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OF HOSPITALS AND HEALTHCARE SYSTEMS

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John C. Bravman, Ph.D., President of Bucknell University, was appointed to the Geisinger Health Board of Directors in September 2012. Dr. Bravman was appointed Chairman of the Board in December 2016 and also chairs the Emergency Action Committee. Dr. Bravman serves as a member on the Geisinger Family, Audit and Compliance, Finance, Governance and Patient Experience, Academic Affairs and Quality committees of the board.

Prior to becoming the 17th President of Bucknell University in 2010, Dr. Bravman served 35 years at Stanford University as a student, faculty member and senior administrator. He is also a professor of electrical engineering at Bucknell, and is the Freeman Thornton Vice Provost for Undergraduate Education and Bing Centennial Professor of Materials Science and Engineering, emeritus, at Stanford.

Dr. Bravman held numerous administrative positions and appointments at Stanford, including department chair, senior associate dean in the School of Engineering, chair of the faculty senate, vice provost for undergraduate education and member of the president's executive cabinet. He established a two-year residential college (Stanford's first), served as co-chair of the university's accreditation reaffirmation process with the Western Association of Schools and Colleges, and led a far-ranging transformation of Stanford's undergraduate experience. The author of more than 160 scholarly publications, Dr. Bravman has won numerous awards as a teacher and advisor, including the Walter J. Gores Award, Stanford University's highest teaching honor.

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Along with his advocacy and health policy representation of NAPH, Larry's clients have included major teaching hospitals, medical schools, integrated health and hospital systems, and state and local governments across the country. He has assisted clients with mergers, reorganizations, conversion to other corporate structures and negotiation of complex contracts, affiliation agreements and joint ventures. Larry's practice also has an international aspect—he is a cofounder of American International Health Alliance, which is funded by USAID, PEPFAR, and other U.S. and international organizations. He has provided advice and assistance to clients throughout the former Soviet Union, and in Eastern Europe, Asia, and Africa.

Larry has written and lectured extensively on topics pertaining to health law and policy. He served as Deputy Assistant Secretary for Health Legislation in the Department of Health and Human Services and as staff counsel and subcommittee staff director for the U.S. Senate Labor and Human Resources Committee (now the Senate HELP Committee). He earned his J.D. from Columbia University and his A.B., cum laude, from Harvard College.

Marian C. Jennings, M.B.A., President of M. Jennings Consulting, Inc. and a Governance Institute advisor, has over 35 years of consulting experience and is a skilled, well-known advisor to boards and executive management of not-for-profit hospitals, health systems, and other healthcare organizations across the U.S. She also is a regular speaker and author for numerous professional organizations.

Ms. Jennings' areas of expertise include governance assessment and enhancement; strategic planning, with a particular focus on integrating strategic and financial planning; and developing effective partnering strategies. One of her greatest strengths lies in her ability to become a trusted, indispensable advisor to her clients, resulting in consulting relationships that have spanned years—and even decades—working on multiple, diverse projects. She challenges her clients to think creatively, strategically, and realistically.

Ms. Jennings has published over 50 articles on healthcare governance, strategy, and partnering/affiliation. She is a regular author and contributor to Governance Institute publications and has spoken regularly for The Governance Institute conferences since 2002. Over the years she has also served as faculty for the American Hospital Association, Healthcare Financial Management Association, the AHA Society for Healthcare Strategy and Market Development, the Catholic Health Association, the Duke Endowment, as well as the Health Care Association of New York State (HANYS) and numerous state hospital associations.

Gary Kaplan, M.D., FACP, FACMPE, FACPE, Chairman & CEO of Virginia Mason Health System, is widely recognized as one of the most influential physician executives and leaders in the U.S. Dr. Kaplan has received significant national and international praise for leading Virginia Mason's efforts to transform healthcare, most notably leading the development of the Virginia Mason Production System® and establishing the Virginia Mason Institute to share expertise with healthcare leaders across the globe. The Virginia Mason Production System® is an internationally recognized improvement methodology that was created by combining the basic tenets of the Toyota Production System, philosophies of lean, and best practices of systems leadership and change management. This methodology has been applied and continually refined for 17 years and has been a driving force in establishing organization-wide learning and improvement cultures where staff at all levels are engaged and empowered to take action for improvement.

Acknowledgements (continued)

Dr. Kaplan has received countless awards and accolades including thirteen appearances on *Modern Healthcare*'s list of the 50 Most Influential Physician Executives in the U.S. In 2013, Dr. Kaplan was elected to membership in the Institute of Medicine and in 2009, he received the John M. Eisenberg Patient Safety and Quality Award for Individual Achievement from the National Quality Forum and The Joint Commission for his contributions to improving patient safety and healthcare quality. Dr. Kaplan also received the Harry J. Harwick Lifetime Achievement Award from the Medical Group Management Association and the American College of Medical Practice Executives in 2009.

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Lawrence R. McEvoy II, M.D., President & CEO of Epidemic Leadership and faculty of The Governance Institute, is an emergency physician, healthcare executive, entrepreneur, and strategic advisor. Larry's diverse perspective renders him an inspiring, design-oriented leader, strategist, advisor, facilitator, and speaker. He has an extensive track record of real-life strategic and operational results—and a unique facility with ecosystems, neuroscience, social intelligence, and human networks—to help hospitals and health systems optimize performance, adaptation, and vitality.

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He serves as an Executive-in-Residence at the Center for Creative Leadership and as a Principal at Brenva Group. He is on the faculty of the American Association of Physician Leaders and The Leadership Development Group, and has presented at the Conference Board, The Executive Development Roundtable, and the American Medical Group Association as well as at numerous healthcare organizations nationwide. He co-founded PracticingExcellence, a Web-based professional collegial community that focuses on the clinician experience as the foundation of healthcare performance, patient experience, and meaning. Most recently, he has founded Epidemic Leadership, where he focuses on the executive work of creating organizations of exponential health and vigor—where results, learning, and vitality rise in parallel and are abundant, infectious, sustained, and sustaining.

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The Governance Institute Member Editorial Board

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

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

About the Authors

Kathryn C. Peisert is Managing Editor of The Governance Institute. She has been in healthcare governance publishing for 16 years and oversees The Governance Institute's library of publications in print and online, DVD/video programs, Webinars, and e-learning courses. She also develops the overall education agenda and programs for Governance Institute conferences. In her role she helps to research and identify recommended board practices and key healthcare governance challenges and issues for the nation's hospital and health system boards.

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The Governance Institute provides trusted, independent information, resources, and tools 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

Governance Structure & 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. This section of the survey looks at board composition, meeting structure, committees, term limits, and compensation. Questions also relate to system and subsidiary board structure and whether boards are changing their structure or activities to succeed with population health and value-based payment models. 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.

Board composition: Board size continues to decrease slightly, and the percentage of independent board members continues to rise. We see this as a move in the right direction—depending on the type of organization and type of board, between 10–15 members is the ideal size to balance out nimbleness in decision making against the right variety of background and perspectives and having enough members to populate board committees. Further, it is not only important but also essential from a compliance standpoint to have a majority of independent directors so that the board can make decisions in the best interests of the organization's stakeholders.

However, physician representation on the board decreased significantly this year, and nurse representation remains virtually non-existent. Having clinical expertise on the board is critical for proper oversight and strategic decision making regarding quality and patient safety, population health and value-based care, innovating care delivery, and improving patient experience. This year's analysis shows a positive correlation between the number of physicians on the board and board performance in terms of fulfilling its duty of loyalty, duty of obedience, and responsibilities for quality and financial oversight.

Other highlights to note include:

- Females and ethnic minorities remain relatively stable compared with previous years (e.g., very few); the concern is that with the growing recognition of the need for more diversity on the board, these numbers should be increasing.
- Board members are 12 years older on average in this group of respondents (69.8 years old).
- This year we see a slight reduction in the percentage of respondents that have a CEO who is a voting board member, for all types of organizations.
- Forty-two percent (42%) of organizations have the CIO attend board meetings (up from 36% in 2017).

> Our position is that while the healthcare industry is being charged with transformation in order to survive—care delivery models must change, along with parallel changes to align management and operations—governance must also change in order to see this transformation through. The data shows very slow, subtle changes at the governance level to respond to industry transformation. However, this is not a time for subtlety. We do not believe this transformation will truly succeed unless more changes are made to governing boards, which hold the power to remove barriers and build frameworks to facilitate the necessary transformation of hospitals to enable the future of healthcare.

Board competencies: We asked boards about their top three essential competencies being sought in the next one to three years for new board members. Typical skills were at the top of the list: finance, strategic planning, and quality/patient safety. Also near the top was consumer-facing business expertise. We expected to see more boards looking for what we term "second curve" competencies, such as innovation/disruption, change management, actuarial/health insurance, and digital/mobile health technology expertise, all of which very few respondents listed as one of their top three.

Board meeting content: Boards continue to increase the use of a consent agenda (79%, up two percentage points from 2017). However, 57% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports. Only 31% is spent in active discussion, deliberation, and debate about strategic priorities of the organization, and 12% to board education.

Committees: The average number of committees overall remains stable at seven. The most prevalent committees are finance (83%), quality (80%), executive (73%), executive compensation (62%), governance/board development (58%), strategic planning (55%), and audit/compliance (53%). The committees showing the most dramatic increase in prevalence this year compared with 2017 are: audit, audit/compliance, physician relations, community benefit, and population heath/community health improvement.

Board member compensation: The percentage of boards that compensate board members decreased this year (7% compensate the board chair, down from 12% in 2017, and 7% compensate other board members, down from 11% in 2017). Also, the level of compensation remains low (less than $5,000).

Board education: 31% of respondents spend $30,000 or more annually for board education, a threshold that has been shown to positively impact board culture and performance. Health systems generally spend more for board education than other types of organizations. The data shows significant positive correlations between the amount of money spent on board member education and overall evaluation of board performance in *all* aspects.

Accountable care organizations: 47% of the respondents are participating in an ACO model of some type (down from 55% in 2017, although this may be due to either the smaller sample size

this year and/or the reduction in the number of Medicare ACOs from 2018–2019). The majority of ACOs are health system owned (37%). Forty-two percent (42%) have a covered patient population of more than 50,000 people; 34% of respondents cover 20,000 or fewer in their ACO.

Board culture: We asked respondents to state how strongly they agreed with a list of nine board culture-related statements. Taken together as a whole to determine the degree of healthy board culture overall, 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: 84% or a B (down from 87% in 2017)
- Health systems: 90% or an A- (down from 93% in 2017)
- Independent hospitals: 82% or a B- (down from 86% in 2017)
- Subsidiary hospitals: 86% or a B (down from 91% in 2017)
- Government hospitals: 80% or a B- (the same as 2017)

Only 25 respondents (10.2%) reported that they strongly agree with all nine statements.

Population health management and value-based payments: There was very little change in board and management structure/composition (e.g., adding new positions or expertise to help prepare and succeed in these efforts) since 2017. Most organizations continue to add new goals related to these initiatives to their strategic plans. Health systems have made the most changes in this regard.

System–subsidiary governance structure: Systems are more evenly split this year regarding governance structure. About one-third have one system board with fiduciary oversight for the entire system; another third has a system board and subsidiary boards with fiduciary duties; and the final third has a system board and subsidiary advisory boards. Seventy percent (70%) of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders (down significantly from 86% in 2015). Thirty percent (30%) say this is an area that needs improvement. There is a statistical relationship between those that said assignment of responsibility and authority is widely understood and accepted by both local and system-level leaders and overall evaluation of board performance in all aspects, except in terms of fulfilling its duty of care.

We also asked subsidiary boards to tell us whether they retain or share responsibility with the system board for certain board-level issues, or if their system board retains sole responsibility. The most significant findings from this year's survey include:

- While the percentage of subsidiary boards sharing strategic goal-setting responsibility remained about the same as 2017 (60–64% share responsibility with the system), 40% of systems this year retain responsibility for this, compared with only 17% in 2017.
- Significantly more systems responding this year retain responsibility for subsidiary quality and safety goals (44% vs. 19%).
- More subsidiaries retain responsibility for customer service goals (73% vs. 38%).
- Medical staff credentialing is more likely to be a shared responsibility or retained at the system level (40% vs. 7% shared; 40% vs. 5% system-retained).
- Selecting the audit firm is more likely to be a shared responsibility this year (50% vs. 10%; 50% of system boards retain this responsibility in 2019 vs. 75% in 2017).
- Establishing the subsidiary corporate compliance program is more likely to be a shared responsibility (63% vs. 32%).
- More subsidiary boards share responsibility for identifying community health needs (50% vs. 38%).
- Systems are allowing their subsidiaries to share or retain responsibility for setting community health goals as well (50% vs. 41% have shared responsibility and 50% vs. 36% retain responsibility, while 0% of systems retain this responsibility in 2019 vs. 23% in 2017).
- More subsidiaries are involved in setting population health improvement goals (71% vs. 41% shared responsibility).
- Subsidiaries are also more involved in electing/appointing their own board members (50% vs. 38% share this responsibility).

Areas of responsibility in which advisory boards indicate a strong degree of responsibility (either retaining or sharing with the system board) despite their not having legal fiduciary status are:

- Setting our organization's customer service goals
- Identifying our organization's community health needs through the CHNA
- Setting our organization's community health goals
- Addressing social determinants of health for our organization's community

Governance Practices: Adoption & Performance

This year's results show that adoption of our list of recommended practices, for the most part, is widespread. Overall, performance scores are slightly lower this year. Historically, systems have had the highest levels of performance and that continues to be true. They have the highest board performance composite score and the highest percentage of "excellent" and "very good" rankings across the oversight areas. Independent hospitals' scores had the most noticeable drop. Their performance scores went down in every category and they had lower levels of adoption for many practices compared to previous years. While government-sponsored hospitals have lower performance scores than other organizations, which has been true in past surveys as well, they showed the greatest improvement. It is notable to see these organizations enhancing their performance, even with their unique challenges and constraints.

The increase in adoption of duty of loyalty practices reflects a growing focus by the board around conflict-of-interest issues. This is promising at a time when there is heightened concern about board member conflicts. While government-sponsored hospitals tend to have lower adoption in this area, their scores increased for every practice as well. We are also pleased to see that all organization types are continuing to score highly in financial oversight. Five out of the six practices changed on this year's survey, but financial oversight still has the highest performance and adoption of practices.

There remains significant opportunity to improve performance scores

and adoption rates in certain key areas. Quality oversight declined in performance and adoption, which is concerning given boards' critical role in ensuring their organizations are providing safe, high-quality care (especially seeing scores drop in areas such as reviewing quality performance measures and tying clinical improvement and/or patient safety goals to the CEO's performance evaluation). There is also room for improvement in developing physician leaders and assessing their performance, which was a new practice added this year.

Duty of care performance scores were lower as well. Requiring that new board members receive education on their fiduciary duties saw a big dip, which is worrisome considering that board members need to have a clear sense of their legally mandated duties to successfully carry out their responsibilities.

Board development remains at the bottom of the list for both performance and adoption scores. This is a great area of opportunity for boards looking to enhance their performance—and therefore, their organization's performance. It is encouraging to see that more boards are selecting new director candidates from a pool that reflects a broad range of diversity and competencies. But there are still some key practices (such as participating annually in board education and setting annual goals for board and committee performance that support the strategic plan) where adoption is decreasing. There is also very low adoption around using a formal process to evaluate the performance of individual board members, which can help ensure that members are effectively contributing to board work and continually developing their skills.

In an era of disruption and uncertainty where a focused and disciplined strategic planning process is critical, strategic planning should be ranking much higher for both performance and adoption. It is clear that boards need to be spending much more time on strategy in board meetings.

While the previous survey showed an increase in adoption of management oversight practices, that trend did not continue. Adoption scores went down for every practice except one: boards requiring the CEO to maintain a written and current succession plan. We are glad to see adoption going up for this practice since it has historically been stagnant on the lower end of the adoption rates—and hospitals and health systems continue to experience high levels of CEO turnover—although it still remains the least observed practice in this area.

Discussion Questions for Executives & Board Members

We hope this report serves as an important picture of how healthcare boards conduct their business and how they are performing in ensuring accountability of senior management to continuously improve quality/safety/experience, achieve strategic goals, and further the organization towards its future vision. This report can also serve as an education vehicle for boards looking to assess their structure, culture, and adoption of recommended practices, to determine where they fall amongst their peers and look for areas for improvement. The following is a list of questions focusing on the areas of survey data where we are looking for the most improvement in the next iteration of our survey:

- How are we structuring our meeting agendas? What are some ways we can increase the amount of time in our meetings for active discussion, deliberation, and debate about the strategic priorities of the organization?
- How does our governance structure hinder or help the organization's ability to fulfill its strategic goals?
- What efforts can we employ to increase the number of women, people from ethnic minorities, physicians, and nurses on our board? Where are some places we should look for potential directors that we have not considered?
- What are some "second-curve" competencies we need on our board in order to fulfill our strategic vision and transform our organization for the future?
- Does our board receive the education it needs in order to do its job as well as possible?
- Are we doing what we need to in order to succeed with population health management and value-based payments? Or are we still "waiting and seeing" what our peers will do before increasing our investment in such initiatives? What are the risks of waiting vs. acting in this space?
- How and why is it important to improve our board's culture?
- Where are we on the adoption scale of The Governance Institute's list of recommended practices? If there are any practices that we are not considering adopting, why is that? For those that we consider to be not applicable for our organization, why is that and should we reconsider?

Introduction & Reader's Guide

The Governance Institute surveys U.S. not-for-profit hospitals and health systems 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, culture, and adoption and performance of recommended governance practices are continuing to reflect the industry's movement towards care delivery transformation, away from hospital-centric organizations with hospital-centric governance oversight.

Most importantly, this year we surveyed on an updated list of recommended board practices reflecting boards' new and changing responsibilities as their oversight role continues to expand outside hospital walls. We went through an iterative process reviewing research and gathering member feedback and expert experience to determine how we should update the practices, ensuring that the list reflects traditional practices that boards should be continuing to adopt and perform regularly to fulfill organizational mission, fiduciary duties, and compliance. We added new practices that reflect the changing industry and delivery model, including more practices related to oversight outside the walls of the hospital, population health and value-based care oversight, cybersecurity and data privacy, strategic/enterprise risk, and physician-related issues including leadership development and burnout. We then removed practices that seemed to be outdated or no longer as relevant to the board's responsibility to fulfill its mission. (Note: we did not include the governance practices section of the survey in 2017, so this year's report compares 2019 data with 2015 data, the last time we surveyed on governance practices.)

This year's survey sought to uncover how board structure, culture, and adoption and performance of recommended governance practices are continuing to reflect the industry's movement towards care delivery transformation, away from hospital-centric organizations with hospital-centric governance oversight.

Finally, we included "advisory" boards in this year's survey (e.g., those boards that do not hold fiduciary duties at all but make recommendations to a parent or higher-level board that does hold fiduciary duties). So, we take a deeper look at how health system governance is structured and how systems allocate responsibilities and fiduciary authority to their various boards, including a picture of the responsibilities of advisory boards.

This report presents the results by topic and offers comparisons with previous reporting years as well as notable variations by organization type—system boards, independent hospital boards, hospital boards that are part of a multihospital system ("subsidiary" hospitals), and government-sponsored hospital boards. We use frequency tables, reported as a percentage of the total responding to specific questions.

The appendices included in this report shows all 2019 results by frequency (percentages) by organization type, AHA designation, and bed size. (Additional appendices reporting board structure for each organization type are available online at www.governanceinstitute.com/2019biennialsurvey.)

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 4,830. We received 244 responses (5.1%). Of those, 74.2% of respondents had a fiduciary board. Based on the number of hospital facilities owned by the health system respondents, this year, the 244 respondents represent a total of 458 hospitals, or 9.5% of the total hospital survey population. (This represents a smaller population sample than in prior reporting years. For the most part the sample distribution mirrors that of the population, as shown in **Table 1** on the following page; however, when breaking down the data by organization type or size, some of the N sizes are relatively small. We take this into account in this report when it is important to note and when any data variances occur against prior trends.)

Table 1. Survey Responses

	2019		2017		2015		2013	
	Respondents	Population	Respondents	Population	Respondents	Population	Respondents	Population
Organization	**N = 244**	**N = 4,830[1]**	**N = 465**	**N = 4,418**	**N = 355**	**N = 4,121**	**N = 541**	**N = 4,199**
Religious (15)	6%	15%	14%	13%	13%	14%	10%	13%
Secular:								
Government (89)	36%	22%	23%	23%	29%	22%	26%	24%
Non-Government (140)	57%	62%	77%	64%	71%	64%	74%	63%
Number of Beds								
< 100 (98)	40%	56%	52%	56%	37%	42%	36%	43%
100–299 (43)	18%	24%	24%	24%	30%	30%	33%	29%
300+ (54)	22%	20%	24%	20%	33%	28%	30%	28%
System Affiliation (78)	32%	58%	32%	51%	32%	62%	45%	58%

Comparison of Respondents 2019 vs. 2017

Thirty-seven percent (37%) of the respondents in 2019 also responded to the survey in 2017.

Table 2. 2019 vs. 2017 Respondents

	Number of Respondents in 2019	Number of Respondents in 2017	Number of Respondents Who Completed the Survey in Both 2019 and 2017
Systems	52	51	11
Independent Hospitals	166	315	70
Subsidiary Hospitals	26	99	9
Government-Sponsored Hospitals	89	116	38
Total	244	465	90

1 The total survey population increased in 2017 due to our use of different databases to identify and categorize organizations (historically we have used the AHA database; in 2017 we used Billians and in 2019 we used Definitive). This is noted because overall the number of hospitals in the U.S. has been reported to be in decline. AHA reports a total number of 4,148 non-profit, acute care hospitals (government and non-government) in 2019.

Governance Structure

Board Size & Composition

Summary of Findings

- Average board size: 12.4
- Median board size: 11
- Voting board members:
  - Medical staff physicians (not including CMO): average is 0.7; median is 0
  - "Outside" physicians: average is 0.4; median is 0
  - Staff nurses (not including CNO): average is 0.03; median is 0
  - Management (including CMO and CNO): average is 0.3; median is 0
  - Independent board members: average is 9.7; median is 9
  - Female board members: average is 3.3; median is 3
  - Ethnic minority board members: average is 1.2; median is 0
- Term limits: 64% of boards limit the number of consecutive terms; median maximum number of terms is 3.
- Board member age limits: 6% of boards have age limits (up 2 percentage points from 2017); average age limit is 73.0; median is 72
- Average board member age: 69.8 (12 years older than in 2017); median board member age: 72 (14 years older than in 2017)

The average number of board members continues to decrease since 2015—12.4 in 2019, 12.9 in 2017, and 13.6 in 2015—and the median went from 13 in 2015 to 11 this year. The most notable changes in board composition include a significantly smaller number of physicians on the board for all types of organizations, as well as fewer members of the management team. This is offset to some degree by an increase in the number of independent board members (9.7 vs. 9.2 in 2017). Table 3 shows the overall comparison; Tables 4–7 show a comparison of board composition for each organization type.

Table 3. 2019 & 2017 Board Composition

All Respondents	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017
Average # of Voting Board Members	12.4	12.9	0.7	0.8	1.3	2.0	9.7	9.2	0.7	0.9
Median # of Board Members	11	12	0	0	0	1	9	9	0	0

*Includes the CMO and CNO
**Includes employed physicians but does not include the CMO, which is included in management.
***Includes independent physicians (who are not on the organization's medical staff/not employed).
****Includes nurses who are employed by the organization and faith-based representatives.

Table 4. System Board Composition

Systems	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017
Average # of Voting Board Members	16.5	16.3	0.8	0.9	2.1	3.5	12.6	10.4	1.1	1.4
Median # of Board Members	17	15	1	0	2	1	12	11	0	0

Note: Average board size increased slightly, reflected in an increase in independent board members, but medical staff physicians decreased.

Table 5. Independent Hospital Board Composition

Independent Hospitals	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017
Average # of Voting Board Members	10.5	11.9	0.5	0.7	1.0	1.7	8.5	8.9	0.5	0.6
Median # of Board Members	9	11	0	0	0	1	8	8	0	0

Note: Average board size decreased significantly from 2017, across all categories of board members.

Table 6. Subsidiary Hospital Board Composition

Subsidiary Hospitals	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017
Average # of Voting Board Members	15.8	14.6	1.5	1.3	1.7	2.2	11.3	9.6	1.3	1.5
Median # of Board Members	15	14	2	1	1	1	11	9	0	0

Note: Total size increased significantly primarily due to an increase in independent board members; medical staff physicians decreased.

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 (the two categories that saw an increase in size this year), and government-sponsored hospitals have the smallest boards (and trending smaller over time).

All boards have more independent board members this year relative to board size. When broken down by organization type, independent board members *as a percentage of total board members* is as follows:

- All respondents: 78% (vs. 74% in 2015 and 71% in 2017)
- Systems: 76% (vs. 73% in 2015 and 64% in 2017)
- Independent hospitals: 81% (vs. 73% in 2015 and 75% in 2017)
- Subsidiary hospitals: 72% (vs. 67% in 2015 and 66% in 2017)
- Government-sponsored hospitals: 89% (vs. 88% in 2015 and 82% in 2017)

Largest Boards

- Church systems: 22.3 board members
- Organizations with 500–999 beds: 18.4 board members
- Organizations with more than 2,000 beds: 18.4 board members

See Exhibit 1 for a breakdown of board members overall and by organization type for 2019.

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****	
	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017
Average # of Voting Board Members	7.9	9.1	0.3	0.4	0.5	0.6	7.0	7.5	0.2	0.6
Median # of Voting Board Members	7	7	0	0	0	0	7	7	0	0

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

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)

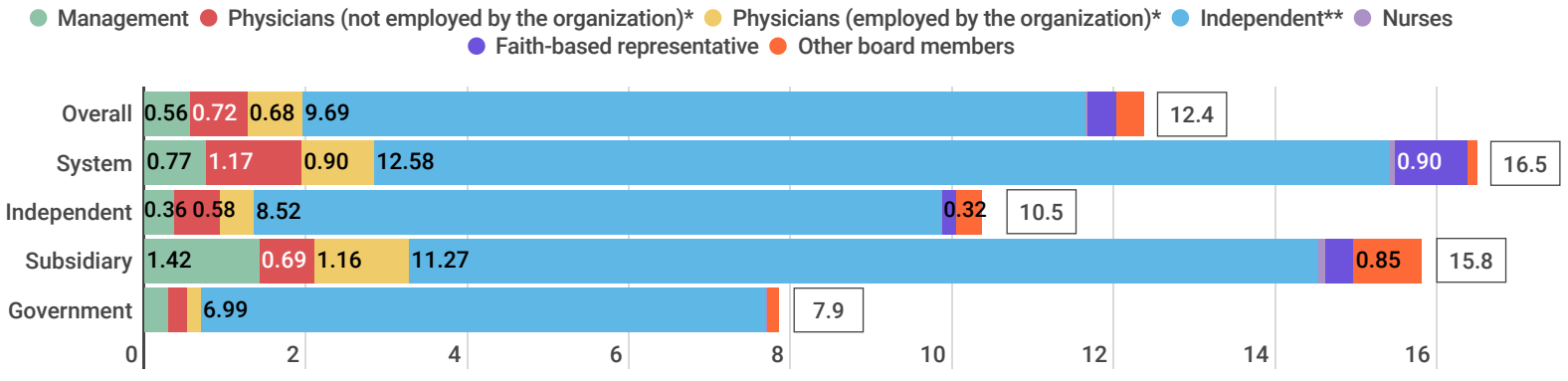
The total average number of physicians on the board (all types of physicians including the CMO and "outside" physicians) is 1.7 (down from 2.9 in 2017). Health system boards have the most physician representation. With the exception of subsidiaries, all other types of boards have a slightly higher level of non-employed vs. employed physician board members. (See Exhibit 2 on the next page. Detail can be found in Appendix 1.)

All types of boards reported a significant decrease in physician representation on the board. We do not yet consider this to represent a trend; we will track this in subsequent surveys and note that this could be due to the smaller sample size of respondents this year. Overall, the breakdown for these categories is shown in Table 8 on the next page.

Overall, there is a moderate statistically significant positive correlation between the number of physicians on the board and board performance in terms of fulfilling its duty of loyalty and duty of obedience, and responsibility for quality and financial oversight.

For independent hospitals, there is a positive correlation between the number of physicians and overall evaluation of board performance in all aspects.

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.

Nurses on the Board

Our survey delineates 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. For 1.2% of respondents, the CNO is a voting or non-voting board member (independent and government-sponsored hospital boards only). This represents a significant decline from our 2017 data, where 10.2% of boards had a voting CNO. Separately, 6.7% of respondents have a nurse on the board other than the CNO (of note here is that 17.6% of health system boards have one nurse on the board other than the CNO, and 16.7% of subsidiary boards have one nurse on the board other than the CNO.) For 78% 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, experience, and customer loyalty. Only 14.6% of respondents this year have plans to add a nurse to the board in the future. (See Appendix 1 for more details.)

Females & Ethnic Minorities on the Board

Most boards (97%) have at least one female board member, but only 49% have ethnic minorities represented on the board, down from 52% in 2017 (see Exhibits 3 and 4 on the following pages). Again, there has not been any significant movement in these areas since 2007. By organization type, health systems have the highest average number of females on the board (4.1), and the highest average number of ethnic minorities (2.2, up from 1.99 in 2017). See Table 9 for detail by organization size.

Table 8. Physicians on the Board 2019 vs. 2017

	On the medical staff but not employed by the organization		On the medical staff and employed by the organization (including CMO)		Not on the medical staff; not employed by the hospital ("outside")	
	2019	2017	2019	2017	2019	2017
Average	0.7	1.3	0.6	0.8	0.4	0.8
Median	0	1	0	0	0	0

Table 9. Female & Ethnic Minority Representation on the Board by Organization Size (2019 vs. 2017)

	Females (average)		Ethnic Minorities (average)	
	2019	2017	2019	2017
< 100 beds	3.1	2.9	0.7	2.9
100–299 beds	3.7	3.6	1.3	3.6
300–499 beds	4.5	4.7	1.9	4.7
500–999 beds	4.3	4.0	3.2	4.0
1000–1999 beds	4.1	4.3	2.6	4.3
2000+ beds	3.6	2.8	2.0	2.8

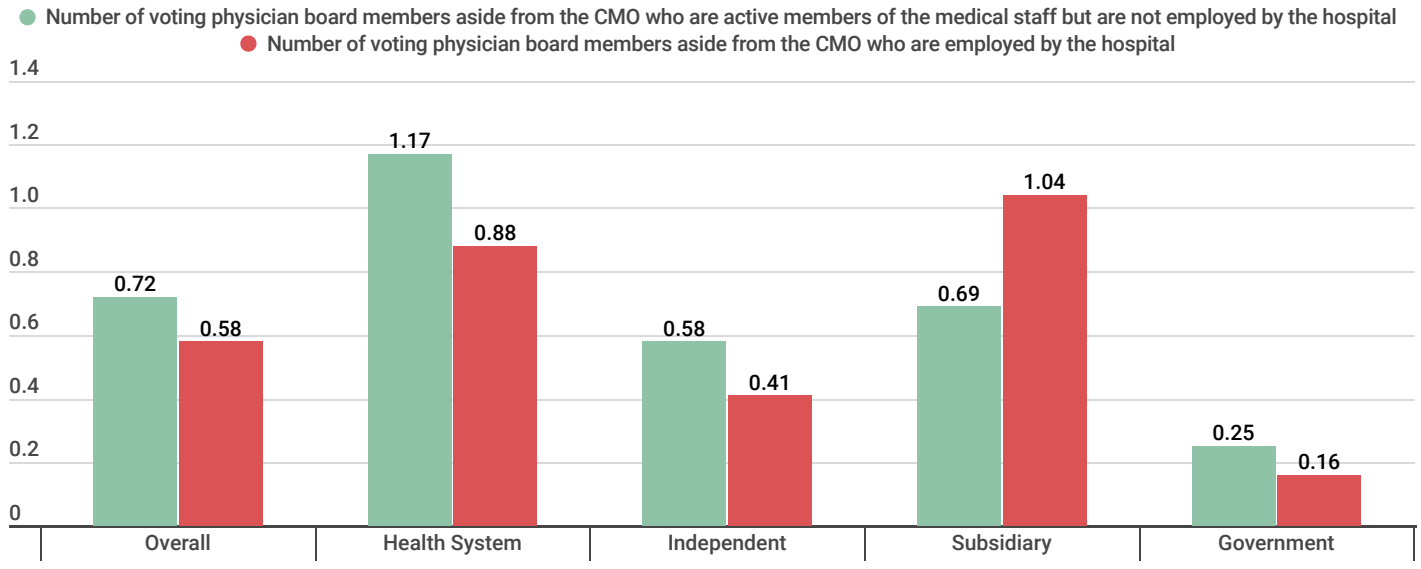
For detail, see Appendix 1

Background of the Organization's Chief Executive & Board Chair

To gain a more complete profile of clinician participation in governance, administrative, and other leadership positions, we ask questions about the background of the chief executive and board chair. This year, the majority for the CEO was management or finance non-profit expertise (64.5%), which is comparable to 2017 results. The chairperson's background is mostly business/finance in the for-profit sector (47.3%) and other non-clinical/non-healthcare expertise (32.9%), which is in line with 2015 and 2017 results.

Thirty-five percent (35%) of respondents' CEOs have a clinical background (physician, nurse, or other), which is up slightly from 2017 (34%). A higher percentage of government-sponsored hospitals have a CEO with a clinical background this year (48%). However, health systems were the most likely to have a physician CEO (15%). In contrast, only 14% of respondents have a board chair with any kind of clinical background (subsidiary boards are the

Exhibit 2. Employed vs. Non-Employed Physicians on the Board



standouts in this category, with 15% having a physician board chair). (See Exhibits 5, 6, and 7 on page 12, and more detail in Appendix 1.)

Age Limits & Average Board Member Age

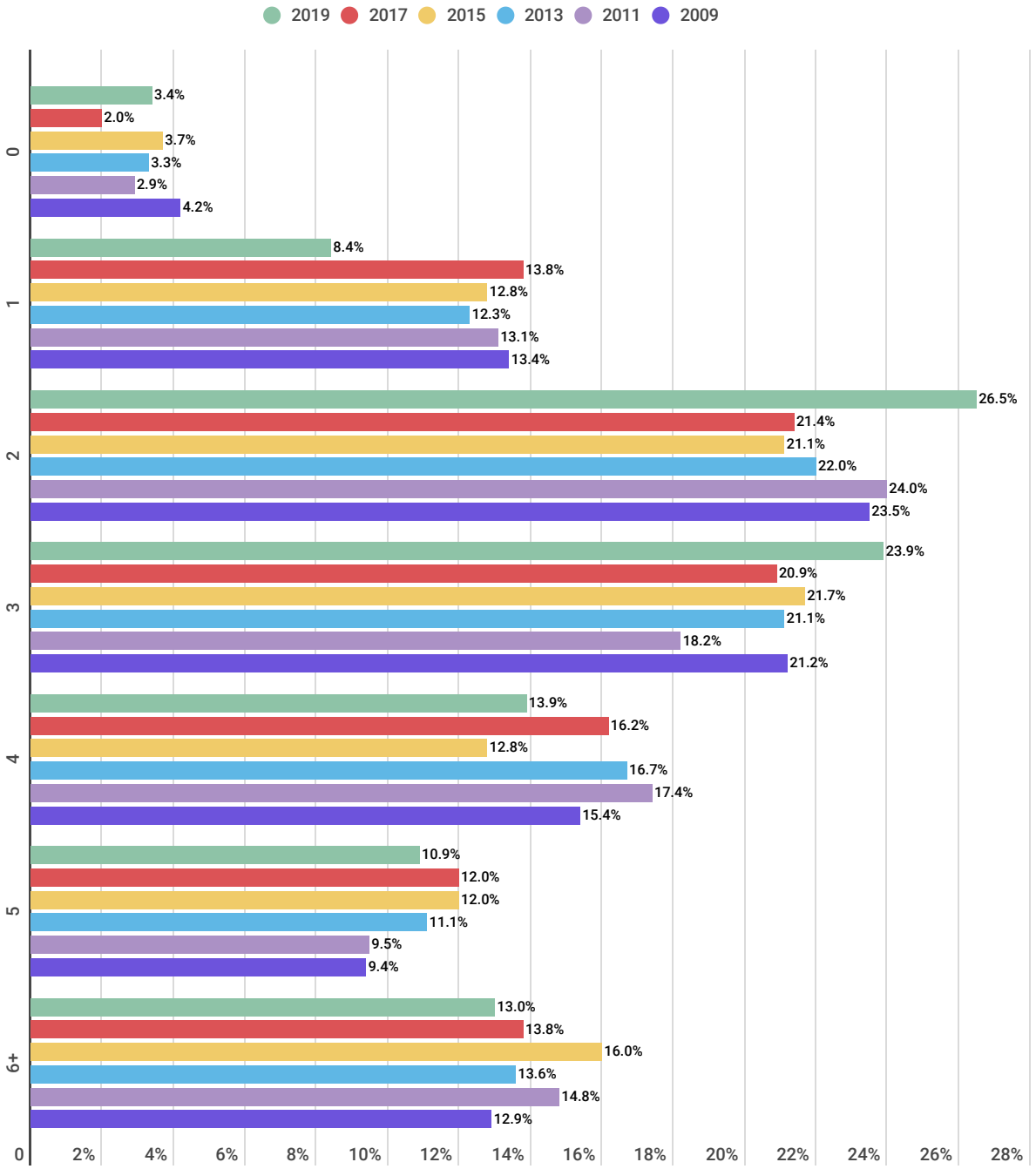
The percentage of organizations that have specified a maximum age for board service increased this year to 6.2% (compared with 4.2% in 2017). The median age limit is 72.

The overall average board member age is 69.8 (median 72), which is significantly older than in 2017 (average 57.8; median 58). The range was 46 to 90 years old.

Needed Board Competencies

New this year, we asked respondents to identify the top three essential core competencies being sought in the next one to three years for new board members. Finance/business acumen and strategic planning/visioning were overwhelmingly the top two across all types of organizations (64.3% and 62.7% respectively, for all respondents combined). Quality and patient safety came in third at 43%. Consumer-facing business expertise was also substantial at 28.7% overall (57.1% of advisory subsidiaries listed this in the top three). Other than consumer expertise, very few of this year's respondents listed what we term "second-curve competencies"

Exhibit 3. Female Board Members



in their top three (e.g., new skills and expertise that were not traditionally sought in prior years, in order to help enable organizations to fulfill strategies to change their business model and transform care delivery). See Table 10 on page 13 for the list of competencies, in order of priority based on overall responses. The ones in italics are those we consider to be "second curve."

"First curve" board competencies remain important; however, we consider "second-curve" competencies to be essential to enable organizations to remain sustainable in the future and hope to see future trends showing boards treating second-curve competencies as higher priorities.

Exhibit 4. Ethnic Minority Board Members

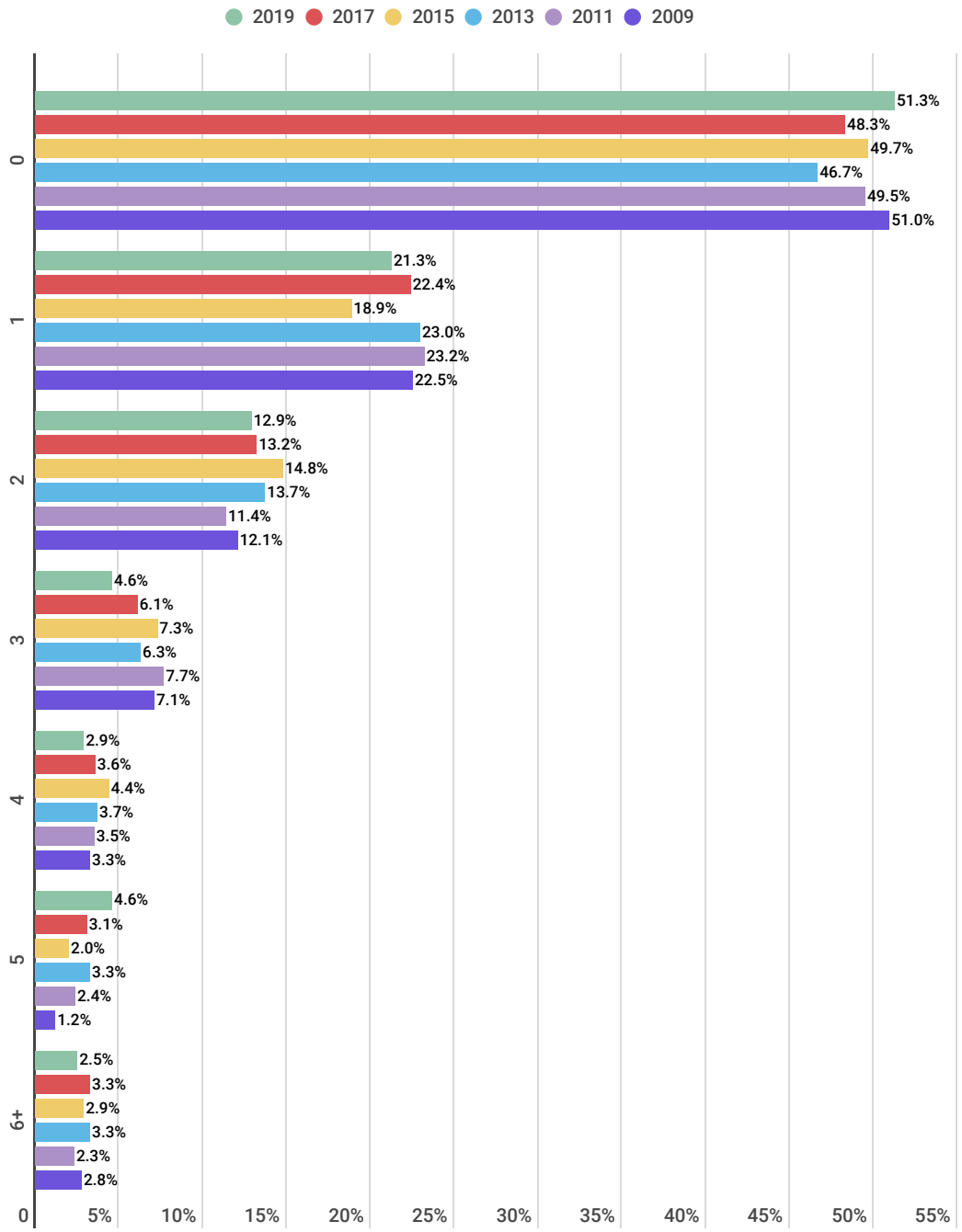


Exhibit 5. Background of the Organization's Chief Executive

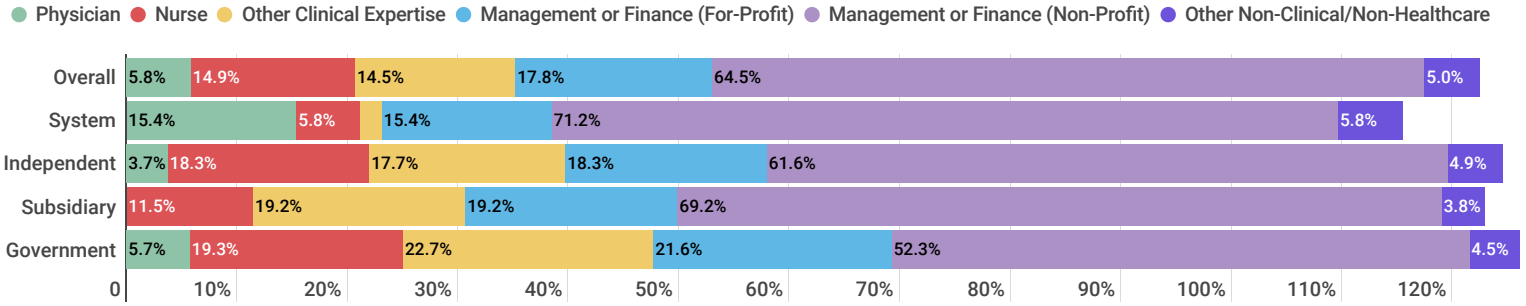


Exhibit 6. Background of the Organization's Chief Executive & Board Chair

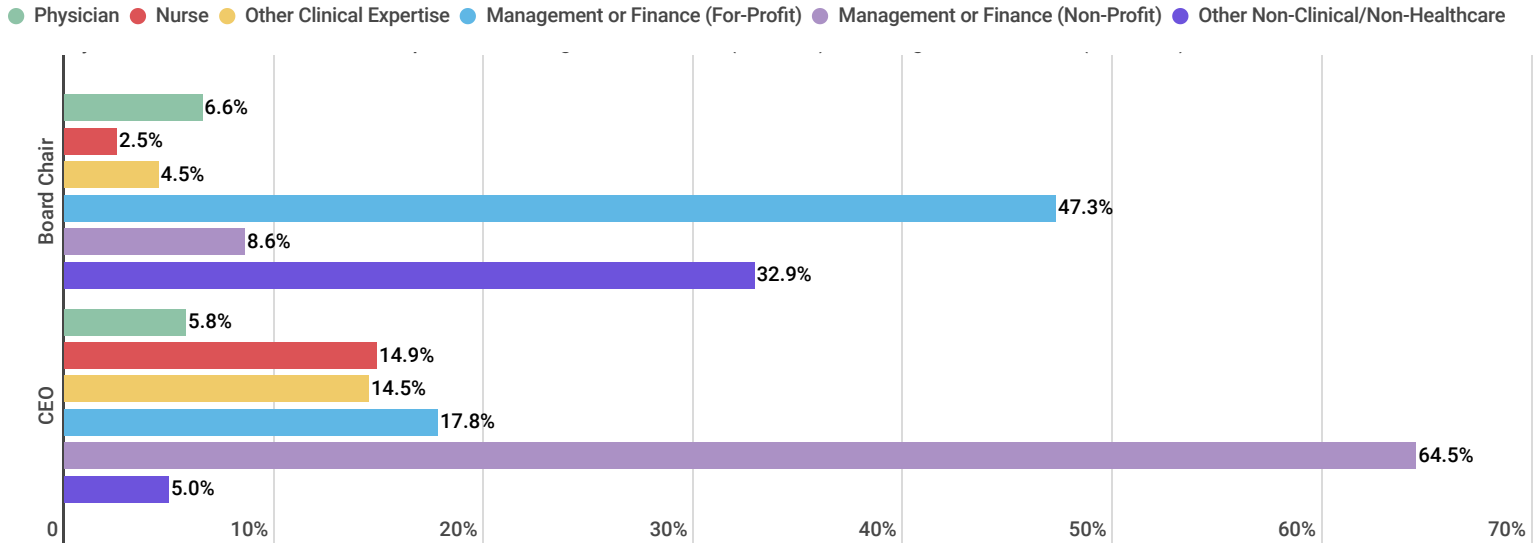
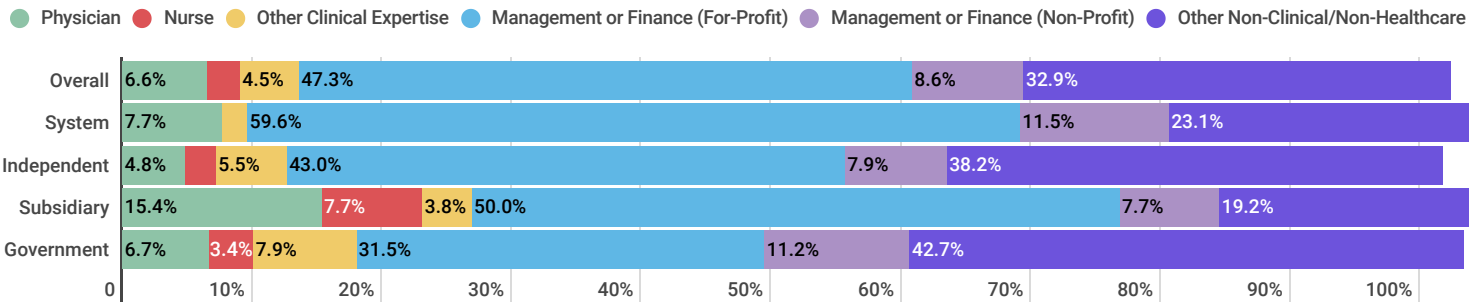


Exhibit 7. Background of the Organization's Board Chair



Defined Terms of Service

Summary of Findings

64% of boards limit the number of consecutive terms (up from 56% in 2017); median maximum number of terms is three. Systems and subsidiaries again are more likely to have term limits. This year, 28% of government-sponsored hospitals limit the maximum number of terms, up from 24% in 2017.

Term limits by type of organization (arrows indicate an upward or downward trend):

- Systems—80% (↓)
- Independent hospitals—57% (↑)
- Subsidiary hospitals—83% (↑)
- Government-sponsored hospitals—28% (↑)

Most respondents (90%) have defined terms for the length of elected service. The median term length remains 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")—64%. Among non-government hospitals and systems, more often than not, boards have chosen to adopt term limits (73%). Most organizations that do have term limits constrain board members to three consecutive terms. (See Exhibit 8 on the next page.)

There is a significant relationship between boards with term limits and board performance in terms of fulfilling its responsibility for management oversight.

Participation on the Board

Summary of Findings

- President/CEO:
  - Voting board member: 40% (down from 48% in 2017)
  - Non-voting board member: 18%
  - Non-board member; regularly attends meetings: 42% (up from 34% in 2017)
- Chief of staff:
  - Voting board member: 25% (down from 33% in 2017)
  - Non-voting board member: 14% (down from 15% in 2017)
  - Non-board member; regularly attends meetings: 39% (up from 36% in 2017)

Table 10. Top Essential Competencies for New Board Members
(highest percentage in bold for each category)

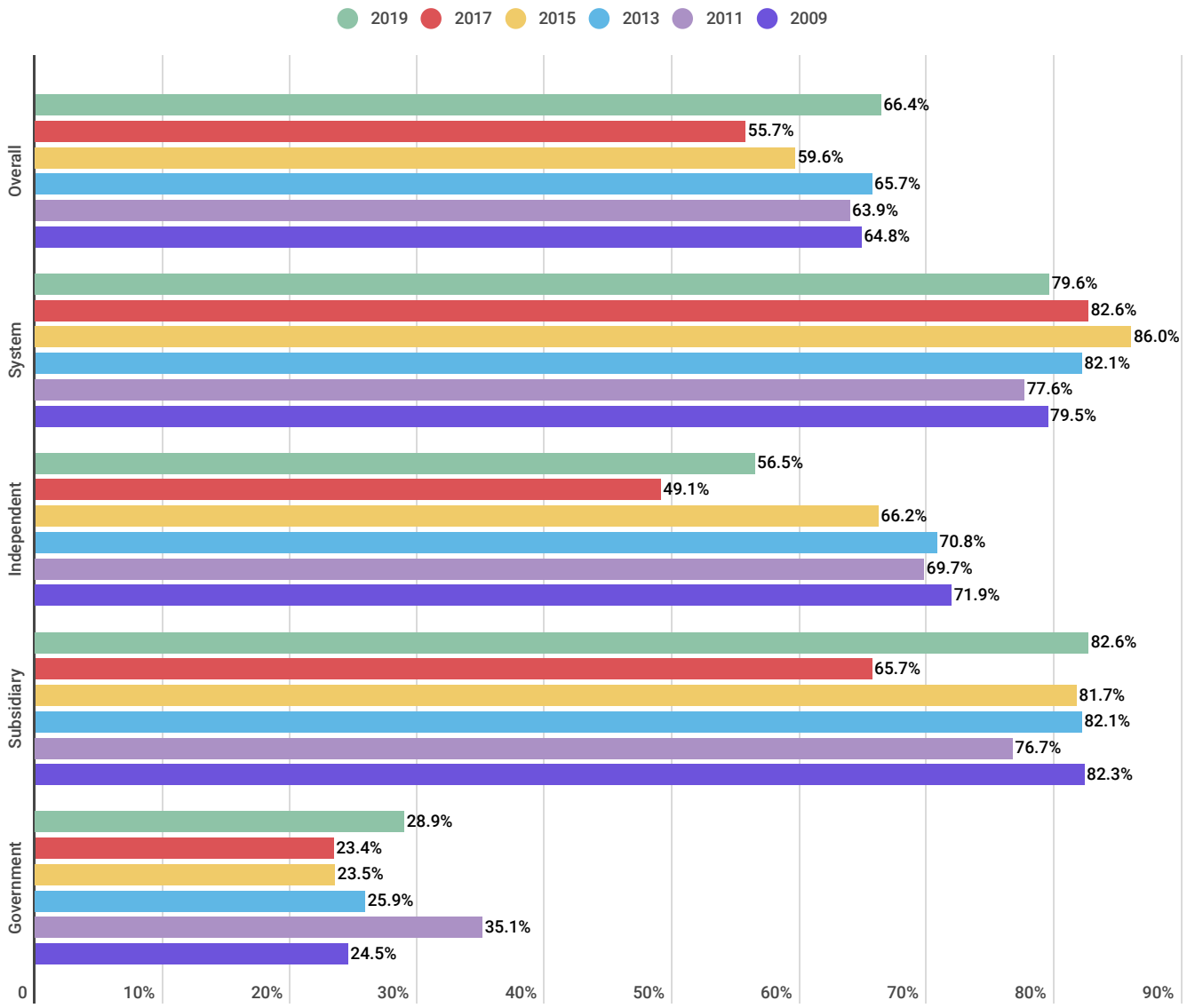
	Overall	Health System	Independent	Subsidiary Fiduciary*	Subsidiary Advisory*	Government
Finance/business acumen	64.3%	65.4%	65.1%	63.2%	42.9%	**73.0%**
Strategic planning and visioning	62.7%	53.8%	68.7%	42.1%	42.9%	**70.8%**
Quality and patient safety	43.0%	28.8%	48.2%	36.8%	42.9%	**49.4%**
Consumer-facing business expertise	28.7%	32.7%	25.3%	36.8%	**57.1%**	22.5%
Innovation/disruption expertise	16.0%	17.3%	13.9%	26.9%	**28.6%**	5.6%
Change management	11.9%	7.7%	12.7%	10.5%	**28.6%**	10.1%
Fundraising	11.1%	7.7%	11.4%	**15.8%**	14.3%	13.5%
Previous non-profit healthcare board experience	10.2%	9.6%	10.8%	5.3%	**14.3%**	10.1%
Digital/mobile health technology expertise	8.6%	**21.2%**	4.8%	10.5%	0.0%	2.2%
IT and social media expertise	8.2%	13.5%	6.0%	**15.8%**	0.0%	5.6%
Legal	8.2%	3.8%	**10.2%**	5.3%	0.0%	7.9%
Actuarial/health insurance/managed care experience	7.8%	**17.3%**	4.8%	10.5%	0.0%	7.9%
Clinical practice experience	7.4%	7.7%	7.8%	0.0%	**14.3%**	5.6%
Medical/science technology expertise	3.7%	**5.8%**	3.0%	5.3%	0.0%	2.2%
Conflict management	1.2%	1.9%	0.6%	0.0%	**14.3%**	0.0%

**Note:* Fiduciary board responses N=19; advisory board responses N=7

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** on the next page). Board participation (voting vs. non-voting and non-members regularly attending board meetings) has remained generally the same overall since 2011. Notable differences this year include:[2]

- Only 40% have an *ex officio* voting President/CEO compared with 48% in 2017; this year more respondents have a chief executive that is not a board member but regularly attends board meetings.
- Only 25% have a voting chief of staff this year compared with 33% in 2017; this year more respondents have a chief of staff that is not a board member but regularly attends meetings.
- More respondents this year have the CNO attend board meetings regularly: 78% vs. 74% in 2017. This is not a large increase but if this does indicate a trend we consider that to be going in the right direction as nurse presence in the boardroom is of growing importance (in fact we advocate for nurse representation on the board, whether from the organization's nursing staff or from outside the organization).
- Only 32% of respondents have a representative of a religious sponsor as a voting board member, compared with 63% in 2017. This year, this person is more likely to not attend meetings at all.

Exhibit 8. Limits on the Maximum Number of Consecutive Terms



2 These variances could be due to the smaller sample size this year.

Variances by Organization Type

Health systems and subsidiaries again have the highest percentage of voting CEO board members (69.2% and 61.5% respectively, although this is down from 74% and 63% in 2017). In contrast, government-sponsored hospitals have the lowest percentage of voting CEO board members (8% this year vs. 10% in 2017). For a large majority of government-sponsored hospitals (71%), the CEO is not a board member but regularly attends meetings. (See Exhibit 9a on the next page.)

Subsidiaries are more likely to have a voting chief of staff (36%). Eighty-three percent (83%) of government-sponsored hospitals have the CNO attend board meetings regularly, compared with 78% overall. Health systems are more likely to have legal counsel attend board meetings (75% vs. 55% overall). More detail is shown in Appendix 1.

Exhibit 9. Participation on the Board

(Includes Only Organizations Where Specific Job Titles Apply)

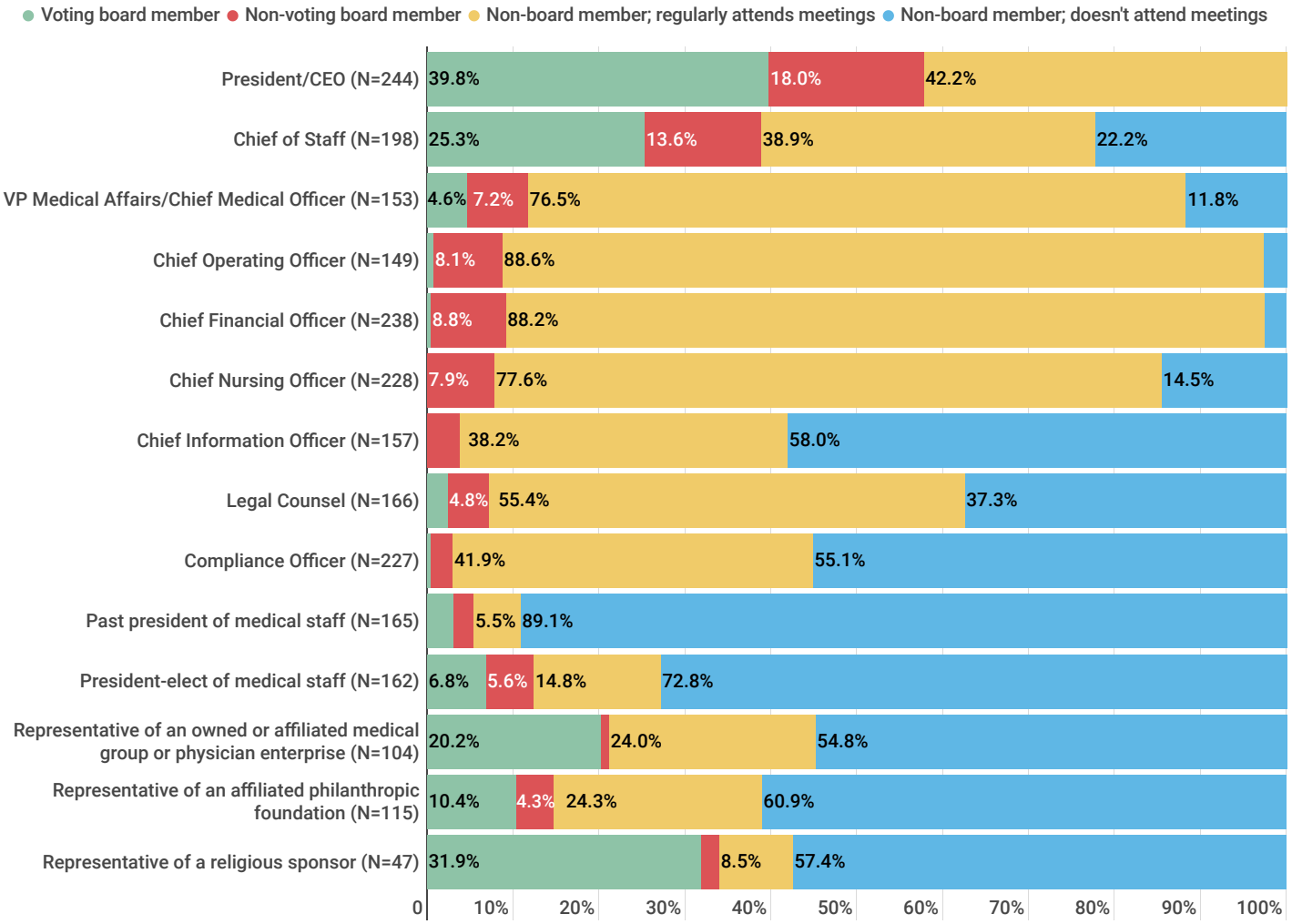
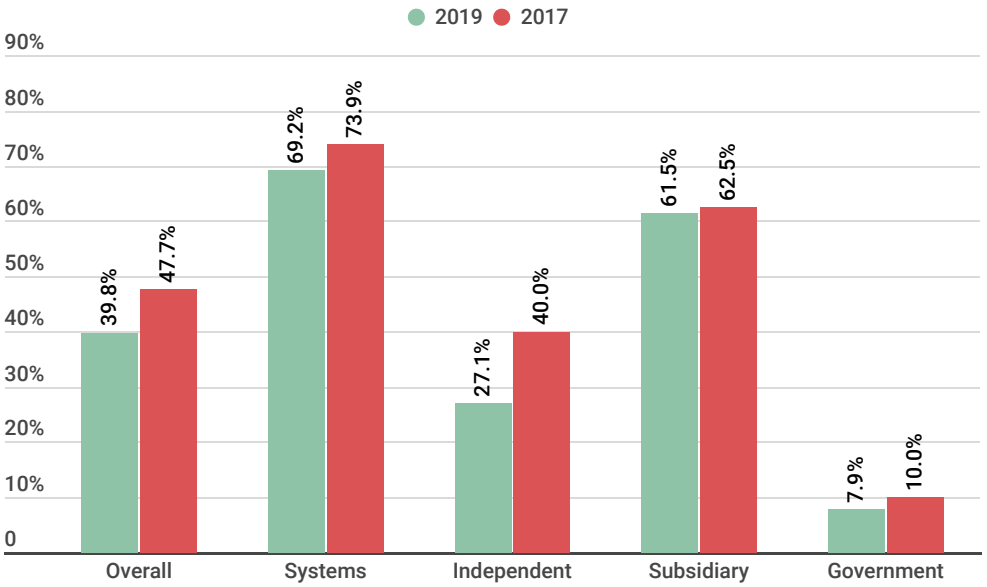


Exhibit 9a. Chief Executive Is a Voting Board Member 2019 vs. 2017



Health systems are the least likely compared to other types of organizations to have a chief of staff at the system level (62% vs. 83% overall). In contrast, 90% of government-sponsored hospitals and 88% of independent hospitals have a chief of staff. Conversely, 96% of health systems have a VPMA/CMO, compared with 64% overall. Eighty-nine (89%) of health systems have a CIO compared with 66% overall (generally the CIO does not attend board meetings). Health systems are also more likely to have a legal counsel (90% vs. 69% overall; this person generally does attend meetings but is not a board member).

