THE GOVERNANCE INSTITUTE

A SERVICE OF nrc HEALTH

ADVANCING GOVERNANCE for a NEW FUTURE of HEALTHCARE

THE GOVERNANCE INSTITUTE'S

2021 BIENNIAL SURVEY

OF HOSPITALS AND HEALTHCARE SYSTEMS

Acknowledgements

The Governance Institute extends deep appreciation to the following people, who contributed a significant amount of their time to reviewing the results and offering commentary on key areas for improvement.

Kenneth Kaufman is Chair of Kaufman Hall, a management consulting firm that provides advisory services and software to hospitals and health systems nationwide. Since 1976, Mr. Kaufman has provided healthcare organizations with expert counsel and guidance in areas including strategy, finance, financial and capital planning, and mergers, acquisitions, and partnerships. Clients include organizations of all types and sizes—community hospitals and health systems, academic medical centers, and regional or national health systems.

Recognized as a leading authority and committed to industry education, Mr. Kaufman has given more than 400 presentations at meetings such as those organized by the American College of Healthcare Executives (ACHE), American Hospital Association, Healthcare Financial Management Association, The Governance Institute, and others.

Mr. Kaufman has authored or coauthored seven books, most recently authoring *Fast and Furious: Observations on Healthcare's Transformation; Focus on Finance,* Second Edition, published by The Governance Institute; and *Best Practice Financial Management,* Third Edition, published by ACHE. In addition, he is often quoted and his articles regularly appear in major healthcare publications. Mr. Kaufman has an M.B.A. with a concentration in hospital administration from the University of Chicago Graduate School of Business.

Randy Oostra, D.M., FACHE, is the President and Chief Executive Officer of ProMedica, a not-for-profit mission-based, integrated healthcare organization headquartered in Toledo, Ohio. It serves communities in Ohio, Michigan, Indiana, Kentucky, Pennsylvania, and West Virginia. To date it offers acute and ambulatory care, a growing network of employed advanced practice providers and board-certified physicians, an insurance company with a dental plan, post-acute, and academic business lines.

Randy has 40 years of healthcare and management expertise, with 20 of those years spent at ProMedica. Randy is regarded as one of the nation's top leaders in healthcare and has earned a spot on several prestigious listings, which include *Modern Healthcare*'*s* 100 Most Influential People in Healthcare and one of 100 great leaders in healthcare according to *Becker's Hospital Review*. He also received the American Heart Association's Pulse of Toledo Award in 2018. ProMedica has received numerous national recognitions and accolades under his leadership. The organization is widely known as a national leader in addressing the social determinants of health and is consistently recognized by national associations and accrediting agencies for superior clinical quality and excellence.

Randy has a strong commitment to the healthcare industry and community with his extensive involvement in numerous professional and civic organizations at the local, regional, and national levels. He serves on the board of the following national organizations: Local Initiatives Support Corporation (LISC), American Hospital Association, Health Research and Educational Trust, and The Root Cause Coalition, which ProMedica founded. He serves on the board of trustees for his alma mater, Northwestern College in Orange City, Iowa, and the following organizations in northwest Ohio: Regional Growth Partnership, The Toledo Museum of Art, Downtown Development Corporation, and The Toledo Symphony as the chair. Randy is also a member of the Ohio and Michigan Hospital Associations and a fellow of the American College of Healthcare Executives.

Randy holds a doctorate in management from Case Western Reserve University, a master's degree in healthcare administration from the University of Minnesota, a master's degree in management from the University of Wisconsin, and a Bachelor of Science degree in biology from Northwestern College.

Michael W. Peregrine, Partner, McDermott Will & Emery, LLP, represents corporations (and their officers and directors) in connection with governance, corporate structure, fiduciary duties, officer–director liability issues, charitable trust law, and corporate alliances. Michael is recognized as one of the leading national practitioners in corporate governance law.

Michael is outside governance counsel to many prominent corporations, including hospitals and health systems, voluntary health organizations, social service agencies, colleges and universities, and health insurance companies. Clients seek Michael's counsel on matters relating to board conduct, structure, effectiveness, composition, and controversy—as well as on internal and external/regulatory challenges to governance. He frequently serves as special counsel in connection with confidential internal board reviews and investigations. He regularly advises boards on complex business transactions, including more than 125 change-of-control transactions in his 37-year career. Recently, Michael has served as Lead Transaction Counsel in connection with a series of nationally prominent combinations of religious-sponsored health systems and large regional health systems/academic medical centers.

Michael is well known as a thought leader in corporate governance. He authors monthly columns on corporate governance for Corporate Counsel magazine and for publications of The Governance Institute. He is also a regular contributor on corporate governance topics to *The New York Times'* "Deal Book" feature, *Corporate Board Member, The Chronicle of Philanthropy,* The Harvard Law School Forum on Corporate Governance and Financial Regulation, The Columbia Law School's Blog on Corporations and the Capital Markets, the New York University School of Law Compliance and Enforcement Forum, and Law 360.

Michael is noted for his extensive experience advising non-profit corporations on matters of corporate law and governance. He authors a monthly publication, *Corporate Law and Governance Newsletter,* and moderates a monthly

Acknowledgements (continued)

director education podcast, "Governing Health." Michael is a co-author of the three corporate governance compliance white papers published jointly by the Office of Inspector General (Department of Health and Human Services) and the American Health Lawyers Association.

Kimberly A. Russel, FACHE, Chief Executive Officer, Russel Advisors, has served as a healthcare executive for over 38 years. For the past 25 years, Kim devoted her energy and talents to serving as a healthcare CEO, first at Mary Greeley Medical Center in Ames, Iowa and from 2008 to early 2020, at Bryan Health in Lincoln, Nebraska. Earlier in her career, Kim served as Chief Operating Officer at the University of Kansas Hospital in Kansas City, Kansas and in various executive roles at Iowa Methodist Medical Center (now Unity Point-Des Moines). Kim recently retired from Bryan Health and formed her own boutique consulting firm, Russel Advisors, which allows her to dedicate her time to advising and assisting healthcare boards and CEOs. She also serves as a Governance Advisor, frequent speaker, and contributor to publications and research projects for The Governance Institute.

Throughout her career, Kim has been an active member of over 20 boards and has served as chair of 10 boards. Kim currently serves on the Foundation for Educational Services board and chairs the Omaha branch board of the Federal Reserve Bank of Kansas City. Kim holds a Bachelor of Science in management from Purdue University and a Master of Health Administration from Washington University.

Antoinette Hardy-Waller, M.J., B.S.N., RN, is Chief Executive Officer of The Leverage Network (TLN), a non-profit organization committed to the promotion and advancement of African Americans to governance and board roles in healthcare. She is an accomplished senior executive, entrepreneur and clinician, with extensive leadership and management experience. She has more than 30 years of experience building, owning, and managing healthcare businesses in the post-acute space. Toni is also a member of the Board of Stewardship Trustees for CommonSpirit Health, a $29 billion faith-based health system operating 142 hospitals in 21 states. She is Chair of the Board Quality and Safety Committee for CommonSpirit Health.

Prior to building TLN, Toni founded Strategic Healthcare Transformations (SHcT), a national consulting firm assisting health systems nationally in the development of post-acute continuums of care and population health strategies. She was also founder and CEO of two successful skilled home health companies, the first of which grew to become the largest proprietary home care company in the Chicagoland area. Toni sold that company to Columbia HCA as their flagship home care company for the Chicago region, Columbia Home Care. Columbia Home Care was the largest national home care company with more than 400 home care agencies across the country.

Toni holds a master's in jurisprudence from Loyola University School of Law and a bachelor's degree in nursing from the University of Illinois Chicago. She has authored several articles including "Why ending disparities in healthcare must start at the top" *(Hospitals & Health Networks Daily, Leadership & Strategy,* January 9, 2017) and "Increasing Board Diversity: An Imperative for Success in the Next Era" *(Nurse Administration Quarterly,* Vol. 39, No.1, January–March 2015) where she speaks about the importance of nurses on boards.

She has served on the boards of Alegent Creighton Health, the National Association for Health Services Executives, and the American Hospital Association's governing boards for The Center for Healthcare Governance and Long Term Care.

The Governance Institute would also like to acknowledge **Justin Kubick, M.B.A.**, Director of Analytics, and **Triet Khuc**, Research Analyst, NRC Health, for conducting the data analysis for this year's report.

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, Managing Editor of The Governance Institute, oversees The Governance Institute's resource library; develops the education agenda and programs for conferences, Webinars, and E-Learning; and researches recommended board practices and key governance issues for U.S. healthcare organizations. Previously she served as Permissions and Copyright Editor for Roxbury Publishing in Los Angeles, CA, now a division of Oxford University Press.

She has authored articles in *Health Affairs, Journal of Health & Life Sciences Law, Prescriptions for Excellence in Health Care,* and *Healthcare Executive,* as well as numerous publications for The Governance Institute. She authored the chapter "Governance for Quality" in the 4th and 5th editions of *The Health Care Quality Book: Vision, Strategy, and Tools* (April 2019 ed. Nash, Joshi, Ransom, and Ransom; 5th edition forthcoming). Most recently, she was a contributor in the recently published book, *Patient No Longer: Why Healthcare Must Deliver the Care Experience that Consumers Want and Expect* (Donohue and Klasko, Health Administration Press, 2020).

Kathryn is a member of the American College of Healthcare Executives and the American Health Law Association. She has a bachelor's degree in communication studies from UCLA and a master's degree from Boston University.

Kayla Wagner is Senior Editor at The Governance Institute. For 11 years, she has helped plan and produce publications and educational tools for Governance Institute members, including newsletters, case studies, white papers, and E-Learning courses. She works to bring board members valuable information that assists them in making more informed decisions for their hospitals and health systems, and she works with writers to provide actionable information readers can apply to their own organizations. Previously she served as a Media Specialist and writer for the Network for a Healthy California as well as Managing Editor at *Upstate Business Journal* and *InSideOut Magazine*. She received her bachelor's degree in English with an emphasis in editing and publishing from California State University, Chico.

The Governance Institute®

The essential resource for governance knowledge and solutions®

1245 Q Street, Lincoln, NE 68508

(877) 712-8778

GovernanceInstitute.com
/The Governance Institute
/thegovinstitute

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

The Governance Institute, a service of NRC Health, 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.

Jona Raasch	Chief Executive Officer
Cynthia Ballow	Vice President, Operations
Kathryn C. Peisert	Managing Editor
Glenn Kramer	Creative Director
Kayla Wagner	Senior Editor
Aliya Flores	Editor

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

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

Table of Contents

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 transforming healthcare delivery. Culture questions relate to how well the board builds relationships, communicates, and makes decisions. Governance structure and culture have remained relatively consistent over the past few surveys. A few differences this year are briefly summarized below.

Board composition: Board size is leveling off at a median of 13—"just right." However, some health system boards remain too large for effective engagement and decision making, and government-sponsored hospital boards remain smaller than ideal, although readers are well aware of the limitations these boards have regarding their control over size and composition.

The most notable movement in the data this year is a small but important uptick in the number of boards with ethnic minorities: 62% have at least one member from an ethnic minority, up from 49% in 2019. In addition, the average number of ethnic minority board members went up from 1.2 to 1.6, and the median went from 0 to 1. These increases are small, but notable due to the fact that this is the first time since 2007 that we have seen *any* movement in this area.

Female representation also increased this year (median increased from 3 to 4 per board), and the average age of board members decreased by over a decade from 2019 (although similar to 2017 numbers with an average age of 58).

New this year, we asked how many board members are from outside the community or region the board serves, which is 0.8 on average; while most organizations do not yet have board members from outside the community, 29% have at least one, with health systems being the most likely (44% have at least one).

While physician representation rose this year it is still lower than we recommend, and nurse representation remains virtually non-existent (in fact, only 18% of boards without at least one nurse have plans to add one in the future). Having clinical expertise on the board is critical for proper oversight and strategic decision making regarding quality, population health and value-based care, addressing social determinants of health, innovating care delivery, and improving patient experience.

Board competencies: We asked boards about their top three essential competencies being sought in the next one to three years for new board members. Strategic planning/visioning, finance/business acumen, and quality/patient safety were overwhelmingly the top three across all types of organizations. This year, population health/social determinants/disparities beat out consumer-facing business expertise for the fourth spot (25% vs. 23% respectively; 37% of subsidiary fiduciary boards listed this as a top competency).

Board meeting content: Boards continue to meet frequently (10–12 times per year) for two to four hours. Generally, the less frequently a board meets, the longer the meetings are. Use of a consent agenda continues to increase (82%, up by five percentage points since 2017). However, that increase in consent agenda use has yet to show signs of progress in freeing up more time for strategic discussion: 58% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports. Only 29% is spent in active discussion, deliberation, and debate about strategic priorities of the organization (down from 31% in 2019, which was still not enough!).

Committees: The average number of committees is eight; one more than in 2019. The most prevalent committees are the same as in 2019: finance (85%), quality (81%), executive (79%), executive compensation (64%), governance/board development (64%, up from 58% in 2019), strategic planning (57%), and audit/compliance (54%). We sought information on two new committees this year: 14% of respondents have an innovation/transformation committee and 17% of respondents have a diversity and inclusion committee.

Board member compensation: The percentage of boards that compensate board members remains relatively stable at 11% (it was 7% in 2019 but 12% in 2017). Thus, despite the decade-long assumption that board member compensation must become more prevalent due to the expanded responsibilities and liability of volunteer directors, this has yet to show in our data.

Board education: 33% of respondents spend $30,000 or more annually for board education, a threshold that has been shown to positively impact board culture and performance (a rising trend from 27% in 2017). Health systems generally spend more for board education, and subsidiaries and government-sponsored hospital boards spend the least. The most popular board education topics this year are: strategic planning/direction (90%), quality/safety (87%), legal/regulatory (80%), and industry trends such as crisis management and value-based purchasing (77%).

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:

- Overall: 88% or a B+ (improved from 84% or B in 2019)
- Health systems: 92% or an A- (up from 90% in 2019)
- Independent hospitals: 84% or a B (up from 82% or B- in 2019)
- Subsidiary hospitals: 90% or an A- (up from 86% or B in 2019)
- Government hospitals: 82% or a B- (up from 80% in 2019)

All types of organizations have improved their culture grades this year compared with 2019; however, these scores are similar to our 2017 numbers. Only 34 respondents (8.7%) reported that they strongly agree with all nine statements.

Coronavirus pandemic: This year we wanted to learn more about how well boards and CEOs felt they were prepared to deal with the pandemic, how well they were able to lead their organizations through this crisis, and what changes they made from a structural standpoint to help this effort. There was wide agreement that CEOs and boards were prepared to deal with the pandemic and did an effective job leading and overseeing their organizations during this time.

Sixty-eight percent (68%) of respondents made changes of some kind to their structure or practices due to the pandemic, the most common being:

- Increased frequency of communication between the board and CEO/senior management/physician leaders (62%)
- Updated strategic and financial plans to address implications related to the pandemic (44%)

However, very few organizations did the following:

- Added board members with crisis management experience
- Added members to the management team with crisis management experience
- Added board members with digital technology and/or telemedicine/virtual care expertise

Population health management and value-based payments: 43% of respondents have not made any structure changes to the board or management since 2019 to help with population health management. Forty-eight percent (48%) did not make any such changes since 2019 to expand value-based payments. The level of activity in these areas has leveled off since 2017, so we assume that this group of boards feel they have adequate competencies on their boards and management teams to address these efforts. The majority of movement remains in adding new goals and metrics to strategic and financial plans and quality dashboards.

Our correlation analysis this year showed the following significant relationships:

- Boards with term limits are 37% more likely to cite excellent performance in the fiduciary duties and core responsibilities.
- Boards whose quality committees meet more frequently are 63% more likely to have adopted all of the quality oversight practices.
- Systems that said the assignment of governance responsibility and authority is widely understood and accepted by both local and system-level leaders are 67% more likely than those indicating that this is an area that needs improvement to cite excellent performance in the fiduciary duties and core responsibilities.

System–subsidiary governance structure: Most systems (46%) have still retained a multi-tiered governance structure with a system board and fiduciary subsidiaries. Eighteen percent (18%) have a system board with subsidiary advisory boards, and 32% have only one system board with fiduciary oversight for the entire system.

While we are not yet seeing more movement towards an operating model with centralized control at the system level—at least in the governance structure—the responsibilities of subsidiaries are shifting, with the following areas expanding in their degree of system-level control:

- More system boards are setting their subsidiaries' strategic goals.
- More system boards are determining their subsidiaries' capital and operating budgets.
- More system boards are electing/appointing the subsidiary board members.
- For systems with only advisory subsidiary boards, more are identifying their organization's community health needs through the CHNA, setting population and community health goals, and addressing social determinants of health at the system level.

Advisory board profile: When comparing the structure and composition of "advisory" subsidiary boards (those that do not have fiduciary duties or decision-making authority) to fiduciary subsidiary boards, the following distinctions come to light:

- Advisory boards are more likely to have term limits.
- They are much less likely to have legal counsel attend board meetings and executive sessions.
- They tend to meet less often (quarterly rather than monthly) and for a shorter period of time (less than two hours for 80% of them).
- They contribute less investment to board member education (under $10,000 annually; perhaps these board members participate in education funded by the system board).
- They have fewer committees (most typically finance, quality/safety, and strategic planning).
- They tend to have more physician and nurse representation on their quality committees.

Refer to the full report for a picture of the governance practices that are most widely adopted by these boards.

Governance Practices: Adoption & Performance

This year's results show that adoption of our list of recommended practices, for the most part, continues to be widespread. Overall, performance scores are higher this year for *all* fiduciary duties and core responsibilities. Importantly, this year we are seeing the percentage of organizations selecting "not applicable for our board" across many of the practices decrease since 2019, which we consider to be a strong indicator that our list of practices is directly relevant to what non-profit healthcare boards should be doing in order to fulfill their organizational mission and vision.

While community benefit and advocacy is still low in both performance and adoption scores, it is encouraging to see that these performance scores improved the most. All organizations saw improvement in the board increasing their efforts to ensure their hospitals and health systems are

effectively addressing social determinants of health. This is critical at a time when it is clear just how much impact outside factors (e.g., housing, access to healthy food, employment, and behavioral health) have on a community's health.

Board development remains at the bottom of the list for both performance and adoption scores, but this practice also saw significant improvement this year. 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, given the heightened awareness in the benefits this brings to an organization. The least-adopted practice in this area continues to be using a formal process to evaluate the performance of individual board members, which is important to ensure that members are effectively contributing to board work and continually developing their skills, as well as enabling the board to apply reappointment criteria.

The previous survey showed a decrease in adoption scores for management oversight practices, so it was great to see those scores increase this year. The least-observed practice continues to be maintaining a written, current CEO and senior executive succession plan. Adoption has gone up during the last reporting periods, but all organizations need to be better prepared for both planned and unforeseen changes in leadership.

In 2023 we will be looking for improved performance and adoption of the practices regarding setting strategic direction. We were not surprised to see performance in this area struggle this year due to the pandemic forcing our nation's boards and executive leadership to dig into real-time crises, making it extremely difficult to maintain focus on the future. But we know that this focus must begin again in earnest, in a way that hasn't been done before, as soon as possible.

Concluding Remarks

This report contains a lot of data points on individual pieces of information, whether regarding the makeup of boards or their activities, which, taken individually, can seem insignificant. The big picture we see over the past decade of reporting on this survey is that, each reporting year, boards show small, incremental improvements in the right direction (for the most part). However, there are still critical areas that have not moved in the right direction much at all (board meeting time spent in active discussion and debate about strategic priorities being the most critical one). We hope that the lessons learned through the coronavirus pandemic, which revealed how flexible, nimble, agile, and swift healthcare organizations can be when the urgency requires it, can help boards progress more swiftly as well. We believe that healthcare delivery cannot be transformed unless the board itself is transformative.

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?
- 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?
- Are there any governance practice areas in which we have low levels of adoption but the board thinks we are high-performing in that area? What might account for this discrepancy?

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. The 2021 survey continued our longitudinal assessment of how board structure, culture, and practices reflect the industry's movement towards value-based care. The report includes analysis on how systems structure their allocation of responsibilities with their subsidiary boards, how board structure and culture correlate with board practices and overall board performance, and how the coronavirus pandemic has influenced governance trends.

A new distinction made in our 2019 report was to separate out the data on "advisory" boards (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). In 2021 we continue to look at non-fiduciary boards separately (we have a larger group of these boards this year) so that we can 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 clearer picture of the responsibilities of advisory boards and how those are trending from 2019 to 2021.

The 2021 survey continued our longitudinal assessment of how board structure, culture, and practices reflect the industry's movement towards value-based care. The report includes analysis on how systems structure their allocation of responsibilities with their subsidiary boards, how board structure and culture correlate with board practices and overall board performance, and how the coronavirus pandemic has influenced governance trends.

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 multi-hospital 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 2021 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/2021biennialsurvey.)

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 the 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 4,766. We received 389 responses. Of those, 85% of respondents had a fiduciary board. Based on the number of hospital facilities owned by the health system respondents this year (931), the 389 respondents represent a total of 1,292 hospitals, or 27.1% of the total hospital survey population. For the most part, the sample distribution mirrors that of the population, as shown in **Table 1**.

Table 1. Survey Responses

	2021		2019		2017		2015	
	Respondents	Population	Respondents	Population	Respondents	Population	Respondents	Population
Organization	**N = 389**	**N = 4,766**	**N = 244**	**N = 4,830[1]**	**N = 465**	**N = 4,418**	**N = 355**	**N = 4,121**
Religious (41)	11%	15%	6%	15%	14%	13%	13%	14%
Secular:								
Government (107)	28%	23%	36%	22%	23%	23%	29%	22%
Non-Government (241)	62%	62%	57%	62%	77%	64%	71%	64%
Number of Beds								
< 100 (190)	49%	55%	40%	56%	52%	56%	37%	42%
100–299 (86)	22%	24%	18%	24%	24%	24%	30%	30%
300+ (113)	29%	21%	22%	20%	24%	20%	33%	28%
System Affiliation (109)	54%	60%	32%	58%	32%	51%	32%	62%

Comparison of Respondents 2021 vs. 2019

Twenty-two percent (22%) of the respondents in 2021 also responded to the survey in 2019.

Table 2. 2021 vs. 2019 Respondents

	Number of Respondents in 2021	Number of Respondents in 2019	Number of Respondents Who Completed the Survey in Both 2021 and 2019
Systems	101	52	15
Independent Hospitals	179	166	58
Subsidiary Hospitals	109	26	11
Government-Sponsored Hospitals	107	89	32
Total	389	244	84

1 The total survey population increased in 2019 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 since 2019 we have 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 3,908 non-profit, acute care hospitals (government and non-government) in 2021.

Governance Structure

Board Size & Composition

SUMMARY OF FINDINGS

- Average board size: 12.9
- Median board size: 13
- Voting board members:
  - Medical staff physicians (not including CMO): average is 1.7; median is 0
  - "Outside" physicians: average is 0.4; median is 0
  - Staff nurses (not including CNO): average is 0.12; median is 0
  - Management (including CMO and CNO): average is 0.8; median is 0
  - Independent board members: average is 9.7; median is 9
  - Female board members: average is 3.7; median is 4
  - Ethnic minority board members: average is 1.6; median is 1
  - Average number of voting board members from outside the community or region the organization serves: 0.8
- Term limits: 64% of boards limit the number of consecutive terms; median maximum number of terms is 3.
- Board member age limits: 5% of boards have age limits; average age limit is 73.6; median is 75.
- Average board member age: 58.1 (12 years younger than in 2019); median board member age: 59 (13 years younger than in 2019).

While previous years showed a consistent although slight continuation of boards decreasing in average size (12.4 in 2019, 12.9 in 2017, and 13.6 in 2015), 2021 shows perhaps a leveling off or right-sizing of the board at 12.9 members, which is right in the middle of our recommended target of 10–15 members. Health systems continue to have the largest boards (15.3 members; down from 16.5 in 2019), while government-sponsored hospitals continue to have the smallest boards (8.3, up slightly from 7.9 in 2019). As with previous surveys, board size generally increases

Table 3. 2021 & 2019 Board Composition

All Respondents	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Average # of Voting Board Members	12.9	12.4	0.8	0.7	1.7	1.3	9.7	9.7	0.7	0.7
Median # of Board Members	13	11	0	0	0	0	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 and nurses (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****	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Average # of Voting Board Members	15.3	16.5	0.8	0.8	2.2	2.1	11.0	12.6	1.2	1.1
Median # of Board Members	15	17	1	1	2	2	11	12	0	0

Note: System board size decreased, reflected in a decrease in independent board members.

Table 5. Independent Hospital Board Composition

Independent Hospitals	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Average # of Voting Board Members	11.2	10.5	0.6	0.5	1.2	1.0	9.1	8.5	0.3	0.5
Median # of Board Members	10	9	0	0	0	0	8	8	0	0

Note: Independent hospital board size increased slightly, due to an increase in independent 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****	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Average # of Voting Board Members	13.8	15.8	1.1	1.5	2.1	1.7	9.4	11.3	1.1	1.3
Median # of Board Members	14	15	1	2	2	1	9	11	0	0

Note: Subsidiary board size decreased, primarily due to a decrease in independent board members.

with organization size for all organization types.

In regards to board composition, the most notable distinction in 2021 is that boards are finally showing a small increase in diversity including gender, ethnicity, and age. The median for female board members went from 3 to 4 this year; board members from an ethnic minority increased from an average of 1.2 to 1.6, with the median increasing from 0 to 1. Board members are 12–13 years younger than in 2019 (although the average board member age in 2019 was about 10 years older than in 2017).

New this year, we are beginning to track the anecdotal trend that more boards may be needing to recruit board members from outside their organization's region or service area, in order to find the right skillsets, competencies, and diversity aspects. On average, boards have 0.8 members from outside their service area. Health systems, not surprisingly, have the highest average at 1.4, with independent hospitals averaging 0.7 and subsidiaries and government-sponsored hospitals averaging 0.5.

While 2019 showed significantly lower physician representation for all types of organizations, as well as fewer members of the management team, the 2021 numbers have risen for both of these categories; however, physician representation on all boards remains lower than what we recommend. Employed physician board members increased from an average of 0.6 to 0.8 this year and independent physicians who are members of the medical staff increased from 0.7 to 0.9. Subsidiary hospitals showed the most increase of medical staff physicians on the board by organization type; independent hospitals and government-sponsored hospitals continue to have the fewest number of physicians on the board compared with other types of organizations. Table 3 shows the overall comparison; Tables 4–7 show a comparison of board composition for each organization type.

Independent board members relative to board size decreased from 2019. When broken down by organization type, independent board members *as a percentage of total board members* is as follows:

- All respondents: 75% (vs. 78% in 2019)
- Systems: 72% (vs. 76% in 2019)
- Independent hospitals: 81% (same as in 2019)
- Subsidiary hospitals: 68% (vs. 72% in 2019)
- Government-sponsored hospitals: 82% (vs. 89% in 2019)

See Exhibit 1 for a breakdown of board members overall and by organization type for 2021.

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****	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Average # of Voting Board Members	8.3	7.9	0.5	0.3	0.8	0.5	6.9	7.0	0.2	0.2
Median # of Voting Board Members	7	7	0	0	0	0	7	7	0	0

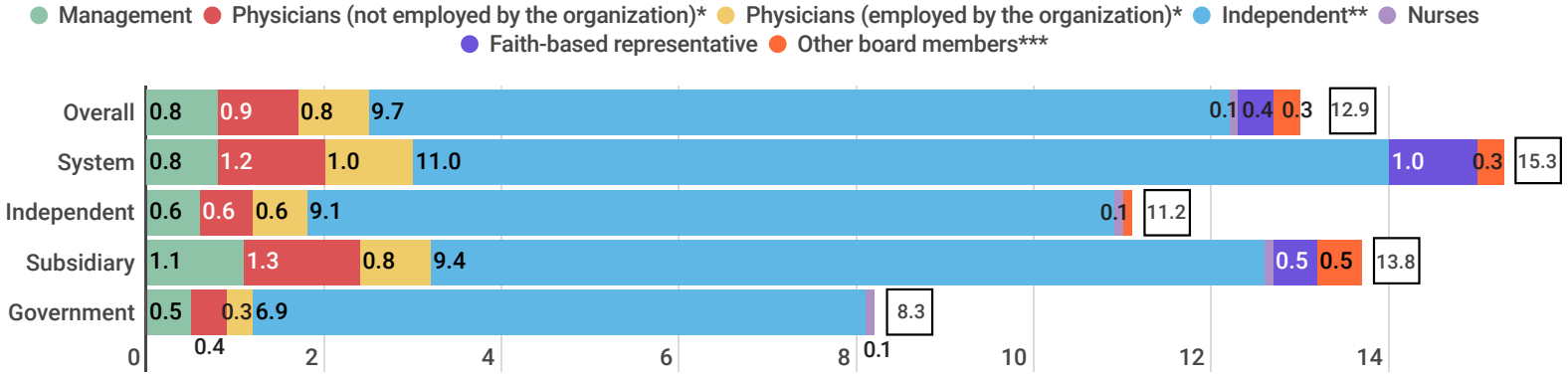
Note: Government hospital board size increased due to slight increases in management and medical staff physicians.

LARGEST BOARDS

- Church systems: 20.3 board members (down from 22.3 in 2019)
- Organizations with more than 2,000 beds: 17.9 (down from 18.4)
- Organizations with 300–499 beds: 17.5

We have noted that in prior surveys, a majority of respondents indicated that they don't make a distinction between employed vs. non-employed physicians when selecting physician board members, so we removed that question from this year's survey. However, the data show a consistent trend of a higher level of non-employed physicians on the board compared with employed physicians.

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.

*** May include physicians and nurses from outside the organization.

Physicians on the Board

Respondents noted physician board membership in the following categories:

- Physicians who are on the medical staff and not employed by the hospital
- Physicians who are on the medical staff and employed by the hospital
- Physicians who are not on the medical staff nor employed (and qualify as "outside" board members)

Table 8. Physicians on the Board since 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")		
	2021	2019	2017	2021	2019	2017	2021	2019	2017
Average	0.9	0.7	1.3	0.9	0.6	0.8	0.4	0.4	0.8
Median	0	0	1	0	0	0	0	0	0

The total average number of physicians on the board (all types of physicians including the CMO and "outside" physicians) rose this year to 2.2, compared with 1.7 in 2019 (it was 2.9 in 2017). Health system boards have the most physician representation with an average of 2.9; government-sponsored hospital boards have the lowest average of 0.98. All types of boards have a slightly higher level of non-employed vs. employed physician board members. (See **Exhibit 2**. Detail can be found in **Appendix 1**.) **Table 8** shows overall physician representation on the board since 2017.

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 or outside nurses are voting board members. For 8.9% of respondents with a CNO, the CNO is a voting or non-voting board member, compared with 7.9% in 2019 and 10.2% in 2017. Only 3.5% of respondents have a staff nurse aside from the CNO who is a voting board member; 35% of respondents have at least one nurse from outside the organization in a voting board position. For 76% of respondents, the CNO is a non-board member but regularly attends meetings.

When these three categories (CNO, staff nurses, and outside nurses) are combined into an average number of nurses on the board, it only comes out to 0.52 (compared with 0.4 in 2019). As has been the case historically, nurse representation on the board remains low, considering the key role nurses play in patient quality of care, experience, and customer loyalty. Only 17.6% of boards without at least one nurse have plans to add one to the board in the future. (See **Appendix 1** for more details.)

Females & Ethnic Minorities on the Board

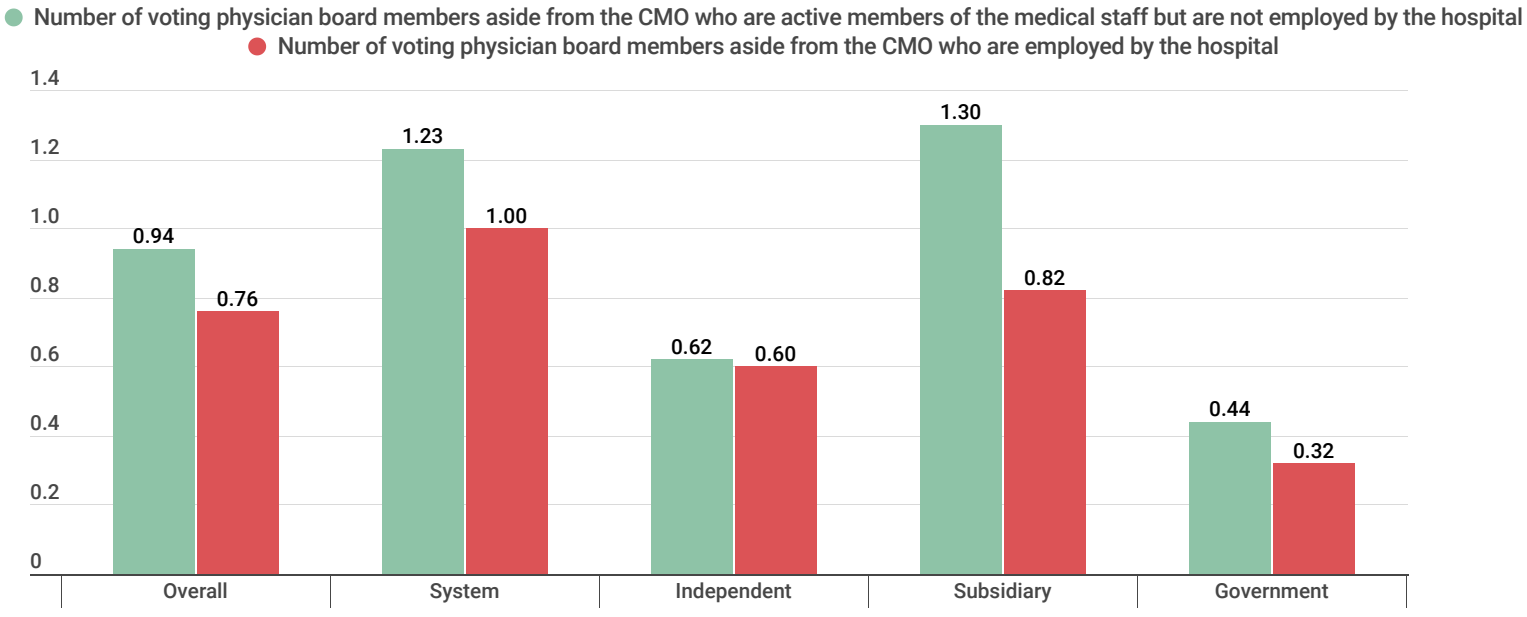
Most boards (98%) have at least one female board member. Only 62% have ethnic minorities represented on the board, but this number is up significantly from 49% in 2019 and 52% in 2017 (see **Exhibits 3** and **4**). By organization type, health systems have the highest average number of females on the board (4.2), and subsidiary boards have the highest average number of ethnic minority

Table 9. Female & Ethnic Minority Representation on the Board by Organization Size since 2017

	Females (average)			Ethnic Minorities (average)		
	2021	2019	2017	2021	2019	2017
< 100 beds	3.1	3.1	2.9	0.8	0.7	2.9
100–299 beds	4.1	3.7	3.6	2.1	1.3	3.6
300–499 beds	4.8	4.5	4.7	2.6	1.9	4.7
500–999 beds	4.7	4.3	4.0	2.9	3.2	4.0
1000–1999 beds	3.1	4.1	4.3	2.1	2.6	4.3
2000+ beds	5.2	3.6	2.8	3.2	2.0	2.8

For detail, see Appendix 1.

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



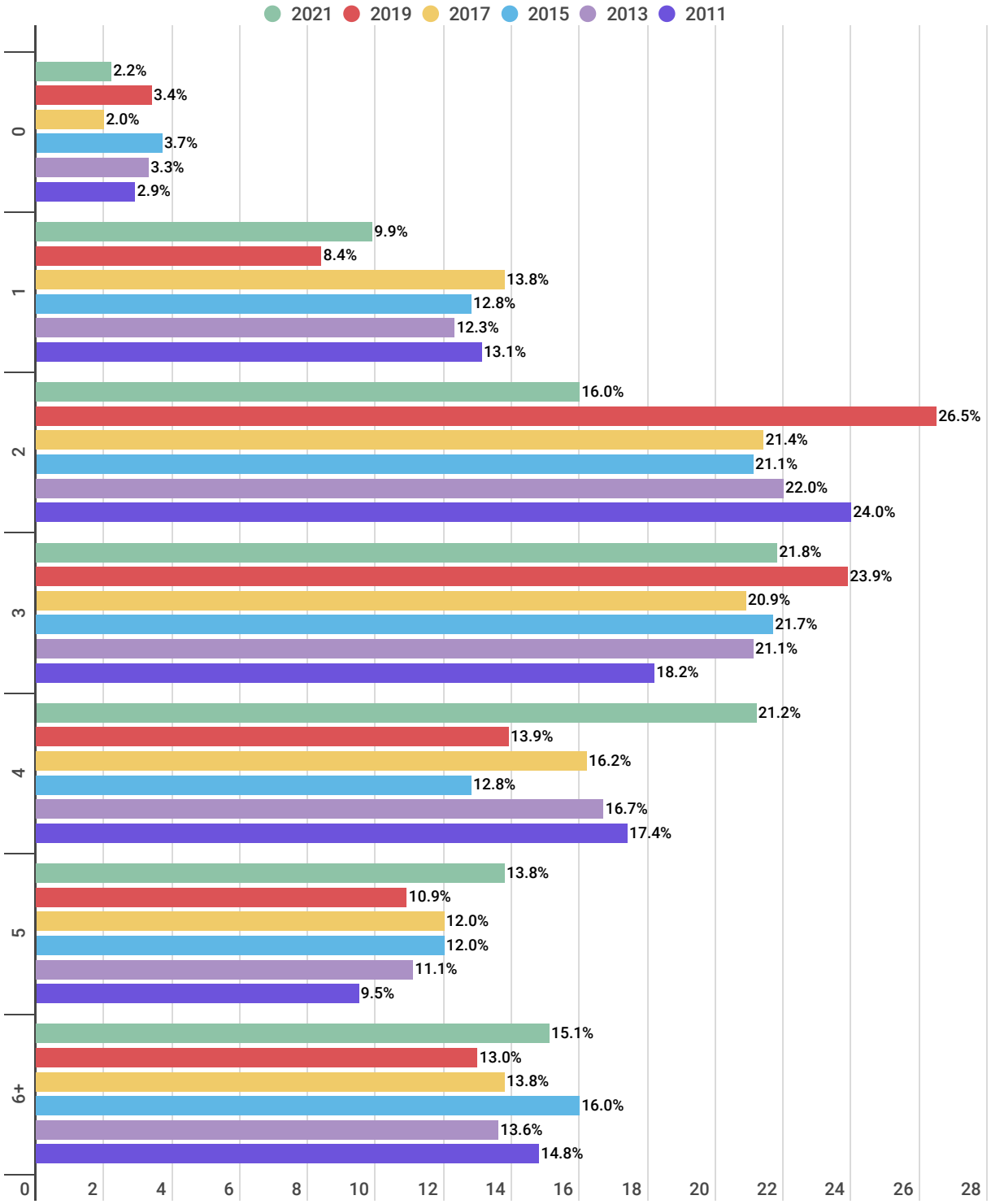
board members (2.2, up from 1.4 in 2019). This year marks the first time since 2007 that we have seen a positive increase in board diversity. However, 38% of organizations still do not have a minority board member.

We looked at the largest boards to see if they tend to have comparatively higher average numbers of females and ethnic minorities, over time since 2015. We found that larger boards do not have a higher percentage of female board members (in fact they tend to have fewer female board members), but they do tend to have a higher percentage of minority board members when compared to the overall respondents (see **Exhibit 5**). (See **Table 9** for detail by organization size.)

Background of the Organization's Chief Executive & Board Chair

To gain a more complete profile of clinician, administrative, and other leadership positions that participate in governance, we ask questions about the background of the chief executive and board chair. This year, most CEOs have non-profit management or finance expertise (60%), remaining relatively stable since 2017.

Exhibit 3. Female Board Members



The chairperson's background is mostly business/finance in the for-profit sector (49.5%) and other non-clinical/non-healthcare expertise (33.3%), also in line with trends since 2017.

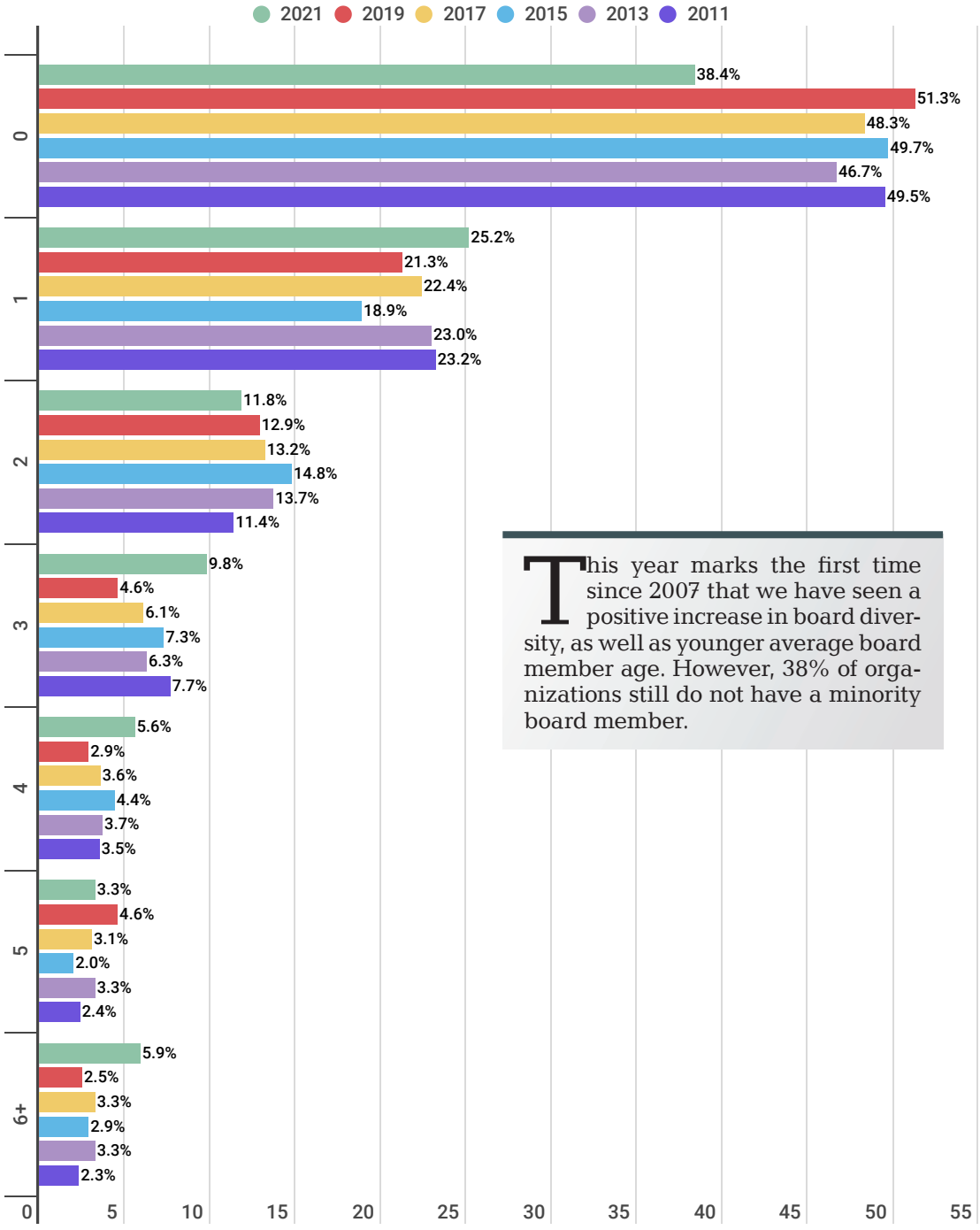
Thirty-nine percent (39%) of respondents' CEOs have a clinical background (physician, nurse, or other), which is up from 35% in 2019. A higher percentage of subsidiary hospitals have a CEO with a clinical background this year (49%). Specifically, 22% of subsidiary hospitals have a nurse CEO. Health systems remain the most likely to have a physician CEO (15%). In contrast, only 10% of respondents have a board chair with any kind of clinical background this year (down from 14% in 2019). (See **Exhibits 6**, **7**, and **8**, 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 is 4.8% (compared with 6.2% in 2019 and 4.2% in 2017). The median age limit is 75, up from 72 in 2019.

The overall average board member age is 58.1 (median 59), which is significantly *younger* than in 2019 (average 69.8; median 72), but in line with 2017

Exhibit 4. Ethnic Minority Board Members



This year marks the first time since 2007 that we have seen a positive increase in board diversity, as well as younger average board member age. However, 38% of organizations still do not have a minority board member.

Exhibit 5. Board Diversity of the Largest Boards Since 2015
(by percentage of total board members)

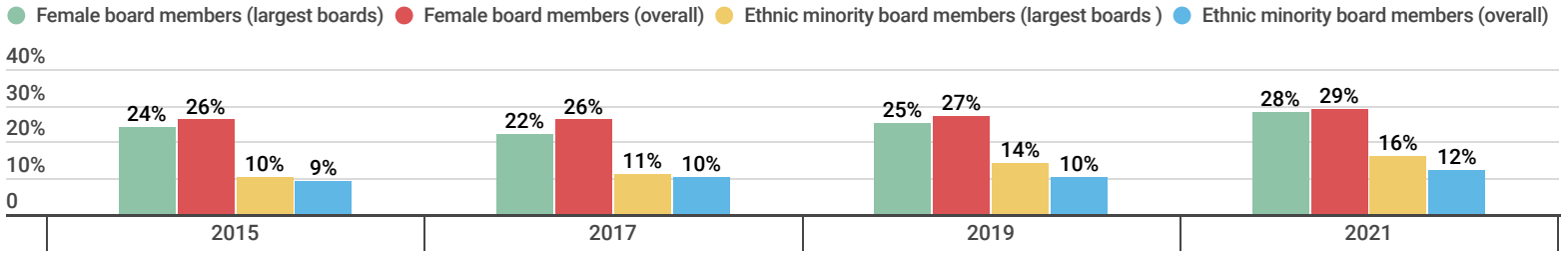


Exhibit 6. Background of the Organization's Chief Executive

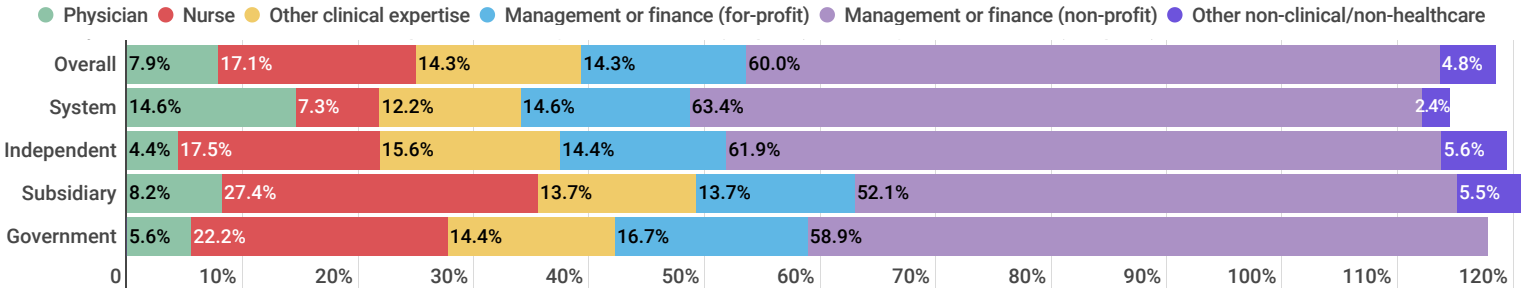


Exhibit 7. Background of the Organization's Chief Executive & Board Chair

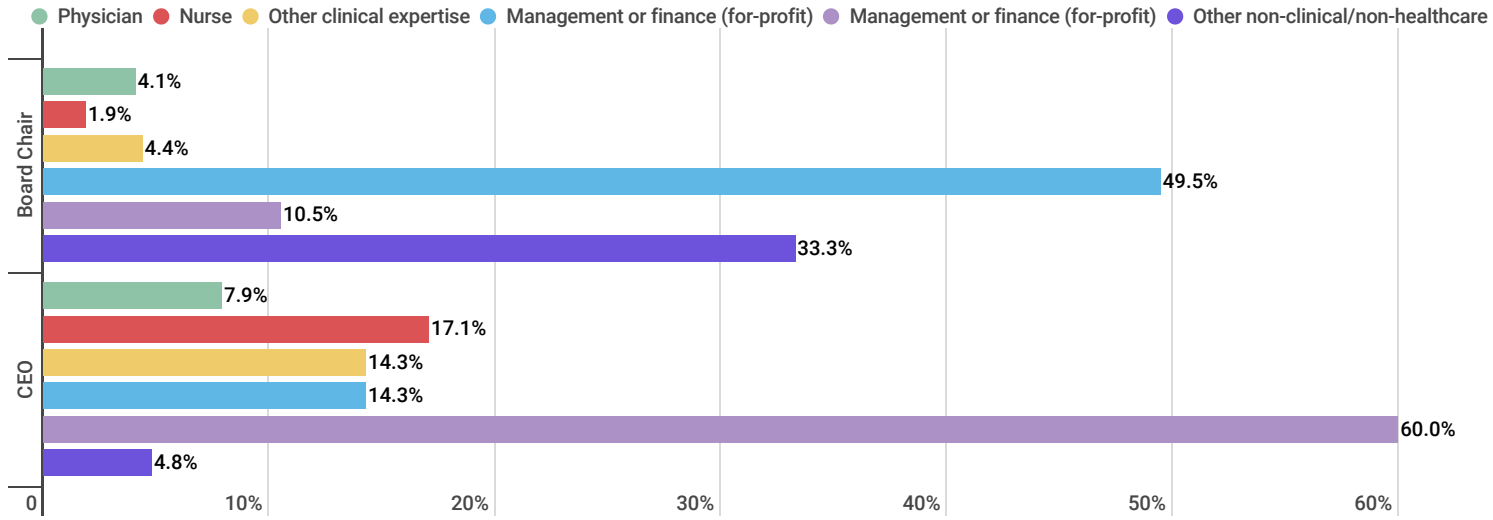
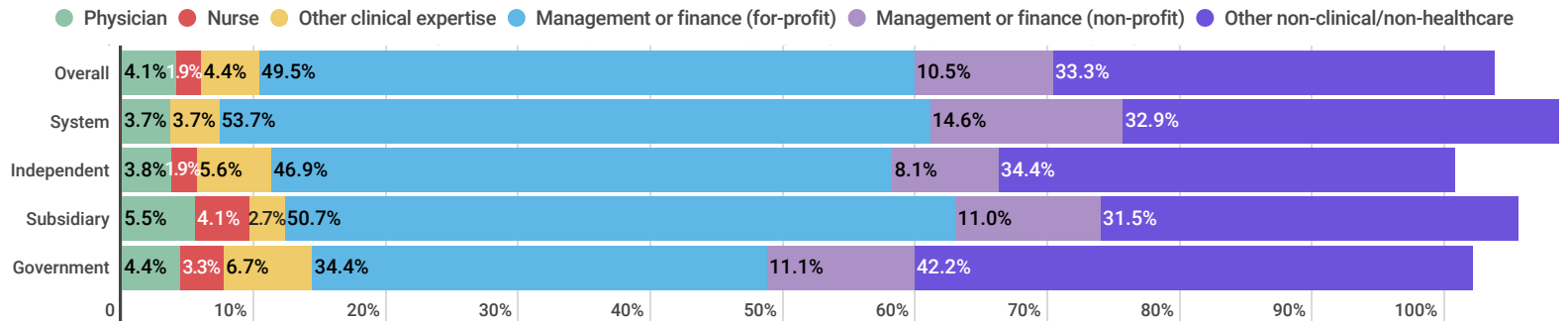


Exhibit 8. Background of the Organization's Board Chair



data (average 57.8; median 58). The range was 40 to 75 years old.

Needed Board Competencies

We asked respondents to identify the top three essential core competencies being sought in the next one to three years for new board members. Strategic planning/visioning, finance/business acumen, and quality/patient safety were overwhelmingly the top three across all types of organizations, although their percentages are lower than in 2019. This year, population health/social determinants/disparities beat out consumer-facing business expertise for the fourth spot (25% vs. 23% respectively; 37% of subsidiary fiduciary boards listed this as a top competency). See **Table 10** 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." This does not mean that "first curve" competencies are no longer needed or less important; however, we consider the second-curve competencies 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.

This year, population health/social determinants/disparities beat out consumer-facing business expertise for the fourth spot (25% vs. 23% respectively; 39% of subsidiary fiduciary boards listed this as a top competency).

Table 10. Top Essential Competencies for New Board Members 2021 vs. 2019
(highest percentage for 2021 in bold for each category)

	Overall		Health System		Independent		Subsidiary Fiduciary*		Subsidiary Advisory*		Government	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Strategic planning and visioning	55.6%	62.7%	50.0%	53.8%	**60.0%**	68.7%	50.8%	42.1%	**60.0%**	42.9%	**60.0%**	70.8%
Finance/business acumen	44.1%	64.3%	43.9%	65.4%	49.4%	65.1%	28.6%	63.2%	**60.0%**	42.9%	**60.0%**	73.0%
Quality and patient safety	40.0%	43.0%	40.2%	28.8%	39.4%	48.2%	39.7%	36.8%	50.0%	42.9%	**51.1%**	49.4%
Population health/ social determinants/ disparities	25.1%	N/A	26.8%	N/A	18.8%	N/A	**38.1%**	N/A	30.0%	N/A	20.0%	N/A
Consumer-facing business expertise	22.9%	28.7%	**24.4%**	32.7%	21.9%	25.3%	23.8%	36.8%	20.0%	57.1%	21.1%	22.5%
Innovation/disruption expertise	13.0%	16.0%	**17.1%**	17.3%	12.5%	13.9%	9.5%	26.9%	10.0%	28.6%	7.8%	5.6%
Clinical practice experience	10.5%	7.4%	12.2%	7.7%	8.1%	7.8%	**14.3%**	0.0%	10.0%	14.3%	7.8%	5.6%
Fundraising	8.9%	11.1%	3.7%	7.7%	11.4%	10.0%	11.1%	15.8%	**20.0%**	14.3%	8.9%	13.5%
IT and social media expertise	8.6%	8.2%	9.8%	13.5%	7.5%	6.0%	9.5%	15.8%	**10.0%**	0.0%	4.4%	5.6%
Change management	8.3%	11.9%	6.1%	7.7%	**12.7%**	10.6%	6.3%	10.5%	0.0%	28.6%	10.0%	10.1%
Digital/mobile health technology expertise	7.3%	8.6%	**14.6%**	21.2%	5.0%	4.8%	4.8%	10.5%	0.0%	0.0%	4.4%	2.2%
Legal	6.7%	8.2%	3.7%	3.8%	9.4%	10.2%	4.8%	5.3%	0.0%	0.0%	**10.0%**	7.9%
Actuarial/health insurance/managed care experience	5.1%	7.8%	**7.3%**	17.3%	3.8%	4.8%	6.3%	10.5%	0.0%	0.0%	1.1%	7.9%
Medical/science/AI technology expertise	4.8%	3.7%	4.9%	5.8%	**5.0%**	3.0%	4.8%	5.3%	0.0%	0.0%	4.4%	2.2%

**Note:* Fiduciary board responses N=91; advisory board responses N=18.

A Broader View of Board Diversity

Kimberly A. Russel, FACHE, CEO, Russel Advisors

SPECIAL COMMENTARY

As our nation's hospitals and health systems face previously unimaginable challenges, the highest level of governance effectiveness and execution is crucial. Composition of the governing body is foundational to strong board performance. Governance-level decision making is vastly improved when the board is composed of directors with a variety of professional and personal backgrounds, competencies, and perspectives. A board is less likely to miss key considerations or potential opportunities if board composition is broadly diverse. The 2021 survey data reveal the first signs of progress in governance diversity (62% of boards have at least one member from an ethnic minority, up from 49% in 2019, and the median number of women on boards went from 3 to 4 this year)—with a caution that healthcare boards still have much more to accomplish.

The 2021 survey data reveal the first signs of progress in governance diversity (62% of boards have at least one member from an ethnic minority, up from 49% in 2019, and the median number of women on boards went from 3 to 4 this year).

The Governance Committee: Robust Work Ahead

The governance committee (sometimes referred to as governance/board development or governance/nominating committee) must become more active in formulating an effective board recruitment strategy that is organization-specific and contributes to the board's vision of the future. Successful governance committees will create an ongoing, long-term strategy to fulfill the goal of a diverse board. This should be exciting work for engaged governance committees—it is an opportunity to influence the board via its composition for many years into the future.

Governance committees should have a broader view than simply sourcing names to fill today's vacancies on the board. Governance committees must have a deep understanding of the organization's strategies and vision. Armed with this information, the committee must thoughtfully envision the organization's needs over the next one to three board terms and then adapt its board recruitment strategy accordingly.

Governance committees should also expect active participation from the CEO. CEOs must be highly involved in identifying potential board talent for consideration by the governance committee. CEOs often have access to community members from population segments that are outside of the business and social circles of existing board members. CEOs should consider every community engagement as an opportunity to spot potential directors.

Some boards have reported success with a "grow your own strategy" of board recruitment. Individuals with both potential and specific expertise are invited to serve as a non-voting member of a board committee. Alternatively, potential board members may be identified from service on an advisory board or foundation board.

Governance committees may also wish to consider adding a director with experience leading an organization that is immersed in attacking one or more key social determinants of health. For example, leaders of human service organizations can bring unique insights to a board, along with connections to different segments of the community.

Finally, it is pressing business to diversify the boards of healthcare organizations—but governance committees must remember that the objective is to recruit individuals with needed competencies and diverse backgrounds/viewpoints, to fill a board that is the ideal size to encourage engagement and sound decision making.

Board Size: A Potential Engagement Accelerator

Board size is a significant driver of board engagement—either positively or negatively. Board size is a balancing act. A board that is too small risks group-think due to limited variety in perspectives; one that is too large risks fragmentation, with sub-groups forming and unequal levels of participation in the boardroom.

Board size can also impact recruitment, in that experienced directors with key competencies may be more attracted to service on smaller boards on which each director's voice and vote carries more influence. Providing all board members sufficient airtime for full participation during meetings can lead to deeper levels of engagement. Board size has fluctuated, with past surveys showing an average board size of 12–14 members.

Board size at health systems remains a concern, although there is progress from 2019 to 2021 (decreasing from 16.5 to 15.3 members). With larger boards, full engagement of all members is difficult. Engagement of a large board through the course of a virtual board meeting is especially challenging. Eager new directors may be disappointed in the board service experience if it is difficult to fully participate with so many voices around the table. Even reducing the size by one or two members can make a difference.

In most cases, it is preferable to downsize the board over time. As vacancies occur due to term limits and other natural turnover, consider leaving seats vacant rather than rushing to fill each opening. As a director approaches the end of a term, have a conversation to determine the director's availability and interest in another term rather than assuming he or she wishes to continue to serve.

Clinicians on Board

This year's survey results show a sliver of progress adding physicians to boards (2.2 physician directors on average, compared to 1.7 in 2019). Although there is certainly no "right" or "wrong" number of physicians, some boards may be missing the strategic benefits of physicians in the boardroom.[1] Government hospitals, often constrained by required appointment or election processes, have the lowest level of physician director participation. Of deeper concern are independent hospitals, which also report a very low level of physicians at the governance level.

Although physician directors usually add profound expertise in quality, patient safety, and medical staff credentialing, effective boards seek expanded contributions from physician directors. For example, physician directors contribute additional nuance to merger and acquisition discussions. Some physicians (depending on their medical specialty) bring a specific competency in biomedical ethics to the board.

> The objective is to recruit individuals with needed competencies and diverse backgrounds/viewpoints, to fill a board that is the ideal size to encourage engagement and sound decision making.

Physicians who are actively practicing medicine often have firsthand insight into the impact of social determinants of health on population health and medical outcomes. Practicing physicians will likely have more daily contact with individuals in differing socioeconomic circumstances than most other directors. These factors are additive to a board's strategic discussions and decisions.

Nurses on boards also provide similar contributions to governance decision making. However, board members with a nursing background are still scarce. In 2021, the average is 0.52 nurses per board compared to 0.40 in 2019. Adding nursing expertise to a healthcare board is another critical governance diversification strategy.

To further broaden clinical expertise on the board, governance committees should also consider prospective directors from other backgrounds such as pharmacy, public health, mental health, and physical therapy.

Independence

Another area for governance committee attention is recruitment of directors who meet the Internal Revenue Service guidelines for independence, which require that boards maintain a majority of independent board members. The survey revealed that all categories of hospitals and health systems, except independent hospitals, contain slightly fewer independent members (from 78% to 75%) compared to 2019, although all boards are still doing a good job of maintaining that majority. Independence is a hallmark of successful boards and an essential ingredient for board credibility with external sources such as regulators, elected officials, and the media.

