Think Bold:

Looking Forward With a Fresh Governance Mindset

THE GOVERNANCE INSTITUTE'S **2023 BIENNIAL SURVEY**
OF HOSPITALS AND HEALTHCARE SYSTEMS

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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.

John D. Fink, Partner, ECG Management Consultants, has spent more than 25 years developing thoughtful solutions to create opportunities and solve problems for healthcare provider organizations. His clients include national and regional health systems, academic medical centers, and community hospitals. The diversity of John's experience helps him see the big picture and perspectives of the many stakeholders involved in the projects he is asked to guide. His base is finance and business planning, and he has led large performance improvement initiatives with strategic, operational, and IT components. The majority of his engagements involve collaboration among provider organizations, often resulting in transactions, joint ventures (JVs), or other mutually beneficial financial arrangements. Over the past several years, John has focused on using his broad experience to help his clients chart the best path to enhance their strategic position, achieve organizational growth, and optimize financial performance. Engagements he personally leads include strategic and financial planning and implementation assistance related to provider collaboration, physician network development, clinical service lines, and ambulatory surgery.

Richard J. "Rick" Gilfillan, M.D., a family physician, is an independent consultant and volunteer working with nonprofit organizations seeking to create accountable, high-value healthcare. Previously he was the CEO of Trinity Health, a $19 billion Catholic health system that serves communities in 22 states, from 2013 to 2019.

For more than 30 years, Dr. Gilfillan has built successful organizations in the for-profit and not-for-profit sectors to deliver better outcomes for people and communities. As the first director of the Center for Medicare and Medicaid Innovation (CMMI), he launched the Center in 2010 and worked quickly with payers and providers to develop innovative models for improving patient care and reducing costs. Prior to his appointment at CMMI, Dr. Gilfillan was President and CEO of Geisinger Health Plan and Executive Vice President of Insurance Operations for Geisinger Health System. He has also served as the Senior Vice President for National Network Management at Coventry Health Care and as the Chief Medical Officer for Independence Blue Cross.

Michael D. Pugh, President, MdP Associates, LLC, leads the advisory and consulting practice for his firm. He has over 30 years of CEO experience in hospitals, healthcare systems, managed care organizations, consulting, and healthcare technology companies and is an internationally known advisor and consultant.

Since 1998, Michael has focused his advisory and consulting practice on helping senior leaders define and execute strategies for improvement and organizational transformation. He works with healthcare delivery organizations, government, and health insurance providers in the U.S. and internationally on business strategy and organizational transformation that results in the reduction of patient harm, improved clinical outcomes, and reduced cost. Michael is an Adjunct Professor at the University of Colorado Denver Business School Health Administration Program, where he teaches Quality and Healthcare Outcomes in the graduate Health Administration Program. He is also an Instructor in the Mt. Sinai Medical School Health Care Leadership Program, where he teaches Strategy for Health Care Delivery Organizations, as well as Leadership and Quality. He is a faculty member of The Governance Institute, a senior faculty member for the Institute for Healthcare Improvement (IHI), and currently serves as the Vice Chair of the IHI Leadership Faculty.

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.

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The Governance Institute Member Editorial Board

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

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About the Authors

Kathryn C. Peisert, Editor in Chief & Senior Director 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* (ed. Nash, Joshi, Ransom, and Ransom; 2019 and 2023). She was also a contributor to *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.

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Table of Contents

Executive Summary

The 2021 survey results showed early indications of the impacts of the coronavirus pandemic on governance focus (activities, time spent, culture)—however, we believe the 2023 results provide a much starker picture of the critical governance functions that were put on hold to deal with the pandemic, and thus a heightened urgency to revisit and accelerate these areas to move organizations in new and important directions.

Key Findings

- **Fewer physicians on the board:** The average number of physicians on the board has declined overall since 2017. We are still looking for more nurse representation on the board as well. ***Our correlation analysis shows a significant positive improvement in board culture as the number of physicians on the board goes up.***

- **Compensation remains low:** Board member compensation remains low overall at around 10%; the amount of compensation remains primarily at $5,000 or less. ***Our analysis does not yet show any relationship between compensating board members and board performance.***

- **"Outside" board members are not yet trending:** It has been assumed (anecdotally) that due to the pandemic and overall talent shortages, more boards are recruiting board members from outside their organization's region or service area to find the right skillsets, competencies, and diversity aspects. However, that assumption is not showing in the data. On average, boards have 0.7 members from outside their service area. Health systems, not surprisingly, have the highest average at 1.3, with independent hospitals averaging 0.4, subsidiaries at 0.6, and government-sponsored hospitals at 0.2. This remains the same or, in some cases slightly lower, than in 2021.

Diversity Efforts Are Beginning to Show

- Most boards (97%) have at least one female board member, and this year we saw the most significant jump in boards that have six or more women (22% compared with 15% in 2021). Fifty-three percent (53%) have between two and four.

- While only 63% have ethnic minorities represented on the board, this number is up significantly from 49% in 2019 and 52% in 2017. This year we saw increases in the percentages of boards having two, three, four, five, and six or more minority board members. While overall these percentages remain small compared to the total, this represents significant and continued movement in the right direction.

Board Meeting Time Matters

- For several years including this year, there is a statistically significant correlation between the use of a consent agenda and boards that spend 40% or more of their board meeting in active discussion, deliberation, and debate about the strategic priorities of the organization. ***In other words, the use of a consent agenda helps to enable boards to spend more time in active discussion.***

- We also see a positive relationship between the amount of ***time spent during board meetings on board member education and the likelihood to report "excellent" performance.***

System/Subsidiary Board Roles Are Getting Clearer

The following responsibilities are showing a distinct movement away from local responsibility and towards system-level responsibility over several years:

- Setting strategic goals for local hospital boards

- Setting quality/safety and customer service goals for local hospital boards

- Appointing/removing local chief executives

- Approving local hospital audits

- Identifying local community health needs through the CHNA and setting community health goals

- Addressing SDOH for local communities

The set of 20 advisory boards responding to this year's report show a much more distinct understanding of their responsibilities (e.g., primarily to advise/make recommendations to the system board).

Governance Practices: Performance Is Suffering

- While financial oversight continues to rank first in performance, quality oversight and setting strategic direction hover well below where they should be, ranked sixth and seventh out of nine categories.

- Overall performance scores are lower this year for *all* fiduciary duties and core responsibilities. This is not surprising given the substantial headwinds hospitals and health systems have endured the last few years.

- Community benefit and advocacy is still low in both performance and adoption scores, even with the knowledge across the industry tying factors outside the hospital setting (housing, finances, food insecurity, employment, etc.) to patients'

health outcomes and increasing total cost of care. ***Some organizations may have retreated from these efforts when other major challenges (e.g., pandemic, financial, and workforce) took center stage.***

Opportunities

Boards have work to do and significant challenges to tackle. However, we see plenty of opportunities for boards to take bolder steps to accelerate innovation and transformation:

- **Add clinicians to the board.** All types of boards maintain a sizeable majority of independent board members, which is recommended by the IRS and other regulatory agencies. *This means there is plenty of room to add clinicians—physicians AND nurses—who may not be independent, without disrupting this majority.*

- **Discuss and debate!** Boards continue to devote more than half of their meeting time (57% on average) to passively listening to reports from management and board committees. *There is ripe opportunity for boards to revamp their meeting agendas, reset expectations for shorter management and committee reports along with pre-meeting preparation, maximize use of the consent agenda, and carve out more time to devote to active discussion, deliberation, and debate about the organization's strategic priorities. This is the most significant way boards can improve their organization's performance and make meeting time most impactful.*

- **Innovate.** This year we see a significant decrease in board and senior leadership activity related to population health, SDOH, and value-based care. *Outside, for-profit disruptors are quickly taking away the profitable service lines from mission-driven hospitals and health systems. Reopen the value discussions with your senior leaders and take a critical look at what was put on pause during COVID. Now is the time to accelerate care delivery transformation, bring in partners with complementary expertise, and push payers to collaborate on payment models that truly work.*

- **Clarify system governance structure.** Again this year, 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 to cite excellent performance than those needing to improve in this area. *Systems: make sure your authority matrix is clear and acceptance of responsibility at every level of governance is wide and deep.*

- **Improve risk management.** We hope to see more boards establish a risk profile and hold management accountable to that. *It is now critical for leadership to predict, identify, and monitor risks and ensure responses are aligned and coordinated.*

- **Secure visionary talent in the most important place**. While management oversight scores improved in 2021, this year they dipped back down. The least-observed practice continues to be maintaining a written, current CEO and senior executive succession plan. *We consider this a strategic imperative—no board can afford to not be fully prepared for the departure of their chief executive and other critical members of the leadership team. Having talented, visionary leadership is a must to successfully move the organization forward.*

Discussion Questions for Executives and Board Members

- What new expertise and diverse perspectives could help our board have more generative discussions and fulfill our organization's vision and strategy? Have we considered adding more physicians, nurses, women, and people from ethnic minorities to the board? Do we need to deploy different recruiting strategies than those that have been used in the past to find these board members?

- How are board meetings currently structured? What can we do differently to better prepare for meetings, make them more impactful, and increase time spent actively discussing, deliberating, and debating about the strategic priorities of the organization?

- What important organizational and governance initiatives and improvement goals were paused due to COVID and its pursuing challenges? For example, do we need to revisit plans related to population health, SDOH, and value-based care? Are we assessing board performance to ensure the board is adopting best practices and has the tools and know-how to accelerate innovation and transformation?

- Do we have a robust CEO and senior executive succession plan? Does the board regularly review and update this plan and ensure that we have the visionary talent needed to move our organization in the right direction?

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 2023 survey continued our longitudinal assessment of board structure, culture, and practices—essentially, who makes up the board and how they conduct their work. 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.

We continue to look at non-fiduciary (e.g., "advisory") boards at subsidiary hospitals separately 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 since we began separating out those two types of boards in 2019.

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

The appendices (which are all online this year) show all 2023 results by frequency (percentages) and by organization type, AHA designation, and bed size (available at www.governanceinstitute.com/2023biennialsurvey). This Web page also has interactive data highlights so that users can see high-level analysis at a glance as well as dive further into specific areas of interest.

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

Who Responded?

All U.S. not-for-profit acute care hospitals and health systems, including government-sponsored organizations (but not federal, state, and public health hospitals), received the survey—a total of 4,764. We received 370 responses (8%). Based on the number of hospital facilities owned by the health system respondents this year (1,450), the 370 respondents represent a total of 1,798 hospitals, or 38% 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

	2023		2021		2019		2017	
	Respondents	Population	Respondents	Population	Respondents	Population	Respondents	Population
Organization	**N = 370**	**N = 4,764**	**N = 389**	**N = 4,766**	**N = 244**	**N = 4,830***	**N = 465**	**N = 4,418**
Religious (29)	8%	15%	11%	15%	6%	15%	14%	13%
Secular:								
Government (113)	31%	22%	28%	23%	36%	22%	23%	23%
Non-Government (271)	73%	63%	62%	62%	57%	62%	77%	64%
Number of Beds								
< 100 (194)	52%	55%	49%	55%	40%	56%	52%	56%
100–299 (66)	18%	23%	22%	24%	18%	24%	24%	24%
300+ (110)	30%	22%	29%	21%	22%	20%	24%	20%
System Affiliation (199)	54%	64%	54%	60%	32%	58%	32%	51%

* 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 use 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 3,922 non-profit, acute care hospitals (government and non-government) in 2023.

Comparison of Respondents 2023 vs. 2021

Forty-one percent (41%) of the respondents in 2023 also responded to the survey in 2021.

Table 2. 2023 vs. 2021 Respondents

	Number of Respondents in 2023	Number of Respondents in 2021	Number of Respondents Who Completed the Survey in both 2023 and 2021
Systems	112	101	55
Independent Hospitals	171	179	66
Subsidiary Hospitals	87	109	30
Government-Sponsored Hospitals	113	107	47
Total	370	389	151

Governance Structure

Board Size & Composition

Summary of Findings

- Average board size: 13.6
- Median board size: 12
- Voting board members:
  - Medical staff physicians (not including CMO): average is 1.8; median is 0
  - "Outside" physicians: average is 0.4; median is 0
  - Staff nurses (not including CNO): average is 0.1; median is 0
  - "Outside" nurses: average is 0.1; median is 0.
  - Management (including CMO and CNO): average is 0.4; median is 0
  - Independent board members: average is 10.2; median is 9
  - Female board members: average is 4.0; median is 4
  - Ethnic minority board members: average is 1.9 (up from 1.2 in 2019); median is 1
  - Average number of voting board members from outside the community or region the board/organization serves: 0.7
- Term limits: 66% of boards limit the number of consecutive terms (rising steadily since 2011); median maximum number of terms remains constant at 3.
- Board member age limits: 6% of boards have age limits; average age limit is 66; median is 75.
- Average board member age: 58 (about the same as in 2021); median remains at 60.

Average board size is slightly higher than in 2021 for systems (16.8, up from 15.3). Other types of boards remain the same average size. As with previous surveys, board size generally increases with organization size for all organization types.

It is assumed (anecdotally) that due to the pandemic and overall talent shortages, more boards are recruiting board

Table 3. 2023 and 2021 Board Composition

All Respondents	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Average # of Voting Board Members	13.6	12.9	0.4	0.8	1.8	1.7	10.2	9.7	1.2	0.7
Median # of Board Members	12	13	0	0	0	0	9	9	0	0

Table 4. System Board Composition

Systems	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Average # of Voting Board Members	16.8	15.3	0.5	0.8	2.3	2.2	12.5	11.0	1.5	1.2
Median # of Board Members	16	15	1	1	2	2	12	11	0	0

Table 5. Independent Hospital Board Composition

Independent Hospitals	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Average # of Voting Board Members	11.3	11.2	0.3	0.6	1.4	1.2	8.8	9.1	0.8	0.3
Median # of Board Members	10	10	0	0	0	0	8	8	0	0

Table 6. Subsidiary Hospital Board Composition

Subsidiary Hospitals	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Average # of Voting Board Members	14.0	13.8	0.6	1.1	2.0	2.1	9.6	9.4	1.9	1.1
Median # of Board Members	12	14	1	1	1	2	8	9	0	0

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

members from outside their organization's region or service area in order to find the right skillsets, competencies, and diversity aspects. However, that assumption is not showing strong in the data as of yet. On average, boards have 0.7 members from outside their service area. Health systems, not surprisingly, have the highest average at 1.3, with independent hospitals averaging 0.4, subsidiaries at 0.6, and government-sponsored hospitals at 0.2. This remains the same or, in some cases slightly lower, than in 2021.

The average number of physicians on the board has declined overall since 2017 (system and subsidiary boards tend to have the most physician representation). On the flip side, while overall numbers are still very low, there has been a significant increase in the average number of nurses on the board since 2017, such that overall clinician representation in governance has remained mostly stable. (Both of these categories remain lower than we recommend; more details can be found in the respective sections below.)

While independent board members relative to board size was down in 2021, those percentages have gone back up to 2019 levels this year. All types of boards maintain a sizeable majority of independent board members, which is recommended by the IRS and other regulatory agencies. (This also means there is more room to add clinicians who may not be independent, without disrupting this majority.)

When broken down by organization type, independent board members as a *percentage of total board members* is as follows:

- All respondents: 77%
- Systems: 77%
- Independent hospitals: 80%
- Subsidiary hospitals: 73%
- Government-sponsored hospitals: 88%

Table 7. Government-Sponsored Hospital Board Composition

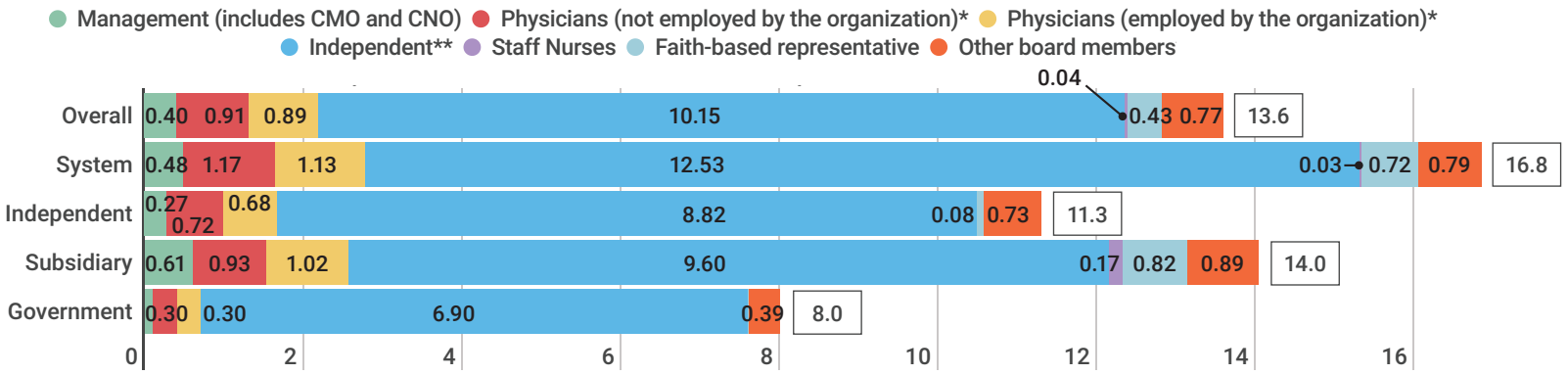
Government-Sponsored Hospitals	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Average # of Voting Board Members	8.0	8.3	0.1	0.5	0.6	0.8	6.9	6.9	0.4	0.2
Median # of Voting Board Members	7	7	0	0	0	0	7	7	0	0

Largest Boards

- Church systems: 17.7 board members (down from 20.3 in 2021)
- Organizations with more than 2,000 beds: 22.2 (up from 17.9)
- Organizations with 500–999 beds: 17.7 (about the same as in 2021)

See **Exhibit 1** for a breakdown of board members overall and by organization type for 2023.

Exhibit 1. Average Number of Board Members



* On the organization's medical staff.

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

Physicians on the Board

Respondents noted physician board membership in the following categories:

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

The total average number of physicians on the board (all types of physicians including the CMO and "outside" physicians) is 2.4. There has been a general downward trend of the number of physicians on the board; the highest average in the past 10 years was in 2017 at 2.9. Health system boards continue to have the most physician representation with an average of 3.0, although this is down from a peak of 4.4 in 2017. Government-sponsored hospital boards continue to have the lowest average of 0.9. **Table 8** shows overall physician representation on the board since 2019.

Table 8. Physicians on the Board Since 2019

	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")		
	2023	2021	2019	2023	2021	2019	2023	2021	2019
Average	0.9	0.9	0.7	1.1	0.9	0.6	0.4	0.4	0.4

Nurses on the Board

For 8.2% of respondents with a CNO, the CNO is a voting or non-voting board member. Five percent (5%) of respondents have a staff nurse aside from the CNO who is a voting board member, which is up from 3.5% in 2021. Thirty-two percent (32%) have at least one nurse from outside the organization in a voting board position. For 75% of respondents, the CNO is a non-board member but regularly attends meetings.

However, the total average number of nurses on the board is only 0.5 (subsidiary boards get credit for the most nurses, at an average of 0.7). Overall, this number declined slightly since 2021, which is the opposite of our recommendation, considering the key role nurses play in patient quality of care, experience, and customer loyalty. Promisingly, 24% of boards without nurses have plans to add one in the future. Longitudinal data show a significant uptick in nurse representation on boards starting in 2019, but in actual numbers, boards went from zero nurse representation to about half of one board seat in that time. Needless to say, there is still a long way to go. (See **Exhibit 2**.) (See **Appendix 1** for more detail by organization type and size.)

Females & Ethnic Minorities on the Board

Most boards (97%) have at least one female board member, and this year we saw the most significant jump in boards that have six or more women (22% compared with 15% in 2021). Fifty-three percent (53%) have between two and four.

While only 63% have ethnic minorities represented on the board, this number is up significantly from 49% in 2019 and 52% in 2017 (see **Exhibits 3** and **4**). This year we saw increases in the percentages of boards having two, three, four, five, and six or more minority board members. While overall these percentages remain small compared to the total, this represents significant and continued movement in the right direction, showing that diversity efforts at the board level are starting to pay off.