Table 11 shows a comparison of prevalence of certain key C-suite positions and whether those people attend board meetings or are board members. Areas in bold indicate the most significant changes from 2017, in either direction. Most notable is an increase in organizations having a compliance officer and legal counsel, along with more presence in the boardroom for these two positions as well as the CIO (See Appendix 1 for a breakdown by organization type and size.)

We have seen a general increase over the years in respondents with an owned or affiliated medical group or physician enterprise (43% in 2019, up from 26% in 2011; 62% of systems have a physician group this year, which is the highest of any type of organization). Of those, 20% have a representative from this group as a voting member of the board. Largely these numbers remain the same as 2017.

Of those organizations that are sponsored by a religious entity (20% of respondents), 32% have a representative from the religious sponsor as a voting member of the board, down from 63% in 2017.

Table 11. Frequency of Position & Board Participation 2019 vs. 2017

	% of respondents with this position		% of respondents noting presence in boardroom		% of respondents noting board member (voting and non-voting)	
	2019	**2017**	**2019**	**2017**	**2019**	**2017**
CFO	97.5%	98.8%	97.4%	97.8%	9.2%	11.9%
CNO	93.8%	94.9%	85.5%	84.4%	**7.9%**	10.2%
Compliance Officer	**93.4%**	90.8%	**44.9%**	41.5%	3.0%	4.3%
Legal Counsel	**69.2%**	66.4%	**62.6%**	72.0%	7.2%	7.6%
CIO	**65.7%**	70.5%	**42.0%**	36.0%	3.8%	4.5%
VPMA/CMO	**63.8%**	69.4%	88.3%	89.1%	**11.8%**	19.9%
COO	**61.8%**	56.3%	97.4%	97.0%	**8.8%**	11.6%

Board Meetings

Summary of Findings

- Most boards meet 10–12 times a year (65%, up from 59% in 2017).
- 59% of responding organizations' board meetings are two to four hours; 33% are less than two hours (similar to 2017).
- 79% of responding organizations use a consent agenda at board meetings (up from 77% in 2017 and part of an overall increasing trend from 62% in 2007).
- 72% have scheduled executive sessions; of these, 62% said executive sessions are scheduled for all or alternating board meetings (similar to 2017).
- 91% said the CEO attends scheduled executive sessions always or most of the time; 45% said physician and nurse board members attend scheduled executive sessions always or most of the time (also similar to 2017).
- New this year, we asked which topics are typically discussed in executive session. The top three were executive performance/evaluation (86%), executive compensation (72%), and miscellaneous governance issues (51%).
- On average, 57% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports (down from 66% in 2017); 31% to active discussion, deliberation, and debate about strategic priorities (up from 24% in 2017); and 12% to board education (the same as 2017).
- 50% 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. Over half invite the CMO and just under half invite the medical staff physicians to attend board retreats.

Board Meeting Frequency & Duration

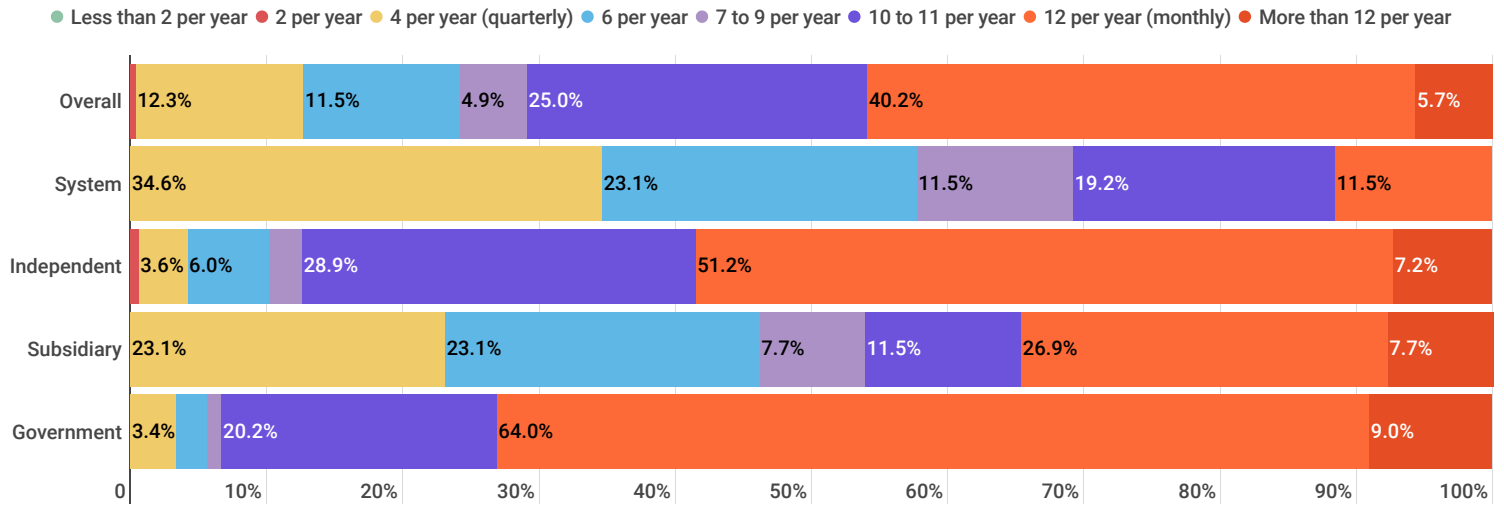
Most boards continue to meet from 10 to 12 times per year (65%, up from 59% in 2017). (See Exhibit 10.) Meeting duration is around the same this year; it tends to be concentrated in the two- to four-hour range (59%) and the next largest group meets for less than two hours (33%). (See Appendix 1 for detail on meeting frequency and duration.)

Some differences by organization type include:

- 35% of system boards and 23% of subsidiary boards meet quarterly.
- 84% of government-sponsored hospital boards meet 10–12 times per year.
- 40% of independent and government-sponsored boards meet less than two hours.
- 20% of system boards meet four to six hours, up from 15% in 2017 and compared with 6% overall.

There is a moderate statistically significant correlation between meeting frequency and duration: the less frequently that boards meet, the longer board meetings are.

Exhibit 10. Number of Board Meetings Per Year



Consent Agenda & Executive Session

Seventy-nine percent (79%) of respondents said the board uses a consent agenda, which has risen steadily from 62% in 2007. (See Exhibit 11.) The percentage of respondents with scheduled executive sessions is 72% (compared with 74% in 2017 and 65% in 2015). (See Exhibit 12 on the next page.)

Since 2009, most respondents continue to schedule executive sessions after or before every board meeting.

We asked who typically attends scheduled executive sessions. Ninety-one percent (91%) of respondents with scheduled executive sessions said the CEO attends always or most of the time (up from 84% in 2015); 45% said clinician board members attend always or most of the time (up from 41% in 2015); and 38% said legal counsel attends always or most of the time (up from 35% in 2017). Forty-eight percent (48%) of health system boards have legal counsel attend executive sessions always or most of the time. (See Exhibit 13 on the next page and Appendix 1.)

Exhibit 11. Use of Consent Agendas Since 2009

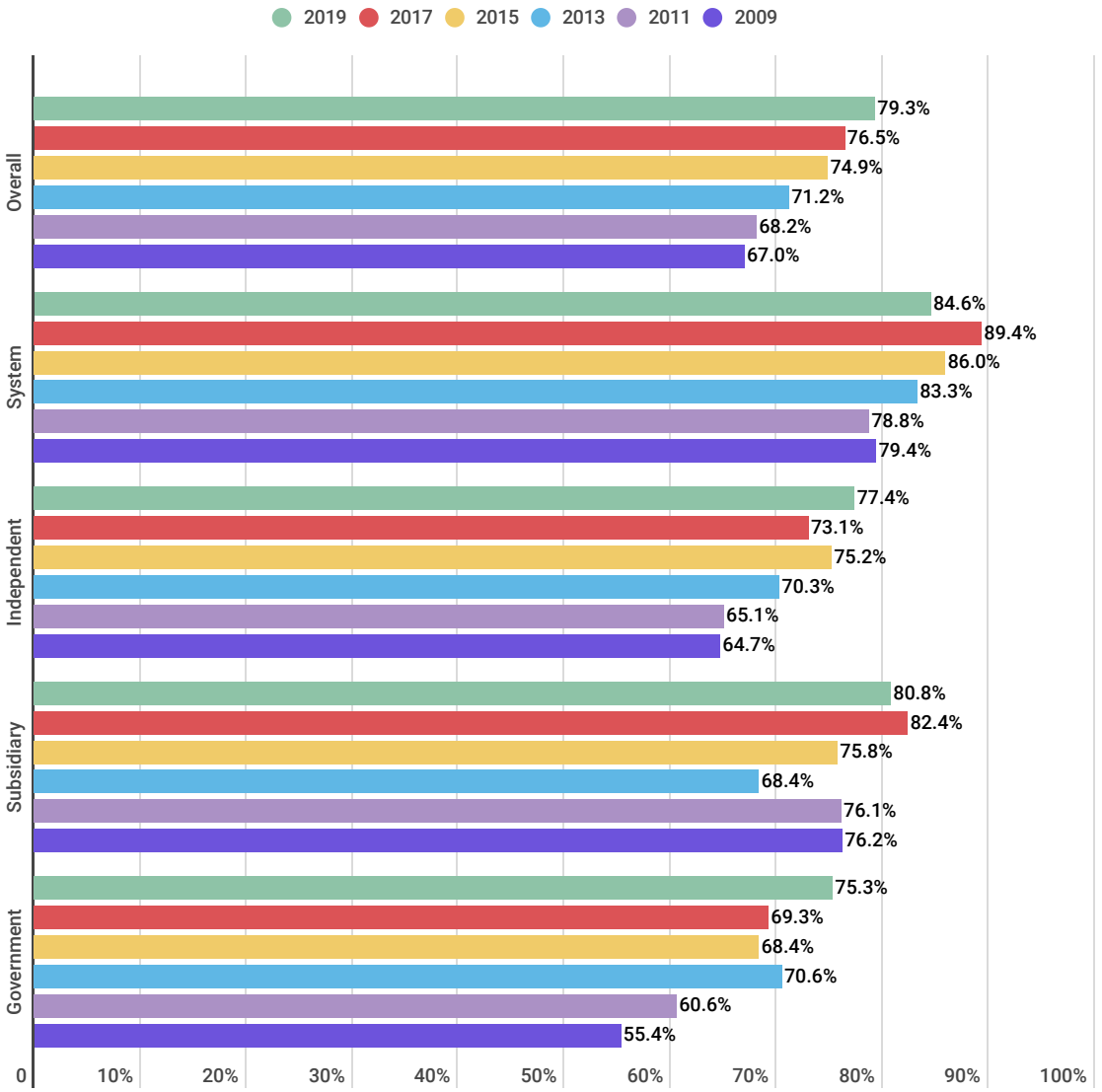


Exhibit 12. Scheduled Executive Sessions Since 2009

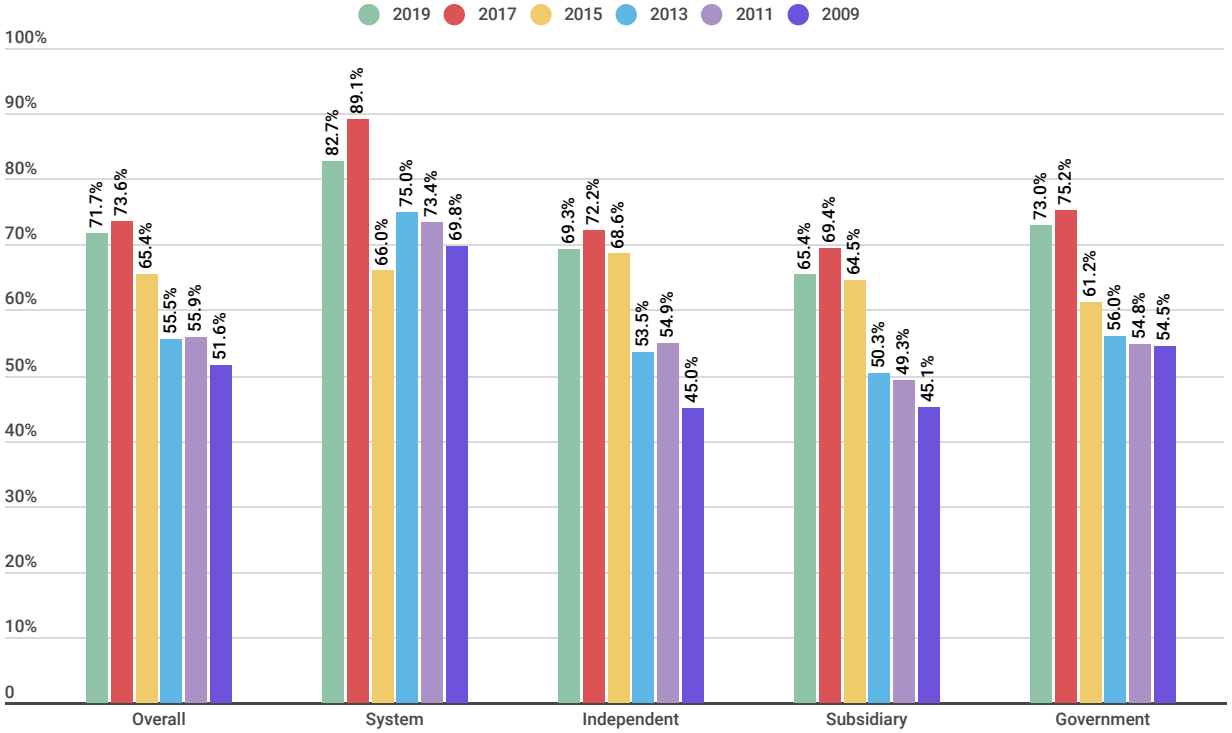
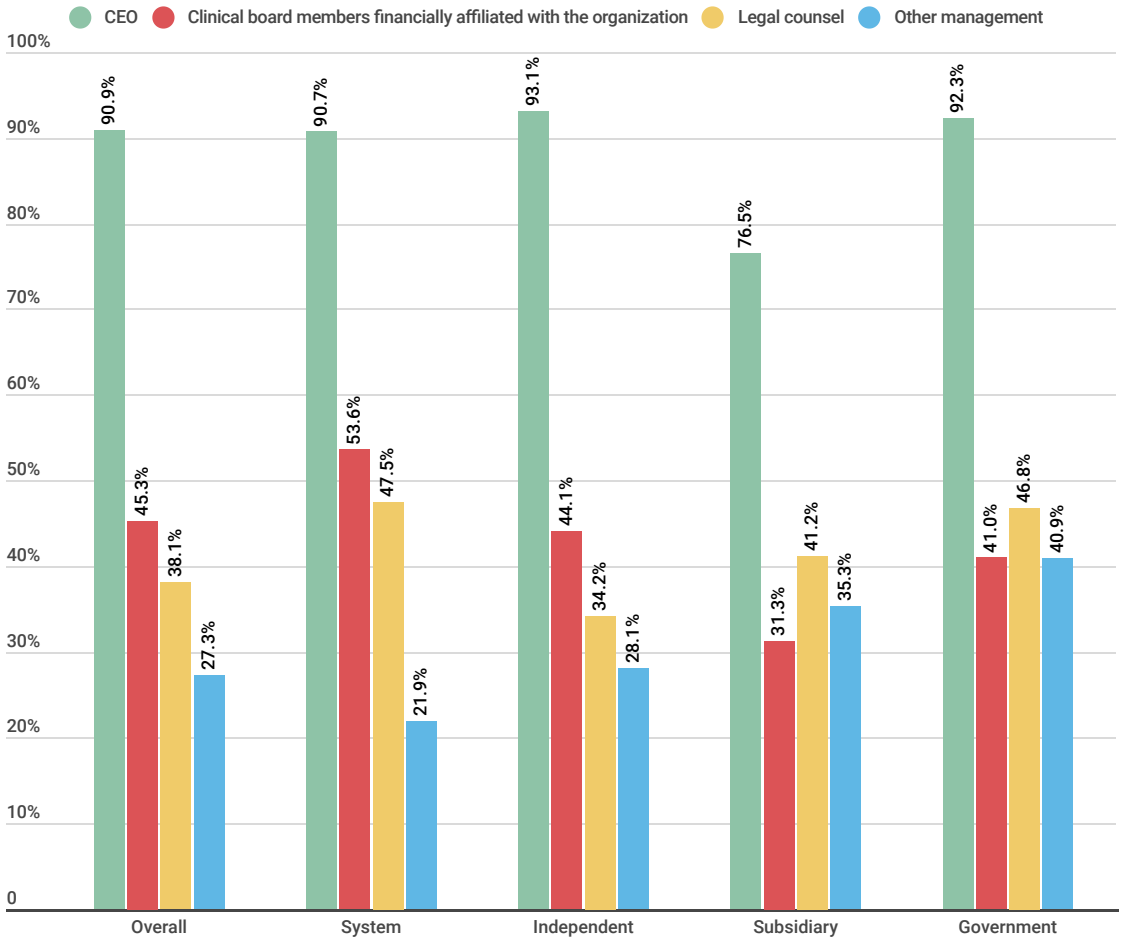


Exhibit 13. Who Attends Scheduled Executive Sessions *(Always and Most of the Time)*



Board Meeting Content

Boards continue to devote more than half of their meeting time to hearing reports from management and board committees. This percentage decreased from 66% in 2017 to 57% this year. The overall breakdown of how meeting time is allocated is as follows:

- Active discussion, deliberation, and debate about strategic priorities of the organization: 30.8%
- Reviewing reports from management, board committees, and subsidiaries (excluding financial and quality/safety): 19.5%
- Reviewing financial performance: 19.2%
- Reviewing quality/safety performance: 18.4%
- Board member education: 12.1%

Meeting time spent discussing strategic priorities has increased this year from 24% to 31% and it should be noted that this is the largest overall chunk of board meeting time. However, the highest percentage of strategic discussion in board meetings was 33% in 2013. Also, time spent on board member education has stayed the same since 2017 but down from a high of 17% in 2013. (See **Exhibit 14**.)

Percentage of meeting time spent in these categories was fairly consistent again this year across organization types. System boards have the highest percentage of meeting time spent on strategic discussion (34%, up from 31% in 2017), and subsidiary hospitals have the highest percentage of meeting time spent on hearing reports from management and board committees (24%).

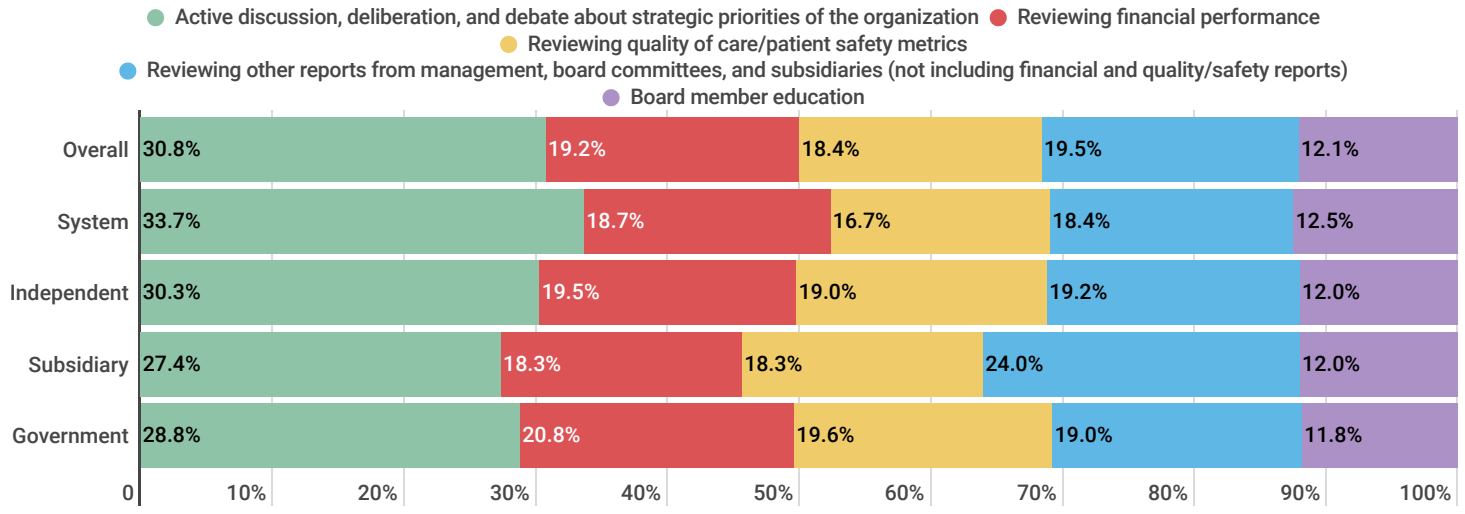
> We recommend that boards spend more than half of their meeting time on strategic discussions due to the continued statistical relationship the data shows between the amount of time devoted to strategic discussion and overall board performance (as opposed to spending the majority of the meeting "listening" to reports which could have been read before the meeting). 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, quality, and all other mission-critical issues that require decision making of a strategic nature. We changed the wording of the question this year to better allow respondents to understand that this category of board meeting time goes beyond simply discussing the strategic plan itself, but also includes any active discussion, deliberation, and debate about any strategic priority for the organization.

Overall, it appears that boards still have a way to go to bring about the recommended shift in board meeting content as there has not been significant movement in this area since 2005. This year, only 7% of respondents spend 50% or more of their meeting time discussing and debating strategic priorities, and 79% spend *40% or less* of the time during their board meetings on strategy (see **Exhibit 15** on the next page). We emphasize this because our research continues to show a 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."

This year, we found that the more meeting time spent discussing strategic issues, the greater the likelihood to report "excellent" or "very good" performance in the following areas:

- All respondents: financial oversight, management oversight
- Systems: management oversight
- Subsidiaries: all fiduciary duties and core oversight areas
- Government: financial oversight and setting strategic direction

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



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.)

"It is revealing that only 31% of meeting time is dedicated to active, discussion, deliberation, and debate about strategic priorities. In 2017, ProMedica began a new practice of data-driven and heavily researched strategic discussions at our board meetings. Now, we assign a different strategic topic for each of our board meetings, provide a related case study in advance, and dedicate at least 1.5 hours of each meeting to strategic discussion."

—Randy Oostra, President & CEO, ProMedica and member of The Governance Institute's editorial board

Board Committees

Summary of Findings

- 5.7% of the respondents do not have board committees (up from 4.9% in 2017).
- Average number of committees is 7.7 (vs. 7.1 in 2017).
- Median remains 7.
- Most prevalent committees (seven committees this year with more than 50% of respondents, listed in order of highest percentage of respondents having this committee): finance (83%), quality (80%), executive (73%), executive compensation (62%), governance/board development (58%), strategic planning (55%), and audit/compliance (53%).
- The committees showing the most dramatic increase in prevalence this year compared with 2017 are: audit, audit/compliance, physician relations, community benefit, and population heath/community health improvement.

Most respondents (94%) noted their board has one or more committees. Independent hospitals have the most committees (average of 8.1) and subsidiaries have the fewest (4.8). (See Exhibit 16.)

Overall, there has been little change in the prevalence of specific types of board committees. The committees showing the most dramatic increase in prevalence this year compared with 2017 are: audit (44% vs. 38%), audit/compliance (53% vs. 34%), physician relations (31% vs. 22%), community benefit (29% vs. 24%), and population heath/community health improvement (23% vs. 18%).

This is the second year we asked about prevalence of a population health/community health improvement committee (separate from community benefit) to discern to what degree organizations are treating this as a priority at the board level. Independent hospitals are more likely to have this committee, with 27% this year (vs. 18% in 2017).

Exhibit 15. Percentage of Board Meeting Time Spent in Active Discussion, Deliberation, & Debate on Strategic Priorities of the Organization

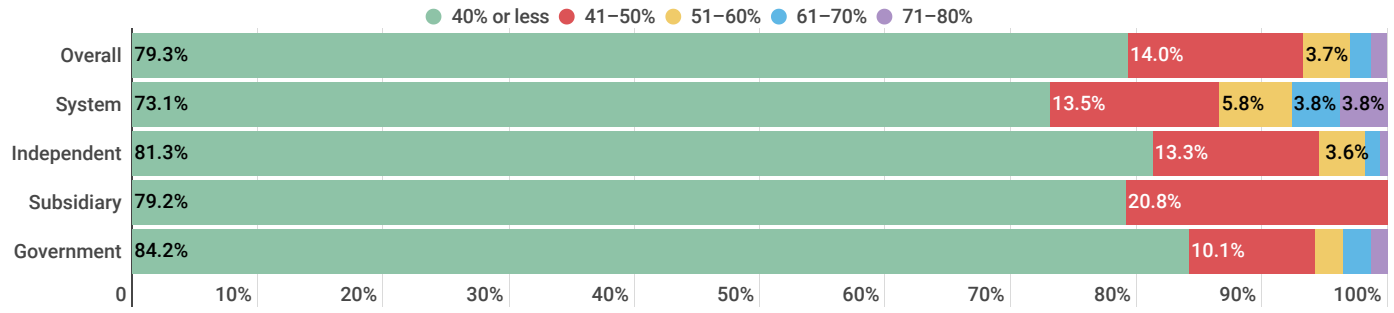
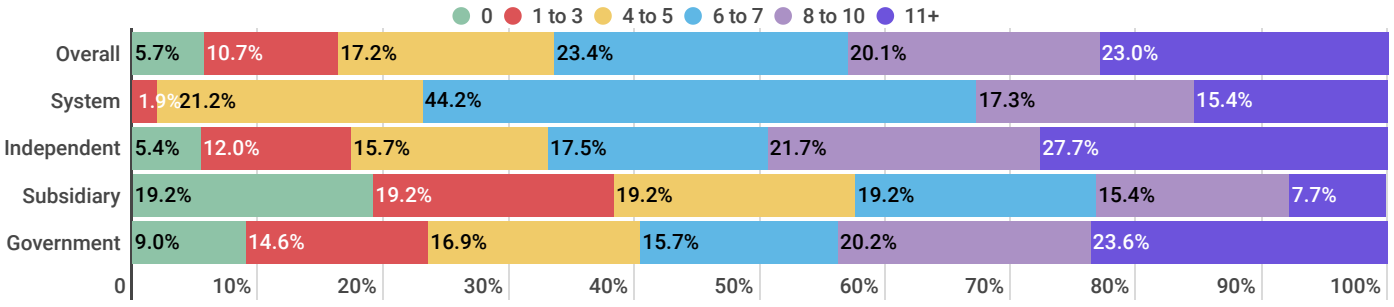


Exhibit 16. Number of Board Committees



Effective Board Meetings—It Can Happen Here Too!

John C. Bravman, Ph.D., President, Bucknell University; Chairman of the Board, Geisinger Health; Bing Centennial Professor, Emeritus, Stanford University

SPECIAL COMMENTARY

We've all been there. Another meeting, another…waste of time? Another chance for pontification? Another opportunity for him to establish that he's the smartest one in the room? Why doesn't everyone see that *I'm the smartest one in the room?!?* And why is most everyone in the room always looking at their screens?

Board meetings are no different than any other, expect that the consequences of success or failure are typically high, as they should be given the canonical function of a board as the final fiduciary for an organization. The price of getting it wrong, if nothing else, should drive everyone involved to ensure that board meetings are effective, efficient, and consequential. And perhaps even enjoyable. But how? It starts with the chair and the CEO, but it requires every member of the board to do their parts.

As with organizations in general, the culture of the board is of paramount importance. As Peter Drucker explained, culture overwhelms strategy, so understanding the culture of the board, and having frank and open discussions about that culture, is an essential foundation of proper board functioning. Do a few members dominate discussions? Or even intimidate others into quiet submission? Or is vigorous debate not just possible, but prized? Does everyone speak up and offer their opinions, deferring perhaps to those with a particular expertise, but sharing their perspectives nonetheless? How are conflicts resolved? Does debate continue in the hallway over a break, with factions gathered in different corners…or is there an unshakeable commitment to full transparency among and between members? How do we assess our effectiveness, and how often? One way to help build and maintain a positive board culture is to ensure sufficient social time at every regular board meeting. This helps ensure that members, who may only see each other a few times per year, establish trusting relationships that are a bedrock of good board governance.

The price of getting it wrong, if nothing else, should drive everyone involved to ensure that board meetings are effective, efficient, and consequential.

In a similar vein, it's critical that the "skills matrix" of a board be assessed and discussed, perhaps every few years, so that the required expertise of the members is established and maintained. An outside entity can be very helpful in this regard, as their detachment and neutrality may help when difficult discussions need to be had. Recently, as documented in the business press and in a bestselling book and soon a movie, a Silicon Valley startup in the healthcare space turned out to be massively fraudulent. Many post-mortems pointed in part to the all-star board who had everything they needed…except the expertise in the technologies at the heart of the claimed inventions.

Effective board meetings typically require significant preparation on the part of every member, by the board's staff, and by everyone who will present or lead a discussion. It falls first to the board chair and the CEO, along with key staff, to assemble a timely and important agenda, and to ensure that every speaker is fully prepared to lead a rich and purposeful discussion. All materials should be available well before the meeting, either electronically or in print. For board members, the most important task is to read and study these materials *before* the meeting, so that they arrive at a meeting ready to engage in substantive dialog. It's helpful to begin a meeting with a brief recap of what was decided at the last meeting, and to review the agenda for the meeting at hand. Why are these topics on the agenda? What do we hope to achieve at this meeting? What does success look like at the end of the day? If everyone has a shared understanding of these and similar questions, and if everyone arrives prepared, the meeting has a chance—but still not a guarantee—of success.

There are many paths towards fulfilling the duties of a board while maximizing the time available for real discussion. Move as much as possible—but no more—to a consent agenda. Don't try to cram into 15 minutes what always takes an hour. The chair must be vigilant and active in ensuring broad participation, limiting the "air time" of a speaker if need be—but tactfully, of course. The chair also has an obligation to speak with "troublesome" individuals, but always in private, offering mild correctives where needed. The chair must also convey to the CEO any concerns and all meaningful feedback from whatever executive sessions were held without the CEO present.

There are seldom any guarantees of a highly effective meeting, but there are many ways to guarantee failure. Establish what the particular vulnerabilities may be for your board, and then avoid them at all cost. With discipline, honest dialogue and feedback, and a shared commitment to making each meeting better than the last, meetings *will* improve. And your organization will be better for it.

Committee Variances by Organization Type: Health Systems vs. Subsidiaries

We try to articulate committee variances between health systems and subsidiaries to determine whether there appears to be a relationship between the committees that tend to be at the system level vs. at the subsidiary level. Examples that stand out this year include:

- 80% of systems have an executive committee, compared with 52% of subsidiaries.
- 94% of systems have a finance committee vs. 58% of subsidiaries.
- 82% of systems have an audit/compliance committee vs. 36% of subsidiaries.
- 86% of systems have a quality/safety committee vs. 69% of subsidiaries.
- 78% of systems have a governance/board development committee vs. 35% of subsidiaries.
- 73% of systems have an executive compensation committee vs. 21% of subsidiaries
- 63% of systems have an investment committee vs. 21% of subsidiaries
- 21% of systems have a community benefit committee vs. 39% of subsidiaries
- 17% of systems have a population health/community health improvement committee vs. 13% of subsidiaries.

Table 12 shows the prevalence of board committees since 2013 (most prevalent committees for 2019 listed first). For detail by organization type and size (both committee prevalence and meeting frequency), refer to Appendix 1.

The Quality Committee

The quality/safety 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 also holding management accountable for implementing actions to improve it). The number of organizations reporting a board-level quality/safety committee is higher in 2019 than in prior years, and especially for systems, independent hospitals, and government-sponsored hospitals. Comparisons by organization type can be found in Table 13.

Table 12. Prevalence of Board Committees

Committee	2019	2017	2015	2013
Finance	83%	81%	84%	76%
Quality and/or Safety	80%	77%	74%	77%
Executive	73%	75%	72%	77%
Executive Compensation	62%	60%	66%	60%
Governance/Board Development	58%	59%	72%	77%
Strategic Planning	55%	52%	57%	57%
Audit/Compliance	53%	38%	51%	34%
Investment	45%	44%	40%	35%
Audit	44%	38%	33%	32%
Compliance	42%	48%	28%	33%
Joint Conference	37%	34%	35%	40%
Facilities/Infrastructure/Maintenance	31%	27%	23%	25%
Physician Relations	31%	22%	21%	19%
Community Benefit	29%	24%	26%	18%
Human Resources	28%	25%	22%	20%
Construction	24%	17%	17%	9%
Population health/community health investment	23%	18%	N/A	N/A
Government Relations/Advocacy	18%	14%	13%	9%

Table 13. Organizations with a Board Quality Committee

	2019	2017	2015	2013	2011
Overall	80%	77%	74%	77%	72%
Systems	86%	82%	84%	85%	74%
Independent Hospitals	80%	72%	80%	80%	74%
Subsidiary Hospitals	69%	87%	81%	86%	77%
Government-Sponsored Hospitals	79%	66%	58%	60%	62%

Quality committees continue to meet primarily monthly (for 48% of respondents); 13% meet bimonthly and 34% meet quarterly.

The average quality committee has 11 people and the most common types of positions on this committee include:

- Voting physician board members (75% have between one and four)
- Physicians from the medical staff (employed and non-employed but non-board members; 56% have between one and four)
- Voting board members who are not physicians (47% have between one and three and 41% have four or more)
- Community members at large (36% have between one and four)

The Executive Committee

Seventy-three percent (73%) of respondents said their board has an executive committee (down slightly from 75% in 2017), and this committee meets "as needed" for 50% of those respondents. For more than half of those with an executive committee, responsibilities include emergency decision making (73% compared with 60% in 2017), advising the CEO (72%, up from 58% in 2017), decision-making authority between full board meetings (61%), and executive compensation (57%). (For detail, see Appendix 1.)

Thirty-three percent (33%) of executive committees have full authority to act on behalf of the board on all issues. Thirty-six percent (36%) have some authority to act on certain issues, and for 31% of executive committees, decisions must be approved or ratified by the full board. A few distinctions by organization type include:

- System boards have the highest percentage of respondents indicating full authority of the executive committee (44%, down from 52% in 2017).
- Forty-six percent (46%) of subsidiary board executive committees have some authority to act on certain issues.
- Executive committees of government-sponsored hospitals have the least amount of authority (15% have full authority; 52% said all executive committee decisions must be ratified by the full board, and only 33% have decision-making authority between full board meetings).

Exhibit 17. Responsibilities of the Executive Committee

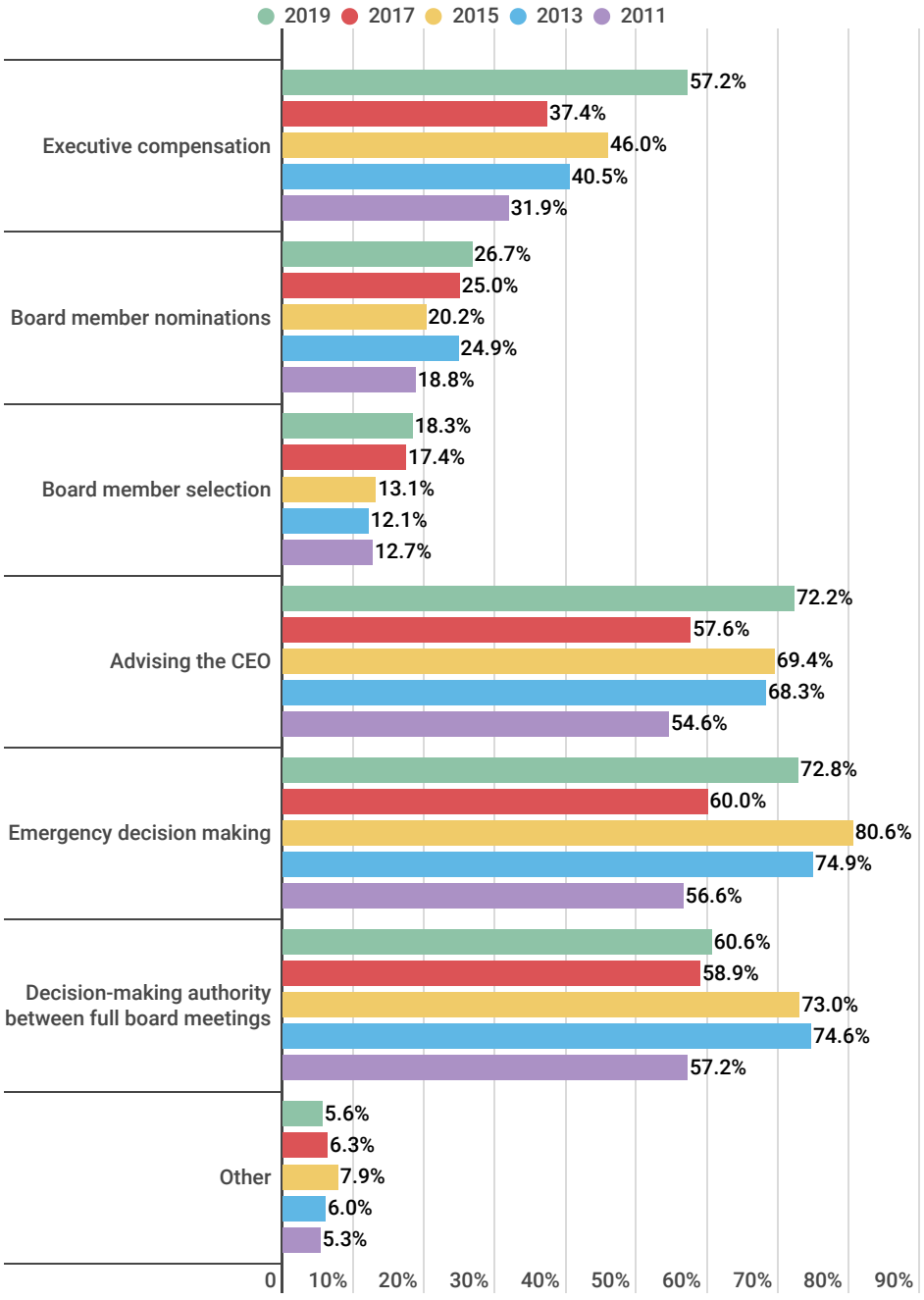
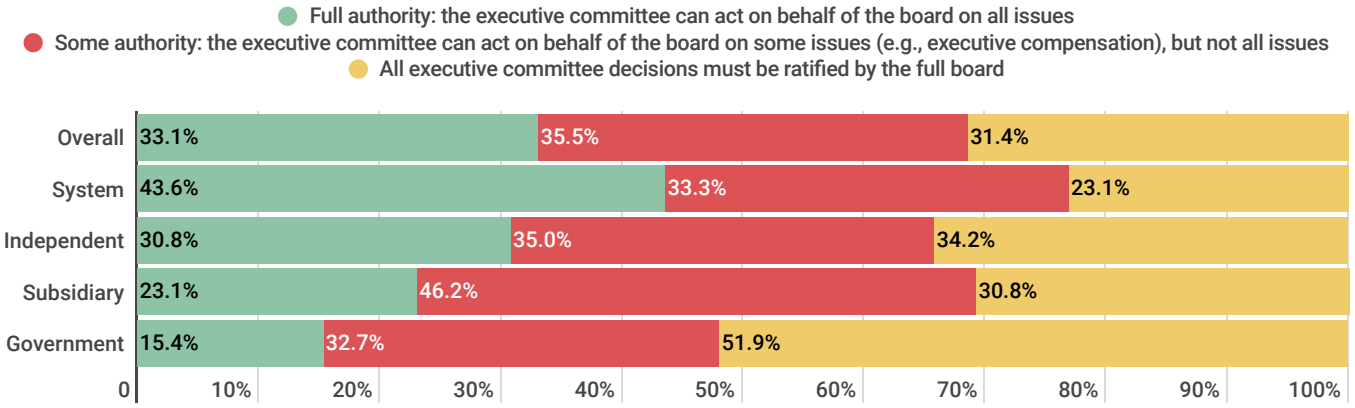


Exhibit 18. Level of Authority of Executive Committee



Board Member Compensation

Summary of Findings

- Overall, 6% of respondents compensate board members.
- 7% of respondents said their board chair is compensated (down from 12% in 2017), and 81% of these said compensation is less than $5,000, up from 62% in 2017.
- 6% compensate other board officers (down from 11% in 2017), and 4% compensate board committee chairs (down from 8% in 2017), but the vast majority compensate these positions for less than $5,000.
- 7% said other board members are compensated (down from 11% in 2017), not including committee chairs and other officers, and 93% of these said compensation is less than $5,000 (up from 63% in 2017).
- 14% of larger systems (1,000+ beds) compensate the board chair, and for those, compensation is over $50,000.
- Government-sponsored hospitals continue to be more likely to compensate board members than other types of organizations (11% compensate some board members: 12% compensate the board chair, 13% compensate other board officers, 9% compensate board committee chairs, and 12% compensate other board members). For all of these categories, compensation is less than $5,000.

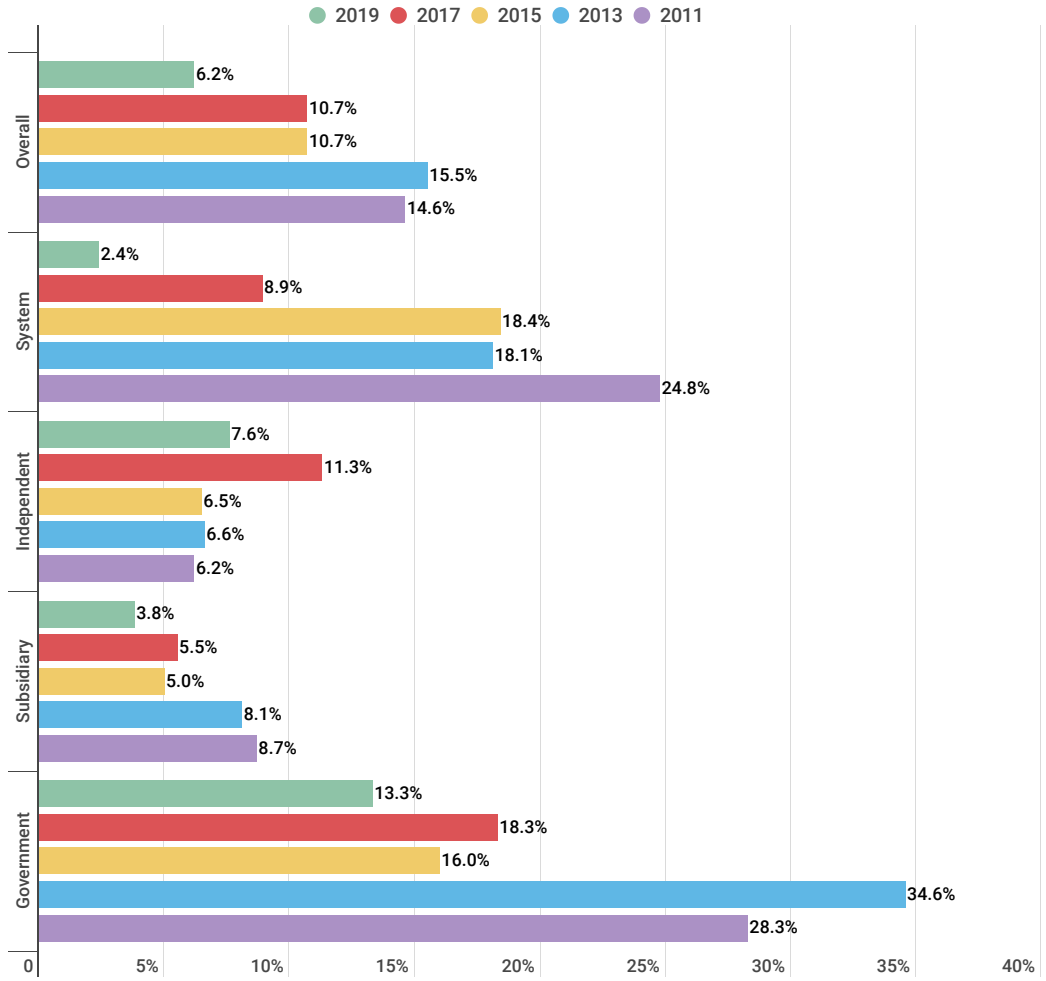
Overall, the trend shows that the prevalence of boards that are compensated remains flat (the trend from 2011–2017) or is decreasing (what the 2019 data show, although this could be due to the smaller sample size this year). This year, the percentage of respondents that provide compensation of any kind decreased for all types of organizations. Government-sponsored hospitals are more likely than others to compensate board members (chairs, committee chairs, and other directors). Subsidiary hospitals are least likely to compensate board members. (See Exhibit 19 on the next page and Table 14.)

With the exception of health systems, the amount of compensation remains low for all kinds of board members that are compensated (of those that do provide compensation, between 81–100% compensate less than $5,000 for the various board positions including board chairs). Sixty-seven percent (67%) of the health systems that compensate pay $50,000 or more to their board chairs, but compensation for other board officers and other board members is $5,000 or less, and this year's group of systems does not compensate committee chairs. (For detail, see Appendix 1.)

Table 14. Percentage of Organizations that Compensate the Board Chair

	2019	2017	2015	2013	2011
Overall	**7.1%**	**12.2%**	**11.1%**	**11.8%**	**12.0%**
Systems	7.1%	10.6%	18.0%	17.5%	21.3%
Independent Hospitals	7.6%	12.8%	6.5%	5.8%	5.2%
Subsidiary Hospitals	3.8%	6.6%	4.9%	6.2%	7.1%
Government-Sponsored Hospitals	12.0%	18.3%	17.8%	23.5%	22.9%

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



Annual Expenditure for Board Member Education

Summary of Findings

- 31% of respondents spend $30,000 or more annually for board education (up from 27% in 2017).
- 0% said they don't spend any money on board education (down from 6% in 2017).
- Health systems generally spend more for board education than other types of organizations (53% of systems spend $50,000 or more, up from 36% in 2017; 39% spend over $75,000, up from 29% in 2017).
- Subsidiaries and government-sponsored hospitals spend the lowest dollar amount for board education (58% and 56%, respectively, spend under $10,000 per year).
- Board education is most often delivered during board meetings; publications are the second most common delivery method (for all types of organizations; this has remained the same as in 2015).
- The most popular internal board education topics remain quality/safety, industry trends and implications, and legal/regulatory.

This year, the data analysis showed statistically significant positive correlations between the amount of money spent on board member education and overall evaluation of board performance in all aspects (e.g., the more money spent on education, the higher the board performance). In 2017, the data analysis showed that for boards spending $30,000 or greater on board education, there is a greater tendency to indicate strong agreement to the questions in the board culture section of the survey. (In 2015 there was also a relationship between spending $30,000 or greater on board education and the tendency to indicate board performance of the fiduciary duties and core responsibilities as "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

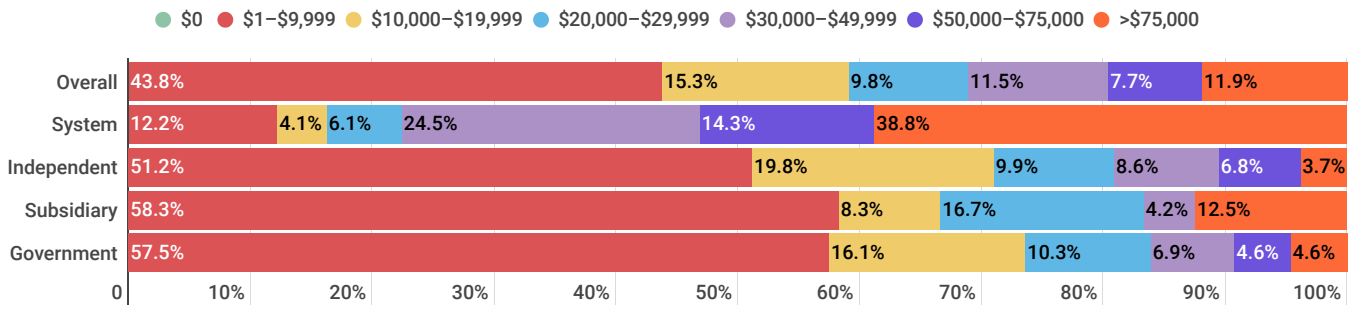
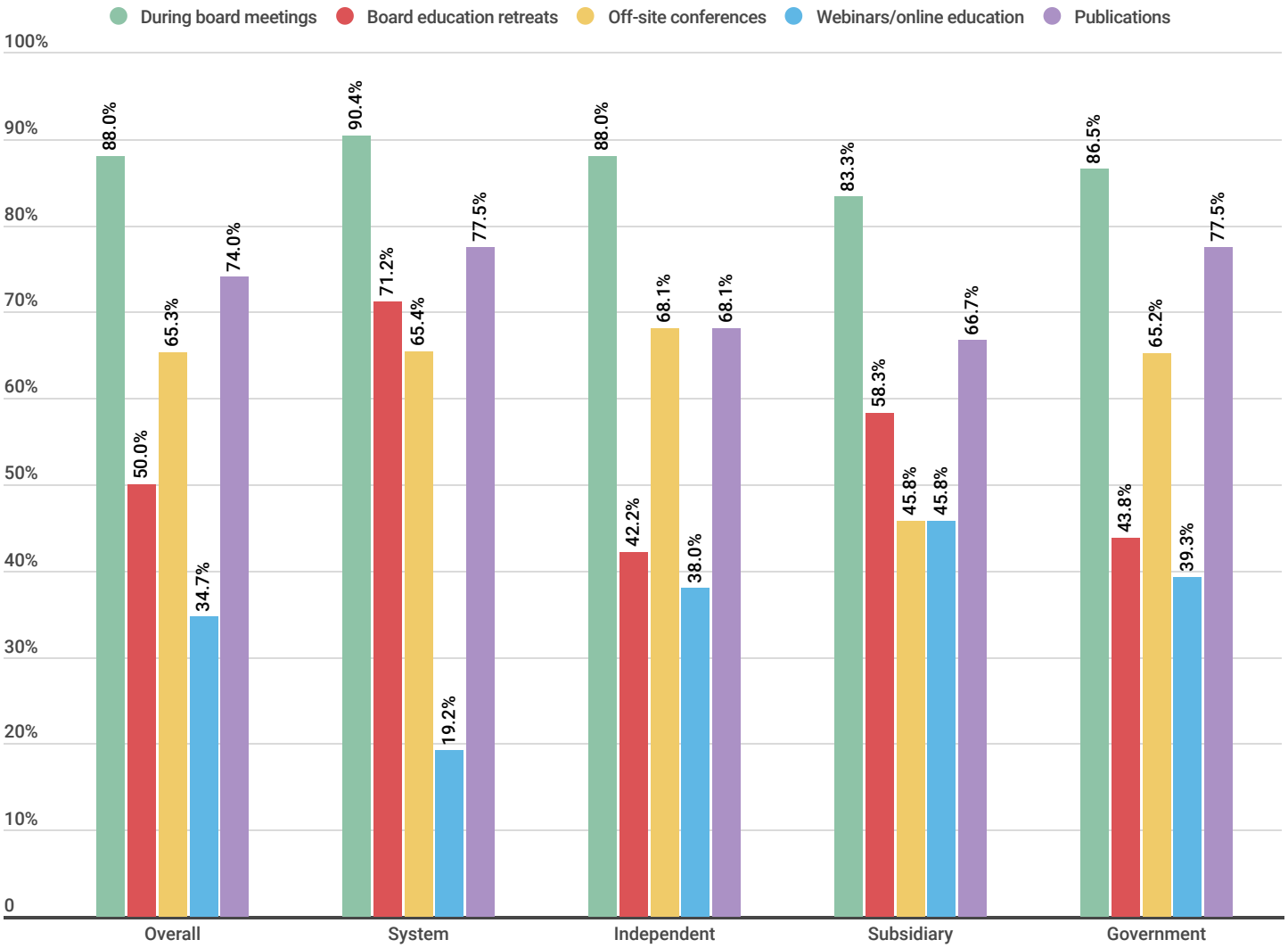


Exhibit 21. Delivery of Board Education



Board Member Preparation

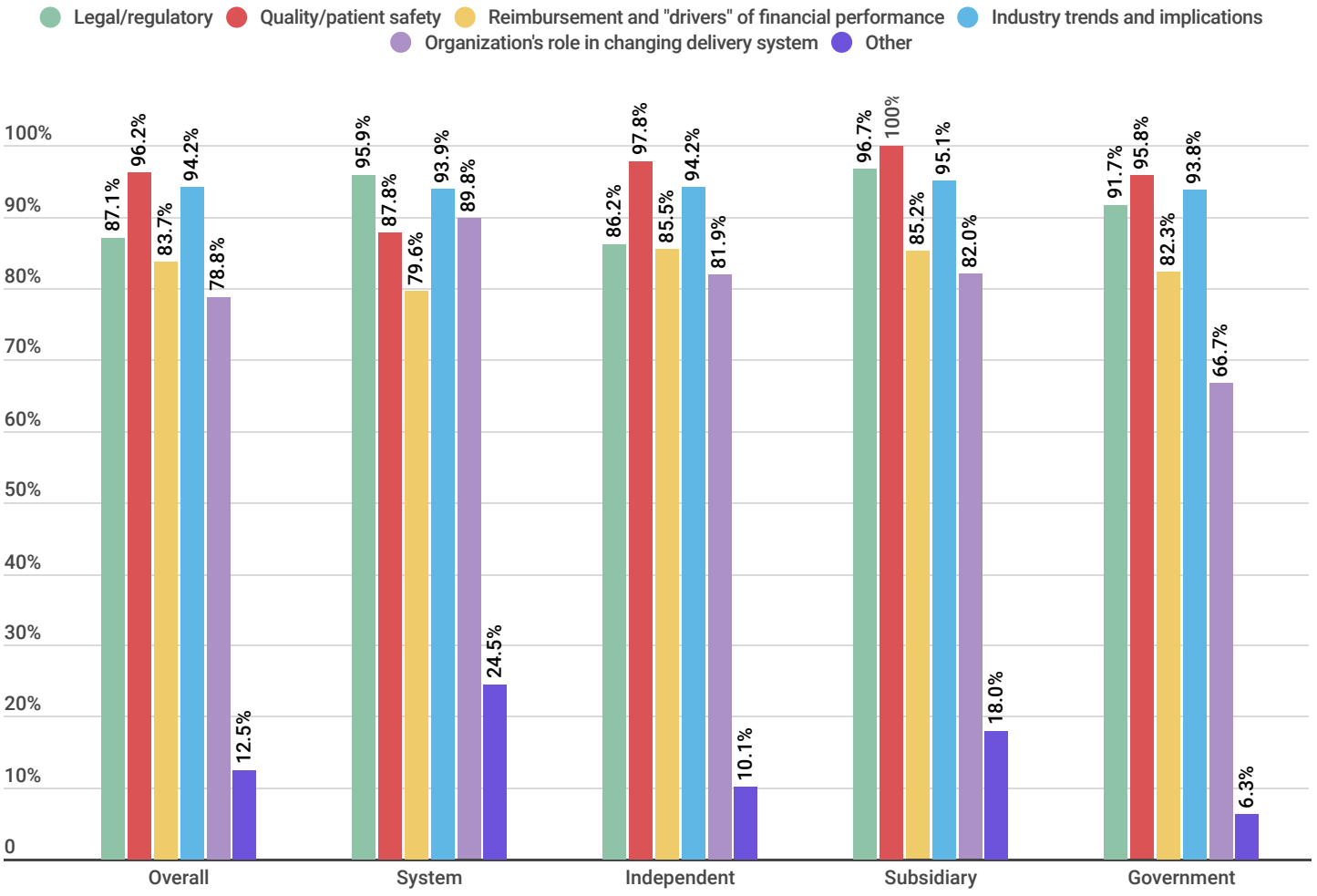
Summary of Findings

Use of Board Portal or Similar Online Tool

- 69% 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 (down from 73% in 2017). Specifically, 63% of respondents already use a board portal, and another 7% are in the process of implementing a portal.
- 90% of health systems use a board portal; and 70% of subsidiary hospitals are in this category (the two types of organizations most likely to use a board portal, although these percentages are down from 2017).
- 39% said the most important benefit of using a board portal is the reduction of paper waste and duplication costs. Thirty-seven percent (37%) said the most important benefit is that it enhances board members' level of preparation for meetings.
- 75% of respondents provide board members with laptops or iPads to access online board materials, which has trended steadily up from 30% in 2011.

This year's analysis showed a significant relationship between the use of a board portal and overall evaluation of board performance in *all* aspects.

Exhibit 22. Topics Covered for Internal Board Education



Staff Investment in Board Matters & Meeting Preparation

We asked about the number of hours per month (combined) devoted to governance/board-related matters by members of the C-suite (phone calls, preparing board reports, presenting during meetings, etc.). Forty percent (40%) spend 10–20 hours per month, and 38% spend less than 10 hours per month. This is generally uniform across organization type, with the exception of health systems, 40% of which spend 10–20 hours per month, and 31% spend 20–40 hours per month.

We also asked about the number of full-time equivalent staff (FTEs) devoted to governance. For 70% of organizations, this is combined with another position (most likely the executive assistant to the president/CEO). Health systems devote the most staff to governance, with 58% having one to two people staffed for this purpose. (See Appendix 1 for more detail.)

