21ST-CENTURY CARE DELIVERY

Governing in the New Healthcare Industry

*THE GOVERNANCE INSTITUTE'S **2015 BIENNIAL SURVEY** OF HOSPITALS AND HEALTHCARE SYSTEMS*

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A service of NATIONAL RESEARCH Corporation

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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.

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EXECUTIVE SUMMARY

THIS YEAR'S SURVEY SOUGHT TO UNCOVER HOW BOARD structure and practices are continuing to change—whether organizations are already operating under a new healthcare governance model focusing on value and population health across the continuum, or whether organizations are still preparing for this as a future state. Generally, movement of any kind is slow to come in healthcare, but legislation and market dynamics over the past five years have created a strong force moving care (and therefore, governance) outside the four walls of the hospital, demanding a clinically integrated, patient-centered, and cost-effective approach.

At the time of publication, more and more hospitals are taking on value-based payments, participating in ACOs, managing the health of populations, and building partnerships to care for patients across the entire care continuum. The Centers for Medicare and Medicaid Services have expanded their goal to having 50% of Medicare payments be value-based by 2018,[1] only three years from now. Boards that remain insular in focusing on overseeing hospital care will not be fulfilling their calling as the industry evolves to a less hospital-centric structure. The data from our surveys continue to show governance evolution in several areas, indicating that boards are slowly shifting their structures and activities to enable them to move forward into this 21st-century healthcare delivery system. There are still, however, multiple opportunities to grasp in order to make this leap, and our hope is that by presenting the state of healthcare governance now, and comparing it to where it was in previous years, healthcare leaders will be able to use this information to better determine where the movement should be, and therefore where to focus effort and resources.

Governance Structure and Culture

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. The governance structure survey questions also relate to system and subsidiary board structure, and whether boards are changing their structure or activities to prepare for population health and value-based payments. Culture questions relate to how the board builds relationships, communicates, and makes decisions. Governance structure has remained relatively consistent over the past few surveys. A few differences this year are briefly summarized below.

1 Melanie Evans and Paul Demko, "Medicare's Payment Reform Push Draws Praise and Fears," *Modern Healthcare,* January 26, 2015.

Board composition: The most significant change this year across all organization types is an increase in the number of independent board members (this increase is primarily seen as a percentage of the total board; board size remained about the same overall, but increased for health systems and subsidiary boards). As a result, independent board members make up a significant majority of the total board for all organization types (ranging from 67% to 88%).

For every type of organization (with the exception of government-sponsored hospitals), there was a significant decrease since 2013 in representation on the board from medical staff physicians (both employed and not employed). However, there was a significant *increase* across all types of organizations since 2013 in board representation from independent physicians. Nurse representation (voting board members) remains virtually non-existent; for 76% of organizations, the CNO is a non-board member but regularly attends meetings.

About a third of respondents have a CEO with some kind of clinical background (physician, nurse, or other), consistent with 2013, although subsidiary hospitals are the most likely of any other organization type (40%). Board chairs are less likely to have a clinical background.

On average, board members are about a year older compared with 2013, and most boards do not have an age limit (7.8%).

This year, 48% of respondents have an owned or affiliated medical group or physician enterprise (compared with 33% in 2013), and of these, 18% have a representative from this group as a voting member of the board.

Board meeting content: Boards continue to devote more than half of their meeting time to hearing reports from management and board committees (24% of board meeting time is spent receiving reports from management, committees, and subsidiaries; 19% reviewing financial performance; 21% reviewing quality of care/patient safety metrics; 26% discussing strategy and setting policy; and 11% on board member education). 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. There is also a statistical relationship between boards that use a consent agenda and those that spend more meeting time discussing strategic issues.

Committees: The average number of committees is 7.5 (up from 5 in 2013 but about the same as 2011). The most significant change this year is the increase in boards having an audit/compliance committee (51% vs. 34% in 2013). Community benefit

committees continue to be more prevalent (26% of responding boards have this committee vs. 18% in 2013). Government-sponsored hospitals are much more likely to have an executive compensation committee this year (50% vs. 35% in 2013 among this group).

The executive committee is less likely to have full authority than in 2013 (36% of respondents this year indicated the committee has full authority to act on behalf of the board on all issues, down from 45%). System boards are more likely than other types of organizations to give this committee full authority (50%).

Board member compensation: 2013 data showed an increase in board member compensation for government-sponsored hospitals (excluding the board chair and other board officers), which skewed the overall trend in an upwards direction for all respondents. However, that increase is not reflected in the 2015 data; compensation for the board chair remains level at 11%, and compensation for other board members is also 11%, lower than the 2011 level (14%). Compensation amounts remain low for both board officers and regular board members (generally less than $5,000 per year).

Board education: This year, the analysis showed that for boards spending $30,000 or greater on board education, there is a greater tendency to indicate that overall board performance is "excellent." Thus it is promising to see that boards are spending more on education compared with previous years; however, there is still room for improvement (only 31% of respondents spend at least this much), especially for government and subsidiary hospitals, which tend to spend the least amount compared to systems and independent hospitals.

Use of board portal or similar online tool: Use of a board portal continues to climb and it can now be considered a commonplace board practice—65% of respondents already use one and an additional 10% are in the process of implementing one now. More and more board members are being given hardware (laptops, mobile tablets, etc.) to access online board materials (70% this year, a steady climb from 30% in 2011).

Accountable care organizations: This year, we wanted to get a picture of how many respondents were participating in some way in an "accountable care" organization (ACO; we included any type of arrangement with public or private payers that would be considered an ACO model). Almost half (47%) of the respondents are participating in an ACO model of some type. The majority of ACOs are health system owned (40%); the second largest percentage overall is a joint venture between two or more entities (20%). The size of the covered patient population is generally large (more than 50,000 people) for all types of organizations; however, a sizeable percentage of respondents cover 20,000 or fewer in their ACO.

Board culture: There was relatively strong agreement again this year with most of the statements related to board culture; this year there was more consistency in agreement across organization types, although systems again had the highest level of agreement for most of the board culture statements.

Due to the high level of agreement (considering both "strongly agree" and "agree"), we calculated an overall average "letter grade" for each type of organization, combining all board culture statements ("strongly agree" and "agree") into one score (showing there is room for improvement):

- Overall: 88% or a B+
- Health systems: 91% or an A-
- Independent hospitals: 89% or a B+
- Subsidiary hospitals: 93% or an A
- Government hospitals: 84% or a B

See the body of the report for more details on the types of culture statements included in the survey.

Population health management: Over half (60%) of respondents have added population health goals (e.g., IT infrastructure, physician integration) to the strategic plan since 2013. But 47% have not made any changes to the board or management team since 2013 in order to manage population health (20% have added physicians to the management team).

Actions taken to succeed with value-based payments: Over half (57%) of respondents have added value-based payment goals to strategic and financial plans since 2013, and 16% have added physicians to the management team (54% have not made any changes to the board or management team since 2013 in order to be successful under value-based payments).

System–subsidiary governance structure: Over half of systems (52%; up from 44% in 2013) have a system board as well as separate local/subsidiary boards with fiduciary responsibilities. Sixty-nine percent (69%) of system boards approve a document or policy specifying allocation of responsibility and authority between system and local boards (about the same as 2013), and 86% 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. This year system boards are more likely than in 2013 to retain authority on certain issues that could be considered "system-level," such as quality, executive compensation, and compliance, and subsidiary

boards continue (as in 2013) to retain authority on approving medical staff appointments and establishing board education and orientation programs, which are usually considered to be "local" issues. Notably, the larger subsidiaries (500+ beds) are more likely than smaller subsidiaries to retain responsibility for setting community benefit goals and evaluating their chief executive (rather than sharing responsibility with the system board).

Governance Practices

In 2013, we made some changes to the list of 95 recommended practices, primarily to reflect legal requirements under the ACA. As such, this year the list of practices remained the same. This list has slowly been growing from a list of 50 practices in 2003. 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.

This year's results show that adoption of our list of recommended practices, for the most part, continues to be widespread. Historically, government-sponsored hospitals tend to have lower rates of adoption of the recommended practices, but this year's increase in both adoption and performance for this group of hospitals is the most significant to be reported since 2007. While their adoption is still much lower than other types of organizations, this is an important finding and it should be emphasized that this indicates a recognition among this group of hospitals that adopting most of these practices is possible within their unique constraints, and is also valuable to the performance of these organizations.

The increase in adoption of several duty of obedience practices related to compliance reflects increasing legal/regulatory attention being paid by boards, which is a good sign. Performance and adoption in quality oversight practices showed significant improvement this year, although reporting quality to the public has decreased, which is notable due to this practice being among those statistically correlated with better process of care and risk-adjusted mortality rates. Financial oversight practice adoption has increased for a majority of the practices. We are also pleased to see the increase in adoption for requiring the CEO to maintain a written and current succession plan, a practice that has historically been stagnant on the lower end of the adoption rates. In seeing adoption of other management oversight practices increase as well, it looks as though boards are paying more attention to the importance of CEO performance for the overall health of their organizations. And community benefit, an increasingly critical area for board oversight, continues to improve in both performance and adoption of practices.

There remains significant opportunity to improve performance scores and adoption rates in certain key areas. The two duty of loyalty practices that have decreased (having disabling guidelines and an independent director definition) are concerning due to the requirements of reporting these on the IRS Form 990. Practices related to audit (having a dedicated committee made up of independent directors to handle the audit process) continue to have low rates of adoption, not just due to the difficulties government hospitals face in being able to adopt these practices, but we also see low adoption among independent hospitals. Strategic planning, a critical skill for every board in this dynamic healthcare market, should be ranking much higher in the list for both performance and adoption, and it is clear that boards need to be spending much more time on strategy in board meetings. In addition, board development remains low on the list for both performance and adoption scores (this area has the highest number of "least-observed" practices; see the "Analysis of Results" section in the second half of the report). The increase in adoption of board development practices this year is promising, but this is a great area of opportunity for boards looking to enhance their performance—and therefore, their organization's performance.

INTRODUCTION AND READER'S GUIDE

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. This year's survey sought to uncover how board structure and practices are continuing to change—whether organizations are already operating under a new healthcare governance model focusing on value and population health across the continuum, or whether organizations are still preparing for this as a future state. Generally, movement of any kind is slow to come in healthcare, but legislation and market dynamics over the past five years have created a strong force moving care (and therefore, governance) outside the four walls of the hospital, demanding a clinically integrated, patient-centered, and cost-effective approach. The data from our surveys continue to show governance evolution in several areas, indicating that boards are slowly shifting their structures and activities to enable them to move forward into this 21st-century healthcare delivery system. There are still, however, multiple opportunities to grasp in order to make this leap, and our hope is that by presenting the state of healthcare governance now, and comparing it to where it was in previous years, healthcare leaders will be able to use this information to better determine where the movement should be, and therefore where to focus effort and resources.

This report presents the results by topic. The first section of the report focuses on governance structure and culture, 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. (Please note as you are reading the results in this section that each respondent had the opportunity to indicate if a given board practice is not applicable for their organization, and those responses are not included in the total scores and percentages. Thus, if a certain group of respondents has a lower level of performance or lower adoption rates of recommended practices, it is not due to the fact that the practices are not relevant or appropriate for their board to adopt.)

In 2013, we made some changes to the list of 95 recommended practices, primarily to reflect legal requirements under the ACA. As such, this year the list of practices remained the same. This list has slowly been growing from a list of 50 practices in 2003. 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 scores) in each oversight area.

The appendices included in this report include 1) results by frequency (percentages) for governance structure and culture, 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 2013 results. (Additional appendices reporting board structure for each organization type are available online at www.governanceinstitute.com/2015biennialsurvey.)

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.

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 4,121. We received 465 responses (11.3%). Of those, 355 respondents had a fiduciary board (8.6%). The survey focuses on boards with legally mandated fiduciary duties, so the data presented includes only those respondents.

Due to the increase in hospitals being affiliated with systems in the total surveyed population, along with there being a lower total number of hospitals due to closures and consolidations and fewer hospitals with their own boards over the past few years, we wanted to get a more clear understanding of how many hospitals are represented by the total respondents. We looked at the number of hospitals "owned" by the system respondents in 2011, 2013, and 2015. In 2011, we had 660 respondents representing a total of 1,142 acute-care hospitals, or 26.9% of the total hospital survey population. In 2013, we had 541 respondents representing a total of 1,030 hospitals, or 24.5% of the total hospital survey population. This year, our 355 respondents represent a total of 883 hospitals, or 21.4% of the total hospital survey population.

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

Comparison of Respondents 2015 vs. 2013

Over half (64%) of the respondents in 2015 also completed and returned the survey in 2013.

Table 1. Survey Responses

	2015		2013		2011	
	Respondents	Population	Respondents	Population	Respondents	Population
Organization	**N = 355**	**N = 4,121**	**N = 541**	**N = 4,199**	**N = 660**	**N = 4,250**
Religious (37)	13%	14%	10%	13%	11%	13%
Secular:						
Government (103)	29%	22%	26%	24%	25%	25%
Non-Government (215)	71%	64%	74%	63%	64%	62%
Number of Beds						
< 100 (133)	37%	42%	36%	43%	39%	46%
100–299 (106)	30%	30%	33%	29%	35%	31%
300+ (116)	33%	28%	30%	28%	26%	23%
System Affiliation (112)	32%	62%	45%	58%	35%	53%

Table 2. 2015 vs. 2013 Respondents

	Number of Respondents in 2015	Number of Respondents in 2013	Number of Respondents Who Completed the Survey in both 2013 and 2015
Systems	50	63	26
Independent Hospitals	140	156	131
Subsidiary Hospitals	62	182	24
Government-Sponsored Hospitals	103	140	46
Total	355	541	227

GOVERNANCE STRUCTURE

Board Size and Composition

Summary of Findings

- Average board size: 13.6
- Median board size: 13
- Voting board members:
  - Medical staff physicians: average is 1.7; median is 1
  - "Outside" physicians: average is 0.9; median is 0
  - Staff nurses including CNO: average is 0.04; median is 0
  - Management: average is 0.9; median is 0
  - Independent board members: average is 10.1; median is 9
  - Female board members: average is 3.5; median is 3
  - Ethnic minority board members: average is 1.2; median is 1
- Term limits: 60% of boards limit the number of consecutive terms (down six points from 2013); median maximum number of terms is 3.
- Board member age limits: 7.8% of boards have age limits (up one percentage point from 2013); average age limit is 72.1; median is 72
- Average board member age: 58.4 (one year older than 2013); median board member age: 60 (two years older than 2013); overall age range on the board is 45 to 75

The average number of board members is about the same as that reported in 2013—13.6 vs. 13.5. The median remained 13. There has been only a slight shift in board composition from 2013 to this year; the most significant being an increase in the number of independent board members. Health system boards have increased again this year by an average of one additional person (up by two people since 2011). The most significant difference is seen for subsidiary boards, which have increased by almost three people. Table 3 shows the

Table 3. 2015 and 2013 Board Composition

All Respondents	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Average # of Voting Board Members	13.6	13.5	0.9	0.7	1.7	2.1	10.1	8.8	0.9	1.8
Median # of Voting Board Members	13	13	0	0	1	1	9	9	0	2

*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 4. System Board Composition

Systems	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Average # of Voting Board Members	17.6	16.7	0.9	1.3	2.0	2.5	12.8	12.6	2.0	0.3
Median # of Voting Board Members	16	17	1	1	1	2	12	13	0	1

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

Table 5. Independent Hospital Board Composition

Independent Hospitals	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Average # of Voting Board Members	14.7	15.1	0.9	0.6	2.1	2.6	10.8	10.3	0.9	1.6
Median # of Voting Board Members	14	14	1	0	1	1	10	10	0	2

Note: Management and independent board members increased slightly; medical staff physicians and other board members decreased slightly.

Table 6. Subsidiary Hospital Board Composition

Subsidiary Hospitals	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Average # of Voting Board Members	18.1	15.4	1.9	1.0	2.7	2.6	12.2	9.8	1.3	2.0
Median # of Voting Board Members	16	14	1	1	2	2	10	10	0	1

Note: Total size increased significantly, reflected in increases in management and independent board members.

overall comparison; Tables 4–7 show a comparison of board composition for each organization type.

As with previous surveys, board size generally increases with organization size for all organization types. Systems and subsidiary boards 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) has increased for all organization types, and most significantly for government-sponsored hospitals. Health systems again reported the highest average number of independent board members (12.6), primarily due to the larger board size overall. When broken down by organization type, independent board members as a percentage of total board members is:

- All respondents: 74% (up from 65% in 2013)
- Systems: 73% (vs. 75% in 2013)
- Independent hospitals: 73% (vs. 68% in 2013)
- Subsidiary hospitals: 67% (vs. 64% in 2013)
- Government-sponsored hospitals: 88% (up from 59% in 2013)

See Exhibit 1 for a breakdown of board members overall and by organization type for 2015.

Table 7. Government-Sponsored Hospital Board Composition

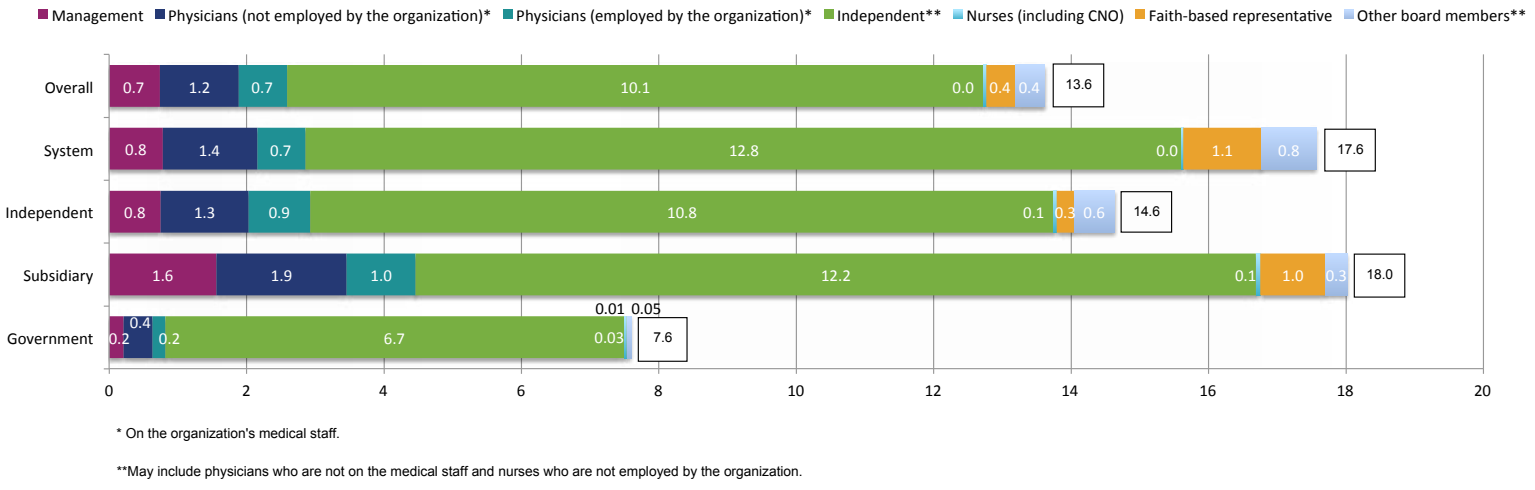
Government-Sponsored Hospitals	Total # of Voting Board Members		Management		Medical Staff Physicians*		Independent Board Members**		Other Board Members***	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Average # of Voting Board Members	7.6	7.8	0.2	0.2	0.6	0.6	6.7	4.6	0.1	2.4
Median # of Voting Board Members	7	7	0	0	0	0	7	5	0	2

Note: Independent board members increased significantly; other board members decreased.

Largest Boards

- Subsidiary hospitals with 300–499 beds: 24.9 (increase from 19.1 in 2013)
- Independent hospitals with 500+ beds: 21.1 (increase from 19.8 in 2013)
- Systems with 2,000+ beds (largest systems): 20.9 (increase from 17.3 in 2013)

Exhibit 1. Average Number of Board Members



* On the organization's medical staff.

**May include physicians who are not on the medical staff and nurses who are not employed by the organization.

Physicians on the Board

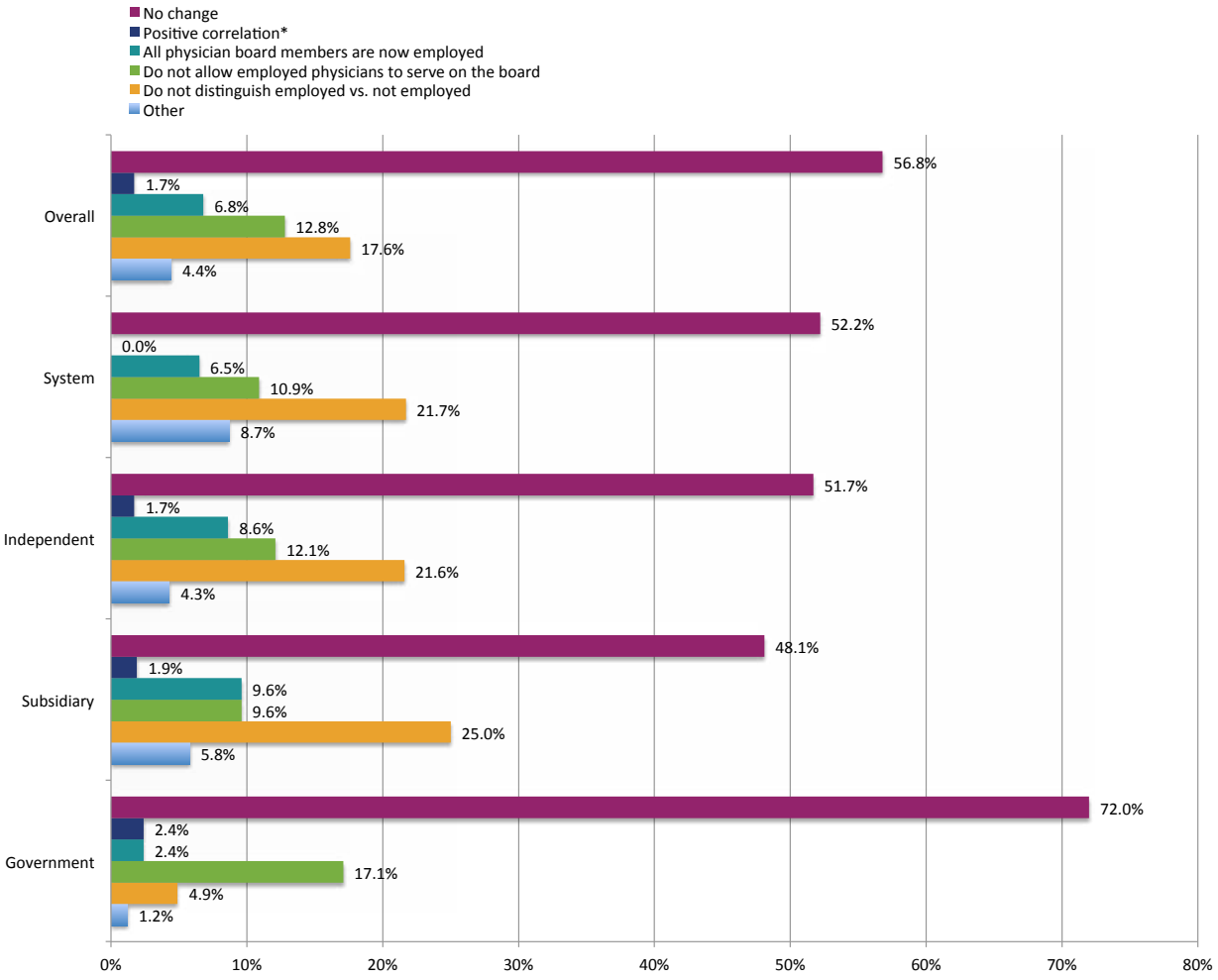
Respondents noted physician board membership in the following categories:

- 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 not on the medical staff nor employed (and qualify as "outside" board members)

Table 8. Physicians on the Board 2015 vs. 2013

	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")	
	2015	2013	2015	2013	2015	2013
Average	1.2	1.4	0.6	0.7	0.9	0.4
Median	1	1	0	0	0	0

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.

The total average number of physicians on the board (all types of physicians including "outside" physicians) is 2.7; the median is 1, about the same as 2013 (average was 2.5). Overall, the breakdown for these categories is shown in **Table 8**.

For every type of organization (with the exception of government-sponsored hospitals), there was a significant decrease since 2013 in representation on the board from medical staff physicians (both employed and not employed). However, there was a significant *increase* across all types of organizations since 2013 in board representation from independent physicians.

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 and 2013, 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

This year's survey delineated nurse representation on the board by separating out the CNO as a voting vs. non-voting member, and whether other nurses from the organization's nursing staff were voting board members. The difference in the way these questions were asked means the numbers aren't directly comparable to previous reporting years. For 8.9% of respondents, the CNO is a voting or non-voting board member (overall average is 0.01 people on the board for this position). Voting representation from other nursing staff resulted in an equally insignificant number (overall average is 0.03 people on the board). For 76% of respondents, the CNO is a non-board member but regularly attends meetings. As has been the case historically, nurse representation on the board remains startlingly low, considering the key role nurses play in patient quality of care, satisfaction, and customer loyalty. (See **Appendix 1** for more details.)

PRACTITIONERS ON BOARD: IS IT TIME FOR GOVERNANCE TO BECOME MORE CLINICAL?

Todd Sagin, M.D., J.D., *President and National Medical Director, Sagin Healthcare Consulting*

{ SPECIAL COMMENTARY }

The changing business model of healthcare has prompted many to argue that individuals with clinical expertise should be more prevalent on hospital and health system boards. According to many healthcare commentators, insight into clinical matters will be critical to define institutional strategies that can achieve the "Triple Aim" to succeed under value-based reimbursement and begin to address population health.

Despite these views, the data from The Governance Institute's 2015 biennial survey shows little significant change in board member composition. This contrasts with changes in hospital management where the survey indicates participation by physicians is increasing. For example, 20% of respondents indicated they have added physicians to the management team to better prepare for initiatives in population health. This change is even more dramatic in health systems, where we now see more physician CEOs than ever before and 34% of survey respondents report they added doctors to their management teams. The survey indicates that the other main driver for the addition of physicians to either the board or management is to enhance institutional ability to respond to value-based payment.

The rationale for adding physicians to a governing board are compelling. Such practitioners bring to the board table their clinical expertise, often an insider's view of the organization, and operational experience in healthcare settings. They can facilitate good working relationships with a hospital's physician community by assuring doctors that they have a voice at the highest level of the organization. Furthermore, efforts to make future healthcare safer and more cost effective will require significant redesign of historic approaches to care delivery. Doctors are a linchpin in such efforts because they have clinical expertise that is essential to the endeavor, and because their resistance to such change can seriously undermine critical progress. Physician board members can be invaluable in vetting strategic plans to ensure they are clinically sound and can be "sold" to their colleagues in a manner that promotes medical staff/board collaboration and cohesion.

Given these arguments, why have so few boards in this year's survey indicated significant physician participation in governance? One explanation may be simple inertia. Since expansion of hospital board size is not generally recommended by governance experts, accommodating more clinicians on a board requires asking other members to vacate their spots. It is simply easier for many boards to live with the status quo than to shuffle the deck. A second explanation may be a concern of having too many "insiders" on the board, thereby jeopardizing not-for-profit tax status. (Most physicians considered for board positions will be characterized as "insiders" by the IRS because of their working relationships with the hospital.) This may be a reason the survey suggests more physician *representation* at board meetings (e.g., for VPMAs and CMOs), but not increased board *membership*. This pattern might also be accounted for if current lay board members find the expertise of doctors intimidating and prefer to have the option to exclude them from board discussions in closed sessions. In addition to these concerns, a board might prefer to minimize physician membership because of the historical fractiousness of many medical staffs. Board members have a legitimate concern that they will be seen

as partisan when they choose a particular doctor to join the governing body. Furthermore, they might rightly fear the disruption caused if adding one or more doctors to the board's composition allows local physician political posturing to dominate boardroom discussions.

The survey data shows nursing executives are similarly excluded from widespread board membership. It has become common for nurse executives to report at board meetings (three-quarters of respondents have the CNO participate at the board level as a member of management) but they have not been sought out as board members despite their clinical expertise and familiarity with hospital functioning. Given the constraints on the number of "insiders" allowed on a hospital board, this is not surprising. A board that significantly restricts physician membership is even less likely to appoint a nurse.

What about using independent/outside physicians to augment the board's competence in areas of need? A few boards appear to be taking advantage of this strategy. A benefit of using such outsiders is the flexibility it provides an institution to search out the precise expertise it requires (e.g., population health, evidence-based medicine, clinical redesign, value-based reimbursement strategies). When a board identifies an appropriate expert it can add this individual to the board without triggering IRS concerns. However, this can be expensive and may come with logistical concerns if the individual is recruited from another part of the country. The survey data showed little movement in adding such members and the practice appears limited at the present time to larger integrated delivery systems.

While a board may prefer to find its members locally, it is surprising that the survey data shows continuing resistance to having employed doctors on the board. Mining this pool of strongly aligned physicians is an obvious place to seek out new board members with clinical expertise. In smaller institutions, a board may succumb to pressure from physicians in private practice who make the self-serving assertion that such appointments result in inappropriate conflicts of interest. While a board must be carefully attuned to such conflicts, they are easily managed (e.g., individual board members employed by the hospital should not serve on compensation committees). If a board does choose to enhance its membership with clinical experts, selecting a strongly aligned and engaged physician makes more sense than one whose loyalties are mixed. The survey does show that more boards (approximately 40%, see **Exhibit 9**) now have a representative of their employed or affiliated physician group or subsidiary sit in as regular invitees to board meetings. This is a sensible practice and will certainly become more common as such groups continue to expand and make up the majority of many medical staffs.

The traditional method for bringing a physician voice to the boardroom has been to have the chief of staff/medical staff president attend board meetings. According to the 2015 survey data, 34% of respondents have this individual serve as a voting board member, while a third do not appoint them to the board. Most boards would be better served by adopting this latter approach. While more physician board members may be a prudent general goal, choosing a short-term elected leader of the organized medical staff has several problems. This individual may not be strongly aligned with the hospital despite being elected by his peers. Indeed, he may have been elected for his combative nature and willingness to advocate vociferously for the interests of various medical staff members. While this is desirable in a representative of an interest group, it is not compatible with the fiduciary responsibilities of a governing board member.

The data in this survey does not reveal whether boards have increased the number of physicians who are not board members but who serve on governance subcommittees. It is likely that the growth in the number and importance of board quality committees has engaged additional physicians in interaction with board members. Prudent boards will also be engaging aligned physicians who are not board members in discussions on institutional strategy, financial planning, medical staff development, and tactics in response to value-based payment. Successful organizations will pursue more intense engagement of this type, rather than the often token discussions traditionally held with medical staff leaders after the substantive deliberations have already occurred.

In the years ahead, I suspect we will see more boards adding clinical experts to their mix. As the healthcare business model continues to shift, the argument for physician board members will only become more compelling. At some institutions these additional members will be outsiders who bring unique skills to the boardroom. Others will recruit from their growing pool of fully aligned, employed physicians. In almost all hospitals and health systems, the growing ranks of physicians in management roles will heighten their interaction with the governing body. However, for now, this year's survey shows this trend has yet to take wing.

Females and Ethnic Minorities on the Board

Most boards (96%) have at least one female board member, but only 50% have ethnic minorities represented on the board (see Exhibits 3 and 4). Again, 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 up from 47.1% in 2007, but is down slightly from 53.3% in 2013). By organization type, subsidiaries have the highest average number of females on the board (4.27), and systems have the highest average number of ethnic minorities (2.24). Responses suggest that in general, as these organizations get larger, female and ethnic minority representation increases (organizations with 2,000+ beds have an average of 5.07 females and 3.21 ethnic minorities). It should be noted that systems of this size also have larger boards. (See Table 9 for detail by organization size.)

Table 9. Female and Ethnic Minority Representation on the Board by Organization Size (2015 vs. 2013)

	Females (average)		Ethnic Minorities (average)	
	2015	2013	2015	2013
< 100 beds	2.8	2.9	0.6	0.6
100–299 beds	3.3	3.8	1.1	1.5
300–499 beds	4.6	4.2	1.5	1.7
500–999 beds	4.2	3.7	2.4	1.9
1,000–1,999 beds	3.4	7.6	2.3	2.4
2,000+ beds	5.1	5.1	3.2	2.3

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, we asked questions about the background of the chief executive and board chair. While in 2013 (the first year we reported on these questions) the overwhelming majority for both the CEO and board chair was a business/finance background, this year's responses were more balanced between business/finance and non-profit expertise for the CEO (47% and 44% respectively). Responses for the board chair were in line with 2013 results.

Thirty-one percent (31%) of respondents' CEOs have a clinical background (physician, nurse, or other), which is up slightly from 2013 (30%). Subsidiary hospitals are more likely than other types of organizations to have a CEO with a clinical background (40.3%). Again this year, health systems were most likely to have a physician CEO (16%). In contrast, only 13% of respondents have a board chair with any kind of clinical background. (See Exhibits 5, 6, and 7.)

Exhibit 3. Female Board Members *(All Respondents)*

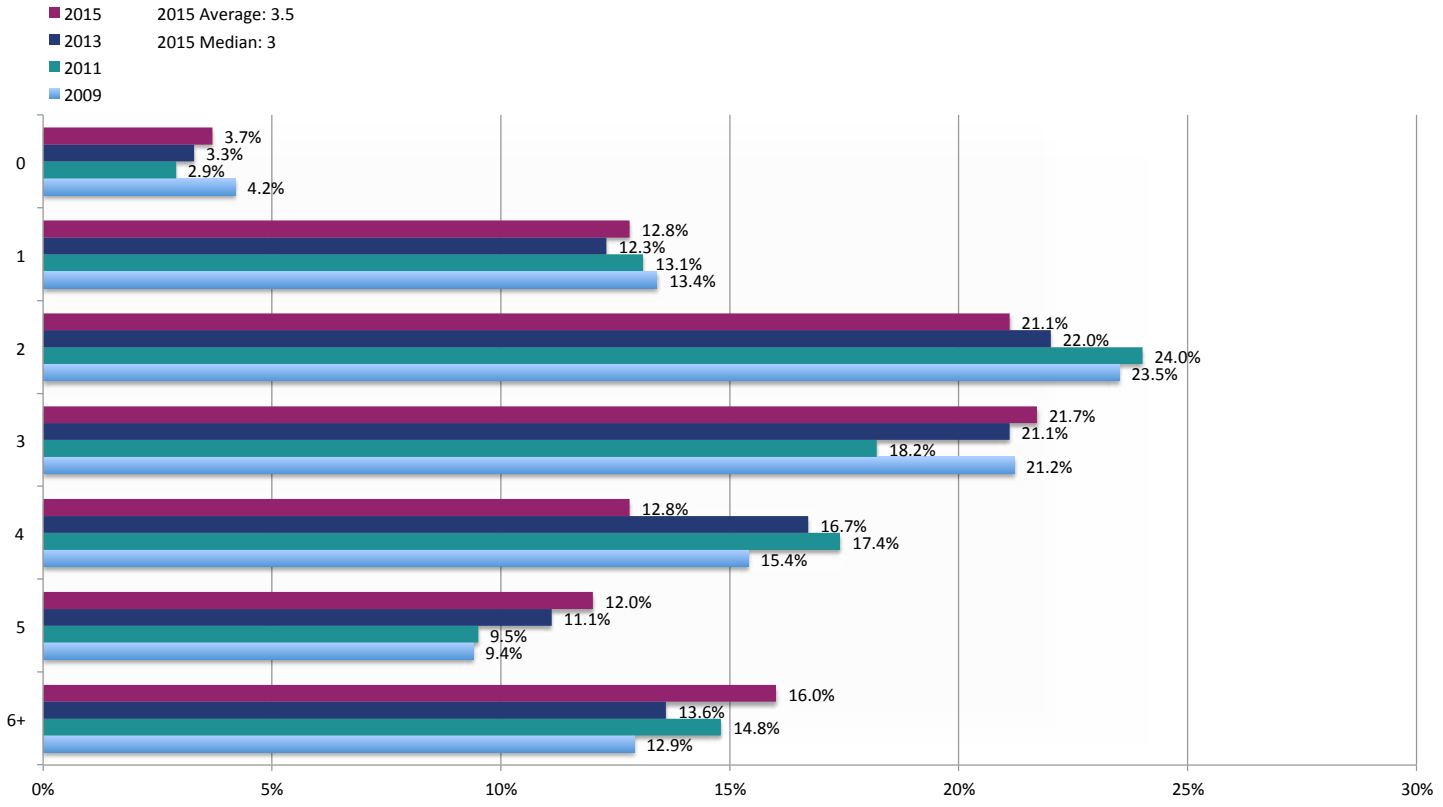


Exhibit 4. Ethnic Minority Board Members *(All Respondents)*

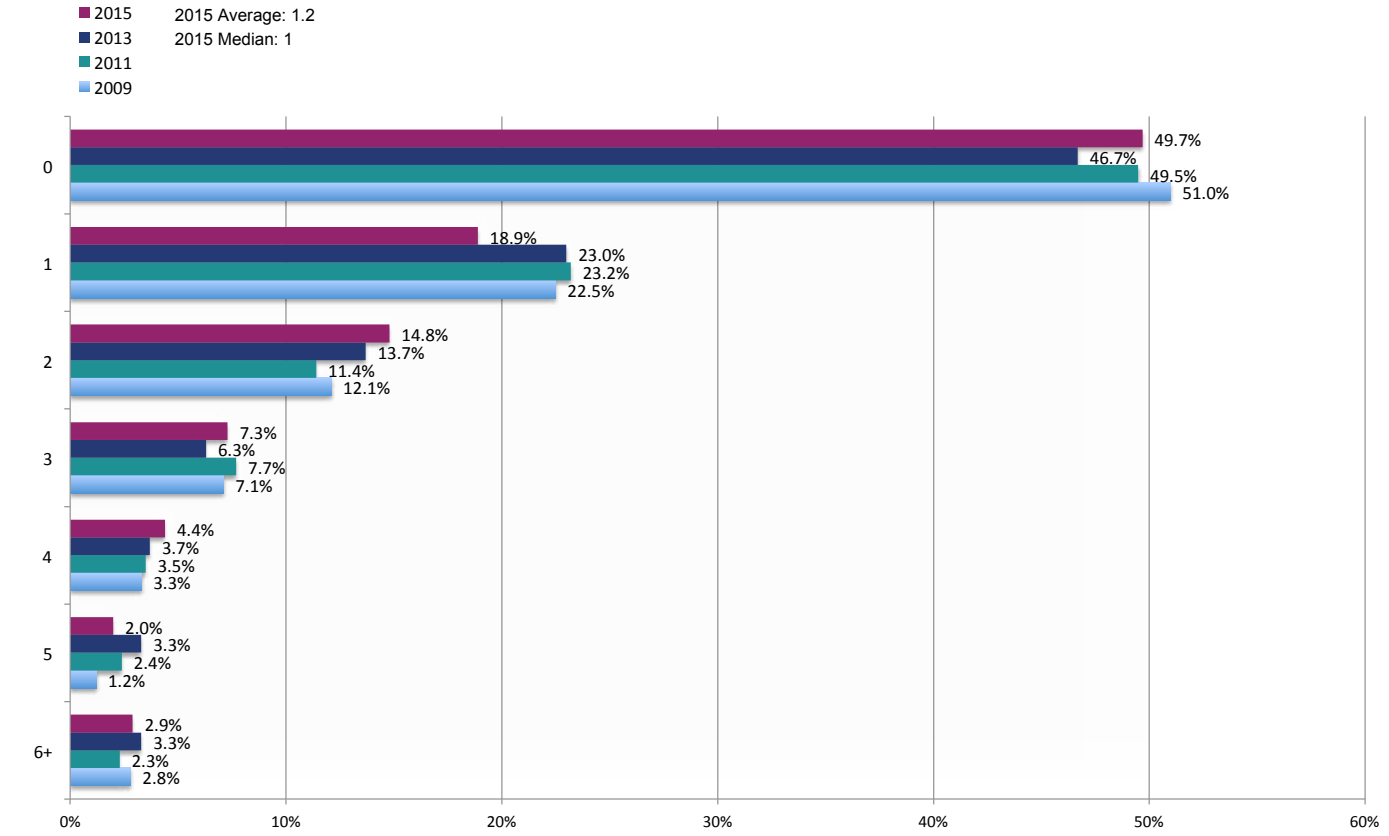


Exhibit 5. Background of the Organization's Chief Executive

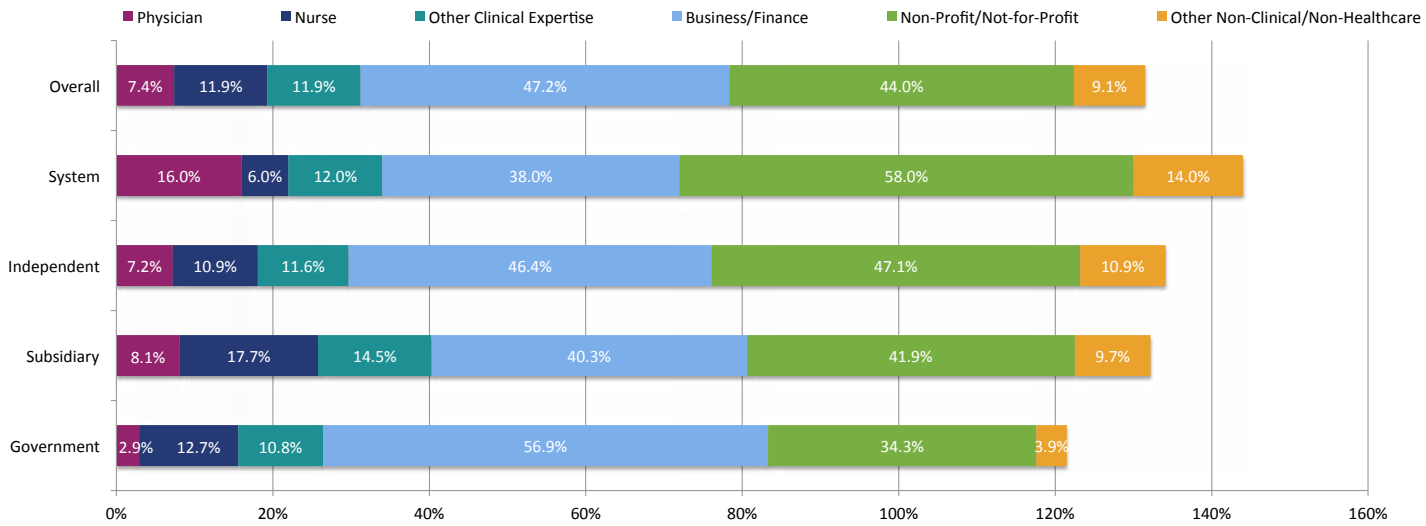


Exhibit 6. Background of the Organization's Chief Executive and Board Chair *(All Respondents)*

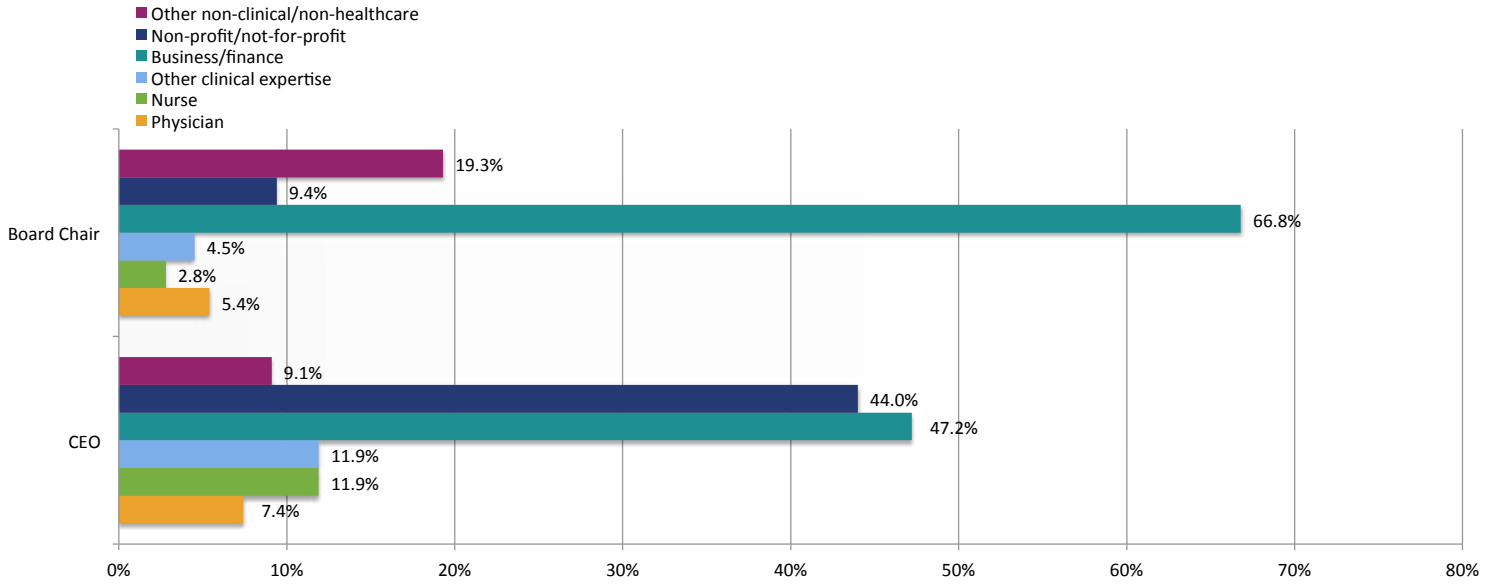
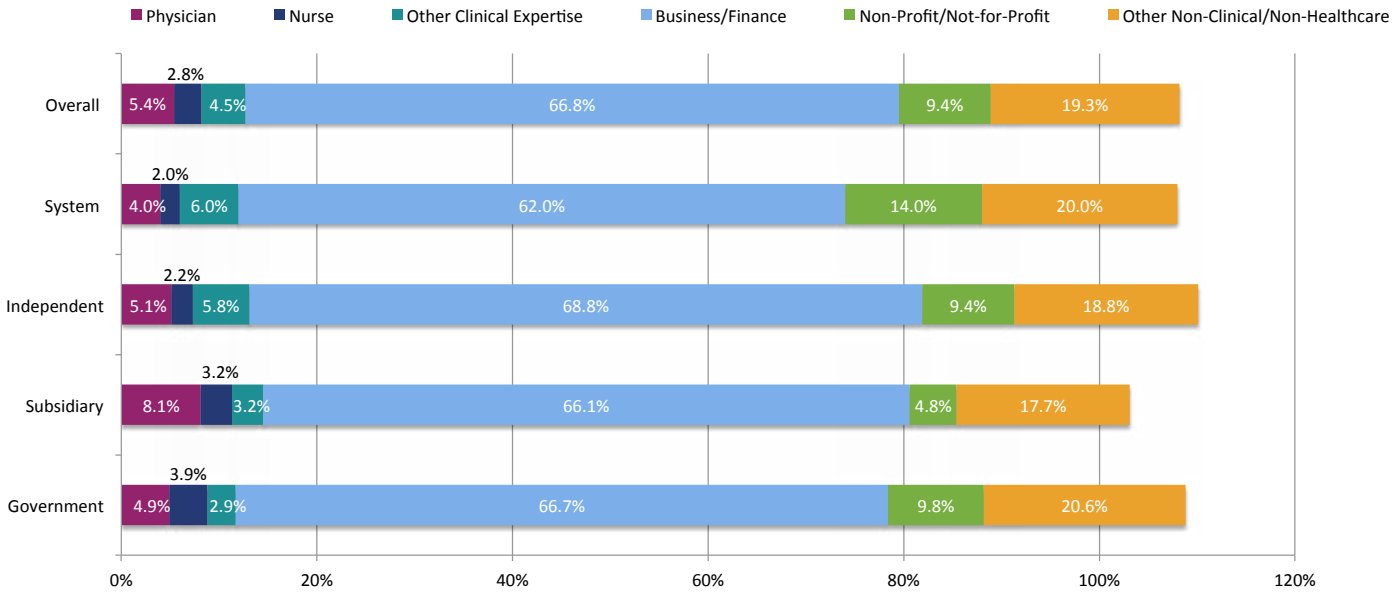


Exhibit 7. Background of the Organization's Board Chair



Age Limits and Average Board Member Age

The percentage of organizations that have specified a maximum age for board service is 7.8% (compared with 6.8% in 2013, 7.6% in 2011, and 8.1% in 2009). The median age limit remains 72.

The overall average board member age is 58.4 (median 60), which is up by about a year from 2013. The range was 45 to 75 years old. Catholic systems continue to have the oldest board members (average 63.2; median 64, also up by about a year from 2013).

Defined Terms of Service

Summary of Findings

60% of boards limit the number of consecutive terms (down from 66% in 2013); the median maximum number of terms is three. Systems and subsidiaries are more likely to have term limits. There is a downward trend in term limits for government hospitals since 2011.

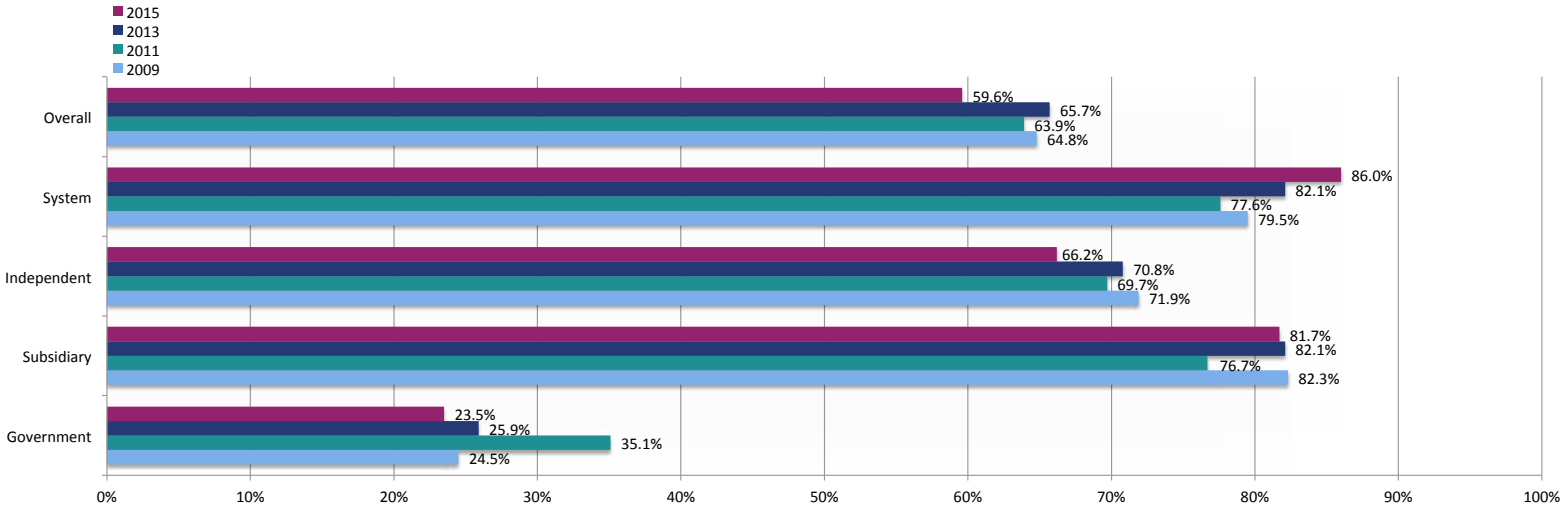
Term limits by type of organization:

- Systems—86% (up from 82.1% in 2013 and 77.6% in 2011)
- Independent hospitals—66% (down from 70.8% in 2013)
- Subsidiary hospitals—82% (about the same as 2013; up from 76.7% in 2011)
- Government-sponsored hospitals—24% (down from 25.9% in 2013)

Most respondents (91%) have defined terms for the length of elected service. The median term length has remained three years (four years for government-sponsored hospitals). A significantly lower percentage of respondents has defined limits for the maximum number of consecutive terms (the deciding factor in "term limits")—60% (indicating a decreasing trend; it was 64% in 2011). Most organizations limit board members to three consecutive terms; government-sponsored hospitals that have term limits allow only two consecutive terms.

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 in both 2013

Exhibit 8. Limits on the Maximum Number of Consecutive Terms



and 2015, indicating that the 2011 results were likely an anomaly. (Term limits are not customary among this group, where board members usually are appointed by a government agency or elected by the general public.)

Among non-government hospitals and systems, more often than not, boards have chosen to adopt term limits (78%). One-hundred percent (100%) of responding Catholic systems (N=7) have term limits; the next highest percentage is 86% of larger organizations (2,000+ beds).

Participation on the Board

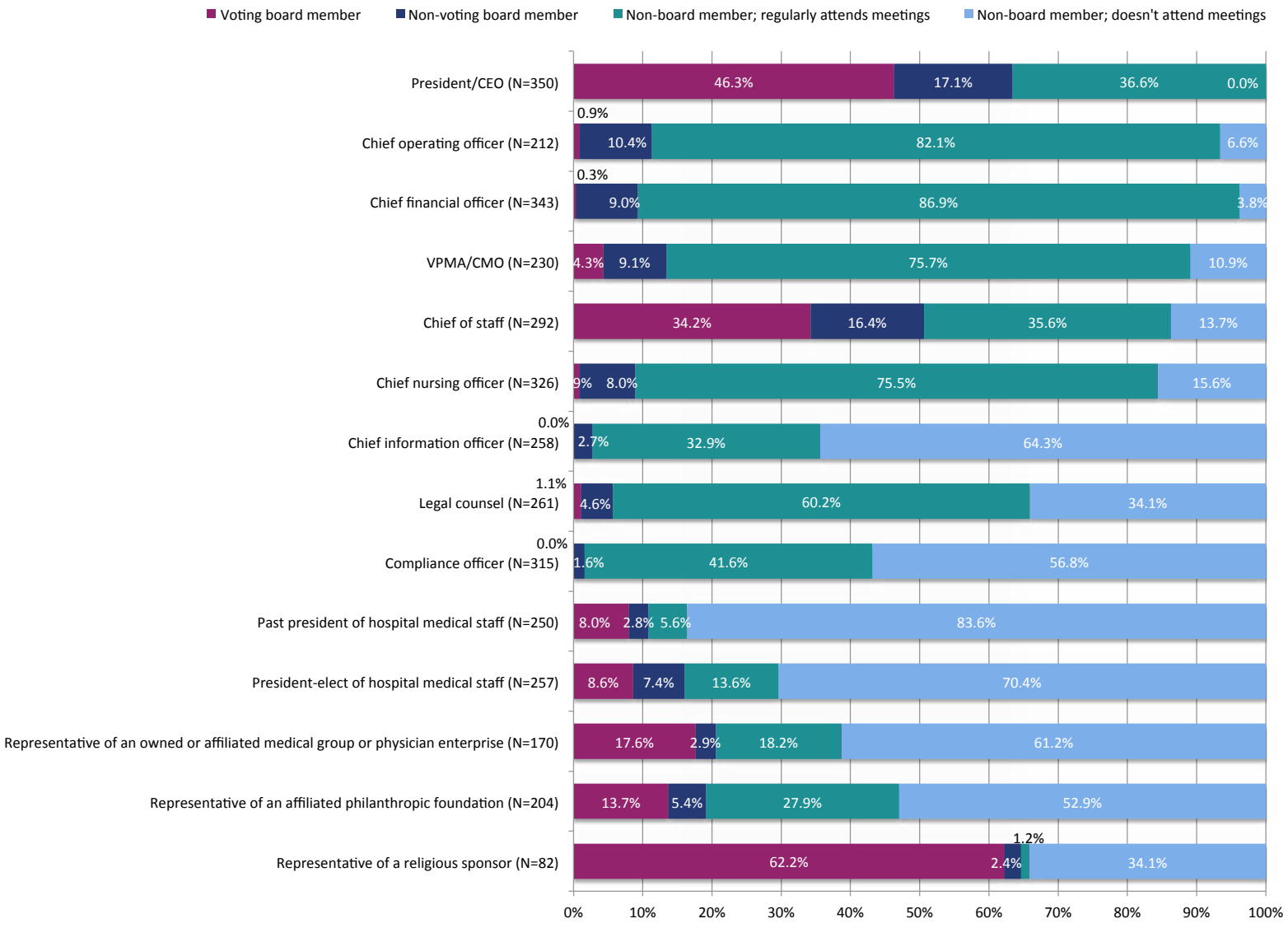
Summary of Findings

- President/CEO:
  - Voting board member: 46% (same as 2013)
  - Non-voting board member: 17% (same as 2013)
- Chief of staff:
  - Voting board member: 34% (down from 38% in 2013)
  - Non-voting board member: 16% (up from 13% in 2013)
- 12% 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 (down from 14% in 2013).