Exhibit 2. Average Number of Nurses on the Board Since 2015

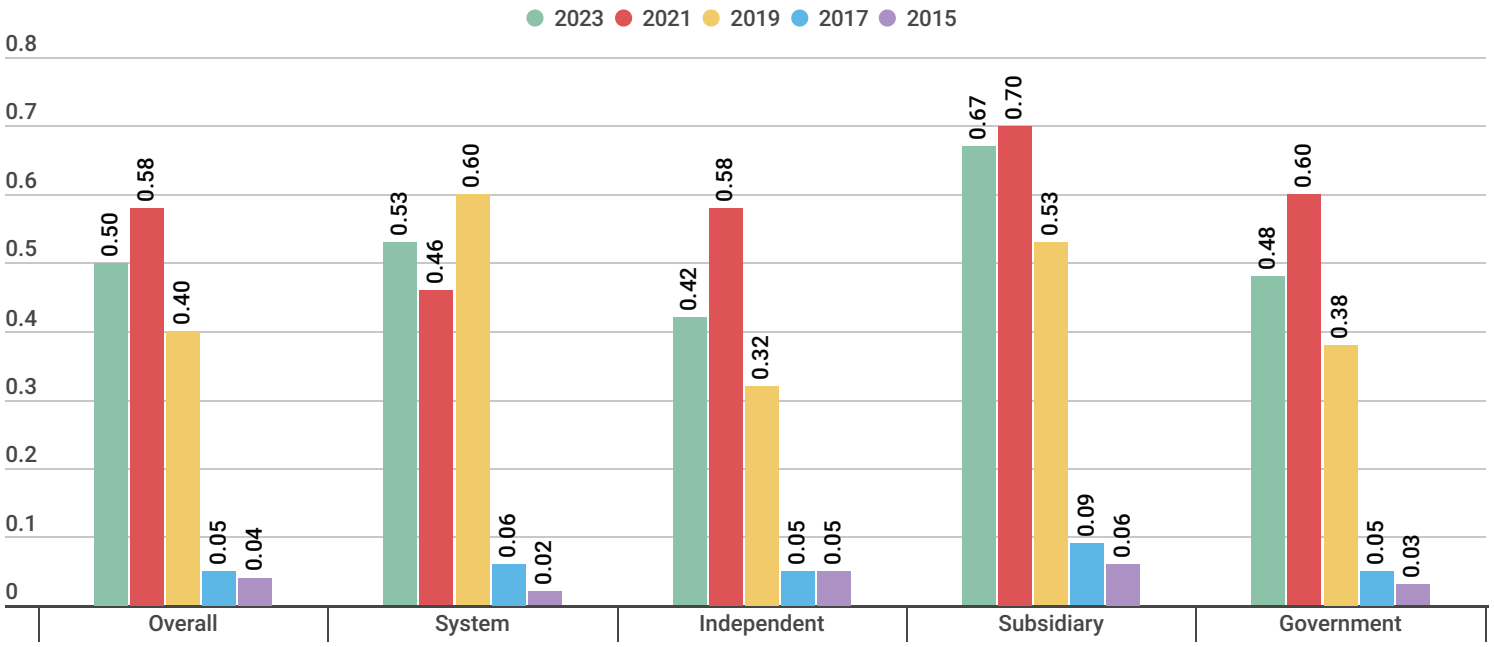


Exhibit 3. Female Board Members

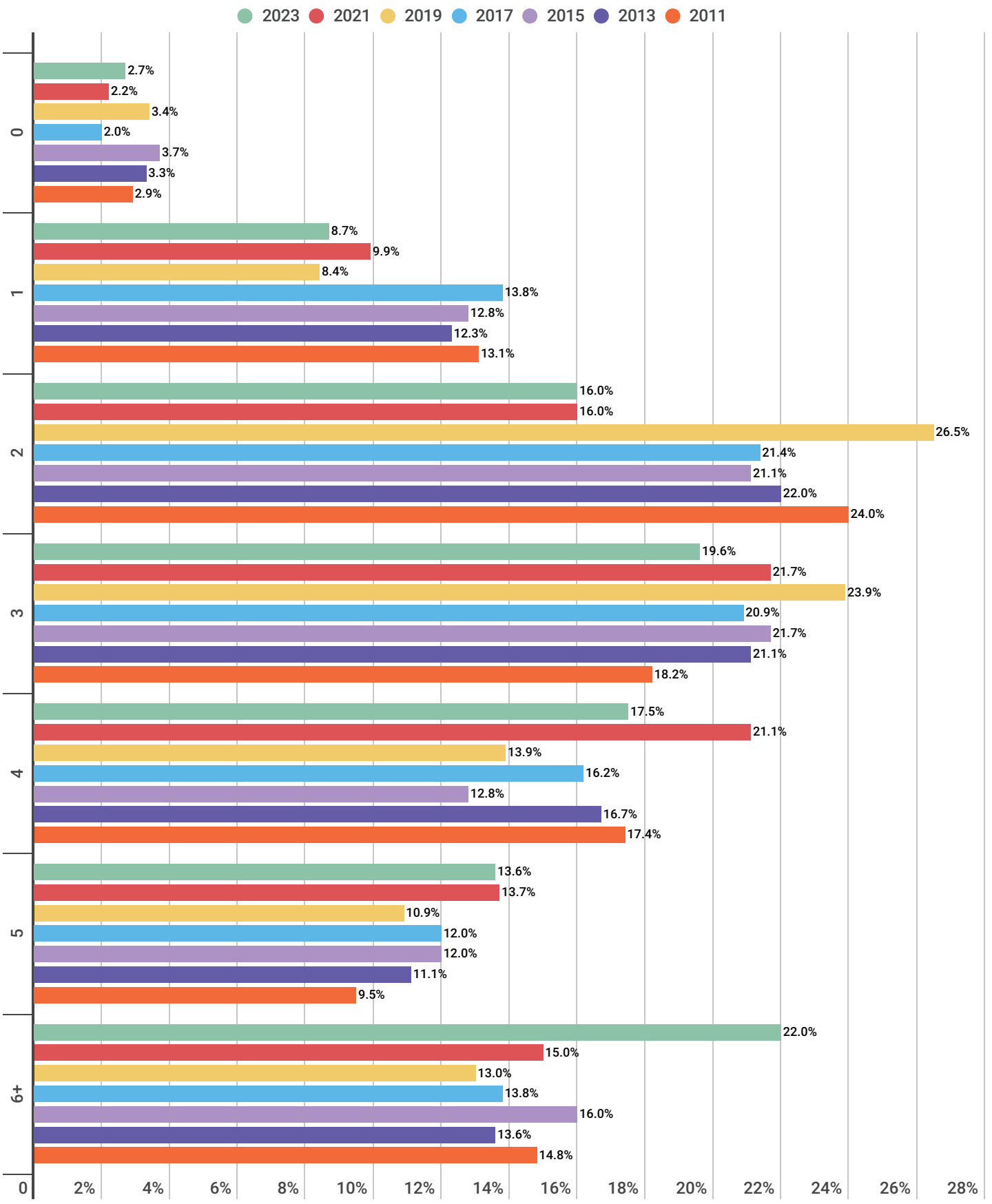


Exhibit 4. Ethnic Minority Board Members

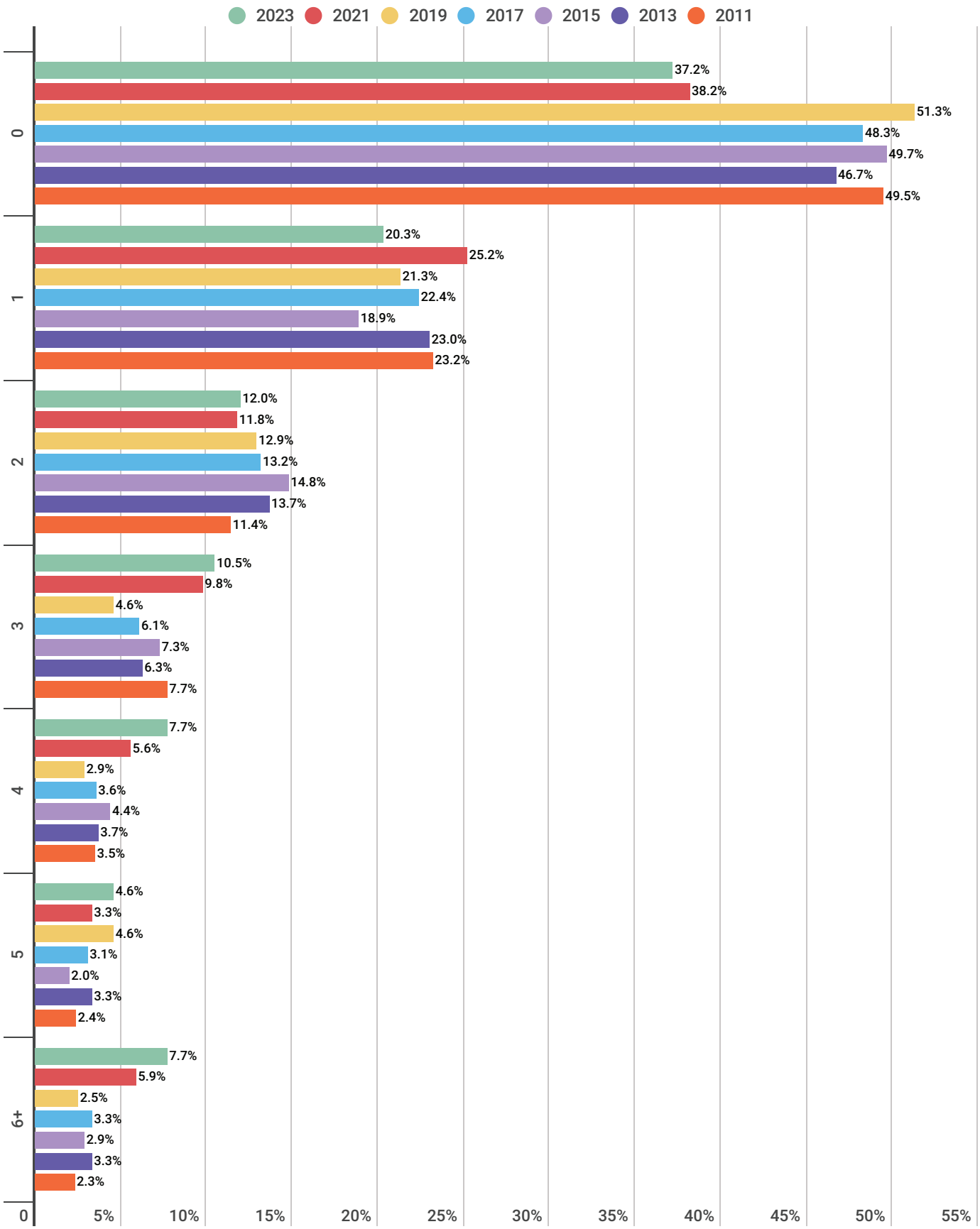


Exhibit 5. Board Diversity of the Largest Boards Since 2015 *(by percentage of total board members)*

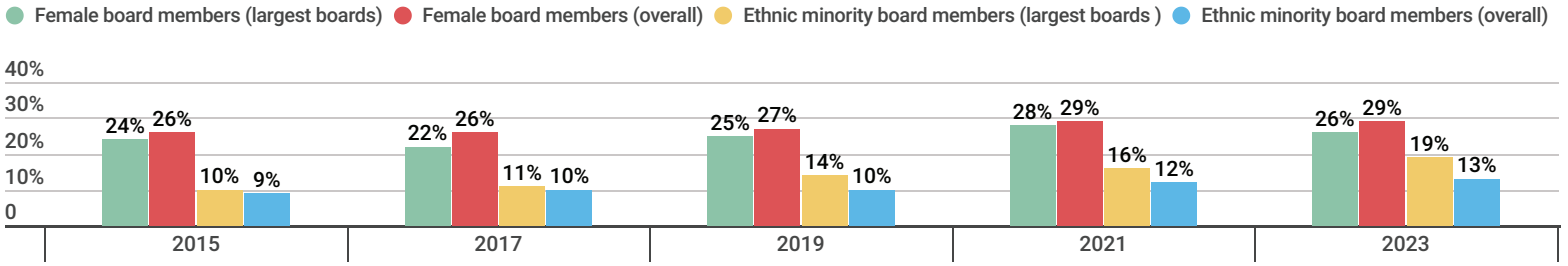


Exhibit 6. Background of the Organization's Chief Executive

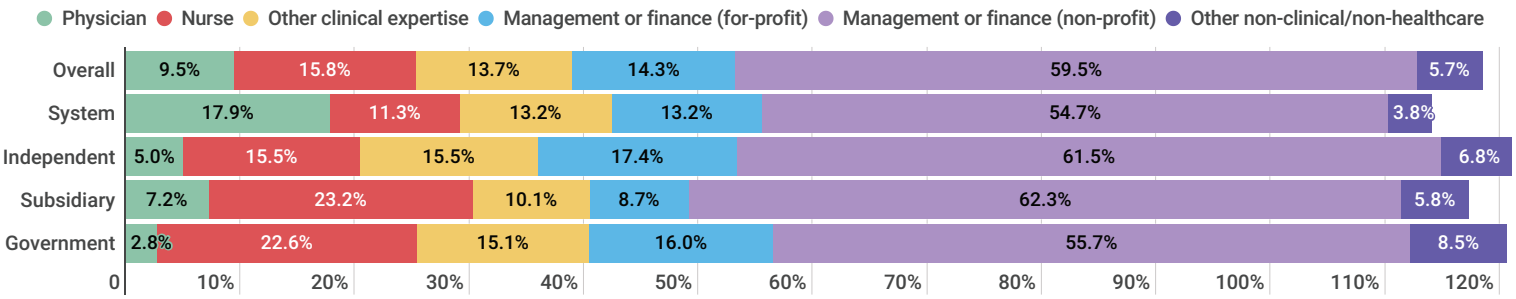


Exhibit 6a. CEO Clinical Background (Nurse/Physician/Other) Since 2019

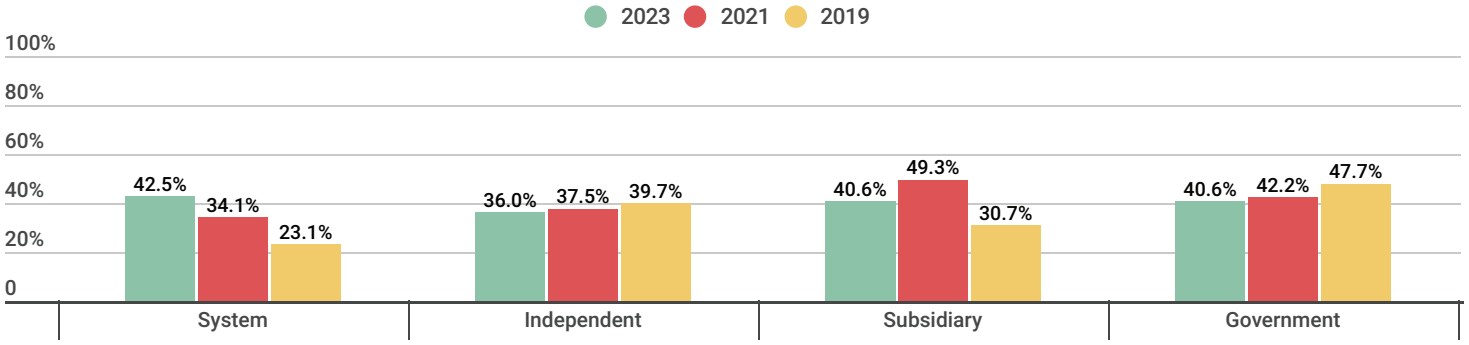
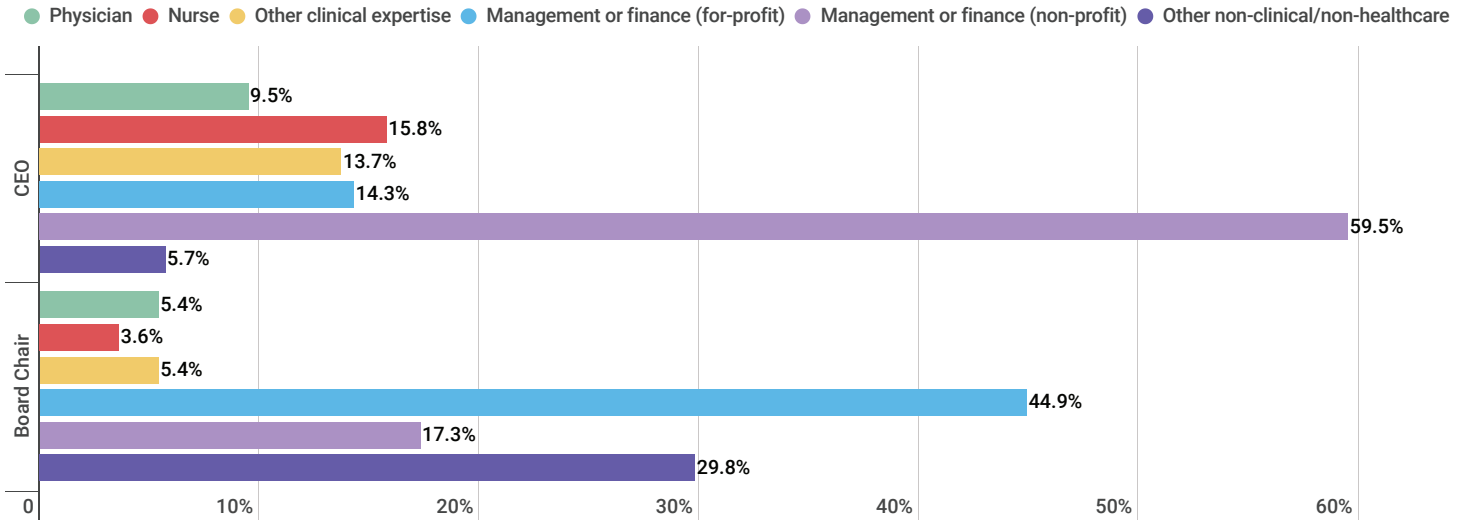


Exhibit 7. Background of the Organization's Chief Executive & Board Chair



By organization type, health systems have the highest average number of females on the board (4.7, up from 4.2 in 2021), and the highest average number of ethnic minority board members (3.0, up from 2.2 in 2021).

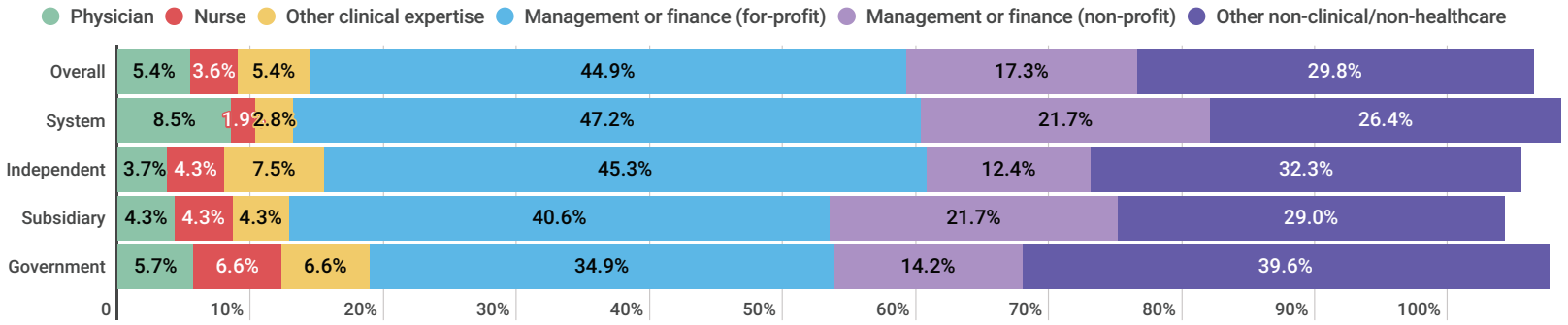
We looked at the largest boards to see if they tend to have comparatively higher average numbers of females and ethnic minorities, over time since 2015. We found that larger boards do not have more female board members, but they do tend to have more minority board members when compared to the overall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

Table 9. Female and Ethnic Minority Representation on the Board by Organization Size Since 2019

	Females (average)			Ethnic Minorities (average)		
	2023	2021	2019	2023	2021	2019
< 100 beds	3.4	3.1	3.1	0.8	0.8	0.7
100–299 beds	4.0	4.1	3.7	2.3	2.1	1.3
300–499 beds	5.0	4.8	4.5	3.8	2.6	1.9
500–999 beds	5.2	4.7	4.3	3.4	2.9	3.2
1000–1999 beds	5.0	3.1	4.1	3.3	2.1	2.6
2000+ beds	5.7	5.2	3.6	4.2	3.2	2.0

For detail, see Appendix 1.

Exhibit 8. Background of the Organization's Board Chair



Board Diversity Efforts Beginning to Show

This year we saw increases in the percentages of boards having two, three, four, five, and six or more minority board members, and this year we saw the most significant jump in boards that have six or more women. While overall these percentages remain small compared to the total, this represents significant and continued movement in the right direction since 2019, showing that diversity efforts at the board level are starting to pay off. However, 37% of boards still have *no* ethnic minority representation.

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 management or finance non-profit expertise (60%), remaining relatively stable since 2017. The chairperson's background is mostly business/finance in the for-profit sector (45%) and other non-clinical/non-healthcare expertise (30%), 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. While previous surveys have shown subsidiary hospitals to have the highest percentage of clinical expertise, this year health systems are the top slot at 43% (this percentage has almost doubled since 2019). Subsidiary and government-sponsored hospitals are most likely to have a nurse CEO (23%), and health systems a physician CEO (18% this year, up from 16% in 2021). In contrast, only 14% of respondents have a board chair with any kind of clinical background, about level with 2019 data. (See **Exhibits 6**, **6a**, **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 6%, about stable

with prior years. The median age limit remains the same at 75.

The overall average board member age is 58.4 (median 60), which is significantly younger than in 2019 (average 69.8; median 72), but in line with 2017 data (average 57.8; median 58). The 2023 age range of board members is 42 to 75 years old.

Needed Board Competencies

We ask 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 remained the top three across all types of organizations, although finance beat out strategy this year for the number one competency. The rest of the competencies, especially what we call "second curve" competencies to help transform the care delivery model away from inpatient/acute care, saw declines from 2021 (those in italics in Table 10). See Table 10 for the list of competencies, in order of priority based on overall responses.

Table 10. Top Essential Competencies for New Board Members 2023 vs. 2021

(highest percentage for 2023 in bold for each category)

	Overall		Health System		Independent		Subsidiary Fiduciary*		Subsidiary Advisory*		Government	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Finance/business acumen	56.7%	44.1%	51.9%	43.9%	61.9%	49.4%	51.9%	28.6%	52.9%	60.0%	**60.4%**	60.0%
Strategic planning and visioning	54.3%	55.6%	47.2%	50.0%	56.3%	60.0%	**67.3%**	50.8%	41.2%	60.0%	63.2%	60.0%
Quality and patient safety	37.3%	40.0%	32.1%	40.2%	39.4%	39.4%	38.5%	39.7%	**47.1%**	50.0%	40.6%	51.1%
Consumer-facing business expertise	20.3%	22.9%	21.7%	24.4%	18.8%	21.9%	17.3%	23.8%	**35.3%**	20.0%	20.8%	21.1%
Population health/social determinants/ disparities	17.3%	25.1%	17.0%	26.8%	14.4%	18.8%	23.1%	38.1%	**29.4%**	30.0%	23.6%	20.0%
Innovation/ disruption expertise	13.4%	13.0%	17.0%	17.1%	10.0%	12.5%	**17.3%**	9.5%	11.8%	10.0%	9.4%	7.8%
Fundraising	9.9%	8.9%	6.6%	3.7%	**12.5%**	11.4%	7.7%	11.1%	11.8%	20.0%	5.7%	8.9%
Legal	8.4%	6.7%	2.8%	3.7%	10.0%	9.4%	**15.4%**	4.8%	5.9%	0.0%	9.4%	10.0%
Public health/policy	7.2%	8.6%	6.6%	6.1%	7.5%	5.6%	3.8%	17.5%	17.6%	20.0%	**9.4%**	11.1%
Cybersecurity	6.9%	4.4%	**10.4%**	7.3%	5.0%	2.5%	7.7%	4.8%	0.0%	10.0%	0.9%	2.2%
Clinical practice experience	6.0%	10.5%	3.8%	12.2%	5.6%	8.1%	**11.5%**	14.3%	5.9%	10.0%	5.7%	7.8%
IT and social media expertise	5.1%	8.6%	7.5%	9.8%	5.0%	7.5%	1.9%	9.5%	0.0%	**10.0%**	3.8%	4.4%
Digital/mobile health technology expertise	4.8%	7.3%	**9.4%**	14.6%	3.1%	5.0%	1.9%	4.8%	0.0%	0.0%	2.8%	4.4%
Actuarial/health insurance/ managed care experience	4.8%	5.1%	**7.5%**	7.3%	4.4%	3.8%	1.9%	6.3%	0.0%	0.0%	0.0%	1.1%
Medical/science/ AI technology expertise	3.3%	4.8%	4.7%	4.9%	3.1%	5.0%	0.0%	4.8%	**5.9%**	0.0%	0.0%	4.4%
Conflict management	1.5%	0.6%	0.0%	1.2%	**2.5%**	0.6%	1.9%	0.0%	0.0%	0.0%	0.9%	0.0%
Change management	1.5%	8.3%	11.3%	6.1%	11.9%	12.7%	13.5%	6.3%	**23.5%**	0.0%	10.4%	10.0%
Venture capital	1.2%	0.6%	**1.9%**	2.4%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	1.1%
Pandemic/ infectious disease	0.3%	0.6%	**0.9%**	1.2%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%

**Note: Fiduciary board responses N=67; advisory board responses N=20*

Defined Terms of Service

Summary of Findings

66% of boards limit the number of consecutive terms (up from 64% in 2021); the median maximum number of terms is three. Health systems remain most likely to have term limits.