Exhibit 23. Most Important Benefit of Board Portal

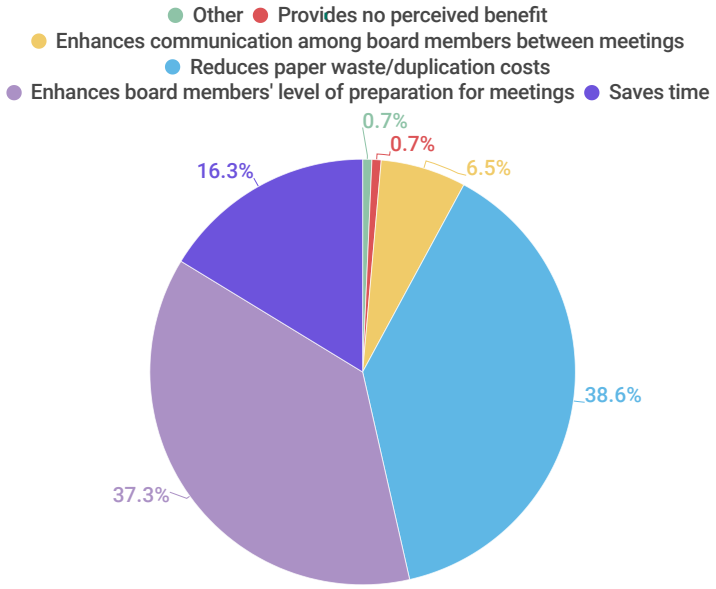
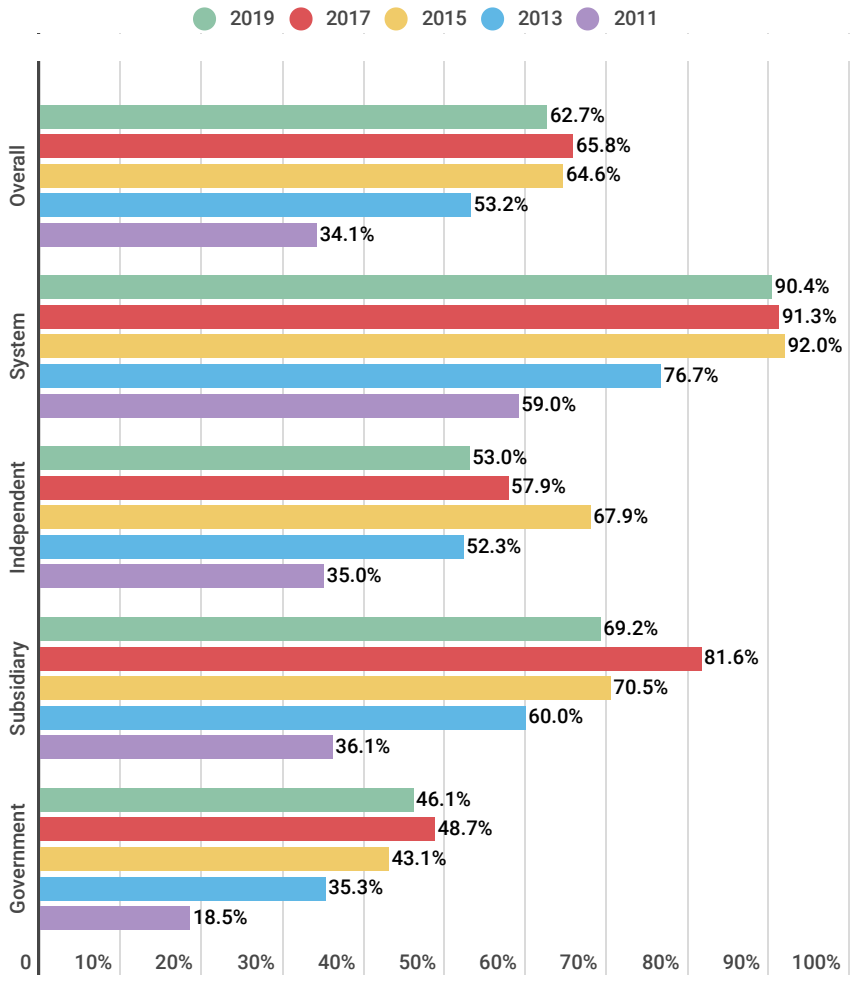


Exhibit 24. Use of Board Portal or Similar Online Tool Since 2011



Accountable Care Organizations

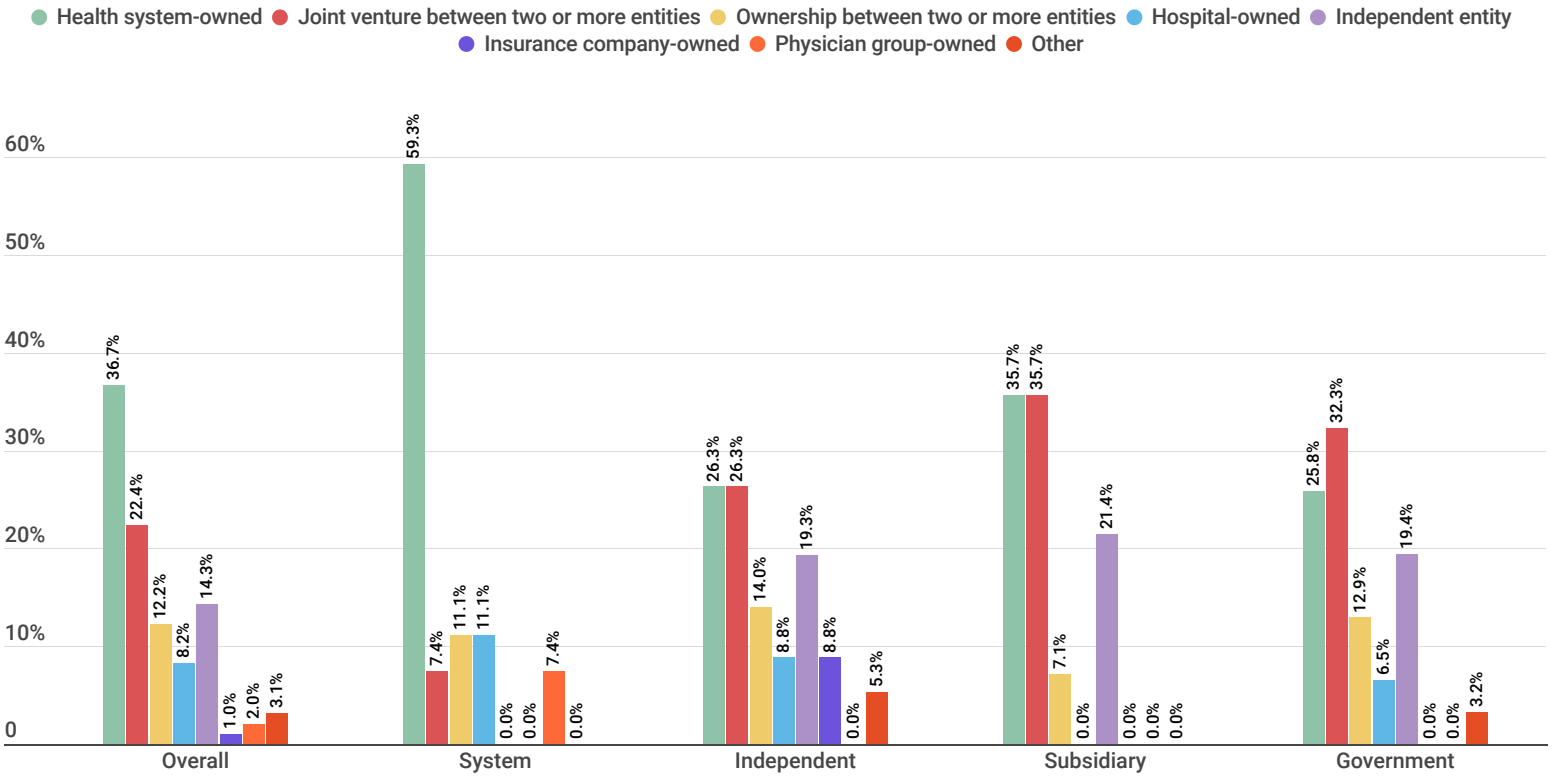
Summary of Findings

- 47% of respondents are participating in an ACO or similarly structured clinically integrated network (down from 55% in 2017).
- Health systems and subsidiary hospitals are more likely than others to be participating in an ACO (52% and 54% respectively).
- Most respondent ACOs are health-system owned (37% overall; 59% for health systems, 36% for subsidiaries, 26% for independent hospitals, and 26% for government-sponsored hospitals).
- 42% of respondents' ACOs cover 50,000 patients or more.
- The average size of the ACO board is 10 people, with minimal representation from the ownership entities (detail can be found in Appendix 1).
- 45% of ACO boards function independently (i.e., do not report to or have a relationship with) the owner entity board. For health systems, 44% of ACO boards are considered subsidiaries of the entity board and the entity board has decision-making authority over some aspects of the ACO.

This is the third year we are reporting on ACO (or other similarly structured clinically integrated network) participation, size, and ownership type. As in prior years, we did not require respondents to specify whether they were participating specifically in a Medicare ACO, but any type of arrangement with public or private payers that would be considered an ACO or similar model.

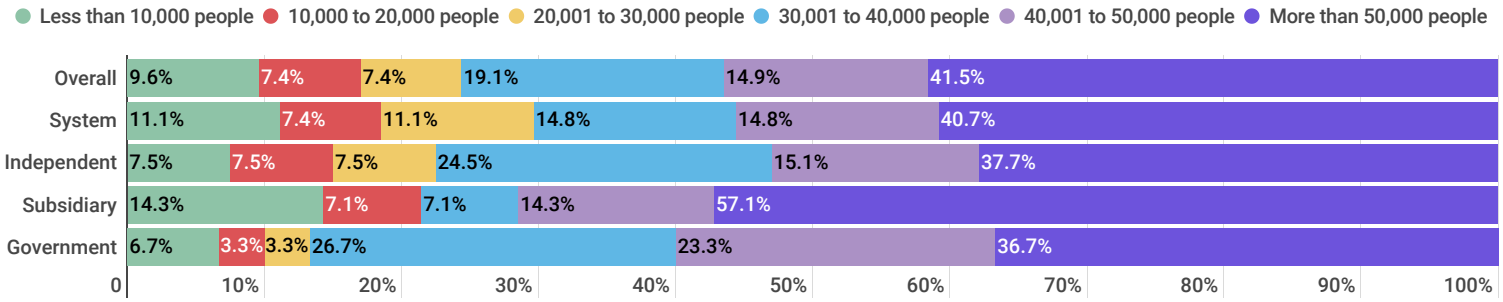
Just under half (47%) of the respondents are participating in an ACO model of some type. This is down from 55% in 2017; this may be due to this year's smaller sample size, and/or the fact that the number of Medicare ACOs across the U.S. declined from 561 in 2018 to 518 in 2019.[3] The majority of respondents' ACOs are health system owned (37%); the second largest percentage overall is a joint venture between two or more entities (22%). A few are considered an ownership between two or more entities (12%) or an independent entity (14%); only 1% is owned by an insurance company and 2% 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 (34%) cover 20,000 or fewer in their ACO (See Exhibit 26 on the next page.)

Exhibit 25. ACO Ownership Structure *(N=98)*



3 Shared Savings Program Fast Facts, as of July 1, 2019, The Centers for Medicare and Medicaid Services. Available at https://go.cms.gov/2LPV0Np.

Exhibit 26. Size of Covered Patient Population under the ACO *(N=98)*



Board Culture

This is the fourth 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 performance of boards' fiduciary duties and core responsibilities. This year we asked respondents to state how strongly they agreed with a list of nine board culture-related statements.

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.)

Combining "agree" and "strongly agree" responses, the board culture statement that scored strongest was:

- Meetings are held at the right frequency for the board to fulfill its duties and responsibilities (95%).

The statement with the lowest score was:

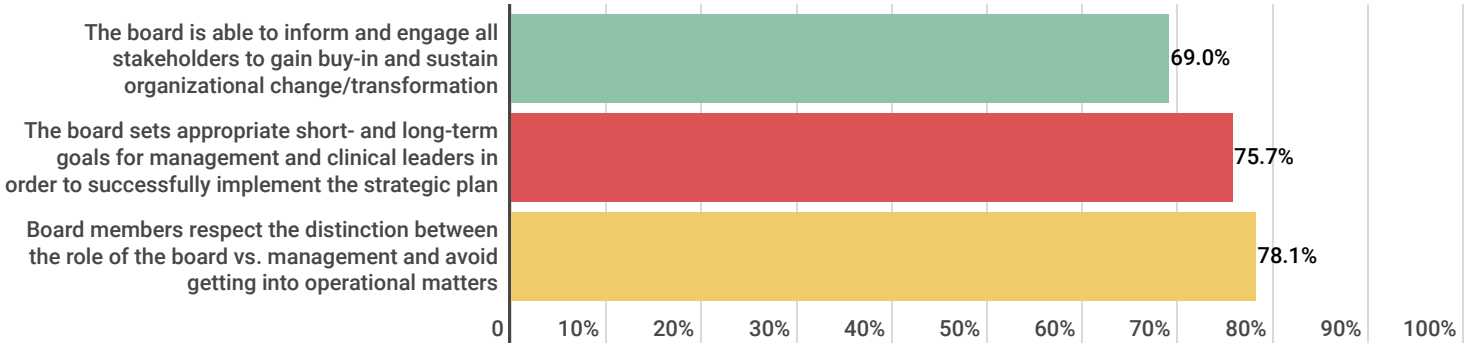
- The board is able to inform and engage all stakeholders to gain buy-in and sustain organizational change/transformation (69%).

Each individual statement regarding board culture is important, but not indicative of a healthy culture by themselves. As such, we looked at these statements taken together as a whole to use as a reliable indicator of a healthy board culture. To determine the degree of healthy board culture overall (all statements combined), 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: 84% or a B (down from 87% in 2017)
- Health systems: 90% or an A- (down from 93% in 2017)
- Independent hospitals: 82% or a B- (down from 86% in 2017)
- Subsidiary hospitals: 86% or a B (down from 91% in 2017)
- Government hospitals: 80% or a B- (the same as 2017)

Only 25 respondents (10.2%) reported that they strongly agree with all nine statements.

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



Reevaluating Board Culture: Developing Collective Ability to Do What Has Never Been Done

Lawrence R. McEvoy II, M.D., President & CEO, Epidemic Leadership

SPECIAL COMMENTARY

At first glance, the numbers in this report on how boards see themselves functioning (e.g., board culture) appear reassuring. The lowest score of combined percentage for "strongly agree"/"agree" responses is 69% for the statement, *"The board is able to inform and engage all stakeholders to gain buy-in and sustain organizational change/transformation."* The combined "strongly agree"/"agree" percentages are 87.2%, 85.5%, and 91.7% respectively for *"the board, management, medical staff, and nursing staff are aligned in pursuing the organization's strategic goals and vision," "board members voice opinions/concerns regardless of how sensitive the matter may be," and "the board engages in constructive dialogue with management."*

Room for improvement certainly, but so far, so good. Contrast those responses with the reality that physician burnout is a widely discussed but unsolved problem, and over half of healthcare executives would leave their jobs if they could.[4] According to the 2018 ACHE annual survey, healthcare CEOs rated their top concerns as financial challenges, governmental mandates, patient safety/quality, and personnel shortage, in that order.[5]

Few boards, executives, physicians, or staff would disagree that healthcare is getting more difficult and more stressful. Leading in complexity—not just to execute on operations and stabilize the balance sheet, which is baseline functionality, but to maintain (grow!) the energy, commitment, and capability of the entire organization and evolve its clinical and health impact—has never been at a higher premium.

Today's healthcare organization is not just a sea of activity, it's an ocean of task saturation. There's "so much going on" that people have trouble finding the space, the permission, and the will to think at a deeper level. The faster we move, the farther behind people are feeling. Micro-processing may follow Moore's law, but humans don't, and in environments as rife with both regulatory burden and technology as healthcare is, the traps of speed and tasking easily fill our days with requirements most urgent rather than work most important.

> Incremental improvement cannot keep pace with the unpredictable certainties of the changing future. It's time for boards to think of governing the quantum organization.

What we've been doing to date, no matter how stable your organization may appear to be, is neither adequate from a human perspective nor sustainable from a financial one. Incremental improvement cannot keep pace with the unpredictable certainties of the changing future. It's time for boards to think of governing the quantum organization—one whose capacity, expressed not in dollars or FTEs but in human ingenuity, alignment, and collective intelligence, can respond effectively to the trifecta of human, financial, and quality challenges that the CEOs highlight as their highest concerns.

Healthcare can be characterized as a lot of things—biggest business in the U.S. economy, the most complex team sport in the world, the impossible integration of mission and margin, a cottage industry gone macro, clinical medicine clashing with an industrial paradigm. It is all these things and more, but it is perhaps most challengingly framed as an exercise in creating the unknown—something that works much better but that we don't quite trust or understand yet.

The problem with creating the unknown, is that in both governance and leadership, we favor what we already know and what we have done, and that means that when we ask ourselves how we're doing, we tend to evaluate ourselves according to what we've known, not what we need to be doing. When we evaluate our own performance, select and promote leaders, endorse and marginalize ways of thinking, anoint and reject strategies, we tend toward the known and the recognized. Nearly everyone in a leadership position in healthcare has been favorably selected because of what they already do, not because of their ability to help themselves and others do things they've never done. But that is what we need.

If we want better leadership in healthcare and its attendant effects, it's time for boards to challenge how they themselves think. If we want better execution and faster evolution of clinical care, financial sustainability, and human vitality in our healthcare organizations, it's time for boards to ask a deeper set of questions. It's time to start asking not just, "How well are we doing?" but, "How well are we thinking? How well is this organization developing its collective ability to think and design itself?"

This foundational question is the one that boards have to unpack into smaller ones, first with awareness and

4 Witt Kieffer, *The Impact of Burnout on Healthcare Executives,* 2018. Available at http://bit.ly/2q0dbrU.
5 ACHE, *Top Issues Confronting Hospitals in 2018.* Available at http://bit.ly/2Doykil.

insight and later with feedback loop after feedback loop: "How do we know we're attracting, growing, and embodying the kind of leadership capacity that will allow us to execute reliably, adapt relentlessly, and sustain energetically?"

Leading better is not just about having more skills or a longer resume; it's about challenging ourselves and each other to think differently—and then multiplying that capacity into every nook and cranny of an organization's work and personnel. Boards can start by challenging themselves to think differently and placing squarely on their governance docket how they invite and challenge the whole organization to think differently, and then designing follow up dialogue and tools to validate that such an evolution of mindset and approach is indeed flowing to every nook and cranny of the organization—top-down, bottom-up, and side-to-side.

I would suggest the following as key questions for boards to ask from a governance perspective, following those questions with rigorous inquiry, with wide stakeholders, on how well those questions are being answered across the organization:

- How do we need to think differently as a board to surface, select, and develop the kind of leadership thinking that will enhance the performance, the learning, and energetic participation of every individual in this place?
- How can we oversee a developmental approach to systems thinking that infuses our processes and mechanics?
- How can we design frank, honest, unfiltered dialogue between stakeholders and the board to support and validate the signal that we are intently governing a sea change in our willingness to listen, explore, and adapt more deeply and more easily?

> In both governance and leadership, we favor what we already know and what we have done, and that means that when we ask ourselves how we're doing, we tend to evaluate ourselves according to what we've known, not what we need to be doing.

Perhaps in aggregated reports of board culture in the future, we'll see scores of 95 and higher on the key questions related to culture in this survey. After we see the numbers associated with those statements, we'll see high-affirmation of the follow-up statement: *"Here is how we know it's happening throughout the organization…"*

Boards must—and do—focus on "what's getting done." Increasingly, the Board of the Future must focus on how it thinks and how new patterns of thought and action are improving what gets done in the organization…everywhere. Boards have moved steadily toward understanding governance; it's now time for them to understand how to direct and govern transformational capacity.

Governance Trends

This year we again 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. To determine directional trends rather than reporting on overall activity without any parameters on timeframe, we asked respondents to indicate any governance-level changes *since 2017*. Thus, the responses this year indicate whether any changes were made between the last reporting year and this year. We show comparisons for each reporting period since 2013, the first year we asked these questions.

Population Health Management

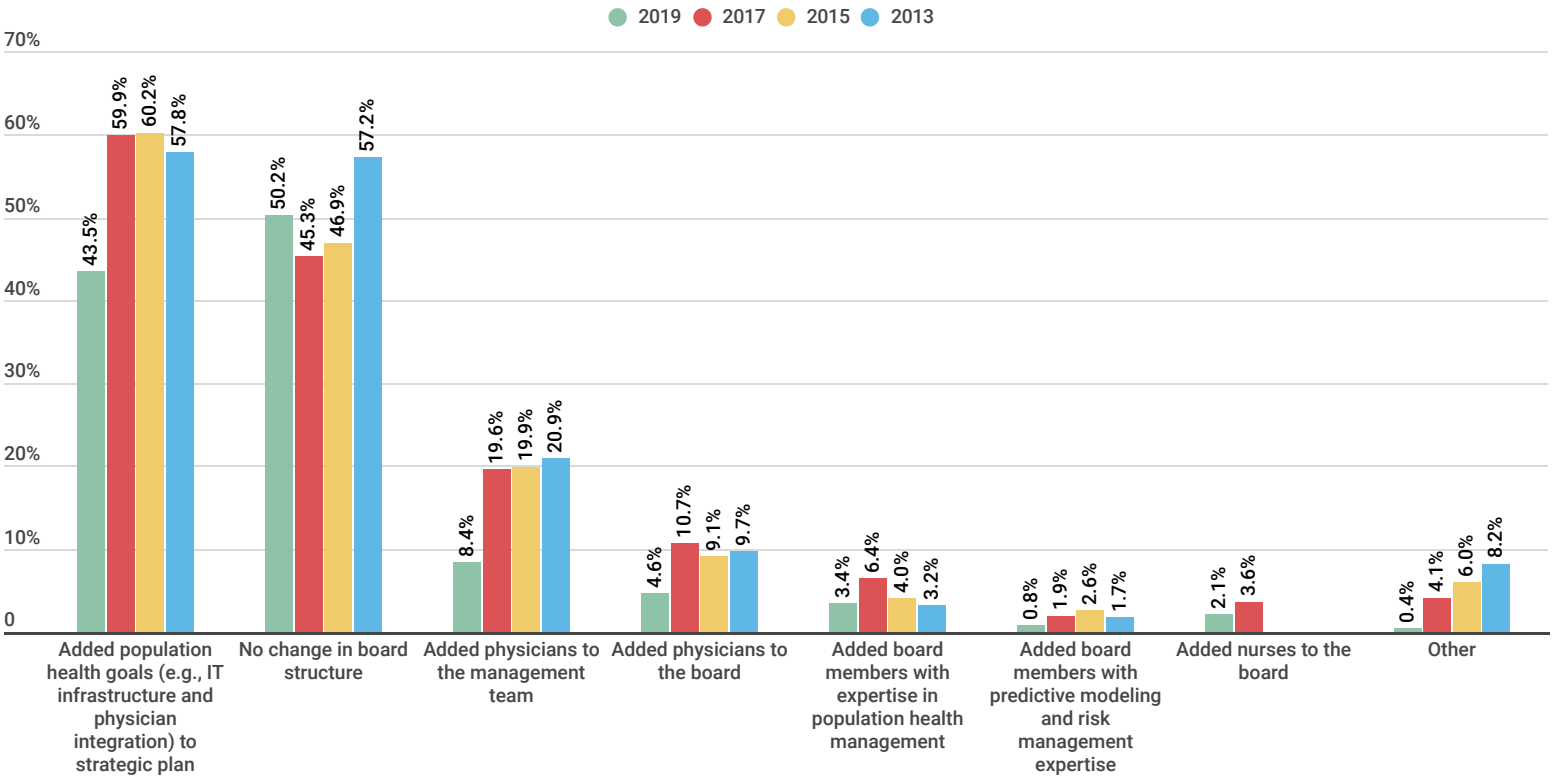
Eighty-two percent (82%) of respondents are making some kind of change to manage population health (up from 65% in 2017); however, the degree of change has diminished since 2017, as indicated by the numbers below:

- 50% of respondents have not made any changes to board structure since 2017 in regards to population health management (45% indicated they had not made any changes from 2015–2017). Generally, it seems that roughly half of healthcare organizations don't consider board structure to be an important factor necessary to change in order to manage population health. We assume efforts are focused elsewhere.
- 44% of respondents have added population health goals (e.g., IT infrastructure and physician integration) to the strategic plan since 2017 (down from 60% in 2017 and 2015). This indicates that fewer boards are continuing to add new population health goals to their strategic plan; possibly boards are working with already existing goals that have been put in place from 2013–2017.
- 22% of respondents have added new population health-related metrics to their board quality/finance dashboards since 2017.
- 8% of respondents have added physicians to the management team since 2017 to manage population health (down from 20% in 2015–2017).
- 5% of respondents have added physicians to the board to help with population health management (down from 11%), and 2% added nurses to the board for this purpose since 2017 (down from 4%).
- Very few organizations have added board expertise in population health management (3%, down from 6% in 2017) and predictive modeling/risk management (1%, down from 2% in 2017).

By organization type, notable variances include:

- Health systems again have shown the most movement compared with other types of organizations in making changes to address population health (96% of systems are making some type of change). The two primary areas showing the most change are adding physicians to the management team (18% compared with 8% overall) and adding population health goals to the strategic plan (50% compared with 44% overall).
- 27% of subsidiaries have added population health metrics to the board quality/finance dashboards (compared with 22% overall).
- 27% of subsidiaries and 24% of government-sponsored hospitals said they are not making plans to manage population health (compared with 18% overall).

Exhibit 28. Changes in Board Structure Since 2013 in Regards to Population Health Management
(respondents selected more than one answer)



Value-Based Payments

Eighty-five percent (85%) of respondents are making some kind of change to be successful with value-based payments (up from 61% in 2017), but again the degree of change appears to have diminished:

- 56% of respondents have not made any changes to the board since 2017 to succeed with value-based payments (this is up from 49% from 2015–2017).
- 40% of respondents have added value-based payment goals to strategic and financial plans since 2017. (56% of respondents added such goals to their plans from 2015–2017, indicating fewer boards added new goals since the last reporting period.)
- 22% have added value-based care metrics to the board quality/finance dashboards since 2017.
- 6% of respondents have added physicians to the management team to succeed with value-based payments (down from 15% in 2017); 8% have added nurses to the management team for this purpose.
- 0% of respondents have added physicians or nurses to the board to help with value-based payments (compared with 9% and 1% in 2017).

By organization type, notable variances include:

- Health systems again have shown the most movement compared with other types of organizations in making changes to succeed with value-based payments (98% of systems are making some type of change). Fifty-five percent (55%) have updated their strategic and financial plans with value-based goals (compared with 40% overall), and 12% have added physicians and nurses to the management team for this purpose (compared with 6% and 8% overall). Finally, 28% have added value-based metrics to the board quality/finance dashboards, compared with 22% overall.
- Only 25% of subsidiaries have updated their strategic and financial plans with value-based goals (compared with 40% overall).
- Twenty-five percent (25%) of subsidiaries and government-sponsored hospitals are not making any plans to prepare for value-based payments (compared with 15% overall).

Exhibit 28a. Changes in Board Structure Since 2017 in Regards to Population Health Management by Organization Type

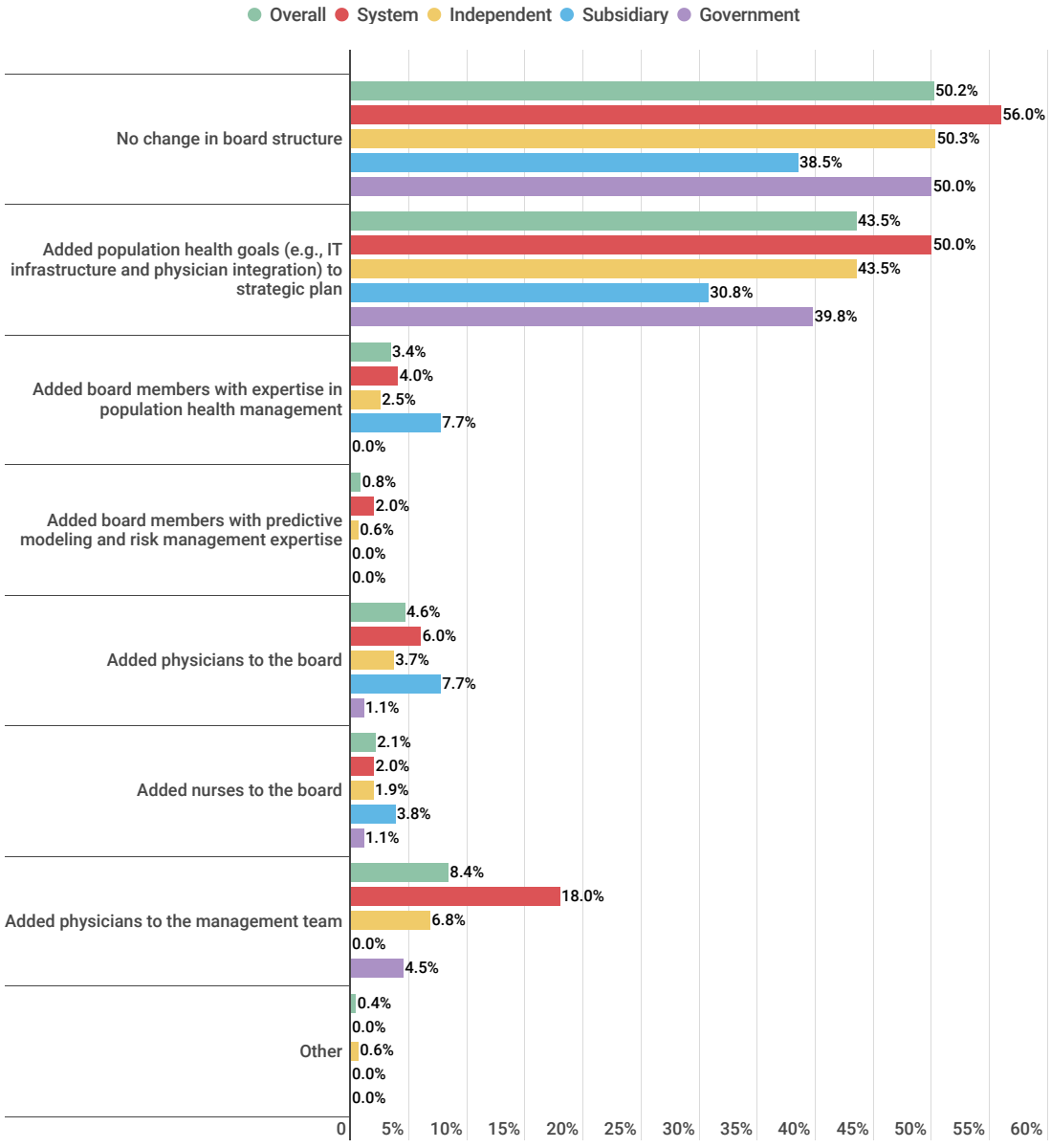


Exhibit 29. Changes in Board Structure Since 2013 to Succeed with Value-Based Payments
(respondents selected more than one answer)

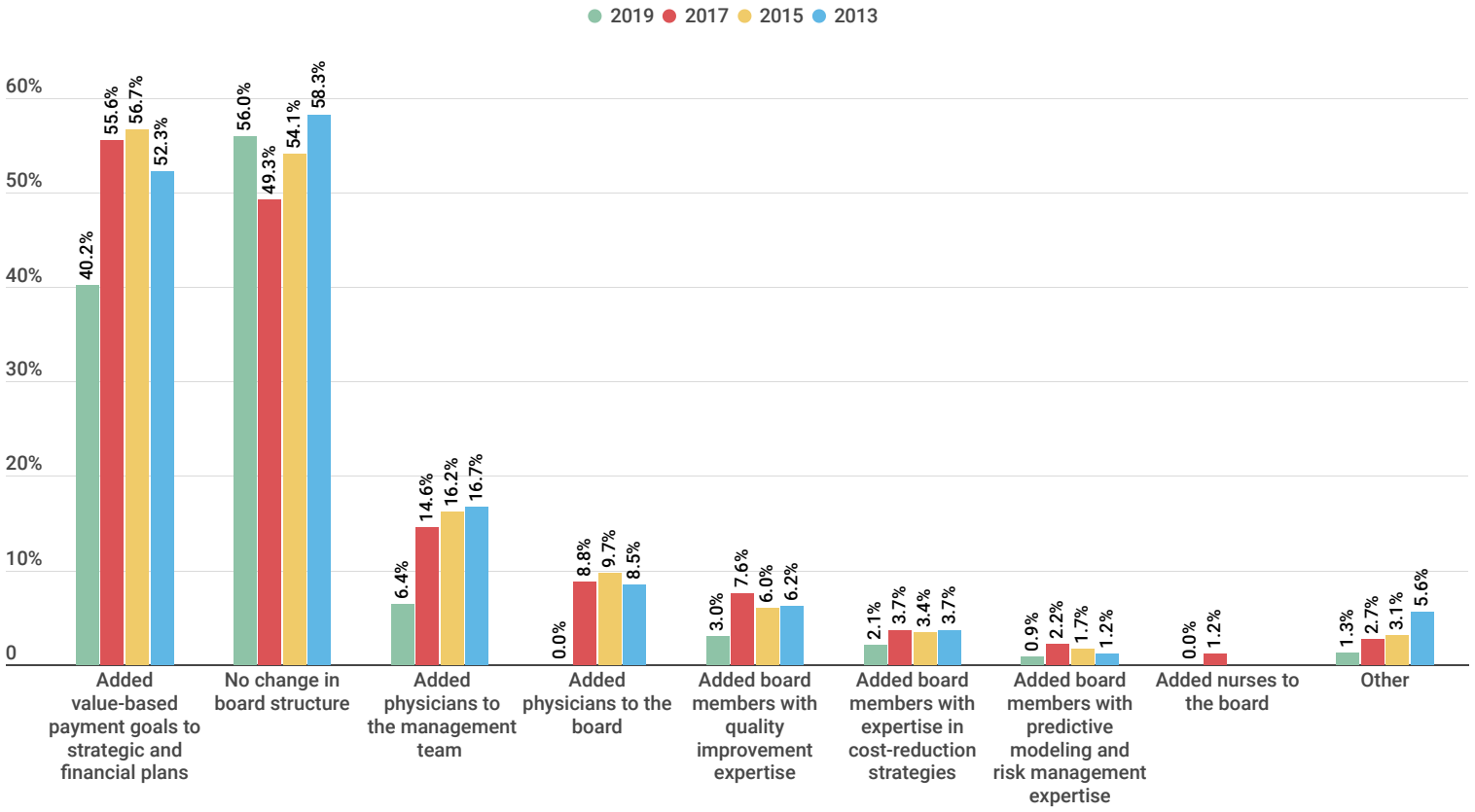
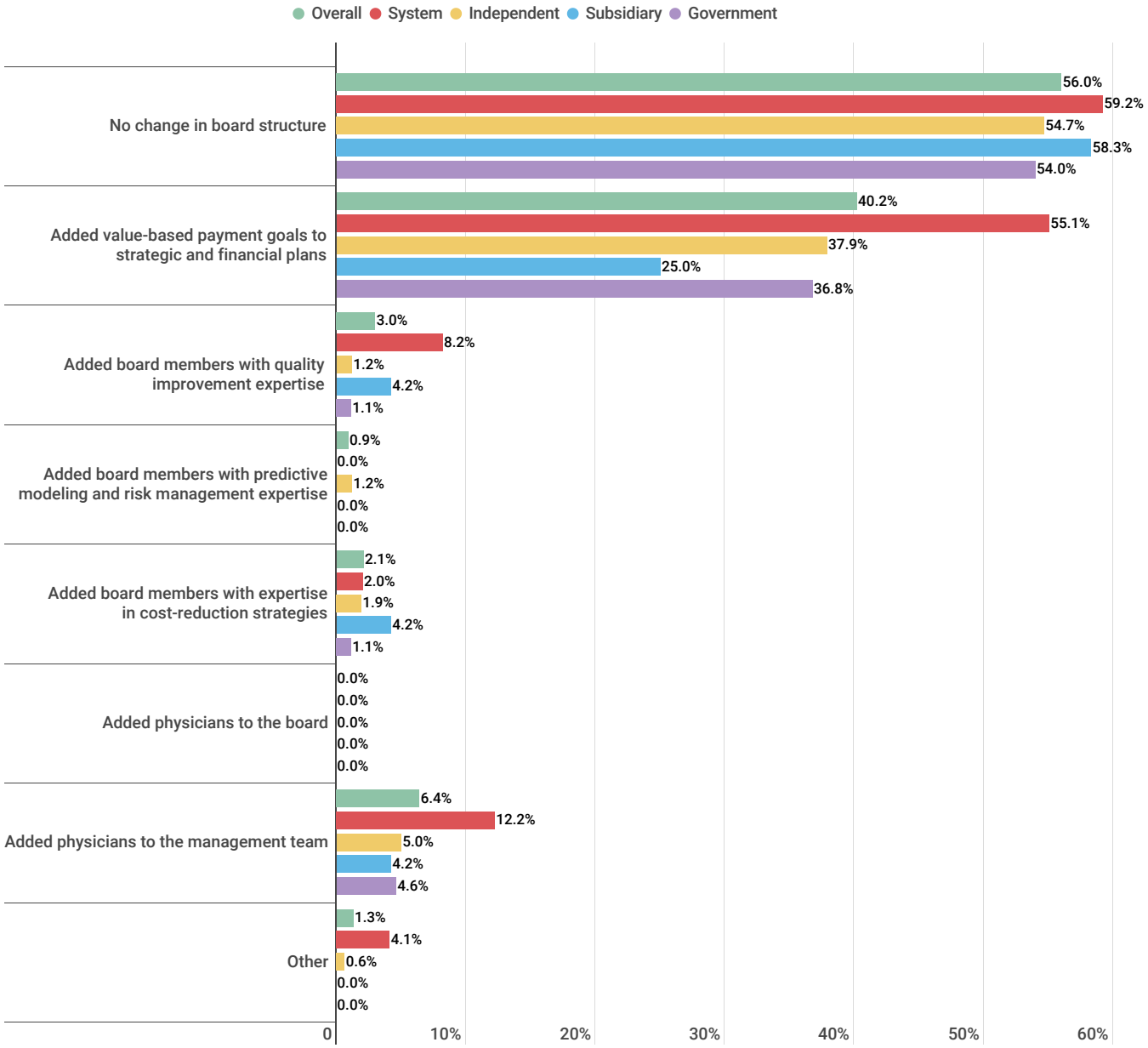


Exhibit 29a. Changes in Board Structure Since 2017 to Succeed with Value-Based Payments by Organization Type



System Governance Structure & 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

In 2015, most systems (52%) had a system board as well as separate local/subsidiary boards with fiduciary responsibilities. In 2017 and 2019, the systems responding were more evenly split with regards to governance structure:

- 34% have one system board with fiduciary oversight for the entire system (33% in 2017)
- 34% have a system board and subsidiary fiduciary boards (35% in 2017)
- 27% have a system board and subsidiary advisory boards (30% in 2017)

Forty-six percent (46%) of systems consider serving on a subsidiary board to be a development step towards a board member being able to serve on the parent/system-level board.

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

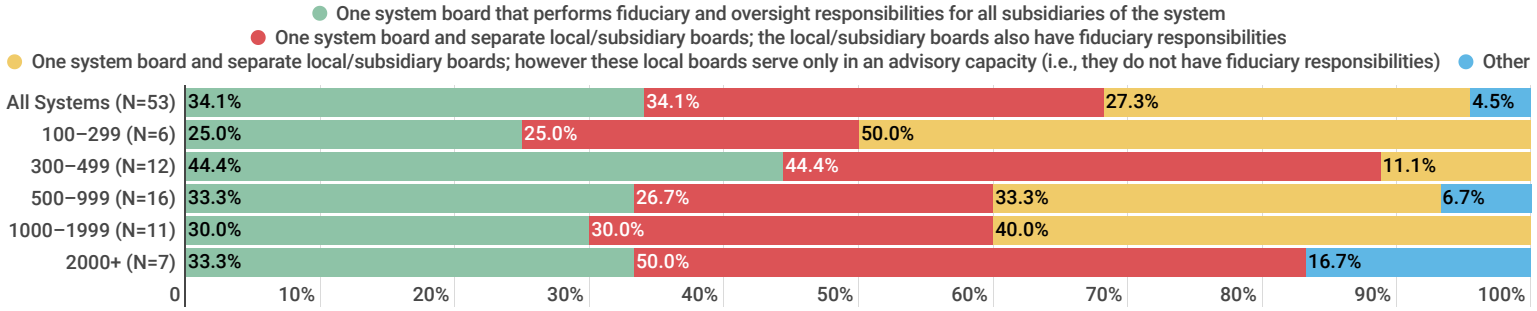
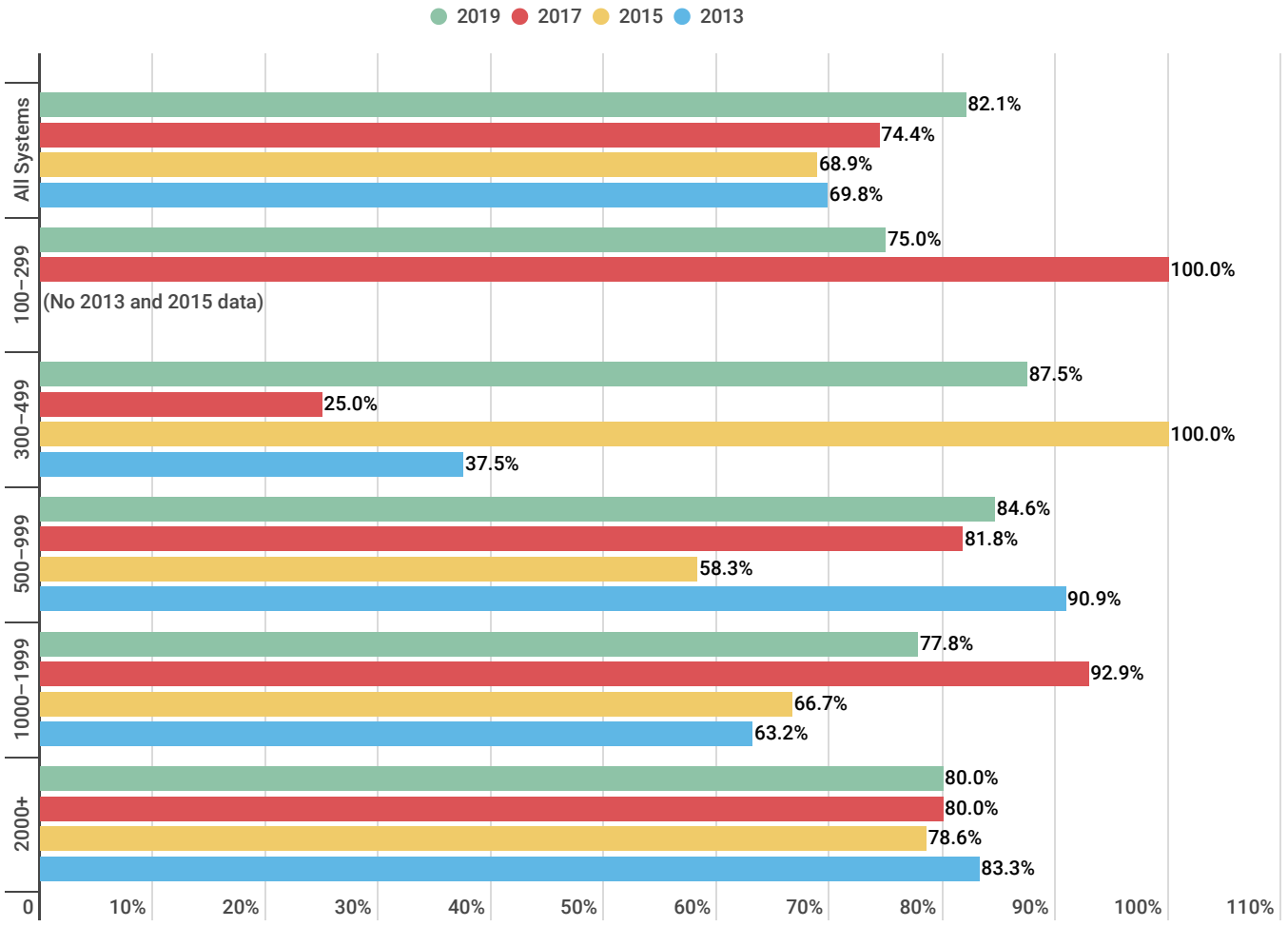


Exhibit 31. System Board Approves a Document or Policy Specifying Allocation of Responsibility & Authority between System & Local Boards



Association of Responsibility/ Authority Understood & Accepted

Overall, 82% of system respondents approve a document or policy specifying allocation of responsibility and authority between system and local boards (up from 74% in 2017). Seventy percent (70%) of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders (up from 61% in 2017). The remaining 30% say that this is an area that needs improvement. (See Exhibits 31 on the previous page and 32.)

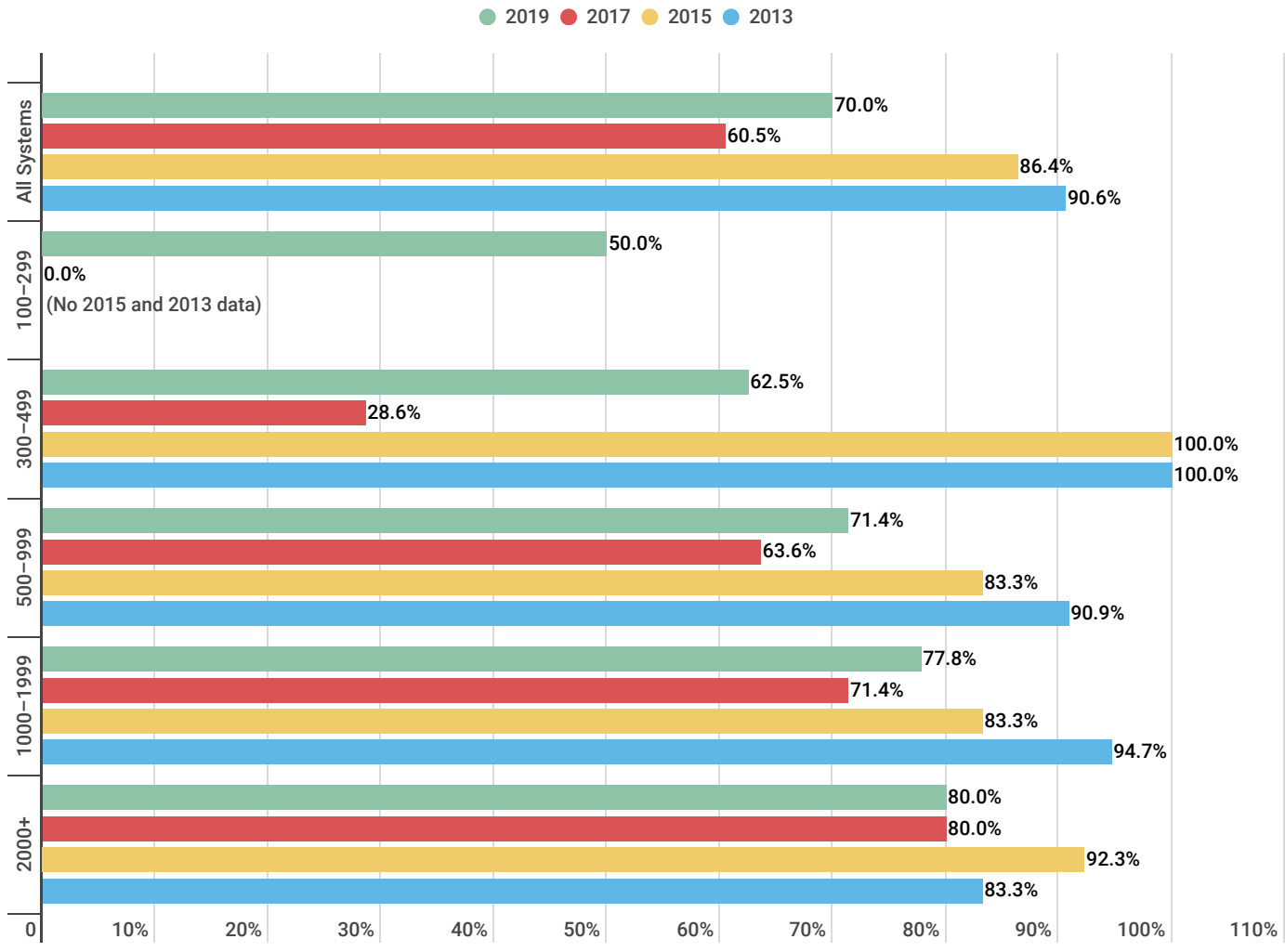
There is a statistical relationship between those that said assignment of responsibility and authority is widely understood and accepted by both local and system-level leaders and higher board performance.

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. We are looking to see if there is a linear trend in systems moving away from a "holding company" model and more towards an "operating company" model. The data since 2013 have shown certain practices that tend to remain at the local level (identifying community health needs and goals, customer service goals, and board education), certain practices that are more likely to remain at system-level control (setting strategic goals, selecting the audit firm, quality/safety goals, and executive appointment and compensation), and then several in between that are "shared." The most significant or interesting highlights we see this year are (while keeping in mind the smaller sample size this year compared with 2017):

- While the percentage of subsidiary boards sharing strategic goal-setting responsibility remained about the same as 2017 (60–64% share responsibility with the system), 40% of systems this year retain responsibility for this, compared with only 16.7% in 2017.
- Significantly more systems responding this year retain responsibility for subsidiary quality and safety goals (44.4% vs. 18.6%).

Exhibit 32. Association of Responsibility and Authority Widely Understood & Accepted by Both Local & System-Level Leaders



- More subsidiaries retain responsibility for customer service goals (72.7% vs. 38.1%).
- Medical staff credentialing is more likely to be a shared responsibility or retained at the system level (40.0% vs. 7.0% shared; 40.0% vs. 4.7% system-retained).
- Selecting the audit firm is more likely to be a shared responsibility this year (50.0% vs. 10.0%; 50.0% of system boards retain this responsibility in 2019 vs. 75.0% in 2017).
- Establishing the subsidiary corporate compliance program is more likely to be a shared responsibility (62.5% vs. 31.8%).
- More subsidiary boards share responsibility for identifying community health needs (50.0% vs. 37.8%).
- Systems are allowing their subsidiaries to share or retain responsibility for setting community health goals as well (50.0% vs. 40.9% have shared responsibility and 50.0% vs. 36.4% retain responsibility, while 0% of systems retain this responsibility in 2019 vs. 22.7% in 2017).
- More subsidiaries are involved in setting population health improvement goals (71.4% vs. 40.9% shared responsibility).
- Subsidiaries are also more involved in electing/appointing their own board members (50.0% vs. 37.8% share this responsibility).

Areas of responsibility in which advisory boards indicate a strong degree of responsibility (either retaining or sharing with the system board) despite their not having legal fiduciary status are:

- Setting our organization's customer service goals
- Identifying our organization's community health needs through the CHNA
- Setting our organization's community health goals
- Addressing social determinants of health for our organization's community

Table 15 on the next page shows a comparison of 2019 and 2017 results (please note that the sample size of subsidiaries responding to this portion of the survey is relatively small). See Exhibit 33 for a comparison focusing on the issues where there has been most movement towards system responsibility since 2015 (advisory boards excluded).

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

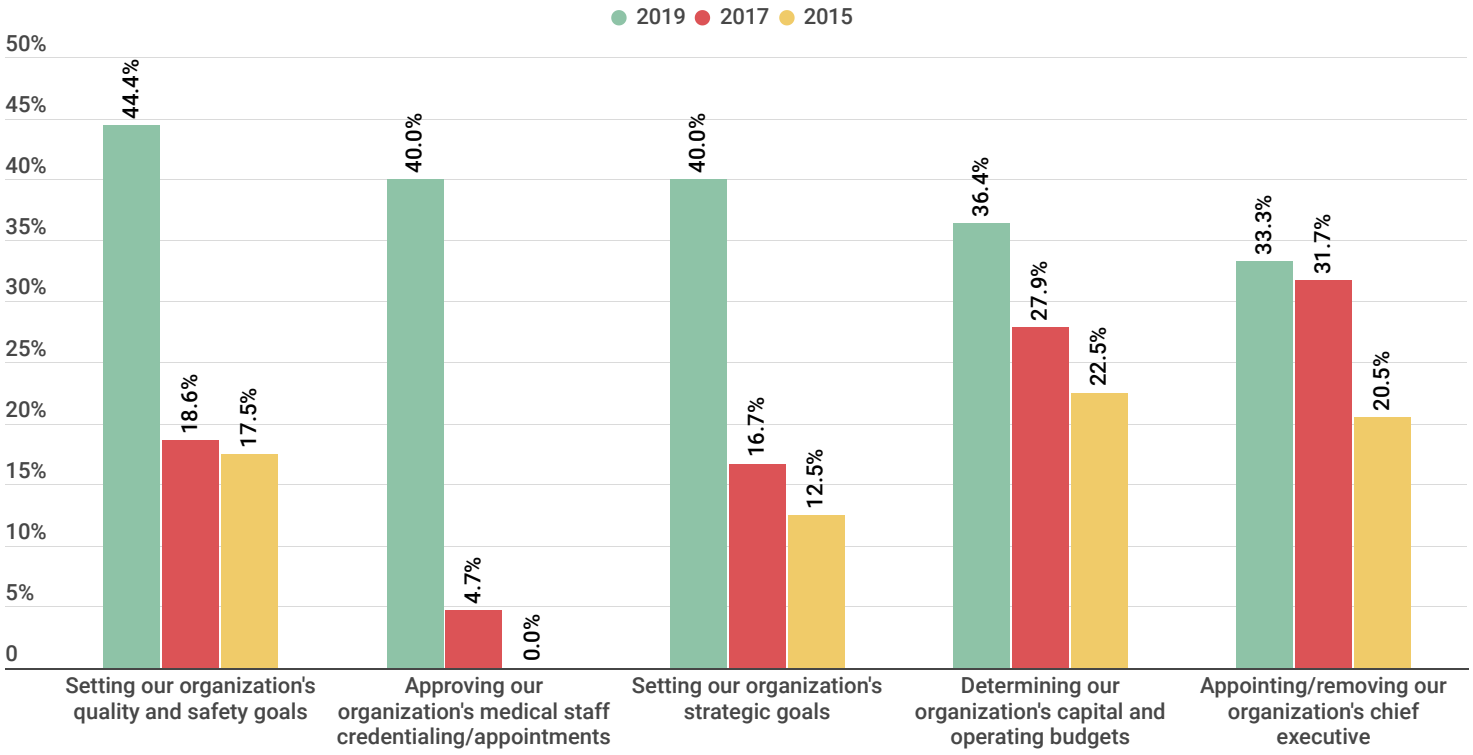


Table 15. Allocation of Decision-Making Authority 2019 vs. 2017

	All Subsidiary Hospital Boards		
	2019		2017*
	Fiduciary Boards	Advisory Boards	
Total number of respondents in each category	**19**	**7**	**64**
ROLE OF THE SUBSIDIARY BOARD IN THE FOLLOWING DECISIONS:			
Setting our organization's strategic goals			
Total responding to this question (N/A not included for all)	11	7	42
Our board retains responsibility	0.0%	16.7%	19.0%
Our board shares responsibility	60.0%	0.0%	64.3%
System board retains responsibility (our board has advisory capacity)	40.0%	83.3%	16.7%
Determining our organization's capital and operating budgets			
Total responding to this question	11	7	43
Our board retains responsibility	18.2%	0.0%	14.0%
Our board shares responsibility	45.5%	0.0%	58.1%
System board retains responsibility (our board has advisory capacity)	36.4%	100.0%	27.9%
Setting our organization's quality and safety goals			
Total responding to this question	11	6	43
Our board retains responsibility	22.2%	16.7%	20.9%
Our board shares responsibility	33.3%	16.7%	60.5%
System board retains responsibility (our board has advisory capacity)	44.4%	66.7%	18.6%
Setting our organization's customer service goals			
Total responding to this question	11	7	42
Our board retains responsibility	72.7%	66.7%	38.1%
Our board shares responsibility	9.1%	0.0%	47.6%
System board retains responsibility (our board has advisory capacity)	18.2%	33.3%	14.3%
Approving our organization's medical staff credentialing/appointments			
Total responding to this question	11	7	43
Our board retains responsibility	20.0%	16.7%	88.4%
Our board shares responsibility	40.0%	16.7%	7.0%
System board retains responsibility (our board has advisory capacity)	40.0%	66.7%	4.7%
Appointing/removing our organization's chief executive			
Total responding to this question	11	7	41
Our board retains responsibility	0.0%	0.0%	17.1%
Our board shares responsibility	66.7%	25.0%	51.2%
System board retains responsibility (our board has advisory capacity)	33.3%	75.0%	31.7%
Determining/approving executive compensation			
Total responding to this question	11	7	42
Our board retains responsibility	16.7%	0.0%	16.7%
Our board shares responsibility	50.0%	0.0%	28.6%
System board retains responsibility (our board has advisory capacity)	33.3%	100.0%	54.8%
Selecting our organization's audit firm			
Total responding to this question	11	7	40
Our board retains responsibility	0.0%	0.0%	15.0%
Our board shares responsibility	50.0%	0.0%	10.0%
System board retains responsibility (our board has advisory capacity)	50.0%	100.0%	75.0%

**In 2017, only fiduciary subsidiary boards were included in the survey.*

	All Subsidiary Hospital Boards		
	2019		2017*
	Fiduciary Boards	Advisory Boards	
Total number of respondents in each category	**19**	**7**	**64**
Approving our organization's audit			
Total responding to this question	11	7	N/A
Our board retains responsibility	0.0%	0.0%	N/A
Our board shares responsibility	85.7%	0.0%	N/A
System board retains responsibility (our board has advisory capacity)	14.3%	100.0%	N/A
Establishing our organization's corporate compliance program			
Total responding to this question	11	7	44
Our board retains responsibility	0.0%	0.0%	4.5%
Our board shares responsibility	62.5%	33.3%	31.8%
System board retains responsibility (our board has advisory capacity)	37.5%	66.7%	63.6%
Identifying our organization's community health needs through the CHNA			
Total responding to this question	10	7	45
Our board retains responsibility	37.%	50.0%	35.6%
Our board shares responsibility	50.0%	25.0%	37.8%
System board retains responsibility (our board has advisory capacity)	12.5%	25.0%	26.7%
Setting our organization's community health goals			
Total responding to this question	11	7	44
Our board retains responsibility	50.0%	50.0%	36.4%
Our board shares responsibility	50.0%	25.0%	40.9%
System board retains responsibility (our board has advisory capacity)	0.0%	25.0%	22.7%
Setting our organization's population health improvement goals			
Total responding to this question	11	7	44
Our board retains responsibility	28.6%	25.0%	34.1%
Our board shares responsibility	71.4%	25.0%	40.9%
System board retains responsibility (our board has advisory capacity)	0.0%	50.0%	25.0%
Addressing social determinants of health for our organization's community			
Total responding to this question	11	7	N/A
Our board retains responsibility	28.6%	20.0%	N/A
Our board shares responsibility	71.4%	60.0%	N/A
System board retains responsibility (our board has advisory capacity)	0.0%	20.0%	N/A
Electing/appointing our organization's board members			
Total responding to this question	11	7	45
Our board retains responsibility	30.0%	14.3%	31.1%
Our board shares responsibility	50.0%	42.9%	37.8%
System board retains responsibility (our board has advisory capacity)	20.0%	42.9%	31.1%
Establishing our board education and orientation programs			
Total responding to this question	11	7	44
Our board retains responsibility	55.6%	20.0%	50.0%
Our board shares responsibility	22.2%	20.0%	31.8%
System board retains responsibility (our board has advisory capacity)	22.2%	60.0%	18.2%

**In 2017, only fiduciary subsidiary boards were included in the survey.*

Advisory Board Profile

Below is a comparison of advisory boards against subsidiary boards overall. These are boards that indicated in the survey that they "make recommendations to another fiduciary body/ are considered an advisory board." Throughout the report, these seven boards' responses are included in the total responses for all subsidiary boards, as this is considered to be a subset of that category. However, we wanted to look at whether the makeup of these non-fiduciary boards is different from fiduciary subsidiaries. (Significant differences only are included in this profile; note N size of 7. More detail can be found in Appendix 1C: Subsidiary Board Structure, provided online at www.governanceinstitute.com/2019biennialsurvey.) Also, be sure to refer to **Table 10** on page 13 to see a comparison of the types of board competencies being sought by these seven advisory boards compared with all other types of boards, which shows some interesting differences.

In general, advisory boards are smaller than other subsidiary boards by about two members. Sixty percent (60%) of the board are independent board members:

Advisory Boards	Total # of Voting Board Members	Management*	Medical Staff Physicians**	Independent Board Members***	Other Board Members****
	2019	2019	2019	2019	2019
Average # of Voting Board Members	13.4	1.9	1.7	8.0	0.9
Median # of Board Members	14	2	2	8	0

*Includes the CMO and CNO
**Includes employed physicians but does not include the CMO, which is included in management.
***Includes independent physicians (who are not on the organization's medical staff/not employed).
****Includes nurses who are employed by the organization and faith-based representatives.

Other variances from subsidiary boards overall:
- Average ethnic minority board members: 3.6 vs. 3.9
- Average female board members: 3.6 vs. 3.9
- Term limits: 100% vs. 83%
- Age limits: 14% vs. 4%
- Voting CEO board member: 71% vs. 62%
- Voting Chief of Staff: 50% vs. 36%
- Legal counsel: 25% attends board meetings vs. 50% for all subsidiaries
- More likely to have a physician board chair (43% vs. 15%)
- Less likely to have a board chair from for-profit management/ finance background (29% vs. 50%)
- 43% meet quarterly (vs. 23%); 43% meet monthly (vs. 27%)
- Expenditure for board education: 80% spend under $10,000 (vs. 58% of all subsidiaries)
- Topics of board education and the ways education is delivered are similar to all other types of boards.
- 71% of advisory boards have C-suite staff spend less than 10 hours per month on governance (vs. 46%); for 100% of them the board support staff position is combined with another position (vs. 81% for all subsidiaries).
- 43% use a board portal (vs. 69%)

Board Meeting Content:
- 21% in active discussion, deliberation, and debate about strategic priorities of the organization (vs. 27%)
- 26% reviewing quality/safety (vs. 18%)

Executive sessions:
- 50% have the CEO attend always; 50% have the CEO attend rarely
- Legal counsel rarely attends executive session
- Topics typically discussed: executive performance/evaluation (50%); misc. governance issues (25%); general strategic planning/issues (25%); M&A strategy (25%); clinical/quality performance (25%); government relations (25%)

Standing Committees:
- The average is 2.1; the median is 1.
- The most prevalent committees for advisory boards are quality/safety (43% or three out of seven); audit/compliance and executive committee (29% or two out of seven).

