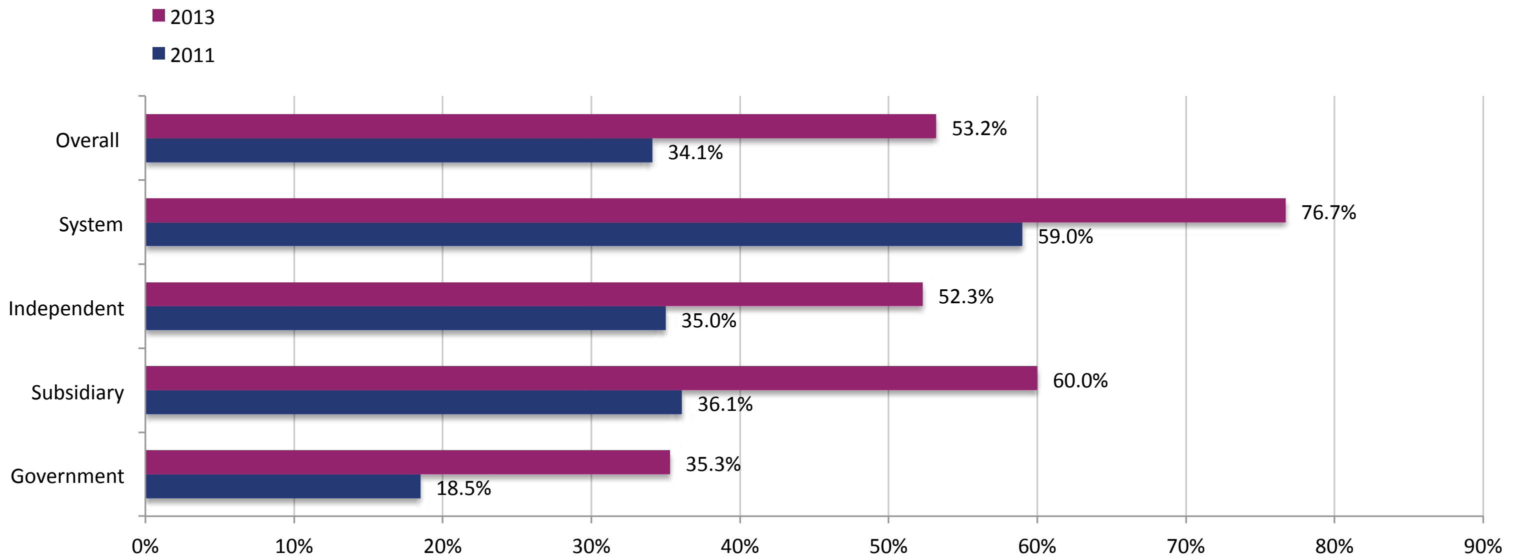
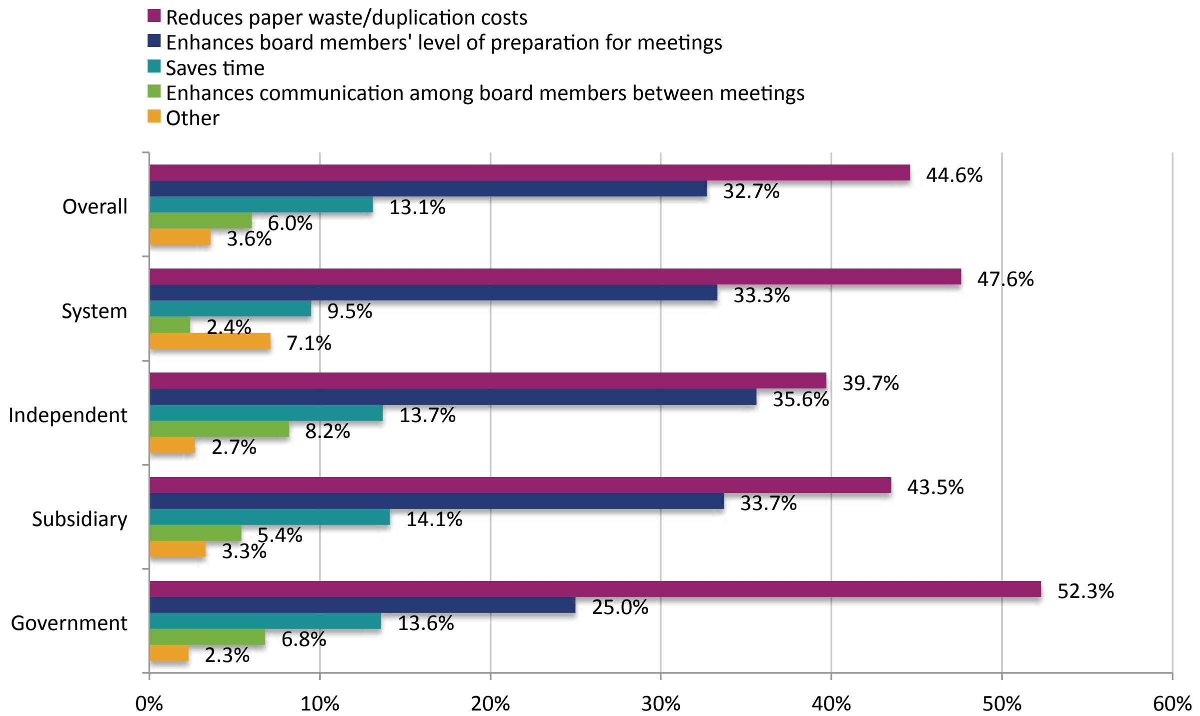


Exhibit 23. Most Important Benefit of Board Portal or Similar Online Tool



Board Culture

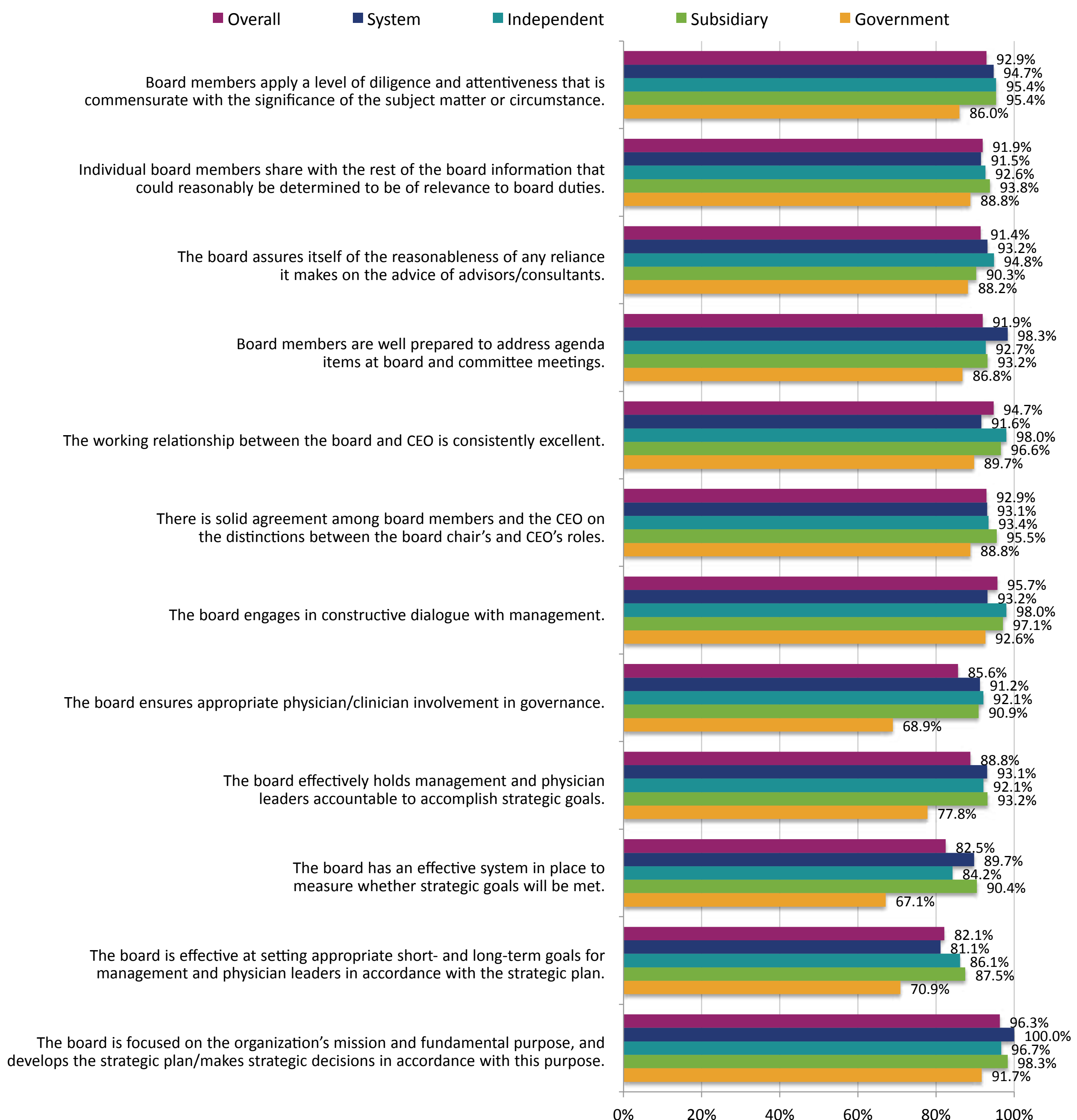
For the first time we asked questions related to aspects of board culture—essentially attempting to determine how well the board is functioning in areas or dynamics that help contribute to overall board performance of the fiduciary duties and core responsibilities (these results are presented in the second half of this report).

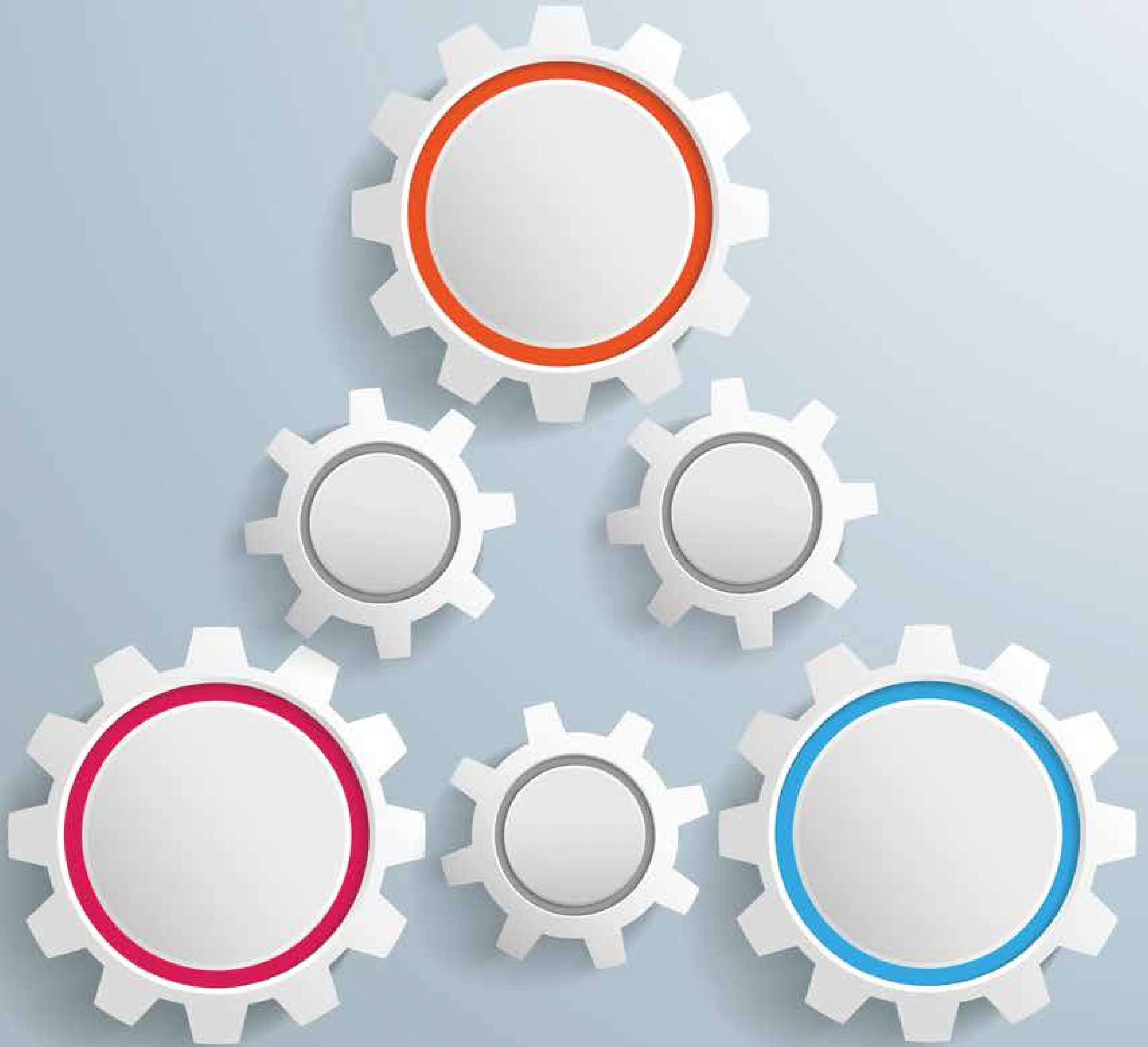
There was relatively strong agreement with most of the statements related to board culture; those with the lowest level of agreement (based on respondents who answered "strongly agree" and "agree") are:

- The board ensures appropriate physician/clinician involvement in governance (86%).
- The board has an effective system in place to measure whether strategic goals will be met (83%).
- The board is effective at setting appropriate short- and long-term goals for management and physician leaders in accordance with the strategic plan (82%).
- The board effectively holds management and physician leaders accountable to accomplish strategic goals (89%).

Not surprisingly, health systems had the highest level of agreement; government-sponsored hospitals had the lowest level of agreement with the statements as a whole and were significantly lower than the other types of organizations (see **Exhibit 24**).

Exhibit 24. Board Culture: Percentage of Respondents Who "Strongly Agree" or "Agree"





EMERGING "BEST" PRACTICES IN CULTURE AND STRUCTURE

Don Seymour, *President, Don Seymour & Associates*

SPECIAL COMMENTARY

Selected results from this year's biennial survey, plus field experience and educated intuition, suggest that many boards are evolving both culturally and structurally—especially system boards. Implicitly, boards are asking themselves, "How can we optimize our working relationships and board organization to best perform our job?"

Cultural Evolution

High-performing boards embrace the knowledge that without the right culture (both in the board and in the organization), they cannot achieve strategic goals. Further they recognize that organizational culture starts at the top, with the board and the CEO. One gets a palpable sense of high-performing culture just sitting through a board meeting in such an organization. The importance of culture is also reflected in the following characteristics.

Board Accountability

High-performing boards regularly assess themselves against others using a valid, third-party assessment tool (such as The Governance Institute's BoardCompass). If they are above the 90th percentile they set new stretch goals; when they have shortcomings, they develop action plans to address them. They also assess individual board member performance before making reappointments, and hold others accountable as well. For example, this year's survey results show that 93% of system boards believe they are effective in holding management and physician leaders accountable for strategic goals (see Exhibit 24). And more system boards (compared with other organizations) use a formal process to evaluate individual board member performance (42% vs. 30% overall). Although there is still much room for improvement, the percentage of system boards that observe this practice has risen by eight percentage points since 2011, the most improvement of any other type of board.

Board Recruitment

Relying on a three-part skill matrix (universal, functional, and other) for guidance, high-performing boards rigorously seek out their successors, striving to find the very best people for the job. When recruiting, rather than shying away from the challenge and time commitment of being a board member, they proudly own it and have the mindset that this is critically important, demanding work but immensely rewarding, likely more so than any other board service. Survey results show that 80% of system boards employ the recommended practice of using competency-based criteria when selecting new members, compared with 57% overall. Increasingly, all boards are utilizing term limits, but systems and their subsidiaries (at 82%) are leading the way (see Exhibit 8). Based on field experience, it can be inferred that high-performing boards are taking a more rigorous approach to recruitment when filling "termed out" seats.

Time Management

Recognizing the importance of this limited resource, high-performing boards maximize their time together, effectively using a rolling, 18-month calendar, a consent agenda (in which items can only be removed and placed on the regular agenda for more discussion *before* the meeting, not during), and a board (not management) operational scorecard they have taken part in developing. They require their chair to use a "heavy gavel" to keep them on point. This year's survey results show that again, system boards are most likely to use a consent agenda (83% compared with 71% overall; see Exhibit 15). It appears boards in general and system boards in particular are increasingly utilizing committees for important work that is then reviewed by the full board. This is especially true for systems, which are much

more likely than other boards to have quality/safety, governance/nominating, finance, and executive compensation committees (see **Table 15**).

One Voice

In each organization there is only one board job description. High-performing boards recognize they are collectively responsible for everything and individually responsible for nothing (except what may be delegated to them by the board). They update job descriptions, set policies, and review committee charters; they set clear expectations for the work allocated to others and they review performance. They place a premium on effective communication within the board, throughout all levels of the organization, among constituencies, and with the community they serve. This is reflected in the survey findings, in which over 90% of respondents indicated the following (see **Exhibit 24**):

- Board members apply a level of diligence and attentiveness commensurate with the significance of the subject matter.
- The working relationship between the board and CEO is consistently excellent.
- The board engages in constructive dialogue with management.

Structural Evolution

Whenever possible, high-performing boards structure themselves to support and enable their culture.

Size

With good intent but mixed results, hospital and system boards have historically adopted the implicit belief that "bigger is better." In a mean twist of fate, however, boards that are too big actually create an unintended consequence—greater authority resides in management and/or the executive committee. How big is too big? Patrick Lencioni, an organizational development expert,[5] provides some insight: *"So many teams I've encountered struggle simply because they're too large. This is a big problem and a common one. A leadership team should be made up with somewhere between three and 12 people, though anything over eight or nine is usually problematic. There is nothing dogmatic about this size limit. It is just a practical reality."*

Is healthcare different? Lencioni doesn't seem to think so and neither do many boards currently in the process of "rightsizing." High-performing boards ask themselves how many people are required to fulfill the board's fiduciary responsibilities, set

5 Author of *The Advantage: Why Organizational Health Trumps Everything Else in Business,* Jossey-Bass, 2012.

strategy and policies, and oversee results. In my experience, these boards are concluding that a smaller board will be more effective, primarily because communication will be enhanced. Yes, there is a lot of work to do, so these boards populate their committees with other community members (not just spreading out the work but also creating a pool of potential board members). While the average board in the survey remains at 13.5 members, with system boards averaging 16.7 members (see **Exhibit 1**), field experience suggests this number will decrease in the near future.

Ex-Officio Members

Some boards accept *ex-officio* members on a *de facto* basis based on board history. High-performing boards no longer do this as a rule without a thoughtful review of the rationale. For example, they rarely permit the medical staff officers to sit *ex-officio* on the board. Instead, they use a skill mix matrix to determine the functions they require and rely on themselves to appoint those most suitable to the role, regardless of *ex officio* or other status. While this issue was not addressed in the survey, field experience supports this premise. One large Midwest system, for example, has only one *ex-officio* board member: the CEO.

Meetings

The Governance Institute and governance experts have long recommended that the full board meet less frequently for longer periods of time, to allow more opportunity for strategic and generative discussions (committees may need to meet more often). High-performing boards are meeting less frequently (every other month or quarterly) and for longer periods of time (four to six hours), to provide an opportunity for a deeper dive on key issues. The board calendar is published at least a year in advance; there is a specified approach to updating/informing anyone who cannot attend a particular meeting. Again, system boards are leading the way in this year's survey results:

- 44% meet four to six times per year, compared with 23% overall (see **Exhibit 14**).
- 25% meet for four hours or more (compared with 6% overall).
- They are the most likely to spend more than half of their meetings discussing strategy and policy (see **Exhibit 18**).

Functional Subsidiaries

There is general agreement within the industry that healthcare providers need to increasingly focus on ambulatory care and population management versus inpatient care. High-performing systems are transitioning their subsidiary boards away from a hospital-centric orientation towards specific functions (e.g., long-term care) and geographic regions. The survey did not specifically query this issue. However it is notable that nearly 70% of system boards specify and document allocation of responsibilities between the parent board and its subsidiary boards (see **Exhibit 28**). Ninety-one percent (91%) indicate that board responsibility and authority are widely understood and accepted both at the parent and subsidiary level. And it is most important to note that the survey results (both this year and in previous years) show some striking parallels between system and subsidiary board practices and performance.

Closing Observations

High-performing boards have adopted an overarching mantra of common sense, fortitude, and discipline. These board members bring their job skills, life experience, and intuition to their board work (not to mention passion). If a clinical, strategic, or operational proposal doesn't make sense they are prepared to insist on a common-sense explanation they can understand. They have the fortitude to speak up and the discipline to stand tall until they have a satisfactory explanation and enough information to make a sound decision. They apply this mantra to themselves and to everyone else in the organization. They are not obstructionist, nor are they mired in operational detail. They listen intently, seeking first to understand, and realize that cooperation and consensus always trump command and control. As they are legally charged to do, they act like prudent fiduciaries.

The survey results show system boards performing higher than other types of boards on many of the recommended practices and board structure issues (but not all—there are some areas where independent and government-sponsored hospitals score as well or better). We know that many systems have more financial strength, more clout in the marketplace, and may be more attractive organizations to qualified board members. However, it is important to emphasize that most boards can find excellent directors who are motivated to improve the organization. All boards have the ability to assess their structure, culture, and governance practices and determine the key missing pieces of the puzzle, in order to move into the category of high-performing board. All boards have the capability to apply common sense, fortitude, and discipline, and we hope that these survey results serve as a strong motivator in this regard.

Governance Trends

This year's report marks the first potential opportunity to see movement at the governance level with respect to major health reform initiatives. Eighty-nine percent (89%) of respondents are making changes of some kind to prepare for population health; and 93% are making changes of some kind to prepare for value-based payments. This indicates some movement on the part of the nation's hospitals and health systems to address problems with quality and cost in the care delivery system. However, most organizations have not made any changes to the board or management team in preparation of these care delivery system changes. (See **Exhibits 25**, **25a**, **26**, and **26a**.)

Exhibit 25. Changes in Board Structure to Prepare for Population Health Management *(All Respondents) (Respondents selected more than one answer.)*

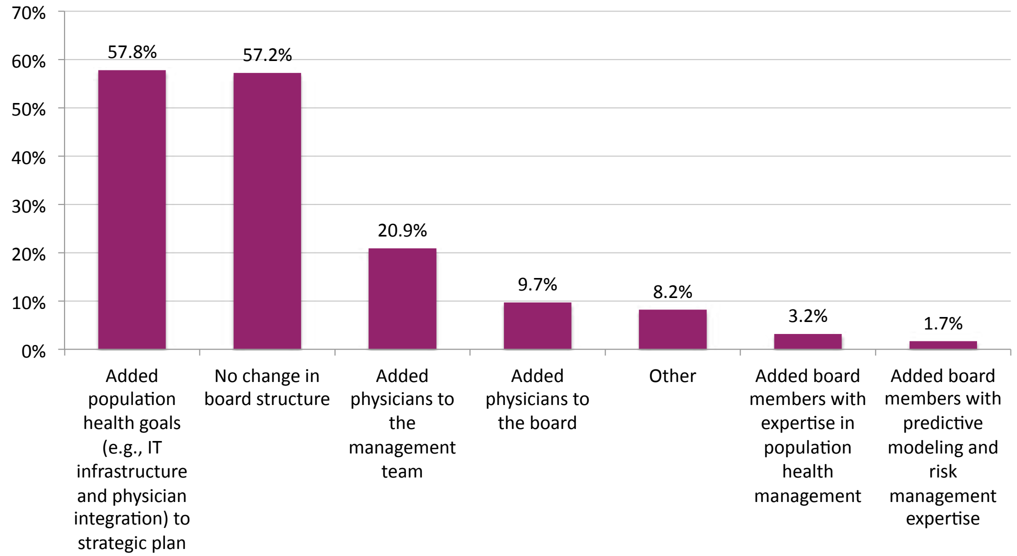


Exhibit 25a. Changes in Board Structure to Prepare for Population Health Management by Organization Type

	Overall	System	Independent	Subsidiary	Government
No change in board structure	57.2%	37.5%	63.2%	56.4%	61.1%
Added population health goals (e.g., IT infrastructure and physician integration) to strategic plan	57.8%	75.0%	57.1%	62.0%	44.2%
Added board members with expertise in population health management	3.2%	5.4%	0.8%	5.5%	1.8%
Added board members with predictive modeling and risk management expertise	1.7%	3.6%	0.8%	3.1%	0.0%
Added physicians to the board	9.7%	17.9%	8.3%	10.4%	6.2%
Added physicians to the management team	20.9%	41.1%	15.8%	26.4%	8.8%
Other	8.2%	12.5%	6.0%	8.6%	8.0%

0% 10% 20% 30% 40% 50% 60% 70% 80%

Population Health Management

- 58% of respondents have added population health goals (e.g., IT infrastructure and physician integration) to the strategic plan.
- 57% of respondents have not made any changes to the board or management team to prepare for population health management.
- 21% of respondents have added physicians to the management team to prepare for population health management.
- Health systems have shown the most movement in this regard: 75% have added population health goals to the strategic plan and 41% have added physicians to the management team to help prepare for population health. In contrast, government-sponsored hospitals are the least likely to have made any changes in this regard.

Exhibit 26. Changes in Board Structure to Prepare for Value-Based Payments
(All Respondents) (Respondents selected more than one answer.)

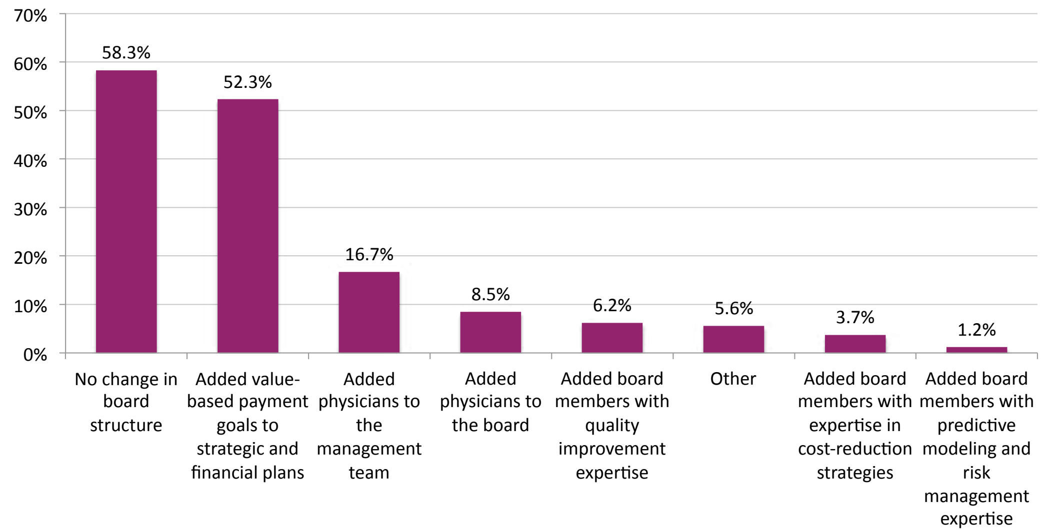


Exhibit 26a. Changes in Board Structure to Prepare for Value-Based Payments by Organization Type

	Overall	System	Independent	Subsidiary	Government
No change in board structure	58.3%	37.0%	62.9%	55.8%	66.1%
Added value-based payment goals to strategic and financial plans	52.3%	70.4%	52.1%	57.0%	37.3%
Added board members with quality improvement expertise	6.2%	7.4%	6.4%	9.9%	0.0%
Added board members with predictive modeling and risk management expertise	1.2%	3.7%	0.7%	1.7%	0.0%
Added board members with expertise in cost-reduction strategies	3.7%	5.6%	1.4%	7.0%	0.8%
Added physicians to the board	8.5%	11.1%	5.7%	12.8%	4.2%
Added physicians to the management team	16.7%	37.0%	12.1%	20.3%	7.6%
Other	5.6%	9.3%	4.3%	5.2%	5.9%

0% 10% 20% 30% 40% 50% 60% 70% 80%

Value-Based Payments

- 58% of respondents have not made any changes to the board or management team to prepare for value-based payments.
- 52% of respondents have added value-based payment goals to strategic and financial plans.
- 17% of respondents have added physicians to the management team to prepare for value-based payments.
- Health systems also show the most movement in this regard: 70% have added value-based payment goals to strategic and financial plans and 37% have added physicians to the management team to help prepare for value-based payments. Again, government-sponsored hospitals are the least likely to have made any changes in this regard.

System Governance Structure and Allocation of Responsibility

This year we added questions for system boards regarding the governance structure of the system overall, whether the system board approves a document or policy specifying allocation of responsibility and authority between system and local boards, and whether that association of responsibility and authority is widely understood and accepted by both local and system-level leaders.

Governance Structure

- Most systems (44%) have a system board as well as separate local/subsidiary boards with fiduciary responsibilities.
- The next largest group (35%) includes systems with only one board at the system level that performs fiduciary and oversight responsibilities for all hospitals in the system.
- 17% have one system board and separate local/subsidiary advisory boards without fiduciary responsibilities.

These findings were generally consistent throughout systems of all sizes, with one exception: for the largest systems (over 2,000 beds), 58% have one system board with separate local/subsidiary boards that also have fiduciary responsibilities. The largest group with only one parent board serving the entire system was for systems with 300–499 beds (50%). (See **Exhibit 27**.)

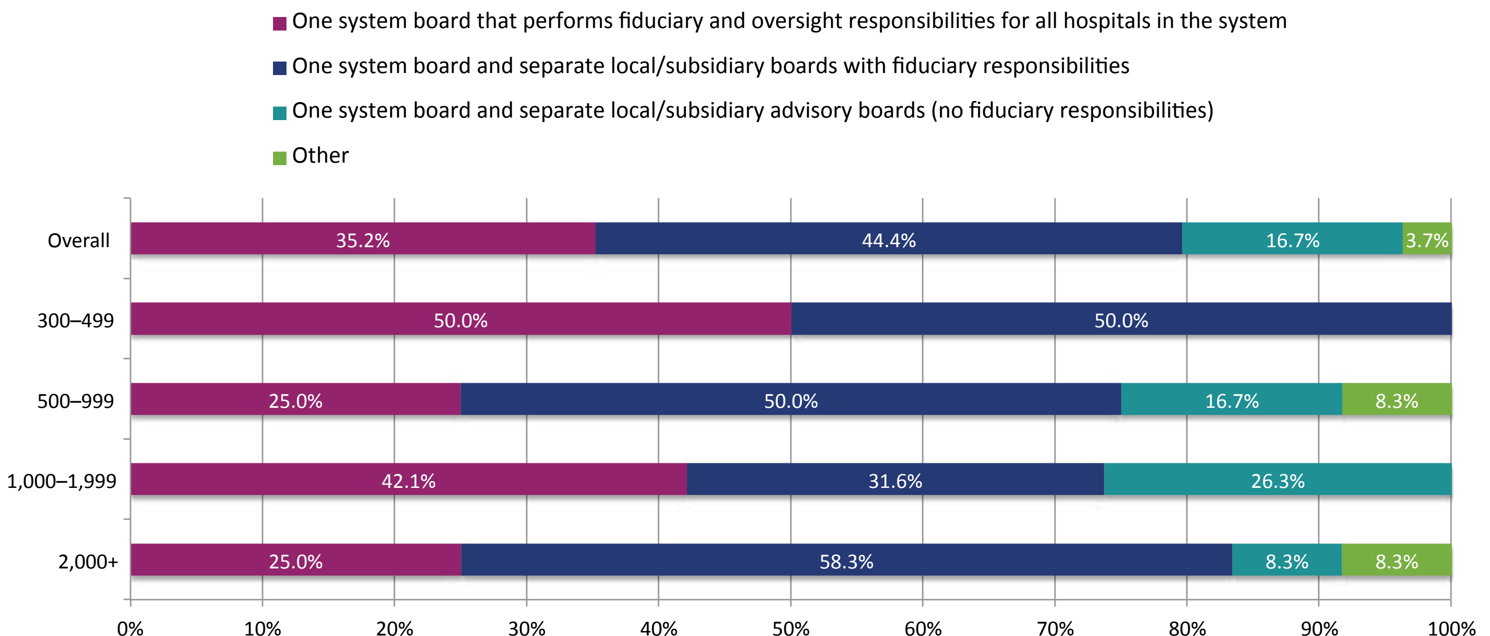
System Board Approval of Document/ Policy Specifying Allocation of Responsibility and Authority

Overall, 70% of system boards approve a document or policy specifying allocation of responsibility and authority between system and local boards. Systems with 500–999 beds are the most likely to approve such a document or policy (91%); smaller systems (300–499 beds) are less likely to have such a document or policy (38%). (See **Exhibit 28**.)

Association of Responsibility/ Authority Understood and Accepted

Overall, 91% of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders. (This includes all respondents, regardless of whether they indicated previously that they have a document or policy specifying responsibility and authority.) One-hundred percent (100%) of systems with 300–499 beds answered "yes" to this question; the lowest percentage to respond "yes" was the largest systems (over 2,000 beds)—83%. (See **Exhibit 29**.)

Exhibit 27. System Governance Structure by Organization Size *(# of Beds)*



Subsidiary Hospitals: Allocation of Decision-Making Authority

Each year we ask subsidiary hospitals to tell us whether they retain full authority, share authority, or whether their higher authority (usually the system board) retains responsibility for various board responsibilities. We were not able to report the results in 2011 due to a small sample size. **Table 19** shows a comparison of 2013 and 2009 results (the last reported year). Most of the movement between the two reporting periods is towards the middle—shared authority (fewer subsidiaries have full authority at the local level, and fewer system boards retain full authority at the system level).

Significant increases in the rate of hospital consolidation and merger/acquisition activity since 2009, as well as research by The Governance Institute, indicates that systems are or will be moving towards more of a corporate/operating company model (retaining more authority at the corporate/system level to standardize processes across the system in order to have more control over quality and cost).[6] The 2013 results for these questions do not reflect this movement directly (although overall survey results indicate a strong relationship between system and subsidiary board performance/activities). However, we are aware of an increase in systems holding their subsidiary boards accountable to reaching certain organizational goals, and thus subsidiary boards having some "ownership" of the issue at the local level. It is possible that this affected this year's results (i.e., subsidiaries indicating that they share responsibility due to their being held accountable by the system to reach goals). We will track this in future reporting years to make a more accurate distinction in this regard.

6 See Larry Stepnick, *System–Subsidiary Board Relations in an Era of Reform: Best Practices in Managing the Evolution to and Maintaining "Systemness"* (white paper), The Governance Institute, Fall 2011, pp. 5–6.

Exhibit 28. System Board Approves a Document or Policy Specifying Allocation of Responsibility and Authority between System and Local Boards *(by Organization Size)*

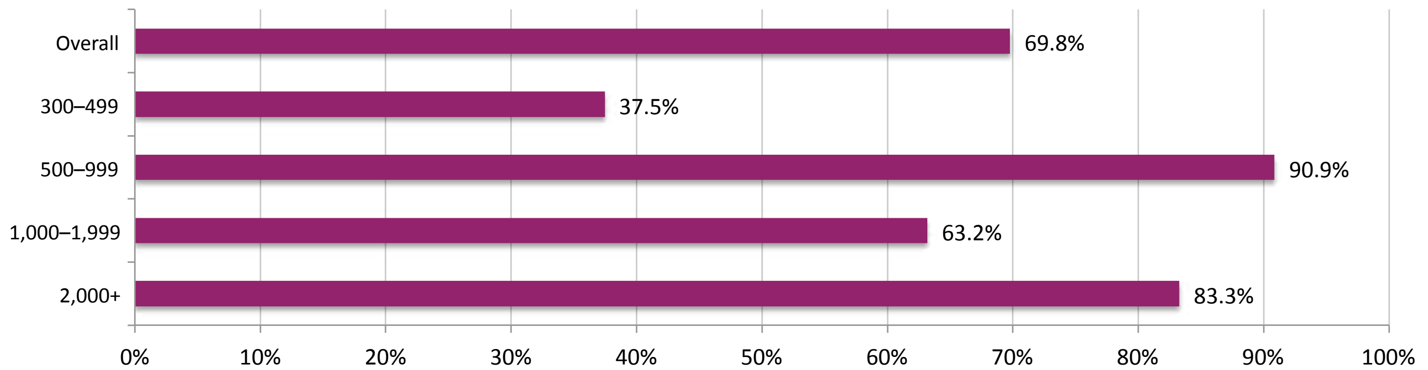


Exhibit 29. Association of Responsibility and Authority Widely Understood and Accepted by Both Local and System-Level Leaders *(by Organization Size)*

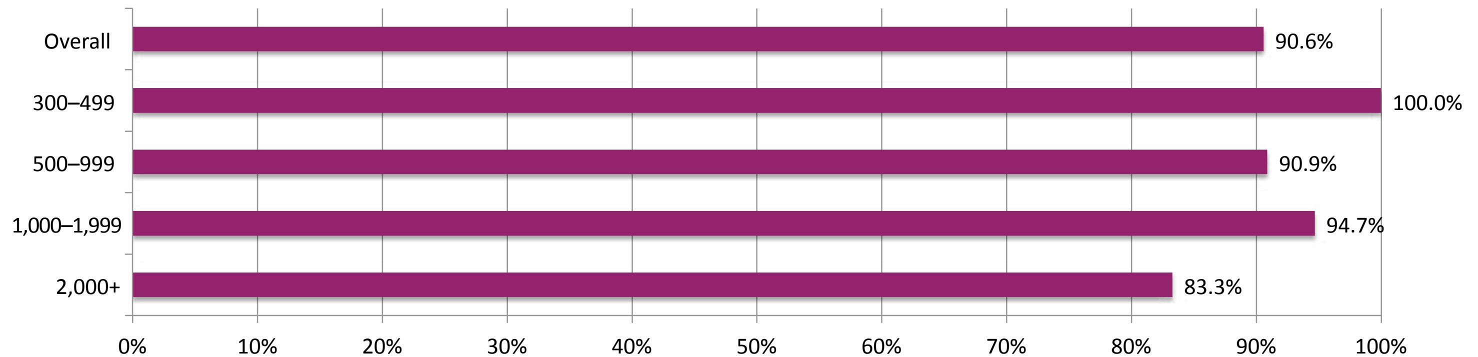


Table 19. Allocation of Decision-Making Authority 2013 and 2009 *(Last Reported Year)*

	All Subsidiary Hospitals		By Organization Size (# of beds)							
			<100		100–299		300–499		500+	
	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009
Total number of respondents in each category	182	133	56	40	65	57	35	24	25	12
To whom is your board accountable?										
Total responding to this question (some selected more than one answer)	*109*	*110*	*31*	*31*	*40*	*47*	*21*	*23*	*17*	*9*
Board or management of a parent holding company	21.1%	21.8%	6.5%	22.6%	35.0%	25.5%	9.5%	17.4%	29.4%	11.1%
Board or management of a health system	77.1%	73.6%	83.9%	77.4%	70.0%	66.0%	85.7%	78.3%	70.6%	88.9%
Religious order or organization	9.2%	17.3%	12.9%	12.9%	5.0%	19.1%	14.3%	21.7%	5.9%	11.1%
Unit of state, county, or local government	0.8%	NA	0.0%	NA	0.0%	NA	0.0%	NA	5.9%	NA
Other	0.9%	2.7%	0.0%	0.0%	2.5%	6.4%	0.0%	0.0%	0.0%	0.0%
ROLE OF THE HIGHER BOARD OR AUTHORITY IN THE FOLLOWING DECISIONS FOR YOUR ORGANIZATION										
Setting our organization's strategic goals										
Total responding to this question	*80*	*110*	*27*	*31*	*31*	*47*	*11*	*23*	*11*	*9*
Our board retains responsibility	26.3%	31.8%	22.2%	25.8%	19.4%	38.3%	45.5%	30.4%	36.4%	22.2%
Our board shares responsibility	62.5%	57.3%	74.1%	64.5%	61.3%	51.1%	45.5%	56.5%	54.5%	66.7%
Higher authority retains responsibility	11.3%	10.9%	3.7%	9.7%	19.4%	10.6%	9.1%	13.0%	9.1%	11.1%
Determining our organization's capital and operating budgets										
Total responding to this question	*80*	*110*	*27*	*31*	*31*	*47*	*11*	*23*	*11*	*9*
Our board retains responsibility	13.8%	11.8%	22.2%	3.2%	3.2%	19.1%	9.1%	4.3%	27.3%	22.2%
Our board shares responsibility	56.3%	57.3%	51.9%	61.3%	64.5%	44.7%	45.5%	74.0%	54.5%	66.7%
Higher authority retains responsibility	30.0%	30.9%	25.9%	35.5%	32.3%	36.2%	45.5%	21.7%	18.2%	11.1%
Setting our organization's quality and safety goals										
Total responding to this question	*80*	*110*	*27*	*31*	*31*	*46*	*11*	*23*	*11*	*9*
Our board retains responsibility	37.5%	40.4%	55.6%	29.0%	22.6%	50.0%	27.3%	39.1%	45.5%	33.3%
Our board shares responsibility	51.3%	50.4%	33.3%	51.6%	64.5%	43.5%	63.6%	56.6%	45.5%	66.7%
Higher authority retains responsibility	11.3%	9.2%	11.1%	19.4%	12.9%	6.5%	9.1%	4.3%	9.1%	0.0%
Setting our organization's customer service goals										
Total responding to this question	*80*	*110*	*27*	*31*	*31*	*47*	*11*	*23*	*11*	*9*
Our board retains responsibility	38.8%	51.8%	51.9%	35.5%	29.0%	59.6%	27.3%	52.2%	45.5%	66.7%
Our board shares responsibility	47.5%	38.2%	37.0%	48.4%	54.8%	29.8%	54.5%	43.5%	45.5%	33.3%
Higher authority retains responsibility	13.8%	10.0%	11.1%	16.1%	16.1%	10.6%	18.2%	4.3%	9.1%	0.0%
Approving our organization's medical staff appointments										
Total responding to this question	*80*	*109*	*27*	*31*	*31*	*47*	*11*	*22*	*11*	*9*
Our board retains responsibility	93.8%	96.3%	88.9%	96.8%	96.8%	100.0%	90.9%	86.4%	100.0%	100.0%
Our board shares responsibility	5.0%	2.8%	7.4%	3.2%	3.2%	0.0%	9.1%	9.1%	0.0%	0.0%
Higher authority retains responsibility	1.3%	0.9%	3.7%	0.0%	0.0%	0.0%	0.0%	4.5%	0.0%	0.0%
Approving/removing our organization's chief executive										
Total responding to this question	*80*	*109*	*27*	*31*	*31*	*46*	*11*	*23*	*11*	*9*
Our board retains responsibility	11.3%	5.5%	14.8%	9.7%	9.7%	2.2%	0.0%	0.0%	18.2%	22.2%
Our board shares responsibility	56.3%	62.4%	44.4%	67.7%	61.3%	65.2%	63.6%	56.5%	63.6%	44.5%
Higher authority retains responsibility	32.5%	32.1%	40.7%	22.6%	29.0%	32.6%	36.4%	43.5%	18.2%	33.3%

	All Subsidiary Hospitals		By Organization Size (# of beds) <100		100–299		300–499		500+	
	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009
Total number of respondents in each category	182	133	56	40	65	57	35	24	25	12
Evaluating our organization's chief executive										
Total responding to this question	*79*	*109*	*27*	*31*	*31*	*46*	*10*	*23*	*11*	*9*
Our board retains responsibility	22.8%	15.6%	22.2%	22.6%	22.6%	15.2%	20.0%	4.3%	27.3%	22.2%
Our board shares responsibility	69.6%	72.5%	74.1%	67.7%	64.5%	78.3%	80.0%	69.6%	63.6%	66.7%
Higher authority retains responsibility	7.6%	11.9%	3.7%	9.7%	12.9%	6.5%	0.0%	26.1%	9.1%	11.1%
Determining/approving executive compensation										
Total responding to this question	*79*	*109*	*27*	*40*	*31*	*47*	*10*	*23*	*11*	*9*
Our board retains responsibility	19.0%	13.8%	18.5%	30.0%	22.6%	21.3%	20.0%	13.0%	9.1%	11.1%
Our board shares responsibility	36.7%	33.9%	29.6%	3.3%	35.5%	23.4%	40.0%	39.2%	54.5%	55.6%
Higher authority retains responsibility	44.3%	52.3%	51.9%	40.0%	41.9%	55.3%	40.0%	47.8%	36.4%	33.3%
Electing/appointing our organization's board members										
Total responding to this question	*79*	*110*	*26*	*31*	*31*	*47*	*11*	*23*	*11*	*9*
Our board retains responsibility	21.5%	20.0%	34.6%	22.6%	9.7%	19.1%	18.2%	13.0%	27.3%	33.3%
Our board shares responsibility	57.0%	50.9%	50.0%	61.3%	74.2%	53.2%	54.5%	43.5%	27.3%	22.2%
Higher authority retains responsibility	21.5%	29.1%	15.4%	16.1%	16.1%	27.7%	27.3%	43.5%	45.5%	44.5%
Selecting our organization's audit firm										
Total responding to this question	*79*	*108*	*26*	*31*	*31*	*45*	*11*	*23*	*11*	*9*
Our board retains responsibility	12.7%	9.3%	11.5%	9.7%	9.7%	13.3%	9.1%	4.3%	27.3%	0.0%
Our board shares responsibility	17.7%	15.7%	19.2%	9.7%	16.1%	15.6%	18.2%	13.1%	18.2%	44.4%
Higher authority retains responsibility	69.6%	75.0%	69.2%	80.6%	74.2%	71.1%	72.7%	82.6%	54.5%	55.6%
Establishing our organization's corporate compliance program										
Total responding to this question	*80*	*110*	*27*	*31*	*31*	*47*	*11*	*23*	*11*	*9*
Our board retains responsibility	17.5%	18.2%	22.2%	19.4%	19.4%	14.8%	9.1%	17.4%	9.1%	33.3%
Our board shares responsibility	40.0%	38.2%	33.3%	29.0%	35.5%	42.6%	72.7%	43.5%	36.4%	33.3%
Higher authority retains responsibility	42.5%	43.6%	44.4%	51.6%	45.2%	42.6%	18.2%	39.1%	54.5%	33.3%
Calculating/measuring our organization's community benefit										
Total responding to this question	*79*	*109*	*26*	*30*	*31*	*47*	*11*	*23*	*11*	*9*
Our board retains responsibility	44.3%	39.4%	34.6%	40.0%	38.7%	38.3%	54.5%	39.1%	72.7%	44.4%
Our board shares responsibility	41.8%	45.0%	50.0%	46.7%	41.9%	46.8%	45.5%	39.1%	18.2%	44.4%
Higher authority retains responsibility	13.9%	15.6%	15.4%	13.3%	19.4%	14.9%	0.0%	21.8%	9.1%	11.2%
Setting community benefit goals										
Total responding to this question	*78*	*NA*	*26*	*NA*	*31*	*NA*	*10*	*NA*	*11*	*NA*
Our board retains responsibility	42.3%	NA	38.5%	NA	51.6%	NA	20.0%	NA	45.5%	NA
Our board shares responsibility	48.7%	NA	61.5%	NA	32.3%	NA	80.0%	NA	36.4%	NA
Higher authority retains responsibility	9.0%	NA	0.0%	NA	16.1%	NA	0.0%	NA	18.2%	NA
Establishing our board education and orientation programs										
Total responding to this question	*79*	*110*	*27*	*31*	*31*	*47*	*10*	*23*	*11*	*9*
Our board retains responsibility	67.1%	70.0%	70.4%	71.0%	71.0%	70.2%	50.0%	60.9%	63.6%	88.9%
Our board shares responsibility	31.6%	25.5%	29.6%	22.5%	25.8%	23.4%	50.0%	39.1%	36.4%	11.1%
Higher authority retains responsibility	1.3%	4.5%	0.0%	6.5%	3.2%	6.4%	0.0%	0.0%	0.0%	0.0%

GOVERNANCE PRACTICES: FIDUCIARY DUTIES AND CORE RESPONSIBILITIES

The Survey

Each survey respondent reviewed 31 recommended practices for fiduciary duties of care, loyalty, and obedience, and 64 recommended practices for core responsibilities (quality oversight, financial oversight, strategic direction, board development, management oversight, and community benefit and advocacy), and then selected from the following choices in terms of board observance/adoption of each practice:

- Yes, the board generally follows this practice.
- No, the board currently does not follow this practice, but is considering it and/or is working on it.
- No, the board does not follow this practice and is not considering it.