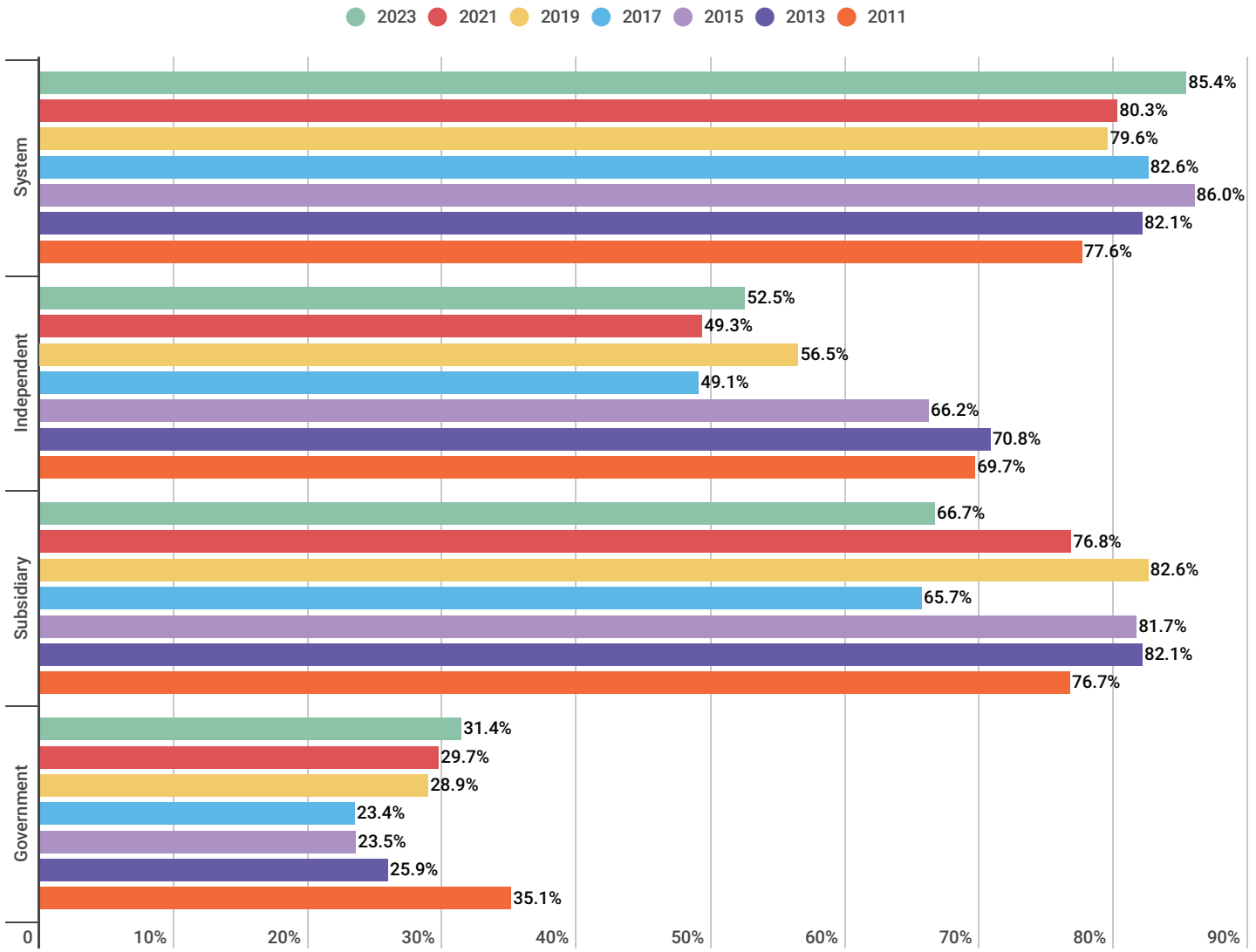
Term limits by type of organization (arrows indicate an upward or downward trend):

- Systems—85% (↑)
- Independent hospitals—53% (↑)
- Subsidiary hospitals—67% (↓)
- Government-sponsored hospitals—31% (↑)

Most respondents (88%) 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")—66%. Among non-government hospitals and systems, more often than not, boards have chosen to adopt term limits. We are now seeing a rising trend in government-sponsored hospital boards having term limits, increasing steadily from 24% 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 9. Limits on the Maximum Number of Consecutive Terms



Participation on the Board

Summary of Findings

- President/CEO:
  - Voting board member: 42% (stable with 2021 but down from a high of 48% in 2017)
  - Non-voting board member: 20%
  - Non-board member; regularly attends meetings: 39%
- Chief of staff:
  - Voting board member: 29%
  - Non-voting board member: 13%
  - Non-board member; regularly attends meetings: 38%
- VPMA/Chief Medical Officer:
  - Voting board member: 8%
  - Non-voting board member: 9%
  - Non-board member; regularly attends meetings: 73%

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 **Exhibits 10** and **10a**; 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:

- This is the first year we asked about board participation of the Chief Information Security Officer (CISO). Of the 40% of respondents with this position, 76% do not have them attend board meetings. Government-sponsored hospitals are most likely to have the CISO attend board meetings (35%). In contrast, the Chief Information Officer is more likely than the CISO to attend board meetings (42% overall, with health systems at 48%).
- The percentage of boards with a voting representative of an owned or affiliated medical group/physician enterprise on the board is 26% this year (up from 20% in 2019).
- Fewer boards have a voting board member from a religious sponsor (37% compared to 51% in 2021).

Variances by Organization Type

- Health system boards again are more likely to have a voting CEO (66%).
- In contrast, government-sponsored hospitals again have the lowest percentage of voting CEO board members (7%).
- Subsidiaries have the highest percentage of voting chiefs of staff compared with other types of organizations (32%).
- Ninety-four percent (94%) of government-sponsored hospitals have the CNO attend board meetings regularly, compared with 83% overall.
- Twenty-four percent (24%) of health system boards do not have their CNO attend meetings regularly, which is up from 21% in 2021.
- Health systems are the most likely to have a CISO (60%); independent hospitals are the least likely (28%).

Exhibit 10. Participation on the Board

(includes only organizations where specific job titles apply)

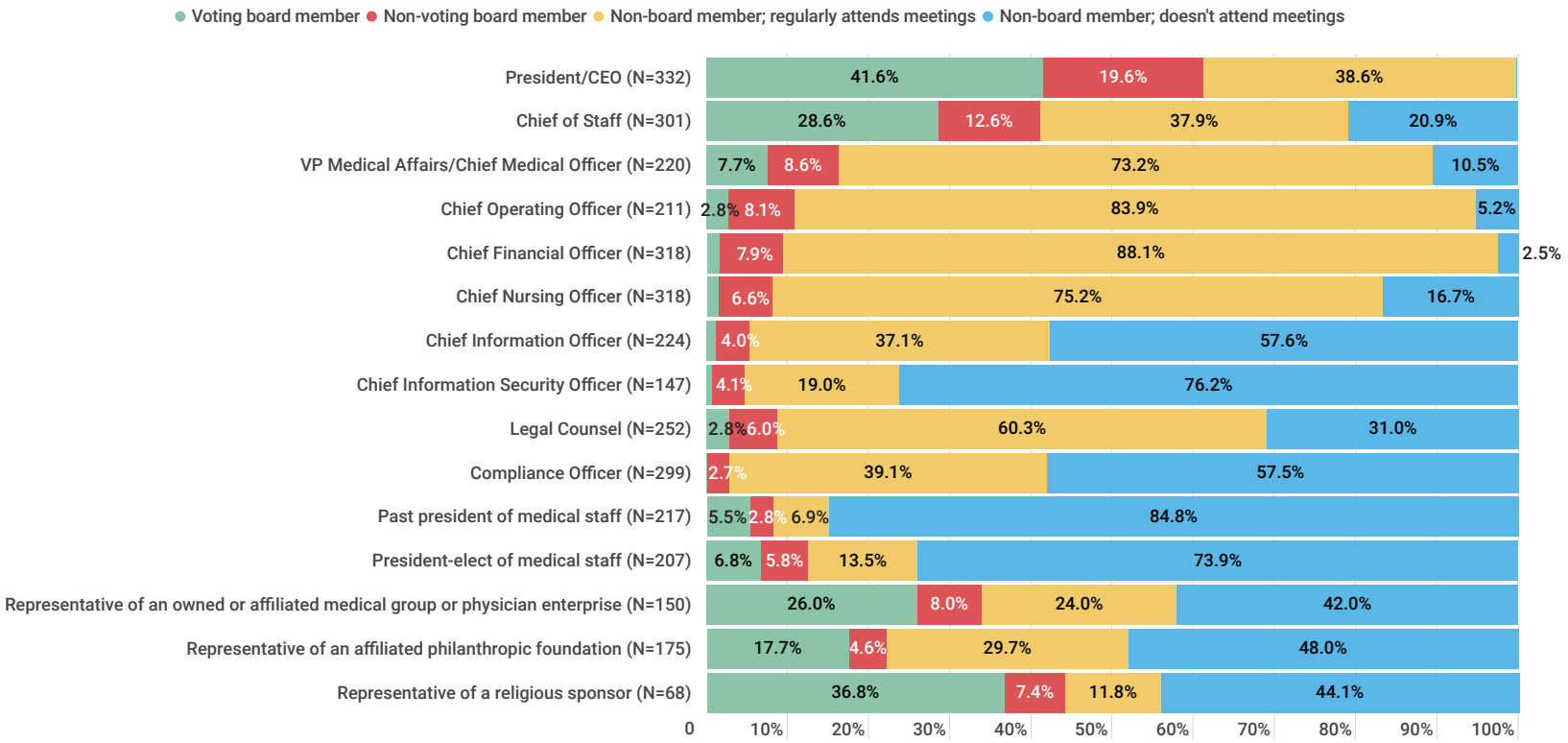
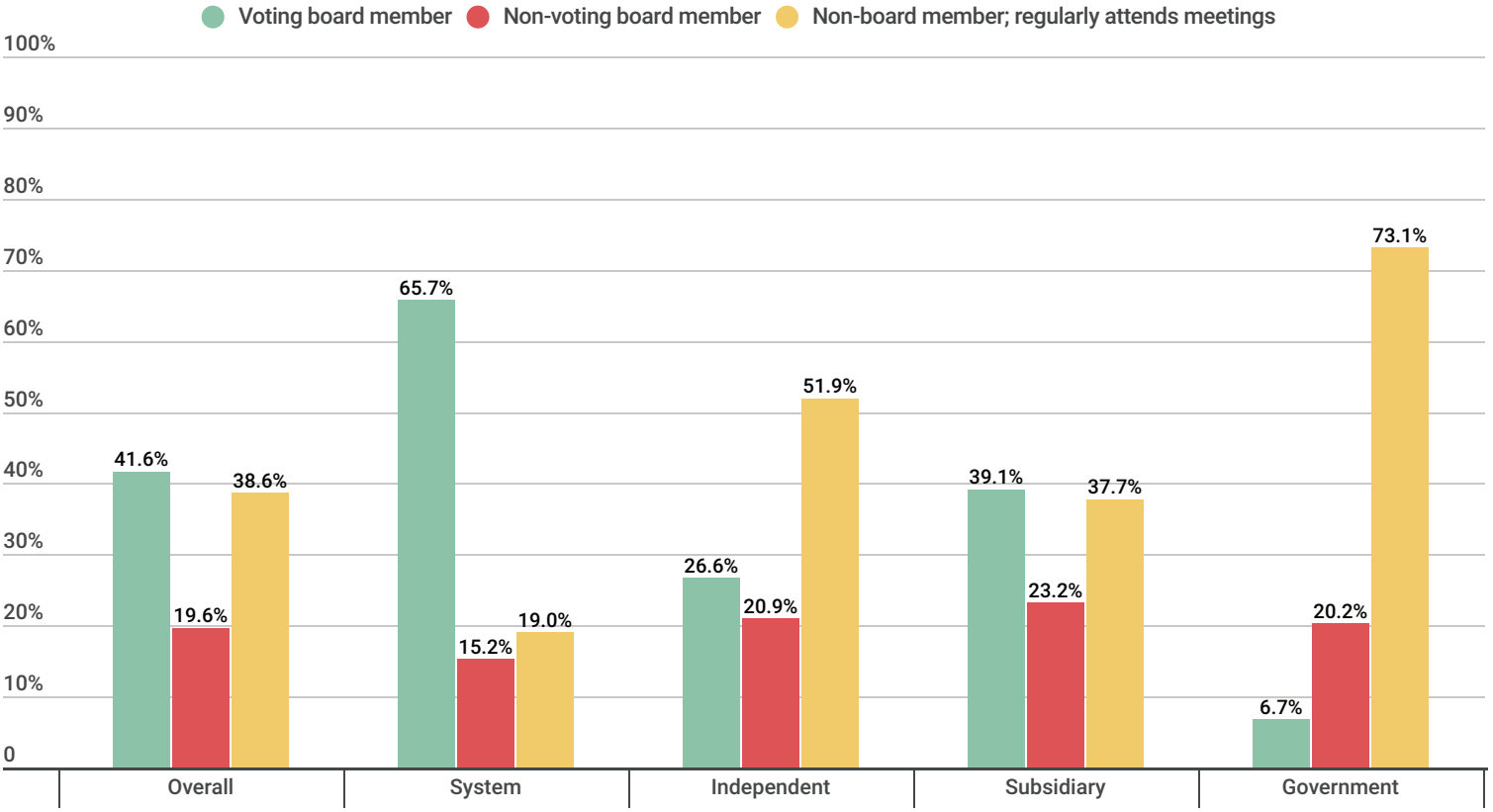


Exhibit 10a. CEO Voting Board Member Status by Organization Type



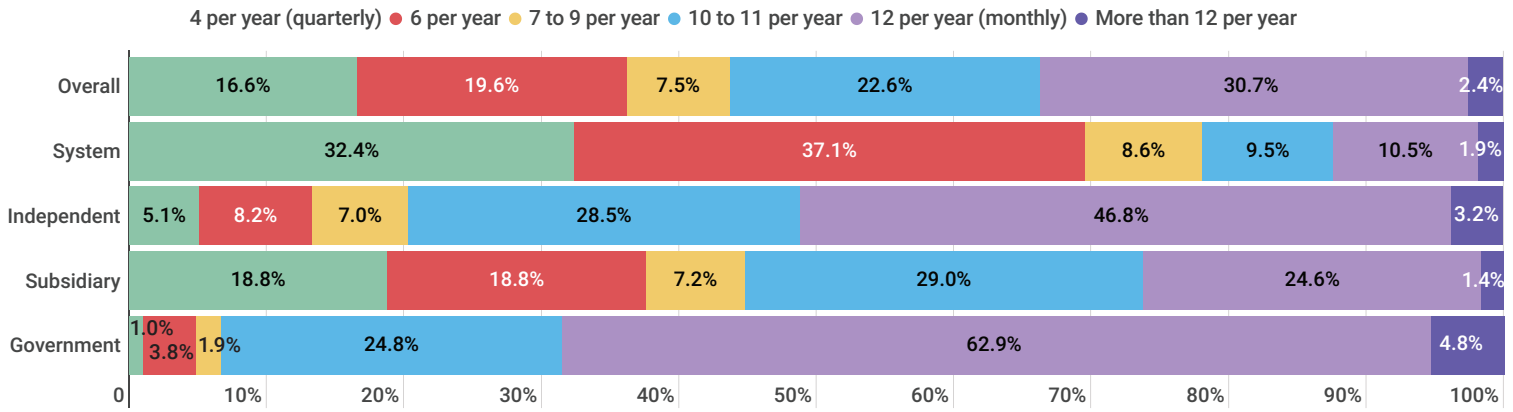
Seventy-nine percent (79%) of health systems have a system-level CMO/VPMA compared with 60% overall. This is contrasted with government-sponsored hospitals, 45% of which have this position. The assumption, then, is that government-sponsored hospitals rely more on leadership and information provided by the chief of staff/medical staff president at board meetings (89% of government hospitals have this position). However, 23% do not have the chief of staff attend meetings 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 2021, in either direction. Most notable is a decrease in the percentage of organizations with many of these management positions. (See **Appendix 1** for a breakdown by organization type and size.)

Table 11. Frequency of Position & Board Participation 2023 vs. 2021

	% of respondents with this position		% of respondents noting presence in boardroom		% of respondents noting board member (voting and non-voting)	
	2023	**2021**	**2023**	**2021**	**2023**	**2021**
CFO	**85.9%**	**98.1%**	97.5%	96.7%	9.4%	11.9%
CNO	**85.9%**	**94.8%**	83.3%	84.9%	8.2%	8.9%
Compliance Officer	**80.8%**	**94.4%**	42.5%	43.9%	3.3%	5.2%
Legal Counsel	68.1%	71.0%	69.0%	72.6%	8.7%	6.5%
CIO	**60.5%**	**70.1%**	42.4%	42.7%	5.4%	4.3%
VPMA/CMO	**59.5%**	**69.0%**	89.5%	90.9%	**16.4%**	**12.9%**
COO	57.0%	60.1%	94.8%	94.6%	10.9%	9.2%

Exhibit 11. Number of Board Meetings Per Year



Board Meetings

Summary of Findings

- Most boards meet 10–12 times a year (53%; this trend remains stable).
- 55% of responding organizations' board meetings are two to four hours; 36% are less than two hours (also stable).
- 79% of responding organizations use a consent agenda at board meetings (an overall increasing trend from 62% in 2007, although this is down slightly from 82% in 2021).
- 66% have scheduled executive sessions (vs. 59% in 2021); of these, 65% said executive sessions are scheduled for all or alternating board meetings.
- 93% said the CEO attends scheduled executive sessions always or most of the time (vs. 88% in 2021); 45% said physician and nurse board members attend scheduled executive sessions always or most of the time (vs. 41% in 2021). Fifty-nine percent (59%) of subsidiary boards have physician and nurse board members attend always or most of the time.
- 40% have legal counsel attend always or most of the time.
- Government-sponsored hospitals are most likely to have other members of the management team attend executive sessions (67% compared with 53% overall).
- The top three topics typically discussed in executive session are executive performance/evaluation (77%), executive compensation (67%), and miscellaneous governance issues (50%).
- On average, 57% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports (about the same since 2019); 30% to active discussion, deliberation, and debate about strategic priorities; and 12% to board education (stable since 2017).
- 48% of responding organizations have annual board retreats (vs. 79% in 2021); the majority of respondents (72% and above) invite the CEO, CNO, CFO, and other C-suite executives to attend. Over half invite the CMO (62%) and just under half invite governance support staff to attend board retreats. Medical staff physicians are less likely to attend board retreats compared with 2021 (36% vs. 48%).

Board Meeting Frequency and Duration

Most boards continue to meet from 10 to 12 times per year (53%; down from a high of 65% in 2019). (See **Exhibit 11**.) Meeting duration continues to be concentrated in the two- to four-hour range (55%) and the next largest group meets for less than two hours (36%). (See **Appendix 1** for detail on meeting frequency and duration.)

Some differences by organization type include:

- Most system boards meet six times per year (37%); the next highest category is quarterly at 32%. (We tend to see that system boards meet less frequently than other types of boards.)
- Subsidiaries are also more likely to meet less frequently than independent and government-sponsored hospital boards (37% meet quarterly or six times per year).
- 88% of government-sponsored hospital boards meet 10–12 times per year, consistent with the trend.
- While most boards meet for two to four hours, 55% of subsidiary and 47% of government-sponsored hospital boards meet for less than 2 hours.
- In general, as we found in 2021, the more meetings boards have, the shorter the meetings are, and vice versa.

Consent Agenda & Executive Session

Seventy-nine percent (79%) of respondents said the board uses a consent agenda, which has risen steadily from 62% in 2007. (See **Exhibit 12**.)

The percentage of respondents with scheduled executive sessions is 66% this year (up from 59% in 2021). (See **Exhibit 13**.) Since 2009, most respondents continue to schedule executive sessions after or before every board meeting. (See **Exhibit 13** and **Appendix 1**.)

We asked who typically attends scheduled executive sessions. Ninety-three percent (93%) of respondents with scheduled executive sessions said the CEO attends always or most of the time; 45% said clinician board members attend always or most of the time (vs. 59% of subsidiary boards); and 40% said legal counsel attends always or most of the time (vs. 54% 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 (77%)
- Executive compensation (67%)
- Miscellaneous governance issues (50%)
- General strategic planning/issues (42%)

Subsidiary boards are less likely to discuss executive compensation and general strategic planning and instead are more likely to cover miscellaneous governance issues in executive session. Health system boards are most likely to discuss executive succession planning and M&A strategy versus other types of boards (49%).

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 (57% on average) to hearing reports from management and board committees. This has remained the same since 2019 although has decreased from 66% in 2017. Overall, 5% of boards spend 50% or more of their meeting time in active discussion of strategic priorities (10% of health system boards do this). Quality and finance are given more equal discussion time than in prior years.