Authorities/responsibilities of the executive committee (N=2):
- Board member nominations (100%)
- Advising the CEO (50%)
- Emergency decision making (50%)
- Level of authority of the executive committee: none (all decisions must be approved/ratified by the full board)

Quality committee profile (N=3; generally, advisory boards' quality committees have a larger clinician presence than other boards):
- 2 voting physician board members
- 2 voting nurse board members
- 4+ other voting board members
- 3–4 medical staff physicians (employed and non-employed but not board members)
- 2 nurses from the nursing staff
- 0–2 community members at large
- Average size of committee: 11.7
- Median: 13

Enhancing the Effectiveness of Shared Governance Structures

Marian C. Jennings, M.B.A., President, M. Jennings Consulting, Inc. and Governance Institute Advisor

SPECIAL COMMENTARY

Within federal and state laws and regulatory requirements, health system boards are self-governing. Simply put, within legal and regulatory constraints, boards can establish their preferred governance structure and processes to fulfill their fiduciary governance responsibilities of financial oversight, quality oversight, setting strategic direction, management oversight, community/benefit and advocacy, and board development.

Across the country, two-thirds of not-for-profit health systems continue to operate in a multi-tiered, shared governance structure wherein the system board "shares" selected fiduciary responsibilities with subsidiary boards, be such latter boards deemed "fiduciary" or "advisory."

In large part, this shared governance structure is an artifact of how not-for-profit health systems were formed: that is, typically through the merger or acquisition of other (usually also not-for-profit) hospitals or smaller systems, each of which had an existing board structure in place. But for many, today's challenge continues to be, "how can our health system optimize governance effectiveness within our shared governance model?" In particular, many systems find that their multi-tier, hospital-centric governance models result in unproductive duplication of efforts and slower-than-desired decision making.

"Sharing" is difficult. Anyone with a sibling understands that what constitutes "fair sharing" often is in the eye of the beholder. Sharing governance responsibilities is no different. For shared governance to work, boards need to play complementary, not duplicative roles, and board members must understand and embrace that notion. Members must clearly understand and accept their unique roles and how each board contributes to overall system success. More pointedly, not all parties need to be involved in all decisions.

Five Requirements for Enhancing Effectiveness

Optimizing performance within a shared governance model requires:

1. **The courage to clearly, honestly, and unapologetically delineate the roles of subsidiary boards, whether fiduciary or advisory.** The crux of this is being willing to acknowledge that while subsidiary boards may continue to "approve" certain actions—such as approving the annual operating budget—the approval instead constitutes a recommendation to the parent. Subsidiary boards rarely exercise final decision-making authorities (powers).

For many, today's challenge continues to be, "how can our health system optimize governance effectiveness within our shared governance model?" In particular, many systems find that their multi-tier, hospital-centric governance models result in unproductive duplication of efforts and slower-than-desired decision making.

   While this should be and often is technically accomplished through a written "governance authorities and responsibilities matrix," achieving real role clarity for each board requires that senior management and board leaders consistently reinforce the message through their actions. For example, these leaders must ensure that subsidiary board meeting agendas are restructured around their designated core responsibilities instead of "what has always been on the agenda" and that few, if any, committees are maintained at subsidiary board levels.
2. **Effective, ongoing communications between the system-level board and subsidiary boards.** Consider using a synchronized annual board meeting calendar for both the system and subsidiary boards and providing regular updates after every system board meeting through a consistent, formal communications vehicle. In addition, ensure that members of subsidiary boards understand how a recommendation from their board or their board's opinions and concerns will be communicated to system leaders.
3. **Effective board orientation** that clearly articulates the differences in the roles, responsibilities, and authorities of all boards within the health system, emphasizing how each uniquely contributes to overall system success.
4. **Custom-tailored ongoing board education** for board members "up and down" the organization.
5. **Competency-based boards at all levels**, recognizing that different competencies will be needed at the subsidiary board level. All too often, subsidiary boards still recruit future board members based upon the competencies needed in the past—not those needed now to fulfill their designated roles and responsibilities. For example, while most subsidiary boards have limited financial responsibilities but are expected to provide guidance on enhancing community health, many such boards still have an abundance of board members with financial experience/expertise but few, if any, members with an understanding of public health or community health.

Consider Adopting a Mirror Board Structure

In addition to the five requirements for shared governance effectiveness outlined above, we urge those operating in a shared governance model to weigh carefully the advantages and disadvantages of adopting a so-called mirror board structure, in which one group of individuals serves as the board for multiple corporate entities. For regional systems, this generally means the same individuals serve on both the system-level board and on subsidiary hospital boards. The mirror board approach in a multi-regional or multi-state health system typically would have the same individuals serve on multiple hospital boards within a designated geographic

region, while the system board would maintain a different board composition/membership.

In our experience, this mirror board structure can significantly streamline system governance while ensuring fulfillment of all fiduciary responsibilities. To keep connections to local communities, systems using a mirror board approach often establish advisory councils at the regional or local levels to share updates on system activities, provide a vehicle for direct communication with system executive leaders, and solicit input around strategic topics. Such councils may meet quarterly or less frequently. A key to success is to encourage those who have not previously served in a governance role to participate in the group, not simply to "rename" what was yesterday's subsidiary board as today's advisory council.

Subsidiary boards have limited financial responsibilities but are expected to provide guidance on enhancing community health, many such boards still have an abundance of board members with financial experience/expertise but few, if any, members with an understanding of public health or community health

Final Thoughts

Few health system governance structures have been designed from the ground up but instead bear the imprint of all the board structures from which the system has evolved. However, today's health systems are vastly different from—and significantly more complex than—a mere compilation of their predecessor organizations.

Health system governance too must change. Such change will not be easy, and achieving it will require patience, planning, and respect for those who have volunteered their talent and time to build today's organization. If successful, rather than simply becoming bigger and more complex as your system grows, your governance structures will become clearer, simpler, and better able to facilitate the achievement of your mission and vision.

Governance Practices: Fiduciary Duties & Core Responsibilities

The Survey

Each survey respondent reviewed 32 recommended practices for fiduciary duties of care, loyalty, and obedience, and 57 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 for our board.

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." This year's list of practices was updated; more details on that are included in the Recommended Practices section below. (Note: we did not include the governance practices section of the survey in 2017, so this section of the report compares 2019 data with 2015 data, the last time we surveyed on governance practices.)

Unless otherwise noted, for this section of the report, scores are combined for all subsidiaries to include both fiduciary and advisory boards, given the small sample size of the advisory board category, because N/A answers were excluded from score calculation. When it seemed important to make a distinction, that distinction is noted. Appendix 2 (adoption and performance percentages) shows both combined scores for all subsidiaries as well as the scores for fiduciary and advisory boards separately. Appendix 3 (composite scores for adoption of practices only) shows scores for fiduciary and advisory boards separately.

Performance Results

Overall performance composite scores for 2019 are slightly lower than in 2015 for all fiduciary duties and core responsibilities. Quality oversight scores declined the most and this oversight area also moved in ranking order from fourth to sixth. Duty of care showed the second-greatest decrease in scores and moved from second to fourth on the list. (See Table 16; areas showing the biggest decrease are in bold.)

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

Performance Rank	Fiduciary Duties and Core Responsibilities	Weighted Average			
		2019	2015	2013	2011
1	Financial Oversight	**4.44**	**4.57**	4.50	4.52
2	Duty of Loyalty	4.37	4.41	4.42	4.41
3	Duty of Obedience	4.35	4.37	4.33	4.23
4	Duty of Care	**4.28**	**4.46**	4.45	4.42
5	Management Oversight	**4.19**	**4.31**	4.26	4.23
6	Quality Oversight	**4.17**	**4.39**	4.29	4.23
7	Strategic Direction	4.08	4.11	4.12	4.05
8	Community Benefit & Advocacy	3.91	3.92	3.91	3.62
9	Board Development	**3.62**	**3.79**	3.76	3.71

Note: areas showing the greatest decline since 2015 are in bold.

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

Fiduciary Duties and Core Responsibilities	Performance Rank				
	2019	2015	2013	2011	2009
Financial Oversight	1	1	1	1	1
Duty of Loyalty	2	3	3	3	3
Duty of Obedience	3	5	4	5*	5
Duty of Care	4	2	2	2	2
Management Oversight	5	6	6	6*	4
Quality Oversight	6	4	5	4*	6
Strategic Direction	7	7	7	7	7
Community Benefit & Advocacy	8	8	8	9	9
Board Development	9	9	9	8	8

*Performance scores for these three oversight areas were tied in 2011 (see Table 16).

Exhibit 34. Overall Board Performance

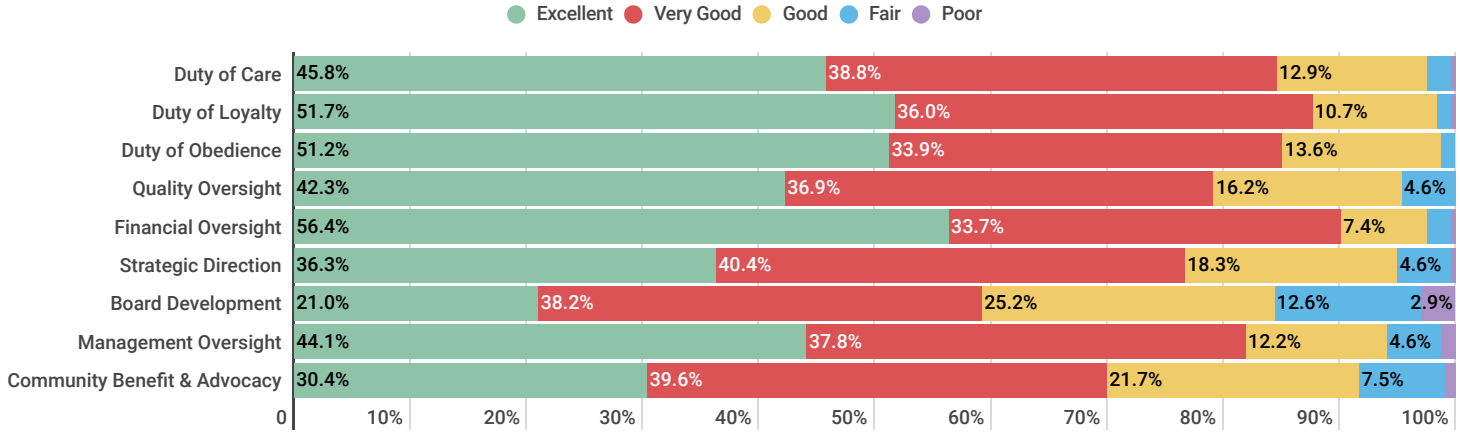
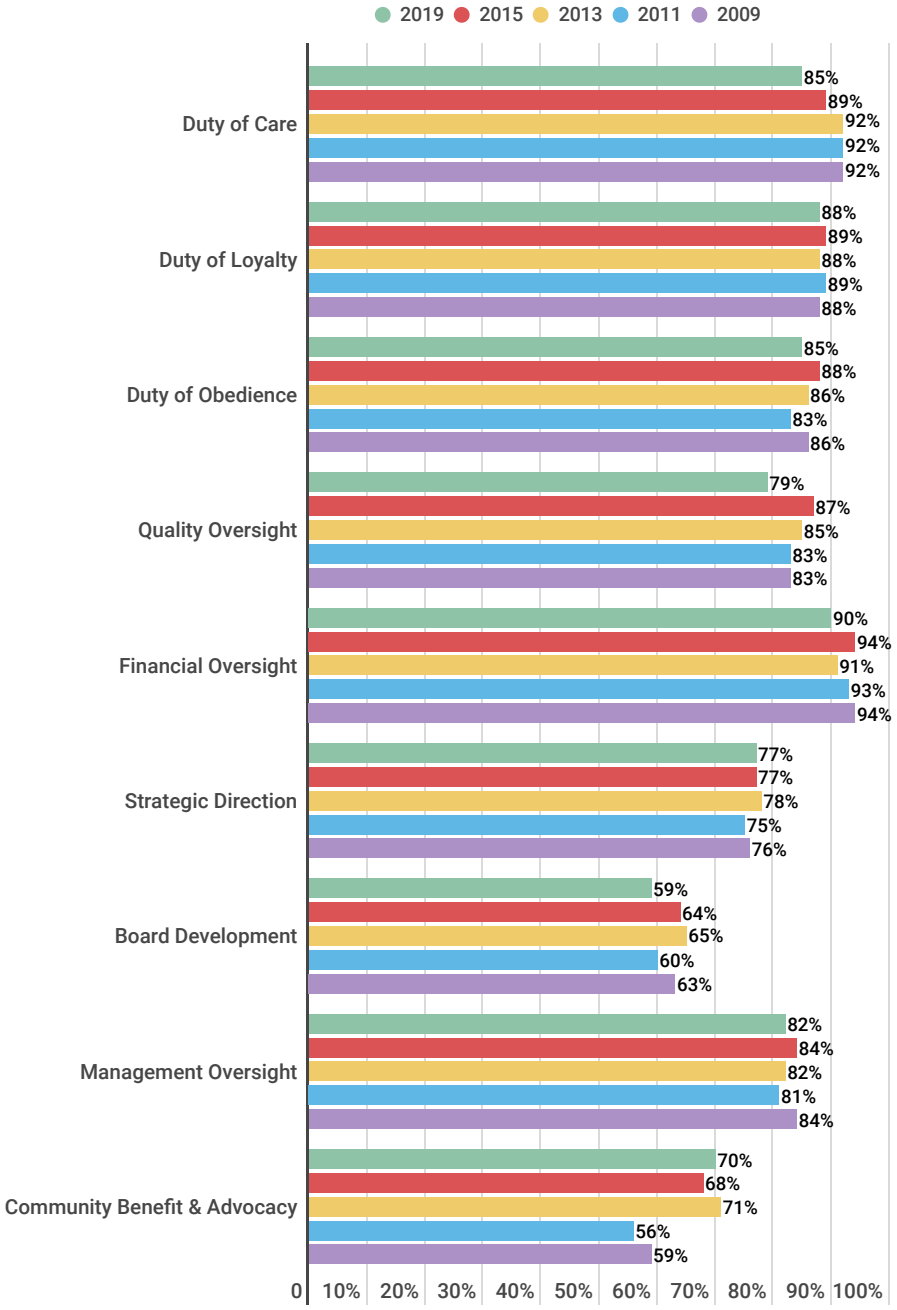


Exhibit 35. Overall Board Performance Since 2009

(Percentage of Respondents Rating Their Board as "Exellent" or "Very Good")



A history of performance ranking by duty and core responsibility appears in Table 17 on the previous page. 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 2019, 2015, 2013, 2011, and 2009 reporting periods, this year's performance ratings show a slight drop compared with previous years in most categories. Quality oversight was improving in 2015 but this year it dropped 8 percentage points. Duty of care, duty of loyalty, duty of obedience, financial oversight, board development, and management oversight have also dropped since 2015. Community benefit and advocacy has improved the most over the years, moving up 11 percentage points since 2009. (See Exhibit 35.)

Table 18 shows the breakdown of "top two" ratings by type of organization for 2019 and 2015. Systems consistently have higher percentages of "top two" ratings than other types of organizations, with the exception of subsidiary boards scoring slightly higher on quality oversight. One notable finding this year is that independent hospitals' scores dropped in every category.

Table 19 shows performance results by composite score (5 = "excellent"). Composite performance scores decreased since 2015 in every area overall and for independent hospitals. For subsidiary hospitals, performance decreased in every category except strategic direction, which went up one percentage point. Systems saw significant improvement in duty of obedience and community benefit and advocacy scores, and government-sponsored hospitals saw the most improvement in duty of loyalty, duty of obedience, strategic direction, and community benefit and advocacy scores.

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

Table 18. Percent of Respondents Who Rated Their Board as Excellent or Very Good 2019 vs. 2015
(Overall and by Organization Type)

Fiduciary Duties and Core Responsibilities*	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2019	2015	2019	2015	2019	2015	2019	2015	2019	2015
Financial Oversight	90%	94%	**96%**	**100%**	88%	96%	92%	92%	87%	89%
Duty of Loyalty	88%	89%	**98%**	**94%**	84%	92%	92%	92%	88%	79%
Duty of Obedience	85%	88%	**98%**	**94%**	82%	90%	80%	89%	84%	84%
Duty of Care	85%	89%	**96%**	**96%**	82%	88%	77%	89%	81%	88%
Management Oversight	82%	84%	**94%**	**96%**	79%	88%	79%	83%	80%	75%
Quality Oversight	79%	87%	88%	**94%**	75%	88%	**92%**	90%	74%	82%
Strategic Direction	77%	77%	**84%**	**88%**	74%	79%	79%	75%	75%	70%
Community Benefit & Advocacy	70%	68%	**85%**	**79%**	65%	67%	72%	74%	66%	61%
Board Development	59%	64%	**75%**	**81%**	54%	62%	62%	69%	53%	55%

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

Table 19. Board Performance Composite Scores 2019 vs. 2015
(Scale: Excellent = 5; Very good = 4; Good = 3; Fair = 2; Poor = 1
Blue boxes = significant improvement; orange boxes = decline)

Fiduciary Duties and Core Responsibilities	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2019	2015	2019	2015	2019	2015	2019	2015	2019	2015
Financial Oversight	4.44	4.57	4.71	4.84	4.33	4.66	4.54	4.56	4.33	4.32
Duty of Care	4.28	4.46	4.62	4.65	4.19	4.47	4.12	4.56	4.16	4.28
Duty of Loyalty	4.37	4.41	4.65	4.60	4.25	4.49	4.56	4.61	4.28	4.07
Quality Oversight	4.17	4.39	4.39	4.50	4.07	4.43	4.36	4.58	4.06	4.17
Duty of Obedience	4.35	4.37	4.77	4.59	4.24	4.42	4.24	4.47	4.25	4.15
Management Oversight	4.19	4.31	4.57	4.71	4.07	4.38	4.17	4.25	4.08	4.05
Strategic Direction	4.08	4.11	4.31	4.39	3.99	4.15	4.13	4.12	4.01	3.91
Community Benefit & Advocacy	3.91	3.92	4.25	4.15	3.80	3.93	3.96	4.13	3.76	3.68
Board Development	3.62	3.79	3.92	4.15	3.50	3.82	3.77	3.89	3.43	3.53

Fiduciary Duties & Core Responsibilities

Fiduciary Duties

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

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

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

Duty of Obedience: The duty of obedience requires board members to ensure that the organization's decisions and activities adhere to its fundamental corporate purpose and charitable mission as stated in its articles of incorporation and bylaws.

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. The board's responsibility for quality oversight includes outcomes, safety, experience, and value. When the word "quality" is included in a practice, it encompasses all of these items.
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 health needs, work to address social determinants of health, improve the health of communities overall, and advocate for the underserved.

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.)*

Updates to Practices for 2019

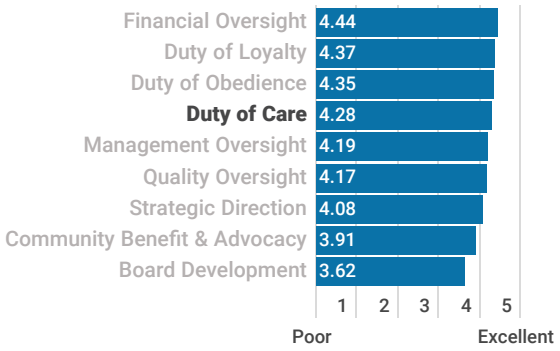
Given the amount of industry change and calls for delivery system transformation, especially moving care outside the walls of the hospital coupled with an increasing urgency for boards to improve quality and patient safety, we updated our list of recommended practices to reflect these changes. To do this, we conducted an iterative process reviewing research and gathering member feedback and expert experience to determine how we should update the practices, ensuring that the list continues to reflect traditional practices that boards should be performing regularly to fulfill organizational mission, fiduciary duties, and compliance. We added new practices that reflect the changing industry and delivery model, including more practices related to oversight outside the walls of the hospital, population health and value-based care oversight, cybersecurity and data privacy, strategic/enterprise risk, and physician-related issues including leadership development and burnout. We then removed a few practices that seemed to be outdated or no longer as relevant to the board's responsibility to fulfill its mission, and evaluated practices that were duplicative to remove all together or rework/combine with others that may have appeared previously under different areas of fiduciary duty or core responsibility. The exhibits in this section of the report, along with **Appendices 2** and **3** note the new practices for which we do not have historical comparison data. For existing practices, the appendices detail how wording may have changed while the overall practice remains the same, and for those practices we maintained historical comparisons as much as possible.

Overview of Results

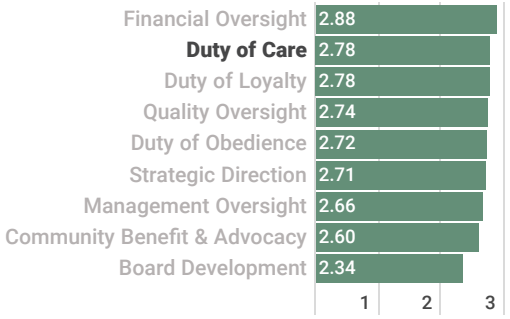
Duty of Care: Key Points

- CEOs gave boards' performance in duty of care the fourth highest performance score (4.28 out of 5). This is a decrease from previous years (it ranked second in 2015 and 2013).
- Duty of care is tied for second in adoption of recommended practices (it ranked second in 2015, and first in 2013).
- The duty of care practices appear to be widely adopted across all types of organizations; the most widely adopted practice was that board members receive important background materials and well-developed agendas within sufficient time to prepare for meetings.
- The most significant decline in adoption was for the following practice: The board requires that new board members receive education on their fiduciary duties (2.70 vs. 2.90 in 2015). These scores dropped substantially for all organization types, especially independent hospitals.
- The practice showing the most increase in adoption from 2015 is: The board reviews and updates, as needed, policies that specify the board's major oversight responsibilities at least every two years" (2.73 vs. 2.64 in 2015). This increased for all organization types.
- There were two new practices in this area for 2019 for which we can't do a 2015 comparison:
  - The board assesses its governance model including structure, policies, processes, and board expectations at least every three years. (This practice showed the lowest adoption score at 2.60.)
  - The board requires management to provide the rationale for their recommendations, including options they considered.

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)*

* = New practice for 2019 (no 2015 data)
** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Reader's guide reminder:

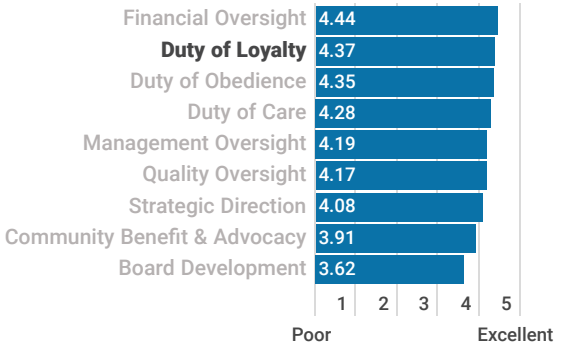
For most practices, adoption is widespread, with the exception of advisory boards, which operate under different rules and constraints given their limited or lack of fiduciary duty. Variations among types of organizations are small and are noted here for general information only. For detail, please see **Appendices 2** and **3.** After the overview of results, we present an analysis of the results in the next section. We include a section on the practices most widely adopted by advisory boards.

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.

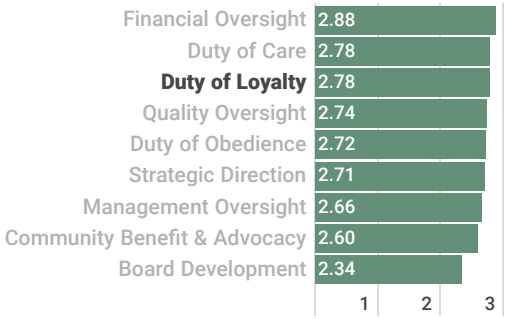
Duty of Loyalty: Key Points

- Duty of loyalty is rated second in performance (up from third in 2015 and 2013).
- It is tied for second in adoption, a significant increase since 2015 where it was rated sixth.
- Adoption has remained the same from 2015 or increased with the following exceptions, which have slightly decreased:
  - » The board assesses the adequacy of its conflict-of-interest policy as well as the sufficiency of its conflicts review process at least every two years. (Government-sponsored hospitals were the only organizations to see an increase in adoption for this practice, 2.64 vs. 2.44 in 2015.)
  - » The board reviews and ensures that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy. (Despite the slight decrease, this practice still scores very high overall at 2.89. Systems also scored a 3.00 for this practice again this year, and government-sponsored hospitals scores increased.)
- The most significant increase in adoption was for enforcing a written policy that states that deliberate violations of conflict of interest will require disciplinary action or potential removal from board service (2.75 vs. 2.57 in 2015). *(This may be due in part to this practice being slightly reworded this year to include the option of "disciplinary action," not just removal from the board.)*
- The most-adopted practices were that the board enforces a conflict-of-interest policy and that board members complete a conflict-of-interest disclosure statement annually. All organization types scored above 2.90 for these practices.
- While government-sponsored hospitals tend to have lower adoption rates for many of these practices compared to other types of organizations (consistent with previous reporting years), their scores improved in every practice this year.
- There was one new practice in this area for 2019 for which we can't do a 2015 comparison: The board has a written policy outlining the organization's approach to physician competition/conflict of interest. (This practice showed the lowest adoption scores at 2.47.)

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)*

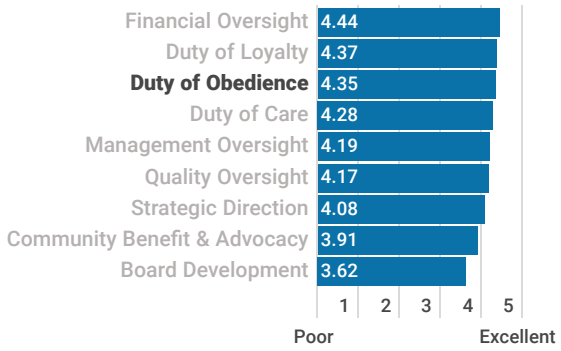
* = New practice for 2019 (no 2015 data)

** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

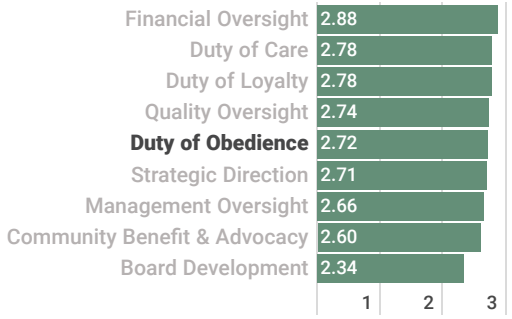
Duty of Obedience: Key Points

- CEOs gave boards' performance in duty of obedience the third highest performance score (4.35 out of 5; this shows an improvement since it was in fifth in 2015).
- Duty of obedience is ranked fifth in adoption of recommended practices (down from fourth place in 2015).
- The most highly adopted practice is that 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. (All organization scored 2.92 or higher.)
- Adoption rates that had the most significant increase were for the following practices:
  - The board follows a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight. (All systems surveyed follow this practice, and government-sponsored hospitals showed substantial improvement in adoption, 2.90 vs. 2.59 in 2015.)
  - The board has established a direct reporting relationship with legal counsel. (This practice saw a significant improvement in 2015 as well.)
- The biggest decrease was in the following practice: Board members responsible for audit oversight meet with external auditors, without management, at least annually. (The scores decreased for all organization types except systems, which stayed the same.)
- There were six new practices in this area for 2019 for which we can't do a 2015 comparison (see **Exhibit 38** on the next page).

Board Performance Composite Scores
(All Respondents)

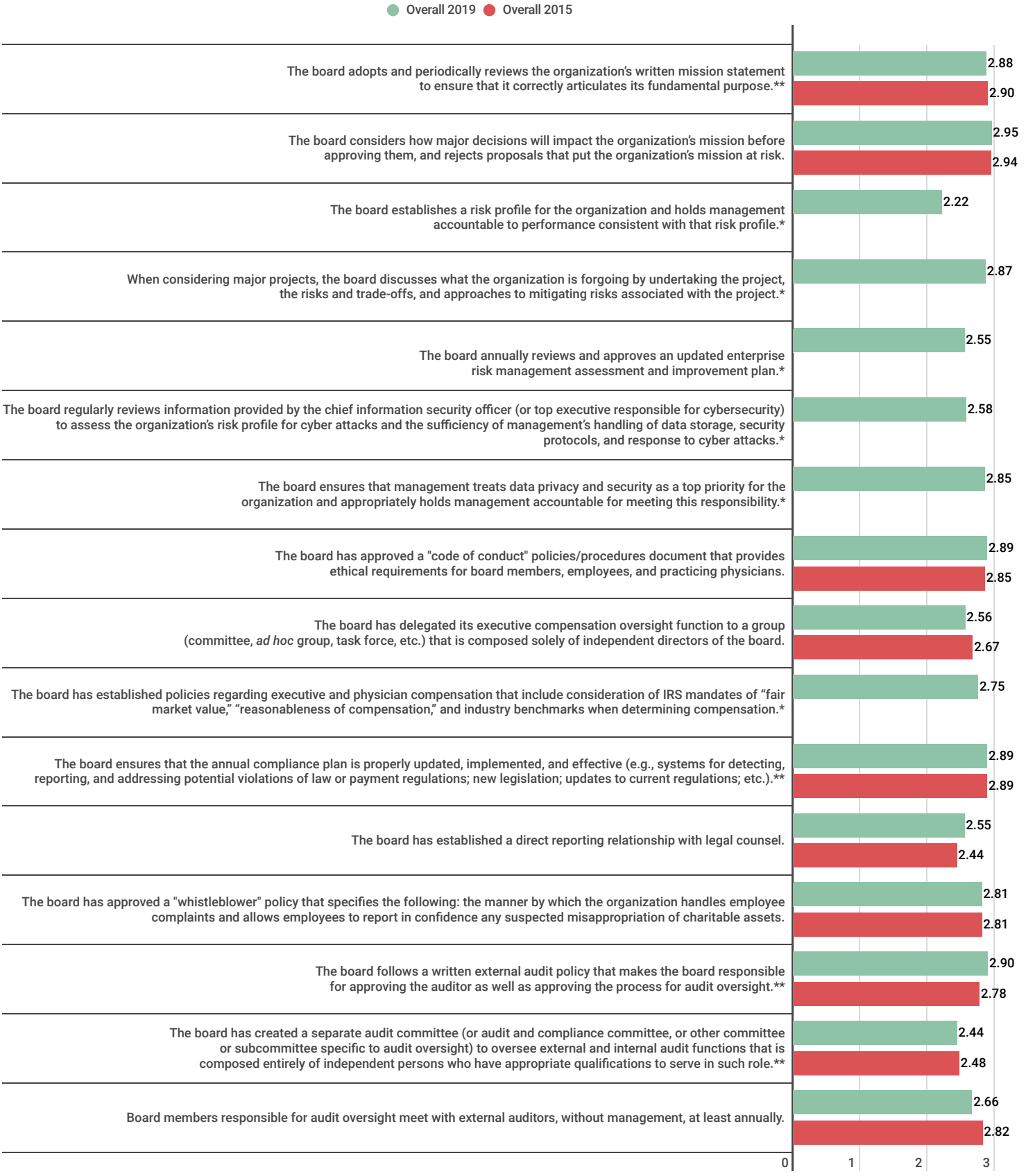


Adoption of Practice Composite Scores
(All Respondents)



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



* = New practice for 2019 (no 2015 data)

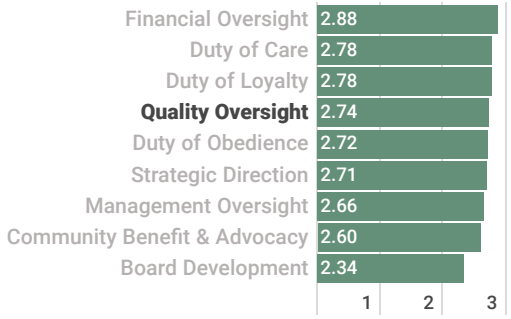
** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Quality Oversight: Key Points

- CEOs gave boards' performance in quality oversight the sixth highest rating (4.17 out of 5, a decrease from 4.39 and a ranking of fourth place).
- Quality oversight is ranked fourth in adoption of practices (down from third place in 2015).
- The most highly adopted practice (2.88 or higher) for all organization types is that the board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible. (This was a new practice added to the survey this year.)
- The biggest decrease was in the following practice: The board annually approves and at least quarterly reviews quality performance measures for all care settings, including population health and value-based care metrics (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) to identify needs for corrective action. (The scores decreased for all organization types.) *(This practice was slightly reworded in 2019 to include "annually approves" and be more specific about which performance measures are reviewed. This may be the cause of the declining scores.)*
- Subsidiary hospital boards (both fiduciary and advisory) received significantly higher ratings than other organizations for two practices: 1) The board requires all hospital clinical programs or services to meet quality-related performance criteria, and 2) The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).
- There were four new practices in this area for 2019 for which we can't do a 2015 comparison (see **Exhibit 39** on the next page).
- Practices that have been shown to improve quality of care (process of care and/or risk-adjusted mortality)[6] are:
  - Establishing a board-level quality committee *(systems and subsidiary hospitals with fiduciary boards 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 adopted across all organization types, although scores dropped this year for all organizations, especially government-sponsored hospitals; this may be due to the question being slightly reworded as noted above)*
  - 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)*
  - Participating in development/approval of explicit criteria to guide medical staff appointments, reappointments, and clinical privileges *(systems and subsidiary hospitals with fiduciary boards showed the highest adoption of this practice)*
  - Including objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation *(adoption scores went down for most organizations this year, with the exception of government-sponsored hospitals, which stayed the same)*
  - Challenging recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff *(systems 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

6 As reported in: Larry Stepnick, *Making a Difference in the Boardroom: Updated Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2014; Larry Stepnick, *Making a Difference in the Boardroom: Preliminary Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2012; H.J. Jiang, C. Lockee, K. Bass, I. Fraser, "Board oversight of quality: Any differences in process of care and mortality?" *Journal of Healthcare Management,* Vol. 54, No. 1 (2009), pp. 15–30; and H.J. Jiang, C. Lockee, K. Bass, I. Fraser, "Board engagement in quality: Findings of a survey of hospital and system leaders," *Journal of Healthcare Management,* Vol. 53, No. 2 (2008), pp. 118–132.

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

* = New practice for 2019 (no 2015 data)

** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Board Members Are Responsible for Patient Safety

Gary S. Kaplan, M.D., Chairman & CEO, Virginia Mason Health System

SPECIAL COMMENTARY

Patient safety is the responsibility of every member of a healthcare organization's team, particularly the board of directors. Yet, governance is one of the most under-leveraged assets we have for advancing the quality and safety agenda.

Across the American healthcare system, we have more information and evidence than ever about how to provide appropriate, high-quality care, and keep patients safe. System flaws are now widely recognized as causes of medical errors and there's a wealth of research about human factors and adverse events. When we think about what we do in healthcare, how can quality and safety not be at the top of our list of priorities?

In The Governance Institute's 2019 biennial survey, 79% of respondents rated their boards as excellent or very good in quality oversight, down from 87% in 2015. To effectively unleash the power of the board, senior management—and the CEO in particular—should embrace the board of directors as an equal partner.

Leading a Culture of Safety: A Blueprint for Success,[7] a 2017 report by a roundtable of experts convened by the Institute for Healthcare Improvement, National Patient Safety Foundation Lucian Leape Institute, and the American College of Healthcare Executives, provides high-level strategies and practical tactics for embedding a culture of safety throughout an organization. It concludes that a key to success is an action plan that engages executive leadership and frontline employees, as well as the board of directors.

I had the honor of serving as co-chair of this project, which serves as a guide for CEOs and other executives. The report explains that the elimination of harm to our patients and workforce is our foremost moral and ethical obligation. It adds:

> "In line with the CEO's responsibilities, the board is responsible for making sure the correct oversight is in place, that quality and safety data are systematically reviewed, and that safety receives appropriate attention as a standing agenda item at all meetings. It is imperative that safety be a foundational factor in how healthcare boards make decisions so that patient and workforce safety culture is a sustainable focus for the organization."

At Virginia Mason, for example, the board's quality oversight committee must approve management's resolutions for all red (most serious) Patient Safety Alerts before they are officially closed. Significantly, close to 10% of the red alerts brought to the quality oversight committee (after our leadership team has determined it has understood the root causes and mistake-proofed the process) are sent back for more work, with the goal of preventing the safety issue from happening again. This speaks to the value and power of the "outside eyes" of the quality oversight committee members, many of whom do not have healthcare backgrounds. This degree of transparency levels the organizational hierarchy, drives accountability, and has a positive impact on our organization's culture of safety and quality.

In this Governance Institute survey, quality oversight ranks fourth in board adoption of practices, down from third place in the 2015 survey. Too often, members of healthcare boards feel inadequate when addressing quality and safety issues or metrics and defer to the technical experts on staff. This is a mistake. Ensuring a sustained focus on quality and safety requires alignment and all-in engagement from the boardroom to the organization's frontlines.

Board discussions about quality and safety are every bit as important as conversations about finances, if not more so. Quality and safety metrics should be a standing feature on every board's monthly dashboard. Board members should understand safety science and be able to interpret metrics if they are to fulfill their responsibility for evaluating where and how their organization is progressing or falling short.

In reality, the board of directors holds the deed for strategic planning and resource allocation, for determining what is most important to the organization and assuring accountability, while respecting the important line between governance and management.

Several years ago, Virginia Mason developed a compact that, at the request of board members, aligns board member responsibilities with organizational expectations. For example, the compact directs our board members to "take ownership" by proactively understanding and participating in quality and safety oversight for the organization.

Our board's regular meetings always begin with a patient and/or family member in the room who describes his or her experience of care at our organization. The board requires that at least half the stories come from patients who have had negative experiences. When the board began this practice, it caused anxiety among some on our leadership team because it is extremely difficult to feel comfortable when someone looks you in the eye and describes how you disappointed or failed them. We've learned that this degree of transparency is necessary if there is to be continuous improvement. Today, including patients' stories as part of our board meetings is looked upon as the norm within the Virginia Mason culture. The patients' experiences remind us that we physicians and other care providers are guests in their lives.

In healthcare, we have no business talking about quality if we cannot keep our patients safe. Safety is the foundation for quality. Quality comes from a relentless focus on improving all aspects of care—from service to outcomes to safety—at every touch point for every patient.

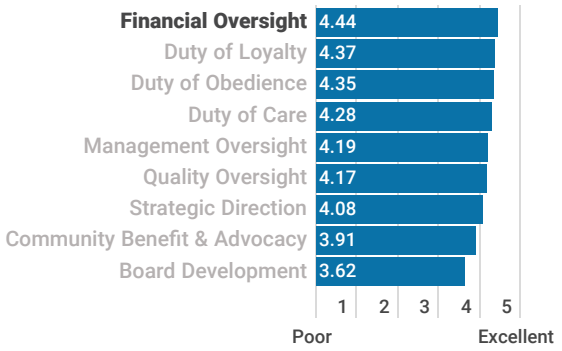
Strong leadership, starting with the board of directors, is essential for continuous and sustainable improvements in care quality and patient safety.

7 Available at http://bit.ly/34aDf1i.

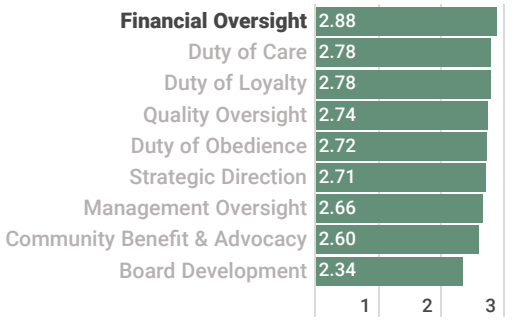
Financial Oversight: Key Points

- CEOs again gave boards' performance in financial oversight the highest performance score (4.44 out of 5).
- Financial oversight is also ranked first in adoption of recommended practices (where it traditionally is ranked, with the exception of 2013 where it was ranked second).
- There is broad adoption of recommended practices in financial oversight across all organization types. The lowest-scoring practice is that the board ensures that the finance and quality committees work together to improve quality while reducing costs and sets value-based performance goals for senior management and physician leaders (which still had an overall score of 2.63, and all organization types scored 2.60 or above).
- Of the advisory boards that indicated that the practices in this section are applicable to their board, the adoption rate of all six practices is 100% or 3.00. However, 50% or more of these boards indicated that none of these practices are applicable for their boards. The practice that is more likely to be applicable for advisory boards (50%) is monitoring financial performance against targets.
- Five out of the six practices in this section are new. The practice that remained the same is: The board reviews financial feasibility of projects before approving them (which received an overall score of 2.98, and systems, fiduciary boards, and advisory boards all scored a perfect 3.00). In previous reporting years, this practice was listed under the duty of care.

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)*

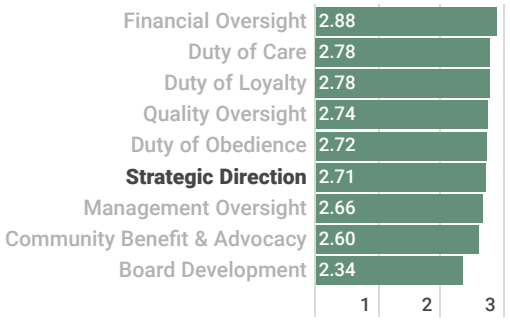
* = New practice for 2019 (no 2015 data)
** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Strategic Direction: Key Points

- CEOs gave boards' performance in setting strategic direction the third lowest rating (4.08 out of 5; about the same as 2015).
- Strategic direction is ranked sixth in adoption of practices (up from seventh in 2011, 2013, and 2015).
- Prevalence of adoption of practices remained very similar for most practices since 2015 with a couple exceptions:
  - Adoption is significantly higher for following board-adopted policies and procedures that define how strategic plans are developed and updated. (This was true for all organization types.)
  - Adoption is much lower for requiring management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability. (All organization types scored lower on this practice.)
- As in 2011, 2013, and 2015 more systems have adopted the practice of focusing on strategic discussions during board meetings compared to all other types of organizations (2.56, which is significantly higher than the 2015 rate of 2.38). This practice still has the lowest adoption rate overall.
- In general, government hospitals tend to have lower levels of adoption for these practices, but adoption has increased since 2015 for six of the practices.
- One new practice was added this year for which we can't do a 2015 comparison: The board works with management to gain awareness of, and prepare to respond to, matters of business disruption.

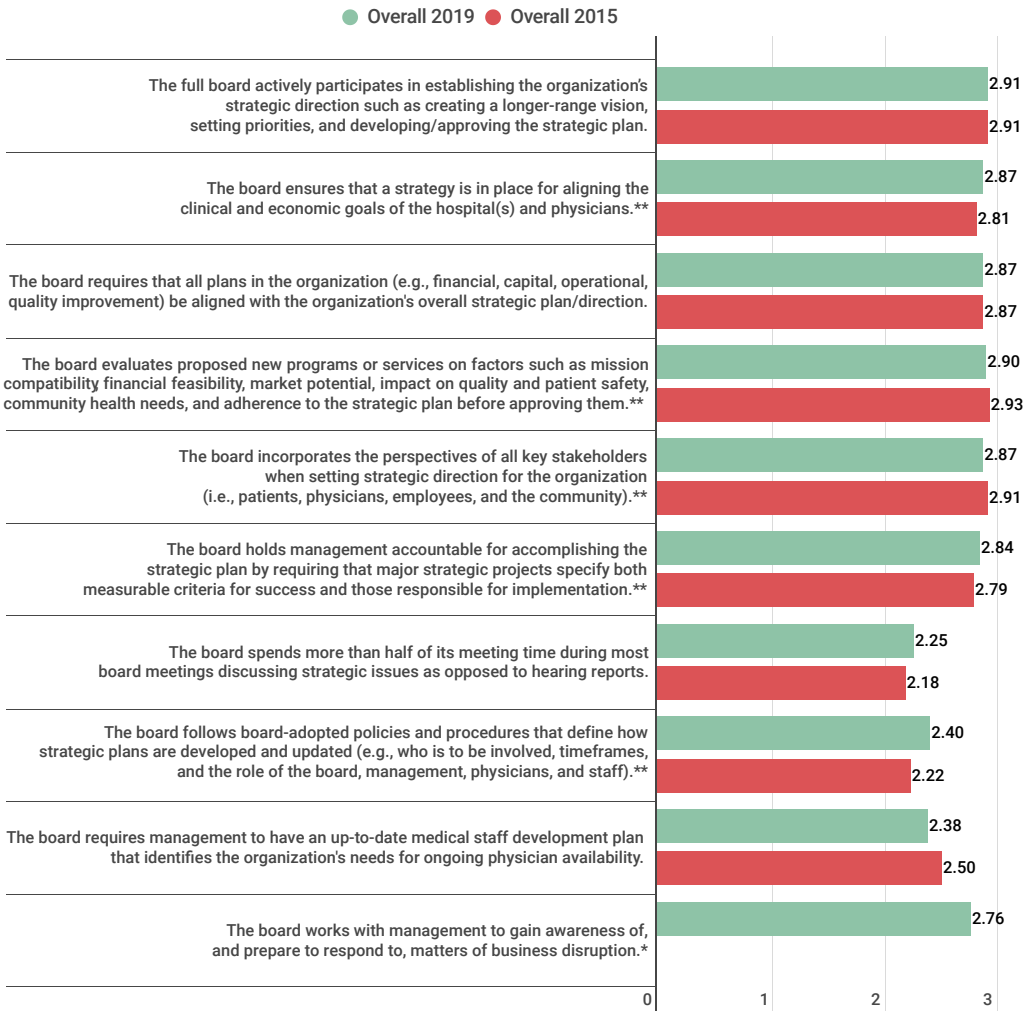
Board Performance Composite Scores
(All Respondents)

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 41. Strategic Direction Composite Scores *(Adoption)*



* = New practice for 2019 (no 2015 data)

** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Peak Effectiveness for Government-Sponsored Hospitals & Health Systems Begins with Governance

Larry S. Gage, Senior Counsel, Alston & Bird, LLP; Senior Advisor, Alvarez & Marsal;
Founder, National Association of Public Hospitals and Health Systems
(now "America's Essential Hospitals")

SPECIAL COMMENTARY

Since I last wrote a special commentary on public hospital governance for The Governance Institute's biennial survey eight years ago,[8] there have been many important changes in the health industry. It is essential for public hospital governing boards to keep abreast of these changes in order to govern effectively. And yet the results of the 2019 survey show that government-sponsored hospital boards may still be deficient in some of the policies and practices that are key to such effectiveness.

Some of these trends and reforms affect the industry as a whole, such as the "digital revolution" that can pose both financial and reputational risks for hospitals and health systems. Consumers are increasingly empowered by new rules, regulations, and policies that require greater transparency on costs, quality, outcomes, and access. Other recent developments include the increased attention to cybersecurity and patient confidentiality and privacy, expanded use of telehealth and other digital tools, the trend toward value-based compensation and away from piecemeal payment methodologies, the heightened emphasis on integration, care coordination and population health, among others.

Some trends may disproportionately affect government-sponsored hospitals, putting even more pressure on the boards of such hospitals. The ongoing implementation of the ACA against the backdrop of constant pressure from those who would erode or repeal it must be carefully monitored for its impact on present and future viability and planning. Even in states that expanded Medicaid coverage for patient populations more likely to be served by government hospitals, many such hospitals failed adequately to predict the likely impact. Some were not prepared for the influx of newly covered patients, while others overspent and overbuilt without taking sufficient steps to compete for those patients.

> Clearly, effective governance will be crucial for public hospitals in responding to these trends and potential crises. As this biennial survey shows, public hospital governance has not evolved rapidly enough to keep pace with industry trends and reforms.

Access to capital could become even more problematic. At the same time, the movement toward hospital industry consolidation has continued and accelerated, further isolating many public hospitals that have been unwilling or unable to join the consolidation trend.

Clearly, effective governance will be crucial for public hospitals in responding to these trends and potential crises. As this biennial survey shows, public hospital governance has not evolved rapidly enough to keep pace with other industry trends and reforms. It is therefore essential that government-sponsored hospitals understand the areas in which they fall short of the rest of the industry, so that they can make the necessary changes to improve the effectiveness of their governance.

Government hospital boards have continued to demonstrate weaker performance than the rest of the industry in several important areas:

1. Government-sponsored hospitals continue to have significantly smaller boards than other categories, with a downward trend since 2017. While the industry trend has been toward smaller, more streamlined boards, there is a de minimus floor below which a board may be incapable of including the range of experience and devoting the necessary time to the important tasks of governing a modern, 21st-century hospital.
2. This group is the least likely of all categories to impose term limits on board membership, a best practice that ensures that boards have opportunities to add members with the necessary skills, experience and perspectives. While many government-sponsored hospitals are limited by the nature of how their board members are selected, more and more we are seeing cases in which such hospitals do have the power to impose term limits.
3. Government hospital boards appear to meet more frequently than other categories (10–12 times per year). While frequent meetings may enable board members to keep abreast of key issues and strategies, they also require substantially more staff resources (both in preparation for board meetings and in digesting and writing up the results) that could detract from the ability of management to implement board-approved strategies and policies and may also lead to board members crossing the important line between management and governance.
4. Government-sponsored hospitals were the least likely to give the executive committee authority to act on behalf of the full board for some or all decisions.

8 Larry S. Gage and James A. Rice, "Strengthening Public Hospital Governance" (special commentary), *Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry,* 2011 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

5. As in previous years, government-sponsored hospital boards reported spending less than all other types of boards on board education (less than $10,000 annually); effective board education is considered essential for effective governance in an era of rapid-fire changes in all of the areas outlined above.
6. Use of board portals has increased substantially between 2011 and 2015, but government hospital boards continue to lag behind the rest of the industry.

At the same time, it is important to point out that government hospitals actually equaled or outperformed the other categories included in this survey in several areas:

1. Government-sponsored hospital boards were as likely as their peers to adopt best practices in a number of areas, including the duty of care, quality oversight, financial oversight, and strategic direction.
2. The proportion of government hospital boards whose performance was rated "excellent" or "very good" was similar to their peers in carrying out responsibilities related to financial oversight, duty of loyalty, duty of obedience, duty of care, management oversight, and strategic direction. However, government hospitals lagged further behind all respondents in the areas of quality oversight, community benefit and advocacy, and board development.
3. Independent board members can provide key diversity of expertise and experience needed to address many current and future trends and concerns, and government-sponsored hospital boards performed well in this area, with 89% of the typical government board being made up of independent members.
4. Having a CEO with a clinical background is also increasingly considered a positive trend leading to effective governance, and the government hospitals in this survey outperformed other categories in this area.
5. In addition, government hospital boards had the highest proportion of several essential competencies being sought for new board members, including finance/business acumen, strategic planning and visioning, and quality and patient safety. At the same time, this group was significantly less likely than their peers in seeking board members with "second-curve" competencies in innovation/disruption, digital/mobile health, medical/science technology, and conflict management.

Improving Governance in Government-Sponsored Hospitals

Effective governance will be an essential component of the ability of government-sponsored hospitals and health systems to successfully respond to the challenges described above. To assist in developing and implementing effective strategies, public hospital governing boards can:

Get educated. Be proactive in learning about the challenges of the future. Management should provide board members with up-to-date information about each of the challenges the hospital is likely to face. Access to key publications, the opportunity to attend national or regional conferences, and regular presentations from key innovators can bring public board members a much greater understanding of the job they need to do.

Improve strategic thinking. Too often, members of public hospital boards are inordinately focused on day-to-day operations such as financial crises, patient care incidents, or meeting the needs of specific patient populations. Each of these issues may be important, but focusing too much attention on them robs the board time and resources to think strategically about long-term needs.

Focus on long-term mission and success. Board members need to check constituency behavior at the boardroom door. Often, public hospital board members are nominated or appointed to represent certain constituencies. Some of those constituencies are no doubt important to the future success of the public hospital. However, it will be more important than ever in facing the challenges of the next several years for boards to maintain the discipline necessary to help management prioritize strategies and focus limited resources on those actions most likely to ensure the hospital's future viability.

Improve community outreach. Board members can be instrumental in forming bonds with other key players in their communities. An increased focus on value-based care and population health will require partnerships with other community organizations that pay attention to the social determinants of health status of vulnerable patients more likely to be served by public hospitals.

Focus on care delivery transformation. Understand the profound underlying changes taking place today in the diagnosis and treatment of many diseases and conditions, and support management in transforming the public health and hospital system from inpatient-centric to a more balanced mix of inpatient and outpatient/ambulatory care.

Set goals for improvement, then give management the breathing room to achieve them. Incent management to work with the board to develop plans to achieve greater operational, competitive, and financial efficiencies, and then provide management with the time and resources to implement those plans. It is more important today than ever to maintain the dividing line between governance and management.

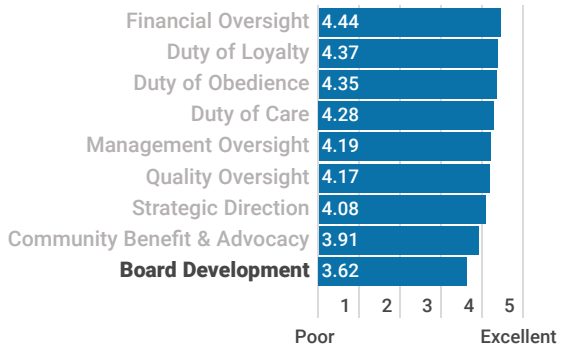
Focus on filling gaps in board member expertise. Public hospitals need a succession plan for their board members that takes into account the changing demographics of their patient population and workforce, as well as the background and technical skills that will be most helpful in addressing the challenges of the future.

In conclusion, effective governance has never been more important for both public and private hospitals and health systems. Quite simply, public hospitals and health systems in most parts of the country still face more barriers to success than private systems, at a time when the challenges have never been greater. The current and future political, fiscal, and competitive environment requires all of the major components of a public hospital or health system to be operating with peak effectiveness, which starts with governance.

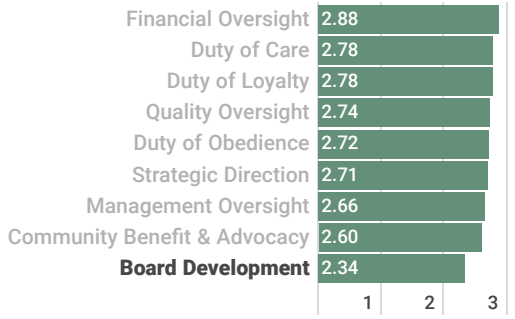
Board Development: Key Points

- CEOs again gave boards' performance in board development the lowest rating (3.62 out of 5; this rating has decreased from 3.79 in 2015).
- Board development is also ranked last in adoption of practices (same as 2013 and 2015).
- The most significant increase in adoption is for selecting new director candidates from a pool that reflects a broad range of diversity and competencies. All organizations scored higher, especially systems (2.88 vs. 2.57 in 2015). *(This practice was reworded. In 2015 the practice was: The board uses competency-based criteria when selecting new board members.)*
- Adoption is much lower this year for the following two practices (across all organization types):
  - Board members participate at least annually in education regarding its responsibilities to fulfill the organization's mission, vision, and strategic goals. *(This practice was slightly reworded this year to be more specific, which may account for the lower adoption scores.)*
  - The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.
- Systems and hospitals with fiduciary boards are more likely than others to use a formal orientation program for new board members.
- Systems 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).
- All organization types have the lowest adoption for using a formal process to evaluate the performance of individual board members.
- There were four new practices in this area for 2019 for which we can't do a 2015 comparison (see **Exhibit 42** on the next page).

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)*

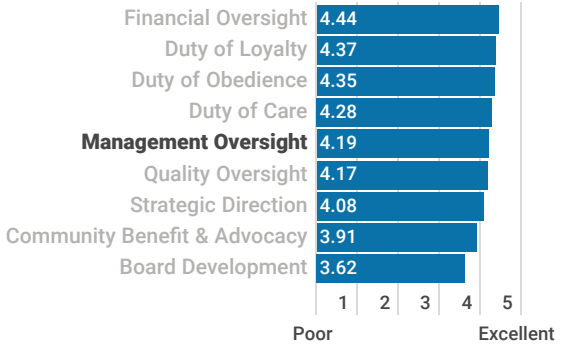
* = New practice for 2019 (no 2015 data)

** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

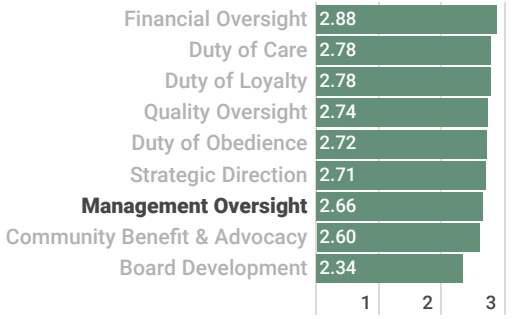
Management Oversight: Key Points

- CEOs gave boards' performance in management oversight the fifth highest performance rating (4.19 out of 5; a decrease from 4.31 in 2015 although its ranking is up from sixth).
- Management oversight moved down to seventh place in adoption of practices (it was ranked fifth in 2015).
- All but one practice decreased in adoption since 2015, with the biggest decrease in the board convening executive sessions periodically without the CEO in attendance (from 2.67 in 2015 to 2.37 in 2019). *(The wording was slightly adjusted this year to no longer imply that CEO performance was discussed during these sessions.)*
- The least observed practice is maintaining a written, current CEO and senior executive succession plan; systems are much more likely than other organizations to have this plan in place.
- One new practice was added this year for which we can't do a 2015 comparison: The board recognizes that CEO (and other senior executive) succession and search planning is a critical responsibility of the board.