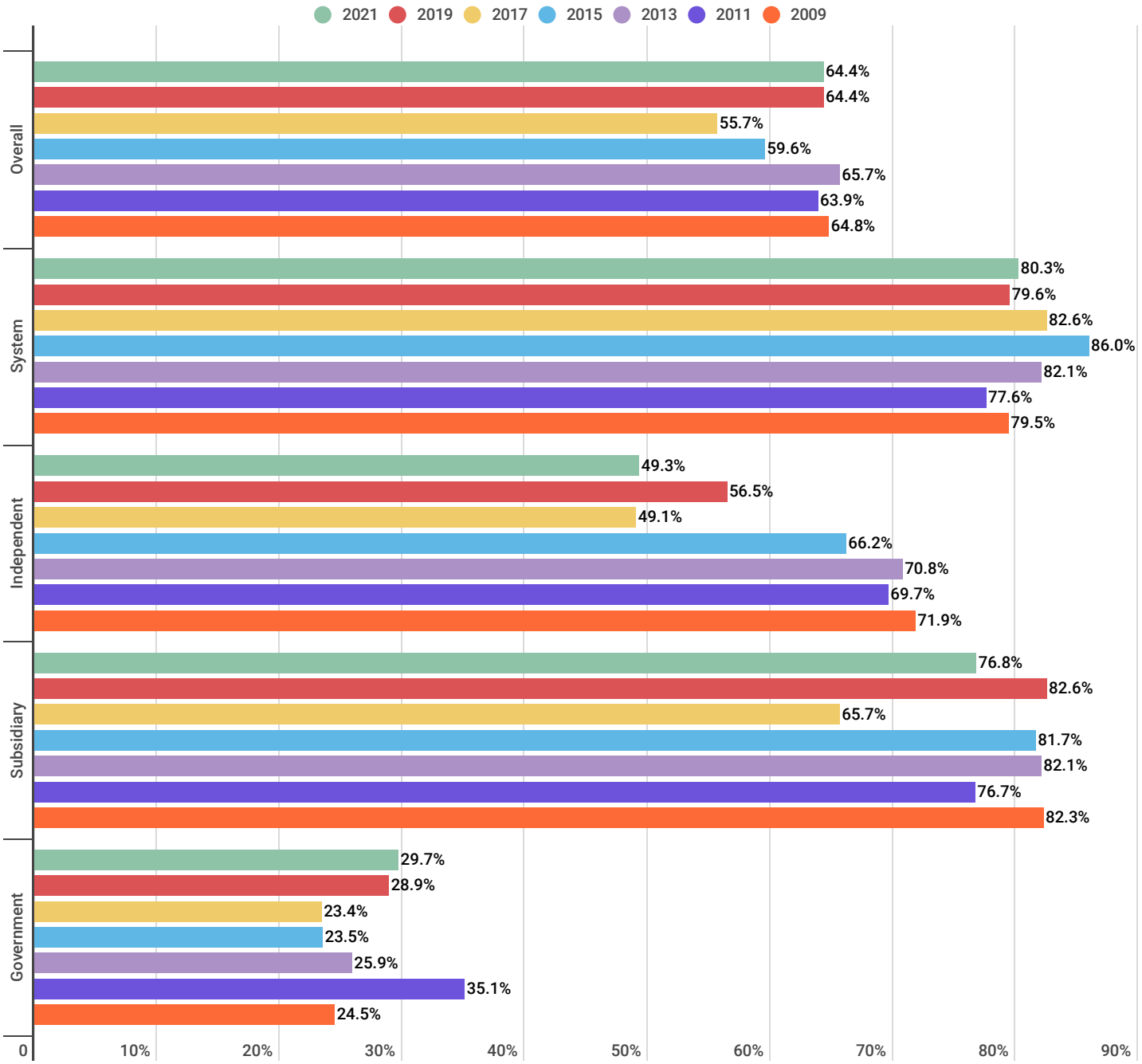
Continued Momentum Needed

It is encouraging that the 2021 survey reveals the first uptick in diversity in the boardroom since 2007. Another bright spot is that the average age of board members in 2021 is 58.1—12 years younger than 2019. Intentional efforts to bring diversity to healthcare governance are beginning to work. However, much work remains for governance committees.

Governance committees have a full agenda—first, to define future governance needs, and next, to clearly identify potential gaps in competencies and diversity. Then the hard work begins: crafting an effective board recruitment strategy that will provide governance leadership in the highly unstable world of healthcare.

1 Kimberly A. Russel, *The Voices of Physicians on Your Board: Maximizing a Hidden Asset,* The Governance Institute, 2020.

Exhibit 9. Limits on the Maximum Number of Consecutive Terms



Defined Terms of Service

SUMMARY OF FINDINGS

64% of boards limit the number of consecutive terms (same as in 2019); median maximum number of terms is three. Systems and subsidiaries again are more likely to have term limits.

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

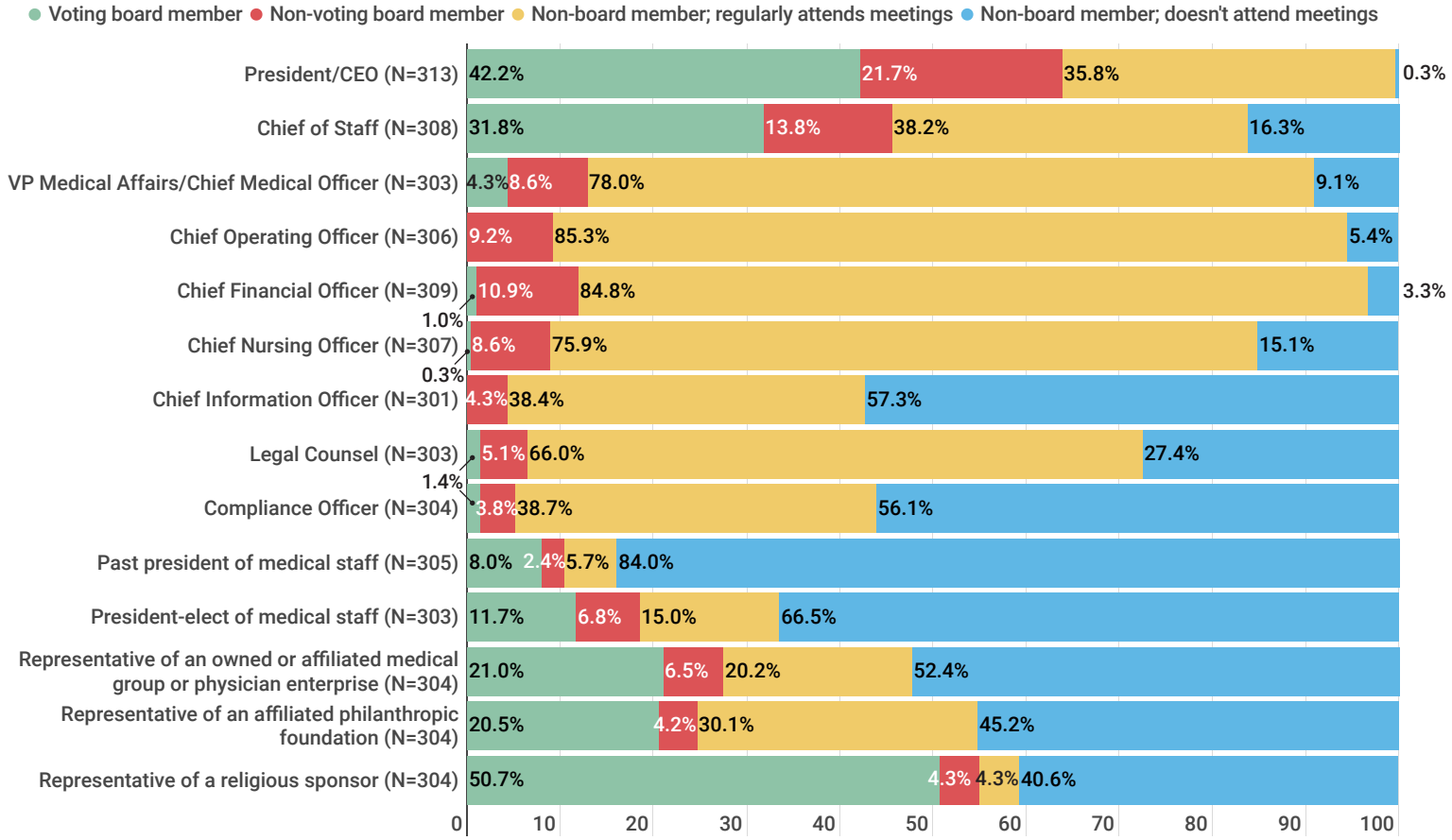
- Systems—80% (→)
- Independent hospitals—49% (↓)
- Subsidiary hospitals—77% (↓)
- Government-sponsored hospitals—30% (↑)

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 (69%). We are now seeing a rising trend in government-sponsored hospital boards having term limits: this year it is at 30%, up from 29% in 2019 and 23% in 2017. Most organizations that do have term limits constrain board members to three consecutive terms. (See **Exhibit 9**.)

This year's correlation analysis shows that those with term limits are 37% more likely to cite "excellent" performance in the fiduciary duties and core responsibilities in the Governance Practices section of this report.

Exhibit 10. Participation on the Board

(includes only organizations where specific job titles apply)



Participation on the Board

SUMMARY OF FINDINGS

- President/CEO:
  - Voting board member: 42% (up from 40% in 2019 but down from 48% in 2017)
  - Non-voting board member: 22% (up from 18% in 2019)
  - Non-board member; regularly attends meetings: 36% (down from 42% in 2019)
- Chief of staff:
  - Voting board member: 32% (up from 25% in 2019; 33% in 2017)
  - Non-voting board member: 14% (same as in 2019)
  - Non-board member; regularly attends meetings: 38% (same as in 2019)

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 10**; more detail can be found in **Appendix 1**). Board participation (voting vs. non-voting and non-members regularly attending board meetings) has remained generally the same overall since 2011. In general, most members of senior management are not board members but regularly attend meetings. Notable differences this year include:

- There is a consistent upward trend of more respondents having a voting chief of staff/president of the medical staff on the board. A slightly higher percentage of respondents assign this position as a non-member who regularly attends meetings.
- 76% of respondents have the CNO regularly attend board meetings as a non-board member (down from 78% in 2019).

Variances by Organization Type

- Health system and subsidiary boards again are more likely to have a voting CEO (70% and 59% respectively, vs. 69% and 62% in 2019).
- In contrast, government-sponsored hospitals tend to have the lowest percentage of voting CEO board members (7% this year vs. 8% in 2019).
- For independent hospitals, the percentage with a voting CEO has declined the most since 2017, from 40% to 20% this year.
- Subsidiaries have the highest percentage of voting chiefs of staff compared with other types of organizations (47%, up from 36% in 2019); for health systems, this position is more likely to be a non-board member who regularly attends meeting (53%).
- 83% of government-sponsored hospitals have the CNO attend board meetings regularly, compared with 76% overall.
- 20% of subsidiary boards do not have the CNO attend regularly (compared with only 8% in 2019).
- A majority of organizations do not have the compliance officer attend meetings regularly (consistent with 2019) although government-sponsored hospitals are more likely to have the compliance officer attend (50%); while most boards have legal counsel attend regularly, 41% of independent hospital boards do not have legal counsel attend regularly.

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 2019, in either direction. Most notable is an increase in organizations having a CIO, along with significantly more legal counsel presence in the boardroom. (See **Appendix 1** for a breakdown by organization type and size.)

Forty percent (41%) of respondents have an owned or affiliated medical group or physician enterprise (vs. 43% in 2019 although this is still significantly higher than in prior years); of those, 20% have a representative from this group as a voting member of the board (51% of systems have a physician group this year, which is the highest of any type of organization). Largely these numbers remain the same as 2019.

Table 11. Frequency of Position & Board Participation 2021 vs. 2019

	% of respondents with this position		% of respondents noting presence in boardroom		% of respondents noting board member (voting and non-voting)	
	2021	2019	2021	2019	2021	2019
CFO	98.1%	97.5%	96.7%	97.4%	11.9%	9.2%
CNO	94.8%	93.8%	84.9%	85.5%	8.9%	7.9%
Compliance Officer	94.4%	93.4%	43.9%	44.9%	**5.2%**	3.0%
Legal Counsel	71.0%	69.2%	**72.6%**	62.6%	6.5%	7.2%
CIO	**70.1%**	65.7%	42.7%	42.0%	4.3%	3.8%
VPMA/CMO	**69.0%**	63.8%	**90.9%**	88.3%	12.9%	11.8%
COO	60.1%	61.8%	94.6%	97.4%	9.2%	8.8%

Board Meetings

SUMMARY OF FINDINGS

- Most boards meet 10–12 times a year (54%).
- 54% of responding organizations' board meetings are two to four hours (vs. 59% in 2019); 37% are less than two hours (vs. 33% in 2019).
- 82% of responding organizations use a consent agenda at board meetings (part of an overall increasing trend from 62% in 2007).
- 59% have scheduled executive sessions (vs. 72% in 2019); of these, 66% said executive sessions are scheduled for all or alternating board meetings (vs. 62% in 2019).
- 88% said the CEO attends scheduled executive sessions always or most of the time (vs. 91% in 2019); 41% said physician and nurse board members attend scheduled executive sessions always or most of the time (vs. 45% in 2019).
- The top three topics typically discussed in executive session were executive performance/evaluation (81%), executive compensation (65%), and miscellaneous governance issues (42%).
- On average, 58% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports (about the same as in 2019); 29% to active discussion, deliberation, and debate about strategic priorities (down from 31%); and 12% to board education (the same as in 2019 and 2017).
- 79% of responding organizations have annual board retreats (vs. 50% in 2019); 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 and governance support staff to attend board retreats.

90% of health systems have a system-level CMO/VPMA compared with 70% overall. This is contrasted with government-sponsored hospitals, 46% of which have this position. The assumption, then, is that government-sponsored hospitals rely more on leadership and information provided by the chief of staff/medical staff president at board meetings. However, 26% of government hospitals do not have the chief of staff attend meetings regularly.

Board Meeting Frequency & Duration

Most boards continue to meet from 10 to 12 times per year (54%; down from 65% in 2019 and 59% in 2017). (See **Exhibit 11**.) Meeting duration is around the same this year; it tends to be concentrated in the two- to four-hour range (54%) and the next largest group meets for less than two hours (37%; up from 33% in 2019). (See **Appendix 1** for detail on meeting frequency and duration.)

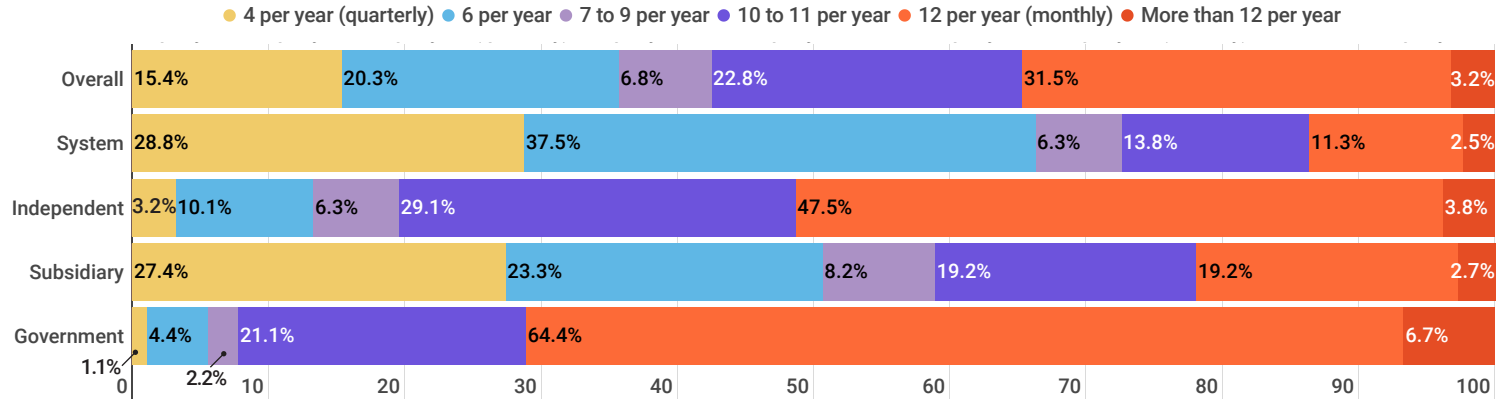
Some differences by organization type include:

- Most system boards meet six times per year (38%); the next highest category is quarterly at 29%. (We tend to see that system boards meet less frequently than other types of boards.)
- Subsidiaries are also more likely to meet only quarterly (27%) or six times per year (23%) than independent and government-sponsored hospital boards.
- 86% of government-sponsored hospital boards meet 10–12 times per year, consistent with the trend.
- While most boards meet for two to four hours, 46% of independent and 48% of government-sponsored hospital boards meet less than two hours.

In general, the more meetings boards have, the shorter the meetings are:

4 per year	**4.4 hours**
6 per year	**4.1 hours**
7–9 per year	**3.5 hours**
10–11 per year	**3.1 hours**
12 or more	**3.0 hours**

Exhibit 11. Number of Board Meetings Per Year



Consent Agenda & Executive Session

Eighty-two percent (82%) of respondents said the board uses a consent agenda, which has risen steadily from 62% in 2007. (See **Exhibit 12**.) The percentage of respondents with scheduled executive sessions is only 59% this year (compared with 72% in 2019, 74% in 2017, and 65% in 2015). (See **Exhibit 13**.)

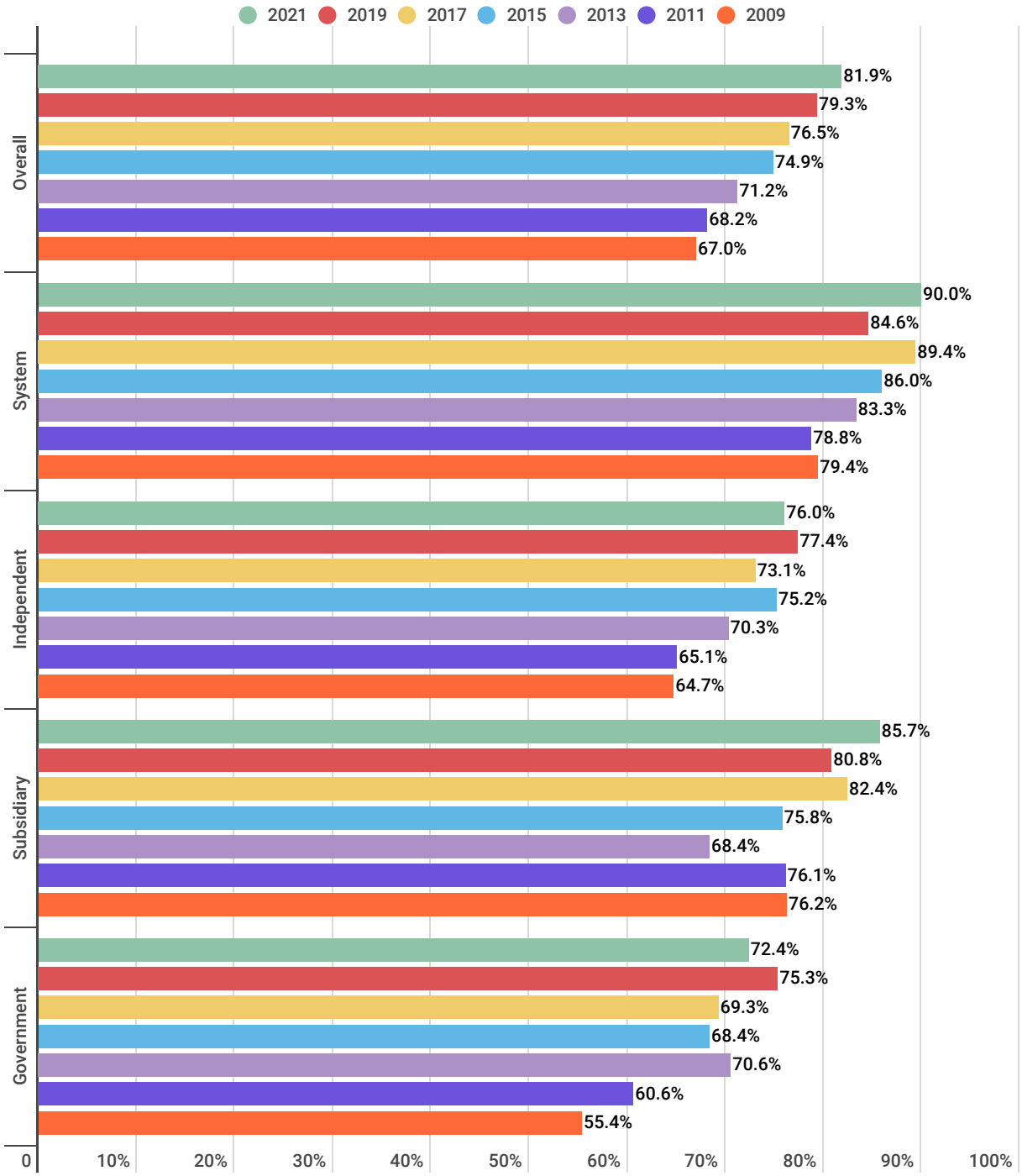
Since 2009, most respondents continue to schedule executive sessions after or before every board meeting.

We asked who typically attends scheduled executive sessions. Eighty-eight percent (88%) of respondents with scheduled executive sessions said the CEO attends always or most of the time; 41% said clinician board members attend always or most of the time (vs. 52% of system boards); and 41% said legal counsel attends always or most of the time (vs. 53% of system boards). (See **Exhibit 14** and **Appendix 1**.)

Topics typically discussed in executive session are largely homogenous across all types of boards. The top four are:

- Executive performance/evaluation (81%)
- Executive compensation (65%)

Exhibit 12. Use of Consent Agendas Since 2009



- Miscellaneous governance issues (42%)
- General strategic planning/issues (39%)

Government-sponsored hospitals are more likely to discuss clinical or quality performance in executive session (41%) than other types of boards, and system boards are more likely to discuss executive succession planning (54%) and board performance and evaluation (47%) in this venue.

Board Meeting Content

While we recommend that boards spend half or more of their meeting time in active discussion, deliberation, and debate about the organization's strategic priorities, boards continue to devote more than half of their meeting time (58% on average) to hearing reports from management and board committees. This remained the same from 2019 although has decreased from 66% in 2017. Overall, 7% of boards spend 50% or more of their meeting time in active discussion of strategic priorities (13% of health system boards). Quality and finance are given more equal discussion time than in prior years.

The overall breakdown of how meeting time is allocated is as follows:

- Active discussion, deliberation, and debate about strategic priorities of the organization: 29.4%
- Reviewing reports from management, board committees, and subsidiaries (excluding financial and quality/safety): 20.9%
- Reviewing financial performance: 18.8%
- Reviewing quality/safety performance: 18.5%
- Board member education: 12.3%

Meeting time spent discussing strategic priorities is 29% 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 15**.)

Exhibit 13. Scheduled Executive Sessions Since 2009

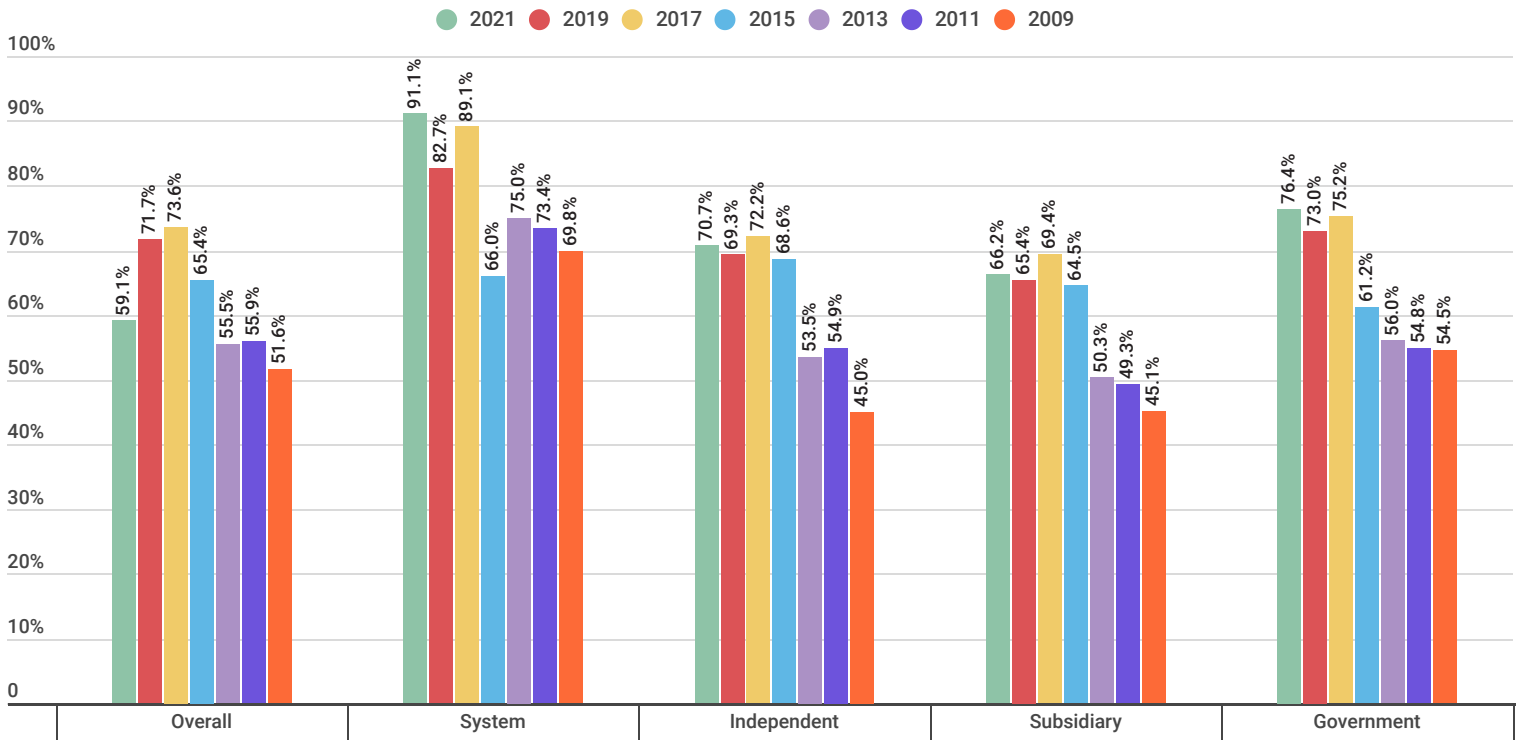
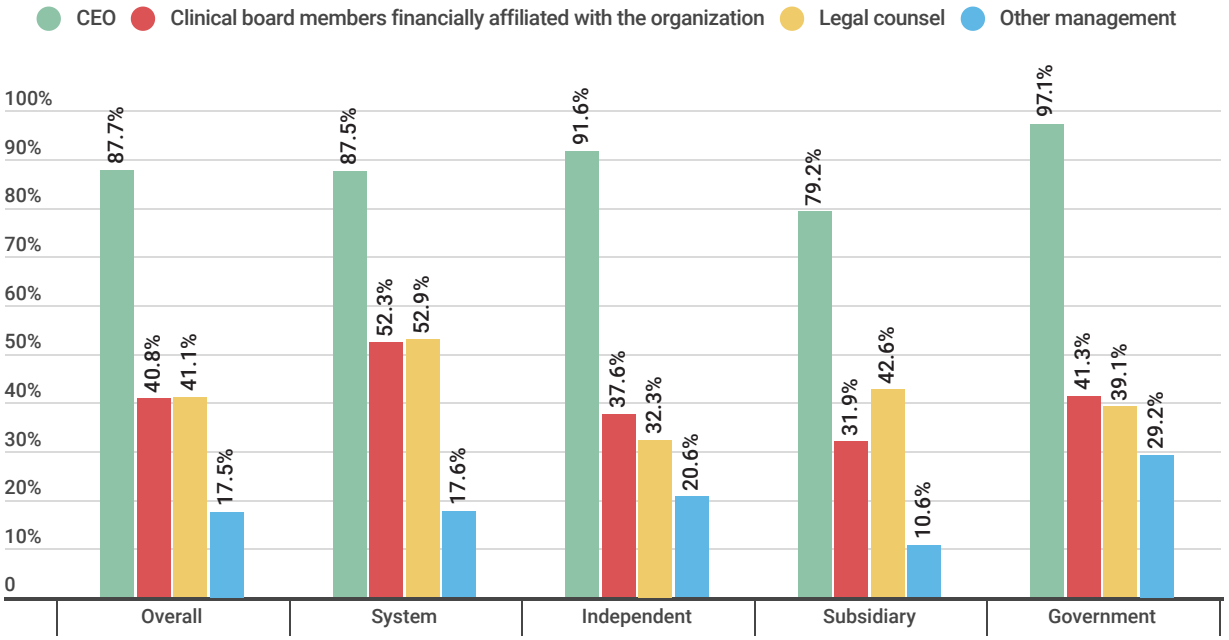


Exhibit 14. Who Attends Scheduled Executive Sessions
(always or most of the time)



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 (36%, up from 34% in 2019 and 31% in 2017). Independent hospital boards have slightly less balance between time spent on finance (21%) and quality (17%).

Eighty-one percent (81%) of responding boards spend *40% or less* of the time during their board meetings on strategy (see **Exhibit 16**). We emphasize this because several prior surveys have shown 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." However, we recognize that between 2019 and 2021, the coronavirus pandemic presented a critical barrier to boards being able to spend as much time on strategy than they otherwise might under "normal" circumstances.

Board Retreats

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, although this year independent hospital boards were more split: 47% have an annual retreat and 35% have one less often than annually (this could be due to the coronavirus pandemic). The CEO, CNO, and other C-suite executives (not including the CMO) are again most likely to attend in addition to board members. All types of boards show an increase from 2019 in having governance support staff and medical staff physicians attend retreats. (See **Appendix 1** for more detail; this has remained the same as or similar to 2017.)

Exhibit 15. Average Percentage of Board Meeting Time Devoted to Reports, Strategy, & Education

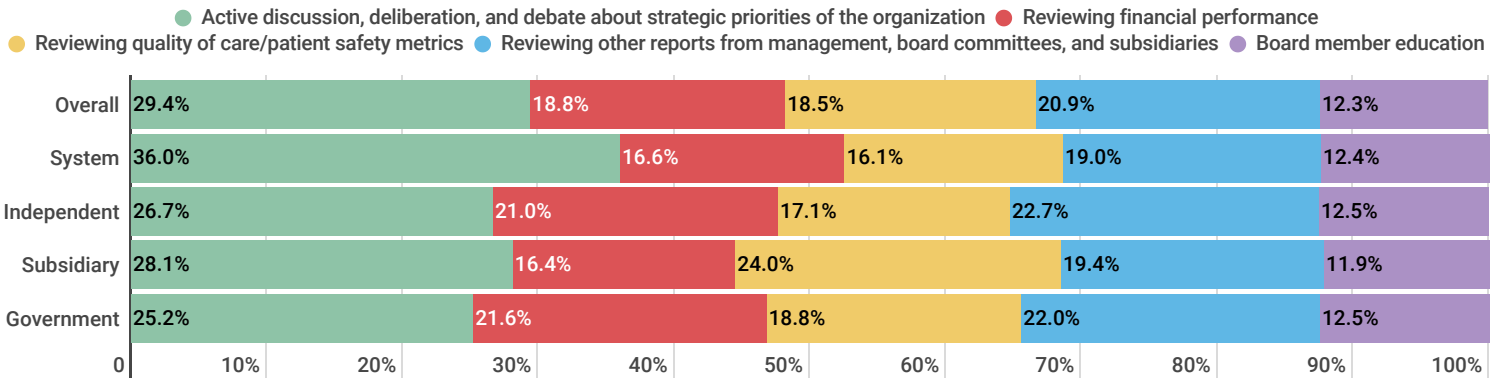
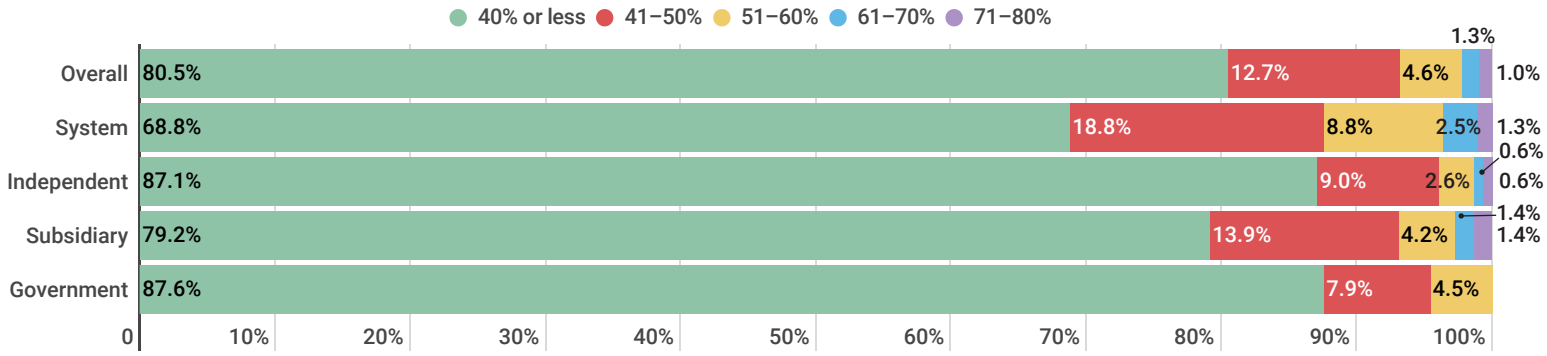


Exhibit 16. Percentage of Board Meeting Time Spent in Active Discussion, Deliberation, & Debate on Strategic Priorities of the Organization



Board Committees

SUMMARY OF FINDINGS

- 3.6% of the respondents do not have board committees (down from 5.7% in 2019).
- Average number of committees is 8.0 (about the same).
- Median remains 7.
- Most prevalent committees are the same as in 2019 (seven committees for more than 50% of respondents): finance (85%), quality (81%), executive (79%), executive compensation (64%), governance/board development (64%, up from 58% in 2019), strategic planning (57%), and audit/compliance (54%).
- Only the governance/board development committee increased in prevalence this year compared with 2019 for all respondents.
- Several committees decreased in prevalence overall compared with 2019: physician relations, investment, facilities, construction, and human resources.

Most respondents (96%) noted their board has one or more committees. Independent hospitals have the most committees (average of 8.5) and government and subsidiary hospitals have the fewest (7.4). (See **Exhibit 17**.)

Overall, there has been little change in the prevalence of specific types of board committees. Only one committee increased significantly in prevalence this year compared with 2019 for all respondents: governance/board development (64% vs. 58% in 2019). We hope this reflects a recognition in the importance of board performance. We are anticipating seeing more significant increases in population/community health improvement and community benefit committees in coming years.

However, going in the right direction, we see a decrease in the types of committees that are better suited to operations and/or *ad hoc* purposes: facilities, construction, and human resources.

There were some differences in committee prevalence for certain types of boards. For example, more health system boards this year have a quality committee (90% vs. 86%) and an executive compensation committee (79% vs. 73%). Independent hospital boards are more likely to have a strategic planning committee this year (63% vs. 59%).

New Committees

Reflecting recent industry trends, we asked this year about prevalence and meeting frequency for innovation/transformation and diversity/inclusion committees. Fourteen percent (14%) of respondents have an innovation committee, which tends to meet as needed for 73% of those respondents. Seventeen percent (17%) have a diversity and inclusion committee, which also meets as needed for 51% of those respondents.

We recognize that between 2019 and 2021, the coronavirus pandemic presented a critical barrier to boards being able to spend as much time on strategy than they otherwise might under "normal" circumstances.

Exhibit 17. Number of Board Committees

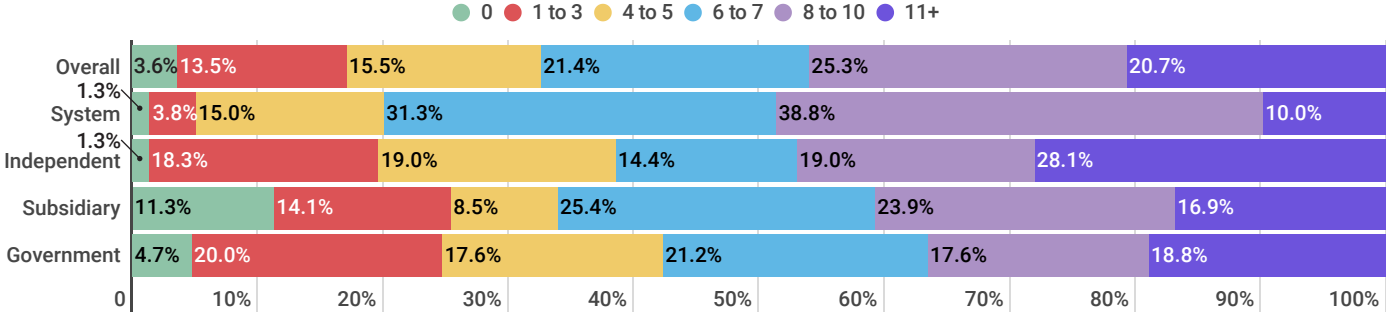


Table 12. Prevalence of Board Committees

Committee	2021	2019	2017	2015	2013
Finance	85%	83%	81%	84%	76%
Quality/Safety	81%	80%	77%	74%	77%
Executive	79%	73%	75%	72%	77%
Executive Compensation	64%	62%	60%	66%	60%
Governance/Board Development	64%	58%	59%	72%	77%
Strategic Planning	57%	55%	52%	57%	57%
Audit/Compliance	54%	53%	38%	51%	34%
Investment	41%	45%	44%	40%	35%
Audit	40%	44%	38%	33%	32%
Compliance	38%	42%	48%	28%	33%
Joint Conference	35%	37%	34%	35%	40%
Facilities/ Infrastructure/ Maintenance	26%	31%	27%	23%	25%
Physician Relations	23%	31%	22%	21%	19%
Community Benefit	29%	29%	24%	26%	18%
Human Resources	24%	28%	25%	22%	20%
Population Health/ Community Health Investment	21%	23%	18%	NA	NA
Construction	20%	24%	17%	17%	9%
Government Relations/Advocacy	18%	18%	14%	13%	9%
Diversity/Inclusion	17%	NA	NA	NA	NA
Innovation/ Transformation	14%	NA	NA	NA	NA

Table 12 shows the prevalence of board committees since 2013 (most prevalent committees for 2021 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 overall number of organizations reporting a board-level quality/safety committee is about the same as in 2019; system and subsidiary boards made the biggest leap this year. Comparisons by organization type can be found in Table 13.

As we recommend, quality committees continue to meet primarily monthly (for 41% of respondents); 35% meet quarterly.

The average quality committee has 11.8 people and the most common types of positions on this committee include:

- Voting physician board members (79% have between one and four)
- Physicians from the medical staff (employed and non-employed but non-board members; 68% have between one and four, up from 56% in 2019)
- Nurses from the nursing staff (60% have at least one, up from 51% in 2019)
- Voting nurse board members (53% have between one and four, up from 41% in 2019)
- Voting board members who are not physicians (45% have between one and three and 48% have four or more)
- Community members at large (49% have between one and four)

This year's correlation analysis shows that boards whose quality committees meet more frequently (monthly, bi-monthly, or quarterly) are 63% more likely to have adopted all of the quality oversight practices in the Governance Practices section of this report.

The Executive Committee

Seventy-nine percent (79%) of respondents said their board has an executive committee (up from 73% in 2019) and this committee meets "as needed" for 45% of those respondents (26% meet monthly). For more than half of those with an executive committee, responsibilities include emergency decision making (72%), advising the CEO (71%), decision-making authority between full board meetings (66%, up from 61% in 2019), and executive compensation (50%). (For detail, see **Appendix 1**.)

Forty-one percent (41%) of executive committees have full authority to act on behalf of the board on all issues (up from 33% in 2019). Thirty-two percent (32%) have some authority to act on certain issues, and for 27% 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 (47%, up from 44% in 2019).
- Executive committees of government-sponsored hospitals have the least amount of authority (27% have full authority, although this is up from 15% in 2019). For 47% of this group, all decisions must be approved by the full board.

Table 13. Organizations with a Board Quality Committee

	2021	2019	2017	2015	2013
Overall	81%	80%	77%	74%	77%
Systems	89%	86%	82%	84%	85%
Independent Hospitals	78%	80%	72%	80%	80%
Subsidiary Hospitals	78%	69%	87%	81%	86%
Government-Sponsored Hospitals	76%	79%	66%	58%	60%

Exhibit 18. Responsibilities of the Executive Committee

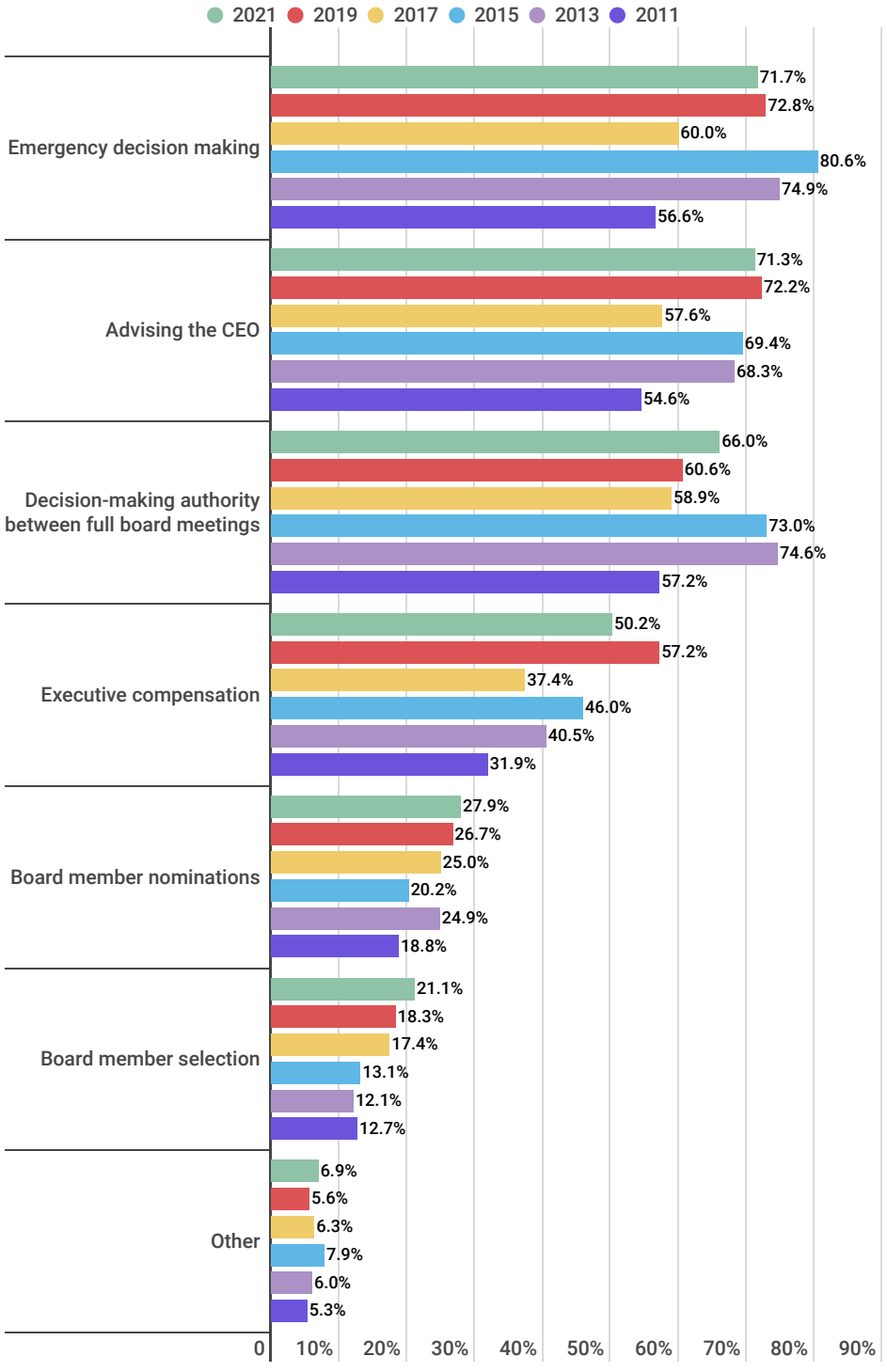
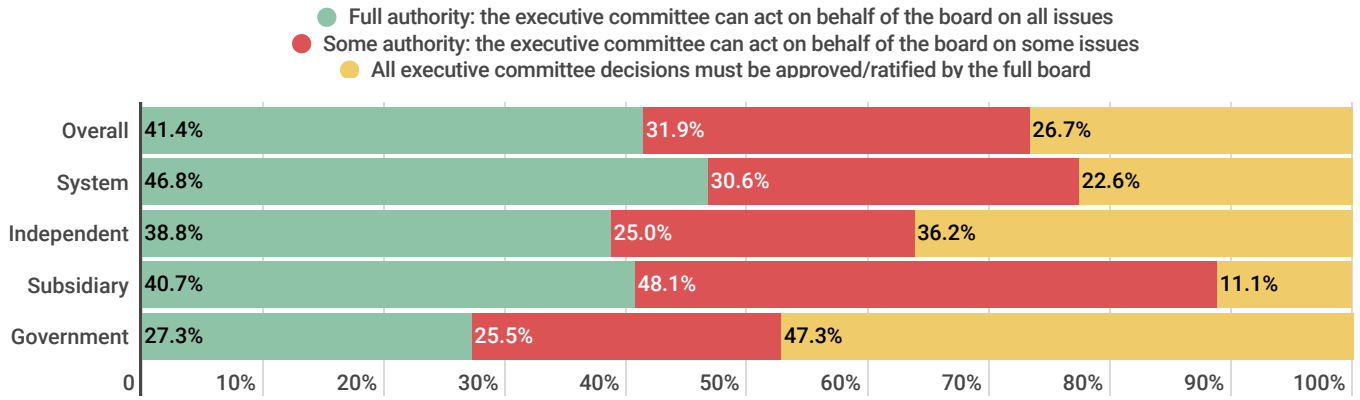


Exhibit 19. Level of Authority of Executive Committee



Board Member Compensation

SUMMARY OF FINDINGS

- Overall, 11% of respondents compensate at least some board members, which has remained stable since 2009.
- 13% of respondents compensate the board chair (the same as in 2019), although the amount of compensation is slightly higher this year (42% compensate board chairs less than $5,000, down from 81% in 2019; 11% compensate between $5,000–$10,000 and 47% compensate over $10,000).
- 11% compensate other board officers, and 10% compensate board committee chairs. The majority (53–56%) compensate these positions for less than $5,000.
- 12% said other board members (non-chairs/officers) are compensated (vs. 7% in 2019 and 11% in 2017), and 50% of these said compensation is less than $5,000 (vs. 93% in 2019 and 63% in 2017). 44% compensate other board members between $5,000–$40,000, and 6% compensate these board members at $50,000 or above.
- 56% of the largest systems (2,000+ beds) compensate the board chair, and for 80% of those, compensation is $50,000 or above. This group also has significantly higher frequency and rates of compensation for the other categories of board members and officers as well, in contrast with 2019 results that showed this group of systems only compensating their board chairs but not other board members, chairs, or officers.
- Government-sponsored hospitals continue to be more likely to compensate board members than other types of organizations (20% compensate the board chair, 18% compensate other board officers, 14% compensate board committee chairs, and 19% compensate other board members). For all of these categories, the vast majority (71% or above) compensate for less than $5,000.

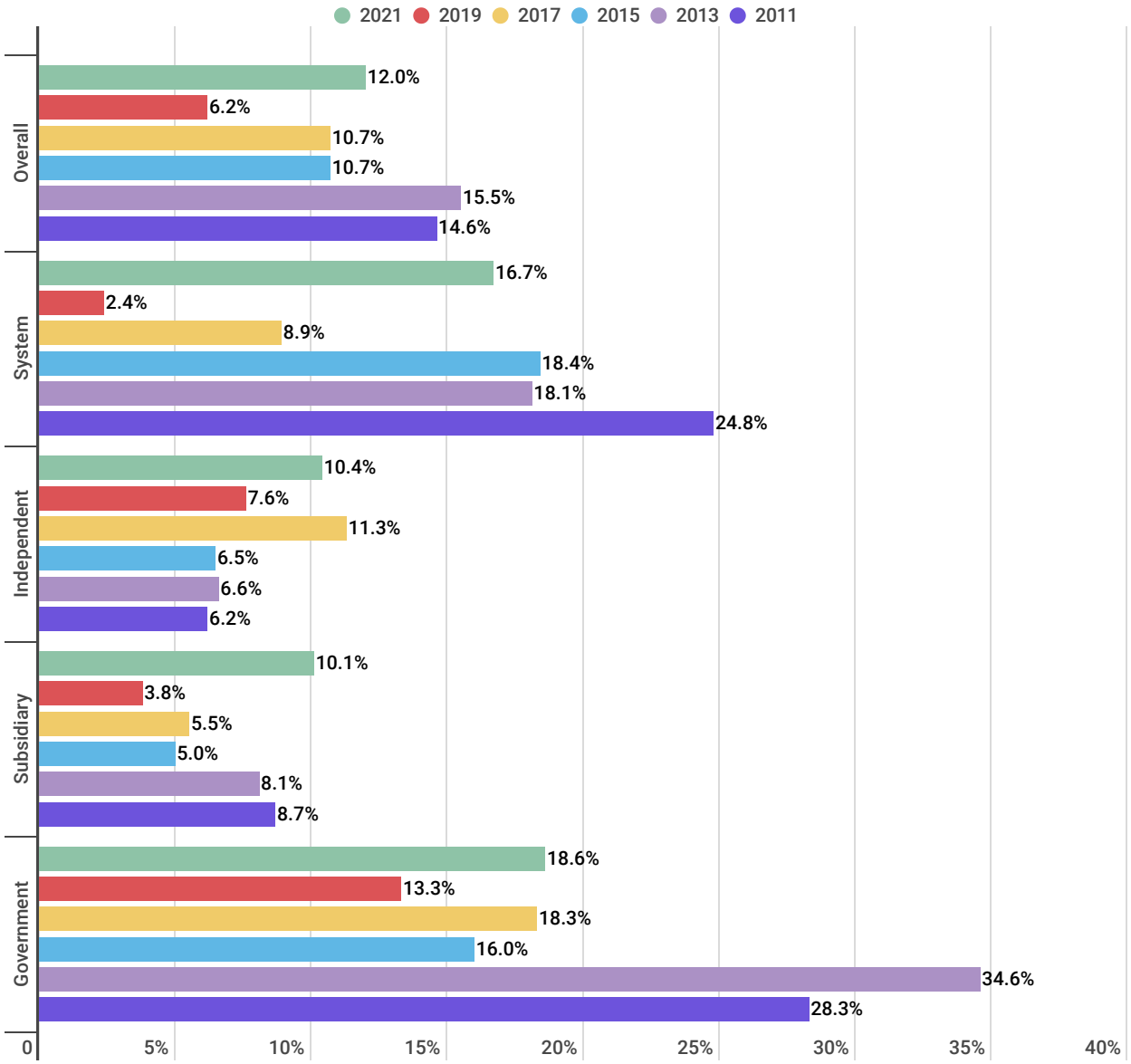
Overall, the trend shows that the prevalence of boards that are compensated remains flat (the trend from 2011–2017). The primary difference in the data this year is that the amount of compensation has gone up and is more varied across types of organizations. Government-sponsored hospitals are more likely than others (18%) to compensate board members (chairs, committee chairs, and other directors), which is consistent with prior years. Health systems are the second largest group by organization type to compensate board members, at 14%. (See Exhibit 20 and Table 14.)

While health systems remain more likely to compensate their board members at higher rates (42% of the health systems that compensate pay $50,000 or more to their board chairs, for example), at least 50% or more among the other types of organizations compensate board members (including chairs) at a rate of less than $5,000. However, this year more subsidiaries and independent hospitals are showing higher compensation levels (between $5,000–$30,000) than in prior years. (For detail, see Appendix 1.)

Table 14. Percentage of Organizations that Compensate the Board Chair

	2021	2019	2017	2015	2013	2011
Overall	**12.6%**	**7.1%**	**12.2%**	**11.1%**	**11.8%**	**12.0%**
Systems	15.2%	7.1%	10.6%	18.0%	17.5%	21.3%
Independent Hospitals	12.3%	7.6%	12.8%	6.5%	5.8%	5.2%
Subsidiary Hospitals	10.1%	3.8%	6.6%	4.9%	6.2%	7.1%
Government-Sponsored Hospitals	19.8%	12.0%	18.3%	17.8%	23.5%	22.9%

Exhibit 20. **Percentage of Organizations that Compensate Other Board Members**
(excluding chairs/officers)



Annual Expenditure for Board Member Education

SUMMARY OF FINDINGS

- 33% of respondents spend $30,000 or more annually for board education (a rising trend from 27% in 2017).
- 6% said they don't spend any money on board education.
- Health systems generally spend more for board education than other types of organizations (42% of systems spend $50,000 or more; 30% spend over $75,000).
- Subsidiaries and government-sponsored hospitals spend the lowest dollar amount for board education (34% of subsidiary boards and 49% of government hospital boards spend under $10,000).
- Board education is most often delivered during board meetings; publications are the second most common delivery method (for all types of organizations; this has remained the same since 2015). Attendance at off-site conferences was in third place this year with 53%.
- The most popular internal board education topics this year are: strategic planning/direction (90%), quality/safety (87%), legal/regulatory (80%), and industry trends such as crisis management and value-based purchasing (77%).

Exhibit 21. Approximate Total Annual Expenditure for Board Education

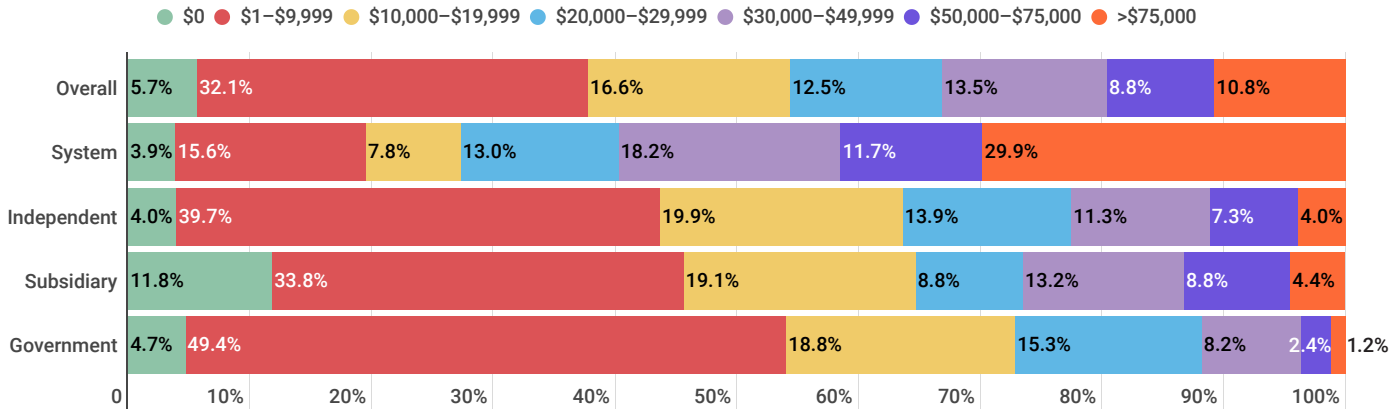


Exhibit 22. Delivery of Board Education

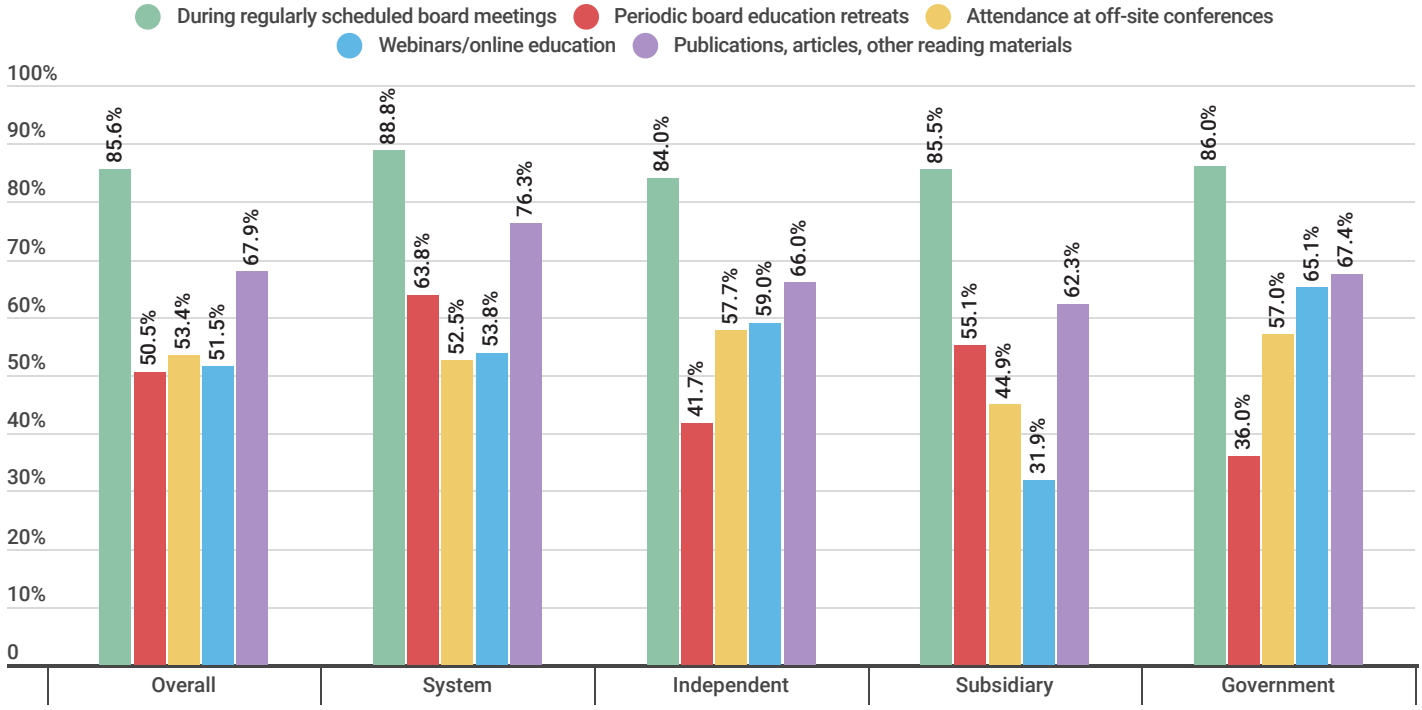
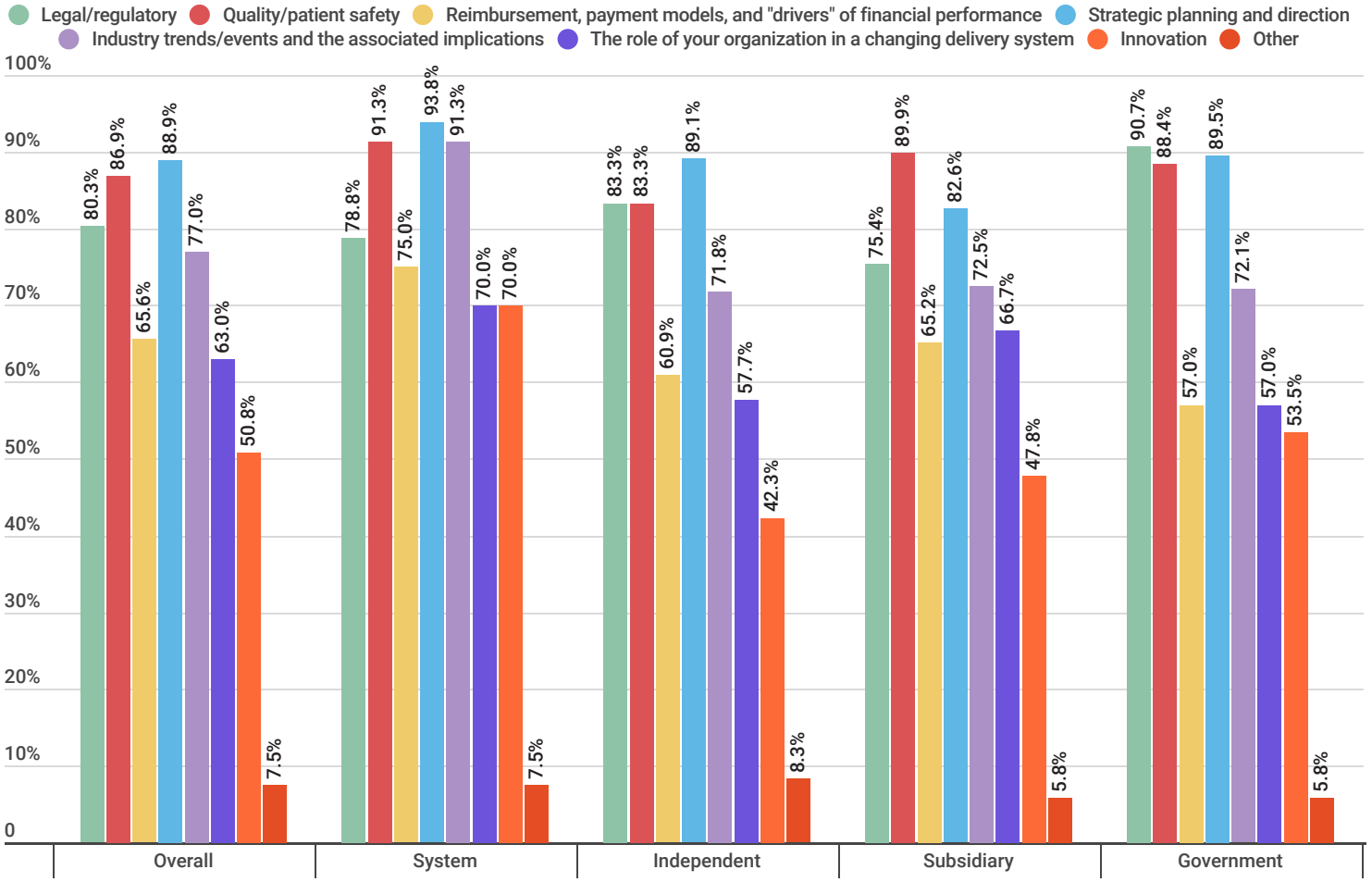


Exhibit 23. Topics Covered for Internal Board Education



Board Member Preparation

SUMMARY OF FINDINGS

Use of Board Portal or Similar Online Tool

- 75% of respondents use a board portal or are in the process of implementing a board portal or similar online tool for board members to access board materials and for board member communication (up from 69% in 2019). Specifically, 71.5% of respondents already use a board portal (vs. 63% in 2019), and another 3.6% are in the process of implementing a portal.
- 94% of system boards use a board portal and 77% of subsidiary hospitals do (the two types of organizations most likely to use a board portal; in 2019 the numbers were 90% and 69%).
- 47% said the most important benefit of using a board portal is that it enhances board members' level of preparation for meetings. Twenty-eight percent (28%), the next highest category, said the best benefit is its reduction of paper waste/duplication costs.
- 65% of respondents provide board members with laptops or iPads to access online board materials (80% of government-sponsored hospitals do).