Exhibit 12. Use of Consent Agendas Since 2011

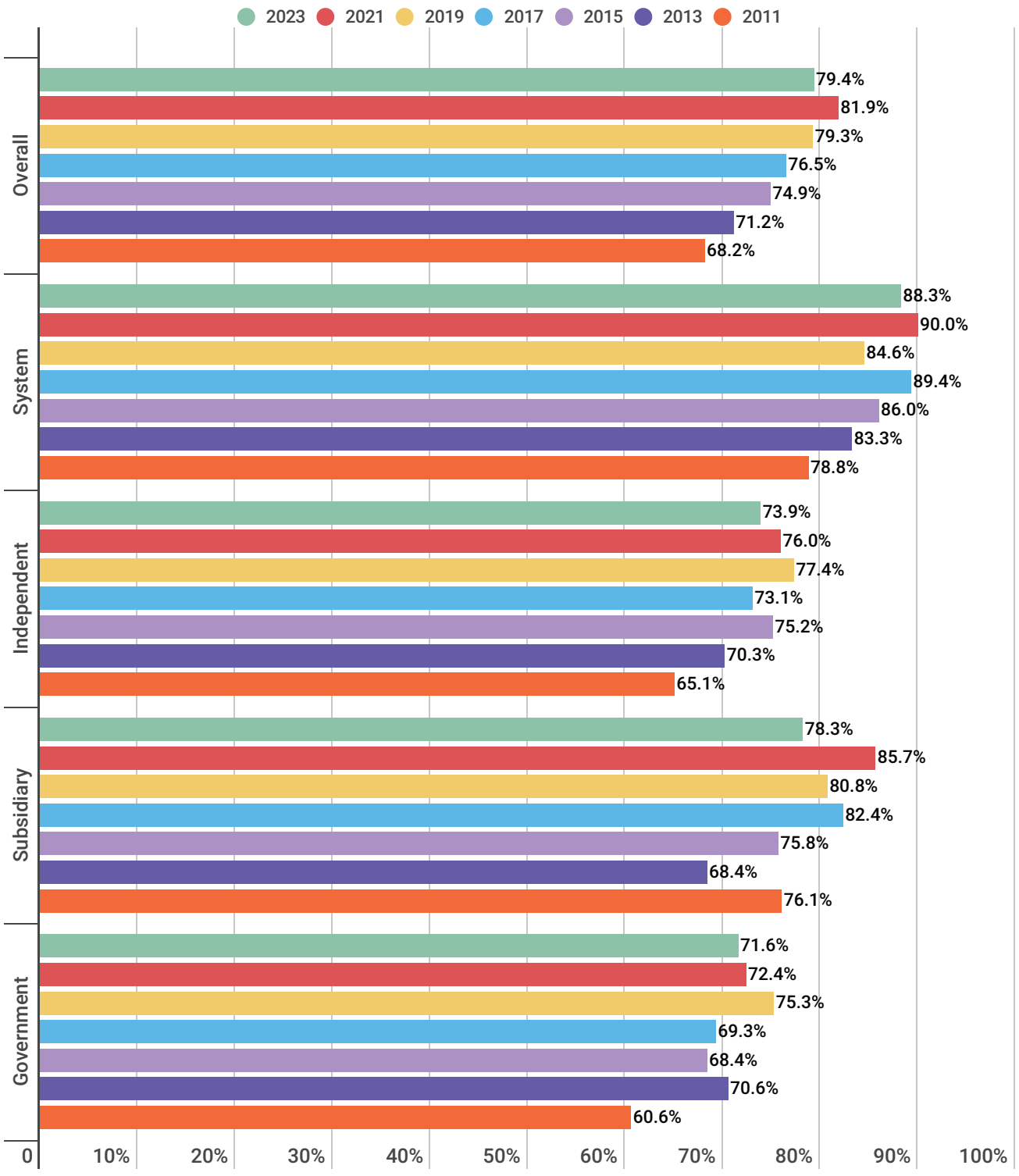


Exhibit 13. Scheduled Executive Sessions Since 2011

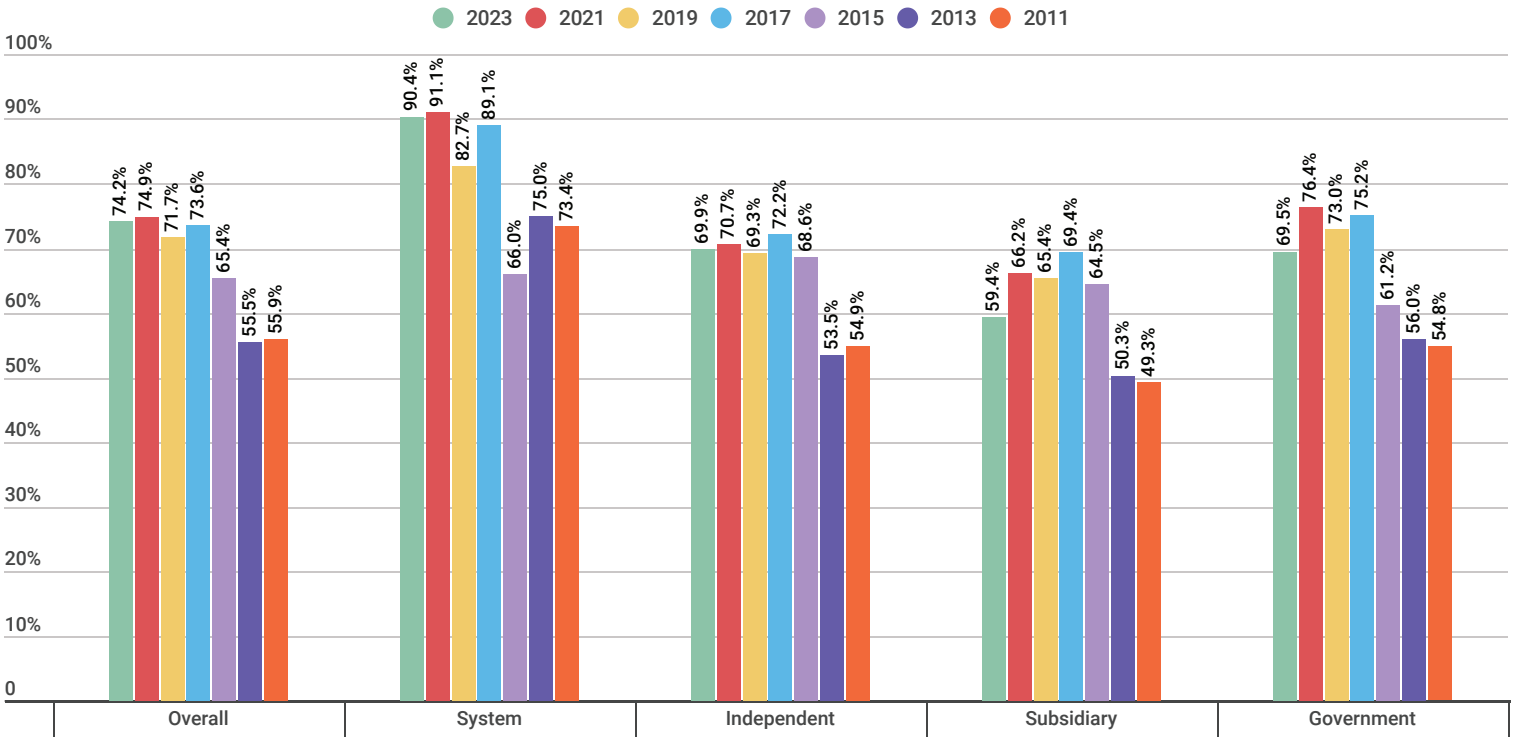
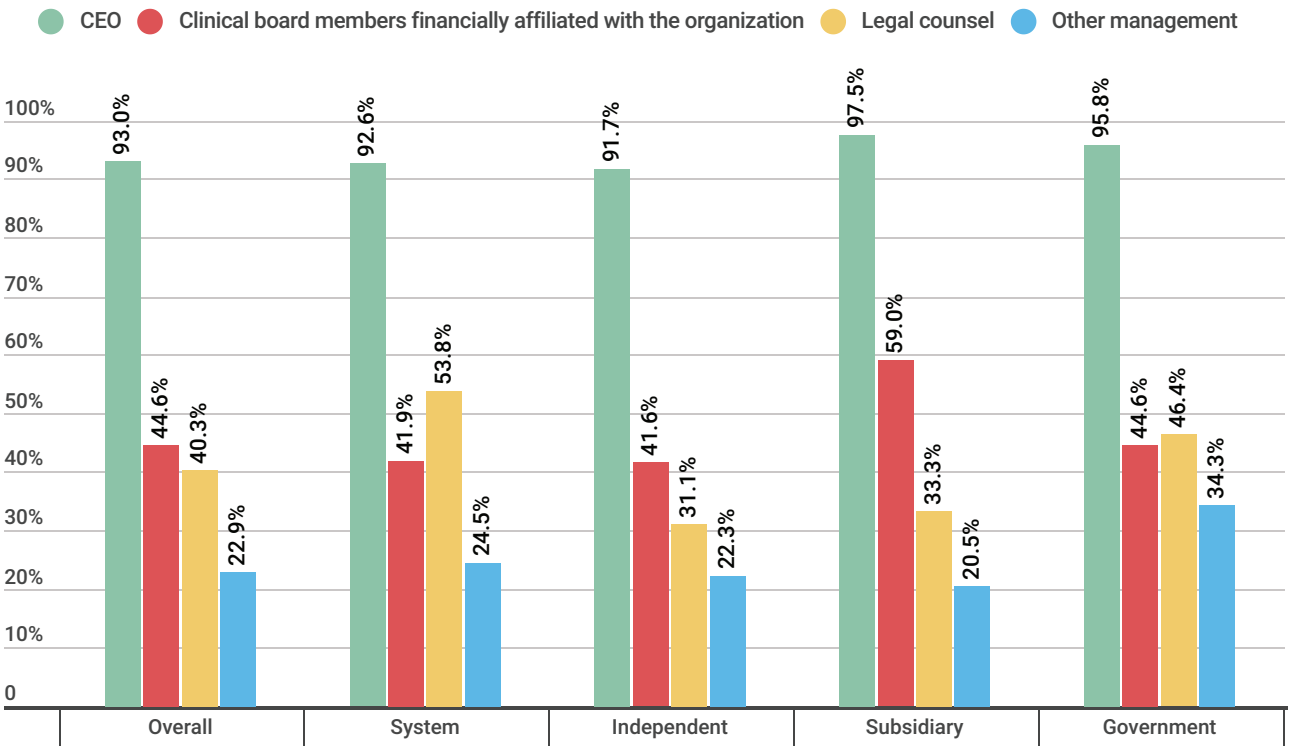


Exhibit 14. Who Attends Scheduled Executive Sessions
(always or most of the time)



Board Meeting Time Matters

For several years including this year, there is a statistically significant correlation between the use of a consent agenda and boards that spend 40% or more of their board meeting in active discussion, deliberation, and debate about the strategic priorities of the organization. ***In other words, the use of a consent agenda helps to enable boards to spend more time in active discussion.***

We also see a positive relationship between the amount of ***time spent during board meetings on board member education and the likelihood to report "excellent" performance*** in the board development recommended practices in the second half of this report.

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

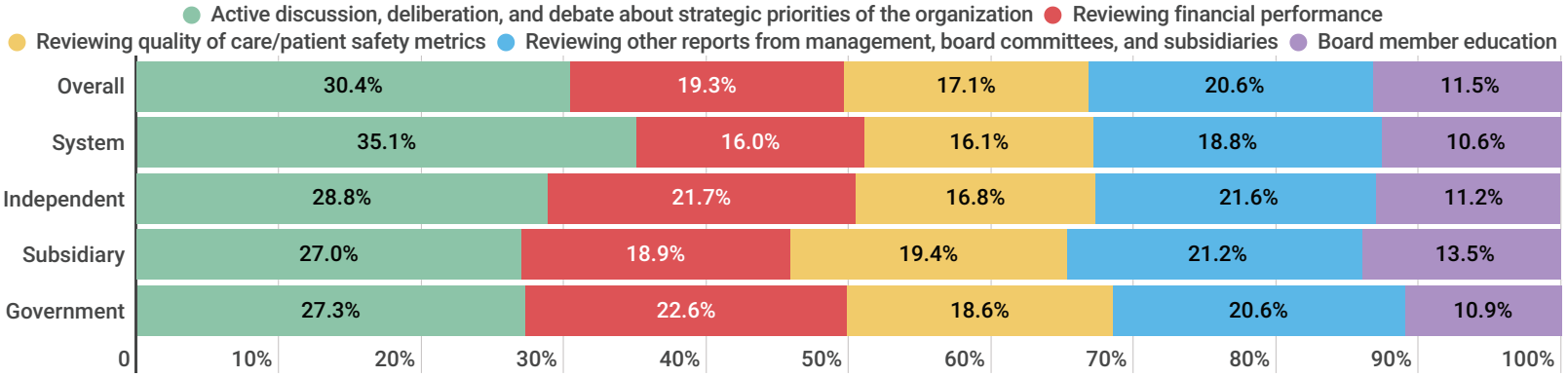


Exhibit 16. Percentage of Board Meeting Time Spent in Active Discussion, Deliberation, & Debate on Strategic Priorities of the Organization

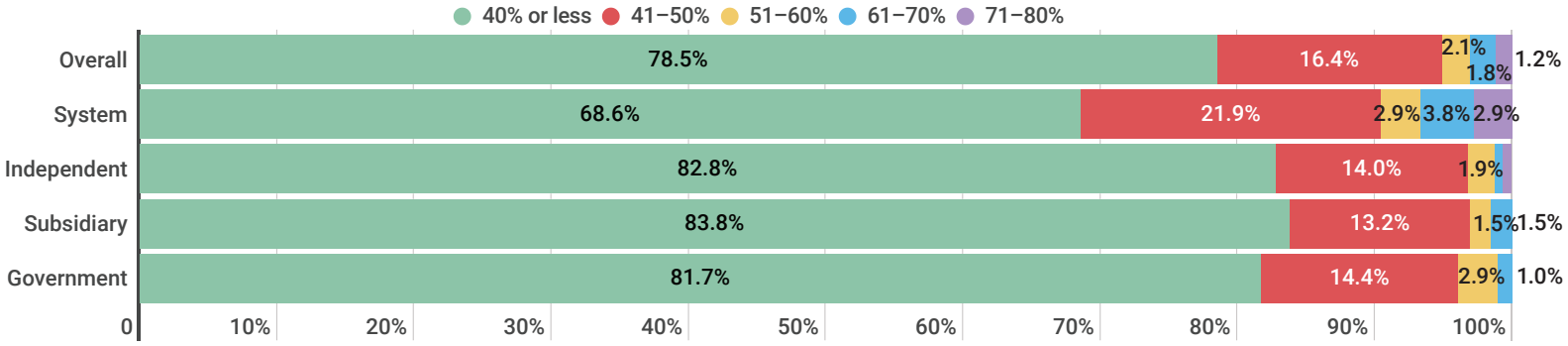
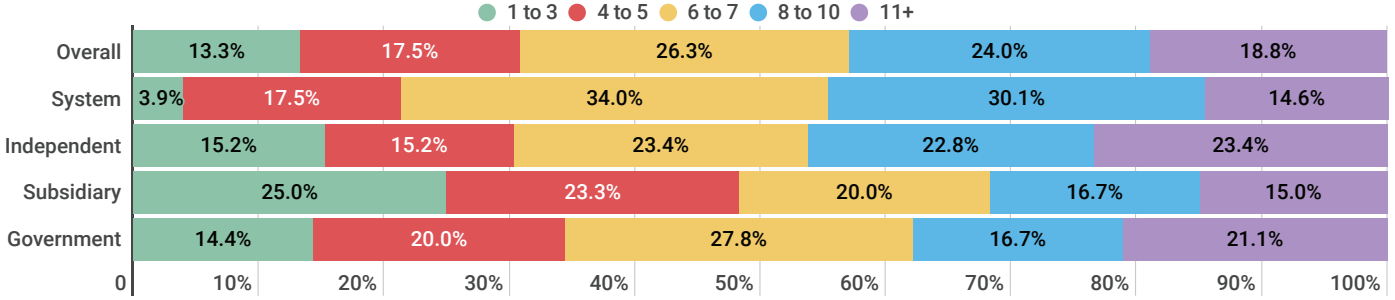


Exhibit 17. Number of Board Committees



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

- Active discussion, deliberation, and debate about strategic priorities of the organization: 30.4% (the largest overall portion of the meeting)
- Reviewing reports from management, board committees, and subsidiaries (excluding financial and quality/safety): 20.6%
- Reviewing financial performance: 19.3%
- Reviewing quality/safety performance: 17.1%
- Board member education: 11.5%

Time spent on board member education has stayed the same since 2017 but is down from a high of 17% in 2013. (See **Exhibit 15**.)

Seventy-nine percent (79%) of responding boards spend 40% or less of the time during their board meetings in active discussion, deliberation, and debate on strategic priorities (see **Exhibit 16**). We emphasize this because several prior surveys have shown a positive correlation for all organization types between spending half or more of the board meeting time discussing strategic issues and respondents indicating higher performance. This year's analysis again shows a positive correlation: *as the amount of time spent in active discussion, deliberation, and debate about strategic priorities increases, boards are more likely to report "excellent" performance in their fiduciary duties and core oversight responsibilities.*

Board Retreats

We asked how often organizations schedule board retreats and who typically attends them (other than board members). Most types of boards have an annual board retreat, although independent and government-sponsored hospitals are more likely to have a retreat less often than once per year. The CEO, CMO, CNO, CFO, and other C-suite executives remain most likely to attend in addition to board members. Just under half (43%) have governance support staff attend (64% of health systems do), and 36% invite their medical staffs to attend board retreats. (See **Appendix 1** for more detail; this has remained about the same since 2017.)

Board Committees

Summary of Findings

- This year, 0% of respondents said they have no board committees.
- Average number of committees is 8.0 (about the same).
- Median remains 7.
- Most prevalent committees are finance (76%), quality (68%), executive (66%), and executive compensation (53%).
- Committees that have historically been prevalent (over 50% of respondents) but showing a decline this year are: governance/board development (48% vs. 64%), strategic planning (43% vs. 57%), and audit/compliance (44% vs. 54%).

While normally the vast majority of respondents have at least one board committee, this is the first year 100% of respondents have at least one committee. Independent and government-sponsored hospitals have the most committees (average of 8.6) and subsidiary hospitals have the fewest (6.6 on average) (See **Exhibit 17**.)

Committee prevalence by type of board varies, which provides a partial lens into the areas that different types of boards are focusing more of their work.

System boards are more likely than other types of boards to have the following committees:

- Executive
- Finance
- Audit/compliance
- Quality
- Governance/board development
- Executive compensation

Subsidiary boards are less likely to have:

- Audit
- Executive compensation
- Enterprise risk

Independent hospital boards are more likely to have:

- Compliance
- Strategic planning
- Physician relations

Government-sponsored hospital boards are more likely to have:

- Compliance
- Physician relations

Boards that have a strategic planning committee are 16% more likely to have adopted our recommended practices for strategic direction and 27% more likely to cite "excellent" performance in setting strategic direction.

In the future we hope to see increasing prevalence of certain "new" board-level committees that may help organizations accelerate business model transformation such as innovation/transformation, diversity/inclusion, and population health/community health improvement. We have not yet seen a trendline develop for these types of committees. These may reflect strategic-level goals that are being addressed by the full board.

Table 12 shows the prevalence of board committees since 2013 (listed in order of prevalence for 2023). 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 percentage of organizations reporting a board-level quality/safety committee is lower this year, although all of the committees are showing lower percentages this year. Comparisons by organization type can be found in **Table 13**.

As we recommend, quality committees continue to meet primarily monthly (for 45% of respondents); 32% meet quarterly.

The average quality committee has 12 people and the most common types of positions on this committee include:

- Voting physician board members (77% have between one and four)
- Physicians from the medical staff (employed and non-employed but non-board members; 60% have between one and four, up from 56% in 2019)
- Nurses from the nursing staff (56% have at least one, up from 51% in 2019)
- Voting nurse board members (49% have between one and four, up from 41% in 2019)
- Voting board members who are not physicians (48% have between one and three and 41% have four or more)
- Community members at large (44% have between one and four)

Boards that have a standing quality committee of the board are 19% more likely to have adopted our quality oversight recommended practices, and 44% more likely to cite "excellent" performance in quality oversight.

Table 12. Prevalence of Board Committees *(All Respondents)*

Committee	2023	2021	2019	2017	2015	2013
Finance	76%	85%	83%	81%	84%	76%
Quality and/or Safety	68%	81%	80%	77%	74%	77%
Executive	66%	79%	73%	75%	72%	77%
Executive Compensation	53%	64%	62%	60%	66%	60%
Governance/ Board Development	48%	64%	58%	59%	72%	77%
Audit/Compliance	44%	54%	53%	38%	51%	34%
Strategic Planning	43%	57%	55%	52%	57%	57%
Investment	31%	41%	45%	44%	40%	35%
Audit	31%	40%	44%	38%	33%	32%
Compliance	30%	38%	42%	48%	28%	33%
Joint Conference	22%	35%	37%	34%	35%	40%
Facilities/ Infrastructure/ Maintenance	20%	26%	31%	27%	23%	25%
Community Benefit	19%	29%	29%	24%	26%	18%
Human Resources	19%	24%	28%	25%	22%	20%
Physician Relations	17%	23%	31%	22%	21%	19%
Population Health/ Community Health Improvement	14%	21%	23%	18%	NA	NA
Construction	14%	20%	24%	17%	17%	9%
Government Relations/Advocacy	13%	18%	18%	14%	13%	9%
Diversity/Inclusion	12%	17%	NA	NA	NA	NA
Innovation/ Transformation	10%	14%	NA	NA	NA	NA

Table 13. Organizations with a Board Quality Committee

	2023	2021	2019	2017	2015	2013
Overall	68%	81%	80%	77%	74%	77%
Systems	79%	89%	86%	82%	84%	85%
Independent Hospitals	66%	78%	80%	72%	80%	80%
Subsidiary Hospitals	55%	78%	69%	87%	81%	86%
Government-Sponsored Hospitals	65%	76%	79%	66%	58%	60%

The Executive Committee

Sixty-six percent (66%) of respondents said their board has an executive committee (71% of system boards do); this committee meets "as needed" for 46% of those respondents (25% meet monthly). For more than half of those with an executive committee, responsibilities include advising the CEO (72%), emergency decision making (70%), decision-making authority between full board meetings (64%), and executive compensation (47%). (For detail, see **Appendix 1**.)

Thirty-nine percent (39%) of executive committees have full authority to act on behalf of the board on all issues. Twenty-eight percent (28%) have some authority to act on certain issues, and for 33% 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 (48%, up from 44% in 2019).
- Executive committees of government-sponsored hospitals have the least amount of authority (25% have full authority, although this is up from 15% in 2019). For 59% of this group, all decisions must be approved by the full board.

Exhibit 18. Responsibilities of the Executive Committee Since 2013

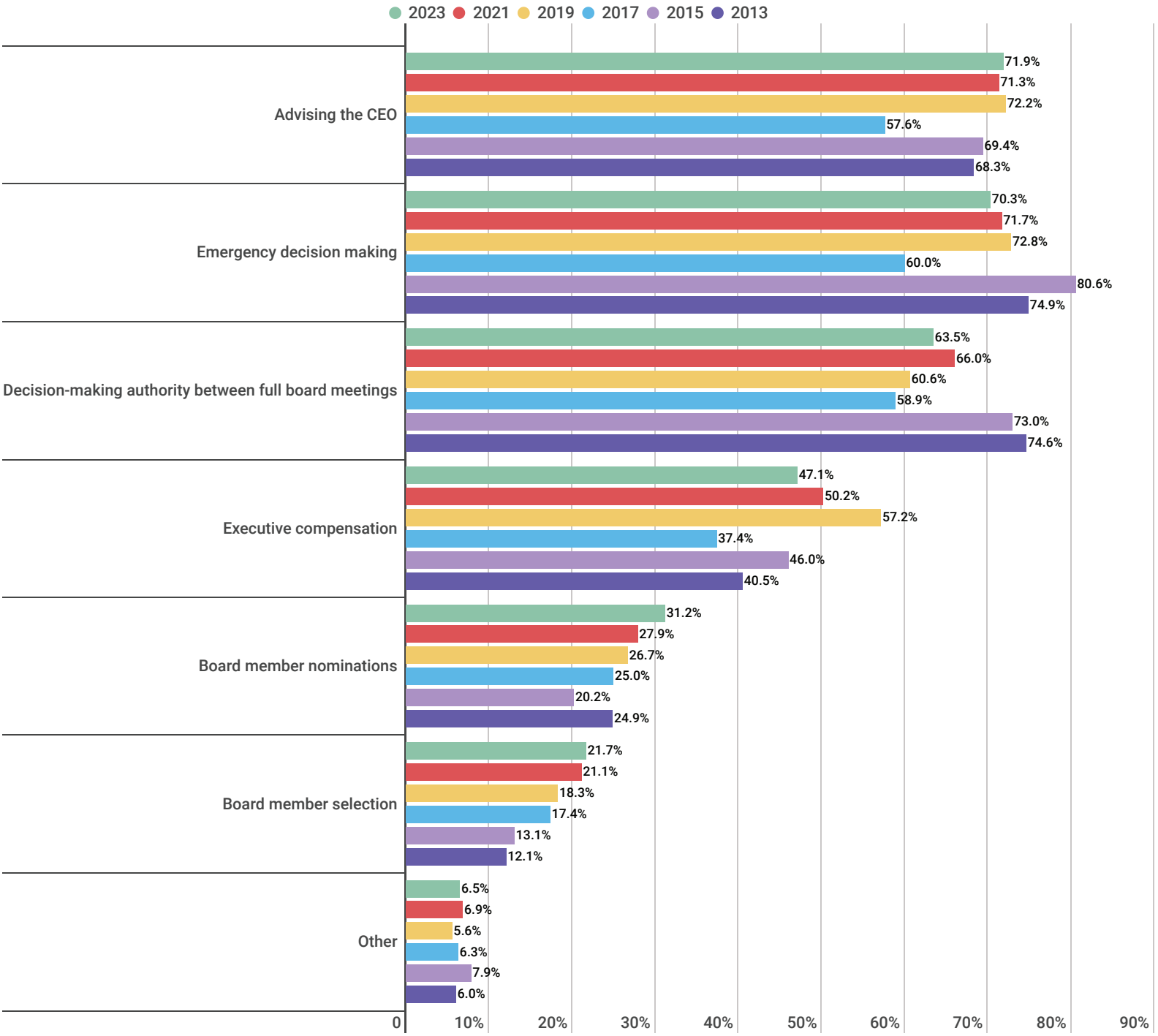


Exhibit 19. Level of Authority of the Executive Committee

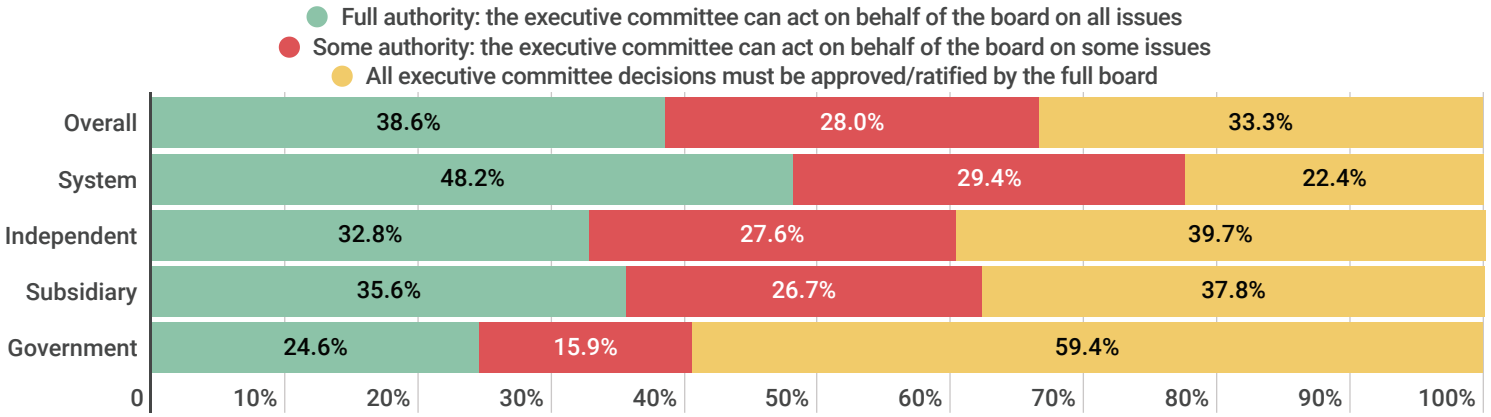
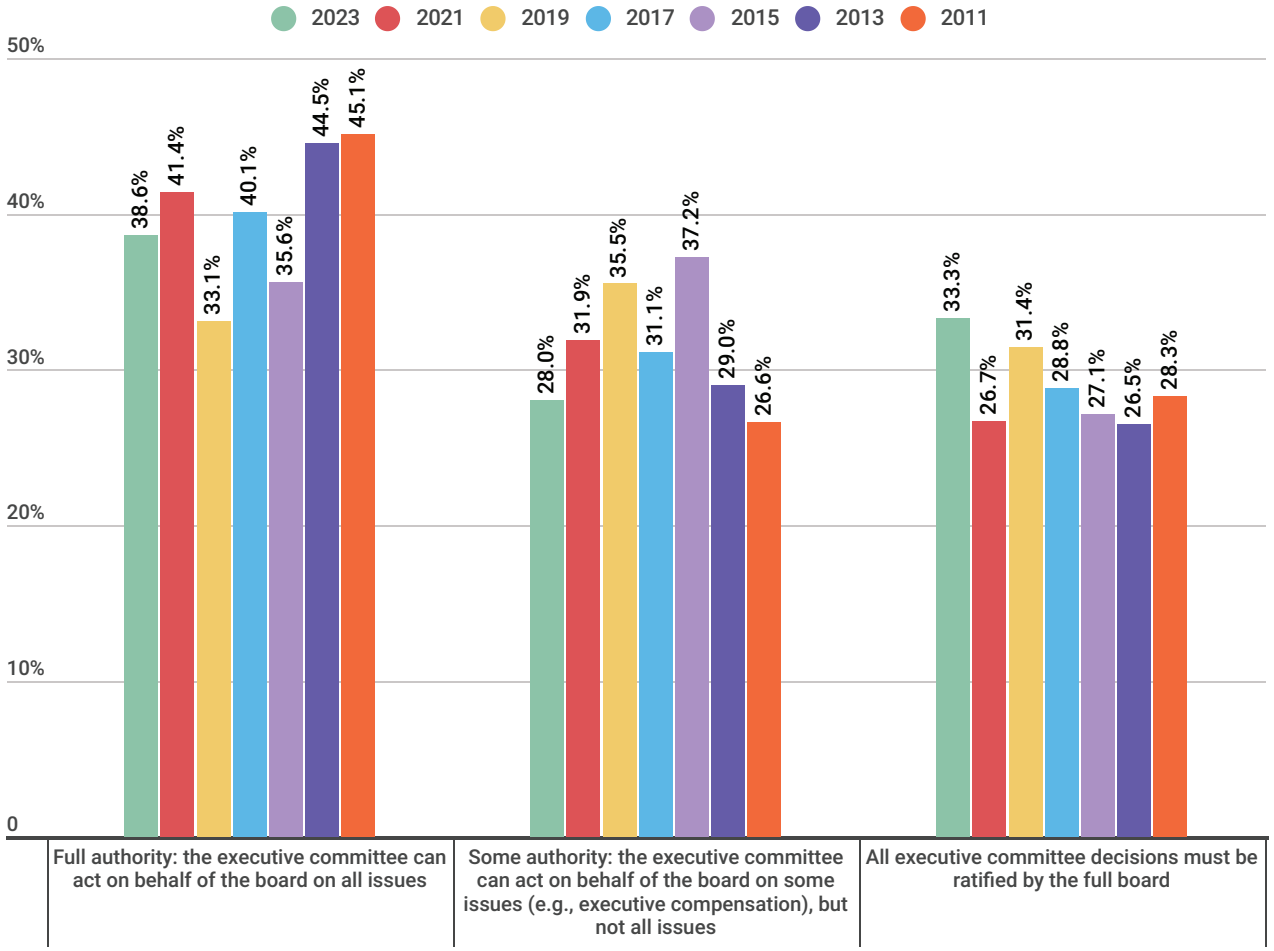