After completing each section, respondents then evaluated their board's overall performance for that specific fiduciary duty or core responsibility on a five-point scale ranging from "excellent" to "poor."

Performance Results

Overall performance composite scores for 2013 are slightly higher than in 2011 with the exception of financial oversight, which is slightly lower than in 2011 (although it still receives the highest performance score overall). Community benefit and advocacy shows the most improvement between 2011 and 2013; duty of obedience also improved substantially (see **Table 20**).

A history of performance ranking by duty and core responsibility appears in **Table 21**. The breakdown of responses for overall performance in each duty and core responsibility appears in **Exhibit 30**.

Table 20. Overall Performance—Composite Score Ranking *(5=Excellent)*

Performance Rank	Fiduciary Duties and Core Responsibilities	Weighted Average 2013	2011	2009	2007
1	Financial Oversight	4.50	4.52	4.51	4.35
2	Duty of Care	4.45	4.42	4.43	4.33
3	Duty of Loyalty	4.42	4.41	4.37	4.18
4	Duty of Obedience	**4.33**	**4.23**	4.24	4.08
5	Quality Oversight	4.29	4.23	4.23	4.08
6	Management Oversight	4.26	4.23	4.28	4.16
7	Strategic Direction	4.12	4.05	4.05	3.95
8	Community Benefit & Advocacy	**3.91**	**3.62**	3.64	3.44
9	Board Development	3.76	3.71	3.74	3.68

Note: areas showing the greatest improvement since 2011 are in bold.

Table 21. Overall Performance—Ranked by Composite Score

Fiduciary Duties and Core Responsibilities	Performance Rank 2013	2011	2009	2007	2005
Financial Oversight	1	1	1	1	1
Duty of Care	2	2	2	2	2
Duty of Loyalty	3	3	3	3	3
Duty of Obedience	4	4*	5	6	4
Quality Oversight	5	5*	6	5	6
Management Oversight	6	6*	4	4	5
Strategic Direction	7	7	7	7	7
Community Benefit & Advocacy	8	9	9	9	9
Board Development	9	8	8	8	8

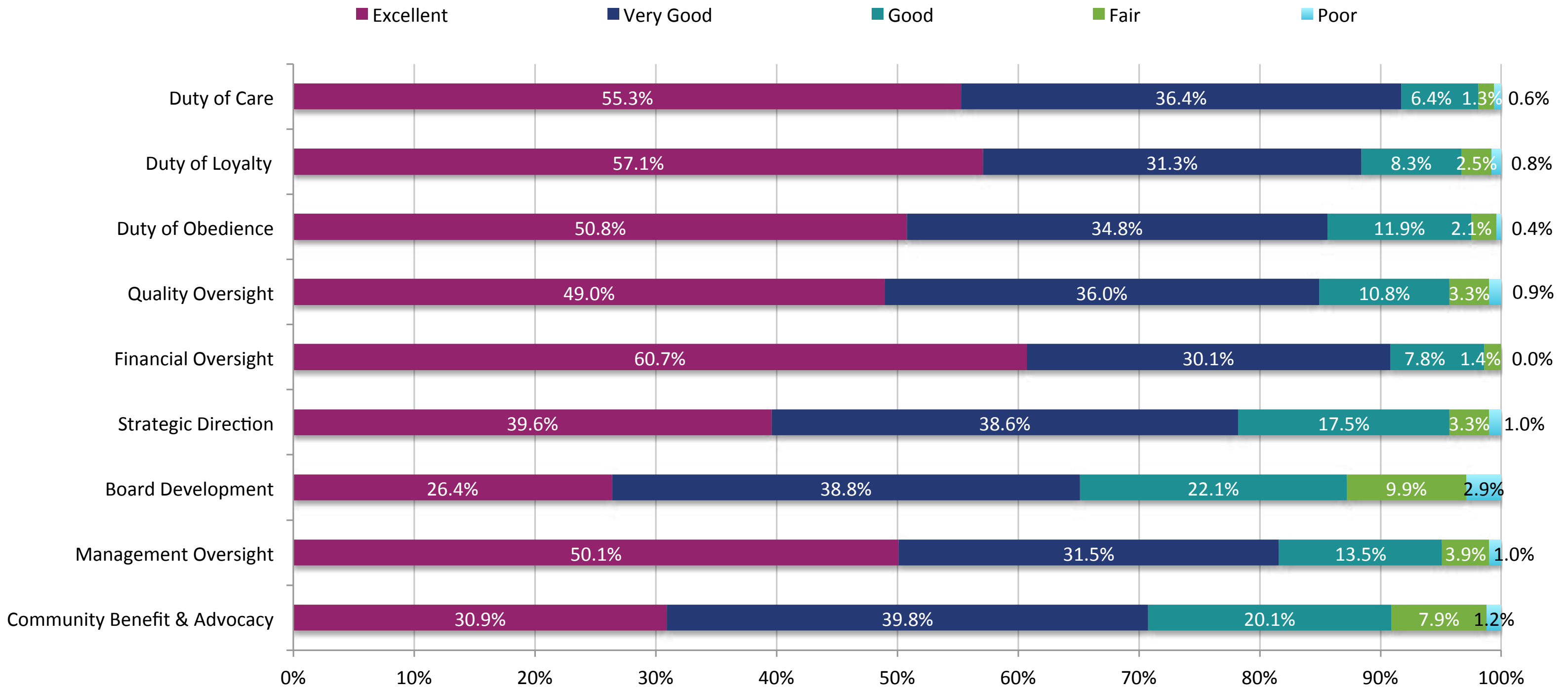
*Performance scores for these three oversight areas were tied in 2011 (see Table 20).

Board Performance across Types of Organizations

When comparing the "top two" ratings (percent of respondents rating their boards "excellent" or "very good") across the 2013, 2011, 2009, and 2007 reporting periods, there was overall improvement in performance from 2007 to 2009; scores in 2011 were slightly lower than 2009. This year's performance ratings vary more significantly compared with previous years depending on the category. The most significant improvement can be seen in community benefit and advocacy; there has been a linear decrease in the "top two" ratings for financial oversight performance since 2009. (See **Exhibit 31**.)

Table 22 shows the breakdown of "top two" ratings by type of organization for 2011 and 2013. Independent hospitals show improvement in all categories, with significant improvement in strategic direction, board

Exhibit 30. Overall Board Performance



development, and community benefit and advocacy. Systems show a decline in performance ratings in the three fiduciary duties, board development, management oversight, and community benefit. However, systems show a significant improvement (and the highest score) in performance of quality oversight. Government-sponsored hospitals showed a decline in performance for the duties of care and loyalty, quality oversight, and financial oversight, but an improvement in board development and community benefit and advocacy.

Table 23 shows performance results by composite score (5 = "excellent").

The remainder of this section of the report briefly presents the adoption prevalence of the recommended practices for all respondents. Significant variation is noted, when relevant, between and among different organization types. All responses by frequency (percentages) appear in **Appendix 2**.

Table 22. Percent of Respondents Who Rated Their Board as "Excellent" or "Very Good" 2013 vs. 2011 *(Overall and by Organization Type)*

Fiduciary Duties and Core Responsibilities*	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Duty of Care	92%	92%	93%	**99%**	94%	93%	**96%**	93%	83%	85%
Financial Oversight	91%	93%	**98%**	**97%**	95%	95%	93%	93%	81%	90%
Duty of Loyalty	88%	89%	92%	**95%**	92%	88%	**94%**	**94%**	76%	81%
Duty of Obedience	86%	83%	93%	**96%**	**91%**	83%	88%	90%	73%	73%
Quality Oversight	85%	83%	**95%**	89%	88%	83%	90%	**91%**	71%	74%
Management Oversight	82%	81%	**91%**	**96%**	86%	82%	83%	82%	70%	71%
Strategic Direction	78%	75%	**95%**	**91%**	81%	76%	83%	81%	61%	62%
Community Benefit & Advocacy	71%	56%	**88%**	**79%**	74%	52%	**79%**	66%	49%	41%
Board Development	65%	60%	**77%**	**86%**	66%	56%	71%	70%	51%	45%

*Highest ratings are in **bold**.

Exhibit 31. Overall Board Performance since 2007
(Percentage of Respondents Rating Their Board as "Excellent" or "Very Good")

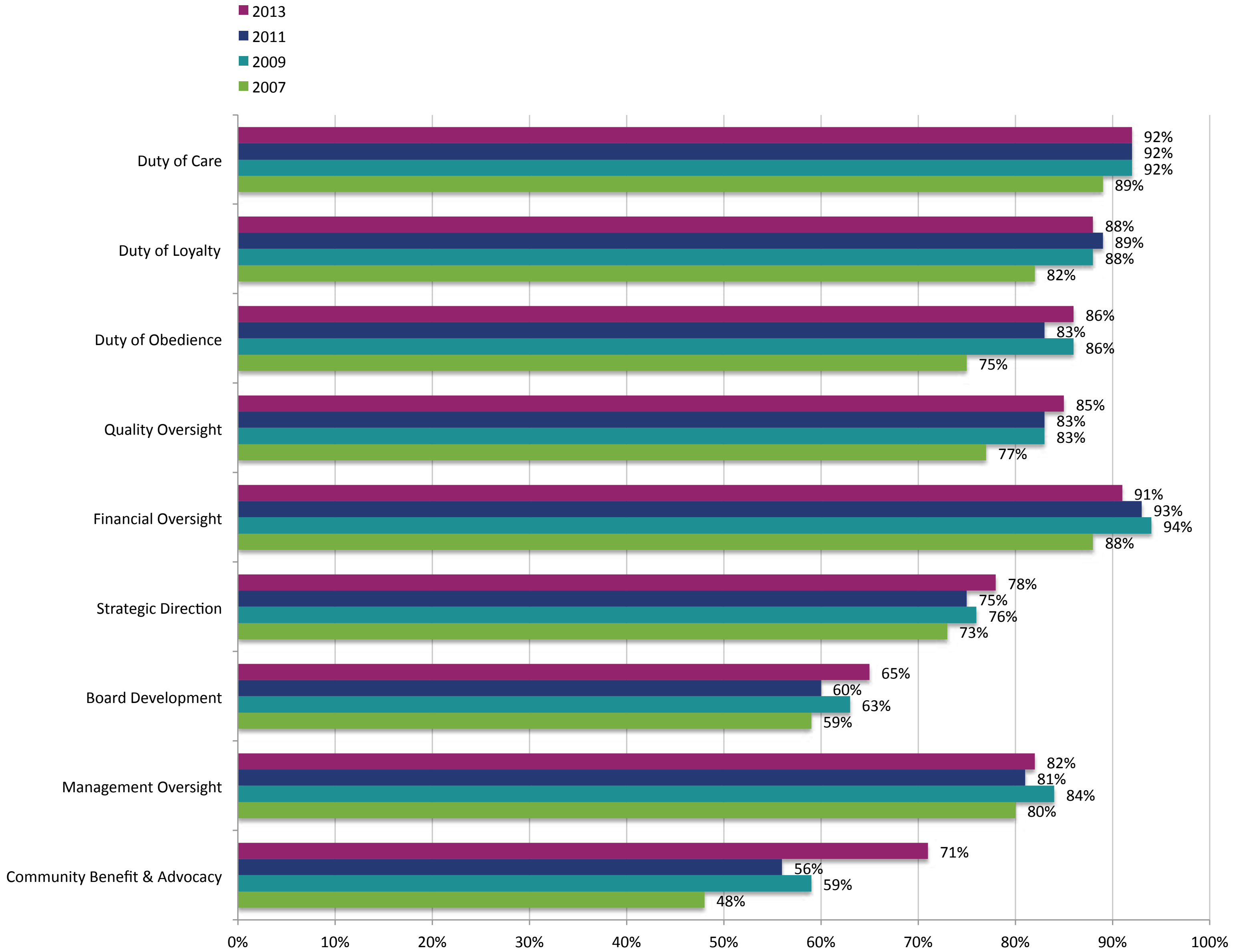


Table 23. Board Performance Composite Scores 2013 vs. 2011
(Scale: Excellent = 5; Very good = 4; Good = 3; Fair = 2; Poor = 1. Blue boxes = significant improvement; orange boxes = decline)

Fiduciary Duties and Core Responsibilities	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	2013	2011	2013	2011	2013	2011	2013	2011
Financial Oversight	4.50	4.52	4.86	4.84	4.59	4.55	4.53	4.54	4.20	4.32
Duty of Care	4.45	4.42	4.66	4.78	4.49	4.40	4.55	4.54	4.17	4.16
Duty of Loyalty	4.42	4.41	4.75	4.70	4.46	4.41	4.56	4.54	4.04	4.17
Duty of Obedience	4.33	4.23	4.63	4.69	4.41	4.20	4.42	4.37	4.01	3.96
Quality Oversight	4.29	4.23	4.57	4.52	4.35	4.19	4.43	4.46	3.90	3.96
Management Oversight	4.26	4.23	4.71	4.79	4.37	4.26	4.32	4.25	3.86	3.89
Strategic Direction	4.12	4.05	4.48	4.53	4.19	3.99	4.26	4.21	3.71	3.77
Community Benefit & Advocacy	3.91	3.62	4.26	4.25	3.99	3.52	4.07	3.89	3.47	3.25
Board Development	3.76	3.71	4.14	4.34	3.79	3.64	3.90	3.99	3.36	3.29

Fiduciary Duties and Core Responsibilities

Fiduciary Duties

Under the laws of most states, directors of not-for-profit corporations are responsible for the management of the business and affairs of the corporation. Directors must direct the organization's officers and govern the organization's efforts in carrying out its mission. In fulfilling their responsibilities, the law requires directors to exercise their fundamental duty of oversight. The duties of care, loyalty, and obedience describe the manner in which directors must carry out their fundamental duty of oversight.

Duty of Care: The duty of care requires board members to have knowledge of all reasonably available and pertinent information before taking action. Directors must act in good faith, with the care of an ordinarily prudent person in similar circumstances, and in a manner he or she reasonably believes to be in the best interest of the organization.

Duty of Loyalty: The duty of loyalty requires board members to discharge their duties unselfishly, in a manner designed to benefit only the corporate enterprise and not board members personally. It incorporates the duty to disclose situations that may present a potential for conflict with the corporation's mission as well as protection of confidential information.

Duty of Obedience: The duty of obedience requires board members to ensure that the organization's decisions and activities adhere to its fundamental corporate purpose and charitable mission as stated in its articles of incorporation and bylaws. This year, we added practices on the board's review of its committee structure and the organization's structure, the conflict review process, and governance assignment for risk management oversight.

Core Responsibilities

The board sets policy, determines the organization's strategic direction, and oversees organizational performance. These responsibilities require the board to make and oversee decisions that move the organization along the desired path to deliver the best and most needed healthcare services to its community. The board accomplishes its responsibilities through oversight—that is, monitoring decisions and actions to ensure they comply with policy and produce intended results. Management and the medical staff are accountable to the board for the decisions they make and the actions they undertake. Proper oversight ensures this accountability.

The six core responsibilities of hospital and health system boards are:

1. **Quality oversight:** Boards have a legal, ethical, and moral obligation to keep patients safe and to ensure they receive the highest quality of care.
2. **Financial oversight:** Boards must protect and enhance their organization's financial resources, and must ensure that these resources are used for legitimate purposes and in legitimate ways.
3. **Strategic direction:** Boards are responsible for envisioning and formulating organizational direction by confirming the organization's mission is being fulfilled, articulating a vision, and specifying goals that result in progress toward the organization's vision.
4. **Board development:** Boards must assume responsibility for effective and efficient performance through ongoing assessment, development, discipline, and attention to improvement.
5. **Management oversight:** Boards are responsible for ensuring high levels of executive management performance and consistent, continuous leadership.
6. **Community benefit and advocacy:** Boards must engage in a full range of efforts to reinforce the organization's grounding in their communities and must strive to truly understand and meet community needs. This is the second year in which we added practices in this area in response to new requirements in the Affordable Care Act.

Recommended Practices

We have characterized the board practices in the survey (shown in the exhibits throughout this section) as "recommended" rather than "best" because, as many of our members have noted, each one has a specific application within each organization. Some are not applicable to some organizations; some will not fit the organization's culture and there may be other practices—not listed here—that are more appropriate; some may work with a board in the future but not at the time of the survey; and so forth.

This list represents what we believe are important "bedrock" practices for effective governance—and, as a result, an effective, successful organization. Again, some may not be relevant for some organizations, but *most are,* and most should be adopted by healthcare boards.

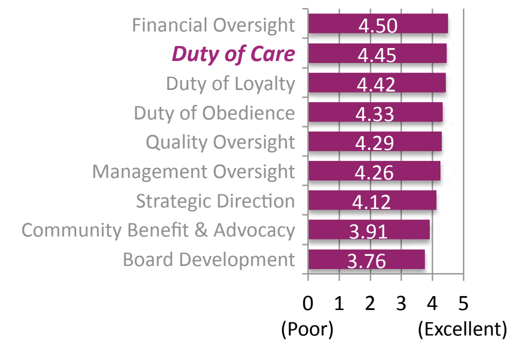
OVERVIEW OF RESULTS

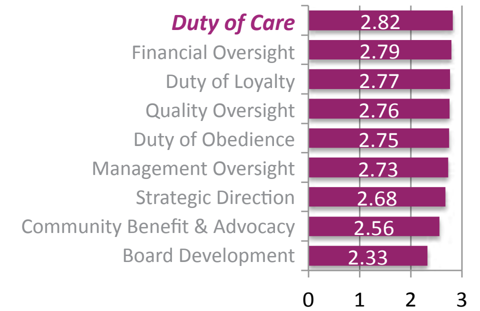
FOR MOST PRACTICES, ADOPTION IS WIDESPREAD. VARIATIONS AMONG TYPES of organizations are small and are noted here for general information only. For detail, please see **Appendices 2** and **3**. After the overview below, we present an analysis of the results in the next section.

READER'S GUIDE REMINDER: RESULTS IN THIS SECTION ARE REPORTED AS COMPOSITE scores—essentially, a weighted average of responses. There are two scales used in this section: 1) an adoption scale (whether the practices have been adopted or not, a scale of 1–3), and 2) a performance scale of 1–5. The performance ratings are for the overall performance in given area, not for the individual board practices.

Duty of Care—Key Points

- CEOs gave boards' performance in duty of care the second highest performance score (4.45 out of 5).
- Duty of care ranks first in adoption of recommended practices (it ranked 2nd in 2011).
- The duty of care practices appear to be widely adopted across all types of organizations, and the prevalence of adoption for all practices is higher or slightly higher than in 2011.
- The lowest-scoring practice under the duty of care in 2011 (The board ensures effective committee structure by updating committee charters annually; with an adoption score of 2.28 out of 3.00) was reworded to be more specific in 2013 (refer to **Exhibit 32**) and thus the adoption of this practice shows a significant increase *(this should be considered an indirect comparison).*
- The practice showing the most increase in adoption from 2011 is: The board receives important background materials within sufficient time to prepare for meetings. Government-sponsored hospitals show the highest increase in adoption of this practice (2.95 in 2013 vs. 2.77 in 2011).





3 = currently have adopted the practice

2 = have not adopted the practice but are considering it and/or working on it

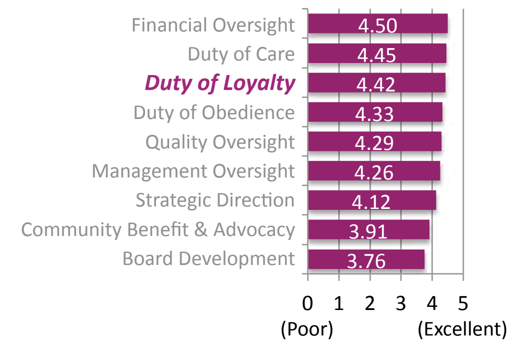
1 = have not adopted and do not intend to adopt the practice

Exhibit 32. Duty of Care Composite Scores *(Adoption)*

Duty of Loyalty—Key Points

- Duty of loyalty is rated third in performance (same as 2011).
- It is rated third in adoption (same as 2011).
- Adoption has remained about the same from 2011 with two exceptions: adoption of a specific definition of "independent director" and adhering to a conflict-of-interest policy with "disabling guidelines" both increased significantly.
- There was one new practice in this area for 2013 for which we can't do a 2011 comparison: The board has a specific process by which disclosed potential conflicts are reviewed by independent, non-conflicted board members with staff support from the general counsel.
- Government-sponsored hospitals are less likely to adopt these practices compared to other organizations, with one exception: they show the highest prevalence of adhering to a conflict-of-interest policy with "disabling guidelines" (2.66).

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

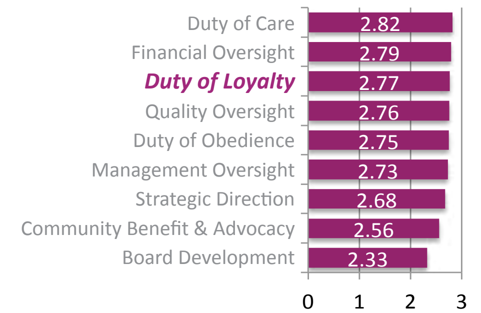


Exhibit 33. Duty of Loyalty Composite Scores *(Adoption)*

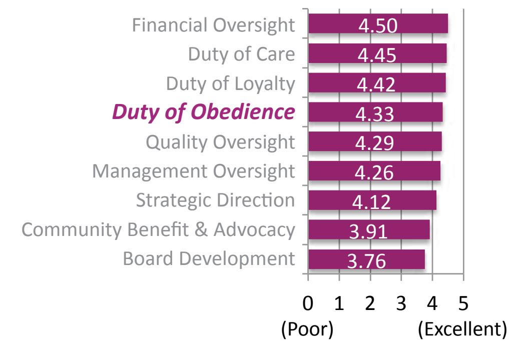
	Overall 2013	Overall 2011
The board has adopted a conflict-of-interest policy that, at a minimum, complies with the most recent IRS definition of conflict of interest.	2.98	2.98
The board adheres to a conflict-of-interest policy that contains "disabling guidelines" that define specific criteria for when a director's material conflict of interest is so great that the director should no longer serve on the board.	2.60	2.40
The board has adopted a specific definition, with measurable standards, of an independent director that, at a minimum, complies with the most recent IRS definition of an "independent director" and takes into consideration any applicable state law.	2.72	2.62
Board members complete a full conflict-of-interest disclosure statement annually.	2.94	2.96
The board has a specific process by which disclosed potential conflicts are reviewed by independent, non-conflicted board members with staff support from the general counsel.	2.59	(no 2011 data)
The board enforces a written policy that states that deliberate violations of conflict of interest constitute grounds for removal from the board.	2.56	2.52
The board assesses the adequacy of its conflict-of-interest policy as well as the sufficiency of its conflict review process at least every two years.	2.69	2.69
The board's enforcement of the organization's conflict-of-interest policy is applied uniformly across all members of the board.	2.90	2.93
The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.	2.80	2.77
The board ensures that the federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.	2.93	2.95

Axis: 0 1 2 3

Duty of Obedience—Key Points

- CEOs gave boards' performance in duty of obedience the fourth highest performance score (4.33 out of 5; this shows a significant increase from 4.23 in 2011).
- Duty of obedience is rated fifth in adoption of recommended practices (same as 2011).
- Two new practices were added this year for which we can't do a 2011 comparison: 1) the board makes an appropriate governance assignment for risk management oversight, and 2) the board (directly or through a dedicated committee) ensures the compliance plan is properly implemented and effective.
- There is a significantly increased degree of adoption for delegation of executive compensation oversight to a group of independent directors.
- Systems are more likely than other types of organizations to: 1) make an appropriate governance assignment for risk management oversight (2.93), 2) delegate executive compensation oversight to a group of independent directors (2.95), 3) ensure the compliance plan is properly implemented and effective (3.00), and 4) approve a "whistleblower" policy that specifies handling of employee complaints and reporting.
- In general, adoption of duty of obedience practices is less prevalent among government-sponsored hospitals, reflecting the distinct nature of governance for this type of organization. *However, there were two practices for which government-sponsored hospitals have higher rates of adoption than all other types of organizations: 1) overseeing a formal assessment at least every two years to ensure fulfillment of the organization's mission (2.72), and 2) establishment of a direct reporting relationship with the general counsel (2.45).*

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

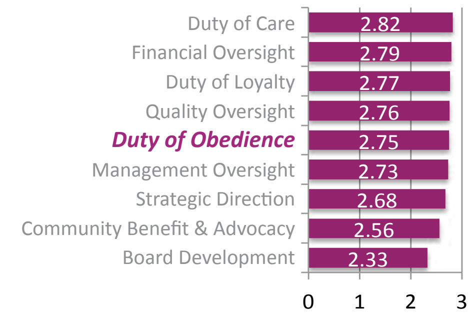


Exhibit 34. Duty of Obedience Composite Scores *(Adoption)*

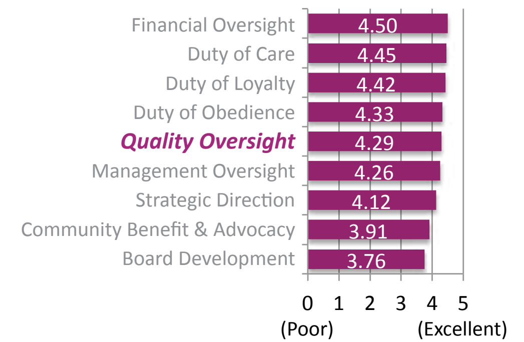
Practice	Overall 2013	Overall 2011
The board oversees a formal assessment at least every two years to ensure fulfillment of the organization's mission.	2.65	2.64
The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.	2.93	2.93
The board considers how major decisions will impact the organization's mission before approving them, and rejects proposals that put the organization's mission at risk.	2.96	2.96
The board makes an appropriate governance assignment for risk management oversight.	2.78	(no 2011 data)
The board has approved a "code of conduct" policies/procedures document that provides ethical requirements for board members, employees, and practicing physicians.	2.81	2.79
The board has delegated its executive compensation oversight function to a group (committee, *ad hoc* group, task force, etc.) that is composed solely of independent directors of the board.	2.69	2.55
The board has approved a compliance plan that *includes* monitoring of arrangements with physicians (e.g., employment, contracting, medical directorships, etc.) to ensure adherence to current laws/regulations.	2.85	2.79
The board (directly or through a dedicated committee) ensures the compliance plan is properly implemented and effective.	2.84	(no 2011 data)
The board routinely receives reports from the compliance officer about the organization's compliance program (e.g., systems for detecting, reporting, and addressing potential violation's of law or payment regulations, new legislation, updates to current regulations, etc.).	2.86	2.83
The board has established a direct reporting relationship with the compliance officer.	2.53	2.51
The board has established a direct reporting relationship with legal counsel.	2.35	2.37
The board has approved a "whistleblower" policy that specifies the following: the manner by which the organization handles employee complaints and allows employees to report in confidence any suspected misappropriation of charitable assets.	2.81	2.78

Scale: 0 1 2 3

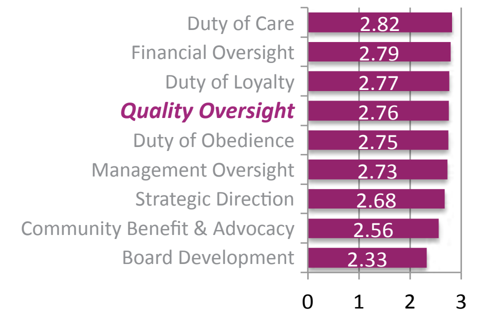
Quality Oversight—Key Points

- CEOs gave boards' performance in quality oversight the fifth highest rating (4.29 out of 5, an increase from 4.23 in 2011).
- Quality oversight is rated fourth in adoption of practices (same as 2011).
- Adoption of practices has remained generally the same since 2011, with the exception of two practices that have increased in adoption: 1) the board works with medical staff and management to set the organization's quality goals (this practice was reworded for 2013—in 2011 the practice was "the board and the medical staff are at least as involved or more involved than management in setting the agenda for the board's discussion surrounding quality," so this reflects an indirect comparison); and 2) the board has a standing quality committee of the board.
- One practice showed a slight decrease in adoption this year: willingness to challenge recommendations of the medical executive committee regarding physician appointment/reappointment to the medical staff.
- Two practices have been highly adopted (2.92 or higher) by all types of organizations: 1) reviewing quality performance measures using dashboards/balanced scorecards, etc. at least quarterly to identify needs for corrective action, and 2) reviewing patient satisfaction/patient experience scores at least annually.
- System and subsidiary hospital boards are more likely than other types of organizations to have a standing quality committee of the board and review quality performance by comparing current performance to the organization's own historical performance as well as industry benchmarks.
- System boards are more likely than other types of organizations to be willing to challenge recommendations of the medical executive committee regarding physician appointment/reappointment to the medical staff.
- Practices that have been shown to improve quality of care (process of care and/or risk-adjusted mortality)[7] are:
  - Establishing a board-level quality committee *(systems and subsidiaries have adopted this practice more than other types of organizations)*
  - Reviewing quality performance measures using dashboards, balanced scorecards, etc. at least quarterly to identify needs for corrective action *(this practice is highly adopted across all organization types)*
  - Basing hospital quality goals on the theoretical ideal *(systems have adopted this practice more than other types of organizations)*
  - Reporting quality/safety performance to the general public *(adoption of this practice is the lowest for all types of organizations; adoption has actually decreased from 2011 for systems and subsidiaries)*
  - Requiring new clinical programs/services to meet quality-related performance criteria
  - Devoting a significant amount of time to quality issues/discussion at most board meetings
  - Board and medical staff involvement in setting the organization's quality goals
  - Board participation in development/approval of explicit criteria to guide medical staff appointments, reappointments, and clinical privileges *(adoption of this practice has decreased from 2011 for systems and government-sponsored hospitals)*

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)



7 As reported in Larry Stepnick, *Making a Difference in the Boardroom: Preliminary Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2012; H.J. Jiang, C. Lockee, K. Bass, I. Fraser, "Board oversight of quality: Any differences in process of care and mortality?" *Journal of Healthcare Management,* Vol. 54, No. 1 (2009), pp. 15–30; and H.J. Jiang, C. Lockee, K. Bass, I. Fraser, "Board engagement in quality: Findings of a survey of hospital and system leaders," *Journal of Healthcare Management,* Vol. 53, No. 2 (2008), pp. 118–132.

Exhibit 35. Quality Oversight Composite Scores *(Adoption)*

THE NEED FOR TRANSFORMATION: BOARD LEADERSHIP IN QUALITY, SAFETY, AND VALUE

Robert M. Wachter, M.D., *Professor, Associate Chair, and Chief of the Division of Hospital Medicine, University of California, San Francisco*

SPECIAL COMMENTARY

THE RESULTS OF THE BIENNIAL GOVERNANCE SURVEY ARE in, and what I am most struck by is the relatively minor fine-tuning of board structure and practices in the face of massive changes in imperatives as they relate to quality, safety, and value. It's as if a hurricane is raging outside and boards are making sure the floors are mopped and the dishwasher is unloaded.

Of course, change is hard, and boards can be forgiven for relying on the tried and true in the face of substantial uncertainty. Yet, just as clinical delivery systems are being forced to transform their culture, structure, information technology, use of data, incentive systems, and workforce compositions to meet a new set of performance imperatives, I believe boards require similar amounts of change in order to meet today's—and tomorrow's—mandates. There is little evidence from this year's survey results that they are in the process of doing so.

A typical hospital board, circa the year 2000, was likely made up of community leaders—mostly successful businessmen and women who were there to help set strategic direction and offer fiduciary wisdom. There was little discussion of quality, safety, patient satisfaction, or efficiency. These was probably no quality committee; boards trusted that their hired CEO and his or her staff were attending to the details of ensuring that the care was good, safe, satisfying, and efficient. Nobody told them otherwise.

While such a structure and focus may have shirked the board's ethical responsibility to ensure the quality of care, it was completely rational from a business perspective. After all, there was essentially no "skin in the game" when it came to clinical performance. So, in the absence of significant accreditation pressure, public reporting, or performance-based payments, treating quality oversight as a low-priority item was both understandable and, in a sense, correct.

Consider the challenges the board now faces in 2013. Value—clinical quality, patient safety, access, patient satisfaction, all divided by the cost of care—has become the name of the game, driven by these and other policy changes, all of which began in the past decade:

- More vigorous accreditation and regulatory pressure, as illustrated by unannounced surveys by The Joint Commission and much more aggressive, state-based oversight of performance and willingness to intervene
- Far more transparency of data and performance, driven by federal reporting of quality, safety, patient experience, and efficiency data on HospitalCompare, coupled with patient-oriented Web sites like Yelp and Angie's List
- New pricing pressures, fueled by exposés like *Time* magazine's "Bitter Pill" opus,[8] and soon-to-be rolled out payment changes that will penalize hospitals for unduly high costs per case
- New quality and safety pressures, from a variety of initiatives such as readmission penalties, "no pay for errors," and value-based purchasing (which already includes quality, safety, and patient experience measures and will soon also include efficiency measures)
- A more-than-doubling of the number of hospitals that have electronic health records and computerized order entry in the past several years, leading to new analytic abilities, new choices regarding whether administration should intervene in clinical practice, and a new set of challenges (including new types of errors and widespread disgruntlement over the data entry burdens on clinicians)

Taken together, hospitals are looking at a landscape in which nearly 10% of their payments will soon hinge on their performance—a percentage that was precisely zero as recently as five years ago. Providing high-value care is no longer an ethical nicety; it is an institutional survival imperative. We will soon see hospitals and healthcare organizations failing because of their inability to deliver the highest quality, safest, most satisfying care at the lowest cost. At this

8 Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us," *Time*, March 4, 2013.

point, it is not clear whether any delivery system will be deemed too big to fail, or too rural to fail, or too good at education or research to fail. It's probably best to assume that nobody will get a free pass in the new world of value.

If this isn't challenging enough, on top of this will be new payment models that shift the perspective from that of the individual patient to that of populations of patients, raising the bar on transitions of care and forcing new and strange bedfellows (hospitals and primary care offices, hospices, home care, and skilled nursing facilities; and delivery organizations and physicians) to come together to meet shared goals. And there will be boatloads of new business models and consumer-facing IT apps whose primary goal is to "disrupt" our ways of doing business. With evidence demonstrating that there are tens of thousands of deaths from medical errors each year,[9] that we provide evidence-based care about half the time,[10] and that the costs of healthcare are threatening to bankrupt our country,[11] many people will be cheering on these disruptors. The status quo does not have many fans.

In the face of all of this change, what should forward-thinking boards be doing? First, not only should every board have a robust quality committee, but these committees should be morphing into "value" committees, concerned not just with quality but with the other elements of the value equation: safety, patient experience, and efficiency/reduction of waste. Far more attention should be paid to the massive transformation new IT systems can offer—in particular, how to squeeze out the maximum value from these systems while minimizing unintended consequences. Significant thought should go into the questions of how to manage the twin transitions from volume to value and from an individual patient to a population perspective. Boards should take a hard look at their membership and ask tough questions, such as: do we have sufficient physician representation in light of all the clinical questions we need to address and the need for hospital–physician alignment and engagement? Do we have board members who are experts in some of the essential competencies, such as quality, safety, and IT?

Yet the results of this survey suggests incremental, or in many cases, no change in the face of these looming imperatives. The number of physicians on boards has actually gone down, from 2.7 in 2011 to 2.5 today. I am on the board of a mid-sized hospital in Oregon, brought on to offer my competencies in quality, safety, and value. Yet, I am an odd duck (as they'd say in Oregon): only 0.4 non-employed/non-medical staff physicians are on the average board.

It is good news that 77% of hospitals and systems now have quality committees, up from 62% in 2007. But I find it hard to believe that the remaining 23% of hospitals without such committees can adequately develop and implement a quality and value strategy using the full board as the vehicle. Moreover, the survey shows that nearly 60% of boards have made no major changes in board structure to prepare for either population health or for value-based purchasing. Perhaps these organizations assume their historical structure and practices are fine to handle these enormous changes, or they believe these trends will blow over. Both seem unlikely.

I recently lectured the medical students at my institution, and told them that the world had shifted. "Folks, your career will be defined by a new set of imperatives. You, and the systems you'll be working in, will be judged based on value: measures of quality, safety, patient experience, and the costs of care," I said gravely. One of the students raised his hand, and in that charming blend of naivety and blinding insight that smart novices often offer, challenged me. "What exactly were you trying to achieve?" he asked.

It was a wonderful question. Creating systems that can reliably deliver high-value care, for every patient, every time, should have been our goal all along. But let's be honest: in the absence of any kind of an incentive system to do so, it wasn't. Meeting this new set of imperatives will require a transformation of everything we do and think. This kind of change shouldn't end with the board. It should start with it.