Board Performance Composite Scores
(All Respondents)

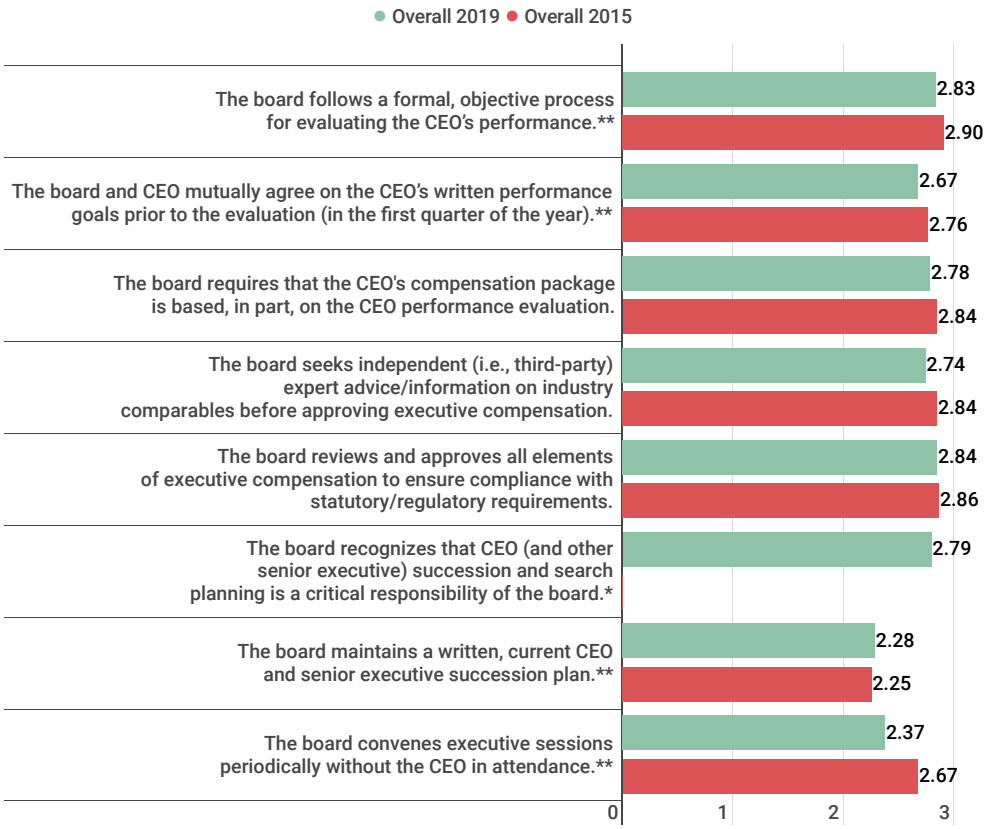


Adoption of Practice Composite Scores
(All Respondents)



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 43. Management Oversight Composite Scores *(Adoption)*

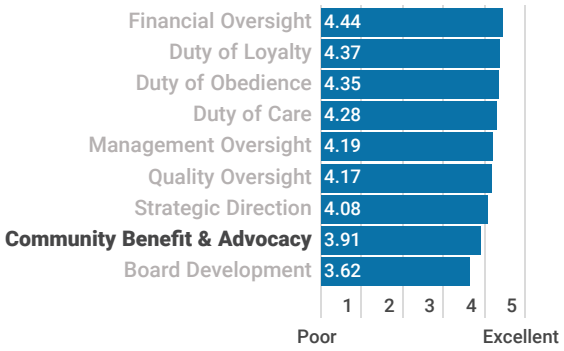


* = New practice for 2019 (no 2015 data)
** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Community Benefit & Advocacy: Key Points

- CEOs gave boards' performance in community benefit and advocacy the second lowest performance rating (3.91 out of 5; about the same as 2015).
- Community benefit and advocacy is ranked second to last in adoption of practices (same as 2015).
- Prevalence of adoption of practices remained very similar for most practices since 2015 with a couple exceptions:
- Adoption is significantly higher for having a written policy establishing the board's role in fund development and/or philanthropy (although this is still the least prevalent practice for all types of organizations; this has remained one of the least-observed practices in all oversight areas for several reporting years).
- Adoption is much lower for adopting 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, and measurable goals for the organization. (This is true for all organization types.)
- Compared to other practices in this area, the one most adopted by all types of organizations (except advisory boards) is: 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.
- One new practice was added this year for which we can't do a 2015 comparison: The board ensures that the organization effectively addresses social determinants of health (e.g., housing, access to healthy food, employment, financial strain, behavioral health, personal safety) in the context of its community benefit activities.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)

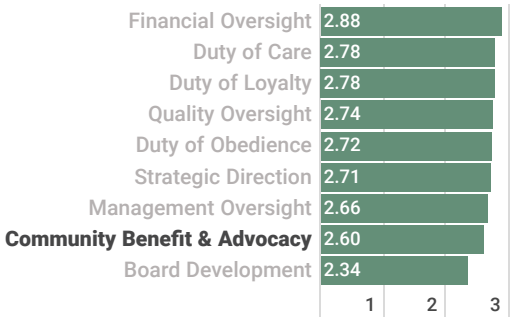


Exhibit 44. Community Benefit & Advocacy Composite Scores *(Adoption)*

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

* = New practice for 2019 (no 2015 data)
** = Wording of practice was revised from 2015 (see Appendix 3 for detail)

Advisory Board Practice Adoption

The list below reflects the practices that have been widely adopted by the eight advisory boards responding to this section of the report (2.8 and above on a 3-point weighted scale). Detail is shown in Appendix 3; however, due to the high number of N/A responses to many of the practices, the adoption composite scores in Appendix 3 for advisory boards are generally higher than those of other types of boards. Appendix 2 shows the percentages of respondents that indicated a practice was "not applicable for my board." Practices for which 40% or more boards indicated "not applicable" are not included in the list below even if their composite adoption score was 2.8 and above.

Duty of Care

- Board members receive important background materials and well-developed agendas within sufficient time to prepare for meetings.
- The board requires management to provide the rationale for their recommendations, including options they considered.

Duty of Loyalty

- The board uniformly and consistently enforces 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 has a specific process by which disclosed potential conflicts are reviewed by independent, non-conflicted board members with staff support from the general counsel.
- The board enforces a written policy that states that deliberate violations of conflict of interest will require disciplinary action or potential removal from board service.
- The board follows a specific definition, with measurable standards, of an "independent director" that, at a minimum, complies with the most recent IRS definition and takes into consideration any applicable state law.
- The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.

Duty of Obedience

- The board adopts and periodically reviews the organization's written mission statement to ensure that it 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 approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.
- The board requires all hospital clinical programs or services to meet quality-related performance criteria.
- The board annually approves and at least quarterly reviews quality performance measures for all care settings, including population health and value-based care metrics (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) to identify needs for corrective action.
- The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.
- The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).
- The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.
- The board ensures consistency in quality reporting, standards, policies, and interventions such as corrective action with practitioners across the entire organization.

Financial Oversight

- The board monitors financial performance against targets established by the board related to liquidity ratios, profitability, activity, and debt, and demands corrective action in response to under-performance.

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 ensures that a strategy is in place for aligning the clinical and economic goals of the hospital(s) and physicians.
- The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, impact on quality and patient safety, community health needs, and adherence to the strategic plan before approving them.
- The board incorporates the perspectives of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).
- The board holds management accountable for accomplishing the strategic plan by requiring that major strategic projects specify both measurable criteria for success and those responsible for implementation.
- The board works with management to gain awareness of, and prepare to respond to, matters of business disruption.

Management Oversight

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

Community Benefit & Advocacy

- The board holds management accountable for implementing strategies to meet the needs of the community, as identified through the community health needs assessment.
- The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).

Analysis of Results

This year's results show that adoption of our list of recommended practices, for the most part, is widespread. Overall, performance scores are slightly lower this year. Historically, systems have had the highest levels of performance and that continues to be true. They have the highest board performance composite score and the highest percentage of "excellent" and "very good" rankings across the oversight areas. Independent hospitals' scores had the most noticeable drop. Their performance scores went down in every category, and they had lower levels of adoption for many practices compared to previous years. While government-sponsored hospitals have lower performance scores than other organizations, which has been true in past surveys as well, they showed the greatest improvement. It is notable to see these organizations enhancing their performance, even with their unique challenges and constraints.

The increase in adoption of duty of loyalty practices reflects a growing focus by the board around conflict-of-interest issues. This is promising at a time when there is heightened concern about board member conflicts. While government-sponsored hospitals tend to have lower adoption in this area, their scores increased for every practice as well. We are also pleased to see that all organization types are continuing to score high in financial oversight. Five out of the six practices changed on this year's survey, but financial oversight still has the highest performance and adoption.

There remains significant opportunity to improve performance scores and adoption rates in certain key areas. Quality oversight declined in performance and adoption, which is concerning given boards' critical role in ensuring their organizations are providing safe, high-quality care (especially seeing scores drop in areas such as reviewing quality performance measures and tying clinical improvement and/or patient safety goals to the CEO's performance evaluation). There is also room for improvement in developing physician leaders and assessing their performance, which was a new practice added this year. Duty of care performance scores were lower as well. Requiring that new board members receive education on their fiduciary duties saw a big dip, which is worrisome considering that board members need to have a clear sense of their legally mandated duties to successfully carry out their responsibilities.

There remains significant opportunity to improve performance scores and adoption rates in certain key areas. Quality oversight declined in performance and adoption, which is concerning given boards' critical role in ensuring their organizations are providing safe, high-quality care.

Board development remains at the bottom of the list for both performance and adoption scores. This is a great area of opportunity for boards looking to enhance their performance—and therefore, their organization's performance. It is encouraging to see that more boards are selecting new director candidates from a pool that reflects a broad range of diversity and competencies. But there are still some key practices (such as participating annually in board education and setting annual goals for board and committee performance that support the strategic plan) where adoption is decreasing. There is also very low adoption around using a formal process to evaluate the performance of individual board members, which can help ensure that members are effectively contributing to board work and continually developing their skills.

In an era of disruption and uncertainty where a focused and disciplined strategic planning process is critical, strategic planning should be ranking much higher for both performance and adoption. It is clear that boards need to be spending much more time on strategy in board meetings. While the previous survey showed an increase in adoption of management oversight practices, that trend did not continue. Adoption scores went down for every practice except one: boards requiring the CEO to maintain a written and current succession plan. We are glad to see adoption going up for this practice since it has historically been stagnant on the lower end of the adoption rates—and hospitals and health systems continue to experience high levels of CEO turnover—although it still remains the least observed practice in this area.

Most & 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[6] for all respondents except those who selected "not applicable in our organization." This list of 15 practices includes (those with an asterisk were also on the 2015 most observed list):

Duty of Care

- Board members receive important background materials and well-developed agendas within sufficient time to prepare for meetings*
- The board requires management to provide the rationale for their recommendations, including options they considered.

6 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.

Duty of Loyalty
- The board uniformly and consistently enforces 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.*

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.*
- The board follows a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight.

Quality Oversight
- The board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.

Financial Oversight
- The board is sufficiently informed and discusses the multi-year strategic/financial plan before approving it.
- The board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it.
- The board reviews financial feasibility of projects before approving them.*
- The board monitors financial performance against targets established by the board related to liquidity ratios, profitability, activity, and debt, and demands corrective action in response to under-performance.

Strategic Direction
- The full board actively participates in establishing the organization's strategic direction such as creating a longer-range vision, setting priorities, and developing/approving the strategic plan.*
- The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, impact on quality and patient safety, community health needs, and adherence to the strategic plan before approving them.*

Community Benefit & Advocacy
- 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.*
- The board provides oversight with respect to organizational compliance with IRS tax-exemption requirements concerning community benefit and related requirements.

We also identified the practices that have been adopted by the ***least number*** of respondents. This year only one practice met the criteria (which was also on the 2015 least observed list):

Board Development
- The board uses a formal process to evaluate the performance of individual board members.*

Appendix 3 shows composite scores for most and least observed practices overall and by organization type, comparing 2019 and 2015.

Appendix 1. Governance Structure

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Does your board have fiduciary duties and decision-making authority?																			
Total responding in each category	31	2	10	19	6	4	1	0	1	4	19	0	2	16	6	3	2	0	0
Yes, for all board activities	41.9%	50.0%	80.0%	21.1%	83.3%	75.0%	100.0%	0.0%	100.0%	25.0%	36.8%	0.0%	0.0%	50.0%	50.0%	33.3%	0.0%	0.0%	0.0%
Yes, for some board activities	32.3%	0.0%	20.0%	42.1%	16.7%	25.0%	0.0%	0.0%	0.0%	50.0%	36.8%	0.0%	0.0%	31.3%	16.7%	33.3%	50.0%	0.0%	0.0%
No, our board makes recommendations to another fiduciary body/is considered an advisory board	25.8%	50.0%	0.0%	36.8%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	26.3%	0.0%	100.0%	18.8%	33.3%	33.3%	50.0%	0.0%	0.0%
How is your board selected?																			
Elected by the public	19.0%	1.9%	25.6%	11.5%	40.4%	27.0%	60.0%	0.0%	63.6%	11.1%	9.1%	0.0%	0.0%	22.9%	7.0%	0.0%	5.0%	9.1%	0.0%
Appointed by a government body	23.1%	15.4%	27.4%	11.5%	46.1%	56.8%	40.0%	87.5%	27.3%	0.0%	11.1%	0.0%	10.3%	25.0%	25.6%	26.7%	10.0%	27.3%	0.0%
Appointed by a parent/system	8.7%	15.4%	3.0%	30.8%	0.0%	0.0%	0.0%	0.0%	0.0%	22.2%	11.1%	16.7%	17.9%	5.2%	14.0%	13.3%	20.0%	18.2%	12.5%
Self-perpetuating	39.3%	53.8%	34.8%	38.5%	7.9%	8.1%	0.0%	12.5%	6.1%	55.6%	54.5%	50.0%	66.7%	36.5%	41.9%	53.3%	50.0%	45.5%	62.5%
Other	9.9%	13.5%	9.1%	7.7%	5.6%	8.1%	0.0%	0.0%	3.0%	11.1%	14.1%	33.3%	5.1%	10.4%	11.6%	6.7%	15.0%	0.0%	25.0%
Total number of seated, voting board members (includes vacant positions for which you currently are recruiting)																			
Total responding in each category	242	53	166	26	88	36	5	8	33	9	100	6	39	96	43	15	20	11	8
1 to 7	28.1%	3.8%	37.8%	15.4%	61.4%	63.9%	60.0%	37.5%	66.7%	0.0%	14.0%	0.0%	0.0%	31.3%	11.6%	0.0%	0.0%	9.1%	0.0%
8 to 10	19.8%	11.5%	23.2%	15.4%	23.9%	25.0%	0.0%	50.0%	21.2%	33.3%	20.0%	16.7%	7.7%	29.2%	18.6%	13.3%	5.0%	9.1%	0.0%
11 to 15	23.6%	28.8%	22.0%	23.1%	10.2%	5.6%	40.0%	12.5%	9.1%	33.3%	30.0%	0.0%	38.5%	21.9%	27.9%	53.3%	25.0%	27.3%	25.0%
16 to 22	23.6%	42.3%	15.9%	34.6%	4.5%	5.6%	0.0%	0.0%	3.0%	22.2%	32.0%	33.3%	43.6%	14.6%	39.5%	20.0%	55.0%	45.5%	62.5%
23 to 30	2.1%	5.8%	0.6%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	1.0%	16.7%	5.1%	2.1%	0.0%	13.3%	5.0%	0.0%	0.0%
31 +	2.9%	7.7%	0.6%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	33.3%	5.1%	1.0%	2.3%	0.0%	10.0%	9.1%	12.5%
Average	12.35	16.50	10.49	15.81	7.86	7.67	8.60	8.63	7.42	14.00	14.03	22.33	16.26	11.00	14.23	14.33	18.40	15.91	18.38
Median	11	17	9	15	7	7	7	9	7	12	13	20	16	9	14	13	17	16	17
Range	2 to 60	7 to 35	2 to 60	5 to 41	2 to 22	2 to 19	5 to 15	7 to 11	5 to 22	9 to 23	4 to 60	10 to 35	9 to 31	2 to 60	5 to 31	9 to 23	9 to 35	7 to 31	11 to 31

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Number of independent voting board members (per IRS definition of independent director)																			
Total responding in each category	241	52	163	26	88	36	5	8	33	9	99	6	39	95	43	15	20	11	8
0 to 2	2.9%	0.0%	4.3%	0.0%	5.7%	5.6%	0.0%	0.0%	6.1%	11.1%	1.0%	0.0%	0.0%	4.2%	2.3%	0.0%	0.0%	0.0%	0.0%
3 to 4	2.1%	1.9%	1.2%	7.7%	1.1%	0.0%	0.0%	0.0%	3.0%	0.0%	2.0%	16.7%	2.6%	1.1%	0.0%	6.7%	5.0%	0.0%	0.0%
5 to 6	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7+	95.0%	98.1%	94.5%	92.3%	93.2%	94.4%	100.0%	100.0%	90.9%	88.9%	97.0%	83.3%	97.4%	94.7%	97.7%	93.3%	95.0%	100.0%	100.0%
Average	9.69	12.58	8.52	11.27	6.99	6.94	7.80	7.63	6.76	9.00	10.78	12.00	12.77	8.85	10.86	11.00	12.75	13.09	15.38
Median	9	12	8	11	7	7	7	7	7	8	10	13	12	8	11	11	13	13	13
Range	0 to 60	4 to 29	0 to 60	4 to 29	0 to 19	0 to 18	5 to 15	6 to 9	0 to 19	0 to 21	0 to 60	4 to 17	4 to 29	0 to 60	2 to 29	4 to 18	4 to 18	7 to 24	9 to 29
Number of voting management board members (non-clinician)																			
Total responding in each category	172	40	109	23	50	21	2	1	22	9	76	6	31	62	35	10	15	10	8
0	44.2%	15.0%	60.6%	17.4%	86.0%	85.7%	100.0%	100.0%	90.9%	33.3%	34.2%	16.7%	9.7%	54.8%	28.6%	30.0%	13.3%	10.0%	12.5%
1	40.1%	70.0%	32.1%	26.1%	6.0%	4.8%	0.0%	0.0%	9.1%	55.6%	44.7%	50.0%	77.4%	30.6%	54.3%	50.0%	60.0%	80.0%	75.0%
2	11.6%	15.0%	4.6%	39.1%	4.0%	4.8%	0.0%	0.0%	0.0%	11.1%	14.5%	33.3%	12.9%	9.7%	8.6%	20.0%	26.7%	10.0%	12.5%
3	2.3%	0.0%	0.9%	13.0%	2.0%	4.8%	0.0%	0.0%	0.0%	0.0%	3.9%	0.0%	0.0%	1.6%	5.7%	0.0%	0.0%	0.0%	0.0%
4 +	1.7%	0.0%	1.8%	4.3%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	3.2%	2.9%	0.0%	0.0%	0.0%	0.0%
Average	0.56	0.77	0.36	1.42	0.19	0.17	0.00	0.00	0.06	0.78	0.73	1.17	0.82	0.44	0.88	0.60	0.85	0.91	1.00
Median	0	1	0	2	0	0	0	0	0	1	1	1	1	0	1	0	1	1	1
Range	0 to 7	0 to 2	0 to 7	0 to 4	0 to 7	0 to 3	0 to 0	0 to 0	0 to 1	0 to 2	0 to 4	0 to 2	0 to 2	0 to 4	0 to 7	0 to 2	0 to 2	0 to 2	0 to 2
Number of voting Chief Medical Officer board members																			
Total responding in each category	103	11	80	12	43	16	0	3	21	3	47	2	8	42	18	3	5	4	1
0	78.6%	90.9%	77.5%	75.0%	83.7%	81.3%	0.0%	33.3%	90.5%	100.0%	70.2%	50.0%	100.0%	73.8%	83.3%	100.0%	80.0%	100.0%	100.0%
1	20.4%	9.1%	21.3%	25.0%	14.0%	18.8%	0.0%	33.3%	9.5%	0.0%	29.8%	50.0%	0.0%	26.2%	16.7%	0.0%	20.0%	0.0%	0.0%
2 +	1.0%	0.0%	1.3%	0.0%	2.3%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average	0.10	0.02	0.12	0.12	0.09	0.08	0.00	0.38	0.06	0.00	0.14	0.17	0.00	0.11	0.07	0.00	0.05	0.00	0.00
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 2	0 to 1	0 to 2	0 to 1	0 to 2	0 to 1	0 to 0	0 to 2	0 to 1	0 to 0	0 to 1	0 to 1	0 to 0	0 to 1	0 to 1	0 to 0	0 to 1	0 to 0	0 to 0

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
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	160	37	104	19	52	20	2	4	22	5	69	5	29	58	35	11	16	8	3
0	43.8%	27.0%	50.0%	42.1%	65.4%	70.0%	100.0%	0.0%	72.7%	40.0%	34.8%	60.0%	24.1%	50.0%	17.1%	27.3%	18.8%	37.5%	66.7%
1	25.6%	32.4%	23.1%	26.3%	28.8%	25.0%	0.0%	75.0%	22.7%	0.0%	23.2%	0.0%	34.5%	29.3%	28.6%	36.4%	18.8%	37.5%	0.0%
2	18.8%	21.6%	16.3%	26.3%	3.8%	0.0%	0.0%	25.0%	4.5%	20.0%	27.5%	0.0%	27.6%	12.1%	37.1%	27.3%	31.3%	12.5%	33.3%
3	6.9%	5.4%	7.7%	5.3%	1.9%	5.0%	0.0%	0.0%	0.0%	40.0%	10.1%	0.0%	3.4%	6.9%	14.3%	0.0%	12.5%	0.0%	0.0%
4 +	5.0%	13.5%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	40.0%	10.3%	1.7%	2.9%	9.1%	18.8%	12.5%	0.0%
Average	0.72	1.17	0.58	0.69	0.25	0.22	0.00	0.63	0.21	0.89	0.88	1.83	1.15	0.50	1.28	1.00	1.80	0.91	0.25
Median	0	1	0	0	0	0	0	1	0	0	0	0	1	0	1	1	1	0	0
Range	0 to 7	0 to 7	0 to 5	0 to 3	0 to 3	0 to 3	0 to 0	0 to 2	0 to 2	0 to 3	0 to 5	0 to 7	0 to 6	0 to 5	0 to 4	0 to 5	0 to 7	0 to 5	0 to 2
Number of voting physician board members aside from the CMO who are employed by the hospital																			
Total responding in each category	150	38	93	19	48	19	1	1	23	3	65	4	30	52	29	10	16	9	4
0	48.7%	31.6%	60.2%	26.3%	87.5%	89.5%	0.0%	100.0%	91.3%	66.7%	30.8%	50.0%	23.3%	40.4%	44.8%	20.0%	25.0%	55.6%	75.0%
1	29.3%	44.7%	20.4%	42.1%	6.3%	5.3%	0.0%	0.0%	8.7%	33.3%	36.9%	25.0%	50.0%	34.6%	31.0%	50.0%	37.5%	33.3%	0.0%
2	11.3%	10.5%	11.8%	10.5%	2.1%	5.3%	0.0%	0.0%	0.0%	0.0%	18.5%	25.0%	10.0%	15.4%	10.3%	30.0%	6.3%	11.1%	0.0%
3	4.7%	2.6%	3.2%	15.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.2%	0.0%	3.3%	5.8%	6.9%	0.0%	6.3%	0.0%	0.0%
4 +	6.0%	10.5%	4.3%	5.3%	4.2%	0.0%	100.0%	0.0%	0.0%	0.0%	4.6%	0.0%	13.3%	3.8%	6.9%	0.0%	25.0%	0.0%	25.0%
Average	0.58	0.88	0.41	1.04	0.16	0.08	0.80	0.00	0.06	0.11	0.79	0.50	1.10	0.53	0.70	0.73	1.55	0.45	0.50
Median	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0
Range	0 to 6	0 to 5	0 to 5	0 to 6	0 to 5	0 to 2	0 to 4	0 to 0	0 to 1	0 to 1	0 to 5	0 to 2	0 to 6	0 to 4	0 to 5	0 to 2	0 to 6	0 to 2	0 to 4
Number of voting Chief Nursing Officer board members																			
Total responding in each category	83	11	66	6	37	14	0	1	19	2	35	1	8	33	15	3	4	4	1
0	98.8%	100.0%	98.5%	100.0%	97.3%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%
1	1.2%	0.0%	1.5%	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average	0.00	0.00	0.01	0.00	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 1	0 to 0	0 to 1	0 to 0	0 to 1	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 1	0 to 0	0 to 0	0 to 0	0 to 0

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Number of voting board members who are nurses from the organization's nursing staff aside from the CNO																			
Total responding in each category	105	17	76	12	44	16	2	1	22	2	43	2	14	38	23	4	7	7	2
0	93.3%	82.4%	97.4%	83.3%	97.7%	93.8%	100.0%	100.0%	100.0%	100.0%	93.0%	50.0%	85.7%	97.4%	91.3%	100.0%	71.4%	85.7%	100.0%
1	6.7%	17.6%	2.6%	16.7%	2.3%	6.3%	0.0%	0.0%	0.0%	0.0%	7.0%	50.0%	14.3%	2.6%	8.7%	0.0%	28.6%	14.3%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average	0.03	0.06	0.01	0.08	0.01	0.03	0.00	0.00	0.00	0.00	0.03	0.17	0.05	0.01	0.05	0.00	0.1	0.09	0.00
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 1	0 to 1	0 to 1	0 to 1	0 to 1	0 to 1	0 to 0	0 to 0	0 to 0	0 to 0	0 to 1	0 to 1	0 to 1	0 to 1	0 to 1	0 to 0	0 to 1	0 to 1	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	115	23	79	13	44	16	1	1	23	6	43	6	16	43	20	7	10	6	3
0	84.3%	52.2%	94.9%	76.9%	100.0%	100.0%	100.0%	100.0%	100.0%	33.3%	93.0%	0.0%	68.8%	88.4%	100.0%	57.1%	50.0%	66.7%	33.3%
1	3.5%	17.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	14.3%	20.0%	16.7%	0.0%
2	0.9%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.3%	0.0%	0.0%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%
3	3.5%	4.3%	2.5%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	2.3%	16.7%	0.0%	4.7%	0.0%	0.0%	0.0%	16.7%	33.3%
4 +	7.8%	26.1%	2.5%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	2.3%	83.3%	6.3%	4.7%	0.0%	28.6%	30.0%	0.0%	33.3%
Average	0.35	0.90	0.17	0.35	0.00	0.00	0.00	0.00	0.00	3.11	0.09	6.5	0.21	0.23	0.00	0.73	1.25	0.36	1.25
Median	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0
Range	0 to 12	0 to 11	0 to 12	0 to 4	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 12	0 to 4	3 to 11	0 to 4	0 to 10	0 to 0	0 to 6	0 to 11	0 to 3	0 to 7
Number of other types of voting board members																			
Total responding in each category	69	9	54	6	28	12	1	1	12	3	30	1	7	27	13	4	1	4	1
0	73.9%	44.4%	79.6%	66.7%	89.3%	91.7%	100.0%	100.0%	83.3%	66.7%	70.0%	100.0%	28.6%	77.8%	69.2%	25.0%	0.0%	75.0%	100.0%
1	8.7%	44.4%	1.9%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	3.3%	0.0%	57.1%	0.0%	7.7%	50.0%	100.0%	25.0%	0.0%
2	4.3%	11.1%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%	14.3%	0.0%	15.4%	25.0%	0.0%	0.0%	0.0%
3	1.4%	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%
4 +	11.6%	0.0%	13.0%	16.7%	10.7%	8.3%	0.0%	0.0%	16.7%	0.0%	16.7%	0.0%	0.0%	18.5%	7.7%	0.0%	0.0%	0.0%	0.0%
Average	0.33	0.12	0.32	0.85	0.16	0.14	0.00	0.00	0.27	0.11	0.59	0.00	0.15	0.32	0.37	0.27	0.05	0.09	0.00
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 21	0 to 2	0 to 11	0 to 21	0 to 5	0 to 5	0 to 0	0 to 0	0 to 5	0 to 1	0 to 21	0 to 0	0 to 2	0 to 8	0 to 11	0 to 2	0 to 1	0 to 1	0 to 0

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Number of "outside"/non-affiliated physicians among the independent, voting board members																			
Total responding in each category	206	46	140	20	75	32	5	6	28	7	84	5	35	82	36	12	17	11	8
0	70.9%	52.2%	75.7%	80.0%	81.3%	81.3%	100.0%	50.0%	89.3%	85.7%	69.0%	40.0%	54.3%	73.2%	69.4%	66.7%	41.2%	45.5%	50.0%
1	19.9%	32.6%	17.1%	10.0%	13.3%	18.8%	0.0%	33.3%	7.1%	0.0%	20.2%	20.0%	37.1%	18.3%	30.6%	25.0%	29.4%	36.4%	12.5%
2	5.8%	8.7%	4.3%	10.0%	4.0%	0.0%	0.0%	16.7%	0.0%	0.0%	8.3%	0.0%	5.7%	4.9%	0.0%	8.3%	17.6%	9.1%	25.0%
3	1.9%	4.3%	1.4%	0.0%	1.3%	0.0%	0.0%	0.0%	3.6%	14.3%	0.0%	20.0%	2.9%	1.2%	0.0%	0.0%	5.9%	9.1%	12.5%
4+	1.5%	2.2%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	20.0%	0.0%	2.4%	0.0%	0.0%	5.9%	0.0%	0.0%
Average	0.43	0.72	0.36	0.30	0.25	0.19	0.00	0.67	0.18	0.43	0.46	1.60	0.57	0.41	0.31	0.42	1.06	0.82	1.00
Median	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	1
Range	0 to 4	0 to 4	0 to 4	0 to 2	0 to 3	0 to 1	0 to 0	0 to 2	0 to 3	0 to 3	0 to 4	0 to 4	0 to 3	0 to 4	0 to 1	0 to 2	0 to 4	0 to 3	0 to 3
Number of "outside"/non-affiliated nurses among the independent, voting board members																			
Total responding in each category	210	48	142	20	74	31	5	6	28	7	88	5	36	81	37	14	17	11	8
0	70.0%	62.5%	73.9%	60.0%	70.3%	64.5%	60.0%	83.3%	75.0%	71.4%	72.7%	40.0%	66.7%	75.3%	67.6%	64.3%	41.2%	72.7%	87.5%
1	24.3%	25.0%	22.5%	35.0%	23.0%	25.8%	40.0%	16.7%	21.4%	14.3%	25.0%	20.0%	27.8%	22.2%	32.4%	28.6%	35.3%	18.2%	0.0%
2	4.8%	10.4%	2.8%	5.0%	6.8%	9.7%	0.0%	0.0%	3.6%	14.3%	1.1%	20.0%	5.6%	2.5%	0.0%	7.1%	17.6%	9.1%	12.5%
3	0.5%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4+	0.5%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	5.9%	0.0%	0.0%
Average	0.37	0.54	0.30	0.45	0.36	0.45	0.40	0.17	0.29	0.43	0.31	1.40	0.39	0.27	0.32	0.43	0.94	0.36	0.25
Median	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0
Range	0 to 4	0 to 4	0 to 3	0 to 2	0 to 2	0 to 2	0 to 1	0 to 1	0 to 2	0 to 2	0 to 3	0 to 4	0 to 2	0 to 2	0 to 1	0 to 2	0 to 4	0 to 2	0 to 2
If you do not have a nurse serving as a voting board member currently, do you have plans to add one in the future?																			
Total responding in each category	48	7	38	3	18	6	0	0	11	1	23	0	6	18	10	2	1	2	1
Yes	14.6%	0.0%	18.4%	0.0%	11.1%	16.7%	0.0%	0.0%	9.1%	0.0%	21.7%	0.0%	0.0%	27.8%	0.0%	50.0%	0.0%	0.0%	0.0%
No	85.4%	100.0%	81.6%	100.0%	88.9%	83.3%	0.0%	0.0%	90.9%	100.0%	78.3%	0.0%	100.0%	72.2%	100.0%	50.0%	100.0%	100.0%	100.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Numer of female voting board members																			
Total responding in each category	238	51	162	25	89	37	5	8	33	8	97	6	38	96	40	15	19	11	8
0	3.4%	2.0%	3.1%	8.0%	2.2%	2.7%	0.0%	0.0%	3.0%	25.0%	3.1%	0.0%	2.6%	4.2%	0.0%	0.0%	0.0%	0.0%	12.5%
1	8.4%	7.8%	9.3%	4.0%	11.2%	21.6%	0.0%	12.5%	0.0%	0.0%	7.2%	0.0%	7.9%	10.4%	5.0%	13.3%	0.0%	0.0%	12.5%
2	26.5%	19.6%	30.2%	16.0%	39.3%	40.5%	40.0%	25.0%	42.4%	0.0%	20.6%	0.0%	21.1%	27.1%	25.0%	0.0%	15.8%	45.5%	12.5%
3	23.9%	13.7%	25.9%	32.0%	30.3%	16.2%	20.0%	50.0%	45.5%	37.5%	19.6%	0.0%	21.1%	25.0%	22.5%	13.3%	26.3%	0.0%	25.0%
4	13.9%	15.7%	14.8%	4.0%	7.9%	8.1%	20.0%	12.5%	6.1%	25.0%	17.5%	0.0%	18.4%	14.6%	15.0%	20.0%	15.8%	27.3%	0.0%
5	10.9%	13.7%	9.9%	12.0%	5.6%	8.1%	20.0%	0.0%	3.0%	12.5%	15.5%	16.7%	10.5%	10.4%	15.0%	20.0%	15.8%	0.0%	12.5%
6+	13.0%	27.5%	6.8%	24.0%	3.4%	2.7%	0.0%	0.0%	0.0%	0.0%	16.5%	83.3%	18.4%	8.3%	17.5%	33.3%	26.3%	27.3%	25.0%
Average	3.32	4.08	3.00	3.88	2.63	2.43	3.20	2.63	2.61	2.75	3.67	6.83	3.63	3.09	3.70	4.47	4.32	4.09	3.63
Median	3	4	3	3	2	2	3	3	3	3	3	7	3	3	3	5	4	4	3
Range	0 to 10	0 to 9	0 to 8	0 to 10	0 to 7	0 to 7	2 to 5	1 to 4	0 to 5	0 to 5	0 to 10	5 to 8	0 to 9	0 to 10	1 to 7	1 to 7	2 to 8	2 to 9	0 to 8
Number of voting board members from an ethnic minority																			
Total responding in each category	240	50	164	26	89	37	5	8	33	9	99	6	37	97	43	14	19	11	8
0	51.3%	26.0%	61.0%	38.5%	62.9%	64.9%	60.0%	62.5%	66.7%	44.4%	52.5%	16.7%	27.0%	58.8%	41.9%	35.7%	10.5%	18.2%	12.5%
1	21.3%	20.0%	20.1%	30.8%	18.0%	24.3%	20.0%	12.5%	15.2%	22.2%	24.2%	33.3%	18.9%	24.7%	25.6%	28.6%	15.8%	9.1%	25.0%
2	12.9%	20.0%	10.4%	15.4%	4.5%	5.4%	0.0%	12.5%	3.0%	33.3%	14.1%	16.7%	24.3%	9.3%	18.6%	14.3%	26.3%	18.2%	37.5%
3	4.6%	8.0%	3.7%	3.8%	2.2%	0.0%	0.0%	12.5%	3.0%	0.0%	5.1%	0.0%	10.8%	4.1%	4.7%	0.0%	10.5%	18.2%	12.5%
4	2.9%	8.0%	1.8%	0.0%	4.5%	2.7%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	8.1%	1.0%	4.7%	0.0%	10.5%	18.2%	0.0%
5	4.6%	14.0%	1.2%	7.7%	4.5%	2.7%	0.0%	0.0%	6.1%	0.0%	2.0%	16.7%	10.8%	1.0%	2.3%	14.3%	10.5%	18.2%	12.5%
6+	2.5%	4.0%	1.8%	3.8%	3.4%	0.0%	20.0%	0.0%	3.0%	0.0%	2.0%	16.7%	0.0%	1.0%	2.3%	7.1%	15.8%	0.0%	0.0%
Average	1.15	2.20	0.79	1.35	0.99	0.59	1.80	0.75	0.94	0.89	0.92	3.17	1.86	0.71	1.26	1.86	3.21	2.64	2.00
Median	0	2	0	1	0	0	0	0	0	1	0	1	2	0	1	1	2	3	2
Range	0 to 10	0 to 10	0 to 8	0 to 6	0 to 8	0 to 5	0 to 8	0 to 3	0 to 7	0 to 2	0 to 8	0 to 10	0 to 5	0 to 6	0 to 8	0 to 8	0 to 10	0 to 5	0 to 5
Do your bylaws specify defined terms for the length of elected service?																			
Total responding in each category	243	52	165	26	88	37	5	7	33	9	101	6	39	97	43	15	20	11	8
Yes	90.1%	96.2%	88.5%	88.5%	85.2%	73.0%	100.0%	85.7%	93.9%	100.0%	92.1%	100.0%	92.3%	88.7%	95.3%	86.7%	95.0%	100.0%	100.0%
Length of term (in years) (median)	3	3	3	3	4	4	4	3	3	3	3	3	3	3	3	3	3	3	3

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Do your bylaws limit the number of consecutive terms? ("term limits")																			
Total responding in each category	219	49	147	23	76	28	5	6	31	9	93	6	35	87	41	13	19	11	7
Yes	64.4%	79.6%	56.5%	82.6%	28.9%	28.6%	40.0%	50.0%	19.4%	77.8%	81.7%	83.3%	88.6%	64.4%	73.2%	69.2%	84.2%	90.9%	71.4%
Maximum number of terms (median)	3	3	3	3	2	2	3	2	2	3	3	3	3	3	3	3	3	3	3
Maximum age for serving on the board ("age limit")																			
Total responding in each category	242	52	164	26	89	37	5	8	33	9	99	6	39	97	43	15	20	11	8
Yes	6.2%	19.2%	2.4%	3.8%	1.1%	0.0%	0.0%	0.0%	3.0%	11.1%	4.0%	0.0%	23.1%	2.1%	7.0%	20.0%	5.0%	18.2%	50.0%
Average age limit	73.00	74.30	70.00	75.00	70.67	70.00	N/A	N/A	72.00	68.00	72.33	N/A	74.56	70.00	71.67	80.00	72.00	70.00	72.75
Median age limit	72	72	70	75	72	70	N/A	N/A	72	68	72	N/A	72	70	72	75	72	70	72
Range age limit	65 to 90	70 to 90	65 to 75	75 to 75	65 to 75	65 to 75	N/A	N/A	72 to 72	68 to 68	70 to 75	N/A	70 to 90	65 to 75	68 to 75	75 to 90	72 to 72	70 to 70	72 to 75
Average board member age (approximate)																			
Total responding in each category	207	41	144	25	80	33	5	7	32	8	85	4	30	82	39	11	15	9	7
Average	69.76	59.63	57.87	59.92	70.67	70.00	NA	NA	72.00	68.00	58.75	NA	74.56	57.00	71.67	80.00	72.00	70.00	72.75
Median	72	61	58	60	72	70	NA	NA	72	68	71	NA	72	67	72	75	72	70	72
Range	45 to 90	50 to 67	45 to 72	50 to 70	65 to 75	65 to 75	NA	NA	72 to 72	68 to 68	70 to 75	NA	70 to 90	65 to 75	68 to 75	75 to 90	72 to 72	70 to 70	72 to 75
Participation on the board (N/A not included)																			
President/CEO																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Voting board member	39.8%	69.2%	27.1%	61.5%	7.9%	5.4%	0.0%	0.0%	12.1%	55.6%	49.5%	83.3%	76.9%	31.6%	53.5%	53.3%	70.0%	81.8%	87.5%
Non-voting board member	18.0%	7.7%	21.7%	15.4%	21.3%	24.3%	20.0%	37.5%	15.2%	11.1%	19.8%	0.0%	10.3%	22.4%	14.0%	20.0%	0.0%	0.0%	12.5%
Non-board member; regularly attends meetings	42.2%	23.1%	51.2%	23.1%	70.8%	70.3%	80.0%	62.5%	72.7%	33.3%	30.7%	16.7%	12.8%	45.9%	32.6%	26.7%	30.0%	18.2%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents with this position	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Chief of Staff																			
Total responding in each category	240	50	164	26	88	36	5	8	33	9	100	6	37	98	41	15	20	11	7
Voting board member	25.3%	19.4%	24.8%	36.4%	11.3%	12.1%	0.0%	37.5%	6.7%	12.5%	40.5%	0.0%	25.0%	27.9%	25.7%	36.4%	28.6%	14.3%	0.0%
Non-voting board member	13.6%	9.7%	15.2%	9.1%	11.3%	12.1%	25.0%	12.5%	6.7%	12.5%	16.7%	50.0%	8.3%	12.8%	22.9%	27.3%	0.0%	0.0%	50.0%
Non-board member; regularly attends meetings	38.9%	54.8%	37.9%	22.7%	51.3%	51.5%	75.0%	50.0%	50.0%	25.0%	26.2%	50.0%	45.8%	34.9%	45.7%	18.2%	57.1%	71.4%	50.0%
Non-board member; does not regularly attend meetings	22.2%	16.1%	22.1%	31.8%	26.3%	24.2%	0.0%	0.0%	36.7%	50.0%	16.7%	0.0%	20.8%	24.4%	5.7%	18.2%	14.3%	14.3%	0.0%
Percentage of respondents with this position	82.5%	62.0%	88.4%	84.6%	90.9%	91.7%	80.0%	100.0%	90.9%	88.9%	84.0%	33.3%	64.9%	87.8%	85.4%	73.3%	70.0%	63.6%	28.6%
VP Medical Affairs/Chief Medical Officer																			
Total responding in each category	240	52	162	26	88	36	5	8	33	9	98	6	39	95	43	15	20	11	8
Voting board member	4.6%	2.0%	5.8%	5.9%	2.3%	0.0%	0.0%	0.0%	5.6%	0.0%	7.8%	20.0%	0.0%	8.3%	0.0%	0.0%	5.6%	0.0%	0.0%
Non-voting board member	7.2%	4.0%	8.1%	11.8%	4.5%	6.7%	0.0%	0.0%	0.0%	0.0%	10.9%	0.0%	5.4%	4.2%	10.5%	7.1%	5.6%	0.0%	12.5%
Non-board member; regularly attends meetings	76.5%	84.0%	74.4%	64.7%	79.5%	80.0%	100.0%	100.0%	83.3%	100.0%	70.3%	60.0%	83.8%	66.7%	81.6%	85.7%	83.3%	100.0%	75.0%
Non-board member; does not regularly attend meetings	11.8%	10.0%	11.6%	17.6%	13.6%	13.3%	0.0%	0.0%	11.1%	0.0%	10.9%	20.0%	10.8%	20.8%	7.9%	7.1%	5.6%	0.0%	12.5%
Percentage of respondents with this position	63.8%	96.2%	53.1%	65.4%	50.0%	41.7%	80.0%	25.0%	54.5%	33.3%	65.3%	83.3%	94.9%	50.5%	88.4%	93.3%	90.0%	100.0%	100.0%
Chief Operating Officer																			
Total responding in each category	241	52	163	26	86	35	5	8	32	9	101	6	39	97	43	15	20	11	8
Voting board member	0.7%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%
Non-voting board member	8.1%	5.1%	7.5%	17.6%	2.1%	5.0%	0.0%	0.0%	0.0%	0.0%	13.4%	0.0%	7.1%	9.1%	6.3%	10.0%	5.6%	0.0%	0.0%
Non-board member; regularly attends meetings	88.6%	89.7%	90.3%	76.5%	93.6%	85.0%	100.0%	100.0%	100.0%	100.0%	85.1%	100.0%	85.7%	87.3%	90.6%	80.0%	88.9%	100.0%	100.0%
Non-board member; does not regularly attend meetings	2.7%	2.6%	2.2%	5.9%	4.3%	10.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	3.6%	3.6%	3.1%	10.0%	0.0%	0.0%	0.0%
Percentage of respondents with this position	61.8%	75.0%	57.1%	65.4%	54.7%	57.1%	60.0%	50.0%	53.1%	22.2%	66.3%	83.3%	71.8%	56.7%	74.4%	66.7%	90.0%	72.7%	87.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Chief Operating Officer																			
Total responding in each category	241	52	163	26	86	35	5	8	32	9	101	6	39	97	43	15	20	11	8
Voting board member	0.7%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%
Non-voting board member	8.1%	5.1%	7.5%	17.6%	2.1%	5.0%	0.0%	0.0%	0.0%	0.0%	13.4%	0.0%	7.1%	9.1%	6.3%	10.0%	5.6%	0.0%	0.0%
Non-board member; regularly attends meetings	88.6%	89.7%	90.3%	76.5%	93.6%	85.0%	100.0%	100.0%	100.0%	100.0%	85.1%	100.0%	85.7%	87.3%	90.6%	80.0%	88.9%	100.0%	100.0%
Non-board member; does not regularly attend meetings	2.7%	2.6%	2.2%	5.9%	4.3%	10.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	3.6%	3.6%	3.1%	10.0%	0.0%	0.0%	0.0%
Respondents with this position	61.8%	75.0%	57.1%	65.4%	54.7%	57.1%	60.0%	50.0%	53.1%	22.2%	66.3%	83.3%	71.8%	56.7%	74.4%	66.7%	90.0%	72.7%	87.5%
Chief Financial Officer																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Voting board member	0.4%	0.0%	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	8.8%	7.8%	9.8%	4.2%	5.7%	8.3%	0.0%	12.5%	3.1%	25.0%	10.1%	0.0%	10.5%	8.3%	7.0%	13.3%	10.0%	0.0%	0.0%
Non-board member; regularly attends meetings	88.2%	90.2%	88.3%	83.3%	93.1%	88.9%	100.0%	87.5%	96.9%	62.5%	85.9%	100.0%	86.8%	87.5%	93.0%	80.0%	90.0%	100.0%	100.0%
Non-board member; does not regularly attend meetings	2.5%	2.0%	1.8%	8.3%	1.1%	2.8%	0.0%	0.0%	0.0%	12.5%	3.0%	0.0%	2.6%	3.1%	0.0%	6.7%	0.0%	0.0%	0.0%
Percentage of respondents with this position	97.5%	98.1%	98.2%	92.3%	97.8%	97.3%	100.0%	100.0%	97.0%	88.9%	98.0%	100.0%	97.4%	98.0%	100.0%	100.0%	100.0%	90.9%	100.0%
Chief Nursing Officer																			
Total responding in each category	243	51	166	26	89	37	5	8	33	9	101	6	38	98	43	15	20	10	8
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	7.9%	4.7%	8.1%	12.5%	3.5%	5.6%	0.0%	0.0%	3.1%	14.3%	12.1%	0.0%	6.5%	10.4%	4.8%	7.1%	5.6%	0.0%	0.0%
Non-board member; regularly attends meetings	77.6%	74.4%	78.3%	79.2%	82.6%	83.3%	50.0%	87.5%	84.4%	71.4%	75.8%	80.0%	71.0%	79.2%	83.3%	78.6%	88.9%	62.5%	40.0%
Non-board member; does not regularly attend meetings	14.5%	20.9%	13.7%	8.3%	14.0%	11.1%	50.0%	12.5%	12.5%	14.3%	12.1%	20.0%	22.6%	10.4%	11.9%	14.3%	5.6%	37.5%	60.0%
Percentage of respondents with this position	93.8%	84.3%	97.0%	92.3%	96.6%	97.3%	80.0%	100.0%	97.0%	77.8%	98.0%	83.3%	81.6%	98.0%	97.7%	93.3%	90.0%	80.0%	62.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Chief Information Officer																			
Total responding in each category	239	52	162	25	87	36	5	8	32	9	98	6	39	94	42	15	20	11	8
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	3.8%	4.3%	3.2%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	5.7%	1.9%	3.2%	7.1%	5.6%	0.0%	0.0%
Non-board member; regularly attends meetings	38.2%	43.5%	39.8%	16.7%	39.1%	40.0%	100.0%	25.0%	33.3%	40.0%	34.8%	80.0%	37.1%	33.3%	48.4%	28.6%	50.0%	30.0%	42.9%
Non-board member; does not regularly attend meetings	58.0%	52.2%	57.0%	77.8%	60.9%	60.0%	0.0%	75.0%	66.7%	60.0%	59.1%	20.0%	57.1%	64.8%	48.4%	64.3%	44.4%	70.0%	57.1%
Percentage of respondents with this position	65.7%	88.5%	57.4%	72.0%	52.9%	55.6%	40.0%	50.0%	46.9%	55.6%	67.3%	83.3%	89.7%	57.4%	73.8%	93.3%	90.0%	90.9%	87.5%
Legal Counsel																			
Total responding in each category	240	52	163	25	88	37	5	8	32	9	98	6	39	94	43	15	20	11	8
Voting board member	2.4%	0.0%	2.0%	11.1%	1.5%	4.2%	0.0%	0.0%	0.0%	0.0%	5.3%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	4.8%	10.6%	2.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	0.0%	14.3%	3.7%	2.8%	25.0%	11.1%	0.0%	0.0%
Non-board member; regularly attends meetings	55.4%	74.5%	47.5%	50.0%	57.6%	66.7%	33.3%	57.1%	50.0%	66.7%	43.9%	100.0%	62.9%	40.7%	66.7%	58.3%	77.8%	81.8%	100.0%
Non-board member; does not regularly attend meetings	37.3%	14.9%	48.5%	33.3%	40.9%	29.2%	66.7%	42.9%	50.0%	33.3%	45.6%	0.0%	22.9%	51.9%	30.6%	16.7%	11.1%	18.2%	0.0%
Percentage of respondents with this position	69.2%	90.4%	62.0%	72.0%	75.0%	64.9%	60.0%	87.5%	87.5%	33.3%	58.2%	83.3%	89.7%	57.4%	83.7%	80.0%	90.0%	100.0%	100.0%
Compliance Officer																			
Total responding in each category	243	52	165	26	89	37	5	8	33	9	100	6	39	97	43	15	20	11	8
Voting board member	0.4%	0.0%	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	2.6%	6.1%	1.9%	0.0%	1.2%	2.9%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	8.3%	1.1%	0.0%	13.3%	5.3%	0.0%	0.0%
Non-board member; regularly attends meetings	41.9%	34.7%	44.2%	41.7%	51.8%	47.1%	20.0%	37.5%	64.5%	37.5%	40.4%	50.0%	22.2%	42.9%	43.6%	46.7%	47.4%	20.0%	25.0%
Non-board member; does not regularly attend meetings	55.1%	59.2%	53.9%	54.2%	47.0%	50.0%	80.0%	62.5%	35.5%	62.5%	56.4%	50.0%	69.4%	56.0%	56.4%	40.0%	47.4%	80.0%	75.0%
Percentage of respondents with this position	93.4%	94.2%	93.3%	92.3%	93.3%	91.9%	100.0%	100.0%	93.9%	88.9%	94.0%	100.0%	92.3%	93.8%	90.7%	100.0%	95.0%	90.9%	100.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Independent	Subsidiary	Government	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Past president of medical staff																			
Total responding in each category	241	52	165	24	89	37	5	8	33	9	98	6	39	95	43	15	20	11	8
Voting board member	3.0%	10.0%	1.7%	0.0%	3.3%	4.0%	0.0%	0.0%	4.2%	0.0%	1.4%	0.0%	8.3%	1.4%	2.6%	10.0%	13.3%	0.0%	0.0%
Non-voting board member	2.4%	6.7%	1.7%	0.0%	1.7%	4.0%	0.0%	0.0%	0.0%	16.7%	0.0%	0.0%	8.3%	2.9%	0.0%	10.0%	6.7%	0.0%	0.0%
Non-board member; regularly attends meetings	5.5%	3.3%	6.7%	0.0%	3.3%	8.0%	0.0%	0.0%	0.0%	0.0%	8.3%	33.3%	0.0%	4.3%	5.3%	10.0%	6.7%	0.0%	0.0%
Non-board member; does not regularly attend meetings	89.1%	80.0%	89.9%	100.0%	91.7%	84.0%	100.0%	100.0%	95.8%	83.3%	90.3%	66.7%	83.3%	91.3%	92.1%	70.0%	73.3%	100.0%	100.0%
Percentage of respondents with this position	68.5%	57.7%	72.1%	66.7%	67.4%	67.6%	80.0%	87.5%	72.7%	66.7%	73.5%	50.0%	61.5%	72.6%	88.4%	66.7%	75.0%	45.5%	25.0%
President-elect of medical staff																			
Total responding in each category	239	51	163	25	88	36	5	8	33	9	98	6	38	96	41	15	20	11	8
Voting board member	6.8%	9.4%	4.5%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.2%	0.0%	16.7%	5.4%	2.9%	30.0%	6.3%	16.7%	0.0%
Non-voting board member	5.6%	15.6%	3.6%	0.0%	1.9%	4.2%	0.0%	0.0%	0.0%	0.0%	3.9%	0.0%	20.8%	4.1%	5.9%	20.0%	12.5%	0.0%	0.0%
Non-board member; regularly attends meetings	14.8%	18.8%	14.3%	11.1%	16.7%	29.2%	0.0%	0.0%	5.0%	0.0%	15.8%	33.3%	8.3%	8.1%	17.6%	10.0%	37.5%	16.7%	0.0%
Non-board member; does not regularly attend meetings	72.8%	56.3%	77.7%	72.2%	81.5%	66.7%	100.0%	100.0%	95.0%	100.0%	71.1%	66.7%	54.2%	82.4%	73.5%	40.0%	43.8%	66.7%	100.0%
Percentage of respondents with this position	67.8%	62.7%	68.7%	72.0%	61.4%	66.7%	60.0%	75.0%	60.6%	55.6%	77.6%	50.0%	63.2%	77.1%	82.9%	66.7%	80.0%	54.5%	25.0%
Representative of an owned or affiliated medical group or physician enterprise																			
Total responding in each category	240	52	163	25	87	37	5	7	32	9	99	6	39	95	43	15	20	11	8
Voting board member	20.2%	12.5%	19.7%	45.5%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	33.3%	33.3%	17.4%	18.8%	20.7%	20.0%	20.0%	12.5%	25.0%
Non-voting board member	1.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	3.4%	0.0%	0.0%	0.0%	0.0%
Non-board member; regularly attends meetings	24.0%	25.0%	27.9%	0.0%	35.5%	45.5%	100.0%	33.3%	21.4%	50.0%	20.0%	0.0%	17.4%	21.9%	34.5%	20.0%	30.0%	12.5%	0.0%
Non-board member; does not regularly attend meetings	54.8%	62.5%	50.8%	54.5%	64.5%	54.5%	0.0%	66.7%	78.6%	0.0%	44.4%	66.7%	65.2%	59.4%	41.4%	60.0%	50.0%	75.0%	75.0%
Percentage of respondents with this position	43.3%	61.5%	37.4%	44.0%	35.6%	29.7%	20.0%	42.9%	43.8%	22.2%	45.5%	50.0%	59.0%	33.7%	67.4%	66.7%	50.0%	72.7%	50.0%

All Respondents	Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Representative of an affiliated philanthropic foundation																			
Total responding in each category	241	52	164	25	88	37	5	7	33	9	99	6	39	95	43	15	20	11	8
Voting board member	10.4%	3.6%	11.4%	17.6%	2.3%	6.7%	0.0%	0.0%	0.0%	20.0%	19.6%	0.0%	5.6%	9.8%	16.1%	11.1%	8.3%	0.0%	0.0%
Non-voting board member	4.3%	10.7%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	16.7%	0.0%	6.5%	22.2%	8.3%	0.0%	0.0%
Non-board member; regularly attends meetings	24.3%	25.0%	27.1%	11.8%	39.5%	33.3%	50.0%	40.0%	47.1%	20.0%	10.9%	33.3%	22.2%	19.5%	25.8%	11.1%	33.3%	0.0%	33.3%
Non-board member; does not regularly attend meetings	60.9%	60.7%	58.6%	70.6%	58.1%	60.0%	50.0%	60.0%	52.9%	60.0%	65.2%	66.7%	55.6%	70.7%	51.6%	55.6%	50.0%	100.0%	66.7%
Percentage of respondents with this position	47.7%	53.8%	42.7%	68.0%	48.9%	40.5%	80.0%	71.4%	51.5%	55.6%	46.5%	50.0%	46.2%	43.2%	72.1%	60.0%	60.0%	54.5%	37.5%
Representative of a religious sponsor																			
Total responding in each category	241	51	165	25	89	37	5	8	33	9	99	6	38	96	43	14	20	11	8
Voting board member	31.9%	61.5%	13.6%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	22.2%	83.3%	50.0%	26.3%	0.0%	50.0%	57.1%	25.0%	100.0%
Non-voting board member	2.1%	0.0%	0.0%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%
Non-board member; regularly attends meetings	8.5%	7.7%	9.1%	8.3%	16.7%	0.0%	100.0%	0.0%	0.0%	20.0%	0.0%	16.7%	0.0%	15.8%	0.0%	0.0%	14.3%	0.0%	0.0%
Non-board member; does not regularly attend meetings	57.4%	30.8%	77.3%	50.0%	83.3%	100.0%	0.0%	0.0%	100.0%	20.0%	72.2%	0.0%	50.0%	57.9%	100.0%	50.0%	14.3%	75.0%	0.0%
Percentage of respondents with this position	19.5%	25.5%	13.3%	48.0%	13.5%	5.4%	20.0%	0.0%	21.2%	55.6%	18.2%	100.0%	15.8%	19.8%	16.3%	28.6%	35.0%	36.4%	25.0%
Background of the organization's CEO																			
Total responding in each category	242	52	164	26	88	37	4	8	33	9	100	6	39	98	42	14	20	11	8
Physician	5.8%	15.4%	3.7%	0.0%	5.7%	5.4%	25.0%	0.0%	3.0%	0.0%	3.0%	16.7%	12.8%	4.1%	2.4%	28.6%	20.0%	9.1%	0.0%
Nurse	14.9%	5.8%	18.3%	11.5%	19.3%	21.6%	0.0%	37.5%	15.2%	22.2%	14.0%	0.0%	7.7%	19.4%	9.5%	7.1%	10.0%	0.0%	0.0%
Other clinical expertise	14.5%	1.9%	17.7%	19.2%	22.7%	21.6%	25.0%	25.0%	24.2%	11.1%	13.0%	0.0%	2.6%	20.4%	14.3%	0.0%	0.0%	0.0%	12.5%
Management or finance (for-profit)	17.8%	15.4%	18.3%	19.2%	21.6%	21.6%	25.0%	0.0%	24.2%	22.2%	16.0%	0.0%	15.4%	17.3%	23.8%	14.3%	20.0%	18.2%	0.0%
Management or finance (non-profit/ not-for-profit)	64.5%	71.2%	61.6%	69.2%	52.3%	48.6%	50.0%	50.0%	57.6%	77.8%	70.0%	66.7%	74.4%	63.3%	69.0%	57.1%	65.0%	72.7%	87.5%
Other non-clinical/ non-healthcare	5.0%	5.8%	4.9%	3.8%	4.5%	5.4%	0.0%	0.0%	6.1%	11.1%	4.0%	16.7%	5.1%	2.0%	7.1%	14.3%	0.0%	9.1%	12.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Background of the organization's board chairperson																			
Total responding in each category	243	52	165	26	89	37	5	8	33	9	100	6	39	98	43	15	20	11	8
Physician	6.6%	7.7%	4.8%	15.4%	6.7%	2.7%	0.0%	12.5%	9.1%	0.0%	7.0%	0.0%	7.7%	4.1%	7.0%	0.0%	20.0%	18.2%	12.5%
Nurse	2.5%	0.0%	2.4%	7.7%	3.4%	5.4%	0.0%	0.0%	3.0%	11.1%	2.0%	0.0%	0.0%	4.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Other clinical expertise	4.5%	1.9%	5.5%	3.8%	7.9%	2.7%	0.0%	0.0%	12.1%	11.1%	2.0%	0.0%	2.6%	5.1%	2.3%	0.0%	0.0%	9.1%	0.0%
Management or finance (for-profit)	47.3%	59.6%	43.0%	50.0%	31.5%	27.0%	40.0%	37.5%	33.3%	55.6%	55.0%	50.0%	61.5%	44.9%	53.5%	53.3%	40.0%	72.7%	75.0%
Management or finance (non-profit/not-for-profit)	8.6%	11.5%	7.9%	7.7%	11.2%	13.5%	20.0%	12.5%	9.1%	0.0%	5.0%	0.0%	15.4%	8.2%	9.3%	20.0%	10.0%	9.1%	0.0%
Other non-clinical/ non-healthcare	32.9%	23.1%	38.2%	19.2%	42.7%	51.4%	60.0%	37.5%	36.4%	33.3%	29.0%	50.0%	17.9%	34.7%	30.2%	26.7%	35.0%	0.0%	12.5%
Top three essential core competencies being sought in the next one to three years for new board members																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Finance/business acumen	64.3%	65.4%	65.1%	57.7%	73.0%	75.7%	60.0%	62.5%	75.8%	55.6%	58.4%	83.3%	59.0%	67.3%	62.8%	60.0%	55.0%	54.5%	62.5%
Strategic planning and visioning	62.7%	53.8%	68.7%	42.3%	70.8%	73.0%	80.0%	75.0%	63.6%	88.9%	55.4%	83.3%	53.8%	70.4%	58.1%	40.0%	40.0%	81.8%	37.5%
Quality and patient safety	43.0%	28.8%	48.2%	38.5%	49.4%	29.7%	60.0%	75.0%	63.6%	0.0%	48.5%	16.7%	28.2%	51.0%	32.6%	33.3%	20.0%	54.5%	12.5%
Previous non-profit healthcare board experience	10.2%	9.6%	10.8%	7.7%	10.1%	16.2%	0.0%	0.0%	9.1%	22.2%	8.9%	0.0%	12.8%	9.2%	14.0%	13.3%	10.0%	0.0%	25.0%
Change management	11.9%	7.7%	12.7%	15.4%	10.1%	13.5%	0.0%	0.0%	9.1%	33.3%	13.9%	0.0%	7.7%	12.2%	11.6%	0.0%	10.0%	18.2%	12.5%
Conflict management	1.2%	1.9%	0.6%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.0%	0.0%	2.6%	2.0%	0.0%	0.0%	0.0%	9.1%	0.0%
Clinical practice experience	7.4%	7.7%	7.8%	3.8%	5.6%	8.1%	0.0%	0.0%	6.1%	0.0%	7.9%	16.7%	10.3%	8.2%	0.0%	6.7%	5.0%	9.1%	25.0%
Legal	8.2%	3.8%	10.2%	3.8%	7.9%	5.4%	40.0%	12.5%	6.1%	22.2%	8.9%	0.0%	5.1%	10.2%	14.0%	6.7%	0.0%	9.1%	0.0%
Actuarial/health insurance/managed care experience	7.8%	17.3%	4.8%	7.7%	7.9%	10.8%	0.0%	0.0%	6.1%	0.0%	7.9%	0.0%	10.3%	3.1%	11.6%	20.0%	20.0%	9.1%	25.0%
IT and social media expertise	8.2%	13.5%	6.0%	11.5%	5.6%	0.0%	20.0%	0.0%	9.1%	11.1%	6.9%	0.0%	17.9%	6.1%	2.3%	26.7%	25.0%	9.1%	0.0%
Digital/mobile health technology expertise	8.6%	21.2%	4.8%	7.7%	2.2%	0.0%	0.0%	0.0%	6.1%	0.0%	8.9%	0.0%	25.6%	4.1%	9.3%	13.3%	15.0%	9.1%	50.0%
Medical/science technology expertise	3.7%	5.8%	3.0%	3.8%	2.2%	2.7%	0.0%	0.0%	3.0%	0.0%	4.0%	0.0%	7.7%	4.1%	2.3%	0.0%	10.0%	9.1%	0.0%
Consumer-facing business expertise	28.7%	32.7%	25.3%	42.3%	22.5%	21.6%	0.0%	62.5%	15.2%	33.3%	30.7%	50.0%	33.3%	24.5%	30.2%	46.7%	35.0%	18.2%	12.5%
Innovation/disruption expertise	16.0%	17.3%	13.9%	26.9%	5.6%	10.8%	0.0%	12.5%	0.0%	11.1%	24.8%	33.3%	15.4%	13.3%	25.6%	13.3%	30.0%	9.1%	25.0%
Fundraising	11.1%	7.7%	11.4%	15.4%	13.5%	10.8%	40.0%	0.0%	15.2%	22.2%	8.9%	16.7%	7.7%	10.2%	14.0%	13.3%	15.0%	0.0%	12.5%
Other	7.0%	5.8%	6.6%	11.5%	13.5%	21.6%	0.0%	0.0%	12.1%	0.0%	4.0%	0.0%	2.6%	4.1%	11.6%	6.7%	10.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Regularly scheduled board meetings per year																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Less than 2 per year	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2 per year	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4 per year (quarterly)	12.3%	34.6%	3.6%	23.1%	3.4%	0.0%	0.0%	0.0%	3.0%	33.3%	7.9%	83.3%	28.2%	7.1%	7.0%	26.7%	30.0%	54.5%	37.5%
6 per year	11.5%	23.1%	6.0%	23.1%	2.2%	5.4%	0.0%	0.0%	0.0%	11.1%	13.9%	0.0%	28.2%	7.1%	18.6%	6.7%	20.0%	18.2%	62.5%
7 to 9 per year	4.9%	11.5%	2.4%	7.7%	1.1%	2.7%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	15.4%	2.0%	9.3%	13.3%	15.0%	9.1%	0.0%
10 to 11 per year	25.0%	19.2%	28.9%	11.5%	20.2%	18.9%	20.0%	37.5%	15.2%	33.3%	33.7%	16.7%	12.8%	30.6%	34.9%	20.0%	10.0%	18.2%	0.0%
12 per year (monthly)	40.2%	11.5%	51.2%	26.9%	64.0%	59.5%	80.0%	50.0%	75.8%	22.2%	32.7%	0.0%	15.4%	44.9%	27.9%	26.7%	15.0%	0.0%	0.0%
More than 12 per year	5.7%	0.0%	7.2%	7.7%	9.0%	13.5%	0.0%	12.5%	6.1%	0.0%	5.9%	0.0%	0.0%	8.2%	2.3%	6.7%	10.0%	0.0%	0.0%
Approximate duration (scheduled) of a typical board meeting																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Less than 2 hours	32.8%	7.7%	40.4%	34.6%	40.4%	40.5%	80.0%	50.0%	36.4%	33.3%	36.6%	16.7%	7.7%	45.9%	30.2%	6.7%	10.0%	0.0%	0.0%
2 to 4 hours	59.0%	61.5%	58.4%	57.7%	55.1%	56.8%	20.0%	50.0%	60.6%	66.7%	61.4%	33.3%	64.1%	54.1%	62.8%	80.0%	70.0%	45.5%	62.5%
4 to 6 hours	5.7%	21.2%	1.2%	3.8%	4.5%	2.7%	0.0%	0.0%	3.0%	0.0%	1.0%	33.3%	17.9%	0.0%	7.0%	6.7%	15.0%	45.5%	12.5%
6 to 8 hours	1.6%	5.8%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	7.7%	0.0%	0.0%	6.7%	0.0%	9.1%	12.5%
More than 8 hours	0.8%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.7%	2.6%	0.0%	0.0%	0.0%	5.0%	0.0%	12.5%
The board uses a consent agenda																			
Total responding in each category	242	52	164	26	89	37	5	8	33	9	99	6	39	96	43	15	20	11	8
Yes	79.3%	84.6%	77.4%	80.8%	75.3%	67.6%	80.0%	75.0%	81.8%	55.6%	82.8%	83.3%	84.6%	74.0%	88.4%	86.7%	100.0%	72.7%	50.0%
Board meeting content: average and median percent of meeting time spent:																			
Active discussion, deliberation, and debate about strategic priorities of the organization																			
Average	30.76	33.71	30.33	27.38	28.79	27.22	21.00	28.75	33.03	28.13	30.45	33.33	36.23	30.03	29.81	34.00	36.70	34.00	27.5
Median	25	30	28	25	25	20	20	30	30	25	27	30	30	25	25	30	34	30	25
Reviewing financial performance																			
Average	19.22	18.69	19.52	18.33	20.79	22.57	10.00	21.25	19.39	20.00	18.45	21.00	17.21	19.30	18.79	20.67	15.40	19.45	16.88
Median	20	20	20	20	20	25	10	20	20	20	20	17	15	20	20	20	13	20	15
Reviewing quality of care/patient safety metrics																			
Average	18.42	16.71	18.96	18.33	19.61	20.14	36.00	21.25	15.45	18.13	18.68	11.50	16.15	18.99	20.14	15.67	15.60	20.82	14.75
Median	20	15	20	18	20	20	30	20	15	20	20	10	15	20	20	15	15	15	12