Exhibit 24. Most Important Benefit of Board Portal

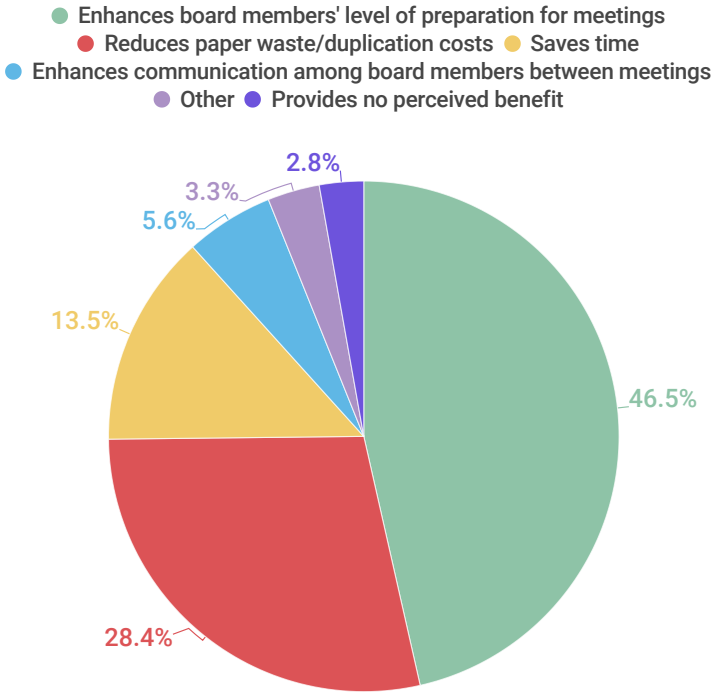
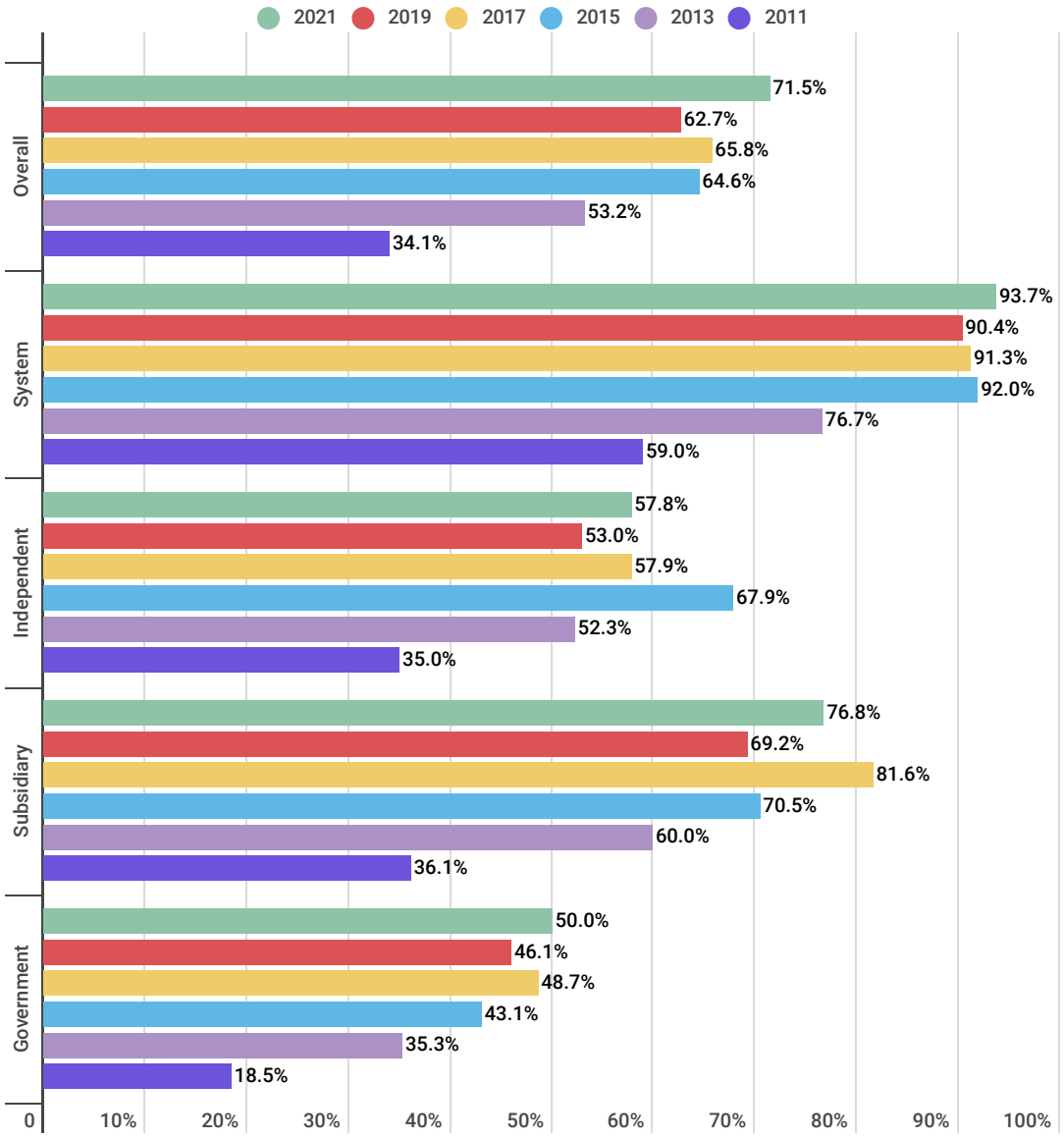


Exhibit 25. Use of Board Portal or Similar Online Tool Since 2011



Respondents that answered "yes" to using a board portal and "are in the process of implementing" a board portal are twice as likely than those that answered "no" this year to cite "excellent" performance in all of the fiduciary duties and oversight responsibilities in the Governance Practices section of this report.

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.). Thirty-nine percent (39%) spend 10–20 hours per month (about the same as in 2019), and 34% spend less than 10 hours per month (vs. 38% in 2019). This is generally uniform across organization type, with the exception of health systems, 44% of which spend 10–20 hours per month, and 43% of subsidiaries spend less than 10 hours per month.

We also asked about the number of full-time equivalent staff (FTEs) devoted to governance. For 62% of organizations, this is combined with another position (most likely the executive assistant to the president/CEO; down from 70% in 2019). Health systems continue to devote the most staff to governance, with 55% having one to two people staffed for this purpose.

New this year, we wanted to know who is the primary staff involved in supporting the board. For the vast majority (78% overall and for 92% of independent hospital boards), the CEO's executive assistant or other administrative assistant is also the primary board support staff person. Thirty-two percent (32%) of systems have a dedicated governance support professional, and 14% of systems engage their chief legal officer for this role. (See **Appendix 1** for more detail.)

Board Culture

Our prior research has shown that a healthy board culture makes an impact on its ability to effectively oversee and improve organizational performance, as well as impacting board performance and organizational culture. We asked respondents to state how strongly they agreed with a list of nine board culture-related statements related to how well the board communicates (both among its own board members and with others), its relationship with the CEO, effectiveness in measuring goals and holding those responsible accountable for reaching goals, and other aspects of board culture—essentially attempting to determine how well the board is functioning in areas or aspects that help contribute to overall board performance of their fiduciary duties and core responsibilities.

Exhibit 26 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 (94%; this was also the highest-scoring culture statement in 2019 at 95%).

The statement with the lowest score was:

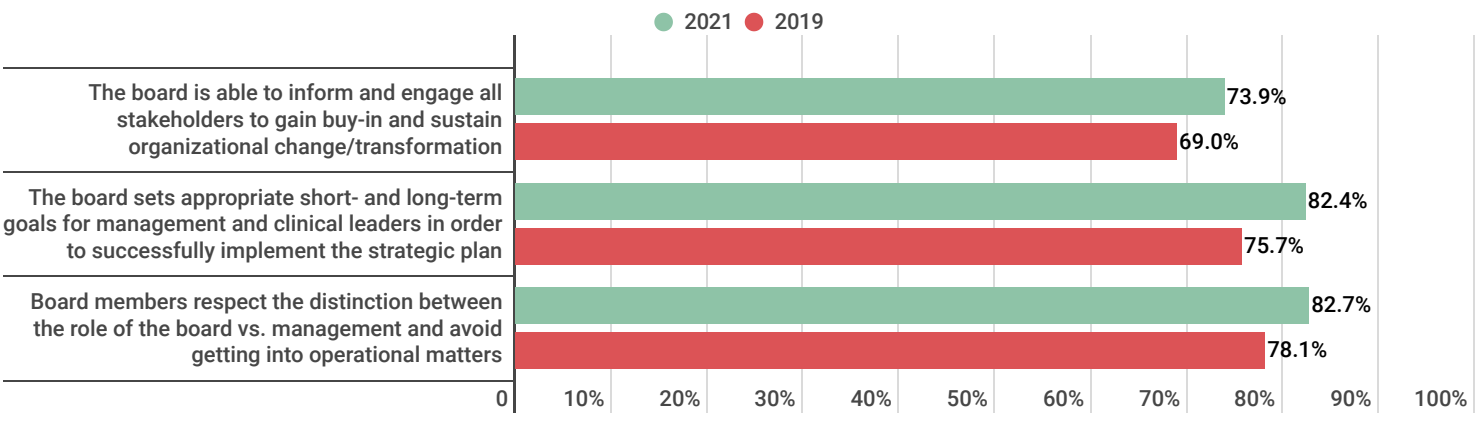
- The board is able to inform and engage all stakeholders to gain buy-in and sustain organizational change/transformation (74%; also the lowest-scoring culture statement in 2019 with 69%).

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:

- Overall: 88% or a B+ (improved from 84% or B in 2019)
- Health systems: 92% or an A- (up from 90% in 2019)
- Independent hospitals: 84% or a B (up from 82% or B- in 2019)
- Subsidiary hospitals: 90% or an A- (up from 86% or B in 2019)
- Government hospitals: 82% or a B- (up from 80% in 2019)

All types of organizations have improved their culture grades this year compared with 2019; however, these scores are similar to our 2017 numbers, as 2019 reflected a decreasing trend or potential outlier. Health systems, our top performer, still only received an A- grade. Only 34 respondents (8.7%) reported that they strongly agree with all nine statements. We hope to see more significant improvement in this area in the future.

Exhibit 26. Board Culture: Percentage of Respondents Who Strongly Agree or Agree *(lowest scoring areas)*



Governance Trends

Coronavirus Pandemic

This year, we asked respondents about whether and how their boards changed their structure or practices due to the pandemic; how well the board and CEO were prepared to deal with the coronavirus pandemic; and how well the board and CEO led the organization through the crisis.

Sixty-eight percent (68%) of respondents made changes of some kind to their structure or practices due to the pandemic. Health systems and subsidiaries were most likely to make such changes (73% and 79%, respectively), and government-sponsored hospitals were least likely (39%).

The most common structure or practice changes made to address the pandemic include:

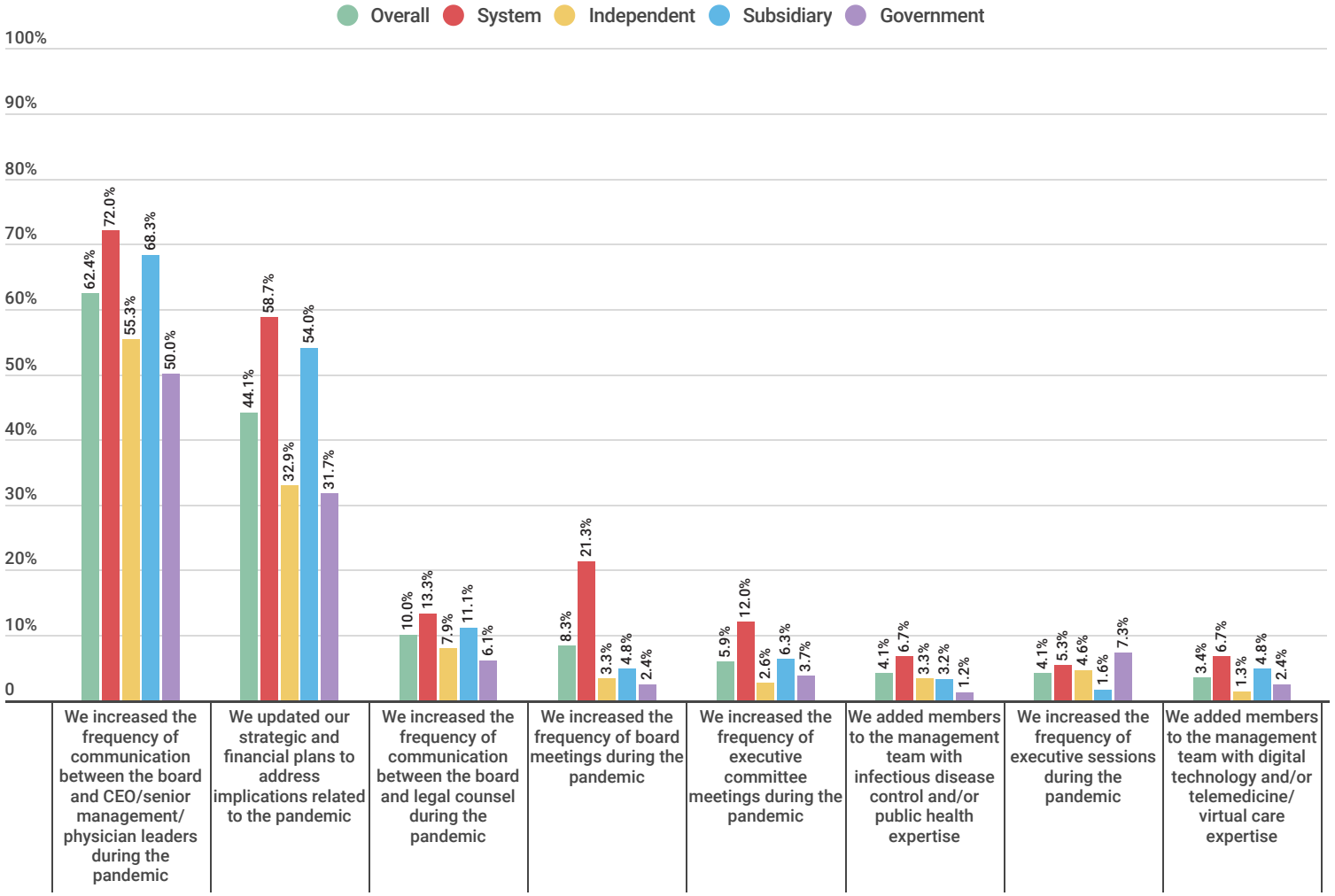
- Increased frequency of communication between the board and CEO/ senior management/physician leaders (62%)
- Updated strategic and financial plans to address implications related to the pandemic (44%)

However, most organizations did *not* do the following:

- Add board members with crisis management experience
- Add members to the management team with crisis management experience
- Add board members with digital technology and/or telemedicine/virtual care expertise

See **Exhibit 27** for more detail overall and by organization type.

Exhibit 27. Changes in Structure or Practices to Address the Pandemic



Generally, we see wide agreement that boards have done an effective job overseeing the organization through the pandemic (93% agree or strongly agree); a smaller percentage agreed that the board was prepared to deal with the pandemic, however (80% agreed or strongly agreed). The data are similar across all organization types for the most part; the most significant outlier was government-sponsored hospital board preparation to deal with the pandemic (only 74% agreed or strongly agreed).

In contrast, there is overwhelming agreement across all organizations that CEOs were both prepared to deal with the pandemic (93% agreed or strongly agreed) and also did an effective job leading their organizations through the pandemic (97% agreed or strongly agreed). (Note: CEOs were usually the ones completing our survey.)

Population Health Management & Value-Based Payments

We again asked boards what types of structural changes to the board and board-related activities they are doing to expand 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 2019*. Thus, the responses this year indicate whether any changes were made between the last reporting year and this year.

Eighty-four percent (84%) of respondents have made some kind of change regarding population health since 2019, indicating a continued expansion of effort in this area:

- 50% of respondents have added population health goals (e.g., IT infrastructure and physician integration) to the strategic plan since 2019 (up from 44%).
- 25% of respondents have added new population health-related metrics to their board quality/finance dashboards since 2019 (up from 22%).
- 10% of respondents have added physicians to the management team since 2019 to manage population health (up from 8%), and 8% have added nurses to the management team to help with this effort (up from 6%). (13% of subsidiaries have taken both of these actions, the highest-percentage group.)
- 6% of respondents have added physicians to the board to help with population health management (up from 5%) and 2% added nurses to the board for this purpose since 2019 (about the same).
- 43% of respondents have not made any changes to board structure since 2019 to help with population health management. The level of activity in this area has leveled off since 2017, so we assume that these respondents feel they have adequate competencies on their board to address population health and thus efforts are focused elsewhere.

Eighty-two percent (82%) of respondents have made some kind of change to be successful with/expand value-based payments since 2019:

- 38% of respondents have added value-based payment goals to strategic and financial plans since 2019 (this has trended down since 2017 when the high was 56%).
- 21% have added value-based care metrics to the board quality/finance dashboards since 2019 (32% of health systems have done this).
- 8% of respondents have added physicians to the management team to succeed with value-based payments; 6% have added nurses to the management team for this purpose.
- 4% of respondents added physicians to the board to help with value-based payments, and 1% added a nurse to the board for this purpose.
- 3% added board members with expertise in quality improvement processes.
- 48% of respondents have not made any changes to the board since 2019 to succeed with or expand value-based payments (this is down from 56% who did not make changes from 2017 to 2019).

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

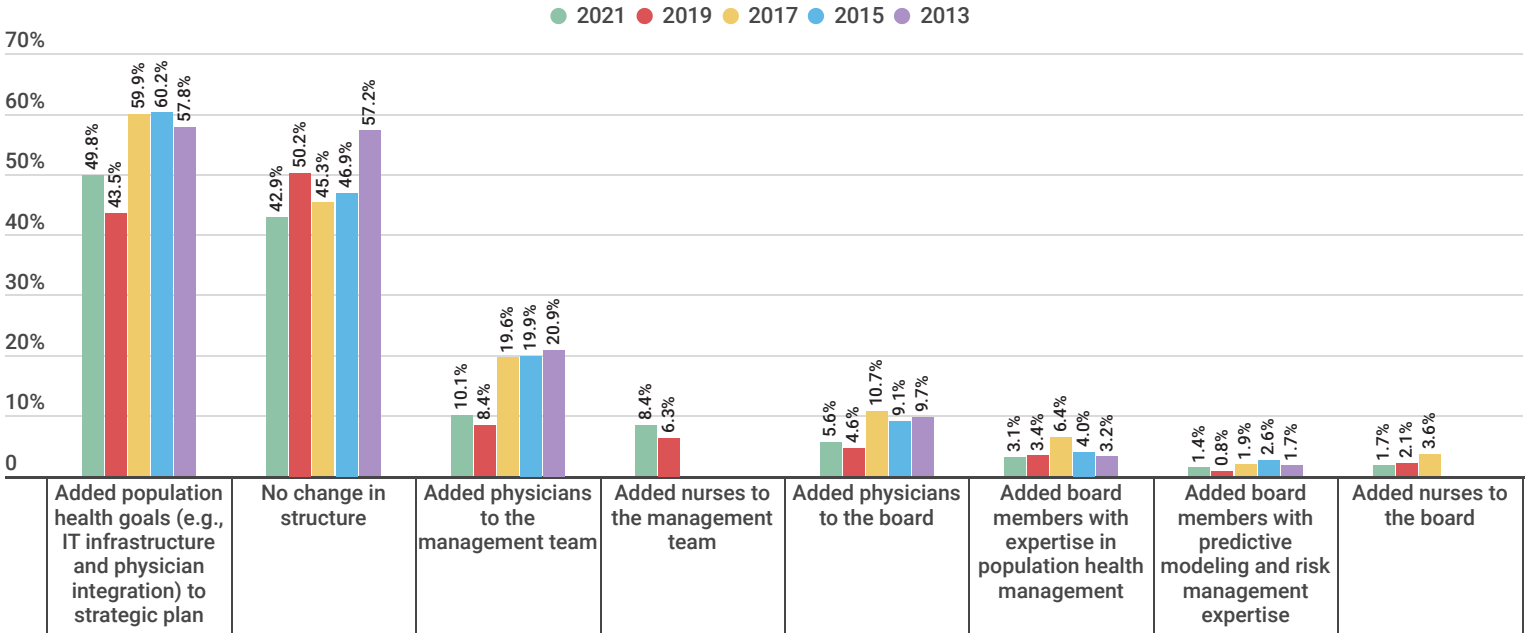


Exhibit 28a. Changes in Structure Since 2019 in Regards to Population Health by Organization Type

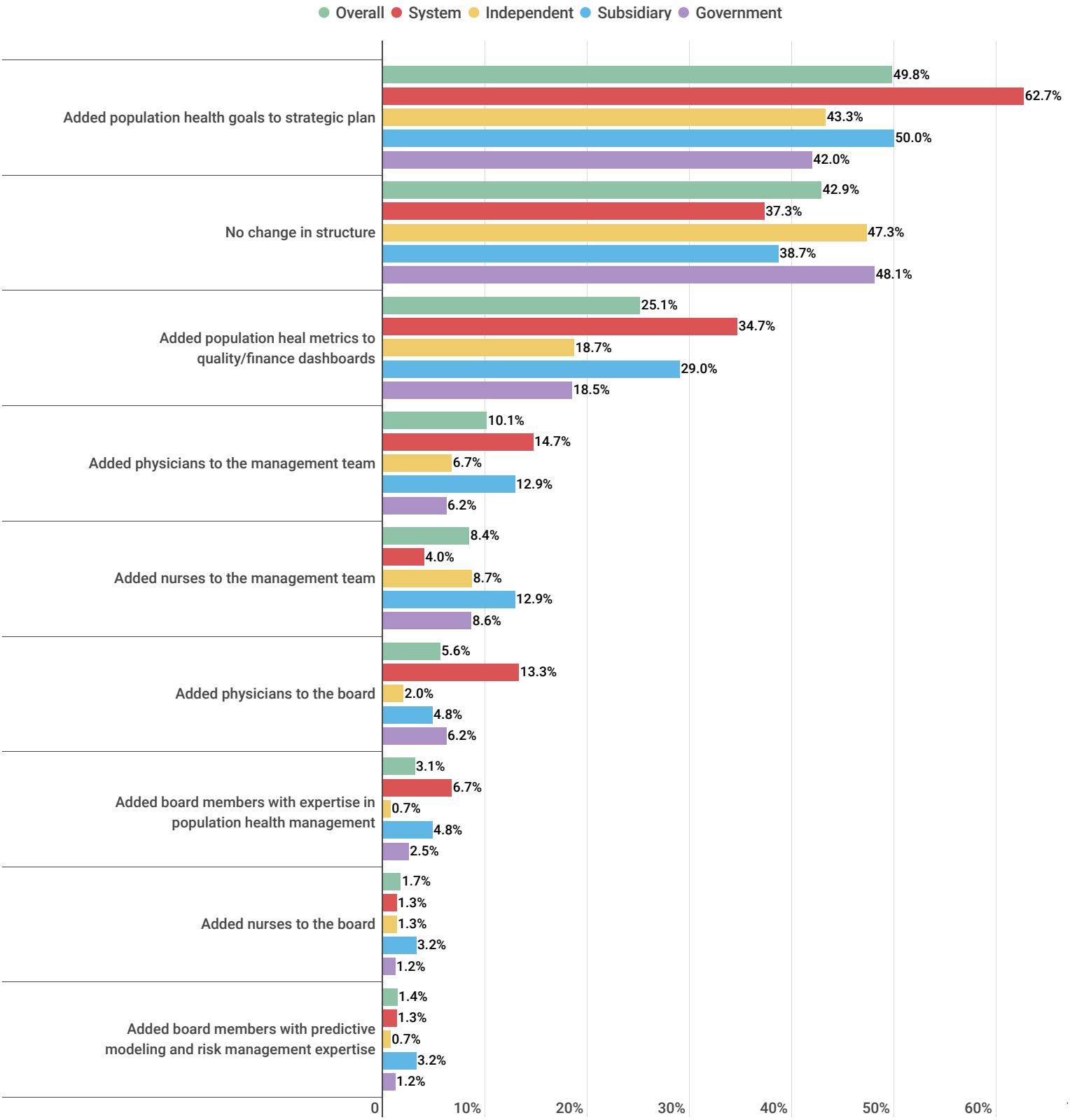


Exhibit 29. Changes in Structure Since 2013 to Succeed with Value-Based Payments
(respondents selected more than one answer)

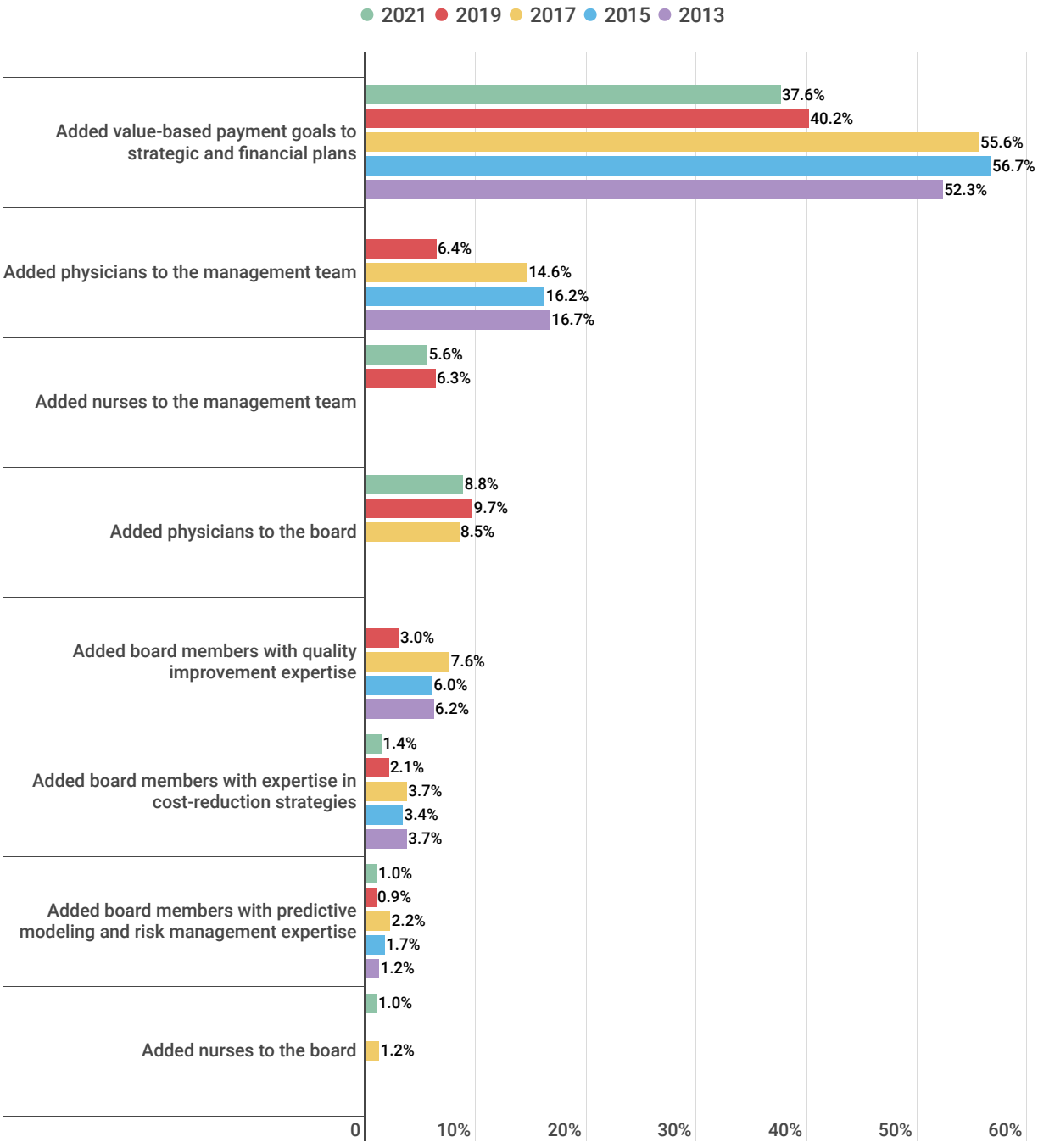


Exhibit 29a. Changes in Structure Since 2019 to Succeed with Value-Based Payments by Organization Type

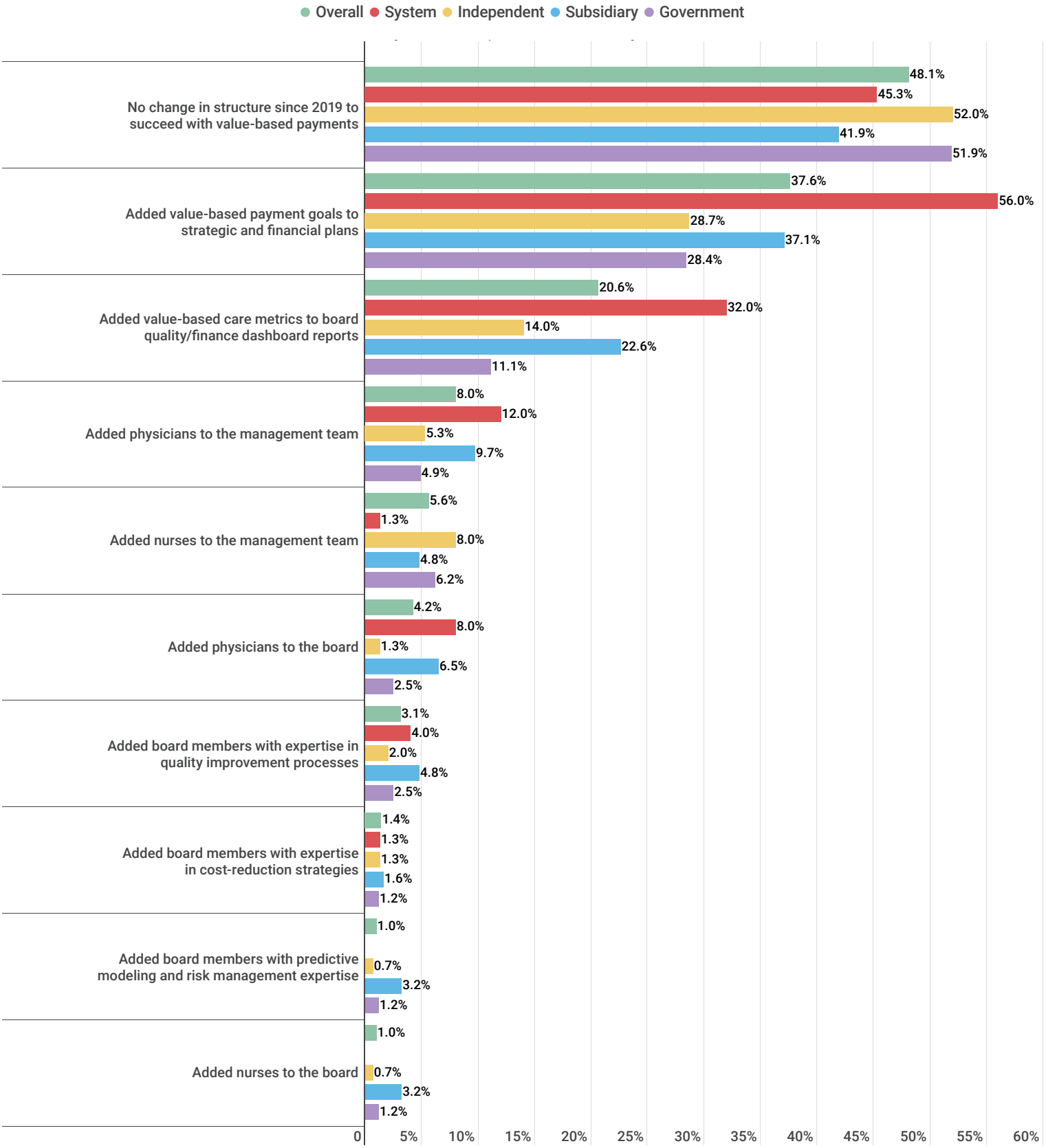


Exhibit 30. System Governance Structure by Organization Size *(# of beds)*

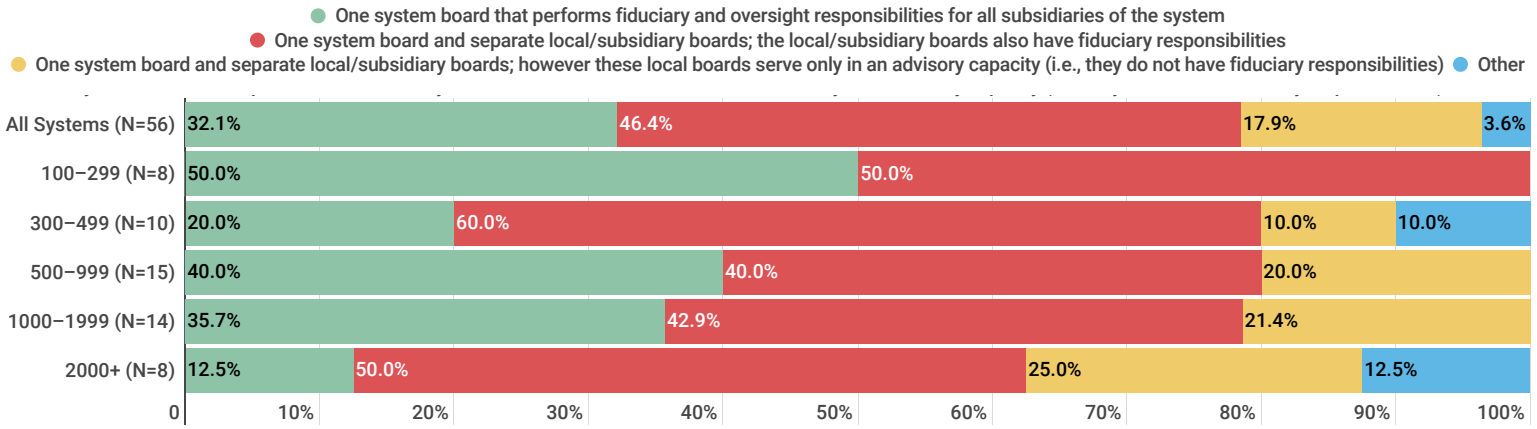
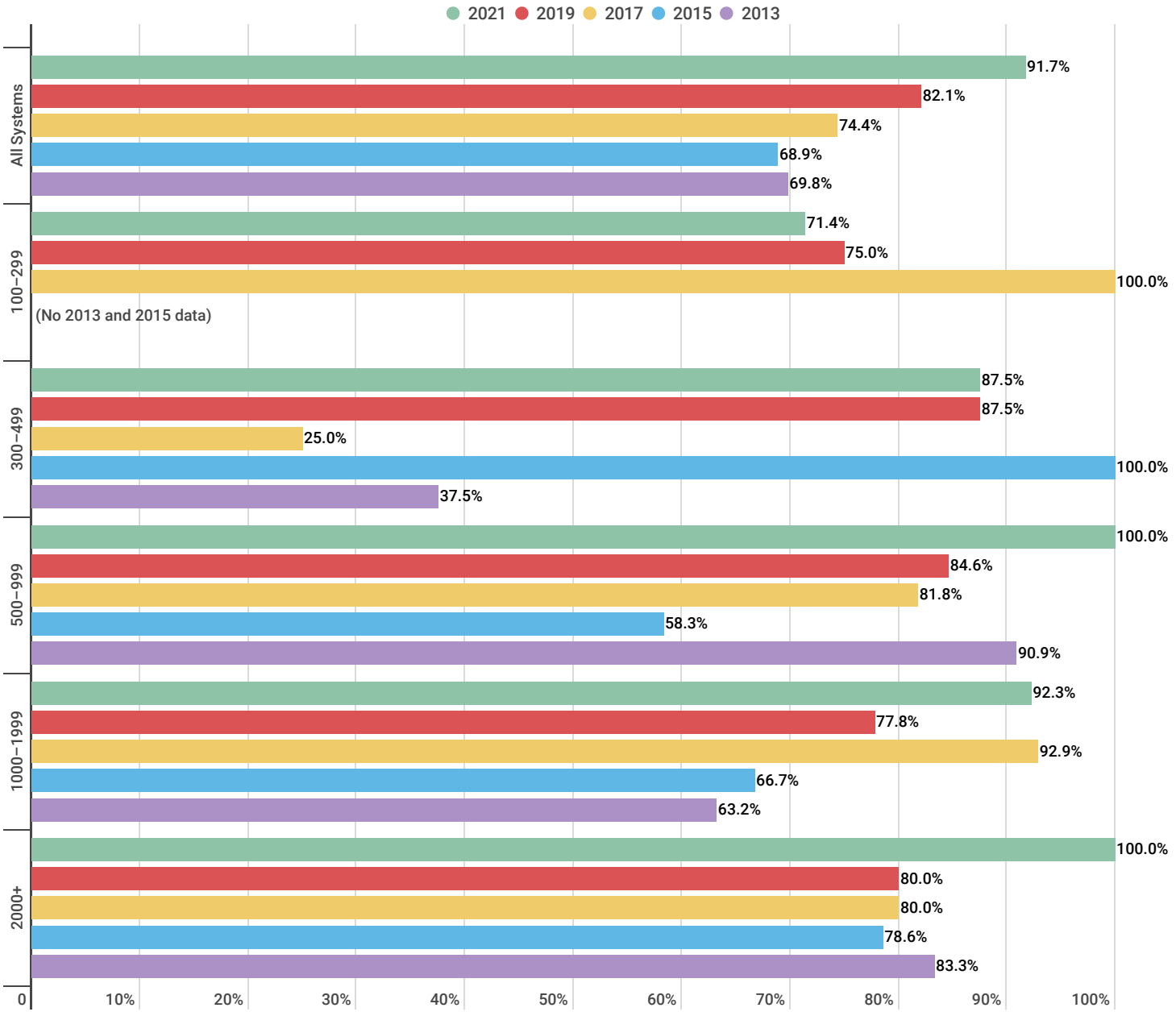


Exhibit 31. System Board Approves a Document or Policy Specifying Allocation of Responsibility & Authority between System & Local Boards



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

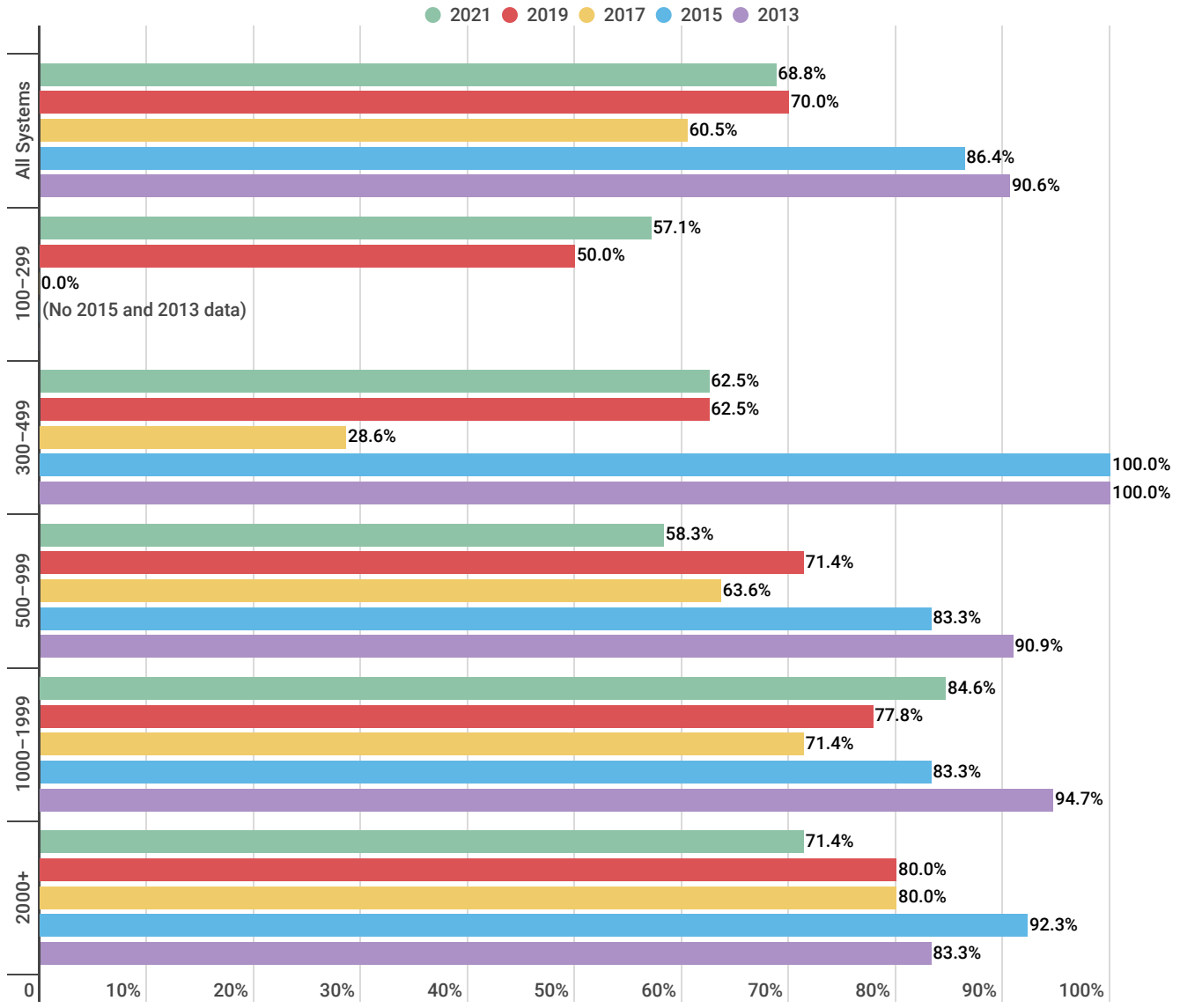
In 2015, most systems (52%) had a system board as well as separate local/subsidiary boards with fiduciary responsibilities. In 2017 and 2019, the systems responding were more evenly split across each of the three categories below. This year, our responding group of systems is showing more of a traditional structure similar to 2015:

- 32% have one system board with fiduciary oversight for the entire system (34% in 2019)
- 46% have a system board and subsidiary fiduciary boards (34% in 2019)
- 18% have a system board and subsidiary advisory boards (27% in 2019)

Thirty-nine percent (39%) 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 (compared with 46% in 2019).

This year, our correlation analysis shows that systems that said the assignment of governance responsibility and authority is widely understood and accepted by both local and system-level leaders are 67% more likely than those indicating that this is an area that needs improvement to cite excellent performance in the Governance Practices section of this report.

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



Association of Responsibility/ Authority Understood and Accepted

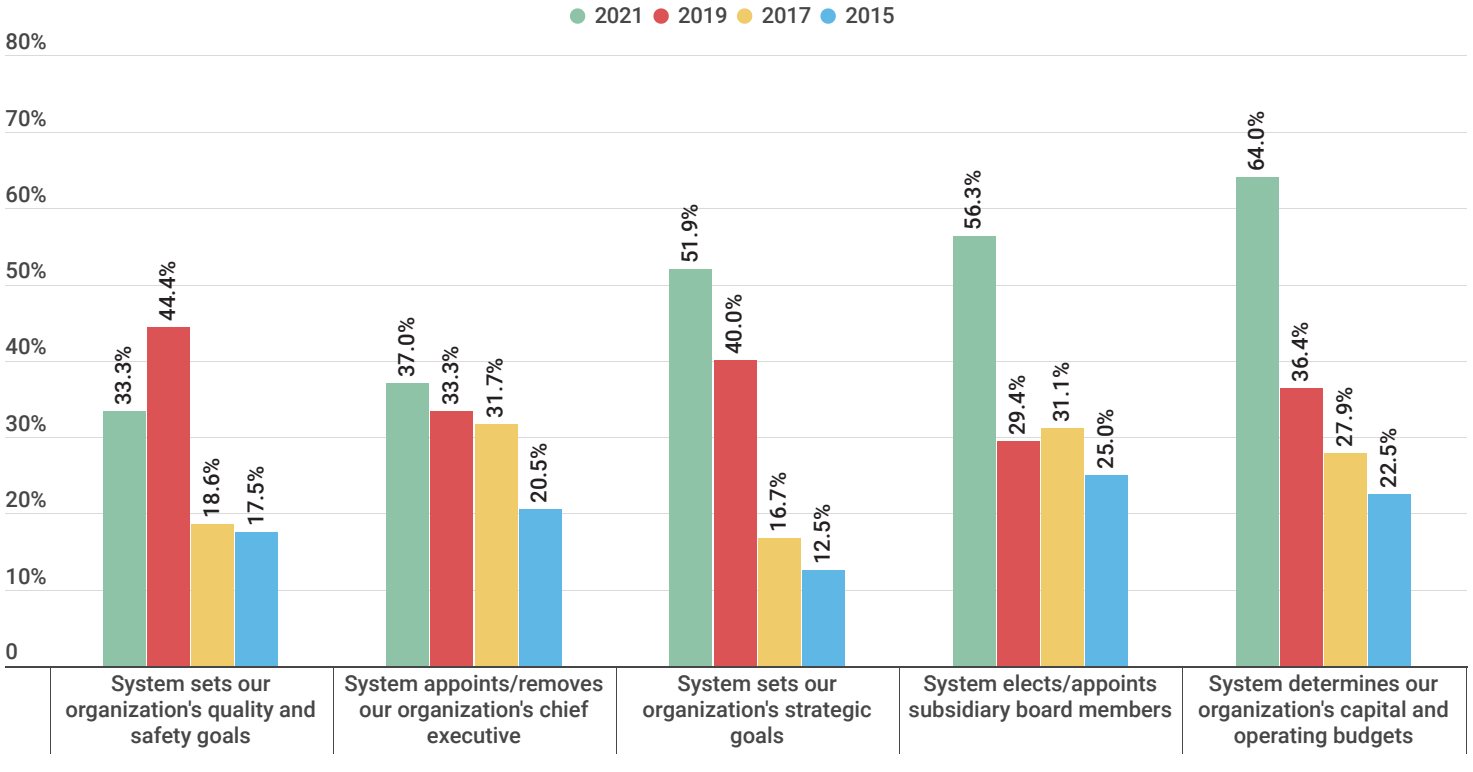
Overall, 92% of system respondents approve a document or policy specifying allocation of responsibility and authority between system and local boards (up from 82% in 2019 and 74% in 2017). Sixty-nine percent (69%) of system respondents said that the assignment of responsibility and authority is widely understood and accepted by both local and system-level leaders (about the same as in 2019). The remaining 31% say that this is an area that needs improvement. (See **Exhibits 31** and **32**.)

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 or have shared responsibility with local boards (quality and safety goals, customer service goals, community and population health goals, social determinants of health, and board education), and certain practices that are more likely to remain at system-level control (setting strategic goals, audit/compliance, and executive appointment and compensation). The most significant or interesting highlights we see this year are:

- More fiduciary subsidiary boards are reporting that their system board sets their organization's strategic goals (50% this year vs. 40% in 2019).
- More fiduciary subsidiary boards are also reporting that their system board determines their organization's capital and operating budgets (59% this year vs. 36% in 2019).
- One big change this year in responsibility moving to the system level is electing/appointing the subsidiary board members (56% of subsidiary boards say this is done at the system level compared with 30% in 2019).
- Both fiduciary and advisory subsidiary boards are more likely to share the responsibility of setting quality and safety goals, rather than retaining responsibility or relying on the system board to do this.
- Fiduciary subsidiary boards are more likely to retain responsibility for medical staff credentialing (82% this year vs. 20% in 2019). Thirty-three percent (33%) of advisory boards also say they retain this responsibility compared with 17% in 2019.
- Fiduciary subsidiary boards are more likely to share the responsibility of appointing/removing their chief executive (61%); in contrast, only 22% of advisory boards share this responsibility with their system board and 67% say this is done at the system board level.
- 53% of fiduciary subsidiary boards share the responsibility of determining executive compensation; 80% of advisory boards say this is done at the system level.
- 52% of fiduciary subsidiary boards retain the responsibility of identifying their organization's community health needs through the CHNA; 67% of advisory boards say this is done at the system board level.
- 50% of fiduciary subsidiary boards share the responsibility of setting their organization's community health goals; 67% of advisory boards say this is done at the system level.
- Similarly, 55% of fiduciary subsidiary boards share the responsibility of setting population health improvement goals while 63% of advisory boards say this is done at the system level.
- Also in keeping with the above numbers, 52% of fiduciary subsidiary boards retain the responsibility of addressing social determinants of health while 63% of advisory boards say this is done at the system level.

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



This year there were four areas of responsibility in which advisory boards indicated a relatively strong degree of responsibility (either retaining or sharing with the system board) despite their not having legal fiduciary status:

- Setting our organization's quality and safety goals
- Setting our organization's customer service goals
- Approving our organization's medical staff credentialing/appointments
- Establishing our board education and orientation program

Table 15 shows a comparison of 2021 and 2019 results (please note that the 2019 results include a relatively small sample size). See Exhibit 33 for a comparison focusing on the issues where there has been most movement towards system responsibility since 2015 (advisory boards excluded).

Table 15. Allocation of Decision-Making Authority 2021 vs. 2019

Subsidiary Hospital Boards	Fiduciary Boards	Advisory Boards	Fiduciary Boards	Advisory Boards
Total number of respondents in each category	**91**	**18**	**19**	**7**
ROLE OF THE SUBSIDIARY BOARD IN THE FOLLOWING DECISIONS:	**2021**		**2019**	
Setting our organization's strategic goals				
Total responding to this question (N/A not included for all)	18	9	11	7
Our board retains responsibility	22.2%	0.0%	0.0%	16.7%
Our board shares responsibility	27.8%	44.4%	60.0%	0.0%
System board retains responsibility (our board has advisory capacity)	50.0%	55.6%	40.0%	83.3%
Determining our organization's capital and operating budgets				
Total responding to this question	17	8	11	7
Our board retains responsibility	17.6%	0.0%	18.2%	0.0%
Our board shares responsibility	23.5%	25.0%	45.5%	0.0%
System board retains responsibility (our board has advisory capacity)	58.8%	75.0%	36.4%	100.0%
Setting our organization's quality and safety goals				
Total responding to this question	24	9	11	6
Our board retains responsibility	29.2%	11.1%	22.2%	16.7%
Our board shares responsibility	41.7%	44.4%	33.3%	16.7%
System board retains responsibility (our board has advisory capacity)	29.2%	44.4%	44.4%	66.7%
Setting our organization's customer service goals				
Total responding to this question	22	9	11	7
Our board retains responsibility	36.4%	11.1%	72.7%	66.7%
Our board shares responsibility	31.8%	44.4%	9.1%	0.0%
System board retains responsibility (our board has advisory capacity)	31.8%	44.4%	18.2%	33.3%
Approving our organization's medical staff credentialing/appointments				
Total responding to this question	22	9	11	7
Our board retains responsibility	81.8%	33.3%	20.0%	16.7%
Our board shares responsibility	13.6%	11.1%	40.0%	16.7%
System board retains responsibility (our board has advisory capacity)	4.5%	55.6%	40.0%	66.7%
Appointing/removing our organization's chief executive				
Total responding to this question	18	9	11	7
Our board retains responsibility	16.7%	11.1%	0.0%	0.0%
Our board shares responsibility	61.1%	22.2%	66.7%	25.0%
System board retains responsibility (our board has advisory capacity)	22.2%	66.7%	33.3%	75.0%
Determining/approving executive compensation				
Total responding to this question	15	5	11	7
Our board retains responsibility	33.3%	0.0%	16.7%	0.0%
Our board shares responsibility	53.3%	20.0%	50.0%	0.0%
System board retains responsibility (our board has advisory capacity)	13.3%	80.0%	33.3%	100.0%

Subsidiary Hospital Boards	Fiduciary Boards	Advisory Boards	Fiduciary Boards	Advisory Boards
Total number of respondents in each category	**91**	**18**	**19**	**7**
ROLE OF THE SUBSIDIARY BOARD IN THE FOLLOWING DECISIONS:	**2021**		**2019**	
Selecting our organization's audit firm				
Total responding to this question	12	3	11	7
Our board retains responsibility	16.7%	0.0%	0.0%	0.0%
Our board shares responsibility	50.0%	33.3%	50.0%	0.0%
System board retains responsibility (our board has advisory capacity)	33.3%	66.7%	50.0%	100.0%
Approving our organization's audit				
Total responding to this question	14	3	11	7
Our board retains responsibility	21.4%	0.0%	0.0%	0.0%
Our board shares responsibility	42.9%	33.3%	85.7%	0.0%
System board retains responsibility (our board has advisory capacity)	35.7%	66.7%	14.3%	100.0%
Establishing our organization's corporate compliance program				
Total responding to this question	15	5	11	7
Our board retains responsibility	26.7%	20.0%	0.0%	0.0%
Our board shares responsibility	26.7%	20.0%	62.5%	33.3%
System board retains responsibility (our board has advisory capacity)	46.7%	60.0%	37.5%	66.7%
Identifying our organization's community health needs through the CHNA				
Total responding to this question	23	9	10	7
Our board retains responsibility	52.2%	22.2%	37.%	50.0%
Our board shares responsibility	30.4%	11.1%	50.0%	25.0%
System board retains responsibility (our board has advisory capacity)	17.4%	66.7%	12.5%	25.0%
Setting our organization's community health goals				
Total responding to this question	22	9	11	7
Our board retains responsibility	31.8%	22.2%	50.0%	50.0%
Our board shares responsibility	50.0%	11.1%	50.0%	25.0%
System board retains responsibility (our board has advisory capacity)	18.2%	66.7%	0.0%	25.0%
Setting our organization's population health improvement goals				
Total responding to this question	20	8	11	7
Our board retains responsibility	30.0%	12.5%	28.6%	25.0%
Our board shares responsibility	55.0%	25.0%	71.4%	25.0%
System board retains responsibility (our board has advisory capacity)	15.0%	62.5%	0.0%	50.0%
Addressing social determinants of health for our organization's community				
Total responding to this question	21	8	11	7
Our board retains responsibility	52.4%	25.0%	28.6%	20.0%
Our board shares responsibility	23.8%	12.5%	71.4%	60.0%
System board retains responsibility (our board has advisory capacity)	23.8%	62.5%	0.0%	20.0%
Electing/appointing our organization's board members				
Total responding to this question	24	8	11	7
Our board retains responsibility	16.7%	25.0%	30.0%	14.3%
Our board shares responsibility	29.2%	12.5%	50.0%	42.9%
System board retains responsibility (our board has advisory capacity)	54.2%	62.5%	20.0%	42.9%
Establishing our board education and orientation programs				
Total responding to this question	22	9	11	7
Our board retains responsibility	36.4%	33.3%	55.6%	20.0%
Our board shares responsibility	50.0%	33.3%	22.2%	20.0%
System board retains responsibility (our board has advisory capacity)	13.6%	33.3%	22.2%	60.0%

Advisory Board Profile

Below is a comparison of advisory board structure and composition 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 18 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. More detail can be found in Appendix 1C: Subsidiary Board Structure, provided online at www.governanceinstitute.com/2021biennialsurvey. Also, be sure to refer to **Table 10** to see a comparison of the types of board competencies being sought by these advisory boards compared with all other types of boards, which shows some interesting differences. (The Governance Practices section of this report indicates any meaningful distinctions between fiduciary and advisory subsidiary boards with regards to adoption and performance of our recommended practices.)

This year, advisory boards are about the same size as fiduciary subsidiary boards (in 2019 they were smaller by about 2 members). Sixty-five percent (65%) of the board are independent board members (compared with 60% in 2019; and compared with 69% independent board members of fiduciary subsidiary boards):

Advisory Boards	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Average # of Voting Board Members	13.4	13.4	0.7	1.9	2.9	1.7	8.7	8.0	1.0	0.9
Median # of Board Members	14	14	0	2	1	2	9	8	0	0

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

Other structure and composition variances compared with fiduciary subsidiary boards:

- Average number of board members from outside the community: 0.2 vs. 0.5.
- Average ethnic minority board members: 2.6 vs. 2.2 (both of these numbers declined since 2019).
- Average female board members: 3.7 vs. 4.1 (both of these numbers increased slightly since 2019).
- Term limits: 80% vs. 76%.
- Voting chief of staff: 33% vs. 49%.
- Legal counsel: 17% regularly attend board meetings, vs. 66%.
- More likely to have a nurse CEO (50% vs. 24%).
- More likely to have a board chair with management/finance experience in the non-profit sector (40% vs. 6%).
- 50% meet quarterly (vs. 24%), and usually meetings are less than two hours (80% vs. 31%).
- Advisory boards spend less for board education: 70% spend under $10,000 (vs. 41%).
- Quality and strategic planning are the two highest topics indicated for board education (80% each; although these are also the two highest topics indicated for fiduciary board education as well) and 90% of advisory boards indicated that education takes place during regularly scheduled board meetings.
- For 90% of advisory boards, the board support staff position is combined with another position (vs. 57%).

Board meeting content:

- 32% of board meeting time spent in active discussion, deliberation, and debate about strategic priorities of the organization (up from 21% in 2019 and compared with 28% of fiduciary board meeting time).
- 30% of board meeting time is spent reviewing quality/safety (up from 26% in 2019 and compared with 23% of fiduciary board meeting time).

Executive sessions:

- 80% have the CEO attend always or most of the time; 20% have the CEO attend rarely (compared with 50% in 2019); this is about the same as fiduciary subsidiaries.
- Physician or nurse board members rarely attend (in contrast with fiduciary subsidiaries, 35% of which have these board members attend always or most of the time).
- Legal counsel rarely attends for 75% of advisory boards; this was in significant contrast with fiduciary boards, 47% of which have the legal counsel attend always or most of the time.
- Topics typically discussed in executive session were similar for both types of subsidiary boards, with the primary differences being: executive compensation (60% of fiduciary boards discuss this in executive session vs. 40% of advisory boards); M&A strategy (33% of fiduciary boards vs. 0% of advisory boards); and board performance and evaluation (24% of fiduciary boards vs. 0% of advisory boards).

Standing committees:

- The most prevalent committees for advisory boards (above 50%) are finance (67%), quality/safety (78%), and strategic planning (67%).
- Fiduciary boards also tend to have the above committees, and in addition are much more likely to have the following: executive committee (82% of fiduciary boards vs. 50% of advisory boards); audit/compliance (51% vs. 33%); governance/board development (69% vs. 44%); and executive compensation (53% vs. 33%).
- Neither type of subsidiary board respondents showed significant prevalence of community benefit or population health improvement committees. Perhaps this work is done at the full board level.

Authorities/responsibilities of the executive committee (N=5):

- Advising the CEO (60%, compared with 80% of fiduciary boards).
- Emergency decision making (60%, compared with 78% of fiduciary boards).
- Decision-making authority between meetings (40%, compared with 71% of fiduciary boards).
- Board member nominations (40%).
- Level of authority of the executive committee: 60% of advisory boards allow the executive committee some authority to make decisions on behalf of the full board; 20% of advisory boards do not allow the executive committee to have any decision-making authority. (Fiduciary subsidiary executive committees are more evenly split between having full or partial authority.)

Quality committee (N=8):

- 50% have 4 or more physician board members (compared with 21% of fiduciary board quality committees).
- 50% have 2 nurse board members (45% of fiduciary boards have 0 nurse board members on the quality committee).
- 50% have 1 medical staff physician and 13% have 2 (58% of fiduciary boards have 2 or more medical staff physicians).
- 57% have at least 1 nurse from the nursing staff (vs. 51% of fiduciary boards).Governance Practices: Fiduciary Duties & Core Responsibilities

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."

Unless otherwise noted, for this section of the report, scores are combined for all subsidiaries to include both fiduciary and advisory boards, 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

Performance composite scores for 2021 are higher than in 2019 for *all* fiduciary duties and core responsibilities, and the performance ranking order stayed the same (with duty of obedience and duty of care being tied in third place this year). While community benefit and advocacy and board development are still ranked last, the oversight scores for these two responsibilities showed the most improvement. (See **Table 16**; areas showing the biggest increase are in bold.)

A history of performance ranking by duty and core responsibility appears in **Table 17**. The breakdown of responses for overall performance in each duty and core responsibility appears in **Exhibit 34**. *(Note: we did not survey on governance practices in 2017.)*

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

Performance Rank	Fiduciary Duties and Core Responsibilities	Weighted Average			
		2021	2019	2015	2013
1	Financial Oversight	4.52	4.44	4.57	4.50
2	Duty of Loyalty	4.43	4.37	4.41	4.42
3	Duty of Obedience	4.37	4.35	4.37	4.33
4	Duty of Care	4.37	4.28	4.46	4.45
5	Management Oversight	**4.30**	**4.19**	4.31	4.26
6	Quality Oversight	**4.29**	**4.17**	4.39	4.29
7	Strategic Direction	**4.19**	**4.08**	4.11	4.12
8	Community Benefit & Advocacy	**4.12**	**3.91**	3.92	3.91
9	Board Development	**3.82**	**3.62**	3.79	3.76

Note: areas showing the greatest increase since 2019 are in bold.