9 Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System,* National Academy Press, 2000.

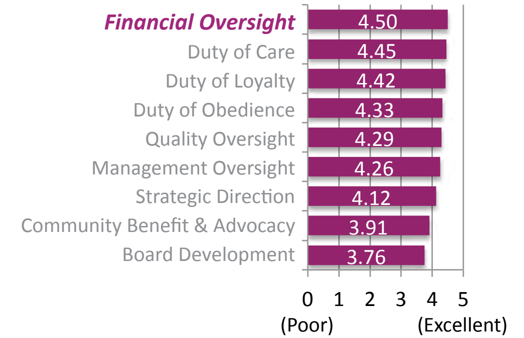
10 E. McGlynn, S. Asch, J. Adams, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine,* Vol. 348 (2003); pp. 2635–2645.

11 Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,* National Academy Press, 2012.

Financial Oversight—Key Points

- CEOs gave boards' performance in financial oversight the highest performance score (4.50 out of 5; down slightly from 4.52 in 2011).
- Financial oversight is rated second in adoption of recommended practices (it has been ranked first in adoption since 2009).
- There is broad adoption of most recommended practices in financial oversight across all organization types with the exception of two practices related to audit oversight: 1) creation of a separate committee responsible for audit oversight, and 2) a policy specifying that the audit committee be made up of independent directors.
- Adoption of one practice decreased from 2011: board members responsible for audit oversight meet with external auditors, without management, at least annually (2.74 vs. 2.81 in 2011).
- As in 2011, practices related to audit and audit oversight appear to be the only areas of relative discrepancy among organization types—for example, fewer government-sponsored hospitals have created a separate committee that has audit as a major responsibility, and fewer have specified that committee members must be independent directors (here, the nature of board composition for government-sponsored hospitals appears to be a major factor in adoption of this specific practice).

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

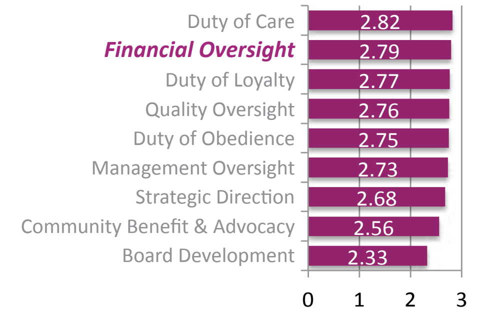
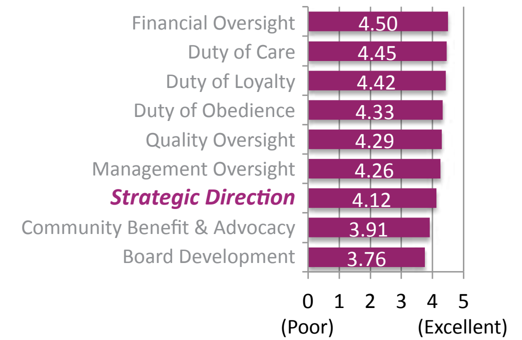


Exhibit 36. Financial Oversight Composite Scores *(Adoption)*

Practice	Overall 2013	Overall 2011
The board approves the organization's capital and financial plans.	2.99	2.99
The board reviews information at least quarterly on the organization's financial performance against plans.	2.99	2.99
The board demands corrective actions in response to under-performance on capital and financial plans.	2.86	2.86
The board requires that the organization's strategic and financial plans be aligned.	2.91	2.91
The board monitors the organization's debt obligations and investment portfolios.	2.96	2.96
Board members responsible for audit oversight meet with external auditors, without management, at least annually.	2.74	2.81
The board has a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight.	2.76	2.77
The board has created a separate audit committee (or audit and compliance committee, or another committee or subcommittee specific to audit oversight) to oversee the external and internal audit functions.	2.44	2.39
The board has adopted a policy that specifies that the audit committee (or other committee/subcommittee whose primary responsibility is audit oversight) must be composed entirely of independent persons who have appropriate qualifications to serve in such role.	2.32	2.27
The board has adopted a policy on financial assistance for the poor and uninsured that adheres to the mission and complies with federal and state requirements.	2.96	2.96

Strategic Direction—Key Points

- CEOs gave boards' performance in setting strategic direction the seventh highest rating (4.12 out of 5; an increase from 4.05 in 2011).
- Strategic direction is rated seventh in adoption of practices (same as 2011; it was sixth in 2009).
- Prevalence of adoption of practices remained about the same or slightly higher compared with 2011; one practice decreased slightly in adoption (requiring management to have an up-to-date medical staff development plan).
- One new practice was added this year for which we can't do a 2011 comparison: the board approves a strategy for aligning the clinical and economic goals of the hospital(s) and physicians.
- As in 2011, more systems have adopted the practice of focusing on strategic discussions during board meetings compared to all other types of organizations (2.53). Significantly fewer government-sponsored hospitals have adopted or are considering adopting this practice.
- Again, the similarity in practice between systems and subsidiary hospitals is striking, but not surprising (these organizations have higher rates of adoption than the overall rate for every practice).



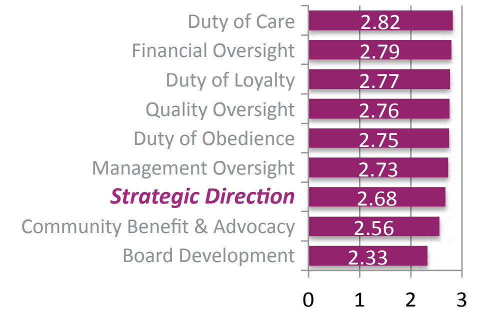


Exhibit 37. Strategic Direction Composite Scores *(Adoption)*

	Overall 2013	Overall 2011
The full board actively participates in establishing the organization's strategic direction such as creating a longer-range vision, setting priorities, and developing/approving the strategic plan.	2.92	2.93
The board approves a strategy for aligning the clinical and economic goals of the hospital(s) and physicians.	2.85	(no 2011 data)
The board requires that all plans in the organization (e.g., financial, capital, operational, quality improvement) be aligned with the organization's overall strategic plan/direction.	2.89	2.88
The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, impact on quality and patient safety, and so forth.	2.94	2.95
The board discusses the needs of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).	2.92	2.94
The board considers how the organization's strategic plan addresses community health status/needs before approving the plan.	2.80	2.75
The board requires that major strategic projects specify *both* measurable criteria for success *and* who is responsible for implementation.	2.80	2.75
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.	2.39	2.33
The board spends more than half of its meeting time during most board meetings discussing strategic issues as opposed to hearing reports.	2.22	2.15
The board has adopted policies and procedures that define how strategic plans are developed and updated (e.g., who is to be involved, timeframes, and the role of the board, management, physicians, and staff).	2.22	2.17
The board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability.	2.56	2.61
The board has established policies regarding physician compensation (e.g., physician employment, financial support for physician recruitment, payment for ED call, etc.) that include consideration of "fair market value" and industry benchmarks when determining compensation.	2.60	2.47

(Scale: 0 1 2 3)

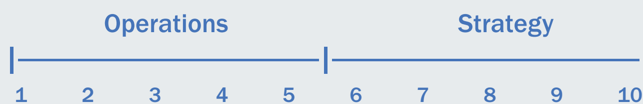
BEST PRACTICES FOR A STRATEGICALLY ORIENTED BOARD

Guy M. Masters, M.P.A., *Senior Vice President, The Camden Group*

SPECIAL COMMENTARY

Is your board more focused on operations-related concerns or strategic and policy issues? What areas does your board focus on as highest priority based on time and energy spent? In our work assisting boards to be more effective, we often use the following diagnostic exercise at board meetings and retreats to assess where the board places priority based on time and energy spent.

Using a scale of 1 to 10, how much time and focus does your board currently spend on operations versus strategic issues? Using this same scale, how much time and focus *should* the board ideally be spending on operations versus strategic issues? Is there an appropriate balance, or a significant gap between current practices and a desired ideal state?



This simple exercise always generates great discussion regarding priorities, board member effectiveness, culture, relevant contributions, and issues that are of most importance. In most cases, board members recognize the need and desire to allocate more time to robust discussions on strategy, policy, and the status of the organization's transition to a fee-for-value world.

How does your board rate when assessing operations versus strategic focus? Is there a healthy balance, or do you lean more heavily toward operations? It is unusual for hospital/health system boards to indicate that they spend "too much" time discussing strategic issues; limiting this time to an annual strategic planning board retreat is inadequate.

Strategic Priority Governance Guidelines

The 2013 biennial survey results show that the typical board spends 50 percent of its time devoted to hearing reports from management and committees. Thirty-three percent (33%) of meeting time, on average, is spent discussing strategic issues and policy.

The survey results also show that a portion of system boards, in particular, spend more than half of their board meeting time discussing strategy and setting policy. Having a clearly articulated vision and strategic direction provides a solid base for coordinating all of the organization's operational activities around common purposes and desired outcomes. Vision and strategy-driven planning "pulls" the organization forward, while operationally-driven plans tend to "push" toward fixed performance targets.

The 2014–2015 board agenda and checklist regarding strategy and policy oversight should take into account the principles described below.

As appropriate, increase the amount of time spent in board meetings to discuss strategic issues as opposed to hearing reports:

- Use consent agendas where possible to streamline the reporting/decision-making process.
- Periodically use an outside resource or facilitator to present on specific strategic issues, events, or trends, and then facilitate a dialogue about the strategic and business implications.
- Stimulate the discussion format with contrarian views to challenge your assumptions and bring new ideas to the table. Consider bringing in local employers, brokers, or other "in the trenches" representatives to keep the board in touch with current activities.

Clearly articulate a board process and accountability for aligning the clinical and economic goals of the hospital/health system and physicians. This is an essential priority if you are maintaining a pluralistic physician strategy (i.e., a mix of employed and independent providers on the medical staff). Clinical integration and care delivery redesign requires aligned incentives and payment models that address the unique needs of both types of physicians.

The strategic planning committee must be charged with a stronger leadership role beyond the traditional approach of periodic developing and monitoring the three- or five-year strategic plan. The strategic plan itself must be developed so that it will guide and frame all of the operational aspects of the organization. The plan must be the coordinating and integrating driver for all other organizational plans including financial, capital, operations, quality improvement, medical staff development, facilities master site plans, and individual department business operations plans. This is the most effective and efficient way to align and integrate the priorities and activities across the organization consistent with the mission, vision, and values. Any other way can result in internal fragmentation,

duplication, competition, silos, and inconsistent priorities. Consider the following questions:

- Does your strategic plan have the breadth, depth, and scope to focus, guide, and channel the activities of all other plans in the organization?
- Is it linked with your financial plans to ensure that the organization's financial resources and position is consistent with the strategic framework on which the organization is operating?

Reenergize Your Strategic Planning Committee

Does your board have a strategic planning committee? The 2013 biennial survey shows that 57% of responding organizations have a strategic planning committee, while five types of board committees are more prevalent in these organizations: executive (77%), quality/safety (77%), governance/nominating (77%), finance (76%), and executive compensation (60%). While these committees have very important purposes that should not be diminished, they do not deal primarily with strategic issues.

If your board has a strategic planning committee, it is essential to accelerate and expand the scope and impact of this group. This committee must take a leading role in reframing the strategic direction of the organization and accelerating momentum where change is required as the environment rapidly evolves. The committee can productively engage in scenario planning and modeling, exploring creative alliances (e.g., with competitors, retail organizations, technology companies, private equity firms, health plans, employers, post-acute providers, others), and make sure that the strategic and business activities of all components of the organization are aligned, integrated, and pursuing common goals and purposes.

If your organization does not have a strategic planning committee of the board, now is the time to consider whether the organization would benefit from having this type of intellectual focus, considering trends and issues impacting the mission, vision, values, and strategic direction of the organization in a rapidly evolving industry and economic environment. Some organizations devote all strategic planning efforts to the full board. This structure may work well for smaller boards that can have full-board discussions and make decisions without getting bogged down by too many differing perspectives. However, considering the list of strategy-related work described above, these boards must take care to ensure that the board can devote the time necessary to not only getting the work done, but doing it well, such that the organization can develop and maintain a strong strategic position with clear direction and accountability.

It is key to note, however, that regardless of whether the board has a strategic planning committee to which to delegate a majority of the background work required to develop a robust strategic plan, this does not take the place of "strategic" discussions at most board meetings, which are key for an effective and engaged board. These discussions cover a myriad of topics, not just related to the strategic plan directly, but "strategic"—i.e., intentional, deliberate, generative discussions that enable informed decision making.

Expanding Strategic Planning Committee Horizons

We recently attended a board meeting at a major healthcare system in the Southeast with The Governance Institute's staff to report the results of their annual BoardCompass® self-assessment survey. During the meeting we reviewed the assessment findings and began asking questions about the role of the strategic planning committee and its effectiveness. The organization's service area includes several large, competing health systems. All of these organizations are aggressively aligning and integrating with local independent hospitals, physicians, and other providers along the continuum to be competitive for accountable care strategies, value-based reimbursement, and bundled payment.

Board members began responding to questions about the competitive landscape, their own current strategies (and related costs), and the returns on investment that they desired. After an hour of robust (unplanned) discussion, several board members made comments such as, "Why don't we do this more often?" and, "This discussion has changed my perspective on why we're doing what we're doing!"

Keep in mind that this is a very sophisticated, well-performing system. We were amazed that a few direct questions about the marketplace and their allocation of resources relative to key trends and their expected returns created a forum for open dialogue that hasn't previously occurred in subcommittee or full board meetings. We were told that, in the past, strategic planning committee activities centered largely on oversight of the three-year cycle of strategic plan development, annual retreats, and periodic reports generated by management on the status of major strategic plan initiatives.

Are directors provided opportunities to regularly engage in robust strategic dialogue about the market, competitor activities, and industry trends at your committee and board meetings?

Essential Strategic Topics and Questions to Consider in a Post-Reform Era

The following are examples of questions many boards are discussing, both in strategic planning committees and in full board meetings. These questions can be tailored to the needs of your organization to engage directors in purposeful strategic dialogue regarding future direction, challenges, and opportunities:

- Can we remain an independent organization? Should we remain independent? What strategies will support the direction we choose?
- Who are our competitors now? Who will our competitors be in the future? Under what circumstances could our competitors be considered future partners?
- What service lines/payer sources generate our margins today? What service lines/payers will generate our revenues and margins in the next three to five years?
- If we were on the board of our major competitors, what top five strategies could we implement that would severely impair our organization?
- Are we among the 58% of biennial survey respondents that have added population health management goals to their strategic plan? In this context, what patient groups are we most likely to “capture” and have success with?
  - » How many “covered lives” can we expect to be responsible for in the next five years?
  - » Who will be our competition for these patients?
  - » What resources and areas of expertise will be necessary for success in this arena? (What capabilities do we have, and what will we need to acquire?)
  - » Who is responsible for and how are we staying in tune with the activities of employers, payers, and the state insurance exchanges to ensure we are timing our initiatives with the activities in our market?
- How have we engaged our physicians and other personnel in our transition to a population health-focused organization?
  - » How are we adapting our human resources recruiting, training, and compensation to ensure that we are attracting and retaining the critical personnel to ensure our success in this “new” world?
  - » What effort has been given and resourced to redesign our care models across the continuum to ensure a patient-focused attention to population health?
- What would it take for us to survive (and thrive) on a Medicare reimbursement standard for most of our commercial payers? What changes will be required operationally, clinically, financially, and in other areas to achieve breakeven or better on Medicare rates?
- How would our organization respond if inpatient admissions were to decline (e.g., 15–25%) in the next three to five years?
- How many covered/contract lives would it take for our organization to reach a critical mass “tipping point” for shifting our cultural orientation away from fee-for-service toward managing value-based and at-risk payment models?
  - » Some health systems have identified the critical threshold level of 30–35% of revenues coming from prospective payment/risk-oriented sources. What level is our organization at now? What could it be in three to five years?
  - » What elements need to change now in our systems, processes, and other capabilities in order to be prepared?

- Does our capital plan reflect our strategic ambitions? Have we linked our strategic aims with our financial planning for the future?
- Does our organization have a physician alignment and engagement strategy that will facilitate retention and recruitment of an adequate supply of primary care and specialty physicians required to support our delivery network and model going forward?

In addition to adding the above questions to your board meeting agenda, consider designating 15 minutes to “heard-on-the-street” open discussions at each board meeting. This allows board members to raise questions, make observations, and explore current events and activities of payers, providers, competitors, retail outlets, etc.

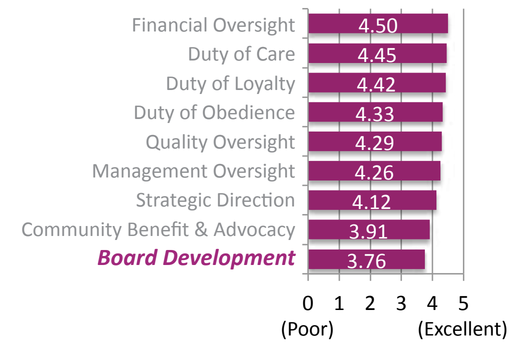
Vision, Strategic Insight, Execution, and Accountability

The board is responsible for clearly articulating a compelling and energizing future vision for the organization. A clearly defined vision can be broken down into prioritized desired outcomes, and then delegated to management for execution. Vision-driven boards will lead with insight and clarity, make difficult judgments and decisions based on available data and facts, and hold their organizations accountable for performance and results. How often does the board even reflect on the vision of the organization and tie it to the current direction? An effective board will know that uncertain times create opportunities for those with the vision and acumen required to see and seize them.

Board Development—Key Points

- CEOs gave boards' performance in board development the lowest rating (3.76 out of 5). The rating has increased from 3.71 in 2011; however, it scores lower in performance compared with other areas this year.
- Board development is ranked last in adoption of practices (down from 2nd to last in 2011).
- Prevalence of adoption of practices decreased compared to 2011 for all but two practices.
- Two new practices were added this year for which we can't do a 2011 comparison: 1) assessing the board's bylaws/structures at least every three years, and 2) establishing a compact regarding mutual expectations with the board chair. The latter practice scored significantly lower in rate of adoption than the other board development practices.
- Significantly fewer organizations have adopted a formal process to evaluate individual board member performance, performance requirements for board member reappointment, and a mentoring program for new board members (consistent with 2009 and 2011).
- Systems were the only type of organization to score above 2.00 for all practices in this area.
- As in 2011, government-sponsored hospitals have a lower incidence of adoption of each of these practices than other organization types (in fact, adoption rates actually decreased from 2011 for seven out of nine practices, even though a higher percentage of government-sponsored hospitals rated their board's performance as "excellent" or "very good" compared with 2011)—a stark indication of the constraints these organizations face when it comes to improving board performance.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

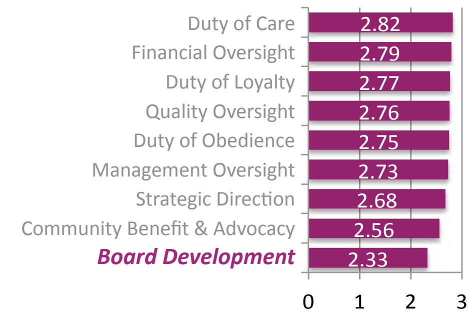
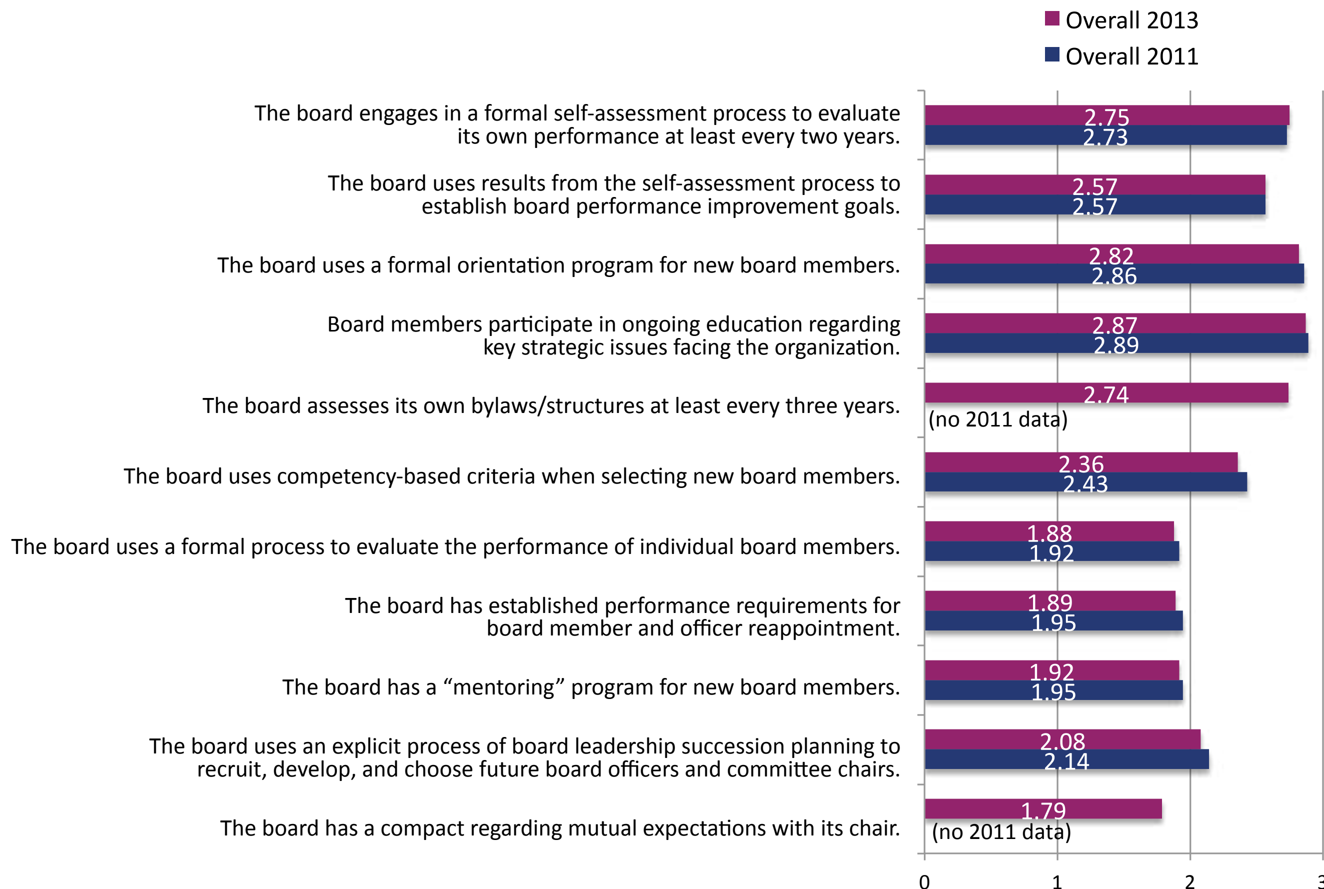


Exhibit 38. Board Development Composite Scores *(Adoption)*



BOARD DEVELOPMENT: TYPE OF ORGANIZATION INFLUENCES ADOPTION

Roger W. Witalis, FACHE, *President, WITALIS & Company, Inc.*

SPECIAL COMMENTARY

Since 2005, board development has ranked eighth of the nine core areas of responsibility in performance. Over the years, there has been an increasing intensity of pressure on healthcare boards to improve governance practices. Unfortunately, performance rankings for board development fell to ninth this year, behind community benefit and advocacy. (See **Tables 20** and **21**.) This ranking is a little misleading at face value because the primary reason why it fell to last place was due to an increase in the level of performance in community benefit and advocacy. However, scores generally remain lower than they should be for both performance and adoption of the practices related to board development. As there is indeed a relationship between performance scores and adoption scores, this commentary takes a closer look at the recommended practices in board development and the corresponding adoption scores, with particular attention to variance across organization types.

The 2013 survey included 11 recommended practices in the core area of board development (see **Exhibit 38**). Visually, it is notable that adoption of the practices in the top half of the list in this exhibit is higher than the bottom half. The table on this page shows composite practice adoption scores by organization type, divided by the average combined score of the first five practices (those showing higher rates of adoption) compared with the average combined score of the remaining six practices (those showing lower rates of adoption). Systems and their subsidiaries adopt the recommended practices to a higher degree than independent and government-sponsored hospitals. While independent hospitals hold their own with systems and subsidiaries, government hospital scores plummet in the last six practices, dramatically affecting the overall composite score and its interpretation. There are reasons for this: public not-for-profit organizations operate in a manner that is significantly different from private not-for-profits, with the most important distinction being that their boards are made up of publicly elected or appointed board members, and therefore do not or cannot adopt the last six recommended practices. A discussion of the six practices with lower adoption scores is below.

Board Development Recommended Practices: Low vs. High Adoption (Average Combined Adoption Scores)*

Organization Type	First 5 Practices (Higher Adoption)	Last 6 Practices (Lower Adoption)	All Practices
Systems	2.85	2.25	2.53
Independent Hospitals	2.78	2.03	2.37
Subsidiary Hospitals	2.81	2.07	2.41
Government-Sponsored Hospitals	2.59	1.63	2.06
Overall	2.75	1.99	2.33

*Composite adoption scores are calculated on a three-point scale where the board: 1 = has not and does not intend to adopt the practice; 2 = has not adopted but is considering and/or working on it; and 3 = has adopted and generally follows the practice. The survey does include "not applicable in our organization," and those responses are not calculated in the composite score, so it can be assumed that those respondents who selected "1" for any given practice consider the practice to be potentially applicable to their board.

The board uses competency-based criteria when selecting new board members.

Public hospital boards are composed of individuals elected by specific or general constituencies or are appointed by another public body such as a city or county. Residency, age, electability, and political connection are powerful criteria. Competency may become a factor only upon reelection. However, some proactive public hospital boards have found creative ways to work around this barrier, by instituting a recommendation process to the appointing/nominating body including information about specific skills and competencies new candidates should have.

The board uses a formal process to evaluate the performance of individual board members.

The only effective evaluation process for elected board members is the election and recall process. For appointed public board members, it could be change in composition of the appointing body or a number of other politically related changes.

The board has established performance requirements for board member and officer reappointment.

Again, publicly elected board member reappointment is based on the success or failure to be reelected. Officer appointment may be

mandated by statute (e.g., longest tenured member) or based on political alliances within the board, but seldom based on established performance requirements.

The board has a "mentoring" program for new board members.
Most likely, new public board members will have an orientation session with the CEO and perhaps the chair and committee chairs. Often the newly elected member ran on a campaign that criticized the performance of incumbent board members making it unlikely other members would be willing to become a mentor. Mentor relations may occur due to alignment of common agendas or affiliations but seldom due to board policy or common practice.

The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.
Since the tenure of elected board members is in the hands of the electorate, not the board, it is difficult to predict which director will be available at some future date. During the director's term (two to four years) some planning may occur but the appointment is most often political rather than strategic.

The board has a compact regarding mutual expectations with its chair.
This practice, which is new on the survey this year, showed the lowest adoption of all board development practices, regardless of organization type. The relationship between the board chair and the rest of the board is extremely important; much of the success of the board can hinge upon the strength of its chair to keep discussions on topic/task, encourage points of view and candidness from all board members, call out conflicts of interest, and be a motivating leader and facilitator. Beyond the board chair's job description, setting expectations in advance so both the chair and the board know and understand (and agree upon) the chair's role and relationship is beneficial to overall board performance. Since this is a new practice it is likely that adoption rates will increase in future reporting years. And unlike the practices above, this practice is indeed something that government-sponsored hospitals (and all organizations for that matter) can and should consider adopting.

When looking at the percentage of respondents by organization type that rated their board's performance in board development as "excellent," 19% of government-sponsored hospital respondents answered "excellent," compared with 26% overall and 40% of health systems. If government-sponsored hospitals were excluded from the board development practices (since they are less likely to be able to adopt most of the practices), the composite performance score of 3.76 overall (based on a five-point scale where 5 = excellent), would rise to 3.94.

However, there are other areas of responsibility in which government-sponsored hospitals also score lower compared with other organizations, and many of these lower-scoring areas include practices that are appropriate for government hospitals. Of the entire list of 95 recommended best practices across all nine core areas of responsibility, four were the ***least adopted*** practices when looking at overall combined scores of all organization types (scoring 1.00–1.99 on the three-point adoption scale). Government-sponsored hospitals scored below 2.00 for 11 practices. Similarly, government hospitals demonstrated the least number of ***most adopted*** practices (11 practices scoring between 2.90–3.00). In contrast, systems had 43 practices with an adoption score of 2.90 or higher; subsidiaries had 33, and independent hospitals had 25.

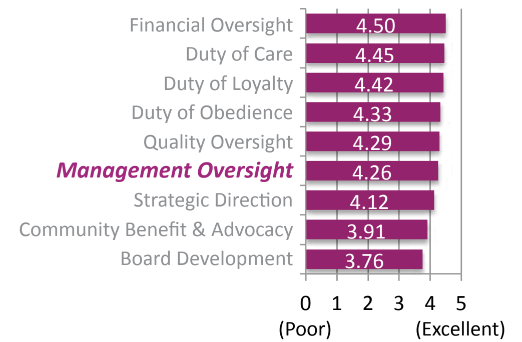
Clearly all recommended practices do not fit all hospitals equally, and most notably government-sponsored hospitals, so we recommend that readers take this into account when looking at overall scores (the report highlights variations by organization type to provide a better picture). But the important point is that while government-sponsored hospitals face certain and daunting board structure challenges that other boards don't contend with, there are ways they can continue to improve their performance, enhance the possibilities of getting the "right" people at the boardroom table, and provide board members with education opportunities so that if they don't have the necessary knowledge when they are appointed to the board, they can develop those skills and knowledge in order to move the organization in the desired direction.[12]

12 For more information on ways public hospitals can improve their board performance, see Elaine Zablocki, "Public Hospital Governance Challenges Represent Opportunities for High Performance" (special section), *BoardRoom Press,* The Governance Institute, June 2013.

Management Oversight—Key Points

- CEOs gave boards' performance in management oversight the sixth highest performance rating (4.26 out of 5; an increase from 4.23 in 2011 although its ranking slipped from fifth place).
- Management oversight is rated sixth in adoption of practices (it was rated fifth in 2011).
- Only two practices have increased slightly in adoption from 2011: 1) following a formal process for evaluating CEO performance, and 2) requiring that CEO compensation be determined with consideration of "fair market value" and "reasonableness of compensation."
- Without exception, the practice adoption is more prevalent among systems than for other organization types; government-sponsored hospitals have the least prevalent adoption of practices. This is consistent with 2011.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

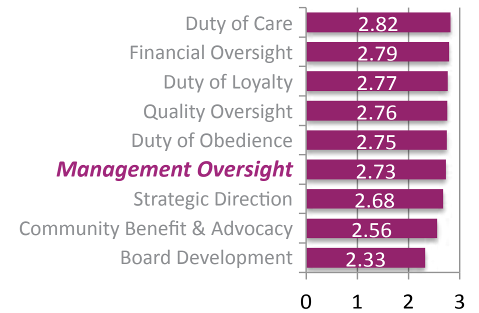
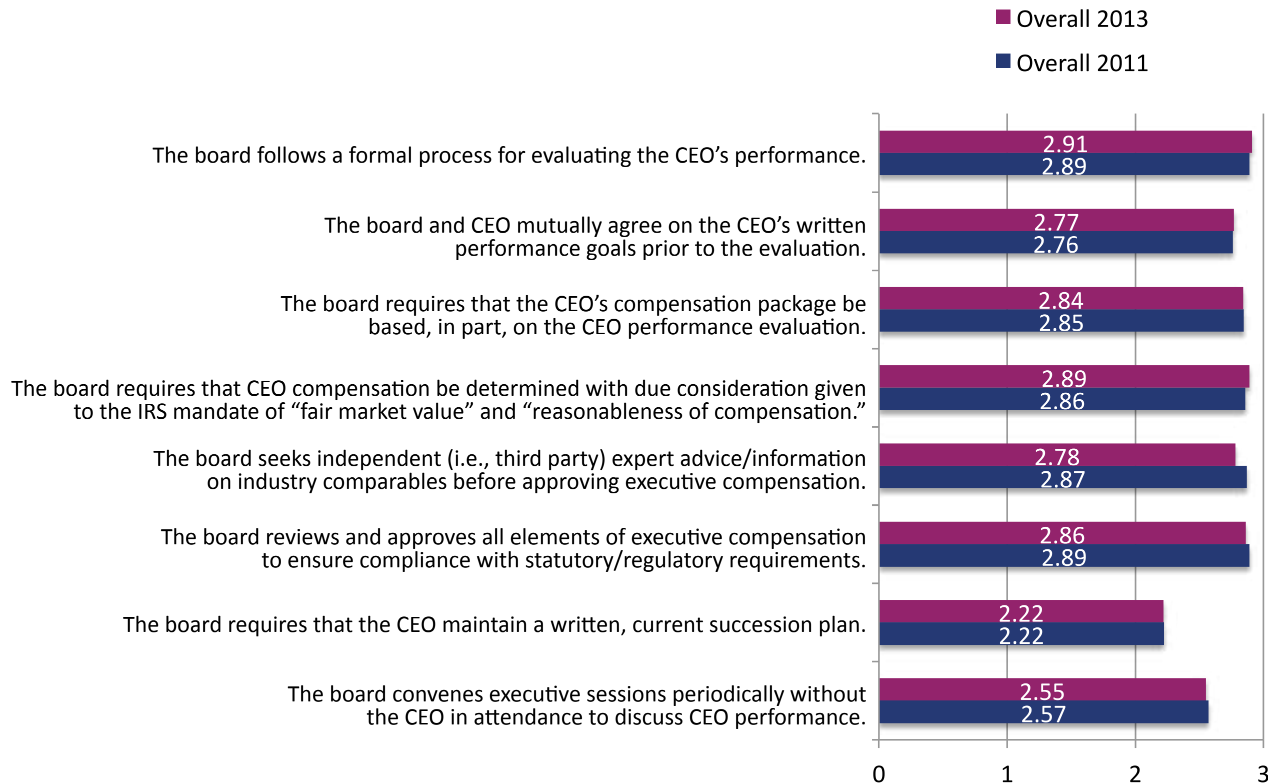


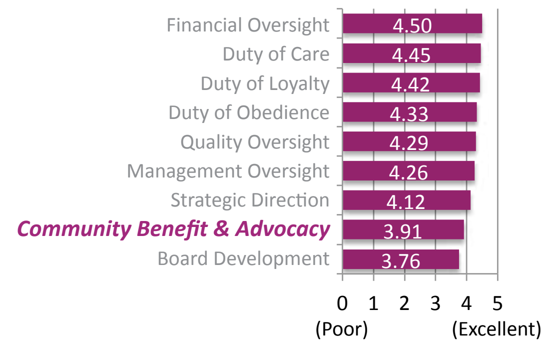
Exhibit 39. Management Oversight Composite Scores *(Adoption)*



Community Benefit & Advocacy—Key Points

- CEOs gave boards' performance in community benefit and advocacy the second lowest performance rating (3.91 out of 5; increased from 3.62 in 2011).
- Community benefit and advocacy is rated second to last in adoption of practices *(since 2009 this area has rated last in adoption of practices as well as performance; this year the practices have been reworked to include more emphasis on community benefit practices related to the Patient Protection and Affordable Care Act, which is the primary reason for the uptick in performance and adoption this year. However, there is still much room for improvement in both adoption and performance compared to most other areas).*
- Two new practices were added this year for which we cannot make a 2011 comparison: 1) providing oversight with respect to organizational compliance with internal revenue code tax-exemption requirements concerning community benefit, and 2) working closely with legal counsel to ensure all advocacy efforts are consistent with tax-exempt status requirements.
- Prevalence of adoption of practices increased compared to 2011 for all but two practices (which remained about the same).
- Compared to other practices in this area, the one most adopted by all types of organizations is: ensuring that a community health needs assessment is conducted at least every three years.
- The least prevalent practice for all types of organizations is: having a written policy establishing the board's role in fund development/philanthropy.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

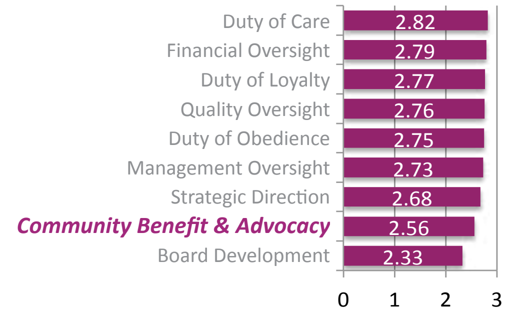


Exhibit 40. Community Benefit & Advocacy Composite Scores *(Adoption)*

Practice	Overall 2013	Overall 2011
The board has adopted a policy or policies on community benefit that includes *all* of the following characteristics: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, measurable goals for the organization, a financial assistance policy, and commitment to communicate transparently with the public.	2.44	2.45
The board provides oversight with respect to organizational compliance with internal revenue code tax-exemption requirements concerning community benefit and related requirements.	2.78	(no 2011 data)
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).	2.77	2.70
The board actively supports the organization's fund development program (e.g., board members give according to their abilities, identify potential donors, participate in solicitations, serve on fund development committees).	2.61	2.52
The board has a written policy establishing the board's role in fund development and/or philanthropy.	1.86	1.81
The board works closely with legal counsel to ensure all advocacy efforts are consistent with the requirements of tax-exempt status.	2.55	(no 2011 data)
The board has adopted a policy regarding information transparency, explaining to the public in understandable terms its performance on measures of quality, safety, pricing, and customer service.	2.27	2.28
The board ensures that a community health needs assessment is conducted at least every three years to understand health issues and perceptions of the organization of the communities served.	2.85	2.61
The board ensures the adoption of implementation strategies that meet the needs of the community, as identified through the community health needs assessment.	2.76	2.41
The board requires that management annually report community benefit value to the general public (i.e., the community).	2.66	2.61

Axis: 0 1 2 3

Analysis of Results

This year's results show that adoption of our list of recommended practices, for the most part, continues to be widespread. However, adoption rates have not increased significantly; in most cases adoption has either remained stagnant or decreased slightly. In contrast, we have seen a small increase in boards' rating of overall performance in most of the oversight areas covered in the survey. The leap in adoption and performance from years 2007 to 2009 was significant, and in 2011 and 2013 we are seeing a leveling off.

This is the first year indicating a decline in the performance composite score for financial oversight. This area continues to score higher than most other areas in both performance and adoption but we have seen a slight decline in "top two" ratings since 2009. The decline is small; however, given the impacts of tightening hospital reimbursement rates and increasing challenges related to reducing costs and preparing for value-based payment models, it is possible that boards may continue in future reporting years to feel their performance in financial oversight is not as strong as it has been in years past, as they become more accustomed to new financial metrics and essentially a new payment system.

There remains significant opportunity to improve performance scores and adoption rates in certain areas, most specifically board development, some practices related to advocacy and fundraising, one practice under management oversight (requiring the CEO to maintain a current, written succession plan usually scores much lower than the other practices in this area and we consider this to be a particularly important practice to adopt), and quality oversight (it is our belief that quality oversight is an area in which boards should be reporting extremely high practice adoption rates as well as performance scores, and while these are both moving in the right direction, there is still much room for improvement).

Most and Least Observed Practices

Many of the 95 recommended practices tend to be either in place or under consideration by respondents. We identified the ***most observed*** practices[13] for all respondents except those who selected "not applicable in our organization"—this list of 22 practices includes (those with an asterisk were also on the 2011 most observed list):

Duty of Care

- The board requires that new board members receive education on their fiduciary duties.*
- The board reviews financial feasibility of projects before approving them.*
- The board considers whether new projects adhere to the organization's strategic plan before approving them.*
- The board receives important background materials within sufficient time to prepare for meetings.
- The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).*

Duty of Loyalty

- The board has adopted a conflict-of-interest policy that, at a minimum, complies with the most recent IRS definition of conflict of interest.*
- Board members complete a full conflict-of-interest disclosure statement annually.*
- The board's enforcement of the conflict-of-interest policy is applied uniformly across all members of the board.*
- The board ensures that the federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.*

Duty of Obedience

- The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.*
- The board considers how major decisions will impact the organization's mission before approving them, and rejects proposals that put the organization's mission at risk.*

Quality Oversight

- The board reviews quality performance (using dashboards, balanced scorecards, run charts, or some other standard mechanism for board-level reporting) at least quarterly to identify needs for corrective action.*
- The board reviews patient satisfaction/patient experience scores at least annually (including those publicly reported by CMS).*

Financial Oversight

- The board approves the organization's capital and financial plans.*
- The board reviews information at least quarterly on the organization's financial performance against plans.*
- The board requires that the organization's strategic and financial plans be aligned.*
- The board monitors the organization's debt obligations and investment portfolio.*
- The board has adopted a policy on financial assistance for the poor and uninsured that adheres to the mission and complies with federal and state requirements.*

13 For most and least observed practices, we used a composite score ranking methodology with 3.00 indicating most acceptance and 1.00 indicating least acceptance. For most observed practices, we used weighted averages of 2.90–3.00. For least observed practices, we considered weighted averages of 1.00–1.99.

Strategic Direction

- The full board actively participates in establishing the organization's strategic direction such as creating a longer-range vision, setting priorities, and developing/approving the strategic plan.*
- The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, impact on quality and patient safety, and so forth.*
- The board discusses the needs of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).*

Management Oversight

- The board follows a formal process for evaluating the CEO's performance.

We also identified the practices that have been adopted by the ***least number*** of respondents. Four practices met the criteria (all of which were also on the 2011 least observed list):

Board Development

- The board uses a formal process to evaluate the performance of individual board members.*
- The board has established performance requirements for board member and officer reappointment.*
- The board has a "mentoring" program for new board members.*

Community Benefit & Advocacy

- The board has a written policy establishing the board's role in fund development and/or philanthropy.*

Appendix 3 shows composite scores for most and least observed practices overall and by organization type, comparing 2013 and 2011.

Significance of Individual Governance Practices and Overall Performance

Generally, we found a strong correlation between adoption of practices and respondents rating their board's performance as "excellent" or "very good" (69 of the 95 practices have a very strong relationship between adoption and performance, and another 11 practices have a somewhat strong relationship). Only five of the practices had no correlation with performance (i.e., no relationship at all, not even one that would be considered statistically significant but weak):

- Duty of care: The board reviews financial feasibility of projects before approving them.
- Duty of care: The board receives important background materials within sufficient time to prepare for meetings.
- Duty of care: The board has a written policy specifying minimum meeting attendance requirements.
- Duty of care: The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).
- Financial oversight: The board has adopted a policy on financial assistance for the poor and uninsured that adheres to the mission and complies with federal and state requirements.