Exhibit 19a. Authority of the Executive Committee Since 2011



Board Member Compensation

Summary of Findings

- Overall, 10% of respondents compensate at least some board members, which has remained roughly stable since 2009.
- 10% of respondents compensate the board chair (down from 13% in 2021).
- Compensation amounts for the board chair tend to be less than $5,000 (47%); 21% compensate between $5,000–$10,000 and 32% compensate over $10,000.
- 9% compensate other board officers (down from 11% in 2021), and 8% compensate board committee chairs (down from 10%). The majority (58–66%) compensate these positions at less than $5,000.
- 10% said other board members (non-chairs/officers) are compensated, and 61% of these said compensation is less than $5,000 (vs. 93% in 2019). Twenty-eight percent (28%) compensate other board members between $5,000–$39,999, and 11% compensate these board members at $40,000 or above.
- 13% of the largest systems (2,000+ beds) compensate the board chair, and for 75% of those, compensation is $50,000 or more.
- Government-sponsored hospitals continue to be more likely to compensate board members than other types of organizations (19% compensate the board chair, 18% compensate other board officers, 15% compensate board committee chairs, and 19% compensate other board members). For all of these categories, the vast majority (75% or above) compensate at less than $5,000.

Overall, the trend shows that the prevalence of board positions that are compensated has ranged from 10–12% since 2011 when we started asking this question. Government-sponsored hospitals are more likely than others (17%) 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 13%. (See **Exhibit 20** and **Table 14**.)

Our analysis does not yet show a relationship between compensating board members and board performance.

Exhibit 20. Percentage of Organizations that Compensate Board Members Since 2013
(excluding chairs/officers)

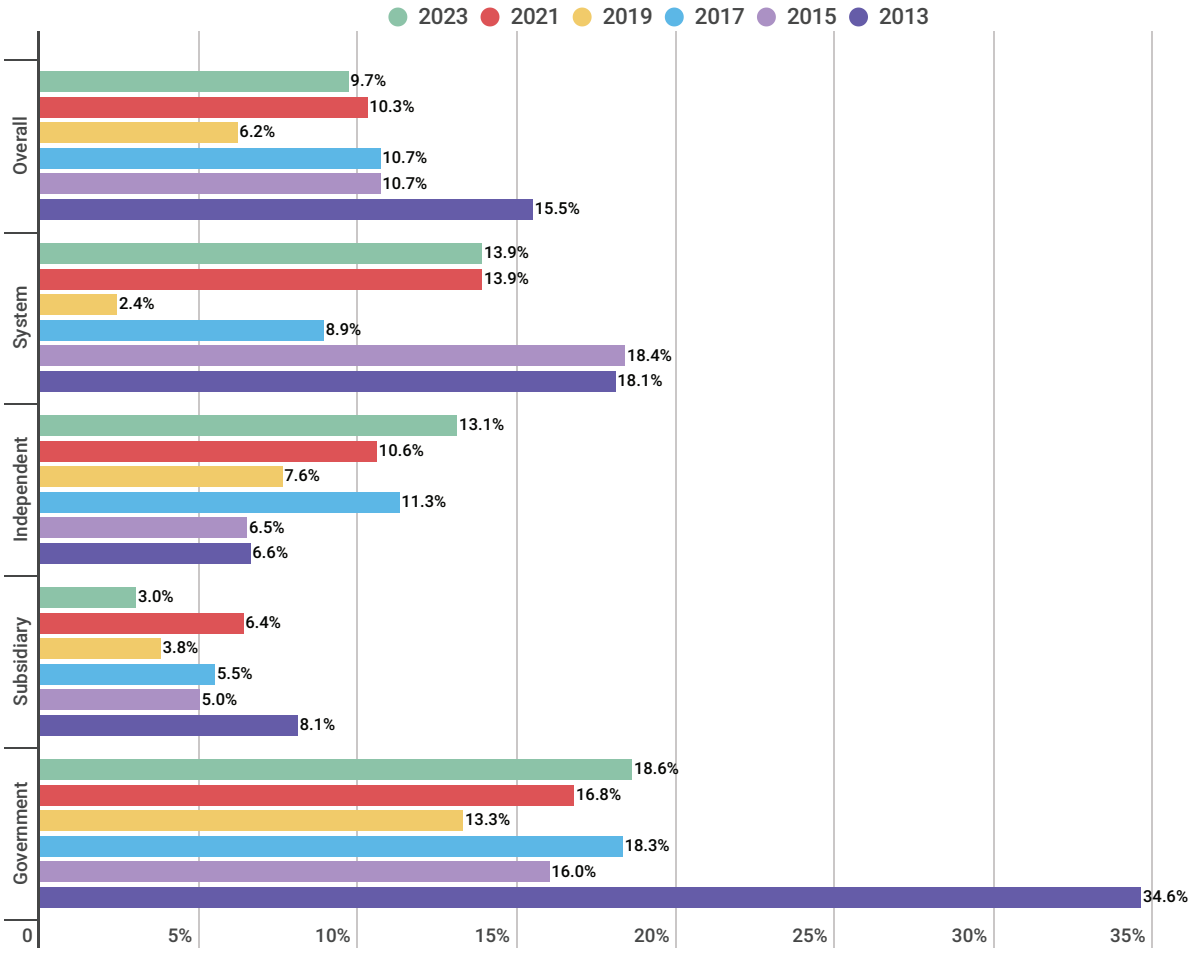


Table 14. Percentage of Organizations that Compensate the Board Chair

	2023	2021	2019	2017	2015	2013	2011
Overall	**10.3%**	**12.6%**	**7.1%**	**12.2%**	**11.1%**	**11.8%**	**12.0%**
Systems	14.7%	15.2%	7.1%	10.6%	18.0%	17.5%	21.3%
Independent Hospitals	13.6%	12.3%	7.6%	12.8%	6.5%	5.8%	5.2%
Subsidiary Hospitals	2.9%	10.1%	3.8%	6.6%	4.9%	6.2%	7.1%
Government-Sponsored Hospitals	19.2%	19.8%	12.0%	18.3%	17.8%	23.5%	22.9%

Annual Expenditure for Board Member Education

Summary of Findings

- 29% of respondents spend $40,000 or more annually for board education.
- 3% said they don't spend any money on board education.
- Health systems generally spend more for board education than other types of organizations (50% of systems spend $40,000 or more; 25% spend $80,000 or more).
- Subsidiaries and government-sponsored hospitals spend the lowest dollar amount for board education (51% of both of these groups 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 at 58%.
- The most popular internal board education topics this year are: strategic planning/direction (85%), quality/safety (84%), legal/regulatory (81%), the role of your organization in a changing delivery system (51%), and innovation (44%).

Exhibit 21. Approximate Total Annual Expenditure for Board Education

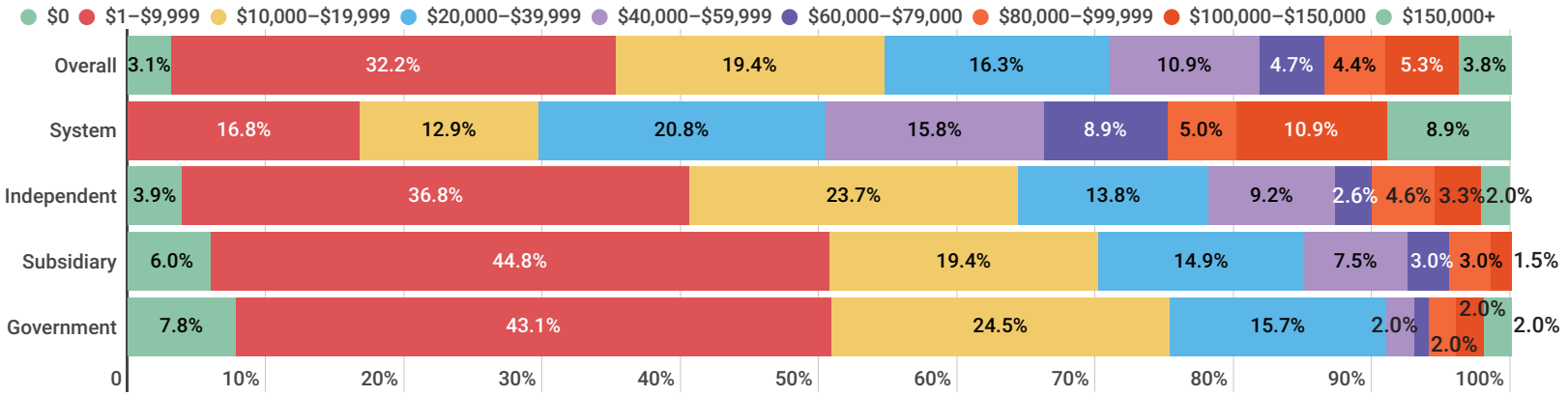


Exhibit 22. Delivery of Board Education

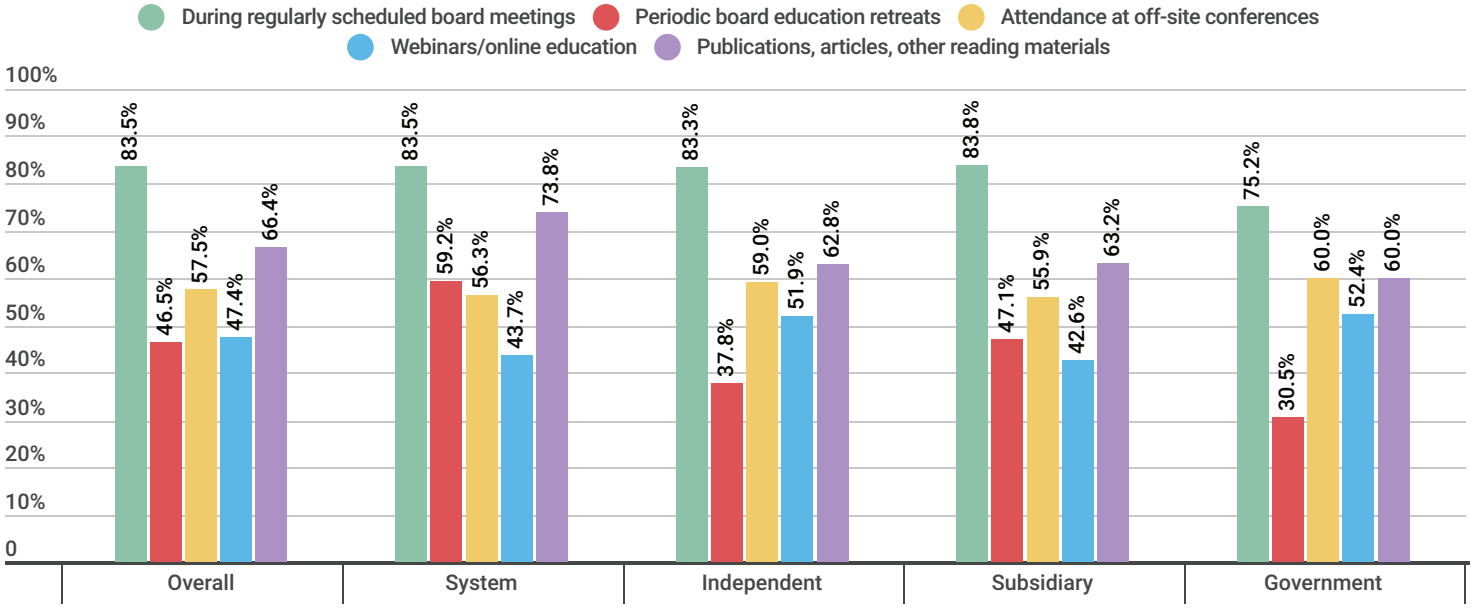
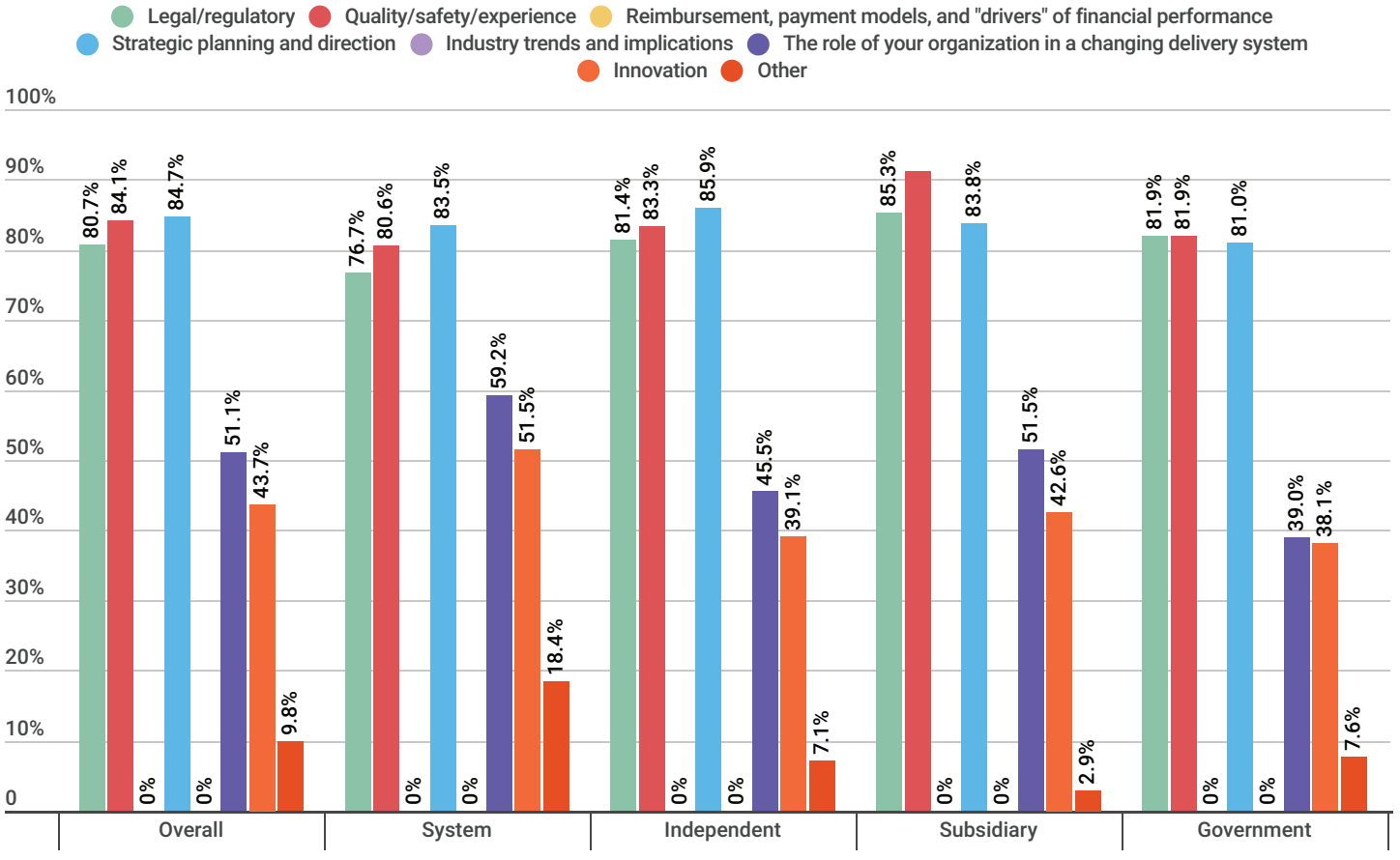


Exhibit 23. Topics Covered for Internal Board Education



Board Member Preparation

Summary of Findings

Use of Board Portal or Similar Online Tool

- 77% 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. Specifically, 72% of respondents already use a board portal, and another 5% are in the process of implementing a portal. We have continued to see these numbers rise incrementally since 2017.
- Most organizations that use a portal continue to provide hardware (laptops, tablets, etc.) to their board members for this purpose.
- 91% of system boards use a board portal.
- 40% said the most important benefit of using a board portal is that it enhances board members' level of preparation for meetings. Twenty-six percent (26%), the next highest category, said the best benefit is its enhancement of security and confidentiality of board communication and materials. (This is the first year we asked about security/confidentiality of the board portal being an important benefit; last year the second highest category for this question was reducing paper waste/duplication costs.)

Exhibit 24. Most Important Benefit of Board Portal

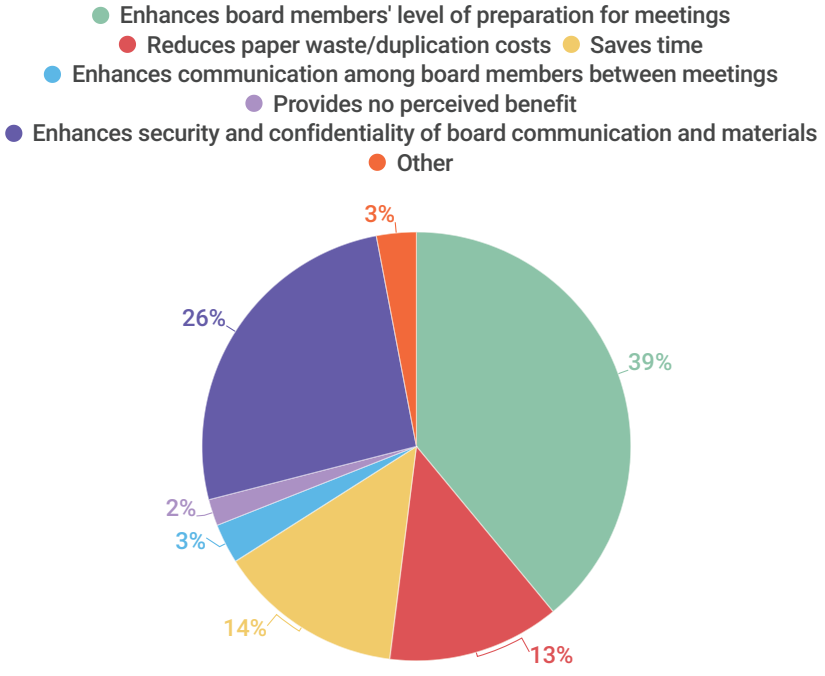
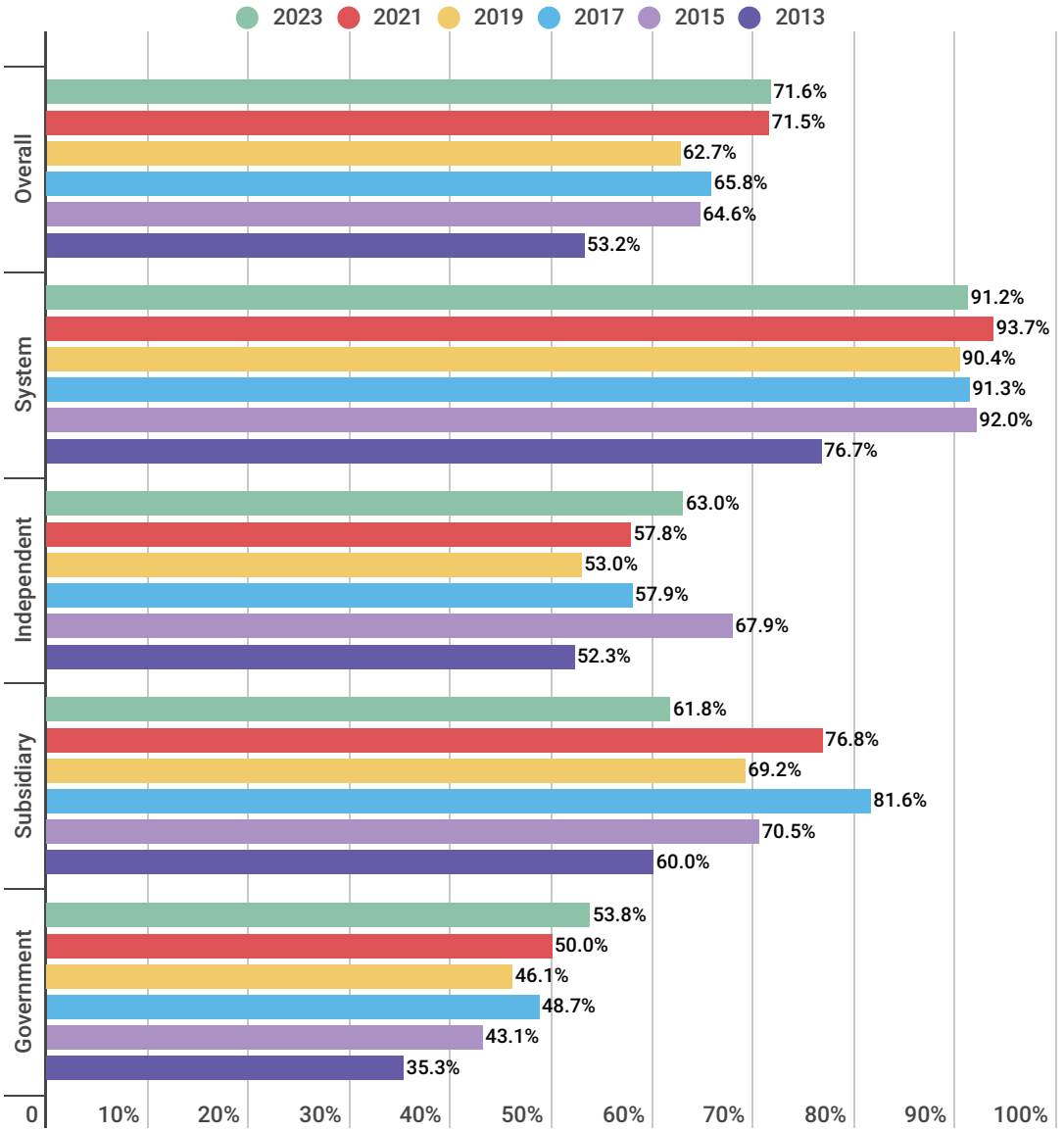


Exhibit 25. Use of Board Portal or Similar Online Tool Since 2013



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.). Forty percent (40%) spend 10–20 hours per month (about the same since 2019), and 33% spend less than 10 hours per month (also about the same). This is generally uniform across organization type, with the exception of health systems, 28% of which spend 20–40 hours per month.