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

Fiduciary Duties and Core Responsibilities	Performance Rank				
	2021	2019	2015	2013	2011
Financial Oversight	1	1	1	1	1
Duty of Loyalty	2	2	3	3	3
Duty of Obedience	3*	3	5	4	5*
Duty of Care	4*	4	2	2	2
Management Oversight	5	5	6	6	6*
Quality Oversight	6	6	4	5	4*
Strategic Direction	7	7	7	7	7
Community Benefit & Advocacy	8	8	8	8	9
Board Development	9	9	9	9	8

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

Exhibit 34. Overall Board Performance

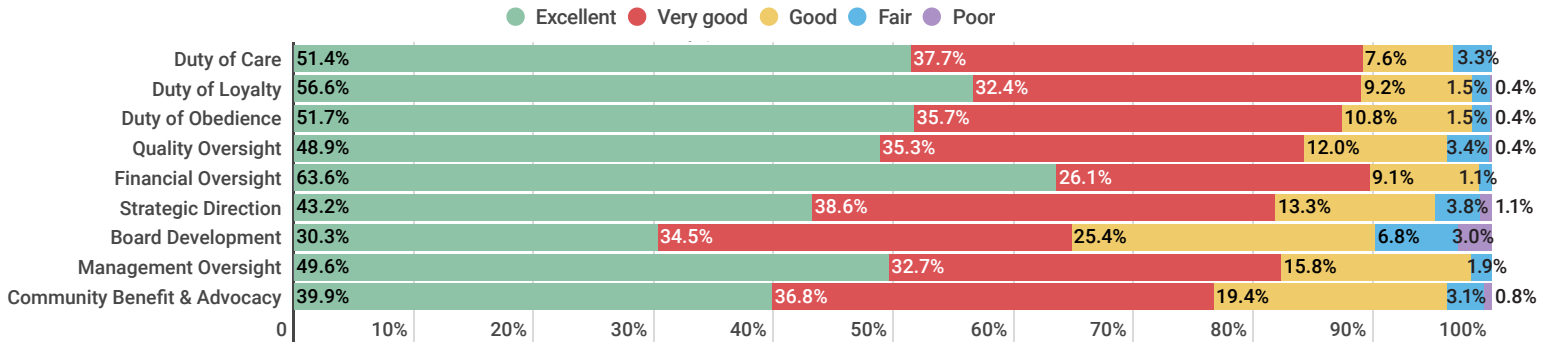
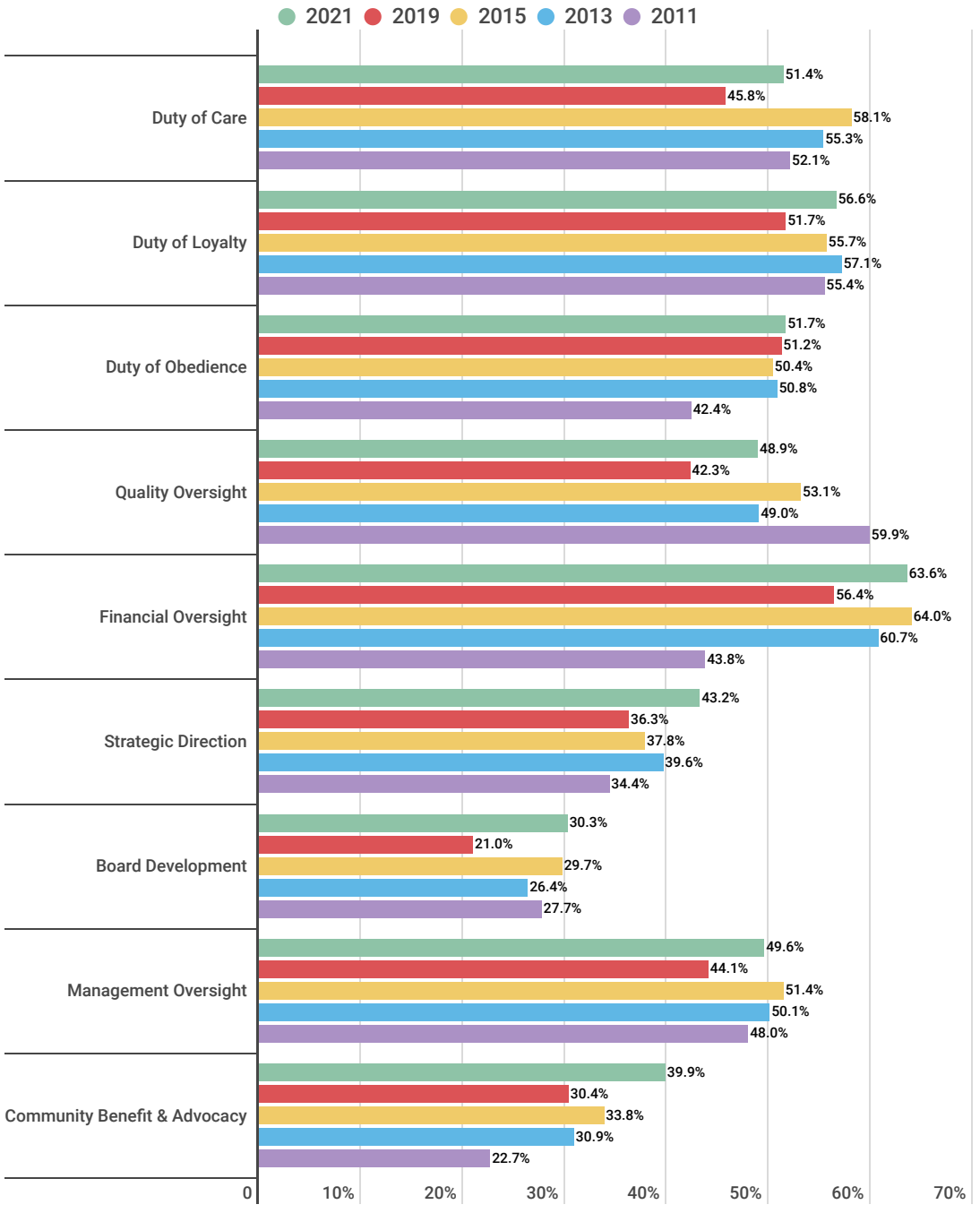


Exhibit 35. Excellent Board Performance Since 2011

(percentage of respondents rating their board as "excellent")

When comparing the "top two" ratings (percent of respondents rating their boards "excellent" or "very good") since 2009, this year's performance ratings tend to be similar or show a slight increase compared with previous years. Community benefit and advocacy has improved the most over the years, moving up 18 percentage points since 2009. Strategic planning has improved as well, up 7 percentage points since 2011. Many of the scores that dropped in 2019 improved in 2021. For example, quality oversight dropped 8 percentage points in 2019, but moved up 5 percentage points in 2021. ***However, the percentage of respondents rating their boards "excellent" has only hovered between 21-64% across reporting years, depending on the category, with the stakes only getting higher for boards needing to be at their best.*** (See Exhibit 35.)



Board Performance across Types of Organizations

Table 18 shows the breakdown of "top two" ratings by type of organization for 2021 and 2019. 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 in 2019. This year, government-sponsored hospitals scored the lowest in every category except strategic direction, where independent hospitals scored one percentage point lower.

Table 19 shows performance results by composite score (5 = "excellent"). Composite performance scores increased since 2019 in every area overall, with community benefit and advocacy and board development increasing the most:

- Subsidiary hospitals and independent hospitals saw the biggest increase in community benefit and advocacy.
- Subsidiary hospitals also saw an increase in duty of care scores.
- For systems, the biggest increase was in quality oversight.
- Government-sponsored hospitals saw the least improvement, with scores in duty of obedience and duty of loyalty decreasing the most.

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 2021 vs. 2019

(overall and by organization type)

Fiduciary Duties & Core Responsibilities	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Financial Oversight	90%	90%	**99%**	**96%**	86%	88%	90%	92%	79%	87%
Duty of Loyalty	89%	88%	**96%**	**98%**	85%	84%	92%	92%	78%	88%
Duty of Obedience	87%	85%	**97%**	**98%**	84%	82%	85%	80%	78%	84%
Duty of Care	89%	85%	**94%**	**96%**	86%	82%	92%	77%	83%	81%
Management Oversight	82%	82%	**91%**	**94%**	81%	79%	75%	79%	71%	80%
Quality Oversight	84%	79%	**91%**	88%	81%	75%	83%	**92%**	79%	74%
Strategic Direction	82%	77%	**90%**	**84%**	77%	74%	81%	79%	78%	75%
Community Benefit & Advocacy	77%	70%	**79%**	**85%**	75%	65%	78%	72%	67%	66%
Board Development	65%	59%	**79%**	**75%**	57%	54%	66%	62%	49%	53%

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

Table 19. Board Performance Composite Scores 2021 vs. 2019

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

Fiduciary Duties & Core Responsibilities	Overall		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
Financial Oversight	4.52	4.44	4.76	4.71	4.43	4.33	4.46	4.54	4.27	4.33
Duty of Care	4.37	4.28	4.58	4.62	4.25	4.19	4.43	4.12	4.19	4.16
Duty of Loyalty	4.43	4.37	4.67	4.65	4.28	4.25	4.53	4.56	4.17	4.28
Quality Oversight	4.29	4.17	4.55	4.39	4.12	4.07	4.40	4.36	4.06	4.06
Duty of Obedience	4.37	4.35	4.61	4.77	4.23	4.24	4.42	4.24	4.09	4.25
Management Oversight	4.30	4.19	4.51	4.57	4.24	4.07	4.18	4.17	4.05	4.08
Strategic Direction	4.19	4.08	4.46	4.31	4.06	3.99	4.18	4.13	4.09	4.01
Community Benefit & Advocacy	4.12	3.91	4.23	4.25	4.00	3.80	4.28	3.96	3.83	3.76
Board Development	3.82	3.62	4.03	3.92	3.68	3.50	3.91	3.77	3.53	3.43

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 for any given practice is not due to the practice being not applicable to some types of boards.)*

Overview of Results

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

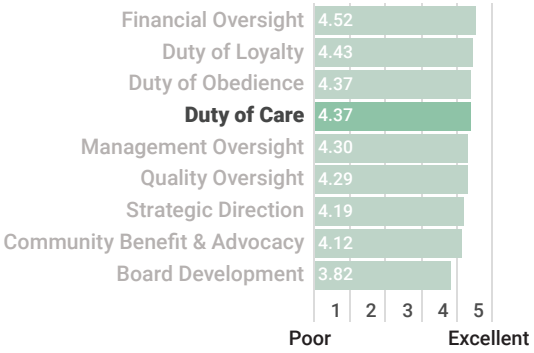
Reader's guide reminder: Results in this section are reported as composite scores—essentially, a weighted average of responses. There are two scales used in this section:

1. An adoption scale (whether the practices have been adopted or not, a scale of 1–3)
2. A performance scale of 1–5 (poor, fair, good, very good, and excellent). The performance ratings are for the overall performance in a given area, not for the individual board practices.

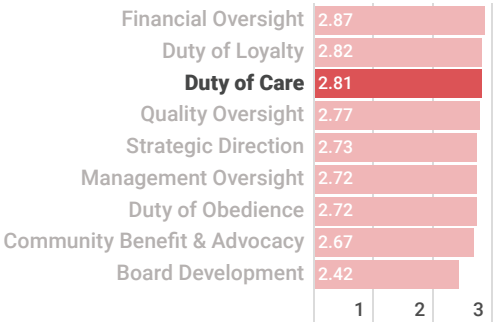
DUTY OF CARE: KEY POINTS

- CEOs gave boards' performance in duty of care the third-highest performance score (4.37 out of 5, tied with duty of obedience).
- Duty of care is third in adoption of recommended practices; it ranked second in 2019 (tied with duty of loyalty) and 2015, and first in 2013.
- The duty of care practices appear to be widely adopted across all types of organizations; the most widely adopted practices are:
  - 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.
- No significant declines in adoption were observed this year.
- The practice showing the highest increase in adoption from 2019 is: The board assesses its governance model including structure, policies, processes, and board expectations at least every three years (2.70 vs. 2.60 in 2019). This increased for all organization types, with the most significant increase for subsidiary hospitals with advisory boards (2.57 vs. 2.00 in 2019).
- Subsidiary hospitals with advisory boards also saw significant increase in adopting: 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 (2.71 vs. 2.00 in 2019).

Board Performance Composite Scores
(All Respondents)

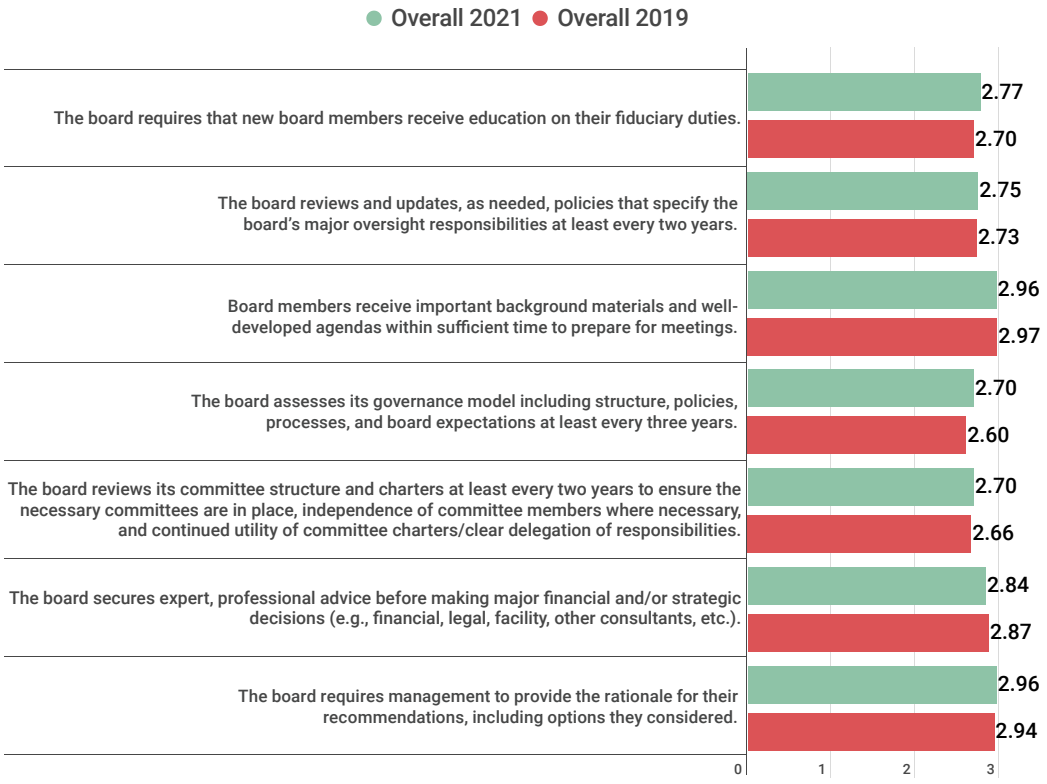


Adoption of Practice Composite Scores
(All Respondents)



3 = Currently have adopted the practice
2 = Have not adopted the practice but are considering it and/or working on it
1 = Have not adopted and do not intend to adopt the practice

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

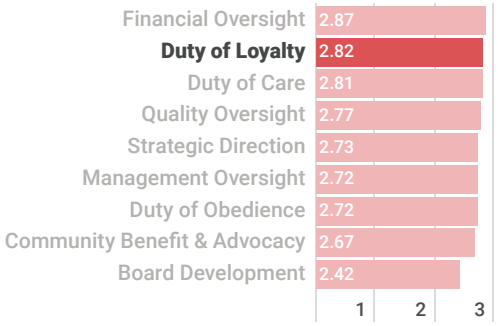


DUTY OF LOYALTY: KEY POINTS

- Duty of loyalty is rated second in performance (same as 2019, but up from third in 2015 and 2013).
- Just as in 2019, it is second in adoption; this is a significant increase since 2015 where it was rated sixth.
- The most significant increase in adoption was for the board assessing the adequacy of its conflict-of-interest policy as well as the sufficiency of its conflicts review process at least every two years (2.80 vs. 2.67 in 2019). Systems had the biggest increase in adoption of this practice, moving from 2.60 in 2019 to 2.86 in 2021.
- There were no significant decreases in adoption overall; only a slight decrease in the board enforcing a written policy that states that deliberate violations of conflict of interest will require disciplinary action or potential removal from board service (2.69 vs 2.75 in 2019).
- 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 (same as in 2019). All organization types scored above 2.90 for these practices.
- Subsidiary hospitals with advisory boards also showed decreased adoption of a specific process by which potential conflicts are reviewed by independent, non-conflicted board members (2.63 vs. 3.00 in 2019).
- The least adopted practice is having a written policy outlining the organization's approach to physician competition/conflict of interest, with government-sponsored hospitals having the lowest adoption and decline (2.33 vs. 2.44 in 2019). Subsidiary advisory boards also had a significant drop in adoption of this practice (2.71 vs. 3.00 in 2019).

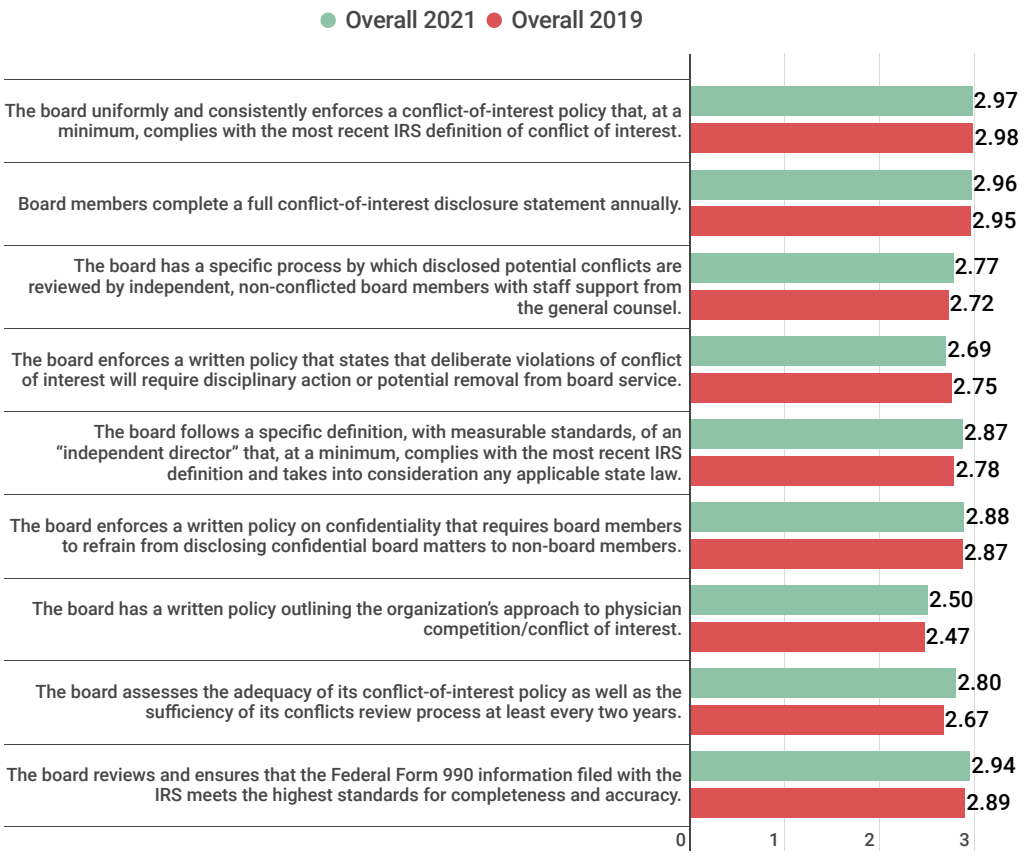
Board Performance Composite Scores
(All Respondents)

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)*



The Critical Importance of Continuing Conflicts Oversight

Michael W. Peregrine, Partner, McDermott Will & Emery LLP

SPECIAL COMMENTARY

Hospital and health system boards need to take conflicts-of-interest oversight seriously and not treat it as an afterthought. This is one of the major board takeaways from The Governance Institute's 2021 biennial survey.

The issue isn't whether most hospitals and health systems have in place leadership-level conflicts-of-interest protocols; they do. Rather, the issue—as raised in this year's survey—is whether they are committed to maintaining those protocols in a manner consistent with the evolving sophistication of the organization. Are their conflicts policies keeping up with organizational growth and diversification? If they are, it's a mark of attentive governance. If they're not, it's a problem.

What's the basis for this observation? Among the survey's multiple duty of loyalty-related questions are two that relate directly to the process of maintaining conflicts policies and practices updated and current. One question speaks to whether the board "has a specific process by which disclosed conflicts are reviewed by independent, non-conflicted board members with support from the general counsel." Another question asks if the board "enforces a written policy that states that deliberated violations of conflict of interest will require disciplinary action or potential removal from board service."

For these "no-brainer" questions, the survey results are surprisingly mediocre. While the overall results for most of the duty of care and duty of loyalty questions reflect very high levels of compliance by respondents, the results on these and several related questions are closer to the average than they are to the top tier of performance. For such an essential duty-of-loyalty compliance element, the survey numbers really stand out. What's the hesitation? What's the holdback?

Assiduous board-level attention to conflicts identification and resolution is less a "best practice" than it is an expectation amongst leading hospitals and health systems. Few industry sectors have changed more in scope and orientation in recent years than healthcare—especially provider organizations. They have grown, diversified, invested, ventured, expanded their operational portfolios, and generally increased the sophistication with which they operate. Their boards have diversified across the spectrum, not only as to race and gender but also as to competencies and experiences.

As provider organizations have grown, diversified, and expanded their operational portfolios and sophistication, their boards have diversified across the spectrum, including competencies and experiences. The risk of ignoring how these changes affect conflicts policies and procedures is felt in the ability to protect against reputational harm, the threat to the sustainability of transactions, and the need to recruit and retain dedicated directors and trustees.

Common sense, as well as diligent evaluation, would suggest that the scope of potential conflicts arising from this change and diversification would be substantial. Hospitals and health systems are involved in more businesses; have more vendor relationships, investments, and partnerships; and have more officers, directors, and other leaders with more relationships and interests. All in all, this provides plentiful fodder for actual and apparent conflicts. And the risk of ignoring how this change and evaluation affects conflicts policies and procedures is felt in the ability to protect against reputational harm, the threat to the sustainability of transactions, and the need to recruit and retain dedicated directors and trustees.

Thus, there is a need to consistently review and upgrade the conflicts protocol on a regular basis. That includes a number of steps. As to the conflicts policy, that means evaluating whether it is broad enough to cover the entirety of the corporate system and its officers and directors; whether it adequately covers the types of interests and relationships that can create conflicts; and whether it fairly and appropriately captures interests with competitors. As to the disclosure questionnaire, it needs to present the types of questions that will capture the range of likely conflicts, and it must demand vigorous attention by directors to identify interests and a commitment to make full and complete disclosure. It also means dealing appropriately with directors who do not satisfy the policy or who possess material conflicts. And, finally, it means assuring that the board truly understands what is at issue, and addresses the potential for conflicts in the transactions that it is asked to approve.

Effective conflicts resolution also impacts the director recruitment and board diversity efforts. The nomination process should include active review of a candidate's existing interests, relationships and other potential biases so that when appointed they will come with known, pre-existing conflicts. The desire for industry and issue-specific competencies and diversities across the spectrum is not an excuse to ignore the conflicts potential arising from otherwise problematic nominations.

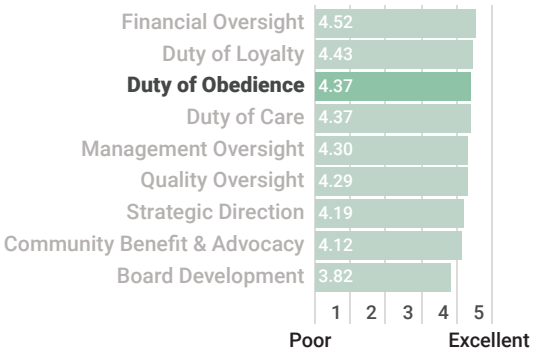
Perhaps in reality the survey results project more of a problem than what really exists; most hospitals and health systems do maintain appropriately scoped conflicts-of-interest policies. But even so, the data as presented provides a useful purpose—it's mirror-looking time for boards. Are our conflicts policies and practices really up to grade? Are we applying the most sophisticated approach to conflicts identification and resolution? Could it be that we are behind our peers in this practice? Those questions deserve fair board review—and a recognition that the "fix" to any identified deficiencies is likely to be as cultural as it is procedural.

DUTY OF OBEDIENCE: KEY POINTS

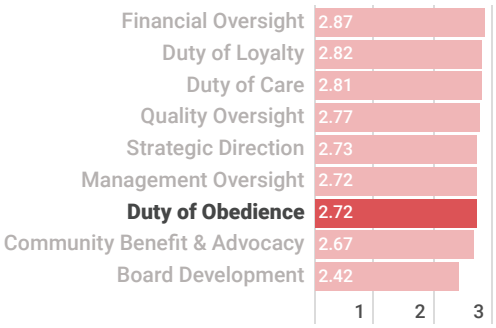
- CEOs gave boards' performance in duty of obedience the third-highest performance score (4.37 out of 5, tied with duty of care). This is the same as in 2019, but an improvement since it was fifth in 2015.
- However, duty of obedience is ranked sixth in adoption of recommended practices (tied with management oversight). This is down from fifth place in 2019 and fourth place in 2015.
- Consistent with 2019, 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 organizations scored 2.89 or higher.)
- Adoption rates that had the most significant increase were for the following practices:
  - The board establishes a risk profile for the organization and holds management accountable to performance consistent with that risk profile. (All organization types increased adoption of this practice.)
  - Board members responsible for audit oversight meet with external auditors, without management, at least annually. (All organization types saw a significant increase, except systems, which experienced a decrease from 2.94 in 2019 to 2.76 in 2021.)
- Overall, adoption did not dramatically decrease; seven of the practices saw a slight decrease (between 1–4 points). Systems scored much lower this year on the board having established a direct reporting relationship with legal counsel (2.48 vs. 2.73 in 2019).

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

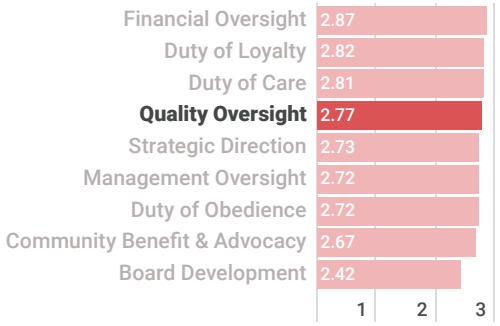
Exhibit 38. Duty of Obedience Composite Scores *(Adoption)*

QUALITY OVERSIGHT: KEY POINTS

- CEOs gave boards' performance in quality oversight fifth place (4.29 out of 5, an increase from 4.17 in 2019).
- Quality oversight is ranked fourth in adoption of practices (same as in 2019).
- The most highly adopted practice was that the board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.
- While the adoption score is the lowest of the 11 practices, the practice with the biggest increase in adoption is: the board allocates sufficient resources to developing physician leaders and assessing their performance (2.53 vs 2.39 in 2019). All organization types increased their adoption of this practice.
- Systems significantly increased their inclusion of objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation (2.96 vs. 2.78 in 2019).
- Practices that have been shown to improve quality of care (process of care and/or risk-adjusted mortality) are:[2]
  - Establishing a board-level quality committee *(systems and subsidiary hospitals 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 systems, independent hospitals, and government-sponsored hospitals).*
  - Requiring all clinical programs/services to meet quality-related performance criteria *(this practice is adopted across all organization types, with subsidiaries having the highest adoption scores).*
  - Devoting a significant amount of time to quality issues/discussion at most board meetings *(all organization types had a slight decrease in scores for this practice; subsidiaries have the highest adoption).*
  - Participating in development/approval of explicit criteria to guide medical staff appointments, reappointments, and clinical privileges *(systems and subsidiaries 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 up for most organizations this year, except for government-sponsored hospitals; systems have the highest adoption scores).*
  - Willingness to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff *(this practice is widely adopted across all organization types, with systems and subsidiaries having the highest adoption scores).*

Board Performance Composite Scores
(All Respondents)

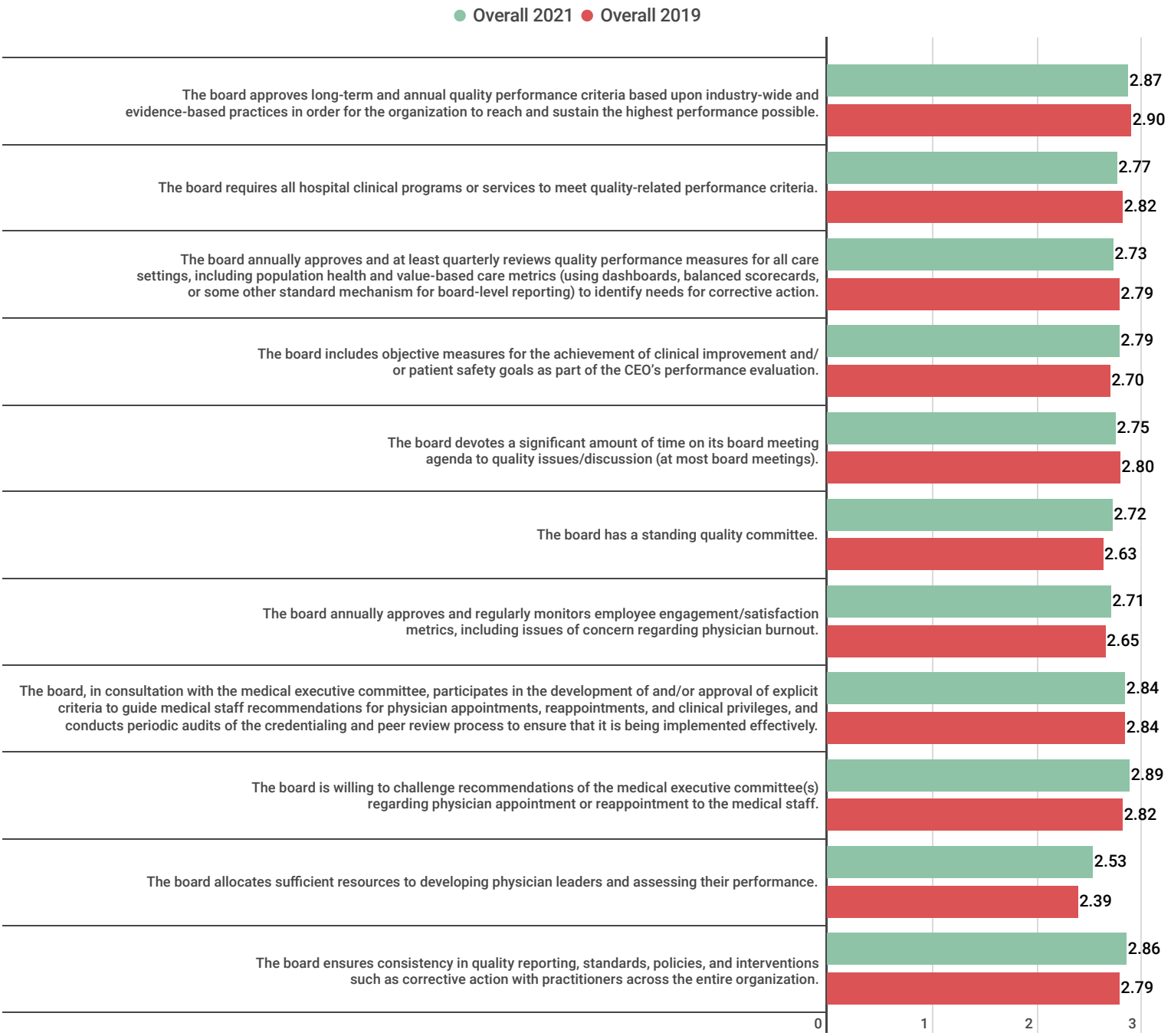
Adoption of Practice Composite Scores
(All Respondents)



3 = Currently have adopted the practice
2 = Have not adopted the practice but are considering it and/or working on it
1 = Have not adopted and do not intend to adopt the practice

2 As reported in: Larry Stepnick, *Making a Difference in the Boardroom: 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)*



Responsible Governance Has Its Finger on the Pulse of Quality

Antoinette Hardy-Waller, M.J., B.S.N., RN, President & CEO, The Leverage Network; Board Member and Chair of the Quality, Safety, & Patient Experience Committee, CommonSpirit Health, Chicago

SPECIAL COMMENTARY

Quality must be at the heart of every healthcare organization's mission. Providing care that improves population health, is safe, and affords an excellent patient experience should be the "why" any provider exists. As with other elements of performance, it takes all hands on deck, including a well-informed board that regularly reviews data on adverse events, community health, and public ratings among other essential metrics. In fact, research has demonstrated a correlation between board prioritization of quality oversight and enhanced performance on key quality measures.[3] Despite this, governance has been an underutilized lever to deliver the very best care across all dimensions of quality.

Although there are some impressive numbers across other key performance indicators in this report, board oversight of quality is at 4.29 on a scale of 1.0 to 5.0. Though a slight improvement from 2019 (4.17), it remains well below financial oversight, fiduciary duties, and management oversight. Fewer than 80% of respondents said their boards devote significant time on their agendas for quality issues/discussion. I find that this lower emphasis on quality in some organizations is not because boards don't find quality important; it's that they may not have a strong working knowledge of the importance of clinical quality and therefore are not as engaged.

Collectively, this inattention leads to tolerance of a U.S. healthcare system in which at least a quarter of all procedures represent waste,[4] life expectancy is lower than comparable countries,[5] and costs are double those of any other nation.[6]

We must pause for a moment to consider the COVID Effect. During the public health emergency, providers were given a "time out" on quality reporting and the resulting ratings systems. Keeping the doors open amid a falloff in elective procedures and attention to managing a devastating crisis may have sidetracked a focus on clinical quality matters.

And yet, decades after the publication of *To Err is Human* and endless research on waste and ineffective care, it is surprising that this survey finds that the practice of reviewing quality scorecards regularly fell slightly from 2019. Having a quality scorecard is key to being able to articulate the organization's goals and progress toward those goals. Management is often incented to achieving set goals, including quality, and it is hard to see how a board that won't hold regular discussions on the topic can perform this oversight effectively.

I was privileged to serve as Chair of the Quality and Safety Committee of the board of Catholic Health Initiatives (CHI), a legacy organization to what is now CommonSpirit Health. We embarked on a journey to significantly enhance clinical performance. It involved a unique partnership between the board, CEO, and senior leadership. It began with building the board's knowledge and understanding of quality and its impact across all facets of the organization to gain better engagement and ownership. A quality discussion (affectionately called, "a quality moment") was on the agenda for every board meeting. It helped that our CEO, Kevin Lofton, made quality a personal priority as a significant part of his performance evaluation.

For CHI, getting the board on board for quality was just a first step. Developing a balanced scorecard that would capture "big dot" indicators—whole-system measures that reflect the overall quality and performance of the entire enterprise—would prove to be a challenge of time and resources. Having board buy-in and ownership of quality as a priority made the decision to allocate needed resources an easy one. A "single source of truth" analytics platform aligned the board with senior-level management, enabling alignment on measures and progress. Over one year, we realized double-digit quality improvements across the scorecard.

The COVID Effect has another dimension—the pandemic changed how we perceive care delivery. Caring for patients outside of the hospital walls has become more prevalent. If we truly want to provide the very best care possible to all we serve, we now know we must better understand the nature of communities we serve: the people, the cultures, and the impact of systemic racism on health indicators. The staggeringly disproportionate impact of COVID on people of color is a wakeup call for boards.

How do we begin to effectively address health equity in our own organizations? We have made health equity a priority at CommonSpirit Health. We have learned that how we improve quality is inextricably tied to how we eradicate the social, economic, environmental, and clinical drivers of inequity. We are working to ensure that we are accurately capturing race, ethnicity, and language data in defined acute and ambulatory encounters across the enterprise. We aim to build on this foundational work to further capture information that allows us to meaningfully and measurably close equity related gaps in care for those we serve.

High-performing organizations will be those that understand clinical quality as central to the enterprise, and at the same time know that this can only be achieved if all people rightfully receive the very best care we can provide every time we touch their lives.

3 Institute of Medicine, *To Err Is Human: Building a Safer Health System,* The National Academies Press, 1999.

4 W.H. Shrank, T.L. Rogstad, and N. Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," *JAMA,* Vol. 322, No. 15 (2019): pp. 1501–1509.

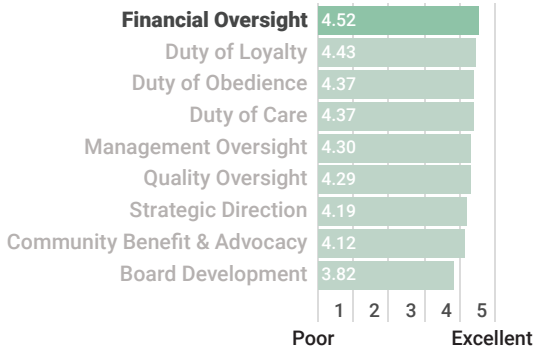
5 Peterson-KFF Health System Tracker, "How does U.S. life expectancy compare to other countries?," September 28, 2021.

6 Peterson-KFF Health System Tracker, "What drives health spending in the U.S. compared to other countries?," September 25, 2020.

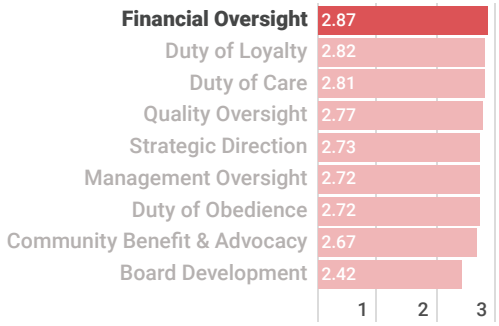
FINANCIAL OVERSIGHT: KEY POINTS

- CEOs again gave boards' performance in financial oversight the highest performance score (4.52 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 highest adoption is for these two practices:
  - The board reviews financial feasibility of projects before approving them. (All organization types have fully adopted this practice, except subsidiary hospitals with advisory boards.)
  - The board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it. (All organization types have adopted this practice at a rate of 2.97 or higher, except subsidiary hospitals with advisory boards, which rate at 2.67.)
- The lowest-adopted practice is ensuring 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 a relatively high overall adoption rate of 2.64, with all organization types at 2.60 or above).
- All organizations except subsidiary hospitals with advisory boards saw a decrease in adoption for the board annually reviewing and approving the investment policy. Government-sponsored hospitals saw the biggest decrease in adoption of this practice (2.57 vs. 2.76 in 2019), followed by subsidiary hospitals with fiduciary boards (2.75 vs. 2.92 in 2019).
- For subsidiary hospitals with fiduciary boards, the adoption rate for five out of the six practices is 100% or 3.00.

Board Performance Composite Scores
(All Respondents)

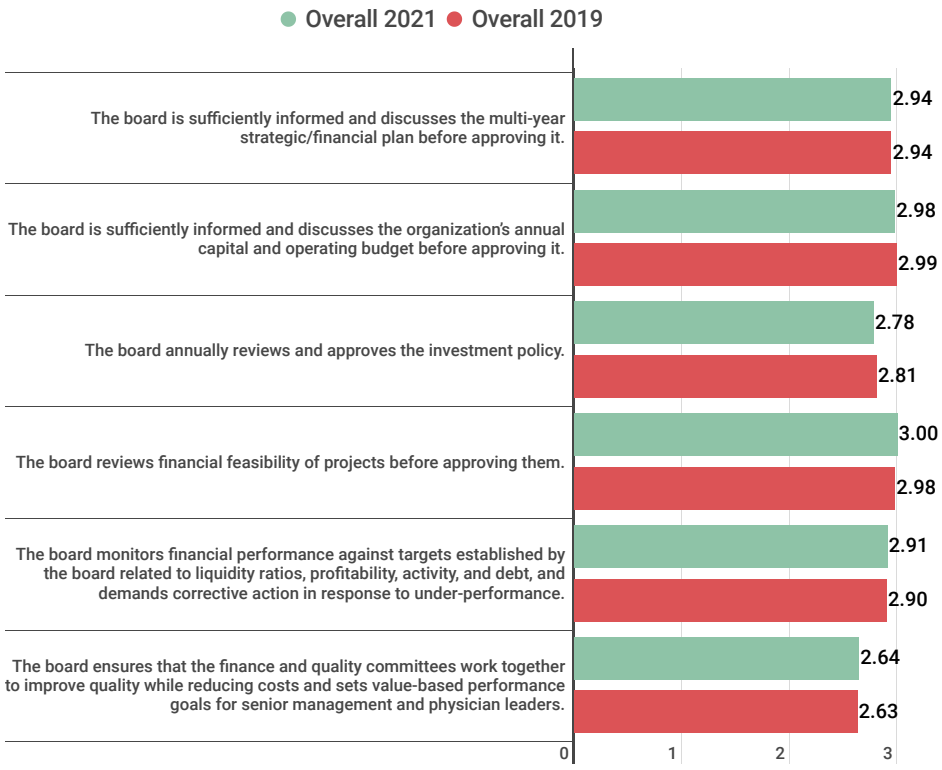


Adoption of Practice Composite Scores
(All Respondents)



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)*



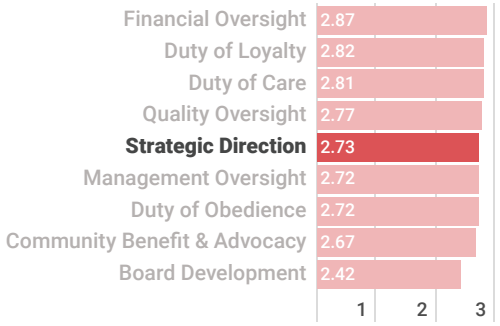
STRATEGIC DIRECTION: KEY POINTS

- CEOs gave boards' performance in setting strategic direction the third-lowest rating (4.19 out of 5; the same rank as 2019, although the score went up from 4.08).
- Strategic direction is ranked fifth in adoption of practices (up from sixth in 2019 and seventh in 2011, 2013, and 2015).
- The most highly adopted practice is: the full board actively participates in establishing the organization's strategic direction (with an overall score of 2.91, same as in 2019).
- Prevalence of adoption of practices remained very similar for most practices since 2019 with the board requiring management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability having the biggest increase (2.50 vs. 2.38 in 2019). All organizations scored higher on this practice, especially subsidiary hospitals with fiduciary duties (2.85 vs. 2.32 in 2019), subsidiary hospitals with advisory boards (2.57 vs. 2.20 in 2019), and systems (2.59 vs. 2.39 in 2019). In 2019, all organization types had lower adoption rates for this practice than the previous reporting year.
- Similar to previous reporting years, the practice of spending more than half of board meeting time on strategic discussions has the lowest adoption. As in 2011, 2013, 2015, and 2019, more systems have adopted this practice (2.48, which is down from 2.56 in 2019 but higher than the 2015 rate of 2.38).
- In general, government hospitals tend to have slightly lower levels of adoption for these practices, but adoption has increased since 2019 for seven of the practices.

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

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

Taking the Time to Reset

Kenneth Kaufman, Managing Director & Chair, Kaufman, Hall & Associates, LLC

SPECIAL COMMENTARY

Earlier this year, an article in *The New York Times* caught my attention. The article explored the COVID-era phenomenon of "languishing"—a sense of stagnation or just getting by after months of enduring the "collective fog" of the pandemic.[7] It occurred to me that organizations are as susceptible to languishing as individuals, and that few organizations deserve to feel a sense of languishing more than healthcare providers. They have battled multiple surges in COVID infections, each more dispiriting than the last, especially as cases that lead to hospitalization are increasingly concentrated among individuals who could have avoided the worst outcomes by getting vaccinated, but choose not to do so.

Healthcare providers might deserve to indulge in a moment of languish, but it is not an indulgence that can last for long. The agenda facing hospital and health system boards and management is larger and more complicated than ever before. This has created a new fiduciary responsibility: assuring that the organization moves past its collective funk to a path that takes on the many challenges facing hospitals and health systems and creates excitement about the future.

The first step in fulfilling this duty is resetting the strategic plan, and this is going to require an effort that goes well beyond current practice. While The Governance Institute recommends spending more than half of meeting time discussing strategic issues as opposed to hearing reports, the results of the 2021 biennial survey indicate that on average, boards are spending only 30% of their time in active discussion about the organization's strategic priorities, while almost 60% of their time is spent reviewing financial performance, quality and safety metrics, and other reports. The remaining percentage of their time—12%—is dedicated to board education.

The gap between recommendation and current practice in time spent discussing strategic issues is particularly troubling given the enormity of the challenges boards and management face in resetting the strategic plan. No hospital board can set a correct strategic direction without accurately recognizing and reacting to unprecedented external business conditions. To name a few:

- The unknown post-COVID care and economic environment
- Accelerating business technological changes
- Rapidly evolving changes in consumer demand
- The escalating demands of the social justice movement
- Fast-developing strategic requirements of climate change
- A divisive political/business environment
- An American culture that is increasingly difficult to interpret and navigate

Every board also must recognize the power and influence of a fast-changing stakeholder environment. In the recent past, healthcare system stakeholders included the board, management, and doctors—period. But now, the stakeholders that impinge on health system operations and policy include patients, employees, sub-groups of employees, multiple communities, local government, state government, the federal government, political movements, religious influences, other not-for-profit organizations, big media, and social media. It all comes together to form an essentially uncontrollable business environment that seems to change by the day and sometimes by the hour.

The sheer number and complexity of these issues point to the question of board development, another area where current practice lags recommended performance. Board members cannot be expected to equip themselves fully with the knowledge they need to take on all the issues they must address; board and management leaders should be identifying areas where board education is needed and devoting time to board development accordingly. The results, however, indicate that board development is where hospitals and health systems are performing the worst; in fact, it is the only area where performance is closer to "poor" than to "excellent."

An issue such as social justice or climate change cannot be addressed as a simple discussion point on a board agenda, let alone in a report from management. These issues will require thoughtful board development and intensive and potentially emotional discussions as the board and management come to terms with the potential impact of these issues on the health system, determine the health system's response, understand potential repercussions, and set the strategic direction accordingly.

The issues that board and management face are the same that are creating the sense of languishing with which I began this commentary, and they are affecting individual staff as well. There is almost certainly a connection between individual languishing and the phenomenon that is being described as "the great attrition"—the more than 15 million U.S. workers who have quit their jobs since April 2021.[8] This phenomenon stretches across industries, including healthcare: McKinsey data indicates that 36% of healthcare and social assistance workers are at least "somewhat likely" to leave their job in the next three to six months. Individuals are looking for a reason to reengage and get excited about the work they do.

A clear message from the board and management that they understand the issues that are troubling staff—and have set a clear strategic direction that addresses these issues head on—will help generate the excitement needed to move from languishing to thriving, both as individuals and as a collective organization. But this will require dedicating much more time to board development and active discussion. Few items are more important today than strategic direction: board and management leaders need to put in the time needed to get it right. They will find that it is time well spent.

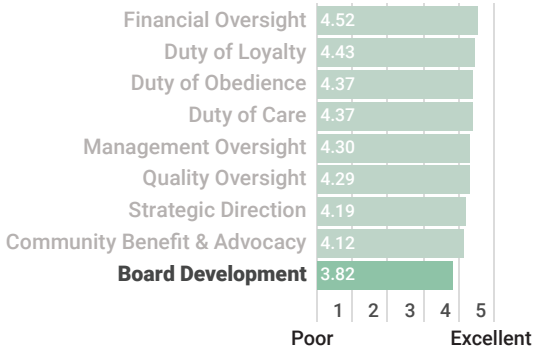
7 Adam Grant, "There's a Name for the Blah You're Feeling: It's Called Languishing," *The New York Times,* April 19, 2021; updated July 29, 2021.

8 Aaron De Smet, Bonnie Dowling, Marino Mugayar-Baldocchi, and Bill Schaninger, "'Great Attrition' or 'Great Attraction'? The Choice Is Yours," McKinsey & Company, Sept. 8, 2021.

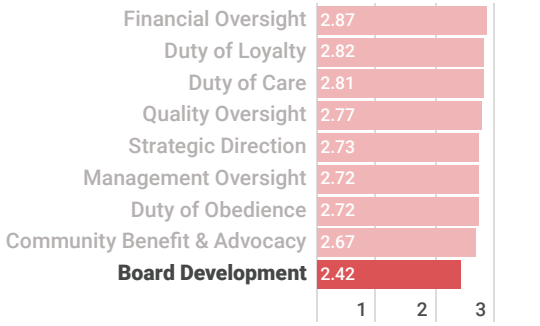
BOARD DEVELOPMENT: KEY POINTS

- CEOs again gave boards' performance in board development the lowest rating (3.82 out of 5; this rating has increased from 3.62 in 2019).
- Board development is also ranked last in adoption of practices (same as 2013, 2015, and 2019).
- Although board development still ranks last, overall adoption scores improved for every practice except one: the board enforces a policy on board member term limits and retirement age. (This practice decreased from 2.53 in 2019 to 2.35 in 2021, with all organization types having a significant decrease besides subsidiary hospitals with fiduciary boards.)
- The most significant increase in adoption for all types of organizations is: the board sets annual goals for board and committee performance that support the organization's strategic plan/direction (2.35 vs. 2.13 in 2019).
- The most highly adopted practice is: 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. Systems and subsidiary hospitals with fiduciary boards continue to be more likely than others to use a formal orientation program for new board members.
- Just as in 2019, the least-adopted practice is: the board uses a formal process to evaluate the performance of individual board members. Government-sponsored hospitals have the lowest adoption rates and saw a decrease this year (1.76 vs. 1.90 in 2019).

Board Performance Composite Scores
(All Respondents)

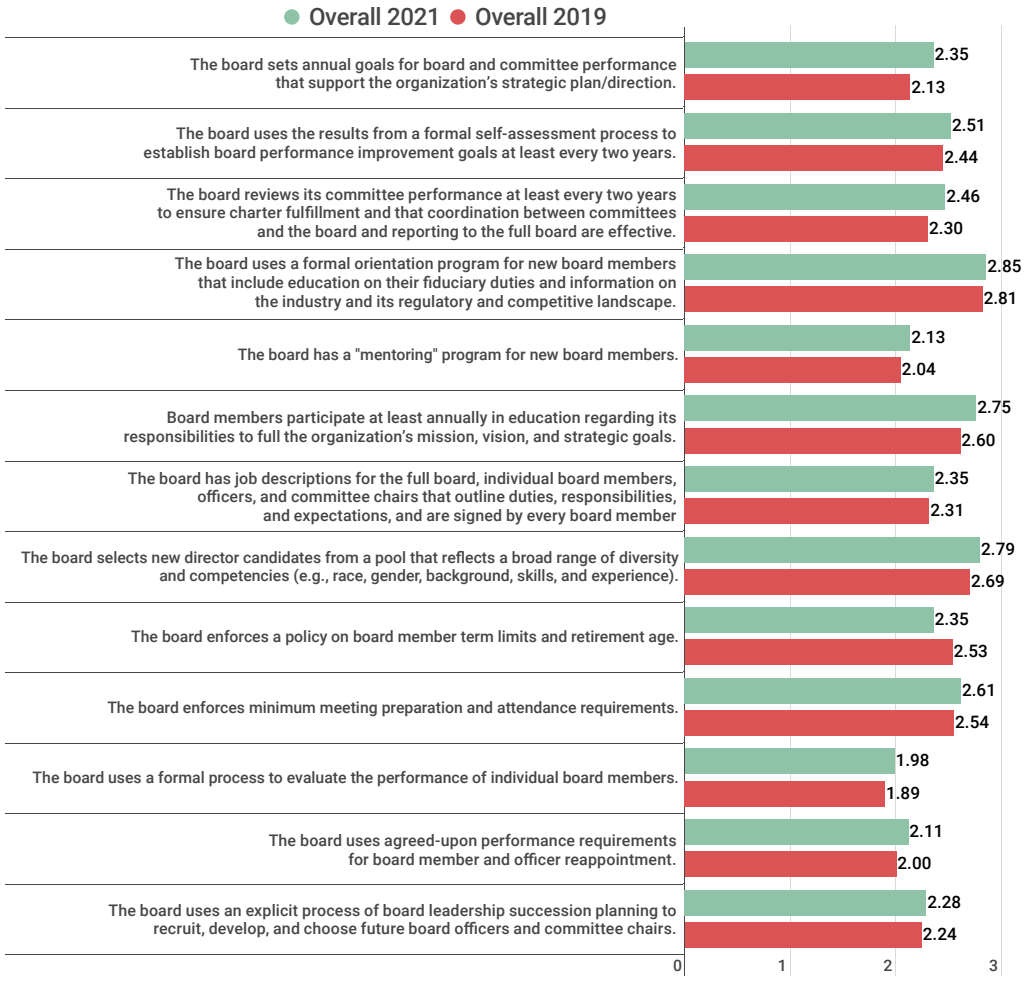


Adoption of Practice Composite Scores
(All Respondents)



3 = Currently have adopted the practice
2 = Have not adopted the practice but are considering it and/or working on it
1 = Have not adopted and do not intend to adopt the practice

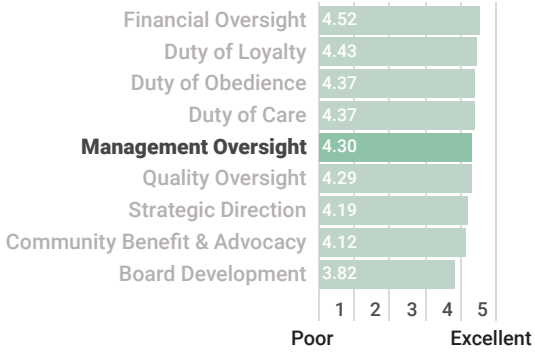
Exhibit 42. Board Development Composite Scores *(Adoption)*



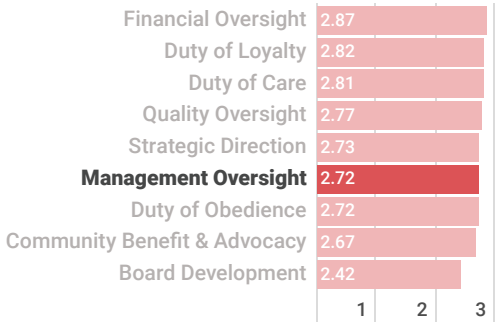
MANAGEMENT OVERSIGHT: KEY POINTS

- CEOs gave boards' performance in management oversight the fourth-highest performance rating (4.30 out of 5; same rank as 2019 but up from 4.19).
- Management oversight is ranked sixth in adoption of practices (tied with duty of obedience). It was ranked seventh in 2019 and fifth in 2015.
- All practices slightly increased in adoption since 2019, with the biggest increase in the board seeking independent expert advice/information on industry comparables before approving executive compensation (2.86 vs. 2.74 in 2019). Independent hospitals and government-sponsored hospitals had the biggest increase, and systems have the highest adoption.
- The least-observed practice continues to be maintaining a written, current CEO and senior executive succession plan; just as in 2019, systems are much more likely than other organizations to have this plan in place.

Board Performance Composite Scores
(All Respondents)

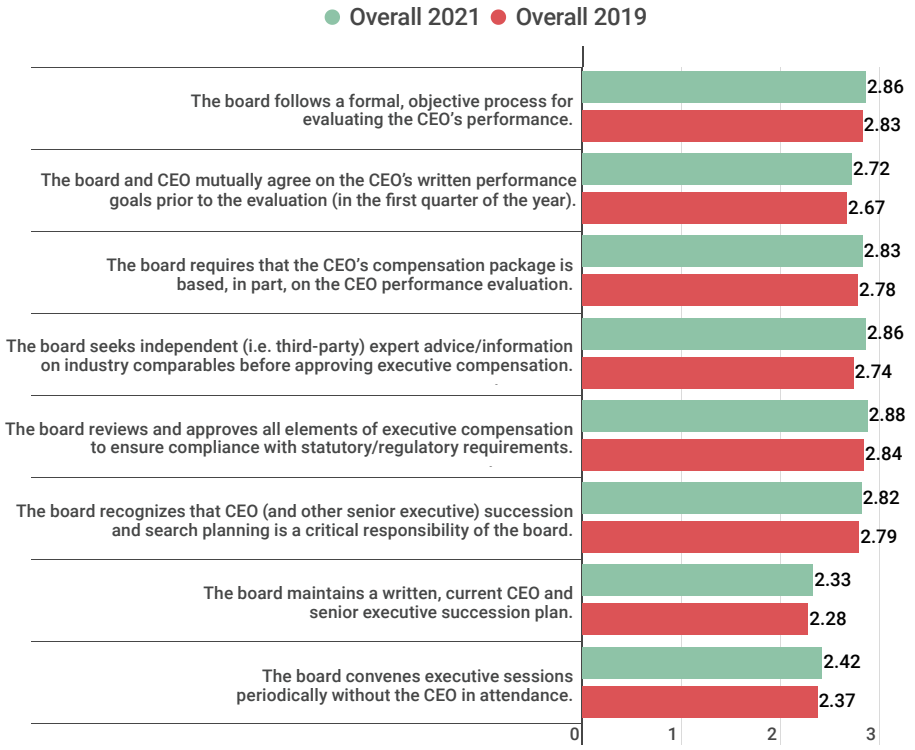


Adoption of Practice Composite Scores
(All Respondents)



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

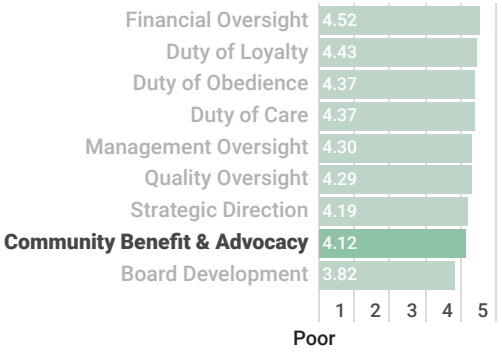
Exhibit 43. Management Oversight Composite Scores *(Adoption)*



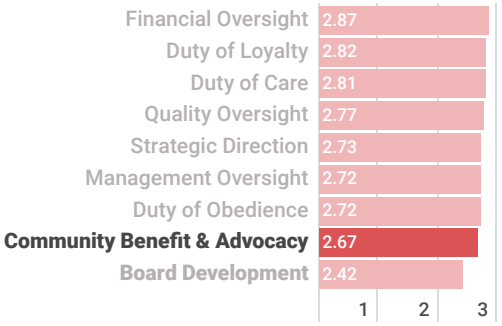
COMMUNITY BENEFIT & ADVOCACY: KEY POINTS

- CEOs gave boards' performance in community benefit and advocacy the second lowest performance rating (4.12 out of 5; same rank as 2019 but up from 3.91).
- Community benefit and advocacy is ranked second to last in adoption of practices (same as 2019 and 2015).
- All practices increased in adoption since 2019 except one: the board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).
- The practice that had the biggest increase was the board ensuring that the organization effectively addresses social determinants of health in the context of its community benefit activities. This practice was new in 2019 and moved from 2.43 to 2.61 in 2021, with scores increasing significantly for all organization types.
- The least-observed practice is having a written policy establishing the board's role in fund development and/or philanthropy (2.20). This has remained one of the least-observed practices in all oversight areas for several reporting years, although there has been a significant increase in adoption over time (increasing from 1.93 in 2015).
- Compared to other practices in this area, the one most adopted by all types of organizations 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.

Board Performance Composite Scores
(All Respondents)

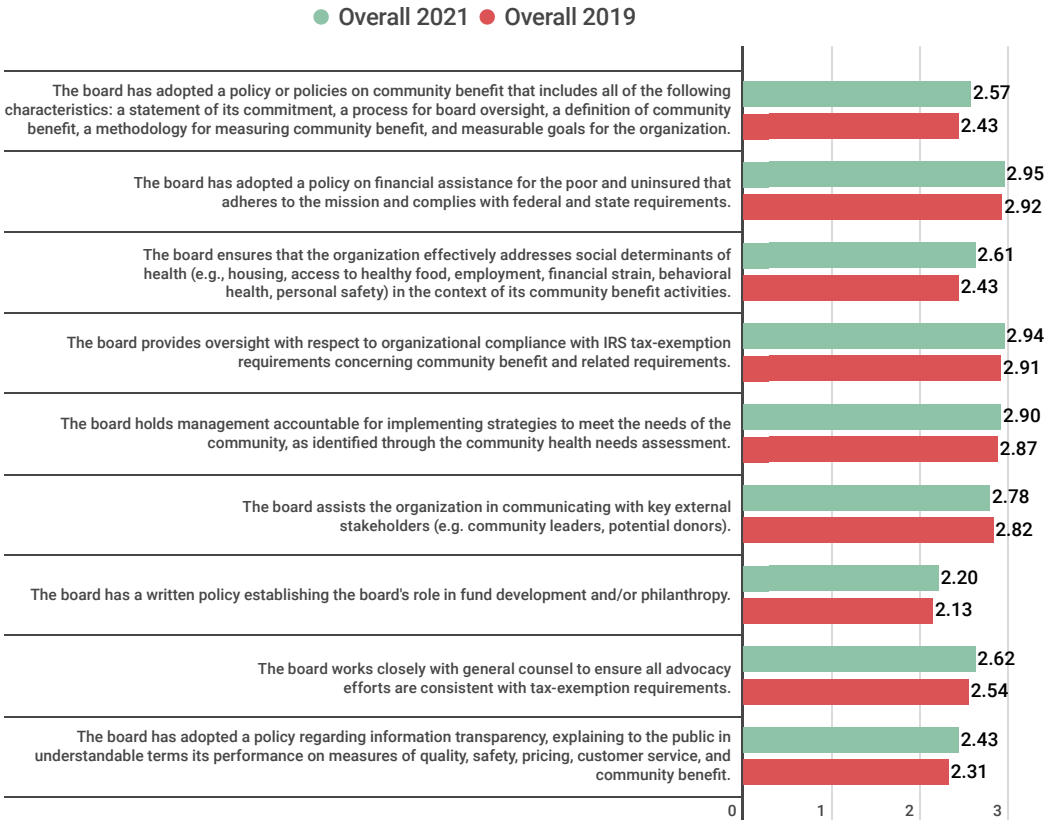


Adoption of Practice Composite Scores
(All Respondents)



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



Rethink the Priority of Community Benefit & Advocacy Practices

Randy Oostra, D.M., FACHE, President & CEO, ProMedica

SPECIAL COMMENTARY

Given the nature of not-for-profit health systems, one would expect community benefit and advocacy to be a top priority. Yet, The Governance Institute's 2021 biennial survey shows community benefit and advocacy ranked among the lowest practice areas adopted by health system boards, with little change over the past eight years. While boards undoubtedly have many priorities vying for their attention, they should rethink their organizations' community benefit and advocacy, as it should be one of the highest-ranked practice areas.