Observance/adoption of these practices appears to make no difference with respect to how the board's performance was rated by respondents; that is, even though nearly all respondents said they generally follow the practices noted here, some still rated their board's overall performance in the duty of care and financial oversight as good, fair, or poor, rather than excellent or very good.

CONCLUDING REMARKS

This year's survey results show consistency in most areas with our last reporting year in 2011, including pervasive adoption for a majority of the recommended practices. A few key areas of movement have been highlighted throughout this report. The changes that have the most potential implications on the role/focus of governance in the next few years are discussed briefly below.

Structure

There has still not been any significant movement in the amount of time boards spend on strategic discussions and setting policy versus hearing reports from management and committees. We recommend spending more than half of board meeting time on strategic discussions, due to the positive relationship between this and performance in the fiduciary duties and core responsibilities. There are times when management and committee reports can be placed on the consent agenda and reviewed prior to the meeting to free up additional time. There is a disconnect in the data here: nearly three-quarters of boards are using a consent agenda, indicating that though this is relatively widespread it is unclear whether the consent agenda is being optimized or used appropriately, since boards are still not spending enough time on the essential work of strategy, policy, and decision making.

This is the second reporting year that the percentage of respondents compensating board members (other than board chairs) has increased. However, this year's results show that the increase is due to activity on the part of government-sponsored hospitals only, as the percentage of other types of organizations that compensate board members has decreased. Many governance experts predict that director compensation will increase due to the increase in legal liability, complexity, and time commitment needed from board members. Board chair compensation has increased slightly over the years from 10% to 12% of boards compensating the board chair; however, the data does not yet reflect a strong increasing trend for compensating other board members.

The rise in the average number of committees from 2009 to 2011 was remarkable (from an average of five to seven committees); the 2013 number of committees has gone back to 2009 numbers. While committee work is important and essential to enhance the work of the full board, we are pleased to see that there is not a trend of increasing numbers of committees. Too many committees can result in confusion, duplication of effort, and lack of focus; in addition, the time spent reporting on committee work during board meetings can become unwieldy. We recommend that boards structure their committees appropriately and efficiently so that each committee has a clear charter and responsibility, that individual board members are using their skills while not being stretched too thin, and that the committee work allows the board to free up time for the essential strategic discussions. Finally and most importantly, the committees should be focused at the governance level and not delve into operations issues. Along these lines, we are optimistic about the continuing increasing trend in the percentage of organizations with a standing quality committee, one of the recommended practices that has been shown to have a direct relationship with organizational performance and quality of care in other research (cited previously in the body of this report).

The slight decrease in physician representation on the board is somewhat concerning. Moreover, nurse representation both on the board and on the quality committee remains very low. As the healthcare business model moves to a focus on value, the clinical perspective from both nurses and physicians is becoming ever more essential at the governance level. We will continue to track movement towards clinical experience in the CEO and board chair positions as well, in this light.

The most significant increase since 2011 is the percentage of boards using a board portal or similar online tool. In addition, there has been a large increase in the percentage of boards providing members with laptops or iPads to access online board materials. We hope that the increasing use of technology will help boards work more efficiently and effectively, as well as allowing more access to industry news, information, and educational materials (ideally resulting in more informed and educated board members).

Systems and Their Subsidiaries: Allocation of Responsibility and Authority

Given the significant increase in the number of organizations affiliated with a system over the past two years, we felt it was important to assess how systems and subsidiaries are structured and how they determine and allocate responsibility and authority for governance activities. Most systems have a system board as well as local subsidiary boards that also have fiduciary responsibilities. So we have yet to see significant movement towards a single board at the corporate level, although some governance experts expect to see more movement in this direction in the coming years.

Most subsidiary hospitals share authority with the system board for most of the governance activities we asked about that had the potential to be held in control at the system level. Again, we do not yet see movement in this area towards an "operating company model" in which the majority of control is held at the system level, although there are fewer governance activities that are "owned" fully by the subsidiary board compared with 2009.

Most system boards approve a document specifying allocation of responsibility and authority between the system and local boards, and a significant majority of system respondents indicated that this authority is widely accepted and understood throughout all leadership levels across the system. This indicates a healthy degree of organization, communication, and accountability between systems and subsidiaries, and may be one indicator of why there is such a strong parallel between adoption and performance between these two groups of organizations.

Board Culture

For the first time this year we attempted to determine how well boards are functioning in the context of culture: communication, relationships, group dynamics, focus on mission fulfillment, and effectiveness in accomplishing goals and holding those responsible accountable. A significant majority of the respondents agreed or strongly agreed with most of the culture-related statements. There were a handful of particularly key statements that scored lower on the scale in comparison with the others, although their percentages were relatively high (as reported). This area showed a particular challenge for government-sponsored hospitals, which had the lowest level of agreement for most of these statements (the lowest-scoring one being, "the board has an effective system in place to measure whether strategic goals will be met"). In future reporting years we will attempt to connect the level of agreement with the board culture statements and adoption and performance of recommended practices to discern whether these statements are strong indicators of effectiveness in board performance.

Moving to a New Business Model

We also looked this year at changes boards are making to prepare for population health and value-based payments (i.e., moving to a new business model). Almost 90% of respondents are making changes of some kind to prepare for population health; and 93% are making changes of some kind to prepare for value-based payments. This indicates some movement on the part of the nation's hospitals and health systems to address problems with quality and cost in the care delivery system. More than half of respondents have added goals related to both of these issues to the strategic and financial plans, but most respondents have not yet made any changes to the board or management team. We anticipate that the kinds of skills and leadership required to be successful in managing the health of populations and transitioning away from fee-for-service may be very different than the skills and leadership that has brought the healthcare system to where it is today. We will continue to look at movement in these areas as the industry moves further along the reform trajectory in the coming years.

Practices

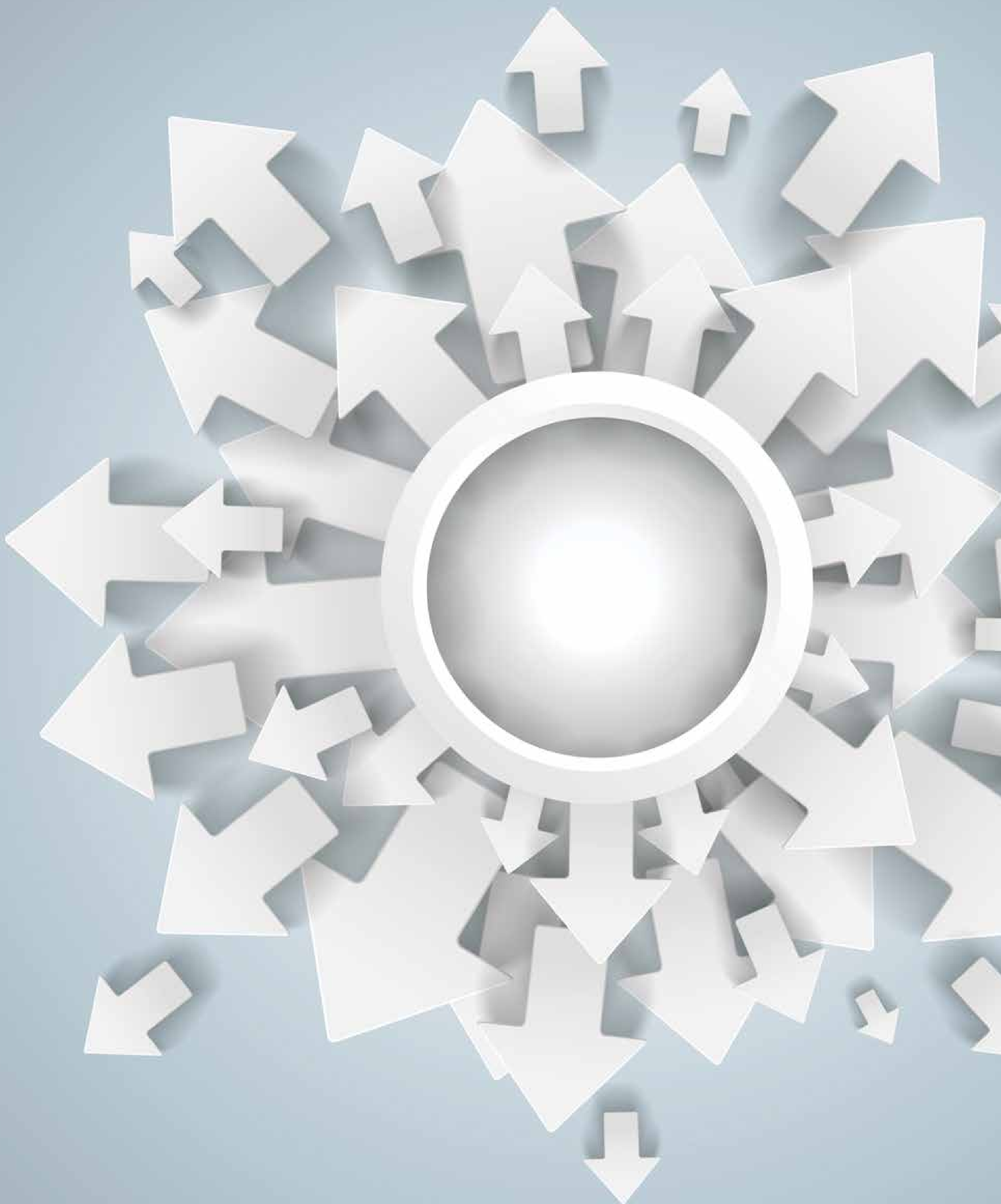
We do not see a significant increase in adoption of most of the 95 recommended practices compared to 2011, although there has been an increase in board performance in duty of obedience, quality oversight, strategic direction, board development, and community benefit and advocacy, which showed the greatest amount of improved performance as well as a significant increase in adoption of some of the practices. The least observed practices this year fall primarily under board development, one area that shows much room for improvement both in adoption and performance.

Financial oversight continues to score high in adoption and performance, however, this is the first time that financial oversight has shown a decrease in performance composite score (although the decrease is small). Due to this decrease, duty of care beats financial oversight for the number one spot in the percentage of respondents who rated their board as "excellent" or "very good." As the payment model shifts away from fee-for-service to value-based contracts, hospitals and health systems will have to anticipate how their revenue stream will be affected, in some ways by issues that are not directly under the hospital's control. With this, in addition to continued downward pressure on reimbursements within the fee-for-service system, it is not surprising to see a decline in boards' performance of financial oversight. This will be an area of focus for all boards going forward and we may also see the recommended practices in this section

evolve as boards begin measuring financial performance differently.

This year again shows a striking parallel between system and subsidiary adoption and performance of a majority of the recommended practices, indicating a close relationship and high degree of communication between system boards and their subsidiary boards. Across the survey, systems tend to perform higher than other types of organizations, with subsidiaries and independent hospitals close behind (although they outperform systems in certain areas). Government-sponsored hospitals continue to lag behind the others in adoption and performance of most of the recommended practices, as well as issues regarding recommended board structure, clinician representation on the board, and time spent during board meetings on strategic discussions. However, there were some areas in which government-sponsored hospitals improved greatly this year, and indeed a couple in which they outperformed other organizations. This may indicate a knowledge and desire on the part of government-sponsored hospitals to make meaningful change in spite of their many barriers and challenges affecting governance with which private organizations do not contend.

Given that the analysis this year shows a relationship between 90 out of the 95 practices between adoption of the practice and overall board performance, we consider this list of recommended practices to be particularly relevant and an indicator of how boards should be spending their time during this transition to a value-based business model. The role and scope of the hospital and health system will continue to evolve as we move further along the value journey. As such, the role and scope of the governing board will evolve as well, and we will endeavor to capture that evolution in this data in the years to come.



APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Total number of seated, voting board members (includes vacant positions for which you currently are recruiting)																				
Total responding in each category	525	60	152	175	138	57	13	6	62	38	289	8	4	48	194	174	75	52	19	11
1–7	21.1%	6.7%	7.2%	6.9%	60.9%	70.2%	53.8%	33.3%	56.5%	5.3%	7.3%	0.0%	0.0%	8.3%	42.8%	12.1%	5.3%	3.8%	5.3%	0.0%
8–10	15.6%	5.0%	15.8%	9.7%	27.5%	24.6%	30.8%	50.0%	27.4%	5.3%	13.5%	25.0%	0.0%	2.1%	22.7%	16.1%	4.0%	13.5%	0.0%	0.0%
11–15	32.8%	31.7%	39.5%	45.7%	9.4%	5.3%	15.4%	16.7%	11.3%	57.9%	40.8%	37.5%	25.0%	31.3%	25.3%	38.5%	41.3%	34.6%	21.1%	27.3%
16–22	24.6%	41.7%	30.9%	30.9%	2.2%	0.0%	0.0%	0.0%	4.8%	31.6%	30.8%	37.5%	50.0%	41.7%	7.7%	29.9%	38.7%	38.5%	31.6%	63.6%
23–30	4.2%	15.0%	3.3%	4.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.5%	0.0%	25.0%	16.7%	1.0%	2.3%	5.3%	5.8%	42.1%	9.1%
31 +	1.7%	0.0%	3.3%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	0.0%	0.0%	0.5%	1.1%	5.3%	3.8%	0.0%	0.0%
Average	13.46	16.65	15.09	15.40	7.81	7.14	8.23	8.33	8.29	14.34	15.38	14.38	20.25	16.73	9.86	14.03	17.47	15.87	20.32	17.27
Median	13	17	14	14	7	7	7	9	7	15	14	15	21	17	9	14	15	15	21	17
Range	2 to 77	5 to 29	5 to 69	5 to 77	2 to 20	4 to 15	5 to 15	5 to 11	2 to 20	7 to 22	5 to 77	9 to 19	15 to 24	5 to 29	4 to 77	2 to 69	7 to 60	5 to 44	7 to 28	11 to 23
Number of voting independent board members (per IRS definition of independent director)																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0–2	22.0%	5.0%	17.6%	17.1%	40.0%	33.3%	50.0%	50.0%	42.9%	18.4%	17.2%	0.0%	0.0%	6.3%	34.4%	17.0%	17.3%	9.6%	0.0%	9.1%
3–4	1.7%	0.0%	2.0%	1.7%	2.1%	3.5%	0.0%	0.0%	1.6%	2.6%	1.7%	0.0%	0.0%	0.0%	1.0%	2.3%	4.0%	0.0%	0.0%	0.0%
5–6	10.2%	6.7%	3.9%	9.1%	20.0%	22.8%	14.3%	33.3%	17.5%	10.5%	6.2%	12.5%	0.0%	6.3%	15.4%	8.0%	4.0%	11.5%	5.3%	0.0%
7 +	66.1%	88.3%	76.5%	72.0%	37.9%	40.4%	35.7%	16.7%	38.1%	68.4%	74.8%	87.5%	100.0%	87.5%	49.2%	72.7%	74.7%	78.8%	94.7%	90.9%
Average	8.84	12.58	10.25	9.75	4.55	4.74	3.86	3.33	4.65	8.50	10.18	12.50	15.50	12.35	6.14	9.23	11.05	10.88	15.89	13.55
Median	9	13	10	10	5	5	3	3	5	10	10	13	14	13	6	9	10	11	16	14
Range	0 to 71	0 to 23	0 to 41	0 to 71	0 to 19	0 to 15	0 to 15	0 to 9	0 to 19	0 to 17	0 to 71	5 to 18	13 to 21	0 to 23	0 to 71	0 to 36	0 to 57	0 to 41	6 to 23	0 to 20
Number of voting management board members																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0	53.0%	20.0%	52.3%	34.3%	91.4%	91.2%	100.0%	100.0%	88.9%	15.8%	46.2%	0.0%	0.0%	25.0%	74.9%	48.9%	40.0%	25.0%	21.1%	9.1%
1	36.0%	71.7%	40.5%	45.1%	4.3%	7.0%	0.0%	0.0%	3.2%	50.0%	42.1%	100.0%	100.0%	64.6%	16.4%	40.9%	49.3%	53.8%	63.2%	81.8%
2	5.5%	1.7%	3.3%	12.0%	1.4%	0.0%	0.0%	0.0%	3.2%	18.4%	6.6%	0.0%	0.0%	2.1%	4.6%	4.5%	9.3%	9.6%	0.0%	0.0%
3	2.5%	0.0%	3.3%	4.0%	0.7%	0.0%	0.0%	0.0%	1.6%	5.3%	3.4%	0.0%	0.0%	0.0%	2.6%	1.7%	0.0%	9.6%	0.0%	0.0%
4 +	3.0%	6.7%	0.7%	4.6%	2.1%	1.8%	0.0%	0.0%	3.2%	10.5%	1.7%	0.0%	0.0%	8.3%	1.5%	4.0%	1.3%	1.9%	15.8%	9.1%
Average	0.71	1.25	0.59	1.02	0.23	0.16	0.00	0.00	0.37	1.53	0.73	1.00	1.00	1.31	0.41	0.76	0.75	1.35	1.32	1.18
Median	0	1	0	1	0	0	0	0	0	1	1	1	1	1	0	1	1	1	1	1
Range	0 to 17	0 to 17	0 to 4	0 to 6	0 to 10	0 to 5	0 to 0	0 to 0	0 to 10	0 to 6	0 to 5	1 to 1	1 to 1	0 to 17	0 to 5	0 to 10	0 to 5	0 to 17	0 to 5	0 to 4

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Number of voting physician board members who are active members of the medical staff but are not employed by the hospital																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0	38.1%	35.0%	28.8%	25.1%	65.7%	71.9%	57.1%	66.7%	61.9%	34.2%	25.9%	87.5%	25.0%	27.1%	56.4%	27.3%	22.7%	25.0%	31.6%	63.6%
1	23.3%	18.3%	21.6%	23.4%	27.1%	22.8%	35.7%	33.3%	28.6%	23.7%	22.4%	12.5%	25.0%	18.8%	26.2%	25.6%	13.3%	21.2%	15.8%	27.3%
2	14.2%	16.7%	18.3%	17.1%	5.0%	3.5%	7.1%	0.0%	6.3%	13.2%	18.3%	0.0%	0.0%	20.8%	10.3%	15.9%	21.3%	17.3%	5.3%	9.1%
3	13.1%	15.0%	17.0%	17.7%	2.1%	1.8%	0.0%	0.0%	3.2%	15.8%	17.6%	0.0%	25.0%	16.7%	5.6%	15.3%	22.7%	15.4%	31.6%	0.0%
4 +	11.4%	15.0%	14.4%	16.6%	0.0%	0.0%	0.0%	0.0%	0.0%	13.2%	15.9%	0.0%	25.0%	16.7%	1.5%	15.9%	20.0%	21.2%	15.8%	0.0%
Average	1.44	1.60	1.76	1.91	0.44	0.35	0.50	0.33	0.51	1.71	1.86	0.13	2.00	1.81	0.70	1.77	2.17	2.08	1.95	0.45
Median	1	1	1	2	0	0	0	0	0	1	2	0	2	2	0	1	2	2	2	0
Range	0 to 8	0 to 6	0 to 8	0 to 8	0 to 3	0 to 3	0 to 2	0 to 1	0 to 3	0 to 8	0 to 8	0 to 1	0 to 4	0 to 6	0 to 4	0 to 8	0 to 8	0 to 8	0 to 6	0 to 2
Number of voting physician board members who are active members of the medical staff and are employed by the hospital																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0	64.4%	55.0%	55.6%	56.6%	87.9%	91.2%	78.6%	66.7%	88.9%	57.9%	55.9%	75.0%	25.0%	54.2%	72.8%	61.9%	60.0%	55.8%	47.4%	54.5%
1	19.3%	20.0%	23.5%	22.9%	10.0%	7.0%	21.4%	33.3%	7.9%	13.2%	24.5%	25.0%	50.0%	16.7%	15.9%	20.5%	21.3%	23.1%	21.1%	27.3%
2	9.3%	10.0%	10.5%	14.3%	1.4%	1.8%	0.0%	0.0%	1.6%	15.8%	12.1%	0.0%	0.0%	12.5%	7.2%	10.8%	9.3%	13.5%	5.3%	9.1%
3	3.6%	6.7%	5.9%	3.4%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%	4.1%	0.0%	25.0%	6.3%	2.6%	3.4%	4.0%	3.8%	15.8%	0.0%
4 +	3.4%	8.3%	4.6%	2.9%	0.7%	0.0%	0.0%	0.0%	1.6%	5.3%	3.4%	0.0%	0.0%	10.4%	1.5%	3.4%	5.3%	3.8%	10.5%	9.1%
Average	0.65	0.93	0.86	0.73	0.19	0.11	0.21	0.33	0.24	0.89	0.78	0.25	1.25	1.02	0.46	0.68	0.80	0.77	1.21	0.82
Median	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Range	0 to 9	0 to 4	0 to 9	0 to 4	0 to 8	0 to 2	0 to 1	0 to 1	0 to 8	0 to 4	0 to 9	0 to 1	0 to 3	0 to 4	0 to 8	0 to 6	0 to 9	0 to 4	0 to 4	0 to 4
Number of voting physician board members who are active members of the medical staff and who have contracts with the hospital																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0	62.7%	56.7%	52.9%	53.1%	87.9%	91.2%	78.6%	83.3%	87.3%	44.7%	54.1%	100.0%	50.0%	50.0%	80.0%	57.4%	41.3%	44.2%	63.2%	72.7%
1	16.3%	18.3%	19.6%	18.3%	9.3%	7.0%	14.3%	0.0%	11.1%	18.4%	19.0%	0.0%	25.0%	20.8%	11.3%	18.2%	21.3%	25.0%	10.5%	9.1%
2	10.8%	11.7%	15.7%	13.1%	2.1%	1.8%	0.0%	16.7%	1.6%	21.1%	13.4%	0.0%	25.0%	12.5%	5.1%	13.6%	17.3%	15.4%	5.3%	9.1%
3	4.2%	5.0%	3.3%	8.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%	5.5%	0.0%	0.0%	6.3%	2.1%	3.4%	9.3%	5.8%	10.5%	0.0%
4 +	6.1%	8.3%	8.5%	7.4%	0.7%	0.0%	7.1%	0.0%	0.0%	7.9%	7.9%	0.0%	0.0%	10.4%	1.5%	7.4%	10.7%	9.6%	10.5%	9.1%
Average	0.77	0.97	0.96	1.03	0.16	0.11	0.43	0.33	0.14	1.18	0.97	0.00	0.75	1.15	0.34	0.90	1.29	1.13	1.05	0.64
Median	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	1	1	0	0
Range	0 to 10	0 to 6	0 to 5	0 to 10	0 to 4	0 to 2	0 to 4	0 to 2	0 to 2	0 to 5	0 to 10	0 to 0	0 to 2	0 to 6	0 to 4	0 to 10	0 to 5	0 to 5	0 to 6	0 to 4

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Number of voting physician board members who are not active members of the medical staff																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0	82.2%	65.0%	81.0%	83.4%	89.3%	96.5%	71.4%	83.3%	87.3%	78.9%	82.8%	37.5%	75.0%	68.8%	89.2%	83.5%	73.3%	78.8%	63.2%	45.5%
1	11.4%	21.7%	10.5%	12.0%	7.1%	1.8%	14.3%	16.7%	9.5%	21.1%	10.0%	25.0%	0.0%	22.9%	6.2%	10.8%	18.7%	15.4%	21.1%	27.3%
2	3.8%	8.3%	6.5%	2.3%	0.7%	0.0%	0.0%	0.0%	1.6%	0.0%	4.8%	12.5%	25.0%	6.3%	2.6%	3.4%	6.7%	1.9%	10.5%	9.1%
3	0.8%	3.3%	0.7%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	25.0%	0.0%	0.0%	0.0%	0.6%	0.0%	1.9%	0.0%	18.2%
4 +	1.9%	1.7%	1.3%	1.7%	2.9%	1.8%	14.3%	0.0%	1.6%	0.0%	1.7%	0.0%	0.0%	2.1%	2.1%	1.7%	1.3%	1.9%	5.3%	0.0%
Average	0.38	0.55	0.38	0.41	0.28	0.14	1.07	0.17	0.24	0.21	0.42	1.25	0.50	0.44	0.31	0.32	0.52	0.42	0.63	1.00
Median	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Range	0 to 15	0 to 4	0 to 10	0 to 15	0 to 7	0 to 7	0 to 7	0 to 1	0 to 7	0 to 1	0 to 15	0 to 3	0 to 2	0 to 4	0 to 14	0 to 10	0 to 15	0 to 9	0 to 4	0 to 3
Total number of voting physician board members (excludes those with contracts)																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
Average	2.47	3.08	3.00	3.05	0.91	0.60	1.78	0.83	0.99	2.81	3.06	1.63	1.75	1.46	1.47	2.77	3.49	3.27	3.79	2.27
Median	1	1	1	1	0	0	0	1	0	1	2	1	2	1	0	1	2	2	2	1
Number of voting board members who are nurses																				
Total responding in each category	528	60	153	175	140	57	14	6	63	38	290	8	4	48	195	176	75	52	19	11
0	71.8%	65.0%	71.9%	72.0%	74.3%	77.2%	71.4%	83.3%	71.4%	65.8%	72.8%	37.5%	75.0%	68.8%	77.4%	71.0%	58.7%	73.1%	68.4%	72.7%
1	21.0%	21.7%	22.9%	20.6%	19.3%	21.1%	28.6%	0.0%	17.5%	15.8%	22.4%	12.5%	25.0%	22.9%	16.4%	24.4%	29.3%	21.2%	15.8%	0.0%
2	5.7%	8.3%	4.6%	5.7%	5.7%	1.8%	0.0%	16.7%	9.5%	13.2%	4.1%	25.0%	0.0%	6.3%	6.2%	4.0%	6.7%	5.8%	10.5%	9.1%
3	0.8%	1.7%	0.7%	0.6%	0.7%	0.0%	0.0%	0.0%	1.6%	5.3%	0.0%	0.0%	0.0%	2.1%	0.0%	0.6%	2.7%	0.0%	5.3%	0.0%
4 +	0.8%	3.3%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	25.0%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	18.2%
Average	0.39	0.57	0.34	0.42	0.33	0.25	0.29	0.33	0.41	0.58	0.36	1.63	0.25	0.42	0.29	0.34	0.71	0.33	0.53	0.91
Median	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0
Range	0 to 10	0 to 4	0 to 3	0 to 10	0 to 3	0 to 2	0 to 1	0 to 2	0 to 3	0 to 3	0 to 10	0 to 4	0 to 1	0 to 3	0 to 2	0 to 3	0 to 10	0 to 2	0 to 3	0 to 4

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Number of female voting board members																				
Total responding in each category	522	60	150	173	139	57	14	6	62	37	286	8	4	48	193	172	75	51	20	11
0	3.3%	0.0%	2.0%	1.2%	8.6%	10.5%	7.1%	16.7%	6.5%	0.0%	1.7%	0.0%	0.0%	0.0%	3.6%	5.2%	1.3%	0.0%	0.0%	0.0%
1	12.3%	8.3%	9.3%	6.4%	24.5%	31.6%	21.4%	16.7%	19.4%	0.0%	8.7%	0.0%	0.0%	10.4%	16.6%	11.0%	6.7%	13.7%	5.0%	0.0%
2	22.0%	21.7%	20.7%	21.4%	24.5%	21.1%	42.9%	16.7%	24.2%	13.5%	22.0%	0.0%	50.0%	22.9%	29.0%	20.3%	12.0%	21.6%	5.0%	27.3%
3	21.1%	23.3%	20.0%	20.8%	21.6%	24.6%	7.1%	33.3%	21.0%	16.2%	21.0%	0.0%	25.0%	27.1%	19.7%	20.3%	28.0%	15.7%	25.0%	27.3%
4	16.7%	13.3%	20.7%	17.3%	12.9%	8.8%	14.3%	16.7%	16.1%	16.2%	19.2%	0.0%	0.0%	16.7%	19.2%	15.1%	13.3%	17.6%	25.0%	0.0%
5	11.1%	8.3%	12.7%	15.6%	5.0%	1.8%	7.1%	0.0%	8.1%	16.2%	14.0%	0.0%	0.0%	10.4%	5.7%	15.1%	16.0%	11.8%	10.0%	9.1%
6 +	13.6%	25.0%	14.7%	17.3%	2.9%	1.8%	0.0%	0.0%	4.8%	37.8%	13.3%	100.0%	25.0%	12.5%	6.2%	12.8%	22.7%	19.6%	30.0%	36.4%
Average	3.69	5.10	4.14	3.88	2.37	2.04	2.21	2.17	2.73	6.16	3.72	15.88	3.25	3.46	2.88	3.83	4.21	3.73	7.60	5.09
Median	3	3	3	4	2	2	2	3	3	5	3	9	3	3	3	3	4	3	4	3
Range	0 to 70	1 to 70	0 to 56	0 to 20	0 to 9	0 to 7	0 to 5	0 to 4	0 to 9	2 to 56	0 to 34	6 to 70	2 to 6	1 to 10	0 to 20	0 to 56	0 to 15	1 to 9	1 to 70	2 to 12
Number of voting board members from an ethnic minority																				
Total responding in each category	512	59	148	169	136	53	14	6	63	37	280	8	4	47	188	169	74	50	20	11
0	46.7%	25.4%	50.7%	39.1%	61.0%	69.8%	50.0%	33.3%	58.7%	32.4%	46.1%	37.5%	0.0%	25.5%	69.1%	42.0%	32.4%	24.0%	10.0%	0.0%
1	23.0%	23.7%	20.3%	26.6%	21.3%	13.2%	35.7%	50.0%	22.2%	24.3%	23.6%	25.0%	0.0%	25.5%	19.7%	24.9%	24.3%	26.0%	25.0%	27.3%
2	13.7%	28.8%	13.5%	13.6%	7.4%	9.4%	0.0%	0.0%	7.9%	18.9%	12.9%	12.5%	50.0%	29.8%	5.9%	15.4%	17.6%	20.0%	25.0%	45.5%
3	6.3%	10.2%	8.1%	4.7%	4.4%	1.9%	0.0%	16.7%	6.3%	5.4%	6.4%	12.5%	0.0%	10.6%	2.7%	5.3%	10.8%	12.0%	15.0%	9.1%
4	3.7%	5.1%	1.4%	6.5%	2.2%	0.0%	7.1%	0.0%	3.2%	13.5%	2.9%	0.0%	25.0%	4.3%	0.0%	3.6%	6.8%	10.0%	10.0%	9.1%
5	3.3%	6.8%	0.7%	5.3%	2.2%	3.8%	0.0%	0.0%	1.6%	2.7%	3.2%	12.5%	25.0%	4.3%	1.6%	3.6%	2.7%	4.0%	15.0%	9.1%
6 +	3.3%	0.0%	5.4%	4.1%	1.5%	1.9%	7.1%	0.0%	0.0%	2.7%	5.0%	0.0%	0.0%	0.0%	1.1%	5.3%	5.4%	4.0%	0.0%	0.0%
Average	1.28	1.66	1.24	1.56	0.79	0.70	1.14	1.00	0.78	1.70	1.37	1.50	3.25	1.55	0.55	1.50	1.72	1.92	2.35	2.27
Median	1	2	0	1	0	0	1	1	0	1	1	1	3	1	0	1	1	2	2	2
Range	0 to 13	0 to 5	0 to 10	0 to 13	0 to 7	0 to 7	0 to 7	0 to 3	0 to 5	0 to 9	0 to 13	0 to 5	2 to 5	0 to 5	0 to 8	0 to 13	0 to 10	0 to 9	0 to 5	1 to 5

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
If you employ physicians in your organization, have there been any changes in governance structure since you have begun employing physicians?																				
Total responding in each category	528	62	151	177	138	57	14	6	61	39	289	9	4	49	191	175	75	54	21	12
Physician representation on the board is now entirely made up of employed physicians	2.3%	1.6%	4.6%	1.7%	0.7%	1.8%	0.0%	0.0%	0.0%	2.6%	3.1%	0.0%	0.0%	2.0%	2.1%	2.9%	1.3%	1.9%	4.8%	0.0%
There has been a positive correlation (i.e., the number of employed physicians on the board corresponds with the percentage of employed physicians on the medical staff)	2.1%	3.2%	4.0%	0.6%	1.4%	1.8%	7.1%	0.0%	0.0%	5.1%	1.7%	0.0%	0.0%	4.1%	0.5%	2.9%	5.3%	1.9%	0.0%	0.0%
There has been no change in board membership	56.1%	54.8%	47.7%	60.5%	60.1%	63.2%	42.9%	100.0%	57.4%	56.4%	54.3%	66.7%	75.0%	51.0%	53.9%	57.7%	54.7%	55.6%	61.9%	66.7%
We do not allow employed physicians to serve on the board	9.5%	11.3%	11.3%	7.3%	9.4%	10.5%	14.3%	0.0%	8.2%	7.7%	9.3%	0.0%	0.0%	14.3%	8.4%	10.3%	10.7%	11.1%	4.8%	8.3%
We do not distinguish between employed vs. non-employed physicians when selecting board members	14.4%	16.1%	16.6%	18.1%	6.5%	8.8%	14.3%	0.0%	3.3%	20.5%	17.0%	0.0%	25.0%	18.4%	11.5%	15.4%	14.7%	20.4%	14.3%	16.7%
We do not employ physicians	11.4%	8.1%	8.6%	8.5%	19.6%	10.5%	21.4%	0.0%	29.5%	5.1%	9.0%	33.3%	0.0%	4.1%	19.9%	5.7%	8.0%	5.6%	9.5%	8.3%
Other	4.4%	4.8%	7.3%	3.4%	2.2%	3.5%	0.0%	0.0%	1.6%	2.6%	5.5%	0.0%	0.0%	6.1%	3.7%	5.1%	5.3%	3.7%	4.8%	0.0%
Do your bylaws specify defined terms for the length of elected service?																				
Total responding in each category	533	62	154	178	139	56	14	6	63	41	291	9	4	49	194	176	77	53	21	12
Yes	88.9%	90.3%	90.3%	94.9%	79.1%	78.6%	85.7%	100.0%	76.2%	100.0%	91.8%	100.0%	75.0%	89.8%	85.6%	90.3%	90.9%	94.3%	85.7%	91.7%
Length of term (in years) (median)	3	3	3	3	4	5	4	4	3	3	3	3	3	3	3	3	3	3	3	3