We also asked about the number of full-time equivalent staff (FTEs) devoted to governance. For 61% of organizations, this is combined with another position (most likely the executive assistant to the president/CEO; about the same as in 2021). Health systems continue to devote the most staff to governance, with 54% having one to two people staffed for this purpose (5% of systems have three to four people).

For the vast majority (78% overall and for 91% of subsidiary hospital boards), the CEO's executive assistant or other administrative assistant is also the primary board support staff person. Thirty percent (30%) of systems have a dedicated governance support professional, and 14% of systems engage their chief legal officer for this role. This has remained stable since 2021. (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 (96%; this has remained the highest-scoring board culture statement since 2019).

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 (73%; also the lowest-scoring culture statement since 2019).

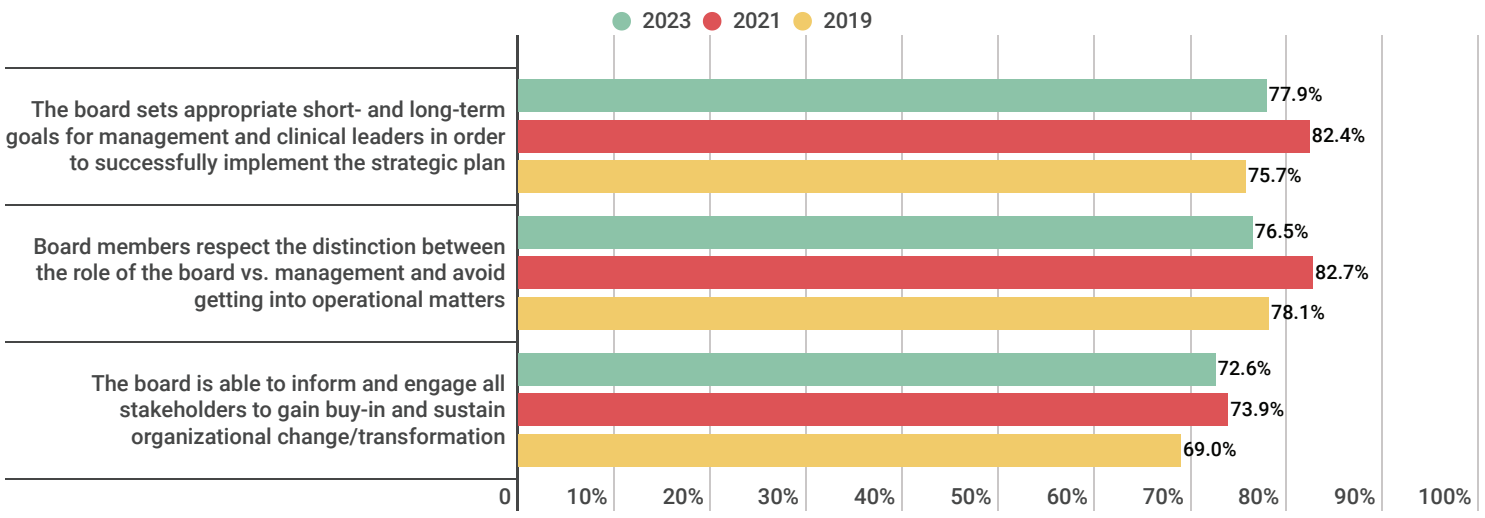
Each individual statement regarding board culture is important, but not indicative of a healthy culture by themselves. As such, we look at these statements taken together as a whole to use as a reliable indicator of a healthy board culture. To determine the degree of healthy board culture overall (all 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+
- Health systems: 92% or an A-
- Independent hospitals: 84% or a B
- Subsidiary hospitals: 90% or an A-
- Government hospitals: 82% or a B-

All of these scores remain the same as in 2021. Health systems, our top performer, still only received an A- grade. Only 33 respondents (9%) reported that they strongly agree with all nine statements. We hope to see more significant improvement in this area in the future.

Board culture improves with the number of physicians on the board (this year's data shows a positive relationship up to six physicians; for those with seven physicians and above the sample size is too small).

Exhibit 26. Board Culture: Percentage of Respondents Who Strongly Agree or Agree Since 2019
(lowest scoring areas)



SPECIAL COMMENTARY

Physician Directors: A Positive Impact on Board Culture

Kimberly A. Russel, FACHE, CEO, Russel Advisors

Hospitals and health systems have emerged from the pandemic facing severe headwinds on all fronts, including workforce challenges, economic health, and societal change. Likewise, the boards of hospitals and health systems have been under pressure with many facing existential decisions. To successfully navigate the choppy external environment, a board culture that is both strong and effective is imperative.

The 2023 biennial survey revealed an overall board culture score of 88% (B+)—identical to 2021 results. Within the overall score, the independent hospital category (score of 84%) and the government hospital category (score of 82%) received the lowest scores, although the survey demonstrates room for improvement for all types of organizations. Board composition changes, the new reality of virtual meetings, and financial challenges have each contributed to a shifting culture in the boardroom. A vital question for board leadership: What actions can be taken to strengthen board culture?

A key finding of this year is that board culture improves with the number of physicians on the board. The survey shows a positive relationship between board culture and boards with up to six physicians. This finding complements past research from The Governance Institute and this author.[1]

Physician directors have proven to be valuable board members. In addition to expertise in areas such as quality, population health, and medical staff matters, physician directors contribute beneficial insights to strategic planning, merger/acquisition decisions, growth strategies, and economic prioritization. Physician directors from specialties with a high level of direct patient contact (such as primary care and emergency medicine) add knowledge and nuance to boardroom discussions about SDOH; these physicians see firsthand the challenges patients experience. Often, physician directors will have more daily contact with individuals from underserved populations than any other director in the boardroom.

An incidental finding of this past research is that community board members deeply value physician directors and their boardroom contributions; community directors pointed out that serving alongside physicians elevated their hospital/health system board experience compared to other corporate and community boards.

Unfortunately, this year's survey notes a general downward trend in the number of physician directors. Although there has been a slight increase up to an average of 2.4 physician directors per board since 2019, this number is still less than the average of 2.9 physician directors per board in 2017. These decreases have occurred against a slight increase in average board size.

A crucial question: Why has the number of physicians serving on boards declined since 2017?

Governance committees charged with director recruitment may be concerned about potential conflicts of interest and/or a desire for independent directors. As physician career paths have changed over the years, the physician talent pipeline has broadened into roles outside the traditional hospital. Physician talent pools are no longer limited to members of the local medical staff. Physicians with the ability to serve as an independent director are living and working in our communities. Governance committees may need to explore new recruitment avenues to identify potential independent physician board candidates. (Moreover, the data show that all types of boards are maintaining a significant majority of independent board members, which means there is room to add more clinicians without disrupting this majority.)

Other boards have added physician directors who actively practice medicine at the hospital or health system—which, even if not employed by the organization still places these physicians in an "insider" status (per IRS guidance). A limited number of insider directors can be found on most boards. With an effective conflict of interest policy, physicians who are considered insider directors may still fully participate and contribute to an effective board. The central point is that independent directors should always hold a majority on the board.

Time limitations for physician directors may also be a factor. The time requirements of governance impact all directors. Many boards are doubling down on governance efficiency to ensure that the time of all directors is well-respected and efficiently used. Perhaps surprisingly, the previously referenced research found that physicians are very willing to make the time sacrifice for meaningful board service.

Proportionally, the number of directly employed physicians is increasing. Some boards exclude employed physicians from serving as voting directors to mitigate the risk of conflict of interest. These boards may wish to explore other sources of physician talent (see discussion above).

The potential to breach governance/management boundaries may be cited as a reason to invite fewer physicians into the boardroom. Frankly, this risk can occur with both medical and community board members. The best prevention is robust board recruitment coupled with a thorough onboarding process and ongoing education regarding the differences between these roles and the dangers of boards crossing over the management line.

The risks presented by physician board membership can be prevented or mitigated with comprehensive governance processes. The benefits—such as improvement in overall board culture as demonstrated in the 2023 survey—conferred on boards that are taking full advantage of physician members outweigh the risks. These survey results should generate a conversation point for governance committees: Would our board—and its culture—benefit from the addition of more physician directors? ■

1 Kimberly A. Russel, *The Voices of Physicians on Your Board,* The Governance Institute, Summer 2020.

Governance Trends

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 2021. Thus, the responses this year indicate whether any changes were made between the last reporting year and this year.

This year we see a significant decrease across all types of organizations making any changes to expand population health management. Overall, 48% of respondents have made some kind of change since 2021, compared with 84% of respondents reporting in 2021 that they had made new changes since 2019. The most significant area of activity this year is:

- 34% of respondents have added population health goals (e.g., IT infrastructure and physician integration) to the strategic plan since 2021 (compared with 50% in 2021).

This year, only 39% of respondents have made some change since 2021 to succeed with value-based payments, compared with 82% in 2021:

- 27% of respondents have added value-based payment goals to strategic and financial plans since 2021 (compared with 39% in 2021).

Exhibit 27. Changes in Structure Since 2013 to Expand Population Health Management
(respondents selected more than one answer)

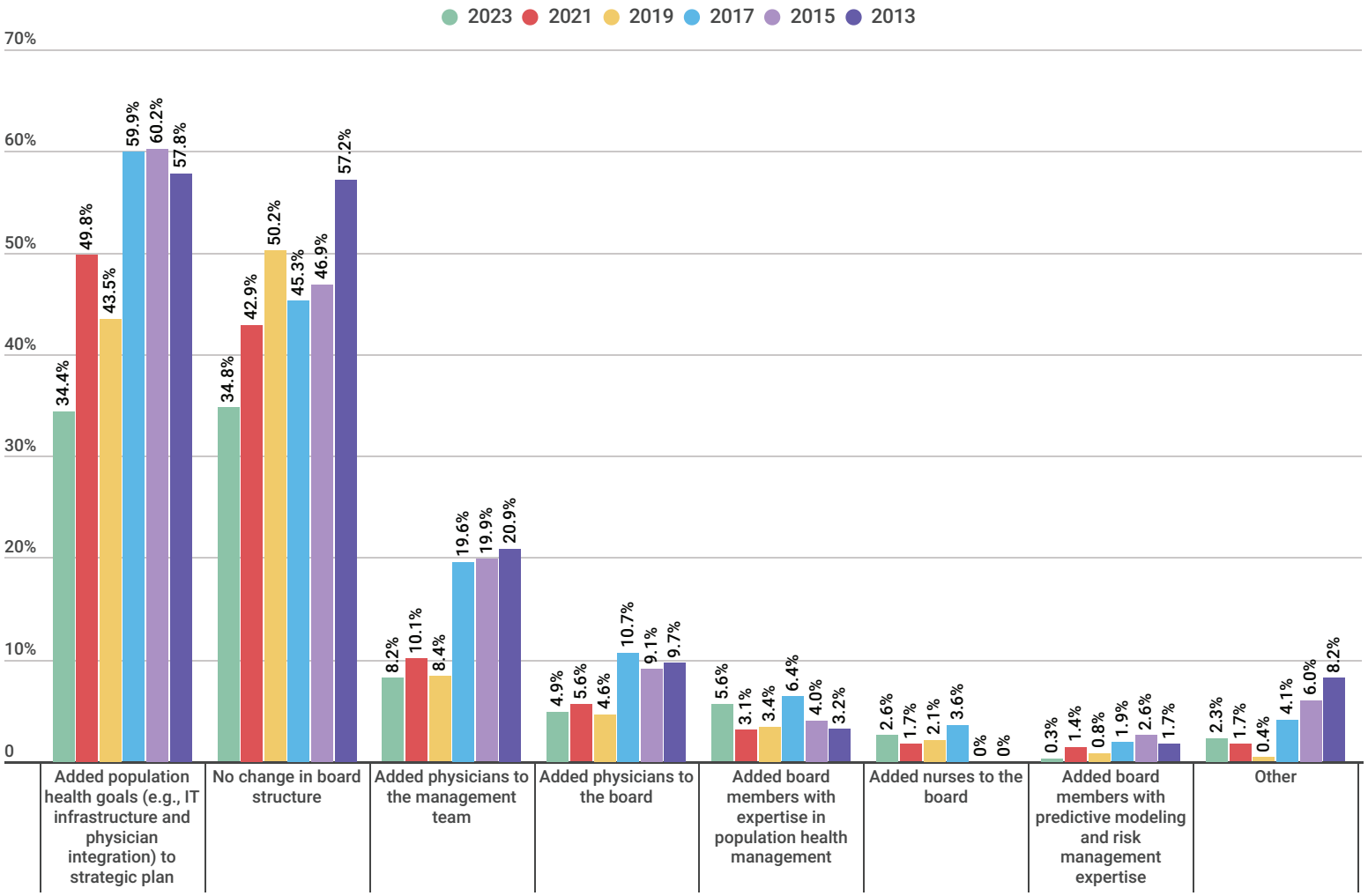


Exhibit 27a. Percentage of Organizations Making Changes to Expand Population Health Management Since 2017

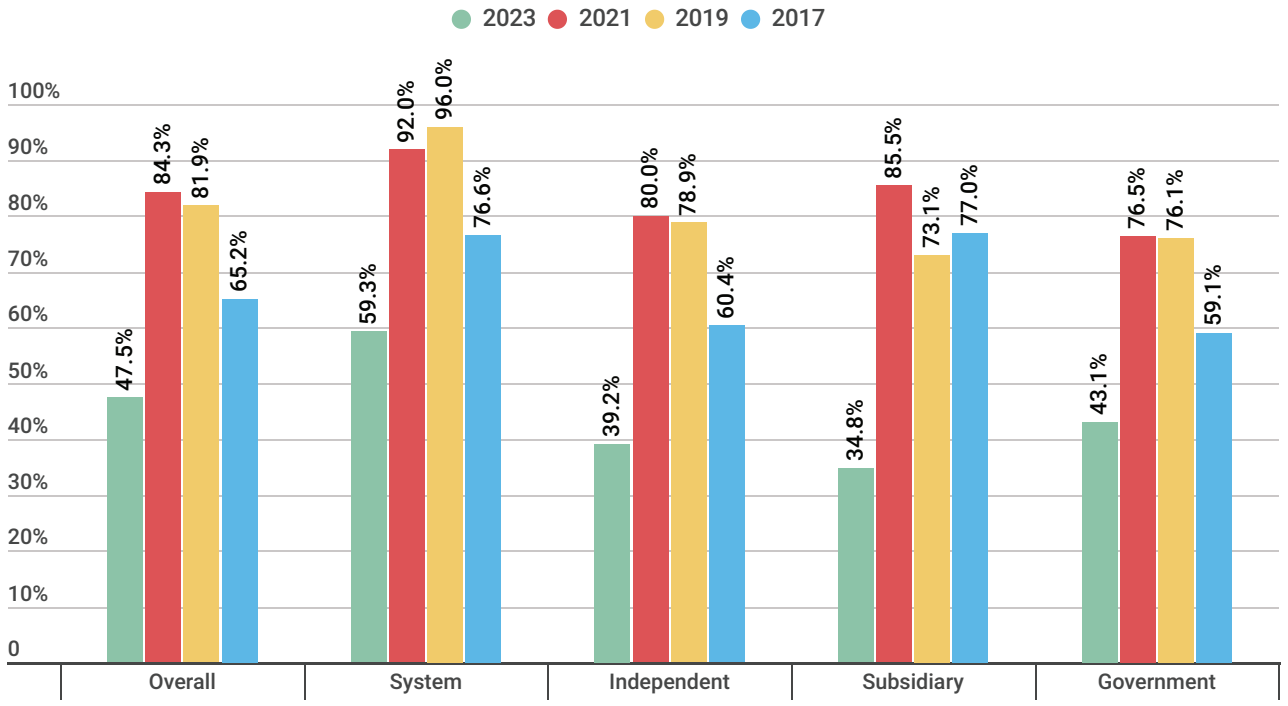


Exhibit 28. Percentage of Organizations Making Changes to Succeed with Value-Based Payments Since 2017

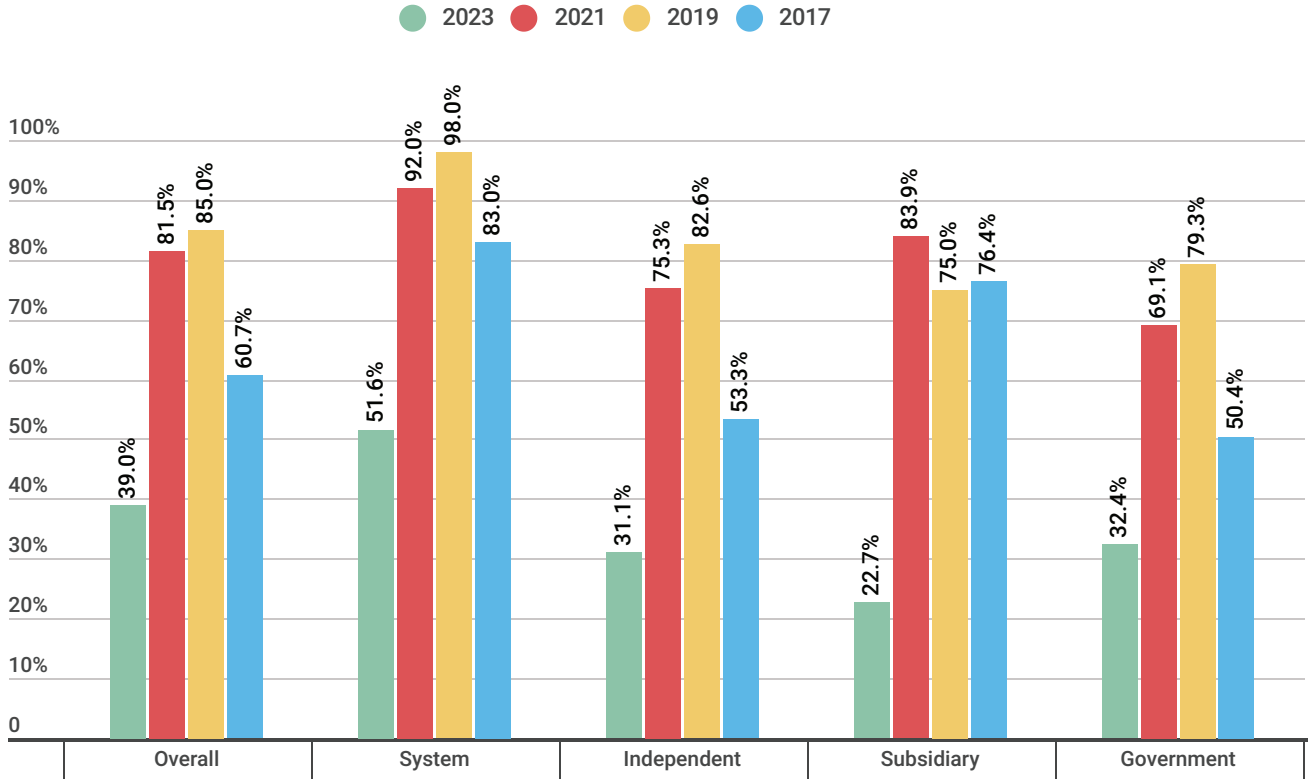
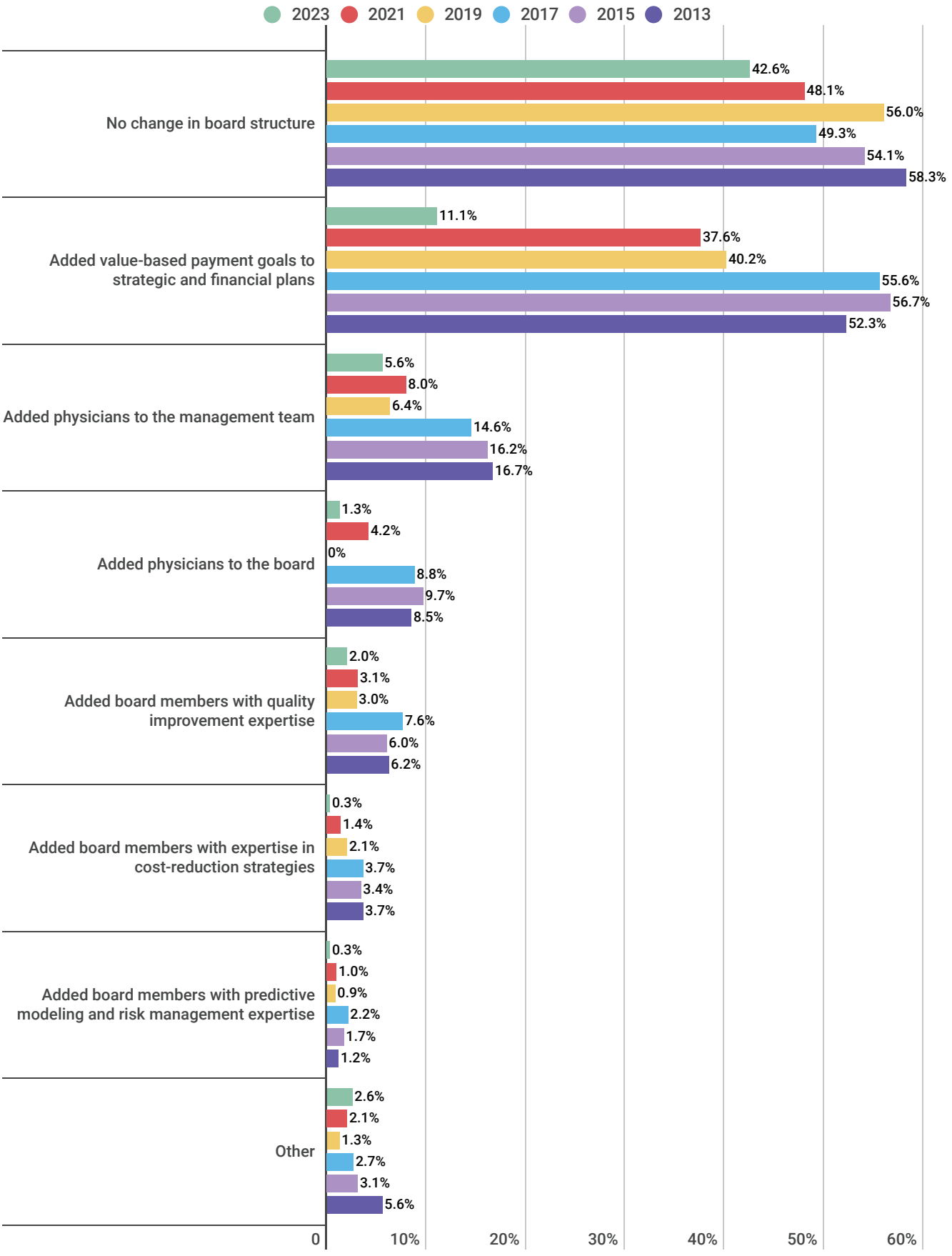


Exhibit 28a. Changes in Structure Since 2013 to Succeed with Value-Based Payments



SPECIAL COMMENTARY

Driving Value & Equity in Health System Transformation

Rick Gilfillan, M.D., Independent Consultant

Hospitals and health systems are squarely on the horns of the "Innovator's Dilemma." After a heroic response to COVID, many now face financial and operational challenges that threaten their viability. America's decline in life expectancy and ever higher healthcare costs continue to clarify the need for higher value and more equitable healthcare. But hospitals and health systems seem to be pulling back on the limited efforts they made in that direction. Meanwhile, for-profit innovator firms, operating in a gold rush mentality under the banner of "value-based care," have built alternative delivery approaches that threaten the key drivers of hospital sustainability. Now, the largest for-profit organizations in the U.S.—Amazon, WalMart, CVS—are acquiring and scaling up those disruptors to position them to control much of the projected $6.6 trillion healthcare spend by 2031.

The Governance Institute's 2023 biennial survey shows a continued decline in activity since 2019 at the board and management level regarding value-based care strategies, setting goals and metrics related to value, staffing, adding board members with specific skills, and other related activities. The decline in activity in these areas is most significant from 2021 to 2023; for example, 11 percent of responding organizations added value-based payment goals to their strategic and financial plans in 2023, compared with 38 percent in 2021. At the same time, some hospital systems with their own insurance companies are asking whether those are essential.