Community benefit and advocacy practices are not only core to not-for-profit health system missions; they are strongly connected to environmental, social, and governance (ESG) standards. ESG standards were derived from investment philosophies, and they are increasingly gaining consumer attention. Consequently, ESG-related action and inaction present significant risk and reward potential.

As consumers demand more from organizations, health systems will undoubtedly find it beneficial to have a solid plan in place. ESG standards and metrics can provide a helpful framework for advanced planning. But, first things first—boards must understand the need to intensify their focus on community benefit and advocacy.

Fulfilling the Anchor Institution Role

In discussions with boards across the country, ProMedica has heard about widely varying approaches to community benefit and advocacy. For some, the approach to the practice area has been no approach at all; the sentiment being, "It's not our job and we don't get paid to do it." That likely stems from the understanding that most administrators do not think about community benefit and advocacy regularly—but they should. Studies show that 80% of an individual's health and well-being are determined by social factors, while only 20% are impacted by traditional clinical care.

It is evident that health systems need to step outside of their comfort zones. They need to focus on how they can significantly impact health outcomes in their communities by addressing the root causes of health and well-being.

Fortunately, several health systems have moved beyond limited thinking to incorporate efforts outside of the clinical setting. But, are those efforts enough? Health systems should ask themselves if they are making the right impact relative to their resources.

It is evident that health systems need to step outside of their comfort zones. They need to focus on how they can significantly impact health outcomes in their communities by addressing the root causes of health and well-being.

Fortunately, several health systems have moved beyond limited thinking to incorporate efforts outside of the clinical setting. But, are those efforts enough? Health systems should ask themselves if they are making the right impact relative to their resources.

For more than a decade, ProMedica's philosophy has centered on the concept that health systems have a responsibility to serve as anchor institutions in their communities. ProMedica's shift from a traditional health system to one that fully embraces its role as a community-based, accountable anchor institution did not happen overnight. It required the board and leadership to think and act differently and to take some risks.

A major part of serving as an anchor institution is taking a leadership role in addressing the social (and personal) determinants of health. To effectively lead, health systems need to move beyond token efforts to more strategic, broad-based plans. ProMedica has taken an "all-in" approach that includes far-reaching efforts, such as establishing a grocery store in a food desert, providing financial coaching, driving workforce development, supporting early childhood and advanced education, and working to improve the safety and energy efficiency of homes.

Of course, making significant progress in SDOH requires resources—namely, funding. Interestingly, "creating a policy establishing the board's role in fund development and/or philanthropy" was the lowest-ranked practice in the survey's community benefit and advocacy category. This is certainly an area that boards should explore further. While ProMedica commits a sizeable amount of its financial resources to SDOH every year, it is also a leader in leveraging philanthropic dollars to support social causes. The organization recently established the ProMedica Impact Fund, a bold, eight-year plan to raise $1 billion for efforts to accelerate and scale SDOH interventions.

To help ensure that anchor institution plans move forward, boards need to make sure the topic becomes and remains a regular part of board meetings—even periodically dedicating several hours to the topic.

Addressing Health Equity/Disparities

Recent social injustices and the COVID-19 pandemic, among other things, have shined a spotlight on health equity and disparity challenges that have long plagued our communities. Minority populations and individuals living in poverty continue to be disproportionately impacted. Life expectancies from one neighborhood to the next can vary by 20 years. As such, efforts to prioritize community benefit and advocacy need to focus on health equity and disparity inside and outside of healthcare settings.

Boards should engage management to better understand health system approaches to diversity, equity, and inclusion. It is important to determine whether a health system welcomes all and protects the dignity of all. Boards should seek to understand if their health

systems are responsive to all stakeholders' diverse needs and expectations. They also should explore efforts to help ensure that everyone associated with their health systems feels seen, heard, valued, and safe.

From an internal perspective, ProMedica's recent efforts to address health equity and disparities include employee education on talent diversity, diversity council and employee resource groups, health equity, and supplier diversity. ProMedica's community efforts on this front include initiatives to address issues such as infant mortality, COVID-19 vaccination in underserved communities, and the impact of adverse childhood experiences.

Advancing Public Health Partnerships

The recent pandemic also has highlighted a lack of integration with public health and a lack of resources for public health. While some health systems think their work should be separate from the public health arena, the pandemic has taught us that we need to take a more active role in coordinating, collaborating, and addressing public health issues.

> A major part of serving as an anchor institution is taking a leadership role in addressing the social (and personal) determinants of health. To effectively lead, health systems need to move beyond token efforts to more strategic, broad-based plans.
>
> To help ensure that anchor institution plans move forward, boards need to make sure the topic becomes and remains a regular part of board meetings—even periodically dedicating several hours to the topic.

Every health system needs to make judgment calls about its resources and what it can accomplish. But, when health systems look at the health and well-being of the community and see gaps that public health cannot fill due to a lack of resources, they need to determine whether or not helping to fill those gaps should be part of their community benefit work.

Preparing to Take Action

The need for health systems to elevate their community benefit and advocacy practices is long overdue. The impact of the COVID-19 pandemic makes taking action more urgent than ever. That does not mean it will be easy. Still, there are steps boards can take to start making progress:

1. Review the health system mission statement.
2. Ask health system leaders to engage in broader discussions about what the organization is and is not doing.
3. Benchmark against health systems that are industry leaders in community benefit and advocacy.
4. Analyze why the health system is not doing some of the things that industry leaders are doing.
5. Consider reprioritizing the health system's efforts.
6. Identify new funding sources that could help support community benefit and advocacy.

By following these steps and becoming familiar with ESG standards and metrics, boards will be well-positioned to bolster the adoption of community benefit and advocacy practices. Boards accepting this challenge will likely be surprised by their progress and the positive impact on their communities.

Advisory Board Practice Adoption

The list below reflects the practices that have been widely adopted by the 9 advisory boards responding to this section of the report (2.9 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 sometimes 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 2.9 and above.

2021 vs. 2019 Comparison: In 2019 this list had 27 practices; this year, our similarly-sized sample reflects wide adoption of only 19 practices (with none under the duty of care or strategic direction; all of the management oversight practices were listed as N/A for more than 40% of these boards and thus those are not reflected here despite some high adoption scores). We will continue to track this in future survey years to gain a more accurate picture of the types of practices advisory boards have in place.

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 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 enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.
- 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.
- The board reviews and ensures that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.

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.
- 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.
- 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.
- The board ensures that the annual compliance plan is properly updated, implemented, and effective.

Quality Oversight

- The board has a standing quality committee.
- The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.
- 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.
- The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.

Financial Oversight

- 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.

Board Development

- 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).

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 holds management accountable for implementing strategies to meet the needs of the community, as identified through the community health needs assessment.

Analysis of Results

Overall, performance scores are higher this year for all fiduciary duties and core responsibilities. 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. Importantly, this year we are seeing the percentage of organizations selecting "not applicable for our board" across many of the practices decrease since 2019, which we consider to be a strong indicator that our list of practices is directly relevant to what nonprofit healthcare boards should be doing in order to fulfill their organizational mission and vision.

We are pleased to see that all organization types are continuing to score high in financial oversight, especially given the financial disruptions caused by the pandemic. Duty of loyalty significantly increased in adoption in 2019 and continues to be highly adopted in 2021. This shows that boards are maintaining their focus on conflict-of-interest issues. Most boards are enforcing conflict-of-interest policies and completing conflict-of-interest disclosure statements annually, and an increasing number of boards are regularly assessing the adequacy of their conflict-of-interest policy and review process. Duty of care also remains towards the top of the list for adoption and performance. More boards are regularly assessing their governance model including structure, policies, processes, and board expectations. This is critical in the ever-evolving healthcare industry where having a sound governance model in place is key to the board being able to effectively lead the organization. While there has been a steady but small decrease in adoption of duty of obedience practices, one notable increase is that more boards across all organization types are establishing a risk profile for the organization and holding management accountable to performance consistent with that risk profile.

While community benefit and advocacy is still low in both performance and adoption scores, it is encouraging to see that these performance scores improved the most. All organizations saw improvement in the board increasing their efforts to ensure their hospitals and health systems are effectively addressing social determinants of health. This is critical at a time when it is clear just how much impact outside factors (e.g., housing, access to healthy food, employment, and behavioral health) have on a community's health.

Board development remains at the bottom of the list for both performance and adoption scores, but this practice also saw significant improvement in scores this year. 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, given the heightened awareness in the benefits this brings to an organization. Many more boards are also setting annual goals for board and committee performance that support the organization's strategic plan/direction. But there are still some key practices where performance (while increasing) is low, such as having an effective board leadership succession planning process, agreed-upon performance requirements for board member and officer reappointment, and establishing a mentoring program for new board members. The least-adopted practice in this area continues to be using a formal process to evaluate the performance of individual board members, which is important to ensure that members are effectively contributing to board work and continually developing their skills, as well as enabling the board to apply reappointment criteria.

The previous survey showed a decrease in adoption scores for management oversight practices, so it was great to see those scores increase this year. The least-observed practice continues to be maintaining a written, current CEO and senior executive succession plan. Adoption has gone up during the last reporting periods, but all organizations need to be better prepared for both planned and unforeseen changes in leadership.

In 2023 we will be looking for improved performance and adoption of the practices regarding setting strategic direction. We were not surprised to see performance in this area struggle this year due to the pandemic forcing our nation's boards and executive leadership to dig into real-time crises, making it extremely difficult to maintain focus on the future. But we know that this focus must begin again in earnest, in a way that hasn't been done before, as soon as possible.

Most & Least Observed Practices

Many of the 89 recommended practices tend to be either in place or under consideration by respondents. We identified the ***most observed*** practices[9] for all respondents except those who selected "not applicable in our organization." This list of 14 practices includes (those with an asterisk were also on the 2019 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.*

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 reviews and ensures that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.

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 ensures that the annual compliance plan is properly updated, implemented, and effective (e.g.,

9 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.

systems for detecting, reporting, and addressing potential violations of law or payment regulations; new legislation; updates to current regulations; etc.).

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.*

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 2019 and 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 2021 and 2019.

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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	128	8	11	109	18	10	0	2	125	25	79	1	5	60	39	16	11	1	1
Yes, for all board activities	53.9%	50.0%	63.6%	53.2%	83.3%	90.0%	0.0%	100.0%	53.6%	48.0%	50.6%	0.0%	40.0%	53.3%	59.0%	43.8%	54.5%	100.0%	0.0%
Yes, for some board activities	31.3%	50.0%	27.3%	30.3%	5.6%	0.0%	0.0%	0.0%	32.0%	28.0%	35.4%	100.0%	60.0%	28.3%	28.2%	43.8%	36.4%	0.0%	100.0%
No, our board makes recommendations to another fiduciary body/is considered an advisory board	14.8%	0.0%	9.1%	16.5%	11.1%	10.0%	0.0%	0.0%	14.4%	24.0%	13.9%	0.0%	0.0%	18.3%	12.8%	12.5%	9.1%	0.0%	0.0%
How is your board selected?																			
Total responding in each category	336	88	164	84	95	39	9	8	312	19	148	10	64	168	72	32	38	16	10
Elected by the public	10.7%	3.4%	19.5%	1.2%	33.7%	25.6%	33.3%	0.0%	11.5%	0.0%	2.7%	0.0%	0.0%	19.0%	1.4%	3.1%	5.3%	0.0%	0.0%
Appointed by a government body	28.3%	22.7%	35.4%	20.2%	54.7%	61.5%	44.4%	75.0%	28.8%	10.5%	19.6%	20.0%	15.6%	35.1%	19.4%	31.3%	23.7%	18.8%	0.0%
Appointed by a parent/system	16.7%	21.6%	1.8%	40.5%	1.1%	2.6%	0.0%	0.0%	17.0%	47.4%	18.2%	50.0%	21.9%	8.3%	22.2%	21.9%	31.6%	25.0%	30.0%
Self-perpetuating	35.1%	39.8%	32.3%	35.7%	5.3%	5.1%	0.0%	12.5%	34.6%	36.8%	48.6%	30.0%	48.4%	28.6%	43.1%	37.5%	34.2%	50.0%	60.0%
Other	9.2%	12.5%	11.0%	2.4%	5.3%	5.1%	22.2%	12.5%	8.0%	5.3%	10.8%	0.0%	14.1%	8.9%	13.9%	6.3%	5.3%	6.3%	10.0%
Total number of seated, voting board members (includes vacant positions for which you currently are recruiting)																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
1 to 7	20.2%	8.6%	30.8%	10.4%	52.7%	50.0%	55.6%	37.5%	21.5%	5.6%	10.1%	0.0%	0.0%	32.1%	7.5%	9.7%	8.8%	6.7%	0.0%
8 to 10	16.1%	9.9%	21.4%	11.7%	26.9%	28.9%	11.1%	50.0%	17.1%	5.6%	14.4%	22.2%	5.2%	23.5%	11.9%	12.9%	0.0%	6.7%	0.0%
11 to 15	36.9%	38.3%	32.1%	45.5%	11.8%	10.5%	33.3%	12.5%	34.8%	55.6%	48.2%	11.1%	48.3%	30.9%	46.3%	41.9%	38.2%	53.3%	25.0%
16 to 22	21.5%	32.1%	13.2%	27.3%	5.4%	5.3%	0.0%	0.0%	21.5%	33.3%	23.0%	22.2%	39.7%	11.1%	32.8%	22.6%	38.2%	20.0%	62.5%
23 to 30	2.8%	8.6%	0.0%	2.6%	1.1%	2.6%	0.0%	0.0%	2.7%	0.0%	1.4%	33.3%	5.2%	0.0%	1.5%	3.2%	14.7%	6.7%	12.5%
31 +	1.6%	2.5%	1.3%	1.3%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	2.2%	11.1%	1.7%	0.6%	0.0%	9.7%	0.0%	6.7%	0.0%
Average	12.87	15.33	11.19	13.75	8.34	8.89	8.78	7.88	12.67	14.11	14.01	20.33	15.86	10.27	14.25	17.52	16.09	15.33	17.88
Median	13	15	10	14	7	7	7	8.5	12	14	13	20	15	9	14	14	16	14	16
Range	0 to 78	2 to 39	0 to 78	0 to 32	0 to 27	0 to 27	5 to 15	2 to 11	0 to 78	5 to 22	0 to 78	10 to 34	8 to 39	0 to 32	5 to 24	2 to 78	4 to 28	5 to 34	14 to 30

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0 to 2	2.5%	1.2%	1.3%	6.5%	3.2%	2.6%	0.0%	12.5%	2.7%	5.6%	2.9%	0.0%	0.0%	3.1%	1.5%	6.5%	0.0%	0.0%	0.0%
3 to 4	2.5%	3.7%	1.9%	2.6%	3.2%	0.0%	0.0%	0.0%	2.7%	5.6%	1.4%	11.1%	1.7%	3.1%	0.0%	6.5%	2.9%	0.0%	0.0%
5 to 6	15.8%	7.4%	23.9%	7.8%	37.6%	39.5%	33.3%	25.0%	16.7%	5.6%	9.4%	0.0%	1.7%	23.5%	11.9%	3.2%	5.9%	6.7%	0.0%
7+	79.2%	87.7%	73.0%	83.1%	55.9%	57.9%	66.7%	62.5%	77.8%	83.3%	86.3%	88.9%	96.6%	70.4%	86.6%	83.9%	91.2%	93.3%	100.0%
Average	9.66	11.01	9.09	9.40	6.88	7.21	7.78	6.63	9.54	9.17	10.59	12.67	11.55	8.12	10.30	13.19	11.21	11.07	12.38
Median	9	11	8	9	7	7	7	8	9	10	10	14	11	7	10	10	11	11	13
Range	0 to 75	0 to 30	0 to 75	0 to 24	0 to 19	0 to 19	5 to 15	0 to 9	0 to 75	0 to 15	0 to 75	4 to 18	4 to 30	0 to 18	0 to 19	0 to 75	3 to 20	5 to 19	8 to 17
Number of voting management board members (non-clinician)																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	54.9%	33.3%	76.1%	33.8%	87.1%	78.9%	100.0%	100.0%	54.9%	27.8%	51.8%	11.1%	25.9%	72.8%	43.3%	38.7%	29.4%	20.0%	25.0%
1	36.3%	63.0%	18.9%	44.2%	5.4%	10.5%	0.0%	0.0%	35.8%	50.0%	37.4%	88.9%	70.7%	18.5%	47.8%	51.6%	55.9%	80.0%	75.0%
2	5.4%	2.5%	1.9%	15.6%	3.2%	2.6%	0.0%	0.0%	5.5%	22.2%	6.5%	0.0%	1.7%	5.6%	3.0%	9.7%	8.8%	0.0%	0.0%
3	1.3%	0.0%	0.0%	5.2%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	2.9%	0.0%	0.0%	1.2%	3.0%	0.0%	0.0%	0.0%	0.0%
4 +	2.2%	1.2%	3.1%	1.3%	4.3%	7.9%	0.0%	0.0%	2.4%	0.0%	1.4%	0.0%	1.7%	1.9%	3.0%	0.0%	5.9%	0.0%	0.0%
Average	0.66	0.73	0.46	1.00	0.42	0.71	0.00	0.00	0.67	0.94	0.71	0.89	0.81	0.45	0.87	0.71	1.12	0.80	0.75
Median	0	1	0	1	0	0	0	0	0	1	0	1	1	0	1	1	1	1	1
Range	0 to 11	0 to 4	0 to 11	0 to 7	0 to 9	0 to 9	0 to 0	0 to 0	0 to 11	0 to 2	0 to 11	0 to 1	0 to 4	0 to 7	0 to 11	0 to 2	0 to 9	0 to 1	0 to 1
Number of voting Chief Medical Officer board members																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	89.9%	92.6%	86.8%	93.5%	92.5%	94.7%	88.9%	87.5%	89.4%	94.4%	86.3%	88.9%	93.1%	85.8%	92.5%	100.0%	97.1%	86.7%	87.5%
1	9.5%	6.2%	12.6%	6.5%	7.5%	5.3%	11.1%	12.5%	9.9%	5.6%	12.9%	11.1%	5.2%	14.2%	6.0%	0.0%	0.0%	13.3%	12.5%
2 +	0.6%	1.2%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.7%	0.0%	1.7%	0.0%	1.5%	0.0%	2.9%	0.0%	0.0%
Average	0.12	0.12	0.14	0.06	0.08	0.05	0.11	0.13	0.12	0.06	0.14	0.11	0.14	0.14	0.09	0.00	0.15	0.13	0.13
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 5	0 to 5	0 to 2	0 to 1	0 to 1	0 to 1	0 to 1	0 to 1	0 to 5	0 to 1	0 to 2	0 to 1	0 to 5	0 to 1	0 to 2	0 to 0	0 to 5	0 to 1	0 to 1

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	53.3%	42.0%	64.8%	41.6%	71.0%	68.4%	77.8%	25.0%	56.0%	50.0%	47.5%	66.7%	37.9%	69.1%	32.8%	48.4%	23.5%	40.0%	75.0%
1	20.2%	24.7%	17.6%	20.8%	20.4%	18.4%	11.1%	62.5%	19.1%	5.6%	20.1%	0.0%	27.6%	15.4%	28.4%	12.9%	29.4%	40.0%	0.0%
2	14.2%	14.8%	11.9%	18.2%	4.3%	5.3%	0.0%	12.5%	14.3%	33.3%	18.0%	11.1%	15.5%	8.0%	23.9%	19.4%	20.6%	13.3%	12.5%
3	7.3%	12.3%	3.1%	10.4%	3.2%	5.3%	11.1%	0.0%	5.8%	5.6%	7.9%	11.1%	12.1%	4.3%	7.5%	9.7%	20.6%	0.0%	12.5%
4 +	5.0%	6.2%	2.5%	9.1%	1.1%	2.6%	0.0%	0.0%	4.8%	5.6%	6.5%	11.1%	6.9%	3.1%	7.5%	9.7%	5.9%	6.7%	0.0%
Average	0.94	1.23	0.62	1.30	0.44	0.58	0.44	0.88	0.87	1.11	1.09	1.22	1.29	0.59	1.31	1.32	1.56	1.07	0.63
Median	0	1	0	1	0	0	0	1	0	1	1	0	1	0	1	1	1	1	0
Range	0 to 6	0 to 6	0 to 5	0 to 6	0 to 5	0 to 5	0 to 3	0 to 2	0 to 6	0 to 4	0 to 6	0 to 6	0 to 6	0 to 5	0 to 6	0 to 6	0 to 4	0 to 6	0 to 3
Number of voting physician board members aside from the CMO who are employed by the hospital																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	61.2%	50.6%	68.6%	57.1%	84.9%	81.6%	88.9%	87.5%	63.5%	61.1%	52.5%	77.8%	41.4%	70.4%	49.3%	54.8%	47.1%	53.3%	75.0%
1	17.0%	25.9%	14.5%	13.0%	7.5%	10.5%	0.0%	0.0%	16.0%	16.7%	18.0%	11.1%	31.0%	14.2%	22.4%	16.1%	20.6%	20.0%	12.5%
2	12.9%	11.1%	9.4%	22.1%	4.3%	7.9%	0.0%	12.5%	12.6%	16.7%	18.7%	11.1%	12.1%	11.1%	16.4%	9.7%	17.6%	20.0%	0.0%
3	5.4%	6.2%	4.4%	6.5%	0.0%	0.0%	0.0%	0.0%	4.8%	5.6%	7.9%	0.0%	8.6%	2.5%	7.5%	12.9%	8.8%	6.7%	0.0%
4 +	3.5%	6.2%	3.1%	1.3%	3.2%	0.0%	11.1%	0.0%	3.1%	0.0%	2.9%	0.0%	6.9%	1.9%	4.5%	6.5%	5.9%	0.0%	12.5%
Average	0.76	1.00	0.60	0.82	0.32	0.26	0.44	0.25	0.71	0.67	0.91	0.33	1.19	0.52	0.96	1.16	1.12	0.80	0.63
Median	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0
Range	0 to 8	0 to 8	0 to 6	0 to 4	0 to 6	0 to 2	0 to 4	0 to 2	0 to 8	0 to 3	0 to 4	0 to 2	0 to 8	0 to 6	0 to 4	0 to 8	0 to 5	0 to 3	0 to 4
Number of voting Chief Nursing Officer board members																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	98.1%	100.0%	98.1%	96.1%	98.9%	100.0%	100.0%	100.0%	98.3%	100.0%	96.4%	100.0%	100.0%	98.1%	98.5%	96.8%	97.1%	100.0%	100.0%
1	1.9%	0.0%	1.9%	3.9%	1.1%	0.0%	0.0%	0.0%	1.7%	0.0%	3.6%	0.0%	0.0%	1.9%	1.5%	3.2%	2.9%	0.0%	0.0%
2 +	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average	0.02	0.00	0.02	0.04	0.01	0.00	0.00	0.00	0.02	0.00	0.04	0.00	0.00	0.02	0.01	0.03	0.03	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 1	0 to 1	0 to 0	0 to 0	0 to 0	0 to 1	0 to 0	0 to 1	0 to 0	0 to 0	0 to 1	0 to 1	0 to 1	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	95.6%	97.5%	96.2%	92.2%	95.7%	97.4%	100.0%	100.0%	95.2%	83.3%	95.7%	100.0%	98.3%	96.3%	95.5%	90.3%	97.1%	100.0%	87.5%
1	3.5%	2.5%	3.1%	5.2%	3.2%	2.6%	0.0%	0.0%	3.8%	11.1%	3.6%	0.0%	1.7%	3.1%	4.5%	6.5%	0.0%	0.0%	12.5%
2	0.6%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.7%	5.6%	0.7%	0.0%	0.0%	0.0%	0.0%	3.2%	2.9%	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 +	0.3%	0.0%	0.6%	0.0%	1.1%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Average	0.08	0.02	0.09	0.10	0.14	0.03	0.00	0.00	0.09	0.22	0.05	0.00	0.02	0.09	0.04	0.13	0.06	0.00	0.13
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 10	0 to 1	0 to 10	0 to 2	0 to 10	0 to 1	0 to 0	0 to 0	0 to 10	0 to 2	0 to 2	0 to 0	0 to 1	0 to 10	0 to 1	0 to 2	0 to 2	0 to 0	0 to 1
Number of voting board members who represent a faith-based institution that is affiliatied with or sponsors your organization																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	86.1%	75.3%	96.2%	76.6%	96.8%	97.4%	100.0%	100.0%	85.7%	33.3%	92.8%	11.1%	81.0%	90.7%	83.6%	80.6%	85.3%	73.3%	62.5%
1	8.5%	9.9%	3.8%	16.9%	2.2%	0.0%	0.0%	0.0%	8.9%	50.0%	5.8%	22.2%	10.3%	7.4%	13.4%	9.7%	2.9%	13.3%	0.0%
2	1.3%	3.7%	0.0%	1.3%	1.1%	2.6%	0.0%	0.0%	1.4%	5.6%	0.0%	0.0%	3.4%	0.6%	0.0%	0.0%	5.9%	0.0%	12.5%
3	0.3%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.7%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0.0%	0.0%
4 +	3.8%	11.1%	0.0%	3.9%	0.0%	0.0%	0.0%	0.0%	3.8%	11.1%	0.7%	66.7%	5.2%	1.2%	1.5%	9.7%	5.9%	13.3%	25.0%
Average	0.39	0.95	0.04	0.52	0.04	0.05	0.00	0.00	0.40	1.61	0.11	5.00	0.52	0.19	0.27	0.58	0.41	1.47	2.63
Median	0	0	0	0	0	0	0	0	0	1	0	4	0	0	0	0	0	0	0
Range	0 to 15	0 to 15	0 to 1	0 to 12	0 to 2	0 to 2	0 to 0	0 to 0	0 to 15	0 to 12	0 to 4	0 to 15	0 to 10	0 to 12	0 to 6	0 to 6	0 to 5	0 to 10	0 to 15
Number of other types of voting board members																			
Total responding in each category	317	81	159	77	93	38	9	8	293	18	139	9	58	162	67	31	34	15	8
0	91.8%	90.1%	95.0%	87.0%	98.9%	100.0%	100.0%	100.0%	92.2%	94.4%	88.5%	88.9%	87.9%	95.7%	86.6%	90.3%	88.2%	100.0%	62.5%
1	3.5%	4.9%	2.5%	3.9%	1.1%	0.0%	0.0%	0.0%	3.1%	0.0%	4.3%	11.1%	5.2%	2.5%	6.0%	0.0%	2.9%	0.0%	25.0%
2	0.9%	1.2%	0.6%	1.3%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	1.4%	0.0%	1.7%	0.0%	3.0%	0.0%	2.9%	0.0%	0.0%
3	1.3%	1.2%	0.0%	3.9%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	2.2%	0.0%	1.7%	0.6%	0.0%	6.5%	0.0%	0.0%	12.5%
4 +	2.5%	2.5%	1.9%	3.9%	0.0%	0.0%	0.0%	0.0%	2.4%	5.6%	3.6%	0.0%	3.4%	1.2%	4.5%	3.2%	5.9%	0.0%	0.0%
Average	0.26	0.26	0.14	0.51	0.01	0.00	0.00	0.00	0.26	0.33	0.39	0.11	0.34	0.14	0.40	0.39	0.44	0.00	0.63
Median	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Range	0 to 10	0 to 7	0 to 6	0 to 10	0 to 1	0 to 0	0 to 0	0 to 0	0 to 10	0 to 6	0 to 10	0 to 1	0 to 7	0 to 10	0 to 9	0 to 6	0 to 7	0 to 0	0 to 3

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 from outside the community or region your board/organization serves																			
Total responding in each category	280	75	139	66	80	30	9	8	259	14	125	7	54	139	59	28	31	15	8
0	71.4%	56.0%	79.1%	72.7%	87.5%	86.7%	88.9%	75.0%	72.6%	78.6%	71.2%	14.3%	53.7%	82.0%	61.0%	82.1%	61.3%	53.3%	0.0%
1	12.5%	18.7%	10.1%	10.6%	5.0%	3.3%	11.1%	12.5%	12.7%	14.3%	13.6%	0.0%	22.2%	7.2%	20.3%	10.7%	22.6%	13.3%	12.5%
2	6.1%	4.0%	3.6%	13.6%	1.3%	0.0%	0.0%	12.5%	5.8%	7.1%	9.6%	14.3%	3.7%	5.8%	8.5%	0.0%	9.7%	6.7%	0.0%
3	2.9%	5.3%	2.2%	1.5%	1.3%	3.3%	0.0%	0.0%	1.9%	0.0%	2.4%	0.0%	7.4%	2.2%	1.7%	7.1%	0.0%	0.0%	25.0%
4+	7.1%	16.0%	5.0%	1.5%	5.0%	6.7%	0.0%	0.0%	6.9%	0.0%	3.2%	71.4%	13.0%	2.9%	8.5%	0.0%	6.5%	26.7%	62.5%
Average	0.81	1.37	0.65	0.48	0.48	0.63	0.11	0.38	0.78	0.29	0.66	5.57	1.15	0.49	1.00	0.32	0.87	1.87	4.38
Median	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	4
Range	0 to 10	0 to 10	0 to 10	0 to 4	0 to 9	0 to 9	0 to 1	0 to 2	0 to 10	0 to 2	0 to 10	0 to 10	0 to 8	0 to 10	0 to 10	0 to 3	0 to 10	0 to 8	1 to 8
Number of "outside"/non-affiliated physicians among the independent, voting board members																			
Total responding in each category	277	74	137	66	80	30	9	8	256	16	121	8	52	139	56	29	31	14	8
0	75.5%	67.6%	81.0%	72.7%	85.0%	86.7%	100.0%	75.0%	75.4%	81.3%	72.7%	50.0%	69.2%	84.2%	67.9%	72.4%	67.7%	57.1%	50.0%
1	14.1%	17.6%	11.7%	15.2%	10.0%	6.7%	0.0%	12.5%	14.1%	6.3%	16.5%	25.0%	15.4%	10.8%	19.6%	6.9%	19.4%	28.6%	12.5%
2	9.4%	13.5%	6.6%	10.6%	5.0%	6.7%	0.0%	12.5%	9.4%	6.3%	9.9%	25.0%	13.5%	5.0%	12.5%	13.8%	9.7%	14.3%	37.5%
3	0.7%	0.0%	0.7%	1.5%	0.0%	0.0%	0.0%	0.0%	0.8%	6.3%	0.8%	0.0%	0.0%	0.0%	0.0%	6.9%	0.0%	0.0%	0.0%
4+	0.4%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	3.2%	0.0%	0.0%
Average	0.36	0.50	0.27	0.41	0.20	0.20	0.00	0.38	0.37	0.38	0.39	0.75	0.50	0.21	0.45	0.55	0.52	0.57	0.88
Median	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Range	0 to 4	0 to 4	0 to 3	0 to 3	0 to 2	0 to 2	0 to 0	0 to 2	0 to 4	0 to 3	0 to 3	0 to 2	0 to 4	0 to 2	0 to 2	0 to 3	0 to 4	0 to 2	0 to 2
Number of "outside"/non-affiliated nurses among the independent, voting board members																			
Total responding in each category	281	76	139	66	79	30	9	8	258	15	125	8	54	136	61	30	31	14	9
0	64.8%	63.2%	65.5%	65.2%	65.8%	53.3%	55.6%	100.0%	65.1%	66.7%	67.2%	37.5%	61.1%	72.8%	59.0%	60.0%	45.2%	85.7%	33.3%
1	29.5%	31.6%	28.8%	28.8%	29.1%	40.0%	44.4%	0.0%	29.5%	26.7%	27.2%	37.5%	35.2%	22.1%	34.4%	33.3%	51.6%	7.1%	55.6%
2	4.6%	5.3%	5.0%	3.0%	3.8%	3.3%	0.0%	0.0%	4.3%	0.0%	4.8%	25.0%	3.7%	3.7%	6.6%	3.3%	3.2%	7.1%	11.1%
3	1.1%	0.0%	0.7%	3.0%	1.3%	3.3%	0.0%	0.0%	1.2%	6.7%	0.8%	0.0%	0.0%	1.5%	0.0%	3.3%	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	0.42	0.42	0.41	0.44	0.41	0.57	0.44	0.00	0.41	0.47	0.39	0.88	0.43	0.34	0.48	0.50	0.58	0.21	0.78
Median	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1
Range	0 to 3	0 to 2	0 to 3	0 to 3	0 to 3	0 to 3	0 to 1	0 to 0	0 to 3	0 to 3	0 to 3	0 to 2	0 to 2	0 to 3	0 to 2	0 to 3	0 to 2	0 to 2	0 to 2

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
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	91	22	50	19	29	10	3	3	84	3	42	1	16	56	16	4	8	6	1
Yes	17.6%	13.6%	16.0%	26.3%	6.9%	20.0%	0.0%	0.0%	19.0%	66.7%	21.4%	0.0%	18.8%	16.1%	12.5%	25.0%	25.0%	33.3%	0.0%
No	82.4%	86.4%	84.0%	73.7%	93.1%	80.0%	100.0%	100.0%	81.0%	33.3%	78.6%	100.0%	81.3%	83.9%	87.5%	75.0%	75.0%	66.7%	100.0%
Numer of female voting board members																			
Total responding in each category	312	82	156	74	91	37	9	8	288	17	135	9	60	158	67	29	35	14	9
0	2.2%	1.2%	2.6%	2.7%	3.3%	0.0%	0.0%	0.0%	2.4%	5.9%	2.2%	0.0%	0.0%	3.2%	0.0%	3.4%	2.9%	0.0%	0.0%
1	9.9%	2.4%	14.1%	9.5%	22.0%	21.6%	0.0%	50.0%	9.7%	5.9%	5.9%	0.0%	3.3%	13.9%	9.0%	0.0%	5.7%	7.1%	0.0%
2	16.0%	14.6%	19.2%	10.8%	20.9%	24.3%	22.2%	12.5%	16.0%	11.8%	14.8%	0.0%	15.0%	20.3%	10.4%	17.2%	8.6%	14.3%	11.1%
3	21.8%	20.7%	25.0%	16.2%	26.4%	27.0%	44.4%	12.5%	22.6%	11.8%	21.5%	22.2%	18.3%	24.7%	16.4%	17.2%	14.3%	50.0%	11.1%
4	21.2%	22.0%	18.6%	25.7%	15.4%	8.1%	22.2%	25.0%	20.8%	35.3%	21.5%	0.0%	28.3%	20.3%	29.9%	17.2%	14.3%	14.3%	22.2%
5	13.8%	17.1%	11.5%	14.9%	5.5%	8.1%	0.0%	0.0%	13.5%	11.8%	17.8%	11.1%	18.3%	12.0%	16.4%	6.9%	25.7%	14.3%	0.0%
6+	15.1%	22.0%	9.0%	20.3%	6.6%	10.8%	11.1%	0.0%	14.9%	17.6%	16.3%	66.7%	16.7%	5.7%	17.9%	37.9%	28.6%	0.0%	55.6%
Average	3.70	4.21	3.26	4.05	2.81	3.05	3.56	2.13	3.68	3.82	3.98	5.78	4.07	3.09	4.09	4.76	4.66	3.14	5.22
Median	4	4	3	4	3	3	3	2	3	4	4	6	4	3	4	4	5	3	6
Range	0 to 10	0 to 10	0 to 10	0 to 10	0 to 10	1 to 10	2 to 8	1 to 4	0 to 10	0 to 7	0 to 10	3 to 9	1 to 10	0 to 8	1 to 10	0 to 10	0 to 10	1 to 5	2 to 7
Number of voting board members from an ethnic minority																			
Total responding in each category	305	82	151	72	90	36	9	8	281	16	130	9	60	154	65	28	35	14	9
0	38.4%	19.5%	53.6%	27.8%	44.4%	44.4%	55.6%	25.0%	38.8%	43.8%	41.5%	22.2%	23.3%	53.9%	30.8%	25.0%	11.4%	21.4%	0.0%
1	25.2%	28.0%	24.5%	23.6%	33.3%	27.8%	22.2%	62.5%	25.3%	6.3%	23.8%	22.2%	21.7%	28.6%	23.1%	14.3%	31.4%	14.3%	11.1%
2	11.8%	17.1%	9.3%	11.1%	8.9%	8.3%	11.1%	0.0%	11.4%	0.0%	11.5%	0.0%	21.7%	9.7%	12.3%	14.3%	14.3%	14.3%	22.2%
3	9.8%	14.6%	6.0%	12.5%	3.3%	5.6%	0.0%	12.5%	10.0%	25.0%	9.2%	0.0%	18.3%	4.5%	9.2%	21.4%	11.4%	35.7%	22.2%
4	5.6%	8.5%	2.6%	8.3%	2.2%	5.6%	0.0%	0.0%	5.3%	18.8%	3.8%	22.2%	8.3%	0.6%	12.3%	3.6%	5.7%	14.3%	33.3%
5	3.3%	4.9%	0.0%	8.3%	2.2%	2.8%	0.0%	0.0%	3.2%	0.0%	3.8%	11.1%	3.3%	1.3%	4.6%	10.7%	5.7%	0.0%	0.0%
6+	5.9%	7.3%	4.0%	8.3%	5.6%	5.6%	11.1%	0.0%	6.0%	6.3%	6.2%	22.2%	3.3%	1.3%	7.7%	10.7%	20.0%	0.0%	11.1%
Average	1.61	2.15	1.03	2.21	1.24	1.36	1.56	1.00	1.60	2.00	1.56	3.00	1.93	0.81	2.05	2.61	2.91	2.07	3.22
Median	1	2	0	1	1	1	0	1	1	2	1	4	2	0	1	2	2	3	3
Range	0 to 10	0 to 9	0 to 10	0 to 10	0 to 10	0 to 8	0 to 10	0 to 3	0 to 10	0 to 7	0 to 10	0 to 6	0 to 8	0 to 8	0 to 10	0 to 10	0 to 10	0 to 4	1 to 6

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 specify defined terms for the length of elected service?																			
Total responding in each category	312	82	155	75	89	36	9	8	288	18	136	9	60	157	67	30	35	14	9
Yes	90.1%	92.7%	87.1%	93.3%	82.0%	83.3%	77.8%	75.0%	89.6%	94.4%	93.4%	100.0%	91.7%	87.3%	94.0%	90.0%	91.4%	92.9%	100.0%
Length of term (in years) (median)	3	3	3	3	4	4	3	3	3	3	3	3	3	3	3	3	3	3	3
Do your bylaws limit the number of consecutive terms? ("term limits")																			
Total responding in each category	281	76	136	69	74	31	7	6	258	16	127	9	55	138	63	26	32	13	9
Yes	64.4%	80.3%	49.3%	76.8%	29.7%	29.0%	57.1%	16.7%	63.6%	75.0%	71.7%	100.0%	85.5%	49.3%	77.8%	69.2%	81.3%	92.3%	88.9%
Maximum number of terms (median)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Maximum age for serving on the board ("age limit")																			
Total responding in each category	311	80	158	73	89	36	9	8	287	16	138	9	59	159	67	29	33	14	9
Yes	4.8%	10.0%	2.5%	4.1%	3.4%	5.6%	11.1%	0.0%	4.9%	6.3%	3.6%	0.0%	10.2%	2.5%	4.5%	10.3%	3.0%	21.4%	11.1%
Average age limit	73.64	74.75	71.00	73.33	71.67	70.00	75.00	N/A	73.64	68.00	75.00	N/A	74.67	73.33	71.00	75.00	75.00	74.33	75.00
Median age limit	75	75	68	75	75	70	75	N/A	75	68	75	N/A	75	75	70	75	75	75	75
Range age limit	65 to 80	70 to 78	65 to 80	70 to 75	65 to 75	65 to 75	75 to 75	0 to 0	65 to 80	68 to 68	70 to 80	0 to 0	70 to 78	65 to 80	68 to 75	75 to 75	75 to 75	70 to 78	75 to 75
Average board member age (approximate)																			
Total responding in each category	268	74	133	61	74	30	9	8	244	15	117	9	53	130	58	27	31	13	9
Average	58.11	59.35	57.25	58.48	59.22	57.90	59.56	59.88	58.11	58.27	56.73	61.11	59.06	56.91	57.45	59.37	60.45	61.31	63.22
Median	59	60	56	59	60	56	60	62	59	59	56	60	59	55	58	60	60	61	63
Range	40 to 75	50 to 75	40 to 72	45 to 74	45 to 74	50 to 74	50 to 70	50 to 71	40 to 74	50 to 65	40 to 72	50 to 68	50 to 75	40 to 74	45 to 67	50 to 75	50 to 70	55 to 68	60 to 70

All Respondents		Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Participation on the board (N/A not included)																			
President/CEO																			
Total responding in each category	313	81	159	73	90	37	9	8	289	17	137	9	60	161	66	29	34	14	9
Voting board member	42.2%	70.4%	20.1%	58.9%	6.7%	8.1%	11.1%	0.0%	41.9%	70.6%	44.5%	100.0%	73.3%	23.0%	53.0%	55.2%	70.6%	85.7%	88.9%
Non-voting board member	21.7%	12.3%	28.9%	16.4%	21.1%	18.9%	11.1%	12.5%	22.1%	23.5%	27.7%	0.0%	11.7%	28.0%	16.7%	24.1%	8.8%	7.1%	11.1%
Non-board member; regularly attends meetings	35.8%	17.3%	50.9%	23.3%	72.2%	73.0%	77.8%	87.5%	35.6%	5.9%	27.0%	0.0%	15.0%	48.4%	30.3%	20.7%	20.6%	7.1%	0.0%
Non-board member; does not regularly attend meetings	0.3%	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.7%	0.0%	0.0%	0.6%	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%
Chief of Staff/President of Medical Staff																			
Total responding in each category	283	66	151	66	84	34	9	8	263	13	132	4	50	150	64	25	27	10	7
Voting board member	31.8%	19.7%	30.5%	47.0%	10.7%	14.7%	11.1%	25.0%	30.8%	30.8%	50.0%	25.0%	20.0%	30.0%	46.9%	24.0%	29.6%	0.0%	14.3%
Non-voting board member	13.8%	12.1%	13.2%	16.7%	7.1%	2.9%	11.1%	12.5%	14.4%	30.8%	17.4%	0.0%	12.0%	12.7%	17.2%	20.0%	14.8%	0.0%	0.0%
Non-board member; regularly attends meetings	38.2%	53.0%	39.1%	21.2%	56.0%	52.9%	55.6%	62.5%	38.0%	15.4%	24.2%	75.0%	48.0%	36.7%	28.1%	44.0%	48.1%	50.0%	85.7%
Non-board member; does not regularly attend meetings	16.3%	15.2%	17.2%	15.2%	26.2%	29.4%	22.2%	0.0%	16.7%	23.1%	8.3%	0.0%	20.0%	20.7%	7.8%	12.0%	7.4%	50.0%	0.0%
Percentage of respondents with this position	68.0%	60.5%	70.6%	71.0%	63.6%	59.5%	66.7%	87.5%	67.4%	70.6%	76.0%	22.2%	63.3%	62.7%	85.9%	69.0%	76.5%	57.1%	11.1%
VP Medical Affairs/Chief Medical Officer																			
Total responding in each category	209	72	81	56	45	17	5	5	189	15	87	7	55	69	60	28	30	13	9
Voting board member	4.3%	5.6%	3.7%	3.6%	2.2%	0.0%	0.0%	20.0%	4.8%	6.7%	3.4%	14.3%	5.5%	4.3%	3.3%	3.6%	0.0%	15.4%	11.1%
Non-voting board member	8.6%	5.6%	8.6%	12.5%	6.7%	0.0%	0.0%	20.0%	9.5%	40.0%	6.9%	0.0%	5.5%	8.7%	13.3%	7.1%	3.3%	0.0%	11.1%
Non-board member; regularly attends meetings	78.0%	77.8%	79.0%	76.8%	82.2%	88.2%	100.0%	60.0%	76.7%	53.3%	81.6%	85.7%	74.5%	73.9%	81.7%	82.1%	86.7%	53.8%	77.8%
Non-board member; does not regularly attend meetings	9.1%	11.1%	8.6%	7.1%	8.9%	11.8%	0.0%	0.0%	9.0%	0.0%	8.0%	0.0%	14.5%	13.0%	1.7%	7.1%	10.0%	30.8%	0.0%
Percentage of respondents with this position	69.0%	90.0%	52.6%	81.2%	50.6%	45.9%	55.6%	62.5%	67.7%	88.2%	67.4%	77.8%	93.2%	45.1%	92.3%	96.6%	90.9%	92.9%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	184	58	73	53	47	19	3	5	172	12	78	7	40	73	46	22	23	11	9
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	9.2%	5.2%	4.1%	20.8%	2.1%	0.0%	0.0%	20.0%	9.9%	41.7%	11.5%	0.0%	5.0%	9.6%	10.9%	13.6%	4.3%	0.0%	11.1%
Non-board member; regularly attends meetings	85.3%	93.1%	84.9%	77.4%	83.0%	94.7%	66.7%	60.0%	84.3%	58.3%	84.6%	100.0%	95.0%	82.2%	82.6%	86.4%	91.3%	100.0%	88.9%
Non-board member; does not regularly attend meetings	5.4%	1.7%	11.0%	1.9%	14.9%	5.3%	33.3%	20.0%	5.8%	0.0%	3.8%	0.0%	0.0%	8.2%	6.5%	0.0%	4.3%	0.0%	0.0%
Percentage of respondents with this position	60.1%	72.5%	47.1%	74.6%	52.8%	51.4%	33.3%	62.5%	61.0%	70.6%	59.1%	77.8%	67.8%	46.8%	70.8%	75.9%	69.7%	78.6%	100.0%
Chief Financial Officer																			
Total responding in each category	303	81	156	66	87	36	9	8	279	15	132	9	60	153	64	29	34	14	9
Voting board member	1.0%	0.0%	0.0%	4.5%	0.0%	0.0%	0.0%	0.0%	1.1%	6.7%	1.5%	0.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	10.9%	4.9%	11.5%	16.7%	8.0%	5.6%	0.0%	25.0%	11.5%	33.3%	13.6%	0.0%	5.0%	13.7%	12.5%	6.9%	2.9%	0.0%	11.1%
Non-board member; regularly attends meetings	84.8%	95.1%	87.2%	66.7%	88.5%	88.9%	100.0%	75.0%	83.9%	53.3%	80.3%	100.0%	95.0%	81.7%	81.3%	93.1%	91.2%	100.0%	88.9%
Non-board member; does not regularly attend meetings	3.3%	0.0%	1.3%	12.1%	3.4%	5.6%	0.0%	0.0%	3.6%	6.7%	4.5%	0.0%	0.0%	2.6%	6.3%	0.0%	5.9%	0.0%	0.0%
Percentage of respondents with this position	98.1%	100.0%	98.7%	94.3%	97.8%	97.3%	100.0%	100.0%	97.9%	88.2%	98.5%	100.0%	100.0%	96.8%	98.5%	100.0%	100.0%	100.0%	100.0%
Chief Nursing Officer																			
Total responding in each category	291	71	154	66	87	36	9	8	270	17	128	5	54	152	62	28	31	11	7
Voting board member	0.3%	0.0%	0.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	0.0%	0.0%
Non-voting board member	8.6%	2.8%	9.1%	13.6%	5.7%	2.8%	0.0%	12.5%	8.9%	35.3%	10.2%	0.0%	1.9%	10.5%	9.7%	7.1%	3.2%	0.0%	0.0%
Non-board member; regularly attends meetings	75.9%	76.1%	80.5%	65.2%	82.8%	86.1%	66.7%	75.0%	75.6%	52.9%	75.8%	100.0%	70.4%	77.0%	75.8%	78.6%	80.6%	36.4%	85.7%
Non-board member; does not regularly attend meetings	15.1%	21.1%	10.4%	19.7%	11.5%	11.1%	33.3%	12.5%	15.2%	11.8%	13.3%	0.0%	27.8%	12.5%	14.5%	14.3%	12.9%	63.6%	14.3%
Percentage of respondents with this position	94.8%	88.8%	98.1%	94.3%	97.8%	97.3%	100.0%	100.0%	95.4%	100.0%	96.2%	55.6%	91.5%	96.8%	96.9%	96.6%	91.2%	78.6%	77.8%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	211	74	90	47	50	18	6	4	189	9	89	7	56	81	50	27	32	14	7
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	4.3%	2.7%	4.4%	6.4%	6.0%	0.0%	0.0%	25.0%	4.8%	11.1%	4.5%	0.0%	1.8%	6.2%	4.0%	3.7%	3.1%	0.0%	0.0%
Non-board member; regularly attends meetings	38.4%	41.9%	36.7%	36.2%	34.0%	33.3%	33.3%	25.0%	37.0%	22.2%	41.6%	42.9%	39.3%	27.2%	46.0%	63.0%	37.5%	28.6%	42.9%
Non-board member; does not regularly attend meetings	57.3%	55.4%	58.9%	57.4%	60.0%	66.7%	66.7%	50.0%	58.2%	66.7%	53.9%	57.1%	58.9%	66.7%	50.0%	33.3%	59.4%	71.4%	57.1%
Percentage of respondents with this position	70.1%	92.5%	58.4%	70.1%	56.2%	48.6%	66.7%	50.0%	68.2%	56.3%	69.5%	77.8%	94.9%	52.6%	80.6%	93.1%	97.0%	100.0%	77.8%
Legal Counsel																			
Total responding in each category	215	72	90	53	60	21	8	4	198	9	86	8	52	81	56	25	32	13	8
Voting board member	1.4%	0.0%	2.2%	1.9%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	3.5%	0.0%	0.0%	2.5%	1.8%	0.0%	0.0%	0.0%	0.0%
Non-voting board member	5.1%	1.4%	4.4%	11.3%	3.3%	0.0%	0.0%	0.0%	5.6%	44.4%	4.7%	0.0%	1.9%	6.2%	7.1%	4.0%	3.1%	0.0%	0.0%
Non-board member; regularly attends meetings	66.0%	87.5%	52.2%	60.4%	58.3%	61.9%	37.5%	100.0%	64.6%	33.3%	59.3%	87.5%	88.5%	46.9%	60.7%	88.0%	87.5%	92.3%	100.0%
Non-board member; does not regularly attend meetings	27.4%	11.1%	41.1%	26.4%	38.3%	38.1%	62.5%	0.0%	29.3%	22.2%	32.6%	12.5%	9.6%	44.4%	30.4%	8.0%	9.4%	7.7%	0.0%
Percentage of respondents with this position	71.0%	91.1%	58.1%	76.8%	67.4%	56.8%	88.9%	50.0%	71.0%	56.3%	65.6%	88.9%	89.7%	52.6%	87.5%	89.3%	94.1%	92.9%	88.9%
Compliance Officer																			
Total responding in each category	287	76	144	67	82	33	9	8	266	15	126	9	55	142	63	28	32	14	8
Voting board member	1.4%	1.3%	1.4%	1.5%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	2.4%	0.0%	1.8%	0.7%	3.2%	0.0%	3.1%	0.0%	0.0%
Non-voting board member	3.8%	1.3%	4.9%	4.5%	1.2%	0.0%	0.0%	0.0%	3.8%	6.7%	6.3%	0.0%	1.8%	5.6%	3.2%	0.0%	3.1%	0.0%	0.0%
Non-board member; regularly attends meetings	38.7%	34.2%	43.1%	34.3%	50.0%	48.5%	44.4%	37.5%	39.5%	26.7%	38.1%	44.4%	25.5%	43.7%	31.7%	42.9%	40.6%	21.4%	12.5%
Non-board member; does not regularly attend meetings	56.1%	63.2%	50.7%	59.7%	48.8%	51.5%	55.6%	62.5%	55.6%	66.7%	53.2%	55.6%	70.9%	50.0%	61.9%	57.1%	53.1%	78.6%	87.5%
Percentage of respondents with this position	94.4%	96.2%	93.5%	94.4%	94.3%	89.2%	100.0%	100.0%	94.7%	88.2%	94.7%	100.0%	94.8%	91.6%	96.9%	96.6%	100.0%	100.0%	88.9%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Past president of medical staff																			
Total responding in each category	212	51	111	50	63	24	6	7	196	11	97	3	38	102	52	22	26	8	2
Voting board member	8.0%	5.9%	5.4%	16.0%	1.6%	0.0%	0.0%	0.0%	7.7%	18.2%	11.3%	0.0%	7.9%	2.9%	17.3%	9.1%	11.5%	0.0%	0.0%
Non-voting board member	2.4%	2.0%	1.8%	4.0%	1.6%	0.0%	0.0%	0.0%	2.6%	9.1%	2.1%	0.0%	2.6%	2.0%	3.8%	0.0%	3.8%	0.0%	0.0%
Non-board member; regularly attends meetings	5.7%	7.8%	4.5%	6.0%	7.9%	4.2%	16.7%	14.3%	5.6%	9.1%	2.1%	0.0%	10.5%	2.0%	3.8%	18.2%	15.4%	0.0%	0.0%
Non-board member; does not regularly attend meetings	84.0%	84.3%	88.3%	74.0%	88.9%	95.8%	83.3%	85.7%	84.2%	63.6%	84.5%	100.0%	78.9%	93.1%	75.0%	72.7%	69.2%	100.0%	100.0%
Percentage of respondents with this position	69.5%	63.0%	72.1%	71.4%	70.8%	64.9%	66.7%	87.5%	69.8%	64.7%	74.6%	33.3%	63.3%	66.2%	80.0%	75.9%	76.5%	57.1%	22.2%
President-elect of medical staff																			
Total responding in each category	206	49	108	49	56	22	6	7	188	12	98	2	38	96	55	20	26	8	1
Voting board member	11.7%	10.2%	9.3%	18.4%	1.8%	4.5%	0.0%	0.0%	10.1%	16.7%	17.3%	0.0%	10.5%	10.4%	18.2%	5.0%	11.5%	0.0%	0.0%
Non-voting board member	6.8%	4.1%	4.6%	14.3%	3.6%	0.0%	0.0%	0.0%	6.4%	16.7%	8.2%	0.0%	5.3%	5.2%	10.9%	5.0%	7.7%	0.0%	0.0%
Non-board member; regularly attends meetings	15.0%	20.4%	12.0%	16.3%	14.3%	18.2%	16.7%	14.3%	14.9%	25.0%	13.3%	50.0%	15.8%	9.4%	18.2%	35.0%	15.4%	12.5%	0.0%
Non-board member; does not regularly attend meetings	66.5%	65.3%	74.1%	51.0%	80.4%	77.3%	83.3%	85.7%	68.6%	41.7%	61.2%	50.0%	68.4%	75.0%	52.7%	55.0%	65.4%	87.5%	100.0%
Percentage of respondents with this position	68.0%	60.5%	70.6%	71.0%	63.6%	59.5%	66.7%	87.5%	67.4%	70.6%	76.0%	22.2%	63.3%	62.7%	85.9%	69.0%	76.5%	57.1%	11.1%
Representative of an owned or affiliated medical group or physician enterprise																			
Total responding in each category	124	41	49	34	28	11	1	5	116	7	54	4	31	38	37	17	19	10	3
Voting board member	21.0%	17.1%	22.4%	23.5%	14.3%	9.1%	0.0%	40.0%	17.2%	14.3%	27.8%	25.0%	16.1%	13.2%	27.0%	35.3%	21.1%	10.0%	0.0%
Non-voting board member	6.5%	2.4%	6.1%	11.8%	0.0%	0.0%	0.0%	0.0%	6.9%	14.3%	11.1%	0.0%	3.2%	5.3%	10.8%	0.0%	10.5%	0.0%	0.0%
Non-board member; regularly attends meetings	20.2%	24.4%	20.4%	14.7%	25.0%	27.3%	100.0%	20.0%	20.7%	14.3%	16.7%	25.0%	22.6%	21.1%	21.6%	17.6%	15.8%	30.0%	0.0%
Non-board member; does not regularly attend meetings	52.4%	56.1%	51.0%	50.0%	60.7%	63.6%	0.0%	40.0%	55.2%	57.1%	44.4%	50.0%	58.1%	60.5%	40.5%	47.1%	52.6%	60.0%	100.0%
Percentage of respondents with this position	40.8%	50.6%	31.8%	49.3%	31.5%	29.7%	11.1%	62.5%	41.4%	43.8%	41.5%	44.4%	51.7%	24.8%	56.9%	58.6%	55.9%	71.4%	33.3%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	166	51	73	42	42	14	5	5	155	9	72	4	39	62	44	21	24	11	4
Voting board member	20.5%	13.7%	24.7%	21.4%	11.9%	7.1%	20.0%	0.0%	20.0%	22.2%	29.2%	0.0%	15.4%	27.4%	22.7%	14.3%	8.3%	9.1%	25.0%
Non-voting board member	4.2%	2.0%	1.4%	11.9%	0.0%	0.0%	0.0%	0.0%	4.5%	33.3%	4.2%	0.0%	2.6%	0.0%	11.4%	4.8%	4.2%	0.0%	0.0%
Non-board member; regularly attends meetings	30.1%	35.3%	30.1%	23.8%	35.7%	35.7%	60.0%	40.0%	30.3%	22.2%	25.0%	50.0%	33.3%	29.0%	25.0%	47.6%	33.3%	18.2%	25.0%
Non-board member; does not regularly attend meetings	45.2%	49.0%	43.8%	42.9%	52.4%	57.1%	20.0%	60.0%	45.2%	22.2%	41.7%	50.0%	48.7%	43.5%	40.9%	33.3%	54.2%	72.7%	50.0%
Percentage of respondents with this position	54.6%	63.8%	47.4%	60.0%	47.2%	37.8%	55.6%	62.5%	55.4%	56.3%	55.0%	50.0%	65.0%	40.0%	68.8%	75.0%	70.6%	78.6%	44.4%
Representative of a religious sponsor																			
Total responding in each category	69	30	18	21	9	4	0	0	66	11	20	8	21	23	16	9	9	8	4
Voting board member	50.7%	50.0%	27.8%	71.4%	33.3%	25.0%	0.0%	0.0%	50.0%	81.8%	45.0%	75.0%	38.1%	52.2%	56.3%	55.6%	44.4%	37.5%	50.0%
Non-voting board member	4.3%	3.3%	5.6%	4.8%	0.0%	0.0%	0.0%	0.0%	4.5%	0.0%	10.0%	0.0%	4.8%	4.3%	6.3%	0.0%	11.1%	0.0%	0.0%
Non-board member; regularly attends meetings	4.3%	6.7%	0.0%	4.8%	0.0%	0.0%	0.0%	0.0%	4.5%	9.1%	0.0%	25.0%	0.0%	4.3%	0.0%	0.0%	11.1%	0.0%	25.0%
Non-board member; does not regularly attend meetings	40.6%	40.0%	66.7%	19.0%	66.7%	75.0%	0.0%	0.0%	40.9%	9.1%	45.0%	0.0%	57.1%	39.1%	37.5%	44.4%	33.3%	62.5%	25.0%
Percentage of respondents with this position	22.7%	37.0%	11.7%	30.4%	10.1%	10.8%	0.0%	0.0%	23.6%	64.7%	15.5%	88.9%	35.0%	14.7%	25.4%	31.0%	27.3%	57.1%	44.4%
Background of the organization's CEO																			
Total responding in each category	315	82	160	73	90	37	9	8	291	17	138	9	61	160	66	29	35	15	10
Physician	7.9%	14.6%	4.4%	8.2%	5.6%	0.0%	11.1%	0.0%	8.2%	11.8%	5.8%	22.2%	13.1%	3.1%	4.5%	20.7%	20.0%	13.3%	20.0%
Nurse	17.1%	7.3%	17.5%	27.4%	22.2%	16.2%	22.2%	37.5%	17.2%	29.4%	17.4%	11.1%	6.6%	20.6%	21.2%	13.8%	5.7%	6.7%	0.0%
Other clinical expertise	14.3%	12.2%	15.6%	13.7%	14.4%	21.6%	0.0%	12.5%	13.7%	11.8%	15.9%	11.1%	11.5%	15.6%	15.2%	13.8%	14.3%	0.0%	10.0%
Management or finance (for-profit)	14.3%	14.6%	14.4%	13.7%	16.7%	21.6%	22.2%	25.0%	14.4%	23.5%	11.6%	22.2%	13.1%	15.6%	15.2%	6.9%	8.6%	26.7%	10.0%
Management or finance (non-profit/ not-for-profit)	60.0%	63.4%	61.9%	52.1%	58.9%	62.2%	66.7%	50.0%	60.5%	41.2%	60.1%	66.7%	65.6%	58.1%	62.1%	55.2%	60.0%	73.3%	70.0%
Other non-clinical/ non-healthcare	4.8%	2.4%	5.6%	5.5%	0.0%	0.0%	0.0%	0.0%	4.1%	5.9%	8.7%	0.0%	3.3%	5.0%	9.1%	3.4%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	315	82	160	73	90	37	9	8	291	17	138	9	61	160	66	29	35	15	10
Physician	4.1%	3.7%	3.8%	5.5%	4.4%	2.7%	0.0%	0.0%	3.8%	5.9%	4.3%	0.0%	3.3%	3.1%	7.6%	0.0%	2.9%	6.7%	10.0%
Nurse	1.9%	0.0%	1.9%	4.1%	3.3%	5.4%	0.0%	0.0%	2.1%	0.0%	2.2%	0.0%	0.0%	2.5%	1.5%	3.4%	0.0%	0.0%	0.0%
Other clinical expertise	4.4%	3.7%	5.6%	2.7%	6.7%	10.8%	0.0%	12.5%	4.1%	0.0%	4.3%	0.0%	3.3%	6.9%	0.0%	10.3%	0.0%	0.0%	0.0%
Management or finance (for-profit)	49.5%	53.7%	46.9%	50.7%	34.4%	32.4%	44.4%	50.0%	49.5%	58.8%	52.9%	55.6%	60.7%	40.6%	54.5%	62.1%	60.0%	60.0%	70.0%
Management or finance (non-profit/not-for-profit)	10.5%	14.6%	8.1%	11.0%	11.1%	13.5%	22.2%	0.0%	11.0%	11.8%	7.2%	22.2%	14.8%	9.4%	10.6%	17.2%	5.7%	20.0%	10.0%
Other non-clinical/ non-healthcare	33.3%	32.9%	34.4%	31.5%	42.2%	37.8%	44.4%	37.5%	33.0%	29.4%	31.2%	33.3%	26.2%	40.6%	27.3%	20.7%	37.1%	13.3%	10.0%
Top three essential core competencies being sought in the next one to three years for new board members																			
Total responding in each category	315	82	160	73	90	37	9	8	291	17	138	9	61	160	66	29	35	15	10
Finance/business acumen	44.1%	43.9%	49.4%	32.9%	51.1%	40.5%	66.7%	75.0%	42.6%	41.2%	39.9%	44.4%	44.3%	48.8%	43.9%	48.3%	42.9%	6.7%	20.0%
Venture capital	0.6%	2.4%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	1.6%	0.6%	1.5%	0.0%	0.0%	0.0%	0.0%
Strategic planning and visioning	55.6%	50.0%	60.0%	52.1%	60.0%	73.0%	66.7%	25.0%	55.7%	64.7%	55.1%	44.4%	49.2%	59.4%	59.1%	55.2%	40.0%	33.3%	60.0%
Quality and patient safety	40.0%	40.2%	39.4%	41.1%	51.1%	51.4%	44.4%	50.0%	40.5%	17.6%	38.4%	22.2%	36.1%	43.8%	40.9%	31.0%	37.1%	40.0%	10.0%
Change management	8.3%	6.1%	10.6%	5.5%	10.0%	13.5%	0.0%	12.5%	8.2%	0.0%	8.7%	0.0%	8.2%	10.6%	6.1%	6.9%	2.9%	6.7%	10.0%
Conflict management	0.6%	1.2%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.7%	0.0%	1.6%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%
Clinical practice	10.5%	12.2%	8.1%	13.7%	7.8%	0.0%	22.2%	25.0%	10.0%	0.0%	12.3%	11.1%	13.1%	8.8%	7.6%	13.8%	17.1%	26.7%	0.0%
Legal	6.7%	3.7%	9.4%	4.1%	10.0%	10.8%	0.0%	25.0%	6.9%	0.0%	6.5%	11.1%	3.3%	9.4%	6.1%	3.4%	2.9%	0.0%	0.0%
Actuarial/health insurance/managed care	5.1%	7.3%	3.8%	5.5%	1.1%	0.0%	0.0%	0.0%	5.5%	5.9%	5.8%	0.0%	9.8%	3.8%	4.5%	6.9%	5.7%	13.3%	10.0%
IT and social media	8.6%	9.8%	7.5%	9.6%	4.4%	5.4%	0.0%	12.5%	8.6%	11.8%	10.1%	11.1%	9.8%	8.1%	7.6%	13.8%	11.4%	6.7%	0.0%
Digital/mobile health technology	7.3%	14.6%	5.0%	4.1%	4.4%	2.7%	22.2%	0.0%	7.6%	0.0%	5.8%	33.3%	13.1%	3.8%	4.5%	13.8%	5.7%	33.3%	30.0%
Medical/science/AI technology	4.8%	4.9%	5.0%	4.1%	4.4%	5.4%	0.0%	0.0%	4.8%	0.0%	5.1%	0.0%	6.6%	4.4%	1.5%	6.9%	14.3%	0.0%	0.0%
Cybersecurity	4.4%	7.3%	2.5%	5.5%	2.2%	2.7%	0.0%	0.0%	4.1%	5.9%	4.3%	0.0%	8.2%	1.9%	9.1%	0.0%	8.6%	6.7%	10.0%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Consumer-facing business	22.9%	24.4%	21.9%	23.3%	21.1%	27.0%	33.3%	12.5%	22.3%	29.4%	21.7%	44.4%	23.0%	23.8%	19.7%	13.8%	22.9%	33.3%	40.0%
Public health/public policy	8.6%	6.1%	5.6%	17.8%	11.1%	10.8%	0.0%	25.0%	8.6%	5.9%	9.4%	11.1%	3.3%	8.1%	7.6%	10.3%	11.4%	13.3%	0.0%
Pandemic/infectious disease	0.6%	1.2%	0.6%	0.0%	1.1%	0.0%	11.1%	0.0%	0.7%	0.0%	0.7%	0.0%	0.0%	0.6%	1.5%	0.0%	0.0%	0.0%	0.0%
Population health and social determinants of health/disparities	25.1%	26.8%	18.8%	37.0%	20.0%	21.6%	22.2%	0.0%	26.5%	47.1%	25.4%	22.2%	26.2%	20.0%	22.7%	41.4%	42.9%	20.0%	20.0%
Innovation/disruption	13.0%	17.1%	12.5%	9.6%	7.8%	5.4%	11.1%	25.0%	13.4%	0.0%	14.5%	11.1%	21.3%	8.8%	16.7%	13.8%	11.4%	26.7%	40.0%
Fundraising	8.9%	3.7%	10.0%	12.3%	8.9%	10.8%	0.0%	12.5%	9.3%	29.4%	9.4%	0.0%	3.3%	10.6%	12.1%	3.4%	5.7%	0.0%	0.0%
Other	8.6%	2.4%	11.9%	8.2%	10.0%	8.1%	0.0%	0.0%	8.2%	23.5%	8.7%	11.1%	1.6%	11.3%	7.6%	3.4%	5.7%	6.7%	0.0%
Regularly scheduled board meetings per year																			
Total responding in each category	311	80	158	73	90	37	9	8	287	17	136	9	59	160	65	29	34	14	9
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	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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 per year (quarterly)	15.4%	28.8%	3.2%	27.4%	1.1%	0.0%	0.0%	0.0%	15.0%	35.3%	13.2%	66.7%	28.8%	6.3%	15.4%	24.1%	20.6%	71.4%	44.4%
6 per year	20.3%	37.5%	10.1%	23.3%	4.4%	8.1%	0.0%	0.0%	20.9%	17.6%	19.9%	33.3%	44.1%	9.4%	27.7%	34.5%	32.4%	28.6%	55.6%
7 to 9 per year	6.8%	6.3%	6.3%	8.2%	2.2%	2.7%	0.0%	0.0%	6.3%	5.9%	11.0%	0.0%	5.1%	6.3%	10.8%	3.4%	8.8%	0.0%	0.0%
10 to 11 per year	22.8%	13.8%	29.1%	19.2%	21.1%	10.8%	66.7%	25.0%	23.0%	29.4%	28.7%	0.0%	13.6%	27.5%	23.1%	24.1%	14.7%	0.0%	0.0%
12 per year (monthly)	31.5%	11.3%	47.5%	19.2%	64.4%	73.0%	33.3%	75.0%	31.4%	11.8%	24.3%	0.0%	8.5%	47.5%	20.0%	10.3%	17.6%	0.0%	0.0%
More than 12 per year	3.2%	2.5%	3.8%	2.7%	6.7%	5.4%	0.0%	0.0%	3.5%	0.0%	2.9%	0.0%	0.0%	3.1%	3.1%	3.4%	5.9%	0.0%	0.0%
Approximate duration (scheduled) of a typical board meeting																			
Total responding in each category	309	79	158	72	90	37	9	8	285	17	135	9	58	159	65	29	33	14	9
Less than 2 hours	37.2%	19.0%	46.2%	37.5%	47.8%	54.1%	66.7%	25.0%	37.9%	23.5%	40.7%	11.1%	20.7%	48.4%	32.3%	34.5%	21.2%	0.0%	0.0%
2 to 4 hours	54.0%	55.7%	51.3%	58.3%	48.9%	45.9%	33.3%	75.0%	53.3%	76.5%	55.6%	44.4%	53.4%	48.4%	64.6%	58.6%	66.7%	50.0%	22.2%
4 to 6 hours	6.5%	16.5%	2.5%	4.2%	3.3%	0.0%	0.0%	0.0%	6.3%	0.0%	3.7%	11.1%	19.0%	3.1%	3.1%	6.9%	12.1%	14.3%	55.6%
6 to 8 hours	1.3%	5.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	0.0%	11.1%	5.2%	0.0%	0.0%	0.0%	0.0%	21.4%	11.1%
More than 8 hours	1.0%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%	22.2%	1.7%	0.0%	0.0%	0.0%	0.0%	14.3%	11.1%
The board uses a consent agenda																			
Total responding in each category	304	80	154	70	87	36	9	7	280	16	133	9	59	155	64	28	34	14	9
Yes	81.9%	90.0%	76.0%	85.7%	72.4%	63.9%	77.8%	85.7%	81.4%	93.8%	82.7%	100.0%	88.1%	74.2%	93.8%	85.7%	88.2%	85.7%	88.9%