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Reviewing other reports from management, board committees, and subsidiaries (not including financial and quality/safety reports)																			
Average	19.50	18.38	19.21	23.96	18.99	19.19	14.00	17.50	19.70	24.38	20.14	23.17	17.49	20.19	19.67	19.00	16.60	14.73	25.88
Median	20	15	20	20	20	20	10	17	20	20	20	20	15	20	20	20	12	12	25
Board member education																			
Average	12.09	12.50	11.98	12.00	11.83	10.89	19.00	11.25	12.42	9.38	12.28	11.00	12.92	11.49	11.58	10.67	15.70	11.00	15.00
Median	10	10	10	10	10	10	20	10	10	10	10	10	10	10	10	10	15	10	15
Percent of meeting time spent in active discussion, deliberation, and debate about strategic priorities																			
Total responding in each category	242	52	166	24	89	37	5	8	33	8	100	6	39	97	43	15	20	11	8
0–10%	7.4%	5.8%	7.8%	8.3%	9.0%	10.8%	0.0%	12.5%	9.1%	12.5%	7.0%	0.0%	5.1%	8.2%	4.7%	6.7%	5.0%	9.1%	0.0%
11–20%	29.8%	28.8%	30.1%	29.2%	34.8%	40.5%	80.0%	12.5%	18.2%	12.5%	30.0%	16.7%	23.1%	28.9%	39.5%	20.0%	30.0%	27.3%	50.0%
21–30%	25.6%	23.1%	24.1%	41.7%	24.7%	18.9%	20.0%	50.0%	30.3%	50.0%	24.0%	33.3%	25.6%	28.9%	20.9%	33.3%	10.0%	18.2%	25.0%
31–40%	16.5%	15.4%	19.3%	0.0%	15.7%	13.5%	0.0%	12.5%	24.2%	12.5%	18.0%	33.3%	12.8%	15.5%	18.6%	13.3%	10.0%	18.2%	12.5%
41–50%	14.0%	13.5%	13.3%	20.8%	10.1%	10.8%	0.0%	12.5%	9.1%	12.5%	17.0%	0.0%	17.9%	13.4%	9.3%	20.0%	25.0%	9.1%	12.5%
51–60%	3.7%	5.8%	3.6%	0.0%	2.2%	2.7%	0.0%	0.0%	3.0%	0.0%	4.0%	16.7%	5.1%	2.1%	4.7%	0.0%	15.0%	9.1%	0.0%
61–70%	1.7%	3.8%	1.2%	0.0%	2.2%	2.7%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	5.1%	2.1%	0.0%	0.0%	5.0%	9.1%	0.0%
71–80%	1.2%	3.8%	0.6%	0.0%	1.1%	0.0%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	5.1%	1.0%	2.3%	6.7%	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%	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	175	43	115	17	65	24	3	7	27	4	67	6	33	66	33	14	15	8	8
After or before every board meeting	54.9%	74.4%	50.4%	35.3%	49.2%	58.3%	33.3%	42.9%	44.4%	0.0%	52.2%	66.7%	75.8%	50.0%	45.5%	71.4%	66.7%	62.5%	87.5%
After or before every other board meeting	7.4%	7.0%	7.0%	11.8%	9.2%	8.3%	0.0%	0.0%	11.1%	25.0%	4.5%	0.0%	9.1%	7.6%	9.1%	0.0%	6.7%	12.5%	12.5%
Quarterly	6.9%	0.0%	9.6%	5.9%	10.8%	4.2%	33.3%	14.3%	14.8%	0.0%	7.5%	0.0%	0.0%	10.6%	6.1%	0.0%	6.7%	0.0%	0.0%
Twice a year	3.4%	4.7%	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	4.5%	16.7%	3.0%	1.5%	3.0%	7.1%	6.7%	0.0%	0.0%
Once a year	8.0%	2.3%	7.0%	29.4%	6.2%	4.2%	0.0%	0.0%	7.4%	50.0%	10.4%	0.0%	3.0%	9.1%	6.1%	0.0%	6.7%	12.5%	0.0%
Less often than once a year	3.4%	7.0%	1.7%	5.9%	3.1%	8.3%	0.0%	0.0%	0.0%	0.0%	3.0%	16.7%	3.0%	1.5%	3.0%	14.3%	0.0%	12.5%	0.0%
Other	16.0%	4.7%	20.9%	11.8%	21.5%	16.7%	33.3%	42.9%	22.2%	0.0%	17.9%	0.0%	6.1%	19.7%	27.3%	7.1%	6.7%	0.0%	0.0%
The CEO attends scheduled executive sessions																			
Total responding in each category	176	43	116	17	65	24	3	6	27	4	68	6	33	66	33	14	15	8	8
Always	61.9%	53.5%	64.7%	64.7%	75.4%	87.5%	66.7%	66.7%	74.1%	25.0%	57.4%	66.7%	48.5%	68.2%	69.7%	50.0%	46.7%	37.5%	62.5%
Most of the time	29.0%	37.2%	28.4%	11.8%	16.9%	8.3%	33.3%	16.7%	18.5%	25.0%	33.8%	33.3%	42.4%	22.7%	30.3%	42.9%	46.7%	37.5%	37.5%
Sometimes	4.5%	4.7%	3.4%	11.8%	4.6%	4.2%	0.0%	0.0%	3.7%	0.0%	5.9%	0.0%	3.0%	4.5%	0.0%	0.0%	6.7%	12.5%	0.0%
Rarely	4.5%	4.7%	3.4%	11.8%	3.1%	0.0%	0.0%	16.7%	3.7%	50.0%	2.9%	0.0%	6.1%	4.5%	0.0%	7.1%	0.0%	12.5%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Physician or nurse board members who are on the staff, employed, or financially affiliated with the organization attend scheduled executive seessions																			
Total responding in each category	168	41	111	16	61	21	3	7	25	4	65	5	33	64	32	14	14	6	8
Always	31.0%	39.0%	27.9%	31.3%	29.5%	14.3%	33.3%	42.9%	40.0%	25.0%	30.8%	40.0%	33.3%	31.3%	37.5%	42.9%	42.9%	50.0%	25.0%
Most of the time	14.3%	14.6%	16.2%	0.0%	11.5%	9.5%	0.0%	28.6%	8.0%	0.0%	16.9%	0.0%	18.2%	15.6%	18.8%	21.4%	7.1%	16.7%	0.0%
Sometimes	11.9%	4.9%	11.7%	31.3%	18.0%	28.6%	33.3%	14.3%	12.0%	0.0%	10.8%	0.0%	6.1%	15.6%	6.3%	7.1%	7.1%	0.0%	0.0%
Rarely	42.9%	41.5%	44.1%	37.5%	41.0%	47.6%	33.3%	14.3%	40.0%	75.0%	41.5%	60.0%	42.4%	37.5%	37.5%	28.6%	42.9%	33.3%	75.0%
Legal counsel attends scheduled executive sessions																			
Total responding in each category	168	40	111	17	64	24	3	7	25	4	64	5	31	65	31	13	14	7	8
Always	29.8%	42.5%	25.2%	29.4%	35.9%	33.3%	0.0%	42.9%	44.0%	0.0%	21.9%	40.0%	35.5%	27.7%	29.0%	38.5%	42.9%	28.6%	62.5%
Most of the time	8.3%	5.0%	9.0%	11.8%	10.9%	16.7%	33.3%	14.3%	4.0%	0.0%	7.8%	0.0%	6.5%	4.6%	16.1%	7.7%	14.3%	0.0%	12.5%
Sometimes	19.6%	20.0%	18.9%	23.5%	10.9%	12.5%	33.3%	0.0%	8.0%	25.0%	26.6%	20.0%	22.6%	18.5%	22.6%	23.1%	21.4%	14.3%	12.5%
Rarely	42.3%	32.5%	46.8%	35.3%	42.2%	37.5%	33.3%	42.9%	44.0%	75.0%	43.8%	40.0%	35.5%	49.2%	32.3%	30.8%	21.4%	57.1%	12.5%
Other management attends scheduled executive sessions																			
Total responding in each category	172	41	114	17	66	24	3	7	27	4	65	5	32	65	32	14	15	7	8
Always	12.2%	14.6%	11.4%	11.8%	19.7%	25.0%	0.0%	14.3%	22.2%	25.0%	4.6%	20.0%	9.4%	9.2%	12.5%	7.1%	20.0%	0.0%	25.0%
Most of the time	15.1%	7.3%	16.7%	23.5%	21.2%	16.7%	0.0%	71.4%	18.5%	0.0%	13.8%	0.0%	9.4%	20.0%	12.5%	0.0%	13.3%	14.3%	12.5%
Sometimes	31.4%	34.1%	28.1%	47.1%	30.3%	41.7%	33.3%	14.3%	18.5%	0.0%	33.8%	20.0%	34.4%	27.7%	28.1%	42.9%	46.7%	28.6%	25.0%
Rarely	41.3%	43.9%	43.9%	17.6%	28.8%	16.7%	66.7%	0.0%	40.7%	75.0%	47.7%	60.0%	46.9%	43.1%	46.9%	50.0%	20.0%	57.1%	37.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Topics typically discussed in executive sessions																			
Total responding in each category	176	43	116	17	65	23	3	7	27	4	68	6	33	67	32	14	15	8	8
Executive performance/ evaluation	86.4%	83.7%	88.8%	76.5%	83.1%	69.6%	66.7%	100.0%	92.6%	100.0%	86.8%	83.3%	90.9%	86.6%	81.3%	92.9%	86.7%	87.5%	75.0%
Executive compensation	72.2%	72.1%	75.0%	52.9%	75.4%	65.2%	66.7%	57.1%	88.9%	75.0%	69.1%	83.3%	69.7%	68.7%	81.3%	64.3%	86.7%	50.0%	75.0%
Miscellaneous governance issues	51.1%	58.1%	47.4%	58.8%	40.0%	39.1%	66.7%	28.6%	40.7%	25.0%	57.4%	33.3%	66.7%	52.2%	56.3%	57.1%	53.3%	75.0%	25.0%
General strategic planning/issues	43.2%	53.5%	37.1%	58.8%	47.7%	65.2%	33.3%	42.9%	33.3%	25.0%	35.3%	66.7%	48.5%	35.8%	53.1%	57.1%	60.0%	50.0%	37.5%
M&A strategy	25.6%	48.8%	17.2%	23.5%	16.9%	26.1%	0.0%	14.3%	11.1%	25.0%	20.6%	66.7%	45.5%	20.9%	28.1%	28.6%	53.3%	50.0%	62.5%
Financial performance	25.0%	25.6%	23.3%	35.3%	23.1%	34.8%	33.3%	14.3%	11.1%	25.0%	26.5%	0.0%	30.3%	22.4%	31.3%	42.9%	20.0%	12.5%	12.5%
Clinical or quality performance/ measures	27.3%	23.3%	25.9%	47.1%	44.6%	47.8%	0.0%	42.9%	48.1%	0.0%	17.6%	16.7%	18.2%	32.8%	12.5%	28.6%	33.3%	25.0%	12.5%
Board recruitment and selection	27.3%	32.6%	27.6%	11.8%	23.1%	13.0%	33.3%	14.3%	33.3%	50.0%	25.0%	33.3%	36.4%	23.9%	31.3%	28.6%	13.3%	37.5%	62.5%
Executive succession planning	41.5%	55.8%	36.2%	41.2%	24.6%	21.7%	0.0%	28.6%	29.6%	50.0%	45.6%	66.7%	60.6%	34.3%	53.1%	35.7%	53.3%	75.0%	62.5%
Board performance and evaluation	29.5%	44.2%	23.3%	35.3%	24.6%	26.1%	0.0%	14.3%	29.6%	0.0%	26.5%	50.0%	45.5%	25.4%	25.0%	50.0%	26.7%	50.0%	37.5%
Government relations	10.2%	14.0%	9.5%	5.9%	15.4%	21.7%	0.0%	0.0%	14.8%	0.0%	4.4%	0.0%	15.2%	6.0%	6.3%	14.3%	13.3%	12.5%	12.5%
Other	16.5%	4.7%	21.6%	11.8%	29.2%	26.1%	33.3%	28.6%	29.6%	0.0%	13.2%	0.0%	3.0%	22.4%	15.6%	0.0%	13.3%	0.0%	0.0%
Frequency of scheduled board retreats																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Quarterly	0.8%	0.0%	1.2%	0.0%	2.2%	0.0%	0.0%	0.0%	6.1%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	5.0%	0.0%	0.0%
Twice a year	7.8%	15.4%	5.4%	7.7%	4.5%	5.4%	0.0%	25.0%	0.0%	0.0%	7.9%	0.0%	17.9%	7.1%	11.6%	6.7%	15.0%	18.2%	0.0%
Once a year	50.0%	59.6%	47.0%	50.0%	50.6%	37.8%	80.0%	50.0%	54.5%	22.2%	46.5%	66.7%	61.5%	50.0%	51.2%	66.7%	60.0%	45.5%	75.0%
Less often than once a year	29.1%	15.4%	34.3%	23.1%	30.3%	37.8%	20.0%	25.0%	27.3%	55.6%	33.7%	16.7%	10.3%	26.5%	32.6%	20.0%	10.0%	18.2%	12.5%
Other	12.3%	9.6%	12.0%	19.2%	12.4%	18.9%	0.0%	0.0%	12.1%	22.2%	11.9%	16.7%	10.3%	15.3%	4.7%	6.7%	10.0%	18.2%	12.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Who typically attends board retreats, other than board members?																			
Total responding in each category	228	51	155	22	83	34	5	7	31	8	92	6	39	88	41	13	20	11	8
CEO	96.1%	100.0%	96.1%	86.4%	96.4%	94.1%	100.0%	100.0%	96.8%	87.5%	94.6%	100.0%	100.0%	92.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CMO	61.8%	90.2%	52.9%	59.1%	48.2%	50.0%	80.0%	42.9%	35.5%	62.5%	60.9%	83.3%	89.7%	45.5%	85.4%	84.6%	90.0%	100.0%	87.5%
CNO	75.9%	68.6%	78.7%	72.7%	73.5%	70.6%	80.0%	85.7%	71.0%	50.0%	82.6%	66.7%	71.8%	76.1%	95.1%	76.9%	80.0%	63.6%	37.5%
CFO	86.0%	96.1%	86.5%	59.1%	86.7%	88.2%	100.0%	85.7%	80.6%	50.0%	83.7%	100.0%	94.9%	79.5%	97.6%	92.3%	95.0%	100.0%	100.0%
Other C-suite executives/senior leaders	78.1%	92.2%	74.8%	68.2%	74.7%	79.4%	80.0%	85.7%	64.5%	50.0%	76.1%	100.0%	92.3%	69.3%	92.7%	84.6%	95.0%	100.0%	100.0%
Governance support staff	36.4%	60.8%	29.0%	31.8%	26.5%	26.5%	40.0%	28.6%	16.1%	0.0%	37.0%	66.7%	59.0%	28.4%	41.5%	61.5%	75.0%	63.6%	12.5%
Medical staff physicians	44.3%	43.1%	45.8%	36.4%	38.6%	38.2%	20.0%	57.1%	41.9%	37.5%	50.0%	50.0%	43.6%	47.7%	56.1%	46.2%	50.0%	54.5%	12.5%
Nurses	11.0%	13.7%	9.7%	13.6%	8.4%	8.8%	0.0%	14.3%	6.5%	0.0%	12.0%	33.3%	12.8%	11.4%	9.8%	7.7%	10.0%	27.3%	12.5%
Other	11.8%	13.7%	11.6%	9.1%	14.5%	14.7%	0.0%	14.3%	16.1%	12.5%	7.6%	0.0%	17.9%	11.4%	12.2%	0.0%	10.0%	18.2%	25.0%
Number of standing committees																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
0	5.7%	0.0%	5.4%	19.2%	9.0%	13.5%	0.0%	0.0%	9.1%	11.1%	4.0%	0.0%	2.6%	7.1%	0.0%	0.0%	5.0%	0.0%	0.0%
1 to 3	10.7%	1.9%	12.0%	19.2%	14.6%	10.8%	0.0%	37.5%	15.2%	33.3%	8.9%	0.0%	2.6%	14.3%	4.7%	0.0%	0.0%	0.0%	12.5%
4 to 5	17.2%	21.2%	15.7%	19.2%	16.9%	13.5%	0.0%	12.5%	27.3%	33.3%	13.9%	33.3%	20.5%	17.3%	14.0%	26.7%	15.0%	27.3%	12.5%
6 to 7	23.4%	44.2%	17.5%	19.2%	15.7%	18.9%	20.0%	0.0%	9.1%	11.1%	21.8%	33.3%	46.2%	18.4%	20.9%	26.7%	55.0%	54.5%	25.0%
8 to 10	20.1%	17.3%	21.7%	15.4%	20.2%	24.3%	20.0%	37.5%	15.2%	11.1%	23.8%	16.7%	12.8%	20.4%	32.6%	6.7%	20.0%	9.1%	25.0%
11+	23.0%	15.4%	27.7%	7.7%	23.6%	18.9%	60.0%	12.5%	24.2%	0.0%	27.7%	16.7%	15.4%	22.4%	27.9%	40.0%	5.0%	9.1%	25.0%
Average	7.68	7.71	8.12	4.77	7.36	7.11	11.80	6.38	6.82	3.89	8.42	7.83	7.33	7.37	9.02	9.07	7.10	7.27	7.63
Median	7	7	7	4	7	6	12	7	5	4	8	7	7	7	8	7	7	6	8
Range	0 to 18	2 to 18	0 to 18	0 to 12	0 to 18	0 to 18	6 to 18	1 to 12	0 to 18	0 to 9	0 to 18	5 to 13	0 to 18	0 to 18	1 to 18	4 to 18	0 to 16	4 to 18	2 to 12

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Standing Committees: Meeting Frequency (N/A Excluded)																			
Executive																			
Total responding in each category	236	51	160	25	84	35	5	7	31	9	99	6	38	96	42	14	20	11	8
Monthly	26.0%	9.8%	32.8%	15.4%	31.4%	35.0%	0.0%	0.0%	44.4%	0.0%	33.8%	0.0%	6.7%	26.4%	35.3%	20.0%	14.3%	12.5%	0.0%
Bi-monthly	5.8%	12.2%	2.5%	15.4%	3.9%	5.0%	0.0%	0.0%	5.6%	0.0%	5.0%	16.7%	10.0%	0.0%	11.8%	0.0%	14.3%	25.0%	0.0%
Quarterly	11.6%	17.1%	9.2%	15.4%	11.8%	5.0%	33.3%	33.3%	11.1%	16.7%	8.8%	16.7%	16.7%	12.5%	11.8%	20.0%	14.3%	0.0%	42.9%
Semi-annually	3.5%	7.3%	2.5%	0.0%	3.9%	5.0%	0.0%	0.0%	0.0%	0.0%	2.5%	16.7%	3.3%	1.4%	0.0%	0.0%	14.3%	12.5%	0.0%
Annually	3.5%	2.4%	4.2%	0.0%	5.9%	5.0%	0.0%	16.7%	5.6%	16.7%	1.3%	0.0%	3.3%	2.8%	2.9%	0.0%	7.1%	0.0%	0.0%
As needed	49.7%	51.2%	48.7%	53.8%	43.1%	45.0%	66.7%	50.0%	33.3%	66.7%	48.8%	50.0%	60.0%	56.9%	38.2%	60.0%	35.7%	50.0%	57.1%
Percentage of respondents with this committee	73.3%	80.4%	74.4%	52.0%	60.7%	57.1%	60.0%	85.7%	58.1%	66.7%	80.8%	100.0%	78.9%	75.0%	81.0%	71.4%	70.0%	72.7%	87.5%
Finance																			
Total responding in each category	240	51	163	26	88	37	5	8	32	9	99	5	39	95	43	15	20	11	7
Monthly	59.5%	43.8%	66.4%	46.7%	73.5%	84.0%	60.0%	57.1%	76.9%	60.0%	57.0%	0.0%	47.2%	62.3%	70.0%	60.0%	36.8%	40.0%	16.7%
Bi-monthly	12.0%	12.5%	8.0%	46.7%	2.9%	8.0%	0.0%	0.0%	0.0%	0.0%	18.6%	0.0%	16.7%	10.4%	12.5%	13.3%	26.3%	0.0%	33.3%
Quarterly	19.5%	39.6%	13.9%	6.7%	8.8%	4.0%	0.0%	14.3%	7.7%	40.0%	17.4%	100.0%	30.6%	11.7%	17.5%	20.0%	31.6%	60.0%	50.0%
Semi-annually	1.0%	0.0%	1.5%	0.0%	1.5%	0.0%	0.0%	0.0%	3.8%	0.0%	1.2%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	1.0%	0.0%	1.5%	0.0%	2.9%	0.0%	20.0%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	7.0%	4.2%	8.8%	0.0%	10.3%	4.0%	20.0%	28.6%	7.7%	0.0%	5.8%	0.0%	5.6%	13.0%	0.0%	6.7%	5.3%	0.0%	0.0%
Percentage of respondents with this committee	83.3%	94.1%	84.0%	57.7%	77.3%	67.6%	100.0%	87.5%	81.3%	55.6%	86.9%	100.0%	92.3%	81.1%	93.0%	100.0%	95.0%	90.9%	85.7%
Audit																			
Total responding in each category	217	43	150	24	81	36	5	7	28	8	91	4	33	91	37	11	19	9	6
Monthly	1.1%	0.0%	1.3%	0.0%	2.9%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	1.1%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%
Quarterly	14.7%	46.7%	9.0%	0.0%	14.3%	21.4%	0.0%	0.0%	18.2%	0.0%	6.7%	33.3%	50.0%	0.0%	43.8%	33.3%	50.0%	33.3%	0.0%
Semi-annually	10.5%	33.3%	6.4%	0.0%	8.6%	14.3%	33.3%	0.0%	0.0%	0.0%	6.7%	66.7%	20.0%	7.0%	6.3%	33.3%	25.0%	66.7%	0.0%
Annually	47.4%	6.7%	55.1%	50.0%	48.6%	28.6%	66.7%	80.0%	54.5%	100.0%	55.6%	0.0%	10.0%	60.5%	37.5%	16.7%	0.0%	0.0%	100.0%
As needed	25.3%	6.7%	28.2%	50.0%	25.7%	28.6%	0.0%	20.0%	27.3%	0.0%	31.1%	0.0%	10.0%	32.6%	12.5%	16.7%	12.5%	0.0%	0.0%
Percentage of respondents with this committee	43.8%	34.9%	52.0%	8.3%	43.2%	38.9%	60.0%	71.4%	39.3%	25.0%	49.5%	75.0%	30.3%	47.3%	43.2%	54.5%	42.1%	33.3%	16.7%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	**244**	**52**	**166**	**26**	**89**	**37**	**5**	**8**	**33**	**9**	**101**	**6**	**39**	**98**	**43**	**15**	**20**	**11**	**8**
2019 Biennial Survey Frequency Table	**Overall**	**Health System**	**Independent**	**Subsidiary**	**Government**	**County**	**City**	**County/ City**	**District/ Authority**	**Church Hospital**	**Secular Hospital**	**Other Church System**	**Other System**	**<100**	**100–299**	**300–499**	**500–999**	**1000–1999**	**2000+**
Compliance																			
Total responding in each category	218	43	151	24	82	36	5	7	29	8	91	4	33	91	38	12	19	8	6
Monthly	16.5%	11.8%	18.3%	0.0%	21.6%	28.6%	0.0%	0.0%	15.4%	0.0%	13.2%	0.0%	15.4%	19.4%	18.8%	0.0%	25.0%	0.0%	0.0%
Bi-monthly	2.2%	0.0%	2.8%	0.0%	5.4%	7.1%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%
Quarterly	42.9%	41.2%	42.3%	66.7%	37.8%	35.7%	50.0%	33.3%	46.2%	0.0%	52.6%	0.0%	38.5%	38.9%	50.0%	40.0%	50.0%	75.0%	50.0%
Semi-annually	5.5%	11.8%	4.2%	0.0%	5.4%	0.0%	25.0%	33.3%	0.0%	0.0%	2.6%	50.0%	7.7%	8.3%	6.3%	0.0%	12.5%	0.0%	0.0%
Annually	9.9%	17.6%	7.0%	33.3%	2.7%	7.1%	0.0%	0.0%	0.0%	100.0%	10.5%	0.0%	23.1%	2.8%	12.5%	40.0%	0.0%	25.0%	0.0%
As needed	23.1%	17.6%	25.4%	0.0%	27.0%	21.4%	25.0%	33.3%	30.8%	0.0%	21.1%	50.0%	15.4%	30.6%	0.0%	20.0%	12.5%	0.0%	50.0%
Percentage of respondents with this committee	41.7%	39.5%	47.0%	12.5%	45.1%	38.9%	80.0%	42.9%	44.8%	12.5%	41.8%	50.0%	39.4%	39.6%	42.1%	41.7%	42.1%	50.0%	33.3%
Audit/compliance																			
Total responding in each category	230	50	155	25	81	34	5	7	29	9	97	6	37	90	43	14	20	11	7
Monthly	10.7%	7.3%	11.3%	22.2%	16.7%	20.0%	0.0%	0.0%	18.2%	0.0%	9.3%	0.0%	10.0%	12.5%	6.5%	9.1%	15.4%	0.0%	0.0%
Bi-monthly	8.3%	17.1%	2.8%	11.1%	6.7%	10.0%	0.0%	100.0%	0.0%	0.0%	3.7%	0.0%	20.0%	3.1%	3.2%	9.1%	30.8%	11.1%	14.3%
Quarterly	44.6%	56.1%	39.4%	33.3%	33.3%	40.0%	0.0%	0.0%	45.5%	50.0%	44.4%	60.0%	53.3%	18.8%	64.5%	63.6%	38.5%	66.7%	85.7%
Semi-annually	6.6%	9.8%	5.6%	0.0%	6.7%	10.0%	0.0%	0.0%	0.0%	0.0%	5.6%	20.0%	6.7%	12.5%	0.0%	0.0%	15.4%	11.1%	0.0%
Annually	12.4%	4.9%	15.5%	22.2%	10.0%	0.0%	33.3%	0.0%	9.1%	50.0%	16.7%	0.0%	6.7%	25.0%	16.1%	9.1%	0.0%	0.0%	0.0%
As needed	17.4%	4.9%	25.4%	11.1%	26.7%	20.0%	66.7%	0.0%	27.3%	0.0%	20.4%	20.0%	3.3%	28.1%	9.7%	9.1%	0.0%	11.1%	0.0%
Percentage of respondents with this committee	52.6%	82.0%	45.8%	36.0%	37.0%	29.4%	60.0%	14.3%	37.9%	22.2%	55.7%	83.3%	81.1%	35.2%	72.1%	78.6%	65.0%	81.8%	100.0%
Quality (or quality and safety)																			
Total responding in each category	237	50	161	26	87	37	5	7	32	8	99	6	37	95	42	14	18	11	8
Monthly	48.1%	44.2%	49.2%	50.0%	55.1%	66.7%	40.0%	25.0%	53.8%	33.3%	45.1%	0.0%	48.4%	41.7%	67.6%	66.7%	50.0%	22.2%	14.3%
Bi-monthly	12.7%	11.6%	11.7%	22.2%	7.2%	0.0%	20.0%	25.0%	7.7%	33.3%	17.1%	0.0%	12.9%	13.9%	16.2%	8.3%	6.3%	22.2%	28.6%
Quarterly	34.4%	39.5%	33.6%	27.8%	31.9%	26.7%	40.0%	50.0%	34.6%	33.3%	34.1%	100.0%	32.3%	40.3%	16.2%	25.0%	37.5%	44.4%	57.1%
Semi-annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	4.8%	4.7%	5.5%	0.0%	5.8%	6.7%	0.0%	0.0%	3.8%	0.0%	3.7%	0.0%	6.5%	4.2%	0.0%	0.0%	6.3%	11.1%	0.0%
Percentage of respondents with this committee	79.7%	86.0%	79.5%	69.2%	79.3%	81.1%	100.0%	57.1%	81.3%	37.5%	82.8%	66.7%	83.8%	75.8%	88.1%	85.7%	88.9%	81.8%	87.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Governance/board development																			
Total responding in each category	231	50	155	26	83	36	5	7	29	8	97	6	37	93	41	15	19	9	8
Monthly	9.6%	2.6%	13.8%	0.0%	13.2%	0.0%	0.0%	100.0%	13.3%	0.0%	11.3%	0.0%	3.6%	11.9%	8.8%	9.1%	0.0%	0.0%	0.0%
Bi-monthly	5.9%	10.3%	2.3%	22.2%	5.3%	7.7%	25.0%	0.0%	0.0%	0.0%	4.8%	0.0%	10.7%	0.0%	11.8%	0.0%	14.3%	0.0%	14.3%
Quarterly	29.6%	48.7%	21.8%	22.2%	21.1%	23.1%	25.0%	0.0%	13.3%	50.0%	24.2%	60.0%	46.4%	16.7%	32.4%	54.5%	42.9%	71.4%	28.6%
Semi-annually	11.9%	20.5%	8.0%	11.1%	13.2%	15.4%	0.0%	0.0%	20.0%	0.0%	8.1%	20.0%	17.9%	2.4%	14.7%	9.1%	28.6%	28.6%	42.9%
Annually	10.4%	2.6%	12.6%	22.2%	10.5%	23.1%	0.0%	0.0%	6.7%	50.0%	12.9%	0.0%	3.6%	19.0%	11.8%	0.0%	0.0%	0.0%	14.3%
As needed	32.6%	15.4%	41.4%	22.2%	36.8%	30.8%	50.0%	0.0%	46.7%	0.0%	38.7%	20.0%	17.9%	50.0%	20.6%	27.3%	14.3%	0.0%	0.0%
Percentage of respondents with this committee	58.4%	78.0%	56.1%	34.6%	45.8%	36.1%	80.0%	28.6%	51.7%	25.0%	63.9%	83.3%	75.7%	45.2%	82.9%	73.3%	73.7%	77.8%	87.5%
Executive compensation																			
Total responding in each category	232	52	156	24	85	36	5	8	30	7	95	6	39	93	40	15	19	11	8
Monthly	0.7%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	9.1%	0.0%	0.0%	0.0%
Bi-monthly	2.1%	2.6%	1.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	3.6%	0.0%	0.0%	9.1%	9.1%	0.0%	0.0%
Quarterly	12.5%	34.2%	4.0%	20.0%	4.4%	0.0%	0.0%	0.0%	6.7%	0.0%	6.3%	40.0%	35.7%	0.0%	16.1%	9.1%	36.4%	62.5%	42.9%
Semi-annually	14.6%	23.7%	11.9%	0.0%	6.7%	5.9%	25.0%	0.0%	6.7%	0.0%	15.6%	20.0%	25.0%	9.4%	22.6%	36.4%	27.3%	0.0%	28.6%
Annually	45.1%	15.8%	55.4%	60.0%	53.3%	47.1%	50.0%	60.0%	60.0%	100.0%	53.1%	20.0%	14.3%	67.9%	35.5%	18.2%	9.1%	25.0%	28.6%
As needed	25.0%	21.1%	27.7%	0.0%	35.6%	47.1%	25.0%	40.0%	26.7%	0.0%	21.9%	20.0%	17.9%	22.6%	25.8%	18.2%	18.2%	12.5%	0.0%
Percentage of respondents with this committee	62.1%	73.1%	64.7%	20.8%	52.9%	47.2%	80.0%	62.5%	50.0%	28.6%	67.4%	83.3%	71.8%	57.0%	77.5%	73.3%	57.9%	72.7%	87.5%
Strategic planning																			
Total responding in each category	227	47	155	25	84	37	5	7	30	7	96	5	35	94	38	14	16	10	7
Monthly	12.1%	14.3%	10.9%	18.2%	14.0%	12.5%	0.0%	0.0%	25.0%	25.0%	9.3%	0.0%	14.3%	6.0%	17.4%	28.6%	0.0%	33.3%	0.0%
Bi-monthly	7.3%	14.3%	5.4%	9.1%	12.0%	12.5%	20.0%	33.3%	6.3%	0.0%	3.7%	0.0%	7.1%	2.0%	13.0%	0.0%	20.0%	33.3%	0.0%
Quarterly	23.4%	33.3%	20.7%	27.3%	18.0%	25.0%	40.0%	0.0%	6.3%	0.0%	24.1%	0.0%	50.0%	24.0%	21.7%	28.6%	40.0%	33.3%	33.3%
Semi-annually	7.3%	14.3%	5.4%	9.1%	10.0%	12.5%	0.0%	0.0%	12.5%	0.0%	3.7%	50.0%	7.1%	6.0%	8.7%	14.3%	10.0%	0.0%	33.3%
Annually	28.2%	0.0%	37.0%	9.1%	28.0%	16.7%	20.0%	66.7%	31.3%	50.0%	35.2%	0.0%	0.0%	42.0%	21.7%	0.0%	10.0%	0.0%	0.0%
As needed	21.8%	23.8%	20.7%	27.3%	18.0%	20.8%	20.0%	0.0%	18.8%	25.0%	24.1%	50.0%	21.4%	20.0%	17.4%	28.6%	20.0%	0.0%	33.3%
Percentage of respondents with this committee	54.6%	44.7%	59.4%	44.0%	59.5%	64.9%	100.0%	42.9%	53.3%	57.1%	56.3%	40.0%	40.0%	53.2%	60.5%	50.0%	62.5%	30.0%	42.9%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Physician relations																			
Total responding in each category	224	48	151	25	82	36	5	6	29	7	94	5	36	90	40	14	17	10	7
Monthly	26.1%	22.2%	25.5%	40.0%	30.0%	33.3%	0.0%	0.0%	44.4%	0.0%	25.8%	0.0%	16.7%	24.1%	40.0%	14.3%	50.0%	100.0%	0.0%
Bi-monthly	4.3%	0.0%	5.5%	0.0%	3.3%	8.3%	0.0%	0.0%	0.0%	0.0%	6.5%	0.0%	0.0%	6.9%	6.7%	0.0%	0.0%	0.0%	0.0%
Quarterly	10.1%	11.1%	9.1%	20.0%	16.7%	25.0%	50.0%	0.0%	11.1%	0.0%	3.2%	0.0%	16.7%	6.9%	13.3%	28.6%	0.0%	0.0%	0.0%
Semi-annually	5.8%	0.0%	5.5%	20.0%	10.0%	8.3%	0.0%	50.0%	0.0%	0.0%	3.2%	0.0%	0.0%	3.4%	6.7%	0.0%	0.0%	0.0%	0.0%
Annually	5.8%	0.0%	7.3%	0.0%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	6.5%	0.0%	0.0%	10.3%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	47.8%	66.7%	47.3%	20.0%	33.3%	25.0%	50.0%	50.0%	44.4%	100.0%	54.8%	100.0%	66.7%	48.3%	33.3%	57.1%	50.0%	0.0%	0.0%
Percentage of respondents with this committee	30.8%	18.8%	36.4%	20.0%	36.6%	33.3%	40.0%	66.7%	31.0%	14.3%	33.0%	20.0%	16.7%	32.2%	37.5%	50.0%	11.8%	10.0%	0.0%
Investment																			
Total responding in each category	227	49	154	24	82	36	5	7	28	6	97	5	37	92	40	15	18	10	7
Monthly	15.7%	9.7%	18.2%	20.0%	10.3%	16.7%	33.3%	0.0%	0.0%	0.0%	21.7%	0.0%	13.0%	15.2%	30.4%	10.0%	0.0%	14.3%	20.0%
Bi-monthly	4.9%	9.7%	1.5%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	13.0%	3.0%	0.0%	10.0%	8.3%	14.3%	0.0%
Quarterly	40.2%	58.1%	31.8%	40.0%	24.1%	16.7%	33.3%	0.0%	33.3%	0.0%	41.3%	75.0%	52.2%	24.2%	52.2%	70.0%	66.7%	28.6%	60.0%
Semi-annually	7.8%	3.2%	9.1%	20.0%	6.9%	8.3%	0.0%	0.0%	0.0%	0.0%	10.9%	25.0%	0.0%	12.1%	4.3%	0.0%	16.7%	0.0%	0.0%
Annually	8.8%	3.2%	12.1%	0.0%	17.2%	16.7%	0.0%	0.0%	33.3%	0.0%	6.5%	0.0%	4.3%	15.2%	13.0%	0.0%	0.0%	14.3%	0.0%
As needed	22.5%	16.1%	27.3%	0.0%	41.4%	41.7%	33.3%	100.0%	33.3%	0.0%	15.2%	0.0%	17.4%	30.3%	0.0%	10.0%	8.3%	28.6%	20.0%
Percentage of respondents with this committee	44.9%	63.3%	42.9%	20.8%	35.4%	33.3%	60.0%	14.3%	32.1%	0.0%	47.4%	80.0%	62.2%	35.9%	57.5%	66.7%	66.7%	70.0%	71.4%
Joint conference																			
Total responding in each category	226	48	154	24	84	36	5	7	30	7	94	5	36	92	41	14	16	10	7
Monthly	15.7%	20.0%	13.2%	40.0%	15.2%	23.1%	0.0%	0.0%	9.1%	0.0%	16.7%	0.0%	16.7%	13.5%	19.0%	0.0%	0.0%	100.0%	100.0%
Bi-monthly	2.4%	10.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	16.7%	2.7%	0.0%	12.5%	0.0%	0.0%	0.0%
Quarterly	15.7%	20.0%	16.2%	0.0%	12.1%	7.7%	50.0%	25.0%	9.1%	0.0%	19.0%	100.0%	0.0%	13.5%	23.8%	25.0%	0.0%	0.0%	0.0%
Semi-annually	4.8%	0.0%	5.9%	0.0%	12.1%	15.4%	0.0%	25.0%	9.1%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	3.6%	0.0%	4.4%	0.0%	6.1%	15.4%	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	0.0%	8.1%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	57.8%	50.0%	58.8%	60.0%	54.5%	38.5%	50.0%	50.0%	72.7%	100.0%	59.5%	0.0%	66.7%	56.8%	57.1%	62.5%	100.0%	0.0%	0.0%
Percentage of respondents with this committee	36.7%	20.8%	44.2%	20.8%	39.3%	36.1%	40.0%	57.1%	36.7%	14.3%	44.7%	20.0%	16.7%	40.2%	51.2%	57.1%	6.3%	10.0%	14.3%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Facilities/infrastructure/maintenance																			
Total responding in each category	226	47	154	25	85	37	5	7	30	7	94	5	35	92	40	14	18	10	6
Monthly	22.9%	25.0%	19.3%	60.0%	37.5%	38.5%	66.7%	0.0%	36.4%	100.0%	9.4%	0.0%	0.0%	14.3%	42.9%	25.0%	0.0%	100.0%	0.0%
Bi-monthly	8.6%	25.0%	7.0%	0.0%	12.5%	15.4%	0.0%	33.3%	9.1%	0.0%	3.1%	0.0%	25.0%	7.1%	0.0%	0.0%	50.0%	0.0%	50.0%
Quarterly	14.3%	0.0%	15.8%	20.0%	9.4%	15.4%	0.0%	0.0%	9.1%	0.0%	21.9%	0.0%	0.0%	17.9%	7.1%	0.0%	25.0%	0.0%	0.0%
Semi-annually	1.4%	0.0%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	1.4%	0.0%	1.8%	0.0%	3.1%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	51.4%	50.0%	54.4%	20.0%	37.5%	30.8%	33.3%	33.3%	45.5%	0.0%	62.5%	100.0%	75.0%	57.1%	50.0%	75.0%	25.0%	0.0%	50.0%
Percentage of respondents with this committee	31.0%	17.0%	37.0%	20.0%	37.6%	35.1%	60.0%	42.9%	36.7%	14.3%	34.0%	20.0%	11.4%	30.4%	35.0%	28.6%	22.2%	10.0%	33.3%
Construction (separate from facilities)																			
Total responding in each category	223	48	151	24	83	36	5	6	30	7	92	5	36	91	39	14	17	10	7
Monthly	13.2%	20.0%	12.5%	0.0%	27.3%	16.7%	0.0%	50.0%	33.3%	0.0%	3.8%	0.0%	0.0%	9.1%	20.0%	0.0%	0.0%	100.0%	0.0%
Bi-monthly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Quarterly	1.9%	0.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%
Semi-annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	84.9%	80.0%	85.4%	0.0%	72.7%	83.3%	100.0%	50.0%	66.7%	100.0%	92.3%	100.0%	100.0%	90.9%	70.0%	100.0%	100.0%	0.0%	100.0%
Percentage of respondents with this committee	23.8%	10.4%	31.8%	0.0%	26.5%	16.7%	60.0%	33.3%	30.0%	14.3%	28.3%	20.0%	8.3%	24.2%	25.6%	21.4%	5.9%	10.0%	14.3%
Government relations/advocacy																			
Total responding in each category	224	48	152	24	84	36	5	6	31	7	92	5	36	90	40	14	18	10	7
Monthly	4.9%	16.7%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	0.0%	25.0%	5.6%	0.0%	0.0%	0.0%	50.0%	0.0%
Bi-monthly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Quarterly	2.4%	0.0%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%
Semi-annually	9.8%	16.7%	5.9%	100.0%	17.6%	25.0%	0.0%	0.0%	20.0%	0.0%	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%
Annually	4.9%	0.0%	5.9%	0.0%	11.8%	12.5%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%
As needed	78.0%	66.7%	82.4%	0.0%	70.6%	62.5%	50.0%	0.0%	80.0%	0.0%	84.2%	100.0%	75.0%	94.4%	75.0%	100.0%	50.0%	0.0%	0.0%
Percentage of respondents with this committee	18.3%	12.5%	22.4%	4.2%	20.2%	22.2%	40.0%	0.0%	16.1%	0.0%	20.7%	20.0%	11.1%	20.0%	20.0%	21.4%	11.1%	20.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Human resources																			
Total responding in each category	230	49	156	25	86	37	5	6	32	7	95	5	37	93	40	15	18	10	7
Monthly	16.9%	0.0%	14.3%	80.0%	25.0%	38.5%	0.0%	0.0%	12.5%	100.0%	10.7%	0.0%	0.0%	14.8%	33.3%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	6.2%	9.1%	4.1%	20.0%	3.6%	7.7%	0.0%	0.0%	0.0%	0.0%	10.7%	0.0%	0.0%	3.7%	0.0%	14.3%	0.0%	0.0%	0.0%
Quarterly	24.6%	54.5%	20.4%	0.0%	28.6%	23.1%	25.0%	100.0%	37.5%	0.0%	10.7%	100.0%	57.1%	11.1%	33.3%	71.4%	50.0%	50.0%	0.0%
Semi-annually	6.2%	9.1%	6.1%	0.0%	10.7%	7.7%	25.0%	0.0%	12.5%	0.0%	3.6%	0.0%	0.0%	3.7%	11.1%	0.0%	25.0%	0.0%	50.0%
Annually	7.7%	0.0%	10.2%	0.0%	3.6%	0.0%	25.0%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	7.4%	11.1%	0.0%	0.0%	0.0%	50.0%
As needed	38.5%	27.3%	44.9%	0.0%	28.6%	23.1%	25.0%	0.0%	37.5%	0.0%	50.0%	0.0%	42.9%	59.3%	11.1%	14.3%	25.0%	50.0%	0.0%
Percentage of respondents with this committee	28.3%	22.4%	31.4%	20.0%	32.6%	35.1%	80.0%	16.7%	25.0%	14.3%	29.5%	20.0%	18.9%	29.0%	22.5%	46.7%	22.2%	20.0%	28.6%
Community benefit																			
Total responding in each category	225	48	151	26	82	36	5	5	30	7	95	5	36	92	40	14	17	10	7
Monthly	7.6%	10.0%	2.2%	30.0%	4.8%	0.0%	0.0%	0.0%	16.7%	50.0%	5.6%	0.0%	14.3%	3.4%	6.7%	0.0%	0.0%	0.0%	50.0%
Bi-monthly	9.1%	20.0%	4.3%	20.0%	9.5%	10.0%	0.0%	0.0%	0.0%	0.0%	8.3%	0.0%	14.3%	6.9%	13.3%	0.0%	0.0%	50.0%	50.0%
Quarterly	22.7%	30.0%	21.7%	20.0%	23.8%	30.0%	0.0%	0.0%	33.3%	0.0%	22.2%	0.0%	28.6%	27.6%	33.3%	33.3%	0.0%	0.0%	0.0%
Semi-annually	9.1%	10.0%	6.5%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	13.9%	0.0%	14.3%	3.4%	20.0%	0.0%	100.0%	0.0%	0.0%
Annually	18.2%	20.0%	19.6%	10.0%	23.8%	30.0%	50.0%	0.0%	16.7%	50.0%	13.9%	0.0%	14.3%	24.1%	6.7%	33.3%	0.0%	50.0%	0.0%
As needed	33.3%	10.0%	45.7%	0.0%	38.1%	30.0%	50.0%	0.0%	33.3%	0.0%	36.1%	0.0%	14.3%	34.5%	20.0%	33.3%	0.0%	0.0%	0.0%
Percentage of respondents with this committee	29.3%	20.8%	30.5%	38.5%	25.6%	27.8%	40.0%	0.0%	20.0%	28.6%	37.9%	0.0%	19.4%	31.5%	37.5%	21.4%	5.9%	20.0%	28.6%
Population health/community health improvement																			
Total responding in each category	222	47	151	24	83	36	5	6	30	6	93	5	35	90	40	14	17	10	6
Monthly	13.5%	12.5%	12.2%	33.3%	10.0%	0.0%	0.0%	0.0%	16.7%	0.0%	16.0%	0.0%	16.7%	18.2%	9.1%	0.0%	0.0%	0.0%	100.0%
Bi-monthly	7.7%	25.0%	4.9%	0.0%	10.0%	11.1%	0.0%	0.0%	0.0%	0.0%	4.0%	0.0%	16.7%	4.5%	9.1%	0.0%	50.0%	50.0%	0.0%
Quarterly	13.5%	12.5%	14.6%	0.0%	20.0%	33.3%	0.0%	0.0%	16.7%	0.0%	8.0%	0.0%	16.7%	9.1%	27.3%	33.3%	0.0%	0.0%	0.0%
Semi-annually	9.6%	0.0%	9.8%	33.3%	10.0%	11.1%	50.0%	0.0%	0.0%	0.0%	12.0%	0.0%	0.0%	4.5%	18.2%	0.0%	0.0%	0.0%	0.0%
Annually	13.5%	25.0%	12.2%	0.0%	15.0%	22.2%	0.0%	0.0%	16.7%	0.0%	12.0%	0.0%	16.7%	13.6%	0.0%	33.3%	0.0%	50.0%	0.0%
As needed	42.3%	25.0%	46.3%	33.3%	35.0%	22.2%	50.0%	0.0%	50.0%	100.0%	48.0%	0.0%	33.3%	50.0%	36.4%	33.3%	50.0%	0.0%	0.0%
Percentage of respondents with this committee	23.4%	17.0%	27.2%	12.5%	24.1%	25.0%	40.0%	0.0%	20.0%	16.7%	26.9%	0.0%	17.1%	24.4%	27.5%	21.4%	11.8%	20.0%	16.7%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Authorities/responsibilities of the executive committee																			
Total responding in each category	180	41	125	14	57	23	3	7	20	6	81	6	30	75	35	10	14	8	7
Executive compensation	57.2%	39.0%	64.8%	42.9%	61.4%	56.5%	100.0%	85.7%	55.0%	66.7%	61.7%	66.7%	33.3%	65.3%	51.4%	40.0%	50.0%	25.0%	14.3%
Board member nominations	26.7%	29.3%	22.4%	57.1%	19.3%	17.4%	33.3%	14.3%	20.0%	33.3%	28.4%	33.3%	33.3%	25.3%	25.7%	60.0%	28.6%	25.0%	0.0%
Board member selection	18.3%	26.8%	15.2%	21.4%	14.0%	17.4%	33.3%	0.0%	10.0%	16.7%	16.0%	50.0%	26.7%	13.3%	14.3%	50.0%	21.4%	25.0%	14.3%
Advising the CEO	72.2%	63.4%	76.0%	64.3%	70.2%	60.9%	100.0%	71.4%	85.0%	66.7%	76.5%	50.0%	70.0%	72.0%	82.9%	100.0%	57.1%	62.5%	28.6%
Emergency decision making	72.8%	75.6%	72.8%	64.3%	66.7%	56.5%	33.3%	42.9%	90.0%	100.0%	71.6%	66.7%	83.3%	65.3%	80.0%	90.0%	71.4%	75.0%	71.4%
Decision-making authority between full board meetings	60.6%	70.7%	58.4%	50.0%	49.1%	52.2%	66.7%	28.6%	45.0%	66.7%	63.0%	83.3%	70.0%	58.7%	74.3%	70.0%	64.3%	62.5%	100.0%
Other	5.6%	2.4%	7.2%	0.0%	10.5%	21.7%	0.0%	0.0%	5.0%	0.0%	4.9%	0.0%	0.0%	4.0%	2.9%	0.0%	0.0%	12.5%	0.0%
What level of authority does the executive committee have?																			
Total responding in each category	172	39	120	13	52	19	3	6	20	5	80	5	30	73	33	10	13	7	7
Full authority: the executive committee can act on behalf of the board on all issues; committee decisions do not require full-board ratification	33.1%	43.6%	30.8%	23.1%	15.4%	15.8%	33.3%	0.0%	15.0%	40.0%	40.0%	60.0%	40.0%	26.0%	39.4%	50.0%	30.8%	57.1%	57.1%
Some authority: the executive committee can act on behalf of the board on some issues (e.g., executive compensation), but not all issues	35.5%	33.3%	35.0%	46.2%	32.7%	26.3%	33.3%	50.0%	30.0%	60.0%	36.3%	20.0%	36.7%	37.0%	36.4%	30.0%	38.5%	28.6%	28.6%
All executive committee decisions must be approved/ ratified by the full board	31.4%	23.1%	34.2%	30.8%	51.9%	57.9%	33.3%	50.0%	55.0%	0.0%	23.8%	20.0%	23.3%	37.0%	24.2%	20.0%	30.8%	14.3%	14.3%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Number and types of positions on the quality committee																			
Total responding in each category	181	41	124	16	65	27	5	4	25	3	80	5	28	70	34	13	17	7	6
Voting physician board members																			
0	25.4%	9.8%	30.6%	25.0%	44.6%	40.7%	60.0%	25.0%	56.0%	33.3%	17.5%	0.0%	7.1%	31.4%	5.9%	15.4%	5.9%	14.3%	0.0%
1	28.2%	14.6%	33.9%	18.8%	35.4%	40.7%	0.0%	75.0%	28.0%	0.0%	30.0%	20.0%	10.7%	31.4%	29.4%	7.7%	5.9%	28.6%	16.7%
2	18.8%	26.8%	15.3%	25.0%	7.7%	11.1%	20.0%	0.0%	4.0%	0.0%	23.8%	0.0%	35.7%	21.4%	17.6%	15.4%	35.3%	14.3%	50.0%
3	10.5%	12.2%	8.9%	18.8%	4.6%	3.7%	0.0%	0.0%	8.0%	33.3%	13.8%	20.0%	10.7%	10.0%	17.6%	23.1%	5.9%	14.3%	16.7%
4+	17.1%	36.6%	11.3%	12.5%	7.7%	3.7%	20.0%	0.0%	4.0%	33.3%	15.0%	60.0%	35.7%	5.7%	29.4%	38.5%	47.1%	28.6%	16.7%
Voting nurse board members																			
0	58.6%	53.7%	62.1%	43.8%	67.7%	55.6%	100.0%	75.0%	68.0%	33.3%	55.0%	20.0%	57.1%	64.3%	47.1%	53.8%	41.2%	71.4%	83.3%
1	21.0%	29.3%	18.5%	18.8%	16.9%	18.5%	0.0%	25.0%	20.0%	33.3%	20.0%	40.0%	28.6%	17.1%	32.4%	23.1%	29.4%	28.6%	16.7%
2	9.4%	7.3%	7.3%	31.3%	7.7%	14.8%	0.0%	0.0%	4.0%	0.0%	12.5%	20.0%	3.6%	7.1%	8.8%	15.4%	11.8%	0.0%	0.0%
3	6.6%	9.8%	5.6%	6.3%	4.6%	7.4%	0.0%	0.0%	4.0%	33.3%	5.0%	20.0%	10.7%	8.6%	5.9%	7.7%	17.6%	0.0%	0.0%
4+	4.4%	0.0%	6.5%	0.0%	3.1%	3.7%	0.0%	0.0%	4.0%	0.0%	7.5%	0.0%	0.0%	2.9%	5.9%	0.0%	0.0%	0.0%	0.0%
Voting board members who are not physicians or nurses																			
0	11.6%	12.2%	12.9%	0.0%	15.4%	7.4%	0.0%	50.0%	24.0%	0.0%	8.8%	20.0%	10.7%	17.1%	2.9%	7.7%	5.9%	14.3%	0.0%
1	9.4%	2.4%	12.1%	6.3%	10.8%	7.4%	0.0%	0.0%	20.0%	33.3%	10.0%	0.0%	3.6%	10.0%	5.9%	0.0%	5.9%	0.0%	16.7%
2	18.8%	12.2%	23.4%	0.0%	26.2%	18.5%	60.0%	50.0%	28.0%	0.0%	17.5%	20.0%	7.1%	21.4%	17.6%	15.4%	5.9%	0.0%	33.3%
3	18.8%	22.0%	16.9%	25.0%	15.4%	18.5%	0.0%	0.0%	16.0%	0.0%	18.8%	20.0%	28.6%	21.4%	14.7%	30.8%	23.5%	0.0%	0.0%
4+	41.4%	51.2%	34.7%	68.8%	32.3%	48.1%	40.0%	0.0%	12.0%	66.7%	45.0%	40.0%	50.0%	30.0%	58.8%	46.2%	58.8%	85.7%	50.0%
Medical staff/employed physicians (non-board members)																			
0	44.2%	48.8%	42.7%	43.8%	49.2%	59.3%	40.0%	75.0%	36.0%	33.3%	38.8%	60.0%	46.4%	48.6%	26.5%	38.5%	41.2%	71.4%	50.0%
1	19.9%	12.2%	22.6%	18.8%	20.0%	3.7%	0.0%	0.0%	44.0%	0.0%	22.5%	0.0%	17.9%	24.3%	11.8%	15.4%	11.8%	14.3%	16.7%
2	12.2%	9.8%	13.7%	6.3%	12.3%	7.4%	60.0%	25.0%	4.0%	33.3%	12.5%	20.0%	7.1%	11.4%	11.8%	7.7%	17.6%	14.3%	0.0%
3	7.7%	9.8%	7.3%	6.3%	6.2%	11.1%	0.0%	0.0%	4.0%	0.0%	8.8%	20.0%	7.1%	5.7%	17.6%	15.4%	5.9%	0.0%	0.0%
4+	16.0%	19.5%	13.7%	25.0%	12.3%	18.5%	0.0%	0.0%	12.0%	33.3%	17.5%	0.0%	21.4%	10.0%	32.4%	23.1%	23.5%	0.0%	33.3%
Nurses from the nursing staff (non-board members)																			
0	48.6%	70.7%	41.9%	43.8%	46.2%	51.9%	20.0%	25.0%	40.0%	66.7%	41.3%	40.0%	75.0%	44.3%	32.4%	69.2%	64.7%	85.7%	66.7%
1	13.3%	12.2%	12.1%	25.0%	15.4%	14.8%	40.0%	0.0%	16.0%	0.0%	11.3%	40.0%	10.7%	8.6%	17.6%	7.7%	17.6%	14.3%	16.7%
2	16.6%	2.4%	21.0%	18.8%	18.5%	11.1%	20.0%	75.0%	20.0%	33.3%	20.0%	0.0%	3.6%	21.4%	17.6%	7.7%	5.9%	0.0%	0.0%
3	9.9%	4.9%	12.1%	6.3%	12.3%	18.5%	20.0%	0.0%	8.0%	0.0%	12.5%	0.0%	0.0%	12.9%	11.8%	7.7%	0.0%	0.0%	0.0%
4+	11.6%	9.8%	12.9%	6.3%	7.7%	3.7%	0.0%	0.0%	16.0%	0.0%	15.0%	20.0%	10.7%	12.9%	20.6%	7.7%	11.8%	0.0%	16.7%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Community members at-large																			
0	63.5%	51.2%	66.1%	75.0%	67.7%	59.3%	40.0%	100.0%	76.0%	100.0%	62.5%	60.0%	53.6%	71.4%	58.8%	53.8%	58.8%	57.1%	33.3%
1	16.0%	17.1%	15.3%	18.8%	10.8%	11.1%	20.0%	0.0%	12.0%	0.0%	20.0%	0.0%	21.4%	11.4%	14.7%	15.4%	11.8%	28.6%	16.7%
2	9.4%	14.6%	8.1%	6.3%	9.2%	7.4%	40.0%	0.0%	4.0%	0.0%	8.8%	40.0%	7.1%	10.0%	8.8%	15.4%	17.6%	0.0%	16.7%
3	2.2%	2.4%	2.4%	0.0%	3.1%	0.0%	0.0%	0.0%	8.0%	0.0%	2.5%	0.0%	0.0%	1.4%	5.9%	0.0%	0.0%	0.0%	16.7%
4+	8.8%	14.6%	8.1%	0.0%	9.2%	22.2%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	17.9%	5.7%	11.8%	15.4%	11.8%	14.3%	16.7%
Other																			
0	82.9%	90.2%	80.6%	81.3%	81.5%	88.9%	100.0%	75.0%	68.0%	100.0%	81.3%	100.0%	85.7%	82.9%	76.5%	100.0%	82.4%	100.0%	100.0%
1	2.2%	0.0%	3.2%	0.0%	3.1%	3.7%	0.0%	0.0%	4.0%	0.0%	2.5%	0.0%	0.0%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%
2	3.3%	2.4%	3.2%	6.3%	6.2%	3.7%	0.0%	25.0%	8.0%	0.0%	1.3%	0.0%	3.6%	2.9%	2.9%	0.0%	0.0%	0.0%	0.0%
3	3.9%	0.0%	5.6%	0.0%	3.1%	0.0%	0.0%	0.0%	8.0%	0.0%	6.3%	0.0%	0.0%	4.3%	8.8%	0.0%	0.0%	0.0%	0.0%
4+	7.7%	7.3%	7.3%	12.5%	6.2%	3.7%	0.0%	0.0%	12.0%	0.0%	8.8%	0.0%	10.7%	5.7%	11.8%	0.0%	17.6%	0.0%	0.0%
Size of quality committee																			
Average	10.75	12.56	9.97	12.19	8.69	10.15	8.60	4.50	7.68	12.00	11.59	13.20	12.57	9.23	14.56	11.92	14.06	10.00	13.67
Median	10	13	9	12	7	8	7	5	7	11	10	14	13	9	13	11	14	9	7
Range	1 to 37	2 to 37	1 to 27	3 to 32	1 to 27	1 to 27	5 to 14	2 to 6	1 to 21	6 to 19	1 to 32	9 to 19	2 to 37	1 to 27	6 to 32	5 to 18	4 to 25	2 to 14	3 to 37
Approximate total annual expenditure for board education																			
Total responding in each category	235	49	162	24	87	35	5	8	33	9	96	6	37	93	42	14	20	10	8
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$1–$9,999	43.8%	12.2%	51.2%	58.3%	57.5%	68.6%	40.0%	50.0%	57.6%	77.8%	41.7%	16.7%	13.5%	55.9%	33.3%	21.4%	10.0%	0.0%	0.0%
$10,000–$19,999	15.3%	4.1%	19.8%	8.3%	16.1%	5.7%	40.0%	12.5%	27.3%	0.0%	20.8%	0.0%	5.4%	15.1%	16.7%	7.1%	0.0%	0.0%	37.5%
$20,000–$29,999	9.8%	6.1%	9.9%	16.7%	10.3%	11.4%	20.0%	12.5%	6.1%	0.0%	13.5%	0.0%	2.7%	14.0%	9.5%	7.1%	5.0%	0.0%	12.5%
$30,000–$49,999	11.5%	24.5%	8.6%	4.2%	6.9%	5.7%	0.0%	0.0%	9.1%	0.0%	11.5%	33.3%	21.6%	6.5%	14.3%	21.4%	30.0%	40.0%	12.5%
$50,000–$75,000	7.7%	14.3%	6.8%	0.0%	4.6%	5.7%	0.0%	12.5%	0.0%	11.1%	7.3%	0.0%	16.2%	5.4%	19.0%	7.1%	10.0%	20.0%	0.0%
>$75,000	11.9%	38.8%	3.7%	12.5%	4.6%	2.9%	0.0%	12.5%	0.0%	11.1%	5.2%	50.0%	40.5%	3.2%	7.1%	35.7%	45.0%	40.0%	37.5%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Topics covered for internal board development/education																			
Total responding in each category	241	51	165	25	88	36	5	8	33	9	100	6	38	97	43	15	20	10	8
Legal/regulatory	87.1%	88.2%	88.5%	76.0%	90.9%	88.9%	100.0%	100.0%	87.9%	66.7%	84.0%	83.3%	92.1%	86.6%	90.7%	80.0%	100.0%	90.0%	62.5%
Quality/patient safety	89.2%	86.3%	90.9%	84.0%	87.5%	80.6%	100.0%	75.0%	93.9%	88.9%	91.0%	100.0%	86.8%	88.7%	83.7%	100.0%	85.0%	100.0%	75.0%
Reimbursement and "drivers" of financial performance	74.3%	78.4%	77.0%	48.0%	70.5%	63.9%	80.0%	87.5%	69.7%	77.8%	74.0%	100.0%	78.9%	70.1%	72.1%	73.3%	85.0%	70.0%	87.5%
Industry trends and the associated implications (e.g., value-based purchasing, population health management, health insurance exchanges, expansion of Medicaid, market disruptors, etc.)	88.0%	96.1%	89.1%	64.0%	84.1%	77.8%	100.0%	87.5%	84.8%	66.7%	89.0%	100.0%	97.4%	82.5%	93.0%	100.0%	95.0%	90.0%	87.5%
The role of your organization in a changing delivery system	67.2%	84.3%	60.6%	76.0%	55.7%	50.0%	40.0%	50.0%	60.6%	66.7%	69.0%	100.0%	84.2%	57.7%	76.7%	73.3%	85.0%	90.0%	100.0%
Other	10.8%	17.6%	8.5%	12.0%	8.0%	11.1%	0.0%	0.0%	9.1%	11.1%	9.0%	16.7%	21.1%	9.3%	14.0%	13.3%	15.0%	0.0%	25.0%
Delivery of board education																			
Total responding in each category	242	53	167	24	89	37	5	8	33	9	99	6	39	96	43	15	20	11	8
During regularly scheduled board meetings	88.0%	90.4%	88.0%	83.3%	86.5%	86.5%	100.0%	87.5%	87.9%	100.0%	86.9%	100.0%	89.7%	87.5%	90.7%	80.0%	90.0%	90.9%	100.0%
Periodic board education retreats	50.0%	71.2%	42.2%	58.3%	43.8%	32.4%	40.0%	62.5%	48.5%	33.3%	45.5%	100.0%	71.8%	44.8%	58.1%	66.7%	80.0%	72.7%	75.0%
Attendance at off-site conferences	65.3%	65.4%	68.1%	45.8%	65.2%	54.1%	80.0%	75.0%	69.7%	33.3%	67.7%	66.7%	66.7%	63.5%	69.8%	73.3%	70.0%	63.6%	37.5%
Webinars/online education	34.7%	19.2%	38.0%	45.8%	39.3%	27.0%	40.0%	62.5%	54.5%	11.1%	40.4%	33.3%	15.4%	38.5%	32.6%	26.7%	20.0%	9.1%	12.5%
Publications, articles, other reading materials	74.0%	78.8%	73.5%	66.7%	77.5%	78.4%	60.0%	75.0%	75.8%	55.6%	70.7%	83.3%	76.9%	66.7%	72.1%	100.0%	80.0%	63.6%	75.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Number of hours per month combined devoted to governance/board-related matters by members of the C-suite (phone calls, preparing board reports, presenting during meetings, etc.)																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
< 10 hours per month	38.1%	15.4%	44.0%	46.2%	42.7%	48.6%	60.0%	37.5%	36.4%	66.7%	41.6%	50.0%	10.3%	51.0%	30.2%	13.3%	15.0%	0.0%	25.0%
10–20 hours per month	39.8%	40.4%	41.0%	30.8%	40.4%	37.8%	20.0%	37.5%	42.4%	22.2%	40.6%	16.7%	43.6%	36.7%	46.5%	26.7%	40.0%	63.6%	37.5%
20–40 hours per month	14.3%	30.8%	9.6%	11.5%	11.2%	8.1%	20.0%	25.0%	12.1%	0.0%	11.9%	16.7%	30.8%	9.2%	11.6%	40.0%	25.0%	18.2%	37.5%
40–60 hours per month	4.5%	5.8%	3.6%	7.7%	3.4%	2.7%	0.0%	0.0%	6.1%	0.0%	5.0%	0.0%	7.7%	3.1%	9.3%	13.3%	10.0%	0.0%	0.0%
60+ hours per month	3.3%	7.7%	1.8%	3.8%	2.2%	2.7%	0.0%	0.0%	3.0%	11.1%	1.0%	16.7%	7.7%	0.0%	2.3%	6.7%	10.0%	18.2%	0.0%
Number of FTEs devoted to governance (i.e., board support staff)																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
< 1 or the job is combined with another position	69.3%	40.4%	76.5%	80.8%	77.5%	75.7%	60.0%	87.5%	87.9%	88.9%	72.3%	50.0%	41.0%	81.6%	55.8%	46.7%	40.0%	18.2%	37.5%
1–2	27.9%	57.7%	21.7%	7.7%	20.2%	21.6%	40.0%	12.5%	9.1%	11.1%	23.8%	50.0%	56.4%	17.3%	39.5%	53.3%	55.0%	81.8%	50.0%
2–4	2.5%	1.9%	1.2%	11.5%	1.1%	2.7%	0.0%	0.0%	0.0%	0.0%	4.0%	0.0%	2.6%	1.0%	2.3%	0.0%	5.0%	0.0%	12.5%
4–6	0.4%	0.0%	0.6%	0.0%	1.1%	0.0%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.3%	0.0%	0.0%	0.0%	0.0%
More than 6	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Annual average cash compensation for the board chair																			
Total responding in each category	226	42	158	26	83	33	5	7	33	9	96	5	33	92	41	14	17	7	7
No compensation	92.9%	92.9%	92.4%	96.2%	88.0%	90.9%	100.0%	85.7%	87.9%	100.0%	96.9%	100.0%	90.9%	94.6%	97.6%	100.0%	94.1%	85.7%	85.7%
< $5,000	81.3%	33.3%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	66.7%	0.0%	33.3%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
$5,000–$9,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15,000–$19,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$30,000–$39,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50,000 +	18.8%	66.7%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	66.7%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Percentage of respondents with compensation for this position	7.1%	7.1%	7.6%	3.8%	12.0%	9.1%	0.0%	14.3%	12.1%	0.0%	3.1%	0.0%	9.1%	5.4%	2.4%	0.0%	5.9%	14.3%	14.3%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Annual average cash compensation for other board officers																			
Total responding in each category	226	42	158	26	83	34	5	7	32	9	97	5	32	93	41	14	17	7	6
No compensation	93.8%	97.6%	92.4%	96.2%	86.7%	88.2%	100.0%	85.7%	87.5%	100.0%	96.9%	100.0%	100.0%	94.6%	97.6%	100.0%	94.1%	100.0%	100.0%
< $5,000	92.9%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	66.7%	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
$5,000–$9,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15,000–$19,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$30,000–$39,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50,000 +	7.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents with compensation for this position	6.2%	2.4%	7.6%	3.8%	13.3%	11.8%	0.0%	14.3%	12.5%	0.0%	3.1%	0.0%	0.0%	5.4%	2.4%	0.0%	5.9%	0.0%	0.0%
Annual average cash compensation for board committee chairs																			
Total responding in each category	226	40	160	26	82	33	5	7	32	9	99	5	31	94	41	14	17	6	6
No compensation	96.5%	100.0%	95.0%	100.0%	91.5%	90.9%	100.0%	85.7%	96.9%	100.0%	99.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%
< $5,000	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5,000–$9,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15,000–$19,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$30,000–$39,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents with compensation for this position	3.5%	0.0%	5.0%	0.0%	8.5%	9.1%	0.0%	14.3%	3.1%	0.0%	1.0%	0.0%	0.0%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Annual average cash compensation for other board members																			
Total responding in each category	225	39	160	26	83	33	5	7	33	9	98	5	30	93	41	14	17	6	6
No compensation	93.3%	97.4%	91.9%	96.2%	88.0%	90.9%	100.0%	85.7%	87.9%	100.0%	95.9%	100.0%	96.7%	93.5%	97.6%	100.0%	94.1%	100.0%	100.0%
< $5,000	93.3%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	75.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
$5,000–$9,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15,000–$19,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20,000–$29,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$30,000–$39,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50,000 +	6.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents with compensation for this position	6.7%	2.6%	8.1%	3.8%	12.0%	9.1%	0.0%	14.3%	12.1%	0.0%	4.1%	0.0%	3.3%	6.5%	2.4%	0.0%	5.9%	0.0%	0.0%
Use of board portal or similar online tool to communicate and access board materials																			
Total responding in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
Yes	62.7%	90.4%	53.0%	69.2%	46.1%	37.8%	100.0%	50.0%	45.5%	55.6%	65.3%	100.0%	89.7%	53.1%	83.7%	86.7%	90.0%	90.9%	100.0%
No, but we are in the process of implementing	6.6%	0.0%	9.0%	3.8%	11.2%	5.4%	0.0%	25.0%	15.2%	0.0%	5.9%	0.0%	0.0%	10.2%	0.0%	0.0%	0.0%	0.0%	0.0%
No	30.7%	9.6%	38.0%	26.9%	42.7%	56.8%	0.0%	25.0%	39.4%	44.4%	28.7%	0.0%	10.3%	36.7%	16.3%	13.3%	10.0%	9.1%	0.0%
Most important benefit to the board in using a board portal or online tool																			
Total responding in each category	153	47	88	18	41	14	5	4	15	5	66	6	35	52	36	13	18	10	8
Saves time	16.3%	10.6%	19.3%	16.7%	14.6%	14.3%	40.0%	25.0%	6.7%	80.0%	15.2%	33.3%	8.6%	21.2%	13.9%	30.8%	5.6%	10.0%	12.5%
Enhances board members' level of preparation for meetings	37.3%	42.6%	30.7%	55.6%	34.1%	42.9%	20.0%	25.0%	40.0%	0.0%	37.9%	16.7%	48.6%	28.8%	33.3%	53.8%	38.9%	40.0%	50.0%
Reduces paper waste/ duplication costs	38.6%	38.3%	43.2%	16.7%	48.8%	42.9%	40.0%	50.0%	46.7%	0.0%	37.9%	33.3%	34.3%	40.4%	47.2%	7.7%	44.4%	40.0%	37.5%
Enhances communication among board members between meetings	6.5%	4.3%	6.8%	11.1%	2.4%	0.0%	0.0%	0.0%	6.7%	20.0%	9.1%	16.7%	2.9%	9.6%	5.6%	0.0%	5.6%	10.0%	0.0%
Provides no perceived benefit	0.7%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%
Other	0.7%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%