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 (same as 2013). Health systems and subsidiaries again have the highest percentage of voting CEO board members (78% and 76%, respectively). In contrast, government-sponsored hospitals have the lowest percentage of voting CEO board members (7%).

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



For a large majority of government-sponsored hospitals (74%), the CEO is not a board member but regularly attends meetings. (See Exhibit 9a.)

The chief of staff is a voting board member for 34% of respondents this year (down from 38% in 2013). Subsidiary hospitals are most likely to have a voting chief of staff on the board (51%), and government-sponsored hospitals are the least likely (12%), but the chief of staff regularly attends board meetings for 53% of government-sponsored hospitals.

Health systems are the least likely compared to other types of organizations to have a chief of staff at the system level (60% vs. 83% overall). In contrast, 94% of government-sponsored hospitals and 86% of subsidiaries have a chief of staff.

There has been a significant increase in the percentage of respondents with certain C-suite positions serving on the board; also there has been an increase in the prevalence of organizations having a legal counsel and VPMA/CMO (see Table 10). (See Appendix 1 for a breakdown by organization type and size.)

We have seen a significant increase in respondents with an owned or affiliated medical group or physician enterprise (48%, up from 33% in 2013 and 26% in 2011; 68% of systems have a physician group this year). Of those, 18% have a representative from this group as a voting member of the board.

Of those organizations that are sponsored by a religious entity (10% of respondents), 62% have a representative from the religious sponsor as a voting member of the board.

Exhibit 9a. Chief Executive Is a Voting Board Member 2015 vs. 2013

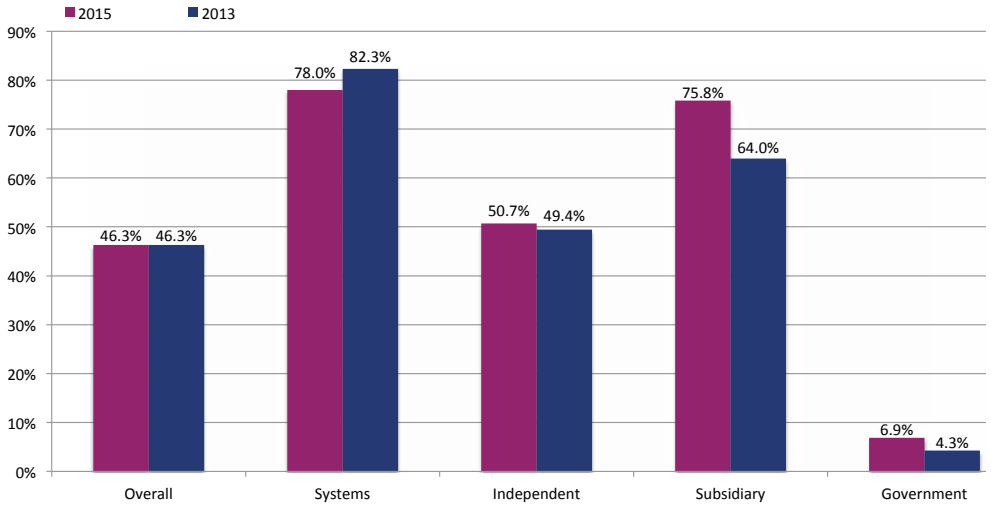


Table 10. Frequency of Position and Board Participation 2015 vs. 2013

	% of respondents **with this position**		% of respondents **noting presence in boardroom**		% of respondents **noting board member (voting and non-voting)**	
	2015	**2013**	**2015**	**2013**	**2015**	**2013**
CFO	96.9%	98.3%	96.2%	97.9%	**9.3%**	3.6%
CNO	92.1%	95.8%	84.4%	86.4%	**8.9%**	4.1%
Compliance Officer	88.9%	92.2%	43.2%	47.0%	1.6%	1.6%
Legal Counsel	**73.7%**	69.4%	65.9%	68.1%	**5.7%**	2.5%
CIO	72.9%	75.8%	35.6%	35.0%	**2.7%**	0.9%
VPMA/CMO	**65.0%**	61.7%	89.1%	90.7%	**13.4%**	8.6%
COO	59.9%	59.2%	93.4%	96.2%	**11.3%**	5.4%

Board Meetings

Summary of Findings

- Most boards (62%) meet 10–12 times a year (85% of government-sponsored hospital boards meet 10–12 times per year).
- 63% of responding organizations' board meetings are two to four hours; 31% are less than two hours.
- 75% of responding organizations use a consent agenda at board meetings (up from 71% in 2013).
- 65% have scheduled executive sessions (up from 56% in 2013); of these, 71% said executive sessions are scheduled for all or alternating board meetings.
- 84% said the CEO attends scheduled executive sessions always or most of the time; 41% said physician/clinician board members attend scheduled executive sessions always or most of the time (compared with 58% in 2013).
- On average, 63% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports; 26% to discussing strategic issues/policy (down from 33% in 2013); and 11% to board education (down from 17% in 2013).
- 52% of responding organizations have annual board retreats; more than three-quarters of respondents invite the CEO, CNO, CFO, and other C-suite executives to attend. Just over half invite the CMO and medical staff physicians to attend board retreats.

Board Meeting Frequency and Duration

Most boards continue to meet from 10 to 12 times per year (62%, down from 67% in 2013). (See **Exhibit 10**.) Meeting duration is a little longer this year; it tends to be concentrated in the two- to four-hour range (63%, up from 48% in 2013) and the next largest group meets for one to two hours (31%). (See **Appendix 1** for detail on meeting frequency and duration.)

Some differences by organization type include:

- 38% of system boards and 34% of subsidiary boards meet six times per year.
- 26% of system boards meet quarterly.
- 11% of subsidiary boards meet for four to six hours; 10% of system boards meet for more than eight hours.
- 41% of government-sponsored hospitals meet for less than two hours.

Consent Agenda and Executive Session

Three-quarters of respondents said the board uses a consent agenda (75%, which has risen steadily from 62% in 2007). (See **Exhibit 11**.) The percentage of respondents with scheduled executive sessions has risen from 56% to 65%. (See **Exhibit 12**.) Since 2009, most respondents continue to schedule executive sessions after or before every board meeting.

This year's analysis shows that there is a relationship between using a consent agenda and boards that generally spend more than half of meeting time discussing strategic issues.

We asked who typically attends scheduled executive sessions. Eighty-four percent (84%) of respondents with scheduled executive sessions said the CEO attends always or most of the time (about the same as 2013); 41% said clinician board members attend always or most of the time (down from 58% in 2013 and 66% in 2011); and 36% said legal counsel attends always or most of the time (about the same as 2013). (See **Exhibit 13**.)

Board Meeting Content

Boards continue to devote more than half of their meeting time to hearing reports from management and board committees. This percentage has increased from 50% in 2013 to 63% in 2015; however, this year's survey made a distinction between hearing management and committee reports and reviewing financial and quality/safety reports, which may be the reason for the change. (The breakdown this year is 24% of board meeting time receiving reports from management, committees, and subsidiaries; 19% reviewing financial performance; 21% reviewing quality of care/patient safety metrics; 26% discussing strategy and setting policy; and 11% on board member education.)

Exhibit 10. Number of Board Meetings Per Year

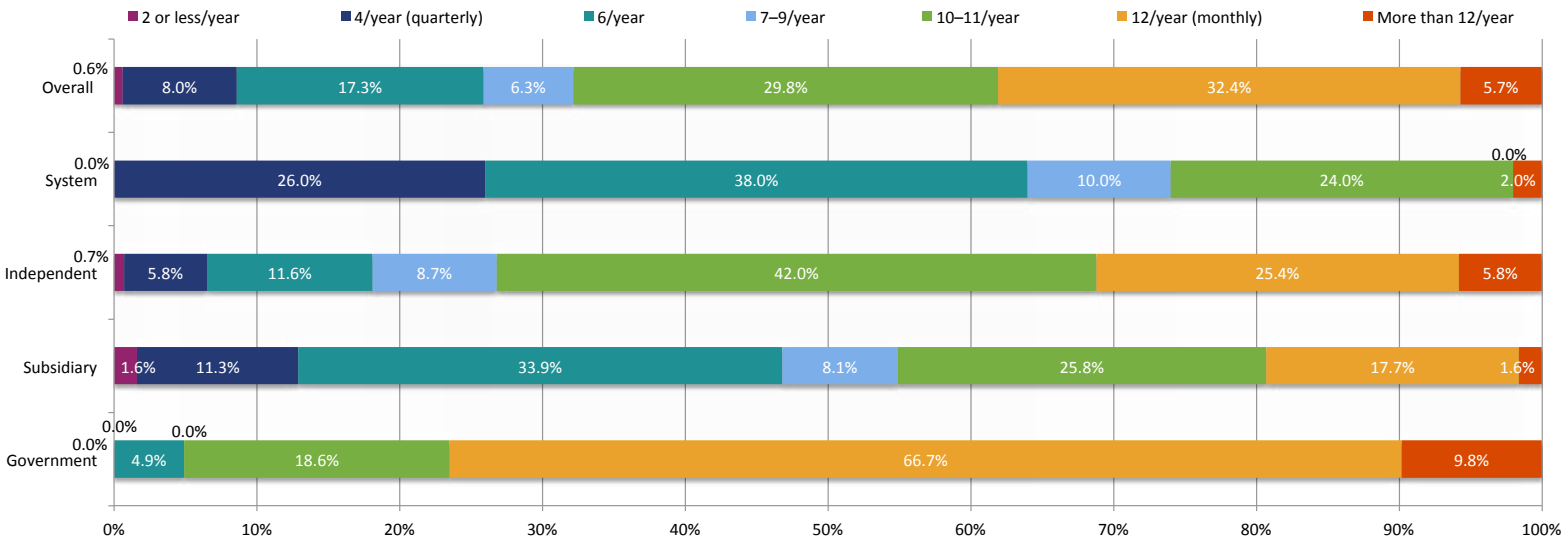


Exhibit 11. Use of Consent Agendas

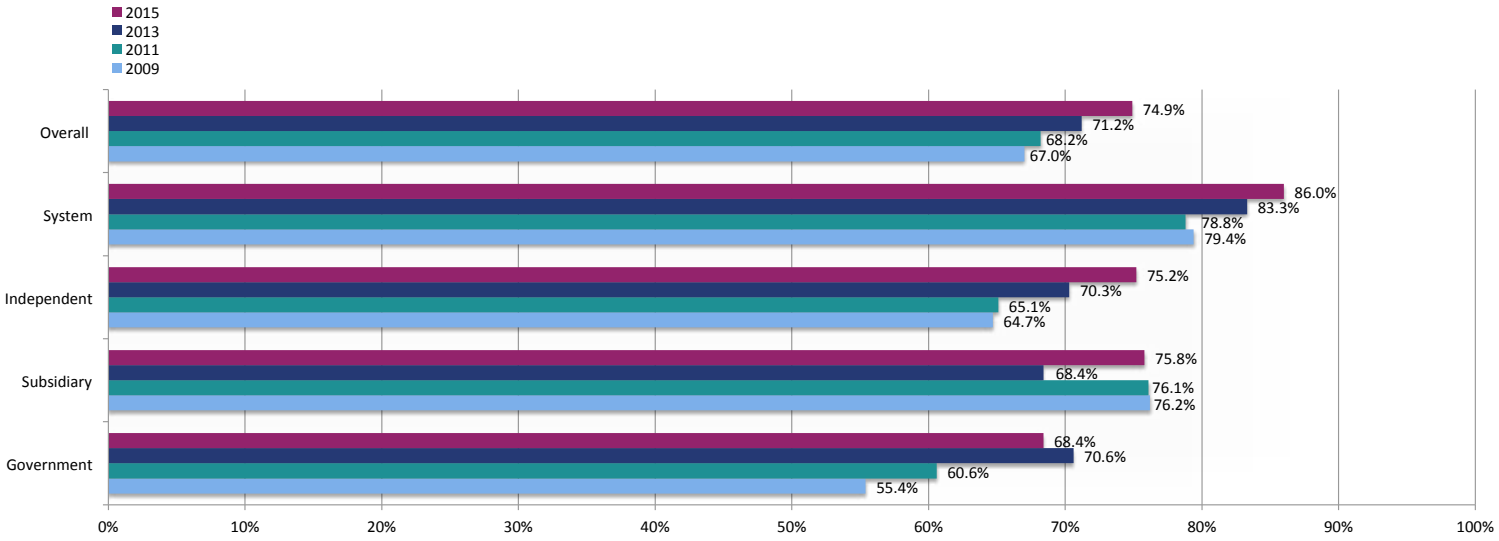


Exhibit 12. Scheduled Executive Sessions Since 2009

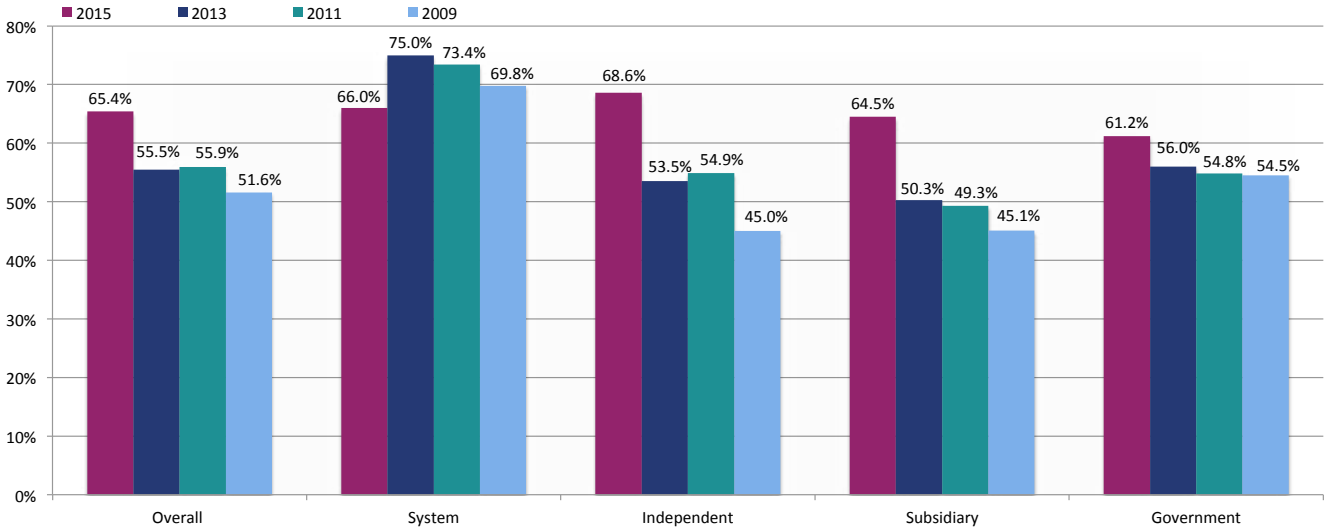


Exhibit 13. Who Attends Scheduled Executive Sessions *(Always and Most of the Time)*

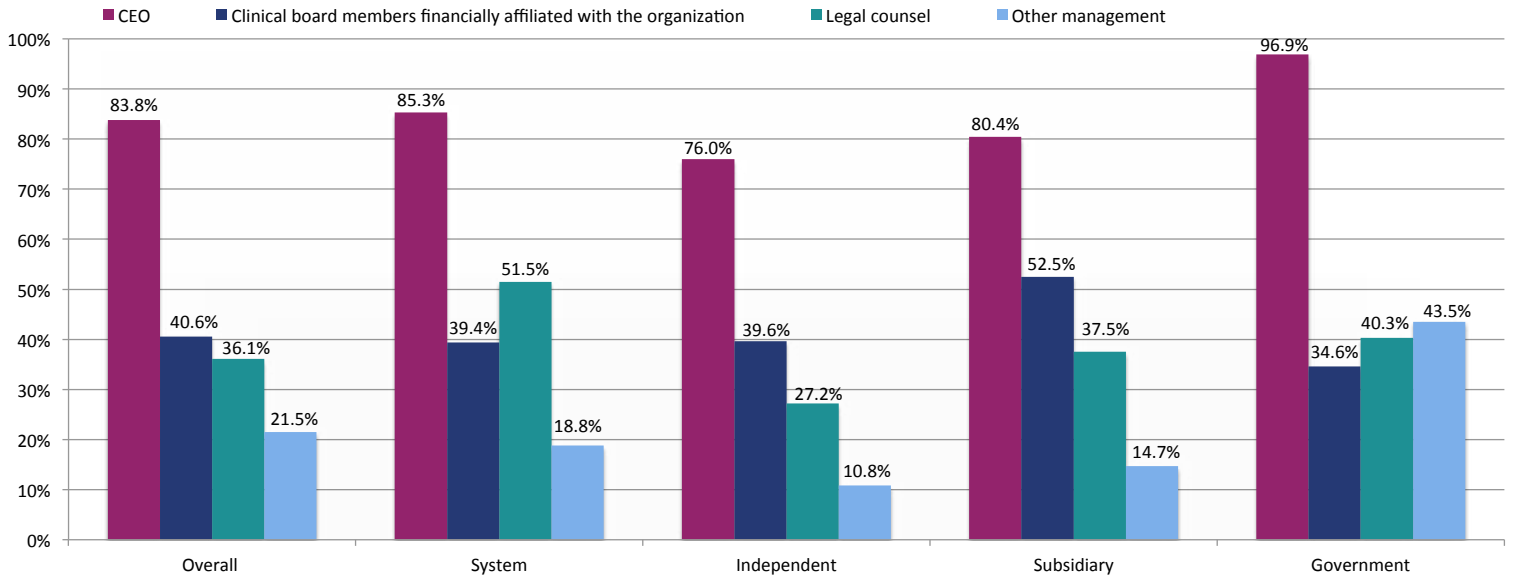
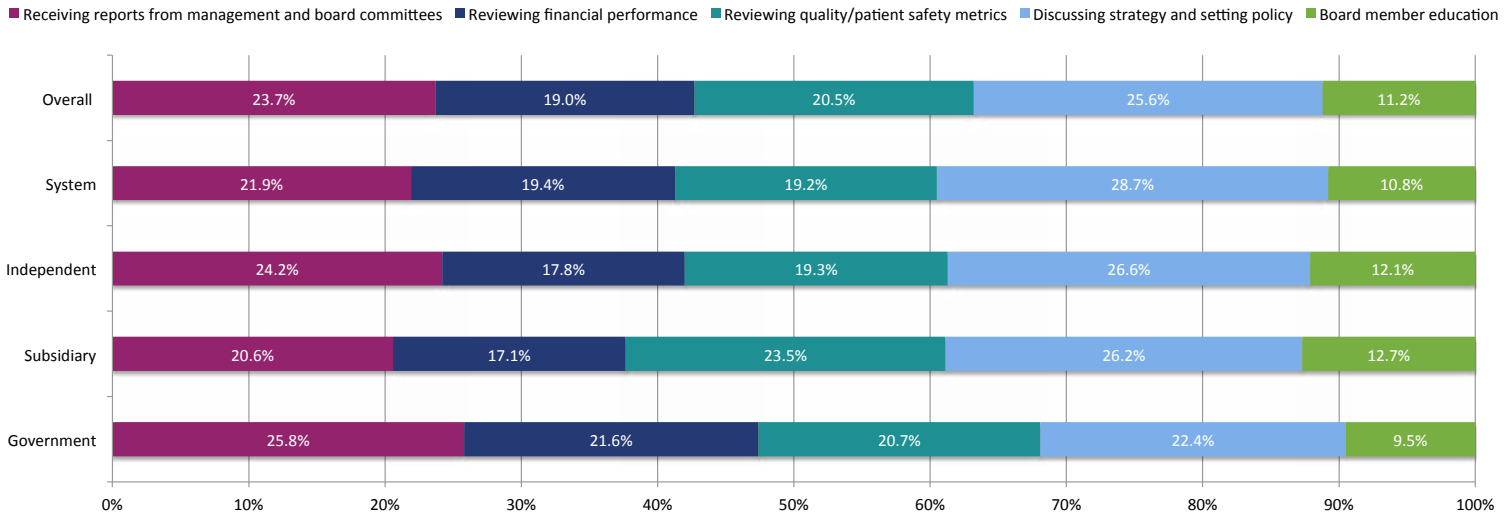


Exhibit 14. Average Percentage of Board Meeting Time Devoted to Reports, Strategy, and Education

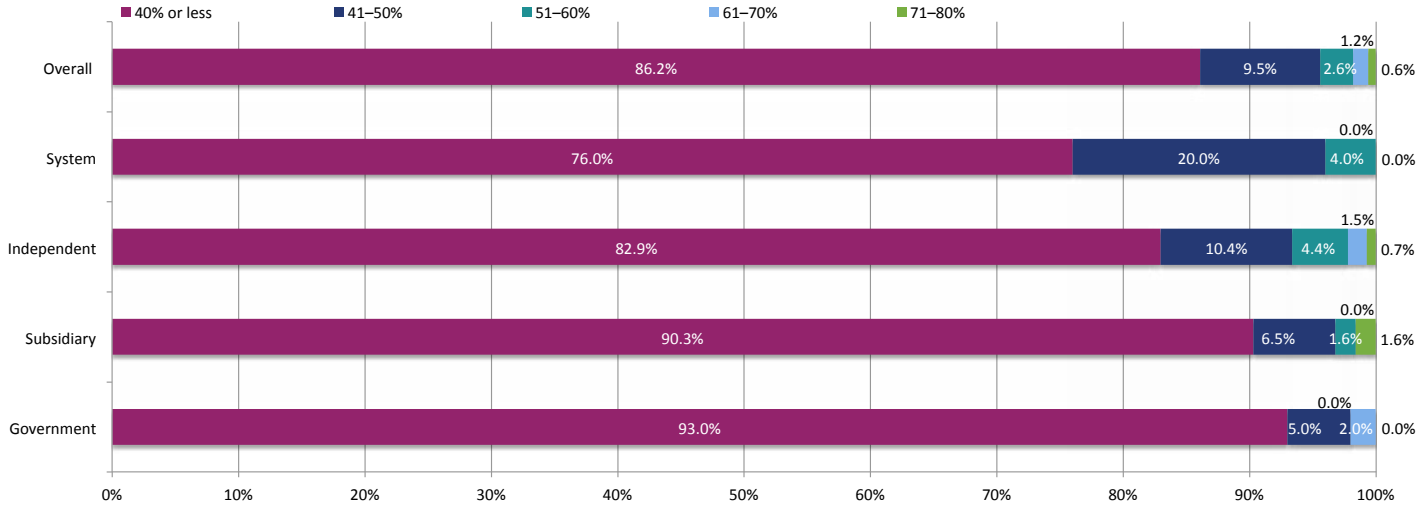


However, meeting time spent discussing strategy/setting policy has gone down overall (26% vs. 33% in 2013). Also, time spent on board member education is down from 17% in 2013. (See **Exhibit 14**.)

Percentage of meeting time spent in these categories was fairly consistent this year across organization type. System boards spend the most amount of time on strategy and policy (29%), and subsidiary hospitals spend the most amount of meeting time on board member education (13%).

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, and in fact the data is showing a decline in the amount of board meeting time spent on strategy this year, with 86% of the responding organizations spending *40% or less* of the time during their board meetings on strategy, compared with 74% in 2013 (see **Exhibit 15**). 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.

Exhibit 15. Percentage of Board Meeting Time Spent on Strategy/Policy



We recommend that boards spend more than half of their meeting time on strategic discussions due to the continued statistical relationship the data shows between the amount of time devoted to strategic discussion and overall board performance. For boards that indicate they generally spend more than half of meeting time discussing strategic issues, there is a greater tendency to indicate that overall board performance is excellent. "Strategic discussions" include issues around finance and quality (and other mission-critical issues) that require decision making of a strategic nature.

In addition, although we don't explicitly recommend that boards have a strategic planning committee of the board (due to unique circumstances for organizations by type, size, and other considerations), this year's analysis does show that boards with a strategic planning committee have a greater tendency to indicate that overall board performance for strategic direction is "excellent" or "very good."

Board Retreats

This year we asked how often organizations schedule board retreats and who typically attends them (other than board members). Across all organization types, most respondents have an annual board retreat. The CEO and other C-suite executives (not including the CMO) are most likely to attend in addition to board members. Health systems are more likely than other types of organizations to invite the CMO and governance support staff. (See **Appendix 1** for more detail.)

Board Committees

Summary of Findings

- 5.2% of the respondents do not have board committees (about the same as 2013).
- Average number of committees is 7.5 (up from 2013 but about the same as 2011).
- Median: 7
- Most prevalent committees (more than 50% of respondents): executive (72%), quality (74%), governance/nominating (72%), finance (84%), executive compensation (66%), strategic planning (57%), and audit/compliance (51%, a significant increase from 34% in 2013). With the exception of audit/compliance, these committees have remained the most prevalent since 2011.
- The committees that have increased in prevalence most significantly are: finance (84%, up from 76%); executive compensation (66% vs. 60%); audit/compliance as indicated above; and community benefit (26% vs. 18%).

Most respondents (95%) noted their board has one or more committees. Health systems and independent hospitals have the most committees (median of 8) but the number of committees is basically the same across organization types, in contrast with 2013. (See **Exhibit 16**.)

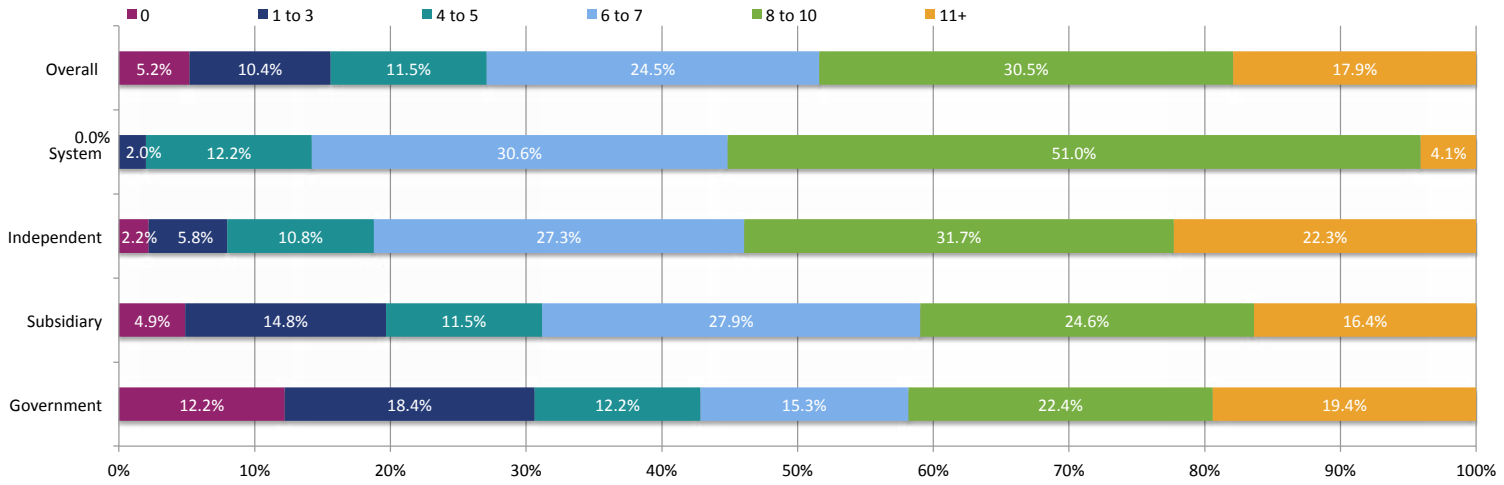
Overall, there has been little change in the prevalence of specific types of board committees; however, we do see a significant increase in the prevalence of community benefit and audit/compliance committees, and the increase in finance committees is notable.

Specifically, we have seen some committee movement away from subsidiary hospitals and towards health systems in comparison with 2013. Such is the case with the executive committee (80% of health systems vs. 71% of subsidiaries in 2015; contrasted with 75% of health systems and 85% of subsidiaries in 2013). This is also the case with the finance committee, which is up 10 percentage points for health systems and down slightly for subsidiaries compared with 2013. In 2013, subsidiaries were more likely to have a strategic planning committee than systems (58% vs. 46%); this year, systems are equally likely to have this committee (52% for both systems and subsidiaries).

The prevalence of the audit/compliance committee is up across all types of organizations, and we are seeing lower prevalence of the separate compliance committee, indicating that some boards are developing more efficient committee structures in this regard by combining the audit and compliance committees into one.

For the community benefit committee (which has typically been towards the bottom of the list), prevalence is significantly higher across all types of organizations, but

Exhibit 16. Number of Board Committees



most significantly for subsidiary hospitals (34%, a 14% increase from 2013).

Notably, the overall prevalence of the executive compensation committee is higher primarily due to a substantial increase for government-sponsored hospitals since 2013 (50% vs. 35%). The prevalence of this committee in other types of organizations remained constant for independent and subsidiary hospitals; it is seven percentage points lower for health systems (78% vs. 85%).

Table 11 shows the prevalence of board committees since 2009 (most prevalent committees for 2015 listed first). For detail by organization type and size (both committee prevalence and meeting frequency), refer to Appendix 1.

The Quality Committee

The quality committee is the only committee for which we consider it a best practice for all organizations to have a standing committee of the board, regardless of organization type or size (primarily due to the amount of work involved in measuring and reporting on quality, and

Table 11. Prevalence of Board Committees *(All Respondents)*

Committee	2015	2013	2011	2009
Finance	84%	76%	76%	73%
Quality and/or Safety	74%	77%	72%	70%
Executive	72%	77%	78%	75%
Governance/Nominating	72%	77%	73%	72%
Executive Compensation	66%	60%	56%	54%
Strategic Planning	57%	57%	56%	54%
Audit/Compliance	51%	34%	30%	28%
Investment	40%	35%	36%	31%
Joint Conference	35%	40%	39%	40%
Audit	33%	32%	32%	26%
Compliance	28%	33%	31%	25%
Community Benefit	26%	18%	20%	15%
Facilities/Infrastructure/Maintenance	23%	25%	25%	22%
Human Resources	22%	20%	22%	24%
Physician Relations	21%	19%	17%	16%
Construction	17%	9%	16%	14%
Government Relations/Advocacy	13%	9%	11%	10%

also holding management accountable for implementing actions to improve it). The number of organizations reporting a board-level quality/safety committee is slightly lower overall since 2013, and especially for subsidiary hospitals; however, these levels still maintain a significant increasing trend overall since 2007 (indicating that organizations are more focused on quality as a priority). Comparisons by organization type can be found in Table 12.

Table 12. Organizations with a Board Quality Committee

	2015	2013	2011	2009	2007
Overall	74%	77%	72%	70%	62%
Systems	84%	85%	74%	78%	76%
Independent Hospitals	80%	80%	74%	74%	64%
Subsidiary Hospitals	81%	86%	77%	76%	70%
Government-Sponsored Hospitals	58%	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=263 for quality committee here in the structure section, and N=333 for quality committee in the practices section, in which 81% of the respondents reported a standing quality committee of the board, up from 79% in 2013). (See detail in Appendices 1 and 2.)

This year's analysis shows that organizations with a standing board-level quality committee have higher rates of adoption of the recommended practices in quality oversight (presented in the Governance Practices section of this report). In addition, the analysis shows that boards with a quality committee have a greater tendency to indicate that overall board performance for quality oversight is "excellent" or "very good."

Quality committees continue to meet primarily monthly (for 47% of respondents); 20% meet bimonthly and 28% meet quarterly. Health system quality committees meet less frequently compared to other types of organizations (31% meet monthly, 26% meet bimonthly, and 43% meet quarterly). Independent and government hospital quality committees are more likely to meet monthly (53% and 55% respectively).

The Executive Committee

Seventy-two percent (72%) of respondents said their board has an executive committee (down from 77% in 2013), and this committee meets "as needed" for 53% of those respondents (about the same since 2011). For more than half of those with an executive committee, responsibilities include advising the CEO (69%), emergency decision making (81%), and decision-making authority between full board meetings (73%). (For detail, see Appendix 1.)

This committee is less likely to have full authority than in 2013 (36% of respondents this year indicated the committee has full authority to act on behalf of the board on all issues, down from 45%). A few distinctions by organization type include:

- System boards have the highest percentage of respondents indicating full authority of the executive committee (50%). Ninety-three percent (93%) of system boards have decision-making authority between board meetings.
- Executive committees of government-sponsored hospitals have the least amount

Exhibit 17. Responsibilities of the Executive Committee *(All Respondents)*

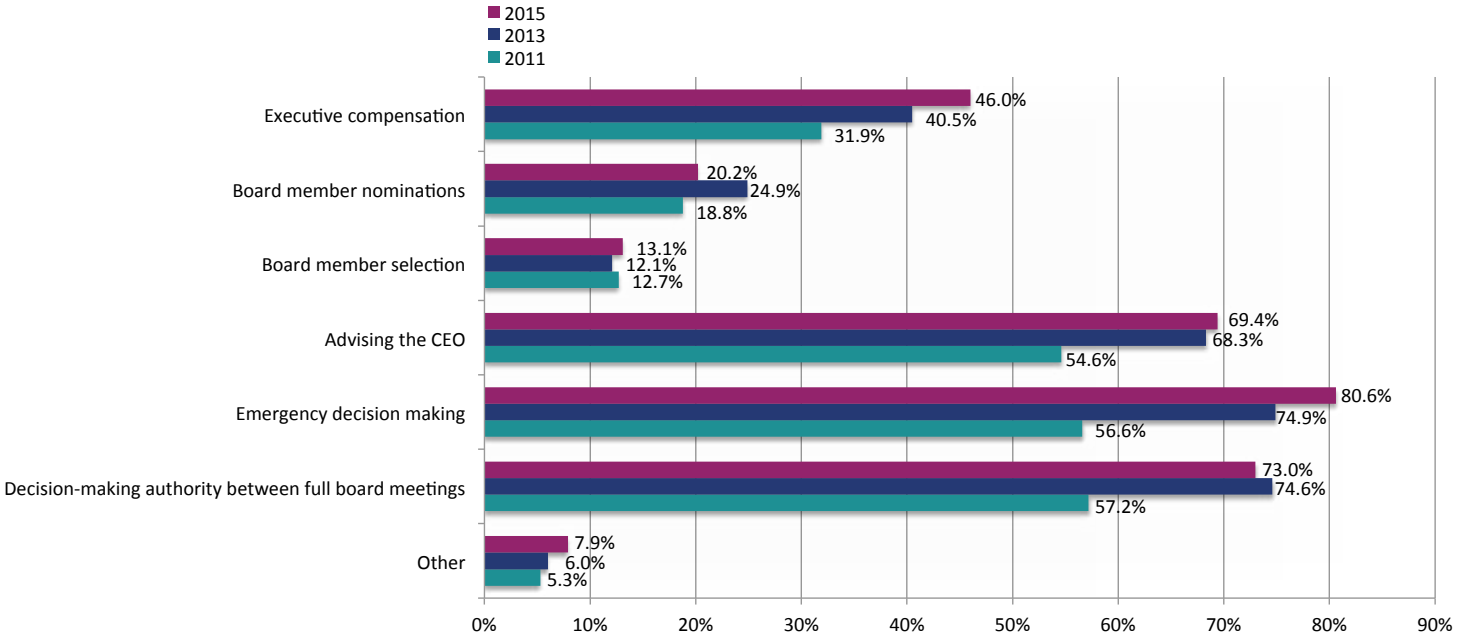
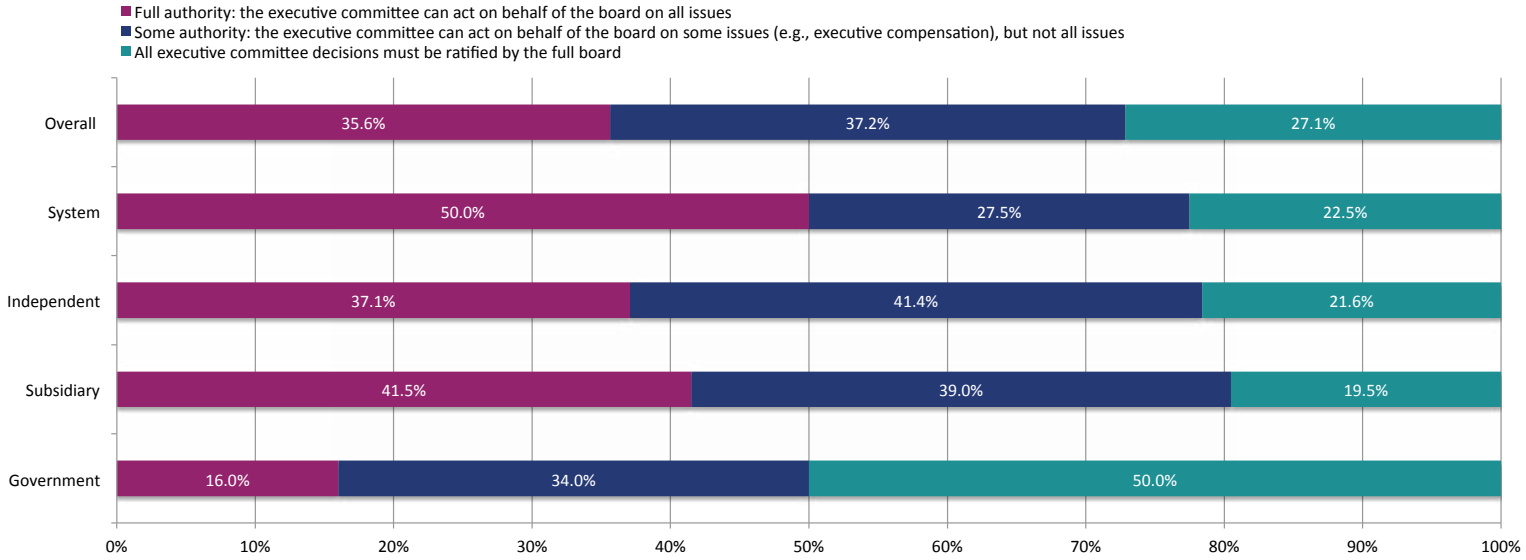


Exhibit 18. Level of Authority of Executive Committee



of authority (50% said all executive committee decisions must be ratified by the full board).

- Fifty-one percent (51%) of independent hospitals and 58% of government-sponsored hospitals also assign this committee responsibility for executive compensation decisions.
- Thirty-four percent (34%) of subsidiary hospitals with an executive committee use this committee for board member nominations.

Committee Meeting Frequency

This year, most organizations reported similar meeting frequencies for each committee compared with 2013. Table 13 shows the most common meeting frequencies (50% of respondents or higher). *(Please note that for some of the less prevalent committees—from physician relations down to government relations/advocacy—respondent sample size is very small, as indicated in Appendix 1.)* For the other committees, meeting frequency varies more randomly.

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

Table 13. Most Common Committee Meeting Frequencies

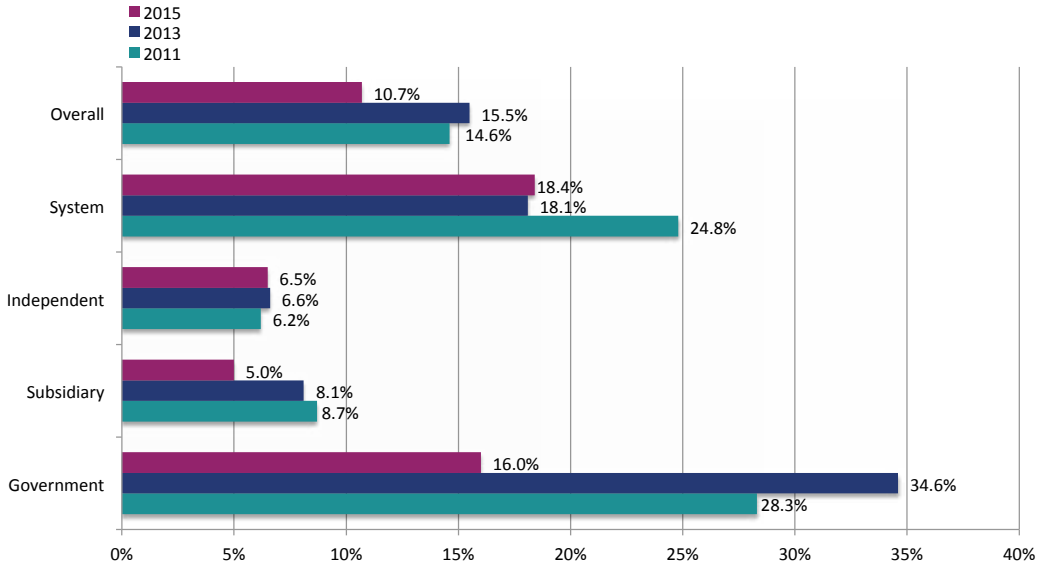
Committee	Meeting Frequency (% of all respondents)	Highest Percentage of Meeting Frequency by Organization Type
Executive	As needed (53%)	Systems (60% as needed)
Finance	Monthly (61%)	Government (73% monthly)
Audit/Compliance	Quarterly (53%)	Systems (74% quarterly)
Physician Relations	As needed (56%)	Government (65% as needed)
Investment	Quarterly (59%)	Systems (77% quarterly)
Joint Conference	As needed (52%)	Subsidiaries (59% as needed)
Facilities/Infrastructure/Maintenance	As needed (58%)	Government (66% as needed)
Construction	As needed (86%)	Systems (100% as needed)
Government Relations/Advocacy	As needed (70%)	Government (87% as needed)

Board Member Compensation

Summary of Findings

- 11% of respondents said their board chair is compensated (down one percentage point from both 2013 and 2011), and 61% of these said compensation is less than $5,000 (about the same as 2013).
- 11% said some or all other board members are compensated (down from 16% in 2013), and 62% of these said compensation is less than $5,000.
- There was a significant decrease in the percentage of government-sponsored hospitals that compensate board members (16% in 2015 vs. 35% in 2013 and 28% in 2011).
- Systems and government-sponsored hospitals are more likely to compensate board members than independent and subsidiary hospitals.

Exhibit 19. Percentage of Organizations that Compensate Other Board Members
(excluding chair, other officers, and committee chairs)



Previous reporting years (2011 and 2013) showed a very small increase in board member compensation (excluding the board chair). However, this year shows a drop off indicating that any previously perceived upwards trend does not exist. (See Exhibit 19.)

Compensation for the board chair has essentially remained constant since 2011 (11%). As with previous years, systems and government-sponsored hospitals are the most likely to compensate the board chair, although this percentage has decreased to below the 2007 level for government hospitals (see Table 14).

A significant majority of respondents said board chair compensation is less than $10,000 per year; compensation for other board members is generally less than $5,000. We also asked whether boards compensate board officers (10%, about the same as 2013) and board committee chairs (8.6%, up from 6.5%). Compensation for board officers was less than $5,000, and compensation for committee chairs was also primarily less than $5,000. (For detail, see Appendix 1.)

Table 14. Percentage of Organizations that Compensate the Board Chair

	2015	2013	2011	2009	2007
Overall	**11.1%**	**11.8%**	**12.0%**	**9.6%**	**9.5%**
Systems	18.0%	17.5%	21.3%	12.7%	10.0%
Independent Hospitals	6.5%	5.8%	5.2%	4.7%	3.9%
Subsidiary Hospitals	4.9%	6.2%	7.1%	5.3%	8.5%
Government-Sponsored Hospitals	17.8%	23.5%	22.9%	19.1%	19.9%

Annual Expenditure for Board Member Education

Summary of Findings

- 31% of respondents spend $30,000 or more annually for board education (up from 26% in 2013).
- 2.6% said they don't spend any money on board education (about the same as 2013).
- Health systems generally spend more for board education than other types of organizations, and the dollar amount has gone up this year (48% of systems spend $50,000 or more vs. 38% in 2013; 32% spend over $75,000 vs. 22% in 2013).
- Again this year, government-sponsored hospitals spend the lowest dollar amount for board education (54% spend under $10,000).
- Board education is most often delivered during board meetings; publications are the second most common delivery method (for all types of organizations).
- Popular internal board education topics include: legal/regulatory, quality/safety, and industry trends and implications.

This year, the data analysis showed that for boards spending $30,000 or greater on board education, there is a greater tendency to indicate that overall board performance is "excellent." Thus it is promising to see that boards are spending more on education compared with previous years; however, there is still room for improvement, especially for government and subsidiary hospitals, which tend to spend the least amount compared to systems and independent hospitals.

Exhibit 20. Approximate Total Annual Expenditure for Board Education

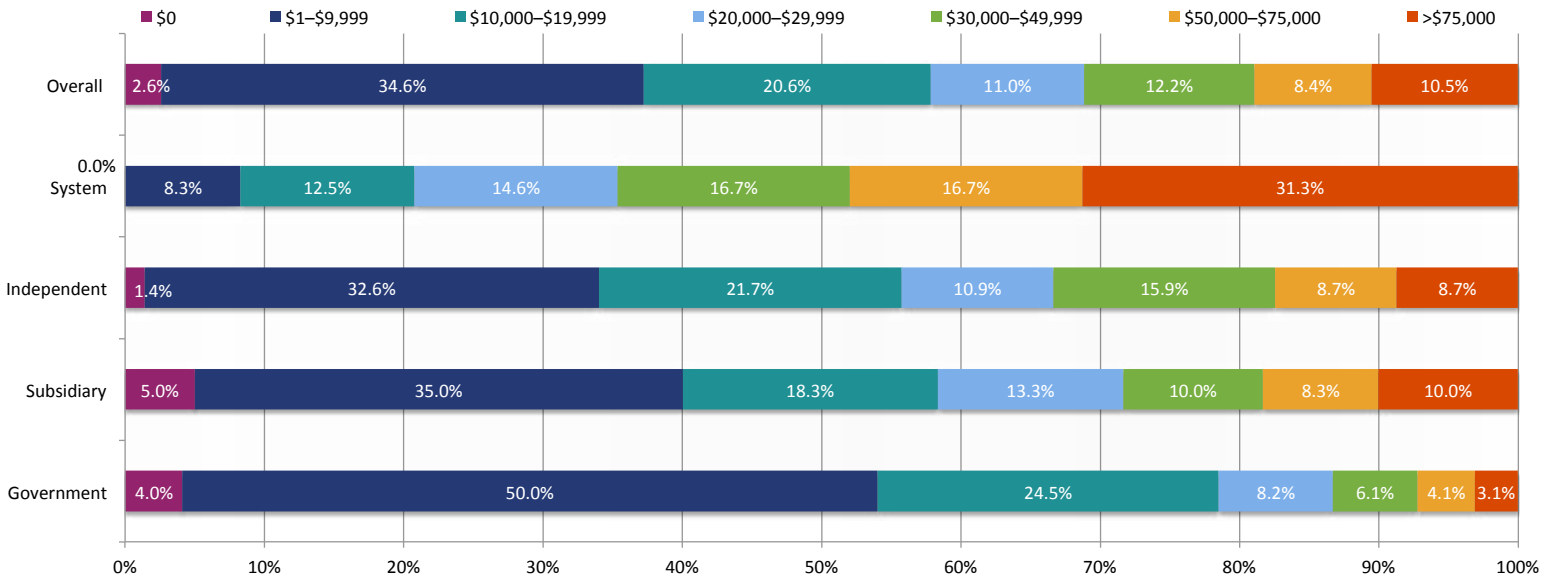


Exhibit 21. Delivery of Board Education

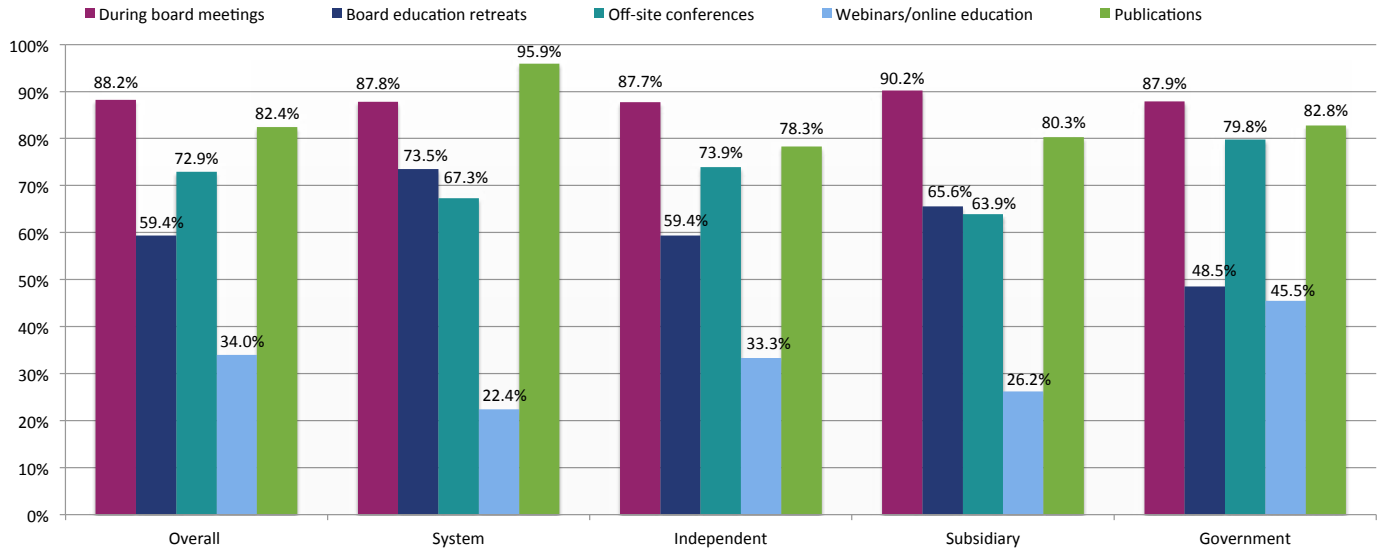
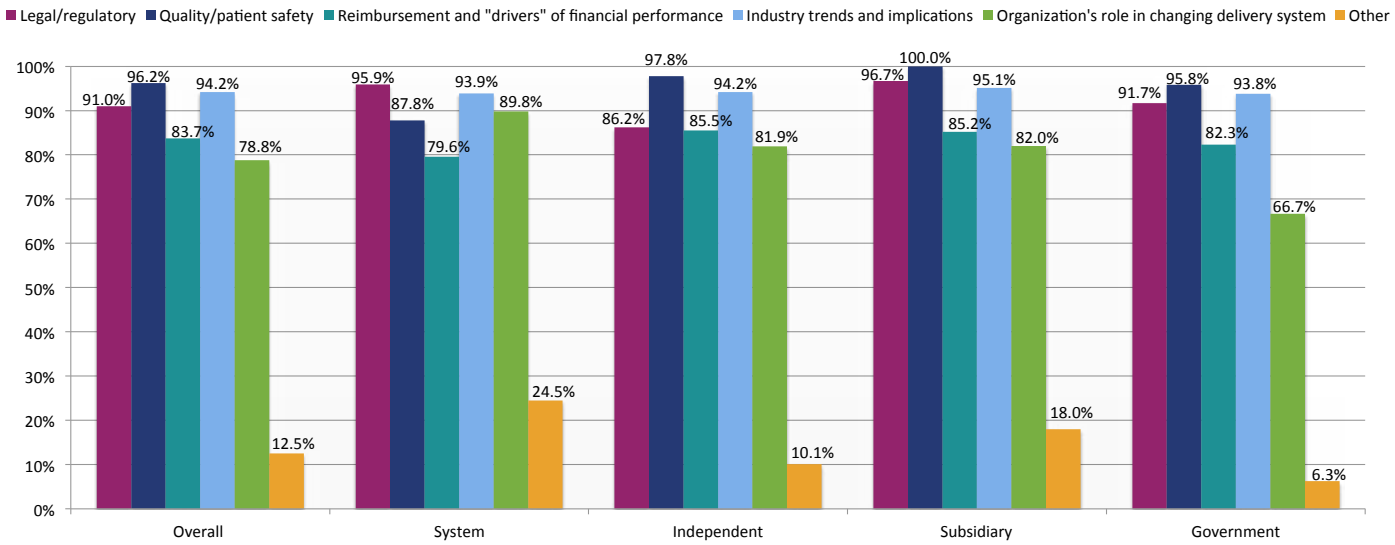


Exhibit 22. Topics Covered for Internal Board Education



IMPROVING ALIGNMENT AMONG ACUTE- AND POST-ACUTE PROVIDER BOARDS IS ESSENTIAL IN THE FEE-FOR-VALUE LANDSCAPE

Andy Edeburn, M.A., *Vice President, The Camden Group, and*
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{ SPECIAL COMMENTARY }

As our healthcare system migrates toward fee-for-value and population health, it has become an imperative for acute hospitals and health systems to increase their understanding of the broader continuum of care involving services before and after a hospital stay. For many this has fostered a resurgent interest in post-acute care (PAC; services provided immediately after a hospital stay), and PAC's ability to deliver value in terms of improved care coordination and patient management, enhanced health outcomes, and reduced costs. Governance entities for both acute and post-acute organizations, however, are oftentimes unfamiliar with one another and their respective priorities and challenges. As changes in healthcare delivery and payment drive greater alignment, boards from both sides must better understand one another to successfully guide their respective organizations and establish effective strategic and operational relationships.

Environmental Issues Driving Acute Care Hospitals' Focus on Post-Acute Care

In communities that have either a predominant orientation to fee-for-service (FFS) care or those rapidly evolving to fee-for-value (FFV) and population health, hospital and hospital system leadership are making PAC one of the focal points of their strategic and operational initiatives. Four environmental catalysts are driving this activity:

- Changes in reimbursement by Medicare and commercial payers keep increasing pressure to shrink the cost of acute care by reducing length of stay via more efficient transition of patients to their homes and PAC settings, and minimizing readmissions through enhanced care management in those destinations.
- With increasing frequency, providers in shared savings and risk-based arrangements (bundled payments, ACOs), bear full responsibility for the delivery of PAC and its associated costs. The number of lives in bundled payments and ACOs continues to rise (e.g., nationally, ACO lives are projected to increase from approximately 23.5 million today to over 72 million by 2020). This general trend is escalated by the Centers for Medicare and Medicaid Services' (CMS) Comprehensive Care for Joint Replacement (CCJR) initiative, which becomes operational January 1, 2016. CCJR mandates that payment for an episode of joint replacement care cover the inpatient stay as well as any care provided within 90 days of discharge, including PAC settings like skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), and long-term acute care hospitals (LTACHs). Initially, the CCJR will apply to between 800–1,000 hospitals nationwide; that number is expected to increase, and CMS has already indicated its intent to expand that mandate to other clinical services as well. Cardiac care is likely the next target. As a consequence, acute-care hospitals are beginning to proactively extend protocols, care management, and electronic health record connectivity to the PAC settings to better manage and reduce the cost of care in those locations.
- Our national age wave is driving rapid growth in the number of patients with long-term chronic care management needs—a significant proportion of which utilize PAC services.

- Limited PAC capacity and high occupancy rates in many communities delays placement of patients requiring PAC services. Given the regulatory requirements and the capital investment associated with building new or buying existing PAC settings, hospitals and hospital systems are forming strategic relationships with PAC providers to enhance access and address the care management and cost-reduction issues listed above. Competition for these strategic relationships is escalating.

What Acute-Care Hospital Board Members Need to Know About Post-Acute Care

Given the increasing attention to PAC in hospital/system strategic and operational initiatives, it is imperative that acute-care board members have a working knowledge of each of the topics listed below. They should expect and require members of the executive management team to provide education and regular progress reports on these subjects:

1. Pace and degree of evolution of their community from FFS to FFV and population health at any given point in time

2. A "high level" understanding of PAC specific to:
   - » The components of the PAC continuum (e.g., SNF, IRF, HHA, LTACH)
   - » The degree to which those services are available in the community through the hospital's/system's own organization and independent entities
   - » The role of PAC in care management and PAC's fit with bundled payment, ACOs, and other risk arrangements
   - » General trends in reimbursement levels for and the potential contribution margin of PAC services (relative attractiveness of build/buy versus a strategic relationship)
3. Specific to the hospital's/system's PAC strategy:
   - » The nature and focus of the strategy
   - » Which individual(s) have responsibility for implementing the strategy
   - » The annual performance metrics specific to the strategy
4. Criteria used by the hospital/system to identify, evaluate, and select PAC strategic partners (it is notable that completion of the research and evaluation steps should be the responsibility of the hospital/system senior management)

Key Issues Regarding the Acute-Care Hospital/ PAC Relationship from the Perspective of the PAC Entity

The historical relationship between acute and PAC providers has typically been managed at the operational level of acute hospital discharge planners and PAC intake staff. As acute organizations broaden their understanding of and interest in PAC at a more strategic level, the PAC provider community and its governing boards need to improve not only their understanding of acute hospital imperatives and challenges but also how these relationships will differ into the future.