All Respondents		Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 meeting content: average and median percent of meeting time spent:																			
Active discussion, deliberation, and debate about strategic priorities of the organization																			
Average	29.44	35.95	26.69	28.13	25.18	21.30	27.22	33.13	28.94	30.59	27.92	41.11	37.17	27.65	26.97	34.72	32.79	34.50	40.56
Median	25	33	25	25	23	20	30	35	25	30	25	40	38	25	25	30	30	33	35
Reviewing financial performance																			
Average	18.78	16.59	21.01	16.39	21.56	24.22	18.33	20.00	18.92	18.53	18.29	21.11	15.39	20.70	17.89	15.83	15.41	17.00	16.11
Median	20	15	20	18	20	20	20	20	20	20	20	20	15	20	20	15	15	15	20
Reviewing quality of care/patient safety metrics																			
Average	18.47	16.11	17.10	24.03	18.78	19.08	20.56	19.38	18.74	20.88	19.71	10.00	15.80	18.11	20.89	17.31	20.29	13.57	12.22
Median	20	20	15	20	20	15	20	20	20	20	20	10	20	20	20	20	20	10	15
Reviewing other reports from management, board committees, and subsidiaries (not including financial and quality/safety reports)																			
Average	20.94	18.96	22.68	19.42	21.98	23.57	20.00	16.25	21.06	18.82	21.65	18.33	18.80	21.37	21.27	19.93	17.97	24.21	20.56
Median	20	20	20	20	20	20	20	13	20	20	20	20	20	20	20	15	20	25	20
Board member education																			
Average	12.33	12.39	12.52	11.88	12.51	11.84	13.89	11.25	12.30	11.18	12.33	9.44	12.85	12.08	12.98	12.21	13.53	10.71	10.56
Median	10	10	10	10	10	10	10	13	10	10	10	10	10	10	10	10	10	10	10
Percent of meeting time spent in active discussion, deliberation, and debate about strategic priorities																			
Total responding in each category	307	80	155	72	89	37	9	8	284	17	133	9	59	158	63	29	34	14	9
0–10%	9.8%	3.8%	10.3%	15.3%	14.6%	21.6%	11.1%	0.0%	10.2%	0.0%	10.5%	0.0%	5.1%	11.4%	9.5%	3.4%	14.7%	0.0%	0.0%
11–20%	27.7%	16.3%	33.5%	27.8%	34.8%	37.8%	33.3%	25.0%	27.5%	17.6%	32.3%	0.0%	13.6%	31.6%	31.7%	27.6%	14.7%	7.1%	11.1%
21–30%	30.0%	30.0%	31.6%	26.4%	30.3%	29.7%	33.3%	25.0%	31.0%	58.8%	27.8%	33.3%	25.4%	30.4%	31.7%	24.1%	26.5%	42.9%	22.2%
31–40%	13.0%	18.8%	11.6%	9.7%	7.9%	5.4%	11.1%	25.0%	13.0%	11.8%	12.0%	44.4%	18.6%	8.9%	17.5%	10.3%	11.8%	28.6%	44.4%
41–50%	12.7%	18.8%	9.0%	13.9%	7.9%	2.7%	11.1%	25.0%	12.3%	5.9%	12.0%	0.0%	25.4%	12.0%	6.3%	20.7%	23.5%	14.3%	0.0%
51–60%	4.6%	8.8%	2.6%	4.2%	4.5%	2.7%	0.0%	0.0%	3.9%	5.9%	2.3%	11.1%	8.5%	3.2%	3.2%	10.3%	5.9%	7.1%	11.1%
61–70%	1.3%	2.5%	0.6%	1.4%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	1.5%	0.0%	3.4%	1.3%	0.0%	3.4%	2.9%	0.0%	0.0%
71–80%	1.0%	1.3%	0.6%	1.4%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	1.5%	11.1%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	11.1%
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%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Frequency of scheduled executive sessions (N/A excluded)																			
Total respondents that hold scheduled executive sessions	230	72	111	47	68	27	6	6	208	13	88	8	53	109	47	25	27	13	9
After or before every board meeting	57.8%	68.1%	55.9%	46.8%	61.8%	55.6%	50.0%	66.7%	58.2%	46.2%	51.1%	75.0%	64.2%	56.0%	42.6%	64.0%	63.0%	84.6%	88.9%
After or before every other board meeting	7.8%	4.2%	10.8%	6.4%	11.8%	18.5%	16.7%	0.0%	8.7%	7.7%	6.8%	0.0%	5.7%	11.0%	4.3%	12.0%	3.7%	0.0%	0.0%
Quarterly	3.9%	1.4%	6.3%	2.1%	7.4%	7.4%	16.7%	0.0%	4.3%	0.0%	4.5%	0.0%	0.0%	4.6%	6.4%	0.0%	3.7%	0.0%	0.0%
Twice a year	8.7%	5.6%	10.8%	8.5%	5.9%	3.7%	0.0%	0.0%	8.2%	0.0%	13.6%	0.0%	7.5%	10.1%	8.5%	0.0%	14.8%	7.7%	0.0%
Once a year	5.7%	4.2%	4.5%	10.6%	2.9%	0.0%	16.7%	0.0%	6.3%	23.1%	5.7%	12.5%	3.8%	6.4%	10.6%	0.0%	3.7%	0.0%	0.0%
Less often than once a year	3.9%	2.8%	2.7%	8.5%	2.9%	7.4%	0.0%	0.0%	4.3%	15.4%	3.4%	0.0%	3.8%	3.7%	4.3%	8.0%	3.7%	0.0%	0.0%
Other	12.2%	13.9%	9.0%	17.0%	7.4%	7.4%	0.0%	33.3%	10.1%	7.7%	14.8%	12.5%	15.1%	8.3%	23.4%	16.0%	7.4%	7.7%	11.1%
The CEO attends scheduled executive sessions																			
Total responding in each category	227	72	107	48	68	27	6	6	204	13	86	8	52	107	48	24	27	12	9
Always	56.8%	59.7%	57.0%	52.1%	69.1%	74.1%	83.3%	66.7%	58.3%	61.5%	45.3%	62.5%	57.7%	62.6%	41.7%	58.3%	48.1%	75.0%	66.7%
Most of the time	30.8%	27.8%	34.6%	27.1%	27.9%	18.5%	16.7%	33.3%	31.4%	38.5%	34.9%	12.5%	28.8%	29.0%	39.6%	33.3%	29.6%	8.3%	33.3%
Sometimes	6.6%	12.5%	3.7%	4.2%	2.9%	7.4%	0.0%	0.0%	5.4%	0.0%	4.7%	25.0%	13.5%	2.8%	8.3%	4.2%	18.5%	16.7%	0.0%
Rarely	5.7%	0.0%	4.7%	16.7%	0.0%	0.0%	0.0%	0.0%	4.9%	0.0%	15.1%	0.0%	0.0%	5.6%	10.4%	4.2%	3.7%	0.0%	0.0%
Physician or nurse board members who are on the staff, employed, or financially affiliated with the organization attend scheduled executive sessions																			
Total responding in each category	213	65	101	47	63	24	6	6	190	12	84	8	46	103	45	24	23	10	8
Always	27.7%	38.5%	22.8%	23.4%	23.8%	20.8%	16.7%	50.0%	26.8%	33.3%	21.4%	12.5%	45.7%	23.3%	24.4%	37.5%	30.4%	50.0%	37.5%
Most of the time	13.1%	13.8%	14.9%	8.5%	17.5%	25.0%	16.7%	0.0%	13.2%	0.0%	14.3%	0.0%	10.9%	15.5%	11.1%	8.3%	13.0%	10.0%	12.5%
Sometimes	18.8%	10.8%	25.7%	14.9%	15.9%	12.5%	0.0%	16.7%	20.0%	33.3%	25.0%	12.5%	8.7%	23.3%	20.0%	12.5%	13.0%	0.0%	12.5%
Rarely	40.4%	36.9%	36.6%	53.2%	42.9%	41.7%	66.7%	33.3%	40.0%	33.3%	39.3%	75.0%	34.8%	37.9%	44.4%	41.7%	43.5%	40.0%	37.5%
Legal counsel attends scheduled executive sessions																			
Total responding in each category	214	68	99	47	64	23	6	6	192	12	82	8	48	101	43	24	27	10	9
Always	27.6%	36.8%	20.2%	29.8%	31.3%	26.1%	33.3%	50.0%	27.1%	41.7%	19.5%	37.5%	31.3%	26.7%	23.3%	41.7%	25.9%	40.0%	11.1%
Most of the time	13.6%	16.2%	12.1%	12.8%	7.8%	4.3%	16.7%	0.0%	13.0%	0.0%	17.1%	12.5%	18.8%	8.9%	14.0%	25.0%	18.5%	10.0%	22.2%
Sometimes	23.8%	29.4%	19.2%	25.5%	17.2%	17.4%	16.7%	16.7%	24.0%	25.0%	24.4%	37.5%	29.2%	15.8%	27.9%	16.7%	48.1%	20.0%	44.4%
Rarely	35.0%	17.6%	48.5%	31.9%	43.8%	52.2%	33.3%	33.3%	35.9%	33.3%	39.0%	12.5%	20.8%	48.5%	34.9%	16.7%	7.4%	30.0%	22.2%

All Respondents		Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 management attends scheduled executive sessions																			
Total responding in each category	217	68	102	47	65	25	6	6	195	12	83	8	49	103	45	23	25	12	9
Always	7.4%	7.4%	9.8%	2.1%	15.4%	24.0%	0.0%	33.3%	6.7%	0.0%	2.4%	12.5%	6.1%	10.7%	2.2%	4.3%	4.0%	16.7%	0.0%
Most of the time	10.1%	10.3%	10.8%	8.5%	13.8%	12.0%	33.3%	0.0%	10.3%	16.7%	8.4%	12.5%	6.1%	9.7%	11.1%	13.0%	8.0%	0.0%	22.2%
Sometimes	34.6%	42.6%	33.3%	25.5%	30.8%	24.0%	0.0%	33.3%	35.4%	33.3%	32.5%	0.0%	49.0%	32.0%	31.1%	34.8%	52.0%	33.3%	33.3%
Rarely	47.9%	39.7%	46.1%	63.8%	40.0%	40.0%	66.7%	33.3%	47.7%	50.0%	56.6%	75.0%	38.8%	47.6%	55.6%	47.8%	36.0%	50.0%	44.4%
Topics typically discussed in executive sessions																			
Total responding in each category	240	76	114	50	69	28	6	6	217	13	94	8	56	111	50	26	29	14	10
Executive performance/ evaluation	80.8%	85.5%	81.6%	72.0%	91.3%	92.9%	83.3%	66.7%	80.2%	69.2%	73.4%	87.5%	82.1%	82.9%	80.0%	73.1%	79.3%	85.7%	80.0%
Executive compensation	65.0%	65.8%	67.5%	58.0%	69.6%	67.9%	100.0%	50.0%	63.1%	61.5%	62.8%	50.0%	66.1%	67.6%	66.0%	69.2%	58.6%	57.1%	50.0%
Miscellaneous governance issues	42.1%	44.7%	43.0%	36.0%	37.7%	46.4%	50.0%	50.0%	41.9%	46.2%	43.6%	87.5%	37.5%	41.4%	44.0%	46.2%	37.9%	28.6%	60.0%
General strategic planning/issues	38.8%	39.5%	43.0%	28.0%	49.3%	42.9%	83.3%	66.7%	38.2%	30.8%	35.1%	25.0%	35.7%	43.2%	34.0%	38.5%	37.9%	14.3%	50.0%
M&A strategy	20.8%	25.0%	14.0%	30.0%	17.4%	17.9%	33.3%	0.0%	20.3%	30.8%	19.1%	0.0%	28.6%	14.4%	26.0%	46.2%	20.7%	14.3%	10.0%
Financial performance	15.4%	13.2%	17.5%	14.0%	14.5%	14.3%	16.7%	50.0%	14.7%	15.4%	18.1%	25.0%	10.7%	13.5%	22.0%	19.2%	6.9%	14.3%	20.0%
Clinical or quality performance/ measures	22.9%	17.1%	28.1%	20.0%	40.6%	42.9%	33.3%	50.0%	23.5%	23.1%	18.1%	12.5%	10.7%	28.8%	20.0%	23.1%	20.7%	7.1%	0.0%
Board recruitment and selection	22.5%	18.4%	27.2%	18.0%	18.8%	14.3%	16.7%	33.3%	22.1%	23.1%	25.5%	37.5%	19.6%	26.1%	18.0%	23.1%	3.4%	35.7%	40.0%
Executive succession planning	38.3%	53.9%	33.3%	26.0%	33.3%	32.1%	66.7%	50.0%	36.4%	38.5%	33.0%	50.0%	51.8%	29.7%	34.0%	61.5%	34.5%	64.3%	70.0%
Board performance and evaluation	34.2%	47.4%	30.7%	22.0%	27.5%	28.6%	50.0%	50.0%	32.7%	38.5%	26.6%	62.5%	50.0%	30.6%	26.0%	42.3%	34.5%	71.4%	40.0%
Government relations	11.3%	9.2%	10.5%	16.0%	18.8%	10.7%	16.7%	33.3%	11.1%	15.4%	10.6%	0.0%	3.6%	13.5%	8.0%	15.4%	13.8%	0.0%	0.0%
Other	18.8%	13.2%	26.3%	10.0%	24.6%	21.4%	0.0%	50.0%	18.9%	0.0%	21.3%	12.5%	12.5%	20.7%	16.0%	23.1%	20.7%	14.3%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Frequency of scheduled board retreats																			
Total responding in each category	306	78	156	72	89	37	9	8	282	17	134	9	57	158	64	29	33	14	8
Quarterly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Twice a year	8.8%	14.1%	7.1%	6.9%	5.6%	2.7%	11.1%	0.0%	8.5%	0.0%	8.2%	0.0%	19.3%	6.3%	7.8%	6.9%	12.1%	28.6%	25.0%
Once a year	52.6%	59.0%	46.8%	58.3%	47.2%	35.1%	33.3%	62.5%	51.4%	47.1%	56.0%	66.7%	52.6%	45.6%	65.6%	58.6%	60.6%	50.0%	37.5%
Less often than once a year	28.8%	17.9%	35.3%	26.4%	34.8%	43.2%	33.3%	37.5%	30.5%	41.2%	27.6%	22.2%	19.3%	36.1%	21.9%	24.1%	18.2%	14.3%	25.0%
Other	9.8%	9.0%	10.9%	8.3%	12.4%	18.9%	22.2%	0.0%	9.6%	11.8%	8.2%	11.1%	8.8%	12.0%	4.7%	10.3%	9.1%	7.1%	12.5%
Who typically attends board retreats, other than board members?																			
Total responding in each category	312	81	159	72	89	37	9	8	288	17	137	9	60	158	66	29	35	14	10
CEO	88.8%	92.6%	85.5%	91.7%	84.3%	86.5%	77.8%	87.5%	88.2%	94.1%	89.1%	100.0%	91.7%	87.3%	92.4%	96.6%	80.0%	100.0%	80.0%
CMO	63.1%	82.7%	49.7%	70.8%	48.3%	45.9%	55.6%	62.5%	62.5%	82.4%	61.3%	66.7%	83.3%	47.5%	78.8%	82.8%	77.1%	85.7%	70.0%
CNO	74.0%	75.3%	73.6%	73.6%	73.0%	75.7%	66.7%	75.0%	74.3%	76.5%	74.5%	55.6%	76.7%	72.2%	81.8%	82.8%	71.4%	50.0%	70.0%
CFO	76.6%	84.0%	73.0%	76.4%	75.3%	81.1%	66.7%	75.0%	79.2%	64.7%	75.9%	77.8%	83.3%	75.9%	77.3%	75.9%	80.0%	92.9%	50.0%
Other C-suite executives/ senior leaders	77.6%	93.8%	66.7%	83.3%	67.4%	67.6%	55.6%	87.5%	76.7%	76.5%	76.6%	100.0%	91.7%	67.7%	86.4%	89.7%	88.6%	100.0%	70.0%
Governance support staff	46.5%	66.7%	31.4%	56.9%	29.2%	29.7%	44.4%	12.5%	44.8%	47.1%	46.7%	55.6%	70.0%	29.1%	63.6%	69.0%	65.7%	64.3%	50.0%
Medical staff physicians	47.8%	45.7%	46.5%	52.8%	47.2%	43.2%	33.3%	75.0%	46.9%	64.7%	48.2%	11.1%	48.3%	46.2%	56.1%	58.6%	45.7%	35.7%	10.0%
Nurses	11.5%	14.8%	8.8%	13.9%	6.7%	10.8%	0.0%	0.0%	11.5%	17.6%	12.4%	0.0%	16.7%	6.3%	16.7%	20.7%	20.0%	7.1%	10.0%
Other	16.3%	18.5%	18.9%	8.3%	20.2%	18.9%	22.2%	25.0%	14.9%	11.8%	12.4%	22.2%	20.0%	17.1%	13.6%	24.1%	14.3%	7.1%	20.0%
Number of standing committees																			
Total responding in each category	304	80	153	71	85	34	9	8	280	17	134	9	59	154	64	29	34	14	9
0	3.6%	1.3%	1.3%	11.3%	4.7%	8.8%	0.0%	0.0%	3.9%	0.0%	5.2%	0.0%	0.0%	3.2%	4.7%	0.0%	8.8%	0.0%	0.0%
1 to 3	13.5%	3.8%	18.3%	14.1%	20.0%	17.6%	22.2%	0.0%	14.3%	29.4%	11.9%	11.1%	3.4%	20.8%	4.7%	10.3%	5.9%	0.0%	11.1%
4 to 5	15.5%	15.0%	19.0%	8.5%	17.6%	29.4%	11.1%	0.0%	16.1%	5.9%	15.7%	33.3%	11.9%	19.5%	10.9%	10.3%	2.9%	35.7%	11.1%
6 to 7	21.4%	31.3%	14.4%	25.4%	21.2%	14.7%	11.1%	75.0%	21.1%	5.9%	19.4%	11.1%	32.2%	16.9%	21.9%	34.5%	23.5%	28.6%	33.3%
8 to 10	25.3%	38.8%	19.0%	23.9%	17.6%	20.6%	22.2%	12.5%	23.6%	47.1%	18.7%	33.3%	44.1%	16.2%	29.7%	31.0%	47.1%	28.6%	44.4%
11+	20.7%	10.0%	28.1%	16.9%	18.8%	8.8%	33.3%	12.5%	21.1%	11.8%	29.1%	11.1%	8.5%	23.4%	28.1%	13.8%	11.8%	7.1%	0.0%
Average	8.02	7.68	8.50	7.38	7.35	5.85	8.89	8.38	8.00	7.53	8.62	7.78	7.80	7.81	9.09	7.90	7.65	7.29	6.89
Median	7	7	7	7	6	5	8	7	7	8	7	7	8	6	8	7	8	6	7
Range	0 to 21	0 to 21	0 to 21	0 to 21	0 to 21	0 to 21	2 to 21	6 to 20	0 to 21	1 to 20	0 to 21	3 to 21	1 to 18	0 to 21	0 to 21	2 to 20	0 to 18	4 to 21	1 to 9

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	61	120	55	57	22	6	5	214	14	112	8	45	120	54	20	25	8	9
Monthly	26.3%	21.3%	30.8%	21.8%	38.6%	31.8%	50.0%	40.0%	26.2%	21.4%	25.0%	0.0%	20.0%	30.0%	31.5%	25.0%	8.0%	25.0%	0.0%
Bi-monthly	12.3%	14.8%	8.3%	18.2%	3.5%	4.5%	0.0%	0.0%	12.6%	7.1%	16.1%	12.5%	15.6%	7.5%	22.2%	10.0%	20.0%	0.0%	11.1%
Quarterly	11.0%	16.4%	11.7%	3.6%	8.8%	13.6%	16.7%	0.0%	11.2%	14.3%	8.9%	50.0%	11.1%	10.0%	3.7%	20.0%	12.0%	37.5%	22.2%
Semi-annually	3.4%	4.9%	3.3%	1.8%	3.5%	4.5%	0.0%	0.0%	3.7%	7.1%	2.7%	0.0%	4.4%	2.5%	1.9%	0.0%	12.0%	12.5%	0.0%
Annually	1.7%	3.3%	1.7%	0.0%	1.8%	0.0%	16.7%	0.0%	1.9%	0.0%	0.9%	0.0%	4.4%	2.5%	0.0%	5.0%	0.0%	0.0%	0.0%
As needed	45.3%	39.3%	44.2%	54.5%	43.9%	45.5%	16.7%	60.0%	44.4%	50.0%	46.4%	37.5%	44.4%	47.5%	40.7%	40.0%	48.0%	25.0%	66.7%
Percentage of respondents with this committee	78.7%	79.2%	78.9%	77.5%	67.9%	64.7%	66.7%	62.5%	77.3%	82.4%	83.6%	88.9%	80.4%	78.4%	85.7%	69.0%	78.1%	57.1%	100.0%
Finance																			
Total responding in each category	252	74	131	47	69	24	9	8	229	10	109	8	56	121	56	25	28	14	8
Monthly	51.2%	32.4%	61.8%	51.1%	69.6%	45.8%	88.9%	75.0%	51.1%	50.0%	53.2%	0.0%	32.1%	62.0%	57.1%	32.0%	42.9%	14.3%	0.0%
Bi-monthly	17.1%	21.6%	13.0%	21.3%	1.4%	4.2%	0.0%	0.0%	17.5%	10.0%	22.9%	37.5%	23.2%	10.7%	19.6%	24.0%	32.1%	7.1%	37.5%
Quarterly	23.0%	41.9%	13.0%	21.3%	13.0%	16.7%	0.0%	25.0%	22.3%	40.0%	15.6%	62.5%	41.1%	12.4%	17.9%	44.0%	25.0%	71.4%	62.5%
Semi-annually	2.0%	1.4%	2.3%	2.1%	0.0%	0.0%	0.0%	0.0%	2.2%	0.0%	3.7%	0.0%	1.8%	2.5%	1.8%	0.0%	0.0%	7.1%	0.0%
Annually	1.2%	0.0%	2.3%	0.0%	2.9%	4.2%	0.0%	0.0%	0.9%	0.0%	0.9%	0.0%	0.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	5.6%	2.7%	7.6%	4.3%	13.0%	29.2%	11.1%	0.0%	6.1%	0.0%	3.7%	0.0%	1.8%	9.9%	3.6%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents with this committee	84.6%	93.7%	87.3%	68.1%	83.1%	70.6%	100.0%	100.0%	83.6%	58.8%	83.2%	88.9%	96.6%	81.2%	87.5%	89.3%	82.4%	100.0%	88.9%
Audit																			
Total responding in each category	111	22	73	16	31	8	5	3	100	6	55	4	15	64	26	10	9	1	1
Monthly	6.3%	4.5%	8.2%	0.0%	16.1%	0.0%	0.0%	0.0%	6.0%	0.0%	3.6%	0.0%	0.0%	7.8%	3.8%	10.0%	0.0%	0.0%	0.0%
Bi-monthly	2.7%	0.0%	2.7%	6.3%	3.2%	0.0%	0.0%	0.0%	3.0%	16.7%	1.8%	0.0%	0.0%	0.0%	7.7%	0.0%	11.1%	0.0%	0.0%
Quarterly	18.0%	36.4%	8.2%	37.5%	6.5%	12.5%	0.0%	33.3%	18.0%	50.0%	12.7%	75.0%	33.3%	7.8%	26.9%	30.0%	33.3%	100.0%	100.0%
Semi-annually	15.3%	27.3%	8.2%	31.3%	9.7%	12.5%	20.0%	33.3%	13.0%	16.7%	12.7%	25.0%	33.3%	6.3%	23.1%	30.0%	44.4%	0.0%	0.0%
Annually	40.5%	22.7%	50.7%	18.8%	38.7%	50.0%	60.0%	0.0%	42.0%	16.7%	50.9%	0.0%	26.7%	56.3%	23.1%	20.0%	11.1%	0.0%	0.0%
As needed	17.1%	9.1%	21.9%	6.3%	25.8%	25.0%	20.0%	33.3%	18.0%	0.0%	18.2%	0.0%	6.7%	21.9%	15.4%	10.0%	0.0%	0.0%	0.0%
Percentage of respondents with this committee	40.2%	33.3%	51.4%	23.5%	38.8%	25.0%	62.5%	37.5%	39.5%	35.3%	44.4%	66.7%	30.6%	45.1%	41.9%	38.5%	32.1%	10.0%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Compliance																			
Total responding in each category	104	19	69	16	37	14	6	2	99	6	47	1	13	64	26	7	5	2	0
Monthly	13.5%	21.1%	10.1%	18.8%	24.3%	14.3%	33.3%	0.0%	14.1%	0.0%	8.5%	0.0%	7.7%	18.8%	3.8%	14.3%	0.0%	0.0%	0.0%
Bi-monthly	7.7%	10.5%	7.2%	6.3%	5.4%	7.1%	16.7%	0.0%	7.1%	16.7%	6.4%	0.0%	15.4%	3.1%	19.2%	14.3%	0.0%	0.0%	0.0%
Quarterly	43.3%	47.4%	40.6%	50.0%	35.1%	28.6%	16.7%	100.0%	43.4%	50.0%	44.7%	100.0%	53.8%	35.9%	50.0%	71.4%	40.0%	100.0%	0.0%
Semi-annually	10.6%	10.5%	13.0%	0.0%	13.5%	14.3%	33.3%	0.0%	10.1%	0.0%	10.6%	0.0%	7.7%	10.9%	15.4%	0.0%	0.0%	0.0%	0.0%
Annually	4.8%	5.3%	5.8%	0.0%	5.4%	7.1%	0.0%	0.0%	5.1%	0.0%	4.3%	0.0%	7.7%	6.3%	0.0%	0.0%	20.0%	0.0%	0.0%
As needed	20.2%	5.3%	23.2%	25.0%	16.2%	28.6%	0.0%	0.0%	20.2%	33.3%	25.5%	0.0%	7.7%	25.0%	11.5%	0.0%	40.0%	0.0%	0.0%
Percentage of respondents with this committee	38.2%	30.2%	48.3%	24.2%	46.3%	42.4%	75.0%	25.0%	39.4%	35.3%	38.5%	20.0%	27.1%	44.4%	44.1%	26.9%	20.0%	20.0%	0.0%
Audit/compliance																			
Total responding in each category	151	59	59	33	30	8	6	4	138	9	62	6	44	54	39	18	21	12	7
Monthly	8.6%	6.8%	8.5%	12.1%	23.3%	12.5%	16.7%	0.0%	8.0%	11.1%	6.5%	0.0%	2.3%	7.4%	17.9%	5.6%	4.8%	0.0%	0.0%
Bi-monthly	10.6%	15.3%	5.1%	12.1%	3.3%	12.5%	0.0%	0.0%	10.9%	0.0%	11.3%	50.0%	11.4%	1.9%	10.3%	22.2%	19.0%	8.3%	28.6%
Quarterly	53.6%	66.1%	45.8%	45.5%	43.3%	50.0%	16.7%	75.0%	52.9%	44.4%	46.8%	33.3%	75.0%	38.9%	51.3%	66.7%	61.9%	83.3%	71.4%
Semi-annually	4.6%	3.4%	5.1%	6.1%	3.3%	0.0%	0.0%	0.0%	4.3%	11.1%	4.8%	16.7%	2.3%	5.6%	5.1%	0.0%	4.8%	8.3%	0.0%
Annually	12.6%	5.1%	18.6%	15.2%	16.7%	12.5%	33.3%	25.0%	13.8%	11.1%	17.7%	0.0%	4.5%	29.6%	5.1%	5.6%	0.0%	0.0%	0.0%
As needed	9.9%	3.4%	16.9%	9.1%	10.0%	12.5%	33.3%	0.0%	10.1%	22.2%	12.9%	0.0%	4.5%	16.7%	10.3%	0.0%	9.5%	0.0%	0.0%
Percentage of respondents with this committee	54.3%	78.7%	43.7%	48.5%	38.5%	26.7%	75.0%	50.0%	53.9%	56.3%	51.2%	75.0%	80.0%	39.7%	66.1%	64.3%	65.6%	85.7%	77.8%
Quality (or quality and safety)																			
Total responding in each category	240	70	117	53	64	23	8	7	216	13	104	7	52	112	57	25	28	11	7
Monthly	40.8%	40.0%	40.2%	43.4%	45.3%	39.1%	37.5%	28.6%	41.2%	53.8%	38.5%	0.0%	42.3%	39.3%	47.4%	56.0%	39.3%	18.2%	0.0%
Bi-monthly	19.6%	22.9%	16.2%	22.6%	12.5%	8.7%	37.5%	28.6%	19.9%	7.7%	21.2%	42.9%	25.0%	12.5%	28.1%	20.0%	28.6%	9.1%	42.9%
Quarterly	34.6%	37.1%	34.2%	32.1%	32.8%	47.8%	12.5%	42.9%	33.3%	30.8%	35.6%	57.1%	32.7%	37.5%	24.6%	24.0%	32.1%	72.7%	57.1%
Semi-annually	1.3%	0.0%	2.6%	0.0%	4.7%	0.0%	12.5%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	0.4%	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.5%	7.7%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	3.3%	0.0%	6.8%	0.0%	4.7%	4.3%	0.0%	0.0%	3.7%	0.0%	4.8%	0.0%	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of respondents with this committee	81.1%	89.7%	78.0%	77.9%	76.2%	67.6%	100.0%	87.5%	79.4%	76.5%	80.6%	77.8%	91.2%	75.2%	90.5%	89.3%	84.8%	78.6%	77.8%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	186	63	77	46	35	11	4	4	167	14	81	6	50	68	49	25	28	9	7
Monthly	6.5%	4.8%	9.1%	4.3%	11.4%	9.1%	0.0%	25.0%	6.0%	0.0%	8.6%	0.0%	2.0%	11.8%	2.0%	12.0%	0.0%	0.0%	0.0%
Bi-monthly	16.7%	17.5%	18.2%	13.0%	11.4%	9.1%	50.0%	0.0%	16.8%	7.1%	18.5%	50.0%	16.0%	10.3%	24.5%	8.0%	25.0%	11.1%	28.6%
Quarterly	33.9%	49.2%	27.3%	23.9%	20.0%	18.2%	0.0%	0.0%	32.3%	42.9%	25.9%	33.3%	54.0%	17.6%	24.5%	44.0%	57.1%	77.8%	71.4%
Semi-annually	5.9%	3.2%	6.5%	8.7%	2.9%	0.0%	0.0%	25.0%	5.4%	7.1%	8.6%	0.0%	4.0%	8.8%	8.2%	4.0%	0.0%	0.0%	0.0%
Annually	12.4%	9.5%	15.6%	10.9%	20.0%	18.2%	50.0%	0.0%	13.8%	0.0%	14.8%	16.7%	6.0%	19.1%	8.2%	12.0%	7.1%	11.1%	0.0%
As needed	24.7%	15.9%	23.4%	39.1%	34.3%	45.5%	0.0%	50.0%	25.7%	42.9%	23.5%	0.0%	18.0%	32.4%	32.7%	20.0%	10.7%	0.0%	0.0%
Percentage of respondents with this committee	63.5%	79.7%	53.5%	65.7%	42.7%	34.4%	50.0%	50.0%	61.9%	82.4%	63.8%	66.7%	86.2%	46.9%	77.8%	86.2%	82.4%	69.2%	77.8%
Executive compensation																			
Total responding in each category	186	60	91	35	41	15	7	5	168	7	84	4	50	76	48	19	27	11	5
Monthly	0.5%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	2.0%	0.0%	0.0%	5.3%	0.0%	0.0%	0.0%
Bi-monthly	3.8%	5.0%	2.2%	5.7%	2.4%	6.7%	0.0%	0.0%	3.0%	0.0%	3.6%	0.0%	6.0%	1.3%	2.1%	5.3%	11.1%	9.1%	0.0%
Quarterly	18.8%	35.0%	9.9%	14.3%	4.9%	0.0%	0.0%	0.0%	17.9%	14.3%	15.5%	25.0%	36.0%	3.9%	18.8%	21.1%	40.7%	27.3%	100.0%
Semi-annually	11.8%	20.0%	8.8%	5.7%	7.3%	0.0%	14.3%	40.0%	10.1%	0.0%	8.3%	25.0%	22.0%	2.6%	16.7%	26.3%	14.8%	27.3%	0.0%
Annually	40.3%	23.3%	53.8%	34.3%	51.2%	60.0%	71.4%	20.0%	42.3%	28.6%	47.6%	25.0%	22.0%	60.5%	35.4%	26.3%	18.5%	18.2%	0.0%
As needed	24.7%	15.0%	25.3%	40.0%	34.1%	33.3%	14.3%	40.0%	26.2%	57.1%	25.0%	25.0%	12.0%	31.6%	27.1%	15.8%	14.8%	18.2%	0.0%
Percentage of respondents with this committee	63.5%	78.9%	61.5%	50.7%	48.8%	44.1%	77.8%	62.5%	62.5%	41.2%	65.6%	50.0%	89.3%	51.7%	76.2%	67.9%	81.8%	78.6%	62.5%
Strategic planning																			
Total responding in each category	163	34	92	37	45	16	4	6	150	9	81	3	25	87	39	14	15	6	2
Monthly	8.6%	20.6%	6.5%	2.7%	11.1%	0.0%	0.0%	16.7%	8.0%	0.0%	4.9%	33.3%	16.0%	6.9%	2.6%	28.6%	13.3%	16.7%	0.0%
Bi-monthly	9.2%	11.8%	8.7%	8.1%	4.4%	0.0%	25.0%	16.7%	8.7%	11.1%	9.9%	0.0%	16.0%	5.7%	10.3%	14.3%	20.0%	0.0%	50.0%
Quarterly	23.3%	32.4%	19.6%	24.3%	17.8%	18.8%	25.0%	16.7%	22.7%	22.2%	21.0%	66.7%	36.0%	20.7%	17.9%	28.6%	26.7%	83.3%	0.0%
Semi-annually	9.2%	8.8%	12.0%	2.7%	6.7%	12.5%	0.0%	0.0%	9.3%	11.1%	11.1%	0.0%	8.0%	8.0%	15.4%	0.0%	6.7%	0.0%	50.0%
Annually	22.7%	8.8%	23.9%	32.4%	35.6%	43.8%	25.0%	0.0%	23.3%	22.2%	22.2%	0.0%	4.0%	31.0%	17.9%	7.1%	13.3%	0.0%	0.0%
As needed	27.0%	17.6%	29.3%	29.7%	24.4%	25.0%	25.0%	50.0%	28.0%	33.3%	30.9%	0.0%	20.0%	27.6%	35.9%	21.4%	20.0%	0.0%	0.0%
Percentage of respondents with this committee	57.0%	46.6%	63.0%	55.2%	54.9%	48.5%	50.0%	75.0%	57.0%	52.9%	64.3%	37.5%	47.2%	60.0%	63.9%	50.0%	48.4%	46.2%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Enterprise risk																			
Total responding in each category	55	9	31	15	13	1	1	3	54	3	31	1	7	28	16	4	3	4	0
Monthly	7.3%	0.0%	3.2%	20.0%	7.7%	0.0%	0.0%	0.0%	7.4%	0.0%	9.7%	0.0%	0.0%	10.7%	6.3%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	7.3%	11.1%	6.5%	6.7%	7.7%	0.0%	0.0%	33.3%	7.4%	0.0%	6.5%	0.0%	14.3%	0.0%	18.8%	0.0%	33.3%	0.0%	0.0%
Quarterly	23.6%	44.4%	16.1%	26.7%	23.1%	0.0%	0.0%	66.7%	24.1%	0.0%	22.6%	0.0%	42.9%	14.3%	25.0%	50.0%	33.3%	50.0%	0.0%
Semi-annually	5.5%	22.2%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	3.7%	0.0%	3.2%	100.0%	14.3%	0.0%	6.3%	25.0%	0.0%	25.0%	0.0%
Annually	12.7%	0.0%	9.7%	26.7%	7.7%	100.0%	0.0%	0.0%	13.0%	66.7%	12.9%	0.0%	0.0%	17.9%	6.3%	25.0%	0.0%	0.0%	0.0%
As needed	43.6%	22.2%	61.3%	20.0%	53.8%	0.0%	100.0%	0.0%	44.4%	33.3%	45.2%	0.0%	28.6%	57.1%	37.5%	0.0%	33.3%	25.0%	0.0%
Percentage of respondents with this committee	19.4%	12.5%	21.7%	22.1%	15.7%	2.9%	12.5%	37.5%	20.7%	17.6%	25.2%	14.3%	13.2%	19.4%	26.2%	14.8%	9.7%	33.3%	0.0%
Physician relations																			
Total responding in each category	64	11	36	17	15	4	2	1	60	4	35	1	9	34	15	8	5	1	1
Monthly	25.0%	18.2%	30.6%	17.6%	33.3%	25.0%	50.0%	100.0%	25.0%	25.0%	25.7%	0.0%	11.1%	17.6%	53.3%	12.5%	20.0%	0.0%	0.0%
Bi-monthly	7.8%	9.1%	0.0%	23.5%	0.0%	0.0%	0.0%	0.0%	6.7%	25.0%	8.6%	0.0%	11.1%	5.9%	13.3%	12.5%	0.0%	0.0%	0.0%
Quarterly	12.5%	36.4%	5.6%	11.8%	0.0%	0.0%	0.0%	0.0%	13.3%	0.0%	11.4%	100.0%	33.3%	5.9%	6.7%	37.5%	0.0%	100.0%	100.0%
Semi-annually	3.1%	9.1%	0.0%	5.9%	0.0%	0.0%	0.0%	0.0%	1.7%	0.0%	2.9%	0.0%	11.1%	0.0%	6.7%	12.5%	0.0%	0.0%	0.0%
Annually	3.1%	0.0%	5.6%	0.0%	6.7%	25.0%	0.0%	0.0%	3.3%	0.0%	2.9%	0.0%	0.0%	5.9%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	48.4%	27.3%	58.3%	41.2%	60.0%	50.0%	50.0%	0.0%	50.0%	50.0%	48.6%	0.0%	33.3%	64.7%	20.0%	25.0%	80.0%	0.0%	0.0%
Percentage of respondents with this committee	23.0%	15.7%	25.4%	25.8%	18.3%	11.8%	25.0%	12.5%	23.3%	23.5%	28.9%	14.3%	17.6%	23.9%	25.4%	28.6%	17.2%	8.3%	12.5%
Investment (separate from Finance)																			
Total responding in each category	119	44	49	26	17	3	2	3	107	5	57	7	33	43	28	16	17	8	7
Monthly	2.5%	2.3%	4.1%	0.0%	5.9%	0.0%	0.0%	0.0%	1.9%	0.0%	1.8%	0.0%	3.0%	2.3%	7.1%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	6.7%	9.1%	4.1%	7.7%	0.0%	0.0%	0.0%	0.0%	6.5%	0.0%	7.0%	42.9%	3.0%	2.3%	7.1%	6.3%	11.8%	12.5%	14.3%
Quarterly	59.7%	77.3%	44.9%	57.7%	41.2%	33.3%	50.0%	100.0%	57.9%	80.0%	50.9%	57.1%	81.8%	39.5%	64.3%	81.3%	58.8%	87.5%	85.7%
Semi-annually	7.6%	6.8%	4.1%	15.4%	11.8%	33.3%	0.0%	0.0%	7.5%	20.0%	7.0%	0.0%	6.1%	7.0%	7.1%	12.5%	11.8%	0.0%	0.0%
Annually	3.4%	2.3%	6.1%	0.0%	0.0%	0.0%	0.0%	0.0%	3.7%	0.0%	5.3%	0.0%	3.0%	7.0%	0.0%	0.0%	5.9%	0.0%	0.0%
As needed	20.2%	2.3%	36.7%	19.2%	41.2%	33.3%	50.0%	0.0%	22.4%	0.0%	28.1%	0.0%	3.0%	41.9%	14.3%	0.0%	11.8%	0.0%	0.0%
Percentage of respondents with this committee	41.3%	57.9%	33.8%	38.8%	20.5%	8.8%	25.0%	37.5%	40.4%	31.3%	45.6%	77.8%	60.0%	30.1%	45.9%	57.1%	51.5%	57.1%	77.8%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Joint conference																			
Total responding in each category	98	12	65	21	30	11	4	4	90	4	54	1	9	59	24	8	4	2	1
Monthly	11.2%	16.7%	12.3%	4.8%	23.3%	36.4%	25.0%	25.0%	12.2%	0.0%	5.6%	0.0%	11.1%	10.2%	12.5%	12.5%	0.0%	0.0%	100.0%
Bi-monthly	4.1%	8.3%	3.1%	4.8%	0.0%	0.0%	0.0%	0.0%	4.4%	0.0%	5.6%	0.0%	11.1%	5.1%	0.0%	0.0%	25.0%	0.0%	0.0%
Quarterly	10.2%	8.3%	10.8%	9.5%	10.0%	0.0%	25.0%	0.0%	10.0%	25.0%	9.3%	0.0%	11.1%	10.2%	4.2%	37.5%	0.0%	0.0%	0.0%
Semi-annually	7.1%	16.7%	4.6%	9.5%	6.7%	9.1%	0.0%	0.0%	6.7%	0.0%	5.6%	0.0%	22.2%	6.8%	4.2%	0.0%	25.0%	50.0%	0.0%
Annually	5.1%	8.3%	6.2%	0.0%	10.0%	18.2%	0.0%	0.0%	5.6%	0.0%	1.9%	100.0%	0.0%	6.8%	0.0%	0.0%	0.0%	50.0%	0.0%
As needed	62.2%	41.7%	63.1%	71.4%	50.0%	36.4%	50.0%	75.0%	61.1%	75.0%	72.2%	0.0%	44.4%	61.0%	79.2%	50.0%	50.0%	0.0%	0.0%
Percentage of respondents with this committee	34.5%	16.7%	45.1%	30.9%	36.1%	32.4%	50.0%	50.0%	34.5%	23.5%	43.5%	14.3%	17.0%	41.0%	39.3%	28.6%	13.8%	14.3%	12.5%
Facilities																			
Total responding in each category	73	12	46	15	22	7	1	2	69	2	39	1	9	46	12	5	9	1	0
Monthly	16.4%	16.7%	19.6%	6.7%	27.3%	28.6%	0.0%	0.0%	15.9%	0.0%	12.8%	0.0%	11.1%	19.6%	16.7%	20.0%	0.0%	0.0%	0.0%
Bi-monthly	8.2%	8.3%	4.3%	20.0%	0.0%	0.0%	0.0%	0.0%	5.8%	0.0%	12.8%	0.0%	11.1%	4.3%	16.7%	0.0%	22.2%	0.0%	0.0%
Quarterly	13.7%	16.7%	8.7%	26.7%	4.5%	0.0%	0.0%	0.0%	14.5%	50.0%	15.4%	0.0%	22.2%	6.5%	33.3%	20.0%	22.2%	0.0%	0.0%
Semi-annually	5.5%	8.3%	4.3%	6.7%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	7.7%	0.0%	11.1%	4.3%	8.3%	20.0%	0.0%	0.0%	0.0%
Annually	9.6%	0.0%	15.2%	0.0%	22.7%	28.6%	100.0%	50.0%	10.1%	0.0%	5.1%	0.0%	0.0%	15.2%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	46.6%	50.0%	47.8%	40.0%	45.5%	42.9%	0.0%	50.0%	49.3%	50.0%	46.2%	100.0%	44.4%	50.0%	25.0%	40.0%	55.6%	100.0%	0.0%
Percentage of respondents with this committee	26.0%	16.9%	31.9%	22.7%	26.8%	21.2%	12.5%	25.0%	26.7%	11.8%	31.7%	14.3%	17.3%	32.2%	19.7%	17.9%	31.0%	7.7%	0.0%
Construction (separate from facilities)																			
Total responding in each category	56	6	37	13	20	4	3	2	56	4	28	1	3	38	11	2	3	1	1
Monthly	10.7%	33.3%	5.4%	15.4%	15.0%	0.0%	0.0%	0.0%	10.7%	25.0%	3.6%	0.0%	33.3%	7.9%	18.2%	50.0%	0.0%	0.0%	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	10.7%	16.7%	2.7%	30.8%	0.0%	0.0%	0.0%	0.0%	10.7%	25.0%	14.3%	0.0%	33.3%	7.9%	18.2%	0.0%	0.0%	0.0%	100.0%
Semi-annually	1.8%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	3.6%	0.0%	0.0%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%
Annually	3.6%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	7.1%	0.0%	0.0%	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	73.2%	50.0%	86.5%	46.2%	85.0%	100.0%	100.0%	100.0%	73.2%	50.0%	71.4%	100.0%	33.3%	78.9%	54.5%	50.0%	100.0%	100.0%	0.0%
Percentage of respondents with this committee	19.6%	8.3%	25.5%	18.8%	24.1%	11.8%	37.5%	25.0%	21.3%	23.5%	22.2%	14.3%	5.7%	26.2%	17.7%	7.1%	10.0%	7.7%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Government relations/advocacy																			
Total responding in each category	52	8	33	11	18	6	2	2	50	2	24	2	6	29	11	1	7	2	2
Monthly	1.9%	0.0%	3.0%	0.0%	5.6%	0.0%	0.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	3.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	7.7%	37.5%	3.0%	0.0%	5.6%	0.0%	50.0%	0.0%	8.0%	0.0%	0.0%	50.0%	33.3%	0.0%	9.1%	0.0%	28.6%	0.0%	50.0%
Quarterly	17.3%	37.5%	12.1%	18.2%	11.1%	33.3%	0.0%	0.0%	18.0%	0.0%	16.7%	50.0%	33.3%	10.3%	27.3%	0.0%	0.0%	100.0%	50.0%
Semi-annually	7.7%	0.0%	9.1%	9.1%	5.6%	0.0%	0.0%	0.0%	6.0%	0.0%	12.5%	0.0%	0.0%	0.0%	18.2%	0.0%	28.6%	0.0%	0.0%
Annually	5.8%	0.0%	9.1%	0.0%	11.1%	16.7%	0.0%	0.0%	6.0%	0.0%	4.2%	0.0%	0.0%	10.3%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	59.6%	25.0%	63.6%	72.7%	61.1%	50.0%	50.0%	100.0%	60.0%	100.0%	66.7%	0.0%	33.3%	75.9%	45.5%	100.0%	42.9%	0.0%	0.0%
Percentage of respondents with this committee	18.3%	11.0%	23.2%	15.9%	21.7%	17.6%	25.0%	25.0%	19.1%	11.8%	19.5%	28.6%	11.1%	20.3%	18.0%	3.6%	22.6%	15.4%	25.0%
Human resources																			
Total responding in each category	68	11	42	15	24	9	2	2	62	2	33	4	5	41	13	3	7	1	3
Monthly	13.2%	27.3%	11.9%	6.7%	25.0%	22.2%	0.0%	0.0%	12.9%	0.0%	6.1%	0.0%	20.0%	14.6%	23.1%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	5.9%	9.1%	2.4%	13.3%	0.0%	0.0%	0.0%	0.0%	6.5%	0.0%	9.1%	25.0%	0.0%	4.9%	0.0%	0.0%	14.3%	0.0%	33.3%
Quarterly	22.1%	36.4%	14.3%	33.3%	16.7%	11.1%	50.0%	0.0%	21.0%	50.0%	18.2%	50.0%	40.0%	9.8%	30.8%	66.7%	42.9%	0.0%	66.7%
Semi-annually	13.2%	18.2%	16.7%	0.0%	16.7%	22.2%	0.0%	100.0%	9.7%	0.0%	9.1%	0.0%	40.0%	12.2%	7.7%	33.3%	28.6%	0.0%	0.0%
Annually	1.5%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	1.6%	0.0%	3.0%	0.0%	0.0%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	44.1%	9.1%	52.4%	46.7%	41.7%	44.4%	50.0%	0.0%	48.4%	50.0%	54.5%	25.0%	0.0%	56.1%	38.5%	0.0%	14.3%	100.0%	0.0%
Percentage of respondents with this committee	23.9%	15.1%	29.4%	22.1%	28.9%	26.5%	25.0%	25.0%	23.8%	11.8%	26.8%	50.0%	9.4%	28.7%	21.3%	10.7%	23.3%	7.7%	33.3%
Community benefit																			
Total responding in each category	82	14	46	22	21	7	3	1	76	6	42	1	12	46	20	5	10	1	0
Monthly	6.1%	0.0%	6.5%	9.1%	14.3%	0.0%	0.0%	0.0%	6.6%	16.7%	2.4%	0.0%	0.0%	6.5%	5.0%	0.0%	10.0%	0.0%	0.0%
Bi-monthly	6.1%	21.4%	2.2%	4.5%	0.0%	0.0%	0.0%	0.0%	5.3%	0.0%	4.8%	0.0%	25.0%	2.2%	5.0%	0.0%	30.0%	0.0%	0.0%
Quarterly	22.0%	42.9%	15.2%	22.7%	19.0%	14.3%	66.7%	0.0%	21.1%	33.3%	16.7%	0.0%	41.7%	15.2%	25.0%	60.0%	30.0%	0.0%	0.0%
Semi-annually	6.1%	7.1%	8.7%	0.0%	4.8%	0.0%	0.0%	100.0%	3.9%	0.0%	7.1%	0.0%	8.3%	2.2%	20.0%	0.0%	0.0%	0.0%	0.0%
Annually	20.7%	28.6%	19.6%	18.2%	23.8%	57.1%	0.0%	0.0%	22.4%	0.0%	19.0%	100.0%	25.0%	21.7%	15.0%	0.0%	30.0%	100.0%	0.0%
As needed	39.0%	0.0%	47.8%	45.5%	38.1%	28.6%	33.3%	0.0%	40.8%	50.0%	50.0%	0.0%	0.0%	52.2%	30.0%	40.0%	0.0%	0.0%	0.0%
Percentage of respondents with this committee	28.9%	19.4%	32.2%	31.9%	25.3%	20.6%	37.5%	12.5%	29.1%	35.3%	33.9%	14.3%	22.6%	31.7%	33.3%	17.9%	33.3%	7.7%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Population health/community health improvement																			
Total responding in each category	59	10	34	15	15	3	2	1	56	6	30	1	7	33	17	4	4	1	0
Monthly	5.1%	10.0%	2.9%	6.7%	13.3%	0.0%	0.0%	0.0%	5.4%	16.7%	0.0%	0.0%	0.0%	6.1%	5.9%	0.0%	0.0%	0.0%	0.0%
Bi-monthly	8.5%	10.0%	5.9%	13.3%	6.7%	0.0%	50.0%	0.0%	8.9%	0.0%	10.0%	0.0%	14.3%	6.1%	11.8%	0.0%	25.0%	0.0%	0.0%
Quarterly	20.3%	40.0%	11.8%	26.7%	20.0%	33.3%	0.0%	0.0%	19.6%	33.3%	13.3%	0.0%	42.9%	12.1%	29.4%	75.0%	0.0%	0.0%	0.0%
Semi-annually	6.8%	10.0%	5.9%	6.7%	0.0%	0.0%	0.0%	0.0%	5.4%	16.7%	6.7%	0.0%	14.3%	3.0%	11.8%	25.0%	0.0%	0.0%	0.0%
Annually	15.3%	30.0%	17.6%	0.0%	26.7%	66.7%	0.0%	0.0%	16.1%	0.0%	6.7%	100.0%	28.6%	18.2%	0.0%	0.0%	50.0%	100.0%	0.0%
As needed	44.1%	0.0%	55.9%	46.7%	33.3%	0.0%	50.0%	100.0%	44.6%	33.3%	63.3%	0.0%	0.0%	54.5%	41.2%	0.0%	25.0%	0.0%	0.0%
Percentage of respondents with this committee	21.1%	13.9%	24.1%	22.4%	18.5%	9.1%	28.6%	12.5%	21.8%	35.3%	24.6%	14.3%	13.2%	23.4%	28.3%	14.3%	13.3%	7.7%	0.0%
Innovation/transformation																			
Total responding in each category	40	8	25	7	10	1	1	1	37	1	22	2	5	20	9	6	3	2	0
Monthly	7.5%	12.5%	8.0%	0.0%	10.0%	0.0%	0.0%	0.0%	2.7%	0.0%	4.5%	0.0%	20.0%	5.0%	11.1%	0.0%	33.3%	0.0%	0.0%
Bi-monthly	2.5%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	4.5%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%
Quarterly	12.5%	37.5%	4.0%	14.3%	10.0%	0.0%	0.0%	0.0%	13.5%	0.0%	9.1%	50.0%	20.0%	0.0%	11.1%	50.0%	0.0%	50.0%	0.0%
Semi-annually	2.5%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	4.5%	0.0%	0.0%	5.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Annually	2.5%	0.0%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	0.0%	4.5%	0.0%	0.0%	5.0%	0.0%	0.0%	0.0%	0.0%	0.0%
As needed	72.5%	50.0%	84.0%	57.1%	80.0%	100.0%	100.0%	100.0%	75.7%	100.0%	72.7%	50.0%	60.0%	85.0%	66.7%	50.0%	66.7%	50.0%	0.0%
Percentage of respondents with this committee	14.1%	11.1%	17.5%	10.3%	12.2%	2.9%	12.5%	12.5%	14.2%	5.9%	17.7%	28.6%	9.4%	14.0%	14.8%	21.4%	10.0%	15.4%	0.0%
Diversity and inclusion																			
Total responding in each category	43	7	27	9	11	2	2	1	42	1	25	1	5	20	12	4	2	4	1
Monthly	7.0%	14.3%	7.4%	0.0%	18.2%	0.0%	50.0%	0.0%	7.1%	0.0%	0.0%	0.0%	20.0%	5.0%	8.3%	0.0%	0.0%	25.0%	0.0%
Bi-monthly	18.6%	28.6%	14.8%	22.2%	18.2%	50.0%	0.0%	100.0%	16.7%	0.0%	20.0%	0.0%	20.0%	10.0%	33.3%	25.0%	0.0%	0.0%	100.0%
Quarterly	7.0%	14.3%	0.0%	22.2%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	8.0%	0.0%	20.0%	0.0%	0.0%	50.0%	0.0%	25.0%	0.0%
Semi-annually	9.3%	14.3%	7.4%	11.1%	0.0%	0.0%	0.0%	0.0%	9.5%	0.0%	12.0%	0.0%	20.0%	0.0%	25.0%	0.0%	0.0%	25.0%	0.0%
Annually	7.0%	14.3%	7.4%	0.0%	9.1%	50.0%	0.0%	0.0%	7.1%	0.0%	4.0%	0.0%	20.0%	10.0%	0.0%	0.0%	50.0%	0.0%	0.0%
As needed	51.2%	14.3%	63.0%	44.4%	54.5%	0.0%	50.0%	0.0%	52.4%	100.0%	56.0%	100.0%	0.0%	75.0%	33.3%	25.0%	50.0%	25.0%	0.0%
Percentage of respondents with this committee	16.6%	11.9%	19.9%	14.1%	13.4%	5.9%	25.0%	14.3%	16.7%	6.7%	21.7%	16.7%	12.2%	14.3%	22.2%	19.0%	8.0%	30.8%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	247	66	125	56	61	23	6	5	224	14	115	8	49	124	56	21	28	8	10
Executive compensation	50.2%	37.9%	58.4%	46.4%	54.1%	60.9%	83.3%	40.0%	51.3%	42.9%	55.7%	50.0%	34.7%	65.3%	39.3%	38.1%	32.1%	37.5%	10.0%
Board member nominations	27.9%	19.7%	31.2%	30.4%	37.7%	26.1%	66.7%	60.0%	28.6%	42.9%	25.2%	25.0%	18.4%	31.5%	37.5%	19.0%	10.7%	12.5%	10.0%
Board member selection	21.1%	24.2%	20.8%	17.9%	26.2%	30.4%	33.3%	20.0%	21.0%	35.7%	15.7%	50.0%	18.4%	19.4%	28.6%	19.0%	14.3%	25.0%	20.0%
Advising the CEO	71.3%	66.7%	70.4%	78.6%	78.7%	91.3%	66.7%	80.0%	71.0%	78.6%	68.7%	50.0%	69.4%	75.0%	71.4%	66.7%	60.7%	100.0%	40.0%
Emergency decision making	71.7%	66.7%	72.0%	76.8%	68.9%	69.6%	66.7%	40.0%	71.9%	92.9%	73.0%	75.0%	65.3%	69.4%	78.6%	76.2%	75.0%	62.5%	50.0%
Decision-making authority between full board meetings	66.0%	72.7%	61.6%	67.9%	52.5%	69.6%	16.7%	40.0%	65.6%	78.6%	67.8%	87.5%	71.4%	61.3%	69.6%	66.7%	78.6%	62.5%	70.0%
Other	6.9%	12.1%	6.4%	1.8%	1.6%	0.0%	0.0%	0.0%	6.3%	7.1%	6.1%	25.0%	12.2%	3.2%	7.1%	19.0%	3.6%	0.0%	40.0%
What level of authority does the executive committee have?																			
Total responding in each category	232	62	116	54	55	21	6	5	209	14	109	8	46	117	54	19	26	7	9
Full authority: the executive committee can act on behalf of the board on all issues; committee decisions do not require full-board ratification	41.4%	46.8%	38.8%	40.7%	27.3%	38.1%	33.3%	0.0%	41.1%	64.3%	42.2%	62.5%	45.7%	35.0%	40.7%	63.2%	50.0%	28.6%	66.7%
Some authority: the executive committee can act on behalf of the board on some issues (e.g., executive compensation), but not all issues	31.9%	30.6%	25.0%	48.1%	25.5%	19.0%	16.7%	60.0%	32.5%	28.6%	37.6%	12.5%	30.4%	29.9%	38.9%	21.1%	34.6%	28.6%	33.3%
All executive committee decisions must be approved/ ratified by the full board	26.7%	22.6%	36.2%	11.1%	47.3%	42.9%	50.0%	40.0%	26.3%	7.1%	20.2%	25.0%	23.9%	35.0%	20.4%	15.8%	15.4%	42.9%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	233	64	117	52	62	22	8	7	212	13	103	7	48	113	53	25	24	11	7
Voting physician board members																			
0	21.0%	7.8%	30.8%	15.4%	43.5%	31.8%	37.5%	14.3%	22.6%	23.1%	14.6%	0.0%	8.3%	36.3%	5.7%	8.0%	8.3%	9.1%	0.0%
1	24.5%	12.5%	32.5%	21.2%	35.5%	45.5%	12.5%	85.7%	25.9%	7.7%	27.2%	28.6%	8.3%	29.2%	22.6%	16.0%	20.8%	9.1%	28.6%
2	19.3%	23.4%	14.5%	25.0%	9.7%	13.6%	25.0%	0.0%	19.3%	23.1%	23.3%	28.6%	20.8%	17.7%	30.2%	12.0%	4.2%	27.3%	28.6%
3	16.3%	21.9%	14.5%	13.5%	4.8%	9.1%	0.0%	0.0%	15.6%	23.1%	18.4%	28.6%	22.9%	11.5%	18.9%	28.0%	20.8%	9.1%	28.6%
4+	18.9%	34.4%	7.7%	25.0%	6.5%	0.0%	25.0%	0.0%	16.5%	23.1%	16.5%	14.3%	39.6%	5.3%	22.6%	36.0%	45.8%	45.5%	14.3%
Voting nurse board members																			
0	46.7%	35.9%	54.9%	42.3%	50.0%	45.5%	25.0%	71.4%	46.2%	46.2%	51.5%	14.3%	37.5%	58.9%	41.2%	40.0%	21.7%	45.5%	0.0%
1	31.0%	37.5%	28.3%	28.8%	29.0%	31.8%	37.5%	28.6%	31.3%	23.1%	29.3%	42.9%	37.5%	22.3%	37.3%	28.0%	60.9%	9.1%	71.4%
2	12.2%	15.6%	9.7%	13.5%	11.3%	9.1%	12.5%	0.0%	12.5%	23.1%	10.1%	0.0%	16.7%	9.8%	15.7%	16.0%	4.3%	27.3%	14.3%
3	5.2%	6.3%	4.4%	5.8%	6.5%	9.1%	25.0%	0.0%	5.3%	0.0%	4.0%	42.9%	2.1%	4.5%	3.9%	4.0%	4.3%	18.2%	14.3%
4+	4.8%	4.7%	2.7%	9.6%	3.2%	4.5%	0.0%	0.0%	4.8%	7.7%	5.1%	0.0%	6.3%	4.5%	2.0%	12.0%	8.7%	0.0%	0.0%
Voting board members who are not physicians or nurses																			
0	7.4%	3.2%	7.8%	11.5%	6.6%	9.5%	0.0%	0.0%	8.1%	15.4%	8.8%	0.0%	4.2%	11.6%	1.9%	4.0%	4.2%	9.1%	0.0%
1	8.7%	3.2%	12.9%	5.8%	13.1%	19.0%	12.5%	14.3%	9.5%	15.4%	8.8%	0.0%	2.1%	12.5%	7.7%	4.0%	0.0%	9.1%	0.0%
2	20.8%	22.2%	20.7%	19.2%	32.8%	19.0%	37.5%	57.1%	19.5%	7.7%	14.7%	42.9%	18.8%	24.1%	17.3%	12.0%	20.8%	27.3%	14.3%
3	15.6%	20.6%	14.7%	11.5%	8.2%	14.3%	25.0%	0.0%	16.2%	23.1%	15.7%	0.0%	25.0%	10.7%	19.2%	20.0%	33.3%	0.0%	14.3%
4+	47.6%	50.8%	44.0%	51.9%	39.3%	38.1%	25.0%	28.6%	46.7%	38.5%	52.0%	57.1%	50.0%	41.1%	53.8%	60.0%	41.7%	54.5%	71.4%
Medical staff/employed physicians (non-board members)																			
0	32.2%	17.5%	41.5%	29.2%	53.3%	66.7%	57.1%	42.9%	34.2%	18.2%	29.3%	33.3%	11.9%	43.7%	24.0%	16.7%	15.0%	22.2%	40.0%
1	24.2%	17.5%	29.2%	20.8%	21.7%	14.3%	14.3%	28.6%	23.2%	27.3%	29.3%	16.7%	16.7%	28.2%	22.0%	20.8%	10.0%	11.1%	60.0%
2	17.5%	24.6%	14.2%	16.7%	13.3%	9.5%	28.6%	14.3%	17.9%	18.2%	15.2%	16.7%	28.6%	17.5%	16.0%	16.7%	25.0%	22.2%	0.0%
3	8.5%	7.0%	6.6%	14.6%	5.0%	4.8%	0.0%	14.3%	8.9%	9.1%	12.0%	0.0%	7.1%	6.8%	16.0%	8.3%	5.0%	0.0%	0.0%
4+	17.5%	33.3%	8.5%	18.8%	6.7%	4.8%	0.0%	0.0%	15.8%	27.3%	14.1%	33.3%	35.7%	3.9%	22.0%	37.5%	45.0%	44.4%	0.0%
Nurses from the nursing staff (non-board members)																			
0	39.8%	34.5%	39.3%	47.8%	41.0%	38.1%	62.5%	14.3%	40.0%	36.4%	44.4%	33.3%	30.2%	38.8%	40.8%	37.5%	38.1%	33.3%	80.0%
1	19.0%	31.0%	15.0%	13.0%	14.8%	19.0%	25.0%	28.6%	17.9%	18.2%	12.2%	0.0%	41.9%	15.5%	20.4%	29.2%	28.6%	11.1%	0.0%
2	19.0%	20.7%	21.5%	10.9%	19.7%	23.8%	0.0%	28.6%	18.9%	27.3%	15.6%	33.3%	20.9%	17.5%	18.4%	20.8%	14.3%	44.4%	20.0%
3	9.5%	5.2%	11.2%	10.9%	9.8%	9.5%	0.0%	0.0%	10.0%	9.1%	11.1%	16.7%	4.7%	13.6%	8.2%	4.2%	4.8%	0.0%	0.0%
4+	12.8%	8.6%	13.1%	17.4%	14.8%	9.5%	12.5%	28.6%	13.2%	9.1%	16.7%	16.7%	2.3%	14.6%	12.2%	8.3%	14.3%	11.1%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Community members at-large																			
0	51.2%	35.6%	60.0%	51.0%	67.7%	76.2%	62.5%	71.4%	52.6%	33.3%	50.0%	66.7%	32.6%	58.5%	44.7%	33.3%	45.5%	55.6%	60.0%
1	14.1%	13.6%	16.2%	10.2%	8.1%	0.0%	12.5%	28.6%	13.9%	16.7%	16.7%	0.0%	18.6%	15.1%	23.4%	4.2%	4.5%	11.1%	0.0%
2	13.1%	28.8%	4.8%	12.2%	8.1%	9.5%	12.5%	0.0%	11.3%	8.3%	8.9%	33.3%	27.9%	7.5%	6.4%	25.0%	40.9%	11.1%	20.0%
3	6.1%	6.8%	2.9%	12.2%	1.6%	0.0%	0.0%	0.0%	6.7%	25.0%	6.7%	0.0%	7.0%	5.7%	6.4%	12.5%	4.5%	0.0%	0.0%
4+	15.5%	15.3%	16.2%	14.3%	14.5%	14.3%	12.5%	0.0%	15.5%	16.7%	17.8%	0.0%	14.0%	13.2%	19.1%	25.0%	4.5%	22.2%	20.0%
Other																			
0	44.6%	43.8%	36.8%	72.7%	50.0%	33.3%	100.0%	0.0%	44.6%	66.7%	41.4%	100.0%	33.3%	37.5%	43.8%	75.0%	42.9%	50.0%	0.0%
1	13.8%	12.5%	15.8%	9.1%	15.0%	33.3%	0.0%	50.0%	16.1%	33.3%	10.3%	0.0%	16.7%	12.5%	18.8%	0.0%	14.3%	50.0%	0.0%
2	13.8%	25.0%	10.5%	9.1%	20.0%	0.0%	0.0%	0.0%	14.3%	0.0%	6.9%	0.0%	25.0%	15.6%	12.5%	12.5%	14.3%	0.0%	0.0%
3	7.7%	12.5%	7.9%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	10.3%	0.0%	16.7%	6.3%	12.5%	12.5%	0.0%	0.0%	0.0%
4+	20.0%	6.3%	28.9%	9.1%	15.0%	33.3%	0.0%	50.0%	17.9%	0.0%	31.0%	0.0%	8.3%	28.1%	12.5%	0.0%	28.6%	0.0%	0.0%
Size of quality committee																			
Average	11.75	13.80	10.05	13.00	8.92	8.41	8.75	8.86	11.45	13.08	12.06	11.71	14.48	9.46	12.66	15.83	15.79	13.64	11.00
Median	11	13	9	12	8	8	7	9	10	14	11	13	13	8	12	16	14	13	11
Range	1 to 41	5 to 31	2 to 30	1 to 41	1 to 21	1 to 17	5 to 17	3 to 14	1 to 41	3 to 25	3 to 41	6 to 15	5 to 31	1 to 24	3 to 30	6 to 31	4 to 41	7 to 28	5 to 22
Approximate total annual expenditure for board education																			
Total responding in each category	296	77	151	68	85	35	9	8	274	17	128	9	57	154	60	28	32	13	9
$0	5.7%	3.9%	4.0%	11.8%	4.7%	8.6%	11.1%	0.0%	5.8%	0.0%	7.8%	0.0%	5.3%	3.9%	5.0%	7.1%	15.6%	0.0%	11.1%
$1–$9,999	32.1%	15.6%	39.7%	33.8%	49.4%	51.4%	55.6%	62.5%	34.3%	52.9%	27.3%	33.3%	10.5%	46.1%	23.3%	25.0%	6.3%	0.0%	11.1%
$10,000–$19,999	16.6%	7.8%	19.9%	19.1%	18.8%	17.1%	11.1%	0.0%	17.5%	23.5%	18.0%	0.0%	10.5%	18.2%	20.0%	25.0%	3.1%	7.7%	0.0%
$20,000–$29,999	12.5%	13.0%	13.9%	8.8%	15.3%	14.3%	22.2%	12.5%	12.4%	5.9%	13.3%	22.2%	7.0%	13.6%	13.3%	10.7%	9.4%	15.4%	0.0%
$30,000–$49,999	13.5%	18.2%	11.3%	13.2%	8.2%	2.9%	0.0%	12.5%	12.0%	5.9%	16.4%	0.0%	19.3%	8.4%	18.3%	14.3%	34.4%	7.7%	0.0%
$50,000–$75,000	8.8%	11.7%	7.3%	8.8%	2.4%	2.9%	0.0%	12.5%	8.4%	11.8%	10.9%	0.0%	14.0%	6.5%	13.3%	7.1%	9.4%	23.1%	0.0%
>$75,000	10.8%	29.9%	4.0%	4.4%	1.2%	2.9%	0.0%	0.0%	9.5%	0.0%	6.3%	44.4%	33.3%	3.2%	6.7%	10.7%	21.9%	46.2%	77.8%