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Do your bylaws limit the maximum number of consecutive terms?																				
Total responding in each category	463	56	137	162	108	43	11	6	48	38	261	9	3	44	164	155	67	48	18	11
Yes	65.7%	82.1%	70.8%	82.1%	25.9%	25.6%	72.7%	33.3%	14.6%	89.5%	75.1%	77.8%	100.0%	81.8%	47.6%	71.6%	77.6%	83.3%	83.3%	72.7%
Maximum number of terms (median)	3	3	3	3	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Maximum age for serving on the board (“age limits”)																				
Total responding in each category	532	62	154	177	139	57	13	6	63	41	290	9	4	49	195	175	76	53	21	12
Yes	6.8%	17.7%	5.8%	6.8%	2.9%	0.0%	7.7%	0.0%	4.8%	4.9%	6.6%	0.0%	0.0%	22.4%	3.1%	5.7%	9.2%	9.4%	28.6%	16.7%
Age Limits																				
Average	72.45	72.10	72.44	72.80	N/A	N/A	N/A	N/A	N/A	73.00	72.59	N/A	N/A	72.10	75.00	72.56	72.33	72.00	72.40	71.00
Median	72	72	72	72	N/A	N/A	N/A	N/A	N/A	73	72	N/A	N/A	72	75	72	72	72	72	71
Range	70 to 80	70 to 75	70 to 78	70 to 80	N/A	N/A	N/A	N/A	N/A	70 to 76	70 to 80	N/A	N/A	70 to 75	70 to 80	70 to 78	70 to 75	70 to 75	70 to 75	70 to 72
Average board member age																				
Total responding in each category	504	57	147	166	134	54	14	6	60	38	275	8	4	45	187	167	75	46	18	11
Average	57.34	59.26	56.95	56.70	57.72	57.41	56.57	57.17	58.33	55.63	56.98	62.50	59.25	58.69	56.92	57.16	57.48	57.65	58.72	62.55
Median	58	60	56	56	58	59	58	59	58	56	56	63	58	59	56	57	58	58	58	62
Range	40 to 70	50 to 70	40 to 70	45 to 70	45 to 70	45 to 70	50 to 62	50 to 60	45 to 70	45 to 70	40 to 70	60 to 65	55 to 67	50 to 70	40 to 70	45 to 70	48 to 65	50 to 70	50 to 68	60 to 68
Honorary or emeritus board members																				
Total responding in each category	534	62	154	178	140	57	14	6	63	41	291	9	4	49	195	176	77	53	21	12
Yes	19.1%	29.0%	26.6%	20.2%	5.0%	3.5%	14.3%	0.0%	4.8%	12.2%	24.7%	22.2%	25.0%	30.6%	8.2%	19.3%	32.5%	30.2%	28.6%	41.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Participation on the board (N/A not included)																				
President/CEO																				
Total responding in each category	534	62	154	178	140	57	14	6	63	41	291	9	4	49	195	176	77	53	21	12
Board member and a voting member	46.3%	82.3%	49.4%	64.0%	4.3%	5.3%	0.0%	0.0%	4.8%	92.7%	52.2%	100.0%	100.0%	77.6%	22.6%	49.4%	61.0%	77.4%	81.0%	91.7%
Board member but not a voting member	16.5%	8.1%	22.7%	15.7%	14.3%	10.5%	7.1%	16.7%	19.0%	2.4%	21.3%	0.0%	0.0%	10.2%	19.5%	14.2%	20.8%	13.2%	4.8%	8.3%
Non-board member but regularly attends meetings	37.1%	9.7%	27.9%	19.7%	81.4%	84.2%	92.9%	83.3%	76.2%	4.9%	26.1%	0.0%	0.0%	12.2%	57.9%	35.8%	18.2%	9.4%	14.3%	0.0%
Non-board member and does not attend meetings	0.2%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
Respondents with this position	99.8%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%
Chief of Staff																				
Total responding in each category	431	40	129	136	126	50	13	5	58	34	231	1	4	35	172	141	62	37	14	5
Board member and a voting member	37.6%	35.0%	51.2%	47.8%	13.5%	10.0%	7.7%	20.0%	17.2%	47.1%	49.8%	0.0%	50.0%	34.3%	30.8%	45.4%	45.2%	24.3%	42.9%	40.0%
Board member but not a voting member	13.2%	10.0%	14.7%	15.4%	10.3%	6.0%	23.1%	0.0%	12.1%	20.6%	14.3%	0.0%	0.0%	11.4%	14.5%	10.6%	14.5%	21.6%	0.0%	0.0%
Non-board member but regularly attends meetings	33.9%	32.5%	24.8%	22.8%	55.6%	58.0%	53.8%	80.0%	51.7%	23.5%	23.8%	0.0%	25.0%	34.3%	32.0%	37.6%	30.6%	35.1%	28.6%	40.0%
Non-board member and does not attend meetings	15.3%	22.5%	9.3%	14.0%	20.6%	26.0%	15.4%	0.0%	19.0%	8.8%	12.1%	100.0%	25.0%	20.0%	22.7%	6.4%	9.7%	18.9%	28.6%	20.0%
Respondents with this position	80.7%	64.5%	83.2%	76.4%	90.6%	89.3%	92.9%	83.3%	92.1%	82.9%	79.1%	11.1%	100.0%	71.4%	88.7%	79.7%	80.5%	69.8%	66.7%	41.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Chief Operating Officer																				
Total responding in each category	315	43	102	105	65	24	4	5	32	23	184	3	3	37	71	121	58	44	14	7
Board member and a voting member	2.5%	2.3%	2.9%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	3.3%	0.0%	0.0%	2.7%	2.8%	1.7%	5.2%	2.3%	0.0%	0.0%
Board member but not a voting member	2.9%	0.0%	3.9%	3.8%	1.5%	0.0%	0.0%	0.0%	3.1%	0.0%	4.3%	0.0%	0.0%	0.0%	4.2%	2.5%	3.4%	2.3%	0.0%	0.0%
Non-board member but regularly attends meetings	90.8%	93.0%	89.2%	89.5%	93.8%	87.5%	100.0%	100.0%	96.9%	87.0%	89.7%	66.7%	100.0%	94.6%	87.3%	93.4%	87.9%	90.9%	92.9%	100.0%
Non-board member and does not attend meetings	3.8%	4.7%	3.9%	2.9%	4.6%	12.5%	0.0%	0.0%	0.0%	8.7%	2.7%	33.3%	0.0%	2.7%	5.6%	2.5%	3.4%	4.5%	7.1%	0.0%
Respondents with this position	59.2%	69.4%	66.2%	59.7%	46.4%	42.1%	28.6%	83.3%	50.8%	56.1%	63.7%	33.3%	75.0%	75.5%	37.0%	68.4%	75.3%	83.0%	66.7%	58.3%
VP Medical Affairs/Chief Medical Officer																				
Total responding in each category	329	55	101	130	43	18	3	3	19	34	197	5	4	46	56	125	70	49	20	9
Board member and a voting member	4.3%	3.6%	5.0%	4.6%	2.3%	0.0%	0.0%	33.3%	0.0%	0.0%	5.6%	0.0%	0.0%	4.3%	7.1%	4.0%	2.9%	2.0%	10.0%	0.0%
Board member but not a voting member	4.3%	0.0%	9.9%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	0.0%	0.0%	8.9%	4.8%	4.3%	0.0%	0.0%	0.0%
Non-board member but regularly attends meetings	82.1%	81.8%	80.2%	83.8%	81.4%	66.7%	100.0%	66.7%	94.7%	88.2%	81.2%	80.0%	75.0%	82.6%	69.6%	85.6%	84.3%	89.8%	65.0%	88.9%
Non-board member and does not attend meetings	9.4%	14.5%	5.0%	8.5%	16.3%	33.3%	0.0%	0.0%	5.3%	11.8%	6.1%	20.0%	25.0%	13.0%	14.3%	5.6%	8.6%	8.2%	25.0%	11.1%
Respondents with this position	61.7%	88.7%	65.2%	73.4%	30.9%	31.6%	23.1%	50.0%	30.2%	85.0%	67.5%	55.6%	100.0%	93.9%	28.9%	71.0%	90.9%	92.5%	95.2%	75.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Chief Financial Officer																				
Total responding in each category	524	61	153	173	137	55	14	6	62	40	286	9	4	48	186	176	77	53	20	12
Board member and a voting member	0.2%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
Board member but not a voting member	3.4%	0.0%	4.6%	4.6%	2.2%	1.8%	0.0%	0.0%	3.2%	0.0%	5.2%	0.0%	0.0%	0.0%	7.0%	1.7%	2.6%	0.0%	0.0%	0.0%
Non-board member but regularly attends meetings	94.3%	100.0%	93.5%	93.6%	93.4%	89.1%	100.0%	100.0%	95.2%	100.0%	92.7%	100.0%	100.0%	100.0%	90.3%	95.5%	96.1%	98.1%	100.0%	100.0%
Non-board member and does not attend meetings	2.1%	0.0%	1.3%	1.7%	4.4%	9.1%	0.0%	0.0%	1.6%	0.0%	1.7%	0.0%	0.0%	0.0%	2.7%	2.3%	1.3%	1.9%	0.0%	0.0%
Respondents with this position	98.3%	98.4%	98.7%	97.7%	98.6%	98.2%	100.0%	100.0%	98.4%	97.6%	98.3%	100.0%	100.0%	98.0%	96.4%	99.4%	100.0%	100.0%	95.2%	100.0%
Chief Nursing Officer																				
Total responding in each category	508	51	152	168	137	55	14	6	62	38	282	6	4	41	184	175	76	49	15	9
Board member and a voting member	1.0%	2.0%	1.3%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	0.7%	0.0%	0.0%	2.4%	0.5%	1.7%	0.0%	0.0%	6.7%	0.0%
Board member but not a voting member	3.1%	0.0%	3.9%	3.6%	2.9%	3.6%	0.0%	0.0%	3.2%	0.0%	4.3%	0.0%	0.0%	0.0%	4.9%	1.7%	3.9%	2.0%	0.0%	0.0%
Non-board member but regularly attends meetings	82.3%	74.5%	82.9%	84.5%	81.8%	78.2%	92.9%	83.3%	82.3%	89.5%	83.0%	83.3%	100.0%	70.7%	80.4%	86.3%	82.9%	79.6%	66.7%	77.8%
Non-board member and does not attend meetings	13.6%	23.5%	11.8%	10.7%	15.3%	18.2%	7.1%	16.7%	14.5%	5.3%	12.1%	16.7%	0.0%	26.8%	14.1%	10.3%	13.2%	18.4%	26.7%	22.2%
Respondents with this position	95.8%	82.3%	98.1%	96.6%	98.6%	96.5%	100.0%	100.0%	100.0%	92.7%	97.9%	66.7%	100.0%	83.7%	96.3%	99.4%	98.7%	92.5%	71.4%	75.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Chief Information Officer																				
Total responding in each category	402	58	126	123	95	38	8	6	43	26	223	6	4	48	115	142	68	45	20	12
Board member and a voting member	0.2%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%
Board member but not a voting member	0.7%	0.0%	0.0%	0.8%	2.1%	2.6%	0.0%	0.0%	2.3%	0.0%	0.4%	0.0%	0.0%	0.0%	1.7%	0.7%	0.0%	0.0%	0.0%	0.0%
Non-board member but regularly attends meetings	34.1%	37.9%	39.7%	26.8%	33.7%	36.8%	50.0%	16.7%	30.2%	26.9%	34.1%	16.7%	50.0%	39.6%	24.3%	35.9%	42.6%	33.3%	50.0%	33.3%
Non-board member and does not attend meetings	64.9%	62.1%	59.5%	72.4%	64.2%	60.5%	50.0%	83.3%	67.4%	69.2%	65.5%	83.3%	50.0%	60.4%	73.9%	62.7%	57.4%	66.7%	50.0%	66.7%
Respondents with this position	75.8%	93.5%	81.3%	69.9%	69.3%	67.9%	61.5%	100.0%	69.4%	65.0%	76.6%	66.7%	100.0%	98.0%	59.6%	81.6%	88.3%	84.9%	95.2%	100.0%
Legal Counsel																				
Total responding in each category	369	56	96	122	95	31	6	5	53	30	188	7	4	45	101	127	63	47	20	11
Board member and a voting member	1.4%	0.0%	3.1%	0.8%	1.1%	3.2%	0.0%	0.0%	0.0%	3.3%	1.6%	0.0%	0.0%	0.0%	2.0%	2.4%	0.0%	0.0%	0.0%	0.0%
Board member but not a voting member	1.1%	0.0%	1.0%	1.6%	1.1%	0.0%	0.0%	0.0%	1.9%	0.0%	1.6%	0.0%	0.0%	0.0%	2.0%	1.6%	0.0%	0.0%	0.0%	0.0%
Non-board member but regularly attends meetings	65.6%	92.9%	57.3%	59.0%	66.3%	61.3%	83.3%	80.0%	66.0%	50.0%	59.6%	100.0%	100.0%	91.1%	41.6%	63.0%	74.6%	89.4%	100.0%	100.0%
Non-board member and does not attend meetings	32.0%	7.1%	38.5%	38.5%	31.6%	35.5%	16.7%	20.0%	32.1%	46.7%	37.2%	0.0%	0.0%	8.9%	54.5%	33.1%	25.4%	10.6%	0.0%	0.0%
Respondents with this position	69.4%	90.3%	61.9%	68.9%	68.8%	55.4%	46.2%	83.3%	84.1%	73.2%	64.6%	77.8%	100.0%	91.8%	52.3%	72.2%	81.8%	88.7%	95.2%	91.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Compliance Officer																				
Total responding in each category	485	59	140	160	126	48	13	6	59	37	263	9	4	46	168	163	73	50	19	12
Board member and a voting member	0.4%	0.0%	0.7%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	0.4%	0.0%	0.0%	0.0%	0.6%	0.6%	0.0%	0.0%	0.0%	0.0%
Board member but not a voting member	1.2%	0.0%	0.0%	1.9%	2.4%	2.1%	0.0%	0.0%	3.4%	0.0%	1.1%	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-board member but regularly attends meetings	45.4%	40.7%	42.9%	37.5%	60.3%	60.4%	69.2%	50.0%	59.3%	40.5%	39.9%	44.4%	0.0%	43.5%	51.8%	50.3%	32.9%	30.0%	47.4%	25.0%
Non-board member and does not attend meetings	53.0%	59.3%	56.4%	60.0%	37.3%	37.5%	30.8%	50.0%	37.3%	56.8%	58.6%	55.6%	100.0%	56.5%	44.0%	49.1%	67.1%	70.0%	52.6%	75.0%
Respondents with this position	92.2%	95.2%	92.7%	91.4%	91.3%	85.7%	100.0%	100.0%	93.7%	90.2%	92.3%	100.0%	100.0%	93.9%	87.0%	94.8%	97.3%	94.3%	90.5%	100.0%
Elected leader of hospital medical staff																				
Total responding in each category	419	48	124	149	98	43	7	5	43	36	237	2	4	42	136	145	72	43	17	6
Board member and a voting member	40.8%	33.3%	53.2%	53.7%	9.2%	7.0%	0.0%	0.0%	14.0%	47.2%	54.4%	50.0%	50.0%	31.0%	35.3%	49.7%	40.3%	32.6%	35.3%	33.3%
Board member but not a voting member	10.0%	6.3%	10.5%	12.8%	7.1%	4.7%	14.3%	0.0%	9.3%	16.7%	11.0%	0.0%	0.0%	7.1%	10.3%	6.9%	15.3%	14.0%	5.9%	0.0%
Non-board member but regularly attends meetings	27.2%	27.1%	22.6%	14.1%	53.1%	51.2%	71.4%	60.0%	51.2%	16.7%	18.1%	0.0%	25.0%	28.6%	26.5%	30.3%	20.8%	30.2%	29.4%	16.7%
Non-board member and does not attend meetings	22.0%	33.3%	13.7%	19.5%	30.6%	37.2%	14.3%	40.0%	25.6%	19.4%	16.5%	50.0%	25.0%	33.3%	27.9%	13.1%	23.6%	23.3%	29.4%	50.0%
Respondents with this position	80.3%	77.4%	83.2%	86.1%	71.0%	75.4%	53.8%	83.3%	69.4%	87.8%	84.3%	22.2%	100.0%	85.7%	70.8%	86.3%	93.5%	82.7%	81.0%	50.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Past president of hospital medical staff																				
Total responding in each category	388	44	122	137	85	33	8	5	39	33	226	2	3	39	114	146	68	38	16	6
Board member and a voting member	8.2%	11.4%	9.8%	10.9%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%	10.6%	0.0%	0.0%	12.8%	3.5%	8.2%	11.8%	18.4%	0.0%	16.7%
Board member but not a voting member	2.1%	0.0%	2.5%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	3.1%	0.0%	0.0%	0.0%	0.0%	2.7%	1.5%	7.9%	0.0%	0.0%
Non-board member but regularly attends meetings	3.9%	6.8%	4.1%	1.5%	5.9%	6.1%	0.0%	20.0%	5.1%	0.0%	3.1%	0.0%	66.7%	2.6%	2.6%	3.4%	2.9%	7.9%	12.5%	0.0%
Non-board member and does not attend meetings	85.8%	81.8%	83.6%	83.9%	94.1%	93.9%	100.0%	80.0%	94.9%	87.9%	83.2%	100.0%	33.3%	84.6%	93.9%	85.6%	83.8%	65.8%	87.5%	83.3%
Respondents with this position	73.5%	72.1%	79.2%	77.8%	62.0%	58.9%	57.1%	83.3%	63.9%	80.5%	78.2%	22.2%	75.0%	81.3%	59.1%	83.9%	89.5%	73.1%	76.2%	50.0%
President-elect of hospital medical staff																				
Total responding in each category	378	48	121	133	76	32	5	5	34	32	222	2	4	42	106	139	70	40	17	6
Board member and a voting member	9.3%	6.3%	14.0%	11.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.4%	0.0%	0.0%	7.1%	6.6%	10.1%	11.4%	15.0%	0.0%	0.0%
Board member but not a voting member	5.3%	4.2%	9.1%	4.5%	1.3%	3.1%	0.0%	0.0%	0.0%	6.3%	6.8%	0.0%	25.0%	2.4%	1.9%	6.5%	8.6%	5.0%	5.9%	0.0%
Non-board member but regularly attends meetings	11.1%	16.7%	16.5%	6.0%	7.9%	9.4%	0.0%	0.0%	8.8%	0.0%	12.6%	0.0%	50.0%	14.3%	2.8%	15.8%	10.0%	17.5%	11.8%	16.7%
Non-board member and does not attend meetings	74.3%	72.9%	60.3%	78.2%	90.8%	87.5%	100.0%	100.0%	91.2%	93.8%	66.2%	100.0%	25.0%	76.2%	88.7%	67.6%	70.0%	62.5%	82.4%	83.3%
Respondents with this position	71.5%	77.4%	78.1%	76.0%	55.5%	58.2%	35.7%	83.3%	54.8%	78.0%	76.8%	22.2%	100.0%	85.7%	54.9%	79.9%	92.1%	75.5%	81.0%	50.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Representative of an affiliated school of medicine																				
Total responding in each category	105	27	25	39	14	6	1	0	7	17	47	2	2	23	13	28	21	25	14	4
Board member and a voting member	16.2%	14.8%	24.0%	15.4%	7.1%	0.0%	0.0%	N/A	14.3%	11.8%	21.3%	50.0%	50.0%	8.7%	7.7%	17.9%	19.0%	20.0%	14.3%	0.0%
Board member but not a voting member	6.7%	18.5%	4.0%	2.6%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	4.3%	0.0%	0.0%	21.7%	0.0%	0.0%	4.8%	16.0%	7.1%	25.0%
Non-board member but regularly attends meetings	7.6%	11.1%	4.0%	5.1%	14.3%	33.3%	0.0%	N/A	0.0%	5.9%	4.3%	0.0%	0.0%	13.0%	0.0%	10.7%	4.8%	4.0%	21.4%	0.0%
Non-board member and does not attend meetings	69.5%	55.6%	68.0%	76.9%	78.6%	66.7%	100.0%	N/A	85.7%	82.4%	70.2%	50.0%	50.0%	56.5%	92.3%	71.4%	71.4%	60.0%	57.1%	75.0%
Respondents with this position	19.8%	44.3%	16.1%	22.0%	10.3%	10.7%	7.7%	0.0%	11.3%	41.5%	16.2%	22.2%	50.0%	47.9%	6.7%	16.0%	27.6%	49.0%	66.7%	33.3%
Representative of an owned or affiliated medical group or physician enterprise																				
Total responding in each category	176	31	47	67	31	13	2	2	14	20	94	2	4	25	40	58	31	30	11	6
Board member and a voting member	23.9%	16.1%	25.5%	28.4%	19.4%	23.1%	0.0%	0.0%	21.4%	45.0%	23.4%	0.0%	0.0%	20.0%	32.5%	22.4%	25.8%	23.3%	9.1%	0.0%
Board member but not a voting member	4.0%	0.0%	4.3%	6.0%	3.2%	0.0%	0.0%	50.0%	0.0%	0.0%	6.4%	0.0%	0.0%	0.0%	5.0%	3.4%	9.7%	0.0%	0.0%	0.0%
Non-board member but regularly attends meetings	17.0%	35.5%	21.3%	9.0%	9.7%	0.0%	0.0%	0.0%	21.4%	10.0%	14.9%	0.0%	75.0%	32.0%	5.0%	17.2%	12.9%	23.3%	27.3%	66.7%
Non-board member and does not attend meetings	55.1%	48.4%	48.9%	56.7%	67.7%	76.9%	100.0%	50.0%	57.1%	45.0%	55.3%	100.0%	25.0%	48.0%	57.5%	56.9%	51.6%	53.3%	63.6%	33.3%
Respondents with this position	33.3%	50.0%	30.7%	38.5%	22.3%	23.2%	14.3%	33.3%	22.2%	48.8%	32.9%	22.2%	100.0%	51.0%	20.7%	33.7%	40.3%	56.6%	52.4%	50.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	**Overall**	**Health System**	**Indepen-dent**	**Subsidiary**	**Govern-ment**	**County**	**City**	**County/ City**	**District/ Authority**	**Church Hospital**	**Secular Hospital**	**Catholic System**	**Other Church System**	**Other System**	**<100**	**100–299**	**300–499**	**500–999**	**1,000–1,999**	**2,000+**
Representative of an affiliated philanthropic foundation																				
Total responding in each category	254	34	66	100	54	22	5	3	24	31	135	2	4	28	68	85	48	38	10	5
Board member and a voting member	19.3%	14.7%	21.2%	29.0%	1.9%	4.5%	0.0%	0.0%	0.0%	12.9%	28.9%	0.0%	25.0%	14.3%	20.6%	20.0%	16.7%	23.7%	10.0%	0.0%
Board member but not a voting member	2.8%	0.0%	4.5%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	4.4%	0.0%	0.0%	0.0%	2.9%	1.2%	4.2%	5.3%	0.0%	0.0%
Non-board member but regularly attends meetings	35.4%	47.1%	31.8%	32.0%	38.9%	31.8%	40.0%	100.0%	37.5%	48.4%	28.1%	0.0%	50.0%	50.0%	23.5%	34.1%	52.1%	34.2%	40.0%	60.0%
Non-board member and does not attend meetings	42.5%	38.2%	42.4%	35.0%	59.3%	63.6%	60.0%	0.0%	62.5%	35.5%	38.5%	100.0%	25.0%	35.7%	52.9%	44.7%	27.1%	36.8%	50.0%	40.0%
Respondents with this position	48.0%	55.7%	42.9%	56.8%	39.1%	38.6%	38.5%	50.0%	38.7%	75.6%	46.7%	22.2%	100.0%	58.3%	35.1%	48.9%	62.3%	73.1%	47.6%	45.5%
Representative of a religious sponsor																				
Total responding in each category	104	21	17	60	6	2	2	1	1	39	38	8	3	10	18	29	26	17	7	7
Board member and a voting member	68.3%	66.7%	58.8%	78.3%	0.0%	0.0%	0.0%	0.0%	0.0%	87.2%	60.5%	100.0%	66.7%	40.0%	44.4%	82.8%	69.2%	64.7%	71.4%	71.4%
Board member but not a voting member	2.9%	9.5%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	33.3%	10.0%	0.0%	0.0%	3.8%	0.0%	0.0%	28.6%
Non-board member but regularly attends meetings	5.8%	0.0%	5.9%	5.0%	33.3%	0.0%	50.0%	100.0%	0.0%	2.6%	7.9%	0.0%	0.0%	0.0%	11.1%	3.4%	7.7%	5.9%	0.0%	0.0%
Non-board member and does not attend meetings	23.1%	23.8%	35.3%	15.0%	66.7%	100.0%	50.0%	0.0%	100.0%	7.7%	31.6%	0.0%	0.0%	50.0%	44.4%	13.8%	19.2%	29.4%	28.6%	0.0%
Respondents with this position	19.6%	33.9%	11.0%	34.1%	4.3%	3.6%	14.3%	16.7%	1.6%	95.1%	13.1%	88.9%	75.0%	20.4%	9.4%	16.5%	33.8%	32.7%	33.3%	58.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Background of the organization's CEO																				
Total responding in each category	532	62	155	175	140	57	14	6	63	38	292	9	4	49	195	177	76	51	21	12
Physician	4.9%	14.5%	7.1%	2.9%	0.7%	0.0%	7.1%	0.0%	0.0%	0.0%	5.5%	0.0%	50.0%	14.3%	0.5%	4.5%	7.9%	11.8%	19.0%	8.3%
Nurse	12.6%	6.5%	10.3%	17.1%	12.1%	15.8%	14.3%	16.7%	7.9%	18.4%	13.4%	22.2%	0.0%	4.1%	14.9%	11.9%	9.2%	13.7%	4.8%	16.7%
Other clinical expertise	12.6%	4.8%	5.8%	14.3%	21.4%	21.1%	21.4%	16.7%	22.2%	18.4%	9.2%	11.1%	0.0%	4.1%	20.5%	9.0%	7.9%	7.8%	4.8%	0.0%
Business/ finance	71.2%	71.0%	71.6%	67.4%	75.7%	70.2%	78.6%	50.0%	82.5%	63.2%	70.2%	77.8%	75.0%	69.4%	72.3%	74.0%	67.1%	66.7%	57.1%	83.3%
Non-profit/ not-for-profit	27.3%	38.7%	23.9%	25.7%	27.9%	28.1%	21.4%	0.0%	31.7%	23.7%	25.0%	55.6%	25.0%	36.7%	29.7%	22.0%	27.6%	25.5%	28.6%	66.7%
Other non-clinical/ non-healthcare	6.8%	14.5%	5.8%	6.9%	4.3%	3.5%	0.0%	16.7%	4.8%	2.6%	6.8%	22.2%	0.0%	14.3%	6.7%	4.5%	6.6%	9.8%	14.3%	16.7%
Background of the organization's board chairperson																				
Total responding in each category	530	61	153	176	140	57	14	6	63	38	291	9	4	48	194	175	77	51	21	12
Physician	7.0%	6.6%	11.8%	7.4%	1.4%	1.8%	0.0%	0.0%	1.6%	5.3%	10.0%	11.1%	0.0%	6.3%	5.2%	8.6%	9.1%	5.9%	4.8%	8.3%
Nurse	2.5%	1.6%	1.3%	2.3%	4.3%	3.5%	0.0%	0.0%	6.3%	5.3%	1.4%	11.1%	0.0%	0.0%	3.6%	2.3%	1.3%	0.0%	0.0%	8.3%
Other clinical expertise	4.0%	3.3%	1.3%	4.0%	7.1%	0.0%	7.1%	0.0%	14.3%	0.0%	3.1%	22.2%	0.0%	0.0%	5.2%	2.3%	3.9%	3.9%	4.8%	8.3%
Business/ finance	67.5%	72.1%	63.4%	67.6%	70.0%	64.9%	64.3%	83.3%	74.6%	73.7%	64.6%	44.4%	75.0%	77.1%	63.4%	68.0%	74.0%	70.6%	61.9%	83.3%
Non-profit/ not-for-profit	7.4%	16.4%	7.8%	6.8%	3.6%	3.5%	7.1%	0.0%	3.2%	18.4%	5.8%	33.3%	0.0%	14.6%	6.7%	4.0%	10.4%	9.8%	14.3%	25.0%
Other non-clinical/ non-healthcare	21.3%	16.4%	24.2%	19.3%	22.9%	29.8%	28.6%	33.3%	14.3%	7.9%	23.4%	22.2%	25.0%	14.6%	24.7%	20.6%	16.9%	17.6%	23.8%	16.7%
Number of standing committees																				
Total responding in each category	469	49	141	153	126	48	12	5	61	36	258	6	3	40	175	160	66	44	15	9
0	5.8%	0.0%	2.8%	2.6%	15.1%	18.8%	0.0%	0.0%	16.4%	0.0%	3.1%	0.0%	0.0%	0.0%	12.0%	3.1%	1.5%	0.0%	0.0%	0.0%
1 to 3	24.9%	8.2%	21.3%	26.1%	34.1%	35.4%	8.3%	40.0%	37.7%	38.9%	21.7%	16.7%	0.0%	7.5%	38.3%	20.6%	9.1%	25.0%	0.0%	0.0%
4 to 5	32.4%	16.3%	31.9%	35.9%	34.9%	35.4%	41.7%	20.0%	34.4%	47.2%	32.2%	0.0%	0.0%	20.0%	31.4%	35.0%	39.4%	31.8%	6.7%	0.0%
6 to 7	17.7%	34.7%	18.4%	17.6%	10.3%	8.3%	41.7%	0.0%	6.6%	8.3%	19.4%	50.0%	33.3%	32.5%	9.1%	21.3%	24.2%	20.5%	33.3%	33.3%
8 to 10	15.6%	34.7%	21.3%	13.7%	4.0%	2.1%	8.3%	20.0%	3.3%	5.6%	19.0%	33.3%	33.3%	35.0%	7.4%	17.5%	19.7%	15.9%	46.7%	55.6%
11 +	3.6%	6.1%	4.3%	3.9%	1.6%	0.0%	0.0%	20.0%	1.6%	0.0%	4.7%	0.0%	33.3%	5.0%	1.7%	2.5%	6.1%	6.8%	13.3%	11.1%
Average	4.97	6.90	5.49	5.08	3.51	3.13	5.42	5.80	3.25	4.08	5.45	6.67	8.67	6.80	3.71	5.24	6.02	5.57	8.47	8.33
Median	5	7	5	5	4	3	6	5	3	4	5	7	8	7	3	5	6	5	9	8
Range	0 to 14	1 to 12	0 to 13	0 to 14	0 to 11	0 to 8	2 to 10	1 to 11	0 to 11	1 to 9	0 to 14	3 to 8	7 to 11	1 to 12	0 to 14	0 to 13	0 to 13	1 to 12	5 to 11	7 to 12