To that end, here are four key points PAC provider boards need to understand moving forward:

1. Proactively expanding and strengthening relationships with acute organizations represents a core PAC business strategy in the future, especially with those organizations that are accelerating their shift into FFV. Most PAC organizations depend on a hospital relationship for referrals, and as acute organizations pursue select providers, the risk of losing such a relationship could be potentially devastating to patient volume. Because most PAC settings must operate at greater than 90% occupancy to be operationally viable, any decline in volume would severely impact revenue and threaten survival. PAC boards and their leadership teams are well-advised to align their strategic intentions with that of major hospital partners.
2. Securing relationships will depend primarily on PAC provider performance, especially for outcomes. PAC organizations must additionally demonstrate best-in-class performance around hospital readmissions, post-acute length of stay, patient satisfaction, and patient functional improvement (among many others) to be a preferred partner. Since payment for acute hospitals, ACOs, and other FFV entities is increasingly driven by outcomes, and as they seek to manage care across the full continuum of care, PAC providers must position themselves to deliver a competitively superior value on cost, quality, and accessibility for the hospital. A forward-looking PAC board and leadership team must understand this value proposition and ensure that the organization can consistently demonstrate value through each of these characteristics.
3. The nature and scope of the acute-care hospital/PAC relationship is likely to evolve quickly. While a preferred relationship with an acute hospital will invite increased attention to the patient care dynamic, it may also drive an opportunity for greater strategic engagement—joint ventures for program development, shared approaches to care management and clinical pathway development, integrating health information technology, and risk-sharing for bundled payment. To capitalize on those opportunities, clinical skill development is a particularly important area of integration and engagement, as the clinical capabilities of PAC employees often lags those of acute hospitals. Embedding hospital-aligned physicians in the PAC as medical directors or

attending physicians is equally important. For many PAC entities, all of these integration efforts will demand greater expertise than is typically present in PAC management and leadership teams. Thus, PAC boards and management teams should be attuned to leveraging the expertise of acute hospital leadership teams to foster improved strategic and operational relationships with the hospital and enhance PAC performance in general.

4. Increasing scale is becoming particularly important for PAC organizations as acute organizations want to concentrate their relationships in as few PAC options as possible. As such, organizational growth must remain a strategic priority for PACs, but their boards should carefully determine how this will be effectively managed. Several states limit PAC expansion via regulatory frameworks (like certificate of need programs), and many PAC entities have limited capital to pursue aggressive expansion efforts. For this reason, achieving scale will likely depend on partnering and collaborating with other post-acute entities (either horizontally or vertically) via networks, collaboratives, or out-right mergers. This can invite a host of challenges for PAC boards—concern about loss of identity, impact to quality, and changes in governance. In preparation, PAC boards and management teams must establish criteria and processes for identifying and evaluating potential strategic partners supporting an expansion of scale.

The FFV landscape and clinical integration across the healthcare continuum will demand a broader knowledge. Therefore, the boards of both acute-care and PAC organizations have much to learn. Ongoing education about changes in healthcare delivery and payment should be a regular component of board meetings for both types of organizations. This process should draw upon lessons learned from within and outside the boundaries of the industry. At the same time, the historical composition of PAC boards should be enhanced to ensure the skills necessary to guide the organization through the changes discussed above. Members who bring key skills from finance and legal circles, as well as other healthcare perspectives, will be essential to understand and interpret new opportunities and expectations. Finally, it will be important to address some degree of interaction and daresay integration among acute and PAC leadership teams and boards. Establishing a framework for ongoing dialog at leadership and governance levels will be critical in understanding and supporting the evolution of truly integrated continuums of care.

As more acute and PAC organizations work together and expand governance outside the walls of their own institutions, the structure and practices of these boards are likely to grow more similar. PAC boards will need a benchmark upon which to gauge their own performance. The data presented in this report represents a first step in exploring PAC boards and governance issues. An evolving dataset that encompasses the wide diversity of PAC entities and structures will be essential for both acute and post-acute boards as they partner and align across the continuum to improve care and coordination.

Use of Board Portal or Similar Online Tool

Summary of Findings

- 75% 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 67% in 2013). Specifically, 65% of respondents in 2015 already use a board portal vs. 53% in 2013.
- 98% of health systems are using or in the process of implementing a board portal; and 79% of subsidiary hospitals are in this category (the two types of organizations most likely to use a board portal).
- 36% said the most important benefit of using a board portal is the reduction of paper waste and duplication costs (same as 2013). Thirty percent (30%) said it enhances board members' level of preparation for meetings.
- 70% of respondents provide board members with laptops or iPads to access online board materials, compared with 59% in 2013 and 30% in 2011.

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

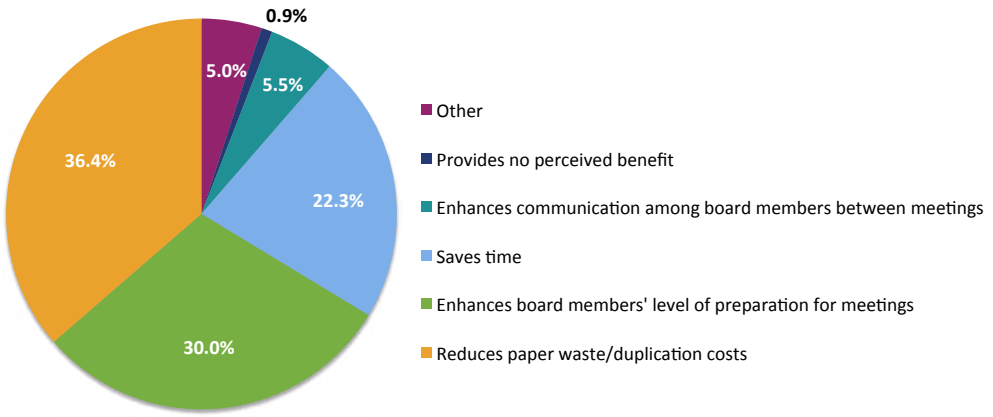
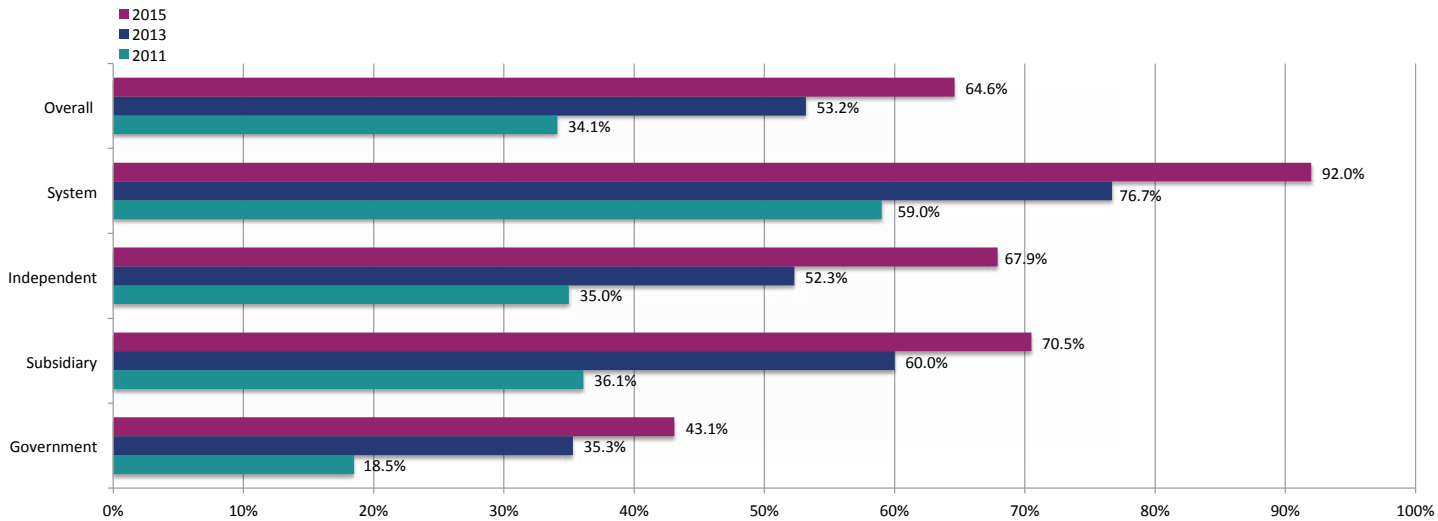


Exhibit 24. Use of Board Portal or Similar Online Tool Since 2011



Accountable Care Organizations

Summary of Findings

- 47% of respondents are participating in an ACO or similarly structured clinically integrated network.
- Health systems and subsidiary hospitals are more likely than others to be participating in an ACO (76% and 68% respectively).
- Most respondent ACOs are health-system owned (40% overall; 55% for health systems and 59% for subsidiary hospitals).
- For government-sponsored hospitals participating in an ACO (27% of respondents), the ownership structure is most likely to be either a joint venture between two or more entities (22%) or an ownership between two or more entities (30%).

This year, we wanted to get a picture of how many respondents were participating in some way in an "accountable care" organization (ACO). We did not require respondents to specify whether they were participating specifically in the CMS Medicare Shared Savings Program ACO, but any type of arrangement with public or private payers that would be considered an ACO model.

Almost half (47%) of the respondents are participating in an ACO model of some type. The majority of ACOs are health system owned (40%); the second largest percentage overall is a joint venture between two or more entities (20%). A few are hospital-owned or an independent entity (10% and 8% respectively); only 2.6% are owned by an insurance company and 3.4% are owned by a physician group. (See **Exhibit 25**.) The size of the covered patient population is generally large (more than 50,000 people) for all types of organizations; however, a sizeable percentage of respondents cover 20,000 or fewer in their ACO. (See **Exhibit 26**.)

Exhibit 25. ACO Ownership Structure *(N=117)*

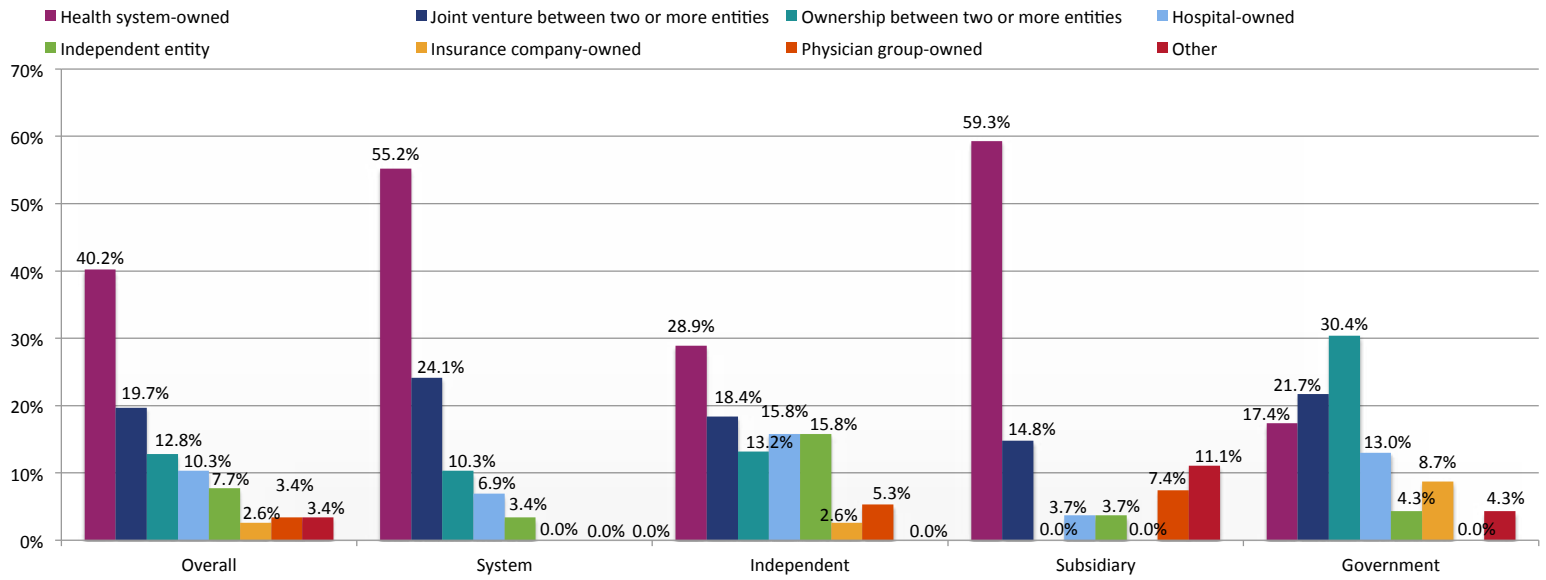
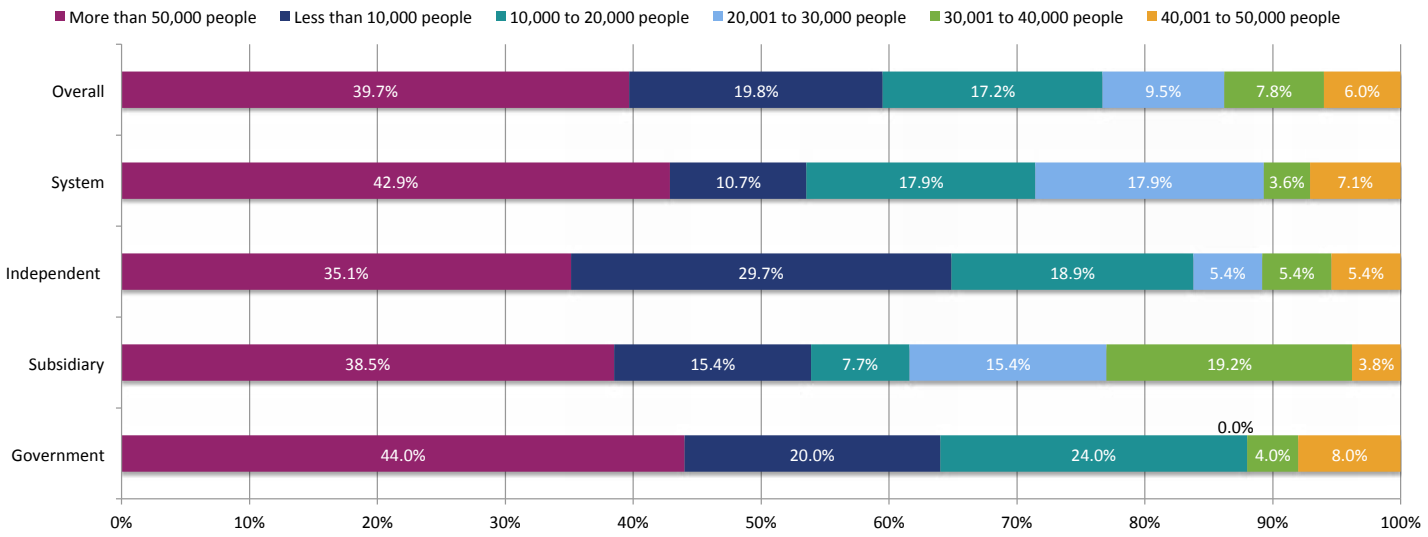


Exhibit 26. Size of Covered Patient Population under the ACO *(N=116)*



Board Culture

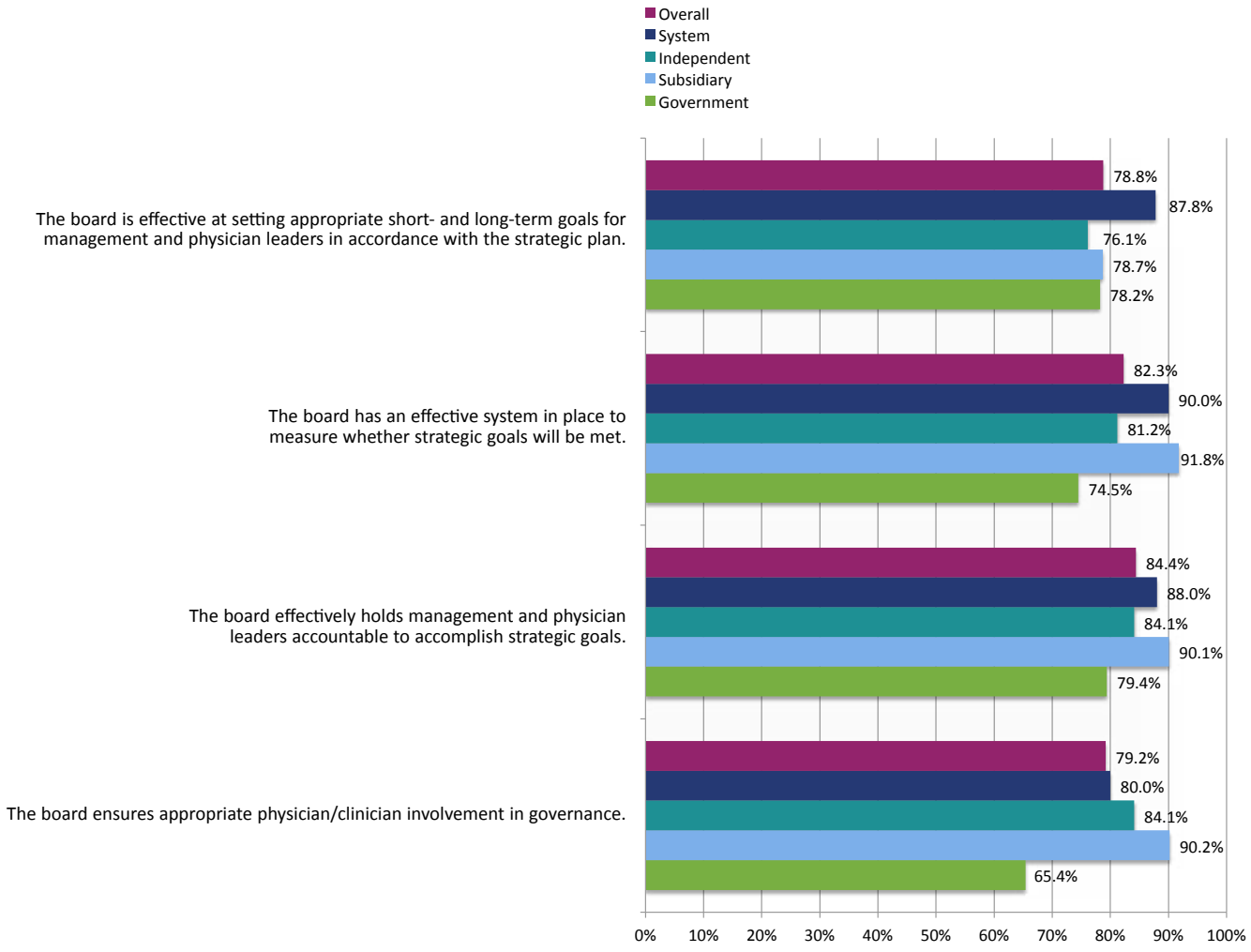
This is the second reporting year in which we asked questions related to how well the board communicates (both among its own board members and with others), its relationship with the CEO, effectiveness in measuring goals and holding those responsible accountable for reaching goals, and other aspects of board culture—essentially attempting to determine how well the board is functioning in areas or aspects that help contribute to overall board performance of the fiduciary duties and core responsibilities (presented in the second half of this report). We asked respondents to state how strongly they agreed with a list of 13 board culture-related statements.

There was relatively strong agreement again this year with most of the statements related to board culture; this year there was more consistency in agreement across organization types, although systems again had the highest level of agreement for most of the board culture statements. Due to the potential for respondents to assess their board's culture on the survey as more effective than in actuality, we highlight here only the areas that had the lowest level of agreement. **Exhibit 27** shows the level of agreement by organization type for the lowest scoring areas of board culture. (See **Appendix 1** for all of the aspects of board culture we surveyed.)

Due to the high level of agreement (considering both "strongly agree" and "agree"), we calculated an overall average "letter grade" for each type of organization, combining all board culture statements ("strongly agree" and "agree") into one score (showing there is room for improvement):

- Overall: 88% or a B+
- Health systems: 91% or an A-
- Independent hospitals: 89% or a B+
- Subsidiary hospitals: 93% or an A
- Government hospitals: 84% or a B

Exhibit 27. Board Culture: Percentage of Respondents Who "Strongly Agree" or "Agree" *(lowest scoring areas)*



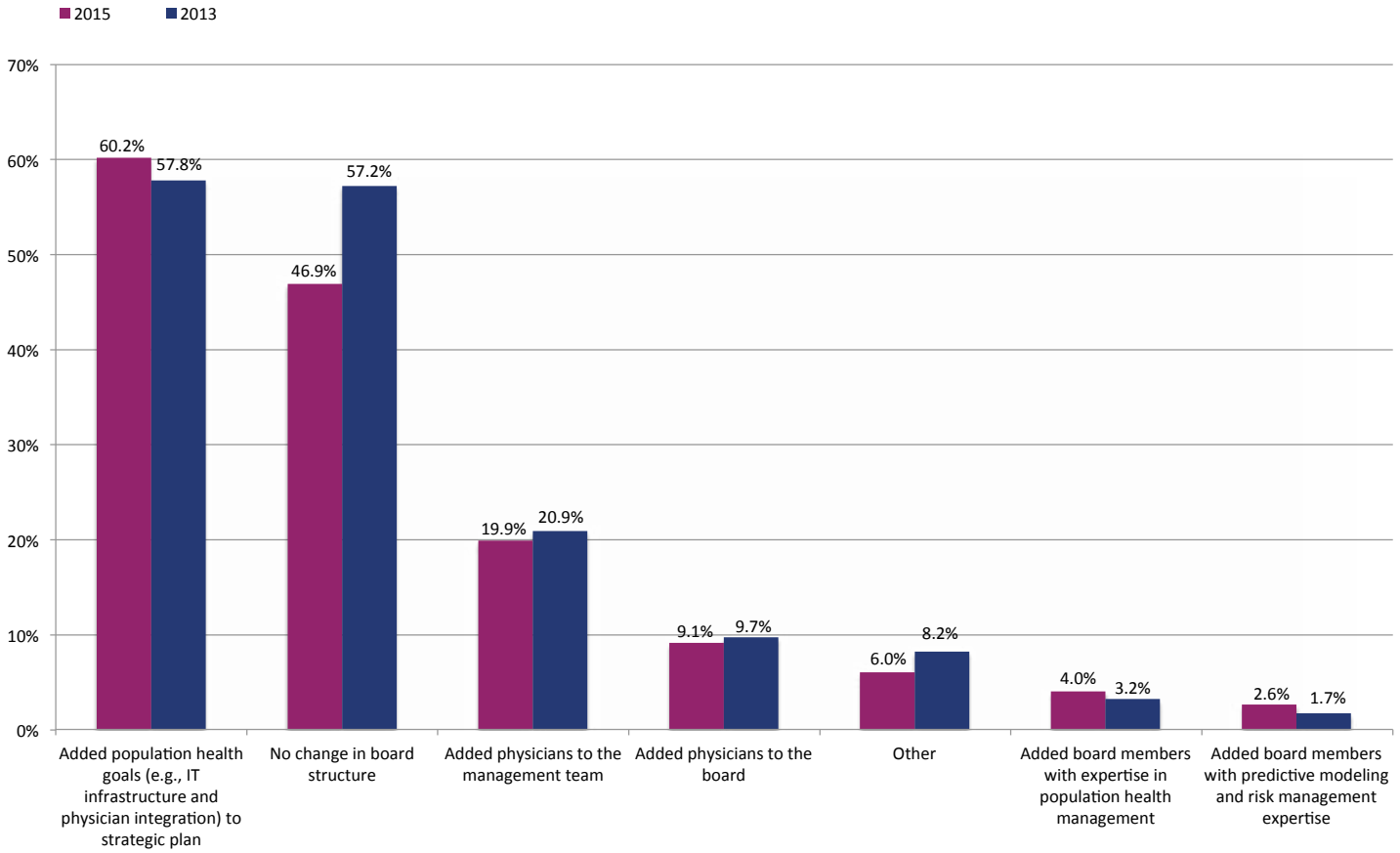
Governance Trends

2013 was the first year we reported on movement at the governance level with respect to major health reform initiatives. We asked boards what types of structural changes to the board and board-related activities they are doing to prepare for population health management and value-based payments. 2015 represents a comparison and potential indicator of any directional trends. As such, we asked respondents to indicate any governance-level changes *since 2013*.

Population Health Management

- 60% of respondents have added population health goals (e.g., IT infrastructure and physician integration) to the strategic plan *since 2013*. (58% reported adding such goals to the strategic plan in 2013.)
- 47% of respondents have not made any changes to the board or management team *since 2013* in regards to population health management. (57% indicated they had not made any changes in 2013.)
- 20% of respondents have added physicians to the management team *since 2013* to manage population health. However, only 4% have added board members with expertise in population health, and only 9% have added physicians to the board to help in this regard.
- Health systems again have shown the most movement in this regard: 76% have added population health goals to the strategic plan and 34% have added physicians to the management team to help manage population health. In contrast, government-sponsored hospitals are the least likely to have made any changes in this regard.

Exhibit 28. Changes in Board Structure Since 2013 in Regards to Population Health *(All Respondents)*



Value-Based Payments

- 54% of respondents have not made any changes to the board or management team *since 2013* to succeed with value-based payments.
- 57% of respondents have added value-based payment goals to strategic and financial plans *since 2013*. (52% of respondents added such goals to their plans in 2013.)
- 16% of respondents have added physicians to the management team to succeed with value-based payments (about the same as 2013).
- Health systems again show the most movement in this regard: 78% have added value-based payment goals to strategic and financial plans (up from 70% in 2013), and 32% have added physicians to the management team to help succeed with value-based payments. Again, government-sponsored hospitals are the least likely to have made any changes in this regard.

Exhibit 28a. Changes in Board Structure Since 2013 in Regards to Population Health Management by Organization Type

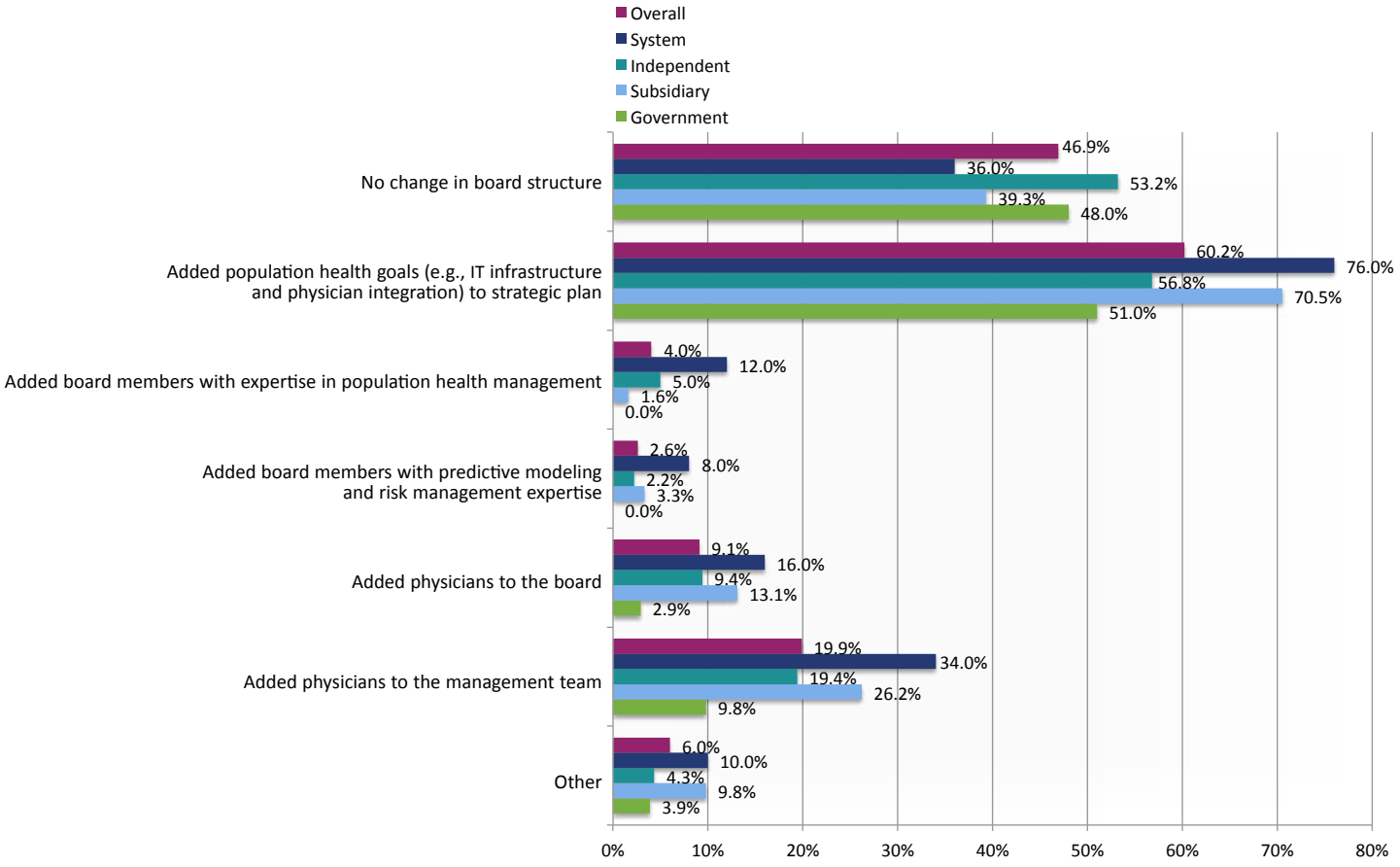


Exhibit 29. Changes in Board Structure Since 2013 to Succeed with Value-Based Payments *(All Respondents)*
(Respondents selected more than one answer.)

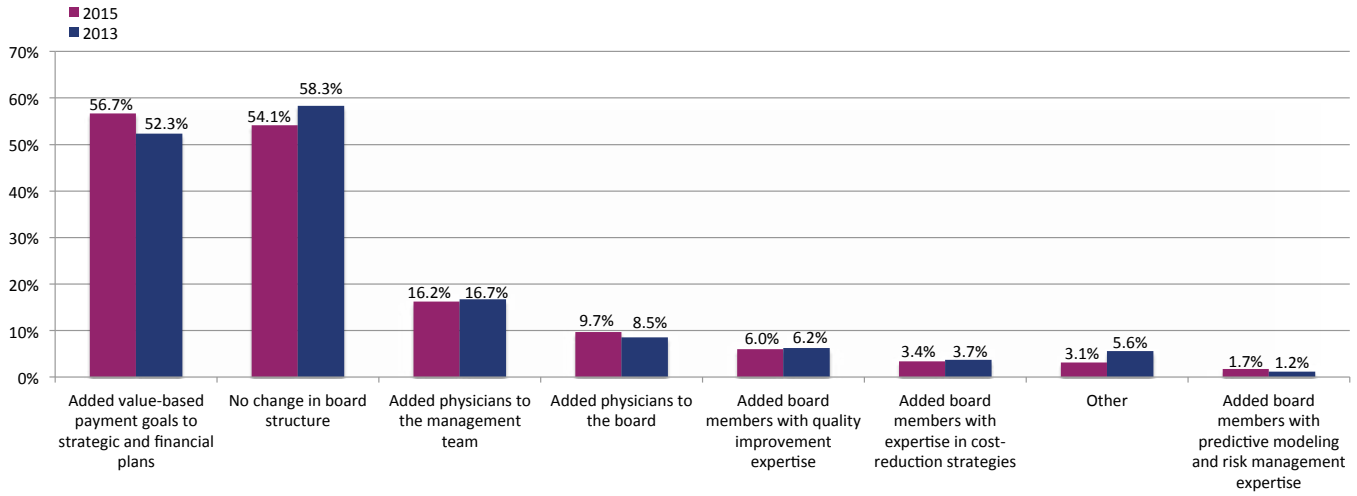
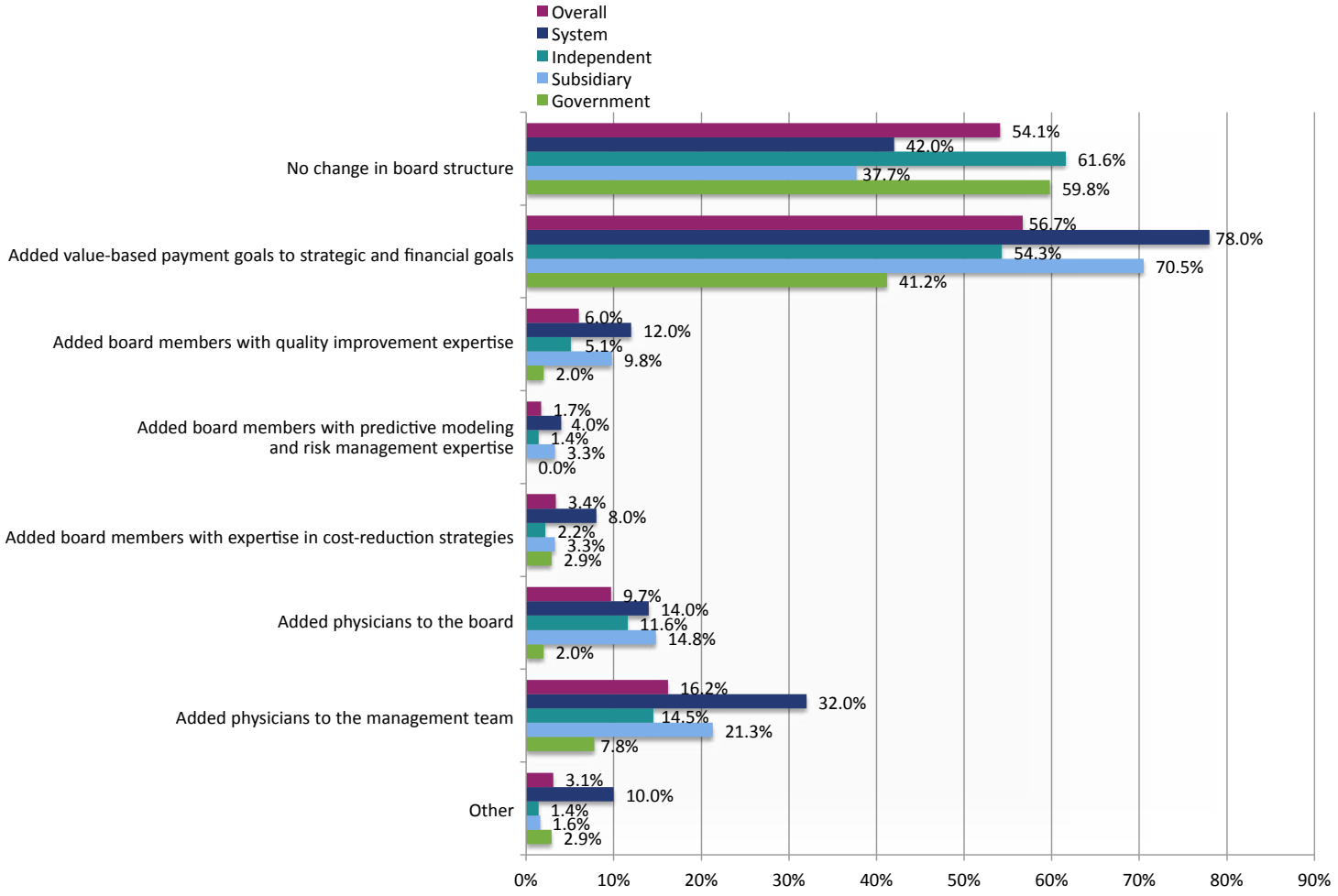


Exhibit 29a. Changes in Board Structure Since 2013 to Succeed with Value-Based Payments by Organization Type



ACOS AND VALUE-BASED CARE DELIVERY

Brian J. Silverstein, M.D., *Managing Partner, HC Wisdom*

{ SPECIAL COMMENTARY }

IT IS NOTHING SHORT OF AMAZING HOW much attention is being focused on value-based care delivery while the fact base on this concept is just in its infancy. It is clear that fee-for-service has been a positive model for the provider community, but the environment has changed, with the costs of healthcare finally reaching the boiling point that we have been predicting for years.

However, the actions we are taking now are not proven strategies and ancient literature is confusing to interpret due to significant variation in local markets and implementation. That being said, the survey data this year is consistent with national trends of creating accountable care organizations (ACOs).

ACOs are organizations that agree to be accountable for the quality, cost, and overall care of a group of patients. While there are some commonalties among ACOs, there is material variation in the implementation and operations of each organization. ACOs commonly adopt philosophies and implement programs that are based upon population health management.

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. Population health created a focus on the determinants of health including social, environmental, cultural, and physical. The intent of population health management is to migrate the focus of care on reacting to an individual's acute problem to looking at the root cause and creating interventions that are deployed with segments of the population to result in an overall improvement.

ACOs can be described by a number of factors, but the two most common are the types of contracts held by the ACO and the types of equity owners of the ACO.

Most ACOs start out with one payer contract and then, over time, expand to have multiple contracts. The most common contract is a CMS Medicare Shared Savings Program (MSSP). (CMS offers multiple types of contracts.) Most commercial insurance companies have ACO programs, although each one is specific to the insurance company, which allows them to differentiate in the market but creates significant operational challenges for providers. Some ACOs elect to manage the health system's employees and dependents as a learning lab. There are also a number of ACOs with Medicaid contracts.

Many ACOs are started and held by health systems as they have the capital and tolerance to invest in an organization that may not produce financial returns for years. Other ACOs have mixed equity models, while some ACOs are exclusively provider owned. Perhaps more important than the equity ownership is the role of providers in the governance and management of the ACO. It is common to have the health system be the equity owner and then have a majority, if not all, of the board be made up of providers.

Most ACOs start out with a shared savings contract in which the patients are still in a fee-for-service model but with an overlay looking at total cost of care, and the opportunity to share any savings with the ACO. The risk involved in this type of arrangement is limited to the cost of operations. Some ACOs have contracts in which they assume risk for the total cost of care. This is not yet common but likely to increase over time.

There is a lot of focus on the size of the populations ACOs are managing. Size creates actuarial stability for performance measurement by reducing the probability that an outcome is due to chance. The size guidelines are usually based upon insurance type and risk in the contract. For example, the base utilization in Medicare is higher than commercial populations resulting in larger minimum populations for commercial contracts. The MSSP program only requires a minimum of 5,000 attributed lives, and that size could vary in a contract involving either partial or full risk.

Physician engagement and leadership is likely the most important success factor affecting an ACO's ability to implement

population health. In addition to this, there are a number of other factors required to ensure organizational success including:

- Contracting expertise including alignment of incentives across contracts
- A functional IT system including analytics and workflow
- Effective patient segmentation and interventions
- A system of care designed around the patient
- Engaging and activating patients/healthy non-patients
- A performance network
- Strategic selection of partners including community organizations
- Incentives aligned with transparent clinical and financial performance metrics

It is possible that many markets are not going to have material business opportunities with value-based care delivery due to a lower total cost of care starting point or a shortage of providers. In markets where there is an opportunity, health systems are challenged to operate an organization designed to achieve reductions in cost of care that is at times in conflict with the core fee-for-service model. In addition, the operations on the provider level become challenging when there are a range of payer contracts and only some are built upon value-based care delivery.

Furthermore, not all ACOs aspire to create shared savings as a primary goal. Others may chose to focus on quality, provider relationships, care coordination, and infrastructure development.

With these factors in mind, the data from this year's survey makes it clear that we are moving very rapidly to create ACOs. Over time, accountable care will continue to evolve and we will find the best path forward, individually and collectively, to improve population health and provide value to patients.

System Governance Structure and Allocation of Responsibility

We asked system boards about 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 (52%, up from 44% in 2013) have a system board as well as separate local/subsidiary boards with fiduciary responsibilities.
- Twenty-eight percent (28%) of system respondents have one board at the system level that performs fiduciary and oversight responsibilities for all hospitals in the system (a decline from 35% in 2013).
- Seventeen percent (17%) have one system board and separate local/subsidiary advisory boards without fiduciary responsibilities (about the same as 2013).

Association of Responsibility/ Authority Understood and Accepted

Overall, 86% of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders (a slight decrease from 2013). (This includes all respondents, regardless of whether they indicated previously that they have a document or policy specifying responsibility and authority.) (See Exhibit 32.)

Exhibit 30. System Governance Structure by Organization Size *(# of Beds)*

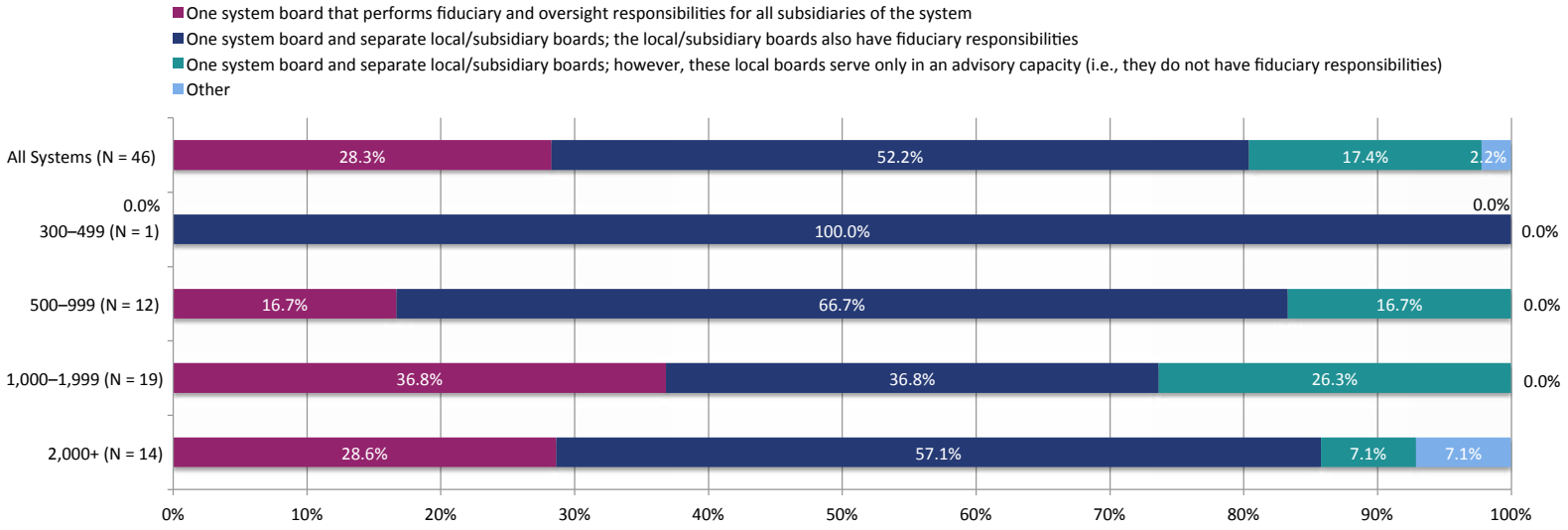


Exhibit 31. System Board Approves a Document/Policy Specifying Allocation of Responsibility and Authority between System and Local Boards *(by Organization Size)*

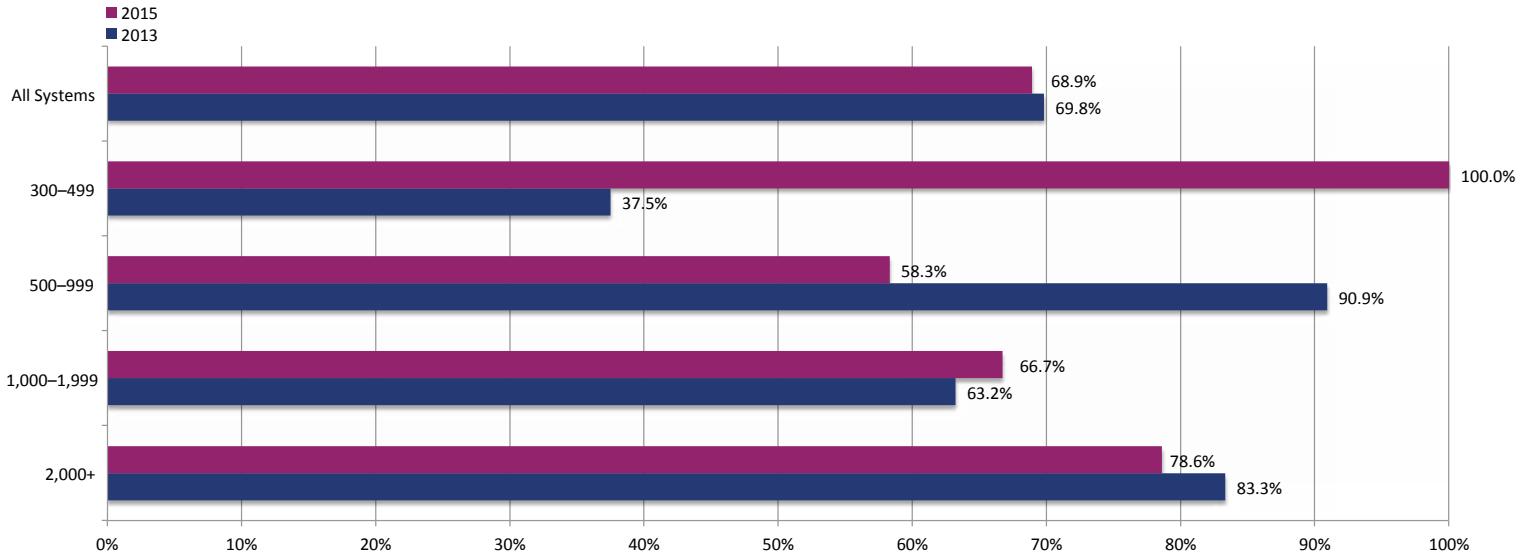
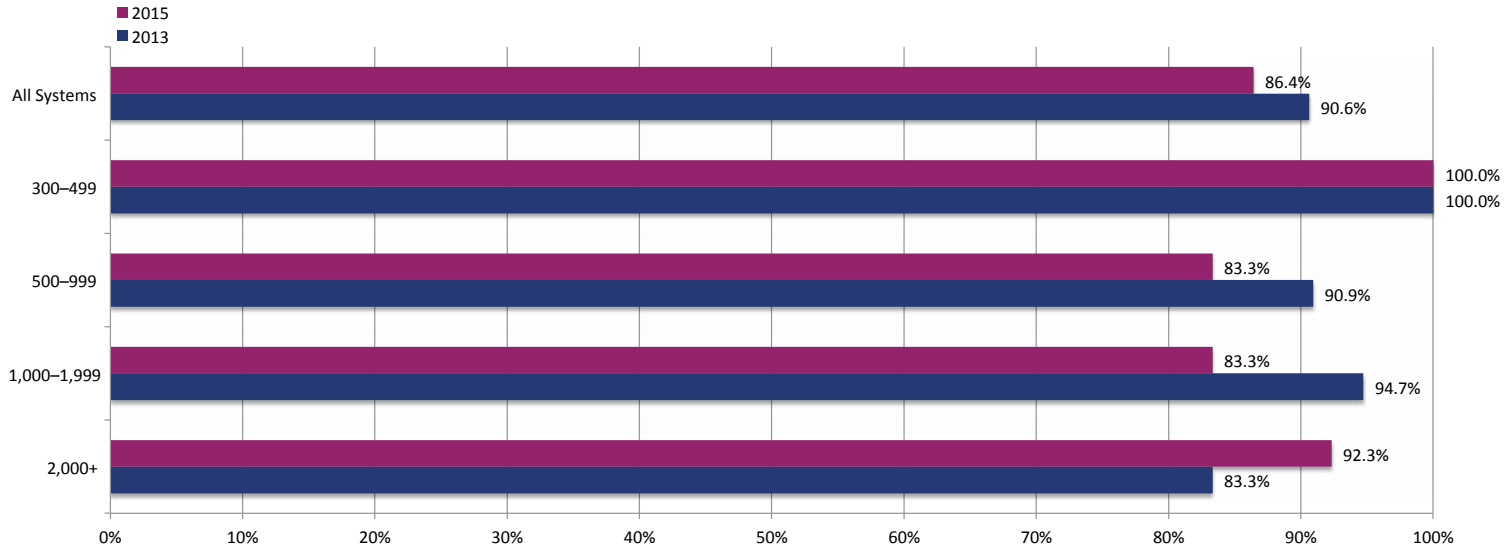


Exhibit 32. Assignment of Responsibility and Authority Widely Understood and Accepted by Both Local and System-Level Leaders *(by Organization Size)*



Subsidiary Hospitals: Allocation of Decision-Making Authority

Each year we ask subsidiary hospitals to tell us whether they retain full responsibility, share responsibility, or whether their higher authority (usually the system board) retains responsibility for various board responsibilities. In 2013 most of the movement was seen towards shared responsibility (fewer subsidiaries have full responsibility at the local level, and more system boards share this responsibility), indicating a slight movement away from the traditional "holding company" system model. This year system boards are more likely than in 2013 to retain authority on certain issues that could be considered "system-level," such as quality, executive compensation, and compliance, and subsidiary boards continue (as in 2013) to retain authority on approving medical staff appointments and establishing board education and orientation programs, which are usually considered to be "local" issues. Notably, the larger subsidiaries (500+ beds) are more likely than smaller subsidiaries to retain responsibility for setting community benefit goals and evaluating their chief executive (rather than sharing responsibility).

This data could represent a trend in which systems are taking more initiative to standardize certain issues across their subsidiaries that most affect the system as a whole, while allowing local boards to retain responsibility in areas that require more intimate knowledge of the immediate community. See **Exhibit 33** for a comparison focusing on the issues where there has been most movement towards system responsibility since 2013. **Table 15** shows a comparison of 2015 and 2013 results (please note that the sample size of subsidiaries responding to this portion of the survey in 2015 is relatively small).

Exhibit 33. Board Issues Showing Increase in System-Level Responsibility

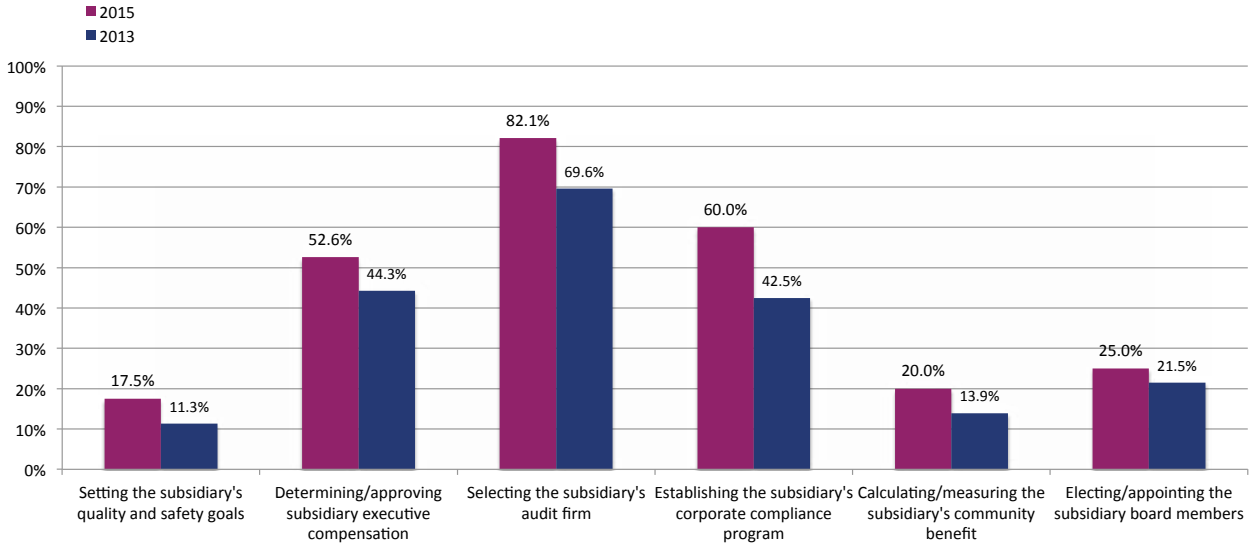


Table 15. Allocation of Decision-Making Authority 2015 vs. 2013

	By Organization Size (# of beds)									
	All Subsidiary Hospitals		<100		100–299		300–499		500+	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Total number of respondents in each category	40	182	14	56	14	65	6	35	6	25
To whom is your board accountable?										
Total responding to this question (some selected more than one answer)	*39*	*109*	*13*	*31*	*14*	*40*	*6*	*21*	*6*	*17*
Board of a parent/health system	97.4%	77.1%	100%	83.9%	92.9%	70.0%	100%	85.7%	100%	70.6%
Board or council of a religious order or organization	7.7%	9.2%	0.0%	12.9%	14.3%	5.0%	0.0%	14.3%	16.7%	5.9%
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	*40*	*80*	*14*	*27*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	17.5%	26.3%	21.4%	22.2%	14.3%	19.4%	33.3%	45.5%	0.0%	36.4%
Our board shares responsibility	70.0%	62.5%	64.3%	74.1%	85.7%	61.3%	50.0%	45.5%	66.7%	54.5%
Higher authority retains responsibility	12.5%	11.3%	14.3%	3.7%	0.0%	19.4%	16.7%	9.1%	33.3%	9.1%
Determining our organization's capital and operating budgets										
Total responding to this question	*40*	*80*	*14*	*27*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	5.0%	13.8%	14.3%	22.2%	0.0%	3.2%	0.0%	9.1%	0.0%	27.3%
Our board shares responsibility	72.5%	56.3%	71.4%	51.9%	64.3%	64.5%	100%	45.5%	66.7%	54.5%
Higher authority retains responsibility	22.5%	30.0%	14.3%	25.9%	35.7%	32.3%	0.0%	45.5%	33.3%	18.2%
Setting our organization's quality and safety goals										
Total responding to this question	*40*	*80*	*14*	*27*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	27.5%	37.5%	21.4%	55.6%	28.6%	22.6%	33.3%	27.3%	33.3%	45.5%
Our board shares responsibility	55.0%	51.3%	64.3%	33.3%	50.0%	64.5%	50.0%	63.6%	50.0%	45.5%
Higher authority retains responsibility	17.5%	11.3%	14.3%	11.1%	21.4%	12.9%	16.7%	9.1%	16.7%	9.1%
Setting our organization's customer service goals										
Total responding to this question	*40*	*80*	*14*	*27*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	35.0%	38.8%	28.6%	51.9%	35.7%	29.0%	50.0%	27.3%	33.3%	45.5%
Our board shares responsibility	50.0%	47.5%	57.1%	37.0%	50.0%	54.8%	33.3%	54.5%	50.0%	45.5%
Higher authority retains responsibility	15.0%	13.8%	14.3%	11.1%	14.3%	16.1%	16.7%	18.2%	16.7%	9.1%
Approving our organization's medical staff appointments										
Total responding to this question	*40*	*80*	*14*	*27*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	87.5%	93.8%	71.4%	88.9%	92.9%	96.8%	100%	90.9%	100%	100%
Our board shares responsibility	12.5%	5.0%	28.6%	7.4%	7.1%	3.2%	0.0%	9.1%	0.0%	0.0%
Higher authority retains responsibility	0.0%	1.3%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Appointing/removing our organization's chief executive										
Total responding to this question	*39*	*80*	*14*	*27*	*13*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	5.1%	11.3%	7.1%	14.8%	0.0%	9.7%	0.0%	0.0%	16.7%	18.2%
Our board shares responsibility	74.4%	56.3%	78.6%	44.4%	84.6%	61.3%	66.7%	63.6%	50.0%	63.6%
Higher authority retains responsibility	20.5%	32.5%	14.3%	40.7%	15.4%	29.0%	33.3%	36.4%	33.3%	18.2%
Evaluating our organization's chief executive										
Total responding to this question	*40*	*79*	*14*	*27*	*14*	*31*	*6*	*10*	*6*	*11*
Our board retains responsibility	32.5%	22.8%	35.7%	22.2%	28.6%	22.6%	0.0%	20.0%	66.7%	27.3%
Our board shares responsibility	57.5%	69.6%	50.0%	74.1%	57.1%	64.5%	100%	80.0%	33.3%	63.6%
Higher authority retains responsibility	10.0%	7.6%	14.3%	3.7%	14.3%	12.9%	0.0%	0.0%	0.0%	9.1%

	By Organization Size (# of beds)									
	All Subsidiary Hospitals		<100		100–299		300–499		500+	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Total number of respondents in each category	40	182	14	56	14	65	6	35	6	25
Determining/approving executive compensation										
Total responding to this question	*38*	*79*	*13*	*27*	*14*	*31*	*6*	*10*	*5*	*11*
Our board retains responsibility	13.2%	19.0%	7.7%	18.5%	7.1%	22.6%	16.7%	20.0%	40.0%	9.1%
Our board shares responsibility	34.2%	36.7%	46.2%	29.6%	35.7%	35.5%	33.3%	40.0%	0.0%	54.5%
Higher authority retains responsibility	52.6%	44.3%	46.2%	51.9%	57.1%	41.9%	50.0%	40.0%	60.0%	36.4%
Electing/appointing our organization's board members										
Total responding to this question	*40*	*79*	*14*	*26*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	15.0%	21.5%	14.3%	34.6%	14.3%	9.7%	33.3%	18.2%	0.0%	27.3%
Our board shares responsibility	60.0%	57.0%	71.4%	50.0%	57.1%	74.2%	66.7%	54.5%	33.3%	27.3%
Higher authority retains responsibility	25.0%	21.5%	14.3%	15.4%	28.6%	16.1%	0.0%	27.3%	66.7%	45.5%
Selecting our organization's audit firm										
Total responding to this question	*39*	*79*	*14*	*26*	*13*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	10.3%	12.7%	14.3%	11.5%	7.7%	9.7%	16.7%	9.1%	0.0%	27.3%
Our board shares responsibility	7.7%	17.7%	7.1%	19.2%	7.7%	16.1%	33.3%	18.2%	16.7%	18.2%
Higher authority retains responsibility	82.1%	69.6%	78.6%	69.2%	84.6%	74.2%	16.7%	72.7%	83.3%	54.5%
Establishing our organization's corporate compliance program										
Total responding to this question	*40*	*80*	*14*	*27*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	12.5%	17.5%	14.3%	22.2%	7.1%	19.4%	16.7%	9.1%	16.7%	9.1%
Our board shares responsibility	27.5%	40.0%	42.9%	33.3%	21.4%	35.5%	33.3%	72.7%	0.0%	36.4%
Higher authority retains responsibility	60.0%	42.5%	42.9%	44.4%	71.4%	45.2%	50.0%	18.2%	83.3%	54.5%
Calculating/measuring our organization's community benefit										
Total responding to this question	*40*	*79*	*14*	*26*	*14*	*31*	*6*	*11*	*6*	*11*
Our board retains responsibility	35.0%	44.3%	28.6%	34.6%	35.7%	38.7%	50.0%	54.5%	33.3%	72.7%
Our board shares responsibility	45.0%	41.8%	42.9%	50.0%	50.0%	41.9%	33.3%	45.5%	50.0%	18.2%
Higher authority retains responsibility	20.0%	13.9%	28.6%	15.4%	14.3%	19.4%	16.7%	0.0%	16.7%	9.1%
Setting community benefit goals										
Total responding to this question	*40*	*78*	*14*	*26*	*14*	*31*	*6*	*10*	*6*	*11*
Our board retains responsibility	42.5%	42.3%	28.6%	38.5%	42.9%	51.6%	50.0%	20.0%	66.7%	45.5%
Our board shares responsibility	45.0%	48.7%	57.1%	61.5%	42.9%	32.3%	33.3%	80.0%	33.3%	36.4%
Higher authority retains responsibility	12.5%	9.0%	14.3%	0.0%	14.3%	16.1%	16.7%	0.0%	0.0%	18.2%
Establishing our board education and orientation programs										
Total responding to this question	*39*	*79*	*14*	*27*	*14*	*31*	*6*	*10*	*5*	*11*
Our board retains responsibility	61.5%	67.1%	42.9%	70.4%	78.6%	71.0%	66.7%	50.0%	60.0%	63.6%
Our board shares responsibility	33.3%	31.6%	50.0%	29.6%	21.4%	25.8%	33.3%	50.0%	20.0%	36.4%
Higher authority retains responsibility	5.1%	1.3%	7.1%	0.0%	0.0%	3.2%	0.0%	0.0%	20.0%	0.0%

THE BOARD MEMBER AS CONSUMER: EXPANDING OVERSIGHT OF STRATEGY, QUALITY, AND PATIENT EXPERIENCE TO INCLUDE CONSUMER EXPECTATIONS

Ryan Donohue, *Corporate Director of Program Development, National Research Corporation*

{ SPECIAL COMMENTARY }

Consumerism is an issue coursing through the healthcare industry at an increasingly frequent rate. As healthcare payment models shift from volume—a black and white measurement—to value, a metric informed in part by those receiving care, it's clear consumer perception has become part of the healthcare equation. How hospitals and health systems face the task of understanding and capitalizing on such a vast, diverse audience of people is a key question to ponder. What we know for sure: hospitals and health systems have traditionally not focused much effort on understanding the consumer point of view. Reform-based changes are ensuring that this mindset stays in the past.