All Respondents		Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Board members are provided with hardware (laptops, iPads, etc.) to access online board materials																			
Total responding in each category	153	47	88	18	41	14	5	4	15	5	66	6	35	52	36	13	18	10	8
Yes	75.2%	68.1%	83.0%	55.6%	87.8%	78.6%	80.0%	100.0%	93.3%	40.0%	75.8%	33.3%	71.4%	71.2%	83.3%	61.5%	83.3%	60.0%	75.0%
No, but we are considering it at this time	3.9%	4.3%	2.3%	11.1%	4.9%	7.1%	20.0%	0.0%	0.0%	0.0%	3.0%	0.0%	5.7%	3.8%	5.6%	0.0%	5.6%	10.0%	0.0%
No, and we are not considering it at this time	20.9%	27.7%	14.8%	33.3%	7.3%	14.3%	0.0%	0.0%	6.7%	60.0%	21.2%	66.7%	22.9%	25.0%	11.1%	38.5%	11.1%	30.0%	25.0%
Participation in an accountable care organization or similarly structured clinically integrated network																			
Total responding in each category	201	41	135	25	76	34	3	6	27	8	82	5	30	80	40	9	18	10	7
Yes	47.3%	68.3%	39.3%	56.0%	38.2%	44.1%	66.7%	33.3%	29.6%	37.5%	47.6%	40.0%	73.3%	37.5%	55.0%	55.6%	50.0%	70.0%	57.1%
ACO ownership structure																			
Total responding in each category	98	27	57	14	31	15	2	2	10	3	41	2	21	31	23	6	10	6	4
Independent entity	14.3%	0.0%	19.3%	21.4%	19.4%	20.0%	50.0%	0.0%	20.0%	33.3%	17.1%	0.0%	0.0%	22.6%	4.3%	0.0%	10.0%	0.0%	0.0%
Physician group-owned	2.0%	7.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	4.8%	0.0%	0.0%	16.7%	10.0%	0.0%	0.0%
Hospital-owned	8.2%	11.1%	8.8%	0.0%	6.5%	13.3%	0.0%	0.0%	0.0%	0.0%	9.8%	0.0%	9.5%	3.2%	17.4%	16.7%	10.0%	0.0%	0.0%
Health system-owned	36.7%	59.3%	26.3%	35.7%	25.8%	20.0%	0.0%	0.0%	30.0%	33.3%	31.7%	50.0%	61.9%	25.8%	39.1%	16.7%	60.0%	83.3%	100.0%
Insurance company-owned	1.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.8%	0.0%	0.0%	16.7%	0.0%	0.0%	0.0%
Joint venture between two or more entities	22.4%	7.4%	26.3%	35.7%	32.3%	40.0%	50.0%	100.0%	10.0%	33.3%	24.4%	0.0%	4.8%	32.3%	21.7%	33.3%	0.0%	0.0%	0.0%
Ownership between two or more entities	12.2%	11.1%	14.0%	7.1%	12.9%	6.7%	0.0%	0.0%	30.0%	0.0%	12.2%	0.0%	14.3%	6.5%	17.4%	0.0%	10.0%	16.7%	0.0%
Other	3.1%	0.0%	5.3%	0.0%	3.2%	0.0%	0.0%	0.0%	10.0%	0.0%	4.9%	0.0%	0.0%	9.7%	0.0%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Number of seats and types of entities on the ACO board																			
Total responding in each category	9	2	6	1	2	0	0	0	2	0	5	0	2	2	4	0	1	0	0
Insurance company																			
0	77.8%	100.0%	83.3%	0.0%	50.0%	0.0%	0.0%	0.0%	50.0%	0.0%	80.0%	0.0%	100.0%	100.0%	75.0%	0.0%	100.0%	0.0%	0.0%
1	11.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4+	11.1%	0.0%	16.7%	0.0%	50.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital																			
0	11.1%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%
1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	11.1%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
3	11.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%
4+	66.7%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	80.0%	0.0%	0.0%	100.0%	50.0%	0.0%	0.0%	0.0%	0.0%
Physician-Hospital Organization																			
0	88.9%	50.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	50.0%	100.0%	75.0%	0.0%	100.0%	0.0%	0.0%
1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4+	11.1%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%
Medical Group																			
0	66.7%	50.0%	83.3%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	60.0%	0.0%	50.0%	100.0%	50.0%	0.0%	0.0%	0.0%	0.0%
1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	11.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%
3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4+	22.2%	50.0%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	50.0%	0.0%	25.0%	0.0%	100.0%	0.0%	0.0%
Health System																			
0	77.8%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	75.0%	0.0%	0.0%	0.0%	0.0%
1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	11.1%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
3	11.1%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	25.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Other																			
0	88.9%	100.0%	83.3%	100.0%	50.0%	0.0%	0.0%	0.0%	50.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
1	11.1%	0.0%	16.7%	0.0%	50.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Size of ACO Board																			
Average	10.33	10.00	11.17	6.00	13.00	N/A	N/A	N/A	13.00	N/A	9.40	N/A	10.00	9.00	12.50	N/A	8.00	N/A	N/A
Median	10	10	10	6	13	N/A	N/A	N/A	13	N/A	8	N/A	10	9	14	N/A	8	N/A	N/A
Range	6 to 16	8 to 12	7 to 16	6 to 6	10 to 16	N/A	N/A	N/A	10 to 16	N/A	6 to 16	N/A	8 to 12	8 to 10	6 to 16	N/A	8 to 8	N/A	N/A
Approximate size of covered patient popluation under the ACO																			
Total responding in each category	94	27	53	14	30	15	2	2	9	2	39	2	21	29	22	6	9	6	4
Less than 10,000 people	14.9%	14.8%	15.1%	14.3%	23.3%	26.7%	50.0%	100.0%	0.0%	50.0%	7.7%	50.0%	9.5%	13.8%	18.2%	16.7%	22.2%	0.0%	0.0%
10,000 to 20,000 people	19.1%	14.8%	24.5%	7.1%	26.7%	26.7%	50.0%	0.0%	22.2%	0.0%	20.5%	50.0%	4.8%	24.1%	4.5%	0.0%	33.3%	16.7%	0.0%
20,001 to 30,000 people	7.4%	11.1%	7.5%	0.0%	3.3%	6.7%	0.0%	0.0%	0.0%	0.0%	7.7%	0.0%	14.3%	6.9%	13.6%	16.7%	0.0%	16.7%	0.0%
30,001 to 40,000 people	7.4%	7.4%	7.5%	7.1%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	10.3%	0.0%	9.5%	10.3%	4.5%	0.0%	0.0%	33.3%	0.0%
40,001 to 50,000 people	9.6%	11.1%	7.5%	14.3%	6.7%	6.7%	0.0%	0.0%	11.1%	0.0%	10.3%	0.0%	14.3%	3.4%	18.2%	16.7%	11.1%	0.0%	0.0%
More than 50,000 people	41.5%	40.7%	37.7%	57.1%	36.7%	33.3%	0.0%	0.0%	66.7%	50.0%	43.6%	0.0%	47.6%	41.4%	40.9%	50.0%	33.3%	33.3%	100.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
Nature of relationship between ACO board and owner entity board (e.g., health system board)																			
Total responding in each category	91	25	53	13	29	14	2	2	9	2	38	2	20	29	22	5	8	6	3
The ACO board is independent and does not have a relationship with the entity board	42.9%	20.0%	52.8%	46.2%	51.7%	57.1%	50.0%	50.0%	55.6%	100.0%	44.7%	50.0%	20.0%	55.2%	27.3%	40.0%	12.5%	16.7%	0.0%
The ACO board is considered a subsidiary of the entity board, and the entity board has decision-making authority over some aspects of the ACO	23.1%	44.0%	15.1%	15.4%	13.8%	21.4%	50.0%	0.0%	0.0%	0.0%	15.8%	50.0%	50.0%	13.8%	31.8%	20.0%	62.5%	33.3%	66.7%
The ACO board reports progress to the entity board but retains all decision-making authority regarding the ACO	26.4%	24.0%	28.3%	23.1%	31.0%	21.4%	0.0%	50.0%	33.3%	0.0%	31.6%	0.0%	15.0%	24.1%	40.9%	40.0%	0.0%	33.3%	33.3%
Other	7.7%	12.0%	3.8%	15.4%	3.4%	0.0%	0.0%	0.0%	11.1%	0.0%	7.9%	0.0%	15.0%	6.9%	0.0%	0.0%	25.0%	16.7%	0.0%
Board Culture: level of agreement with the following statements																			
Board members demonstrate a clear understanding of the board's roles and responsibilities																			
Total responding in each category	243	52	165	26	89	37	5	8	33	9	100	6	39	97	43	15	20	11	8
Strongly agree	39.5%	53.8%	34.5%	42.3%	29.2%	27.0%	20.0%	25.0%	36.4%	44.4%	41.0%	66.7%	53.8%	37.1%	34.9%	46.7%	45.0%	72.7%	62.5%
Agree	48.6%	44.2%	51.5%	38.5%	53.9%	48.6%	80.0%	75.0%	48.5%	33.3%	47.0%	33.3%	46.2%	45.4%	60.5%	46.7%	50.0%	18.2%	25.0%
Neither agree nor disagree	7.8%	1.9%	8.5%	15.4%	9.0%	13.5%	0.0%	0.0%	6.1%	22.2%	9.0%	0.0%	0.0%	10.3%	2.3%	6.7%	5.0%	9.1%	12.5%
Disagree	3.7%	0.0%	4.8%	3.8%	6.7%	10.8%	0.0%	0.0%	6.1%	0.0%	3.0%	0.0%	0.0%	6.2%	2.3%	0.0%	0.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.6%	0.0%	1.1%	0.0%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Meetings are held at the right frequency for the board to fulfill its duties and responsibilities																			
Total responding in each category	243	52	165	26	89	37	5	8	33	9	100	6	39	97	43	15	20	11	8
Strongly agree	58.0%	61.5%	57.6%	53.8%	56.2%	51.4%	40.0%	37.5%	72.7%	44.4%	60.0%	66.7%	59.0%	53.6%	60.5%	53.3%	50.0%	72.7%	75.0%
Agree	36.6%	32.7%	36.4%	46.2%	36.0%	37.8%	60.0%	50.0%	24.2%	55.6%	36.0%	33.3%	35.9%	44.3%	34.9%	40.0%	35.0%	18.2%	25.0%
Neither agree nor disagree	2.1%	1.9%	2.4%	0.0%	3.4%	2.7%	0.0%	0.0%	3.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	6.7%	5.0%	9.1%	0.0%
Disagree	3.3%	3.8%	3.6%	0.0%	4.5%	8.1%	0.0%	12.5%	0.0%	0.0%	2.0%	0.0%	5.1%	2.1%	4.7%	0.0%	10.0%	0.0%	0.0%
Strongly disagree	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
The board's culture allows for active participation, candid communication, and rigorous decision making																			
Total responding in each category	242	52	164	26	88	36	5	8	33	9	100	6	39	97	43	15	20	11	8
Strongly agree	52.1%	55.8%	48.8%	65.4%	48.9%	41.7%	20.0%	62.5%	63.6%	55.6%	53.0%	50.0%	56.4%	45.4%	67.4%	46.7%	50.0%	54.5%	62.5%
Agree	37.2%	36.5%	39.0%	26.9%	40.9%	41.7%	80.0%	37.5%	27.3%	33.3%	33.0%	50.0%	38.5%	43.3%	25.6%	40.0%	40.0%	36.4%	12.5%
Neither agree nor disagree	8.3%	5.8%	9.1%	7.7%	6.8%	11.1%	0.0%	0.0%	6.1%	11.1%	12.0%	0.0%	2.6%	9.3%	2.3%	13.3%	5.0%	9.1%	25.0%
Disagree	2.5%	1.9%	3.0%	0.0%	3.4%	5.6%	0.0%	0.0%	3.0%	0.0%	2.0%	0.0%	2.6%	2.1%	4.7%	0.0%	5.0%	0.0%	0.0%
Strongly disagree	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
The board engages in constructive dialogue with management																			
Total responding in each category	240	51	163	26	87	35	5	8	33	9	99	6	39	97	43	15	19	10	8
Strongly agree	51.7%	62.7%	46.0%	65.4%	49.4%	51.4%	20.0%	50.0%	57.6%	55.6%	48.5%	50.0%	64.1%	45.4%	55.8%	53.3%	63.2%	60.0%	62.5%
Agree	40.0%	33.3%	44.8%	23.1%	36.8%	31.4%	60.0%	50.0%	27.3%	44.4%	44.4%	50.0%	33.3%	44.3%	34.9%	33.3%	31.6%	40.0%	37.5%
Neither agree nor disagree	6.7%	3.9%	7.4%	7.7%	10.3%	14.3%	20.0%	0.0%	9.1%	0.0%	6.1%	0.0%	2.6%	8.2%	7.0%	13.3%	5.3%	0.0%	0.0%
Disagree	1.7%	0.0%	1.8%	3.8%	3.4%	2.9%	0.0%	0.0%	6.1%	0.0%	1.0%	0.0%	0.0%	2.1%	2.3%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Board members respect the distinction between the role of the board vs. management and avoid getting into operational matters																			
Total responding in each category	242	52	164	26	88	36	5	8	33	9	100	6	39	97	43	15	20	11	8
Strongly agree	36.0%	42.3%	32.9%	42.3%	28.4%	25.0%	40.0%	25.0%	33.3%	44.4%	38.0%	33.3%	46.2%	40.2%	27.9%	20.0%	30.0%	72.7%	50.0%
Agree	42.1%	44.2%	42.1%	38.5%	39.8%	38.9%	40.0%	75.0%	30.3%	33.3%	44.0%	66.7%	41.0%	37.1%	53.5%	53.3%	55.0%	9.1%	37.5%
Neither agree nor disagree	11.6%	13.5%	11.0%	11.5%	18.2%	22.2%	0.0%	0.0%	18.2%	11.1%	6.0%	0.0%	12.8%	8.2%	11.6%	20.0%	5.0%	18.2%	12.5%
Disagree	9.1%	0.0%	12.2%	7.7%	10.2%	8.3%	20.0%	0.0%	15.2%	11.1%	12.0%	0.0%	0.0%	13.4%	4.7%	6.7%	10.0%	0.0%	0.0%
Strongly disagree	1.2%	0.0%	1.8%	0.0%	3.4%	5.6%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	1.0%	2.3%	0.0%	0.0%	0.0%	0.0%
Board members voice opinions/concerns regardless of how sensitive the matter may be																			
Total responding in each category	243	52	165	26	89	37	5	8	33	9	100	6	39	97	43	15	20	11	8
Strongly agree	37.4%	48.1%	32.7%	46.2%	41.6%	43.2%	20.0%	37.5%	48.5%	33.3%	31.0%	66.7%	41.0%	33.0%	37.2%	46.7%	35.0%	54.5%	62.5%
Agree	48.1%	40.4%	50.9%	46.2%	47.2%	40.5%	80.0%	62.5%	42.4%	33.3%	51.0%	16.7%	51.3%	52.6%	51.2%	40.0%	55.0%	36.4%	0.0%
Neither agree nor disagree	11.5%	7.7%	13.9%	3.8%	9.0%	13.5%	0.0%	0.0%	6.1%	22.2%	15.0%	16.7%	5.1%	12.4%	9.3%	6.7%	5.0%	9.1%	25.0%
Disagree	2.9%	3.8%	2.4%	3.8%	2.2%	2.7%	0.0%	0.0%	3.0%	11.1%	3.0%	0.0%	2.6%	2.1%	2.3%	6.7%	5.0%	0.0%	12.5%
Strongly disagree	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
The board sets appropriate short- and long-term goals for management and clinical leaders in order to successfully implement the strategic plan																			
Total responding in each category	242	52	164	26	89	37	5	8	33	9	99	6	39	97	43	15	20	11	8
Strongly agree	30.2%	42.3%	23.2%	50.0%	24.7%	27.0%	0.0%	50.0%	21.2%	44.4%	29.3%	50.0%	38.5%	26.8%	34.9%	26.7%	35.0%	36.4%	75.0%
Agree	45.5%	40.4%	50.0%	26.9%	44.9%	35.1%	80.0%	37.5%	51.5%	11.1%	49.5%	0.0%	51.3%	45.4%	51.2%	46.7%	35.0%	63.6%	12.5%
Neither agree nor disagree	14.9%	9.6%	16.5%	15.4%	16.9%	21.6%	0.0%	12.5%	15.2%	0.0%	17.2%	33.3%	5.1%	16.5%	11.6%	13.3%	20.0%	0.0%	12.5%
Disagree	9.5%	7.7%	10.4%	7.7%	13.5%	16.2%	20.0%	0.0%	12.1%	44.4%	4.0%	16.7%	5.1%	11.3%	2.3%	13.3%	10.0%	0.0%	0.0%
Strongly disagree	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
The board is able to inform and engage all stakeholders to gain buy-in and sustain organizational change/transformation																			
Total responding in each category	242	52	164	26	88	36	5	8	33	9	100	6	39	96	43	15	20	11	8
Strongly agree	21.5%	32.7%	16.5%	30.8%	18.2%	16.7%	20.0%	12.5%	24.2%	44.4%	18.0%	33.3%	30.8%	16.7%	25.6%	26.7%	30.0%	27.3%	50.0%
Agree	47.5%	44.2%	48.8%	46.2%	43.2%	38.9%	40.0%	75.0%	36.4%	22.2%	53.0%	16.7%	53.8%	47.9%	51.2%	46.7%	60.0%	54.5%	25.0%
Neither agree nor disagree	24.0%	23.1%	25.6%	15.4%	28.4%	33.3%	40.0%	12.5%	24.2%	0.0%	24.0%	50.0%	15.4%	26.0%	16.3%	26.7%	10.0%	18.2%	25.0%
Disagree	7.0%	0.0%	9.1%	7.7%	10.2%	11.1%	0.0%	0.0%	15.2%	33.3%	5.0%	0.0%	0.0%	9.4%	7.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
The board, management, medical staff, and nursing staff are aligned in pursuing the organization's strategic goals and vision																			
Total responding in each category	242	51	165	26	89	37	5	8	33	9	100	6	38	97	43	14	20	11	8
Strongly agree	41.7%	45.1%	40.6%	42.3%	37.1%	32.4%	40.0%	37.5%	45.5%	55.6%	43.0%	16.7%	50.0%	37.1%	48.8%	57.1%	40.0%	36.4%	37.5%
Agree	45.5%	52.9%	43.6%	42.3%	42.7%	43.2%	60.0%	50.0%	33.3%	33.3%	46.0%	83.3%	47.4%	44.3%	46.5%	42.9%	60.0%	63.6%	62.5%
Neither agree nor disagree	11.2%	2.0%	13.3%	15.4%	18.0%	24.3%	0.0%	12.5%	15.2%	11.1%	9.0%	0.0%	2.6%	17.5%	2.3%	0.0%	0.0%	0.0%	0.0%
Disagree	1.7%	0.0%	2.4%	0.0%	2.2%	0.0%	0.0%	0.0%	6.1%	0.0%	2.0%	0.0%	0.0%	1.0%	2.3%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
How has your board structure/practices changed since 2017 in regards to population health management?																			
Total responding in each category	237	50	161	26	88	36	5	8	33	8	98	5	38	96	41	15	19	11	8
N/A; we are not currently making plans to manage population health	18.1%	4.0%	21.1%	26.9%	23.9%	30.6%	20.0%	25.0%	18.2%	37.5%	17.3%	20.0%	2.6%	24.0%	12.2%	6.7%	10.5%	0.0%	12.5%
We have not changed our board structure to prepare for population health management	50.2%	56.0%	50.3%	38.5%	50.0%	47.2%	40.0%	25.0%	60.6%	50.0%	48.0%	80.0%	52.6%	50.0%	41.5%	53.3%	42.1%	54.5%	62.5%
We have updated the strategic plan to include goals regarding population health management, including building IT infrastructure and physician integration	43.5%	50.0%	43.5%	30.8%	39.8%	30.6%	40.0%	50.0%	45.5%	25.0%	43.9%	0.0%	60.5%	35.4%	68.3%	53.3%	42.1%	54.5%	50.0%
We have added board members with expertise in population health management to help us achieve this goal	3.4%	4.0%	2.5%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	5.3%	1.0%	9.8%	0.0%	10.5%	0.0%	0.0%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	0.8%	2.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	2.6%	1.0%	0.0%	0.0%	0.0%	9.1%	0.0%
We have added physicians to the board to help us achieve this goal	4.6%	6.0%	3.7%	7.7%	1.1%	0.0%	0.0%	0.0%	3.0%	0.0%	7.1%	0.0%	7.9%	4.2%	7.3%	6.7%	0.0%	0.0%	12.5%
We have added nurses to the board to help us achieve this goal	2.1%	2.0%	1.9%	3.8%	1.1%	2.8%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	2.6%	2.1%	0.0%	6.7%	0.0%	0.0%	0.0%
We have added physicians to the management team to help us achieve this goal	8.4%	18.0%	6.8%	0.0%	4.5%	2.8%	0.0%	0.0%	9.1%	0.0%	9.2%	20.0%	15.8%	4.2%	12.2%	20.0%	15.8%	9.1%	25.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
We have added nurses to the management team to help us achieve this goal	6.3%	8.0%	6.2%	3.8%	4.5%	0.0%	0.0%	12.5%	9.1%	0.0%	7.1%	0.0%	10.5%	4.2%	9.8%	6.7%	15.8%	9.1%	0.0%
We have added population health-related metrics to our board quality/finance dashboard reports	22.4%	24.0%	21.1%	26.9%	20.5%	25.0%	0.0%	12.5%	21.2%	0.0%	25.5%	20.0%	23.7%	16.7%	34.1%	20.0%	31.6%	18.2%	25.0%
Other	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents currently making changes to manage population health	81.9%	96.0%	78.9%	73.1%	76.1%	69.4%	80.0%	75.0%	81.8%	62.5%	82.7%	80.0%	97.4%	76.0%	87.8%	93.3%	89.5%	100.0%	87.5%
How has your board structure/practices changed since 2017 in order to be successful with value-based payments?																			
Total responding in each category	234	49	161	24	87	36	5	8	33	9	96	5	37	93	42	15	19	10	8
N/A; we are not currently making plans to prepare for value-based payments	15.0%	2.0%	17.4%	25.0%	20.7%	25.0%	20.0%	25.0%	15.2%	44.4%	12.5%	20.0%	0.0%	20.4%	4.8%	6.7%	5.3%	0.0%	0.0%
We have not changed our board structure to prepare for value-based payments	56.0%	59.2%	54.7%	58.3%	54.0%	55.6%	40.0%	25.0%	66.7%	44.4%	57.3%	80.0%	56.8%	61.3%	45.2%	53.3%	47.4%	50.0%	87.5%
We have updated the strategic and financial plans to include goals regarding value-based payments	40.2%	55.1%	37.9%	25.0%	36.8%	30.6%	40.0%	50.0%	33.3%	11.1%	38.5%	20.0%	62.2%	28.0%	64.3%	66.7%	52.6%	60.0%	37.5%
We have added board members with expertise in quality improvement processes to help us achieve this goal	3.0%	8.2%	1.2%	4.2%	1.1%	2.8%	0.0%	0.0%	0.0%	0.0%	3.1%	0.0%	8.1%	2.2%	2.4%	13.3%	0.0%	0.0%	12.5%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	0.9%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.0%	1.1%	2.4%	0.0%	0.0%	0.0%	0.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	244	52	166	26	89	37	5	8	33	9	101	6	39	98	43	15	20	11	8
2019 Biennial Survey Frequency Table	Overall	Health System	Indepen-dent	Subsid-iary	Govern-ment	County	City	County/ City	District/ Authority	Church Hospital	Secular Hospital	Other Church System	Other System	<100	100–299	300–499	500–999	1000–1999	2000+
We have added board members with expertise in cost reduction strategies to help us achieve this goal	2.1%	2.0%	1.9%	4.2%	1.1%	0.0%	0.0%	0.0%	3.0%	0.0%	3.1%	0.0%	2.7%	1.1%	7.1%	0.0%	0.0%	0.0%	12.5%
We have added physicians to the board to help us achieve this goal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
We have added nurses to the board to help us achieve this goal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
We have added physicians to the management team to help us achieve this goal	6.4%	12.2%	5.0%	4.2%	4.6%	2.8%	0.0%	0.0%	9.1%	0.0%	6.3%	0.0%	13.5%	3.2%	11.9%	13.3%	15.8%	0.0%	12.5%
We have added nurses to the management team to help us achieve this goal	7.7%	12.2%	6.2%	8.3%	3.4%	0.0%	0.0%	12.5%	6.1%	0.0%	9.4%	0.0%	16.2%	8.6%	11.9%	13.3%	5.3%	10.0%	12.5%
We have added value-based care metrics to our board quality/finance dashboard reports	22.2%	28.6%	20.5%	20.8%	16.1%	16.7%	0.0%	25.0%	15.2%	0.0%	28.1%	0.0%	29.7%	19.4%	33.3%	40.0%	26.3%	10.0%	12.5%
Other	1.3%	4.1%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	5.4%	0.0%	0.0%	0.0%	5.3%	0.0%	12.5%
Percentage of respondents currently making changes to be successful with value-based payments	85.0%	98.0%	82.6%	75.0%	79.3%	75.0%	80.0%	75.0%	84.8%	55.6%	87.5%	80.0%	100.0%	79.6%	95.2%	93.3%	94.7%	100.0%	100.0%