All Respondents		Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Topics covered for internal board development/education																			
Total responding in each category	305	80	156	69	86	35	9	8	282	17	134	9	59	155	63	29	34	14	10
Legal/regulatory	80.3%	78.8%	83.3%	75.4%	90.7%	94.3%	88.9%	75.0%	80.1%	82.4%	76.1%	77.8%	74.6%	84.5%	77.8%	79.3%	82.4%	71.4%	40.0%
Quality/patient safety	86.9%	91.3%	83.3%	89.9%	88.4%	85.7%	100.0%	75.0%	86.2%	88.2%	84.3%	77.8%	91.5%	86.5%	84.1%	93.1%	91.2%	92.9%	70.0%
Reimbursement, payment models, and "drivers" of financial performance	65.6%	75.0%	60.9%	65.2%	57.0%	62.9%	55.6%	62.5%	64.5%	76.5%	66.4%	55.6%	74.6%	60.0%	66.7%	86.2%	70.6%	78.6%	50.0%
Strategic planning and direction	88.9%	93.8%	89.1%	82.6%	89.5%	85.7%	88.9%	75.0%	89.4%	100.0%	85.1%	100.0%	91.5%	89.0%	88.9%	89.7%	85.3%	100.0%	80.0%
Industry trends/events and the associated implications (e.g., crisis management, value-based purchasing, population health management, market disruptors, etc.)	77.0%	91.3%	71.8%	72.5%	72.1%	74.3%	77.8%	62.5%	77.0%	88.2%	72.4%	100.0%	88.1%	70.3%	79.4%	89.7%	79.4%	100.0%	90.0%
The role of your organization in a changing delivery system	63.0%	70.0%	57.7%	66.7%	57.0%	60.0%	55.6%	37.5%	61.7%	58.8%	64.2%	100.0%	64.4%	56.8%	63.5%	79.3%	70.6%	71.4%	70.0%
Innovation	50.8%	70.0%	42.3%	47.8%	53.5%	57.1%	55.6%	37.5%	49.6%	52.9%	41.8%	77.8%	62.7%	41.3%	50.8%	72.4%	67.6%	64.3%	60.0%
Other	7.5%	7.5%	8.3%	5.8%	5.8%	5.7%	0.0%	12.5%	6.7%	5.9%	8.2%	11.1%	8.5%	5.8%	9.5%	10.3%	8.8%	7.1%	10.0%
Delivery of board education																			
Total responding in each category	305	80	156	69	86	35	9	8	282	17	134	9	59	155	63	29	34	14	10
During regularly scheduled board meetings	85.6%	88.8%	84.0%	85.5%	86.0%	82.9%	100.0%	87.5%	85.5%	64.7%	85.8%	100.0%	88.1%	84.5%	84.1%	86.2%	88.2%	92.9%	90.0%
Periodic board education retreats	50.5%	63.8%	41.7%	55.1%	36.0%	42.9%	33.3%	62.5%	48.6%	76.5%	48.5%	66.7%	66.1%	39.4%	60.3%	65.5%	52.9%	78.6%	70.0%
Attendance at off-site conferences	53.4%	52.5%	57.7%	44.9%	57.0%	54.3%	44.4%	50.0%	52.1%	47.1%	53.7%	66.7%	47.5%	57.4%	49.2%	48.3%	52.9%	64.3%	20.0%
Webinars/online education	51.5%	53.8%	59.0%	31.9%	65.1%	68.6%	66.7%	50.0%	50.4%	35.3%	44.8%	66.7%	49.2%	54.2%	42.9%	62.1%	47.1%	50.0%	50.0%
Publications, articles, other reading materials	67.9%	76.3%	66.0%	62.3%	67.4%	68.6%	55.6%	75.0%	66.3%	58.8%	64.9%	100.0%	72.9%	65.2%	63.5%	75.9%	70.6%	78.6%	90.0%

All Respondents		Overall and by Organization Type				By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	297	77	153	67	85	35	9	8	274	17	130	9	56	153	61	29	31	14	9
< 10 hours per month	34.3%	19.5%	37.9%	43.3%	35.3%	40.0%	66.7%	25.0%	35.4%	35.3%	40.8%	11.1%	21.4%	43.8%	34.4%	20.7%	9.7%	21.4%	22.2%
10–20 hours per month	39.4%	44.2%	38.6%	35.8%	40.0%	40.0%	22.2%	37.5%	39.8%	41.2%	35.4%	66.7%	42.9%	35.9%	47.5%	31.0%	48.4%	42.9%	33.3%
20–40 hours per month	17.2%	22.1%	17.0%	11.9%	16.5%	17.1%	11.1%	12.5%	17.5%	23.5%	15.4%	22.2%	19.6%	15.0%	9.8%	31.0%	29.0%	21.4%	11.1%
40–60 hours per month	5.1%	7.8%	3.9%	4.5%	5.9%	2.9%	0.0%	12.5%	4.0%	0.0%	4.6%	0.0%	7.1%	2.6%	6.6%	6.9%	9.7%	7.1%	11.1%
60+ hours per month	4.0%	6.5%	2.6%	4.5%	2.4%	0.0%	0.0%	12.5%	3.3%	0.0%	3.8%	0.0%	8.9%	2.6%	1.6%	10.3%	3.2%	7.1%	22.2%
Number of FTEs devoted to governance (i.e., board support staff)																			
Total responding in each category	300	78	154	68	86	35	9	8	277	17	131	9	57	155	62	28	32	14	9
< 1 or the job is combined with another position	61.7%	38.5%	74.0%	60.3%	68.6%	74.3%	55.6%	75.0%	63.9%	76.5%	67.9%	33.3%	36.8%	79.4%	56.5%	46.4%	21.9%	35.7%	22.2%
1–2	33.3%	55.1%	21.4%	35.3%	23.3%	17.1%	44.4%	25.0%	31.0%	17.6%	29.8%	44.4%	59.6%	18.1%	41.9%	50.0%	59.4%	57.1%	55.6%
3–4	4.3%	5.1%	4.5%	2.9%	7.0%	5.7%	0.0%	0.0%	4.3%	5.9%	2.3%	22.2%	1.8%	1.9%	1.6%	3.6%	18.8%	7.1%	11.1%
5–6	0.3%	0.0%	0.0%	1.5%	1.2%	2.9%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
More than 6	0.3%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%
Primary staff involved in supporting the board																			
Total responding in each category	298	78	152	68	85	35	9	7	275	17	130	9	57	153	62	28	32	14	9
CEO's executive assistant or another administrative assistant	77.5%	53.8%	92.1%	72.1%	85.9%	94.3%	88.9%	100.0%	76.7%	88.2%	83.1%	44.4%	54.4%	92.8%	79.0%	67.9%	37.5%	42.9%	33.3%
Dedicated governance support professional staff member(s)	16.1%	32.1%	4.6%	23.5%	9.4%	5.7%	11.1%	0.0%	16.4%	5.9%	13.8%	44.4%	29.8%	4.6%	17.7%	25.0%	43.8%	28.6%	55.6%
Chief legal officer/ general counsel	6.4%	14.1%	3.3%	4.4%	4.7%	0.0%	0.0%	0.0%	6.9%	5.9%	3.1%	11.1%	15.8%	2.6%	3.2%	7.1%	18.8%	28.6%	11.1%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Annual average cash compensation for the board chair																			
Total responding in each category	302	79	154	69	86	35	9	8	279	17	132	9	58	155	62	29	33	14	9
No compensation	87.4%	84.8%	87.7%	89.9%	80.2%	82.9%	100.0%	75.0%	87.5%	94.1%	93.2%	77.8%	84.5%	84.5%	96.8%	96.6%	93.9%	71.4%	44.4%
< $5,000	42.1%	8.3%	63.2%	42.9%	70.6%	100.0%	0.0%	0.0%	45.7%	0.0%	44.4%	0.0%	0.0%	62.5%	0.0%	0.0%	50.0%	0.0%	0.0%
$5,000–$9,999	10.5%	0.0%	10.5%	28.6%	17.6%	0.0%	0.0%	50.0%	11.4%	0.0%	11.1%	0.0%	0.0%	12.5%	50.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	13.2%	8.3%	15.8%	14.3%	11.8%	0.0%	0.0%	50.0%	11.4%	100.0%	11.1%	0.0%	11.1%	16.7%	50.0%	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	10.5%	8.3%	10.5%	14.3%	0.0%	0.0%	0.0%	0.0%	8.6%	0.0%	33.3%	0.0%	11.1%	8.3%	0.0%	0.0%	50.0%	0.0%	20.0%
$30,000–$39,999	2.6%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
$40,000–$49,999	7.9%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.6%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	75.0%	0.0%
$50,000 +	13.2%	41.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	100.0%	33.3%	0.0%	0.0%	0.0%	0.0%	25.0%	80.0%
Percentage of respondents with compensation for this position	12.6%	15.2%	12.3%	10.1%	19.8%	17.1%	0.0%	25.0%	12.5%	5.9%	6.8%	22.2%	15.5%	15.5%	3.2%	3.4%	6.1%	28.6%	55.6%
Annual average cash compensation for other board officers																			
Total responding in each category	301	79	154	68	86	35	9	8	278	16	132	9	58	154	62	29	33	14	9
No compensation	89.4%	88.6%	89.0%	91.2%	81.4%	82.9%	100.0%	87.5%	89.2%	100.0%	93.9%	88.9%	87.9%	85.7%	98.4%	100.0%	93.9%	71.4%	66.7%
< $5,000	56.3%	11.1%	82.4%	50.0%	81.3%	100.0%	0.0%	0.0%	60.0%	0.0%	62.5%	0.0%	0.0%	77.3%	0.0%	0.0%	50.0%	0.0%	0.0%
$5,000–$9,999	6.3%	0.0%	0.0%	33.3%	6.3%	0.0%	0.0%	0.0%	6.7%	0.0%	12.5%	0.0%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	9.4%	11.1%	11.8%	0.0%	12.5%	0.0%	0.0%	100.0%	6.7%	0.0%	0.0%	0.0%	14.3%	9.1%	100.0%	0.0%	0.0%	0.0%	0.0%
$15,000–$19,999	3.1%	0.0%	5.9%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	12.5%	0.0%	0.0%	4.5%	0.0%	0.0%	0.0%	0.0%	0.0%
$20,000–$29,999	9.4%	22.2%	0.0%	16.7%	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%	12.5%	0.0%	28.6%	0.0%	0.0%	0.0%	50.0%	25.0%	33.3%
$30,000–$39,999	6.3%	22.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%	0.0%	0.0%	28.6%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%
$40,000–$49,999	3.1%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%
$50,000 +	6.3%	22.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%	0.0%	100.0%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	66.7%
Percentage of respondents with compensation for this position	10.6%	11.4%	11.0%	8.8%	18.6%	17.1%	0.0%	12.5%	10.8%	0.0%	6.1%	11.1%	12.1%	14.3%	1.6%	0.0%	6.1%	28.6%	33.3%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 board committee chairs																			
Total responding in each category	300	79	152	69	84	34	9	8	277	17	132	9	58	153	62	29	33	14	9
No compensation	90.0%	87.3%	91.4%	89.9%	85.7%	85.3%	100.0%	87.5%	89.9%	94.1%	93.9%	88.9%	86.2%	87.6%	100.0%	96.6%	93.9%	71.4%	55.6%
< $5,000	53.3%	10.0%	84.6%	57.1%	83.3%	100.0%	0.0%	0.0%	57.1%	100.0%	62.5%	0.0%	0.0%	78.9%	0.0%	0.0%	50.0%	0.0%	0.0%
$5,000–$9,999	10.0%	10.0%	0.0%	28.6%	8.3%	0.0%	0.0%	0.0%	7.1%	0.0%	12.5%	0.0%	12.5%	10.5%	0.0%	100.0%	0.0%	0.0%	0.0%
$10,000–$14,999	6.7%	0.0%	15.4%	0.0%	8.3%	0.0%	0.0%	100.0%	7.1%	0.0%	12.5%	0.0%	0.0%	10.5%	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	10.0%	20.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	12.5%	0.0%	25.0%	0.0%	0.0%	0.0%	50.0%	25.0%	25.0%
$30,000–$39,999	10.0%	30.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.7%	0.0%	0.0%	0.0%	37.5%	0.0%	0.0%	0.0%	0.0%	50.0%	25.0%
$40,000–$49,999	3.3%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%
$50,000 +	6.7%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	0.0%	100.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%
Percentage of respondents with compensation for this position	10.0%	12.7%	8.6%	10.1%	14.3%	14.7%	0.0%	12.5%	10.1%	5.9%	6.1%	11.1%	13.8%	12.4%	0.0%	3.4%	6.1%	28.6%	44.4%
Annual average cash compensation for other board members (non-chairs/officers)																			
Total responding in each category	301	78	154	69	86	35	9	8	278	17	132	9	57	155	62	29	33	14	8
No compensation	88.0%	83.3%	89.6%	89.9%	81.4%	82.9%	100.0%	75.0%	88.1%	94.1%	93.9%	77.8%	84.2%	86.5%	96.8%	93.1%	93.9%	71.4%	37.5%
< $5,000	50.0%	7.7%	81.3%	57.1%	75.0%	100.0%	0.0%	0.0%	54.5%	100.0%	62.5%	0.0%	0.0%	81.0%	0.0%	0.0%	50.0%	0.0%	0.0%
$5,000–$9,999	8.3%	0.0%	6.3%	28.6%	12.5%	0.0%	0.0%	50.0%	9.1%	0.0%	12.5%	0.0%	0.0%	9.5%	50.0%	0.0%	0.0%	0.0%	0.0%
$10,000–$14,999	8.3%	7.7%	12.5%	0.0%	6.3%	0.0%	0.0%	50.0%	6.1%	0.0%	12.5%	0.0%	11.1%	9.5%	50.0%	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	11.1%	23.1%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	12.5%	0.0%	33.3%	0.0%	0.0%	50.0%	50.0%	25.0%	20.0%
$30,000–$39,999	16.7%	46.2%	0.0%	0.0%	6.3%	0.0%	0.0%	0.0%	18.2%	0.0%	0.0%	50.0%	44.4%	0.0%	0.0%	50.0%	0.0%	75.0%	40.0%
$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 +	5.6%	15.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	0.0%	50.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	40.0%
Percentage of respondents with compensation for this position	12.0%	16.7%	10.4%	10.1%	18.6%	17.1%	0.0%	25.0%	11.9%	5.9%	6.1%	22.2%	15.8%	13.5%	3.2%	6.9%	6.1%	28.6%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Use of board portal or similar online tool to communicate and access board materials																			
Total responding in each category	302	79	154	69	86	35	9	8	279	17	132	9	58	155	62	29	33	14	9
Yes	71.5%	93.7%	57.8%	76.8%	50.0%	45.7%	77.8%	62.5%	69.9%	70.6%	73.5%	88.9%	96.6%	49.0%	93.5%	93.1%	97.0%	100.0%	100.0%
No, but we are in the process of implementing	3.6%	1.3%	3.2%	7.2%	4.7%	2.9%	0.0%	12.5%	3.9%	0.0%	4.5%	0.0%	1.7%	6.5%	0.0%	3.4%	0.0%	0.0%	0.0%
No	24.8%	5.1%	39.0%	15.9%	45.3%	51.4%	22.2%	25.0%	26.2%	29.4%	22.0%	11.1%	1.7%	44.5%	6.5%	3.4%	3.0%	0.0%	0.0%
Most important benefit to the board in using a board portal or online tool																			
Total responding in each category	215	73	89	53	43	16	7	5	194	12	97	8	55	76	58	27	31	14	9
Saves time	13.5%	15.1%	9.0%	18.9%	2.3%	0.0%	14.3%	0.0%	13.9%	8.3%	17.5%	0.0%	18.2%	11.8%	15.5%	14.8%	9.7%	21.4%	11.1%
Enhances board members' level of preparation for meetings	46.5%	53.4%	44.9%	39.6%	44.2%	50.0%	42.9%	40.0%	44.8%	33.3%	46.4%	50.0%	50.9%	43.4%	48.3%	55.6%	45.2%	42.9%	44.4%
Reduces paper waste/ duplication costs	28.4%	20.5%	34.8%	28.3%	34.9%	37.5%	42.9%	20.0%	29.9%	33.3%	28.9%	50.0%	18.2%	35.5%	22.4%	18.5%	29.0%	28.6%	33.3%
Enhances communication among board members between meetings	5.6%	4.1%	9.0%	1.9%	16.3%	12.5%	0.0%	40.0%	6.2%	0.0%	3.1%	0.0%	3.6%	5.3%	8.6%	0.0%	9.7%	0.0%	0.0%
Provides no perceived benefit	2.8%	4.1%	1.1%	3.8%	2.3%	0.0%	0.0%	0.0%	2.6%	8.3%	1.0%	0.0%	5.5%	1.3%	3.4%	0.0%	6.5%	7.1%	0.0%
Other	3.3%	2.7%	1.1%	7.5%	0.0%	0.0%	0.0%	0.0%	2.6%	16.7%	3.1%	0.0%	3.6%	2.6%	1.7%	11.1%	0.0%	0.0%	11.1%
Board members are provided with hardware (laptops, iPads, etc.) to access online board materials																			
Total responding in each category	215	73	89	53	43	16	7	5	194	12	97	8	55	76	58	27	31	14	9
Yes	64.7%	63.0%	68.5%	60.4%	79.1%	68.8%	85.7%	80.0%	63.9%	41.7%	64.9%	75.0%	56.4%	71.1%	65.5%	55.6%	58.1%	57.1%	66.7%
No, but we are considering it at this time	4.7%	6.8%	2.2%	5.7%	4.7%	6.3%	0.0%	0.0%	4.6%	8.3%	2.1%	0.0%	9.1%	3.9%	0.0%	11.1%	6.5%	14.3%	0.0%
No, and we are not considering it at this time	30.7%	30.1%	29.2%	34.0%	16.3%	25.0%	14.3%	20.0%	31.4%	50.0%	33.0%	25.0%	34.5%	25.0%	34.5%	33.3%	35.5%	28.6%	33.3%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 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	284	74	147	63	84	34	9	8	270	15	123	9	53	151	55	25	31	14	8
Strongly agree	43.7%	50.0%	41.5%	41.3%	35.7%	29.4%	77.8%	37.5%	43.0%	53.3%	43.1%	33.3%	56.6%	39.7%	43.6%	48.0%	61.3%	35.7%	50.0%
Agree	47.2%	47.3%	44.9%	52.4%	46.4%	44.1%	22.2%	50.0%	47.4%	46.7%	48.0%	66.7%	43.4%	46.4%	54.5%	44.0%	32.3%	64.3%	50.0%
Neither agree nor disagree	5.3%	2.7%	7.5%	3.2%	10.7%	14.7%	0.0%	0.0%	5.6%	0.0%	4.9%	0.0%	0.0%	7.9%	0.0%	4.0%	6.5%	0.0%	0.0%
Disagree	3.2%	0.0%	4.8%	3.2%	6.0%	8.8%	0.0%	12.5%	3.3%	0.0%	3.3%	0.0%	0.0%	5.3%	0.0%	4.0%	0.0%	0.0%	0.0%
Strongly disagree	0.7%	0.0%	1.4%	0.0%	1.2%	2.9%	0.0%	0.0%	0.7%	0.0%	0.8%	0.0%	0.0%	0.7%	1.8%	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	284	74	147	63	84	34	9	8	270	15	123	9	53	151	54	25	32	14	8
Strongly agree	59.5%	56.8%	60.5%	60.3%	56.0%	50.0%	66.7%	75.0%	59.3%	73.3%	59.3%	66.7%	60.4%	58.9%	59.3%	60.0%	62.5%	57.1%	62.5%
Agree	34.9%	37.8%	32.7%	36.5%	36.9%	44.1%	22.2%	25.0%	34.8%	26.7%	34.1%	33.3%	35.8%	35.8%	33.3%	32.0%	31.3%	42.9%	37.5%
Neither agree nor disagree	3.5%	4.1%	4.1%	1.6%	3.6%	5.9%	0.0%	0.0%	3.7%	0.0%	4.1%	0.0%	3.8%	3.3%	3.7%	8.0%	3.1%	0.0%	0.0%
Disagree	2.1%	1.4%	2.7%	1.6%	3.6%	0.0%	11.1%	0.0%	2.2%	0.0%	2.4%	0.0%	0.0%	2.0%	3.7%	0.0%	3.1%	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's culture allows for active participation, candid communication, and rigorous decision making																			
Total responding in each category	283	74	146	63	84	34	9	8	269	15	122	9	53	150	55	25	31	14	8
Strongly agree	51.9%	62.2%	45.2%	55.6%	47.6%	41.2%	66.7%	62.5%	51.7%	53.3%	47.5%	66.7%	66.0%	48.0%	41.8%	68.0%	64.5%	57.1%	87.5%
Agree	38.2%	36.5%	39.0%	38.1%	39.3%	41.2%	22.2%	25.0%	37.9%	46.7%	39.3%	33.3%	32.1%	38.0%	50.9%	24.0%	35.5%	35.7%	12.5%
Neither agree nor disagree	7.8%	1.4%	11.6%	6.3%	10.7%	14.7%	0.0%	12.5%	8.2%	0.0%	9.8%	0.0%	1.9%	11.3%	3.6%	8.0%	0.0%	7.1%	0.0%
Disagree	1.8%	0.0%	3.4%	0.0%	2.4%	2.9%	11.1%	0.0%	1.9%	0.0%	2.5%	0.0%	0.0%	2.0%	3.6%	0.0%	0.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.8%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%
The board engages in constructive dialogue with management																			
Total responding in each category	279	70	146	63	82	32	9	8	265	15	123	9	50	150	54	25	28	14	8
Strongly agree	59.1%	68.6%	52.7%	63.5%	58.5%	46.9%	66.7%	87.5%	58.5%	66.7%	52.8%	77.8%	70.0%	57.3%	51.9%	76.0%	64.3%	57.1%	75.0%
Agree	35.5%	31.4%	38.4%	33.3%	32.9%	43.8%	22.2%	0.0%	36.2%	26.7%	41.5%	22.2%	30.0%	36.0%	38.9%	24.0%	35.7%	42.9%	25.0%
Neither agree nor disagree	3.9%	0.0%	6.2%	3.2%	4.9%	3.1%	11.1%	0.0%	3.8%	6.7%	4.9%	0.0%	0.0%	4.7%	7.4%	0.0%	0.0%	0.0%	0.0%
Disagree	1.1%	0.0%	2.1%	0.0%	3.7%	6.3%	0.0%	12.5%	1.1%	0.0%	0.0%	0.0%	0.0%	1.3%	1.9%	0.0%	0.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.8%	0.0%	0.0%	0.7%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 respect the distinction between the role of the board vs. management and avoid getting into operational matters																			
Total responding in each category	283	73	147	63	83	33	9	8	269	15	123	9	53	151	54	25	31	14	8
Strongly agree	39.9%	39.7%	36.1%	49.2%	34.9%	24.2%	66.7%	25.0%	40.1%	66.7%	39.0%	33.3%	43.4%	39.7%	33.3%	48.0%	45.2%	50.0%	25.0%
Agree	42.8%	43.8%	43.5%	39.7%	37.3%	45.5%	11.1%	62.5%	42.0%	26.7%	48.0%	55.6%	41.5%	41.1%	53.7%	44.0%	32.3%	35.7%	50.0%
Neither agree nor disagree	11.3%	15.1%	10.2%	9.5%	15.7%	12.1%	11.1%	0.0%	11.5%	6.7%	8.1%	11.1%	13.2%	11.3%	7.4%	8.0%	19.4%	7.1%	25.0%
Disagree	4.9%	1.4%	8.2%	1.6%	9.6%	15.2%	11.1%	0.0%	5.2%	0.0%	4.1%	0.0%	1.9%	6.6%	3.7%	0.0%	3.2%	7.1%	0.0%
Strongly disagree	1.1%	0.0%	2.0%	0.0%	2.4%	3.0%	0.0%	12.5%	1.1%	0.0%	0.8%	0.0%	0.0%	1.3%	1.9%	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	283	73	147	63	83	33	9	8	269	15	123	9	53	151	54	25	31	14	8
Strongly agree	40.3%	35.6%	38.8%	49.2%	44.6%	48.5%	55.6%	50.0%	40.1%	46.7%	38.2%	33.3%	37.7%	39.1%	42.6%	52.0%	38.7%	28.6%	37.5%
Agree	50.2%	57.5%	48.3%	46.0%	48.2%	45.5%	33.3%	25.0%	50.2%	53.3%	48.8%	55.6%	54.7%	51.0%	44.4%	40.0%	58.1%	57.1%	62.5%
Neither agree nor disagree	6.7%	6.8%	8.8%	1.6%	3.6%	3.0%	0.0%	12.5%	6.7%	0.0%	8.9%	11.1%	7.5%	7.3%	9.3%	0.0%	3.2%	14.3%	0.0%
Disagree	2.8%	0.0%	4.1%	3.2%	3.6%	3.0%	11.1%	12.5%	3.0%	0.0%	4.1%	0.0%	0.0%	2.6%	3.7%	8.0%	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 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	278	73	147	58	83	33	9	8	264	15	118	9	53	150	51	25	30	14	8
Strongly agree	32.0%	38.4%	29.9%	29.3%	32.5%	24.2%	55.6%	75.0%	31.4%	26.7%	28.0%	44.4%	39.6%	26.0%	29.4%	52.0%	46.7%	35.7%	37.5%
Agree	50.4%	52.1%	51.0%	46.6%	38.6%	45.5%	22.2%	12.5%	50.8%	46.7%	58.5%	55.6%	50.9%	50.0%	58.8%	40.0%	40.0%	57.1%	62.5%
Neither agree nor disagree	13.7%	8.2%	14.3%	19.0%	25.3%	30.3%	22.2%	0.0%	14.0%	20.0%	8.5%	0.0%	7.5%	18.7%	9.8%	4.0%	10.0%	7.1%	0.0%
Disagree	3.6%	1.4%	4.1%	5.2%	3.6%	0.0%	0.0%	12.5%	3.4%	6.7%	4.2%	0.0%	1.9%	4.7%	2.0%	4.0%	3.3%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.8%	0.0%	0.0%	0.7%	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	276	72	146	58	82	32	9	8	262	15	118	8	53	149	51	25	30	14	7
Strongly agree	26.4%	33.3%	24.0%	24.1%	23.2%	28.1%	55.6%	0.0%	26.0%	26.7%	23.7%	25.0%	37.7%	22.8%	19.6%	40.0%	40.0%	28.6%	42.9%
Agree	47.5%	44.4%	46.6%	53.4%	40.2%	31.3%	33.3%	62.5%	46.6%	46.7%	55.9%	37.5%	41.5%	47.0%	58.8%	28.0%	50.0%	42.9%	42.9%
Neither agree nor disagree	21.4%	18.1%	23.3%	20.7%	30.5%	34.4%	11.1%	37.5%	22.5%	26.7%	16.1%	25.0%	17.0%	24.8%	15.7%	32.0%	10.0%	14.3%	14.3%
Disagree	4.7%	4.2%	6.2%	1.7%	6.1%	6.3%	0.0%	0.0%	5.0%	0.0%	4.2%	12.5%	3.8%	5.4%	5.9%	0.0%	0.0%	14.3%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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, management, medical staff, and nursing staff are aligned in pursuing the organization's strategic goals and vision																			
Total responding in each category	282	73	146	63	83	33	9	8	268	15	122	9	53	151	54	24	31	14	8
Strongly agree	44.7%	50.7%	41.8%	44.4%	39.8%	33.3%	66.7%	50.0%	44.4%	46.7%	43.4%	66.7%	50.9%	42.4%	42.6%	62.5%	54.8%	21.4%	50.0%
Agree	44.7%	43.8%	42.5%	50.8%	42.2%	45.5%	22.2%	37.5%	44.8%	53.3%	45.9%	33.3%	45.3%	42.4%	51.9%	37.5%	38.7%	64.3%	50.0%
Neither agree nor disagree	8.9%	5.5%	13.0%	3.2%	15.7%	18.2%	11.1%	12.5%	9.0%	0.0%	8.2%	0.0%	3.8%	12.6%	3.7%	0.0%	6.5%	14.3%	0.0%
Disagree	1.8%	0.0%	2.7%	1.6%	2.4%	3.0%	0.0%	0.0%	1.9%	0.0%	2.5%	0.0%	0.0%	2.6%	1.9%	0.0%	0.0%	0.0%	0.0%
Strongly disagree	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Governance Trends																			
How has your board structure/practices changed due to the coronavirus pandemic?																			
Total responding in each category	290	75	152	63	82	33	9	8	275	15	129	9	55	150	58	26	33	14	9
N/A; we did not change our board structure or practices due to the pandemic	32.4%	26.7%	40.1%	20.6%	48.8%	60.6%	33.3%	50.0%	32.4%	40.0%	22.5%	33.3%	29.1%	41.3%	22.4%	15.4%	24.2%	42.9%	11.1%
We updated our strategic and financial plans to address implications related to the pandemic	44.1%	58.7%	32.9%	54.0%	31.7%	21.2%	44.4%	62.5%	44.0%	53.3%	45.0%	66.7%	54.5%	35.3%	48.3%	73.1%	45.5%	71.4%	33.3%
We added board members with crisis management experience	0.3%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%
We added members to the management team with infectious disease control and/ or public health expertise.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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 added board members with digital technology and/or telemedicine/virtual care expertise	0.7%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	3.6%	0.0%	1.7%	3.8%	0.0%	0.0%	0.0%
We added members to the management team with crisis management expertise	1.0%	2.7%	0.7%	0.0%	1.2%	3.0%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	3.6%	0.7%	0.0%	0.0%	3.0%	7.1%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 added members to the management team with infectious disease control and/or public health expertise	4.1%	6.7%	3.3%	3.2%	1.2%	3.0%	0.0%	0.0%	3.3%	0.0%	4.7%	0.0%	9.1%	2.7%	3.4%	7.7%	6.1%	14.3%	0.0%
We added members to the management team with digital technology and/or telemedicine/virtual care expertise	3.4%	6.7%	1.3%	4.8%	2.4%	3.0%	0.0%	0.0%	2.9%	0.0%	2.3%	11.1%	7.3%	2.0%	1.7%	7.7%	6.1%	7.1%	11.1%
We increased the frequency of board meetings during the pandemic	8.3%	21.3%	3.3%	4.8%	2.4%	0.0%	0.0%	0.0%	8.4%	6.7%	4.7%	44.4%	20.0%	1.3%	5.2%	26.9%	12.1%	21.4%	55.6%
We increased the frequency of executive committee meetings during the pandemic	5.9%	12.0%	2.6%	6.3%	3.7%	3.0%	0.0%	25.0%	5.8%	6.7%	3.9%	22.2%	10.9%	2.7%	12.1%	3.8%	6.1%	7.1%	22.2%
We increased the frequency of executive sessions during the pandemic	4.1%	5.3%	4.6%	1.6%	7.3%	6.1%	0.0%	25.0%	4.4%	0.0%	1.6%	22.2%	3.6%	4.0%	1.7%	3.8%	3.0%	7.1%	22.2%
We increased the frequency of communication between the board and CEO/senior management/ physician leaders during the pandemic	62.4%	72.0%	55.3%	68.3%	50.0%	39.4%	55.6%	62.5%	62.5%	60.0%	65.1%	77.8%	72.7%	54.0%	69.0%	76.9%	69.7%	71.4%	77.8%
We increased the frequency of communication between the board and legal counsel during the pandemic	10.0%	13.3%	7.9%	11.1%	6.1%	3.0%	0.0%	25.0%	10.2%	0.0%	11.6%	22.2%	12.7%	6.7%	12.1%	7.7%	9.1%	14.3%	55.6%
Other	9.0%	8.0%	9.2%	9.5%	6.1%	6.1%	11.1%	0.0%	9.1%	13.3%	11.6%	0.0%	7.3%	11.3%	5.2%	7.7%	9.1%	7.1%	0.0%
Percentage of respondents who made changes to board structure/ practices due to the pandemic	67.6%	73.3%	59.9%	79.4%	51.2%	39.4%	66.7%	50.0%	67.6%	60.0%	77.5%	66.7%	70.9%	58.7%	77.6%	84.6%	75.8%	57.1%	88.9%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
Our board was prepared to deal with the impacts of the coronavirus pandemic on our organization																			
Total responding in each category	282	74	146	62	82	33	9	8	268	15	122	9	54	149	54	25	32	14	8
Strongly agree	29.8%	43.2%	25.3%	24.2%	28.0%	24.2%	44.4%	37.5%	28.7%	20.0%	25.4%	44.4%	42.6%	22.1%	29.6%	36.0%	46.9%	50.0%	50.0%
Agree	50.4%	47.3%	47.3%	61.3%	46.3%	54.5%	22.2%	37.5%	51.1%	60.0%	53.3%	33.3%	50.0%	49.7%	53.7%	56.0%	50.0%	42.9%	37.5%
Neither agree nor disagree	14.9%	6.8%	19.9%	12.9%	19.5%	18.2%	22.2%	12.5%	14.9%	20.0%	15.6%	11.1%	5.6%	20.8%	13.0%	8.0%	3.1%	0.0%	12.5%
Disagree	4.6%	2.7%	6.8%	1.6%	4.9%	3.0%	11.1%	12.5%	4.9%	0.0%	5.7%	11.1%	1.9%	6.7%	3.7%	0.0%	0.0%	7.1%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.0%	1.2%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Our board has done an effective job overseeing our organization through the pandemic																			
Total responding in each category	281	73	147	61	82	33	9	8	268	15	122	9	53	150	54	25	30	14	8
Strongly agree	51.6%	64.4%	46.3%	49.2%	50.0%	51.5%	44.4%	62.5%	51.1%	33.3%	48.4%	66.7%	64.2%	44.7%	48.1%	56.0%	76.7%	71.4%	62.5%
Agree	41.3%	31.5%	43.5%	47.5%	40.2%	39.4%	44.4%	37.5%	41.8%	60.0%	44.3%	22.2%	34.0%	45.3%	48.1%	40.0%	20.0%	21.4%	37.5%
Neither agree nor disagree	6.0%	4.1%	8.2%	3.3%	7.3%	9.1%	11.1%	0.0%	6.0%	6.7%	6.6%	11.1%	1.9%	8.0%	3.7%	4.0%	3.3%	7.1%	0.0%
Disagree	0.7%	0.0%	1.4%	0.0%	1.2%	0.0%	0.0%	0.0%	0.7%	0.0%	0.8%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Strongly disagree	0.4%	0.0%	0.7%	0.0%	1.2%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Our CEO was prepared to deal with the impacts of the coronavirus pandemic on our organization																			
Total responding in each category	283	74	147	62	82	33	9	8	269	15	123	9	54	150	54	25	32	14	8
Strongly agree	57.6%	67.6%	55.8%	50.0%	54.9%	54.5%	44.4%	62.5%	56.9%	46.7%	54.5%	66.7%	70.4%	50.7%	55.6%	68.0%	81.3%	57.1%	75.0%
Agree	35.3%	21.6%	38.1%	45.2%	37.8%	39.4%	44.4%	37.5%	36.8%	46.7%	40.7%	11.1%	20.4%	41.3%	38.9%	28.0%	15.6%	28.6%	12.5%
Neither agree nor disagree	6.0%	9.5%	4.8%	4.8%	6.1%	6.1%	0.0%	0.0%	5.2%	6.7%	4.1%	22.2%	7.4%	7.3%	3.7%	4.0%	3.1%	7.1%	12.5%
Disagree	1.1%	1.4%	1.4%	0.0%	1.2%	0.0%	11.1%	0.0%	1.1%	0.0%	0.8%	0.0%	1.9%	0.7%	1.9%	0.0%	0.0%	7.1%	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%
Our CEO has done an effective job leading our organization through the pandemic																			
Total responding in each category	283	74	147	62	82	33	9	8	269	15	123	9	54	150	54	25	32	14	8
Strongly agree	69.3%	75.7%	68.0%	64.5%	65.9%	66.7%	55.6%	50.0%	68.4%	60.0%	68.3%	77.8%	77.8%	65.3%	63.0%	76.0%	90.6%	71.4%	75.0%
Agree	27.9%	20.3%	28.6%	35.5%	30.5%	30.3%	44.4%	50.0%	29.0%	40.0%	29.3%	22.2%	18.5%	30.7%	35.2%	24.0%	9.4%	21.4%	25.0%
Neither agree nor disagree	2.5%	2.7%	3.4%	0.0%	3.7%	3.0%	0.0%	0.0%	2.2%	0.0%	2.4%	0.0%	1.9%	4.0%	1.9%	0.0%	0.0%	0.0%	0.0%
Disagree	0.4%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	7.1%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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 2019 in regards to population health management?																			
Total responding in each category	287	75	150	62	81	33	9	8	273	15	127	9	55	149	57	25	33	14	9
N/A; we are not currently making plans to manage population health	15.7%	8.0%	20.0%	14.5%	23.5%	39.4%	33.3%	0.0%	16.5%	33.3%	11.8%	22.2%	7.3%	23.5%	8.8%	12.0%	3.0%	7.1%	0.0%
We have not changed our board structure to prepare for population health management	42.9%	37.3%	47.3%	38.7%	48.1%	33.3%	55.6%	62.5%	44.0%	20.0%	45.7%	55.6%	32.7%	46.3%	42.1%	40.0%	30.3%	57.1%	22.2%
We have updated the strategic plan to include goals regarding population health management, including building IT infrastructure and physician integration	49.8%	62.7%	43.3%	50.0%	42.0%	30.3%	44.4%	62.5%	50.2%	40.0%	49.6%	55.6%	63.6%	40.3%	52.6%	72.0%	60.6%	64.3%	66.7%
We have added board members with expertise in population health management to help us achieve this goal	3.1%	6.7%	0.7%	4.8%	2.5%	6.1%	0.0%	0.0%	2.6%	0.0%	2.4%	0.0%	7.3%	0.7%	5.3%	8.0%	6.1%	7.1%	0.0%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	1.4%	1.3%	0.7%	3.2%	1.2%	3.0%	0.0%	0.0%	1.5%	0.0%	1.6%	0.0%	1.8%	0.0%	0.0%	4.0%	9.1%	0.0%	0.0%
We have added physicians to the board to help us achieve this goal	5.6%	13.3%	2.0%	4.8%	6.2%	9.1%	11.1%	12.5%	5.5%	0.0%	1.6%	11.1%	14.5%	2.0%	5.3%	12.0%	18.2%	0.0%	11.1%
We have added nurses to the board to help us achieve this goal	1.7%	1.3%	1.3%	3.2%	1.2%	3.0%	0.0%	0.0%	1.8%	0.0%	2.4%	0.0%	1.8%	0.7%	3.5%	0.0%	6.1%	0.0%	0.0%
We have added physicians to the management team to help us achieve this goal	10.1%	14.7%	6.7%	12.9%	6.2%	6.1%	11.1%	12.5%	9.5%	13.3%	9.4%	11.1%	16.4%	8.1%	7.0%	20.0%	12.1%	21.4%	11.1%

All Respondents	Overall and by Organization Type					By AHA Control Code								By Organization Size (# of Beds)					
Total number of respondents in each category	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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+
We have added nurses to the management team to help us achieve this goal	8.4%	4.0%	8.7%	12.9%	8.6%	6.1%	11.1%	12.5%	8.4%	0.0%	11.8%	0.0%	3.6%	8.7%	10.5%	4.0%	9.1%	7.1%	0.0%
We have added population health-related metrics to our board quality/ finance dashboard reports	25.1%	34.7%	18.7%	29.0%	18.5%	18.2%	22.2%	12.5%	24.9%	33.3%	22.8%	22.2%	38.2%	15.4%	33.3%	36.0%	42.4%	21.4%	44.4%
Other	1.7%	1.3%	2.0%	1.6%	3.7%	0.0%	0.0%	12.5%	1.5%	6.7%	0.8%	0.0%	0.0%	2.0%	1.8%	4.0%	0.0%	0.0%	0.0%
Percentage of respondents currently making changes to manage population health	84.3%	92.0%	80.0%	85.5%	76.5%	60.6%	66.7%	100.0%	83.5%	66.7%	88.2%	77.8%	92.7%	76.5%	91.2%	88.0%	97.0%	92.9%	100.0%
How has your board structure/practices changed since 2019 in order to be successful with value-based payments?																			
Total responding in each category	287	75	150	62	81	33	9	8	273	15	127	9	55	149	57	25	33	14	9
N/A; we are not currently making plans to prepare for value-based payments	18.5%	8.0%	24.7%	16.1%	30.9%	51.5%	22.2%	0.0%	19.4%	33.3%	13.4%	22.2%	7.3%	27.5%	10.5%	8.0%	9.1%	7.1%	0.0%
We have not changed our board structure to prepare for value-based payments	48.1%	45.3%	52.0%	41.9%	51.9%	30.3%	66.7%	87.5%	48.4%	20.0%	51.2%	55.6%	41.8%	52.3%	42.1%	52.0%	33.3%	71.4%	22.2%
We have updated the strategic and financial plans to include goals regarding value-based payments	37.6%	56.0%	28.7%	37.1%	28.4%	24.2%	33.3%	37.5%	37.4%	26.7%	36.2%	55.6%	54.5%	26.2%	42.1%	68.0%	45.5%	50.0%	66.7%
We have added board members with expertise in quality improvement processes to help us achieve this goal	3.1%	4.0%	2.0%	4.8%	2.5%	6.1%	0.0%	0.0%	2.9%	0.0%	3.9%	0.0%	3.6%	1.3%	3.5%	12.0%	6.1%	0.0%	0.0%
We have added board members with predictive modeling and risk management expertise to help us achieve this goal	1.0%	0.0%	0.7%	3.2%	1.2%	3.0%	0.0%	0.0%	1.1%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	4.0%	6.1%	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	389	101	179	109	107	45	10	9	365	28	169	13	72	190	86	37	42	21	13
2021 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	1.4%	1.3%	1.3%	1.6%	1.2%	3.0%	0.0%	0.0%	1.5%	0.0%	1.6%	0.0%	1.8%	1.3%	0.0%	4.0%	3.0%	0.0%	0.0%
We have added physicians to the board to help us achieve this goal	4.2%	8.0%	1.3%	6.5%	2.5%	6.1%	0.0%	0.0%	3.7%	6.7%	3.1%	0.0%	9.1%	0.7%	5.3%	12.0%	15.2%	0.0%	0.0%
We have added nurses to the board to help us achieve this goal	1.0%	0.0%	0.7%	3.2%	1.2%	3.0%	0.0%	0.0%	1.1%	0.0%	1.6%	0.0%	0.0%	0.7%	1.8%	0.0%	3.0%	0.0%	0.0%
We have added physicians to the management team to help us achieve this goal	8.0%	12.0%	5.3%	9.7%	4.9%	6.1%	11.1%	0.0%	8.1%	13.3%	7.1%	22.2%	10.9%	3.4%	10.5%	16.0%	15.2%	14.3%	11.1%
We have added nurses to the management team to help us achieve this goal	5.6%	1.3%	8.0%	4.8%	6.2%	6.1%	11.1%	0.0%	5.5%	0.0%	8.7%	0.0%	0.0%	4.7%	8.8%	8.0%	6.1%	0.0%	0.0%
We have added value-based care metrics to our board quality/finance dashboard reports	20.6%	32.0%	14.0%	22.6%	11.1%	12.1%	22.2%	0.0%	19.8%	13.3%	20.5%	11.1%	38.2%	11.4%	29.8%	36.0%	30.3%	14.3%	44.4%
Other	2.1%	1.3%	2.7%	1.6%	1.2%	3.0%	0.0%	0.0%	1.8%	0.0%	3.1%	11.1%	0.0%	2.7%	1.8%	0.0%	0.0%	0.0%	11.1%
Percentage of respondents currently making changes to be successful with value-based payments	81.5%	92.0%	75.3%	83.9%	69.1%	48.5%	77.8%	100.0%	80.6%	66.7%	86.6%	77.8%	92.7%	72.5%	89.5%	92.0%	90.9%	92.9%	100.0%