Meanwhile, at the top of the hospital and health system chain of command, board members present an intriguing conduit to the consumer. While the board must understand what consumers think about the organization as a driver of future patient trends and ultimately a predictor of future organizational success, board members themselves represent potential proxies of consumers. Board members typically come from other industries and often have the requisite tools to understand consumer engagement. The ability to walk the line between organizational steward and patient expectation proxy is immensely valuable at a time when healthcare's value is shifting.

When it comes to representing consumers, more than anything consumers want to feel their concerns are heard at the highest levels of healthcare. This is actually true of every industry. An unheard consumer is an unhappy consumer. The survey data shows virtually all boards are now reviewing patient satisfaction data on an annual basis. This is a great start with the great audience, but more must be done to ensure the consumer voice is resonant throughout the organization. First, patients represent only a sliver of the consumers in any given community. Though they aren't wearing a gown, many consumers are forming opinions of caregivers and creating behavior patterns, which will affect their healthcare choices in the future. Hospitals and health systems must consider the patient perspective, but a broader market view is also encouraged to fully understand the effects of consumerism. Imagine the power consumer feedback would possess if it was reported not only to the board, but down through the ranks to all caregivers, and real-time consumer feedback was valued to the same degree as quality and safety metrics?

Understanding the big picture on consumers is necessitated by the population health movement. Organizational success no longer stays within the four walls of the hospital. Understanding an entire population's success is required intelligence to survive in healthcare's future landscape. This year's data indicates that three in five organizations have added population health-based goals. The next question will be: what behaviors within the population must be tracked and managed to ensure goals are fulfilled? It's difficult, if not impossible, to move a population toward any particular goal without first understanding what makes them tick.

Hospitals and health systems are not without progress in consumer-friendly innovations. Nearly half of respondents (47%) are participating in an ACO or similar network. ACOs are perfect examples of the clinical integration necessary for care to become truly coordinated. Why is this valuable to consumers? As healthcare organizations layer new, innovative experiences over a complex delivery model, the consumer call for coordinated care has never been louder. Consumers often cite confusion as a main barrier to better understanding—and experiencing healthcare—as they expect it to be. When expectations aren't met, patients aren't as satisfied and outcomes may be disrupted. In this way, understanding consumer wants before aiming to fulfill consumer needs is a promising strategy in an industry that has much to ponder as consumerism runs deeper and deeper into its future.

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 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.
- Not applicable in our organization.

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 2015 are slightly higher than in 2013, and the ranking order remains the same with the exception of quality oversight, which went up from 5th to 4th place this year and also improved the most significantly of any other performance area (see Table 16; areas showing most improvement are in bold).

A history of performance ranking by duty and core responsibility appears in Table 17. The breakdown of responses for overall performance in each duty and core responsibility appears in Exhibit 34.

Board Performance across Types of Organizations

When comparing the "top two" ratings (percent of respondents rating their boards "excellent" or "very good") across the 2015, 2013, 2011, and 2009 reporting periods, this year's performance ratings vary more significantly compared with previous years depending on the category. The most significant improvement can be seen in financial oversight, which is back up to the 2009 level; quality oversight shows a 4 percentage-point improvement from 2009 to 2015, and community benefit/advocacy, though it is lower this year than in 2013, reflects an overall increase from 2009 of 9 percentage points. Duty of care, strategic direction, and board development ratings have also dropped since 2013. (See Exhibit 35.)

Table 18 shows the breakdown of "top two" ratings by type of organization for 2015 and 2013. Systems consistently have higher percentages of "top two" ratings than other types of organizations, most of which have remained level or increased since 2013, with the exception of strategic direction and community benefit/advocacy. What is most notable this year is the significant level of improvement in every category for government-sponsored hospitals.

Table 19 shows performance results by composite score (5 = "excellent"). In contrast to the "top two" percentage rankings, composite performance scores for

Table 16. Overall Performance—Composite Score Ranking *(5=Excellent)*

Performance Rank	Fiduciary Duties and Core Responsibilities	Weighted Average 2015	2013	2011	2009
1	Financial Oversight	**4.57**	**4.50**	4.52	4.51
2	Duty of Care	4.46	4.45	4.42	4.43
3	Duty of Loyalty	4.41	4.42	4.41	4.37
4	Quality Oversight	**4.39**	**4.29**	4.23	4.23
5	Duty of Obedience	**4.37**	**4.33**	4.23	4.24
6	Management Oversight	**4.31**	**4.26**	4.23	4.28
7	Strategic Direction	4.11	4.12	4.05	4.05
8	Community Benefit & Advocacy	3.92	3.91	3.62	3.64
9	Board Development	3.79	3.76	3.71	3.74

Note: areas showing the greatest improvement since 2013 are in bold.

Table 17. Overall Performance Year Over Year—Ranked by Composite Score

Fiduciary Duties and Core Responsibilities	Performance Rank 2015	2013	2011	2009	2007
Financial Oversight	1	1	1	1	1
Duty of Care	2	2	2	2	2
Duty of Loyalty	3	3	3	3	3
Quality Oversight	4	5	4*	6	5
Duty of Obedience	5	4	5*	5	6
Management Oversight	6	6	6*	4	4
Strategic Direction	7	7	7	7	7
Community Benefit & Advocacy	8	8	9	9	9
Board Development	9	9	8	8	8

*Performance scores for these three oversight areas were tied in 2011 (see Table 18).

Exhibit 34. Overall Board Performance

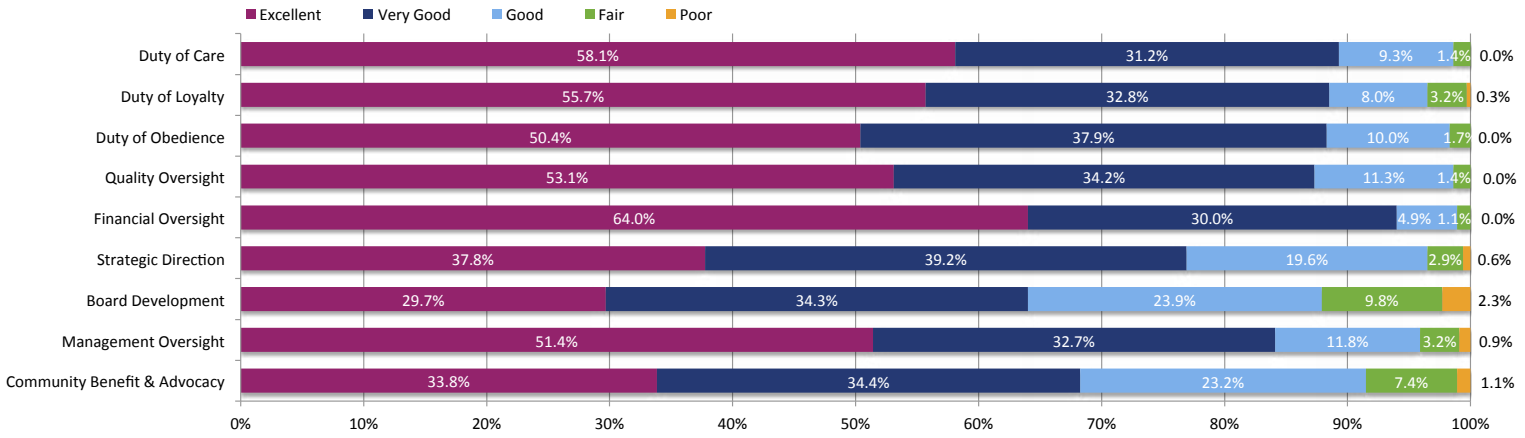
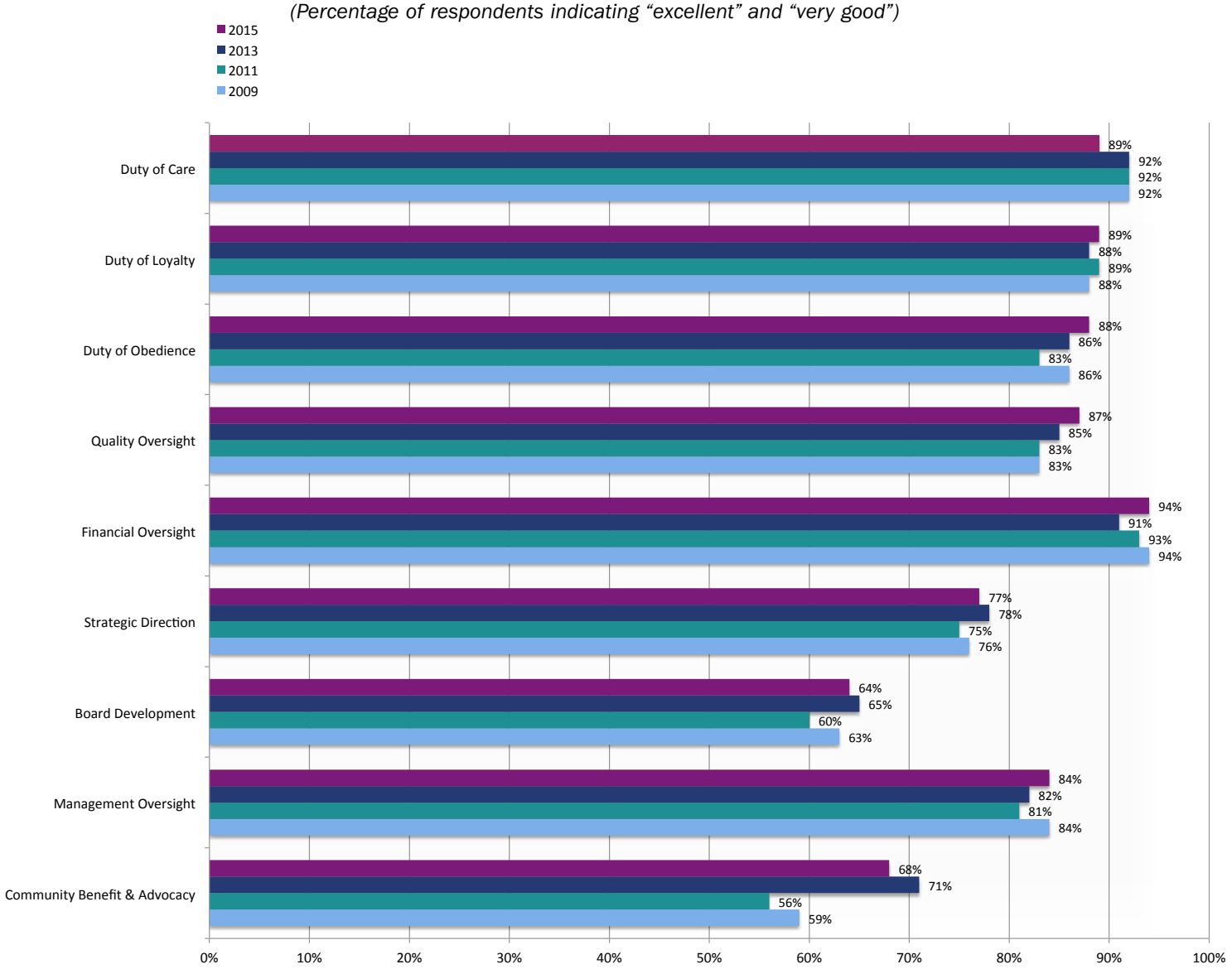


Exhibit 35. Overall Board Performance Since 2009

(Percentage of respondents indicating "excellent" and "very good")



systems have decreased in most areas this year. Strategic direction scores decreased for systems, independent hospitals, and subsidiaries. Again, government-sponsored hospitals' composite performance scores all show a significant increase from 2013.

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**.

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

Table 18. Percent of Respondents Who Rated Their Board as "Excellent" or "Very Good" 2015 vs. 2013 *(Overall and by Organization Type)*

Fiduciary Duties and Core Responsibilities*	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Financial Oversight	94%	91%	**100%**	**98%**	96%	95%	92%	93%	89%	81%
Duty of Care	89%	92%	**96%**	93%	88%	94%	89%	**96%**	88%	83%
Duty of Loyalty	89%	88%	**94%**	92%	92%	92%	92%	**94%**	79%	76%
Duty of Obedience	88%	86%	**94%**	**93%**	90%	91%	89%	88%	84%	73%
Quality Oversight	87%	85%	**94%**	**95%**	88%	88%	90%	90%	82%	71%
Management Oversight	84%	82%	**96%**	**91%**	88%	86%	83%	83%	75%	70%
Strategic Direction	77%	78%	**88%**	**95%**	79%	81%	75%	83%	70%	61%
Community Benefit & Advocacy	68%	71%	**79%**	**88%**	67%	74%	74%	79%	61%	49%
Board Development	64%	65%	**81%**	**77%**	62%	66%	69%	71%	55%	51%

*Highest ratings for each oversight area and year are in **bold**.

Table 19. Board Performance Composite Scores 2015 vs. 2013

(Scale: Excellent = 5; Very good = 4; Good = 3; Fair = 2; Poor = 1. Purple boxes = significant improvement; orange boxes = decline)

Fiduciary Duties and Core Responsibilities	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2015	2013	2015	2013	2015	2013	2015	2013	2015	2013
Financial Oversight	4.57	4.50	4.84	4.86	4.66	4.59	4.56	4.53	4.32	4.20
Duty of Care	4.46	4.45	4.65	4.66	4.47	4.49	4.56	4.55	4.28	4.17
Duty of Loyalty	4.41	4.42	4.60	4.75	4.49	4.46	4.61	4.56	4.07	4.04
Quality Oversight	4.39	4.29	4.50	4.57	4.43	4.35	4.58	4.43	4.17	3.90
Duty of Obedience	4.37	4.33	4.59	4.63	4.42	4.41	4.47	4.42	4.15	4.01
Management Oversight	4.31	4.26	4.71	4.71	4.38	4.37	4.25	4.32	4.05	3.86
Strategic Direction	4.11	4.12	4.39	4.48	4.15	4.19	4.12	4.26	3.91	3.71
Community Benefit & Advocacy	3.92	3.91	4.15	4.26	3.93	3.99	4.13	4.07	3.68	3.47
Board Development	3.79	3.76	4.15	4.14	3.82	3.79	3.89	3.90	3.53	3.36

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.

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.

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, regardless of organization type. *(It is important to note that for each practice, respondents had the opportunity to indicate if it was not applicable to their organization, and N/A responses are not included in the adoption scores. Therefore, a lower level of adoption among government-sponsored hospitals for any given practice is not due to the practice being not applicable.)*

OVERVIEW OF RESULTS

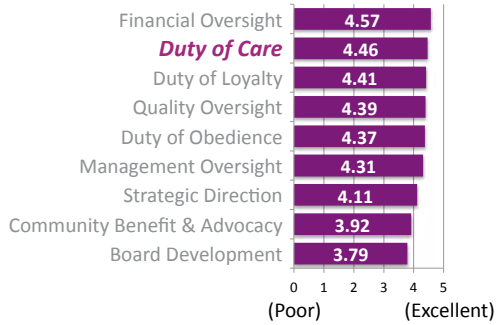
For most practices, adoption is widespread. Variations among types of organizations are small and are noted here for general information only. For detail, please see **Appendices 2** and **3**. After the overview, we present an analysis of the results in the next section.

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 (poor, fair, good, very good, and excellent). The performance ratings are for the overall performance in given area, not for the individual board practices.

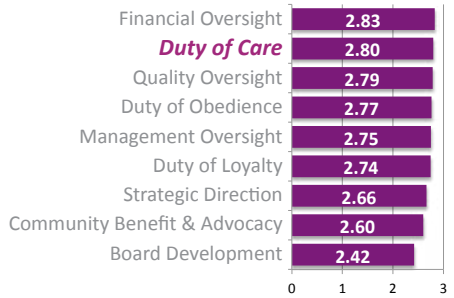
Duty of Care: Key Points

- CEOs gave boards' performance in duty of care the second highest performance score (4.46 out of 5).
- Duty of care ranks second in adoption of recommended practices (it ranked first in 2013).
- The duty of care practices appear to be widely adopted across all types of organizations; however, the prevalence of adoption for most practices is roughly the same or slightly lower than 2013.
- The most significant decline in adoption was for the following two practices:
  1. "The board has a written policy specifying minimum attendance requirements" (2.57 vs. 2.61 in 2013; subsidiary hospitals have the lowest adoption score of 2.35). This is perhaps due to an increase in board members flying in from out of the area for meetings and/or participating via teleconference (we have received enough anecdotal evidence regarding this to reasonably assume that this is an increasing trend).
  2. "The board secures expert, professional advice before making major financial and/or strategic decisions" (2.89 vs. 2.93 in 2013).

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

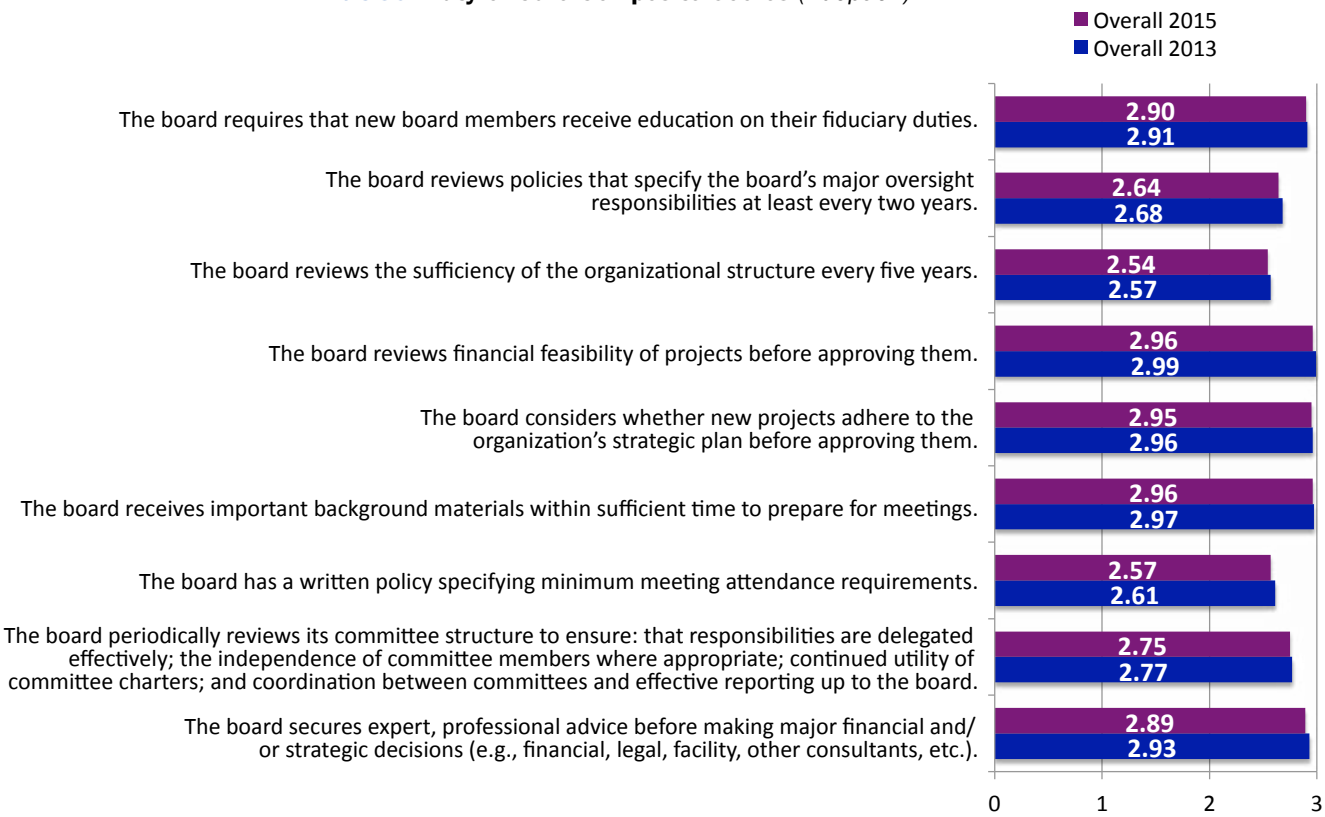


3 = currently have adopted the practice

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

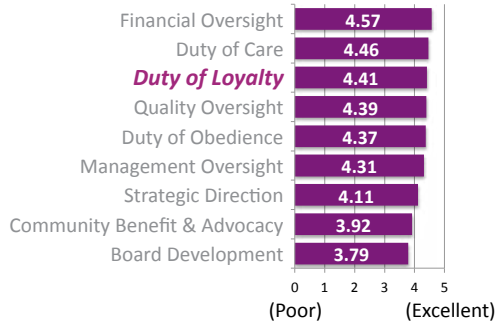
Exhibit 36. Duty of Care Composite Scores *(Adoption)*



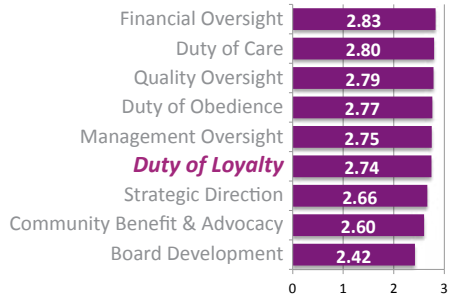
Duty of Loyalty: Key Points

- Duty of loyalty is rated third in performance (same as 2011 and 2013).
- It is rated sixth in adoption, a significant decline from 2013 and 2011 (third place).
- Adoption has remained about the same from 2013 with the following exceptions, which have decreased: 1) adoption of "disabling guidelines," 2) adoption of a specific IRS-compliant definition of an "independent director," and 3) enforcing a written policy on board member confidentiality.
- Government-sponsored hospitals have lower adoption rates for these practices compared to other types of organizations (consistent with previous reporting years); notably, adoption among government hospitals has declined for several of the practices since 2013.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

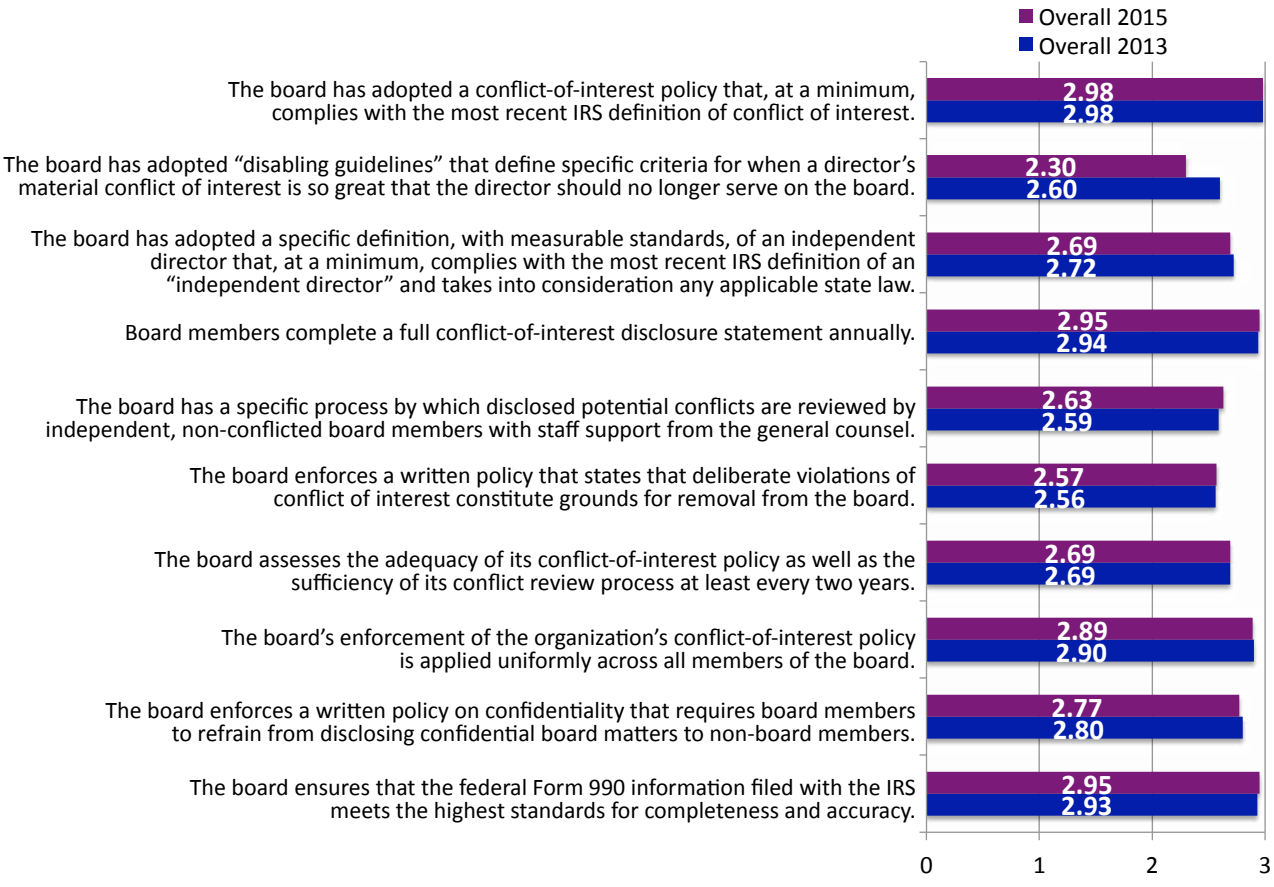


3 = currently have adopted the practice

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

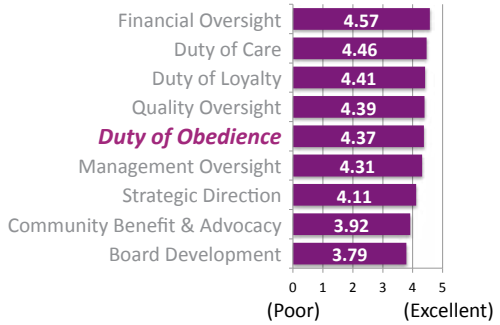
Exhibit 37. Duty of Loyalty Composite Scores *(Adoption)*



Duty of Obedience: Key Points

- CEOs gave boards' performance in duty of obedience the fifth highest performance score (4.37 out of 5; this shows a second reported increase from 4.23 in 2011 and 4.33 in 2013).
- Duty of obedience is ranked fourth in adoption of recommended practices (up from fifth place in 2013).
- Adoption rates have increased for the following practices:
  1. "The board has approved a 'code of conduct' policies/procedures document…"
  2. "The board ensures the compliance plan is properly implemented and effective."
  3. "The board has established a direct reporting relationship with the compliance officer."
  4. "The board has established a direct reporting relationship with the legal counsel."
- Systems were more likely than other types of organizations to adopt several of these practices in previous years; this year, in contrast, adoption is more consistent across organization types.
- 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, adoption rates increased significantly among this group for nine of the 12 practices.*

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

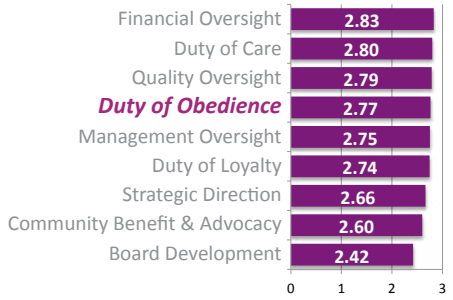


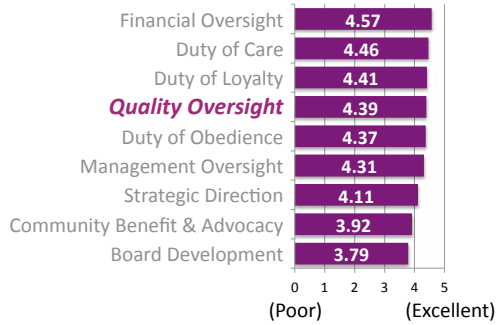
Exhibit 38. Duty of Obedience Composite Scores *(Adoption)*

Quality Oversight: Key Points

- CEOs gave boards' performance in quality oversight the fourth highest rating (4.39 out of 5, an increase from 4.29 in 2013 and a ranking of fifth place).
- Quality oversight is ranked third in adoption of practices (up from fourth place in 2013).
- Adoption rates have increased for eight out of the 13 practices (see **Exhibit 39**).
- Two practices have been highly adopted (2.94 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. (These were also the highest adopted practices across all organizations in 2013.)
- System and subsidiary hospital boards are more likely than other types of organizations to work with the medical staff and management to set the organization's quality goals.
- Subsidiary hospitals have extremely high adoption rates (2.91 or higher) for nine of the 13 practices (the most of any organization type). They are also the only group to have an adoption rate of 3.00 (the highest possible) for two of the practices: reviewing quality performance by comparing current performance with historical performance and industry benchmarks, and reviewing patient experience scores at least annually.
- Practices that have been shown to improve quality of care (process of care and/or risk-adjusted mortality)[2] 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 *(subsidiaries 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 and has continued to decrease since 2011, with the exception of government hospitals, which is the only group to increase adoption of this practice since 2013)*
  - Requiring new clinical programs/services to meet quality-related performance criteria *(subsidiaries have adopted this practice more than other types of organizations)*
  - Devoting a significant amount of time to quality issues/discussion at most board meetings *(subsidiaries have adopted this practice more than other types of organizations)*
  - Board and medical staff involvement in setting the organization's quality goals *(systems and subsidiaries have adopted this practice more than other types of organizations)*
  - Board participation in development/approval of explicit criteria to guide medical staff appointments, reappointments, and clinical privileges *(subsidiaries have adopted this practice more than other types of organizations)*

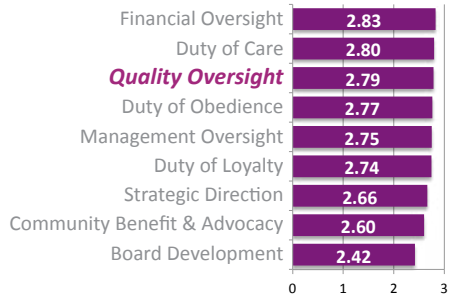
Board Performance Composite Scores

(All Respondents)



Adoption of Practice Composite Scores

(All Respondents)



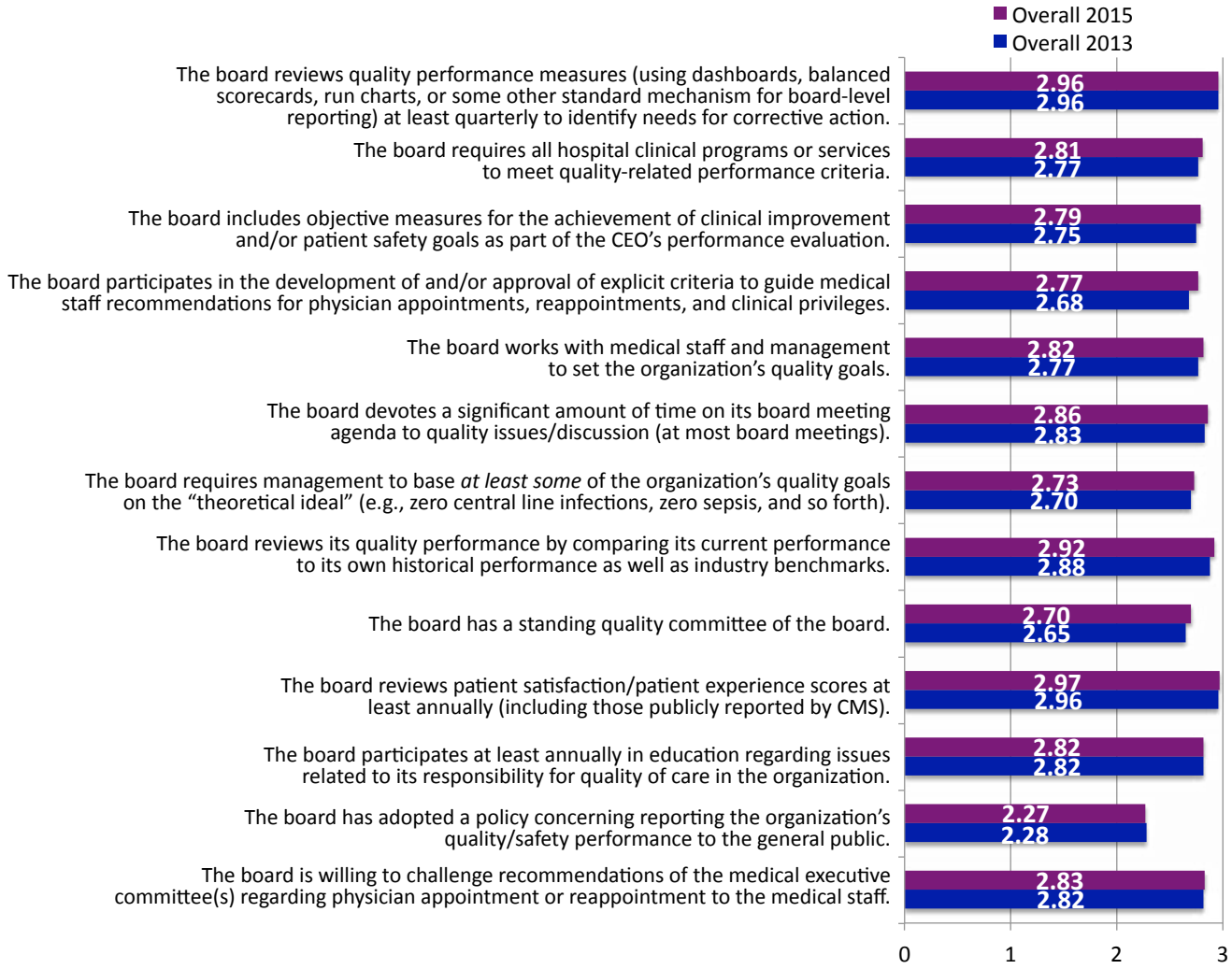
3 = currently have adopted the practice

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

2 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, and 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, and 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 39. Quality Oversight Composite Scores *(Adoption)*



GOVERNANCE FOR THE TRIPLE AIM

Dan Schummers, *Chief of Staff, Institute for Healthcare Improvement*

{ SPECIAL COMMENTARY }

More than 20 years of experience has underscored the Institute for Healthcare Improvement's (IHI's) belief that the quality and safety of care delivered by a healthcare organization are inextricably linked to the board of directors' accountability for quality and safety. This position is informed by IHI's work to bring the methods and tools of quality improvement to healthcare since the 1990s, and further validated during IHI's 100,000 Lives Campaign (2004–2006) and 5 Million Lives Campaign (2006–2008), in which more than 4,000 U.S. hospitals engaged in a national effort to improve acute-care safety and quality. During this time, the link between board engagement and healthcare organization performance was codified in two seminal Institute of Medicine reports, *To Err Is Human*[3] (2000) and *Crossing the Quality Chasm*[4] (2001). The literature during these years consistently supported and detailed the interconnections between organizational performance and effective governance[5] and it is now broadly accepted that ultimate responsibility and accountability for safe, high-quality care rests with governing boards.

The data from this year's survey demonstrates that this accountability continues to take root. Increasingly, organizations are adopting such best practices as establishing a board quality committee, providing opportunities to educate board members on quality and safety, and devoting significant meeting time (IHI's recommendation is at least 25%) to addressing issues of quality and safety. Today, boards that still narrowly construe their fiduciary responsibility as pertaining only to the organization's financial health and vitality are outliers.

The decade between *To Err Is Human* and passage of the Affordable Care Act was an era of important change for boards, and recent years have seen another foundational shift. Since 2008, IHI has advocated that the goal of health systems should be to simultaneously improve the patient experience of care, improve the health of a population, and reduce per-capita costs—what IHI calls the Triple Aim.[6] Healthcare systems around the world are adopting the Triple Aim as an overall framework for organizational excellence, and IHI has learned much in its seven years of experience.[7] This expansion of fiduciary accountability to include the health of communities once again requires boards to carefully consider their composition. During the 2000s, some argued that increased scrutiny on quality and safety meant that traditional community representation on boards was a weakness.[8] Physician leadership is essential to effective governance—both at the board and senior management levels—yet, as boards broaden their focus and responsibilities to pursue the Triple Aim, their expertise and experience needs to broaden as well. Improving the health of communities will be aided by engaging community representatives, who are often ideally positioned to focus on the social determinants

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

4 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* Committee on Quality of Health Care in America, National Academies Press, 2001.

5 J. Conway, "Getting Boards on Board: Engaging Governing Boards in Quality and Safety," *Joint Commission Journal on Quality and Patient Safety,* 2008; pp. 214–220.

6 D.M. Berwick, T.W. Nolan, and J. Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs,* May/June 2008; pp. 759–769.

7 J.W. Whittington, K. Nolan, N. Lewis, and T. Torres, "Pursuing the Triple Aim: The First Seven Years," *Milbank Quarterly,* 2015; pp. 263–300.

8 J.E. Orlikoff, "Building Better Boards in the New Era of Accountability," *Frontiers of Health Services Management,* 2005; pp. 3–12.

of health. Improving patient care, especially the experience of care, requires nursing representation on boards. And reducing per-capita costs, and improving value, is significantly aided by representation by business leaders in the community, who often have more experience than their healthcare colleagues in improving efficiency and creating value.

The survey data reveals both strengths and areas for improvement with regard to the ideal board composition for pursuing the Triple Aim. One strength, for the reasons stated above, is the significant representation of individuals with business or finance backgrounds, both at the chief executive and board chair levels. An area for improvement is increasing nurse representation on boards, which could be achieved both by making the chief nursing officer a voting (or non-voting) member of the board and by engaging more independent nurse executives as board members. Another area for improvement is in the representation of patients. Many boards have adopted the effective practice of examining quality and safety through the eyes of a patient by relating a patient story at meetings, or even better, by inviting a patient to share their care experience story directly with the board. Boards can go even further and elect patients (or leaders who represent patients in their professional life) as full voting members. IHI's experience, and the experience of many of its partnering organizations, has been that changing who is in the room significantly changes the conversation in the room.

Another way boards can pursue the Triple Aim is to expand the educational opportunities and resources available to board members related to community health.[9,10] Orienting boards to resources such as County Health Rankings and Roadmaps (www.countyhealthrankings.org) can assist with identifying the unique health needs of their communities (and completing community health needs assessments is now an IRS requirement for non-profit hospitals). Even more valuable is leveraging community representation on boards to map all *assets* in a community that can contribute to improved health. In IHI's experience, this assets-based approach is more motivating than other, more traditional needs-based approaches.

Achieving the Triple Aim in a community will take a broad effort that focuses as much on the social determinants of health as it does on the performance of the local health system. The Governance Institute's continued focus on spreading best practices and measuring how boards are changing, as exemplified in this survey report, are essential inputs to improving health and healthcare.

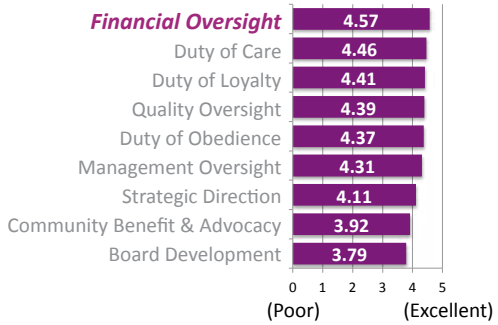
9 Orlikoff, 2005.

10 M. Laderman and J. Whittington, "Assessing Community Health Needs," *Healthcare Executive,* September 2015; pp. 70–73.

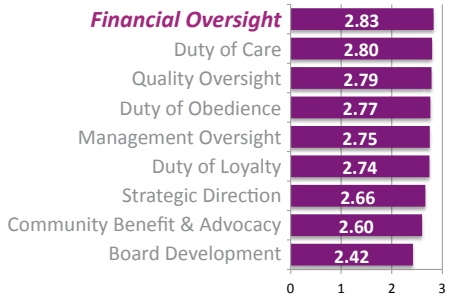
Financial Oversight: Key Points

- CEOs again gave boards' performance in financial oversight the highest performance score (4.57 out of 5; a significant increase from 4.50 in 2013).
- Financial oversight is also ranked first in adoption of recommended practices (where it traditionally is ranked; however, it slipped to second place in 2013).
- 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 rates increased since 2013 for seven of the 10 practices.
- As in 2011 and 2013, 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 these specific practices).

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

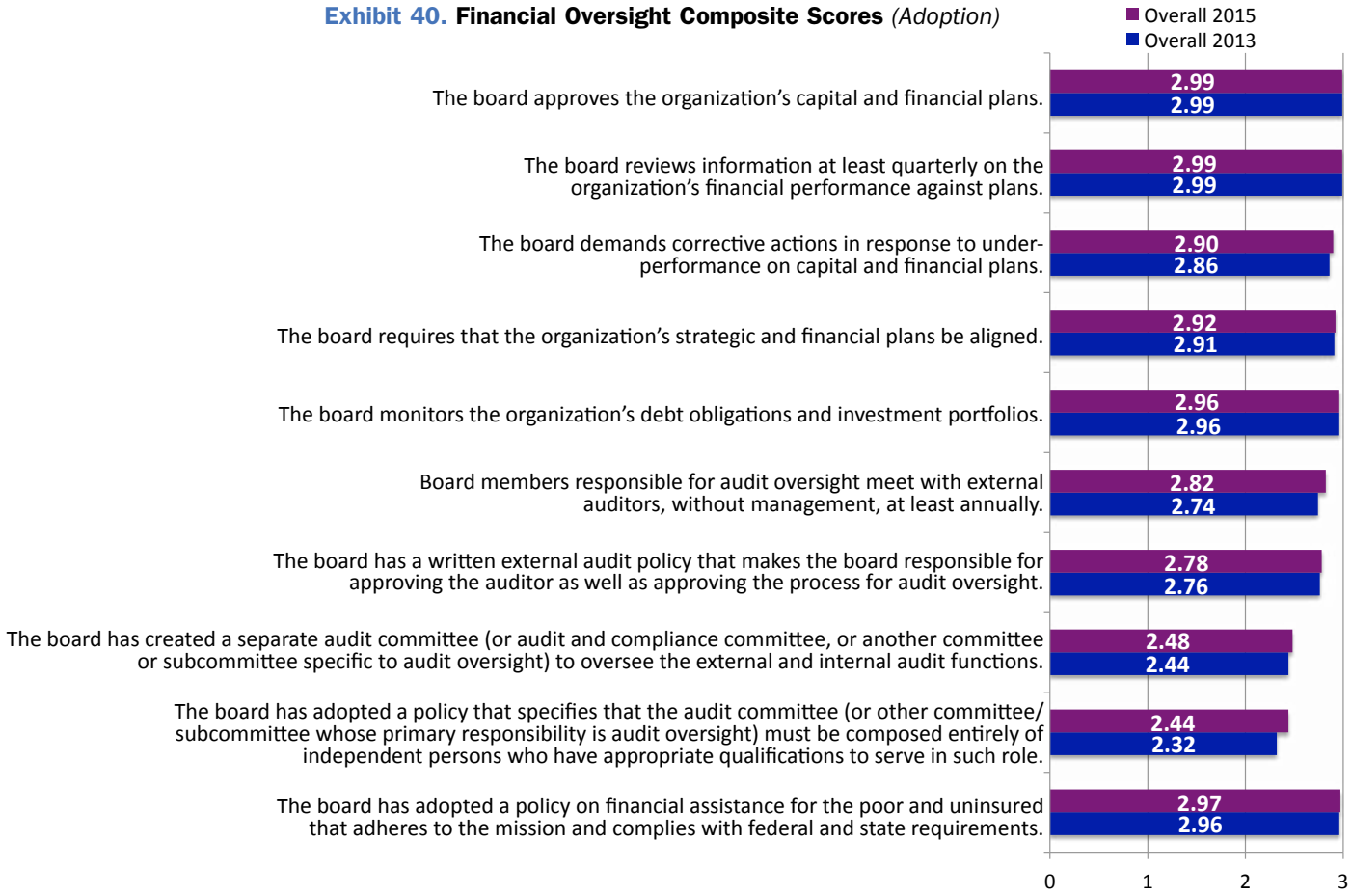


3 = currently have adopted the practice

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 40. Financial Oversight Composite Scores *(Adoption)*



THE VALUE JOURNEY: HOW BOARDS CAN MOVE BEYOND GOAL-SETTING TO GOAL ACHIEVEMENT

Joseph J. Fifer, FHFMA, CPA, *President & CEO, Healthcare Financial Management Association*

{ SPECIAL COMMENTARY }

Health systems and hospitals have been taking tentative steps in the direction of value-based payment for a while now, but 2015 may go down as the tipping point—at least from the payer standpoint.

Payers Are Picking Up the Pace

Both public and private payers are sending strong signals that they intend to accelerate the value transformation. Consider these developments:

- By the end of 2018, half of Medicare payments to providers will come through alternative payment models such as ACOs, bundled payments, and other value-oriented vehicles.
- Traditional Medicare payments will be increasingly tied to quality measures, such as in the Medicare Hospital Readmission Reduction Program and the Hospital Inpatient Value-Based Purchasing Program. The government expects quality- or value-based payments to account for 90% of its provider payout by the end of 2018.
- Private payers are moving with equal speed. In one of many examples, six large health systems and four large health insurers joined together in 2015 as the Health Care Transformation Task Force, with the goal of pushing 75% of the insurers' business into value-based arrangements by 2020.
- In July, the federal government proposed a first: It wants a new bundled payment program for joint replacements to be *mandatory* for most hospitals in 75 geographic areas.

For health system and hospital boards, failing to heed these signals will have severe consequences. Healthcare economist David Cutler, featured in the Fall 2015 issue of the HFMA publication *Leadership*, summed it up this way: "The world is changing so that if you're not delivering high value, you will get killed."

How Boards Should Rethink Their Approach to Financial Oversight

Financial oversight has been a traditional strength of boards, and the 2015 biennial survey results confirm that boards continue to excel in this arena. As the healthcare industry changes its business model—moving from volume to value—directors will be challenged to align their approach with the new payment environment. Every healthcare leader has seen the value shift coming, but many health systems and hospitals have been slow to react. Most healthcare payment is still fee-for-service—and that has allowed some organizations to justify focusing on revenue generation as opposed to managing the total cost of care—a key component of the value equation.

The good news is that the survey results document that the move to value-based payment is moving up on the priority list for America's hospital and health system boards. Indeed, 57% of respondents have added value-based payment goals to their organization's strategic and financial plans since 2013. Those organizations are to be commended. But setting goals is just the first step, and there is reason to be concerned that boards may not be optimally positioned to move past that stage. To move forward, boards should adopt the following five strategies.

Encourage the development of organizational capabilities for value. To succeed with value-based payment, health systems and hospitals must be able to deliver high-value care, a concept that was not even in play a decade ago. For the past five years, HFMA's Value Project has been researching value as defined by care purchasers. Drawing on the perspectives of the nation's top health systems and hospitals, as well as patients, employers, and public and private payers, the Value Project identified capabilities in four broad areas needed to succeed in the value era. Every board should be monitoring progress toward goals in these four areas:

- **People and culture:** Development of a culture that nurtures collaboration, creativity, and accountability
- **Business intelligence:** The use of quality and financial data to support organizational decision making
- **Performance improvement:** The use of data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** Development of effective care networks that support the prediction and management of different forms of patient-related risk

Develop board members' skill sets and expertise. More than half (54%) of respondents to the 2015 survey have not made any changes to the board or management team since 2013 to succeed with value-based payments, and only 16% have added physicians to the management team to succeed with value-based payments. Any healthcare organization that has not assessed the skills and strengths of its board members and executive leaders in relation to the challenges of value-based care should make this a priority. This can be addressed both through selection criteria for new board members, when the opportunity arises, and through board education.

Experiment with value-based payment. Many leading organizations are using value-based payments for the self-funded insurance plans that cover their own employees, which is an excellent way to gain experience while educating employees about value-based care. Another strategy: explore opportunities to partner with payers on value-based payment pilots. Forward-thinking payers are ready to develop mutually beneficial contracts and share data to support the delivery of high-value care.

Direct the hospital's leadership team to manage through the transition. The goals and metrics currently used to guide health systems to success in the volume-driven, fee-for-service payment model often conflict with those for emerging value-based payment models. As everyone knows by now, in the fee-for-service world, filling inpatient beds is almost always a financial win, but in value-based payment models, inpatient stays should be avoided if appropriate care can be provided in an outpatient setting. And that's just the beginning.

Boards must support management as they face the daunting challenge of having one foot in the legacy fee-for-service environment and the other in the value-driven world. Most healthcare organizations will have revenues coming from multiple payment models, some of which conflict, for the foreseeable future. All health systems and hospitals need a strategy for navigating through this time of change and making it clear how progress will be monitored and measured.

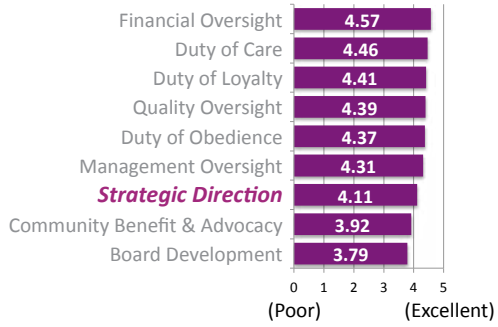
Challenge assumptions. With the pace of change accelerating, the organization's goals may not be ambitious enough. Preparing for value-based payment should no longer be treated as an optional or "nice-to-have" activity. Make sure the bar is being set high enough to bring about meaningful change in the next two years.

None of these transformational activities will happen without support and guidance from the very top of the organization. Every health system and hospital must embark on its own value journey, and the board of directors has a key role in establishing that journey's pace, parameters, and prospects for success.