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Standing Committees: Meeting Frequency																				
Executive																				
Total responding in each category	405	45	135	148	77	31	7	3	36	36	247	6	4	35	135	141	62	44	16	7
Monthly	25.7%	8.9%	29.6%	21.6%	36.4%	38.7%	42.9%	66.7%	30.6%	11.1%	27.5%	0.0%	0.0%	11.4%	20.7%	33.3%	24.2%	25.0%	12.5%	14.3%
Bimonthly	11.9%	22.2%	10.4%	15.5%	1.3%	0.0%	0.0%	0.0%	2.8%	33.3%	10.1%	16.7%	50.0%	20.0%	4.4%	8.5%	17.7%	22.7%	37.5%	42.9%
Quarterly	4.7%	11.1%	3.7%	4.7%	2.6%	3.2%	0.0%	33.3%	0.0%	2.8%	4.5%	16.7%	0.0%	11.4%	3.0%	3.5%	6.5%	9.1%	12.5%	0.0%
Semi-annually	1.5%	0.0%	3.0%	0.7%	1.3%	0.0%	0.0%	0.0%	2.8%	2.8%	1.6%	0.0%	0.0%	0.0%	3.0%	1.4%	0.0%	0.0%	0.0%	0.0%
Annually	0.7%	0.0%	1.5%	0.0%	1.3%	0.0%	0.0%	0.0%	2.8%	0.0%	0.8%	0.0%	0.0%	0.0%	0.7%	1.4%	0.0%	0.0%	0.0%	0.0%
As needed	55.6%	57.8%	51.9%	57.4%	57.1%	58.1%	57.1%	0.0%	61.1%	50.0%	55.5%	66.7%	50.0%	57.1%	68.1%	51.8%	51.6%	43.2%	37.5%	42.9%
Respondents with this committee	77.3%	75.0%	87.7%	84.6%	57.0%	58.5%	50.0%	50.0%	58.1%	87.8%	85.8%	75.0%	100.0%	72.9%	71.1%	81.0%	82.7%	84.6%	76.2%	58.3%
Finance																				
Total responding in each category	390	51	114	133	92	30	13	6	43	35	212	5	4	42	129	129	66	37	19	10
Monthly	61.0%	33.3%	62.3%	62.4%	72.8%	56.7%	76.9%	100.0%	79.1%	45.7%	65.1%	0.0%	25.0%	38.1%	65.9%	69.8%	63.6%	35.1%	31.6%	20.0%
Bimonthly	15.1%	25.5%	16.7%	19.5%	1.1%	3.3%	0.0%	0.0%	0.0%	31.4%	16.0%	20.0%	50.0%	23.8%	7.8%	14.7%	13.6%	32.4%	36.8%	20.0%
Quarterly	14.6%	41.2%	11.4%	13.5%	5.4%	13.3%	0.0%	0.0%	2.3%	20.0%	11.3%	80.0%	25.0%	38.1%	6.2%	11.6%	18.2%	27.0%	31.6%	60.0%
Semi-annually	1.0%	0.0%	2.6%	0.0%	1.1%	3.3%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	1.6%	0.0%	1.5%	2.7%	0.0%	0.0%
Annually	0.8%	0.0%	0.9%	0.0%	2.2%	6.7%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	0.8%	0.0%	2.7%	0.0%	0.0%
As needed	7.4%	0.0%	6.1%	4.5%	17.4%	16.7%	23.1%	0.0%	18.6%	2.9%	5.7%	0.0%	0.0%	0.0%	17.8%	3.1%	3.0%	0.0%	0.0%	0.0%
Respondents with this committee	75.9%	86.4%	76.0%	76.9%	69.7%	57.7%	92.9%	100.0%	71.7%	85.4%	75.2%	62.5%	100.0%	89.4%	68.6%	76.8%	88.0%	72.5%	90.5%	90.9%
Finance/Audit																				
Total responding in each category	182	13	63	62	44	16	6	2	20	12	113	0	0	13	69	72	20	15	5	1
Monthly	30.8%	7.7%	36.5%	27.4%	34.1%	43.8%	16.7%	0.0%	35.0%	25.0%	32.7%	0.0%	0.0%	7.7%	36.2%	34.7%	25.0%	6.7%	0.0%	0.0%
Bimonthly	7.1%	15.4%	7.9%	8.1%	2.3%	0.0%	0.0%	0.0%	5.0%	16.7%	7.1%	0.0%	0.0%	15.4%	4.3%	5.6%	15.0%	6.7%	20.0%	100.0%
Quarterly	20.9%	30.8%	17.5%	27.4%	13.6%	18.8%	0.0%	0.0%	15.0%	25.0%	22.1%	0.0%	0.0%	30.8%	11.6%	22.2%	15.0%	60.0%	40.0%	0.0%
Semi-annually	7.7%	23.1%	4.8%	8.1%	6.8%	6.3%	33.3%	0.0%	0.0%	0.0%	7.1%	0.0%	0.0%	23.1%	2.9%	11.1%	10.0%	6.7%	20.0%	0.0%
Annually	15.9%	15.4%	14.3%	12.9%	22.7%	18.8%	50.0%	50.0%	15.0%	16.7%	13.3%	0.0%	0.0%	15.4%	20.3%	11.1%	20.0%	13.3%	20.0%	0.0%
As needed	17.6%	7.7%	19.0%	16.1%	20.5%	12.5%	0.0%	50.0%	30.0%	16.7%	17.7%	0.0%	0.0%	7.7%	24.6%	15.3%	15.0%	6.7%	0.0%	0.0%
Respondents with this committee	38.1%	25.5%	45.0%	38.5%	34.9%	32.0%	42.9%	40.0%	35.1%	31.6%	43.0%	0.0%	0.0%	32.5%	38.5%	46.2%	29.9%	31.9%	27.8%	9.1%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Audit																				
Total responding in each category	153	21	45	61	26	8	3	1	14	13	93	1	1	19	45	56	29	12	7	4
Monthly	5.2%	9.5%	0.0%	8.2%	3.8%	0.0%	0.0%	0.0%	7.1%	7.7%	4.3%	0.0%	0.0%	10.5%	2.2%	7.1%	6.9%	0.0%	0.0%	25.0%
Bimonthly	7.2%	14.3%	6.7%	8.2%	0.0%	0.0%	0.0%	0.0%	0.0%	15.4%	6.5%	0.0%	0.0%	15.8%	0.0%	7.1%	13.8%	0.0%	28.6%	25.0%
Quarterly	30.1%	47.6%	28.9%	29.5%	19.2%	12.5%	0.0%	0.0%	28.6%	38.5%	28.0%	0.0%	100.0%	47.4%	4.4%	26.8%	44.8%	83.3%	57.1%	50.0%
Semi-annually	11.1%	14.3%	15.6%	9.8%	3.8%	0.0%	33.3%	0.0%	0.0%	7.7%	12.9%	100.0%	0.0%	10.5%	2.2%	14.3%	20.7%	8.3%	14.3%	0.0%
Annually	17.0%	4.8%	20.0%	16.4%	23.1%	50.0%	0.0%	0.0%	14.3%	15.4%	18.3%	0.0%	0.0%	5.3%	40.0%	12.5%	3.4%	0.0%	0.0%	0.0%
As needed	29.4%	9.5%	28.9%	27.9%	50.0%	37.5%	66.7%	100.0%	50.0%	15.4%	30.1%	0.0%	0.0%	10.5%	51.1%	32.1%	10.3%	8.3%	0.0%	0.0%
Respondents with this committee	32.1%	39.6%	33.6%	37.7%	20.5%	16.0%	21.4%	20.0%	24.1%	33.3%	36.2%	14.3%	25.0%	45.2%	25.0%	35.4%	42.6%	29.3%	38.9%	36.4%
Audit/Compliance																				
Total responding in each category	161	36	45	57	23	7	4	2	10	11	91	5	3	28	35	43	39	24	12	8
Monthly	8.1%	11.1%	6.7%	7.0%	8.7%	14.3%	0.0%	0.0%	10.0%	9.1%	6.6%	0.0%	0.0%	14.3%	14.3%	4.7%	7.7%	8.3%	0.0%	12.5%
Bimonthly	8.7%	13.9%	11.1%	7.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.2%	7.7%	0.0%	0.0%	17.9%	0.0%	9.3%	7.7%	16.7%	25.0%	0.0%
Quarterly	52.2%	66.7%	44.4%	57.9%	30.4%	42.9%	0.0%	0.0%	40.0%	45.5%	52.7%	100.0%	100.0%	57.1%	22.9%	46.5%	59.0%	70.8%	75.0%	87.5%
Semi-annually	8.7%	2.8%	13.3%	8.8%	8.7%	14.3%	25.0%	0.0%	0.0%	0.0%	12.1%	0.0%	0.0%	3.6%	2.9%	14.0%	17.9%	0.0%	0.0%	0.0%
Annually	3.1%	0.0%	4.4%	3.5%	4.3%	0.0%	0.0%	0.0%	10.0%	9.1%	3.3%	0.0%	0.0%	0.0%	11.4%	2.3%	0.0%	0.0%	0.0%	0.0%
As needed	19.3%	5.6%	20.0%	15.8%	47.8%	28.6%	75.0%	100.0%	40.0%	18.2%	17.6%	0.0%	0.0%	7.1%	48.6%	23.3%	7.7%	4.2%	0.0%	0.0%
Respondents with this committee	34.2%	66.7%	33.6%	35.8%	18.5%	14.0%	28.6%	33.3%	18.5%	28.9%	35.7%	62.5%	75.0%	66.7%	19.8%	28.3%	59.1%	51.1%	66.7%	72.7%
Compliance																				
Total responding in each category	156	12	51	55	38	14	4	4	16	14	92	0	0	12	64	59	22	5	5	1
Monthly	23.7%	0.0%	19.6%	29.1%	28.9%	28.6%	0.0%	50.0%	31.3%	35.7%	22.8%	N/A	0.0%	0.0%	29.7%	23.7%	18.2%	0.0%	0.0%	0.0%
Bimonthly	13.5%	25.0%	15.7%	16.4%	2.6%	0.0%	0.0%	0.0%	6.3%	14.3%	16.3%	N/A	N/A	25.0%	7.8%	15.3%	18.2%	40.0%	20.0%	0.0%
Quarterly	37.2%	50.0%	35.3%	40.0%	31.6%	35.7%	50.0%	25.0%	25.0%	50.0%	35.9%	N/A	N/A	50.0%	29.7%	37.3%	45.5%	60.0%	60.0%	100.0%
Semi-annually	5.8%	16.7%	3.9%	5.5%	5.3%	7.1%	25.0%	0.0%	0.0%	0.0%	5.4%	N/A	N/A	16.7%	6.3%	3.4%	9.1%	0.0%	20.0%	0.0%
Annually	3.2%	0.0%	3.9%	1.8%	5.3%	0.0%	0.0%	25.0%	6.3%	0.0%	3.3%	N/A	N/A	0.0%	4.7%	3.4%	0.0%	0.0%	0.0%	0.0%
As needed	16.7%	8.3%	21.6%	7.3%	26.3%	28.6%	25.0%	0.0%	31.3%	0.0%	16.3%	N/A	N/A	8.3%	21.9%	16.9%	9.1%	0.0%	0.0%	0.0%
Respondents with this committee	33.1%	23.5%	38.1%	34.2%	30.2%	27.5%	28.6%	66.7%	29.1%	35.0%	36.1%	0.0%	0.0%	30.0%	35.2%	38.8%	32.4%	12.2%	26.3%	10.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Quality and/or Safety																				
Total responding in each category	396	50	120	148	78	30	13	5	30	33	235	5	4	41	113	143	67	44	18	11
Monthly	52.5%	32.0%	56.7%	53.4%	57.7%	56.7%	61.5%	80.0%	53.3%	36.4%	57.4%	0.0%	25.0%	36.6%	56.6%	54.5%	64.2%	36.4%	33.3%	9.1%
Bimonthly	20.7%	36.0%	17.5%	23.6%	10.3%	10.0%	0.0%	0.0%	16.7%	33.3%	19.1%	20.0%	75.0%	34.1%	12.4%	19.6%	17.9%	38.6%	33.3%	45.5%
Quarterly	24.7%	30.0%	25.0%	22.3%	25.6%	26.7%	30.8%	20.0%	23.3%	30.3%	22.6%	80.0%	0.0%	26.8%	24.8%	25.2%	17.9%	25.0%	33.3%	45.5%
Semi-annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	2.0%	2.0%	0.8%	0.7%	6.4%	6.7%	7.7%	0.0%	6.7%	0.0%	0.9%	0.0%	0.0%	2.4%	6.2%	0.7%	0.0%	0.0%	0.0%	0.0%
Respondents with this committee	77.0%	84.7%	79.5%	85.5%	59.5%	56.6%	92.9%	83.3%	51.7%	82.5%	82.7%	62.5%	100.0%	87.2%	61.1%	83.1%	89.3%	89.8%	85.7%	91.7%
Governance/Nominating																				
Total responding in each category	385	54	125	142	64	24	8	3	29	31	236	6	4	44	111	138	64	41	19	12
Monthly	6.2%	5.6%	11.2%	2.1%	6.3%	0.0%	12.5%	0.0%	10.3%	0.0%	7.2%	0.0%	0.0%	6.8%	4.5%	9.4%	7.8%	0.0%	0.0%	8.3%
Bimonthly	7.8%	18.5%	5.6%	7.7%	3.1%	4.2%	12.5%	0.0%	0.0%	6.5%	6.8%	16.7%	50.0%	15.9%	0.9%	8.7%	10.9%	9.8%	21.1%	16.7%
Quarterly	17.1%	27.8%	15.2%	20.4%	4.7%	4.2%	12.5%	0.0%	3.4%	16.1%	18.2%	50.0%	50.0%	22.7%	4.5%	17.4%	28.1%	22.0%	26.3%	41.7%
Semi-annually	5.5%	5.6%	6.4%	7.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.9%	5.9%	16.7%	0.0%	4.5%	2.7%	4.3%	6.3%	14.6%	0.0%	16.7%
Annually	16.6%	11.1%	18.4%	17.6%	15.6%	20.8%	12.5%	66.7%	6.9%	32.3%	16.1%	0.0%	0.0%	13.6%	23.4%	14.5%	12.5%	14.6%	21.1%	0.0%
As needed	46.8%	31.5%	43.2%	45.1%	70.3%	70.8%	50.0%	33.3%	79.3%	32.3%	45.8%	16.7%	0.0%	36.4%	64.0%	45.7%	34.4%	39.0%	31.6%	16.7%
Respondents with this committee	76.5%	91.5%	85.6%	82.6%	50.8%	47.1%	57.1%	50.0%	52.7%	77.5%	84.9%	75.0%	100.0%	93.6%	61.7%	82.6%	86.5%	83.7%	90.5%	100.0%
Executive Compensation																				
Total responding in each category	297	46	109	96	46	21	4	3	18	12	193	4	3	39	72	119	51	29	18	8
Monthly	1.7%	4.3%	1.8%	0.0%	2.2%	0.0%	0.0%	0.0%	5.6%	0.0%	1.0%	0.0%	33.3%	2.6%	0.0%	2.5%	0.0%	3.4%	5.6%	0.0%
Bimonthly	1.7%	4.3%	0.0%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.6%	0.0%	0.0%	5.1%	0.0%	0.0%	3.9%	6.9%	5.6%	0.0%
Quarterly	16.8%	39.1%	16.5%	11.5%	6.5%	4.8%	25.0%	33.3%	0.0%	8.3%	14.5%	100.0%	66.7%	30.8%	2.8%	10.1%	21.6%	37.9%	44.4%	75.0%
Semi-annually	13.5%	21.7%	11.9%	16.7%	2.2%	4.8%	0.0%	0.0%	0.0%	0.0%	15.0%	0.0%	0.0%	25.6%	6.9%	11.8%	23.5%	10.3%	22.2%	25.0%
Annually	26.9%	15.2%	33.0%	21.9%	34.8%	42.9%	25.0%	66.7%	22.2%	58.3%	25.9%	0.0%	0.0%	17.9%	43.1%	25.2%	25.5%	17.2%	5.6%	0.0%
As needed	39.4%	15.2%	36.7%	46.9%	54.3%	47.6%	50.0%	0.0%	72.2%	33.3%	42.0%	0.0%	0.0%	17.9%	47.2%	50.4%	25.5%	24.1%	16.7%	0.0%
Respondents with this committee	60.1%	85.2%	76.2%	57.5%	35.4%	40.4%	28.6%	50.0%	31.0%	33.3%	70.4%	57.1%	75.0%	90.7%	39.6%	72.1%	71.8%	61.7%	94.7%	80.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Strategic Planning																				
Total responding in each category	286	25	99	95	67	20	9	3	35	22	172	2	1	22	96	105	50	22	7	6
Monthly	16.1%	8.0%	10.1%	17.9%	25.4%	25.0%	22.2%	33.3%	25.7%	9.1%	14.5%	0.0%	100.0%	4.5%	15.6%	18.1%	14.0%	18.2%	14.3%	0.0%
Bimonthly	10.5%	28.0%	11.1%	9.5%	4.5%	5.0%	0.0%	33.3%	2.9%	9.1%	10.5%	0.0%	0.0%	31.8%	4.2%	4.8%	18.0%	36.4%	28.6%	33.3%
Quarterly	27.6%	40.0%	36.4%	25.3%	13.4%	15.0%	22.2%	0.0%	11.4%	45.5%	29.1%	100.0%	0.0%	36.4%	17.7%	30.5%	34.0%	36.4%	28.6%	50.0%
Semi-annually	4.5%	4.0%	3.0%	7.4%	3.0%	5.0%	0.0%	0.0%	2.9%	4.5%	5.2%	0.0%	0.0%	4.5%	4.2%	5.7%	4.0%	0.0%	0.0%	16.7%
Annually	12.6%	12.0%	9.1%	15.8%	13.4%	10.0%	22.2%	0.0%	14.3%	22.7%	11.0%	0.0%	0.0%	13.6%	20.8%	10.5%	6.0%	0.0%	28.6%	0.0%
As needed	28.7%	8.0%	30.3%	24.2%	40.3%	40.0%	33.3%	33.3%	42.9%	9.1%	29.7%	0.0%	0.0%	9.1%	37.5%	30.5%	24.0%	9.1%	0.0%	0.0%
Respondents with this committee	57.3%	45.5%	66.0%	57.6%	51.9%	39.2%	64.3%	60.0%	59.3%	61.1%	61.6%	28.6%	25.0%	50.0%	51.6%	63.3%	69.4%	48.9%	36.8%	54.5%
Physician Relations																				
Total responding in each category	94	6	28	30	30	9	1	2	18	10	48	0	0	6	42	29	12	5	4	2
Monthly	22.3%	33.3%	21.4%	26.7%	16.7%	11.1%	0.0%	0.0%	22.2%	20.0%	25.0%	N/A	N/A	33.3%	16.7%	24.1%	25.0%	20.0%	50.0%	50.0%
Bimonthly	5.3%	0.0%	7.1%	6.7%	3.3%	0.0%	100.0%	0.0%	0.0%	10.0%	6.3%	N/A	N/A	0.0%	0.0%	6.9%	8.3%	40.0%	0.0%	0.0%
Quarterly	10.6%	16.7%	7.1%	16.7%	6.7%	11.1%	0.0%	0.0%	5.6%	30.0%	8.3%	N/A	N/A	16.7%	4.8%	6.9%	33.3%	20.0%	25.0%	0.0%
Semi-annually	3.2%	0.0%	3.6%	0.0%	6.7%	11.1%	0.0%	0.0%	5.6%	0.0%	2.1%	N/A	N/A	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	3.2%	0.0%	7.1%	0.0%	3.3%	11.1%	0.0%	0.0%	0.0%	0.0%	4.2%	N/A	N/A	0.0%	2.4%	6.9%	0.0%	0.0%	0.0%	0.0%
As needed	55.3%	50.0%	53.6%	50.0%	63.3%	55.6%	0.0%	100.0%	66.7%	40.0%	54.2%	N/A	N/A	50.0%	69.0%	55.2%	33.3%	20.0%	25.0%	50.0%
Respondents with this committee	19.1%	11.3%	19.3%	17.9%	23.6%	17.3%	7.7%	33.3%	32.1%	26.3%	17.5%	0.0%	0.0%	14.3%	23.0%	17.8%	16.9%	10.9%	21.1%	18.2%
Investment																				
Total responding in each category	174	40	59	52	23	7	1	2	13	8	103	8	2	30	34	57	35	22	16	10
Monthly	7.5%	5.0%	6.8%	13.5%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	8.7%	0.0%	0.0%	6.7%	11.8%	7.0%	5.7%	9.1%	6.3%	0.0%
Bimonthly	8.0%	10.0%	6.8%	9.6%	4.3%	0.0%	0.0%	0.0%	7.7%	12.5%	7.8%	0.0%	0.0%	13.3%	2.9%	3.5%	14.3%	18.2%	6.3%	10.0%
Quarterly	55.7%	70.0%	61.0%	50.0%	30.4%	28.6%	100.0%	50.0%	23.1%	37.5%	57.3%	75.0%	100.0%	66.7%	32.4%	61.4%	57.1%	54.5%	75.0%	70.0%
Semi-annually	9.8%	7.5%	10.2%	13.5%	4.3%	14.3%	0.0%	0.0%	0.0%	0.0%	12.6%	12.5%	0.0%	6.7%	11.8%	8.8%	11.4%	4.5%	12.5%	10.0%
Annually	2.9%	0.0%	3.4%	1.9%	8.7%	0.0%	0.0%	0.0%	15.4%	12.5%	1.9%	0.0%	0.0%	0.0%	5.9%	5.3%	0.0%	0.0%	0.0%	0.0%
As needed	16.1%	7.5%	11.9%	11.5%	52.2%	57.1%	0.0%	50.0%	53.8%	12.5%	11.7%	12.5%	0.0%	6.7%	35.3%	14.0%	11.4%	13.6%	0.0%	10.0%
Respondents with this committee	34.7%	70.2%	40.1%	31.1%	17.7%	13.2%	7.1%	33.3%	22.8%	21.1%	37.3%	100.0%	50.0%	66.7%	18.6%	34.5%	49.3%	44.9%	76.2%	83.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Joint Conference																				
Total responding in each category	199	14	62	57	66	31	6	2	27	10	109	0	0	14	80	74	28	11	4	2
Monthly	8.5%	21.4%	4.8%	7.0%	10.6%	12.9%	33.3%	0.0%	3.7%	0.0%	6.4%	N/A	N/A	21.4%	5.0%	10.8%	10.7%	18.2%	0.0%	0.0%
Bimonthly	4.5%	7.1%	6.5%	7.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	5.5%	N/A	N/A	7.1%	2.5%	5.4%	0.0%	18.2%	25.0%	0.0%
Quarterly	18.6%	21.4%	14.5%	15.8%	24.2%	12.9%	33.3%	50.0%	33.3%	10.0%	15.6%	N/A	N/A	21.4%	13.8%	21.6%	21.4%	18.2%	50.0%	0.0%
Semi-annually	4.5%	0.0%	4.8%	1.8%	7.6%	9.7%	0.0%	0.0%	7.4%	0.0%	3.7%	N/A	N/A	0.0%	6.3%	5.4%	0.0%	0.0%	0.0%	0.0%
Annually	2.0%	0.0%	4.8%	0.0%	1.5%	3.2%	0.0%	0.0%	0.0%	0.0%	2.8%	N/A	N/A	0.0%	3.8%	1.4%	0.0%	0.0%	0.0%	0.0%
As needed	61.8%	50.0%	64.5%	68.4%	56.1%	61.3%	33.3%	50.0%	55.6%	70.0%	66.1%	N/A	N/A	50.0%	68.8%	55.4%	67.9%	45.5%	25.0%	100.0%
Respondents with this committee	40.0%	25.5%	42.8%	34.5%	49.6%	58.5%	42.9%	33.3%	45.0%	26.3%	40.1%	0.0%	0.0%	31.8%	43.2%	45.4%	38.4%	23.4%	21.1%	18.2%
Facilities/Infrastructure/Maintenance																				
Total responding in each category	122	5	30	43	44	17	3	3	21	5	68	0	0	5	59	37	15	8	2	1
Monthly	20.5%	0.0%	30.0%	14.0%	22.7%	23.5%	0.0%	33.3%	23.8%	20.0%	20.6%	N/A	N/A	0.0%	23.7%	18.9%	26.7%	0.0%	0.0%	0.0%
Bimonthly	9.8%	20.0%	10.0%	11.6%	6.8%	5.9%	33.3%	0.0%	4.8%	0.0%	11.8%	N/A	N/A	20.0%	1.7%	18.9%	6.7%	25.0%	50.0%	0.0%
Quarterly	13.9%	40.0%	16.7%	11.6%	11.4%	11.8%	33.3%	33.3%	4.8%	20.0%	13.2%	N/A	N/A	40.0%	8.5%	10.8%	20.0%	50.0%	0.0%	100.0%
Semi-annually	2.5%	0.0%	3.3%	4.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.4%	N/A	N/A	0.0%	1.7%	5.4%	0.0%	0.0%	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	53.3%	40.0%	40.0%	58.1%	59.1%	58.8%	33.3%	33.3%	66.7%	60.0%	50.0%	N/A	N/A	40.0%	64.4%	45.9%	46.7%	25.0%	50.0%	0.0%
Respondents with this committee	24.5%	9.1%	20.8%	25.6%	33.8%	32.7%	21.4%	50.0%	36.2%	13.2%	24.8%	0.0%	0.0%	11.4%	32.1%	22.7%	20.8%	17.0%	10.0%	9.1%
Construction																				
Total responding in each category	47	2	9	12	24	10	1	1	12	1	20	0	0	2	30	9	6	0	2	0
Monthly	10.6%	0.0%	11.1%	8.3%	12.5%	0.0%	100.0%	0.0%	16.7%	0.0%	10.0%	N/A	N/A	0.0%	13.3%	11.1%	0.0%	N/A	0.0%	0.0%
Bimonthly	2.1%	0.0%	0.0%	0.0%	4.2%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	3.3%	0.0%	0.0%	N/A	0.0%	0.0%
Quarterly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%
Semi-annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%
As needed	87.2%	100.0%	88.9%	91.7%	83.3%	90.0%	0.0%	100.0%	83.3%	100.0%	90.0%	N/A	N/A	100.0%	83.3%	88.9%	100.0%	N/A	100.0%	0.0%
Respondents with this committee	9.4%	3.5%	6.3%	7.0%	18.8%	19.2%	7.7%	16.7%	21.1%	2.5%	7.3%	0.0%	0.0%	4.3%	16.5%	5.5%	8.0%	0.0%	10.0%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Government Relations/Advocacy																				
Total responding in each category	45	5	12	16	12	4	0	1	7	3	25	1	0	4	15	13	8	3	4	2
Monthly	8.9%	0.0%	25.0%	0.0%	8.3%	0.0%	N/A	0.0%	14.3%	0.0%	12.0%	0.0%	N/A	0.0%	6.7%	15.4%	12.5%	0.0%	0.0%	0.0%
Bimonthly	6.7%	0.0%	0.0%	6.3%	16.7%	25.0%	N/A	0.0%	14.3%	33.3%	0.0%	0.0%	N/A	0.0%	6.7%	0.0%	12.5%	33.3%	0.0%	0.0%
Quarterly	26.7%	80.0%	16.7%	37.5%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	32.0%	100.0%	N/A	75.0%	13.3%	7.7%	25.0%	66.7%	75.0%	100.0%
Semi-annually	2.2%	0.0%	8.3%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	4.0%	0.0%	N/A	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	55.6%	20.0%	50.0%	56.3%	75.0%	75.0%	N/A	100.0%	71.4%	66.7%	52.0%	0.0%	N/A	25.0%	73.3%	76.9%	37.5%	0.0%	25.0%	0.0%
Respondents with this committee	9.0%	8.8%	8.2%	9.3%	9.4%	7.7%	0.0%	16.7%	12.5%	7.5%	9.0%	14.3%	0.0%	8.7%	8.2%	8.0%	10.7%	6.1%	20.0%	18.2%
Human Resources																				
Total responding in each category	101	16	25	32	28	10	6	1	11	4	53	3	1	12	37	31	13	11	5	4
Monthly	16.8%	12.5%	16.0%	9.4%	28.6%	20.0%	33.3%	100.0%	27.3%	0.0%	13.2%	0.0%	0.0%	16.7%	18.9%	16.1%	30.8%	9.1%	0.0%	0.0%
Bimonthly	10.9%	12.5%	12.0%	15.6%	3.6%	10.0%	0.0%	0.0%	0.0%	25.0%	13.2%	0.0%	100.0%	8.3%	2.7%	16.1%	7.7%	27.3%	20.0%	0.0%
Quarterly	32.7%	56.3%	28.0%	37.5%	17.9%	20.0%	33.3%	0.0%	9.1%	0.0%	35.8%	100.0%	0.0%	50.0%	21.6%	32.3%	30.8%	45.5%	40.0%	100.0%
Semi-annually	7.9%	6.3%	12.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	9.4%	0.0%	0.0%	8.3%	5.4%	9.7%	15.4%	9.1%	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	31.7%	12.5%	32.0%	25.0%	50.0%	50.0%	33.3%	0.0%	63.6%	25.0%	28.3%	0.0%	0.0%	16.7%	51.4%	25.8%	15.4%	9.1%	40.0%	0.0%
Respondents with this committee	20.1%	27.1%	17.2%	18.7%	21.9%	18.9%	46.2%	16.7%	19.6%	10.3%	19.1%	37.5%	25.0%	25.5%	20.1%	19.0%	17.6%	22.4%	23.8%	33.3%
Community Benefit																				
Total responding in each category	90	12	25	35	18	8	1	1	8	7	53	0	2	10	25	29	20	8	7	1
Monthly	13.3%	0.0%	20.0%	8.6%	22.2%	12.5%	0.0%	0.0%	37.5%	0.0%	15.1%	N/A	0.0%	0.0%	8.0%	13.8%	25.0%	12.5%	0.0%	0.0%
Bimonthly	10.0%	8.3%	12.0%	11.4%	5.6%	12.5%	0.0%	0.0%	0.0%	28.6%	9.4%	N/A	0.0%	10.0%	8.0%	6.9%	15.0%	12.5%	14.3%	0.0%
Quarterly	40.0%	66.7%	36.0%	48.6%	11.1%	12.5%	100.0%	0.0%	0.0%	71.4%	39.6%	N/A	0.0%	80.0%	32.0%	34.5%	35.0%	75.0%	71.4%	0.0%
Semi-annually	6.7%	8.3%	4.0%	8.6%	5.6%	0.0%	0.0%	100.0%	0.0%	0.0%	7.5%	N/A	50.0%	0.0%	0.0%	13.8%	5.0%	0.0%	0.0%	100.0%
Annually	3.3%	8.3%	0.0%	5.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	N/A	50.0%	0.0%	0.0%	3.4%	5.0%	0.0%	14.3%	0.0%
As needed	26.7%	8.3%	28.0%	17.1%	55.6%	62.5%	0.0%	0.0%	62.5%	0.0%	24.5%	N/A	0.0%	10.0%	52.0%	27.6%	15.0%	0.0%	0.0%	0.0%
Respondents with this committee	17.8%	21.1%	17.0%	20.1%	14.2%	15.4%	7.7%	16.7%	14.3%	17.5%	18.9%	0.0%	50.0%	21.7%	13.6%	17.5%	26.7%	16.3%	35.0%	9.1%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Responsibilities/authorities of the executive committee																				
Total responding in each category	398	45	132	149	72	32	7	3	30	34	247	6	4	35	134	137	62	43	15	7
Executive compensation	40.5%	20.0%	50.0%	34.9%	47.2%	62.5%	42.9%	33.3%	33.3%	29.4%	43.7%	0.0%	0.0%	25.7%	46.3%	48.9%	22.6%	32.6%	20.0%	14.3%
Board member nominations	24.9%	13.3%	22.7%	28.2%	29.2%	28.1%	28.6%	66.7%	26.7%	50.0%	22.3%	0.0%	0.0%	17.1%	30.6%	19.7%	22.6%	30.2%	20.0%	14.3%
Board member selection	12.1%	6.7%	11.4%	13.4%	13.9%	12.5%	0.0%	33.3%	16.7%	23.5%	10.9%	16.7%	0.0%	5.7%	14.2%	8.0%	12.9%	18.6%	6.7%	14.3%
Advising the CEO	68.3%	66.7%	68.9%	65.8%	73.6%	68.8%	71.4%	100.0%	76.7%	70.6%	66.8%	50.0%	50.0%	71.4%	68.7%	67.9%	61.3%	81.4%	66.7%	57.1%
Emergency deci-sion making	74.9%	77.8%	80.3%	73.2%	66.7%	62.5%	57.1%	66.7%	73.3%	73.5%	76.9%	83.3%	25.0%	82.9%	74.6%	74.5%	74.2%	74.4%	86.7%	71.4%
Decision-making authority between full board meetings	74.6%	80.0%	77.3%	82.6%	50.0%	43.8%	42.9%	33.3%	60.0%	88.2%	78.9%	66.7%	75.0%	82.9%	67.2%	73.0%	85.5%	83.7%	86.7%	71.4%
Other	6.0%	0.0%	4.5%	8.1%	8.3%	6.3%	28.6%	0.0%	6.7%	5.9%	6.5%	0.0%	0.0%	0.0%	6.7%	5.1%	8.1%	7.0%	0.0%	0.0%
What level of authority does the executive committee have?																				
Total responding in each category	393	45	129	147	72	32	7	3	30	34	242	6	4	35	134	132	62	43	15	7
Full authority: the executive committee can act of behalf of the board on all issues	44.5%	48.9%	45.7%	52.4%	23.6%	21.9%	28.6%	33.3%	23.3%	67.6%	46.7%	83.3%	50.0%	42.9%	38.1%	41.7%	51.6%	60.5%	53.3%	42.9%
Some authority: the executive committee can act on behalf of the board on some issues (e.g., execu-tive compensa-tion), but not all issues	29.0%	40.0%	33.3%	24.5%	23.6%	28.1%	0.0%	0.0%	26.7%	23.5%	29.3%	0.0%	25.0%	48.6%	25.4%	27.3%	35.5%	30.2%	40.0%	42.9%
All executive committee deci-sions must be ratified by the full board	26.5%	11.1%	20.9%	23.1%	52.8%	50.0%	71.4%	66.7%	50.0%	8.8%	24.0%	16.7%	25.0%	8.6%	36.6%	31.1%	12.9%	9.3%	6.7%	14.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Number and types of positions on the quality committee																				
Total responding in each category	359	47	109	136	67	26	12	3	26	28	217	4	4	39	94	136	65	37	18	9
Average number of physician board members	2.59	4.09	2.81	2.68	1.00	0.65	1.25	0.67	1.27	2.64	2.75	2.25	2.50	4.44	1.31	2.61	3.05	3.97	4.17	3.56
Average number of non-physician board members	4.26	5.23	3.96	4.56	3.46	3.12	2.08	2.00	4.62	4.36	4.29	5.25	5.00	5.26	3.48	4.00	4.63	5.14	6.06	6.56
Average number of physi-cians from the medical staff (who are not board members)	2.23	2.81	2.01	2.51	1.61	1.35	1.67	3.67	1.62	3.18	2.17	0.00	3.00	3.08	1.24	1.97	3.08	3.81	3.39	1.44
Average number of nurses	2.07	1.66	1.88	2.34	2.13	1.96	1.42	1.67	2.69	3.71	1.93	2.25	0.00	1.77	2.20	1.82	2.74	1.76	1.22	2.78
Average number of commu-nity members at-large	1.28	2.02	1.17	1.54	0.42	0.12	0.25	0.00	0.85	2.04	1.29	3.25	0.25	2.08	0.67	0.98	1.66	1.89	2.33	4.78
Average number of other committee members	1.35	0.89	1.41	1.35	1.57	1.77	1.58	0.00	1.54	1.36	1.38	0.50	0.50	0.97	1.67	1.30	1.14	1.00	1.50	1.33
Regularly scheduled board meetings per year																				
Total responding in each category	528	59	155	178	136	56	13	6	61	40	293	8	2	49	194	177	76	49	20	12
4 per year (quarterly)	7.2%	22.0%	6.5%	7.3%	1.5%	0.0%	0.0%	0.0%	3.3%	20.0%	5.1%	62.5%	0.0%	16.3%	2.6%	4.5%	10.5%	16.3%	25.0%	33.3%
6 per year	15.3%	22.0%	12.9%	25.8%	1.5%	0.0%	0.0%	0.0%	3.3%	45.0%	16.4%	12.5%	50.0%	22.4%	7.2%	18.1%	17.1%	28.6%	25.0%	25.0%
7–9 per year	7.0%	11.9%	5.8%	10.1%	2.2%	3.6%	0.0%	16.7%	0.0%	10.0%	7.8%	0.0%	50.0%	12.2%	4.1%	6.8%	11.8%	4.1%	25.0%	8.3%
10–11 per year	29.7%	27.1%	38.1%	32.6%	17.6%	16.1%	30.8%	16.7%	16.4%	12.5%	38.2%	0.0%	0.0%	32.7%	26.3%	34.5%	38.2%	22.4%	15.0%	16.7%
12 per year (monthly)	37.3%	11.9%	32.9%	23.0%	72.1%	73.2%	69.2%	66.7%	72.1%	12.5%	29.7%	0.0%	0.0%	14.3%	56.7%	33.9%	19.7%	20.4%	10.0%	0.0%
More than 12 per year	2.1%	0.0%	1.9%	0.6%	5.1%	7.1%	0.0%	0.0%	4.9%	0.0%	1.4%	0.0%	0.0%	0.0%	3.1%	1.7%	1.3%	2.0%	0.0%	0.0%
Other	1.3%	5.1%	1.9%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	25.0%	0.0%	2.0%	0.0%	0.6%	1.3%	6.1%	0.0%	16.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Approximate duration (scheduled) for board meetings																				
Total responding in each category	528	60	155	177	136	56	13	6	61	40	292	8	3	49	194	176	76	50	20	12
1–2 hours	45.6%	18.3%	41.3%	55.9%	49.3%	41.1%	69.2%	16.7%	55.7%	42.5%	50.0%	0.0%	33.3%	20.4%	56.2%	43.8%	46.1%	34.0%	10.0%	8.3%
2–4 hours	47.9%	51.7%	54.8%	41.8%	46.3%	50.0%	30.8%	83.3%	42.6%	55.0%	46.9%	25.0%	66.7%	55.1%	40.7%	54.0%	46.1%	56.0%	50.0%	50.0%
4–6 hours	4.5%	18.3%	3.2%	1.1%	4.4%	8.9%	0.0%	0.0%	1.6%	0.0%	2.4%	25.0%	0.0%	18.4%	2.6%	2.3%	5.3%	10.0%	25.0%	8.3%
6–8 hours	1.3%	6.7%	0.6%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	2.5%	0.7%	50.0%	0.0%	0.0%	0.5%	0.0%	2.6%	0.0%	5.0%	25.0%
More than 8 hours	0.6%	5.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	0.0%	0.0%	0.0%	10.0%	8.3%
The board uses a consent agenda																				
Total responding in each category	528	60	155	177	136	56	13	6	61	39	293	8	3	49	193	177	76	50	20	12
Yes	71.2%	83.3%	70.3%	68.4%	70.6%	75.0%	84.6%	83.3%	62.3%	87.2%	66.9%	87.5%	66.7%	83.7%	63.2%	76.3%	75.0%	72.0%	80.0%	83.3%
The board has scheduled executive sessions																				
Total responding in each category	526	60	155	177	134	55	13	5	61	40	292	8	3	49	192	176	76	50	20	12
Yes	55.5%	75.0%	53.5%	50.3%	56.0%	56.4%	61.5%	60.0%	54.1%	42.5%	53.1%	87.5%	100.0%	71.4%	49.5%	52.8%	63.2%	64.0%	80.0%	66.7%
Frequency of executive sessions																				
Total responding in each category	293	45	83	89	76	31	8	4	33	17	155	7	3	35	95	94	48	32	16	8
After or before every board meeting	60.4%	71.1%	59.0%	53.9%	63.2%	67.7%	50.0%	75.0%	60.6%	76.5%	54.2%	85.7%	100.0%	65.7%	56.8%	57.4%	62.5%	65.6%	68.8%	87.5%
After or before every other board meeting	7.5%	2.2%	6.0%	10.1%	9.2%	12.9%	0.0%	0.0%	9.1%	5.9%	8.4%	0.0%	0.0%	2.9%	5.3%	7.4%	12.5%	12.5%	0.0%	0.0%
Quarterly	6.5%	8.9%	7.2%	4.5%	6.6%	6.5%	12.5%	0.0%	6.1%	0.0%	6.5%	0.0%	0.0%	11.4%	6.3%	7.4%	4.2%	3.1%	12.5%	12.5%
Twice a year	4.8%	6.7%	4.8%	5.6%	2.6%	0.0%	0.0%	0.0%	6.1%	5.9%	5.2%	14.3%	0.0%	5.7%	5.3%	5.3%	4.2%	3.1%	6.3%	0.0%
Once a year	5.5%	2.2%	4.8%	10.1%	2.6%	3.2%	12.5%	0.0%	0.0%	11.8%	7.1%	0.0%	0.0%	2.9%	9.5%	6.4%	0.0%	3.1%	0.0%	0.0%
Less often than once a year	0.3%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%
Other	15.0%	8.9%	16.9%	15.7%	15.8%	9.7%	25.0%	25.0%	18.2%	0.0%	18.1%	0.0%	0.0%	11.4%	16.8%	14.9%	16.7%	12.5%	12.5%	0.0%
The CEO attends scheduled executive sessions																				
Total responding in each category	292	44	81	90	77	32	8	4	33	17	154	7	3	34	97	93	47	32	15	8
Always	46.6%	34.1%	35.8%	47.8%	63.6%	59.4%	75.0%	100.0%	60.6%	70.6%	39.0%	28.6%	66.7%	32.4%	52.6%	49.5%	51.1%	31.3%	26.7%	12.5%
Most of the time	38.7%	47.7%	46.9%	32.2%	32.5%	40.6%	25.0%	0.0%	30.3%	23.5%	40.9%	42.9%	33.3%	50.0%	35.1%	33.3%	40.4%	50.0%	53.3%	62.5%
Sometimes	10.3%	11.4%	12.3%	14.4%	2.6%	0.0%	0.0%	0.0%	6.1%	0.0%	14.9%	14.3%	0.0%	11.8%	11.3%	11.8%	4.3%	6.3%	13.3%	25.0%
Rarely	4.5%	6.8%	4.9%	5.6%	1.3%	0.0%	0.0%	0.0%	3.0%	5.9%	5.2%	14.3%	0.0%	5.9%	1.0%	5.4%	4.3%	12.5%	6.7%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Physician board members attend scheduled executive sessions																				
Total responding in each category	251	37	72	80	62	24	6	4	28	16	136	1	3	33	82	84	43	23	14	5
Always	42.2%	43.2%	37.5%	55.0%	30.6%	25.0%	33.3%	75.0%	28.6%	68.8%	44.1%	0.0%	66.7%	42.4%	32.9%	48.8%	48.8%	52.2%	35.7%	0.0%
Most of the time	15.9%	16.2%	19.4%	15.0%	12.9%	4.2%	33.3%	0.0%	17.9%	6.3%	18.4%	0.0%	0.0%	18.2%	15.9%	15.5%	18.6%	13.0%	14.3%	20.0%
Sometimes	9.6%	5.4%	5.6%	8.8%	17.7%	16.7%	0.0%	0.0%	25.0%	6.3%	7.4%	0.0%	0.0%	6.1%	14.6%	7.1%	7.0%	8.7%	7.1%	0.0%
Rarely	32.3%	35.1%	37.5%	21.3%	38.7%	54.2%	33.3%	25.0%	28.6%	18.8%	30.1%	100.0%	33.3%	33.3%	36.6%	28.6%	25.6%	26.1%	42.9%	80.0%
Legal counsel attends scheduled executive sessions																				
Total responding in each category	262	40	70	81	71	29	6	4	32	16	135	3	3	34	81	88	45	26	15	7
Always	25.6%	25.0%	17.1%	19.8%	40.8%	31.0%	50.0%	75.0%	43.8%	6.3%	20.0%	0.0%	66.7%	23.5%	24.7%	28.4%	26.7%	26.9%	13.3%	14.3%
Most of the time	11.8%	25.0%	8.6%	8.6%	11.3%	6.9%	16.7%	0.0%	15.6%	0.0%	9.6%	0.0%	0.0%	29.4%	3.7%	8.0%	15.6%	26.9%	33.3%	28.6%
Sometimes	20.2%	22.5%	25.7%	16.0%	18.3%	27.6%	0.0%	0.0%	15.6%	31.3%	19.3%	66.7%	33.3%	17.6%	23.5%	15.9%	22.2%	15.4%	26.7%	28.6%
Rarely	42.4%	27.5%	48.6%	55.6%	29.6%	34.5%	33.3%	25.0%	25.0%	62.5%	51.1%	33.3%	0.0%	29.4%	48.1%	47.7%	35.6%	30.8%	26.7%	28.6%
Others attend scheduled executive sessions																				
Total responding in each category	162	22	43	51	46	17	5	3	21	10	84	1	2	19	57	50	28	16	10	1
Always	17.3%	9.1%	14.0%	15.7%	26.1%	11.8%	40.0%	66.7%	28.6%	0.0%	16.7%	0.0%	0.0%	10.5%	17.5%	18.0%	21.4%	18.8%	0.0%	0.0%
Most of the time	17.9%	18.2%	9.3%	15.7%	28.3%	23.5%	20.0%	33.3%	33.3%	0.0%	14.3%	100.0%	0.0%	15.8%	21.1%	14.0%	14.3%	18.8%	20.0%	100.0%
Sometimes	16.7%	22.7%	11.6%	13.7%	21.7%	41.2%	0.0%	0.0%	14.3%	0.0%	14.3%	0.0%	50.0%	21.1%	21.1%	16.0%	3.6%	18.8%	30.0%	0.0%
Rarely	48.1%	50.0%	65.1%	54.9%	23.9%	23.5%	40.0%	0.0%	23.8%	100.0%	54.8%	0.0%	50.0%	52.6%	40.4%	52.0%	60.7%	43.8%	50.0%	0.0%
Approximate total annual expenditure for board education (including memberships, conferences, retreats, and travel)																				
Total responding in each category	523	58	153	176	136	56	13	6	61	40	289	8	3	47	194	176	75	47	20	11
$0	2.5%	1.7%	1.3%	2.8%	3.7%	5.4%	0.0%	0.0%	3.3%	2.5%	2.1%	0.0%	0.0%	2.1%	3.1%	2.8%	1.3%	2.1%	0.0%	0.0%
$1–$9,999	33.7%	12.1%	28.1%	32.4%	50.7%	58.9%	30.8%	50.0%	47.5%	35.0%	29.8%	25.0%	0.0%	10.6%	59.8%	22.2%	8.0%	25.5%	10.0%	9.1%
$10,000–$19,999	21.8%	15.5%	19.6%	23.9%	24.3%	17.9%	23.1%	0.0%	32.8%	27.5%	21.1%	0.0%	33.3%	17.0%	21.1%	23.3%	24.0%	21.3%	15.0%	9.1%
$20,000–$29,999	16.4%	13.8%	23.5%	17.0%	8.8%	8.9%	23.1%	16.7%	4.9%	15.0%	20.8%	12.5%	0.0%	14.9%	9.3%	20.5%	30.7%	12.8%	10.0%	9.1%
$30,000–$49,999	12.8%	19.0%	13.7%	14.2%	7.4%	7.1%	15.4%	33.3%	3.3%	17.5%	13.5%	0.0%	66.7%	19.1%	4.1%	18.8%	17.3%	14.9%	20.0%	18.2%
$50,000–$75,000	7.3%	15.5%	9.8%	4.5%	4.4%	1.8%	7.7%	0.0%	6.6%	0.0%	8.0%	0.0%	0.0%	19.1%	2.1%	9.1%	13.3%	8.5%	20.0%	0.0%
> $75,000	5.5%	22.4%	3.9%	5.1%	0.7%	0.0%	0.0%	0.0%	1.6%	2.5%	4.8%	62.5%	0.0%	17.0%	0.5%	3.4%	5.3%	14.9%	25.0%	54.5%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Annual dollar amount of cash compensation for the board chair																				
Total responding in each category	62	10	9	11	32	14	1	3	14	2	18	4	0	6	25	17	9	5	2	4
< $5,000	62.9%	10.0%	55.6%	54.5%	84.4%	92.9%	100.0%	100.0%	71.4%	100.0%	50.0%	0.0%	N/A	16.7%	88.0%	64.7%	44.4%	40.0%	0.0%	0.0%
$5,000–$9,999	11.3%	10.0%	11.1%	27.3%	6.3%	0.0%	0.0%	0.0%	14.3%	0.0%	22.2%	0.0%	N/A	16.7%	8.0%	17.6%	22.2%	0.0%	0.0%	0.0%
$10,000–$14,999	8.1%	0.0%	22.2%	9.1%	6.3%	0.0%	0.0%	0.0%	14.3%	0.0%	16.7%	0.0%	N/A	0.0%	4.0%	11.8%	22.2%	0.0%	0.0%	0.0%
$15,000–$19,999	6.5%	20.0%	11.1%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	N/A	33.3%	0.0%	5.9%	11.1%	40.0%	0.0%	0.0%
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$30,000–$39,999	1.6%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%
$40,000–$49,999	3.2%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	33.3%	0.0%	0.0%	0.0%	0.0%	50.0%	25.0%
$50,000 +	6.5%	30.0%	0.0%	0.0%	3.1%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	75.0%	N/A	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	75.0%
Respondents with compen-sation for this position	11.8%	17.5%	5.8%	6.2%	23.5%	25.0%	7.1%	50.0%	23.3%	5.1%	6.1%	50.0%	0.0%	12.8%	13.2%	9.5%	11.8%	10.0%	10.5%	36.4%
Annual dollar amount of cash compensation for other board officers																				
Total responding in each category	49	4	8	10	27	11	1	3	12	2	16	1	0	3	23	14	7	4	1	0
< $5,000	75.5%	25.0%	75.0%	70.0%	85.2%	100.0%	100.0%	100.0%	66.7%	100.0%	68.8%	0.0%	N/A	33.3%	95.7%	71.4%	42.9%	50.0%	0.0%	N/A
$5,000–$9,999	8.2%	25.0%	0.0%	10.0%	7.4%	0.0%	0.0%	0.0%	16.7%	0.0%	6.3%	0.0%	N/A	33.3%	0.0%	14.3%	28.6%	0.0%	0.0%	N/A
$10,000–$14,999	10.2%	25.0%	12.5%	10.0%	7.4%	0.0%	0.0%	0.0%	16.7%	0.0%	12.5%	0.0%	N/A	33.3%	4.3%	14.3%	14.3%	25.0%	0.0%	N/A
$15,000–$19,999	2.0%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	N/A
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A
$30,000–$39,999	2.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	N/A
$40,000–$49,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A
$50,000 +	2.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	N/A	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	N/A
Respondents with compen-sation for this position	9.5%	7.1%	5.3%	5.6%	20.6%	20.8%	7.1%	50.0%	20.7%	5.1%	5.5%	12.5%	0.0%	6.5%	12.3%	7.9%	9.3%	8.3%	5.3%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Annual dollar amount of cash compensation for board committee chairs																				
Total responding in each category	33	3	3	9	18	6	1	3	8	1	11	0	0	3	15	8	6	4	0	0
< $5,000	78.8%	33.3%	66.7%	77.8%	88.9%	100.0%	100.0%	100.0%	75.0%	100.0%	72.7%	N/A	N/A	33.3%	93.3%	87.5%	50.0%	50.0%	N/A	N/A
$5,000–$9,999	9.1%	33.3%	33.3%	0.0%	5.6%	0.0%	0.0%	0.0%	12.5%	0.0%	9.1%	N/A	N/A	33.3%	6.7%	0.0%	33.3%	0.0%	N/A	N/A
$10,000–$14,999	9.1%	33.3%	0.0%	11.1%	5.6%	0.0%	0.0%	0.0%	12.5%	0.0%	9.1%	N/A	N/A	33.3%	0.0%	12.5%	16.7%	25.0%	N/A	N/A
$15,000–$19,999	3.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	25.0%	N/A	N/A
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
$30,000–$39,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
$40,000–$49,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
$50,000 +	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
Respondents with compen-sation for this position	6.5%	5.7%	2.0%	5.1%	14.3%	12.2%	7.1%	50.0%	14.0%	2.6%	3.8%	0.0%	0.0%	6.7%	8.3%	4.5%	8.1%	8.2%	0.0%	0.0%
Annual dollar amount of cash compensation for some other board members																				
Total responding in each category	30	4	3	6	17	7	1	3	6	0	9	0	0	4	12	8	7	3	0	0
< $5,000	73.3%	25.0%	33.3%	83.3%	88.2%	100.0%	100.0%	100.0%	66.7%	N/A	66.7%	N/A	N/A	25.0%	91.7%	87.5%	42.9%	33.3%	N/A	N/A
$5,000–$9,999	10.0%	25.0%	33.3%	0.0%	5.9%	0.0%	0.0%	0.0%	16.7%	N/A	11.1%	N/A	N/A	25.0%	8.3%	0.0%	28.6%	0.0%	N/A	N/A
$10,000–$14,999	10.0%	50.0%	0.0%	0.0%	5.9%	0.0%	0.0%	0.0%	16.7%	N/A	0.0%	N/A	N/A	50.0%	0.0%	0.0%	28.6%	33.3%	N/A	N/A
$15,000–$19,999	3.3%	0.0%	0.0%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	11.1%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	33.3%	N/A	N/A
$20,000–$29,999	3.3%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	11.1%	N/A	N/A	0.0%	0.0%	12.5%	0.0%	0.0%	N/A	N/A
$30,000–$39,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
$40,000–$49,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
$50,000 +	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A
Respondents with compen-sation for this position	6.0%	7.4%	2.0%	3.5%	13.9%	14.3%	7.7%	50.0%	11.1%	0.0%	3.2%	0.0%	0.0%	8.7%	6.7%	4.7%	9.3%	6.4%	0.0%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Annual dollar amount of cash compensation for all other board members																				
Total responding in each category	49	6	7	8	28	11	1	3	13	1	14	1	0	5	21	14	8	4	1	1
< $5,000	73.5%	16.7%	71.4%	75.0%	85.7%	90.9%	100.0%	100.0%	76.9%	100.0%	71.4%	0.0%	N/A	20.0%	95.2%	71.4%	50.0%	50.0%	0.0%	0.0%
$5,000–$9,999	10.2%	16.7%	14.3%	12.5%	7.1%	0.0%	0.0%	0.0%	15.4%	0.0%	14.3%	0.0%	N/A	20.0%	4.8%	14.3%	25.0%	0.0%	0.0%	0.0%
$10,000–$14,999	8.2%	33.3%	0.0%	12.5%	3.6%	0.0%	0.0%	0.0%	7.7%	0.0%	7.1%	0.0%	N/A	40.0%	0.0%	7.1%	25.0%	25.0%	0.0%	0.0%
$15,000–$19,999	2.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	N/A	0.0%	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%
$20,000–$29,999	2.0%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
$30,000–$39,999	2.0%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
$40,000–$49,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50,000 +	2.0%	0.0%	0.0%	0.0%	3.6%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%
Respondents with compensation for this position	9.5%	10.7%	4.6%	4.6%	20.7%	20.4%	7.1%	50.0%	21.3%	2.6%	4.9%	12.5%	0.0%	10.9%	11.2%	8.0%	10.5%	8.3%	5.6%	9.1%
Board meeting content—average and median percent of meeting time spent:																				
Receiving reports from management and board committees																				
Average	50.1%	46.8%	48.5%	46.0%	58.4%	58.1%	53.9%	47.0%	60.5%	41.7%	47.8%	35.0%	34.7%	49.4%	55.1%	49.2%	41.7%	47.2%	51.8%	44.1%
Median	50.0%	48.0%	50.0%	40.0%	60.0%	55.0%	55.0%	50.0%	60.0%	40.0%	50.0%	30.0%	34.0%	50.0%	50.0%	50.0%	40.0%	40.0%	50.0%	40.0%
Discussing strategy and setting policy																				
Average	33.3%	36.8%	34.1%	35.4%	28.3%	28.8%	30.0%	35.0%	27.0%	43.8%	33.6%	56.4%	41.0%	33.5%	29.7%	34.0%	39.3%	34.7%	32.3%	39.6%
Median	30.0%	31.5%	30.0%	35.0%	25.0%	30.0%	30.0%	30.0%	25.0%	50.0%	30.0%	60.0%	40.0%	30.0%	30.0%	30.0%	40.0%	35.0%	30.0%	40.0%
Educating board members																				
Average	17.0%	16.8%	17.8%	18.6%	14.3%	13.4%	18.2%	18.0%	14.0%	14.5%	18.7%	10.0%	24.3%	17.2%	15.8%	16.9%	19.2%	19.4%	16.0%	18.0%
Median	15.0%	15.0%	15.0%	20.0%	10.0%	10.0%	20.0%	25.0%	10.0%	15.0%	20.0%	7.5%	20.0%	12.5%	12.0%	15.0%	20.0%	20.0%	10.0%	20.0%
Percentage of meeting time spent discussing strategy and setting policy																				
Total responding in each category	495	56	140	166	133	52	13	5	63	35	271	7	3	46	185	165	70	45	19	11
0–10%	13.1%	7.1%	10.7%	9.0%	23.3%	19.2%	23.1%	20.0%	27.0%	5.7%	10.3%	0.0%	0.0%	8.7%	18.4%	11.5%	5.7%	13.3%	10.5%	0.0%
11–20%	16.0%	10.7%	12.1%	16.9%	21.1%	21.2%	23.1%	0.0%	22.2%	11.4%	15.1%	0.0%	0.0%	13.0%	17.8%	18.2%	8.6%	13.3%	21.1%	0.0%
21–30%	24.0%	32.1%	28.6%	21.7%	18.8%	23.1%	7.7%	40.0%	15.9%	8.6%	26.9%	28.6%	0.0%	34.8%	25.4%	21.8%	25.7%	17.8%	26.3%	45.5%
31–40%	20.8%	19.6%	24.3%	20.5%	18.0%	25.0%	15.4%	0.0%	14.3%	20.0%	22.5%	0.0%	66.7%	19.6%	19.5%	21.8%	21.4%	20.0%	26.3%	18.2%
41–50%	16.0%	16.1%	15.7%	19.3%	12.0%	1.9%	23.1%	20.0%	17.5%	34.3%	15.5%	14.3%	33.3%	15.2%	13.0%	15.8%	18.6%	26.7%	5.3%	27.3%
51–60%	4.6%	5.4%	3.6%	5.4%	4.5%	5.8%	7.7%	20.0%	1.6%	5.7%	4.4%	14.3%	0.0%	4.3%	2.7%	4.8%	8.6%	4.4%	5.3%	9.1%
61–70%	3.2%	5.4%	2.9%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%	4.1%	14.3%	0.0%	4.3%	1.6%	3.6%	8.6%	2.2%	0.0%	0.0%
71–80%	1.8%	1.8%	1.4%	1.8%	2.3%	3.8%	0.0%	0.0%	1.6%	5.7%	1.1%	14.3%	0.0%	0.0%	1.1%	2.4%	2.9%	0.0%	5.3%	0.0%
81% +	0.4%	1.8%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	0.0%	14.3%	0.0%	0.0%	0.5%	0.0%	0.0%	2.2%	0.0%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Use of a board portal or similar online tool to communicate and access board materials																				
Total responding in each category	534	60	155	180	139	56	14	6	63	40	295	8	3	49	195	180	76	51	20	12
No	32.6%	11.7%	32.9%	23.9%	52.5%	55.4%	42.9%	33.3%	54.0%	22.5%	28.8%	0.0%	0.0%	14.3%	56.9%	23.9%	14.5%	11.8%	10.0%	8.3%
No, but we are in the process of implementing	14.2%	11.7%	14.8%	16.1%	12.2%	12.5%	7.1%	0.0%	14.3%	20.0%	14.9%	12.5%	0.0%	12.2%	11.8%	15.0%	18.4%	17.6%	10.0%	8.3%
Yes	53.2%	76.7%	52.3%	60.0%	35.3%	32.1%	50.0%	66.7%	31.7%	57.5%	56.3%	87.5%	100.0%	73.5%	31.3%	61.1%	67.1%	70.6%	80.0%	83.3%
Most important benefit to the board in using a board portal or similar online tool																				
Total responding in each category	251	42	73	92	44	17	7	3	17	17	148	6	3	33	53	96	45	33	15	9
Enhances board members' level of preparation for meetings	32.7%	33.3%	35.6%	33.7%	25.0%	29.4%	14.3%	66.7%	17.6%	17.6%	36.5%	16.7%	33.3%	36.4%	28.3%	33.3%	40.0%	18.2%	40.0%	55.6%
Enhances communication among board members between meetings	6.0%	2.4%	8.2%	5.4%	6.8%	5.9%	14.3%	0.0%	5.9%	5.9%	6.8%	0.0%	0.0%	3.0%	9.4%	6.3%	6.7%	0.0%	6.7%	0.0%
Reduces paper waste/duplication costs	44.6%	47.6%	39.7%	43.5%	52.3%	52.9%	42.9%	33.3%	58.8%	52.9%	40.5%	50.0%	66.7%	45.5%	39.6%	47.9%	40.0%	57.6%	53.3%	0.0%
Saves time	13.1%	9.5%	13.7%	14.1%	13.6%	5.9%	28.6%	0.0%	17.6%	23.5%	12.8%	16.7%	0.0%	9.1%	13.2%	12.5%	11.1%	21.2%	0.0%	22.2%
Other	3.6%	7.1%	2.7%	3.3%	2.3%	5.9%	0.0%	0.0%	0.0%	0.0%	3.4%	16.7%	0.0%	6.1%	9.4%	0.0%	2.2%	3.0%	0.0%	22.2%
Board members are provided with hardware (laptops, iPads, etc.) to access online board materials																				
Total responding in each category	284	46	81	108	49	18	7	4	20	23	166	7	3	36	61	110	51	36	16	10
No, and we are not considering it at this time	27.1%	15.2%	32.1%	31.5%	20.4%	33.3%	0.0%	0.0%	20.0%	8.7%	34.9%	14.3%	33.3%	13.9%	45.9%	23.6%	23.5%	22.2%	12.5%	10.0%
No, but we are considering it at this time	14.4%	15.2%	19.8%	13.0%	8.2%	11.1%	14.3%	0.0%	5.0%	4.3%	17.5%	14.3%	0.0%	16.7%	13.1%	20.0%	7.8%	2.8%	25.0%	20.0%
Yes	58.5%	69.6%	48.1%	55.6%	71.4%	55.6%	85.7%	100.0%	75.0%	87.0%	47.6%	71.4%	66.7%	69.4%	41.0%	56.4%	68.6%	75.0%	62.5%	70.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Board Culture: Level of agreement with the following statements																				
The board is focused on the organization's mission and fundamental purpose, and develops the strategic plan/makes strategic decisions in accordance with this purpose.																				
Total responding in each category	520	58	151	177	134	53	13	6	62	38	290	8	3	47	192	172	75	50	19	12
Strongly agree	74.2%	87.9%	76.2%	78.5%	60.4%	67.9%	38.5%	66.7%	58.1%	86.8%	76.2%	100.0%	100.0%	85.1%	62.0%	77.3%	81.3%	88.0%	89.5%	100.0%
Agree	22.1%	12.1%	20.5%	19.8%	31.3%	26.4%	61.5%	33.3%	29.0%	10.5%	21.4%	0.0%	0.0%	14.9%	31.8%	19.2%	18.7%	10.0%	10.5%	0.0%
Neutral	2.1%	0.0%	1.3%	0.6%	6.0%	1.9%	0.0%	0.0%	11.3%	2.6%	0.7%	0.0%	0.0%	0.0%	4.7%	1.2%	0.0%	0.0%	0.0%	0.0%
Disagree	1.3%	0.0%	2.0%	0.6%	2.2%	3.8%	0.0%	0.0%	1.6%	0.0%	1.4%	0.0%	0.0%	0.0%	1.6%	1.7%	0.0%	2.0%	0.0%	0.0%
Strongly disagree	0.2%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
The board is effective at setting appropriate short- and long-term goals for management and physician leaders in accordance with the strategic plan.																				
Total responding in each category	520	58	152	176	134	53	14	6	61	38	290	8	2	48	190	175	75	50	18	12
Strongly agree	48.1%	55.2%	49.3%	56.8%	32.1%	34.0%	28.6%	33.3%	31.1%	65.8%	51.7%	50.0%	50.0%	56.3%	34.7%	53.1%	54.7%	60.0%	61.1%	75.0%
Agree	34.0%	25.9%	36.8%	30.7%	38.8%	35.8%	35.7%	66.7%	39.3%	21.1%	35.2%	12.5%	50.0%	27.1%	40.5%	32.0%	34.7%	24.0%	27.8%	8.3%
Neutral	13.1%	19.0%	9.9%	10.2%	17.9%	17.0%	14.3%	0.0%	21.3%	10.5%	10.0%	37.5%	0.0%	16.7%	16.8%	10.9%	9.3%	12.0%	11.1%	16.7%
Disagree	4.4%	0.0%	3.9%	1.7%	10.4%	11.3%	21.4%	0.0%	8.2%	2.6%	2.8%	0.0%	0.0%	0.0%	7.4%	3.4%	1.3%	4.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.0%	0.6%	0.7%	1.9%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.5%	0.6%	0.0%	0.0%	0.0%	0.0%
The board has an effective system in place to measure whether strategic goals will be met.																				
Total responding in each category	521	58	152	177	134	53	14	6	61	38	291	8	2	48	191	175	75	50	18	12
Strongly agree	52.0%	69.0%	50.0%	61.6%	34.3%	41.5%	28.6%	16.7%	31.1%	78.9%	53.3%	62.5%	50.0%	70.8%	39.3%	52.0%	62.7%	68.0%	83.3%	75.0%
Agree	30.5%	20.7%	34.2%	28.8%	32.8%	26.4%	42.9%	83.3%	31.1%	18.4%	33.0%	25.0%	50.0%	18.8%	30.9%	33.1%	33.3%	26.0%	5.6%	25.0%
Neutral	12.7%	8.6%	11.8%	6.2%	23.9%	20.8%	21.4%	0.0%	29.5%	0.0%	10.0%	12.5%	0.0%	8.3%	20.9%	11.4%	2.7%	4.0%	11.1%	0.0%
Disagree	4.4%	1.7%	3.3%	2.8%	9.0%	11.3%	7.1%	0.0%	8.2%	2.6%	3.1%	0.0%	0.0%	2.1%	8.4%	2.9%	1.3%	2.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.5%	0.6%	0.0%	0.0%	0.0%	0.0%
The board effectively holds management and physician leaders accountable to accomplish strategic goals.																				
Total responding in each category	521	58	152	176	135	53	14	6	62	38	290	8	3	47	192	174	75	49	19	12
Strongly agree	54.1%	67.2%	53.9%	64.8%	34.8%	35.8%	35.7%	16.7%	35.5%	78.9%	57.2%	62.5%	100.0%	66.0%	37.5%	59.2%	66.7%	69.4%	63.2%	91.7%
Agree	34.7%	25.9%	38.2%	28.4%	43.0%	41.5%	42.9%	66.7%	41.9%	18.4%	34.8%	37.5%	0.0%	25.5%	42.7%	33.3%	30.7%	24.5%	26.3%	8.3%
Neutral	7.7%	6.9%	5.9%	3.4%	15.6%	13.2%	21.4%	16.7%	16.1%	0.0%	5.2%	0.0%	0.0%	8.5%	14.1%	4.0%	2.7%	4.1%	10.5%	0.0%
Disagree	3.3%	0.0%	2.0%	2.8%	6.7%	9.4%	0.0%	0.0%	6.5%	0.0%	2.8%	0.0%	0.0%	0.0%	5.7%	2.9%	0.0%	2.0%	0.0%	0.0%
Strongly disagree	0.2%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/City	District/Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
The board ensures appropriate physician/clinician involvement in governance.																				
Total responding in each category	520	57	152	176	135	53	14	6	62	38	290	7	3	47	192	174	74	50	19	11
Strongly agree	58.7%	64.9%	67.1%	65.3%	37.8%	34.0%	42.9%	66.7%	37.1%	71.1%	65.5%	14.3%	66.7%	72.3%	41.7%	67.8%	68.9%	70.0%	68.4%	72.7%
Agree	26.9%	26.3%	25.0%	25.6%	31.1%	28.3%	28.6%	16.7%	35.5%	23.7%	25.5%	42.9%	33.3%	23.4%	32.8%	23.0%	27.0%	22.0%	21.1%	18.2%
Neutral	9.0%	1.8%	4.6%	7.4%	19.3%	22.6%	28.6%	16.7%	14.5%	5.3%	6.2%	14.3%	0.0%	0.0%	15.1%	7.5%	4.1%	2.0%	0.0%	9.1%
Disagree	4.4%	5.3%	2.6%	1.7%	9.6%	11.3%	0.0%	0.0%	11.3%	0.0%	2.4%	14.3%	0.0%	4.3%	8.3%	1.7%	0.0%	4.0%	10.5%	0.0%
Strongly disagree	1.0%	1.8%	0.7%	0.0%	2.2%	3.8%	0.0%	0.0%	1.6%	0.0%	0.3%	14.3%	0.0%	0.0%	2.1%	0.0%	0.0%	2.0%	0.0%	0.0%
The board engages in constructive dialogue with management.																				
Total responding in each category	522	59	152	177	134	52	14	6	62	38	291	8	3	48	191	175	75	50	19	12
Strongly agree	73.9%	86.4%	76.3%	80.2%	57.5%	61.5%	57.1%	66.7%	53.2%	89.5%	77.0%	87.5%	100.0%	85.4%	62.8%	78.3%	78.7%	86.0%	84.2%	91.7%
Agree	21.8%	6.8%	21.7%	16.9%	35.1%	30.8%	28.6%	33.3%	40.3%	10.5%	20.3%	0.0%	0.0%	8.3%	33.0%	17.1%	18.7%	10.0%	10.5%	0.0%
Neutral	3.3%	5.1%	1.3%	1.7%	6.7%	7.7%	14.3%	0.0%	4.8%	0.0%	1.7%	12.5%	0.0%	4.2%	3.1%	3.4%	2.7%	4.0%	0.0%	8.3%
Disagree	0.2%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Strongly disagree	0.8%	1.7%	0.7%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	2.1%	0.5%	1.1%	0.0%	0.0%	5.3%	0.0%
There is solid agreement among board members and the CEO on the distinctions between the board chair's and CEO's roles.																				
Total responding in each category	519	58	150	177	134	53	14	6	61	38	289	8	3	47	191	173	75	50	19	11
Strongly agree	71.5%	79.3%	72.7%	74.6%	62.7%	67.9%	57.1%	66.7%	59.0%	81.6%	72.7%	87.5%	66.7%	78.7%	61.8%	74.0%	76.0%	80.0%	94.7%	90.9%
Agree	21.4%	13.8%	20.7%	20.9%	26.1%	22.6%	28.6%	33.3%	27.9%	15.8%	21.5%	12.5%	33.3%	12.8%	28.8%	20.2%	18.7%	14.0%	0.0%	0.0%
Neutral	3.9%	5.2%	4.0%	3.4%	3.7%	3.8%	0.0%	0.0%	4.9%	2.6%	3.8%	0.0%	0.0%	6.4%	4.7%	3.5%	2.7%	2.0%	5.3%	9.1%
Disagree	2.9%	1.7%	2.0%	0.6%	7.5%	5.7%	14.3%	0.0%	8.2%	0.0%	1.4%	0.0%	0.0%	2.1%	4.2%	1.7%	2.7%	4.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.5%	0.6%	0.0%	0.0%	0.0%	0.0%
The working relationship between the board and CEO is consistently excellent.																				
Total responding in each category	523	59	152	177	135	53	14	6	62	38	291	8	3	48	192	175	75	50	19	12
Strongly agree	75.0%	81.4%	79.6%	78.0%	63.0%	64.2%	64.3%	83.3%	59.7%	94.7%	76.6%	75.0%	66.7%	83.3%	62.5%	82.3%	81.3%	80.0%	89.5%	83.3%
Agree	19.7%	10.2%	18.4%	18.6%	26.7%	24.5%	21.4%	16.7%	30.6%	5.3%	20.3%	25.0%	33.3%	6.3%	32.3%	12.0%	13.3%	16.0%	5.3%	8.3%
Neutral	4.0%	6.8%	0.7%	2.8%	8.1%	11.3%	14.3%	0.0%	4.8%	0.0%	2.1%	0.0%	0.0%	8.3%	3.6%	4.0%	5.3%	2.0%	5.3%	8.3%
Disagree	1.1%	1.7%	0.7%	0.6%	2.2%	0.0%	0.0%	0.0%	4.8%	0.0%	0.7%	0.0%	0.0%	2.1%	1.6%	1.1%	0.0%	2.0%	0.0%	0.0%
Strongly disagree	0.2%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
Board members are well prepared to address agenda items at board and committee meetings.																				
Total responding in each category	522	58	151	177	136	53	14	6	63	38	290	8	3	47	193	174	75	50	18	12
Strongly agree	58.8%	65.5%	57.6%	66.1%	47.8%	43.4%	50.0%	66.7%	49.2%	84.2%	59.3%	75.0%	66.7%	63.8%	50.3%	63.8%	60.0%	62.0%	72.2%	83.3%
Agree	33.1%	32.8%	35.1%	27.1%	39.0%	45.3%	42.9%	33.3%	33.3%	15.8%	32.8%	12.5%	33.3%	36.2%	37.3%	29.3%	37.3%	30.0%	27.8%	16.7%
Neutral	4.8%	0.0%	4.0%	4.5%	8.1%	7.5%	7.1%	0.0%	9.5%	0.0%	4.8%	0.0%	0.0%	0.0%	7.3%	3.4%	2.7%	6.0%	0.0%	0.0%
Disagree	3.1%	1.7%	2.6%	2.3%	5.1%	3.8%	0.0%	0.0%	7.9%	0.0%	2.8%	12.5%	0.0%	0.0%	5.2%	2.9%	0.0%	2.0%	0.0%	0.0%
Strongly disagree	0.2%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
The board assures itself of the reasonableness of any reliance it makes on the advice of advisors/consultants.																				
Total responding in each category	522	59	152	176	135	53	14	6	62	37	291	8	3	48	192	175	74	50	19	12
Strongly agree	54.0%	67.8%	55.3%	56.8%	43.0%	43.4%	35.7%	50.0%	43.5%	59.5%	55.7%	75.0%	66.7%	66.7%	39.6%	60.0%	60.8%	62.0%	78.9%	83.3%
Agree	37.4%	25.4%	39.5%	33.5%	45.2%	43.4%	57.1%	50.0%	43.5%	35.1%	36.4%	25.0%	33.3%	25.0%	47.4%	32.6%	32.4%	34.0%	21.1%	16.7%
Neutral	7.1%	5.1%	3.9%	8.0%	10.4%	13.2%	7.1%	0.0%	9.7%	2.7%	6.5%	0.0%	0.0%	6.3%	10.9%	5.7%	5.4%	4.0%	0.0%	0.0%
Disagree	1.3%	1.7%	1.3%	1.1%	1.5%	0.0%	0.0%	0.0%	3.2%	0.0%	1.4%	0.0%	0.0%	2.1%	2.1%	1.1%	1.4%	0.0%	0.0%	0.0%
Strongly disagree	0.2%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
Individual board members share with the rest of the board information that could reasonably be determined to be of relevance to board duties.																				
Total responding in each category	519	59	149	177	134	53	14	6	61	38	288	8	3	48	189	174	75	50	19	12
Strongly agree	56.6%	69.5%	55.7%	59.3%	48.5%	49.1%	35.7%	66.7%	49.2%	71.1%	55.9%	62.5%	66.7%	70.8%	47.1%	61.5%	58.7%	58.0%	84.2%	75.0%
Agree	35.3%	22.0%	36.9%	34.5%	40.3%	41.5%	57.1%	33.3%	36.1%	28.9%	36.5%	37.5%	33.3%	18.8%	44.4%	30.5%	34.7%	30.0%	10.5%	25.0%
Neutral	6.4%	5.1%	7.4%	4.5%	8.2%	5.7%	7.1%	0.0%	11.5%	0.0%	6.6%	0.0%	0.0%	6.3%	5.8%	6.9%	4.0%	12.0%	5.3%	0.0%
Disagree	1.7%	3.4%	0.0%	1.7%	3.0%	3.8%	0.0%	0.0%	3.3%	0.0%	1.0%	0.0%	0.0%	4.2%	2.6%	1.1%	2.7%	0.0%	0.0%	0.0%
Strongly disagree	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Board members apply a level of diligence and attentiveness that is commensurate with the significance of the subject matter or circumstance.																				
Total responding in each category	517	57	150	175	135	53	14	6	62	37	288	8	3	46	190	174	72	50	19	12
Strongly agree	66.0%	77.2%	62.7%	73.1%	55.6%	56.6%	50.0%	66.7%	54.8%	86.5%	66.0%	87.5%	66.7%	76.1%	54.2%	68.4%	73.6%	76.0%	89.5%	91.7%
Agree	26.9%	17.5%	32.7%	22.3%	30.4%	30.2%	35.7%	33.3%	29.0%	13.5%	28.8%	0.0%	33.3%	19.6%	36.3%	24.7%	22.2%	16.0%	10.5%	8.3%
Neutral	4.8%	3.5%	2.7%	4.6%	8.1%	7.5%	14.3%	0.0%	8.1%	0.0%	4.2%	0.0%	0.0%	4.3%	5.8%	5.2%	4.2%	4.0%	0.0%	0.0%
Disagree	2.1%	1.8%	1.3%	0.0%	5.9%	5.7%	0.0%	0.0%	8.1%	0.0%	0.7%	12.5%	0.0%	0.0%	3.7%	1.1%	0.0%	4.0%	0.0%	0.0%
Strongly disagree	0.2%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	541	63	156	182	140	57	14	6	63	41	297	9	4	50	197	180	77	54	21	12
2013 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsidiary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
How has your board structure/practices changed in order to prepare for population health management?																				
Total responding in each category	465	56	133	163	113	46	14	6	47	37	259	7	3	46	160	157	69	48	19	12
We have not changed our board structure to prepare for population health management	57.2%	37.5%	63.2%	56.4%	61.1%	60.9%	57.1%	66.7%	61.7%	48.6%	61.0%	28.6%	66.7%	37.0%	66.9%	58.0%	56.5%	43.8%	26.3%	25.0%
We have updated the strategic plan to include goals regarding population health management, including building IT infrastructure and physician integration	57.8%	75.0%	57.1%	62.0%	44.2%	43.5%	50.0%	50.0%	42.6%	70.3%	58.3%	71.4%	33.3%	78.3%	38.8%	65.0%	63.8%	70.8%	84.2%	91.7%
We have added board members with expertise in population health management to help us achieve this goal	3.2%	5.4%	0.8%	5.5%	1.8%	2.2%	7.1%	0.0%	0.0%	8.1%	2.7%	14.3%	0.0%	4.3%	1.3%	3.8%	5.8%	2.1%	5.3%	8.3%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	1.7%	3.6%	0.8%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	5.4%	1.5%	0.0%	0.0%	4.3%	1.3%	1.3%	1.4%	4.2%	0.0%	8.3%
We have added physicians to the board to help us achieve this goal	9.7%	17.9%	8.3%	10.4%	6.2%	6.5%	14.3%	0.0%	4.3%	16.2%	8.5%	28.6%	0.0%	17.4%	5.6%	12.7%	10.1%	6.3%	15.8%	25.0%
We have added physicians to the management team to help us achieve this goal	20.9%	41.1%	15.8%	26.4%	8.8%	4.3%	7.1%	0.0%	14.9%	27.0%	20.8%	57.1%	33.3%	39.1%	7.5%	22.3%	29.0%	31.3%	42.1%	58.3%
Other	8.2%	12.5%	6.0%	8.6%	8.0%	8.7%	0.0%	0.0%	10.6%	8.1%	7.3%	28.6%	0.0%	10.9%	6.9%	6.4%	10.1%	10.4%	15.8%	16.7%
Respondents currently making changes to prepare for population health management	89.3%	94.9%	88.1%	92.6%	83.7%	86.8%	100.0%	100.0%	75.8%	94.9%	89.9%	87.5%	100.0%	95.8%	84.2%	89.7%	92.0%	96.0%	100.0%	100.0%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**541**	**63**	**156**	**182**	**140**	**57**	**14**	**6**	**63**	**41**	**297**	**9**	**4**	**50**	**197**	**180**	**77**	**54**	**21**	**12**
2013 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Catholic System	Other Church System	Other System	<100	100–299	300–499	500–999	1,000–1,999	2,000+
How has your board structure/practices changed in order to prepare for value-based payments?																				
Total responding in each category	484	54	140	172	118	48	14	6	50	39	273	7	3	44	166	167	73	49	18	11
We have not changed our board structure to prepare for value-based payments	58.3%	37.0%	62.9%	55.8%	66.1%	62.5%	71.4%	66.7%	68.0%	51.3%	60.1%	28.6%	66.7%	36.4%	69.3%	58.7%	53.4%	46.9%	33.3%	9.1%
We have updated the strategic and financial plans to include goals regarding value-based payments	52.3%	70.4%	52.1%	57.0%	37.3%	39.6%	35.7%	50.0%	34.0%	64.1%	53.5%	57.1%	33.3%	75.0%	32.5%	59.9%	57.5%	69.4%	72.2%	90.9%
We have added board members with expertise in quality improvement processes to help us achieve this goal	6.2%	7.4%	6.4%	9.9%	0.0%	0.0%	0.0%	0.0%	0.0%	17.9%	7.0%	14.3%	0.0%	6.8%	1.8%	6.6%	11.0%	8.2%	11.1%	18.2%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	1.2%	3.7%	0.7%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	5.1%	0.7%	0.0%	0.0%	4.5%	0.6%	1.2%	1.4%	2.0%	0.0%	9.1%
We have added board members with expertise in cost reduction strategies to help us achieve this goal	3.7%	5.6%	1.4%	7.0%	0.8%	0.0%	0.0%	16.7%	0.0%	7.7%	4.0%	0.0%	0.0%	6.8%	1.8%	3.6%	5.5%	6.1%	5.6%	9.1%
We have added physicians to the board to help us achieve this goal	8.5%	11.1%	5.7%	12.8%	4.2%	4.2%	14.3%	0.0%	2.0%	15.4%	8.8%	14.3%	0.0%	11.4%	5.4%	10.8%	11.0%	6.1%	5.6%	18.2%
We have added physicians to the management team to help us achieve this goal	16.7%	37.0%	12.1%	20.3%	7.6%	4.2%	0.0%	0.0%	14.0%	25.6%	15.4%	42.9%	33.3%	36.4%	6.6%	15.6%	24.7%	26.5%	33.3%	63.6%
Other	5.6%	9.3%	4.3%	5.2%	5.9%	6.3%	0.0%	0.0%	8.0%	7.7%	4.4%	14.3%	0.0%	9.1%	6.0%	4.8%	1.4%	10.2%	5.6%	18.2%
Respondents currently making changes to prepare for value-based payments	92.9%	93.1%	92.7%	97.2%	87.4%	90.6%	100.0%	100.0%	80.6%	100.0%	94.5%	87.5%	100.0%	93.6%	86.5%	96.0%	97.3%	98.0%	100.0%	91.7%