Appendix 2. 2021 Governance Practices: Adoption & Performance

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Duty of Care							
The board requires that board members receive education on their fiduciary duties.							
Total responding to this question	275	72	144	59	50	9	78
Yes	78.2%	86.1%	72.2%	83.1%	84.0%	77.8%	69.2%
No, but considering it and/or working on it	12.7%	9.7%	15.3%	10.2%	10.0%	11.1%	16.7%
No, and not considering it	4.7%	0.0%	7.6%	3.4%	4.0%	0.0%	9.0%
Not applicable for our board	4.4%	4.2%	4.9%	3.4%	2.0%	11.1%	5.1%
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	274	71	143	60	51	9	78
Yes	74.8%	71.8%	79.7%	66.7%	66.7%	66.7%	74.4%
No, but considering it and/or working on it	15.7%	22.5%	11.9%	16.7%	15.7%	22.2%	20.5%
No, and not considering it	4.0%	2.8%	5.6%	1.7%	2.0%	0.0%	2.6%
Not applicable for our board	5.5%	2.8%	2.8%	15.0%	15.7%	11.1%	2.6%
Board members receive necessary background materials and well-developed agendas within sufficient time to prepare for meetings.							
Total responding to this question	276	72	144	60	51	9	78
Yes	95.7%	97.2%	95.8%	93.3%	94.1%	88.9%	93.6%
No, but considering it and/or working on it	4.3%	2.8%	4.2%	6.7%	5.9%	11.1%	6.4%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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	276	72	144	60	51	9	78
Yes	73.9%	83.3%	72.9%	65.0%	64.7%	66.7%	67.9%
No, but considering it and/or working on it	15.6%	12.5%	16.0%	18.3%	19.6%	11.1%	20.5%
No, and not considering it	6.9%	4.2%	9.0%	5.0%	3.9%	11.1%	9.0%
Not applicable for our board	3.6%	0.0%	2.1%	11.7%	11.8%	11.1%	2.6%
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.							
Total responding to this question	274	71	143	60	51	9	77
Yes	72.6%	76.1%	74.8%	63.3%	64.7%	55.6%	72.7%
No, but considering it and/or working on it	17.2%	16.9%	17.5%	16.7%	15.7%	22.2%	16.9%
No, and not considering it	5.8%	7.0%	5.6%	5.0%	5.9%	0.0%	6.5%
Not applicable for our board	4.4%	0.0%	2.1%	15.0%	13.7%	22.2%	3.9%
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	276	71	145	60	51	9	78
Yes	84.8%	87.3%	88.3%	73.3%	76.5%	55.6%	85.9%
No, but considering it and/or working on it	5.4%	2.8%	4.8%	10.0%	9.8%	11.1%	6.4%
No, and not considering it	5.1%	7.0%	5.5%	1.7%	2.0%	0.0%	6.4%
Not applicable for our board	4.7%	2.8%	1.4%	15.0%	11.8%	33.3%	1.3%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
The board requires management to provide the rationale for their recommendations, including options they considered.							
Total responding to this question	271	71	141	59	50	9	77
Yes	94.8%	100.0%	96.5%	84.7%	84.0%	88.9%	97.4%
No, but considering it and/or working on it	2.6%	0.0%	2.1%	6.8%	6.0%	11.1%	1.3%
No, and not considering it	0.7%	0.0%	1.4%	0.0%	0.0%	0.0%	1.3%
Not applicable for our board	1.8%	0.0%	0.0%	8.5%	10.0%	0.0%	0.0%
Please evaluate your board's overall performance in fulfilling its duty of care.							
Total responding to this question	276	71	145	60	51	9	78
Excellent	51.4%	63.4%	44.1%	55.0%	54.9%	55.6%	43.6%
Very Good	37.7%	31.0%	41.4%	36.7%	37.3%	33.3%	39.7%
Good	7.6%	5.6%	9.7%	5.0%	3.9%	11.1%	9.0%
Fair	3.3%	0.0%	4.8%	3.3%	3.9%	0.0%	7.7%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
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	272	69	143	60	51	9	77
Yes	97.1%	98.6%	96.5%	96.7%	96.1%	100.0%	94.8%
No, but considering it and/or working on it	1.8%	1.4%	1.4%	3.3%	3.9%	0.0%	2.6%
No, and not considering it	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	0.7%	0.0%	1.4%	0.0%	0.0%	0.0%	2.6%
Board members complete a full conflict-of-interest disclosure statement annually.							
Total responding to this question	272	70	143	59	50	9	77
Yes	95.6%	98.6%	93.0%	98.3%	98.0%	100.0%	90.9%
No, but considering it and/or working on it	2.9%	1.4%	4.2%	1.7%	2.0%	0.0%	3.9%
No, and not considering it	0.7%	0.0%	1.4%	0.0%	0.0%	0.0%	2.6%
Not applicable for our board	0.7%	0.0%	1.4%	0.0%	0.0%	0.0%	2.6%
The board has a specific process by which disclosed potential conflicts are reviewed by independent, non-conflicted board members with staff support from the general counsel.							
Total responding to this question	271	69	142	60	51	9	77
Yes	81.9%	92.8%	71.8%	93.3%	96.1%	77.8%	71.4%
No, but considering it and/or working on it	7.0%	2.9%	10.6%	3.3%	2.0%	11.1%	10.4%
No, and not considering it	7.7%	1.4%	12.7%	3.3%	2.0%	11.1%	13.0%
Not applicable for our board	3.3%	2.9%	4.9%	0.0%	0.0%	0.0%	5.2%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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.							
Total responding to this question	270	69	142	59	50	9	77
Yes	76.3%	82.6%	66.9%	91.5%	92.0%	88.9%	63.6%
No, but considering it and/or working on it	8.5%	4.3%	12.7%	3.4%	4.0%	0.0%	14.3%
No, and not considering it	10.4%	11.6%	12.7%	3.4%	4.0%	0.0%	11.7%
Not applicable for our board	4.8%	1.4%	7.7%	1.7%	0.0%	11.1%	10.4%
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	268	70	140	58	49	9	77
Yes	84.7%	95.7%	77.1%	89.7%	91.8%	77.8%	74.0%
No, but considering it and/or working on it	5.2%	0.0%	8.6%	3.4%	4.1%	0.0%	6.5%
No, and not considering it	3.4%	1.4%	5.0%	1.7%	0.0%	11.1%	3.9%
Not applicable for our board	6.7%	2.9%	9.3%	5.2%	4.1%	11.1%	15.6%
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	268	68	141	59	50	9	75
Yes	89.2%	91.2%	87.2%	91.5%	90.0%	100.0%	81.3%
No, but considering it and/or working on it	6.0%	2.9%	7.8%	5.1%	6.0%	0.0%	9.3%
No, and not considering it	3.0%	1.5%	3.5%	3.4%	4.0%	0.0%	5.3%
Not applicable for our board	1.9%	4.4%	1.4%	0.0%	0.0%	0.0%	4.0%
The board has a written policy outlining the organization's approach to physician competition/conflict of interest.							
Total responding to this question	269	69	141	59	50	9	77
Yes	61.0%	72.5%	51.8%	69.5%	68.0%	77.8%	48.1%
No, but considering it and/or working on it	17.5%	10.1%	21.3%	16.9%	20.0%	0.0%	23.4%
No, and not considering it	14.5%	13.0%	18.4%	6.8%	6.0%	11.1%	18.2%
Not applicable for our board	7.1%	4.3%	8.5%	6.8%	6.0%	11.1%	10.4%
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	270	69	142	59	50	9	77
Yes	80.7%	87.0%	78.9%	78.0%	74.0%	100.0%	74.0%
No, but considering it and/or working on it	11.1%	11.6%	12.7%	6.8%	8.0%	0.0%	16.9%
No, and not considering it	4.1%	1.4%	7.0%	0.0%	0.0%	0.0%	5.2%
Not applicable for our board	4.1%	0.0%	1.4%	15.3%	18.0%	0.0%	3.9%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	266	69	139	58	49	9	75
Yes	80.5%	89.9%	72.7%	87.9%	85.7%	100.0%	42.7%
No, but considering it and/or working on it	2.3%	0.0%	3.6%	1.7%	2.0%	0.0%	5.3%
No, and not considering it	1.5%	0.0%	2.2%	1.7%	2.0%	0.0%	2.7%
Not applicable for our board	15.8%	10.1%	21.6%	8.6%	10.2%	0.0%	49.3%
Please evaluate your board's overall performance in fulfilling its duty of loyalty.							
Total responding to this question	272	70	143	59	50	9	78
Excellent	56.6%	71.4%	47.6%	61.0%	50%	9%	43.6%
Very Good	32.4%	24.3%	37.1%	30.5%	60.0%	66.7%	34.6%
Good	9.2%	4.3%	11.9%	8.5%	30.0%	33.3%	16.7%
Fair	1.5%	0.0%	2.8%	0.0%	10.0%	0.0%	5.1%
Poor	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%
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	270	70	141	59	50	9	77
Yes	85.9%	88.6%	88.7%	76.3%	78.0%	66.7%	89.6%
No, but considering it and/or working on it	6.7%	8.6%	7.1%	3.4%	4.0%	0.0%	6.5%
No, and not considering it	3.0%	1.4%	4.3%	1.7%	2.0%	0.0%	3.9%
Not applicable for our board	4.4%	1.4%	0.0%	18.6%	16.0%	33.3%	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	270	70	141	59	50	9	76
Yes	91.5%	94.3%	90.8%	89.8%	88.0%	100.0%	90.8%
No, but considering it and/or working on it	5.2%	1.4%	8.5%	1.7%	2.0%	0.0%	7.9%
No, and not considering it	0.7%	1.4%	0.7%	0.0%	0.0%	0.0%	1.3%
Not applicable for our board	2.6%	2.9%	0.0%	8.5%	10.0%	0.0%	0.0%
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	268	68	141	59	50	9	76
Yes	50.7%	66.2%	43.3%	50.8%	50.0%	55.6%	44.7%
No, but considering it and/or working on it	20.5%	16.2%	22.7%	20.3%	22.0%	11.1%	18.4%
No, and not considering it	20.5%	11.8%	29.8%	8.5%	10.0%	0.0%	31.6%
Not applicable for our board	8.2%	5.9%	4.3%	20.3%	18.0%	33.3%	5.3%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
When considering major projects, the board discusses what the organization is forgoing by undertaking the project, the risks and tradeoffs, and approaches to mitigating risks associated with the project.							
Total responding to this question	268	70	140	58	49	9	75
Yes	86.2%	88.6%	85.0%	86.2%	83.7%	100.0%	80.0%
No, but considering it and/or working on it	7.1%	7.1%	8.6%	3.4%	4.1%	0.0%	10.7%
No, and not considering it	4.1%	2.9%	6.4%	0.0%	0.0%	0.0%	8.0%
Not applicable for our board	2.6%	1.4%	0.0%	10.3%	12.2%	0.0%	1.3%
The board annually reviews and approves an updated enterprise risk management assessment and improvement plan.							
Total responding to this question	269	70	141	58	49	9	76
Yes	60.2%	65.7%	58.9%	56.9%	57.1%	55.6%	57.9%
No, but considering it and/or working on it	21.2%	24.3%	22.0%	15.5%	16.3%	11.1%	22.4%
No, and not considering it	12.6%	7.1%	17.0%	8.6%	8.2%	11.1%	17.1%
Not applicable for our board	5.9%	2.9%	2.1%	19.0%	18.4%	22.2%	2.6%
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	270	70	141	59	50	9	77
Yes	63.7%	81.4%	60.3%	50.8%	52.0%	44.4%	58.4%
No, but considering it and/or working on it	20.7%	7.1%	26.2%	23.7%	26.0%	11.1%	24.7%
No, and not considering it	8.9%	10.0%	10.6%	3.4%	4.0%	0.0%	13.0%
Not applicable for our board	6.7%	1.4%	2.8%	22.0%	18.0%	44.4%	3.9%
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	270	69	142	59	50	9	77
Yes	85.2%	92.8%	84.5%	78.0%	78.0%	77.8%	88.3%
No, but considering it and/or working on it	7.4%	4.3%	10.6%	3.4%	4.0%	0.0%	9.1%
No, and not considering it	3.3%	2.9%	4.2%	1.7%	2.0%	0.0%	2.6%
Not applicable for our board	4.1%	0.0%	0.7%	16.9%	16.0%	22.2%	0.0%
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	270	69	142	59	50	9	77
Yes	86.7%	89.9%	88.0%	79.7%	80.0%	77.8%	87.0%
No, but considering it and/or working on it	6.7%	4.3%	8.5%	5.1%	6.0%	0.0%	9.1%
No, and not considering it	3.7%	5.8%	2.1%	5.1%	4.0%	11.1%	1.3%
Not applicable for our board	3.0%	0.0%	1.4%	10.2%	10.0%	11.1%	2.6%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	269	68	142	59	50	9	77
Yes	66.5%	85.3%	63.4%	52.5%	60.0%	11.1%	51.9%
No, but considering it and/or working on it	3.3%	1.5%	5.6%	0.0%	0.0%	0.0%	2.6%
No, and not considering it	16.0%	10.3%	20.4%	11.9%	14.0%	0.0%	28.6%
Not applicable for our board	14.1%	2.9%	10.6%	35.6%	26.0%	88.9%	16.9%
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.							
Total responding to this question	270	69	142	59	50	9	77
Yes	75.6%	92.8%	74.6%	57.6%	64.0%	22.2%	63.6%
No, but considering it and/or working on it	8.1%	2.9%	12.0%	5.1%	4.0%	11.1%	16.9%
No, and not considering it	7.0%	2.9%	10.6%	3.4%	4.0%	0.0%	14.3%
Not applicable for our board	9.3%	1.4%	2.8%	33.9%	28.0%	66.7%	5.2%
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	268	69	141	58	49	9	76
Yes	87.3%	98.6%	88.7%	70.7%	71.4%	66.7%	84.2%
No, but considering it and/or working on it	5.6%	1.4%	7.8%	5.2%	6.1%	0.0%	11.8%
No, and not considering it	1.5%	0.0%	2.8%	0.0%	0.0%	0.0%	2.6%
Not applicable for our board	5.6%	0.0%	0.7%	24.1%	22.4%	33.3%	1.3%
The board has established a direct reporting relationship with general counsel.							
Total responding to this question	268	69	141	58	49	9	76
Yes	63.4%	68.1%	62.4%	60.3%	63.3%	44.4%	67.1%
No, but considering it and/or working on it	6.7%	5.8%	9.2%	1.7%	2.0%	0.0%	6.6%
No, and not considering it	16.4%	21.7%	17.0%	8.6%	10.2%	0.0%	14.5%
Not applicable for our board	13.4%	4.3%	11.3%	29.3%	24.5%	55.6%	11.8%
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	267	68	141	58	49	9	76
Yes	82.8%	88.2%	84.4%	72.4%	77.6%	44.4%	84.2%
No, but considering it and/or working on it	6.7%	7.4%	7.1%	5.2%	4.1%	11.1%	7.9%
No, and not considering it	5.6%	4.4%	7.8%	1.7%	2.0%	0.0%	7.9%
Not applicable for our board	4.9%	0.0%	0.7%	20.7%	16.3%	44.4%	0.0%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	268	68	142	58	49	9	77
Yes	84.0%	92.6%	89.4%	60.3%	67.3%	22.2%	87.0%
No, but considering it and/or working on it	3.4%	1.5%	4.2%	3.4%	4.1%	0.0%	3.9%
No, and not considering it	3.7%	2.9%	4.9%	1.7%	2.0%	0.0%	6.5%
Not applicable for our board	9.0%	2.9%	1.4%	34.5%	26.5%	77.8%	2.6%
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	267	69	140	58	49	9	75
Yes	60.3%	82.6%	56.4%	43.1%	49.0%	11.1%	49.3%
No, but considering it and/or working on it	6.7%	2.9%	9.3%	5.2%	6.1%	0.0%	9.3%
No, and not considering it	19.1%	13.0%	26.4%	8.6%	10.2%	0.0%	29.3%
Not applicable for our board	13.9%	1.4%	7.9%	43.1%	34.7%	88.9%	12.0%
Board members responsible for audit oversight meet with external auditors, without management, at least annually.							
Total responding to this question	266	69	139	58	49	9	76
Yes	76.7%	85.5%	79.9%	58.6%	65.3%	22.2%	73.7%
No, but considering it and/or working on it	3.8%	2.9%	4.3%	3.4%	4.1%	0.0%	2.6%
No, and not considering it	8.3%	10.1%	10.8%	0.0%	0.0%	0.0%	15.8%
Not applicable for our board	11.3%	1.4%	5.0%	37.9%	30.6%	77.8%	7.9%
Please evaluate your board's overall performance in fulfilling its duty of obedience.							
Total responding to this question	269	69	141	59	50	9	76
Excellent	51.7%	63.8%	43.3%	57.6%	58.0%	55.6%	36.8%
Very Good	35.7%	33.3%	40.4%	27.1%	28.0%	22.2%	40.8%
Good	10.8%	2.9%	12.8%	15.3%	14.0%	22.2%	17.1%
Fair	1.5%	0.0%	2.8%	0.0%	0.0%	0.0%	5.3%
Poor	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%
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	266	69	139	58	49	9	77
Yes	87.6%	95.7%	82.7%	89.7%	89.8%	88.9%	77.9%
No, but considering it and/or working on it	8.3%	1.4%	12.9%	5.2%	4.1%	11.1%	15.6%
No, and not considering it	2.3%	1.4%	3.6%	0.0%	0.0%	0.0%	6.5%
Not applicable for our board	1.9%	1.4%	0.7%	5.2%	6.1%	0.0%	0.0%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
The board requires all hospital clinical programs or services to meet quality-related performance criteria.							
Total responding to this question	263	67	138	58	49	9	77
Yes	80.2%	80.6%	77.5%	86.2%	85.7%	88.9%	83.1%
No, but considering it and/or working on it	11.0%	7.5%	13.0%	10.3%	10.2%	11.1%	11.7%
No, and not considering it	5.7%	7.5%	7.2%	0.0%	0.0%	0.0%	3.9%
Not applicable for our board	3.0%	4.5%	2.2%	3.4%	4.1%	0.0%	1.3%
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.							
Total responding to this question	264	68	138	58	49	9	76
Yes	77.3%	76.5%	74.6%	84.5%	83.7%	88.9%	80.3%
No, but considering it and/or working on it	15.5%	14.7%	16.7%	13.8%	14.3%	11.1%	15.8%
No, and not considering it	5.3%	5.9%	6.5%	1.7%	2.0%	0.0%	3.9%
Not applicable for our board	1.9%	2.9%	2.2%	0.0%	0.0%	0.0%	0.0%
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	265	68	139	58	49	9	77
Yes	80.0%	95.6%	75.5%	72.4%	71.4%	77.8%	72.7%
No, but considering it and/or working on it	10.6%	1.5%	15.1%	10.3%	10.2%	11.1%	14.3%
No, and not considering it	4.9%	1.5%	7.9%	1.7%	2.0%	0.0%	13.0%
Not applicable for our board	4.5%	1.5%	1.4%	15.5%	16.3%	11.1%	0.0%
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	265	68	139	58	49	9	77
Yes	79.2%	77.9%	76.3%	87.9%	87.8%	88.9%	79.2%
No, but considering it and/or working on it	14.3%	16.2%	15.1%	10.3%	10.2%	11.1%	14.3%
No, and not considering it	5.3%	2.9%	7.9%	1.7%	2.0%	0.0%	6.5%
Not applicable for our board	1.1%	2.9%	0.7%	0.0%	0.0%	0.0%	0.0%
The board has a standing quality committee.							
Total responding to this question	265	69	138	58	49	9	77
Yes	77.0%	87.0%	71.7%	77.6%	75.5%	88.9%	68.8%
No, but considering it and/or working on it	6.4%	4.3%	9.4%	1.7%	2.0%	0.0%	9.1%
No, and not considering it	9.8%	4.3%	14.5%	5.2%	6.1%	0.0%	15.6%
Not applicable for our board	6.8%	4.3%	4.3%	15.5%	16.3%	11.1%	6.5%
The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.							
Total responding to this question	265	69	138	58	49	9	77
Yes	72.8%	81.2%	70.3%	69.0%	67.3%	77.8%	72.7%
No, but considering it and/or working on it	15.8%	13.0%	19.6%	10.3%	12.2%	0.0%	15.6%
No, and not considering it	6.0%	2.9%	8.7%	3.4%	4.1%	0.0%	9.1%
Not applicable for our board	5.3%	2.9%	1.4%	17.2%	16.3%	22.2%	2.6%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	264	69	137	58	49	9	77
Yes	80.3%	75.4%	83.2%	79.3%	79.6%	77.8%	77.9%
No, but considering it and/or working on it	6.4%	1.4%	8.8%	6.9%	8.2%	0.0%	10.4%
No, and not considering it	4.2%	1.4%	6.6%	1.7%	2.0%	0.0%	9.1%
Not applicable for our board	9.1%	21.7%	1.5%	12.1%	10.2%	22.2%	2.6%
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	264	68	138	58	49	9	77
Yes	80.7%	67.6%	84.8%	86.2%	87.8%	77.8%	83.1%
No, but considering it and/or working on it	5.3%	4.4%	7.2%	1.7%	2.0%	0.0%	7.8%
No, and not considering it	2.3%	1.5%	3.6%	0.0%	0.0%	0.0%	3.9%
Not applicable for our board	11.7%	26.5%	4.3%	12.1%	10.2%	22.2%	5.2%
The board allocates sufficient resources to developing physician leaders and assessing their performance.							
Total responding to this question	263	68	137	58	49	9	76
Yes	56.3%	60.3%	54.7%	55.2%	53.1%	66.7%	55.3%
No, but considering it and/or working on it	17.9%	11.8%	23.4%	12.1%	12.2%	11.1%	19.7%
No, and not considering it	11.0%	8.8%	14.6%	5.2%	6.1%	0.0%	18.4%
Not applicable for our board	14.8%	19.1%	7.3%	27.6%	28.6%	22.2%	6.6%
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	261	68	137	56	47	9	77
Yes	82.0%	82.4%	82.5%	80.4%	83.0%	66.7%	84.4%
No, but considering it and/or working on it	8.0%	1.5%	10.9%	8.9%	8.5%	11.1%	10.4%
No, and not considering it	2.3%	2.9%	2.9%	0.0%	0.0%	0.0%	3.9%
Not applicable for our board	7.7%	13.2%	3.6%	10.7%	8.5%	22.2%	1.3%
Please evaluate your board's overall performance in fulfilling its responsibility for quality oversight.							
Total responding to this question	266	69	139	58	49	9	77
Excellent	48.9%	63.8%	37.4%	58.6%	55.1%	77.8%	32.5%
Very Good	35.3%	27.5%	43.9%	24.1%	26.5%	11.1%	46.8%
Good	12.0%	8.7%	12.2%	15.5%	16.3%	11.1%	15.6%
Fair	3.4%	0.0%	5.8%	1.7%	2.0%	0.0%	5.2%
Poor	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Financial Oversight							
The board is sufficiently informed and discusses the multi-year strategic/financial plan before approving it.							
Total responding to this question	267	69	140	58	49	9	77
Yes	89.9%	98.6%	91.4%	75.9%	81.6%	44.4%	89.6%
No, but considering it and/or working on it	5.2%	1.4%	7.1%	5.2%	2.0%	22.2%	6.5%
No, and not considering it	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	1.3%
Not applicable for our board	4.5%	0.0%	0.7%	19.0%	16.3%	33.3%	2.6%
The board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it.							
Total responding to this question	265	68	140	57	48	9	77
Yes	94.0%	100.0%	97.1%	78.9%	85.4%	44.4%	97.4%
No, but considering it and/or working on it	2.3%	0.0%	2.9%	3.5%	0.0%	22.2%	1.3%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	3.8%	0.0%	0.0%	17.5%	14.6%	33.3%	1.3%
The board annually reviews and approves the investment policy.							
Total responding to this question	266	68	140	58	49	9	77
Yes	69.9%	91.2%	70.0%	44.8%	51.0%	11.1%	57.1%
No, but considering it and/or working on it	7.9%	2.9%	10.0%	8.6%	10.2%	0.0%	14.3%
No, and not considering it	5.3%	1.5%	9.3%	0.0%	0.0%	0.0%	10.4%
Not applicable for our board	16.9%	4.4%	10.7%	46.6%	38.8%	88.9%	18.2%
The board reviews financial feasibility of major projects before approving them.							
Total responding to this question	263	68	137	58	50	8	77
Yes	94.7%	100.0%	98.5%	79.3%	86.0%	37.5%	97.4%
No, but considering it and/or working on it	0.4%	0.0%	0.0%	1.7%	0.0%	12.5%	0.0%
No, and not considering it	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not applicable for our board	4.9%	0.0%	1.5%	19.0%	14.0%	50.0%	2.6%
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.							
Total responding to this question	266	68	140	58	49	9	77
Yes	87.2%	95.6%	88.6%	74.1%	79.6%	44.4%	87.0%
No, but considering it and/or working on it	4.9%	1.5%	7.9%	1.7%	0.0%	11.1%	3.9%
No, and not considering it	1.9%	1.5%	2.9%	0.0%	0.0%	0.0%	6.5%
Not applicable for our board	6.0%	1.5%	0.7%	24.1%	20.4%	44.4%	2.6%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	264	67	140	57	48	9	77
Yes	69.7%	71.6%	69.3%	68.4%	68.8%	66.7%	68.8%
No, but considering it and/or working on it	13.6%	14.9%	15.0%	8.8%	10.4%	0.0%	14.3%
No, and not considering it	9.8%	11.9%	11.4%	3.5%	4.2%	0.0%	11.7%
Not applicable for our board	6.8%	1.5%	4.3%	19.3%	16.7%	33.3%	5.2%
Please evaluate your board's overall performance in fulfilling its responsibility for financial oversight.							
Total responding to this question	264	68	139	57	49	8	77
Excellent	63.6%	77.9%	59.0%	57.9%	61.2%	37.5%	49.4%
Very Good	26.1%	20.6%	26.6%	31.6%	30.6%	37.5%	29.9%
Good	9.1%	1.5%	12.9%	8.8%	6.1%	25.0%	19.5%
Fair	1.1%	0.0%	1.4%	1.8%	2.0%	0.0%	1.3%
Poor	0.0%	0.0%	0.0%	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	264	67	139	58	49	9	76
Yes	89.0%	98.5%	89.9%	75.9%	75.5%	77.8%	88.2%
No, but considering it and/or working on it	7.6%	1.5%	9.4%	10.3%	10.2%	11.1%	9.2%
No, and not considering it	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	1.3%
Not applicable for our board	3.0%	0.0%	0.0%	13.8%	14.3%	11.1%	1.3%
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	264	68	138	58	49	9	76
Yes	81.8%	86.8%	86.2%	65.5%	63.3%	77.8%	86.8%
No, but considering it and/or working on it	12.1%	10.3%	10.9%	17.2%	18.4%	11.1%	10.5%
No, and not considering it	3.0%	2.9%	2.9%	3.4%	4.1%	0.0%	1.3%
Not applicable for our board	3.0%	0.0%	0.0%	13.8%	14.3%	11.1%	1.3%
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	263	68	137	58	49	9	76
Yes	84.0%	92.6%	83.9%	74.1%	73.5%	77.8%	82.9%
No, but considering it and/or working on it	9.9%	5.9%	11.7%	10.3%	10.2%	11.1%	13.2%
No, and not considering it	2.3%	1.5%	3.6%	0.0%	0.0%	0.0%	2.6%
Not applicable for our board	3.8%	0.0%	0.7%	15.5%	16.3%	11.1%	1.3%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	263	68	138	57	48	9	76
Yes	85.2%	97.1%	84.8%	71.9%	70.8%	77.8%	82.9%
No, but considering it and/or working on it	9.1%	2.9%	11.6%	10.5%	10.4%	11.1%	10.5%
No, and not considering it	1.5%	0.0%	2.2%	1.8%	2.1%	0.0%	3.9%
Not applicable for our board	4.2%	0.0%	1.4%	15.8%	16.7%	11.1%	2.6%
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	263	67	138	58	49	9	76
Yes	85.2%	88.1%	87.0%	77.6%	77.6%	77.8%	84.2%
No, but considering it and/or working on it	10.3%	10.4%	11.6%	6.9%	6.1%	11.1%	11.8%
No, and not considering it	0.4%	0.0%	0.7%	0.0%	0.0%	0.0%	1.3%
Not applicable for our board	4.2%	1.5%	0.7%	15.5%	16.3%	11.1%	2.6%
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	265	68	139	58	49	9	76
Yes	85.3%	95.6%	87.1%	69.0%	69.4%	66.7%	85.5%
No, but considering it and/or working on it	9.8%	4.4%	11.5%	12.1%	12.2%	11.1%	11.8%
No, and not considering it	0.8%	0.0%	1.4%	0.0%	0.0%	0.0%	1.3%
Not applicable for our board	4.2%	0.0%	0.0%	19.0%	18.4%	22.2%	1.3%
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	262	65	139	58	49	9	76
Yes	40.8%	52.3%	35.3%	41.4%	42.9%	33.3%	31.6%
No, but considering it and/or working on it	40.5%	43.1%	43.2%	31.0%	30.6%	33.3%	44.7%
No, and not considering it	14.9%	4.6%	19.4%	15.5%	16.3%	11.1%	21.1%
Not applicable for our board	3.8%	0.0%	2.2%	12.1%	10.2%	22.2%	2.6%
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	263	68	138	57	48	9	75
Yes	57.8%	64.7%	57.2%	50.9%	52.1%	44.4%	52.0%
No, but considering it and/or working on it	24.0%	19.1%	27.5%	21.1%	22.9%	11.1%	28.0%
No, and not considering it	11.8%	13.2%	12.3%	8.8%	8.3%	11.1%	17.3%
Not applicable for our board	6.5%	2.9%	2.9%	19.3%	16.7%	33.3%	2.7%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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	260	67	136	57	48	9	75
Yes	56.5%	59.7%	55.1%	56.1%	54.2%	66.7%	52.0%
No, but considering it and/or working on it	20.4%	13.4%	27.2%	12.3%	12.5%	11.1%	28.0%
No, and not considering it	11.9%	10.4%	14.0%	8.8%	8.3%	11.1%	16.0%
Not applicable for our board	11.2%	16.4%	3.7%	22.8%	25.0%	11.1%	4.0%
The board works with management to gain awareness of, and prepare to respond to, matters of business disruption.							
Total responding to this question	264	68	138	58	49	9	76
Yes	81.1%	85.3%	80.4%	77.6%	77.6%	77.8%	76.3%
No, but considering it and/or working on it	11.0%	7.4%	11.6%	13.8%	12.2%	22.2%	14.5%
No, and not considering it	4.2%	4.4%	5.8%	0.0%	0.0%	0.0%	5.3%
Not applicable for our board	3.8%	2.9%	2.2%	8.6%	10.2%	0.0%	3.9%
Please evaluate your board's overall performance in fulfilling its responsibility for setting strategic direction.							
Total responding to this question	264	67	140	57	48	9	77
Excellent	43.2%	56.7%	35.0%	47.4%	47.9%	44.4%	37.7%
Very Good	38.6%	32.8%	43.6%	33.3%	33.3%	33.3%	40.3%
Good	13.3%	10.4%	15.0%	12.3%	10.4%	22.2%	16.9%
Fair	3.8%	0.0%	5.7%	3.5%	4.2%	0.0%	3.9%
Poor	1.1%	0.0%	0.7%	3.5%	4.2%	0.0%	1.3%
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	264	67	138	59	50	9	76
Yes	53.0%	53.7%	50.0%	59.3%	58.0%	66.7%	50.0%
No, but considering it and/or working on it	22.0%	22.4%	25.4%	13.6%	14.0%	11.1%	22.4%
No, and not considering it	20.1%	22.4%	22.5%	11.9%	12.0%	11.1%	23.7%
Not applicable for our board	4.9%	1.5%	2.2%	15.3%	16.0%	11.1%	3.9%
The board uses the results from a formal self-assessment process to establish board performance improvement goals at least every two years.							
Total responding in each category	264%	68%	137%	59%	50	9	76%
Yes	61.0%	73.5%	54.7%	61.0%	62.0%	55.6%	44.7%
No, but considering it and/or working on it	25.8%	17.6%	30.7%	23.7%	26.0%	11.1%	35.5%
No, and not considering it	11.4%	8.8%	13.9%	8.5%	8.0%	11.1%	17.1%
Not applicable for our board	1.9%	0.0%	0.7%	6.8%	4.0%	22.2%	2.6%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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.							
Total responding to this question	265	69	138	58	49	9	76
Yes	54.0%	66.7%	50.0%	48.3%	49.0%	44.4%	47.4%
No, but considering it and/or working on it	24.2%	20.3%	26.8%	22.4%	22.4%	22.2%	21.1%
No, and not considering it	12.5%	11.6%	15.2%	6.9%	6.1%	11.1%	15.8%
Not applicable for our board	9.4%	1.4%	8.0%	22.4%	22.4%	22.2%	15.8%
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	265	68	138	59	50	9	76
Yes	86.4%	94.1%	81.9%	88.1%	90.0%	77.8%	77.6%
No, but considering it and/or working on it	10.9%	4.4%	14.5%	10.2%	10.0%	11.1%	18.4%
No, and not considering it	1.9%	0.0%	3.6%	0.0%	0.0%	0.0%	3.9%
Not applicable for our board	0.8%	1.5%	0.0%	1.7%	0.0%	11.1%	0.0%
The board has a "mentoring" program for new board members.							
Total responding to this question	262	67	137	58	49	9	76
Yes	32.1%	38.8%	29.9%	29.3%	26.5%	44.4%	25.0%
No, but considering it and/or working on it	45.4%	46.3%	43.1%	50.0%	53.1%	33.3%	39.5%
No, and not considering it	19.1%	11.9%	24.1%	15.5%	18.4%	0.0%	32.9%
Not applicable for our board	3.4%	3.0%	2.9%	5.2%	2.0%	22.2%	2.6%
Board members participate at least annually in education regarding its responsibilities to fulfill the organization's mission, vision, and strategic goals.							
Total responding to this question	264	67	138	59	50	9	76
Yes	76.9%	82.1%	76.8%	71.2%	70.0%	77.8%	73.7%
No, but considering it and/or working on it	16.7%	14.9%	18.1%	15.3%	14.0%	22.2%	22.4%
No, and not considering it	3.8%	3.0%	3.6%	5.1%	6.0%	0.0%	3.9%
Not applicable for our board	2.7%	0.0%	1.4%	8.5%	10.0%	0.0%	0.0%
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	261	67	135	59	50	9	75
Yes	52.9%	58.2%	48.9%	55.9%	54.0%	66.7%	46.7%
No, but considering it and/or working on it	24.1%	25.4%	25.2%	20.3%	24.0%	0.0%	29.3%
No, and not considering it	19.2%	16.4%	23.7%	11.9%	12.0%	11.1%	22.7%
Not applicable for our board	3.8%	0.0%	2.2%	11.9%	10.0%	22.2%	1.3%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
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).							
Total responding to this question	263	67	137	59	50	9	76
Yes	70.7%	73.1%	67.9%	74.6%	70.0%	100.0%	51.3%
No, but considering it and/or working on it	9.5%	14.9%	8.0%	6.8%	8.0%	0.0%	6.6%
No, and not considering it	4.2%	3.0%	5.8%	1.7%	2.0%	0.0%	6.6%
Not applicable for our board	15.6%	9.0%	18.2%	16.9%	20.0%	0.0%	35.5%
The board enforces a policy on board member term limits and retirement age.							
Total responding to this question	261	67	135	59	50	9	74
Yes	50.6%	59.7%	43.7%	55.9%	58.0%	44.4%	24.3%
No, but considering it and/or working on it	10.7%	7.5%	10.4%	15.3%	16.0%	11.1%	10.8%
No, and not considering it	21.8%	17.9%	26.7%	15.3%	14.0%	22.2%	31.1%
Not applicable for our board	16.9%	14.9%	19.3%	13.6%	12.0%	22.2%	33.8%
The board enforces minimum meeting preparation and attendance requirements.							
Total responding to this question	264	68	137	59	50	9	76
Yes	70.5%	72.1%	70.8%	67.8%	72.0%	44.4%	64.5%
No, but considering it and/or working on it	13.3%	11.8%	11.7%	18.6%	18.0%	22.2%	9.2%
No, and not considering it	12.1%	11.8%	13.1%	10.2%	10.0%	11.1%	18.4%
Not applicable for our board	4.2%	4.4%	4.4%	3.4%	0.0%	22.2%	7.9%
The board uses a formal process to evaluate the performance of individual board members.							
Total responding to this question	262	67	136	59	50	9	75
Yes	30.9%	29.9%	28.7%	37.3%	36.0%	44.4%	20.0%
No, but considering it and/or working on it	29.4%	32.8%	28.7%	27.1%	30.0%	11.1%	30.7%
No, and not considering it	32.4%	31.3%	37.5%	22.0%	22.0%	22.2%	42.7%
Not applicable for our board	7.3%	6.0%	5.1%	13.6%	12.0%	22.2%	6.7%
The board uses agreed-upon performance requirements for board member and officer reappointment.							
Total responding to this question	263	66	138	59	50%	9%	76
Yes	38.4%	48.5%	30.4%	45.8%	46.0%	44.4%	25.0%
No, but considering it and/or working on it	22.8%	24.2%	22.5%	22.0%	24.0%	11.1%	18.4%
No, and not considering it	28.9%	21.2%	37.0%	18.6%	18.0%	22.2%	38.2%
Not applicable for our board	9.9%	6.1%	10.1%	13.6%	12.0%	22.2%	18.4%
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	262	67	138	57	48%	9%	75
Yes	43.5%	50.7%	37.0%	50.9%	54.2%	33.3%	24.0%
No, but considering it and/or working on it	24.4%	25.4%	27.5%	15.8%	16.7%	11.1%	29.3%
No, and not considering it	19.5%	11.9%	24.6%	15.8%	14.6%	22.2%	26.7%
Not applicable for our board	12.6%	11.9%	10.9%	17.5%	14.6%	33.3%	20.0%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Please evaluate your board's overall performance in fulfilling its responsibility for its own performance and development.							
Total responding to this question	264	68	138	58	49	9	76
Excellent	30.3%	30.9%	26.8%	37.9%	34.7%	55.6%	21.1%
Very Good	34.5%	48.5%	30.4%	27.6%	30.6%	11.1%	27.6%
Good	25.4%	14.7%	29.7%	27.6%	28.6%	22.2%	36.8%
Fair	6.8%	4.4%	10.1%	1.7%	0.0%	11.1%	11.8%
Poor	3.0%	1.5%	2.9%	5.2%	6.1%	0.0%	2.6%
Management Oversight							
The board follows a formal, objective process for evaluating the CEO's performance.							
Total responding to this question	260	68	135	57	48	9	74
Yes	83.1%	92.6%	86.7%	63.2%	66.7%	44.4%	79.7%
No, but considering it and/or working on it	8.8%	5.9%	10.4%	8.8%	8.3%	11.1%	14.9%
No, and not considering it	1.9%	1.5%	2.2%	1.8%	2.1%	0.0%	2.7%
Not applicable for our board	6.2%	0.0%	0.7%	26.3%	22.9%	44.4%	2.7%
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	263	68	137	58	49	9	75
Yes	72.6%	86.8%	73.7%	53.4%	61.2%	11.1%	70.7%
No, but considering it and/or working on it	12.9%	5.9%	18.2%	8.6%	6.1%	22.2%	18.7%
No, and not considering it	6.5%	5.9%	6.6%	6.9%	8.2%	0.0%	8.0%
Not applicable for our board	8.0%	1.5%	1.5%	31.0%	24.5%	66.7%	2.7%
The board requires that the CEO's compensation package be based, in part, on the CEO's performance evaluation.							
Total responding to this question	261	67	136	58	49	9	74
Yes	79.7%	92.5%	83.1%	56.9%	65.3%	11.1%	81.1%
No, but considering it and/or working on it	5.7%	0.0%	8.8%	5.2%	6.1%	0.0%	9.5%
No, and not considering it	5.0%	4.5%	5.9%	3.4%	4.1%	0.0%	5.4%
Not applicable for our board	9.6%	3.0%	2.2%	34.5%	24.5%	88.9%	4.1%
The board seeks independent (i.e., 3rd party) expert advice/information on industry comparables before approving executive compensation.							
Total responding to this question	263	68	137	58	49	9	75
Yes	80.6%	91.2%	83.9%	60.3%	69.4%	11.1%	76.0%
No, but considering it and/or working on it	4.2%	1.5%	7.3%	0.0%	0.0%	0.0%	9.3%
No, and not considering it	4.2%	1.5%	5.1%	5.2%	6.1%	0.0%	8.0%
Not applicable for our board	11.0%	5.9%	3.6%	34.5%	24.5%	88.9%	6.7%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.							
Total responding to this question	262	67	137	58	49	9	75
Yes	81.3%	92.5%	83.9%	62.1%	71.4%	11.1%	81.3%
No, but considering it and/or working on it	5.7%	1.5%	9.5%	1.7%	2.0%	0.0%	9.3%
No, and not considering it	2.7%	1.5%	2.9%	3.4%	4.1%	0.0%	4.0%
Not applicable for our board	10.3%	4.5%	3.6%	32.8%	22.4%	88.9%	5.3%
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	263	68	137	58	49	9	75
Yes	80.6%	92.6%	83.9%	58.6%	63.3%	33.3%	78.7%
No, but considering it and/or working on it	8.7%	2.9%	10.9%	10.3%	12.2%	0.0%	13.3%
No, and not considering it	3.8%	1.5%	5.1%	3.4%	4.1%	0.0%	6.7%
Not applicable for our board	6.8%	2.9%	0.0%	27.6%	20.4%	66.7%	1.3%
The board maintains a written, current CEO and senior executive succession plan.							
Total responding to this question	260	67	135	58	49	9	74
Yes	43.8%	58.2%	43.0%	29.3%	32.7%	11.1%	33.8%
No, but considering it and/or working on it	34.2%	32.8%	38.5%	25.9%	30.6%	0.0%	43.2%
No, and not considering it	13.5%	4.5%	17.0%	15.5%	14.3%	22.2%	20.3%
Not applicable for our board	8.5%	4.5%	1.5%	29.3%	22.4%	66.7%	2.7%
The board convenes executive sessions periodically without the CEO in attendance.							
Total responding to this question	263	68	137	58	49	9	75
Yes	61.6%	72.1%	62.0%	48.3%	53.1%	22.2%	53.3%
No, but considering it and/or working on it	5.7%	4.4%	5.8%	6.9%	6.1%	11.1%	6.7%
No, and not considering it	23.2%	17.6%	26.3%	22.4%	22.4%	22.2%	33.3%
Not applicable for our board	9.5%	5.9%	5.8%	22.4%	18.4%	44.4%	6.7%
Please evaluate your board's overall performance in fulfilling its responsibility for management oversight.							
Total responding to this question	260	68	136	56	49	7	75
Excellent	49.6%	60.3%	45.6%	46.4%	49.0%	28.6%	40.0%
Very Good	32.7%	30.9%	35.3%	28.6%	28.6%	28.6%	30.7%
Good	15.8%	8.8%	16.9%	21.4%	18.4%	42.9%	24.0%
Fair	1.9%	0.0%	2.2%	3.6%	4.1%	0.0%	5.3%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
Community Benefit & Advocacy							
The board has adopted a policy or policies on community benefit that includes all of the following characteristics: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, and measurable goals for the organization.							
Total responding to this question	257	67	132	58	49	9	73
Yes	64.6%	74.6%	57.6%	69.0%	65.3%	88.9%	52.1%
No, but considering it and/or working on it	17.9%	13.4%	22.0%	13.8%	14.3%	11.1%	23.3%
No, and not considering it	11.3%	6.0%	17.4%	3.4%	4.1%	0.0%	21.9%
Not applicable for our board	6.2%	6.0%	3.0%	13.8%	16.3%	0.0%	2.7%
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	256	67	131	58	49	9	73
Yes	91.0%	97.0%	92.4%	81.0%	79.6%	88.9%	91.8%
No, but considering it and/or working on it	2.7%	0.0%	5.3%	0.0%	0.0%	0.0%	5.5%
No, and not considering it	0.8%	0.0%	1.5%	0.0%	0.0%	0.0%	1.4%
Not applicable for our board	5.5%	3.0%	0.8%	19.0%	20.4%	11.1%	1.4%
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	256	66	132	58	49	9	73
Yes	63.7%	72.7%	57.6%	67.2%	67.3%	66.7%	58.9%
No, but considering it and/or working on it	25.0%	19.7%	28.0%	24.1%	24.5%	22.2%	31.5%
No, and not considering it	5.9%	1.5%	9.8%	1.7%	2.0%	0.0%	5.5%
Not applicable for our board	5.5%	6.1%	4.5%	6.9%	6.1%	11.1%	4.1%
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	257	67	132	58	49	9	73
Yes	81.7%	91.0%	78.8%	77.6%	79.6%	66.7%	63.0%
No, but considering it and/or working on it	3.1%	1.5%	4.5%	1.7%	0.0%	11.1%	6.8%
No, and not considering it	1.2%	0.0%	2.3%	0.0%	0.0%	0.0%	1.4%
Not applicable for our board	14.0%	7.5%	14.4%	20.7%	20.4%	22.2%	28.8%
The board holds management accountable for implementing strategies to meet the needs of the community, as identified through the community health needs assessment.							
Total responding to this question	257	67	132	58	49	9	73
Yes	88.7%	85.1%	90.2%	89.7%	89.8%	88.9%	89.0%
No, but considering it and/or working on it	7.8%	10.4%	7.6%	5.2%	6.1%	0.0%	8.2%
No, and not considering it	1.2%	1.5%	1.5%	0.0%	0.0%	0.0%	1.4%
Not applicable for our board	2.3%	3.0%	0.8%	5.2%	4.1%	11.1%	1.4%

Total responding in each category	389	101	179	109	91	18	107
	Overall	Systems	Independent Hospitals	Subsidiary Hospitals *(All)*	Subsidiary Fiduciary Boards	Subsidiary Advisory Boards	Government-Sponsored Hospitals
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).							
Total responding to this question	255	66	131	58	49	9	72
Yes	82.4%	77.3%	80.9%	91.4%	95.9%	66.7%	81.9%
No, but considering it and/or working on it	8.6%	9.1%	10.7%	3.4%	4.1%	0.0%	12.5%
No, and not considering it	6.7%	9.1%	7.6%	1.7%	0.0%	11.1%	1.4%
Not applicable for our board	2.4%	4.5%	0.8%	3.4%	0.0%	22.2%	4.2%
The board has a written policy establishing the board's role in fund development and/or philanthropy.							
Total responding to this question	255	67	131	57	48	9	73
Yes	41.2%	37.3%	35.1%	59.6%	62.5%	44.4%	21.9%
No, but considering it and/or working on it	22.0%	23.9%	22.9%	17.5%	18.8%	11.1%	21.9%
No, and not considering it	23.9%	20.9%	32.1%	8.8%	10.4%	0.0%	37.0%
Not applicable for our board	12.9%	17.9%	9.9%	14.0%	8.3%	44.4%	19.2%
The board works closely with general counsel to assure all advocacy efforts are consistent with tax-exemption requirements.							
Total responding to this question	257	68	132	57	49	8	73
Yes	59.9%	64.7%	55.3%	64.9%	71.4%	25.0%	42.5%
No, but considering it and/or working on it	7.0%	5.9%	8.3%	5.3%	4.1%	12.5%	9.6%
No, and not considering it	11.3%	7.4%	17.4%	1.8%	2.0%	0.0%	19.2%
Not applicable for our board	21.8%	22.1%	18.9%	28.1%	22.4%	62.5%	28.8%
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	254	67	130	57	48	9	73
Yes	56.7%	53.7%	56.2%	61.4%	62.5%	55.6%	60.3%
No, but considering it and/or working on it	21.7%	19.4%	24.6%	17.5%	16.7%	22.2%	26.0%
No, and not considering it	16.1%	17.9%	16.9%	12.3%	14.6%	0.0%	13.7%
Not applicable for our board	5.5%	9.0%	2.3%	8.8%	6.3%	22.2%	0.0%
Please evaluate your board's overall performance in fulfilling its responsibility for community benefit and advocacy.							
Total responding to this question	258	66	134	58	49	9	75
Excellent	39.9%	43.9%	32.8%	51.7%	51.0%	55.6%	29.3%
Very Good	36.8%	34.8%	42.5%	25.9%	28.6%	11.1%	37.3%
Good	19.4%	21.2%	17.9%	20.7%	18.4%	33.3%	22.7%
Fair	3.1%	0.0%	5.2%	1.7%	2.0%	0.0%	8.0%
Poor	0.8%	0.0%	1.5%	0.0%	0.0%	0.0%	2.7%

Appendix 3. Adoption of Governance Practices: Comparison 2021 vs. 2019

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 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**	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
Duty of Care												
The board requires that new board members receive education on their fiduciary duties.	2.77	2.70	2.90	2.87	2.68	2.64	2.95	2.70	2.86	2.80	2.64	2.63
The board reviews and updates, as needed, policies that specify the board's major oversight responsibilities at least every two years.	2.75	2.73	2.71	2.78	2.76	2.71	2.88	2.77	2.71	2.67	2.74	2.72
Board members receive important background materials and well-developed agendas within sufficient time to prepare for meetings.	2.96	2.97	2.97	2.98	2.96	2.96	2.91	2.96	2.88	2.86	2.94	2.99
The board assesses its governance model including structure, policies, processes, and board expectations at least every three years.	2.70	2.60	2.79	2.65	2.65	2.60	2.65	2.50	2.57	2.00	2.61	2.59
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.	2.70	2.66	2.69	2.67	2.71	2.67	2.47	2.50	2.71	2.00	2.69	2.64
The board secures expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.).	2.84	2.87	2.83	2.87	2.84	2.87	2.78	2.86	2.80	2.50	2.81	2.77
The board requires management to provide the rationale for their recommendations, including options they considered.	2.96	2.94	3.00	3.00	2.95	2.93	2.94	2.88	2.88	2.88	2.96	2.91
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.	2.97	2.98	2.99	3.00	2.97	2.97	3.00	3.00	3.00	3.00	2.97	2.97
Board members complete a full conflict-of-interest disclosure statement annually.	2.96	2.95	2.99	3.00	2.93	2.93	3.00	3.00	3.00	3.00	2.91	2.91
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.	2.77	2.72	2.94	2.94	2.62	2.61	2.96	2.88	2.63	3.00	2.62	2.65
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.	2.69	2.75	2.72	2.78	2.59	2.70	3.00	3.00	3.00	3.00	2.58	2.69
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.	2.87	2.78	2.97	2.98	2.80	2.69	2.95	2.95	2.71	2.83	2.83	2.64

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

Governance Practices: Weighted Averages 3 = Practice is 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	
	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.	2.88	2.87	2.94	2.79	2.85	2.87	2.95	3.00	3.00	3.00	2.79	2.80
The board has a written policy outlining the organization's approach to physician competition/conflict of interest.	2.50	2.47	2.62	2.52	2.36	2.41	2.85	2.83	2.71	3.00	2.33	2.44
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.	2.80	2.67	2.86	2.60	2.73	2.68	2.87	2.70	3.00	3.00	2.72	2.64
The board reviews and ensures that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy.	2.94	2.89	3.00	3.00	2.90	2.86	2.90	2.86	3.00	2.50	2.79	2.78
Duty of Obedience												
The board adopts and periodically reviews the organization's written mission statement to ensure that it correctly articulates its fundamental purpose.	2.87	2.88	2.88	2.87	2.84	2.87	2.94	2.95	3.00	2.80	2.86	2.82
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.	2.93	2.95	2.96	2.96	2.90	2.95	2.94	2.92	3.00	3.00	2.89	2.93
The board establishes a risk profile for the organization and holds management accountable to performance consistent with that risk profile.	2.33	2.22	2.58	2.42	2.14	2.13	2.47	2.43	2.80	1.80	2.14	2.13
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.	2.84	2.87	2.87	2.92	2.79	2.86	3.00	2.78	3.00	2.40	2.73	2.92
The board annually reviews and approves an updated enterprise risk management assessment and improvement plan.	2.51	2.55	2.60	2.62	2.43	2.54	2.57	2.47	2.50	2.50	2.42	2.61
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.	2.59	2.58	2.72	2.82	2.51	2.52	2.57	2.47	2.75	3.00	2.47	2.49
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	2.85	2.90	2.90	2.81	2.85	3.00	2.70	3.00	2.33	2.86	2.83
The board has approved a "code of conduct" policies/procedures document that provides ethical requirements for board members, employees, and practicing physicians.	2.85	2.89	2.84	2.92	2.87	2.88	3.00	2.86	2.71	3.00	2.88	2.88
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.	2.59	2.56	2.77	2.76	2.48	2.50	2.50	2.43	3.00	2.33	2.28	2.26

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

Governance Practices: Weighted Averages 3 = Practice is 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	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
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.	2.76	2.75	2.91	2.88	2.66	2.72	3.00	2.63	2.67	3.00	2.52	2.64
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.).	2.91	2.89	2.99	3.00	2.86	2.85	2.92	2.90	3.00	3.00	2.83	2.82
The board has established a direct reporting relationship with legal counsel.	2.54	2.55	2.48	2.73	2.51	2.48	2.86	2.63	3.00	3.00	2.60	2.55
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	2.84	2.88	2.77	2.79	2.86	2.79	2.75	3.00	2.76	2.79
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.	2.88	2.90	2.92	3.00	2.86	2.88	3.00	2.76	3.00	2.50	2.83	2.90
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.	2.48	2.44	2.71	2.84	2.33	2.28	2.89	2.62	3.00	1.00	2.23	2.32
Board members responsible for audit oversight meet with external auditors, without management, at least annually.	2.77	2.66	2.76	2.94	2.73	2.58	3.00	2.55	3.00	1.00	2.63	2.51
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.	2.87	2.90	2.96	2.94	2.80	2.88	3.00	3.00	2.88	3.00	2.71	2.89
The board requires all hospital clinical programs or services to meet quality-related performance criteria.	2.77	2.82	2.77	2.73	2.72	2.83	3.00	2.96	2.88	3.00	2.80	2.84
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.	2.73	2.79	2.73	2.80	2.70	2.78	3.00	2.83	2.88	2.86	2.76	2.77
The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.	2.79	2.70	2.96	2.78	2.69	2.67	2.93	2.75	2.86	2.83	2.60	2.65

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

Governance Practices: Weighted Averages 3 = Practice is 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	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
The board devotes a significant amount of time on its board meeting agenda to quality issues/ discussion (at most board meetings).	2.75	2.80	2.77	2.84	2.69	2.77	2.95	2.96	2.88	3.00	2.73	2.75
The board has a standing quality committee.	2.72	2.63	2.86	2.80	2.60	2.55	2.87	2.77	3.00	2.40	2.57	2.56
The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.	2.71	2.65	2.81	2.74	2.63	2.61	2.81	2.74	3.00	2.71	2.65	2.58
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	2.84	2.94	2.89	2.78	2.83	2.95	2.86	3.00	2.60	2.71	2.83
The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.	2.89	2.82	2.90	2.92	2.85	2.81	3.00	2.74	3.00	2.80	2.84	2.82
The board allocates sufficient resources to developing physician leaders and assessing their performance.	2.53	2.39	2.64	2.62	2.43	2.30	2.82	2.59	2.83	2.00	2.39	2.29
The board ensures consistency in quality reporting, standards, policies, and interventions such as corrective action with practitioners across the entire organization.	2.86	2.79	2.92	2.93	2.83	2.74	3.00	2.83	2.83	2.80	2.82	2.78
Financial Oversight												
The board is sufficiently informed and discusses the multi-year strategic/financial plan before approving it.	2.94	2.94	2.99	2.96	2.91	2.93	3.00	3.00	2.67	3.00	2.91	2.92
The board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it.	2.98	2.99	3.00	3.00	2.97	2.99	3.00	3.00	2.67	3.00	2.99	2.98
The board annually reviews and approves the investment policy.	2.78	2.81	2.94	2.96	2.68	2.75	2.75	2.92	3.00	3.00	2.57	2.76
The board reviews financial feasibility of projects before approving them.	3.00	2.98	3.00	3.00	3.00	2.98	3.00	3.00	2.75	3.00	3.00	2.96
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.	2.91	2.90	2.96	2.94	2.86	2.88	3.00	3.00	2.80	3.00	2.83	2.87
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.	2.64	2.63	2.61	2.67	2.60	2.60	3.00	2.83	3.00	3.00	2.60	2.60

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

Governance Practices: Weighted Averages 3 = Practice is 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	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
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	2.99	2.94	2.89	2.90	2.86	2.90	2.88	2.80	2.88	2.87
The board ensures that a strategy is in place for aligning the clinical and economic goals of the hospital(s) and physicians.	2.81	2.87	2.84	2.90	2.83	2.85	2.79	2.95	2.88	3.00	2.87	2.84
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.	2.85	2.87	2.91	2.96	2.81	2.85	2.92	2.81	2.88	3.00	2.81	2.83
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.	2.87	2.90	2.97	2.94	2.84	2.87	2.86	2.96	2.86	3.00	2.81	2.83
The board incorporates the perspectives of all key stakeholders when setting strategic direction for the organization (i.e., patients, physicians, employees, and the community).	2.88	2.87	2.89	2.85	2.87	2.87	3.00	2.91	2.86	3.00	2.85	2.80
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.	2.88	2.84	2.96	2.83	2.86	2.82	2.92	3.00	2.86	3.00	2.85	2.82
The board spends more than half of its meeting time during most board meetings discussing strategic issues as opposed to hearing reports.	2.27	2.25	2.48	2.56	2.16	2.17	2.19	2.16	2.29	1.86	2.11	2.09
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).	2.49	2.40	2.53	2.46	2.46	2.37	2.69	2.52	2.50	2.00	2.36	2.34
The board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability.	2.50	2.38	2.59	2.39	2.43	2.39	2.85	2.32	2.57	2.20	2.38	2.37
The board works with management to gain awareness of, and prepare to respond to, matters of business disruption.	2.80	2.76	2.83	2.84	2.76	2.73	2.88	2.83	2.75	3.00	2.74	2.76

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

Governance Practices: Weighted Averages 3 = Practice is 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	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
Board Development												
The board sets annual goals for board and committee performance that support the organization's strategic plan/direction.	2.35	2.13	2.32	2.18	2.28	2.07	2.73	2.43	2.63	2.00	2.27	2.11
The board uses the results from a formal self-assessment process to establish board performance improvement goals at least every two years.	2.51	2.44	2.65	2.60	2.41	2.36	2.64	2.57	2.57	2.33	2.28	2.35
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.	2.46	2.30	2.56	2.41	2.38	2.23	2.57	2.59	2.43	2.00	2.38	2.29
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.	2.85	2.81	2.96	2.94	2.78	2.76	2.95	2.87	2.86	2.60	2.74	2.68
The board has a "mentoring" program for new board members.	2.13	2.04	2.28	2.14	2.06	1.99	2.05	2.18	2.57	1.67	1.92	1.95
Board members participate at least annually in education regarding its responsibilities to fulfill the organization's mission, vision, and strategic goals.	2.75	2.60	2.79	2.77	2.74	2.54	2.76	2.65	2.75	2.50	2.70	2.60
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.	2.35	2.31	2.42	2.34	2.26	2.27	2.41	2.54	2.71	2.17	2.24	2.36
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).	2.79	2.69	2.77	2.88	2.76	2.60	2.94	2.74	3.00	2.67	2.69	2.45
The board enforces a policy on board member term limits and retirement age.	2.35	2.53	2.49	2.70	2.21	2.45	2.68	2.64	2.17	2.50	1.90	2.17
The board enforces minimum meeting preparation and attendance requirements.	2.61	2.54	2.63	2.54	2.60	2.55	2.82	2.48	2.43	2.50	2.50	2.55
The board uses a formal process to evaluate the performance of individual board members.	1.98	1.89	1.98	2.06	1.91	1.83	2.35	1.95	2.29	1.50	1.76	1.90
The board uses agreed-upon performance requirements for board member and officer reappointment.	2.11	2.00	2.29	2.19	1.93	1.91	2.47	2.14	2.29	1.50	1.84	1.94
The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.	2.28	2.24	2.44	2.48	2.14	2.12	2.53	2.45	2.17	2.00	1.97	2.05

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

Governance Practices: Weighted Averages 3 = Practice is 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	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
Management Oversight												
The board follows a formal, objective process for evaluating the CEO's performance.	2.86	2.83	2.91	2.92	2.85	2.80	3.00	2.86	2.80	3.00	2.79	2.80
The board and CEO mutually agree on the CEO's written performance goals prior to the evaluation (in the first quarter of the year).	2.72	2.67	2.82	2.76	2.68	2.63	2.80	2.74	2.33	2.75	2.64	2.69
The board requires that the CEO's compensation package is based, in part, on the CEO performance evaluation.	2.83	2.78	2.91	2.88	2.79	2.75	2.82	2.71	3.00	3.00	2.79	2.74
The board seeks independent (i.e., third-party) expert advice/information on industry comparables before approving executive compensation.	2.86	2.74	2.95	2.96	2.82	2.68	2.82	2.75	3.00	3.00	2.73	2.59
The board reviews and approves all elements of executive compensation to ensure compliance with statutory/regulatory requirements.	2.88	2.84	2.95	2.96	2.84	2.81	3.00	2.75	3.00	3.00	2.82	2.76
The board recognizes that CEO (and other senior executive) succession and search planning is a critical responsibility of the board.	2.82	2.79	2.94	2.94	2.79	2.76	2.73	2.71	3.00	2.67	2.73	2.68
The board maintains a written, current CEO and senior executive succession plan.	2.33	2.28	2.56	2.58	2.26	2.18	2.45	2.25	1.67	1.67	2.14	2.19
The board convenes executive sessions periodically without the CEO in attendance.	2.42	2.37	2.58	2.59	2.38	2.30	2.38	2.33	2.00	1.40	2.21	2.22
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.	2.57	2.43	2.73	2.70	2.41	2.35	3.00	2.47	2.88	2.60	2.31	2.35
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.	2.95	2.92	3.00	3.00	2.92	2.90	3.00	2.90	3.00	2.33	2.92	2.89
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.	2.61	2.43	2.76	2.55	2.50	2.39	2.68	2.50	2.71	1.50	2.56	2.35
The board provides oversight with respect to organizational compliance with IRS tax-exemption requirements concerning community benefit and related requirements.	2.94	2.91	2.98	3.00	2.89	2.88	3.00	2.89	2.83	3.00	2.87	2.83

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

Governance Practices: Weighted Averages 3 = Practice is 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**	
	2021	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019	**2021**	2019
The board holds management accountable for implementing strategies to meet the needs of the community, as identified through the community health needs assessment.	2.90	2.87	2.86	2.89	2.89	2.86	3.00	2.95	3.00	3.00	2.89	2.83
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).	2.78	2.82	2.71	2.85	2.74	2.79	3.00	2.95	2.71	3.00	2.84	2.83
The board has a written policy establishing the board's role in fund development and/or philanthropy.	2.20	2.13	2.20	2.15	2.03	2.12	2.78	2.19	2.80	2.25	1.81	2.04
The board works closely with general counsel to ensure all advocacy efforts are consistent with tax-exemption requirements.	2.62	2.54	2.74	2.67	2.47	2.47	2.92	2.71	2.67	3.00	2.33	2.45
The board has adopted a policy regarding information transparency, explaining to the public in understandable terms its performance on measures of quality, safety, pricing, customer service, and community benefit.	2.43	2.31	2.39	2.30	2.40	2.30	2.39	2.40	2.67	2.00	2.47	2.31