Strategic Direction: Key Points

- CEOs gave boards' performance in setting strategic direction the third lowest rating (4.11 out of 5; about the same as 2013).
- Strategic direction is ranked seventh in adoption of practices (same as 2011 and 2013).
- Prevalence of adoption of practices remained about the same or decreased since 2013, with one exception: adoption is significantly higher for the establishment of physician compensation policies that consider fair market value and industry benchmarks.
- As in 2011 and 2013, more systems have adopted the practice of focusing on strategic discussions during board meetings compared to all other types of organizations (2.38; but this is significantly lower than the 2013 rate of 2.53, and adoption rates for this practice have decreased for all types of organizations except government-sponsored hospitals, which has increased from 1.94 to 2.03).
- Subsidiary hospitals have the highest level of adoption for eight of the 12 practices in this group.
- Government hospitals have the lowest level of adoption for these practices, but adoption has increased since 2013 for eight of the practices.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

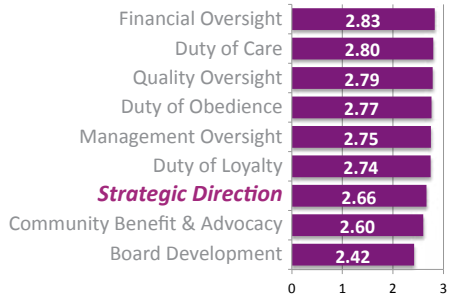
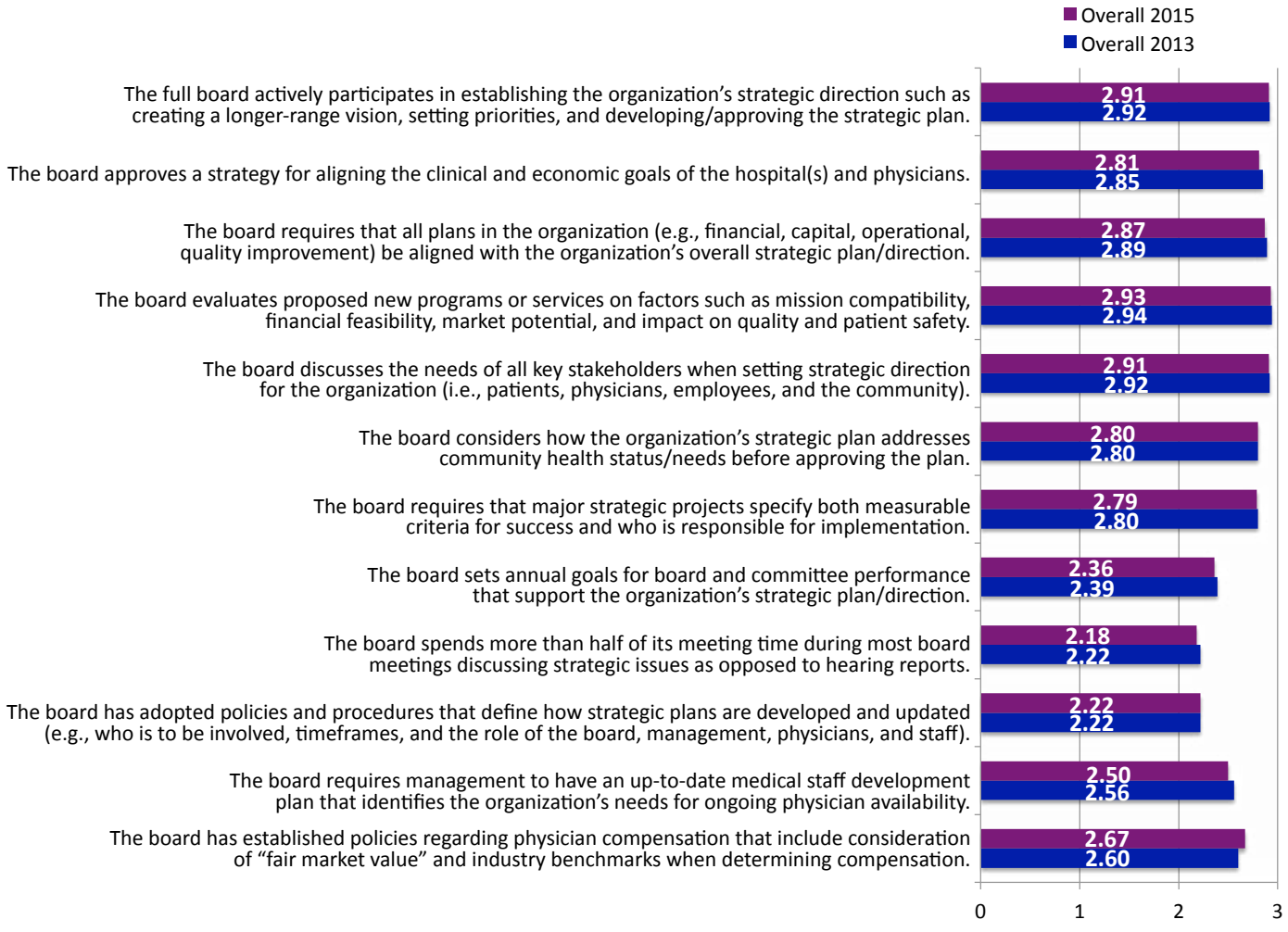


Exhibit 41. Strategic Direction Composite Scores *(Adoption)*



THE BOARD AND STRATEGIC DIRECTION-SETTING DURING HEALTHCARE'S TRANSFORMATION TO VALUE

Mark E. Grube, *Managing Director and Head of the Strategic Advisory Practice, Kaufman, Hall & Associates, LLC*

{ SPECIAL COMMENTARY }

Healthcare's transformation to a new business model that is focused on value and population health demands higher sophistication of leadership than perhaps *ever before* called for in healthcare. Governance and executive teams of the nation's hospitals and health systems must have the knowledge and skills needed to succeed in setting and executing organizational strategies under a very different clinical and business model.

The Board's Role

Direction-setting approaches of contemporary healthcare boards differ.

Given the complexity of the healthcare industry, it is increasingly common for boards to be focused on policy and the broad objective-setting agenda. The board engages in organizational strategy principally through an oversight role, which includes the critical functions of review, approval, and monitoring of a strategic plan that is developed and implemented by the senior executive team. Boards of today's large health systems typically use this approach.

Other boards take a more hands-on role, leading or partnering with the senior executive team in developing the strategy, and providing oversight to its execution. These boards must ensure that they are not "so deep into the weeds" that they decelerate management's responsibility to plan and execute strategies and tactics to meet organizational objectives.

Whichever approach is used, an organization's overall strategy will be based on the unique role it defines for itself in delivering services to specific patient populations.

Board Performance

How do boards rate their performance on the provision of overall strategic direction and adoption of the relevant practices for strategy, as recommended by The Governance Institute?

The overall performance ranking is seventh (out of nine fiduciary duties and core responsibilities). This suggests under-emphasis on strategy. But perhaps the ranking is of less concern when one considers that "strategic discussions," as defined by The Governance Institute, include issues around finance, quality, and other mission-critical matters that require decision making of a strategic nature. The recommendation from The Governance Institute to devote more than half of meeting time to strategic discussions is an excellent one that will likely lift the overall ranking in coming years.

All adoption scores for the 12 strategic-direction practices fall between 2 and 3 on the 3-point scale. The majority are approximately 2.8 or higher. While tantalizingly close to 3, these scores actually *should be* 3. The practices are not simply the best approaches, but are requirements for effective governance of hospital organizations.

Practices with scores of under 2.7 deserve special focus. For example, the practice with the second-lowest score is, "The board has adopted policies and procedures that define how strategic plans are developed and updated." Without definition of who is responsible for plans, plan updates, and their timing, it is unlikely that strategic plans will be properly integrated with capital and financial plans and annual budgets. In the absence of timely, integrated planning, strategies cannot be pursued and achieved within a financial context required to sustain competitive financial performance into the future.

Evolution of Strategy

Practices in strategic direction-setting and strategic planning will evolve in conjunction with the changing healthcare environment. The core elements of strategy—namely the issues boards will be spending the bulk of their time discussing and addressing—are centered on the new organizational competencies required of hospitals and health systems to manage population health.

These competencies include clinical integration, clinical care management, network development, operational/cost efficiency, clinical and business intelligence and actuarial services, purchaser relationships and managed care contracting, financial strength, consumer/customer engagement, and leadership and governance.[11] Boards should be asking, "Does

11 See M.E. Grube, et al., *Managing Population Health: A Strategic Playbook for Best-Fit Growth Opportunities* (white paper), Kaufman Hall, 2015 (www.kaufmanhall.com/thought-leadership/healthcare).

our organizational strategy touch on each core competency required for the value-based services we wish to deliver to defined patient populations?"

Skill sets resident among board members will need to evolve as well to accelerate progress with the strategic agenda. A board with a number of directors who have expertise in specific competencies mentioned earlier, if not in healthcare, but in other industries will be helpful. For example, experience in:

- Talent management or working with and incentivizing highly educated or skilled individuals (e.g., in professional services firms) would be helpful to attracting and maintaining clinical leaders who could advance the organization's clinical integration agenda.
- Growth strategy or negotiations could offer insights helpful to developing and managing the organization's care delivery network.
- Insurance, risk management, and employer benefits and trends (e.g., a human resource director for a large employer) could help advance purchaser/managed care relationship objectives.
- Customer relationship management in technology-enabled businesses (Internet or mobile-based), or use of business intelligence could enhance the consumer engagement strategy
- Change or transformation management in companies that have successful navigated a substantial transition.

Beyond the board's *broadening* of competencies, boards also must ensure *depth* of experience on the senior leadership team in each competence area, for example:

Population health management (PHM) and its associated risk: PHM is an entirely different model of care delivery than episode-based care. The senior executive with oversight of this function ensures that the organization comes to an agreed-upon definition of population health and wellness in target markets, and then moves the organization vigorously forward to provide relevant services in appropriate settings. Particularly important will be expertise in assessing, managing, and mitigating risk assumed by the organization under population health-based contracts with employers and public and commercial payers. For many hospitals and health systems, management of population health contracts that have both upside and downside potential will be a new venture, requiring actuarial and/or insurance expertise to be resident in the organization or purchased from external parties.

Network development: Because most organizations will be part of networks, their leaders must be able to shape or join such networks through making active or even preemptive arrangements with other providers. Leaders must have expertise in securing and maintaining partnerships in portions of the care continuum that are not owned directly by the organization.

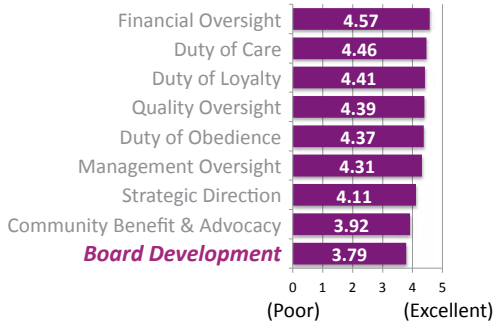
Because governance agendas and skill sets are so broad, a dedicated strategic planning committee or function is of vital importance for ensuring that all direction-setting objectives are explored, executed, and monitored going forward. This committee can be comprised of directors and senior executives (e.g., CEO, chief strategy officer, and others) with particular expertise in new competency areas, and supported by management staff, as required. Current and past board members who are strategic thinkers, and community leaders who might be strategic resources for the organization (and future board members) should be considered.

In most organizations, the board and executive management requirements, structure, and skill sets needed to set strategic direction and guide the organization through the transformation are being, or will need to be, secured or strengthened. Is your organization moving quickly enough to make these changes?

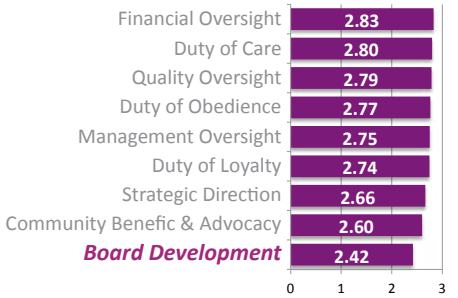
Board Development: Key Points

- CEOs again gave boards' performance in board development the lowest rating (3.79 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 also ranked last in adoption of practices (same as 2013).
- Despite the low rankings compared with other board oversight areas, adoption rates have increased since 2013 for six practices.
- The most significant increase in adoption is for the practice of having a compact regarding mutual expectations between the board and the board chair.
- Systems and subsidiaries are more likely than others to use a formal orientation program for new board members.
- Subsidiaries are most likely to have board members participate in ongoing education regarding key strategic issues.
- Subsidiaries are the only type of organization to have adoption rates of 2.00 or higher for all of the board development practices this year (2.00 is the bottom-level benchmark; anything scoring below this is considered to be among the least-observed practices). (In 2013, systems had this distinction.)
- As in previous years, government-sponsored hospitals have a lower incidence of adoption of each of these practices than other organization types, but their adoption rates have increased since 2013 for eight of the 11 practices.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

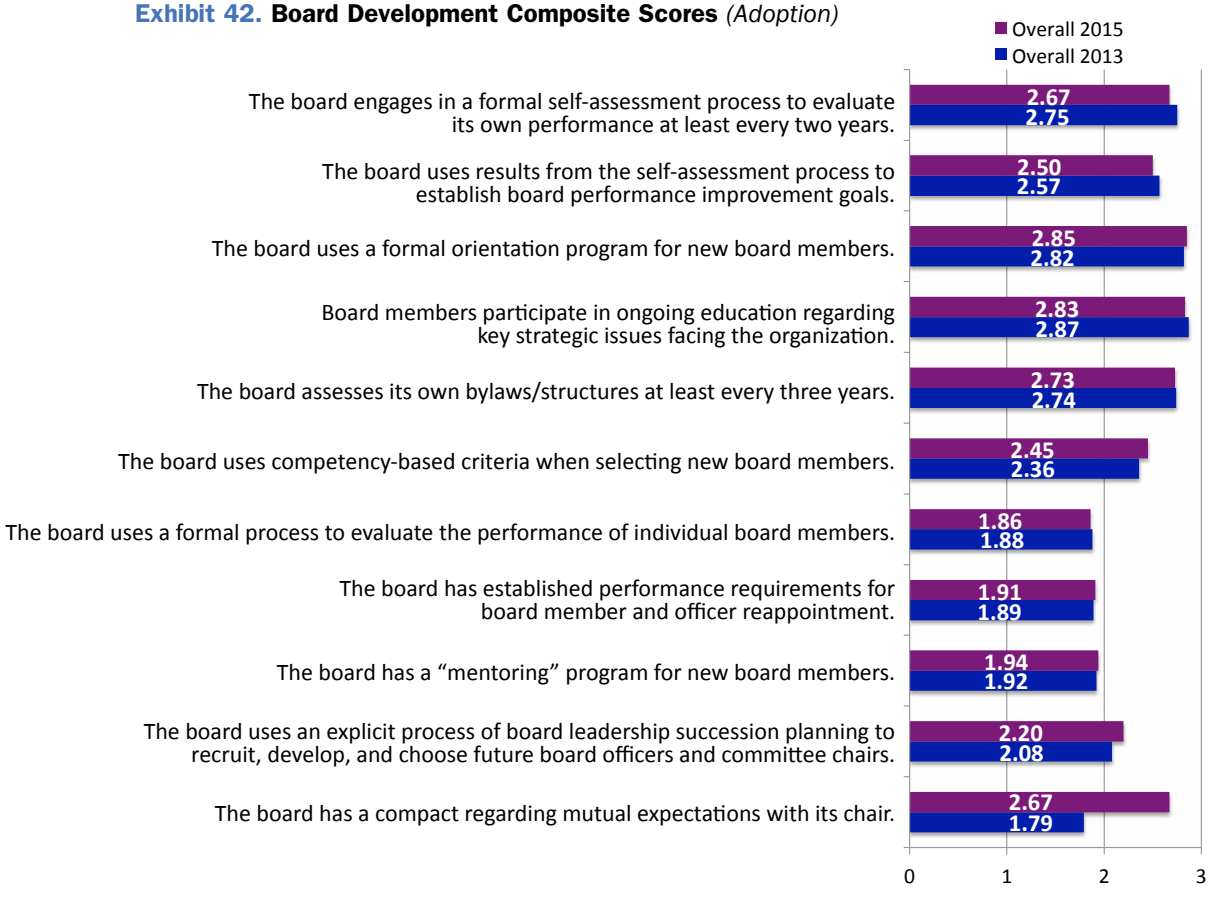


3 = currently have adopted the practice

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

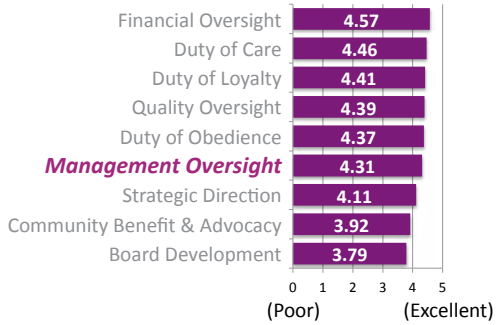
Exhibit 42. Board Development Composite Scores *(Adoption)*



Management Oversight: Key Points

- CEOs again gave boards' performance in management oversight the sixth highest performance rating (4.31 out of 5; an increase from 4.26 in 2013 although its ranking remained the same).
- Management oversight moved up to fifth place in adoption of practices (it was ranked sixth in 2013).
- Three practices have increased in adoption since 2013:
  1. "The board seeks independent expert advice/information on industry comparables before approving executive compensation."
  2. "The board requires that the CEO maintain a written, current succession plan." (This is typically among the least-observed practices and we have not seen upwards movement in adoption of this practice since 2011.)
  3. "The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance."
- The practice adoption is more prevalent among systems and subsidiaries than for other organization types; government-sponsored hospitals have the lowest adoption rates. This is consistent with previous reporting years.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

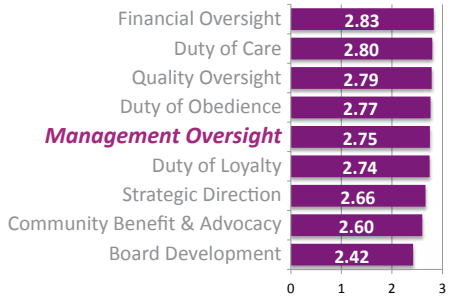
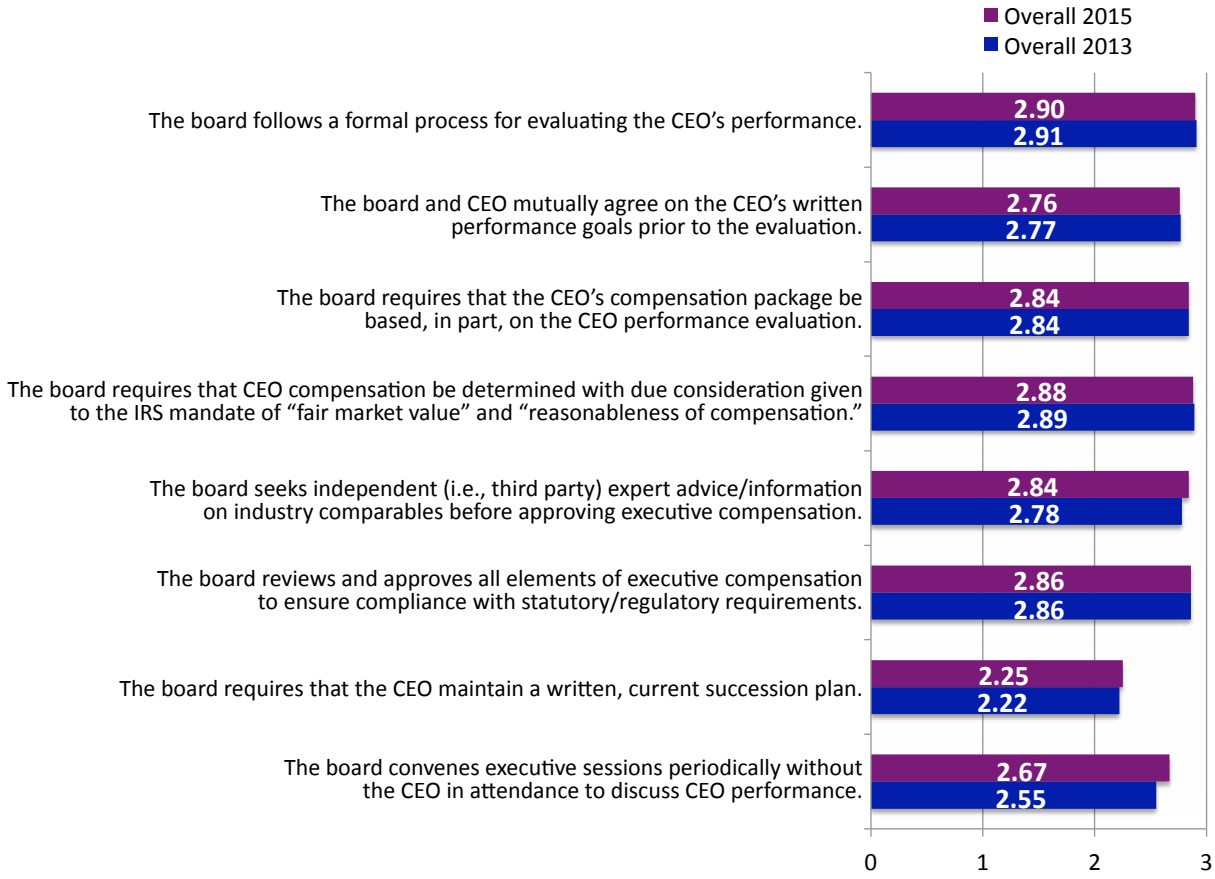


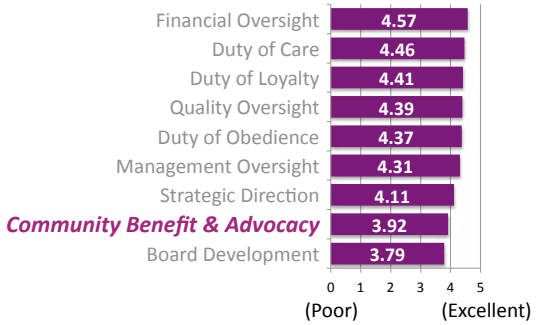
Exhibit 43. Management Oversight Composite Scores *(Adoption)*



Community Benefit and Advocacy: Key Points

- CEOs gave boards' performance in community benefit and advocacy the second lowest performance rating (3.92 out of 5; about the same as 2013).
- Community benefit and advocacy is ranked second to last in adoption of practices (same as 2013).
- Adoption has increased compared to 2013 for all but two practices.
- 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. (This has been a legal requirement under the ACA since 2010 and we have seen consistent increase in adoption of this practice since 2011.)
- The least prevalent practice for all types of organizations is: having a written policy establishing the board's role in fund development/philanthropy (this has remained one of the least-observed practices in all oversight areas for several reporting years).

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

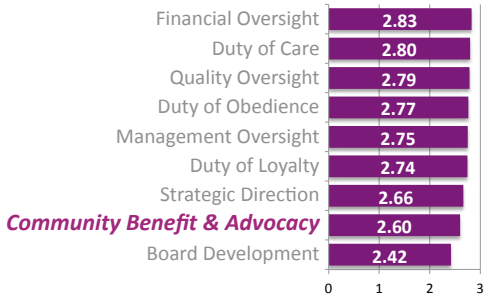


Exhibit 44. Community Benefit and Advocacy Composite Scores *(Adoption)*

Analysis of Results

This year's results show that adoption of our list of recommended practices, for the most part, continues to be widespread. Historically, government-sponsored hospitals tend to have lower rates of adoption of the recommended practices, but this year's increase in both adoption and performance for this group of hospitals is the most significant to be reported since 2007. While their adoption is still much lower than other types of organizations, this is an important finding and it should be emphasized that this indicates a recognition among this group of hospitals that adopting most of these practices is possible within their unique constraints, and is also valuable to the performance of these organizations.

Among other types of organizations, historically systems have had highest levels of adoption and performance, and systems and subsidiaries have had similarities and/or parallels as to which practices were more likely to be adopted. For performance this year, systems still have the highest percentage of "excellent" and "very good" rankings across the oversight areas. But subsidiaries hold the distinction of highest levels of practice adoption in most of the oversight areas.

The increase in adoption of several duty of obedience practices related to compliance reflects increasing legal/regulatory attention being paid by these boards, which is a good sign. Performance and adoption in quality oversight practices showed significant improvement this year, although reporting quality to the public has decreased, which is notable due to this practice being among those statistically correlated with better process of care and risk-adjusted mortality rates. Financial oversight practice adoption has increased for a majority of the practices. We are also pleased to see the increase in adoption for requiring the CEO to maintain a written and current succession plan, a practice that has historically been stagnant on the lower end of the adoption rates. In seeing adoption of other management oversight practices increase as well, it looks as though boards are paying more attention to the importance of CEO performance for the overall health of their organizations. And community benefit, an increasingly critical area for board oversight, continues to improve in both performance and adoption of practices.

There remains significant opportunity to improve performance scores and adoption rates in certain key areas. The two duty of loyalty practices that have decreased (having disabling guidelines and an independent director definition) are concerning due to the requirements of reporting these on the IRS Form 990. Practices related to audit (having a dedicated committee made up of independent directors to handle the audit process) continue to have low rates of adoption, not just due to the difficulties government hospitals face in being able to adopt these practices, but we also see low adoption among independent hospitals. Strategic planning, a critical skill for every board in this dynamic healthcare market, should be ranking much higher in the list for both performance and adoption, and it is clear that boards need to be spending much more time on strategy in board meetings. In addition, board development remains low on the list for both performance and adoption scores (this area has the highest number of "least-observed" practices; see the next section below). The increase in adoption of board development practices this year is promising, but this is a great area of opportunity for boards looking to enhance their performance—and therefore, their organization's performance.

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[12] 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 2013 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.

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 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 its quality performance by comparing its current performance to its own historical performance as well as industry benchmarks.
- The board reviews patient satisfaction/patient experience scores at least annually (including those publicly reported by CMS).*

12 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.

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 demands corrective actions in response to under-performance on capital and financial 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.*

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, and impact on quality and patient safety.*
- 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 2013 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 and 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 2015 and 2013.

Significance of Individual Governance Practices and Overall Performance

We continue to find a strong correlation between adoption of practices and respondents rating their board's performance as "excellent" or "very good" (either a strong or very strong statistical relationship). Only six of the practices had no correlation with performance this year:

- 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 obedience: The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.
- Duty of obedience: 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 patient satisfaction/patient experience scores at least annually (including those publicly reported by CMS).
- Board development: The board assesses its own bylaws/structure at least every three years.

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 above, some still rated their board's overall performance in duty of care, duty of obedience, quality oversight, and board development as good, fair, or poor, rather than excellent or very good.

CONCLUDING REMARKS

YEAR OVER YEAR, MANY aspects of our survey data do not change, although several aspects do. This report continues to paint a telling picture of how boards are structured and how they spend their time, in addition to subtle changes indicating a direction in governance over time. Despite the lower response rate to this year's survey, our respondents continue to mirror the overall survey population when taking into consideration organization type and size, and they represent over 21% of the nation's not-for-profit, acute-care hospitals.

The list below summarizes key aspects of this year's results that we find to be most significant (especially in the context of boards' movement towards doing business in a "21st-century" manner of healthcare delivery):

- There was a significant increase in the percentage of independent board members as a total of the board.
- The increase in the prevalence of the audit/compliance committee is substantial (51% this year, from 34% in 2013).
- The high percentage of respondents having owned/affiliated physician groups (48% of respondents), many with voting-board representation, as well as the high percentage of respondents participating in an ACO of some kind (47%).
- Health systems are showing significant movement in efforts to succeed with value-based payments and population health, by adding goals to the strategic plan and adding physicians to the management team.
- The continued rise in community benefit performance, adoption of practices, and prevalence of having a board-level committee devoted to community benefit, which has risen to 26% from only 15% of boards having this committee in 2009.
- The use of a board portal or similar online tool, as well as providing board members with mobile tablets or laptops to access online materials, are so prevalent to be now considered commonplace.
- Government-sponsored hospitals have increased their adoption of most recommended practices in all fiduciary duty and core responsibility areas—the first reporting year we have seen significant movement among this group of hospitals.

However, the areas of greatest concern and opportunity include:

- The low performance and adoption of strategic direction practices, and most importantly, the little amount of time spent on strategic discussions during board meetings, is concerning given its importance to organizations' success in the industry now.
- The lack of focus on board development practices and setting aside enough meeting time for board education (given the correlation between investment in board education and board performance) should be reconsidered.
- The B+ total score for the culture statements indicate there is quite a bit of room for improvement in board culture, which is a key aspect of boards' ability to be high-functioning.

Our future research will aim to expand this governance picture to all care settings, from physician groups to ACOs to post-acute care organizations—essentially, any care delivery organization that is governed by a fiduciary board, which greatly affects the organization's performance and quality of care delivered. We will continue to seek trends and directions indicating where governance may be going, at what relative speed of change, and perhaps more importantly, where governance needs to go in order to fulfill the ultimate mission of providing quality, customer-centered, and value-based care at the right time, in the right place.

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
1–7	23.2%	0.0%	9.4%	8.1%	62.1%	60.0%	40.0%	45.5%	75.7%	6.7%	9.4%	0.0%	N/A	0.0%	50.4%	11.4%	6.3%	0.0%	0.0%	0.0%
8–10	13.8%	6.0%	12.2%	3.2%	26.2%	22.2%	50.0%	45.5%	18.9%	6.7%	9.9%	0.0%	N/A	7.0%	19.5%	15.2%	6.3%	8.8%	5.0%	0.0%
11–15	31.4%	36.0%	44.6%	35.5%	8.7%	13.3%	10.0%	9.1%	2.7%	30.0%	43.9%	57.1%	N/A	32.6%	20.3%	41.0%	39.6%	38.2%	35.0%	14.3%
16–22	23.7%	42.0%	24.5%	41.9%	2.9%	4.4%	0.0%	0.0%	2.7%	46.7%	26.9%	42.9%	N/A	41.9%	9.0%	24.8%	35.4%	35.3%	45.0%	57.1%
23–30	5.9%	14.0%	6.5%	8.1%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	7.0%	0.0%	N/A	16.3%	0.8%	6.7%	6.3%	11.8%	15.0%	21.4%
31 +	2.0%	2.0%	2.9%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	2.9%	0.0%	N/A	2.3%	0.0%	1.0%	6.3%	5.9%	0.0%	7.1%
Average	13.62	17.58	14.65	18.08	7.61	8.07	8.20	8.18	6.73	16.43	15.58	15.43	N/A	17.93	9.08	13.98	19.02	17.41	17.45	20.86
Median	13	16	14	16	7	7	9	9	5	17	14	15	N/A	17	7	13	15	16	18	21
Range	3 to 141	9 to 34	3 to 35	5 to 141	5 to 22	5 to 22	5 to 11	5 to 11	5 to 17	7 to 35	3 to 141	11 to 22	N/A	9 to 34	3 to 23	5 to 35	5 to 141	9 to 36	10 to 24	13 to 34
Number of independent voting board members (per IRS definition of independent director)																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0–2	1.7%	0.0%	2.2%	1.6%	1.9%	2.2%	0.0%	0.0%	2.7%	0.0%	2.3%	0.0%	N/A	0.0%	1.5%	2.9%	0.0%	0.0%	5.0%	0.0%
3–4	2.5%	2.0%	2.2%	4.8%	1.9%	2.2%	0.0%	0.0%	2.7%	3.3%	2.9%	0.0%	N/A	2.3%	3.8%	1.0%	6.3%	0.0%	0.0%	0.0%
5–6	17.2%	2.0%	7.2%	11.3%	41.7%	35.6%	30.0%	27.3%	56.8%	16.7%	7.0%	0.0%	N/A	2.3%	33.8%	11.4%	6.3%	2.9%	0.0%	0.0%
7 +	78.5%	96.0%	88.5%	82.3%	54.4%	60.0%	70.0%	72.7%	37.8%	80.0%	87.7%	100.0%	N/A	95.3%	60.9%	84.8%	87.5%	97.1%	95.0%	100.0%
Average	10.14	12.76	10.82	12.24	6.69	6.87	7.20	7.27	6.16	10.70	11.36	11.86	N/A	12.91	7.39	9.98	13.88	12.91	12.00	15.29
Median	9	12	10	10	7	7	7	7	5	10	10	10	N/A	12	7	9	11	12	11	16
Range	0 to 131	3 to 26	0 to 31	0 to 131	0 to 15	0 to 15	5 to 10	5 to 9	0 to 14	4 to 31	0 to 131	7 to 17	N/A	3 to 26	0 to 18	0 to 28	3 to 131	6 to 31	0 to 21	8 to 21
Number of voting management board members																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	52.5%	24.0%	46.8%	19.4%	94.2%	88.9%	100.0%	100.0%	97.3%	13.3%	42.7%	0.0%	N/A	27.9%	78.9%	45.7%	33.3%	20.6%	35.0%	21.4%
1	36.2%	74.0%	43.9%	41.9%	3.9%	6.7%	0.0%	0.0%	2.7%	60.0%	40.4%	100.0%	N/A	69.8%	10.5%	41.9%	54.2%	64.7%	55.0%	78.6%
2	6.2%	2.0%	5.8%	21.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.7%	9.4%	0.0%	N/A	2.3%	6.8%	6.7%	8.3%	2.9%	5.0%	.0%
3	2.5%	0.0%	0.7%	11.3%	1.0%	2.2%	0.0%	0.0%	0.0%	6.7%	3.5%	0.0%	N/A	0.0%	1.5%	1.0%	4.2%	11.8%	0.0%	.0%
4 +	2.5%	0.0%	2.9%	6.5%	1.0%	2.2%	0.0%	0.0%	0.0%	3.3%	4.1%	0.0%	N/A	0.0%	2.3%	4.8%	0.0%	0.0%	5.0%	.0%
Average	0.74	0.78	0.75	1.56	0.21	0.47	0.00	0.00	0.03	1.30	0.95	1.00	N/A	0.74	0.38	0.91	0.83	1.06	1.40	0.79
Median	0	1	1	1	0	0	0	0	0	1	1	1	N/A	1	0	1	1	1	1	1
Range	0 to 15	0 to 2	0 to 9	0 to 12	0 to 15	0 to 15	0 to 0	0 to 0	0 to 1	0 to 5	0 to 12	1 to 1	N/A	0 to 2	0 to 5	0 to 12	0 to 3	0 to 3	0 to 15	0 to 1

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 Chief Medical Officer board members																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	90.4%	92.0%	86.3%	87.1%	97.1%	95.6%	100.0%	90.9%	100.0%	86.7%	86.5%	100.0%	N/A	90.7%	90.2%	89.5%	87.5%	94.1%	95.0%	92.9%
1	9.0%	8.0%	12.9%	11.3%	2.9%	4.4%	0.0%	9.1%	0.0%	13.3%	12.3%	0.0%	N/A	9.3%	9.8%	10.5%	8.3%	5.9%	5.0%	7.1%
2 +	0.6%	0.0%	0.7%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	N/A	0.0%	0.0%	0.0%	4.2%	0.0%	0.0%	0.0%
Average	0.12	0.08	0.14	0.24	0.03	0.04	0.00	0.09	0.00	0.13	0.18	0.00	N/A	0.09	0.10	0.10	0.29	0.06	0.05	0.07
Median	0	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0	0	0	0	0	0
Range	0 to 8	0 to 1	0 to 2	0 to 8	0 to 1	0 to 1	0 to 0	0 to 1	0 to 0	0 to 1	0 to 8	0 to 0	N/A	0 to 1	0 to 1	0 to 1	0 to 8	0 to 1	0 to 1	0 to 1
Number of voting physician board members aside from the CMO who are active members of the medical staff but are not employed by the hospital																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	48.3%	48.0%	41.0%	30.6%	68.9%	75.6%	50.0%	45.5%	73.0%	40.0%	37.4%	85.7%	N/A	41.9%	71.4%	38.1%	20.8%	29.4%	45.0%	50.0%
1	19.5%	14.0%	20.1%	17.7%	22.3%	17.8%	50.0%	45.5%	13.5%	23.3%	18.7%	0.0%	N/A	16.3%	19.5%	24.8%	16.7%	14.7%	15.0%	7.1%
2	14.7%	14.0%	19.4%	17.7%	6.8%	2.2%	0.0%	9.1%	13.5%	20.0%	18.7%	14.3%	N/A	14.0%	6.0%	21.0%	27.1%	14.7%	20.0%	0.0%
3	8.8%	10.0%	11.5%	12.9%	1.9%	4.4%	0.0%	0.0%	0.0%	6.7%	12.9%	0.0%	N/A	11.6%	2.3%	7.6%	18.8%	20.6%	5.0%	21.4%
4 +	8.8%	14.0%	7.9%	21.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	12.3%	0.0%	N/A	16.3%	0.8%	8.6%	16.7%	20.6%	15.0%	21.4%
Average	1.15	1.38	1.28	1.90	0.42	0.36	0.50	0.64	0.41	1.27	1.51	0.29	N/A	1.56	0.41	1.30	1.96	2.09	1.40	1.71
Median	1	1	1	2	0	0	1	1	0	1	1	0	N/A	1	0	1	2	2	1	1
Range	0 to 7	0 to 6	0 to 7	0 to 7	0 to 3	0 to 3	0 to 1	0 to 2	0 to 2	0 to 5	0 to 7	0 to 2	N/A	0 to 6	0 to 4	0 to 7	0 to 5	0 to 7	0 to 5	0 to 6
Number of voting physician board members aside from the CMO who are employed by the hospital																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	70.9%	66.0%	61.9%	62.9%	90.3%	84.4%	80.0%	90.9%	100.0%	50.0%	64.3%	100.0%	N/A	60.5%	82.7%	61.9%	56.3%	76.5%	70.0%	64.3%
1	13.6%	18.0%	15.8%	19.4%	4.9%	6.7%	10.0%	9.1%	0.0%	26.7%	15.2%	0.0%	N/A	20.9%	6.0%	20.0%	14.6%	20.6%	10.0%	21.4%
2	8.8%	12.0%	11.5%	9.7%	2.9%	6.7%	0.0%	0.0%	0.0%	10.0%	11.1%	0.0%	N/A	14.0%	5.3%	9.5%	16.7%	2.9%	15.0%	14.3%
3	2.8%	0.0%	5.8%	1.6%	1.0%	2.2%	0.0%	0.0%	0.0%	3.3%	4.7%	0.0%	N/A	0.0%	3.0%	3.8%	4.2%	0.0%	0.0%	0.0%
4 +	4.0%	4.0%	5.0%	6.5%	1.0%	0.0%	10.0%	0.0%	0.0%	10.0%	4.7%	0.0%	N/A	4.7%	3.0%	4.8%	8.3%	0.0%	5.0%	0.0%
Average	0.58	0.62	0.77	0.79	0.17	0.27	0.50	0.09	0.00	0.97	0.74	0.00	N/A	0.72	0.42	0.70	0.96	0.26	0.65	0.50
Median	0	0	0	0	0	0	0	0	0	1	0	0	N/A	0	0	0	0	0	0	0
Range	0 to 9	0 to 5	0 to 5	0 to 9	0 to 4	0 to 3	0 to 4	0 to 1	0 to 0	0 to 4	0 to 9	0 to 0	N/A	0 to 5	0 to 9	0 to 5	0 to 5	0 to 2	0 to 5	0 to 2

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 Chief Nursing Officer board members																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	98.6%	100.0%	99.3%	93.5%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	97.7%	100.0%	N/A	100.0%	100.0%	96.2%	100.0%	97.1%	100.0%	100.0%
1	1.4%	0.0%	0.7%	6.5%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	2.3%	0.0%	N/A	0.0%	0.0%	3.8%	0.0%	2.9%	0.0%	0.0%
2 +	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%
Average	0.01	0.00	0.01	0.06	0.00	0.00	0.00	0.00	0.00	0.03	0.02	0.00	N/A	0.00	0.00	0.04	0.00	0.03	0.00	0.00
Median	0	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0	0	0	0	0	0
Range	0 to 1	0 to 0	0 to 1	0 to 1	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 1	0 to 1	0 to 0	N/A	0 to 0	0 to 0	0 to 1	0 to 0	0 to 1	0 to 0	0 to 0
Number of voting board members who are nurses from the organization's nursing staff aside from the CNO																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	97.7%	98.0%	97.1%	100.0%	97.1%	95.6%	100.0%	90.9%	100.0%	100.0%	97.7%	85.7%	N/A	100.0%	97.7%	97.1%	100.0%	94.1%	100.0%	100.0%
1	2.0%	2.0%	2.2%	0.0%	2.9%	4.4%	0.0%	9.1%	0.0%	0.0%	1.8%	14.3%	N/A	0.0%	1.5%	2.9%	0.0%	5.9%	0.0%	0.0%
2	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%
3	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
4 +	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%
Average	0.03	0.02	0.04	0.00	0.03	0.04	0.00	0.09	0.00	0.00	0.04	0.14	N/A	0.00	0.04	0.03	0.00	0.06	0.00	0.00
Median	0	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0	0	0	0	0	0
Range	0 to 3	0 to 1	0 to 3	0 to 0	0 to 1	0 to 1	0 to 0	0 to 1	0 to 0	0 to 0	0 to 3	0 to 1	N/A	0 to 0	0 to 3	0 to 1	0 to 0	0 to 1	0 to 0	0 to 0
Number of voting board members who represent a faith-based institution that is affiliatied with or sponsors your organization																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	85.6%	72.0%	89.9%	64.5%	99.0%	97.8%	100.0%	100.0%	100.0%	33.3%	90.6%	28.6%	N/A	79.1%	93.2%	88.6%	72.9%	79.4%	75.0%	64.3%
1	5.6%	8.0%	3.6%	16.1%	1.0%	2.2%	0.0%	0.0%	0.0%	30.0%	3.5%	14.3%	N/A	7.0%	3.8%	3.8%	12.5%	5.9%	15.0%	0.0%
2	1.7%	2.0%	1.4%	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	1.2%	0.0%	N/A	2.3%	0.0%	2.9%	2.1%	2.9%	0.0%	7.1%
3	3.4%	6.0%	2.9%	8.1%	0.0%	0.0%	0.0%	0.0%	0.0%	16.7%	2.3%	28.6%	N/A	2.3%	1.5%	3.8%	6.3%	5.9%	5.0%	0.0%
4 +	3.7%	12.0%	2.2%	6.5%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	2.3%	28.6%	N/A	9.3%	1.5%	1.0%	6.3%	5.9%	5.0%	28.6%
Average	0.43	1.14	0.25	0.95	0.01	0.02	0.00	0.00	0.00	1.63	0.26	2.14	N/A	0.98	0.18	0.25	0.75	0.74	0.85	1.71
Median	0	0	0	0	0	0	0	0	0	1	0	3	N/A	0	0	0	0	0	0	0
Range	0 to 11	0 to 11	0 to 6	0 to 11	0 to 1	0 to 1	0 to 0	0 to 0	0 to 0	0 to 9	0 to 11	0 to 4	N/A	0 to 11	0 to 9	0 to 4	0 to 9	0 to 11	0 to 11	0 to 9

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 other types of voting board members																				
Total responding in each category	354	50	139	62	103	45	10	11	37	30	171	7	0	43	133	105	48	34	20	14
0	87.9%	78.0%	84.9%	83.9%	99.0%	100.0%	100.0%	100.0%	97.3%	80.0%	85.4%	100.0%	N/A	74.4%	94.7%	83.8%	85.4%	85.3%	75.0%	85.7%
1	3.4%	4.0%	4.3%	6.5%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	4.1%	0.0%	N/A	4.7%	2.3%	3.8%	4.2%	8.8%	0.0%	0.0%
2	2.3%	2.0%	2.9%	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	3.5%	0.0%	N/A	2.3%	0.8%	3.8%	2.1%	5.9%	0.0%	0.0%
3	2.0%	6.0%	1.4%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	1.8%	0.0%	N/A	7.0%	0.0%	1.9%	6.3%	0.0%	10.0%	0.0%
4 +	4.5%	10.0%	6.5%	1.6%	1.0%	0.0%	0.0%	0.0%	2.7%	3.3%	5.3%	0.0%	N/A	11.6%	2.3%	6.7%	2.1%	0.0%	15.0%	14.3%
Average	0.42	0.80	0.59	0.32	0.05	0.00	0.00	0.00	0.14	0.40	0.53	0.00	N/A	0.93	0.15	0.67	0.35	0.21	1.10	0.79
Median	0	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0	0	0	0	0	0
Range	0 to 16	0 to 6	0 to 16	0 to 4	0 to 5	0 to 0	0 to 0	0 to 0	0 to 5	0 to 4	0 to 16	0 to 0	N/A	0 to 6	0 to 6	0 to 16	0 to 4	0 to 2	0 to 6	0 to 6
Number of "outside"/non-affiliated physicians among the independent, voting board members																				
Total responding in each category	322	45	125	57	95	41	10	10	34	27	155	7	0	38	120	100	42	30	17	13
0	51.9%	40.0%	50.4%	54.4%	57.9%	73.2%	30.0%	20.0%	58.8%	48.1%	52.3%	42.9%	N/A	39.5%	64.2%	52.0%	40.5%	40.0%	29.4%	30.8%
1	25.2%	24.4%	25.6%	14.0%	31.6%	17.1%	60.0%	70.0%	29.4%	33.3%	20.0%	0.0%	N/A	28.9%	26.7%	24.0%	28.6%	23.3%	29.4%	7.7%
2	13.7%	13.3%	16.0%	17.5%	8.4%	4.9%	10.0%	10.0%	11.8%	14.8%	16.8%	28.6%	N/A	10.5%	7.5%	16.0%	19.0%	16.7%	23.5%	15.4%
3	4.0%	15.6%	4.0%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.9%	28.6%	N/A	13.2%	0.8%	3.0%	4.8%	3.3%	5.9%	38.5%
4 +	5.3%	6.7%	4.0%	12.3%	2.1%	4.9%	0.0%	0.0%	0.0%	3.7%	7.1%	0.0%	N/A	7.9%	0.8%	5.0%	7.1%	16.7%	11.8%	7.7%
Average	0.89	1.27	0.87	1.16	0.58	0.49	0.80	0.90	0.53	0.81	0.99	1.43	N/A	1.24	0.48	0.86	1.12	1.57	1.47	1.85
Median	0	1	0	0	0	0	1	1	0	1	0	2	N/A	1	0	0	1	1	1	2
Range	0 to 7	0 to 5	0 to 5	0 to 7	0 to 5	0 to 5	0 to 2	0 to 2	0 to 2	0 to 5	0 to 7	0 to 3	N/A	0 to 5	0 to 5	0 to 5	0 to 5	0 to 7	0 to 5	0 to 4
Number of female voting board members																				
Total responding in each category	351	49	138	62	102	44	10	11	37	30	170	7	0	42	131	105	48	34	19	14
0	3.7%	4.1%	0.0%	1.6%	9.8%	6.8%	0.0%	9.1%	16.2%	0.0%	0.6%	0.0%	N/A	4.8%	3.8%	3.8%	2.1%	2.9%	10.5%	0.0%
1	12.8%	8.2%	10.1%	6.5%	22.5%	34.1%	20.0%	0.0%	16.2%	10.0%	8.8%	0.0%	N/A	9.5%	18.3%	14.3%	4.2%	2.9%	10.5%	7.1%
2	21.1%	16.3%	17.4%	11.3%	34.3%	27.3%	50.0%	45.5%	35.1%	3.3%	17.6%	14.3%	N/A	16.7%	25.2%	20.0%	20.8%	11.8%	21.1%	14.3%
3	21.7%	16.3%	20.3%	25.8%	23.5%	18.2%	10.0%	36.4%	29.7%	30.0%	20.6%	0.0%	N/A	19.0%	24.4%	20.0%	18.8%	29.4%	15.8%	7.1%
4	12.8%	6.1%	20.3%	16.1%	3.9%	4.5%	10.0%	0.0%	2.7%	13.3%	20.0%	0.0%	N/A	7.1%	12.2%	14.3%	10.4%	20.6%	5.3%	7.1%
5	12.0%	16.3%	13.8%	17.7%	3.9%	6.8%	0.0%	9.1%	0.0%	13.3%	15.3%	0.0%	N/A	19.0%	7.6%	17.1%	12.5%	8.8%	21.1%	7.1%
6 +	16.0%	32.7%	18.1%	21.0%	2.0%	2.3%	10.0%	0.0%	0.0%	30.0%	17.1%	85.7%	N/A	23.8%	8.4%	10.5%	31.3%	23.5%	15.8%	57.1%
Average	3.47	4.20	3.88	4.27	2.09	2.09	2.50	2.45	1.86	4.40	3.93	6.71	N/A	3.79	2.83	3.31	4.60	4.24	3.37	5.07
Median	3	4	4	4	2	2	2	2	2	4	4	7	N/A	4	3	3	4	4	3	6
Range	0 to 21	0 to 8	1 to 11	0 to 21	0 to 6	0 to 6	1 to 6	0 to 5	0 to 4	1 to 11	0 to 21	2 to 8	N/A	0 to 8	0 to 8	0 to 10	0 to 21	0 to 11	0 to 8	1 to 8

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 voting board members from an ethnic minority																				
Total responding in each category	344	49	134	60	101	44	9	11	37	29	165	7	0	42	130	102	45	34	19	14
0	49.7%	24.5%	50.7%	38.3%	67.3%	68.2%	44.4%	81.8%	67.6%	51.7%	46.1%	14.3%	N/A	26.2%	71.5%	49.0%	40.0%	17.6%	15.8%	7.1%
1	18.9%	24.5%	22.4%	18.3%	11.9%	6.8%	33.3%	0.0%	16.2%	17.2%	21.8%	28.6%	N/A	23.8%	12.3%	23.5%	28.9%	17.6%	21.1%	14.3%
2	14.8%	16.3%	14.2%	21.7%	10.9%	9.1%	22.2%	9.1%	10.8%	24.1%	15.2%	28.6%	N/A	14.3%	10.8%	12.7%	13.3%	29.4%	26.3%	21.4%
3	7.3%	12.2%	6.0%	11.7%	4.0%	6.8%	0.0%	0.0%	2.7%	3.4%	8.5%	14.3%	N/A	11.9%	1.5%	8.8%	6.7%	14.7%	21.1%	14.3%
4	4.4%	10.2%	2.2%	5.0%	4.0%	4.5%	0.0%	9.1%	2.7%	0.0%	3.6%	14.3%	N/A	9.5%	2.3%	2.9%	4.4%	5.9%	10.5%	21.4%
5	2.0%	4.1%	2.2%	0.0%	2.0%	4.5%	0.0%	0.0%	0.0%	3.4%	1.2%	0.0%	N/A	4.8%	1.5%	1.0%	0.0%	8.8%	0.0%	7.1%
6 +	2.9%	8.2%	2.2%	5.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	N/A	9.5%	0.0%	2.0%	6.7%	5.9%	5.3%	14.3%
Average	1.21	2.24	1.08	1.48	0.71	0.86	0.78	0.55	0.57	0.93	1.25	1.86	N/A	2.31	0.55	1.05	1.51	2.35	2.32	3.21
Median	1	2	0	1	0	0	1	0	0	0	1	2	N/A	2	0	1	1	2	2	3
Range	0 to 13	0 to 10	0 to 13	0 to 7	0 to 5	0 to 5	0 to 2	0 to 4	0 to 4	0 to 5	0 to 13	0 to 4	N/A	0 to 10	0 to 5	0 to 7	0 to 13	0 to 10	0 to 10	0 to 8

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 membership since you have begun employing physicians?																				
Total responding in each category	296	46	116	52	82	37	9	9	27	25	143	6	0	40	104	90	41	29	19	13
Our physician representation on the board is now entirely made up of employed physicians	6.8%	6.5%	8.6%	9.6%	2.4%	2.7%	11.1%	0.0%	0.0%	8.0%	9.1%	0.0%	N/A	7.5%	5.8%	12.2%	2.4%	0.0%	10.5%	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 our medical staff)	1.7%	0.0%	1.7%	1.9%	2.4%	2.7%	11.1%	0.0%	0.0%	0.0%	2.1%	0.0%	N/A	0.0%	1.0%	4.4%	0.0%	0.0%	0.0%	0.0%
There has been no change in our board membership as a result of employing physicians	56.8%	52.2%	51.7%	48.1%	72.0%	73.0%	44.4%	88.9%	74.1%	44.0%	51.7%	66.7%	N/A	50.0%	65.4%	53.3%	48.8%	41.4%	52.6%	76.9%
We do not allow employed physicians to serve on the board	12.8%	10.9%	12.1%	9.6%	17.1%	18.9%	22.2%	0.0%	18.5%	8.0%	11.9%	16.7%	N/A	10.0%	15.4%	8.9%	14.6%	20.7%	5.3%	7.7%
We do not distinguish between employed physicians vs. independent members of the medical staff when selecting physicians to serve on the board	17.6%	21.7%	21.6%	25.0%	4.9%	2.7%	11.1%	11.1%	3.7%	32.0%	21.0%	16.7%	N/A	22.5%	8.7%	17.8%	31.7%	27.6%	26.3%	7.7%
Other	4.4%	8.7%	4.3%	5.8%	1.2%	0.0%	0.0%	0.0%	3.7%	8.0%	4.2%	0.0%	N/A	10.0%	3.8%	3.3%	2.4%	10.3%	5.3%	7.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 specify defined terms for the length of elected service?																				
Total responding in each category	349	50	137	61	101	43	10	11	37	30	168	7	0	43	130	104	48	34	19	14
Yes	91.4%	98.0%	96.4%	88.5%	83.2%	86.0%	80.0%	81.8%	81.1%	96.7%	93.5%	100.0%	N/A	97.7%	86.2%	93.3%	91.7%	97.1%	100.0%	100.0%
Length of term (in years) (median)	3	3	3	3	4	4	4	3	4	3	3	3	N/A	3	3	3	3	3	3	3
Do your bylaws limit the number of consecutive terms? ("term limits")																				
Total responding in each category	344	50	136	60	98	43	10	11	34	29	167	7	0	43	126	104	46	34	20	14
Yes	59.6%	86.0%	66.2%	81.7%	23.5%	25.6%	50.0%	18.2%	14.7%	89.7%	67.7%	100.0%	N/A	83.7%	41.3%	61.5%	71.7%	79.4%	85.0%	85.7%
Maximum number of terms (median)	3	3	3	3	2	2	2	3	2	3	3	3	N/A	3	3	3	3	3	3	3
Maximum age for serving on the board ("age limit")																				
Total responding in each category	348	49	138	62	99	42	10	11	36	30	170	7	0	42	130	104	47	34	20	13
Yes	7.8%	18.4%	6.5%	6.5%	5.1%	2.4%	10.0%	9.1%	5.6%	3.3%	7.1%	.0%	N/A	21.4%	4.6%	7.7%	6.4%	14.7%	20.0%	7.7%
Average Age Limit	72.13	72.30	72.44	71.50	70.00	N/A	70.00	N/A	N/A	70.00	72.33	N/A	N/A	72.30	71.00	72.75	72.33	71.80	71.75	72.00
Median Age Limit	72	72	72	72	N/A	N/A	N/A	N/A	N/A	N/A	72	N/A	N/A	72	71	72	72	72	71	72
Range Age Limit	70 to 78	70 to 75	70 to 78	70 to 72	70 to 70	N/A	70 to 70	N/A	N/A	70 to 70	70 to 78	N/A	N/A	70 to 75	70 to 72	70 to 78	70 to 75	70 to 75	70 to 75	72 to 72
Average board member age (approximate)																				
Total responding in each category	317	46	124	54	93	42	9	11	31	27	151	6	0	40	117	95	43	30	18	14
Average	58.38	58.98	58.25	56.70	59.24	59.38	57.78	59.09	59.52	56.70	57.97	63.17	N/A	58.35	58.13	58.91	57.70	56.90	59.44	60.86
Median	60	60	59	56	60	60	57	60	60	57	59	64	N/A	60	58	60	59	58	60	60
Range	45 to 75	48 to 66	45 to 75	48 to 65	45 to 70	48 to 70	50 to 66	52 to 65	45 to 70	48 to 75	45 to 70	60 to 66	N/A	48 to 66	45 to 70	48 to 75	48 to 67	50 to 65	48 to 65	50 to 66