The dilemma: hospitals and health systems need to decide whether they will disrupt their current business model to compete with these firms or simply stay the course and risk becoming a commoditized minor player in healthcare's future.

The Healthcare Gold Rush

The largest publicly-traded technology companies and healthcare insurers are positioning to take control of a majority of America's healthcare spend at the same time that providers are backing away from taking risk. Small, privately-backed firms like Oak Street Health, Iora Health, Agilon, Summit Health, and ChenMed started this trend by taking total cost-of-care contracts for Medicare Advantage and commercial populations. CVS/Aetna has acquired Oak Street, Walgreens has acquired Summit, Amazon acquired Iora, and WalMart is now rumored to be acquiring ChenMed. Despite being dressed up as "value-based care," these arrangements will result in higher costs for payers, the government, and employers; higher premiums for employees and Medicare beneficiaries; and higher costs for taxpayers. Moreover, these kinds of ventures increase the fragmentation of care in an already overly segmented and complicated delivery system. For-profit ownership guarantees that healthcare dollars will flow out of the system to pay for dividends, profits, and stock repurchasing for the corporations *without showing any tangible benefits for patients, families, and communities.* Left unchecked, the total healthcare spend of taxpayer dollars will end up serving corporate interests, not peoples' needs. In this world, control of the dollars will yield control of the delivery system. Who will drive the direction of healthcare now?

Making the Case for True Transformation

Higher-quality care improves outcomes—and it is the right thing to do—but has not been shown to result in lower costs, despite 30 years of hoping that it would. The only way to spend less on healthcare is to spend less. This means providing fewer services and paying less per unit of service. To be successful in that context means hospitals and health systems must transform to become high-value providers.

But these providers are incumbents facing the disruptive innovators Clay Christensen described in *The Innovator's Dilemma.*[2] Becoming high-value providers that decrease their prices and volume of services threatens current results at a very challenging time. Total cost-of-care contracts can offer pathways to a gradual transition to a new sustainable model. Typically based on a percentage of premium, the dollars reflect today's distribution of services and prices paid. The innovative disruptors seek to decrease those services and prices, keeping the savings as their profit. Hospitals and health systems could take the same contracts and use those savings to fund their transition to a lower-cost delivery system model. The question is whether non-profit hospitals and health systems will fight to be total cost-of-care providers or cede this opportunity to others.

Obstacles to True Value Transformation

Hospitals and health systems face internal and external obstacles:

Internal:
- Today's financial challenges
- "Status quoism"
- Fear of self-disruption

External:
- Limited payer commitment
- Policymakers' negative view of non-profit health systems
- Competition focused on volume-driven success

The Board Must Be the Driver

While hospitals and health systems have been active participants in the movement towards value by participating in CMS accountable care programs, their success to date has produced only about 50 percent of the savings produced by physician-led ACOs. Most observers and policymakers believe this reflects a limited commitment to the program by status-quo organizations. The biennial survey data suggests even this limited commitment is waning.

2 Clayton M. Christensen, *The Innovator's Dilemma: The Revolutionary Book That Will Change the Way You Do Business,* Harper Collins, 2011.

In a world where America's most successful businesses are threatening to take control of healthcare spending, there are at least three reasons hospitals and health systems should step up their efforts and take the leading role in value transformation:

1. Business sustainability
2. Meeting their charitable mission
3. Maintaining America's mission-driven healthcare industry

Driving this transformation in a larger, wider, more accelerated manner now will require a long-term strategic vision that is still grounded in the current reality of very challenging business dynamics. But boards must make the difficult decision to "disrupt" themselves. We are witnessing today the results of inaction, as health systems are gradually losing business to aggressive innovators who are unencumbered by yesterday's business model.

Becoming a high-value delivery system will require major internal operational changes. Hospitals will need to reengineer operations to be profitable at lower prices for outpatient and some inpatient services. They will also require new operational approaches to ensure all services are the right ones delivered in the most efficient sites of care. Systems with owned insurance operations have a significant advantage in making this transition.

This transformation is dependent on the ability to create new external partnerships. To date, individual hospital and collective association advocacy has been largely directed towards improving FFS reimbursement. These efforts have positioned hospitals and health systems as obstructions to value transformation. Boards need to become active drivers of an advocacy agenda aimed at becoming a real partner with others to drive value transformation.

Changing the Payer Relationship

An often cited and frequently accurate reality is that private payers have been unwilling to contract in ways that would drive transformation. But boards and senior leaders, following a committed strategy to transform, can do more to push payers to be real partners. Ask for meetings and explore the offers with each payer in your market—particularly plans like Blue Cross and Blue Shield with leading market share and may share common board members with health systems. Boards can also use their local and state political and regulatory connections to give payers more reason to come to the table. The discussion needs to be about designing new systems that are sustainable, but that also include a plan for hospitals to reasonably transition to the new value-based care model and addresses each party's respective responsibilities to eliminate healthcare inequities.

Impacting large national insurers will require national advocacy through the AHA, the AMA, and others. Boards should encourage their chief executives to push the AHA to make this point louder in the national discourse and place more pressure on Congress to force payers to change the way they do business. While payers do have a powerful D.C. lobby, the reality is that individual hospitals and health systems have strong support on the Hill.

Boards must make the difficult decision to "disrupt" themselves. We are witnessing today the results of inaction, as health systems are gradually losing business to aggressive innovators who are unencumbered by yesterday's business model.

Advocacy will be essential to creating a payer context with CMS and the large national insurers that supports value transformation leadership. Overseeing public advocacy is a core responsibility of the non-profit healthcare board, and often an area that is overlooked due to focus on shorter-term concerns. If boards and senior leaders don't advocate, payers will not change.

Key Questions for the Board

The board can start now by diving into a deep, generative discussion with the following questions as a guide:

1. Is the CEO clearly and visibly committed to leading this transformation?
2. What is the organization's stated strategic intent regarding becoming a high-value health system that addresses inequities and SDOH?
3. What are the strategic objectives that capture this intent?
4. What are the specific goals that are targeted to demonstrate success?
5. How can the organization overcome the core barriers to transformation?
6. Is the strategy reliant on simply providing indiscriminate provision of more health services or on producing better health for the population served?
7. Are the internal incentive systems aligned with the value transformation and health equity objectives?
8. Are the resources provided for the value and health equity objectives adequate to drive the desired results?
9. How has the organization approached the cultural changes required to be successful?
10. Is the board willing to make bolder action to hold management accountable for transformation?

Conclusion: Why Do It?

Change is hard. We know the status quo. Change brings uncertainty and potential failure. Worse yet, we fear that moving to value too fast might erode our revenue. The tendency is to wait, see if the threat is real, and hope we can ride the FFS model for as long as possible. Take a hard look at your organization's mission and think about whether you can continue to fulfill it without this transformation. What is the right way to keep people healthy? What is your fiduciary responsibility today, when the old business model is fading or failing? If for-profit disruptors expand their steal of the profitable pockets of the delivery system, our patients and communities will be vulnerable in a healthcare industry that is driven by profits rather than mission. The visionary founders of American non-profit healthcare—sisters, brothers, rabbis, priests, and dedicated community leaders—addressed the perceived healthcare needs of their time. They left us a legacy of passion, dedication, and commitment. To be their worthy successors we need to transform our institutions to create the high-value equitable healthcare system America needs today. ■

System Governance Structure and Allocation of Responsibility

We asked system boards about the governance structure of the system overall, whether the system board approves a document or policy specifying allocation of responsibility and authority between system and local boards, and whether that association of responsibility and authority is widely understood and accepted by both local and system-level leaders.

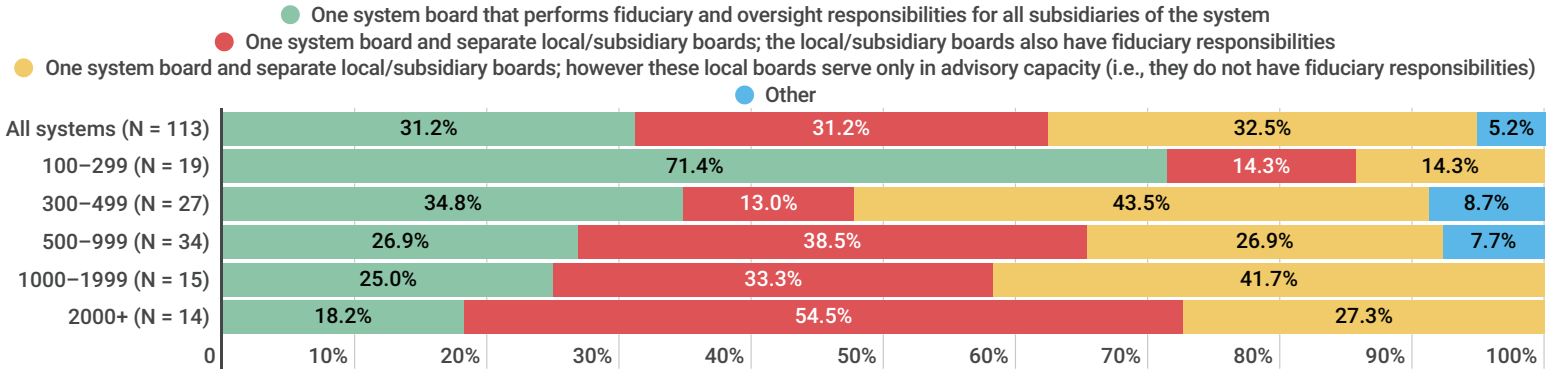
Governance Structure

In 2015, most systems (52%) had a system board as well as separate local/subsidiary boards with fiduciary responsibilities. Since 2017, system respondents have been more evenly split across the three primary governance structures. This year's percentages are as follows:

- 31% have one system board that performs fiduciary and oversight responsibilities for all subsidiaries of the system.
- 31% have one system board and separate local/subsidiary boards that also have fiduciary responsibilities.
- 33% have one system board and separate local/subsidiary boards; however these local boards serve only in an advisory capacity (i.e., they do not have fiduciary responsibilities).

The most striking difference from 2021 is the movement away from fiduciary responsibility at the local board level (in 2021, 46% had fiduciary local boards and only 18% had local advisory boards).

Exhibit 29. System Governance Structure by Organization Size *(# of beds)*



Sixty-two percent (62%) 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 39% in 2021).

Association of Responsibility/ Authority Understood and Accepted

Overall, 83% of system respondents approve a document or policy specifying allocation of responsibility and authority between system and local boards. Seventy-three percent (73%) of system respondents said that the assignment of responsibility and authority is widely understood and accepted by both local and system-level leaders (up from 69% in 2021). The remaining 27% say that this is an area that needs improvement or is not widely understood/ accepted. (See **Exhibits 30** and **31**.)

Again 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 30. System Board Approves a Document or Policy Specifying Allocation of Responsibility & Authority between System & Local Boards

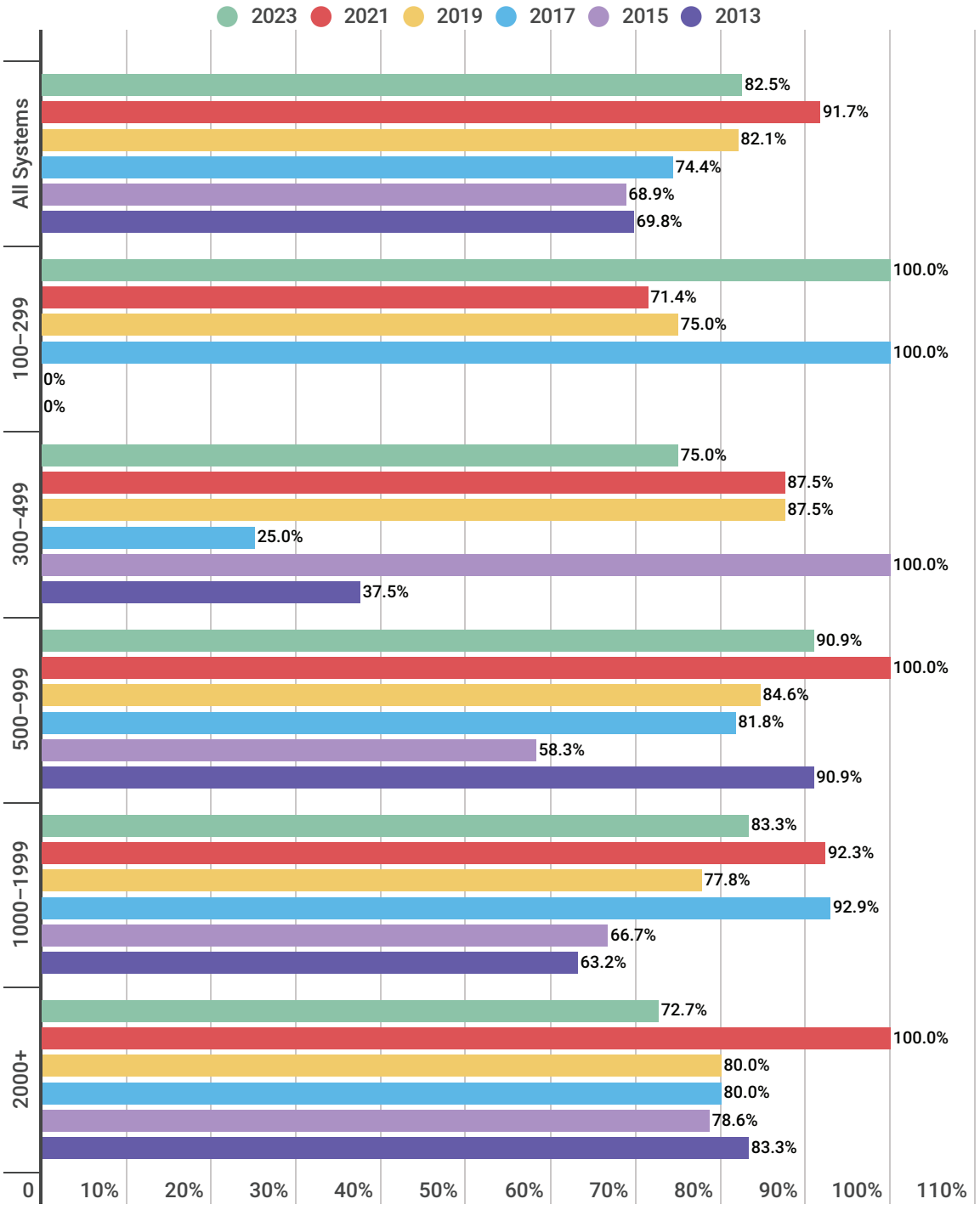
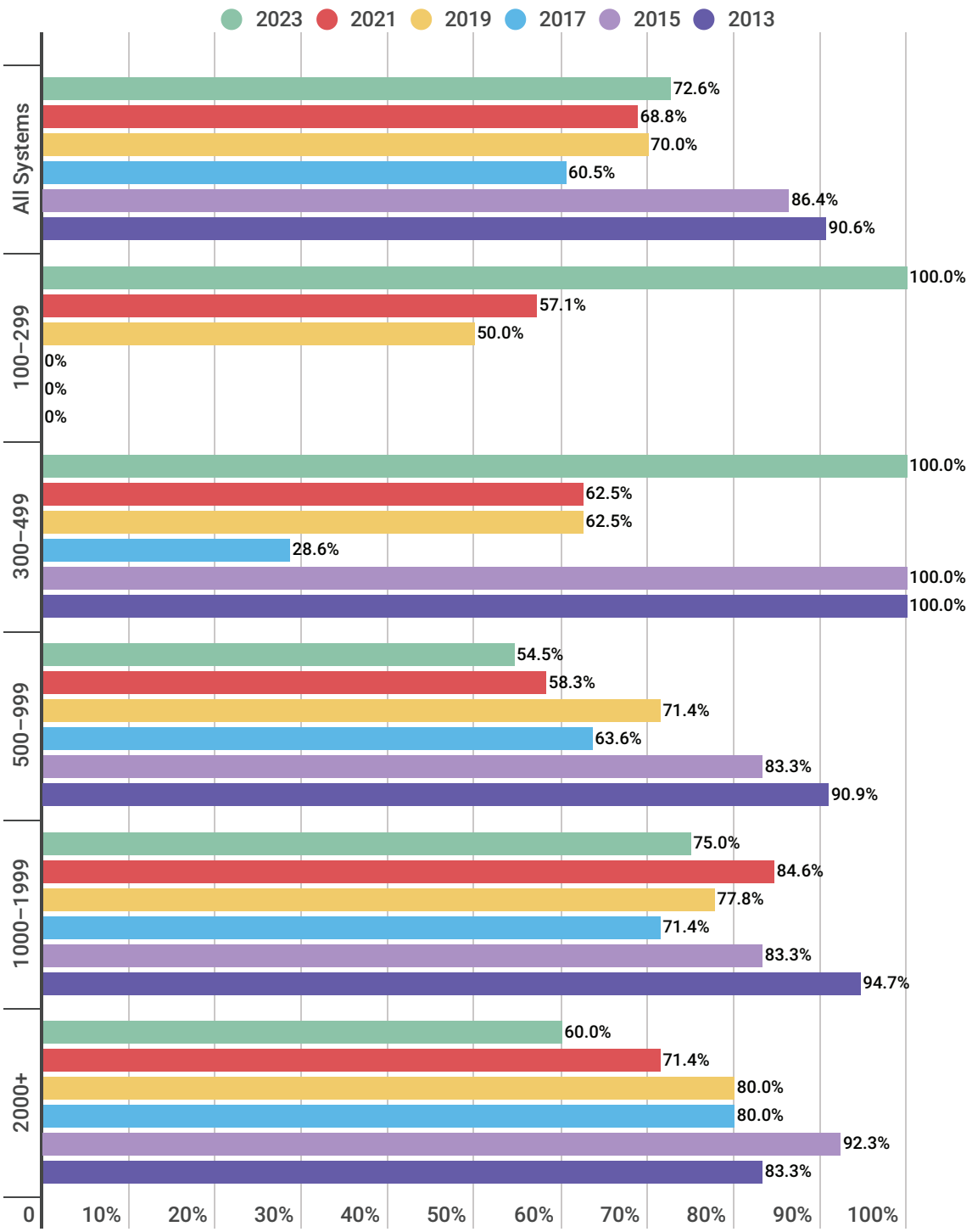


Exhibit 31. Allocation of Responsibility & Authority Widely Understood & Accepted by Both Local & System Leaders



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 (e.g., signs of integration at the governance level). In prior years, data trends showed some more typical areas where subsidiary boards were likely to retain fiduciary responsibility (quality/safety, community/population health, board education and board member appointment). This has been despite some boards declaring themselves "advisory" boards only (no fiduciary duties retained at the subsidiary board level). This is the first year that we see a much clearer line for the advisory boards that responded to this year's survey indicating that the system retains fiduciary responsibility. For the subsidiary fiduciary boards, there have been increases in shared responsibility in some areas, along with increases in system-level responsibility in other areas.

Along those lines, the most significant or interesting highlights for fiduciary subsidiary boards (2023 vs. 2021) are:

- More reported that they share responsibility for determining their organization's capital and operating budgets (52% vs. 42%) and setting their organization's customer service goals (52% vs. 32%).
- One hundred percent (100%) retain responsibility for medical staff credentialing, compared with 19% of advisory boards.
- These boards are more likely to retain responsibility for selecting their organization's audit firm (55% vs. 17%) and approving the audit (60% vs. 21%).
- More reported that they share responsibility with the system for establishing their organization's corporate compliance program (47% vs. 27%).

System boards have increased their authority for the following:

- Appointing/removing the subsidiary chief executive (36% vs. 22%)
- Determining/approving executive compensation (27% vs. 13%)
- Identifying the subsidiary's community health needs (24% vs. 17%)
- Setting the subsidiary's community health goals (24% vs. 18%)
- Setting the subsidiary's population health improvement goals (24% vs. 15%)

Table 15 shows a comparison of 2023 and 2021 results (please note that this data reflects a relatively small sample size). See **Exhibit 32** for a comparison focusing on the issues where there has been most movement towards system-level responsibility since 2015.

Exhibit 32. Board Issues Showing Most Significant Increase in System-Level Responsibility

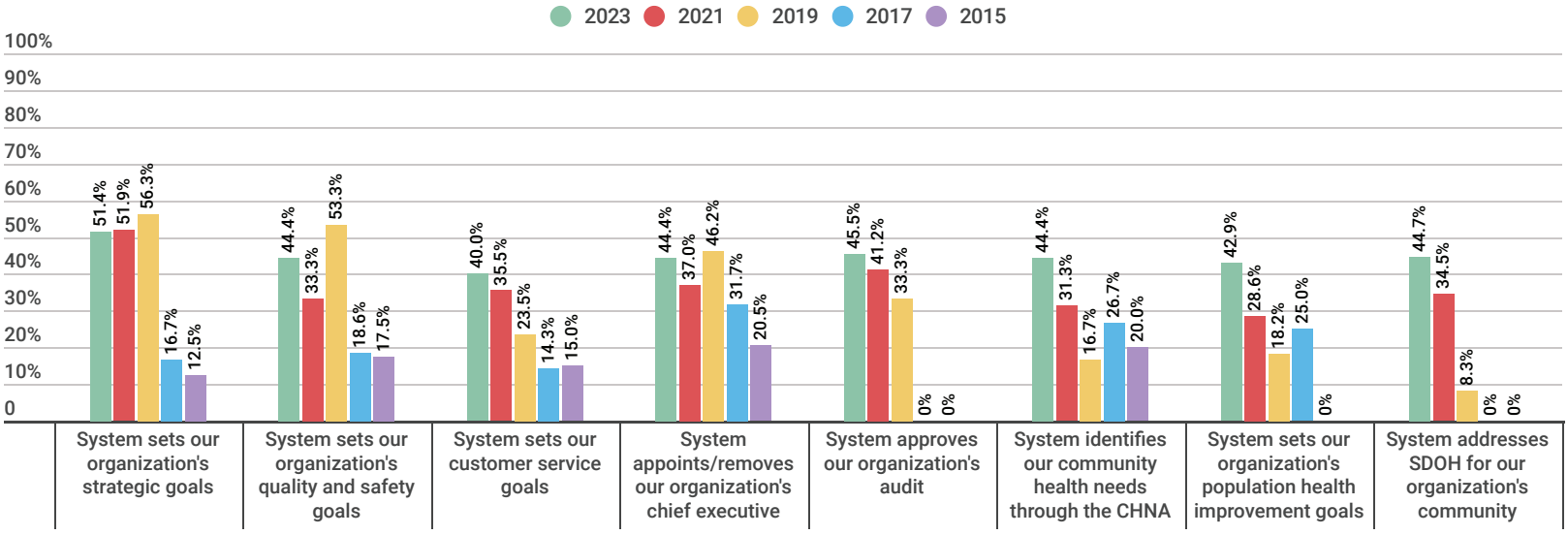


Table 15. Allocation of Decision-Making Authority 2023 vs. 2021

Subsidiary Hospital Boards	Fiduciary Boards	Advisory Boards	Fiduciary Boards	Advisory Boards
Total number of respondents in each category	**67**	**20**	**91**	**18**
ROLE OF THE SUBSIDIARY BOARD IN THE FOLLOWING DECISIONS:	**2023**		**2021**	
Setting our organization's strategic goals				
Total responding to this question (N/A not included for all)	22	15	18	9
Our board retains responsibility	31.8%	6.7%	22.2%	0.0%
Our board shares responsibility	36.4%	13.3%	27.8%	44.4%
System board retains responsibility (our board has advisory capacity)	31.8%	80.0%	50.0%	55.6%
Determining our organization's capital and operating budgets				
Total responding to this question	21	14	17	8
Our board retains responsibility	33.3%	7.1%	17.6%	0.0%
Our board shares responsibility	42.9%	0.0%	23.5%	25.0%
System board retains responsibility (our board has advisory capacity)	23.8%	92.9%	58.8%	75.0%
Setting our organization's quality and safety goals				
Total responding to this question	21	15	24	9
Our board retains responsibility	28.6%	6.7%	29.2%	11.1%
Our board shares responsibility	52.4%	13.3%	41.7%	44.4%
System board retains responsibility (our board has advisory capacity)	19.0%	80.0%	29.2%	44.4%
Setting our organization's customer service goals				
Total responding to this question	21	14	22	9
Our board retains responsibility	33.3%	14.3%	36.4%	11.1%
Our board shares responsibility	52.4%	7.1%	31.8%	44.4%
System board retains responsibility (our board has advisory capacity)	14.3%	78.6%	31.8%	44.4%
Approving our organization's medical staff credentialing/appointments				
Total responding to this question	21	16	22	9
Our board retains responsibility	100.0%	18.8%	81.8%	33.3%
Our board shares responsibility	0.0%	12.5%	13.6%	11.1%
System board retains responsibility (our board has advisory capacity)	0.0%	68.8%	4.5%	55.6%
Appointing/removing our organization's chief executive				
Total responding to this question	22	14	18	9
Our board retains responsibility	31.8%	21.4%	16.7%	11.1%
Our board shares responsibility	31.8%	21.4%	61.1%	22.2%
System board retains responsibility (our board has advisory capacity)	36.4%	57.1%	22.2%	66.7%
Determining/approving executive compensation				
Total responding to this question	15	9	15	5
Our board retains responsibility	40.0%	11.1%	33.3%	0.0%
Our board shares responsibility	33.3%	11.1%	53.3%	20.0%
System board retains responsibility (our board has advisory capacity)	26.7%	77.8%	13.3%	80.0%
Selecting our organization's audit firm				
Total responding to this question	11	6	12	3
Our board retains responsibility	54.5%	16.7%	16.7%	0.0%
Our board shares responsibility	27.3%	0.0%	50.0%	33.3%
System board retains responsibility (our board has advisory capacity)	18.2%	83.3%	33.3%	66.7%