Appendix 2. Governance Practices

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Duty of Care					
The board requires that new board members receive education on their fiduciary duties.					
Total responding to this question	**527**	**59**	**153**	**178**	**137**
Yes, generally	93.0%	98.3%	94.8%	95.5%	85.4%
No, but considering it and/or working on it	4.7%	1.7%	3.3%	2.8%	10.2%
No, and not considering it	2.3%	0.0%	2.0%	1.7%	4.4%
The board reviews policies that specify the board's major oversight responsibilities at least every two years.					
Total responding to this question	**519**	**58**	**152**	**177**	**132**
Yes, generally	75.9%	77.6%	73.0%	74.6%	80.3%
No, but considering it and/or working on it	16.6%	13.8%	20.4%	16.9%	12.9%
No, and not considering it	7.5%	8.6%	6.6%	8.5%	6.8%
The board reviews the sufficiency of the organizational structure every five years.					
Total responding to this question	**509**	**58**	**147**	**173**	**131**
Yes, generally	71.9%	74.1%	75.5%	67.1%	73.3%
No, but considering it and/or working on it	13.4%	17.2%	12.2%	13.9%	12.2%
No, and not considering it	14.7%	8.6%	12.2%	19.1%	14.5%
The board reviews financial feasibility of projects before approving them.					
Total responding to this question	**520**	**59**	**150**	**173**	**138**
Yes, generally	99.2%	96.6%	100.0%	99.4%	99.3%
No, but considering it and/or working on it	0.4%	3.4%	0.0%	0.0%	0.0%
No, and not considering it	0.4%	0.0%	0.0%	0.6%	0.7%
The board considers whether new projects adhere to the organization's strategic plan before approving them.					
Total responding to this question	**522**	**57**	**153**	**174**	**138**
Yes, generally	96.7%	98.2%	96.7%	97.1%	95.7%
No, but considering it and/or working on it	2.7%	1.8%	3.3%	2.9%	2.2%
No, and not considering it	0.6%	0.0%	0.0%	0.0%	2.2%
The board receives important background materials within sufficient time to prepare for meetings.					
Total responding to this question	**528**	**59**	**153**	**179**	**137**
Yes, generally	97.9%	100.0%	96.7%	99.4%	96.4%
No, but considering it and/or working on it	1.5%	0.0%	2.6%	0.6%	2.2%
No, and not considering it	0.6%	0.0%	0.7%	0.0%	1.5%
The board has a written policy specifying minimum meeting attendance requirements.					
Total responding to this question	**511**	**58**	**150**	**175**	**128**
Yes, generally	75.9%	75.9%	75.3%	77.1%	75.0%
No, but considering it and/or working on it	8.8%	10.3%	10.7%	8.0%	7.0%
No, and not considering it	15.3%	13.8%	14.0%	14.9%	18.0%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board periodically reviews its committee structure to ensure: that responsibilities are delegated effectively; the independence of committee members where appropriate; continued utility of committee charters; and coordination between committees and effective reporting up to the board.					
Total responding to this question	**499**	**57**	**146**	**175**	**121**
Yes, generally	84.2%	89.5%	85.6%	90.3%	71.1%
No, but considering it and/or working on it	8.8%	7.0%	6.2%	4.6%	19.0%
No, and not considering it	7.0%	3.5%	8.2%	5.1%	9.9%
The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).					
Total responding to this question	**518**	**59**	**148**	**174**	**137**
Yes, generally	95.8%	98.3%	98.0%	95.4%	92.7%
No, but considering it and/or working on it	1.9%	1.7%	1.4%	1.7%	2.9%
No, and not considering it	2.3%	0.0%	0.7%	2.9%	4.4%
Please evaluate your board's overall performance in fulfilling its duty of care.					
Total responding to this question	**528**	**58**	**153**	**179**	**138**
Excellent	55.3%	72.4%	56.9%	60.9%	39.1%
Very Good	36.4%	20.7%	37.3%	34.6%	44.2%
Good	6.4%	6.9%	4.6%	3.9%	11.6%
Fair	1.3%	0.0%	0.7%	0.0%	4.3%
Poor	0.6%	0.0%	0.7%	0.6%	0.7%
Duty of Loyalty					
The board has adopted a conflict-of-interest policy that, at a minimum, complies with the most recent IRS definition of conflict of interest.					
Total responding to this question	**525**	**60**	**151**	**179**	**135**
Yes, generally	98.7%	100.0%	99.3%	99.4%	96.3%
No, but considering it and/or working on it	1.1%	0.0%	0.7%	0.6%	3.0%
No, and not considering it	0.2%	0.0%	0.0%	0.0%	0.7%
The board adheres to a conflict-of-interest policy that contains "disabling guidelines" that define specific criteria for when a director's material conflict of interest is so great that the director should no longer serve on the board.					
Total responding to this question	**509**	**57**	**151**	**178**	**123**
Yes, generally	74.3%	70.2%	69.5%	76.4%	78.9%
No, but considering it and/or working on it	11.0%	14.0%	12.6%	10.7%	8.1%
No, and not considering it	14.7%	15.8%	17.9%	12.9%	13.0%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has adopted a specific definition, with measurable standards, of an "independent director" that, at a minimum, complies with the most recent IRS definition of an "independent director" and takes into consideration any applicable state law.					
Total responding to this question	**474**	**55**	**145**	**171**	**103**
Yes, generally	79.7%	89.1%	81.4%	82.5%	68.0%
No, but considering it and/or working on it	12.0%	10.9%	14.5%	9.4%	13.6%
No, and not considering it	8.2%	0.0%	4.1%	8.2%	18.4%
Board members complete a full conflict-of-interest disclosure statement annually.					
Total responding to this question	**528**	**59**	**152**	**180**	**137**
Yes, generally	95.5%	100.0%	97.4%	98.3%	87.6%
No, but considering it and/or working on it	3.4%	0.0%	2.0%	1.7%	8.8%
No, and not considering it	1.1%	0.0%	0.7%	0.0%	3.6%
The board has a specific process by which disclosed potential conflicts are reviewed by independent, non-conflicted board members with staff support from the general counsel.					
Total responding to this question	**519**	**59**	**149**	**179**	**132**
Yes, generally	74.2%	86.4%	72.5%	79.3%	63.6%
No, but considering it and/or working on it	11.0%	6.8%	13.4%	10.6%	10.6%
No, and not considering it	14.8%	6.8%	14.1%	10.1%	25.8%
The board enforces a written policy that states that deliberate violations of conflict of interest constitute grounds for removal from the board.					
Total responding to this question	**493**	**56**	**149**	**174**	**114**
Yes, generally	71.4%	71.4%	73.2%	74.7%	64.0%
No, but considering it and/or working on it	13.6%	12.5%	11.4%	12.6%	18.4%
No, and not considering it	15.0%	16.1%	15.4%	12.6%	17.5%
The board assesses the adequacy of its conflict-of-interest policy as well as the sufficiency of its conflict review process at least every two years.					
Total responding to this question	**515**	**57**	**152**	**174**	**132**
Yes, generally	77.3%	87.7%	77.0%	81.0%	68.2%
No, but considering it and/or working on it	14.2%	5.3%	17.8%	12.1%	16.7%
No, and not considering it	8.5%	7.0%	5.3%	6.9%	15.2%
The board's enforcement of the organization's conflict-of-interest policy is uniformly applied across all members of the board.					
Total responding to this question	**519**	**59**	**149**	**179**	**132**
Yes, generally	74.2%	86.4%	72.5%	79.3%	63.6%
No, but considering it and/or working on it	11.0%	6.8%	13.4%	10.6%	10.6%
No, and not considering it	14.8%	6.8%	14.1%	10.1%	25.8%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.					
Total responding to this question	**518**	**58**	**151**	**178**	**131**
Yes, generally	86.3%	87.9%	86.8%	90.4%	79.4%
No, but considering it and/or working on it	7.1%	5.2%	9.3%	4.5%	9.2%
No, and not considering it	6.6%	6.9%	4.0%	5.1%	11.5%
The board ensures that the federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.					
Total responding to this question	**425**	**57**	**149**	**172**	**47**
Yes, generally	95.3%	100.0%	98.7%	95.9%	76.6%
No, but considering it and/or working on it	2.6%	0.0%	0.7%	2.3%	12.8%
No, and not considering it	2.1%	0.0%	0.7%	1.7%	10.6%
Please evaluate your board's overall performance in fulfilling its duty of loyalty.					
Total responding to this question	**527**	**60**	**150**	**179**	**138**
Excellent	57.1%	83.3%	56.7%	63.7%	37.7%
Very Good	31.3%	8.3%	35.3%	30.2%	38.4%
Good	8.3%	8.3%	6.0%	5.0%	15.2%
Fair	2.5%	0.0%	1.3%	0.6%	7.2%
Poor	0.8%	0.0%	0.7%	0.6%	1.4%
Duty of Obedience					
The board oversees a formal assessment of the organization at least every two years to ensure fulfillment of the organization's mission.					
Total responding to this question	**516**	**57**	**150**	**175**	**134**
Yes, generally	75.2%	77.2%	67.3%	77.7%	79.9%
No, but considering it and/or working on it	14.9%	8.8%	19.3%	14.9%	12.7%
No, and not considering it	9.9%	14.0%	13.3%	7.4%	7.5%
The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.					
Total responding to this question	**515**	**58**	**152**	**171**	**134**
Yes, generally	94.2%	98.3%	94.1%	94.7%	91.8%
No, but considering it and/or working on it	4.7%	1.7%	5.3%	3.5%	6.7%
No, and not considering it	1.2%	0.0%	0.7%	1.8%	1.5%
The board considers how major decisions will impact the organization's mission before approving them, and rejects proposals that put the organization's mission at risk.					
Total responding to this question	**515**	**57**	**152**	**175**	**131**
Yes, generally	96.1%	96.5%	98.0%	98.3%	90.8%
No, but considering it and/or working on it	3.3%	3.5%	2.0%	1.7%	6.9%
No, and not considering it	0.6%	0.0%	0.0%	0.0%	2.3%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board makes an appropriate governance assignment for risk management oversight.					
Total responding to this question	**506**	**58**	**148**	**170**	**130**
Yes, generally	84.4%	94.8%	87.2%	88.8%	70.8%
No, but considering it and/or working on it	8.9%	3.4%	8.8%	5.3%	16.2%
No, and not considering it	6.7%	1.7%	4.1%	5.9%	13.1%
The board has approved a "code of conduct" policies/procedures document that provides ethical requirements for board members, employees, and practicing physicians.					
Total responding to this question	**515**	**59**	**151**	**175**	**130**
Yes, generally	85.6%	88.1%	89.4%	88.0%	76.9%
No, but considering it and/or working on it	9.9%	6.8%	9.3%	8.0%	14.6%
No, and not considering it	4.5%	5.1%	1.3%	4.0%	8.5%
The board has delegated its executive compensation oversight function to a group (committee, *ad hoc* group, task force, etc.) that is composed solely of independent directors of the board.					
Total responding to this question	**443**	**56**	**147**	**141**	**99**
Yes, generally	82.6%	96.4%	89.8%	86.5%	58.6%
No, but considering it and/or working on it	3.8%	1.8%	3.4%	2.8%	7.1%
No, and not considering it	13.5%	1.8%	6.8%	10.6%	34.3%
The board has approved a compliance plan that *includes* monitoring of arrangements with physicians (e.g., employment, contracting, medical directorships, etc.) to ensure adherence to current laws/regulations.					
Total responding to this question	**502**	**57**	**150**	**166**	**129**
Yes, generally	89.2%	98.2%	90.0%	89.8%	83.7%
No, but considering it and/or working on it	6.2%	1.8%	6.0%	4.2%	10.9%
No, and not considering it	4.6%	0.0%	4.0%	6.0%	5.4%
The board (directly or through a dedicated committee) ensures the compliance plan is properly implemented and effective.					
Total responding to this question	**505**	**58**	**148**	**170**	**129**
Yes, generally	89.1%	100.0%	91.2%	91.8%	78.3%
No, but considering it and/or working on it	5.5%	0.0%	4.1%	3.5%	12.4%
No, and not considering it	5.3%	0.0%	4.7%	4.7%	9.3%
The board routinely receives reports from the compliance officer about the organization's compliance program (e.g., systems for detecting, reporting, and addressing potential violations of law or payment regulations, new legislation, updates to current regulations, etc.).					
Total responding to this question	**506**	**58**	**146**	**172**	**130**
Yes, generally	88.7%	98.3%	87.0%	93.6%	80.0%
No, but considering it and/or working on it	8.9%	1.7%	11.0%	4.7%	15.4%
No, and not considering it	2.4%	0.0%	2.1%	1.7%	4.6%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has established a direct reporting relationship with the compliance officer.					
Total responding to this question	**489**	**57**	**142**	**162**	**128**
Yes, generally	72.0%	80.7%	69.7%	72.2%	70.3%
No, but considering it and/or working on it	9.0%	3.5%	11.3%	8.0%	10.2%
No, and not considering it	19.0%	15.8%	19.0%	19.8%	19.5%
The board has established a direct reporting relationship with legal counsel.					
Total responding to this question	**464**	**56**	**134**	**153**	**121**
Yes, generally	63.1%	62.5%	57.5%	63.4%	69.4%
No, but considering it and/or working on it	8.8%	8.9%	8.2%	11.1%	6.6%
No, and not considering it	28.0%	28.6%	34.3%	25.5%	24.0%
The board has approved a "whistleblower" policy that specifies the following: the manner by which the organization handles employee complaints *and* allows employees to report in confidence any suspected misappropriation of charitable assets.					
Total responding to this question	**497**	**58**	**149**	**166**	**124**
Yes, generally	86.1%	94.8%	81.9%	90.4%	81.5%
No, but considering it and/or working on it	8.5%	3.4%	12.8%	3.0%	12.9%
No, and not considering it	5.4%	1.7%	5.4%	6.6%	5.6%
Please evaluate your board's overall performance in fulfilling its duty of obedience.					
Total responding to this question	**520**	**59**	**151**	**178**	**132**
Excellent	50.8%	69.5%	51.7%	55.6%	34.8%
Very Good	34.8%	23.7%	39.1%	32.6%	37.9%
Good	11.9%	6.8%	7.9%	10.1%	21.2%
Fair	2.1%	0.0%	1.3%	1.1%	5.3%
Poor	0.4%	0.0%	0.0%	0.6%	0.8%
Quality Oversight					
The board reviews quality performance measures (using dashboards, balanced scorecards, run charts, or some other standard mechanism for board-level reporting) at least quarterly to identify needs for corrective action.					
Total responding to this question	**519**	**58**	**152**	**178**	**131**
Yes, generally	96.1%	94.8%	96.1%	99.4%	92.4%
No, but considering it and/or working on it	3.9%	5.2%	3.9%	0.6%	7.6%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%
The board requires all hospital clinical programs or services to meet quality-related performance criteria.					
Total responding to this question	**517**	**55**	**153**	**178**	**131**
Yes, generally	81.4%	83.6%	80.4%	83.7%	78.6%
No, but considering it and/or working on it	14.5%	12.7%	15.0%	11.8%	18.3%
No, and not considering it	4.1%	3.6%	4.6%	4.5%	3.1%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.					
Total responding to this question	508	56	148	173	131
Yes, generally	81.9%	89.3%	80.4%	91.3%	67.9%
No, but considering it and/or working on it	11.0%	5.4%	12.2%	6.4%	18.3%
No, and not considering it	7.1%	5.4%	7.4%	2.3%	13.7%
The board participates in the development of and/or approval of explicit criteria to guide medical staff recommendations for physician appointments, reappointments, and clinical privileges.					
Total responding to this question	502	42	151	178	131
Yes, generally	79.1%	69.0%	82.1%	84.8%	71.0%
No, but considering it and/or working on it	9.4%	9.5%	9.9%	6.2%	13.0%
No, and not considering it	11.6%	21.4%	7.9%	9.0%	16.0%
The board works with medical staff and management to set the organization's quality goals.					
Total responding to this question	505	50	152	170	133
Yes, generally	83.8%	92.0%	83.6%	91.2%	71.4%
No, but considering it and/or working on it	9.5%	2.0%	13.2%	3.5%	15.8%
No, and not considering it	6.7%	6.0%	3.3%	5.3%	12.8%
The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).					
Total responding to this question	520	57	152	179	132
Yes, generally	85.2%	89.5%	88.8%	88.8%	74.2%
No, but considering it and/or working on it	12.1%	8.8%	9.9%	10.6%	18.2%
No, and not considering it	2.7%	1.8%	1.3%	0.6%	7.6%
The board requires management to base *at least some* of the organization's quality goals on the "theoretical ideal" (e.g., zero central line infections, zero sepsis, and so forth).					
Total responding to this question	513	56	150	177	130
Yes, generally	78.2%	87.5%	80.0%	79.7%	70.0%
No, but considering it and/or working on it	14.0%	8.9%	11.3%	15.8%	16.9%
No, and not considering it	7.8%	3.6%	8.7%	4.5%	13.1%
The board reviews its quality performance by comparing its current performance to its own historical performance as well as industry benchmarks.					
Total responding to this question	518	56	152	178	132
Yes, generally	91.1%	92.9%	91.4%	95.5%	84.1%
No, but considering it and/or working on it	5.6%	5.4%	3.9%	3.4%	10.6%
No, and not considering it	3.3%	1.8%	4.6%	1.1%	5.3%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has a standing quality committee of the board.					
Total responding to this question	**488**	**53**	**150**	**174**	**111**
Yes, generally	78.9%	86.8%	79.3%	86.2%	63.1%
No, but considering it and/or working on it	7.0%	5.7%	7.3%	5.2%	9.9%
No, and not considering it	14.1%	7.5%	13.3%	8.6%	27.0%
The board reviews patient satisfaction/ patient experience scores at least annually (including those publicly reported by CMS).					
Total responding to this question	**522**	**57**	**152**	**179**	**134**
Yes, generally	96.9%	98.2%	96.1%	100.0%	93.3%
No, but considering it and/or working on it	2.3%	0.0%	3.3%	0.0%	5.2%
No, and not considering it	0.8%	1.8%	0.7%	0.0%	1.5%
The board participates at least annually in education regarding issues related to its responsibility for quality of care in the organization.					
Total responding to this question	**518**	**57**	**152**	**177**	**132**
Yes, generally	85.1%	89.5%	87.5%	87.0%	78.0%
No, but considering it and/or working on it	11.4%	8.8%	11.2%	9.0%	15.9%
No, and not considering it	3.5%	1.8%	1.3%	4.0%	6.1%
The board has adopted a policy concerning reporting the organization's quality/safety performance to the general public.					
Total responding to this question	**505**	**56**	**150**	**173**	**126**
Yes, generally	50.5%	48.2%	48.7%	55.5%	46.8%
No, but considering it and/or working on it	26.9%	33.9%	33.3%	23.1%	21.4%
No, and not considering it	22.6%	17.9%	18.0%	21.4%	31.7%
The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.					
Total responding to this question	**496**	**41**	**151**	**175**	**129**
Yes, generally	87.7%	95.1%	86.8%	92.6%	79.8%
No, but considering it and/or working on it	6.9%	4.9%	7.3%	5.1%	9.3%
No, and not considering it	5.4%	0.0%	6.0%	2.3%	10.9%
Please evaluate your board's overall performance in fulfilling its responsibility for quality oversight.					
Total responding to this question	**520**	**58**	**152**	**179**	**131**
Excellent	49.0%	63.8%	50.0%	55.3%	32.8%
Very Good	36.0%	31.0%	37.5%	34.6%	38.2%
Good	10.8%	3.4%	10.5%	8.4%	17.6%
Fair	3.3%	1.7%	1.3%	1.1%	9.2%
Poor	1.0%	0.0%	0.7%	0.6%	2.3%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Financial Oversight					
The board approves the organization's capital and financial plans.					
Total responding to this question	**511**	**59**	**149**	**169**	**134**
Yes, generally	99.6%	100.0%	100.0%	99.4%	99.3%
No, but considering it and/or working on it	0.2%	0.0%	0.0%	0.0%	0.7%
No, and not considering it	0.2%	0.0%	0.0%	0.6%	0.0%
The board reviews information at least quarterly on the organization's financial performance against plans.					
Total responding to this question	**519**	**59**	**150**	**177**	**133**
Yes, generally	99.6%	98.3%	100.0%	100.0%	99.2%
No, but considering it and/or working on it	0.0%	0.0%	0.0%	0.0%	0.0%
No, and not considering it	0.4%	1.7%	0.0%	0.0%	0.8%
The board demands corrective actions in response to under-performance on capital and financial plans.					
Total responding to this question	**509**	**57**	**148**	**172**	**132**
Yes, generally	90.0%	93.0%	88.5%	91.9%	87.9%
No, but considering it and/or working on it	5.9%	5.3%	6.1%	5.2%	6.8%
No, and not considering it	4.1%	1.8%	5.4%	2.9%	5.3%
The board requires that the organization's strategic and financial plans be aligned.					
Total responding to this question	**515**	**59**	**149**	**175**	**132**
Yes, generally	92.4%	96.6%	90.6%	96.0%	87.9%
No, but considering it and/or working on it	6.6%	3.4%	8.1%	2.9%	11.4%
No, and not considering it	1.0%	0.0%	1.3%	1.1%	0.8%
The board monitors the organization's debt obligations and investment portfolio.					
Total responding to this question	**475**	**58**	**148**	**140**	**129**
Yes, generally	96.8%	100.0%	97.3%	95.7%	96.1%
No, but considering it and/or working on it	1.9%	0.0%	1.4%	2.1%	3.1%
No, and not considering it	1.3%	0.0%	1.4%	2.1%	0.8%
Board members responsible for audit oversight meet with external auditors, without management, at least annually.					
Total responding to this question	**462**	**59**	**145**	**137**	**121**
Yes, generally	85.7%	98.3%	92.4%	85.4%	71.9%
No, but considering it and/or working on it	3.0%	0.0%	2.8%	3.6%	4.1%
No, and not considering it	11.3%	1.7%	4.8%	10.9%	24.0%
The board has a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight.					
Total responding to this question	**461**	**57**	**148**	**129**	**127**
Yes, generally	84.4%	94.7%	85.1%	85.3%	78.0%
No, but considering it and/or working on it	6.9%	5.3%	5.4%	6.2%	10.2%
No, and not considering it	8.7%	0.0%	9.5%	8.5%	11.8%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has created a separate audit committee (or audit and compliance committee, or another committee or subcommittee specific to audit oversight) to oversee the external and internal audit functions.					
Total responding to this question	**443**	**58**	**141**	**134**	**110**
Yes, generally	69.8%	91.4%	75.2%	79.1%	40.0%
No, but considering it and/or working on it	4.5%	0.0%	2.8%	5.2%	8.2%
No, and not considering it	25.7%	8.6%	22.0%	15.7%	51.8%
The board has adopted a policy that specifies that the audit committee (or other committee/subcommittee whose primary responsibility is audit oversight) must be composed entirely of independent persons who have appropriate qualifications to serve in such role.					
Total responding to this question	**425**	**55**	**138**	**132**	**100**
Yes, generally	60.5%	85.5%	65.9%	65.2%	33.0%
No, but considering it and/or working on it	10.8%	5.5%	9.4%	12.9%	13.0%
No, and not considering it	28.7%	9.1%	24.6%	22.0%	54.0%
The board has adopted a policy on financial assistance for the poor and uninsured that adheres to the mission and complies with federal and state requirements.					
Total responding to this question	**508**	**59**	**149**	**168**	**132**
Yes, generally	97.0%	100.0%	96.6%	95.2%	98.5%
No, but considering it and/or working on it	1.8%	0.0%	1.3%	3.0%	1.5%
No, and not considering it	1.2%	0.0%	2.0%	1.8%	0.0%
Please evaluate your board's overall performance in fulfilling its responsibility for financial oversight.					
Total responding to this question	**511**	**58**	**147**	**173**	**133**
Excellent	60.7%	89.7%	64.6%	61.3%	42.9%
Very Good	30.1%	8.6%	30.6%	31.2%	37.6%
Good	7.8%	0.0%	4.1%	6.9%	16.5%
Fair	1.4%	1.7%	0.7%	0.6%	3.0%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%
Strategic Direction					
The full board actively participates in establishing the organization's strategic direction such as creating a longer-range vision, setting priorities, and developing the strategic plan.					
Total responding to this question	**516**	**59**	**151**	**173**	**133**
Yes, generally	93.2%	94.9%	96.0%	96.0%	85.7%
No, but considering it and/or working on it	5.6%	1.7%	4.0%	2.9%	12.8%
No, and not considering it	1.2%	3.4%	0.0%	1.2%	1.5%
The board approves a strategy for aligning the clinical and economic goals of the hospital(s) and physicians.					
Total responding to this question	**503**	**52**	**150**	**169**	**132**
Yes, generally	87.9%	90.4%	88.7%	93.5%	78.8%
No, but considering it and/or working on it	9.5%	9.6%	7.3%	5.3%	17.4%
No, and not considering it	2.6%	0.0%	4.0%	1.2%	3.8%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board requires that all plans in the organization (e.g., financial, capital, operational, quality improvement) be aligned with the organization's overall strategic plan/direction.					
Total responding to this question	**515**	**57**	**150**	**174**	**134**
Yes, generally	90.1%	94.7%	91.3%	93.7%	82.1%
No, but considering it and/or working on it	8.5%	5.3%	6.7%	4.6%	17.2%
No, and not considering it	1.4%	0.0%	2.0%	1.7%	0.7%
The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, impact on quality and patient safety, and so forth.					
Total responding to this question	**516**	**58**	**151**	**174**	**133**
Yes, generally	94.4%	94.8%	95.4%	96.6%	90.2%
No, but considering it and/or working on it	5.0%	5.2%	4.6%	2.9%	8.3%
No, and not considering it	0.6%	0.0%	0.0%	0.6%	1.5%
The board discusses the needs of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).					
Total responding to this question	**514**	**58**	**148**	**175**	**133**
Yes, generally	93.8%	96.6%	95.9%	96.0%	87.2%
No, but considering it and/or working on it	4.7%	3.4%	2.0%	2.3%	11.3%
No, and not considering it	1.6%	0.0%	2.0%	1.7%	1.5%
The board considers how the organization's strategic plan addresses community health status/needs before approving the plan.					
Total responding to this question	**513**	**58**	**149**	**175**	**131**
Yes, generally	81.7%	84.5%	79.9%	88.6%	73.3%
No, but considering it and/or working on it	16.4%	12.1%	18.1%	9.7%	25.2%
No, and not considering it	1.9%	3.4%	2.0%	1.7%	1.5%
The board requires that major strategic projects specify *both* measurable criteria for success *and* who is responsible for implementation.					
Total responding to this question	**512**	**57**	**149**	**174**	**132**
Yes, generally	84.2%	86.0%	83.9%	89.1%	77.3%
No, but considering it and/or working on it	12.1%	14.0%	12.1%	7.5%	17.4%
No, and not considering it	3.7%	0.0%	4.0%	3.4%	5.3%
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.					
Total responding to this question	**500**	**55**	**146**	**172**	**127**
Yes, generally	59.0%	61.8%	56.2%	66.3%	51.2%
No, but considering it and/or working on it	21.2%	23.6%	25.3%	13.4%	26.0%
No, and not considering it	19.8%	14.5%	18.5%	20.3%	22.8%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board spends more than half of its meeting time during most board meetings discussing strategic issues as opposed to hearing reports.					
Total responding to this question	**505**	**58**	**149**	**170**	**128**
Yes, generally	43.0%	63.8%	42.3%	48.2%	27.3%
No, but considering it and/or working on it	36.2%	25.9%	38.3%	35.9%	39.1%
No, and not considering it	20.8%	10.3%	19.5%	15.9%	33.6%
The board has adopted policies and procedures that define how strategic plans are developed and updated (e.g., who is to be involved, timeframes, and the role of the board, management, physicians, and staff).					
Total responding to this question	**495**	**57**	**146**	**162**	**130**
Yes, generally	48.7%	59.6%	47.3%	52.5%	40.8%
No, but considering it and/or working on it	25.1%	21.1%	29.5%	19.8%	28.5%
No, and not considering it	26.3%	19.3%	23.3%	27.8%	30.8%
The board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability.					
Total responding to this question	**487**	**45**	**144**	**170**	**128**
Yes, generally	69.0%	75.6%	69.4%	74.7%	58.6%
No, but considering it and/or working on it	18.1%	17.8%	18.1%	14.1%	23.4%
No, and not considering it	12.9%	6.7%	12.5%	11.2%	18.0%
The board has established policies regarding physician compensation (e.g., physician employment, financial support for physician recruitment, payment for ED call, etc.) that includes consideration of "fair market value" and industry benchmarks when determining compensation.					
Total responding to this question	**467**	**51**	**145**	**150**	**121**
Yes, generally	71.7%	80.4%	69.7%	80.0%	60.3%
No, but considering it and/or working on it	16.9%	11.8%	20.7%	8.7%	24.8%
No, and not considering it	11.3%	7.8%	9.7%	11.3%	14.9%
Please evaluate your board's overall performance in fulfilling its responsibility for setting strategic direction.					
Total responding to this question	**513**	**58**	**148**	**174**	**133**
Excellent	39.6%	56.9%	39.9%	45.4%	24.1%
Very Good	38.6%	37.9%	41.2%	37.9%	36.8%
Good	17.5%	1.7%	17.6%	14.9%	27.8%
Fair	3.3%	3.4%	0.7%	1.1%	9.0%
Poor	1.0%	0.0%	0.7%	0.6%	2.3%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Board Development					
The board engages in a formal self-assessment process to evaluate its own performance at least every two years.					
Total responding to this question	515	57	151	175	132
Yes, generally	81.2%	93.0%	83.4%	83.4%	70.5%
No, but considering it and/or working on it	12.6%	5.3%	11.3%	14.9%	14.4%
No, and not considering it	6.2%	1.8%	5.3%	1.7%	15.2%
The board uses the results from the self-assessment process to establish board performance improvement goals.					
Total responding to this question	493	55	144	169	125
Yes, generally	68.0%	81.8%	68.8%	74.6%	52.0%
No, but considering it and/or working on it	21.5%	14.5%	21.5%	19.5%	27.2%
No, and not considering it	10.5%	3.6%	9.7%	5.9%	20.8%
The board uses a formal orientation program for new board members.					
Total responding to this question	515	57	148	177	133
Yes, generally	85.8%	93.0%	90.5%	91.5%	69.9%
No, but considering it and/or working on it	10.7%	7.0%	6.8%	7.3%	21.1%
No, and not considering it	3.5%	0.0%	2.7%	1.1%	9.0%
Board members participate in ongoing education regarding key strategic issues facing the organization.					
Total responding to this question	514	58	151	175	130
Yes, generally	89.1%	91.4%	91.4%	94.3%	78.5%
No, but considering it and/or working on it	9.1%	8.6%	7.9%	4.0%	17.7%
No, and not considering it	1.8%	0.0%	0.7%	1.7%	3.8%
The board assesses its own bylaws/structure at least every three years.					
Total responding to this question	503	58	150	166	129
Yes, generally	80.1%	79.3%	81.3%	78.3%	81.4%
No, but considering it and/or working on it	13.5%	15.5%	13.3%	15.1%	10.9%
No, and not considering it	6.4%	5.2%	5.3%	6.6%	7.8%
The board uses competency-based criteria when selecting new board members.					
Total responding to this question	449	54	145	167	83
Yes, generally	56.8%	79.6%	51.7%	64.7%	34.9%
No, but considering it and/or working on it	22.5%	18.5%	24.8%	21.6%	22.9%
No, and not considering it	20.7%	1.9%	23.4%	13.8%	42.2%
The board uses a formal process to evaluate the performance of individual board members.					
Total responding to this question	481	55	146	173	107
Yes, generally	30.1%	41.8%	30.8%	32.9%	18.7%
No, but considering it and/or working on it	27.7%	32.7%	30.1%	26.6%	23.4%
No, and not considering it	42.2%	25.5%	39.0%	40.5%	57.9%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has established performance requirements for board member reappointment.					
Total responding to this question	480	55	150	171	104
Yes, generally	31.0%	40.0%	32.0%	35.7%	17.3%
No, but considering it and/or working on it	26.9%	30.9%	34.0%	25.1%	17.3%
No, and not considering it	42.1%	29.1%	34.0%	39.2%	65.4%
The board has a "mentoring" program for new board members.					
Total responding to this question	490	53	146	174	117
Yes, generally	30.8%	35.8%	34.9%	31.6%	22.2%
No, but considering it and/or working on it	30.2%	37.7%	32.2%	29.9%	24.8%
No, and not considering it	39.0%	26.4%	32.9%	38.5%	53.0%
The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.					
Total responding to this question	467	54	146	171	96
Yes, generally	39.0%	46.3%	42.5%	46.2%	16.7%
No, but considering it and/or working on it	30.0%	38.9%	31.5%	31.0%	20.8%
No, and not considering it	31.0%	14.8%	26.0%	22.8%	62.5%
The board has a compact regarding mutual expectations with its chair.					
Total responding to this question	481	54	145	170	112
Yes, generally	29.7%	42.6%	29.7%	34.7%	16.1%
No, but considering it and/or working on it	19.5%	22.2%	22.8%	19.4%	14.3%
No, and not considering it	50.7%	35.2%	47.6%	45.9%	69.6%
Please evaluate your board's overall performance in fulfilling its responsibility for its own performance and development.					
Total responding to this question	516	57	150	178	131
Excellent	26.4%	40.4%	24.7%	28.7%	19.1%
Very Good	38.8%	36.8%	41.3%	42.1%	32.1%
Good	22.1%	19.3%	24.0%	20.2%	23.7%
Fair	9.9%	3.5%	8.0%	9.0%	16.0%
Poor	2.9%	0.0%	2.0%	0.0%	9.2%
Management Oversight					
The board follows a formal process for evaluating the CEO's performance.					
Total responding to this question	502	58	150	160	134
Yes, generally	93.4%	100.0%	93.3%	94.4%	89.6%
No, but considering it and/or working on it	4.4%	0.0%	4.7%	5.0%	5.2%
No, and not considering it	2.2%	0.0%	2.0%	0.6%	5.2%
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation.					
Total responding to this question	491	58	149	153	131
Yes, generally	82.9%	89.7%	85.9%	86.9%	71.8%
No, but considering it and/or working on it	11.4%	6.9%	10.7%	7.8%	18.3%
No, and not considering it	5.7%	3.4%	3.4%	5.2%	9.9%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board requires that the CEO's compensation package is based, in part, on the CEO performance evaluation.					
Total responding to this question	**482**	**58**	**149**	**147**	**128**
Yes, generally	89.0%	96.6%	89.9%	93.9%	78.9%
No, but considering it and/or working on it	5.8%	0.0%	6.0%	3.4%	10.9%
No, and not considering it	5.2%	3.4%	4.0%	2.7%	10.2%
The board requires that CEO compensation be determined with due consideration given to the IRS mandate of "fair market value" and "reasonableness of compensation."					
Total responding to this question	**480**	**58**	**150**	**146**	**126**
Yes, generally	92.5%	98.3%	96.7%	95.2%	81.7%
No, but considering it and/or working on it	4.2%	0.0%	2.0%	2.7%	10.3%
No, and not considering it	3.3%	1.7%	1.3%	2.1%	7.9%
The board seeks independent (i.e., third party) expert advice/information on industry comparables before approving executive compensation.					
Total responding to this question	**476**	**56**	**148**	**142**	**130**
Yes, generally	85.9%	98.2%	89.9%	88.7%	73.1%
No, but considering it and/or working on it	5.7%	1.8%	6.8%	4.9%	6.9%
No, and not considering it	8.4%	0.0%	3.4%	6.3%	20.0%
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.					
Total responding to this question	**474**	**56**	**148**	**141**	**129**
Yes, generally	91.1%	98.2%	96.6%	92.2%	80.6%
No, but considering it and/or working on it	3.8%	1.8%	2.0%	2.8%	7.8%
No, and not considering it	5.1%	0.0%	1.4%	5.0%	11.6%
The board requires that the CEO maintain a written, current succession plan.					
Total responding to this question	**480**	**56**	**145**	**150**	**129**
Yes, generally	47.1%	78.6%	54.5%	45.3%	27.1%
No, but considering it and/or working on it	27.7%	14.3%	24.8%	30.7%	33.3%
No, and not considering it	25.2%	7.1%	20.7%	24.0%	39.5%
The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance.					
Total responding to this question	**488**	**58**	**145**	**159**	**126**
Yes, generally	72.1%	89.7%	75.9%	67.9%	65.1%
No, but considering it and/or working on it	10.2%	3.4%	10.3%	8.8%	15.1%
No, and not considering it	17.6%	6.9%	13.8%	23.3%	19.8%
Please evaluate your board's overall performance in fulfilling its responsibility for management oversight.					
Total responding to this question	**511**	**58**	**147**	**173**	**133**
Excellent	50.1%	81.0%	55.1%	50.9%	30.1%
Very Good	31.5%	10.3%	31.3%	32.4%	39.8%
Good	13.5%	6.9%	8.8%	15.0%	19.5%
Fair	3.9%	1.7%	4.8%	1.2%	7.5%
Poor	1.0%	0.0%	0.0%	0.6%	3.0%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Community Benefit & Advocacy					
The board has adopted a policy or policies on community benefit that includes *all* of the following characteristics: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, measurable goals for the organization, a financial assistance policy, and commitment to communicate transparently with the public.					
Total responding to this question	491	55	147	165	124
Yes, generally	56.0%	72.7%	51.7%	66.7%	39.5%
No, but considering it and/or working on it	32.2%	20.0%	37.4%	22.4%	44.4%
No, and not considering it	11.8%	7.3%	10.9%	10.9%	16.1%
The board provides oversight with respect to organizational compliance with internal revenue code tax-exemption requirements concerning community benefit and related requirements.					
Total responding to this question	459	54	147	162	96
Yes, generally	81.9%	98.1%	81.6%	87.0%	64.6%
No, but considering it and/or working on it	13.7%	0.0%	14.3%	10.5%	26.0%
No, and not considering it	4.4%	1.9%	4.1%	2.5%	9.4%
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).					
Total responding to this question	497	50	148	170	129
Yes, generally	82.9%	76.0%	83.1%	86.5%	80.6%
No, but considering it and/or working on it	11.5%	14.0%	12.2%	9.4%	12.4%
No, and not considering it	5.6%	10.0%	4.7%	4.1%	7.0%
The board actively supports the organization's fund development program (e.g., board members give according to their abilities, identify potential donors, participate in solicitations, serve on fund development committees).					
Total responding to this question	467	52	140	163	112
Yes, generally	71.3%	76.9%	74.3%	75.5%	58.9%
No, but considering it and/or working on it	18.2%	11.5%	15.7%	19.0%	23.2%
No, and not considering it	10.5%	11.5%	10.0%	5.5%	17.9%
The board has a written policy establishing the board's role in fund development and/or philanthropy.					
Total responding to this question	457	51	136	161	109
Yes, generally	30.9%	37.3%	33.8%	33.5%	20.2%
No, but considering it and/or working on it	24.7%	17.6%	22.8%	24.2%	31.2%
No, and not considering it	44.4%	45.1%	43.4%	42.2%	48.6%
The board works closely with legal counsel to ensure all advocacy efforts are consistent with the requirements of tax-exempt status.					
Total responding to this question	459	56	139	157	107
Yes, generally	71.9%	83.9%	68.3%	75.8%	64.5%
No, but considering it and/or working on it	11.3%	7.1%	15.8%	5.7%	15.9%
No, and not considering it	16.8%	8.9%	15.8%	18.5%	19.6%