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Participation on the board (N/A not included)																				
President/CEO																				
Total responding in each category	350%	50%	136%	62%	102%	44%	10%	11%	37%	29%	169%	7%	0%	43%	129%	105%	48%	34%	20%	14%
Voting board member	46.3%	78.0%	50.7%	75.8%	6.9%	13.6%	0.0%	0.0%	2.7%	82.8%	54.4%	100.0%	N/A	74.4%	20.2%	48.6%	68.8%	82.4%	60.0%	85.7%
Non-voting board member	17.1%	10.0%	20.6%	11.3%	19.6%	15.9%	30.0%	27.3%	18.9%	6.9%	19.5%	0.0%	N/A	11.6%	21.7%	20.0%	8.3%	2.9%	20.0%	14.3%
Non-board member; regularly attends meetings	36.6%	12.0%	28.7%	12.9%	73.5%	70.5%	70.0%	72.7%	78.4%	10.3%	26.0%	0.0%	N/A	14.0%	58.1%	31.4%	22.9%	14.7%	20.0%	0.0%
Non-board member; does not regularly attend meetings	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%
Respondents with this position	98.9%	100.0%	97.8%	100.0%	99.0%	97.8%	100.0%	100.0%	100.0%	96.7%	98.8%	100.0%	N/A	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Chief Operating Officer																				
Total responding in each category	212	32	89	46	45	16	5	4	20	20	115	3	0	29	47	76	42	26	14	7
Voting board member	0.9%	3.1%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	0.0%	N/A	3.4%	0.0%	0.0%	0.0%	7.7%	0.0%	0.0%
Non-voting board member	10.4%	6.3%	11.2%	15.2%	6.7%	6.3%	0.0%	0.0%	10.0%	15.0%	12.2%	0.0%	N/A	6.9%	12.8%	14.5%	2.4%	7.7%	14.3%	0.0%
Non-board member; regularly attends meetings	82.1%	90.6%	78.7%	76.1%	88.9%	87.5%	80.0%	100.0%	90.0%	60.0%	80.9%	100.0%	N/A	89.7%	83.0%	77.6%	92.9%	69.2%	85.7%	100.0%
Non-board member; does not regularly attend meetings	6.6%	0.0%	9.0%	8.7%	4.4%	6.3%	20.0%	0.0%	0.0%	20.0%	7.0%	0.0%	N/A	0.0%	4.3%	7.9%	4.8%	15.4%	0.0%	0.0%
Respondents with this position	59.9%	64.0%	64.0%	74.2%	43.7%	35.6%	50.0%	36.3%	54.1%	66.7%	67.3%	42.3%	N/A	67.4%	35.3%	72.4%	87.5%	76.5%	70.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 Financial Officer																				
Total responding in each category	343%	50%	136%	59%	98%	41%	10%	11%	36%	30%	165%	7%	0%	43%	126%	103%	46%	34%	20%	14%
Voting board member	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	9.0%	4.0%	10.3%	13.6%	7.1%	7.3%	10.0%	0.0%	8.3%	13.3%	10.9%	0.0%	N/A	4.7%	11.9%	10.7%	2.2%	2.9%	15.0%	0.0%
Non-board member; regularly attends meetings	86.9%	94.0%	85.3%	79.7%	89.8%	85.4%	90.0%	100.0%	91.7%	80.0%	84.2%	100.0%	N/A	93.0%	83.3%	85.4%	95.7%	91.2%	85.0%	92.9%
Non-board member; does not regularly attend meetings	3.8%	2.0%	3.7%	6.8%	3.1%	7.3%	0.0%	0.0%	0.0%	6.7%	4.2%	0.0%	N/A	2.3%	4.8%	2.9%	2.2%	5.9%	0.0%	7.1%
Respondents with this position	96.9%	100.0%	97.8%	95.2%	95.1%	91.1%	100.0%	100.0%	97.3%	100.0%	96.5%	100.0%	N/A	100.0%	94.7%	98.1%	95.8%	100.0%	100.0%	100.0%
VP Medical Affairs/Chief Medical Officer																				
Total responding in each category	230	45	98	46	41	18	5	3	15	24	120	5	0	40	45	78	45	30	19	13
Voting board member	4.3%	0.0%	7.1%	4.3%	2.4%	5.6%	0.0%	0.0%	0.0%	16.7%	4.2%	0.0%	N/A	0.0%	4.4%	6.4%	6.7%	0.0%	0.0%	0.0%
Non-voting board member	9.1%	2.2%	13.3%	8.7%	7.3%	11.1%	0.0%	0.0%	6.7%	12.5%	11.7%	0.0%	N/A	2.5%	13.3%	12.8%	2.2%	6.7%	10.5%	0.0%
Non-board member; regularly attends meetings	75.7%	82.2%	69.4%	73.9%	85.4%	72.2%	100.0%	100.0%	93.3%	58.3%	73.3%	100.0%	N/A	80.0%	71.1%	71.8%	82.2%	83.3%	63.2%	92.3%
Non-board member; does not regularly attend meetings	10.9%	15.6%	10.2%	13.0%	4.9%	11.1%	0.0%	0.0%	0.0%	12.5%	10.8%	0.0%	N/A	17.5%	11.1%	9.0%	8.9%	10.0%	26.3%	7.7%
Respondents with this position	65.0%	90.0%	70.5%	74.2%	39.8%	40.0%	50.0%	27.2%	40.5%	80.0%	70.2%	71.4%	N/A	93.0%	33.4%	74.3%	93.8%	88.2%	95.0%	92.9%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 of Staff																				
Total responding in each category	292	30	112	53	97	42	10	10	35	23	142	2	0	28	118	93	36	23	15	7
Voting board member	34.2%	43.3%	42.9%	50.9%	12.4%	16.7%	0.0%	30.0%	5.7%	43.5%	45.8%	0.0%	N/A	46.4%	24.6%	36.6%	44.4%	56.5%	26.7%	57.1%
Non-voting board member	16.4%	6.7%	21.4%	15.1%	14.4%	7.1%	30.0%	20.0%	17.1%	34.8%	16.9%	0.0%	N/A	7.1%	16.1%	20.4%	13.9%	8.7%	13.3%	14.3%
Non-board member; regularly attends meetings	35.6%	30.0%	26.8%	26.4%	52.6%	52.4%	50.0%	50.0%	54.3%	17.4%	28.2%	100.0%	N/A	25.0%	39.0%	35.5%	33.3%	30.4%	26.7%	28.6%
Non-board member; does not regularly attend meetings	13.7%	20.0%	8.9%	7.5%	20.6%	23.8%	20.0%	0.0%	22.9%	4.3%	9.2%	0.0%	N/A	21.4%	20.3%	7.5%	8.3%	4.3%	33.3%	0.0%
Respondents with this position	82.5%	60.0%	80.6%	85.5%	94.2%	93.3%	100.0%	90.9%	94.6%	76.7%	83.0%	28.6%	N/A	65.1%	88.7%	88.6%	75.0%	67.6%	75.0%	50.0%
Chief Nursing Officer																				
Total responding in each category	326	36	133	59	98	41	9	11	37	29	163	3	0	33	126	100	46	31	14	9
Voting board member	0.9%	0.0%	0.0%	5.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	0.0%	0.0%	2.0%	0.0%	3.2%	0.0%	0.0%
Non-voting board member	8.0%	2.8%	9.0%	10.2%	7.1%	7.3%	11.1%	0.0%	8.1%	13.8%	8.6%	0.0%	N/A	3.0%	8.7%	11.0%	0.0%	6.5%	14.3%	0.0%
Non-board member; regularly attends meetings	75.5%	58.3%	75.9%	72.9%	82.7%	78.0%	66.7%	100.0%	86.5%	65.5%	76.7%	66.7%	N/A	57.6%	77.8%	77.0%	82.6%	67.7%	64.3%	33.3%
Non-board member; does not regularly attend meetings	15.6%	38.9%	15.0%	11.9%	10.2%	14.6%	22.2%	0.0%	5.4%	20.7%	12.9%	33.3%	N/A	39.4%	13.5%	10.0%	17.4%	22.6%	21.4%	66.7%
Respondents with this position	92.1%	72.0%	95.7%	95.2%	95.1%	91.1%	90.0%	100.0%	100.0%	96.7%	95.3%	42.3%	N/A	76.7%	94.7%	95.2%	95.8%	91.2%	70.0%	64.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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	258	45	106	41	66	29	5	6	26	22	125	5	0	40	77	82	39	27	19	14
Voting board member	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%
Non-voting board member	2.7%	0.0%	2.8%	0.0%	6.1%	6.9%	0.0%	0.0%	7.7%	0.0%	2.4%	0.0%	N/A	0.0%	5.2%	3.7%	0.0%	0.0%	0.0%	0.0%
Non-board member; regularly attends meetings	32.9%	28.9%	35.8%	26.8%	34.8%	20.7%	80.0%	16.7%	46.2%	40.9%	32.0%	20.0%	N/A	30.0%	24.7%	39.0%	30.8%	37.0%	36.8%	35.7%
Non-board member; does not regularly attend meetings	64.3%	71.1%	61.3%	73.2%	59.1%	72.4%	20.0%	83.3%	46.2%	59.1%	65.6%	80.0%	N/A	70.0%	70.1%	57.3%	69.2%	63.0%	63.2%	64.3%
Respondents with this position	72.9%	90.0%	76.3%	66.1%	64.1%	64.4%	50.0%	54.5%	70.3%	73.3%	73.1%	71.4%	N/A	93.0%	57.9%	78.1%	81.2%	79.4%	95.0%	100.0%
Legal Counsel																				
Total responding in each category	261%	47%	94%	50%	70%	27%	4%	9%	30%	24%	120%	6%	0%	41%	80%	76%	41%	30%	20%	14%
Voting board member	1.1%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.5%	0.0%	N/A	0.0%	0.0%	3.9%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	4.6%	4.3%	2.1%	6.0%	7.1%	7.4%	0.0%	0.0%	10.0%	4.2%	3.3%	0.0%	N/A	4.9%	5.0%	6.6%	0.0%	0.0%	15.0%	0.0%
Non-board member; regularly attends meetings	60.2%	78.7%	56.4%	64.0%	50.0%	48.1%	50.0%	55.6%	50.0%	58.3%	59.2%	83.3%	N/A	78.0%	35.0%	57.9%	82.9%	80.0%	80.0%	78.6%
Non-board member; does not regularly attend meetings	34.1%	17.0%	38.3%	30.0%	42.9%	44.4%	50.0%	44.4%	40.0%	37.5%	35.0%	16.7%	N/A	17.1%	60.0%	31.6%	17.1%	20.0%	5.0%	21.4%
Respondents with this position	73.7%	94.0%	67.6%	80.6%	70.0%	60.0%	40.0%	81.8%	81.1%	80.0%	70.2%	85.7%	N/A	95.3%	60.2%	72.4%	85.4%	88.2%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Compliance Officer																				
Total responding in each category	315	46	122	57	90	38	8	11	33	27	152	6	0	40	114	95	43	31	18	14
Voting board member	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%
Non-voting board member	1.6%	0.0%	0.0%	1.8%	4.4%	5.3%	0.0%	0.0%	6.1%	0.0%	0.7%	0.0%	N/A	0.0%	3.5%	1.1%	0.0%	0.0%	0.0%	0.0%
Non-board member; regularly attends meetings	41.6%	26.1%	37.7%	31.6%	61.1%	50.0%	50.0%	54.5%	78.8%	37.0%	35.5%	0.0%	N/A	30.0%	50.9%	41.1%	37.2%	29.0%	38.9%	14.3%
Non-board member; does not regularly attend meetings	56.8%	73.9%	62.3%	66.7%	34.4%	44.7%	50.0%	45.5%	15.2%	63.0%	63.8%	100.0%	N/A	70.0%	45.6%	57.9%	62.8%	71.0%	61.1%	85.7%
Respondents with this position	88.9%	92.0%	87.8%	91.9%	87.4%	84.4%	80.0%	100.0%	89.1%	90.0%	88.9%	90.0%	N/A	93.0%	85.7%	90.4%	89.6%	91.2%	90.0%	100.0%
Past president of medical staff																				
Total responding in each category	250	29	106	44	71	29	8	7	27	23	127	0	0	29	77	88	40	25	14	6
Voting board member	8.0%	3.4%	11.3%	13.6%	1.4%	3.4%	0.0%	0.0%	0.0%	4.3%	13.4%	N/A	N/A	3.4%	2.6%	9.1%	12.5%	16.0%	0.0%	16.7%
Non-voting board member	2.8%	0.0%	0.9%	4.5%	5.6%	10.3%	0.0%	0.0%	3.7%	0.0%	2.4%	N/A	N/A	0.0%	3.9%	1.1%	2.5%	4.0%	7.1%	0.0%
Non-board member; regularly attends meetings	5.6%	3.4%	3.8%	11.4%	5.6%	3.4%	0.0%	28.6%	3.7%	4.3%	6.3%	N/A	N/A	3.4%	1.3%	6.8%	10.0%	8.0%	7.1%	0.0%
Non-board member; does not regularly attend meetings	83.6%	93.1%	84.0%	70.5%	87.3%	82.8%	100.0%	71.4%	92.6%	91.3%	78.0%	N/A	N/A	93.1%	92.2%	83.0%	75.0%	72.0%	85.7%	83.3%
Respondents with this position	70.6%	58.0%	76.3%	71.0%	68.9%	64.4%	80.0%	63.6%	72.9%	76.7%	74.3%	N/A	N/A	67.4%	57.9%	83.8%	83.3%	73.5%	70.0%	42.9%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
President-elect of medical staff																				
Total responding in each category	257	28	113	49	67	26	8	7	26	24	138	0	0	28	79	91	43	24	14	6
Voting board member	8.6%	3.6%	10.6%	16.3%	1.5%	0.0%	0.0%	0.0%	3.8%	12.5%	12.3%	N/A	N/A	3.6%	3.8%	8.8%	16.3%	16.7%	0.0%	0.0%
Non-voting board member	7.4%	3.6%	7.1%	8.2%	9.0%	15.4%	12.5%	0.0%	3.8%	12.5%	6.5%	N/A	N/A	3.6%	6.3%	6.6%	2.3%	20.8%	7.1%	16.7%
Non-board member; regularly attends meetings	13.6%	14.3%	10.6%	24.5%	10.4%	15.4%	0.0%	28.6%	3.8%	12.5%	15.2%	N/A	N/A	14.3%	3.8%	16.5%	23.3%	12.5%	14.3%	33.3%
Non-board member; does not regularly attend meetings	70.4%	78.6%	71.7%	51.0%	79.1%	69.2%	87.5%	71.4%	88.5%	62.5%	65.9%	N/A	N/A	78.6%	86.1%	68.1%	58.1%	50.0%	78.6%	50.0%
Respondents with this position	72.6%	56.0%	81.3%	79.0%	65.0%	57.8%	80.0%	63.6%	70.3%	80.0%	80.7%	N/A	N/A	65.1%	59.4%	86.7%	89.6%	70.6%	70.0%	42.3%
Representative of an owned or affiliated medical group or physician enterprise																				
Total responding in each category	170	34	65	33	38	16	4	4	14	17	81	1	0	33	39	50	33	22	15	11
Voting board member	17.6%	26.5%	20.0%	18.2%	5.3%	6.3%	0.0%	25.0%	0.0%	23.5%	18.5%	0.0%	N/A	27.3%	25.6%	8.0%	24.2%	9.1%	13.3%	36.4%
Non-voting board member	2.9%	2.9%	0.0%	3.0%	7.9%	6.3%	25.0%	0.0%	7.1%	5.9%	0.0%	0.0%	N/A	3.0%	5.1%	2.0%	0.0%	0.0%	13.3%	0.0%
Non-board member; regularly attends meetings	18.2%	17.6%	18.5%	12.1%	23.7%	31.3%	25.0%	0.0%	21.4%	29.4%	13.6%	100.0%	N/A	15.2%	17.9%	22.0%	18.2%	13.6%	13.3%	18.2%
Non-board member; does not regularly attend meetings	61.2%	52.9%	61.5%	66.7%	63.2%	56.3%	50.0%	75.0%	71.4%	41.2%	67.9%	0.0%	N/A	54.5%	51.3%	68.0%	57.6%	77.3%	60.0%	45.5%
Respondents with this position	48.0%	68.0%	46.8%	53.2%	36.9%	35.6%	40.0%	36.4%	37.8%	56.7%	47.4%	14.3%	N/A	76.7%	29.3%	47.6%	68.8%	64.7%	75.0%	78.6%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 philanthropic foundation																				
Total responding in each category	204	29	80	43	52	22	6	3	21	20	103	1	0	28	58	69	33	20	15	9
Voting board member	13.7%	20.7%	12.5%	25.6%	1.9%	4.5%	0.0%	0.0%	0.0%	10.0%	18.4%	0.0%	N/A	21.4%	8.6%	14.5%	15.2%	10.0%	20.0%	33.3%
Non-voting board member	5.4%	0.0%	7.5%	4.7%	5.8%	9.1%	0.0%	0.0%	4.8%	5.0%	6.8%	0.0%	N/A	0.0%	6.9%	4.3%	6.1%	5.0%	6.7%	0.0%
Non-board member; regularly attends meetings	27.9%	20.7%	30.0%	27.9%	28.8%	22.7%	50.0%	0.0%	33.3%	45.0%	26.2%	0.0%	N/A	21.4%	20.7%	33.3%	24.2%	55.0%	13.3%	11.1%
Non-board member; does not regularly attend meetings	52.9%	58.6%	50.0%	41.9%	63.5%	63.6%	50.0%	100.0%	61.9%	40.0%	48.5%	100.0%	N/A	57.1%	63.8%	47.8%	54.5%	30.0%	60.0%	55.6%
Respondents with this position	57.6%	58.0%	57.6%	69.4%	50.5%	48.9%	60.0%	27.2%	56.8%	66.7%	60.2%	14.3%	N/A	65.1%	43.6%	65.7%	68.8%	58.8%	75.0%	64.3%
Representative of a religious sponsor																				
Total responding in each category	82	19	28	28	7	3	0	2	2	21	35	6	0	13	16	21	19	12	9	5
Voting board member	62.2%	73.7%	50.0%	82.1%	0.0%	0.0%	N/A	0.0%	0.0%	95.2%	48.6%	100.0%	N/A	61.5%	50.0%	61.9%	63.2%	66.7%	55.6%	100.0%
Non-voting board member	2.4%	0.0%	0.0%	0.0%	28.6%	33.3%	N/A	0.0%	50.0%	0.0%	0.0%	0.0%	N/A	0.0%	6.3%	0.0%	0.0%	0.0%	11.1%	0.0%
Non-board member; regularly attends meetings	1.2%	0.0%	3.6%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	4.8%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	8.3%	0.0%	0.0%
Non-board member; does not regularly attend meetings	34.1%	26.3%	46.4%	17.9%	71.4%	66.7%	N/A	100.0%	50.0%	0.0%	51.4%	0.0%	N/A	38.5%	43.8%	38.1%	36.8%	25.0%	33.3%	0.0%
Respondents with this position	23.2%	38.0%	20.1%	45.2%	6.8%	6.7%	N/A	18.2%	5.4%	70.0%	20.5%	85.7%	N/A	30.2%	12.0%	20.0%	39.6%	35.3%	45.0%	35.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Background of the organization's CEO																				
Total responding in each category	352	50	138	62	102	44	10	11	37	30	170	7	0	43	131	105	48	34	20	14
Physician	7.4%	16.0%	7.2%	8.1%	2.9%	0.0%	10.0%	0.0%	5.4%	6.7%	7.6%	14.3%	N/A	16.3%	1.5%	7.6%	12.5%	11.8%	15.0%	21.4%
Nurse	11.9%	6.0%	10.9%	17.7%	12.7%	13.6%	10.0%	18.2%	10.8%	13.3%	12.9%	0.0%	N/A	7.0%	16.8%	12.4%	6.3%	8.8%	5.0%	0.0%
Other clinical expertise	11.9%	12.0%	11.6%	14.5%	10.8%	13.6%	10.0%	0.0%	10.8%	16.7%	11.8%	42.9%	N/A	7.0%	13.0%	12.4%	10.4%	17.6%	0.0%	7.1%
Business/finance (for-profit)	47.2%	38.0%	46.4%	40.3%	56.9%	52.3%	60.0%	63.6%	59.5%	40.0%	45.3%	14.3%	N/A	41.9%	51.9%	46.7%	50.0%	29.4%	40.0%	50.0%
Non-profit/ not-for-profit	44.0%	58.0%	47.1%	41.9%	34.3%	34.1%	30.0%	27.3%	37.8%	46.7%	45.3%	57.1%	N/A	58.1%	37.4%	42.9%	45.8%	55.9%	65.0%	50.0%
Other non-clinical/ non-healthcare	9.1%	14.0%	10.9%	9.7%	3.9%	6.8%	0.0%	0.0%	2.7%	20.0%	8.8%	28.6%	N/A	11.6%	8.4%	9.5%	4.2%	14.7%	15.0%	7.1%
Background of the organization's board chairperson																				
Total responding in each category	352	50	138	62	102	44	10	11	37	30	170	7	0	43	131	105	48	34	20	14
Physician	5.4%	4.0%	5.1%	8.1%	4.9%	6.8%	0.0%	9.1%	2.7%	3.3%	6.5%	0.0%	N/A	4.7%	3.8%	3.8%	10.4%	8.8%	5.0%	7.1%
Nurse	2.8%	2.0%	2.2%	3.2%	3.9%	6.8%	0.0%	0.0%	2.7%	0.0%	2.9%	14.3%	N/A	0.0%	4.6%	1.0%	0.0%	5.9%	0.0%	7.1%
Other clinical expertise	4.5%	6.0%	5.8%	3.2%	2.9%	2.3%	0.0%	0.0%	5.4%	6.7%	4.7%	14.3%	N/A	4.7%	4.6%	5.7%	4.2%	0.0%	5.0%	7.1%
Business/finance (for-profit)	66.8%	62.0%	68.8%	66.1%	66.7%	59.1%	80.0%	81.8%	67.6%	66.7%	68.2%	42.9%	N/A	65.1%	66.4%	69.5%	70.8%	58.8%	60.0%	64.3%
Non-profit/ not-for-profit	9.4%	14.0%	9.4%	4.8%	9.8%	13.6%	10.0%	9.1%	5.4%	16.7%	6.5%	28.6%	N/A	11.6%	9.2%	12.4%	2.1%	8.8%	15.0%	7.1%
Other non-clinical/ non-healthcare	19.3%	20.0%	18.8%	17.7%	20.6%	25.0%	20.0%	9.1%	18.9%	23.3%	17.6%	28.6%	N/A	18.6%	21.4%	17.1%	14.6%	23.5%	25.0%	14.3%
Regularly scheduled board meetings per year																				
Total responding in each category	352	50	138	62	102	44	10	11	37	30	170	7	0	43	131	105	48	34	20	14
Less than 2 per year	0.3%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
2 per year	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.0%	0.0%	2.1%	0.0%	0.0%	0.0%
4 per year (quarterly)	8.0%	26.0%	5.8%	11.3%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	7.1%	100.0%	N/A	14.0%	3.1%	4.8%	8.3%	14.7%	20.0%	42.9%
6 per year	17.3%	38.0%	11.6%	33.9%	4.9%	6.8%	0.0%	0.0%	5.4%	33.3%	15.9%	0.0%	N/A	44.2%	8.4%	15.2%	14.6%	41.2%	45.0%	28.6%
7 to 9 per year	6.3%	10.0%	8.7%	8.1%	0.0%	0.0%	0.0%	0.0%	0.0%	16.7%	7.1%	0.0%	N/A	11.6%	1.5%	2.9%	20.8%	11.8%	10.0%	7.1%
10 to 11 per year	29.8%	24.0%	42.0%	25.8%	18.6%	13.6%	30.0%	45.5%	13.5%	30.0%	38.2%	0.0%	N/A	27.9%	28.2%	39.0%	29.2%	20.6%	15.0%	21.4%
12 per year (monthly)	32.4%	0.0%	25.4%	17.7%	66.7%	77.3%	60.0%	36.4%	64.9%	10.0%	25.3%	0.0%	N/A	0.0%	49.6%	33.3%	18.8%	11.8%	5.0%	0.0%
More than 12 per year	5.7%	2.0%	5.8%	1.6%	9.8%	2.3%	10.0%	18.2%	16.2%	0.0%	5.3%	0.0%	N/A	2.3%	8.4%	4.8%	6.3%	0.0%	5.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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) of a typical board meeting																				
Total responding in each category	351	50	138	62	101	43	10	11	37	30	170	7	0	43	130	105	48	34	20	14
Less than 2 hours	30.5%	16.0%	34.8%	16.1%	40.6%	34.9%	70.0%	54.5%	35.1%	6.7%	32.9%	0.0%	N/A	18.6%	37.7%	34.3%	22.9%	20.6%	15.0%	7.1%
2 to 4 hours	62.7%	64.0%	60.9%	72.6%	58.4%	62.8%	30.0%	45.5%	64.9%	86.7%	60.6%	42.9%	N/A	67.4%	60.8%	62.9%	60.4%	70.6%	75.0%	50.0%
4 to 6 hours	4.6%	8.0%	2.9%	11.3%	1.0%	2.3%	0.0%	0.0%	0.0%	3.3%	5.9%	28.6%	N/A	4.7%	0.8%	2.9%	16.7%	2.9%	0.0%	21.4%
6 to 8 hours	0.6%	2.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	0.0%	N/A	2.3%	0.0%	0.0%	0.0%	2.9%	0.0%	7.1%
More than 8 hours	1.7%	10.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	28.6%	N/A	7.0%	0.8%	0.0%	0.0%	2.9%	10.0%	14.3%
The board uses a consent agenda																				
Total responding in each category	347	50	137	62	98	41	10	11	36	30	169	7	0	43	128	105	47	34	19	14
Yes	74.9%	86.0%	75.2%	75.8%	68.4%	63.4%	70.0%	72.7%	72.2%	76.7%	75.1%	85.7%	N/A	86.0%	65.6%	78.1%	80.9%	82.4%	84.2%	85.7%
Board meeting content: average and median percent of meeting time spent:																				
Receiving reports from management, board committees, and subsidiaries (not including financial and quality/safety reports)																				
Average	23.70	21.88	24.24	20.58	25.80	25.83	22.00	21.82	27.97	21.38	23.39	18.57	N/A	22.42	24.96	23.75	21.83	21.29	24.42	22.86
Median	20	20	20	20	25	25	23	25	25	20	20	20	N/A	20	25	20	20	20	20	20
Discussing strategy and setting policy																				
Average	25.61	28.72	26.56	26.23	22.41	20.48	21.00	30.91	22.46	25.00	26.70	36.43	N/A	27.47	23.37	25.57	28.77	29.47	21.47	32.14
Median	20	25	20	25	20	20	20	30	20	25	20	30	N/A	25	20	20	25	30	20	30
Reviewing financial performance																				
Average	18.99	19.40	17.81	17.06	21.59	22.62	19.50	20.45	21.32	19.66	17.21	16.14	N/A	19.93	20.64	18.28	16.00	19.00	22.58	14.50
Median	20	20	20	20	20	20	20	20	20	20	16	10	N/A	20	20	20	15	20	25	13
Reviewing quality of care/patient safety metrics																				
Average	20.45	19.22	19.31	23.48	20.72	19.64	27.00	16.82	21.41	22.07	20.38	18.57	N/A	19.33	20.19	19.92	22.45	20.26	21.79	18.71
Median	20	20	20	20	20	20	25	20	20	20	20	15	N/A	20	20	20	20	20	20	20
Board member education																				
Average	11.24	10.78	12.08	12.65	9.48	11.43	10.50	10.00	6.84	11.90	12.32	10.29	N/A	10.86	10.84	12.48	10.96	9.97	9.74	11.79
Median	10	10	10	10	10	10	10	10	5	10	10	10	N/A	10	10	10	10	10	10	10

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Percent of meeting time spent discussing strategy and setting policy																				
Total responding in each category	347	50	135	62	100	42	10	11	37	29	168	7	0	43	128	105	47	34	19	14
0–10%	18.2%	20.0%	17.0%	8.1%	25.0%	26.2%	30.0%	0.0%	29.7%	10.3%	14.9%	0.0%	N/A	23.3%	20.3%	18.1%	12.8%	14.7%	31.6%	7.1%
11–20%	32.3%	18.0%	33.3%	38.7%	34.0%	38.1%	30.0%	45.5%	27.0%	31.0%	35.7%	14.3%	N/A	18.6%	39.1%	32.4%	25.5%	23.5%	26.3%	21.4%
21–30%	26.2%	30.0%	22.2%	30.6%	27.0%	28.6%	30.0%	18.2%	27.0%	34.5%	23.2%	42.9%	N/A	27.9%	24.2%	26.7%	27.7%	26.5%	31.6%	28.6%
31–40%	9.5%	8.0%	10.4%	12.9%	7.0%	2.4%	10.0%	18.2%	8.1%	20.7%	9.5%	0.0%	N/A	9.3%	6.3%	10.5%	17.0%	8.8%	5.3%	14.3%
41–50%	9.5%	20.0%	10.4%	6.5%	5.0%	4.8%	0.0%	9.1%	5.4%	3.4%	10.1%	42.9%	N/A	16.3%	7.8%	4.8%	12.8%	23.5%	0.0%	28.6%
51–60%	2.6%	4.0%	4.4%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	0.0%	N/A	4.7%	1.6%	3.8%	2.1%	2.9%	5.3%	0.0%
61–70%	1.2%	0.0%	1.5%	0.0%	2.0%	0.0%	0.0%	9.1%	2.7%	0.0%	1.2%	0.0%	N/A	0.0%	0.8%	2.9%	0.0%	0.0%	0.0%	0.0%
71–80%	0.6%	0.0%	0.7%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	N/A	0.0%	0.0%	1.0%	2.1%	0.0%	0.0%	0.0%
81% +	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%
Frequency of scheduled executive sessions (N/A excluded)																				
Total respondents that hold scheduled executive sessions	232	33	96	40	63	25	4	9	25	24	112	5	0	28	80	69	39	20	13	11
After or before every board meeting	61.6%	87.9%	54.2%	52.5%	65.1%	72.0%	50.0%	44.4%	68.0%	58.3%	52.7%	100.0%	N/A	85.7%	60.0%	50.7%	59.0%	70.0%	92.3%	100.0%
After or before every other board meeting	9.5%	3.0%	12.5%	7.5%	9.5%	4.0%	0.0%	0.0%	20.0%	4.2%	12.5%	0.0%	N/A	3.6%	10.0%	8.7%	15.4%	10.0%	0.0%	0.0%
Quarterly	5.2%	0.0%	2.1%	15.0%	6.3%	4.0%	25.0%	22.2%	0.0%	4.2%	6.3%	0.0%	N/A	0.0%	5.0%	7.2%	5.1%	5.0%	0.0%	0.0%
Twice a year	6.9%	0.0%	12.5%	2.5%	4.8%	4.0%	25.0%	0.0%	4.0%	12.5%	8.9%	0.0%	N/A	0.0%	10.0%	7.2%	5.1%	5.0%	0.0%	0.0%
Once a year	10.8%	3.0%	13.5%	10.0%	11.1%	16.0%	0.0%	22.2%	4.0%	8.3%	13.4%	0.0%	N/A	3.6%	11.3%	17.4%	7.7%	5.0%	0.0%	0.0%
Less often than once a year	2.2%	0.0%	2.1%	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	8.3%	2.7%	0.0%	N/A	0.0%	1.3%	5.8%	0.0%	0.0%	0.0%	0.0%
Other	3.9%	6.1%	3.1%	5.0%	3.2%	0.0%	0.0%	11.1%	4.0%	4.2%	3.6%	0.0%	N/A	7.1%	2.5%	2.9%	7.7%	5.0%	7.7%	0.0%
The CEO attends scheduled executive sessions																				
Total responding in each category	235	34	96	41	64	25	5	9	25	24	113	6	0	28	81	70	39	20	13	12
Always	51.9%	52.9%	37.5%	46.3%	76.6%	72.0%	60.0%	77.8%	84.0%	45.8%	38.9%	33.3%	N/A	57.1%	65.4%	40.0%	48.7%	40.0%	69.2%	41.7%
Most of the time	31.9%	32.4%	38.5%	34.1%	20.3%	24.0%	40.0%	22.2%	12.0%	41.7%	36.3%	33.3%	N/A	32.1%	21.0%	40.0%	35.9%	45.0%	30.8%	25.0%
Sometimes	9.4%	11.8%	13.5%	7.3%	3.1%	4.0%	0.0%	0.0%	4.0%	8.3%	12.4%	33.3%	N/A	7.1%	7.4%	12.9%	5.1%	5.0%	0.0%	33.3%
Rarely	6.8%	2.9%	10.4%	12.2%	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	12.4%	0.0%	N/A	3.6%	6.2%	7.1%	10.3%	10.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Clinical board members financially affiliated with the organization attend scheduled executive sessions																				
Total responding in each category	219	33	91	40	55	21	4	8	22	22	109	6	0	27	74	65	37	18	13	12
Always	26.9%	18.2%	27.5%	45.0%	18.2%	19.0%	25.0%	25.0%	13.6%	54.5%	28.4%	0.0%	N/A	22.2%	20.3%	32.3%	40.5%	22.2%	23.1%	8.3%
Most of the time	13.7%	21.2%	12.1%	7.5%	16.4%	9.5%	25.0%	25.0%	18.2%	9.1%	11.0%	0.0%	N/A	25.9%	10.8%	13.8%	13.5%	16.7%	15.4%	25.0%
Sometimes	14.6%	6.1%	15.4%	7.5%	23.6%	19.0%	25.0%	12.5%	31.8%	13.6%	12.8%	0.0%	N/A	7.4%	18.9%	15.4%	13.5%	11.1%	0.0%	8.3%
Rarely	44.7%	54.5%	45.1%	40.0%	41.8%	52.4%	25.0%	37.5%	36.4%	22.7%	47.7%	100.0%	N/A	44.4%	50.0%	38.5%	32.4%	50.0%	61.5%	58.3%
Legal counsel attends scheduled executive sessions																				
Total responding in each category	227	33	92	40	62	24	4	9	25	22	110	6	0	27	77	69	38	18	13	12
Always	24.2%	33.3%	20.7%	20.0%	27.4%	20.8%	25.0%	44.4%	28.0%	22.7%	20.0%	0.0%	N/A	40.7%	15.6%	26.1%	31.6%	11.1%	46.2%	41.7%
Most of the time	11.9%	18.2%	6.5%	17.5%	12.9%	16.7%	0.0%	11.1%	12.0%	13.6%	9.1%	16.7%	N/A	18.5%	7.8%	11.6%	15.8%	22.2%	15.4%	8.3%
Sometimes	21.6%	15.2%	27.2%	22.5%	16.1%	25.0%	0.0%	0.0%	16.0%	22.7%	26.4%	33.3%	N/A	11.1%	22.1%	24.6%	18.4%	22.2%	23.1%	8.3%
Rarely	42.3%	33.3%	45.7%	40.0%	43.5%	37.5%	75.0%	44.4%	44.0%	40.9%	44.5%	50.0%	N/A	29.6%	54.5%	37.7%	34.2%	44.4%	15.4%	41.7%
Other management attends scheduled executive sessions																				
Total responding in each category	228	32	93	41	62	25	4	9	24	23	111	6	0	26	78	70	38	17	13	12
Always	6.6%	0.0%	2.2%	4.9%	17.7%	12.0%	0.0%	33.3%	20.8%	0.0%	3.6%	0.0%	N/A	0.0%	9.0%	7.1%	5.3%	5.9%	0.0%	0.0%
Most of the time	14.9%	18.8%	8.6%	9.8%	25.8%	36.0%	0.0%	11.1%	25.0%	4.3%	9.9%	0.0%	N/A	23.1%	19.2%	12.9%	10.5%	5.9%	38.5%	0.0%
Sometimes	25.9%	25.0%	22.6%	19.5%	35.5%	32.0%	100.0%	11.1%	37.5%	26.1%	20.7%	16.7%	N/A	26.9%	35.9%	21.4%	15.8%	23.5%	7.7%	41.7%
Rarely	52.6%	56.3%	66.7%	65.9%	21.0%	20.0%	0.0%	44.4%	16.7%	69.6%	65.8%	83.3%	N/A	50.0%	35.9%	58.6%	68.4%	64.7%	53.8%	58.3%
Frequency of scheduled board retreats																				
Total responding in each category	348	50	137	62	99	41	10	11	37	29	170	7	0	43	128	105	48	34	19	14
Quarterly	1.1%	0.0%	1.5%	1.6%	1.0%	0.0%	0.0%	9.1%	0.0%	0.0%	1.8%	0.0%	N/A	0.0%	0.0%	1.9%	4.2%	0.0%	0.0%	0.0%
Twice a year	9.2%	12.0%	8.8%	9.7%	8.1%	7.3%	0.0%	9.1%	10.8%	6.9%	9.4%	14.3%	N/A	11.6%	6.3%	10.5%	12.5%	11.8%	5.3%	14.3%
Once a year	52.3%	60.0%	52.6%	62.9%	41.4%	29.3%	50.0%	27.3%	56.8%	51.7%	56.5%	42.9%	N/A	62.8%	42.2%	53.3%	64.6%	64.7%	57.9%	57.1%
Less often than once a year	29.9%	20.0%	29.2%	21.0%	41.4%	53.7%	30.0%	54.5%	27.0%	34.5%	25.3%	42.9%	N/A	16.3%	43.0%	26.7%	14.6%	20.6%	15.8%	28.6%
Other	7.5%	8.0%	8.0%	4.8%	8.1%	9.8%	20.0%	0.0%	5.4%	6.9%	7.1%	0.0%	N/A	9.3%	8.6%	7.6%	4.2%	2.9%	21.1%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Who typically attends board retreats, other than board members?																				
Total responding in each category	342	50	135	62	95	41	9	10	35	30	167	7	0	43	124	104	47	34	19	14
CEO	95.3%	98.0%	94.1%	95.2%	95.8%	92.7%	100.0%	100.0%	97.1%	93.3%	94.6%	85.7%	N/A	100.0%	93.5%	97.1%	93.6%	94.1%	100.0%	100.0%
CMO	65.8%	88.0%	74.8%	66.1%	41.1%	39.0%	55.6%	40.0%	40.0%	70.0%	72.5%	71.4%	N/A	90.7%	40.3%	75.0%	83.0%	82.4%	94.7%	85.7%
CNO	78.7%	62.0%	85.9%	77.4%	77.9%	73.2%	77.8%	100.0%	77.1%	76.7%	84.4%	57.1%	N/A	62.8%	77.4%	87.5%	76.6%	82.4%	68.4%	35.7%
CFO	87.7%	96.0%	90.4%	83.9%	82.1%	82.9%	77.8%	100.0%	77.1%	83.3%	89.2%	85.7%	N/A	97.7%	83.1%	88.5%	91.5%	85.3%	100.0%	100.0%
Other C-suite executives/ senior leaders	83.3%	98.0%	81.5%	88.7%	74.7%	70.7%	66.7%	90.0%	77.1%	83.3%	83.8%	100.0%	N/A	97.7%	75.0%	81.7%	93.6%	91.2%	94.7%	100.0%
Governance support staff	42.4%	74.0%	42.2%	51.6%	20.0%	19.5%	22.2%	20.0%	20.0%	53.3%	43.7%	100.0%	N/A	69.8%	21.8%	43.3%	53.2%	64.7%	73.7%	85.7%
Medical staff physicians	54.4%	42.0%	57.0%	51.6%	58.9%	56.1%	77.8%	90.0%	48.6%	63.3%	53.9%	14.3%	N/A	46.5%	50.0%	65.4%	51.1%	52.9%	57.9%	21.4%
Nurses	9.4%	6.0%	9.6%	16.1%	6.3%	7.3%	11.1%	0.0%	5.7%	23.3%	9.6%	0.0%	N/A	7.0%	9.7%	8.7%	10.6%	14.7%	0.0%	7.1%
Other	13.2%	18.0%	13.3%	6.5%	14.7%	12.2%	22.2%	20.0%	14.3%	10.0%	11.4%	0.0%	N/A	20.9%	16.1%	11.5%	10.6%	8.8%	21.1%	7.1%
Number of standing committees																				
Total responding in each category	347	49	139	61	98	42	10	11	35	30	170	7	0	42	129	105	47	34	19	13
0	5.2%	0.0%	2.2%	4.9%	12.2%	21.4%	0.0%	0.0%	8.6%	3.3%	2.9%	0.0%	N/A	0.0%	11.6%	1.0%	4.3%	0.0%	0.0%	0.0%
1 to 3	10.4%	2.0%	5.8%	14.8%	18.4%	19.0%	10.0%	0.0%	25.7%	6.7%	8.8%	14.3%	N/A	0.0%	19.4%	7.6%	0.0%	8.8%	0.0%	0.0%
4 to 5	11.5%	12.2%	10.8%	11.5%	12.2%	7.1%	20.0%	36.4%	8.6%	20.0%	9.4%	14.3%	N/A	11.9%	14.0%	8.6%	10.6%	17.6%	10.5%	0.0%
6 to 7	24.5%	30.6%	27.3%	27.9%	15.3%	14.3%	30.0%	18.2%	11.4%	30.0%	27.1%	28.6%	N/A	31.0%	16.3%	28.6%	29.8%	26.5%	42.1%	23.1%
8 to 10	30.5%	51.0%	31.7%	24.6%	22.4%	16.7%	20.0%	27.3%	28.6%	20.0%	31.2%	42.9%	N/A	52.4%	19.4%	34.3%	36.2%	26.5%	47.4%	76.9%
11+	17.9%	4.1%	22.3%	16.4%	19.4%	21.4%	20.0%	18.2%	17.1%	20.0%	20.6%	0.0%	N/A	4.8%	19.4%	20.0%	19.1%	20.6%	0.0%	0.0%
Average	7.46	7.63	8.24	6.97	6.58	6.14	7.10	7.82	6.57	7.57	7.91	6.57	N/A	7.81	6.56	8.10	8.28	7.53	7.47	8.23
Median	7	8	8	7	7	6	7	7	7	7	8	6	N/A	8	6	8	8	7	7	8
Range	0 to 17	3 to 17	0 to 17	0 to 17	0 to 17	0 to 16	1 to 13	4 to 14	0 to 17	0 to 17	0 to 17	3 to 10	N/A	5 to 17	0 to 17	0 to 17	0 to 17	1 to 17	5 to 10	6 to 10

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 (N/A Excluded)																				
Executive																				
Total responding in each category	255	40	118	44	53	23	7	7	16	26	136	7	0	33	81	80	40	26	16	12
Monthly	25.1%	12.5%	29.7%	15.9%	32.1%	26.1%	42.9%	28.6%	37.5%	19.2%	27.2%	14.3%	N/A	12.1%	19.8%	35.0%	35.0%	11.5%	12.5%	8.3%
Bi-monthly	8.2%	12.5%	5.9%	13.6%	5.7%	8.7%	0.0%	0.0%	6.3%	23.1%	5.1%	0.0%	N/A	15.2%	6.2%	5.0%	5.0%	23.1%	25.0%	0.0%
Quarterly	7.5%	10.0%	4.2%	13.6%	7.5%	4.3%	28.6%	14.3%	0.0%	0.0%	8.1%	28.6%	N/A	6.1%	7.4%	6.3%	10.0%	3.8%	6.3%	16.7%
Semi-annually	4.7%	5.0%	4.2%	4.5%	5.7%	4.3%	0.0%	14.3%	6.3%	7.7%	3.7%	0.0%	N/A	6.1%	4.9%	1.3%	10.0%	3.8%	12.5%	0.0%
Annually	1.6%	0.0%	2.5%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	7.7%	1.5%	0.0%	N/A	0.0%	1.2%	2.5%	2.5%	0.0%	0.0%	0.0%
As needed	52.9%	60.0%	53.4%	50.0%	49.1%	56.5%	28.6%	42.9%	50.0%	42.3%	54.4%	57.1%	N/A	60.6%	60.5%	50.0%	37.5%	57.7%	43.8%	75.0%
Respondents with this committee	72.0%	80.0%	84.9%	71.0%	51.5%	51.1%	70.0%	63.6%	43.2%	86.7%	79.5%	100.0%	N/A	76.7%	60.9%	76.2%	83.3%	76.5%	80.0%	85.7%
Finance																				
Total responding in each category	296	47	128	46	75	27	10	11	27	26	148	5	0	42	98	95	44	27	19	13
Monthly	61.1%	36.2%	67.2%	50.0%	73.3%	74.1%	80.0%	54.5%	77.8%	34.6%	67.6%	0.0%	N/A	40.5%	67.3%	72.6%	56.8%	48.1%	21.1%	30.8%
Bi-monthly	14.2%	27.7%	10.2%	28.3%	4.0%	11.1%	0.0%	0.0%	0.0%	30.8%	12.2%	0.0%	N/A	31.0%	5.1%	10.5%	18.2%	33.3%	42.1%	15.4%
Quarterly	17.6%	36.2%	17.2%	15.2%	8.0%	7.4%	0.0%	27.3%	3.7%	30.8%	14.2%	100.0%	N/A	28.6%	9.2%	14.7%	22.7%	18.5%	36.8%	53.8%
Semi-annually	1.7%	0.0%	1.6%	0.0%	4.0%	3.7%	0.0%	9.1%	3.7%	0.0%	1.4%	0.0%	N/A	0.0%	3.1%	1.1%	2.3%	0.0%	0.0%	0.0%
Annually	1.4%	0.0%	0.8%	0.0%	4.0%	3.7%	0.0%	9.1%	3.7%	0.0%	0.7%	0.0%	N/A	0.0%	4.1%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	4.1%	0.0%	3.1%	6.5%	6.7%	0.0%	20.0%	0.0%	11.1%	3.8%	4.1%	0.0%	N/A	0.0%	11.2%	1.1%	0.0%	0.0%	0.0%	0.0%
Respondents with this committee	83.6%	94.0%	92.1%	74.2%	72.8%	60.0%	100.0%	100.0%	73.0%	86.7%	86.5%	71.4%	N/A	97.7%	73.7%	90.5%	91.7%	79.4%	95.0%	92.9%
Audit																				
Total responding in each category	115	13	58	12	32	15	3	2	12	8	62	0	0	13	43	42	13	9	5	3
Monthly	0.9%	0.0%	0.0%	0.0%	3.1%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	0.0%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	4.3%	15.4%	1.7%	8.3%	3.1%	6.7%	0.0%	0.0%	0.0%	0.0%	3.2%	N/A	N/A	15.4%	4.7%	2.4%	0.0%	11.1%	20.0%	0.0%
Quarterly	24.3%	53.8%	22.4%	41.7%	9.4%	13.3%	0.0%	50.0%	0.0%	62.5%	21.0%	N/A	N/A	53.8%	4.7%	16.7%	69.2%	55.6%	40.0%	100.0%
Semi-annually	17.4%	7.7%	25.9%	0.0%	12.5%	0.0%	33.3%	0.0%	25.0%	25.0%	21.0%	N/A	N/A	7.7%	7.0%	33.3%	15.4%	0.0%	20.0%	0.0%
Annually	38.3%	23.1%	36.2%	25.0%	53.1%	53.3%	66.7%	0.0%	58.3%	12.5%	37.1%	N/A	N/A	23.1%	60.5%	31.0%	7.7%	33.3%	20.0%	0.0%
As needed	14.8%	0.0%	13.8%	25.0%	18.8%	20.0%	0.0%	50.0%	16.7%	0.0%	17.7%	N/A	N/A	0.0%	23.3%	14.3%	7.7%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Respondents with this committee	32.5%	26.0%	41.7%	19.4%	31.1%	33.3%	30.0%	18.2%	32.4%	26.7%	36.3%	N/A	N/A	30.2%	32.3%	40.0%	27.1%	26.5%	25.0%	21.4%
Audit/Compliance																				
Total responding in each category	179	38	76	36	29	13	2	3	11	17	95	6	0	32	40	54	36	23	15	11
Monthly	5.6%	2.6%	7.9%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%	7.4%	0.0%	N/A	3.1%	5.0%	9.3%	2.8%	4.3%	6.7%	0.0%
Bi-monthly	12.8%	15.8%	11.8%	16.7%	6.9%	15.4%	0.0%	0.0%	0.0%	17.6%	12.6%	0.0%	N/A	18.8%	7.5%	7.4%	22.2%	21.7%	20.0%	0.0%
Quarterly	52.5%	73.7%	46.1%	61.1%	31.0%	30.8%	50.0%	33.3%	27.3%	58.8%	49.5%	100.0%	N/A	68.8%	22.5%	48.1%	69.4%	56.5%	66.7%	100.0%
Semi-annually	7.8%	2.6%	14.5%	0.0%	6.9%	7.7%	0.0%	0.0%	9.1%	5.9%	10.5%	0.0%	N/A	3.1%	15.0%	9.3%	2.8%	4.3%	6.7%	0.0%
Annually	9.5%	2.6%	6.6%	5.6%	31.0%	30.8%	0.0%	33.3%	36.4%	5.9%	6.3%	0.0%	N/A	3.1%	20.0%	11.1%	2.8%	8.7%	0.0%	0.0%
As needed	11.7%	2.6%	13.2%	8.3%	24.1%	15.4%	50.0%	33.3%	27.3%	0.0%	13.7%	0.0%	N/A	3.1%	30.0%	14.8%	0.0%	4.3%	0.0%	0.0%
Respondents with this committee	50.6%	76.0%	54.7%	58.1%	28.2%	28.9%	20.0%	27.3%	29.7%	56.7%	55.6%	85.7%	N/A	74.4%	30.1%	51.4%	75.0%	67.6%	75.0%	78.6%
Compliance																				
Total responding in each category	98	10	46	11	31	13	2	3	13	8	49	0	0	10	41	33	9	7	5	3
Monthly	13.3%	10.0%	10.9%	9.1%	19.4%	23.1%	50.0%	0.0%	15.4%	0.0%	12.2%	N/A	N/A	10.0%	12.2%	21.2%	0.0%	14.3%	0.0%	0.0%
Bi-monthly	10.2%	10.0%	10.9%	18.2%	6.5%	0.0%	0.0%	0.0%	15.4%	25.0%	10.2%	N/A	N/A	10.0%	7.3%	9.1%	22.2%	14.3%	20.0%	0.0%
Quarterly	44.9%	60.0%	52.2%	27.3%	35.5%	23.1%	50.0%	66.7%	38.5%	62.5%	44.9%	N/A	N/A	60.0%	41.5%	39.4%	66.7%	28.6%	60.0%	100.0%
Semi-annually	4.1%	0.0%	6.5%	0.0%	3.2%	0.0%	0.0%	0.0%	7.7%	0.0%	6.1%	N/A	N/A	0.0%	7.3%	3.0%	0.0%	0.0%	0.0%	0.0%
Annually	3.1%	0.0%	2.2%	9.1%	3.2%	7.7%	0.0%	0.0%	0.0%	0.0%	4.1%	N/A	N/A	0.0%	0.0%	3.0%	0.0%	28.6%	0.0%	0.0%
As needed	24.5%	20.0%	17.4%	36.4%	32.3%	46.2%	0.0%	33.3%	23.1%	12.5%	22.4%	N/A	N/A	20.0%	31.7%	24.2%	11.1%	14.3%	20.0%	0.0%
Respondents with this committee	27.7%	20.0%	33.1%	17.7%	30.1%	28.9%	20.0%	27.3%	35.1%	26.7%	28.7%	N/A	N/A	23.3%	30.8%	31.4%	18.8%	20.6%	25.0%	21.4%
Quality (or quality and safety)																				
Total responding in each category	263	42	111	50	60	21	7	9	23	27	134	4	0	38	76	91	40	28	16	12
Monthly	47.1%	31.0%	53.2%	38.0%	55.0%	61.9%	42.9%	22.2%	65.2%	29.6%	52.2%	0.0%	N/A	34.2%	42.1%	53.8%	60.0%	46.4%	31.3%	8.3%
Bi-monthly	20.2%	26.2%	18.9%	32.0%	8.3%	14.3%	14.3%	0.0%	4.3%	40.7%	19.4%	0.0%	N/A	28.9%	13.2%	22.0%	15.0%	35.7%	25.0%	25.0%
Quarterly	28.5%	42.9%	26.1%	24.0%	26.7%	19.0%	14.3%	66.7%	21.7%	29.6%	24.6%	100.0%	N/A	36.8%	36.8%	18.7%	25.0%	17.9%	43.8%	66.7%
Semi-annually	1.1%	0.0%	0.0%	2.0%	3.3%	0.0%	14.3%	11.1%	0.0%	0.0%	0.7%	0.0%	N/A	0.0%	0.0%	3.3%	0.0%	0.0%	0.0%	0.0%
Annually	0.4%	0.0%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	4.3%	0.0%	0.0%	0.0%	N/A	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	2.7%	0.0%	1.8%	4.0%	5.0%	4.8%	14.3%	0.0%	4.3%	0.0%	3.0%	0.0%	N/A	0.0%	6.6%	2.2%	0.0%	0.0%	0.0%	0.0%
Respondents with this committee	74.3%	84.0%	79.9%	80.6%	58.3%	46.7%	70.0%	81.8%	62.2%	90.0%	78.4%	57.1%	N/A	88.3%	57.1%	86.7%	83.3%	82.4%	80.0%	85.7%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Development/governance/nominating																				
Total responding in each category	253	42	114	51	46	18	5	7	16	24	141	5	0	37	72	85	38	29	17	12
Monthly	5.5%	9.5%	7.0%	3.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	N/A	10.8%	2.8%	5.9%	10.5%	6.9%	0.0%	8.3%
Bi-monthly	7.1%	11.9%	5.3%	11.8%	2.2%	0.0%	20.0%	0.0%	0.0%	8.3%	7.1%	0.0%	N/A	13.5%	4.2%	9.4%	5.3%	10.3%	11.8%	0.0%
Quarterly	24.1%	45.2%	28.9%	15.7%	2.2%	0.0%	20.0%	0.0%	0.0%	29.2%	24.1%	60.0%	N/A	43.2%	6.9%	24.7%	36.8%	24.1%	47.1%	50.0%
Semi-annually	9.9%	7.1%	8.8%	21.6%	2.2%	0.0%	0.0%	14.3%	0.0%	12.5%	12.8%	20.0%	N/A	5.4%	8.3%	9.4%	15.8%	6.9%	5.9%	16.7%
Annually	19.8%	7.1%	20.2%	15.7%	34.8%	27.8%	40.0%	42.9%	37.5%	29.2%	17.0%	0.0%	N/A	8.1%	30.6%	17.6%	15.8%	17.2%	11.8%	0.0%
As needed	33.6%	19.0%	29.8%	31.4%	58.7%	72.2%	20.0%	42.9%	62.5%	20.8%	31.9%	20.0%	N/A	18.9%	47.2%	32.9%	15.8%	34.5%	23.5%	25.0%
Respondents with this committee	71.5%	84.0%	82.0%	82.3%	44.7%	40.0%	50.0%	63.6%	43.2%	80.0%	82.5%	71.4%	N/A	86.0%	54.1%	81.0%	79.2%	85.3%	85.0%	85.7%
Executive compensation																				
Total responding in each category	234	39	108	36	51	21	6	5	19	16	128	4	0	35	71	76	38	22	17	10
Monthly	3.4%	5.1%	2.8%	2.8%	3.9%	9.5%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	N/A	5.7%	1.4%	2.6%	7.9%	9.1%	0.0%	0.0%
Bi-monthly	2.6%	5.1%	1.9%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	N/A	5.7%	0.0%	1.3%	7.9%	0.0%	5.9%	10.0%
Quarterly	17.9%	53.8%	13.9%	11.1%	3.9%	0.0%	16.7%	0.0%	5.3%	12.5%	13.3%	75.0%	N/A	51.4%	7.0%	7.9%	23.7%	31.8%	47.1%	70.0%
Semi-annually	14.1%	10.3%	17.6%	13.9%	9.8%	14.3%	0.0%	20.0%	5.3%	18.8%	16.4%	25.0%	N/A	8.6%	8.5%	18.4%	18.4%	9.1%	23.5%	0.0%
Annually	35.0%	5.1%	38.9%	38.9%	47.1%	42.9%	66.7%	40.0%	47.4%	37.5%	39.1%	0.0%	N/A	5.7%	53.5%	38.2%	23.7%	22.7%	5.9%	0.0%
As needed	26.9%	20.5%	25.0%	27.8%	35.3%	33.3%	16.7%	40.0%	42.1%	31.3%	25.0%	0.0%	N/A	22.9%	29.6%	31.6%	18.4%	27.3%	17.6%	20.0%
Respondents with this committee	66.1%	78.0%	77.7%	58.1%	49.5%	46.7%	60.0%	45.5%	51.4%	53.3%	74.9%	57.1%	N/A	81.4%	53.4%	72.4%	79.2%	64.7%	85.0%	71.4%
Strategic planning																				
Total responding in each category	200	26	89	32	53	21	6	7	19	18	103	4	0	22	66	67	30	19	9	9
Monthly	10.0%	15.4%	5.6%	15.6%	11.3%	4.8%	0.0%	0.0%	26.3%	0.0%	9.7%	0.0%	N/A	18.2%	6.1%	10.4%	13.3%	15.8%	22.2%	0.0%
Bi-monthly	10.5%	15.4%	10.1%	15.6%	5.7%	4.8%	0.0%	14.3%	5.3%	5.6%	12.6%	0.0%	N/A	18.2%	6.1%	7.5%	16.7%	21.1%	11.1%	22.2%
Quarterly	24.5%	46.2%	23.6%	25.0%	15.1%	19.0%	66.7%	0.0%	0.0%	33.3%	22.3%	100.0%	N/A	36.4%	18.2%	22.4%	20.0%	36.8%	33.3%	66.7%
Semi-annually	8.0%	3.8%	12.4%	3.1%	5.7%	9.5%	0.0%	0.0%	5.3%	5.6%	10.7%	0.0%	N/A	4.5%	12.1%	6.0%	10.0%	0.0%	0.0%	11.1%
Annually	20.0%	7.7%	18.0%	21.9%	28.3%	23.8%	16.7%	42.9%	31.6%	27.8%	17.5%	0.0%	N/A	9.1%	31.8%	16.4%	13.3%	10.5%	22.2%	0.0%
As needed	27.0%	11.5%	30.3%	18.8%	34.0%	38.1%	16.7%	42.9%	31.6%	27.8%	27.2%	0.0%	N/A	13.6%	25.8%	37.3%	26.7%	15.8%	11.1%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Respondents with this committee	56.5%	52.0%	64.0%	51.6%	51.5%	46.7%	60.0%	63.6%	51.4%	60.0%	60.2%	57.1%	N/A	51.2%	49.6%	63.8%	62.5%	55.9%	45.0%	64.3%
Physician relations																				
Total responding in each category	75	7	33	9	26	12	1	2	11	7	35	0	0	7	33	22	10	7	3	0
Monthly	9.3%	14.3%	9.1%	0.0%	11.5%	8.3%	0.0%	0.0%	18.2%	14.3%	5.7%	N/A	N/A	14.3%	3.0%	13.6%	20.0%	14.3%	0.0%	N/A
Bi-monthly	8.0%	0.0%	15.2%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	14.3%	N/A	N/A	0.0%	3.0%	13.6%	20.0%	0.0%	0.0%	N/A
Quarterly	16.0%	42.9%	9.1%	22.2%	15.4%	8.3%	0.0%	50.0%	18.2%	42.9%	5.7%	N/A	N/A	42.9%	15.2%	9.1%	20.0%	14.3%	66.7%	N/A
Semi-annually	8.0%	0.0%	12.1%	11.1%	3.8%	0.0%	0.0%	0.0%	9.1%	0.0%	14.3%	N/A	N/A	0.0%	9.1%	0.0%	20.0%	14.3%	0.0%	N/A
Annually	2.7%	0.0%	3.0%	0.0%	3.8%	0.0%	0.0%	0.0%	9.1%	0.0%	2.9%	N/A	N/A	0.0%	6.1%	0.0%	0.0%	0.0%	0.0%	N/A
As needed	56.0%	42.9%	51.5%	55.6%	65.4%	83.3%	100.0%	50.0%	45.5%	28.6%	57.1%	N/A	N/A	42.9%	63.6%	63.6%	20.0%	57.1%	33.3%	N/A
Respondents with this committee	21.2%	14.0%	23.7%	14.5%	25.2%	26.7%	10.0%	18.1%	29.7%	23.3%	20.5%	N/A	N/A	16.3%	24.8%	21.0%	20.8%	20.6%	15.0%	N/A
Investment																				
Total responding in each category	143	31	68	19	25	9	2	4	10	11	76	6	0	25	35	43	26	18	11	10
Monthly	9.1%	6.5%	8.8%	21.1%	4.0%	0.0%	0.0%	0.0%	10.0%	18.2%	10.5%	0.0%	N/A	8.0%	14.3%	7.0%	7.7%	5.6%	9.1%	10.0%
Bi-monthly	7.7%	9.7%	5.9%	15.8%	4.0%	11.1%	0.0%	0.0%	0.0%	9.1%	7.9%	0.0%	N/A	12.0%	2.9%	7.0%	11.5%	11.1%	18.2%	0.0%
Quarterly	58.7%	77.4%	70.6%	42.1%	16.0%	11.1%	50.0%	25.0%	10.0%	54.5%	65.8%	100.0%	N/A	72.0%	28.6%	60.5%	76.9%	66.7%	63.6%	90.0%
Semi-annually	3.5%	3.2%	4.4%	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%	3.9%	0.0%	N/A	4.0%	2.9%	7.0%	0.0%	0.0%	9.1%	0.0%
Annually	4.2%	3.2%	2.9%	0.0%	12.0%	0.0%	0.0%	0.0%	30.0%	0.0%	2.6%	0.0%	N/A	4.0%	8.6%	4.7%	0.0%	5.6%	0.0%	0.0%
As needed	16.8%	0.0%	7.4%	15.8%	64.0%	77.8%	50.0%	75.0%	50.0%	9.1%	9.2%	0.0%	N/A	0.0%	42.9%	14.0%	3.8%	11.1%	0.0%	0.0%
Respondents with this committee	40.4%	62.0%	48.9%	30.6%	24.3%	20.0%	20.0%	36.4%	27.0%	36.7%	44.4%	85.7%	N/A	58.1%	26.3%	41.0%	54.2%	52.9%	55.0%	71.4%
Joint conference																				
Total responding in each category	123	5	57	17	44	19	4	8	13	10	64	0	0	5	46	52	18	5	2	0
Monthly	13.8%	20.0%	7.0%	17.6%	20.5%	10.5%	50.0%	25.0%	23.1%	10.0%	9.4%	N/A	N/A	20.0%	10.9%	15.4%	16.7%	20.0%	0.0%	N/A
Bi-monthly	3.3%	40.0%	1.8%	5.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	N/A	N/A	40.0%	0.0%	3.8%	0.0%	20.0%	50.0%	N/A
Quarterly	15.4%	20.0%	17.5%	11.8%	13.6%	10.5%	25.0%	12.5%	15.4%	30.0%	14.1%	N/A	N/A	20.0%	15.2%	15.4%	16.7%	0.0%	50.0%	N/A
Semi-annually	6.5%	0.0%	7.0%	5.9%	6.8%	5.3%	0.0%	12.5%	7.7%	0.0%	7.8%	N/A	N/A	0.0%	4.3%	9.6%	5.6%	0.0%	0.0%	N/A
Annually	8.9%	0.0%	10.5%	0.0%	11.4%	21.1%	25.0%	0.0%	0.0%	0.0%	9.4%	N/A	N/A	0.0%	10.9%	9.6%	0.0%	20.0%	0.0%	N/A
As needed	52.0%	20.0%	56.1%	58.8%	47.7%	52.6%	0.0%	50.0%	53.8%	60.0%	56.3%	N/A	N/A	20.0%	58.7%	46.2%	61.1%	40.0%	0.0%	N/A
Respondents with this committee	34.7%	10.0%	41.0%	27.4%	42.7%	42.2%	40.0%	72.7%	35.1%	33.3%	37.4%	N/A	N/A	11.6%	34.6%	49.5%	37.5%	14.7%	10.0%	N/A