Appendix 2. 2019 Governance Practices: Adoption & Performance

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
Duty of Care							
The board requires that board members receive education on their fiduciary duties.							
Total responding to this question	240	52	162	26	19	8	89
Yes	77.1%	92.3%	74.1%	65.4%	73.7%	50.0%	73.0%
No, but considering it and/or working on it	13.3%	1.9%	16.0%	19.2%	21.1%	12.5%	16.9%
No, and not considering it	8.3%	5.8%	9.9%	3.8%	5.3%	0.0%	10.1%
Not applicable for our board	1.3%	0.0%	0.0%	11.5%	0.0%	37.5%	0.0%
The board reviews *and updates, if needed*, policies that specify the board's major oversight responsibilities at least every two years.**							
Total responding to this question	240	52	163	25	18	8	88
Yes	77.5%	80.8%	77.9%	68.0%	77.8%	50.0%	77.3%
No, but considering it and/or working on it	14.6%	13.5%	14.1%	20.0%	16.7%	25.0%	15.9%
No, and not considering it	5.8%	3.8%	7.4%	0.0%	0.0%	0.0%	5.7%
Not applicable for our board	2.1%	1.9%	0.6%	12.0%	5.6%	25.0%	1.1%
Board members receive necessary background materials *and well-developed agendas* within sufficient time to prepare for meetings.**							
Total responding to this question	240	52	163	25	18	8	89
Yes	96.3%	98.1%	96.3%	92.0%	100.0%	75.0%	98.9%
No, but considering it and/or working on it	3.3%	1.9%	3.7%	4.0%	0.0%	12.5%	1.1%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	0.4%	0.0%	0.0%	4.0%	0.0%	12.5%	0.0%
The board assesses its governance model including structure, policies, processes, and board expectations at least every three years.*							
Total responding to this question	241	52	163	26	19	8	89
Yes	68.5%	75.0%	69.3%	50.0%	57.9%	25.0%	66.3%
No, but considering it and/or working on it	16.6%	11.5%	18.4%	15.4%	15.8%	12.5%	19.1%
No, and not considering it	10.8%	11.5%	10.4%	11.5%	10.5%	25.0%	10.1%
Not applicable for our board	4.1%	1.9%	1.8%	23.1%	15.8%	37.5%	4.5%
The board reviews its committee structure and charters at least every two years to assure the necessary committees are in place, independence of committee members where necessary, and continued utility of committee charters/clear delegation of responsibilities.** *2015 wording: The board periodically reviews its committee structure and performance to assure: 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	240	52	163	25	19	7	89
Yes	72.1%	76.9%	73.6%	52.0%	63.2%	14.3%	69.7%
No, but considering it and/or working on it	12.5%	13.5%	11.7%	16.0%	15.8%	14.3%	13.5%
No, and not considering it	10.0%	9.6%	9.8%	12.0%	15.8%	14.3%	10.1%
Not applicable for our board	5.4%	0.0%	4.9%	20.0%	5.3%	57.1%	6.7%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, clinical, other consultants, etc.).							
Total responding to this question	240	52	162	26	19	8	89
Yes	88.3%	92.3%	88.9%	76.9%	89.5%	50.0%	83.1%
No, but considering it and/or working on it	5.4%	1.9%	6.8%	3.8%	0.0%	12.5%	9.0%
No, and not considering it	3.8%	5.8%	3.1%	3.8%	0.0%	12.5%	6.7%
Not applicable for our board	2.5%	0.0%	1.2%	15.4%	10.5%	25.0%	1.1%
The board requires management to provide the rationale for their recommendations, including options they considered.*							
Total responding to this question	238	50	162	26	19	8	88
Yes	94.5%	100.0%	93.8%	88.5%	89.5%	87.5%	92.0%
No, but considering it and/or working on it	3.8%	0.0%	3.7%	11.5%	10.5%	12.5%	4.5%
No, and not considering it	1.3%	0.0%	1.9%	0.0%	0.0%	0.0%	2.3%
Not applicable for our board	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	1.1%
Please evaluate your board's overall performance in fulfilling its duty of care.							
Total responding to this question	240	52	162	26	19	8	88
Excellent	45.8%	65.4%	40.7%	38.5%	47.4%	25.0%	40.9%
Very Good	38.8%	30.8%	41.4%	38.5%	31.6%	50.0%	39.8%
Good	12.9%	3.8%	14.8%	19.2%	21.1%	12.5%	14.8%
Fair	2.1%	0.0%	2.5%	3.8%	0.0%	12.5%	3.4%
Poor	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	1.1%
Duty of Loyalty							
The board *uniformly and consistently enforces* 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	240	52	163	25	19	7	88
Yes, generally	97.5%	100.0%	96.3%	100.0%	100.0%	100.0%	95.5%
No, but considering it and/or working on it	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	1.1%
No, and not considering it	0.8%	0.0%	1.2%	0.0%	0.0%	0.0%	1.1%
Not applicable for our board	1.3%	0.0%	1.8%	0.0%	0.0%	0.0%	2.3%
Board members complete a full conflict-of-interest disclosure statement annually.							
Total responding to this question	240	52	163	25	19	7	88
Yes, generally	95.0%	100.0%	93.3%	96.0%	94.7%	100.0%	90.9%
No, but considering it and/or working on it	2.5%	0.0%	3.7%	0.0%	0.0%	0.0%	4.5%
No, and not considering it	1.3%	0.0%	1.8%	0.0%	0.0%	0.0%	2.3%
Not applicable for our board	1.3%	0.0%	1.2%	4.0%	5.3%	0.0%	2.3%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
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	240	52	163	25	19	7	88
Yes, generally	78.3%	96.2%	70.6%	92.0%	89.5%	100.0%	71.6%
No, but considering it and/or working on it	9.2%	1.9%	12.3%	4.0%	5.3%	0.0%	14.8%
No, and not considering it	9.2%	1.9%	12.3%	4.0%	5.3%	0.0%	9.1%
Not applicable for our board	3.3%	0.0%	4.9%	0.0%	0.0%	0.0%	4.5%
The board enforces a written policy that states that deliberate violations of conflict of interest will require disciplinary action or potential removal from board service.** *2015 wording: 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	238	52	161	25	19	7	87
Yes, generally	80.7%	84.6%	77.6%	92.0%	94.7%	85.7%	74.7%
No, but considering it and/or working on it	6.3%	1.9%	8.7%	0.0%	0.0%	0.0%	8.0%
No, and not considering it	8.8%	9.6%	9.9%	0.0%	0.0%	0.0%	10.3%
Not applicable for our board	4.2%	3.8%	3.7%	8.0%	5.3%	14.3%	6.9%
The board *follows* a specific definition, with measurable standards, of an "independent director" that, at a minimum, complies with the most recent IRS definition and takes into consideration any applicable state law.**							
Total responding to this question	239	52	162	25	19	7	87
Yes, generally	78.2%	96.2%	71.6%	84.0%	89.5%	71.4%	63.2%
No, but considering it and/or working on it	4.6%	1.9%	5.6%	4.0%	0.0%	14.3%	5.7%
No, and not considering it	7.5%	0.0%	11.1%	0.0%	0.0%	0.0%	11.5%
Not applicable for our board	9.6%	1.9%	11.7%	12.0%	10.5%	14.3%	19.5%
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	239	52	162	25	19	7	87
Yes, generally	90.0%	86.5%	90.1%	96.0%	100.0%	85.7%	85.1%
No, but considering it and/or working on it	3.8%	5.8%	3.7%	0.0%	0.0%	0.0%	5.7%
No, and not considering it	4.6%	7.7%	4.3%	0.0%	0.0%	0.0%	6.9%
Not applicable for our board	1.7%	0.0%	1.9%	4.0%	0.0%	14.3%	2.3%
The board has a written policy outlining the organization's approach to physician competition/conflict of interest.* *Note: this practice has been on all prior surveys up to 2015; it was removed from the 2015 survey and added again for 2019.*							
Total responding to this question	233	51	158	24	18	7	86
Yes, generally	59.7%	64.7%	57.0%	66.7%	77.8%	42.9%	58.1%
No, but considering it and/or working on it	15.0%	7.8%	19.0%	4.2%	5.6%	0.0%	16.3%
No, and not considering it	16.7%	17.6%	18.4%	4.2%	5.6%	0.0%	17.4%
Not applicable for our board	8.6%	9.8%	5.7%	25.0%	11.1%	57.1%	8.1%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board assesses the adequacy of its conflict-of-interest policy as well as the sufficiency of its conflicts review process at least every two years.							
Total responding to this question	234	49	160	25	19	7	84
Yes, generally	72.8%	73.1%	74.1%	64.0%	73.7%	42.9%	70.5%
No, but considering it and/or working on it	14.6%	13.5%	16.0%	8.0%	10.5%	0.0%	17.0%
No, and not considering it	8.8%	13.5%	7.4%	8.0%	10.5%	0.0%	9.1%
Not applicable for our board	3.8%	0.0%	2.5%	20.0%	5.3%	57.1%	3.4%
The board *reviews and* ensures that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.							
Total responding to this question	234	49	162	23	19	7	84
Yes, generally	73.9%	87.8%	69.4%	76.0%	84.2%	57.1%	46.4%
No, but considering it and/or working on it	2.6%	0.0%	3.1%	4.0%	0.0%	14.3%	4.8%
No, and not considering it	3.0%	0.0%	3.8%	4.0%	0.0%	14.3%	3.6%
Not applicable for our board	20.5%	12.2%	23.8%	16.0%	15.8%	14.3%	45.2%
Please evaluate your board's overall performance in fulfilling its duty of loyalty.							
Total responding to this question	242	52	165	25	19	7	88
Excellent	51.7%	67.3%	44.8%	64.0%	73.7%	42.9%	45.5%
Very Good	36.0%	30.8%	38.8%	28.0%	26.3%	28.6%	42.0%
Good	10.7%	1.9%	13.9%	8.0%	0.0%	28.6%	9.1%
Fair	1.2%	0.0%	1.8%	0.0%	0.0%	0.0%	2.3%
Poor	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	1.1%
Duty of Obedience							
The board *adopts and periodically reviews* the organization's written mission statement to ensure that it correctly articulates its fundamental purpose.**							
Total responding to this question	242	52%	165	25	19	7	89
Yes, generally	88.8%	90.4%	89.7%	80.0%	89.5%	57.1%	87.6%
No, but considering it and/or working on it	7.0%	5.8%	7.9%	4.0%	0.0%	14.3%	6.7%
No, and not considering it	2.5%	3.8%	2.4%	0.0%	0.0%	0.0%	5.6%
Not applicable for our board	1.7%	0.0%	0.0%	16.0%	10.5%	28.6%	0.0%
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	242	52	165	25	19	7	89
Yes, generally	95.9%	96.2%	96.4%	92.0%	89.5%	100.0%	94.4%
No, but considering it and/or working on it	2.5%	3.8%	2.4%	0.0%	0.0%	0.0%	4.5%
No, and not considering it	1.2%	0.0%	1.2%	4.0%	5.3%	0.0%	1.1%
Not applicable for our board	0.4%	0.0%	0.0%	4.0%	5.3%	0.0%	0.0%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board establishes a risk profile for the organization and holds management accountable to performance consistent with that risk profile.*							
Total responding to this question	240	52	163	25	19	7	87
Yes, generally	48.3%	61.5%	43.6%	52.0%	68.4%	14.3%	46.0%
No, but considering it and/or working on it	17.9%	13.5%	19.6%	16.0%	10.5%	28.6%	16.1%
No, and not considering it	27.5%	21.2%	31.3%	16.0%	10.5%	28.6%	33.3%
Not applicable for our board	6.3%	3.8%	5.5%	16.0%	10.5%	28.6%	4.6%
When considering major projects, the board discusses what the organization is forgoing by undertaking the project, the risks and trade-offs, and approaches to mitigating risks associated with the project.*							
Total responding to this question	238	52	16	25%	19	7	86
Yes, generally	89.1%	90.4%	90.1%	80.0%	94.7%	42.9%	93.0%
No, but considering it and/or working on it	5.5%	3.8%	6.2%	4.0%	0.0%	14.3%	5.8%
No, and not considering it	3.8%	1.9%	3.7%	8.0%	5.3%	14.3%	1.2%
Not applicable for our board	1.7%	3.8%	0.0%	8.0%	0.0%	28.6%	0.0%
The board annually reviews and approves an updated enterprise risk management assessment and improvement plan.*							
Total responding to this question	241	52	164	25	19	7	88
Yes, generally	64.3%	69.2%	64.6%	52.0%	57.9%	42.9%	70.5%
No, but considering it and/or working on it	18.3%	23.1%	18.3%	8.0%	10.5%	0.0%	11.4%
No, and not considering it	12.0%	7.7%	12.8%	16.0%	15.8%	14.3%	12.5%
Not applicable for our board	5.4%	0.0%	4.3%	24.0%	15.8%	42.9%	5.7%
The board regularly reviews information provided by the chief information security officer (or top executive responsible for cybersecurity) to assess the organization's risk profile for cyber attacks and the sufficiency of management's handling of data storage, security protocols, and response to cyber attacks.*							
Total responding to this question	242	52	165	25	19	7	89
Yes, generally	63.6%	86.5%	60.0%	40.0%	47.4%	28.6%	60.7%
No, but considering it and/or working on it	19.4%	5.8%	25.5%	8.0%	10.5%	0.0%	19.1%
No, and not considering it	9.5%	5.8%	10.3%	12.0%	15.8%	0.0%	14.6%
Not applicable for our board	7.4%	1.9%	4.2%	40.0%	26.3%	71.4%	5.6%
The board ensures that management treats data privacy and security as a top priority for the organization and appropriately holds management accountable for meeting this responsibility.*							
Total responding to this question	241	51	165	25	19	7	89
Yes, generally	85.5%	92.2%	86.7%	64.0%	78.9%	28.6%	83.1%
No, but considering it and/or working on it	9.1%	5.9%	10.3%	8.0%	10.5%	0.0%	14.6%
No, and not considering it	2.9%	2.0%	2.4%	8.0%	5.3%	14.3%	1.1%
Not applicable for our board	2.5%	0.0%	0.6%	20.0%	5.3%	57.1%	1.1%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
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	241	52	164	25	19	7	88
Yes, generally	90.0%	96.2%	89.6%	80.0%	89.5%	57.1%	89.8%
No, but considering it and/or working on it	4.1%	0.0%	5.5%	4.0%	5.3%	0.0%	4.5%
No, and not considering it	3.3%	3.8%	3.0%	4.0%	5.3%	0.0%	3.4%
Not applicable for our board	2.5%	0.0%	1.8%	12.0%	0.0%	42.9%	2.3%
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	241	52	164	25	19	7	88
Yes, generally	66.4%	86.5%	64.0%	40.0%	42.1%	28.6%	53.4%
No, but considering it and/or working on it	3.7%	0.0%	5.5%	0.0%	0.0%	0.0%	2.3%
No, and not considering it	17.4%	11.5%	19.5%	16.0%	21.1%	14.3%	30.7%
Not applicable for our board	12.4%	1.9%	11.0%	44.0%	36.8%	57.1%	13.6%
The board has established policies regarding executive and physician compensation that include consideration of IRS mandates of "fair market value," "reasonableness of compensation," and industry benchmarks when determining compensation. *Note: In 2015, this was separated into two separate practices: The board requires that CEO compensation be determined with due consideration given to the IRS mandate of "fair market value" and "reasonableness of compensation," and 2) 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	240	51	164	25	19	7	89
Yes, generally	77.1%	92.2%	76.2%	52.0%	57.9%	42.9%	73.0%
No, but considering it and/or working on it	6.7%	0.0%	9.8%	0.0%	0.0%	0.0%	12.4%
No, and not considering it	8.3%	5.9%	8.5%	12.0%	15.8%	0.0%	11.2%
Not applicable for our board	7.9%	2.0%	5.5%	36.0%	26.3%	57.1%	3.4%
The board ensures that the annual compliance plan is properly updated, implemented, and effective *(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	241	52	164	25	19	7	88
Yes, generally	88.8%	100.0%	86.6%	80.0%	94.7%	42.9%	84.1%
No, but considering it and/or working on it	6.6%	0.0%	9.8%	0.0%	0.0%	0.0%	11.4%
No, and not considering it	2.1%	0.0%	2.4%	4.0%	5.3%	0.0%	3.4%
Not applicable for our board	2.5%	0.0%	1.2%	16.0%	0.0%	57.1%	1.1%
The board has established a direct reporting relationship with general counsel.							
Total responding to this question	240	51	164	25	19	7	89
Yes, generally	62.5%	76.5%	58.5%	60.0%	73.7%	28.6%	62.9%
No, but considering it and/or working on it	7.9%	0.0%	11.0%	4.0%	5.3%	0.0%	7.9%
No, and not considering it	15.4%	11.8%	17.1%	12.0%	15.8%	0.0%	15.7%
Not applicable for our board	14.2%	11.8%	13.4%	24.0%	5.3%	71.4%	13.5%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board has approved a "whistleblower" policy that specifies the manner in which the organization handles employee complaints and allows employees to report in confidence any suspected misappropriation of charitable assets.							
Total responding to this question	240	52	163	25	19	7	87
Yes, generally	81.3%	86.5%	82.2%	64.0%	78.9%	28.6%	80.5%
No, but considering it and/or working on it	8.8%	0.0%	11.7%	8.0%	10.5%	0.0%	11.5%
No, and not considering it	4.6%	5.8%	4.3%	4.0%	5.3%	0.0%	4.6%
Not applicable for our board	5.4%	7.7%	1.8%	24.0%	5.3%	71.4%	3.4%
The board *follows* 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	242	52	165	25	19	7	89
Yes, generally	88.0%	98.1%	89.7%	56.0%	73.7%	14.3%	92.1%
No, but considering it and/or working on it	5.4%	0.0%	6.7%	8.0%	5.3%	14.3%	5.6%
No, and not considering it	2.1%	0.0%	2.4%	4.0%	5.3%	0.0%	2.2%
Not applicable for our board	4.5%	1.9%	1.2%	32.0%	15.8%	71.4%	0.0%
The board has created a separate audit committee (or audit and compliance committee, or other committee or subcommittee specific to audit oversight) to oversee external and internal audit functions *that is composed entirely of independent persons who have appropriate qualifications to serve in such role.***							
Total responding to this question	240	51	164	25	19	7	89
Yes, generally	57.1%	90.2%	49.4%	40.0%	52.6%	0.0%	49.4%
No, but considering it and/or working on it	8.8%	0.0%	12.2%	4.0%	5.3%	0.0%	11.2%
No, and not considering it	19.6%	7.8%	25.0%	8.0%	10.5%	14.3%	22.5%
Not applicable for our board	14.6%	2.0%	13.4%	48.0%	31.6%	85.7%	16.9%
Board members responsible for audit oversight meet with external auditors, without management, at least annually.							
Total responding to this question	239	51	163	25	19	7	87
Yes, generally	69.5%	94.1%	67.5%	32.0%	42.1%	0.0%	63.2%
No, but considering it and/or working on it	7.1%	2.0%	9.2%	4.0%	5.3%	0.0%	10.3%
No, and not considering it	11.3%	2.0%	14.7%	8.0%	10.5%	14.3%	17.2%
Not applicable for our board	12.1%	2.0%	8.6%	56.0%	42.1%	85.7%	9.2%
Please evaluate your board's overall performance in fulfilling its duty of obedience.							
Total responding to this question	242	52	165	25	19	7	88
Excellent	51.2%	78.8%	43.6%	44.0%	52.6%	28.6%	43.2%
Very Good	33.9%	19.2%	38.2%	36.0%	26.3%	57.1%	40.9%
Good	13.6%	1.9%	16.4%	20.0%	21.1%	14.3%	13.6%
Fair	1.2%	0.0%	1.8%	0.0%	0.0%	0.0%	2.3%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
Quality Oversight							
Note: The board's responsibility for quality oversight includes outcomes, safety, experience, and value. When the word "quality" is included in a practice below, it encompasses all of these items.							
The board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.*							
Total responding to this question	241	52	164	25	19	7	89
Yes, generally	89.6%	92.3%	88.4%	92.0%	94.7%	85.7%	88.8%
No, but considering it and/or working on it	7.9%	1.9%	11.0%	0.0%	0.0%	0.0%	11.2%
No, and not considering it	0.8%	1.9%	0.6%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	1.7%	3.8%	0.0%	8.0%	5.3%	14.3%	0.0%
The board requires all hospital clinical programs or services to meet quality-related performance criteria.							
Total responding to this question	240	52	163	25	19	7	89
Yes, generally	85.0%	80.8%	84.7%	96.0%	94.7%	100.0%	86.5%
No, but considering it and/or working on it	9.2%	1.9%	12.3%	4.0%	5.3%	0.0%	9.0%
No, and not considering it	4.2%	11.5%	2.5%	0.0%	0.0%	0.0%	3.4%
Not applicable for our board	1.7%	5.8%	0.6%	0.0%	0.0%	0.0%	1.1%
The board annually approves and at least quarterly reviews quality performance measures for all care settings, including population health and value-based care metrics (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) to identify needs for corrective action.**							
2015 wording: 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	237	52	160	25	19	7	87
Yes, generally	81.0%	82.7%	80.6%	80.0%	78.9%	85.7%	81.6%
No, but considering it and/or working on it	12.7%	7.7%	13.8%	16.0%	15.8%	14.3%	11.5%
No, and not considering it	3.8%	5.8%	3.8%	0.0%	0.0%	0.0%	5.7%
Not applicable for our board	2.5%	3.8%	1.9%	4.0%	5.3%	0.0%	1.1%
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	241	52	164	25	19	7	89
Yes, generally	77.6%	84.6%	75.6%	76.0%	78.9%	71.4%	74.2%
No, but considering it and/or working on it	10.8%	1.9%	12.8%	16.0%	15.8%	14.3%	14.6%
No, and not considering it	9.1%	9.6%	9.8%	4.0%	5.3%	0.0%	10.1%
Not applicable for our board	2.5%	3.8%	1.8%	4.0%	0.0%	14.3%	1.1%
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	239	52	162	25	19	7	88
Yes, generally	82.0%	82.7%	79.6%	96.0%	94.7%	100.0%	78.4%
No, but considering it and/or working on it	12.6%	7.7%	15.4%	4.0%	5.3%	0.0%	15.9%
No, and not considering it	3.3%	3.8%	3.7%	0.0%	0.0%	0.0%	4.5%
Not applicable for our board	2.1%	5.8%	1.2%	0.0%	0.0%	0.0%	1.1%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board has a standing quality committee.							
Total responding to this question	241	52	164	25	19	7	89
Yes, generally	70.1%	78.8%	67.1%	72.0%	78.9%	42.9%	66.3%
No, but considering it and/or working on it	5.8%	1.9%	6.1%	12.0%	10.5%	14.3%	4.5%
No, and not considering it	13.7%	7.7%	17.1%	4.0%	5.3%	14.3%	16.9%
Not applicable for our board	10.4%	11.5%	9.8%	12.0%	5.3%	28.6%	12.4%
The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.*							
Total responding to this question	239	52	163	24	18	7	89
Yes, generally	72.8%	80.8%	69.9%	75.0%	72.2%	85.7%	67.4%
No, but considering it and/or working on it	15.9%	5.8%	19.0%	16.7%	22.2%	0.0%	21.3%
No, and not considering it	9.2%	9.6%	9.8%	4.2%	0.0%	14.3%	10.1%
Not applicable for our board	2.1%	3.8%	1.2%	4.2%	5.6%	0.0%	1.1%
The board, *in consultation with the medical executive committee,* participates in the development of and/or approval of explicit criteria for medical staff recommendations for physician appointments, reappointments, and clinical privileges, and conducts periodic audits of the credentialing and peer review process to ensure that it is being implemented effectively.**							
Total responding to this question	241	52	164	25	19	7	89
Yes, generally	79.3%	67.3%	82.9%	80.0%	89.5	57.1	83.1%
No, but considering it and/or working on it	5.8%	0.0%	7.9%	4.0%	5.3	0.0	6.7%
No, and not considering it	4.1%	3.8%	4.3%	4.0%	0.0	14.3	4.5%
Not applicable for our board	10.8%	28.8%	4.9%	12.0%	5.3	28.6	5.6%
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	241	52	164	25	19	7	89
Yes, generally	77.2%	67.3%	81.1%	72.0%	78.9%	57.1%	80.9%
No, but considering it and/or working on it	9.5%	1.9%	11.0%	16.0%	15.8%	14.3%	12.4%
No, and not considering it	3.3%	1.9%	3.7%	4.0%	5.3%	0.0%	2.2%
Not applicable for our board	10.0%	28.8%	4.3%	8.0%	0.0%	28.6%	4.5%
The board allocates sufficient resources to developing physician leaders and assessing their performance.*							
Total responding to this question	240	52	163	25	19	7	88
Yes, generally	49.2%	57.7%	46.6%	48.0%	57.9%	14.3%	45.5%
No, but considering it and/or working on it	20.0%	5.8%	25.8%	12.0%	10.5%	14.3%	26.1%
No, and not considering it	16.3%	11.5%	19.0%	8.0%	10.5%	14.3%	19.3%
Not applicable for our board	14.6%	25.0%	8.6%	32.0%	21.1%	57.1%	9.1%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board ensures consistency in quality reporting, standards, policies, and interventions such as corrective action with practitioners across the entire organization.*							
Total responding to this question	238	52	161	25	19	7	88
Yes, generally	80.7%	82.7%	80.1%	80.0%	89.5%	57.1%	81.8%
No, but considering it and/or working on it	7.6%	1.9%	9.3%	8.0%	5.3%	14.3%	10.2%
No, and not considering it	6.3%	1.9%	8.1%	4.0%	5.3%	0.0%	5.7%
Not applicable for our board	5.5%	13.5%	2.5%	8.0%	0.0%	28.6%	2.3%
Please evaluate your board's overall performance in fulfilling its responsibility for quality oversight.							
Total responding to this question	241	51	165	25	19	7	89
Excellent	42.3%	56.9%	37.6%	44.0%	52.6%	28.6%	36.0%
Very Good	36.9%	31.4%	37.0%	48.0%	42.1%	57.1%	38.2%
Good	16.2%	5.9%	20.6%	8.0%	5.3%	14.3%	21.3%
Fair	4.6%	5.9%	4.8%	0.0%	0.0%	0.0%	4.5%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Financial Oversight							
The board is sufficiently informed and discusses the multi-year strategic/financial plan before approving it.*							
Total responding to this question	242	52	164	26	19	8	89
Yes, generally	93.0%	98.1%	93.3%	80.8%	100.0%	37.5%	93.3%
No, but considering it and/or working on it	3.7%	0.0%	5.5%	0.0%	0.0%	0.0%	5.6%
No, and not considering it	0.8%	1.9%	0.6%	0.0%	0.0%	0.0%	1.1%
Not applicable for our board	2.5%	0.0%	0.6%	19.2%	0.0%	62.5%	0.0%
The board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it.*							
Total responding to this question	242	52	164	26	19	8	89
Yes, generally	95.5%	98.1%	97.6%	76.9%	94.7%	37.5%	97.8%
No, but considering it and/or working on it	0.8%	0.0%	1.2%	0.0%	0.0%	0.0%	2.2%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	3.7%	1.9%	1.2%	23.1%	5.3%	62.5%	0.0%
The board annually reviews and approves the investment policy.*							
Total responding to this question	240	51	163	26	19	8	89
Yes, generally	70.8%	94.1%	68.1%	42.3%	57.9%	12.5%	64.0%
No, but considering it and/or working on it	7.1%	0.0%	9.8%	3.8%	5.3%	0.0%	10.1%
No, and not considering it	4.2%	2.0%	5.5%	0.0%	0.0%	0.0%	4.5%
Not applicable for our board	17.9%	3.9%	16.6%	53.8%	36.8%	87.5%	21.3%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board reviews financial feasibility of major projects before approving them.							
Total responding to this question	242	52	164	26	19	8	89
Yes, generally	94.6%	98.1%	97.0%	73.1%	89.5%	37.5%	95.5%
No, but considering it and/or working on it	1.7%	0.0%	2.4%	0.0%	0.0%	0.0%	4.5%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	3.7%	1.9%	0.6%	26.9%	10.5%	62.5%	0.0%
The board monitors financial performance against targets established by the board related to liquidity ratios, profitability, activity, and debt, and demands corrective action in response to under-performance.* *Note: In 2015 there were two separate practices related to this: 1) The board reviews information at least quarterly on the organization's financial performance against plans, and 2) The board demands corrective actions in response to under-performance on capital and financial plans.*							
Total responding to this question	242%	52	164	26	19	8	89
Yes, generally	88.8%	96.2%	88.4%	76.9%	89.5%	50.0%	88.8%
No, but considering it and/or working on it	4.5%	1.9%	6.1%	0.0%	0.0%	0.0%	5.6%
No, and not considering it	2.5%	1.9%	3.0%	0.0%	0.0%	0.0%	3.4%
Not applicable for our board	4.1%	0.0%	2.4%	23.1%	10.5%	50.0%	2.2%
The board ensures that the finance and quality committees work together to improve quality while reducing costs and sets value-based performance goals for senior management and physician leaders.*							
Total responding to this question	238	49	163	26	19	8	88
Yes, generally	68.5%	71.4%	68.7%	61.5%	73.7%	37.5%	67.0%
No, but considering it and/or working on it	9.2%	10.2%	9.8%	3.8%	5.3%	0.0%	11.4%
No, and not considering it	11.8%	10.2%	13.5%	3.8%	5.3%	0.0%	12.5%
Not applicable for our board	10.5%	8.2%	8.0%	30.8%	15.8%	62.5%	9.1%
Please evaluate your board's overall performance in fulfilling its responsibility for financial oversight.							
Total responding to this question	243	52	165	26	19	8	89
Excellent	56.4%	75.0%	49.7%	61.5%	73.7%	37.5%	49.4%
Very Good	33.7%	21.2%	38.2%	30.8%	26.3%	37.5%	37.1%
Good	7.4%	3.8%	8.5%	7.7%	0.0%	25.0%	10.1%
Fair	2.1%	0.0%	3.0%	0.0%	0.0%	0.0%	3.4%
Poor	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
Strategic Direction							
The full board actively participates in establishing the organization's strategic direction including creating a longer-range vision and approving the strategic plan.							
Total responding to this question	242	52	164	26	19	8	89
Yes, generally	88.8%	94.2%	89.6%	73.1%	84.2%	50.0%	87.6%
No, but considering it and/or working on it	7.4%	1.9%	9.1%	7.7%	5.3%	12.5%	11.2%
No, and not considering it	0.8%	1.9%	0.6%	0.0%	0.0%	0.0%	1.1%
Not applicable for our board	2.9%	1.9%	0.6%	19.2%	10.5%	37.5%	0.0%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board *ensures that a strategy is in place* for aligning the clinical and economic goals of the hospital(s) and physicians.**							
Total responding to this question	242	51	165	26	19	8	89
Yes, generally	84.7%	86.3%	85.5%	76.9%	84.2%	62.5%	84.3%
No, but considering it and/or working on it	8.7%	5.9%	10.3%	3.8%	5.3%	0.0%	13.5%
No, and not considering it	2.1%	2.0%	2.4%	0.0%	0.0%	0.0%	1.1%
Not applicable for our board	4.5%	5.9%	1.8%	19.2%	10.5%	37.5%	1.1%
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	241	52	164	25	19	7	89
Yes, generally	86.3%	94.2%	85.4%	76.0%	84.2%	57.1%	84.3%
No, but considering it and/or working on it	8.7%	3.8%	11.6%	0.0%	0.0%	0.0%	12.4%
No, and not considering it	2.1%	0.0%	1.8%	8.0%	10.5%	0.0%	2.2%
Not applicable for our board	2.9%	1.9%	1.2%	16.0%	5.3%	42.9%	1.1%
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, *community health needs, and adherence to the strategic plan before approving them.***							
Total responding to this question	243	52	165	26	19	8	89
Yes, generally	89.3%	96.2%	87.9%	84.6%	89.5%	75.0%	85.4%
No, but considering it and/or working on it	7.0%	1.9%	9.1%	3.8%	5.3%	0.0%	12.4%
No, and not considering it	1.6%	1.9%	1.8%	0.0%	0.0%	0.0%	2.2%
Not applicable for our board	2.1%	0.0%	1.2%	11.5%	5.3%	25.0%	0.0%
The board *incorporates the perspectives* of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).**							
Total responding to this question	239	52	161	26	19	8	89
Yes, generally	86.2%	90.4%	85.7%	80.8%	84.2%	75.0%	80.9%
No, but considering it and/or working on it	7.9%	3.8%	9.3%	7.7%	10.5%	0.0%	14.6%
No, and not considering it	2.5%	5.8%	1.9%	0.0%	0.0%	0.0%	2.2%
Not applicable for our board	3.3%	0.0%	3.1%	11.5%	5.3%	25.0%	2.2%
The board *holds management accountable for accomplishing the strategic plan* by requiring that major strategic projects specify both measurable criteria for success and those responsible for implementation.**							
Total responding to this question	239	52	161	26	19	8	89
Yes, generally	84.5%	88.5%	83.2%	84.6%	94.7%	62.5%	84.3%
No, but considering it and/or working on it	10.0%	5.8%	13.0%	0.0%	0.0%	0.0%	13.5%
No, and not considering it	2.9%	5.8%	2.5%	0.0%	0.0%	0.0%	2.2%
Not applicable for our board	2.5%	0.0%	1.2%	15.4%	5.3%	37.5%	0.0%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
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	239	51	162	26	19	8	89
Yes, generally	43.1%	60.8%	38.9%	34.6%	42.1%	12.5%	34.8%
No, but considering it and/or working on it	36.4%	31.4%	37.0%	42.3%	36.8%	50.0%	38.2%
No, and not considering it	18.4%	5.9%	22.2%	19.2%	21.1%	25.0%	25.8%
Not applicable for our board	2.1%	2.0%	1.9%	3.8%	0.0%	12.5%	1.1%
The board *follows board*-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	239	51	162	26	19	8	89
Yes, generally	54.0%	58.8%	52.5%	53.8%	73.7%	12.5%	52.8%
No, but considering it and/or working on it	22.6%	13.7%	26.5%	15.4%	15.8%	12.5%	22.5%
No, and not considering it	16.7%	17.6%	17.3%	11.5%	10.5%	12.5%	20.2%
Not applicable for our board	6.7%	9.8%	3.7%	19.2%	0.0%	62.5%	4.5%
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	238	51	161	26	19	8	88
Yes, generally	52.5%	49.0%	54.0%	50.0%	57.9%	25.0%	55.7%
No, but considering it and/or working on it	21.0%	13.7%	24.8%	11.5%	10.5%	25.0%	22.7%
No, and not considering it	17.6%	17.6%	16.8%	23.1%	26.3%	12.5%	19.3%
Not applicable for our board	8.8%	19.6%	4.3%	15.4%	5.3%	37.5%	2.3%
The board works with management to gain awareness of, and prepare to respond to, matters of business disruption.*							
Total responding to this question	239	51	162	26	19	8	89
Yes, generally	79.9%	84.3%	79.0%	76.9%	84.2%	62.5%	79.8%
No, but considering it and/or working on it	11.3%	7.8%	13.0%	7.7%	10.5%	0.0%	12.4%
No, and not considering it	5.9%	3.9%	6.8%	3.8%	5.3%	0.0%	5.6%
Not applicable for our board	2.9%	3.9%	1.2%	11.5%	0.0%	37.5%	2.2%
Please evaluate your board's overall performance in fulfilling its responsibility for setting strategic direction.							
Total responding to this question	240	51	165	24	18	7	89
Excellent	36.3%	47.1%	32.1%	41.7%	44.4%	42.9%	33.7%
Very Good	40.4%	37.3%	41.8%	37.5%	38.9%	28.6%	41.6%
Good	18.3%	15.7%	20.0%	12.5%	16.7%	0.0%	18.0%
Fair	4.6%	0.0%	5.5%	8.3%	0.0%	28.6%	5.6%
Poor	0.4%	0.0%	0.6%	0.0%	0.0%	0.0%	1.1%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
Board Development							
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.							
Total responding to this question	240	52	162	26	19	8	87
Yes, generally	40.8%	48.1%	37.0%	50.0%	63.2%	12.5%	41.4%
No, but considering it and/or working on it	25.4%	19.2%	29.0%	15.4%	5.3%	37.5%	24.1%
No, and not considering it	28.8%	30.8%	30.2%	15.4%	21.1%	12.5%	31.0%
Not applicable for our board	5.0%	1.9%	3.7%	19.2%	10.5%	37.5%	3.4%
The board uses the results from a formal self-assessment process to establish board performance improvement goals at least every two years.**							
Note: In 2015 this practice was separated into two: 1) The board engages in a formal self-assessment process to evaluate its performance at least every two years, and 2) The board uses the results from the self-assessment process to establish board performance improvement goals.							
Total responding in each category	240	52	163	25	18	8	88
Yes, generally	58.3%	71.2%	54.6%	56.0%	61.1%	37.5%	50.0%
No, but considering it and/or working on it	22.1%	17.3%	23.9%	20.0%	16.7%	25.0%	28.4%
No, and not considering it	16.3%	11.5%	19.0%	8.0%	11.1%	12.5%	17.0%
Not applicable for our board	3.3%	0.0%	2.5%	16.0%	11.1%	25.0%	4.5%
The board reviews its committee performance at least every two years to ensure charter fulfillment and that coordination between committees and the board and reporting to the full board are effective.*							
Note: 2015 wording combined this practice with another under Duty of Care. For 2019 we separated out review of committee structure (see Duty of Care) and committee performance, as shown here.							
Total responding to this question	238	51	161	26	19	8	87
Yes, generally	45.0%	58.8%	41.0%	42.3%	52.6%	12.5%	40.2%
No, but considering it and/or working on it	24.8%	17.6%	28.0%	19.2%	21.1%	12.5%	26.4%
No, and not considering it	18.5%	19.6%	20.5%	3.8%	5.3%	12.5%	16.1%
Not applicable for our board	11.8%	3.9%	10.6%	34.6%	21.1%	62.5%	17.2%
The board uses a formal orientation program for new board members *that includes education on their fiduciary duties and information on the industry and its regulatory and competitive landscape.**							
Total responding to this question	241	52	163	26	19	8	88
Yes, generally	83.0%	96.2%	79.1%	80.8%	94.7%	50.0%	75.0%
No, but considering it and/or working on it	11.2%	1.9%	15.3%	3.8%	5.3%	0.0%	15.9%
No, and not considering it	3.7%	1.9%	4.3%	3.8%	0.0%	12.5%	8.0%
Not applicable for our board	2.1%	0.0%	1.2%	11.5%	0.0%	37.5%	1.1%
The board has a "mentoring" program for new board members.							
Total responding to this question	238	51	161	26	19	8	87
Yes, generally	32.4%	43.1%	28.0%	38.5%	47.4%	12.5%	28.7%
No, but considering it and/or working on it	33.6%	27.5%	37.3%	23.1%	21.1%	25.0%	31.0%
No, and not considering it	28.6%	29.4%	29.2%	23.1%	21.1%	37.5%	33.3%
Not applicable for our board	5.5%	0.0%	5.6%	15.4%	10.5%	25.0%	6.9%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
Board members participate at least annually in education regarding its responsibilities to fulfill the organization's mission, vision, and strategic goals.**							
2015 wording: Board members participate in ongoing education regarding key strategic issues facing the organization.							
Total responding to this question	239	52	161	26	19	8	88
Yes, generally	71.1%	82.7%	68.3%	65.4%	73.7%	50.0%	69.3%
No, but considering it and/or working on it	14.6%	11.5%	15.5%	15.4%	15.8%	12.5%	19.3%
No, and not considering it	12.1%	5.8%	14.9%	7.7%	5.3%	12.5%	10.2%
Not applicable for our board	2.1%	0.0%	1.2%	11.5%	5.3%	25.0%	1.1%
The board has job descriptions for the full board, individual board members, officers, and committee chairs that outline duties, responsibilities, and expectations, and are signed by every board member.*							
Total responding to this question	241	52	163	26	19	8	88
Yes, generally	49.8%	53.8%	46.0%	65.4%	78.9%	37.5%	50.0%
No, but considering it and/or working on it	22.4%	13.5%	27.0%	11.5%	10.5%	12.5%	20.5%
No, and not considering it	20.7%	23.1%	20.9%	15.4%	10.5%	25.0%	18.2%
Not applicable for our board	7.1%	9.6%	6.1%	7.7%	0.0%	25.0%	11.4%
The board selects new director candidates from a pool that reflects a broad range of diversity and competencies (e.g., race, gender, background, skills, and experience).**							
2015 wording: The board uses competency-based criteria when selecting new board members.							
Total responding to this question	240	52	162	26	19	8	87
Yes, generally	63.8%	84.6%	55.6%	73.1%	84.2%	50.0%	39.1%
No, but considering it and/or working on it	8.8%	7.7%	9.3%	7.7%	0.0%	25.0%	6.9%
No, and not considering it	8.3%	1.9%	10.5%	7.7%	10.5%	0.0%	12.6%
Not applicable for our board	19.2%	5.8%	24.7%	11.5%	5.3%	25.0%	41.4%
The board enforces a policy on board member term limits and retirement age.*							
Total responding to this question	239	51	162	26	19	8	87
Yes, generally	55.6%	76.5%	47.5%	65.4%	73.7%	50.0%	29.9%
No, but considering it and/or working on it	4.2%	0.0%	4.9%	7.7%	5.3%	12.5%	4.6%
No, and not considering it	15.5%	13.7%	16.7%	11.5%	10.5%	12.5%	20.7%
Not applicable for our board	24.7%	9.8%	30.9%	15.4%	10.5%	25.0%	44.8%
The board enforces minimum meeting preparation and attendance requirements.**							
2015 wording: The board has a written policy specifying minimum meeting attendance requirements.							
Total responding to this question	240	52	162	26	19	8	87
Yes, generally	65.4%	67.3%	66.0%	57.7%	63.2%	50.0%	62.1%
No, but considering it and/or working on it	10.0%	7.7%	9.9%	15.4%	15.8%	12.5%	8.0%
No, and not considering it	15.8%	17.3%	15.4%	15.4%	15.8%	12.5%	14.9%
Not applicable for our board	8.8%	7.7%	8.6%	11.5%	5.3%	25.0%	14.9%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board uses a formal process to evaluate the performance of individual board members.							
Total responding to this question	241	52	163	26	19	8	88
Yes, generally	28.2%	38.5%	24.5%	30.8%	36.8%	12.5%	26.1%
No, but considering it and/or working on it	22.8%	21.2%	24.5%	15.4%	15.8%	12.5%	21.6%
No, and not considering it	37.8%	32.7%	39.9%	34.6%	31.6%	50.0%	34.1%
Not applicable for our board	11.2%	7.7%	11.0%	19.2%	15.8%	25.0%	18.2%
The board uses *agreed-upon* performance requirements for board member and officer reappointment.**							
Total responding to this question	239	52	161	26	19	8	87
Yes, generally	33.9%	44.2%	29.2%	42.3%	52.6%	12.5%	27.6%
No, but considering it and/or working on it	18.4%	21.2%	19.3%	7.7%	5.3%	12.5%	12.6%
No, and not considering it	34.3%	26.9%	37.3%	30.8%	26.3%	50.0%	32.2%
Not applicable for our board	13.4%	7.7%	14.3%	19.2%	15.8%	25.0%	27.6%
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	241	52	163	26	19	8	88
Yes, generally	41.5%	59.6%	35.0%	46.2%	52.6%	25.0%	28.4%
No, but considering it and/or working on it	24.9%	17.3%	26.4%	30.8%	31.6%	25.0%	18.2%
No, and not considering it	20.7%	15.4%	24.5%	7.7%	5.3%	25.0%	25.0%
Not applicable for our board	12.9%	7.7%	14.1%	15.4%	10.5%	25.0%	28.4%
Please evaluate your board's overall performance in fulfilling its responsibility for its own performance and development.							
Total responding to this question	238	51	161	26	19	8	86
Excellent	21.0%	27.5%	18.6%	23.1%	31.6%	0.0%	17.4%
Very Good	38.2%	47.1%	35.4%	38.5%	36.8%	50.0%	36.0%
Good	25.2%	15.7%	27.3%	30.8%	31.6%	25.0%	23.3%
Fair	12.6%	9.8%	14.3%	7.7%	0.0%	25.0%	18.6%
Poor	2.9%	0.0%	4.3%	0.0%	0.0%	0.0%	4.7%
Management Oversight							
The board follows a formal, *objective* process for evaluating the CEO's performance.**							
Total responding to this question	243	52	165	26	19	8	89
Yes, generally	84.0%	92.3%	83.0%	73.1%	73.7%	75.0%	84.3%
No, but considering it and/or working on it	9.5%	7.7%	10.9%	3.8%	5.3%	0.0%	11.2%
No, and not considering it	3.3%	0.0%	4.2%	3.8%	5.3%	0.0%	4.5%
Not applicable for our board	3.3%	0.0%	1.8%	19.2%	15.8%	25.0%	0.0%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation *(in the first quarter of the year).***							
Total responding to this question	241	50	165	26	19	7	89
Yes, generally	70.1%	80.0%	69.1%	57.7%	63.2%	42.9%	71.9%
No, but considering it and/or working on it	16.6%	12.0%	18.8%	11.5%	10.5%	14.3%	19.1%
No, and not considering it	7.5%	6.0%	8.5%	3.8%	5.3%	0.0%	5.6%
Not applicable for our board	5.8%	2.0%	3.6%	26.9%	21.1%	42.9%	3.4%
The board requires that the CEO's compensation package be based, in part, on the CEO's performance evaluation.							
Total responding to this question	242	51	165	26	19	8	89
Yes, generally	78.9%	90.2%	80.6%	46.2%	63.2%	12.5%	79.8%
No, but considering it and/or working on it	5.4%	3.9%	6.7%	0.0%	0.0%	0.0%	6.7%
No, and not considering it	7.4%	3.9%	8.5%	7.7%	10.5%	0.0%	9.0%
Not applicable for our board	8.3%	2.0%	4.2%	46.2%	26.3%	87.5%	4.5%
The board seeks independent (i.e., third-party) expert advice/information on industry comparables before approving executive compensation.							
Total responding to this question	242	51	165	26	19	8	89
Yes, generally	75.2%	96.1%	74.5%	38.5%	52.6%	12.5%	69.7%
No, but considering it and/or working on it	7.4%	0.0%	10.3%	3.8%	5.3%	0.0%	12.4%
No, and not considering it	7.9%	2.0%	10.3%	3.8%	5.3%	0.0%	13.5%
Not applicable for our board	9.5%	2.0%	4.8%	53.8%	36.8%	87.5%	4.5%
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.							
Total responding to this question	241	51	164	26	19	8	88
Yes, generally	82.2%	98.0%	84.1%	38.5%	52.6%	12.5%	79.5%
No, but considering it and/or working on it	5.0%	0.0%	6.7%	3.8%	5.3%	0.0%	12.5%
No, and not considering it	5.0%	2.0%	6.1%	3.8%	5.3%	0.0%	5.7%
Not applicable for our board	7.9%	0.0%	3.0%	53.8%	36.8%	87.5%	2.3%
The board recognizes that CEO (and other senior executive) succession and search planning is a critical responsibility of the board.*							
Total responding to this question	241	50	165	26	19	8	89
Yes, generally	80.5%	94.0%	81.2%	50.0%	63.2%	25.0%	76.4%
No, but considering it and/or working on it	7.9%	2.0%	9.1%	11.5%	10.5%	12.5%	11.2%
No, and not considering it	5.8%	2.0%	7.3%	3.8%	5.3%	0.0%	10.1%
Not applicable for our board	5.8%	2.0%	2.4%	34.6%	21.1%	62.5%	2.2%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board maintains a written, current CEO and senior executive succession plan.**							
2015 wording: The board requires that the CEO maintain a written, current succession plan.							
Total responding to this question	240	51	164	25	18	8	87
Yes, generally	44.2%	66.7%	39.0%	32.0%	38.9%	12.5%	41.4%
No, but considering it and/or working on it	27.9%	21.6%	31.7%	16.0%	22.2%	0.0%	26.4%
No, and not considering it	18.8%	9.8%	22.0%	16.0%	16.7%	25.0%	24.1%
Not applicable for our board	9.2%	2.0%	7.3%	36.0%	22.2%	62.5%	8.0%
The board convenes executive sessions periodically without the CEO in attendance.**							
2015 wording: The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance.							
Total responding to this question	240	49	165	26	19	8	87
Yes, generally	57.9%	77.6%	53.9%	46.2%	57.9%	12.5%	51.7%
No, but considering it and/or working on it	8.3%	4.1%	10.9%	0.0%	0.0%	0.0%	6.9%
No, and not considering it	24.6%	18.4%	26.7%	23.1%	15.8%	50.0%	32.2%
Not applicable for our board	9.2%	0.0%	8.5%	30.8%	26.3%	37.5%	9.2%
Please evaluate your board's overall performance in fulfilling its responsibility for management oversight.							
Total responding to this question	238	51	163	24	18	7	86
Excellent	44.1%	66.7%	36.8%	45.8%	55.6%	14.3%	36.0%
Very Good	37.8%	27.5%	41.7%	33.3%	33.3%	42.9%	44.2%
Good	12.2%	3.9%	14.7%	12.5%	5.6%	28.6%	12.8%
Fair	4.6%	0.0%	5.5%	8.3%	5.6%	14.3%	5.8%
Poor	1.3%	2.0%	1.2%	0.0%	0.0%	0.0%	1.2%
Community Benefit & Advocacy							
The board has adopted a policy or policies on community benefit that includes all of the following characteristics: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, and measurable goals for the organization.**							
Note: In 2015, this practice included the following phrase at the end: a financial assistance policy, and commitment to communicate transparently with the public.							
Total responding to this question	239	52	162	25	18	8	85
Yes, generally	54.4%	71.2%	50.0%	48.0%	50.0%	50.0%	48.2%
No, but considering it and/or working on it	23.0%	7.7%	29.0%	16.0%	22.2%	0.0%	27.1%
No, and not considering it	14.6%	9.6%	16.7%	12.0%	11.1%	12.5%	16.5%
Not applicable for our board	7.9%	11.5%	4.3%	24.0%	16.7%	37.5%	8.2%
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	238	51	162	25	18	8	86
Yes, generally	89.5%	92.2%	90.7%	76.0%	100.0%	25.0%	88.4%
No, but considering it and/or working on it	3.4%	0.0%	4.9%	0.0%	0.0%	0.0%	5.8%
No, and not considering it	2.1%	0.0%	2.5%	4.0%	0.0%	12.5%	2.3%
Not applicable for our board	5.0%	7.8%	1.9%	20.0%	0.0%	62.5%	3.5%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board ensures that the organization effectively addresses social determinants of health (e.g., housing, access to healthy food, employment, financial strain, behavioral health, personal safety) in the context of its community benefit activities.*							
Total responding to this question	240	51	164	25	18	8	87
Yes, generally	55.0%	64.7%	52.4%	52.0%	72.2%	0.0%	47.1%
No, but considering it and/or working on it	23.8%	13.7%	28.0%	16.0%	11.1%	25.0%	33.3%
No, and not considering it	14.6%	13.7%	15.2%	12.0%	11.1%	25.0%	13.8%
Not applicable for our board	6.7%	7.8%	4.3%	20.0%	5.6%	50.0%	5.7%
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	240	52	163	25	18	8	86
Yes, generally	81.7%	92.3%	79.8%	72.0%	88.9%	37.5%	64.0%
No, but considering it and/or working on it	3.8%	0.0%	5.5%	0.0%	0.0%	0.0%	8.1%
No, and not considering it	2.1%	0.0%	2.5%	4.0%	5.6%	0.0%	2.3%
Not applicable for our board	12.5%	7.7%	12.3%	24.0%	5.6%	62.5%	25.6%
The board holds management accountable for implementing strategies to meet the needs of the community, as identified through the community health needs assessment.** *2015 wording: 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	242	52	165	25	18	8	88
Yes, generally	84.7%	82.7%	86.1%	80.0%	94.4%	50.0%	79.5%
No, but considering it and/or working on it	7.9%	5.8%	9.1%	4.0%	5.6%	0.0%	13.6%
No, and not considering it	2.1%	1.9%	2.4%	0.0%	0.0%	0.0%	1.1%
Not applicable for our board	5.4%	9.6%	2.4%	16.0%	0.0%	50.0%	5.7%
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).							
Total responding to this question	239	50	164	25	18	8	88
Yes, generally	83.3%	86.0%	82.3%	84.0%	94.4%	62.5%	81.8%
No, but considering it and/or working on it	8.8%	6.0%	10.4%	4.0%	5.6%	0.0%	9.1%
No, and not considering it	4.2%	4.0%	4.9%	0.0%	0.0%	0.0%	3.4%
Not applicable for our board	3.8%	4.0%	2.4%	12.0%	0.0%	37.5%	5.7%
The board has a written policy establishing the board's role in fund development and/or philanthropy.							
Total responding to this question	237	49	163	25	18	8	86
Yes, generally	38.4%	40.8%	37.4%	40.0%	44.4%	25.0%	31.4%
No, but considering it and/or working on it	19.4%	14.3%	20.9%	20.0%	27.8%	12.5%	18.6%
No, and not considering it	27.0%	28.6%	27.0%	24.0%	27.8%	12.5%	27.9%
Not applicable for our board	15.2%	16.3%	14.7%	16.0%	0.0%	50.0%	22.1%

Total responding in each category	244	52	166	26	19	8	89
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Key: ** New practice for 2019 ** Reworded practice showing new wording in italics or otherwise noted*							
The board works closely with general counsel to ensure all advocacy efforts are consistent with tax-exemption requirements.** *2015 wording: 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	24	52	163	25	18	8	86
Yes, generally	56.7%	75.0%	50.9%	56.0%	72.2%	25.0%	43.0%
No, but considering it and/or working on it	10.0%	3.8%	12.9%	4.0%	5.6%	0.0%	15.1%
No, and not considering it	13.3%	13.5%	14.1%	8.0%	11.1%	0.0%	11.6%
Not applicable for our board	20.0%	7.7%	22.1%	32.0%	11.1%	75.0%	30.2%
The board has adopted a policy regarding information transparency, explaining to the public in understandable terms its performance on measures of quality, safety, pricing, customer service, *and community benefit.***							
Total responding to this question	239	52	163	24	18	7	86
Yes, generally	48.1%	53.8%	46.6%	45.8%	61.1%	14.3%	46.5%
No, but considering it and/or working on it	26.4%	17.3%	29.4%	25.0%	22.2%	28.6%	30.2%
No, and not considering it	19.2%	25.0%	18.4%	12.5%	11.1%	14.3%	17.4%
Not applicable for our board	6.3%	3.8%	5.5%	16.7%	5.6%	42.9%	5.8%
Please evaluate your board's overall performance in fulfilling its responsibility for community benefit and advocacy.							
Total responding to this question	240	52	163	25	19	7	88
Excellent	30.4%	42.3%	26.4%	32.0%	42.1%	0.0%	25.0%
Very Good	39.6%	42.3%	38.7%	40.0%	36.8%	57.1%	40.9%
Good	21.7%	13.5%	24.5%	20.0%	21.1%	14.3%	21.6%
Fair	7.5%	1.9%	9.2%	8.0%	0.0%	28.6%	10.2%
Poor	0.8%	0.0%	1.2%	0.0%	0.0%	0.0%	2.3%

Appendix 3. Adoption of Governance Practices: Comparison 2019 vs. 2015

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 (N/A not included)	**Overall (all hospitals and health systems)**		**Systems**		**Independent Hospitals**		**Subsidiary Hospitals with Fiduciary Boards**		**Subsidiary Hospitals with Advisory Boards***		**Government-Sponsored Hospitals**	
	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Duty of Care												
The board requires that new board members receive education on their fiduciary duties.	**2.70**	2.90	**2.87**	2.96	**2.64**	2.92	**2.70**	2.92	**2.80**	*No Data*	**2.63**	2.83
The board reviews *and updates, as needed,* policies that specify the board's major oversight responsibilities at least every two years.**	**2.73**	2.64	**2.78**	2.62	**2.71**	2.64	**2.77**	2.62	**2.67**	*No Data*	**2.72**	2.67
Board members receive important background materials and *well-developed agendas* within sufficient time to prepare for meetings.**	**2.97**	2.96	**2.98**	2.98	**2.96**	2.97	**2.96**	3.00	**2.86**	*No Data*	**2.99**	2.91
The board assesses its governance model including structure, policies, processes, and board expectations at least every three years.*	**2.60**	*No Data*	**2.65**	*No Data*	**2.60**	*No Data*	**2.50**	*No Data*	**2.00**	*No Data*	**2.59**	*No Data*
The board reviews its committee structure and charters at least every two years to ensure the necessary committees are in place, independence of committee members where necessary, and continued utility of committee charters/ clear delegation of responsibilities.** *2015 wording: 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.*	**2.66**	2.75	**2.67**	2.74	**2.67**	2.76	**2.50**	2.88	**2.00**	*No Data*	**2.64**	2.65
The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).	**2.87**	2.89	**2.87**	2.84	**2.87**	2.91	**2.86**	2.84	**2.50**	*No Data*	**2.77**	2.92
The board requires management to provide the rationale for their recommendations, including options they considered.*	**2.94**	*No Data*	**3.00**	*No Data*	**2.93**	*No Data*	**2.88**	*No Data*	**2.88**	*No Data*	**2.91**	*No Data*

*A majority of the practices in this appendix are not applicable for most advisory boards. The composite scores here are shown only for those respondents that indicated the practice is applicable to their board. Therefore, adoption rates for this group are skewed higher than for other groups. (See Appendix 2 for detail on which practices are applicable for this group.)

"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 (N/A not included)	Overall (all hospitals and health systems)		Systems		Independent Hospitals		Subsidiary Hospitals with Fiduciary Boards		Subsidiary Hospitals with Advisory Boards*		Government-Sponsored Hospitals	
	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Duty of Loyalty												
The board *uniformly and consistently enforces* 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	**2.97**	2.99	**3.00**	3.00	**3.00**	*No Data*	**2.97**	2.94
Board members complete a full conflict-of-interest disclosure statement annually.	**2.95**	2.95	**3.00**	3.00	**2.93**	2.99	**3.00**	3.00	**3.00**	*No Data*	**2.91**	2.85
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.	**2.72**	2.63	**2.94**	2.86	**2.61**	2.64	**2.88**	2.87	**3.00**	*No Data*	**2.65**	2.33
The board enforces a written policy that states that deliberate violations of conflict of interest will require disciplinary action or potential removal from board service.** *2015 wording: The board enforces a written policy that states that deliberate violations of conflict of interest constitute grounds for removal from the board.*	**2.75**	2.57	**2.78**	2.63	**2.70**	2.58	**3.00**	2.66	**3.00**	*No Data*	**2.69**	2.48
The board *follows* a specific definition, with measurable standards, of an "independent director" that, at a minimum, complies with the most recent IRS definition and takes into consideration any applicable state law.**	**2.78**	2.69	**2.98**	2.80	**2.69**	2.74	**2.95**	2.85	**2.83**	*No Data*	**2.64**	2.44
The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.	**2.87**	2.77	**2.79**	2.83	**2.87**	2.83	**3.00**	2.77	**3.00**	*No Data*	**2.80**	2.66
The board has a written policy outlining the organization's approach to physician competition/conflict of interest.* *Note: this practice has been on all prior surveys up to 2015; it was removed from the 2015 survey and added again for 2019.*	**2.47**	*No Data*	**2.52**	*No Data*	**2.41**	*No Data*	**2.83**	*No Data*	**3.00**	*No Data*	**2.44**	*No Data*
The board assesses the adequacy of its conflict-of-interest policy as well as the sufficiency of its conflicts review process at least every two years.	**2.67**	2.69	**2.60**	2.75	**2.68**	2.77	**2.70**	2.87	**3.00**	*No Data*	**2.64**	2.44
The board *reviews and ensures* that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.**	**2.89**	2.95	**3.00**	3.00	**2.86**	2.99	**2.86**	2.98	**2.50**	*No Data*	**2.78**	2.74

"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 (N/A not included)	Overall (all hospitals and health systems)		Systems		Independent Hospitals		Subsidiary Hospitals with Fiduciary Boards		Subsidiary Hospitals with Advisory Boards*		Government-Sponsored Hospitals	
	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Duty of Obedience												
The board *adopts and periodically reviews* the organization's written mission statement to ensure that it correctly articulates its fundamental purpose.**	**2.88**	2.90	**2.87**	2.92	**2.87**	2.91	**2.95**	2.90	**2.80**	*No Data*	**2.82**	2.87
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.	**2.95**	2.94	**2.96**	2.98	**2.95**	2.93	**2.92**	2.97	**3.00**	*No Data*	**2.93**	2.91
The board establishes a risk profile for the organization and holds management accountable to performance consistent with that risk profile.*	**2.22**	*No Data*	**2.42**	*No Data*	**2.13**	*No Data*	**2.43**	*No Data*	**1.80**	*No Data*	**2.13**	*No Data*
When considering major projects, the board discusses what the organization is forgoing by undertaking the project, the risks and trade-offs, and approaches to mitigating risks associated with the project.*	**2.87**	*No Data*	**2.92**	*No Data*	**2.86**	*No Data*	**2.78**	*No Data*	**2.40**	*No Data*	**2.92**	*No Data*
The board annually reviews and approves an updated enterprise risk management assessment and improvement plan.*	**2.55**	*No Data*	**2.62**	*No Data*	**2.54**	*No Data*	**2.47**	*No Data*	**2.50**	*No Data*	**2.61**	*No Data*
The board regularly reviews information provided by the chief information security officer (or top executive responsible for cybersecurity) to assess the organization's risk profile for cyber attacks and the sufficiency of management's handling of data storage, security protocols, and response to cyber attacks.*	**2.58**	*No Data*	**2.82**	*No Data*	**2.52**	*No Data*	**2.47**	*No Data*	**3.00**	*No Data*	**2.49**	*No Data*
The board ensures that management treats data privacy and security as a top priority for the organization and appropriately holds management accountable for meeting this responsibility.*	**2.85**	*No Data*	**2.90**	*No Data*	**2.85**	*No Data*	**2.70**	*No Data*	**2.33**	*No Data*	**2.83**	*No Data*
The board has approved a "code of conduct" policies/procedures document that provides ethical requirements for board members, employees, and practicing physicians.	**2.89**	2.85	**2.92**	2.94	**2.88**	2.87	**2.86**	2.85	**3.00**	*No Data*	**2.88**	2.79
The board has delegated its executive compensation oversight function to a group (committee, *ad hoc* group, task force, etc.) that is composed solely of independent directors of the board.	**2.56**	2.67	**2.76**	2.96	**2.50**	2.80	**2.43**	2.77	**2.33**	*No Data*	**2.26**	2.29

"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 (N/A not included)	Overall (all hospitals and health systems)		Systems		Independent Hospitals		Subsidiary Hospitals with Fiduciary Boards		Subsidiary Hospitals with Advisory Boards*		Government-Sponsored Hospitals	
	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
The board has established policies regarding executive and physician compensation that include consideration of IRS mandates of "fair market value," "reasonableness of compensation," and industry benchmarks when determining compensation.* *2015 wording: 1) The board requires that CEO compensation be determined with due consideration given to the IRS mandate of "fair market value" and "reasonableness of compensation," and 2) The board has established policies regarding physician compensation that include consideration of "fair market value" and industry benchmarks when determining compensation. Due to the nature of the change we cannot make a historical comparison.*	**2.75**	*No Data*	**2.88**	*No Data*	**2.72**	*No Data*	**2.63**	*No Data*	**3.00**	*No Data*	**2.64**	2.77
The board ensures that the annual compliance plan is properly updated, implemented, and effective *(e.g., systems for detecting, reporting, and addressing potential violations of law or payment regulations; new legislation; updates to current regulations; etc.).***	**2.89**	2.89	**3.00**	2.94	**2.85**	2.87	**2.90**	3.00	**3.00**	*No Data*	**2.82**	2.82
The board has established a direct reporting relationship with legal counsel.	**2.55**	2.44	**2.73**	2.48	**2.48**	2.38	**2.63**	2.26	**3.00**	*No Data*	**2.55**	2.59
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	**2.88**	2.76	**2.79**	2.92	**2.79**	2.80	**3.00**	*No Data*	**2.79**	2.70
The board *follows* a written external audit policy that makes the board responsible for approving the auditor as well as approving the process for audit oversight.**	**2.90**	2.78	**3.00**	2.92	**2.88**	2.85	**2.76**	2.80	**2.50**	*No Data*	**2.90**	2.59
The board has created a separate audit committee (or audit and compliance committee, or other committee or subcommittee specific to audit oversight) to oversee external and internal audit functions *that is composed entirely of independent persons who have appropriate qualifications to serve in such role.***	**2.44**	2.48	**2.84**	2.88	**2.28**	2.45	**2.62**	2.83	**1.00**	*No Data*	**2.32**	2.11
Board members responsible for audit oversight meet with external auditors, without management, at least annually.	**2.66**	2.82	**2.94**	2.94	**2.58**	2.92	**2.55**	2.77	**1.00**	*No Data*	**2.51**	2.65

"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 (N/A not included)	Overall (all hospitals and health systems)		Systems		Independent Hospitals		Subsidiary Hospitals with Fiduciary Boards		Subsidiary Hospitals with Advisory Boards*		Government-Sponsored Hospitals	
	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Quality Oversight												
Note: The board's responsibility for quality oversight includes outcomes, safety, experience, and value. When the word "quality" is included in a practice below, it encompasses all of these items.												
The board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.*	**2.90**	*No Data*	**2.94**	*No Data*	**2.88**	*No Data*	**3.00**	*No Data*	**3.00**	*No Data*	**2.89**	*No Data*
The board requires all hospital clinical programs or services to meet quality-related performance criteria.	**2.82**	2.81	**2.73**	2.80	**2.83**	2.76	**2.96**	2.92	**3.00**	*No Data*	**2.84**	2.82
The board annually approves and at least quarterly reviews quality performance measures for all care settings, including population health and value-based care metrics (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) to identify needs for corrective action.** *2015 wording: 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.*	**2.79**	2.96	**2.80**	2.94	**2.78**	2.96	**2.83**	2.95	**2.86**	*No Data*	**2.77**	2.97
The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.	**2.70**	2.79	**2.78**	2.90	**2.67**	2.81	**2.75**	2.88	**2.83**	*No Data*	**2.65**	2.65
The board devotes a significant amount of time on its board meeting agenda to quality issues/ discussion (at most board meetings).	**2.80**	2.86	**2.84**	2.88	**2.77**	2.86	**2.96**	2.97	**3.00**	*No Data*	**2.75**	2.76
The board has a standing quality committee.	**2.63**	2.70	**2.80**	2.92	**2.55**	2.66	**2.77**	2.88	**2.40**	*No Data*	**2.56**	2.51
The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.*	**2.65**	*No Data*	**2.74**	*No Data*	**2.61**	*No Data*	**2.74**	*No Data*	**2.71**	*No Data*	**2.58**	*No Data*
The board, *in consultation with the medical executive committee,* participates in the development of and/ or approval of explicit criteria to guide medical staff recommendations for physician appointments, reappointments, and clinical privileges, *and conducts periodic audits of the credentialing and peer review process to ensure that it is being implemented effectively.***	**2.84**	2.77	**2.89**	2.71	**2.83**	2.78	**2.86**	2.91	**2.60**	*No Data*	**2.83**	2.72
The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.	**2.82**	2.83	**2.92**	2.82	**2.81**	2.84	**2.74**	2.92	**2.80**	*No Data*	**2.82**	2.79
The board allocates sufficient resources to developing physician leaders and assessing their performance.*	**2.39**	*No Data*	**2.62**	*No Data*	**2.30**	*No Data*	**2.59**	*No Data*	**2.00**	*No Data*	**2.29**	*No Data*
The board ensures consistency in quality reporting, standards, policies, and interventions such as corrective action with practitioners across the entire organization.*	**2.79**	*No Data*	**2.93**	*No Data*	**2.74**	*No Data*	**2.83**	*No Data*	**2.80**	*No Data*	**2.78**	*No Data*

"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 (N/A not included)	Overall (all hospitals and health systems)		Systems		Independent Hospitals		Subsidiary Hospitals with Fiduciary Boards		Subsidiary Hospitals with Advisory Boards*		Government-Sponsored Hospitals	
	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Financial Oversight												
The board is sufficiently informed and discusses the multi-year strategic/financial plan before approving it.*	**2.94**	*No Data*	**2.96**	*No Data*	**2.93**	*No Data*	**3.00**	*No Data*	**3.00**	*No Data*	**2.92**	*No Data*
The board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it.*	**2.99**	*No Data*	**3.00**	*No Data*	**2.99**	*No Data*	**3.00**	*No Data*	**3.00**	*No Data*	**2.98**	*No Data*
The board annually reviews and approves the investment policy.*	**2.81**	*No Data*	**2.96**	*No Data*	**2.75**	*No Data*	**2.92**	*No Data*	**3.00**	*No Data*	**2.76**	*No Data*
The board reviews financial feasibility of projects before approving them.	**2.98**	2.96	**3.00**	3.00	**2.98**	2.96	**3.00**	2.90	**3.00**	*No Data*	**2.96**	2.97
The board monitors financial performance against targets established by the board related to liquidity ratios, profitability, activity, and debt, and demands corrective action in response to under-performance.* *Note: In 2015 there were two separate practices related to this: 1) The board reviews information at least quarterly on the organization's financial performance against plans, and 2) The board demands corrective actions in response to under-performance on capital and financial plans. Due to the nature of the change for 2019 we cannot make a historical comparison.*	**2.90**	*No Data*	**2.94**	*No Data*	**2.88**	*No Data*	**3.00**	*No Data*	**3.00**	*No Data*	**2.87**	*No Data*
The board ensures that the finance and quality committees work together to improve quality while reducing costs and sets value-based performance goals for senior management and physician leaders.*	**2.63**	*No Data*	**2.67**	*No Data*	**2.60**	*No Data*	**2.83**	*No Data*	**3.00**	*No Data*	**2.60**	*No Data*

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

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	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
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**	2.91	**2.94**	2.86	**2.90**	2.96	**2.90**	2.97	**2.80**	*No Data*	**2.87**	2.84
The board *ensures that a strategy is in place* for aligning the clinical and economic goals of the hospital(s) and physicians.**	**2.87**	2.81	**2.90**	2.77	**2.85**	2.85	**2.95**	2.90	**3.00**	*No Data*	**2.84**	2.72
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**	2.87	**2.96**	2.88	**2.85**	2.90	**2.81**	2.95	**3.00**	*No Data*	**2.83**	2.79
The board evaluates proposed new programs or services on factors such as mission compatibility, financial feasibility, market potential, impact on quality and patient safety, *community health needs, and adherence to the strategic plan before approving them.***	**2.90**	2.93	**2.94**	2.92	**2.87**	2.91	**2.96**	2.98	**3.00**	*No Data*	**2.83**	2.92
The board *incorporates the perspectives* of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).**	**2.87**	2.91	**2.85**	2.96	**2.87**	2.90	**2.91**	2.95	**3.00**	*No Data*	**2.80**	2.89
The board *holds management accountable for accomplishing the strategic plan by* requiring that major strategic projects specify both measurable criteria for success and those responsible for implementation.**	**2.84**	2.79	**2.83**	2.82	**2.82**	2.79	**3.00**	2.90	**3.00**	*No Data*	**2.82**	2.72
The board spends more than half of its meeting time during most board meetings discussing strategic issues as opposed to hearing reports.	**2.25**	2.18	**2.56**	2.38	**2.17**	2.20	**2.16**	2.21	**1.86**	*No Data*	**2.09**	2.03
The board *follows board*-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).**	**2.40**	2.22	**2.46**	2.32	**2.37**	2.20	**2.52**	2.28	**2.00**	*No Data*	**2.34**	2.18
The board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability.	**2.38**	2.50	**2.39**	2.42	**2.39**	2.56	**2.32**	2.59	**2.20**	*No Data*	**2.37**	2.42
The board works with management to gain awareness of, and prepare to respond to, matters of business disruption.*	**2.76**	*No Data*	**2.84**	*No Data*	**2.73**	*No Data*	**2.83**	*No Data*	**3.00**	*No Data*	**2.76**	*No Data*

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

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	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Board Development												
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.	**2.13**	2.36	**2.18**	2.32	**2.07**	2.30	**2.43**	2.57	**2.00**	*No Data*	**2.11**	2.34
The board uses the results from a formal self-assessment process to establish board performance improvement goals at least every two years.* *Note: In 2015 this practice was separated into two: 1) The board engages in a formal self-assessment process to evaluate its performance at least every two years, and 2) The board uses the results from the self-assessment process to establish board performance improvement goals. Due to the nature of the change we cannot make a historical comparison.*	**2.44**	*No Data*	**2.60**	*No Data*	**2.36**	*No Data*	**2.57**	*No Data*	**2.33**	*No Data*	**2.35**	*No Data*
The board reviews its committee performance at least every two years to ensure charter fulfillment and that coordination between committees and the board and reporting to the full board are effective.* *Note: 2015 wording combined this practice with another under Duty of Care. For 2019 we separated out review of committee structure (see Duty of Care) and committee performance, as shown here. Due to the nature of the change we cannot provide historical data.*	**2.30**	*No Data*	**2.41**	*No Data*	**2.23**	*No Data*	**2.59**	*No Data*	**2.00**	*No Data*	**2.29**	*No Data*
The board uses a formal orientation program for new board members that *includes education on their fiduciary duties and information on the industry and its regulatory and competitive landscape.***	**2.81**	2.85	**2.94**	2.98	**2.76**	2.88	**2.87**	2.98	**2.60**	*No Data*	**2.68**	2.65
The board has a "mentoring" program for new board members.	**2.04**	1.94	**2.14**	2.00	**1.99**	1.93	**2.18**	2.14	**1.67**	*No Data*	**1.95**	1.81
Board members participate at least annually in education regarding its responsibilities to fulfill the organization's mission, vision, and strategic goals.** *2015 wording: Board members participate in ongoing education regarding key strategic issues facing the organization.*	**2.60**	2.83	**2.77**	2.84	**2.54**	2.86	**2.65**	2.92	**2.50**	*No Data*	**2.60**	2.74
The board has job descriptions for the full board, individual board members, officers, and committee chairs that outline duties, responsibilities, and expectations, and are signed by every board member.*	**2.31**	*No Data*	**2.34**	*No Data*	**2.27**	*No Data*	**2.54**	*No Data*	**2.17**	*No Data*	**2.36**	*No Data*
The board selects new director candidates from a pool that reflects a broad range of diversity and competencies (e.g., race, gender, background, skills, and experience).** *2015 wording: The board uses competency-based criteria when selecting new board members.*	**2.69**	2.45	**2.88**	2.57	**2.60**	2.45	**2.74**	2.63	**2.67**	*No Data*	**2.45**	2.21

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

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	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
The board enforces a policy on board member term limits and retirement age.*	**2.53**	*No Data*	**2.70**	*No Data*	**2.45**	*No Data*	**2.64**	*No Data*	**2.50**	*No Data*	**2.17**	*No Data*
The board enforces minimum meeting preparation and attendance requirements.** *2015 wording: The board has a written policy specifying minimum meeting attendance requirements.*	**2.54**	2.57	**2.54**	2.51	**2.55**	2.64	**2.48**	2.35	**2.50**	*No Data*	**2.55**	2.66
The board uses a formal process to evaluate the performance of individual board members.	**1.89**	1.86	**2.06**	1.96	**1.83**	1.92	**1.95**	2.02	**1.50**	*No Data*	**1.90**	1.62
The board uses *agreed-upon* performance requirements for board member and officer reappointment.**	**2.00**	1.91	**2.19**	1.96	**1.91**	1.97	**2.14**	2.10	**1.50**	*No Data*	**1.94**	1.63
The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.	**2.24**	2.20	**2.48**	2.31	**2.12**	2.23	**2.45**	2.43	**2.00**	*No Data*	**2.05**	1.91
Management Oversight												
The board follows a formal, *objective* process for evaluating the CEO's performance.**	**2.83**	2.90	**2.92**	2.92	**2.80**	2.93	**2.86**	2.95	**3.00**	*No Data*	**2.80**	2.81
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation (in the first quarter of the year).**	**2.67**	2.76	**2.76**	2.84	**2.63**	2.83	**2.74**	2.76	**2.75**	*No Data*	**2.69**	2.64
The board requires that the CEO's compensation package is based, in part, on the CEO performance evaluation.	**2.78**	2.84	**2.88**	2.92	**2.75**	2.88	**2.71**	2.86	**3.00**	*No Data*	**2.74**	2.74
The board seeks independent (i.e., third-party) expert advice/information on industry comparables before approving executive compensation.	**2.74**	2.84	**2.96**	2.96	**2.68**	2.88	**2.75**	2.96	**3.00**	*No Data*	**2.59**	2.66
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.	**2.84**	2.86	**2.96**	2.96	**2.81**	2.86	**2.75**	2.96	**3.00**	*No Data*	**2.76**	2.76
The board recognizes that CEO (and other senior executive) succession and search planning is a critical responsibility of the board.*	**2.79**	*No Data*	**2.94**	*No Data*	**2.76**	*No Data*	**2.71**	*No Data*	**2.67**	*No Data*	**2.68**	*No Data*
The board maintains a written, current CEO and senior executive succession plan.** *2015 wording: The board requires that the CEO maintain a written, current succession plan.*	**2.28**	2.25	**2.58**	2.63	**2.18**	2.27	**2.25**	2.33	**1.67**	*No Data*	**2.19**	1.99
The board convenes executive sessions periodically without the CEO in attendance.** *2015 wording: The board convenes executive sessions periodically without the CEO in attendance to discuss CEO performance.*	**2.37**	2.67	**2.59**	2.83	**2.30**	2.69	**2.33**	2.67	**1.40**	*No Data*	**2.22**	2.56

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	2019	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015	**2019**	2015
Key: ** New practice for 2019 or reworded to the extent that it cannot be compared with historical data* *** Reworded practice showing new wording in italics or otherwise noted*												
Community Benefit & Advocacy												
The board has adopted a policy or policies on community benefit that includes all of the following characteristics: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, and measurable goals for the organization.** *Note: In 2015, this practice included the following phrase at the end: a financial assistance policy, and commitment to communicate transparently with the public.*	**2.43**	2.57	**2.70**	2.63	**2.35**	2.56	**2.47**	2.82	**2.60**	*No Data*	**2.35**	2.41
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.	**2.92**	2.97	**3.00**	2.94	**2.90**	2.98	**2.90**	2.95	**2.33**	*No Data*	**2.89**	2.98
The board ensures that the organization effectively addresses social determinants of health (e.g., housing, access to healthy food, employment, financial strain, behavioral health, personal safety) in the context of its community benefit activities.*	**2.43**	*No Data*	**2.55**	*No Data*	**2.39**	*No Data*	**2.50**	*No Data*	**1.50**	*No Data*	**2.35**	*No Data*
The board provides oversight with respect to organizational compliance with IRS tax-exemption requirements concerning community benefit and related requirements.	**2.91**	2.88	**3.00**	2.96	**2.88**	2.88	**2.89**	2.93	**3.00**	*No Data*	**2.83**	2.78
The board holds management accountable for implementing strategies to meet the needs of the community, as identified through the community health needs assessment.** *2015 wording: The board ensures the adoption of implementation strategies that meet the needs of the community, as identified through the community health needs assessment.*	**2.87**	2.83	**2.89**	2.86	**2.86**	2.85	**2.95**	2.95	**3.00**	*No Data*	**2.83**	2.71
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).	**2.82**	2.78	**2.85**	2.81	**2.79**	2.68	**2.95**	2.89	**3.00**	*No Data*	**2.83**	2.84
The board has a written policy establishing the board's role in fund development and/or philanthropy.	**2.13**	1.93	**2.15**	2.00	**2.12**	2.02	**2.19**	2.07	**2.25**	*No Data*	**2.04**	1.67
The board works closely with general counsel to ensure all advocacy efforts are consistent with tax-exemption requirements.** *2015 wording: The board works closely with legal counsel to assure all advocacy efforts are consistent with the requirements of tax-exempt status.*	**2.54**	2.56	**2.67**	2.83	**2.47**	2.45	**2.71**	2.75	**3.00**	*No Data*	**2.45**	2.48
The board has adopted a policy regarding information transparency, explaining to the public in understandable terms its performance on measures of quality, safety, pricing, customer service, *and community benefit.***	**2.31**	2.26	**2.30**	2.12	**2.30**	2.19	**2.40**	2.37	**2.00**	*No Data*	**2.31**	2.37

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