2013 Governance Practices: Adoption	Overall	System	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has adopted a policy regarding information transparency, explaining to the public in understandable terms its performance on measures of quality, safety, pricing, and customer service.					
Total responding to this question	497	55	146	165	131
Yes, generally	49.1%	56.4%	42.5%	50.3%	51.9%
No, but considering it and/or working on it	29.2%	27.3%	32.2%	26.1%	30.5%
No, and not considering it	21.7%	16.4%	25.3%	23.6%	17.6%
The board ensures that a community health needs assessment is conducted at least every three years to understand health issues and perceptions of the organization of the communities served.					
Total responding to this question	486	55	147	168	116
Yes, generally	87.0%	92.7%	91.2%	97.0%	64.7%
No, but considering it and/or working on it	10.5%	7.3%	8.8%	2.4%	25.9%
No, and not considering it	2.5%	0.0%	0.0%	0.6%	9.5%
The board ensures the adoption of implementation strategies that meet the needs of the community, as identified through the community health needs assessment.					
Total responding to this question	488	54	143	172	119
Yes, generally	79.5%	90.7%	81.8%	89.5%	57.1%
No, but considering it and/or working on it	17.2%	7.4%	17.5%	7.6%	35.3%
No, and not considering it	3.3%	1.9%	0.7%	2.9%	7.6%
The board requires that management annually report community benefit value to the general public (i.e., the community).					
Total responding to this question	488	55	145	168	120
Yes, generally	74.2%	87.3%	73.8%	81.0%	59.2%
No, but considering it and/or working on it	17.6%	9.1%	17.9%	13.1%	27.5%
No, and not considering it	8.2%	3.6%	8.3%	6.0%	13.3%
Please evaluate your board's overall performance in fulfilling its responsibility for community benefit and advocacy.					
Total responding to this question	517	57	148	178	134
Excellent	30.9%	43.9%	31.8%	36.0%	17.9%
Very Good	39.8%	43.9%	42.6%	42.7%	31.3%
Good	20.1%	7.0%	18.9%	14.6%	34.3%
Fair	7.9%	5.3%	6.8%	6.2%	12.7%
Poor	1.2%	0.0%	0.0%	0.6%	3.7%

Appendix 3. Governance Practices: Comparison 2013 vs. 2011

Composite scores are between 1.00 and 3.00, with 1.00 meaning no organization has adopted nor intends to adopt the practice, and 3.00 meaning all organizations currently have adopted the practice.

“most observed” (score 2.90–3.00)

“least observed” (score 1.00–1.99)

Governance Practices: Weighted Averages

3 = Practice is generally observed
2 = Practice is not observed currently, but the board is considering it and/or working on it
1 = Practice is not observed and the board is not considering it

Governance Practices	Overall (all hospitals and systems) 2013	Overall 2011	Systems 2013	Systems 2011	Independent Hospitals 2013	Independent Hospitals 2011	Subsidiary Hospitals 2013	Subsidiary Hospitals 2011	Government-Sponsored Hospitals 2013	Government-Sponsored Hospitals 2011
Duty of Care										
The board requires that new board members receive education on their fiduciary duties.	2.91	2.91	2.98	2.99	2.93	2.90	2.94	2.93	2.81	2.84
The board reviews policies that specify the board’s major oversight responsibilities at least every two years.	2.68	2.66	2.69	2.62	2.66	2.61	2.66	2.73	2.73	2.68
The board reviews the sufficiency of the organizational structure every five years.*	2.57	NA	2.66	NA	2.63	NA	2.48	NA	2.59	NA
The board reviews financial feasibility of projects before approving them.	2.99	2.97	2.97	3.00	3.00	2.98	2.99	2.93	2.99	2.98
The board considers whether new projects adhere to the organization’s strategic plan before approving them.	2.96	2.94	2.98	2.97	2.97	2.94	2.97	2.89	2.93	2.95
The board receives important background materials **within sufficient time** to prepare for meetings.*	2.97	2.83	3.00	2.91	2.96	2.81	2.99	2.90	2.95	2.77
The board has a written policy specifying minimum meeting attendance requirements.	2.61	2.55	2.62	2.48	2.61	2.58	2.62	2.64	2.57	2.44
The board **periodically reviews** its committee structure to ensure: **that responsibilities are delegated effectively; the independence of committee members where appropriate; continued utility of committee charters; and coordination between committees and effective reporting up to the board.***	2.77	2.28	2.86	2.42	2.77	2.22	2.85	2.35	2.61	2.22
The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).	2.93	2.90	2.98	2.92	2.97	2.90	2.93	2.91	2.88	2.88
Duty of Loyalty										
The board has adopted a conflict-of-interest policy that, at a minimum, complies with the most recent IRS definition of conflict of interest.	2.98	2.98	3.00	2.99	2.99	2.98	2.99	2.99	2.96	2.96
The board **adheres to** a conflict-of-interest policy that contains “disabling guidelines” that define specific criteria for when a director’s material conflict of interest is so great that the director should no longer serve on the board.*	2.60	2.40	2.54	2.31	2.52	2.35	2.63	2.64	2.66	2.28
The board has adopted a specific definition, with measurable standards, of an independent director that, at a minimum, complies with the most recent IRS definition of an “independent director” **and takes into consideration any applicable state law.***	2.72	2.62	2.89	2.71	2.77	2.61	2.74	2.77	2.50	2.45
Board members complete a **full** conflict-of-interest disclosure statement annually.*	2.94	2.96	3.00	2.96	2.97	2.99	2.98	3.00	2.84	2.87
The board has a specific process by which disclosed potential conflicts are reviewed by independent, non-conflicted board members with staff support from the general counsel.*	2.59	NA	2.80	NA	2.58	NA	2.69	NA	2.38	NA
The board enforces a written policy that states that deliberate violations of conflict of interest constitute grounds for removal from the board.	2.56	2.52	2.55	2.49	2.58	2.57	2.62	2.67	2.46	2.31
The board assesses the adequacy of its conflict-of-interest policy **as well as the sufficiency of its conflict review process** at least every two years.*	2.69	2.69	2.81	2.74	2.72	2.68	2.74	2.78	2.53	2.60
The board’s enforcement of the organization’s conflict-of-interest policy is applied uniformly across all members of the board.	2.90	2.93	2.95	2.97	2.93	2.92	2.94	2.96	2.81	2.88
The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.	2.80	2.77	2.81	2.74	2.83	2.80	2.85	2.81	2.68	2.70
The board ensures that the federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.	2.93	2.95	3.00	2.99	2.98	2.94	2.94	2.97	2.66	2.90

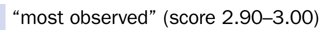
*New phrase (in bold) or practice added in 2013.

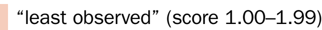
"most observed" (score 2.90–3.00)

"least observed" (score 1.00–1.99)

Governance Practices: Weighted Averages 3 = Practice is generally observed 2 = Practice is not observed currently, but the board is considering it and/or working on it 1 = Practice is not observed and the board is not considering it	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	**2013**	2011	**2013**	2011	**2013**	2011	**2013**	2011
Duty of Obedience										
The board oversees a formal assessment at least every two years to ensure fulfillment of the organization's mission.	**2.65**	2.64	**2.63**	2.49	**2.54**	2.66	**2.70**	2.81	**2.72**	2.53
The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.	**2.93**	2.93	**2.98**	2.96	**2.93**	2.92	**2.93**	2.94	**2.90**	2.91
The board **considers how major decisions will impact the organization's mission before approving them, and** rejects proposals that put the organization's mission at risk.*	**2.96**	2.96	**2.96**	2.99	**2.98**	2.95	**2.98**	2.97	**2.89**	2.96
The board makes an appropriate governance assignment for risk management oversight.*	**2.78**	NA	**2.93**	NA	**2.83**	NA	**2.83**	NA	**2.58**	NA
The board has approved a "code of conduct" policies/procedures document that provides ethical requirements for board members, employees, and practicing physicians.	**2.81**	2.79	**2.83**	2.81	**2.88**	2.79	**2.84**	2.86	**2.68**	2.72
The board has delegated its executive compensation oversight function to a group (committee, *ad hoc* group, task force, etc.) that is composed solely of independent directors of the board.	**2.69**	2.55	**2.95**	2.80	**2.83**	2.66	**2.76**	2.63	**2.24**	2.15
The board has approved a compliance plan that *includes* monitoring of arrangements with physicians (e.g., employment, contracting, medical directorships, etc.) to ensure adherence to current laws/regulations.	**2.85**	2.79	**2.98**	2.92	**2.86**	2.77	**2.84**	2.88	**2.78**	2.70
The board (directly or through a dedicated committee) ensures the compliance plan is properly implemented and effective.*	**2.84**	NA	**3.00**	NA	**2.86**	NA	**2.87**	NA	**2.69**	NA
The board routinely receives reports from the compliance officer about the organization's compliance program (e.g., systems for detecting, reporting, and addressing potential violations of law or payment regulations, new legislation, updates to current regulations, etc.).*	**2.86**	2.83	**2.98**	2.93	**2.85**	2.80	**2.92**	2.91	**2.75**	2.75
The board has established a direct reporting relationship with the compliance officer.	**2.53**	2.51	**2.65**	2.58	**2.51**	2.48	**2.52**	2.64	**2.51**	2.42
The board has established a direct reporting relationship with legal counsel.	**2.35**	2.37	**2.34**	2.47	**2.23**	2.28	**2.38**	2.36	**2.45**	2.47
The board has approved a "whistleblower" policy that specifies the following: the manner by which the organization handles employee complaints *and* allows employees to report in confidence any suspected misappropriation of charitable assets.	**2.81**	2.78	**2.93**	2.89	**2.77**	2.81	**2.84**	2.80	**2.76**	2.68

*New phrase (in bold) or practice added in 2013.

 "most observed" (score 2.90–3.00)

 "least observed" (score 1.00–1.99)

Governance Practices: Weighted Averages 3 = Practice is generally observed 2 = Practice is not observed currently, but the board is considering it and/or working on it 1 = Practice is not observed and the board is not considering it	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	**2013**	2011	**2013**	2011	**2013**	2011	**2013**	2011
Quality Oversight										
The board reviews quality performance measures (using dashboards, balanced scorecards, run charts, or some other standard mechanism for board-level reporting) at least quarterly to identify needs for corrective action.	**2.96**	2.96	**2.95**	2.96	**2.96**	2.97	**2.99**	2.99	**2.92**	2.93
The board requires all hospital clinical programs or services to meet quality-related performance criteria.	**2.77**	2.73	**2.80**	2.75	**2.76**	2.67	**2.79**	2.81	**2.76**	2.75
The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.	**2.75**	2.75	**2.84**	2.82	**2.73**	2.75	**2.89**	2.92	**2.54**	2.57
The board participates in the development of and/or approval of explicit criteria to guide medical staff recommendations for physician appointments, reappointments, and clinical privileges.	**2.68**	2.70	**2.48**	2.73	**2.74**	2.68	**2.76**	2.74	**2.55**	2.67
The board works with medical staff and management to set the organization's quality goals.**	**2.77**	2.36	**2.86**	2.40	**2.80**	2.36	**2.86**	2.49	**2.59**	2.22
The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).	**2.83**	2.75	**2.88**	2.86	**2.88**	2.69	**2.88**	2.85	**2.67**	2.68
The board requires management to base *at least some* of the organization's quality goals on the "theoretical ideal" (e.g., zero central line infections, zero sepsis, and so forth).	**2.70**	2.66	**2.84**	2.73	**2.71**	2.59	**2.75**	2.78	**2.57**	2.62
The board reviews its quality performance by comparing its current performance to its own historical performance **as well as industry benchmarks.***	**2.88**	2.85	**2.91**	2.92	**2.87**	2.81	**2.94**	2.93	**2.79**	2.80
The board has a standing quality committee of the board.	**2.65**	2.57	**2.79**	2.69	**2.66**	2.55	**2.78**	2.75	**2.36**	2.34
The board reviews patient satisfaction/patient experience scores at least annually **(including those publicly reported by CMS).***	**2.96**	2.95	**2.96**	2.97	**2.95**	2.95	**3.00**	2.99	**2.92**	2.92
The board participates at least annually in education regarding issues related to its responsibility for quality of care in the organization.	**2.82**	2.81	**2.88**	2.86	**2.86**	2.79	**2.83**	2.94	**2.72**	2.71
The board has adopted a policy concerning reporting the organization's quality/safety performance to the general public.	**2.28**	2.26	**2.30**	2.46	**2.31**	2.16	**2.34**	2.41	**2.15**	2.17
The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.	**2.82**	2.86	**2.95**	2.90	**2.81**	2.88	**2.90**	2.91	**2.69**	2.78

*New phrase (in bold) or practice added in 2013.

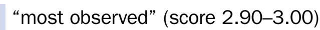
**This practice was reworded from how it appeared in the 2011 report: "The board and medical staff are at least as involved or more involved than management in setting the agenda for the board's discussion surrounding quality." This should be considered an indirect comparison.

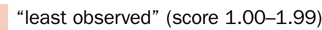
"most observed" (score 2.90–3.00)

"least observed" (score 1.00–1.99)

Governance Practices: Weighted Averages 3 = Practice is generally observed 2 = Practice is not observed currently, but the board is considering it and/or working on it 1 = Practice is not observed and the board is not considering it	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	**2013**	2011	**2013**	2011	**2013**	2011	**2013**	2011
Financial Oversight										
The board approves the organization's capital and financial plans.	**2.99**	2.99	**3.00**	3.00	**3.00**	2.99	**2.99**	2.98	**2.99**	2.99
The board reviews information at least quarterly on the organization's financial performance against plans.	**2.99**	2.99	**2.97**	3.00	**3.00**	2.98	**3.00**	2.99	**2.98**	3.00
The board demands corrective actions in response to under-performance on capital and financial plans.	**2.86**	2.86	**2.91**	2.89	**2.83**	2.84	**2.89**	2.88	**2.83**	2.87
The board requires that the organization's strategic and financial plans be aligned.	**2.91**	2.91	**2.97**	2.89	**2.89**	2.93	**2.95**	2.94	**2.87**	2.86
The board monitors the organization's debt obligations and investment portfolio.	**2.96**	2.96	**3.00**	2.97	**2.96**	2.97	**2.94**	2.93	**2.95**	2.96
Board members responsible for audit oversight meet with external auditors, without management, at least annually.	**2.74**	2.81	**2.97**	2.97	**2.88**	2.81	**2.74**	2.87	**2.48**	2.67
The board has a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight.	**2.76**	2.77	**2.95**	2.92	**2.76**	2.73	**2.77**	2.83	**2.66**	2.73
The board has created a separate audit committee (or audit and compliance committee, or another committee or subcommittee specific to audit oversight) to oversee the external and internal audit functions.	**2.44**	2.39	**2.83**	2.82	**2.53**	2.33	**2.63**	2.68	**1.88**	2.07
The board has adopted a policy that specifies that the audit committee (or other committee/subcommittee whose primary responsibility is audit oversight) must be composed entirely of independent persons **who have appropriate qualifications to serve in such role.***	**2.32**	2.27	**2.76**	2.61	**2.41**	2.32	**2.43**	2.45	**1.79**	1.83
The board has adopted a policy on financial assistance for the poor and uninsured that adheres to the mission and complies with federal and state requirements.	**2.96**	2.96	**3.00**	2.99	**2.95**	2.95	**2.93**	2.95	**2.98**	2.96

*New phrase (in bold) or practice added in 2013.

 "most observed" (score 2.90–3.00)

 "least observed" (score 1.00–1.99)

Governance Practices: Weighted Averages 3 = Practice is generally observed 2 = Practice is not observed currently, but the board is considering it and/or working on it 1 = Practice is not observed and the board is not considering it	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	**2013**	2011	**2013**	2011	**2013**	2011	**2013**	2011
Strategic Direction										
The full board actively participates in establishing the organization's strategic direction such as creating a longer-range vision, setting priorities, and developing/approving the strategic plan.	**2.92**	2.93	**2.92**	2.96	**2.96**	2.95	**2.95**	2.93	**2.84**	2.88
The board approves a strategy for aligning the clinical and economic goals of the hospital(s) and physicians.*	**2.85**	NA	**2.90**	NA	**2.85**	NA	**2.92**	NA	**2.75**	NA
The board requires that all plans in the organization (e.g., financial, capital, operational, quality improvement) be aligned with the organization's overall strategic plan/direction.	**2.89**	2.88	**2.95**	2.89	**2.89**	2.88	**2.92**	2.94	**2.81**	2.84
The board evaluates proposed new programs or services on factors such as **mission compatibility**, financial feasibility, market potential, impact on quality and patient safety, and so forth.*	**2.94**	2.95	**2.95**	2.97	**2.95**	2.95	**2.96**	2.94	**2.89**	2.94
The board discusses the needs of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).	**2.92**	2.94	**2.97**	2.95	**2.94**	2.93	**2.94**	2.90	**2.86**	2.97
The board considers how the organization's strategic plan addresses community health status/needs before approving the plan.	**2.80**	2.75	**2.81**	2.76	**2.78**	2.69	**2.87**	2.81	**2.72**	2.76
The board requires that major strategic projects specify *both* measurable criteria for success *and* who is responsible for implementation.	**2.80**	2.75	**2.86**	2.78	**2.80**	2.73	**2.86**	2.78	**2.72**	2.74
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.	**2.39**	2.33	**2.47**	2.15	**2.38**	2.32	**2.46**	2.57	**2.28**	2.23
The board spends more than half of its meeting time during most board meetings discussing strategic issues as opposed to hearing reports.	**2.22**	2.15	**2.53**	2.45	**2.23**	2.17	**2.32**	2.17	**1.94**	1.96
The board has adopted policies and procedures that define how strategic plans are developed and updated (e.g., who is to be involved, timeframes, and the role of the board, management, physicians, and staff).	**2.22**	2.17	**2.40**	2.32	**2.24**	2.08	**2.25**	2.34	**2.10**	2.08
The board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability.	**2.56**	2.61	**2.69**	2.71	**2.57**	2.61	**2.64**	2.73	**2.41**	2.45
The board has established policies regarding physician compensation (e.g., physician employment, financial support for physician recruitment, payment for ED call, etc.) **that include consideration of "fair market value" and industry benchmarks when determining compensation.***	**2.60**	2.47	**2.73**	2.63	**2.60**	2.39	**2.69**	2.55	**2.45**	2.44

*New phrase (in bold) or practice added in 2013.

"most observed" (score 2.90–3.00)

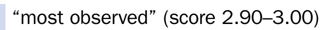
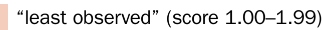
"least observed" (score 1.00–1.99)

Governance Practices: Weighted Averages

3 = Practice is generally observed
2 = Practice is not observed currently, but the board is considering it and/or working on it
1 = Practice is not observed and the board is not considering it

	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	**2013**	2011	**2013**	2011	**2013**	2011	**2013**	2011
Board Development										
The board engages in a formal self-assessment process to evaluate its own performance at least every two years.	**2.75**	2.73	**2.91**	2.89	**2.78**	2.76	**2.82**	2.82	**2.55**	2.53
The board uses the results from the self-assessment process to establish board performance improvement goals.	**2.57**	2.57	**2.78**	2.76	**2.59**	2.56	**2.69**	2.71	**2.31**	2.36
The board uses a formal orientation program for new board members.	**2.82**	2.86	**2.93**	2.95	**2.88**	2.87	**2.90**	2.91	**2.61**	2.76
Board members participate in ongoing education **regarding key strategic issues facing the organization.***	**2.87**	2.89	**2.91**	2.99	**2.91**	2.89	**2.93**	2.89	**2.75**	2.83
The board assesses **its own** bylaws/structures at least every three years.*	**2.74**	NA	**2.74**	NA	**2.76**	NA	**2.72**	NA	**2.74**	NA
The board uses competency-based criteria when selecting new board members.	**2.36**	2.43	**2.78**	2.72	**2.28**	2.41	**2.51**	2.55	**1.93**	2.12
The board uses a formal process to evaluate the performance of individual board members.	**1.88**	1.92	**2.16**	1.99	**1.92**	2.02	**1.92**	2.08	**1.61**	1.52
The board has established performance requirements for board member and officer reappointment.	**1.89**	1.95	**2.11**	2.26	**1.98**	1.92	**1.96**	2.15	**1.52**	1.55
The board has a "mentoring" program for new board members.	**1.92**	1.95	**2.09**	2.14	**2.02**	2.03	**1.93**	1.91	**1.69**	1.74
The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.	**2.08**	2.14	**2.31**	2.48	**2.16**	2.22	**2.23**	2.17	**1.54**	1.76
The board has a compact regarding mutual expectations with its chair.*	**1.79**	NA	**2.07**	NA	**1.82**	NA	**1.89**	NA	**1.46**	NA
Management Oversight										
The board follows a formal process for evaluating the CEO's performance.	**2.91**	2.89	**3.00**	2.96	**2.91**	2.88	**2.94**	2.96	**2.84**	2.83
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation.	**2.77**	2.76	**2.86**	2.92	**2.83**	2.76	**2.82**	2.75	**2.62**	2.68
The board requires that the CEO's compensation package is based, in part, on the CEO performance evaluation.	**2.84**	2.85	**2.93**	2.92	**2.86**	2.89	**2.91**	2.84	**2.69**	2.75
The board requires that CEO compensation be determined with **due consideration given to the IRS mandate of "fair market value" and "reasonableness of compensation."***	**2.89**	2.86	**2.97**	2.97	**2.95**	2.92	**2.93**	2.85	**2.74**	2.72
The board seeks independent (i.e., third party) expert advice/information on industry comparables before approving executive compensation.	**2.78**	2.87	**2.98**	2.95	**2.86**	2.91	**2.82**	2.96	**2.53**	2.72
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.	**2.86**	2.89	**2.98**	2.93	**2.95**	2.92	**2.87**	2.91	**2.69**	2.79
The board requires that the CEO maintain a written, current succession plan.	**2.22**	2.22	**2.71**	2.58	**2.34**	2.31	**2.21**	2.21	**1.88**	1.92
The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance.	**2.55**	2.57	**2.83**	2.81	**2.62**	2.61	**2.45**	2.52	**2.45**	2.42

*New phrase (in bold) or practice added in 2013.

 "most observed" (score 2.90–3.00)  "least observed" (score 1.00–1.99)

Governance Practices: Weighted Averages 3 = Practice is generally observed 2 = Practice is not observed currently, but the board is considering it and/or working on it 1 = Practice is not observed and the board is not considering it	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2013	2011	**2013**	2011	**2013**	2011	**2013**	2011	**2013**	2011
Community Benefit & Advocacy										
The board has adopted a policy or policies on community benefit that includes *all* of the following characteristics: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, measurable goals for the organization, a financial assistance policy, and commitment to communicate transparently with the public.	**2.44**	2.45	**2.65**	2.57	**2.41**	2.43	**2.56**	2.65	**2.23**	2.25
The board provides oversight with respect to organizational compliance with internal revenue code tax-exemption requirements concerning community benefit and related requirements.*	**2.78**	NA	**2.96**	NA	**2.78**	NA	**2.85**	NA	**2.55**	NA
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).	**2.77**	2.70	**2.66**	2.86	**2.78**	2.67	**2.82**	2.75	**2.74**	2.63
The board actively supports the organization's fund development program (e.g., board members give according to their abilities, identify potential donors, participate in solicitations, serve on fund development committees).	**2.61**	2.52	**2.65**	2.51	**2.64**	2.54	**2.70**	2.62	**2.41**	2.37
The board has a written policy establishing the board's role in fund development and/or philanthropy.	**1.86**	1.81	**1.92**	1.78	**1.90**	1.94	**1.91**	1.85	**1.72**	1.57
The board works closely with legal counsel to ensure all advocacy efforts are consistent with the requirements of tax-exempt status.*	**2.55**	NA	**2.75**	NA	**2.53**	NA	**2.57**	NA	**2.45**	NA
The board has adopted a policy regarding information transparency, explaining to the public in understandable terms its performance on measures of quality, safety, pricing, and customer service.	**2.27**	2.28	**2.40**	2.38	**2.17**	2.18	**2.27**	2.40	**2.34**	2.30
The board ensures that a community health needs assessment is conducted at least every three years to understand health issues **and perceptions of the organization** of the communities served.*	**2.85**	2.61	**2.93**	2.84	**2.91**	2.55	**2.96**	2.75	**2.55**	2.46
The board ensures the adoption of implementation strategies that meet the needs of the community, as identified through the community health needs assessment.**	**2.76**	2.41	**2.89**	2.52	**2.81**	2.39	**2.87**	2.54	**2.50**	2.25
The board requires that management annually report community benefit value to the general public (i.e., the community).	**2.66**	2.61	**2.84**	2.87	**2.66**	2.63	**2.75**	2.72	**2.46**	2.32

*New phrase (in bold) or practice added in 2013.

**This practice was reworded from how it appeared in the 2011 report: "The board requires that an action plan be created to respond to issues identified in the community health needs assessment."

NEY
ENE
SCH
printers

PRINTED BY **NEYENESCH PRINTERS**

IN SAN DIEGO, CALIFORNIA