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Facilities/infrastructure/maintenance																				
Total responding in each category	81	4	34	11	32	12	5	5	10	7	38	0	0	4	32	32	8	8	0	1
Monthly	11.1%	25.0%	8.8%	0.0%	15.6%	16.7%	0.0%	0.0%	30.0%	0.0%	7.9%	N/A	N/A	25.0%	9.4%	15.6%	0.0%	12.5%	N/A	0.0%
Bi-monthly	14.8%	25.0%	14.7%	36.4%	6.3%	8.3%	0.0%	0.0%	10.0%	14.3%	21.1%	N/A	N/A	25.0%	3.1%	18.8%	25.0%	25.0%	N/A	100.0%
Quarterly	12.3%	25.0%	11.8%	18.2%	9.4%	8.3%	40.0%	0.0%	0.0%	14.3%	13.2%	N/A	N/A	25.0%	9.4%	15.6%	0.0%	25.0%	N/A	0.0%
Semi-annually	2.5%	0.0%	5.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	N/A	N/A	0.0%	0.0%	6.3%	0.0%	0.0%	N/A	0.0%
Annually	1.2%	0.0%	0.0%	0.0%	3.1%	0.0%	0.0%	0.0%	10.0%	0.0%	0.0%	N/A	N/A	0.0%	3.1%	0.0%	0.0%	0.0%	N/A	0.0%
As needed	58.0%	25.0%	58.8%	45.5%	65.6%	66.7%	60.0%	100.0%	50.0%	71.4%	52.6%	N/A	N/A	25.0%	75.0%	43.8%	75.0%	37.5%	N/A	0.0%
Respondents with this committee	22.9%	8.0%	24.5%	17.7%	31.1%	26.7%	50.0%	45.5%	27.0%	23.3%	22.2%	N/A	N/A	9.3%	24.1%	30.5%	16.7%	23.5%	N/A	7.1%
Construction (separate from facilities)																				
Total responding in each category	59	2	23	6	28	9	3	7	9	5	24	0	0	2	33	16	6	3	0	1
Monthly	6.8%	0.0%	8.7%	0.0%	7.1%	11.1%	0.0%	0.0%	11.1%	0.0%	8.3%	N/A	N/A	0.0%	9.1%	0.0%	16.7%	0.0%	N/A	0.0%
Bi-monthly	3.4%	0.0%	4.3%	0.0%	3.6%	11.1%	0.0%	0.0%	0.0%	20.0%	0.0%	N/A	N/A	0.0%	6.1%	0.0%	0.0%	0.0%	N/A	0.0%
Quarterly	3.4%	0.0%	4.3%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.3%	N/A	N/A	0.0%	0.0%	6.3%	16.7%	0.0%	N/A	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%	0.0%	N/A	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%	N/A	0.0%
As needed	86.4%	100.0%	82.6%	83.3%	89.3%	77.8%	100.0%	100.0%	88.9%	80.0%	83.3%	N/A	N/A	100.0%	84.8%	93.8%	66.7%	100.0%	N/A	100.0%
Respondents with this committee	16.7%	4.0%	16.5%	9.7%	27.2%	20.0%	30.0%	63.6%	24.3%	16.7%	14.0%	N/A	N/A	4.7%	24.8%	15.2%	12.5%	8.8%	N/A	7.1%
Government relations/advocacy																				
Total responding in each category	47	5	17	10	15	7	2	2	4	5	22	0	0	5	20	13	6	6	1	1
Monthly	4.3%	20.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.5%	N/A	N/A	20.0%	0.0%	0.0%	16.7%	16.7%	0.0%	0.0%
Bi-monthly	6.4%	20.0%	5.9%	0.0%	6.7%	14.3%	0.0%	0.0%	0.0%	0.0%	4.5%	N/A	N/A	20.0%	0.0%	7.7%	0.0%	16.7%	0.0%	100.0%
Quarterly	12.8%	40.0%	5.9%	20.0%	6.7%	0.0%	0.0%	50.0%	0.0%	40.0%	4.5%	N/A	N/A	40.0%	0.0%	15.4%	33.3%	16.7%	100.0%	0.0%
Semi-annually	6.4%	0.0%	17.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	13.6%	N/A	N/A	0.0%	0.0%	15.4%	16.7%	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	70.2%	20.0%	70.6%	70.0%	86.7%	85.7%	100.0%	50.0%	100.0%	60.0%	72.7%	N/A	N/A	20.0%	100.0%	61.5%	33.3%	50.0%	0.0%	0.0%
Respondents with this committee	13.3%	10.0%	12.2%	16.1%	14.6%	15.6%	20.0%	18.2%	10.8%	16.7%	12.9%	N/A	N/A	11.6%	15.0%	12.4%	12.5%	17.6%	5.0%	7.1%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Human resources																				
Total responding in each category	78	9	30	14	25	10	4	3	8	3	41	3	0	6	33	23	8	8	2	4
Monthly	10.3%	22.2%	6.7%	7.1%	12.0%	10.0%	25.0%	0.0%	12.5%	0.0%	7.3%	0.0%	N/A	33.3%	12.1%	4.3%	12.5%	25.0%	0.0%	0.0%
Bi-monthly	10.3%	22.2%	10.0%	7.1%	8.0%	10.0%	0.0%	0.0%	12.5%	0.0%	9.8%	0.0%	N/A	33.3%	3.0%	13.0%	12.5%	12.5%	50.0%	25.0%
Quarterly	20.5%	33.3%	23.3%	21.4%	12.0%	20.0%	0.0%	0.0%	12.5%	0.0%	24.4%	66.7%	N/A	16.7%	21.2%	17.4%	12.5%	12.5%	50.0%	50.0%
Semi-annually	9.0%	11.1%	10.0%	7.1%	8.0%	10.0%	25.0%	0.0%	0.0%	33.3%	7.3%	33.3%	N/A	0.0%	0.0%	21.7%	12.5%	0.0%	0.0%	25.0%
Annually	6.4%	0.0%	10.0%	7.1%	4.0%	10.0%	0.0%	0.0%	0.0%	0.0%	9.8%	0.0%	N/A	0.0%	3.0%	8.7%	12.5%	12.5%	0.0%	0.0%
As needed	43.6%	11.1%	40.0%	50.0%	56.0%	40.0%	50.0%	100.0%	62.5%	66.7%	41.5%	0.0%	N/A	16.7%	60.6%	34.8%	37.5%	37.5%	0.0%	0.0%
Respondents with this committee	22.0%	18.0%	21.6%	22.6%	24.3%	22.2%	40.0%	27.3%	21.6%	10.0%	24.0%	42.9%	N/A	14.0%	24.8%	21.9%	16.7%	23.5%	10.0%	28.6%
Community benefit																				
Total responding in each category	91	14	36	21	20	8	2	1	9	9	48	2	0	12	26	26	19	11	4	5
Monthly	11.0%	0.0%	13.9%	14.3%	10.0%	0.0%	0.0%	0.0%	22.2%	11.1%	14.6%	0.0%	N/A	0.0%	7.7%	15.4%	10.5%	18.2%	0.0%	0.0%
Bi-monthly	8.8%	7.1%	11.1%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	12.5%	0.0%	N/A	8.3%	0.0%	11.5%	15.8%	18.2%	0.0%	0.0%
Quarterly	33.0%	78.6%	27.8%	23.8%	20.0%	25.0%	0.0%	0.0%	22.2%	33.3%	25.0%	100.0%	N/A	75.0%	15.4%	19.2%	52.6%	27.3%	75.0%	100.0%
Semi-annually	5.5%	0.0%	8.3%	4.8%	5.0%	0.0%	0.0%	0.0%	11.1%	0.0%	8.3%	0.0%	N/A	0.0%	3.8%	7.7%	5.3%	9.1%	0.0%	0.0%
Annually	12.1%	0.0%	11.1%	19.0%	15.0%	25.0%	0.0%	0.0%	11.1%	33.3%	10.4%	0.0%	N/A	0.0%	19.2%	11.5%	5.3%	18.2%	0.0%	0.0%
As needed	29.7%	14.3%	27.8%	23.8%	50.0%	50.0%	100.0%	100.0%	33.3%	11.1%	29.2%	0.0%	N/A	16.7%	53.8%	34.6%	10.5%	9.1%	25.0%	0.0%
Respondents with this committee	25.7%	28.0%	25.9%	33.9%	19.4%	1.8%	20.0%	9.0%	24.3%	30.0%	28.1%	28.6%	N/A	27.9%	19.5%	24.8%	39.6%	32.4%	20.0%	35.7%
Authorities/responsibilities of the executive committee																				
Total responding in each category	252	40	118	44	50	22	7	7	14	26	136	7	0	33	78	80	40	26	16	12
Executive compensation	46.0%	27.5%	50.8%	36.4%	58.0%	59.1%	85.7%	42.9%	50.0%	46.2%	47.1%	28.6%	N/A	27.3%	51.3%	51.3%	37.5%	53.8%	18.8%	25.0%
Board member nominations	20.2%	15.0%	14.4%	34.1%	26.0%	22.7%	57.1%	28.6%	14.3%	30.8%	17.6%	28.6%	N/A	12.1%	20.5%	15.0%	30.0%	23.1%	18.8%	16.7%
Board member selection	13.1%	7.5%	11.9%	22.7%	12.0%	18.2%	28.6%	0.0%	0.0%	19.2%	14.0%	14.3%	N/A	6.1%	10.3%	12.5%	25.0%	11.5%	6.3%	8.3%
Advising the CEO	69.4%	75.0%	68.6%	59.1%	76.0%	77.3%	85.7%	85.7%	64.3%	69.2%	65.4%	85.7%	N/A	72.7%	66.7%	71.3%	67.5%	65.4%	81.3%	75.0%
Emergency decision making	80.6%	87.5%	80.5%	79.5%	76.0%	63.6%	71.4%	100.0%	85.7%	92.3%	77.9%	100.0%	N/A	84.8%	76.9%	85.0%	82.5%	73.1%	87.5%	75.0%
Decision-making authority between full board meetings	73.0%	92.5%	78.8%	72.7%	44.0%	45.5%	42.9%	57.1%	35.7%	84.6%	75.7%	71.4%	N/A	97.0%	59.0%	75.0%	77.5%	80.8%	93.8%	91.7%
Other	7.9%	5.0%	6.8%	9.1%	12.0%	13.6%	14.3%	14.3%	7.1%	7.7%	7.4%	0.0%	N/A	6.1%	12.8%	2.5%	10.0%	7.7%	6.3%	8.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
What level of authority does the executive committee have?																				
Total responding in each category	247	40	116	41	50	24	7	7	12	24	133	7	0	33	76	77	40	25	17	12
Full authority: the executive committee can act on behalf of the board on all issues; committee decisions do not require full-board ratification	35.6%	50.0%	37.1%	41.5%	16.0%	20.8%	0.0%	28.6%	8.3%	54.2%	35.3%	71.4%	N/A	45.5%	23.7%	37.7%	35.0%	44.0%	52.9%	58.3%
Some authority: the executive committee can act on behalf of the board on some issues (e.g., executive compensation), but not all issues	37.2%	27.5%	41.4%	39.0%	34.0%	37.5%	14.3%	42.9%	33.3%	33.3%	42.1%	14.3%	N/A	30.3%	40.8%	33.8%	42.5%	48.0%	23.5%	16.7%
All executive committee decisions must be approved/ratified by the full board	27.1%	22.5%	21.6%	19.5%	50.0%	41.7%	85.7%	28.6%	58.3%	12.5%	22.6%	14.3%	N/A	24.2%	35.5%	28.6%	22.5%	8.0%	23.5%	25.0%
Approximate total annual expenditure for board education																				
Total responding in each category	344	48	138	60	98	43	9	11	35	30	168	7	0	41	128	103	48	33	20	12
$0	2.6%	0.0%	1.4%	5.0%	4.1%	2.3%	22.2%	0.0%	2.9%	0.0%	3.0%	0.0%	N/A	0.0%	3.1%	1.0%	2.1%	9.1%	0.0%	0.0%
$1–$9,999	34.6%	8.3%	32.6%	35.0%	50.0%	55.8%	22.2%	45.5%	51.4%	46.7%	31.0%	0.0%	N/A	9.8%	57.0%	28.2%	20.8%	12.1%	10.0%	8.3%
$10,000–$19,999	20.6%	12.5%	21.7%	18.3%	24.5%	23.3%	0.0%	18.2%	34.3%	20.0%	20.8%	14.3%	N/A	12.2%	26.6%	24.3%	10.4%	6.1%	20.0%	8.3%
$20,000–$29,999	11.0%	14.6%	10.9%	13.3%	8.2%	9.3%	22.2%	0.0%	5.7%	6.7%	12.5%	28.6%	N/A	12.2%	6.3%	12.6%	16.7%	18.2%	0.0%	25.0%
$30,000–$49,999	12.2%	16.7%	15.9%	10.0%	6.1%	4.7%	22.2%	9.1%	2.9%	16.7%	13.7%	14.3%	N/A	17.1%	5.5%	14.6%	16.7%	30.3%	5.0%	8.3%
$50,000–$75,000	8.4%	16.7%	8.7%	8.3%	4.1%	2.3%	11.1%	18.2%	0.0%	0.0%	10.1%	0.0%	N/A	19.5%	0.8%	11.7%	18.8%	0.0%	25.0%	16.7%
>$75,000	10.5%	31.3%	8.7%	10.0%	3.1%	2.3%	0.0%	9.1%	2.9%	10.0%	8.9%	42.9%	N/A	29.3%	0.8%	7.8%	14.6%	24.2%	40.0%	33.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Topics covered for internal board development/education																				
Total responding in each category	344	49	138	61	96	43	9	11	33	30	169	7	0	42	127	102	48	34	20	13
Legal/regulatory	91.0%	95.9%	86.2%	96.7%	91.7%	95.3%	77.8%	100.0%	87.9%	93.3%	88.8%	100.0%	N/A	95.2%	90.6%	91.2%	91.7%	91.2%	90.0%	92.3%
Quality/patient safety	96.2%	87.8%	97.8%	100.0%	95.8%	95.3%	100.0%	100.0%	93.9%	100.0%	98.2%	71.4%	N/A	90.5%	96.1%	99.0%	97.9%	91.2%	95.0%	84.6%
Reimbursement and "drivers" of financial performance	83.7%	79.6%	85.5%	85.2%	82.3%	83.7%	88.9%	72.7%	81.8%	83.3%	85.8%	71.4%	N/A	81.0%	78.7%	89.2%	89.6%	76.5%	85.0%	84.6%
Industry trends and the associated implications (e.g., value-based purchasing, population health management, health insurance exchanges, expansion of Medicaid, etc.)	94.2%	93.9%	94.2%	95.1%	93.8%	90.7%	100.0%	90.9%	97.0%	96.7%	94.1%	85.7%	N/A	95.2%	95.3%	95.1%	91.7%	91.2%	90.0%	100.0%
The role of your organization in a changing delivery system	78.8%	89.8%	81.9%	82.0%	66.7%	69.8%	44.4%	54.5%	72.7%	76.7%	82.8%	100.0%	N/A	88.1%	72.4%	74.5%	89.6%	88.2%	90.0%	92.3%
Other	12.5%	24.5%	10.1%	18.0%	6.3%	4.7%	11.1%	27.3%	0.0%	16.7%	11.8%	42.9%	N/A	21.4%	8.7%	12.7%	14.6%	14.7%	15.0%	30.8%
Delivery of board education																				
Total responding in each category	347	49	138	61	99	43	10	11	35	30	169	7	0	42	129	103	48	34	20	13
During regularly scheduled board meetings	88.2%	87.8%	87.7%	90.2%	87.9%	93.0%	100.0%	90.9%	77.1%	90.0%	88.2%	85.7%	N/A	88.1%	90.7%	89.3%	85.4%	79.4%	85.0%	92.3%
Periodic board education retreats	59.4%	73.5%	59.4%	65.6%	48.5%	48.8%	50.0%	63.6%	42.9%	70.0%	59.8%	85.7%	N/A	71.4%	48.8%	57.3%	72.9%	70.6%	75.0%	76.9%
Attendance at off-site conferences	72.9%	67.3%	73.9%	63.9%	79.8%	79.1%	60.0%	90.9%	82.9%	73.3%	70.4%	71.4%	N/A	66.7%	71.3%	77.7%	70.8%	79.4%	70.0%	46.2%
Webinars/online education	34.0%	22.4%	33.3%	26.2%	45.5%	37.2%	20.0%	63.6%	57.1%	40.0%	29.6%	14.3%	N/A	23.8%	38.8%	36.9%	31.3%	26.5%	25.0%	7.7%
Publications, articles, other reading materials	82.4%	95.9%	78.3%	80.3%	82.8%	83.7%	60.0%	90.9%	85.7%	90.0%	76.9%	100.0%	N/A	95.2%	72.1%	84.5%	91.7%	94.1%	90.0%	92.3%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
Organizations the board uses for education resources																				
Total responding in each category	348	49	137	60	102	44	10	11	37	30	167	7	0	42	131	102	48	34	20	13
BoardSource®	8.6%	20.4%	9.5%	6.7%	2.9%	0.0%	10.0%	0.0%	5.4%	6.7%	9.0%	28.6%	N/A	19.0%	3.1%	7.8%	12.5%	11.8%	15.0%	38.5%
Carver Policy Governance	1.1%	0.0%	2.2%	0.0%	1.0%	2.3%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	0.0%	1.5%	2.0%	0.0%	0.0%	0.0%	0.0%
Center for Healthcare Governance (AHA)	38.8%	40.8%	38.0%	41.7%	37.3%	34.1%	40.0%	45.5%	37.8%	36.7%	39.5%	71.4%	N/A	35.7%	35.1%	41.2%	41.7%	50.0%	20.0%	46.2%
The Estes Park Institute	19.5%	32.7%	23.4%	15.0%	10.8%	9.1%	10.0%	18.2%	10.8%	20.0%	21.0%	28.6%	N/A	33.3%	8.4%	26.5%	16.7%	41.2%	25.0%	23.1%
The Governance Institute	60.1%	87.8%	64.2%	61.7%	40.2%	40.9%	60.0%	27.3%	37.8%	63.3%	63.5%	100.0%	N/A	85.7%	38.2%	68.6%	72.9%	79.4%	75.0%	92.3%
Health Care Advisory Board	43.7%	55.1%	45.3%	61.7%	25.5%	29.5%	30.0%	18.2%	21.6%	60.0%	48.5%	57.1%	N/A	54.8%	23.7%	53.9%	60.4%	52.9%	55.0%	61.5%
iProtean	2.0%	2.0%	2.9%	1.7%	1.0%	0.0%	0.0%	0.0%	2.7%	3.3%	2.4%	0.0%	N/A	2.4%	0.8%	2.9%	2.1%	2.9%	5.0%	0.0%
Sg2	14.4%	24.5%	10.9%	26.7%	6.9%	4.5%	0.0%	9.1%	10.8%	26.7%	13.8%	14.3%	N/A	26.2%	7.6%	10.8%	27.1%	20.6%	30.0%	23.1%
Independent consultants/ trainers	46.6%	44.9%	50.4%	53.3%	38.2%	29.5%	30.0%	63.6%	43.2%	53.3%	50.9%	28.6%	N/A	47.6%	34.4%	53.9%	58.3%	58.8%	35.0%	53.8%
State healthcare associations	71.8%	36.7%	76.6%	60.0%	89.2%	90.9%	100.0%	100.0%	81.1%	63.3%	73.1%	42.9%	N/A	35.7%	84.0%	79.4%	64.6%	38.2%	50.0%	38.5%
National healthcare associations	39.9%	44.9%	40.9%	38.3%	37.3%	34.1%	30.0%	27.3%	45.9%	36.7%	40.7%	42.9%	N/A	45.2%	37.4%	39.2%	47.9%	32.4%	50.0%	46.2%
Our system's educational material	41.1%	65.3%	35.8%	71.7%	18.6%	22.7%	10.0%	18.2%	16.2%	46.7%	46.7%	100.0%	N/A	59.5%	29.8%	37.3%	50.0%	55.9%	60.0%	84.6%
Our board's own educational material	27.6%	32.7%	28.5%	30.0%	22.5%	29.5%	20.0%	18.2%	16.2%	20.0%	30.5%	57.1%	N/A	28.6%	31.3%	22.5%	22.9%	32.4%	20.0%	46.2%
Other	10.9%	6.1%	12.4%	5.0%	14.7%	9.1%	0.0%	45.5%	16.2%	10.0%	10.2%	0.0%	N/A	7.1%	17.6%	8.8%	6.3%	0.0%	5.0%	15.4%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 average cash compensation for the board chair																				
Total responding in each category	351	50	139	61	101	43	10	11	37	30	170	7	0	43	131	104	48	34	20	14
No compensation	88.9%	82.0%	93.5%	95.1%	82.2%	76.7%	100.0%	81.8%	83.8%	100.0%	92.9%	71.4%	N/A	83.7%	86.3%	93.3%	89.6%	97.1%	80.0%	71.4%
< $5,000%	6.6%	2.0%	2.2%	1.6%	17.8%	23.3%	0.0%	18.2%	16.2%	0.0%	2.4%	0.0%	N/A	2.3%	12.2%	3.8%	4.2%	0.0%	0.0%	7.1%
$5,000–$9,999%	0.9%	2.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	14.3%	N/A	0.0%	0.8%	1.0%	0.0%	0.0%	0.0%	7.1%
$10,000–$14,999%	1.1%	2.0%	1.4%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	2.3%	0.8%	1.0%	2.1%	0.0%	5.0%	0.0%
$15,000–$19,999%	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.0%	0.0%	2.1%	0.0%	0.0%	0.0%
$20,000–$29,999%	0.6%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	4.7%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
$30,000–$39,999%	0.6%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	4.7%	0.0%	0.0%	0.0%	2.9%	5.0%	0.0%
$40,000–$49,999%	0.6%	2.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	2.3%	0.0%	0.0%	2.1%	0.0%	0.0%	7.1%
$50,000 +	0.6%	2.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	14.3%	N/A	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	7.1%
Respondents with compensation for this position	11.1%	18.0%	6.5%	4.9%	17.8%	23.3%	0.0%	18.2%	16.2%	0.0%	7.1%	28.6%	N/A	16.3%	13.7%	6.7%	10.4%	2.9%	20.0%	28.6%
Annual average cash compensation for other board officers																				
Total responding in each category	349	50	138	61	100	43	10	11	36	30	169	7	0	43	130	103	48	34	20	14
No compensation	90.0%	84.0%	94.9%	95.1%	83.0%	76.7%	100.0%	90.9%	83.3%	100.0%	94.1%	71.4%	N/A	86.0%	86.9%	94.2%	91.7%	97.1%	80.0%	78.6%
< $5,000	6.6%	4.0%	2.2%	1.6%	17.0%	23.3%	0.0%	9.1%	16.7%	0.0%	2.4%	14.3%	N/A	2.3%	12.3%	3.9%	2.1%	0.0%	0.0%	14.3%
$5,000–$9,999	1.1%	2.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	2.3%	0.8%	1.9%	0.0%	0.0%	5.0%	0.0%
$10,000–$14,999	0.6%	2.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	2.3%	0.0%	0.0%	2.1%	0.0%	5.0%	0.0%
$15,000–$19,999	0.6%	2.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	2.3%	0.0%	0.0%	2.1%	0.0%	5.0%	0.0%
$20,000–$29,999	0.6%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	N/A	2.3%	0.0%	0.0%	0.0%	2.9%	0.0%	7.1%
$30,000–$39,999	0.6%	2.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	2.3%	0.0%	0.0%	2.1%	0.0%	5.0%	0.0%
$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 +	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%
Respondents with compensation for this position	10.0%	16.0%	5.1%	4.9%	17.0%	23.3%	0.0%	9.1%	16.7%	0.0%	5.9%	28.6%	N/A	14.0%	13.1%	5.8%	8.3%	2.9%	20.0%	21.4%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 average cash compensation for board committee chairs																				
Total responding in each category	347	50	138	60	99	43	10	11	35	30	168	7	0	43	129	103	47	34	20	14
No compensation	91.4%	82.0%	94.9%	96.7%	87.9%	83.7%	100.0%	90.9%	88.6%	100.0%	94.6%	71.4%	N/A	83.7%	89.9%	95.1%	93.6%	97.1%	80.0%	71.4%
< $5,000	4.9%	2.0%	2.2%	1.7%	12.1%	16.3%	0.0%	9.1%	11.4%	0.0%	2.4%	0.0%	N/A	2.3%	8.5%	3.9%	2.1%	0.0%	0.0%	7.1%
$5,000–$9,999	1.2%	4.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	14.3%	N/A	2.3%	0.8%	1.0%	0.0%	0.0%	5.0%	7.1%
$10,000–$14,999	0.3%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	2.3%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%
$15,000–$19,999	0.9%	4.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	4.7%	0.0%	0.0%	2.1%	2.9%	5.0%	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	0.9%	4.0%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	14.3%	N/A	2.3%	0.0%	0.0%	2.1%	0.0%	5.0%	7.1%
$40,000–$49,999	0.3%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%
$50,000 +	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Respondents with compensation for this position	8.6%	18.0%	5.1%	3.3%	12.1%	16.3%	0.0%	9.1%	11.4%	0.0%	5.4%	28.6%	N/A	16.3%	10.1%	4.9%	6.4%	2.9%	20.0%	28.6%
Annual average cash compensation for other board members																				
Total responding in each category	347	49	138	60	100	43	10	11	36	30	168	7	0	42	130	103	48	33	19	14
No compensation	89.3%	81.6%	93.5%	95.0%	84.0%	79.1%	100.0%	81.8%	86.1%	100.0%	92.9%	71.4%	N/A	83.3%	86.9%	94.2%	89.6%	97.0%	78.9%	71.4%
< $5,000	6.6%	4.1%	2.9%	1.7%	16.0%	20.9%	0.0%	18.2%	13.9%	0.0%	3.0%	14.3%	N/A	2.4%	11.5%	3.9%	4.2%	0.0%	0.0%	14.3%
$5,000–$9,999	1.2%	2.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	2.4%	0.8%	1.9%	0.0%	0.0%	5.3%	0.0%
$10,000–$14,999	0.9%	4.1%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	4.8%	0.0%	0.0%	2.1%	3.0%	5.3%	0.0%
$15,000–$19,999	0.6%	2.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	2.4%	0.0%	0.0%	2.1%	0.0%	5.3%	0.0%
$20,000–$29,999	0.3%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%
$30,000–$39,999	0.9%	4.1%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	4.8%	0.0%	0.0%	2.1%	0.0%	5.3%	7.1%
$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 +	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Respondents with compensation for this position	10.7%	18.4%	6.5%	5.0%	16.0%	20.9%	0.0%	18.2%	13.9%	0.0%	7.1%	28.6%	N/A	16.7%	31.1%	5.8%	10.4%	3.0%	21.1%	28.6%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 board portal or similar online tool to communicate and access board materials																				
Total responding in each category	353	50	140	61	102	44	10	11	37	30	171	7	0	43	132	105	48	34	20	14
Yes	64.6%	92.0%	67.9%	70.5%	43.1%	38.6%	60.0%	54.5%	40.5%	60.0%	70.2%	100.0%	N/A	90.7%	41.7%	69.5%	83.3%	79.4%	95.0%	100.0%
No, but we are in the process of implementing	10.2%	6.0%	11.4%	8.2%	11.8%	11.4%	10.0%	9.1%	13.5%	10.0%	10.5%	0.0%	N/A	7.0%	13.6%	10.5%	2.1%	14.7%	5.0%	0.0%
No	25.2%	2.0%	20.7%	21.3%	45.1%	50.0%	30.0%	36.4%	45.9%	30.0%	19.3%	0.0%	N/A	2.3%	44.7%	20.0%	14.6%	5.9%	0.0%	0.0%
Most important benefit to the board in using a board portal or online tool																				
Total responding in each category	220	45	90	41	44	17	6	6	15	18	113	7	0	38	55	69	38	25	19	14
Saves time	22.3%	22.2%	24.4%	22.0%	18.2%	5.9%	33.3%	16.7%	26.7%	22.2%	23.9%	0.0%	N/A	26.3%	29.1%	21.7%	10.5%	24.0%	26.3%	21.4%
Enhances board members' level of preparation for meetings	30.0%	22.2%	30.0%	34.1%	34.1%	41.2%	33.3%	33.3%	26.7%	44.4%	29.2%	14.3%	N/A	23.7%	27.3%	27.5%	50.0%	20.0%	26.3%	21.4%
Reduces paper waste/duplication costs	36.4%	44.4%	35.6%	31.7%	34.1%	35.3%	33.3%	16.7%	40.0%	27.8%	35.4%	71.4%	N/A	39.5%	27.3%	40.6%	31.6%	48.0%	36.8%	42.9%
Enhances communication among board members between meetings	5.5%	4.4%	2.2%	9.8%	9.1%	11.8%	0.0%	33.3%	0.0%	5.6%	4.4%	14.3%	N/A	2.6%	7.3%	5.8%	2.6%	8.0%	0.0%	7.1%
Provides no perceived benefit	0.9%	2.2%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	N/A	2.6%	0.0%	0.0%	2.6%	0.0%	0.0%	7.1%
Other	5.0%	4.4%	7.8%	0.0%	4.5%	5.9%	0.0%	0.0%	6.7%	0.0%	6.2%	0.0%	N/A	5.3%	9.1%	4.3%	2.6%	0.0%	10.5%	0.0%
Board members are provided with hardware (laptops, iPads, etc.) to access online board materials																				
Total responding in each category	227	46	93	44	44	17	6	6	15	18	119	7	0	39	55	73	39	27	19	14
Yes	69.6%	71.7%	67.7%	70.5%	70.5%	82.4%	83.3%	50.0%	60.0%	61.1%	69.7%	100.0%	N/A	66.7%	60.0%	69.9%	69.2%	88.9%	73.7%	64.3%
No, but we are considering it at this time	7.5%	4.3%	7.5%	4.5%	13.6%	5.9%	16.7%	16.7%	20.0%	5.6%	6.7%	0.0%	N/A	5.1%	10.9%	8.2%	10.3%	0.0%	0.0%	7.1%
No, and we are not considering it at this time	22.9%	23.9%	24.7%	25.0%	15.9%	11.8%	0.0%	33.3%	20.0%	33.3%	23.5%	0.0%	N/A	28.2%	29.1%	21.9%	20.5%	11.1%	26.3%	28.6%

APPENDIX 1	Overall and by Organization Type					By AHA Control Code									By Organization Size (# of Beds)					
Total number of respondents in each category	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 in an accountable care organization or similarly structured clinically integrated network																				
Total responding in each category	355	50	140	62	103	45	10	11	37	30	172	7	0	43	133	106	48	34	20	14
Yes	47.3%	76.0%	42.9%	67.7%	27.2%	28.9%	10.0%	45.5%	24.3%	66.7%	47.7%	85.7%	N/A	74.4%	30.8%	39.6%	70.8%	73.5%	70.0%	85.7%
ACO ownership structure																				
Total responding in each category	117	29	38	27	23	11	1	3	8	9	56	4	0	25	27	33	20	15	13	9
Independent entity	7.7%	3.4%	15.8%	3.7%	4.3%	9.1%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	N/A	4.0%	14.8%	6.1%	5.0%	6.7%	7.7%	0.0%
Physician group-owned	3.4%	0.0%	5.3%	7.4%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	5.4%	0.0%	N/A	0.0%	3.7%	6.1%	5.0%	0.0%	0.0%	0.0%
Hospital-owned	10.3%	6.9%	15.8%	3.7%	13.0%	27.3%	0.0%	0.0%	0.0%	11.1%	10.7%	25.0%	N/A	4.0%	14.8%	6.1%	15.0%	13.3%	7.7%	0.0%
Health system-owned	40.2%	55.2%	28.9%	59.3%	17.4%	18.2%	0.0%	33.3%	12.5%	55.6%	39.3%	75.0%	N/A	52.0%	25.9%	39.4%	35.0%	53.3%	53.8%	55.6%
Insurance company-owned	2.6%	0.0%	2.6%	0.0%	8.7%	18.2%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	0.0%	3.7%	6.1%	0.0%	0.0%	0.0%	0.0%
Joint venture between two or more entities	19.7%	24.1%	18.4%	14.8%	21.7%	9.1%	100.0%	33.3%	25.0%	11.1%	17.9%	0.0%	N/A	28.0%	14.8%	21.2%	25.0%	6.7%	23.1%	33.3%
Ownership between two or more entities	12.8%	10.3%	13.2%	0.0%	30.4%	18.2%	0.0%	33.3%	50.0%	11.1%	7.1%	0.0%	N/A	12.0%	18.5%	12.1%	10.0%	13.3%	7.7%	11.1%
Other	3.4%	0.0%	0.0%	11.1%	4.3%	0.0%	0.0%	0.0%	12.5%	0.0%	5.4%	0.0%	N/A	0.0%	3.7%	3.0%	5.0%	6.7%	0.0%	0.0%
Approximate size of covered patient population under the ACO																				
Total responding in each category	116	28	37	26	25	11	1	5	8	10	53	4	0	24	26	34	20	15	12	9
Less than 10,000 people	19.8%	10.7%	29.7%	15.4%	20.0%	9.1%	0.0%	40.0%	25.0%	20.0%	24.5%	25.0%	N/A	8.3%	19.2%	35.3%	15.0%	13.3%	8.3%	0.0%
10,000 to 20,000 people	17.2%	17.9%	18.9%	7.7%	24.0%	27.3%	0.0%	40.0%	12.5%	0.0%	17.0%	25.0%	N/A	16.7%	11.5%	14.7%	20.0%	33.3%	16.7%	11.1%
20,001 to 30,000 people	9.5%	17.9%	5.4%	15.4%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	9.4%	25.0%	N/A	16.7%	3.8%	11.8%	5.0%	13.3%	16.7%	11.1%
30,001 to 40,000 people	7.8%	3.6%	5.4%	19.2%	4.0%	0.0%	0.0%	0.0%	12.5%	10.0%	11.3%	0.0%	N/A	4.2%	3.8%	5.9%	20.0%	6.7%	8.3%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
40,001 to 50,000 people	6.0%	7.1%	5.4%	3.8%	8.0%	9.1%	0.0%	0.0%	12.5%	0.0%	5.7%	0.0%	N/A	8.3%	15.4%	0.0%	0.0%	6.7%	8.3%	11.1%
More than 50,000 people	39.7%	42.9%	35.1%	38.5%	44.0%	54.5%	100.0%	20.0%	37.5%	60.0%	32.1%	25.0%	N/A	45.8%	46.2%	32.4%	40.0%	26.7%	41.7%	66.7%
Board Culture/Effectiveness: 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 mission and purpose.																				
Total responding in each category	351	50	138	62	101	45	10	11	35	29	171	7	0	43	131	104	48	34	20	14
Strongly agree	67.2%	72.0%	68.8%	74.2%	58.4%	51.1%	80.0%	45.5%	65.7%	100.0%	65.5%	71.4%	N/A	72.1%	61.8%	71.2%	70.8%	67.6%	70.0%	71.4%
Agree	29.6%	26.0%	29.0%	22.6%	36.6%	42.2%	20.0%	54.5%	28.6%	0.0%	31.6%	28.6%	N/A	25.6%	35.1%	26.0%	25.0%	29.4%	25.0%	28.6%
Neither agree nor disagree	2.8%	2.0%	2.2%	3.2%	4.0%	4.4%	0.0%	0.0%	5.7%	0.0%	2.9%	0.0%	N/A	2.3%	3.1%	1.9%	4.2%	2.9%	5.0%	0.0%
Disagree	0.3%	0.0%	0.0%	0.0%	1.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	1.0%	0.0%	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%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
The board engages in robust debate/discussions before making major decisions.																				
Total responding in each category	352	50	139	61	102	45	10	11	36	29	171	7	0	43	132	105	48	33	20	14
Strongly agree	47.2%	58.0%	43.2%	54.1%	43.1%	40.0%	40.0%	27.3%	52.8%	65.5%	43.3%	100.0%	N/A	51.2%	39.4%	50.5%	45.8%	54.5%	50.0%	78.6%
Agree	44.6%	36.0%	47.5%	41.0%	47.1%	46.7%	60.0%	72.7%	36.1%	34.5%	47.4%	0.0%	N/A	41.9%	50.8%	41.0%	52.1%	33.3%	40.0%	21.4%
Neither agree nor disagree	6.5%	4.0%	8.6%	4.9%	5.9%	8.9%	0.0%	0.0%	5.6%	0.0%	8.8%	0.0%	N/A	4.7%	9.1%	6.7%	0.0%	9.1%	5.0%	0.0%
Disagree	1.7%	2.0%	0.7%	0.0%	3.9%	4.4%	0.0%	0.0%	5.6%	0.0%	0.6%	0.0%	N/A	2.3%	0.8%	1.9%	2.1%	3.0%	5.0%	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%	N/A	0.0%	0.0%	0.0%	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	349	49	138	61	101	45	10	11	35	28	171	6	0	43	130	105	47	33	20	14
Strongly agree	24.9%	42.9%	22.5%	24.6%	19.8%	15.6%	30.0%	18.2%	22.9%	35.7%	21.1%	50.0%	N/A	41.9%	16.2%	20.0%	36.2%	36.4%	40.0%	57.1%
Agree	53.9%	44.9%	53.6%	54.1%	58.4%	55.6%	70.0%	54.5%	60.0%	57.1%	53.2%	33.3%	N/A	46.5%	59.2%	60.0%	44.7%	45.5%	45.0%	21.4%
Neither agree nor disagree	17.2%	6.1%	20.3%	19.7%	16.8%	24.4%	0.0%	18.2%	11.4%	7.1%	22.2%	16.7%	N/A	4.7%	21.5%	14.3%	17.0%	15.2%	10.0%	14.3%
Disagree	3.7%	6.1%	3.6%	1.6%	4.0%	2.2%	0.0%	9.1%	5.7%	0.0%	3.5%	0.0%	N/A	7.0%	3.1%	4.8%	2.1%	3.0%	5.0%	7.1%
Strongly disagree	0.3%	0.0%	0.0%	0.0%	1.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	1.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 has an effective system in place to measure whether strategic goals will be met.																				
Total responding in each category	351	50	138	61	102	45	10	11	36	29	170	7	0	43	131	105	47	34	20	14
Strongly agree	31.9%	50.0%	31.9%	37.7%	19.6%	13.3%	50.0%	18.2%	19.4%	37.9%	32.9%	71.4%	N/A	46.5%	22.1%	32.4%	36.2%	50.0%	35.0%	57.1%
Agree	50.4%	40.0%	49.3%	54.1%	54.9%	64.4%	40.0%	36.4%	52.8%	51.7%	50.6%	28.6%	N/A	41.9%	58.0%	47.6%	51.1%	35.3%	55.0%	28.6%
Neither agree nor disagree	13.4%	6.0%	14.5%	8.2%	18.6%	13.3%	10.0%	27.3%	25.0%	6.9%	13.5%	0.0%	N/A	7.0%	16.0%	14.3%	12.8%	8.8%	5.0%	7.1%
Disagree	4.3%	4.0%	4.3%	0.0%	6.9%	8.9%	0.0%	18.2%	2.8%	3.4%	2.9%	0.0%	N/A	4.7%	3.8%	5.7%	0.0%	5.9%	5.0%	7.1%
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%	N/A	0.0%	0.0%	0.0%	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	352	50	139	61	102	45	10	11	36	30	170	7	0	43	131	105	48	34	20	14
Strongly agree	37.5%	52.0%	38.8%	42.6%	25.5%	20.0%	60.0%	18.2%	25.0%	43.3%	39.4%	71.4%	N/A	48.8%	22.9%	41.9%	50.0%	47.1%	40.0%	71.4%
Agree	46.9%	36.0%	45.3%	47.5%	53.9%	55.6%	30.0%	63.6%	55.6%	43.3%	46.5%	28.6%	N/A	37.2%	55.7%	43.8%	39.6%	47.1%	45.0%	14.3%
Neither agree nor disagree	12.8%	10.0%	13.7%	8.2%	15.7%	20.0%	10.0%	0.0%	16.7%	6.7%	12.9%	0.0%	N/A	11.6%	16.0%	13.3%	10.4%	2.9%	15.0%	7.1%
Disagree	2.8%	2.0%	2.2%	1.6%	4.9%	4.4%	0.0%	18.2%	2.8%	6.7%	1.2%	0.0%	N/A	2.3%	5.3%	1.0%	0.0%	2.9%	0.0%	7.1%
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%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
The board ensures appropriate physician/clinician involvement in governance.																				
Total responding in each category	351	50	139	61	101	44	10	11	36	30	170	7	0	43	131	104	48	34	20	14
Strongly agree	33.6%	36.0%	38.8%	41.0%	20.8%	15.9%	40.0%	27.3%	19.4%	40.0%	39.4%	14.3%	N/A	39.5%	25.2%	39.4%	41.7%	32.4%	35.0%	42.9%
Agree	45.6%	44.0%	45.3%	49.2%	44.6%	47.7%	30.0%	54.5%	41.7%	46.7%	46.5%	28.6%	N/A	46.5%	44.3%	43.3%	50.0%	50.0%	45.0%	50.0%
Neither agree nor disagree	16.2%	20.0%	12.2%	8.2%	24.8%	25.0%	30.0%	18.2%	25.0%	10.0%	11.2%	57.1%	N/A	14.0%	20.6%	14.4%	8.3%	17.6%	20.0%	7.1%
Disagree	4.6%	0.0%	3.6%	1.6%	9.9%	11.4%	0.0%	0.0%	13.9%	3.3%	2.9%	0.0%	N/A	0.0%	9.9%	2.9%	0.0%	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%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
The board engages in constructive dialogue with management.																				
Total responding in each category	350	50	138	61	101	44	10	11	36	30	169	7	0	43	129	105	48	34	20	14
Strongly agree	57.1%	64.0%	58.7%	60.7%	49.5%	40.9%	50.0%	45.5%	61.1%	66.7%	58.0%	71.4%	N/A	62.8%	48.8%	62.9%	58.3%	55.9%	60.0%	85.7%
Agree	37.7%	30.0%	34.8%	37.7%	45.5%	56.8%	40.0%	45.5%	33.3%	33.3%	36.1%	28.6%	N/A	30.2%	44.2%	33.3%	37.5%	41.2%	35.0%	7.1%
Neither agree nor disagree	3.7%	2.0%	5.1%	1.6%	4.0%	2.3%	10.0%	0.0%	5.6%	0.0%	4.7%	0.0%	N/A	2.3%	6.2%	2.9%	2.1%	0.0%	5.0%	0.0%
Disagree	1.4%	4.0%	1.4%	0.0%	1.0%	0.0%	0.0%	9.1%	0.0%	0.0%	1.2%	0.0%	N/A	4.7%	0.8%	1.0%	2.1%	2.9%	0.0%	7.1%
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%	N/A	0.0%	0.0%	0.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
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	351	50	138	61	102	45	10	11	36	30	169	7	0	43	130	105	48	34	20	14
Strongly agree	57.3%	74.0%	55.1%	54.1%	53.9%	55.6%	50.0%	63.6%	50.0%	66.7%	52.7%	85.7%	N/A	72.1%	51.5%	55.2%	62.5%	64.7%	70.0%	71.4%
Agree	30.2%	18.0%	31.9%	36.1%	30.4%	28.9%	50.0%	27.3%	27.8%	26.7%	34.3%	14.3%	N/A	18.6%	36.9%	27.6%	27.1%	29.4%	15.0%	21.4%
Neither agree nor disagree	7.7%	4.0%	8.7%	6.6%	8.8%	6.7%	0.0%	0.0%	16.7%	6.7%	8.3%	0.0%	N/A	4.7%	6.9%	10.5%	6.3%	5.9%	10.0%	0.0%
Disagree	3.7%	4.0%	2.9%	3.3%	4.9%	6.7%	0.0%	0.0%	5.6%	0.0%	3.6%	0.0%	N/A	4.7%	3.1%	5.7%	2.1%	0.0%	5.0%	7.1%
Strongly disagree	1.1%	0.0%	1.4%	0.0%	2.0%	2.2%	0.0%	9.1%	0.0%	0.0%	1.2%	0.0%	N/A	0.0%	1.5%	1.0%	2.1%	0.0%	0.0%	0.0%
The working relationship between the board and the CEO is consistently excellent.																				
Total responding in each category	351	50	138	61	102	45	10	11	36	30	169	7	0	43	131	104	48	34	20	14
Strongly agree	65.8%	68.0%	66.7%	72.1%	59.8%	53.3%	70.0%	72.7%	61.1%	93.3%	63.9%	57.1%	N/A	69.8%	64.1%	64.4%	75.0%	64.7%	70.0%	57.1%
Agree	27.4%	28.0%	26.1%	24.6%	30.4%	31.1%	30.0%	27.3%	30.6%	6.7%	29.0%	42.9%	N/A	25.6%	27.5%	28.8%	18.8%	35.3%	20.0%	35.7%
Neither agree nor disagree	4.6%	2.0%	5.8%	1.6%	5.9%	11.1%	0.0%	0.0%	2.8%	0.0%	5.3%	0.0%	N/A	2.3%	4.6%	6.7%	4.2%	0.0%	5.0%	0.0%
Disagree	2.0%	2.0%	1.4%	1.6%	2.9%	2.2%	0.0%	0.0%	5.6%	0.0%	1.8%	0.0%	N/A	2.3%	3.8%	0.0%	2.1%	0.0%	0.0%	7.1%
Strongly disagree	0.3%	0.0%	0.0%	0.0%	1.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%
Board members are well prepared to address agenda items at board and committee meetings.																				
Total responding in each category	352	50	139	61	102	45	10	11	36	30	170	7	0	43	131	105	48	34	20	14
Strongly agree	37.2%	40.0%	33.8%	47.5%	34.3%	26.7%	50.0%	27.3%	41.7%	46.7%	36.5%	42.9%	N/A	39.5%	33.6%	34.3%	45.8%	44.1%	40.0%	42.9%
Agree	50.3%	56.0%	55.4%	42.6%	45.1%	51.1%	50.0%	63.6%	30.6%	53.3%	51.2%	57.1%	N/A	55.8%	51.1%	53.3%	41.7%	50.0%	50.0%	50.0%
Neither agree nor disagree	10.2%	4.0%	9.4%	9.8%	14.7%	17.8%	0.0%	0.0%	19.4%	0.0%	11.2%	0.0%	N/A	4.7%	11.5%	11.4%	10.4%	5.9%	5.0%	7.1%
Disagree	2.3%	0.0%	1.4%	0.0%	5.9%	4.4%	0.0%	9.1%	8.3%	0.0%	1.2%	0.0%	N/A	0.0%	3.8%	1.0%	2.1%	0.0%	5.0%	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%	N/A	0.0%	0.0%	0.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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+
The board assures itself of the reasonableness of any reliance it makes on the advice of advisors/consultants.																				
Total responding in each category	350	50	139	60	101	45	10	11	35	29	170	7	0	43	130	105	47	34	20	14
Strongly agree	30.6%	50.0%	25.2%	35.0%	25.7%	22.2%	30.0%	36.4%	25.7%	37.9%	26.5%	71.4%	N/A	46.5%	20.0%	30.5%	38.3%	50.0%	35.0%	50.0%
Agree	60.3%	44.0%	67.6%	61.7%	57.4%	55.6%	60.0%	54.5%	60.0%	58.6%	67.1%	28.6%	N/A	46.5%	66.2%	61.0%	59.6%	47.1%	50.0%	50.0%
Neither agree nor disagree	8.9%	6.0%	7.2%	3.3%	15.8%	20.0%	10.0%	9.1%	14.3%	3.4%	6.5%	0.0%	N/A	7.0%	13.1%	8.6%	2.1%	2.9%	15.0%	0.0%
Disagree	0.3%	0.0%	0.0%	0.0%	1.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	0.8%	0.0%	0.0%	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%	N/A	0.0%	0.0%	0.0%	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	350	50	138	61	101	44	10	11	36	30	169	7	0	43	130	104	48	34	20	14
Strongly agree	33.1%	38.0%	30.4%	42.6%	28.7%	22.7%	30.0%	36.4%	33.3%	43.3%	32.5%	42.9%	N/A	37.2%	26.2%	32.7%	47.9%	38.2%	30.0%	42.9%
Agree	54.6%	44.0%	60.1%	52.5%	53.5%	52.3%	60.0%	45.5%	55.6%	50.0%	59.2%	57.1%	N/A	41.9%	58.5%	59.6%	45.8%	52.9%	40.0%	35.7%
Neither agree nor disagree	10.6%	14.0%	8.7%	4.9%	14.9%	22.7%	10.0%	9.1%	8.3%	6.7%	7.7%	0.0%	N/A	16.3%	13.8%	6.7%	4.2%	5.9%	25.0%	21.4%
Disagree	1.7%	4.0%	0.7%	0.0%	3.0%	2.3%	0.0%	9.1%	2.8%	0.0%	0.6%	0.0%	N/A	4.7%	1.5%	1.0%	2.1%	2.9%	5.0%	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%	N/A	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	351	50	139	60	102	45	10	11	36	30	169	7	0	43	130	105	48	34	20	14
Strongly agree	47.6%	60.0%	49.6%	48.3%	38.2%	35.6%	40.0%	63.6%	33.3%	43.3%	50.3%	85.7%	N/A	55.8%	40.0%	49.5%	52.1%	52.9%	50.0%	71.4%
Agree	45.6%	34.0%	42.4%	50.0%	52.9%	53.3%	60.0%	27.3%	58.3%	56.7%	42.6%	14.3%	N/A	37.2%	51.5%	44.8%	41.7%	44.1%	35.0%	28.6%
Neither agree nor disagree	6.0%	4.0%	7.2%	1.7%	7.8%	8.9%	0.0%	9.1%	8.3%	0.0%	6.5%	0.0%	N/A	4.7%	7.7%	5.7%	4.2%	2.9%	10.0%	0.0%
Disagree	0.9%	2.0%	0.7%	0.0%	1.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	N/A	2.3%	0.8%	0.0%	2.1%	0.0%	5.0%	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%	N/A	0.0%	0.0%	0.0%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 since 2013 in regards to population health management?																				
Total responding in each category	352	50	139	61	102	44	10	11	37	30	170	7	0	43	130	106	48	34	20	14
N/A; we are not currently making plans to manage population health	9.1%	2.0%	9.4%	1.6%	16.7%	22.7%	10.0%	18.2%	10.8%	6.7%	7.1%	0.0%	N/A	2.3%	16.2%	9.4%	0.0%	2.9%	0.0%	0.0%
We have not changed our board structure to prepare for population health management	46.9%	36.0%	53.2%	39.3%	48.0%	50.0%	50.0%	72.7%	37.8%	46.7%	49.4%	14.3%	N/A	39.5%	46.2%	56.6%	39.6%	41.2%	40.0%	28.6%
We have updated the strategic plan to include goals regarding population health management, including building IT infrastructure and physician integration	60.2%	76.0%	56.8%	70.5%	51.0%	40.9%	70.0%	27.3%	64.9%	70.0%	59.4%	85.7%	N/A	74.4%	48.5%	59.4%	75.0%	70.6%	65.0%	92.9%
We have added board members with expertise in population health management to help us achieve this goal	4.0%	12.0%	5.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	42.9%	N/A	7.0%	1.5%	5.7%	4.2%	2.9%	0.0%	21.4%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	2.6%	8.0%	2.2%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	2.4%	0.0%	N/A	9.3%	0.8%	2.8%	2.1%	2.9%	10.0%	7.1%
We have added physicians to the board to help us achieve this goal	9.1%	16.0%	9.4%	13.1%	2.9%	2.3%	0.0%	0.0%	5.4%	13.3%	10.0%	14.3%	N/A	16.3%	3.1%	7.5%	20.8%	14.7%	10.0%	21.4%
We have added physicians to the management team to help us achieve this goal	19.9%	34.0%	19.4%	26.2%	9.8%	11.4%	10.0%	9.1%	8.1%	20.0%	21.8%	57.1%	N/A	30.2%	7.7%	20.8%	35.4%	26.5%	30.0%	42.9%
Other	6.0%	10.0%	4.3%	9.8%	3.9%	4.5%	10.0%	0.0%	2.7%	6.7%	5.9%	42.9%	N/A	4.7%	4.6%	5.7%	6.3%	8.8%	5.0%	14.3%
Respondents currently making changes to manage population health	90.9%	98.0%	90.6%	98.4%	83.3%	77.3%	90.0%	81.8%	89.2%	93.3%	92.9%	100.0%	N/A	97.7%	83.8%	90.6%	100.0%	97.1%	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	**355**	**50**	**140**	**62**	**103**	**45**	**10**	**11**	**37**	**30**	**172**	**7**	**0**	**43**	**133**	**106**	**48**	**34**	**20**	**14**
2015 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 since 2013 in order to be successful with value-based payments?																				
Total responding in each category	351	50	138	61	102	44	10	11	37	30	169	7	0	43	130	105	48	34	20	14
We have not changed our board structure to prepare for value-based payments	54.1%	42.0%	61.6%	37.7%	59.8%	63.6%	70.0%	63.6%	51.4%	60.0%	53.3%	57.1%	N/A	39.5%	59.2%	61.9%	45.8%	41.2%	40.0%	28.6%
We have updated the strategic and financial plans to include goals regarding value-based payments	56.7%	78.0%	54.3%	70.5%	41.2%	36.4%	50.0%	27.3%	48.6%	60.0%	59.2%	85.7%	N/A	76.7%	38.5%	60.0%	68.8%	73.5%	80.0%	85.7%
We have added board members with expertise in quality improvement processes to help us achieve this goal	6.0%	12.0%	5.1%	9.8%	2.0%	0.0%	10.0%	9.1%	0.0%	3.3%	7.1%	14.3%	N/A	11.6%	2.3%	4.8%	14.6%	5.9%	0.0%	28.6%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	1.7%	4.0%	1.4%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	N/A	4.7%	0.8%	1.0%	4.2%	2.9%	0.0%	7.1%
We have added board members with expertise in cost reduction strategies to help us achieve this goal	3.4%	8.0%	2.2%	3.3%	2.9%	2.3%	0.0%	9.1%	2.7%	0.0%	3.0%	0.0%	N/A	9.3%	3.1%	2.9%	2.1%	2.9%	0.0%	21.4%
We have added physicians to the board to help us achieve this goal	9.7%	14.0%	11.6%	14.8%	2.0%	2.3%	0.0%	0.0%	2.7%	13.3%	12.4%	14.3%	N/A	14.0%	2.3%	11.4%	16.7%	17.6%	10.0%	21.4%
We have added physicians to the management team to help us achieve this goal	16.2%	32.0%	14.5%	21.3%	7.8%	11.4%	10.0%	0.0%	5.4%	13.3%	17.2%	42.9%	N/A	30.2%	6.2%	14.3%	27.1%	29.4%	30.0%	35.7%
Other	3.1%	10.0%	1.4%	1.6%	2.9%	4.5%	10.0%	0.0%	0.0%	0.0%	1.8%	0.0%	N/A	11.6%	3.1%	1.0%	2.1%	5.9%	10.0%	7.1%
Respondents currently making changes to be successful with value-based payments	95.2%	100.0%	97.1%	100.0%	87.3%	88.6%	90.0%	81.8%	86.5%	100.0%	97.6%	100.0%	N/A	100.0%	88.5%	98.1%	100.0%	100.0%	100.0%	100.0%

APPENDIX 2. GOVERNANCE PRACTICES

2015 Governance Practices	Overall	Systems	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	**352**	**50**	**140**	**61**	**101**
Yes, generally	92.3%	96.0%	93.6%	93.4%	88.1%
No, but considering it and/or working on it	5.4%	4.0%	5.0%	4.9%	6.9%
No, and not considering it	2.3%	0.0%	1.4%	1.6%	5.0%
The board reviews policies that specify the board's major oversight responsibilities at least every two years.					
Total responding to this question	**351**	**50**	**140**	**61**	**100**
Yes, generally	72.9%	72.0%	72.9%	70.5%	75.0%
No, but considering it and/or working on it	18.5%	18.0%	18.6%	21.3%	17.0%
No, and not considering it	8.5%	10.0%	8.6%	8.2%	8.0%
The board reviews the sufficiency of the organizational structure every five years.					
Total responding to this question	**342**	**50**	**139**	**58**	**95**
Yes, generally	70.5%	74.0%	64.7%	74.1%	74.7%
No, but considering it and/or working on it	13.2%	12.0%	18.0%	8.6%	9.5%
No, and not considering it	16.4%	14.0%	17.3%	17.2%	15.8%
The board reviews financial feasibility of projects before approving them.					
Total responding to this question	**351**	**49**	**140**	**60**	**102**
Yes, generally	97.4%	100.0%	97.1%	95.0%	98.0%
No, but considering it and/or working on it	1.1%	0.0%	2.1%	0.0%	1.0%
No, and not considering it	1.4%	0.0%	0.7%	5.0%	1.0%
The board considers whether new projects adhere to the organization's strategic plan before approving them.					
Total responding to this question	**351**	**49**	**139**	**62**	**101**
Yes, generally	95.4%	95.9%	95.0%	96.8%	95.0%
No, but considering it and/or working on it	3.7%	4.1%	4.3%	1.6%	4.0%
No, and not considering it	0.9%	0.0%	0.7%	1.6%	1.0%
The board receives important background materials within sufficient time to prepare for meetings.					
Total responding to this question	**354**	**50**	**140**	**62**	**102**
Yes, generally	96.6%	98.0%	97.9%	100.0%	92.2%
No, but considering it and/or working on it	2.8%	2.0%	1.4%	0.0%	6.9%
No, and not considering it	0.6%	0.0%	0.7%	0.0%	1.0%
The board has a written policy specifying minimum meeting attendance requirements.					
Total responding to this question	**343**	**49**	**135**	**62**	**97**
Yes, generally	72.3%	71.4%	74.1%	61.3%	77.3%
No, but considering it and/or working on it	12.8%	8.2%	15.6%	12.9%	11.3%
No, and not considering it	14.9%	20.4%	10.4%	25.8%	11.3%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board periodically reviews its committee structure and performance 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	**336**	**50**	**136**	**59**	**91**
Yes, generally	81.0%	78.0%	82.4%	89.8%	74.7%
No, but considering it and/or working on it	12.8%	18.0%	11.0%	8.5%	15.4%
No, and not considering it	6.3%	4.0%	6.6%	1.7%	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	**348**	**49**	**139**	**58**	**102**
Yes, generally	92.5%	89.8%	92.1%	91.4%	95.1%
No, but considering it and/or working on it	4.0%	4.1%	6.5%	1.7%	2.0%
No, and not considering it	3.4%	6.1%	1.4%	6.9%	2.9%
Please evaluate your board's overall performance in fulfilling its duty of care.					
Total responding to this question	**353**	**49**	**139**	**62**	**103**
Excellent	58.1%	69.4%	61.9%	67.7%	41.7%
Very Good	31.2%	26.5%	25.9%	21.0%	46.6%
Good	9.3%	4.1%	10.1%	11.3%	9.7%
Fair	1.4%	0.0%	2.2%	0.0%	1.9%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%
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	**352**	**50**	**138**	**62**	**102**
Yes, generally	98.0%	100.0%	99.3%	100.0%	94.1%
No, but considering it and/or working on it	2.0%	0.0%	0.7%	0.0%	5.9%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%
The board has adopted "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	**331**	**46**	**135**	**61**	**89**
Yes, generally	54.1%	52.2%	55.6%	68.9%	42.7%
No, but considering it and/or working on it	22.1%	32.6%	20.0%	9.8%	28.1%
No, and not considering it	23.9%	15.2%	24.4%	21.3%	29.2%

2015 Governance Practices	Overall	Systems	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	**326**	**49**	**134**	**61**	**82**
Yes, generally	79.1%	85.7%	79.9%	91.8%	64.6%
No, but considering it and/or working on it	11.0%	8.2%	14.2%	1.6%	14.6%
No, and not considering it	9.8%	6.1%	6.0%	6.6%	20.7%
Board members complete a full conflict-of-interest disclosure statement annually.					
Total responding to this question	**349**	**50**	**139**	**61**	**99**
Yes, generally	96.0%	100.0%	98.6%	100.0%	87.9%
No, but considering it and/or working on it	3.2%	0.0%	1.4%	0.0%	9.1%
No, and not considering it	0.9%	0.0%	0.0%	0.0%	3.0%
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	**346**	**49**	**138**	**62**	**97**
Yes, generally	76.3%	87.8%	79.0%	91.9%	56.7%
No, but considering it and/or working on it	10.1%	10.2%	6.5%	3.2%	19.6%
No, and not considering it	13.6%	2.0%	14.5%	4.8%	23.7%
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	**332**	**49**	**132**	**59**	**92**
Yes, generally	71.7%	73.5%	72.0%	78.0%	66.3%
No, but considering it and/or working on it	13.9%	16.3%	13.6%	10.2%	15.2%
No, and not considering it	14.5%	10.2%	14.4%	11.9%	18.5%
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	**345**	**48**	**137**	**61**	**99**
Yes, generally	78.0%	81.3%	82.5%	91.8%	61.6%
No, but considering it and/or working on it	13.3%	12.5%	12.4%	3.3%	21.2%
No, and not considering it	8.7%	6.3%	5.1%	4.9%	17.2%
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	**349**	**49**	**137**	**61**	**102**
Yes, generally	92.6%	93.9%	96.4%	98.4%	83.3%
No, but considering it and/or working on it	4.0%	6.1%	2.9%	1.6%	5.9%
No, and not considering it	3.4%	0.0%	0.7%	0.0%	10.8%

2015 Governance Practices	Overall	Systems	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 information to non-board members.					
Total responding to this question	**346**	**48**	**137**	**61**	**100**
Yes, generally	83.5%	85.4%	87.6%	82.0%	78.0%
No, but considering it and/or working on it	10.1%	12.5%	8.0%	13.1%	10.0%
No, and not considering it	6.4%	2.1%	4.4%	4.9%	12.0%
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	**288**	**47**	**134**	**61**	**46**
Yes, generally	96.5%	100.0%	99.3%	98.4%	82.6%
No, but considering it and/or working on it	2.1%	0.0%	0.7%	1.6%	8.7%
No, and not considering it	1.4%	0.0%	0.0%	0.0%	8.7%
Please evaluate your board's overall performance in fulfilling its duty of loyalty.					
Total responding to this question	**348**	**48**	**139**	**61**	**100**
Excellent	55.7%	72.9%	58.3%	68.9%	36.0%
Very Good	32.8%	20.8%	33.8%	23.0%	43.0%
Good	8.0%	2.1%	6.5%	8.2%	13.0%
Fair	3.2%	2.1%	1.4%	0.0%	8.0%
Poor	0.3%	2.1%	0.0%	0.0%	0.0%
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	**347**	**49**	**139**	**59**	**100**
Yes, generally	73.2%	71.4%	69.1%	79.7%	76.0%
No, but considering it and/or working on it	15.0%	10.2%	18.7%	11.9%	14.0%
No, and not considering it	11.8%	18.4%	12.2%	8.5%	10.0%
The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.					
Total responding to this question	**352**	**50**	**140**	**59**	**103**
Yes, generally	92.3%	94.0%	92.9%	93.2%	90.3%
No, but considering it and/or working on it	5.1%	4.0%	5.0%	3.4%	6.8%
No, and not considering it	2.6%	2.0%	2.1%	3.4%	2.9%
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	**349**	**50**	**138**	**59**	**102**
Yes, generally	95.4%	98.0%	94.9%	98.3%	93.1%
No, but considering it and/or working on it	2.9%	2.0%	2.9%	0.0%	4.9%
No, and not considering it	1.7%	0.0%	2.2%	1.7%	2.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board makes an appropriate governance assignment for risk management oversight.					
Total responding to this question	**341**	**49**	**134**	**56**	**102**
Yes, generally	81.8%	85.7%	75.4%	89.3%	84.3%
No, but considering it and/or working on it	11.4%	10.2%	14.2%	3.6%	12.7%
No, and not considering it	6.7%	4.1%	10.4%	7.1%	2.9%
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	**344**	**50**	**136**	**60**	**98**
Yes, generally	89.0%	96.0%	90.4%	88.3%	83.7%
No, but considering it and/or working on it	7.3%	2.0%	5.9%	8.3%	11.2%
No, and not considering it	3.8%	2.0%	3.7%	3.3%	5.1%
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	**322**	**50**	**132**	**48**	**92**
Yes, generally	81.7%	98.0%	87.1%	87.5%	62.0%
No, but considering it and/or working on it	4.0%	0.0%	5.3%	2.1%	5.4%
No, and not considering it	14.3%	2.0%	7.6%	10.4%	32.6%
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	**338**	**50**	**133**	**57**	**98**
Yes, generally	86.7%	92.0%	88.0%	98.2%	75.5%
No, but considering it and/or working on it	9.2%	4.0%	9.8%	1.8%	15.3%
No, and not considering it	4.1%	4.0%	2.3%	0.0%	9.2%
The board (directly or through a dedicated committee) ensures the compliance plan is properly implemented and effective.					
Total responding to this question	**345**	**49**	**136**	**58**	**102**
Yes, generally	91.0%	95.9%	89.7%	100.0%	85.3%
No, but considering it and/or working on it	6.7%	2.0%	7.4%	0.0%	11.8%
No, and not considering it	2.3%	2.0%	2.9%	0.0%	2.9%
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	**346**	**50**	**137**	**59**	**100**
Yes, generally	88.7%	94.0%	87.6%	98.3%	82.0%
No, but considering it and/or working on it	9.5%	4.0%	10.2%	1.7%	16.0%
No, and not considering it	1.7%	2.0%	2.2%	0.0%	2.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has established a direct reporting relationship with the compliance officer.					
Total responding to this question	**336**	**50**	**133**	**54**	**99**
Yes, generally	75.6%	84.0%	74.4%	83.3%	68.7%
No, but considering it and/or working on it	11.0%	4.0%	12.8%	3.7%	16.2%
No, and not considering it	13.4%	12.0%	12.8%	13.0%	15.2%
The board has established a direct reporting relationship with legal counsel.					
Total responding to this question	**310**	**48**	**120**	**50**	**92**
Yes, generally	67.1%	68.8%	62.5%	60.0%	76.1%
No, but considering it and/or working on it	9.4%	10.4%	12.5%	6.0%	6.5%
No, and not considering it	23.5%	20.8%	25.0%	34.0%	17.4%
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	**339**	**49**	**136**	**56**	**98**
Yes, generally	87.3%	87.8%	93.4%	87.5%	78.6%
No, but considering it and/or working on it	6.8%	0.0%	5.1%	5.4%	13.3%
No, and not considering it	5.9%	12.2%	1.5%	7.1%	8.2%
Please evaluate your board's overall performance in fulfilling its duty of obedience.					
Total responding to this question	**351**	**49**	**137**	**62**	**103**
Excellent	50.4%	65.3%	53.3%	58.1%	35.0%
Very Good	37.9%	28.6%	36.5%	30.6%	48.5%
Good	10.0%	6.1%	8.8%	11.3%	12.6%
Fair	1.7%	0.0%	1.5%	0.0%	3.9%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%
Quality Oversight					
The board reviews quality performance measures (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) at least quarterly to identify needs for corrective action.					
Total responding to this question	**353**	**50**	**138**	**62**	**103**
Yes, generally	96.9%	96.0%	96.4%	96.8%	98.1%
No, but considering it and/or working on it	2.3%	2.0%	3.6%	1.6%	1.0%
No, and not considering it	0.8%	2.0%	0.0%	1.6%	1.0%
The board requires all hospital clinical programs or services to meet quality-related performance criteria.					
Total responding to this question	**350**	**49**	**138**	**61**	**102**
Yes, generally	85.4%	87.8%	81.2%	95.1%	84.3%
No, but considering it and/or working on it	10.3%	4.1%	13.8%	1.6%	13.7%
No, and not considering it	4.3%	8.2%	5.1%	3.3%	2.0%

2015 Governance Practices	Overall	Systems	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	**341**	**48**	**135**	**58**	**100**
Yes, generally	83.9%	91.7%	85.9%	89.7%	74.0%
No, but considering it and/or working on it	11.1%	6.3%	9.6%	8.6%	17.0%
No, and not considering it	5.0%	2.1%	4.4%	1.7%	9.0%
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	**337**	**42**	**136**	**57**	**102**
Yes, generally	86.1%	85.7%	86.0%	93.0%	82.4%
No, but considering it and/or working on it	5.3%	0.0%	5.9%	5.3%	6.9%
No, and not considering it	8.6%	14.3%	8.1%	1.8%	10.8%
The board works with medical staff and management to set the organization's quality goals.					
Total responding to this question	**350**	**48**	**138**	**62**	**102**
Yes, generally	86.3%	93.8%	82.6%	93.5%	83.3%
No, but considering it and/or working on it	9.4%	4.2%	13.8%	4.8%	8.8%
No, and not considering it	4.3%	2.1%	3.6%	1.6%	7.8%
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	**352**	**50**	**139**	**62**	**101**
Yes, generally	87.5%	90.0%	87.8%	96.8%	80.2%
No, but considering it and/or working on it	10.5%	8.0%	10.8%	3.2%	15.8%
No, and not considering it	2.0%	2.0%	1.4%	0.0%	4.0%
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	**350**	**50**	**137**	**61**	**102**
Yes, generally	80.3%	74.0%	82.5%	93.4%	72.5%
No, but considering it and/or working on it	12.0%	12.0%	12.4%	6.6%	14.7%
No, and not considering it	7.7%	14.0%	5.1%	0.0%	12.7%
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	**351**	**50**	**139**	**61**	**101**
Yes, generally	93.7%	96.0%	95.0%	100.0%	87.1%
No, but considering it and/or working on it	4.3%	2.0%	3.6%	0.0%	8.9%
No, and not considering it	2.0%	2.0%	1.4%	0.0%	4.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board has a standing quality committee of the board.					
Total responding to this question	**333**	**48**	**134**	**59**	**92**
Yes, generally	81.1%	93.8%	79.9%	93.2%	68.5%
No, but considering it and/or working on it	7.5%	4.2%	6.7%	1.7%	14.1%
No, and not considering it	11.4%	2.1%	13.4%	5.1%	17.4%
The board reviews patient satisfaction/patient experience scores at least annually (including those publicly reported by CMS).					
Total responding to this question	**352**	**48**	**139**	**62**	**103**
Yes, generally	98.0%	95.8%	99.3%	100.0%	96.1%
No, but considering it and/or working on it	1.1%	2.1%	0.7%	0.0%	1.9%
No, and not considering it	0.9%	2.1%	0.0%	0.0%	1.9%
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	**352**	**50**	**137**	**62**	**103**
Yes, generally	84.7%	78.0%	85.4%	90.3%	83.5%
No, but considering it and/or working on it	12.5%	18.0%	13.1%	8.1%	11.7%
No, and not considering it	2.8%	4.0%	1.5%	1.6%	4.9%
The board has adopted a policy concerning reporting the organization's quality/safety performance to the general public.					
Total responding to this question	**346**	**50**	**136**	**60**	**100**
Yes, generally	48.6%	54.0%	44.9%	53.3%	48.0%
No, but considering it and/or working on it	29.8%	18.0%	33.8%	26.7%	32.0%
No, and not considering it	21.7%	28.0%	21.3%	20.0%	20.0%
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	**332**	**38**	**134**	**61**	**99**
Yes, generally	88.3%	86.8%	89.6%	95.1%	82.8%
No, but considering it and/or working on it	6.9%	7.9%	4.5%	1.6%	13.1%
No, and not considering it	4.8%	5.3%	6.0%	3.3%	4.0%
Please evaluate your board's overall performance in fulfilling its responsibility for quality oversight.					
Total responding to this question	**354**	**50**	**139**	**62**	**103**
Excellent	53.1%	56.0%	56.1%	67.7%	38.8%
Very Good	34.2%	38.0%	31.7%	22.6%	42.7%
Good	11.3%	6.0%	11.5%	9.7%	14.6%
Fair	1.4%	0.0%	0.7%	0.0%	3.9%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Financial Oversight					
The board approves the organization's capital and financial plans.					
Total responding to this question	**346**	**49**	**137**	**60**	**100**
Yes, generally	99.4%	100.0%	98.5%	100.0%	100.0%
No, but considering it and/or working on it	0.3%	0.0%	0.7%	0.0%	0.0%
No, and not considering it	0.3%	0.0%	0.7%	0.0%	0.0%
The board reviews information at least quarterly on the organization's financial performance against plans.					
Total responding to this question	**349**	**50**	**136**	**61**	**102**
Yes, generally	99.1%	98.0%	98.5%	100.0%	100.0%
No, but considering it and/or working on it	0.6%	2.0%	0.7%	0.0%	0.0%
No, and not considering it	0.3%	0.0%	0.7%	0.0%	0.0%
The board demands corrective actions in response to under-performance on capital and financial plans.					
Total responding to this question	**340**	**50**	**133**	**58**	**99**
Yes, generally	92.1%	96.0%	93.2%	94.8%	86.9%
No, but considering it and/or working on it	6.2%	4.0%	4.5%	5.2%	10.1%
No, and not considering it	1.8%	0.0%	2.3%	0.0%	3.0%
The board requires that the organization's strategic and financial plans be aligned.					
Total responding to this question	**345**	**50**	**137**	**59**	**99**
Yes, generally	93.3%	92.0%	93.4%	98.3%	90.9%
No, but considering it and/or working on it	5.8%	8.0%	5.8%	1.7%	7.1%
No, and not considering it	0.9%	0.0%	0.7%	0.0%	2.0%
The board monitors the organization's debt obligations and investment portfolio.					
Total responding to this question	**327**	**49**	**131**	**49**	**98**
Yes, generally	97.6%	98.0%	99.2%	93.9%	96.9%
No, but considering it and/or working on it	0.9%	2.0%	0.0%	0.0%	2.0%
No, and not considering it	1.5%	0.0%	0.8%	6.1%	1.0%
Board members responsible for audit oversight meet with external auditors, without management, at least annually.					
Total responding to this question	**321**	**49**	**131**	**48**	**93**
Yes, generally	88.5%	95.9%	96.2%	85.4%	75.3%
No, but considering it and/or working on it	5.3%	2.0%	0.0%	6.3%	14.0%
No, and not considering it	6.2%	2.0%	3.8%	8.3%	10.8%
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	**323**	**49**	**129**	**49**	**96**
Yes, generally	85.8%	93.9%	91.5%	87.8%	72.9%
No, but considering it and/or working on it	6.2%	4.1%	2.3%	4.1%	13.5%
No, and not considering it	8.0%	2.0%	6.2%	8.2%	13.5%

2015 Governance Practices	Overall	Systems	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	**311**	**48**	**128**	**46**	**89**
Yes, generally	70.4%	93.8%	68.8%	89.1%	50.6%
No, but considering it and/or working on it	6.8%	0.0%	7.8%	4.3%	10.1%
No, and not considering it	22.8%	6.3%	23.4%	6.5%	39.3%
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	**297**	**48**	**125**	**47**	**77**
Yes, generally	68.0%	85.4%	68.8%	80.9%	48.1%
No, but considering it and/or working on it	8.4%	6.3%	8.0%	4.3%	13.0%
No, and not considering it	23.6%	8.3%	23.2%	14.9%	39.0%
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	**346**	**50**	**135**	**61**	**100**
Yes, generally	97.7%	96.0%	98.5%	96.7%	98.0%
No, but considering it and/or working on it	1.4%	2.0%	0.7%	1.6%	2.0%
No, and not considering it	0.9%	2.0%	0.7%	1.6%	0.0%
Please evaluate your board's overall performance in fulfilling its responsibility for financial oversight.					
Total responding to this question	**350**	**49**	**138**	**62**	**101**
Excellent	64.0%	83.7%	71.0%	64.5%	44.6%
Very Good	30.0%	16.3%	25.4%	27.4%	44.6%
Good	4.9%	0.0%	2.2%	8.1%	8.9%
Fair	1.1%	0.0%	1.4%	0.0%	2.0%
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	**347**	**50**	**138**	**58**	**101**
Yes, generally	92.5%	88.0%	96.4%	96.6%	87.1%
No, but considering it and/or working on it	6.3%	10.0%	3.6%	3.4%	9.9%
No, and not considering it	1.2%	2.0%	0.0%	0.0%	3.0%
The board approves a strategy for aligning the clinical and economic goals of the hospital(s) and physicians.					
Total responding to this question	**345**	**48**	**137**	**61**	**99**
Yes, generally	85.5%	83.3%	88.3%	91.8%	78.8%
No, but considering it and/or working on it	10.1%	10.4%	8.8%	6.6%	14.1%
No, and not considering it	4.3%	6.3%	2.9%	1.6%	7.1%

2015 Governance Practices	Overall	Systems	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	**350**	**50**	**137**	**62**	**101**
Yes, generally	88.6%	88.0%	89.8%	95.2%	83.2%
No, but considering it and/or working on it	10.3%	12.0%	10.2%	4.8%	12.9%
No, and not considering it	1.1%	0.0%	0.0%	0.0%	4.0%
The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, and impact on quality and patient safety.					
Total responding to this question	**350**	**50**	**138**	**61**	**101**
Yes, generally	93.7%	92.0%	92.8%	98.4%	93.1%
No, but considering it and/or working on it	5.1%	8.0%	5.1%	1.6%	5.9%
No, and not considering it	1.1%	0.0%	2.2%	0.0%	1.0%
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	**345**	**50**	**136**	**59**	**100**
Yes, generally	92.5%	96.0%	91.2%	94.9%	91.0%
No, but considering it and/or working on it	6.4%	4.0%	7.4%	5.1%	7.0%
No, and not considering it	1.2%	0.0%	1.5%	0.0%	2.0%
The board considers how the organization's strategic plan addresses community health status/needs before approving the plan.					
Total responding to this question	**347**	**49**	**137**	**60**	**101**
Yes, generally	83.3%	89.8%	81.0%	90.0%	79.2%
No, but considering it and/or working on it	13.5%	4.1%	15.3%	8.3%	18.8%
No, and not considering it	3.2%	6.1%	3.6%	1.7%	2.0%
The board requires that major strategic projects specify *both* measurable criteria for success *and* those responsible for implementation.					
Total responding to this question	**349**	**50**	**137**	**62**	**100**
Yes, generally	83.4%	88.0%	82.5%	90.3%	78.0%
No, but considering it and/or working on it	12.6%	6.0%	13.9%	9.7%	16.0%
No, and not considering it	4.0%	6.0%	3.6%	0.0%	6.0%
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.					
Total responding to this question	**342**	**50**	**136**	**60**	**96**
Yes, generally	55.6%	54.0%	51.5%	68.3%	54.2%
No, but considering it and/or working on it	25.1%	24.0%	27.2%	20.0%	26.0%
No, and not considering it	19.3%	22.0%	21.3%	11.7%	19.8%
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	**345**	**50**	**137**	**58**	**100**
Yes, generally	38.3%	54.0%	37.2%	37.9%	32.0%
No, but considering it and/or working on it	41.2%	30.0%	45.3%	44.8%	39.0%
No, and not considering it	20.6%	16.0%	17.5%	17.2%	29.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
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	**338**	**50**	**135**	**54**	**99**
Yes, generally	46.7%	54.0%	44.4%	53.7%	42.4%
No, but considering it and/or working on it	29.0%	24.0%	31.1%	20.4%	33.3%
No, and not considering it	24.3%	22.0%	24.4%	25.9%	24.2%
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	**333**	**45**	**133**	**56**	**99**
Yes, generally	64.0%	60.0%	68.4%	69.6%	56.6%
No, but considering it and/or working on it	22.5%	22.2%	18.8%	19.6%	29.3%
No, and not considering it	13.5%	17.8%	12.8%	10.7%	14.1%
The board has established policies regarding physician compensation that include consideration of "fair market value" and industry benchmarks when determining compensation.					
Total responding to this question	**321**	**48**	**127**	**58**	**88**
Yes, generally	76.6%	87.5%	78.7%	84.5%	62.5%
No, but considering it and/or working on it	13.7%	4.2%	15.0%	5.2%	22.7%
No, and not considering it	9.7%	8.3%	6.3%	10.3%	14.8%
Please evaluate your board's overall performance in fulfilling its responsibility for setting strategic direction.					
Total responding to this question	**347**	**49**	**137**	**60**	**101**
Excellent	37.8%	55.1%	39.4%	38.3%	26.7%
Very Good	39.2%	32.7%	39.4%	36.7%	43.6%
Good	19.6%	8.2%	18.2%	23.3%	24.8%
Fair	2.9%	4.1%	2.2%	1.7%	4.0%
Poor	0.6%	0.0%	0.7%	0.0%	1.0%
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	**347**	**50**	**138**	**60**	**99**
Yes, generally	75.2%	86.0%	76.8%	85.0%	61.6%
No, but considering it and/or working on it	16.7%	8.0%	18.8%	8.3%	23.2%
No, and not considering it	8.1%	6.0%	4.3%	6.7%	15.2%
The board uses the results from the self-assessment process to establish board performance improvement goals.					
Total responding to this question	**332**	**49**	**133**	**59**	**91**
Yes, generally	61.1%	65.3%	61.7%	69.5%	52.7%
No, but considering it and/or working on it	27.4%	22.4%	30.1%	23.7%	28.6%
No, and not considering it	11.4%	12.2%	8.3%	6.8%	18.7%
The board uses a formal orientation program for new board members.					
Total responding to this question	**349**	**50**	**138**	**61**	**100**
Yes, generally	87.1%	98.0%	91.3%	98.4%	69.0%
No, but considering it and/or working on it	10.6%	2.0%	5.8%	1.6%	27.0%
No, and not considering it	2.3%	0.0%	2.9%	0.0%	4.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Board members participate in ongoing education regarding key strategic issues facing the organization.					
Total responding to this question	**349**	**50**	**138**	**61**	**100**
Yes, generally	86.8%	86.0%	88.4%	91.8%	82.0%
No, but considering it and/or working on it	9.7%	12.0%	9.4%	8.2%	10.0%
No, and not considering it	3.4%	2.0%	2.2%	0.0%	8.0%
The board assesses its own bylaws/ structure at least every three years.					
Total responding to this question	**337**	**50**	**134**	**54**	**99**
Yes, generally	80.1%	78.0%	84.3%	83.3%	73.7%
No, but considering it and/or working on it	13.1%	14.0%	11.2%	9.3%	17.2%
No, and not considering it	6.8%	8.0%	4.5%	7.4%	9.1%
The board uses competency-based criteria when selecting new board members.					
Total responding to this question	**295**	**47**	**128**	**59**	**61**
Yes, generally	60.7%	70.2%	57.8%	72.9%	47.5%
No, but considering it and/or working on it	24.1%	17.0%	28.9%	16.9%	26.2%
No, and not considering it	15.3%	12.8%	13.3%	10.2%	26.2%
The board uses a formal process to evaluate the performance of individual board members.					
Total responding to this question	**329**	**48**	**136**	**58**	**87**
Yes, generally	27.4%	37.5%	25.7%	36.2%	18.4%
No, but considering it and/or working on it	31.6%	20.8%	40.4%	29.3%	25.3%
No, and not considering it	41.0%	41.7%	33.8%	34.5%	56.3%
The board has established performance requirements for board member and officer reappointment.					
Total responding to this question	**321**	**48**	**133**	**58**	**82**
Yes, generally	30.2%	33.3%	31.6%	41.4%	18.3%
No, but considering it and/or working on it	30.2%	29.2%	33.8%	27.6%	26.8%
No, and not considering it	39.6%	37.5%	34.6%	31.0%	54.9%
The board has a "mentoring" program for new board members.					
Total responding to this question	**338**	**50**	**136**	**59**	**93**
Yes, generally	30.2%	36.0%	27.2%	39.0%	25.8%
No, but considering it and/or working on it	33.7%	28.0%	38.2%	35.6%	29.0%
No, and not considering it	36.1%	36.0%	34.6%	25.4%	45.2%
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	**319**	**49**	**133**	**58**	**79**
Yes, generally	43.9%	46.9%	45.9%	55.2%	30.4%
No, but considering it and/or working on it	32.3%	36.7%	31.6%	32.8%	30.4%
No, and not considering it	23.8%	16.3%	22.6%	12.1%	39.2%
The board has a clear understanding regarding its mutual expectations with its chair.					
Total responding to this question	**346**	**50**	**136**	**61**	**99**
Yes, generally	78.9%	74.0%	83.8%	83.6%	71.7%
No, but considering it and/or working on it	9.2%	12.0%	8.1%	6.6%	11.1%
No, and not considering it	11.8%	14.0%	8.1%	9.8%	17.2%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Please evaluate your board's overall performance in fulfilling its responsibility for its own performance and development.					
Total responding to this question	**347**	**48**	**135**	**62**	**102**
Excellent	29.7%	43.8%	29.6%	29.0%	23.5%
Very Good	34.3%	37.5%	32.6%	40.3%	31.4%
Good	23.9%	10.4%	28.9%	21.0%	25.5%
Fair	9.8%	6.3%	8.1%	9.7%	13.7%
Poor	2.3%	2.1%	0.7%	0.0%	5.9%
Management Oversight					
The board follows a formal process for evaluating the CEO's performance.					
Total responding to this question	**341**	**49**	**135**	**55**	**102**
Yes, generally	92.4%	93.9%	95.6%	94.5%	86.3%
No, but considering it and/or working on it	5.0%	4.1%	2.2%	5.5%	8.8%
No, and not considering it	2.6%	2.0%	2.2%	0.0%	4.9%
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation.					
Total responding to this question	**336**	**49**	**135**	**51**	**101**
Yes, generally	83.0%	87.8%	88.9%	84.3%	72.3%
No, but considering it and/or working on it	10.4%	8.2%	5.2%	7.8%	19.8%
No, and not considering it	6.5%	4.1%	5.9%	7.8%	7.9%
The board requires that the CEO's compensation package is based, in part, on the CEO's performance evaluation.					
Total responding to this question	**332**	**48**	**134**	**50**	**100**
Yes, generally	89.8%	93.8%	93.3%	90.0%	83.0%
No, but considering it and/or working on it	4.5%	4.2%	1.5%	6.0%	8.0%
No, and not considering it	5.7%	2.1%	5.2%	4.0%	9.0%
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	**334**	**49**	**134**	**53**	**98**
Yes, generally	92.8%	98.0%	94.8%	96.2%	85.7%
No, but considering it and/or working on it	2.7%	0.0%	2.2%	1.9%	5.1%
No, and not considering it	4.5%	2.0%	3.0%	1.9%	9.2%
The board seeks independent (i.e., third party) expert advice/information on industry comparables before approving executive compensation.					
Total responding to this question	**334**	**49**	**134**	**50**	**101**
Yes, generally	89.8%	98.0%	92.5%	98.0%	78.2%
No, but considering it and/or working on it	4.2%	0.0%	3.0%	0.0%	9.9%
No, and not considering it	6.0%	2.0%	4.5%	2.0%	11.9%
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.					
Total responding to this question	**333**	**48**	**133**	**51**	**101**
Yes, generally	91.0%	97.9%	91.0%	98.0%	84.2%
No, but considering it and/or working on it	4.2%	0.0%	4.5%	0.0%	7.9%
No, and not considering it	4.8%	2.1%	4.5%	2.0%	7.9%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
The board requires that the CEO maintain a written, current succession plan.					
Total responding to this question	**336**	**49**	**135**	**54**	**98**
Yes, generally	45.8%	69.4%	45.9%	48.1%	32.7%
No, but considering it and/or working on it	33.6%	24.5%	35.6%	37.0%	33.7%
No, and not considering it	20.5%	6.1%	18.5%	14.8%	33.7%
The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance.					
Total responding to this question	**334**	**48**	**132**	**54**	**100**
Yes, generally	78.1%	89.6%	79.5%	77.8%	71.0%
No, but considering it and/or working on it	10.5%	4.2%	9.8%	11.1%	14.0%
No, and not considering it	11.4%	6.3%	10.6%	11.1%	15.0%
Please evaluate your board's overall performance in fulfilling its responsibility for management oversight.					
Total responding to this question	**346**	**49**	**136**	**59**	**102**
Excellent	51.4%	75.5%	52.9%	49.2%	39.2%
Very Good	32.7%	20.4%	34.6%	33.9%	35.3%
Good	11.8%	4.1%	10.3%	10.2%	18.6%
Fair	3.2%	0.0%	1.5%	6.8%	4.9%
Poor	0.9%	0.0%	0.7%	0.0%	2.0%
Community Benefit and 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	**338**	**48**	**134**	**60**	**96**
Yes, generally	65.1%	70.8%	64.2%	83.3%	52.1%
No, but considering it and/or working on it	26.9%	20.8%	27.6%	15.0%	36.5%
No, and not considering it	8.0%	8.3%	8.2%	1.7%	11.5%
The board provides oversight with respect to organizational compliance with IRS tax-exemption requirements concerning community benefit and related requirements.					
Total responding to this question	**308**	**48**	**134**	**59**	**67**
Yes, generally	90.9%	97.9%	91.0%	94.9%	82.1%
No, but considering it and/or working on it	6.2%	0.0%	6.0%	3.4%	13.4%
No, and not considering it	2.9%	2.1%	3.0%	1.7%	4.5%
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).					
Total responding to this question	**343**	**47**	**136**	**61**	**99**
Yes, generally	84.0%	87.2%	77.2%	90.2%	87.9%
No, but considering it and/or working on it	10.2%	6.4%	14.0%	8.2%	8.1%
No, and not considering it	5.8%	6.4%	8.8%	1.6%	4.0%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
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	**329**	**46**	**131**	**61**	**91**
Yes, generally	70.2%	69.6%	71.8%	80.3%	61.5%
No, but considering it and/or working on it	16.4%	17.4%	17.6%	14.8%	15.4%
No, and not considering it	13.4%	13.0%	10.7%	4.9%	23.1%
The board has a written policy establishing the board's role in fund development and/or philanthropy.					
Total responding to this question	**319**	**44**	**131**	**58**	**86**
Yes, generally	32.0%	38.6%	33.6%	41.4%	19.8%
No, but considering it and/or working on it	29.5%	22.7%	35.1%	24.1%	27.9%
No, and not considering it	38.6%	38.6%	31.3%	34.5%	52.3%
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	**319**	**47**	**132**	**56**	**84**
Yes, generally	72.4%	89.4%	65.2%	83.9%	66.7%
No, but considering it and/or working on it	11.6%	4.3%	14.4%	7.1%	14.3%
No, and not considering it	16.0%	6.4%	20.5%	8.9%	19.0%
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	**342**	**49**	**135**	**60**	**98**
Yes, generally	47.1%	40.8%	43.0%	56.7%	50.0%
No, but considering it and/or working on it	32.2%	30.6%	33.3%	23.3%	36.7%
No, and not considering it	20.8%	28.6%	23.7%	20.0%	13.3%
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	**332**	**49**	**135**	**62**	**86**
Yes, generally	92.5%	98.0%	95.6%	100.0%	79.1%
No, but considering it and/or working on it	5.7%	2.0%	3.7%	0.0%	15.1%
No, and not considering it	1.8%	0.0%	0.7%	0.0%	5.8%
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	**335**	**49**	**136**	**60**	**90**
Yes, generally	85.1%	87.8%	86.0%	95.0%	75.6%
No, but considering it and/or working on it	12.8%	10.2%	12.5%	5.0%	20.0%
No, and not considering it	2.1%	2.0%	1.5%	0.0%	4.4%
The board requires that management annually report community benefit value to the community.					
Total responding to this question	**337**	**49**	**134**	**61**	**93**
Yes, generally	77.4%	81.6%	82.1%	88.5%	61.3%
No, but considering it and/or working on it	14.5%	14.3%	9.7%	3.3%	29.0%
No, and not considering it	8.0%	4.1%	8.2%	8.2%	9.7%

2015 Governance Practices	Overall	Systems	Independent Hospitals	Subsidiary Hospitals	Government-Sponsored Hospitals
Please evaluate your board's overall performance in fulfilling its responsibility for community benefit and advocacy.					
Total responding to this question	**349**	**48**	**137**	**62**	**102**
Excellent	33.8%	39.6%	33.6%	43.5%	25.5%
Very Good	34.4%	39.6%	33.6%	30.6%	35.3%
Good	23.2%	16.7%	26.3%	21.0%	23.5%
Fair	7.4%	4.2%	5.8%	4.8%	12.7%
Poor	1.1%	0.0%	0.7%	0.0%	2.9%

APPENDIX 3. GOVERNANCE PRACTICES: COMPARISON 2015 VS. 2013

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	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
Duty of Care										
The board requires that new board members receive education on their fiduciary duties.	**2.90**	2.91	**2.96**	2.98	**2.92**	2.93	**2.92**	2.94	**2.83**	2.81
The board reviews policies that specify the board's major oversight responsibilities at least every two years.	**2.64**	2.68	**2.62**	2.69	**2.64**	2.66	**2.62**	2.66	**2.67**	2.73
The board reviews the sufficiency of the organizational structure every five years.	**2.54**	2.57	**2.60**	2.66	**2.47**	2.63	**2.57**	2.48	**2.59**	2.59
The board reviews financial feasibility of projects before approving them.	**2.96**	2.99	**3.00**	2.97	**2.96**	3.00	**2.90**	2.99	**2.97**	2.99
The board considers whether new projects adhere to the organization's strategic plan before approving them.	**2.95**	2.96	**2.96**	2.98	**2.94**	2.97	**2.95**	2.97	**2.94**	2.93
The board receives important background materials within sufficient time to prepare for meetings.	**2.96**	2.97	**2.98**	3.00	**2.97**	2.96	**3.00**	2.99	**2.91**	2.95
The board has a written policy specifying minimum meeting attendance requirements.	**2.57**	2.61	**2.51**	2.62	**2.64**	2.61	**2.35**	2.62	**2.66**	2.57
The board periodically reviews its committee structure and performance 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.	**2.75**	2.77	**2.74**	2.86	**2.76**	2.77	**2.88**	2.85	**2.65**	2.61
The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).	**2.89**	2.93	**2.84**	2.98	**2.91**	2.97	**2.84**	2.93	**2.92**	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**	3.00	**2.99**	2.99	**3.00**	2.99	**2.94**	2.96
The board has adopted "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.	**2.30**	2.60	**2.37**	2.54	**2.31**	2.52	**2.48**	2.63	**2.13**	2.66
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.	**2.69**	2.72	**2.80**	2.89	**2.74**	2.77	**2.85**	2.74	**2.44**	2.50
Board members complete a full conflict-of-interest disclosure statement annually.	**2.95**	2.94	**3.00**	3.00	**2.99**	2.97	**3.00**	2.98	**2.85**	2.84
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.	**2.63**	2.59	**2.86**	2.80	**2.64**	2.58	**2.87**	2.69	**2.33**	2.38
The board enforces a written policy that states that deliberate violations of conflict of interest constitute grounds for removal from the board.	**2.57**	2.56	**2.63**	2.55	**2.58**	2.58	**2.66**	2.62	**2.48**	2.46
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	**2.75**	2.81	**2.77**	2.72	**2.87**	2.74	**2.44**	2.53
The board's enforcement of the organization's conflict-of-interest policy is applied uniformly across all members of the board.	**2.89**	2.90	**2.94**	2.95	**2.96**	2.93	**2.98**	2.94	**2.73**	2.81
The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board information to non-board members.	**2.77**	2.80	**2.83**	2.81	**2.83**	2.83	**2.77**	2.85	**2.66**	2.68
The board ensures that the federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.	**2.95**	2.93	**3.00**	3.00	**2.99**	2.98	**2.98**	2.94	**2.74**	2.66

"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	
	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
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.	**2.61**	2.65	**2.53**	2.63	**2.57**	2.54	**2.71**	2.70	**2.66**	2.72
The board ensures that the organization's written mission statement correctly articulates its fundamental purpose.	**2.90**	2.93	**2.92**	2.98	**2.91**	2.93	**2.90**	2.93	**2.87**	2.90
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.	**2.94**	2.96	**2.98**	2.96	**2.93**	2.98	**2.97**	2.98	**2.91**	2.89
The board makes an appropriate governance assignment for risk management oversight.	**2.75**	2.78	**2.82**	2.93	**2.65**	2.83	**2.82**	2.83	**2.81**	2.58
The board has approved a "code of conduct" policies/ procedures document that provides ethical requirements for board members, employees, and practicing physicians.	**2.85**	2.81	**2.94**	2.83	**2.87**	2.88	**2.85**	2.84	**2.79**	2.68
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.	**2.67**	2.69	**2.96**	2.95	**2.80**	2.83	**2.77**	2.76	**2.29**	2.24
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.	**2.83**	2.85	**2.88**	2.98	**2.86**	2.86	**2.98**	2.84	**2.66**	2.78
The board (directly or through a dedicated committee) ensures the compliance plan is properly implemented and effective.	**2.89**	2.84	**2.94**	3.00	**2.87**	2.86	**3.00**	2.87	**2.82**	2.69
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.).	**2.87**	2.86	**2.92**	2.98	**2.85**	2.85	**2.98**	2.92	**2.80**	2.75
The board has established a direct reporting relationship with the compliance officer.	**2.62**	2.53	**2.72**	2.65	**2.62**	2.51	**2.70**	2.52	**2.54**	2.51
The board has established a direct reporting relationship with legal counsel.	**2.44**	2.35	**2.48**	2.34	**2.38**	2.23	**2.26**	2.38	**2.59**	2.45
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**	2.81	**2.76**	2.93	**2.92**	2.77	**2.80**	2.84	**2.70**	2.76

"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	
	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
Quality Oversight										
The board reviews quality performance measures (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) at least quarterly to identify needs for corrective action.	**2.96**	2.96	**2.94**	2.95	**2.96**	2.96	**2.95**	2.99	**2.97**	2.92
The board requires all hospital clinical programs or services to meet quality-related performance criteria.	**2.81**	2.77	**2.80**	2.80	**2.76**	2.76	**2.92**	2.79	**2.82**	2.76
The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.	**2.79**	2.75	**2.90**	2.84	**2.81**	2.73	**2.88**	2.89	**2.65**	2.54
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.	**2.77**	2.68	**2.71**	2.48	**2.78**	2.74	**2.91**	2.76	**2.72**	2.55
The board works with medical staff and management to set the organization's quality goals.	**2.82**	2.77	**2.92**	2.86	**2.79**	2.80	**2.92**	2.86	**2.75**	2.59
The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).	**2.86**	2.83	**2.88**	2.88	**2.86**	2.88	**2.97**	2.88	**2.76**	2.67
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).	**2.73**	2.70	**2.60**	2.84	**2.77**	2.71	**2.93**	2.75	**2.60**	2.57
The board reviews its quality performance by comparing its current performance to its own historical performance as well as industry benchmarks.	**2.92**	2.88	**2.94**	2.91	**2.94**	2.87	**3.00**	2.94	**2.83**	2.79
The board has a standing quality committee of the board.	**2.70**	2.65	**2.92**	2.79	**2.66**	2.66	**2.88**	2.78	**2.51**	2.36
The board reviews patient satisfaction/patient experience scores at least annually (including those publicly reported by CMS).	**2.97**	2.96	**2.94**	2.96	**2.99**	2.95	**3.00**	3.00	**2.94**	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**	2.82	**2.74**	2.88	**2.84**	2.86	**2.89**	2.83	**2.79**	2.72
The board has adopted a policy concerning reporting the organization's quality/safety performance to the general public.	**2.27**	2.28	**2.26**	2.30	**2.24**	2.31	**2.33**	2.34	**2.28**	2.15
The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.	**2.83**	2.82	**2.82**	2.95	**2.84**	2.81	**2.92**	2.90	**2.79**	2.69

"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	
	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
Financial Oversight										
The board approves the organization's capital and financial plans.	**2.99**	2.99	**3.00**	3.00	**2.98**	3.00	**3.00**	2.99	**3.00**	2.99
The board reviews information at least quarterly on the organization's financial performance against plans.	**2.99**	2.99	**2.98**	2.97	**2.98**	3.00	**3.00**	3.00	**3.00**	2.98
The board demands corrective actions in response to under-performance on capital and financial plans.	**2.90**	2.86	**2.96**	2.91	**2.91**	2.83	**2.95**	2.89	**2.84**	2.83
The board requires that the organization's strategic and financial plans be aligned.	**2.92**	2.91	**2.92**	2.97	**2.93**	2.89	**2.98**	2.95	**2.89**	2.87
The board monitors the organization's debt obligations and investment portfolio.	**2.96**	2.96	**2.98**	3.00	**2.98**	2.96	**2.88**	2.94	**2.96**	2.95
Board members responsible for audit oversight meet with external auditors, without management, at least annually.	**2.82**	2.74	**2.94**	2.97	**2.92**	2.88	**2.77**	2.74	**2.65**	2.48
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.	**2.78**	2.76	**2.92**	2.95	**2.85**	2.76	**2.80**	2.77	**2.59**	2.66
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.	**2.48**	2.44	**2.88**	2.83	**2.45**	2.53	**2.83**	2.63	**2.11**	1.88
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.	**2.44**	2.32	**2.77**	2.76	**2.46**	2.41	**2.66**	2.43	**2.09**	1.79
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.	**2.97**	2.96	**2.94**	3.00	**2.98**	2.95	**2.95**	2.93	**2.98**	2.98

"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	
	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
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.	**2.91**	2.92	**2.86**	2.92	**2.96**	2.96	**2.97**	2.95	**2.84**	2.84
The board approves a strategy for aligning the clinical and economic goals of the hospital(s) and physicians.	**2.81**	2.85	**2.77**	2.90	**2.85**	2.85	**2.90**	2.92	**2.72**	2.75
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.	**2.87**	2.89	**2.88**	2.95	**2.90**	2.89	**2.95**	2.92	**2.79**	2.81
The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, and impact on quality and patient safety.	**2.93**	2.94	**2.92**	2.95	**2.91**	2.95	**2.98**	2.96	**2.92**	2.89
The board discusses the needs of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).	**2.91**	2.92	**2.96**	2.97	**2.90**	2.94	**2.95**	2.94	**2.89**	2.86
The board considers how the organization's strategic plan addresses community health status/needs before approving the plan.	**2.80**	2.80	**2.84**	2.81	**2.77**	2.78	**2.88**	2.87	**2.77**	2.72
The board requires that major strategic projects specify *both* measurable criteria for success *and* those responsible for implementation.	**2.79**	2.80	**2.82**	2.86	**2.79**	2.80	**2.90**	2.86	**2.72**	2.72
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.	**2.36**	2.39	**2.32**	2.47	**2.30**	2.38	**2.57**	2.46	**2.34**	2.28
The board spends more than half of its meeting time during most board meetings discussing strategic issues as opposed to hearing reports.	**2.18**	2.22	**2.38**	2.53	**2.20**	2.23	**2.21**	2.32	**2.03**	1.94
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**	2.22	**2.32**	2.40	**2.20**	2.24	**2.28**	2.25	**2.18**	2.10
The board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability.	**2.50**	2.56	**2.42**	2.69	**2.56**	2.57	**2.59**	2.64	**2.42**	2.41
The board has established policies regarding physician compensation that include consideration of "fair market value" and industry benchmarks when determining compensation.	**2.67**	2.60	**2.79**	2.73	**2.72**	2.60	**2.74**	2.69	**2.48**	2.45

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

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	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
Board Development										
The board engages in a formal self-assessment process to evaluate its own performance at least every two years.	**2.67**	2.75	**2.80**	2.91	**2.72**	2.78	**2.78**	2.82	**2.46**	2.55
The board uses the results from the self-assessment process to establish board performance improvement goals.	**2.50**	2.57	**2.53**	2.78	**2.53**	2.59	**2.63**	2.69	**2.34**	2.31
The board uses a formal orientation program for new board members.	**2.85**	2.82	**2.98**	2.93	**2.88**	2.88	**2.98**	2.90	**2.65**	2.61
Board members participate in ongoing education regarding key strategic issues facing the organization.	**2.83**	2.87	**2.84**	2.91	**2.86**	2.91	**2.92**	2.93	**2.74**	2.75
The board assesses its own bylaws/structures at least every three years.	**2.73**	2.74	**2.70**	2.74	**2.80**	2.76	**2.76**	2.72	**2.65**	2.74
The board uses competency-based criteria when selecting new board members.	**2.45**	2.36	**2.57**	2.78	**2.45**	2.28	**2.63**	2.51	**2.21**	1.93
The board uses a formal process to evaluate the performance of individual board members.	**1.86**	1.88	**1.96**	2.16	**1.92**	1.92	**2.02**	1.92	**1.62**	1.61
The board has established performance requirements for board member and officer reappointment.	**1.91**	1.89	**1.96**	2.11	**1.97**	1.98	**2.10**	1.96	**1.63**	1.52
The board has a "mentoring" program for new board members.	**1.94**	1.92	**2.00**	2.09	**1.93**	2.02	**2.14**	1.93	**1.81**	1.69
The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.	**2.20**	2.08	**2.31**	2.31	**2.23**	2.16	**2.43**	2.23	**1.91**	1.54
The board has a clear understanding regarding its mutual expectations with its chair.	**2.67**	1.79	**2.60**	2.07	**2.76**	1.82	**2.74**	1.89	**2.55**	1.46
Management Oversight										
The board follows a formal process for evaluating the CEO's performance.	**2.90**	2.91	**2.92**	3.00	**2.93**	2.91	**2.95**	2.94	**2.81**	2.84
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation.	**2.76**	2.77	**2.84**	2.86	**2.83**	2.83	**2.76**	2.82	**2.64**	2.62
The board requires that the CEO's compensation package is based, in part, on the CEO's performance evaluation.	**2.84**	2.84	**2.92**	2.93	**2.88**	2.86	**2.86**	2.91	**2.74**	2.69
The board requires that CEO compensation be determined with due consideration given to the IRS mandate of "fair market value" and "reasonableness of compensation."	**2.88**	2.89	**2.96**	2.97	**2.92**	2.95	**2.94**	2.93	**2.77**	2.74
The board seeks independent (i.e., third party) expert advice/information on industry comparables before approving executive compensation.	**2.84**	2.78	**2.96**	2.98	**2.88**	2.86	**2.96**	2.82	**2.66**	2.53
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.	**2.86**	2.86	**2.96**	2.98	**2.86**	2.95	**2.96**	2.87	**2.76**	2.69
The board requires that the CEO maintain a written, current succession plan.	**2.25**	2.22	**2.63**	2.71	**2.27**	2.34	**2.33**	2.21	**1.99**	1.88
The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance.	**2.67**	2.55	**2.83**	2.83	**2.69**	2.62	**2.67**	2.45	**2.56**	2.45

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	2015	2013	**2015**	2013	**2015**	2013	**2015**	2013	**2015**	2013
Community Benefit and 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.	**2.57**	2.44	**2.63**	2.65	**2.56**	2.41	**2.82**	2.56	**2.41**	2.23
The board provides oversight with respect to organizational compliance with IRS tax-exemption requirements concerning community benefit and related requirements.	**2.88**	2.78	**2.96**	2.96	**2.88**	2.78	**2.93**	2.85	**2.78**	2.55
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).	**2.78**	2.77	**2.81**	2.66	**2.68**	2.78	**2.89**	2.82	**2.84**	2.74
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).	**2.57**	2.61	**2.57**	2.65	**2.61**	2.64	**2.75**	2.70	**2.38**	2.41
The board has a written policy establishing the board's role in fund development and/or philanthropy.	**1.93**	1.86	**2.00**	1.92	**2.02**	1.90	**2.07**	1.91	**1.67**	1.72
The board works closely with legal counsel to ensure all advocacy efforts are consistent with the requirements of tax-exempt status.	**2.56**	2.55	**2.83**	2.75	**2.45**	2.53	**2.75**	2.57	**2.48**	2.45
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.	**2.26**	2.27	**2.12**	2.40	**2.19**	2.17	**2.37**	2.27	**2.37**	2.34
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.	**2.91**	2.85	**2.98**	2.93	**2.95**	2.91	**3.00**	2.96	**2.73**	2.55
The board ensures the adoption of implementation strategies that meet the needs of the community, as identified through the community health needs assessment.	**2.83**	2.76	**2.86**	2.89	**2.85**	2.81	**2.95**	2.87	**2.71**	2.50
The board requires that management annually report community benefit value to the community.	**2.69**	2.66	**2.78**	2.84	**2.74**	2.66	**2.80**	2.75	**2.52**	2.46

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