Table 15. Allocation of Decision-Making Authority 2023 vs. 2021 *(continued)*

Subsidiary Hospital Boards	Fiduciary Boards	Advisory Boards	Fiduciary Boards	Advisory Boards
Total number of respondents in each category	**67**	**20**	**91**	**18**
ROLE OF THE SUBSIDIARY BOARD IN THE FOLLOWING DECISIONS:	**2023**		**2021**	
Approving our organization's audit				
Total responding to this question	15	7	14	3
Our board retains responsibility	60.0%	14.3%	21.4%	0.0%
Our board shares responsibility	13.3%	0.0%	42.9%	33.3%
System board retains responsibility (our board has advisory capacity)	26.7%	85.7%	35.7%	66.7%
Establishing our organization's corporate compliance program				
Total responding to this question	15	10	15	5
Our board retains responsibility	33.3%	20.0%	26.7%	20.0%
Our board shares responsibility	46.7%	10.0%	26.7%	20.0%
System board retains responsibility (our board has advisory capacity)	20.0%	70.0%	46.7%	60.0%
Identifying our organization's community health needs through the CHNA				
Total responding to this question	21	15	23	9
Our board retains responsibility	57.1%	13.3%	52.2%	22.2%
Our board shares responsibility	19.0%	13.3%	30.4%	11.1%
System board retains responsibility (our board has advisory capacity)	23.8%	73.3%	17.4%	66.7%
Setting our organization's community health goals				
Total responding to this question	21	15	22	9
Our board retains responsibility	47.6%	13.3%	31.8%	22.2%
Our board shares responsibility	28.6%	13.3%	50.0%	11.1%
System board retains responsibility (our board has advisory capacity)	23.8%	73.3%	18.2%	66.7%
Setting our organization's population health improvement goals				
Total responding to this question	21	14	20	8
Our board retains responsibility	38.1%	7.1%	30.0%	12.5%
Our board shares responsibility	38.1%	21.4%	55.0%	25.0%
System board retains responsibility (our board has advisory capacity)	23.8%	71.4%	15.0%	62.5%
Addressing social determinants of health for our organization's community				
Total responding to this question	22	16	21	8
Our board retains responsibility	40.9%	6.3%	52.4%	25.0%
Our board shares responsibility	36.4%	18.8%	23.8%	12.5%
System board retains responsibility (our board has advisory capacity)	22.7%	75.0%	23.8%	62.5%
Electing/appointing our organization's board members				
Total responding to this question	22	16	24	8
Our board retains responsibility	59.1%	12.5%	16.7%	25.0%
Our board shares responsibility	36.4%	18.8%	29.2%	12.5%
System board retains responsibility (our board has advisory capacity)	4.5%	68.8%	54.2%	62.5%
Establishing our board education and orientation programs				
Total responding to this question	22	15	22	9
Our board retains responsibility	59.1%	20.0%	36.4%	33.3%
Our board shares responsibility	31.8%	13.3%	50.0%	33.3%
System board retains responsibility (our board has advisory capacity)	9.1%	66.7%	13.6%	33.3%

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 20 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. Also, be sure to refer to **Table 10** to see a comparison of the types of board competencies being sought by these 20 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 two members). Seventy-one percent (71%) of the board are independent board members (compared with 65% in 2021 and 60% in 2019; and compared with 74% independent board members of fiduciary subsidiary boards):

Advisory Boards	Total # of Voting Board Members		Management*		Medical Staff Physicians**		Independent Board Members***		Other Board Members****	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Average # of Voting Board Members	12.6	13.4	1.5	0.7	1.8	2.9	8.9	8.7	1.5	1.0
Median # of Board Members	12	14	2	0	1	1	8	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.

At a high level, the structure and composition of advisory boards is more similar this year to fiduciary boards. The biggest difference we see is with the dramatic reduction of responsibilities advisory boards "own" at the local level, as shown in **Table 15**. In looking at the trendline over the years since we began separating out advisory boards, despite the small sample size, it shows that systems have gradually been working to clarify the role of advisory boards and that these boards have a better understanding of their role.

Other structure and composition variances compared with fiduciary subsidiary boards:

- Term limits: 100% of advisory boards have term limits (14 responded to this question) vs. 56% of fiduciary subsidiary boards.
- Voting president/CEO: 59% advisory vs. 33% fiduciary.
- CNO is less likely to attend meetings (44% of advisory boards have their CNO attend vs. 78% of fiduciary boards).
- 40% meet only quarterly (vs. 12% of fiduciary boards), and usually meetings are less than two hours.
- Advisory boards are more likely to have their CEO and clinical board members always attend executive sessions, and rarely have their legal counsel attend. The topics typically discussed are miscellaneous governance issues, general strategic planning/issues, and quality performance. In contrast, for fiduciary boards, legal counsel is more likely to attend, and sessions are spent discussing executive performance/evaluation, executive compensation, and miscellaneous governance issues.
- Interestingly, this year 45% of advisory boards have a strategic planning committee compared with 28% of fiduciary boards.
- Advisory boards continue to spend less on board education: 77% spend under $10,000 (up from 70% in 2021 and compared with only 42% of fiduciary boards at this level of spending).
- Advisory boards are much less likely to use a board portal (35% vs. 71%).

Governance Practices: Fiduciary Duties and 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. All appendices are available at www.governanceinstitute.com/2023biennialsurvey.*

Performance Results

Performance composite scores for 2023 are lower than in 2021 for *all* fiduciary duties and core responsibilities—a change from 2021 when all scores were higher than the previous survey year. The performance ranking order stayed almost the same (duty of care ranked higher than duty of obedience this year; in 2021, they were tied). Community benefit and advocacy and board development are still ranked last—these scores declined the most since 2021 but remain higher than 2019 scores. (See **Table 16**; areas showing the biggest decrease 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 33**. (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			
		2023	2021	2019	2015
1	Financial Oversight	4.45	4.52	4.44	4.57
2	Duty of Loyalty	4.36	4.43	4.37	4.41
3	Duty of Care	4.32	4.37	4.28	4.46
4	Duty of Obedience	4.28	4.37	4.35	4.37
5	Management Oversight	4.24	4.30	4.19	4.31
6	Quality Oversight	4.21	4.29	4.17	4.39
7	Strategic Direction	4.16	4.19	4.08	4.11
8	Community Benefit & Advocacy	**3.98**	**4.12**	3.91	3.92
9	Board Development	**3.70**	**3.82**	3.62	3.79

Note: areas showing the greatest decrease since 2021 are in bold.

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

Fiduciary Duties and Core Responsibilities	Performance Rank				
	2023	2021	2019	2015	2013
Financial Oversight	1	1	1	1	1
Duty of Loyalty	2	2	2	3	3
Duty of Care	3	3*	4	2	2
Duty of Obedience	4	4*	3	5	4
Management Oversight	5	5	5	6	6
Quality Oversight	6	6	6	4	5
Strategic Direction	7	7	7	7	7
Community Benefit & Advocacy	8	8	8	8	8
Board Development	9	9	9	9	9

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

Exhibit 33. Overall Board Performance

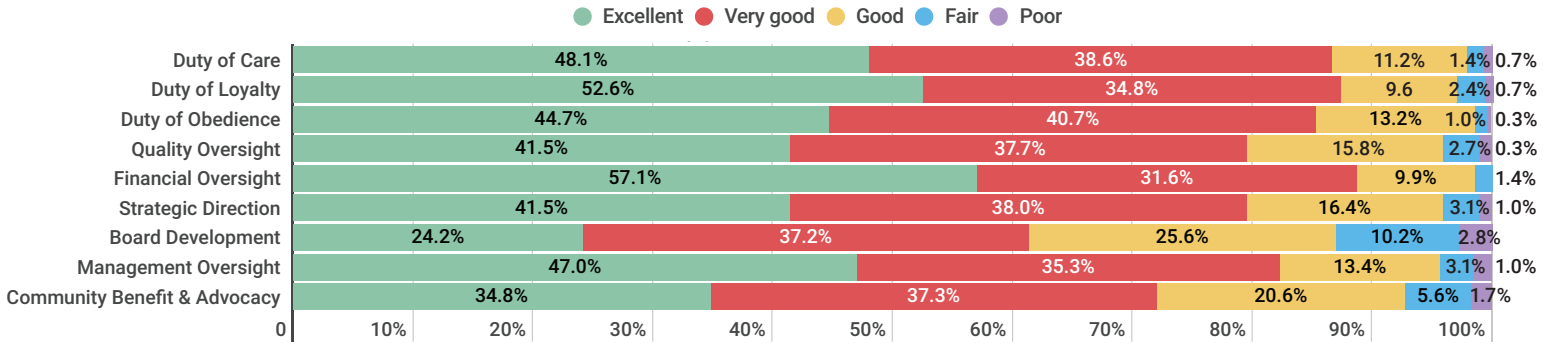
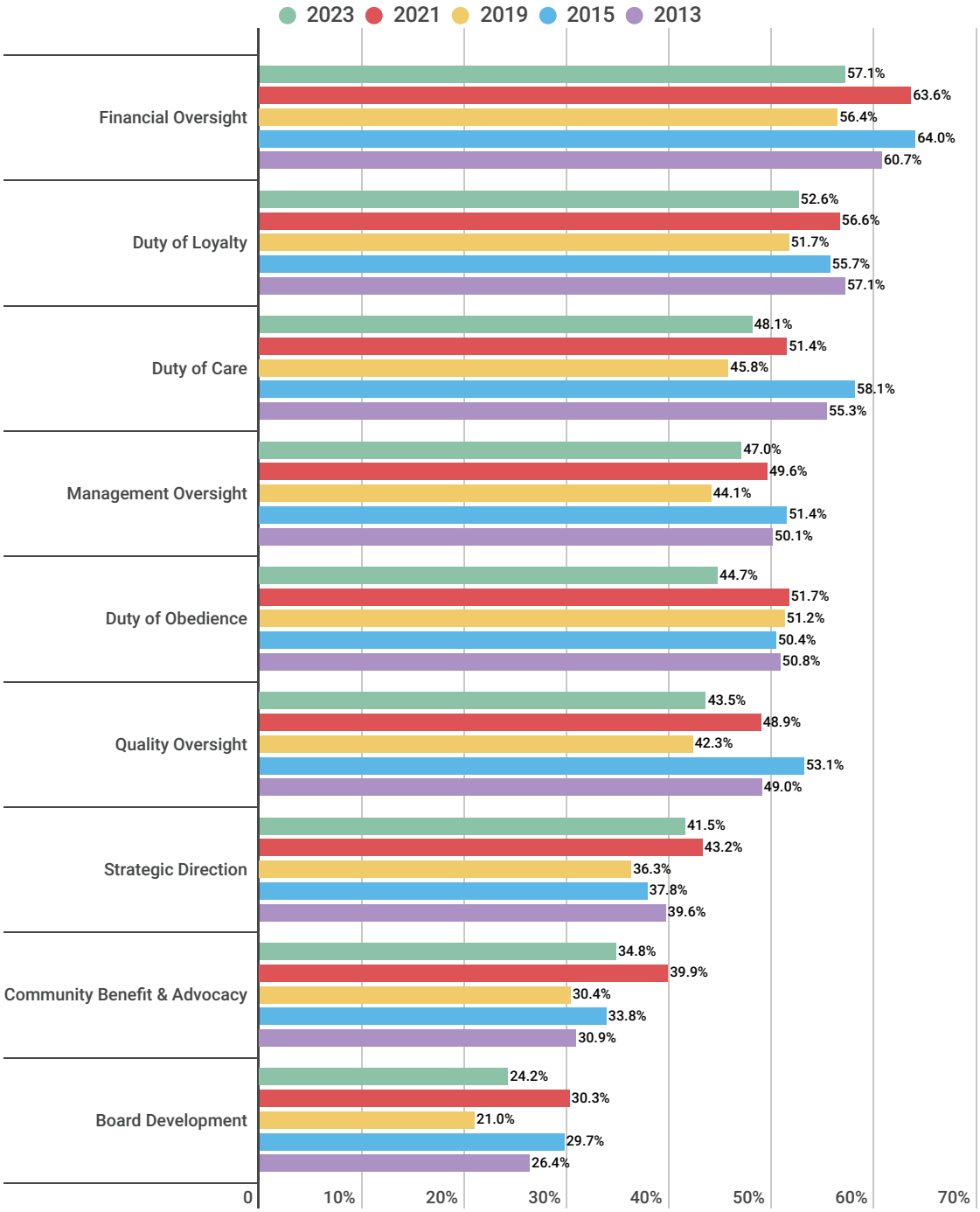


Exhibit 34. Excellent Board Performance Since 2013

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

*Note: We did not survey on governance practices in 2017



When comparing the "top two" ratings (percent of respondents rating their boards "excellent" or "very good"), this year's performance ratings tend to be similar to previous years, with some slightly decreasing. Community benefit and advocacy has improved the most over the years, moving up 16 percentage points since 2011. All of the scores have slightly dropped since 2021, except management oversight, which stayed the same. **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.** For 2023, the percentage of respondents rating their board as "excellent" dropped in all categories compared to 2021. (See Exhibit 34.)

Board Performance across Types of Organizations

Table 18 shows the breakdown of "top two" ratings by type of organization for 2023 and 2021. Systems consistently have higher percentages of "top two" ratings than other types of organizations. This year, government-sponsored hospitals were the only organizations to show improvement, with increases in six of the categories.

Table 19 shows performance results by composite score (5 = "excellent"). Composite performance scores decreased since 2021 in every area overall, with community benefit and advocacy and board development decreasing the most (in 2021, these areas saw the biggest increase). Subsidiaries (down 28 points) saw the biggest decrease in community benefit and advocacy and systems (down 20 points) saw the biggest decrease in board development. Subsidiaries also saw a 27-point decrease in duty of obedience scores. While in 2021, systems had the biggest increase in quality oversight (up 16 points), this survey showed a decrease of 17 points. Government-sponsored hospitals experienced the most improvement, with increased scores in six of the duties and responsibilities.

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** online.)

Table 18. Percent of Respondents Who Rated Their Board as Excellent or Very Good 2023 vs. 2021

(overall and by organization type)

Fiduciary Duties & Core Responsibilities	Overall (all hospitals and systems)		Systems		Independent Hospitals		Subsidiary Hospitals		Government-Sponsored Hospitals	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Financial Oversight	89%	90%	**96%**	**99%**	87%	86%	83%	90%	89%	79%
Duty of Loyalty	87%	89%	**92%**	**96%**	84%	85%	88%	92%	87%	78%
Duty of Obedience	85%	87%	**91%**	**97%**	83%	84%	83%	85%	86%	78%
Duty of Care	87%	89%	**90%**	**94%**	84%	86%	89%	92%	86%	83%
Management Oversight	82%	82%	**92%**	**91%**	78%	81%	77%	75%	84%	71%
Quality Oversight	81%	84%	**88%**	**91%**	76%	81%	83%	83%	79%	79%
Strategic Direction	80%	82%	**90%**	**90%**	73%	77%	78%	81%	70%	78%
Community Benefit & Advocacy	72%	77%	**82%**	**79%**	65%	75%	74%	78%	67%	67%
Board Development	61%	65%	**66%**	**79%**	58%	57%	62%	66%	54%	49%

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

Table 19. Board Performance Composite Scores 2023 vs. 2021

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	
	2023	2021	2023	2021	2023	2021	2023	2021	2023	2021
Financial Oversight	4.45	4.52	4.66	4.76	4.39	4.43	4.27	4.46	4.37	4.27
Duty of Care	4.32	4.37	4.46	4.58	4.27	4.25	4.25	4.43	4.21	4.19
Duty of Loyalty	4.36	4.43	4.59	4.67	4.21	4.28	4.38	4.53	4.19	4.17
Quality Oversight	4.21	4.29	4.38	4.55	4.09	4.12	4.27	4.40	4.09	4.06
Duty of Obedience	4.28	4.37	4.51	4.61	4.21	4.23	4.15	4.42	4.16	4.09
Management Oversight	4.24	4.30	4.55	4.51	4.09	4.24	4.11	4.18	4.10	4.05
Strategic Direction	4.16	4.19	4.43	4.46	4.04	4.06	4.03	4.18	3.99	4.09
Community Benefit & Advocacy	3.98	4.12	4.22	4.23	3.81	4.00	4.00	4.28	3.78	3.83
Board Development	3.70	3.82	3.83	4.03	3.59	3.68	3.75	3.91	3.51	3.53

Fiduciary Duties and Core Responsibilities

Fiduciary Duties

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

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

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

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

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, equity, 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** online. After the overview below, we present an analysis of the results in the next section.

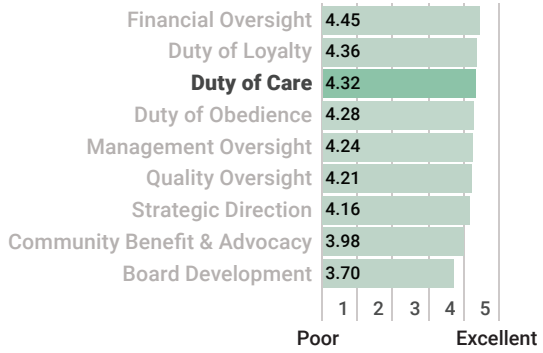
Reader's guide reminder: Results in this section are reported as composite scores—essentially, a weighted average of responses. There are two scales used in this section:

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.

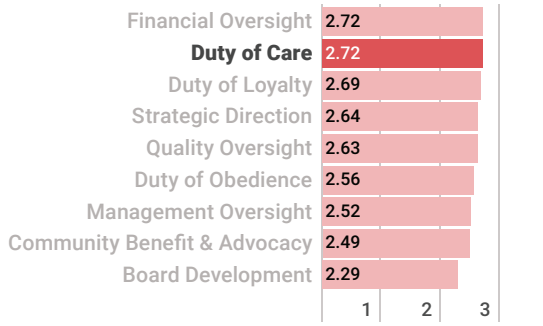
Duty of Care—Key Points

- CEOs gave boards' performance in duty of care the third-highest performance score (4.32 out of 5).
- Duty of care is first in adoption of recommended practices (tied with financial oversight)—up from ranking third in 2021.
- The duty of care practices appear to be widely adopted; the most highly 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.
- The most significant decline in adoption overall (down 20 points) was for: 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; this was also the least-adopted practice. Subsidiary hospitals with advisory boards saw the greatest decline (2.24 vs. 2.71 in 2021). Government-sponsored hospitals also declined significantly in adoption of this practice (2.30 vs. 2.69 in 2021). Systems were the only organizations that improved.
- The lowest scoring practice was subsidiary hospitals with advisory boards securing expert, professional advice before making major financial and/or strategic decisions (e.g., financial, legal, facility, other consultants, etc.)—1.82 vs. 2.80 in 2021. Fifty-nine (59)% of subsidiary advisory boards said this was not applicable to them, so the weighted average score represents those that said they were not considering adopting the practice, but did not indicate that the practice was not applicable to their board.

Board Performance Composite Scores
(All Respondents)

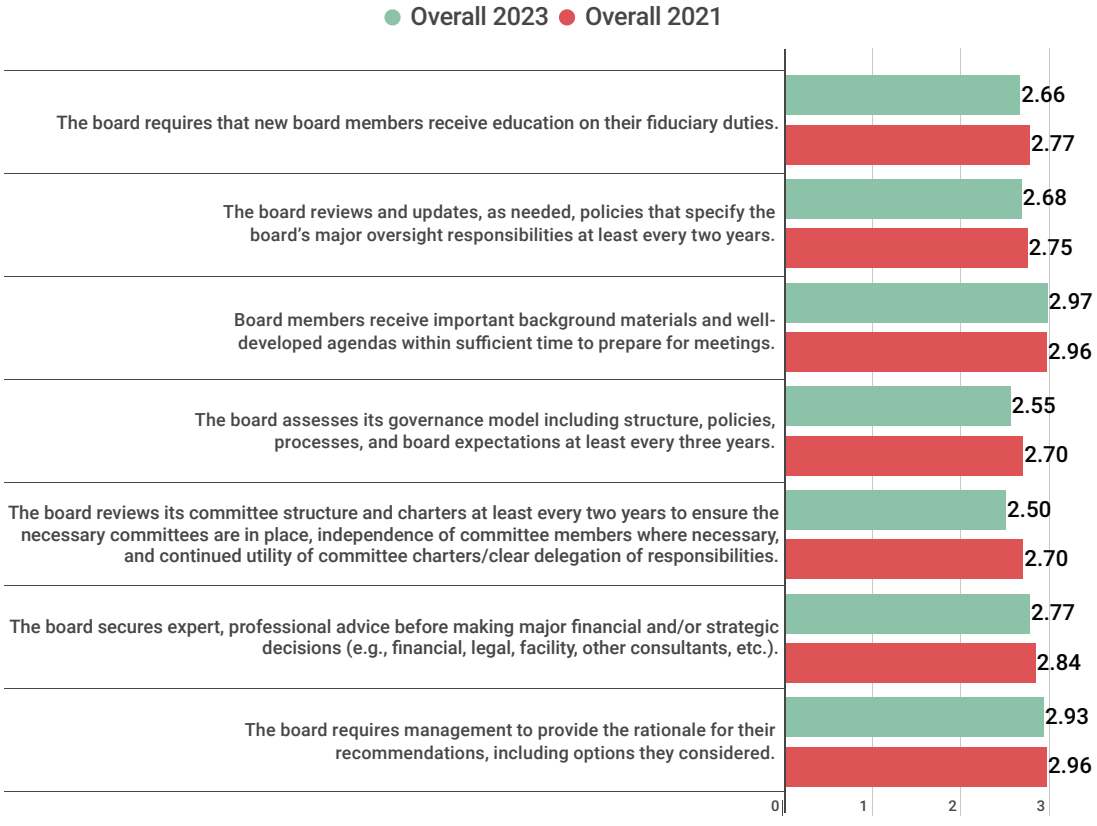


Adoption of Practice Composite Scores
(All Respondents)



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

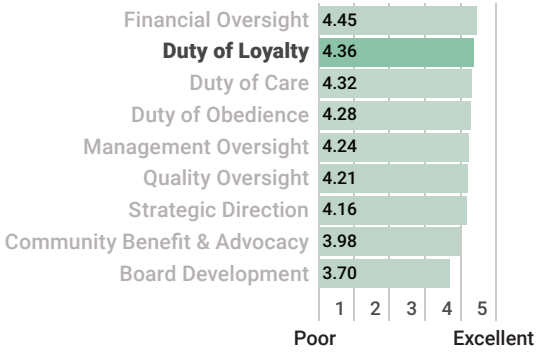
Exhibit 35. Duty of Care Composite Scores *(Adoption)*



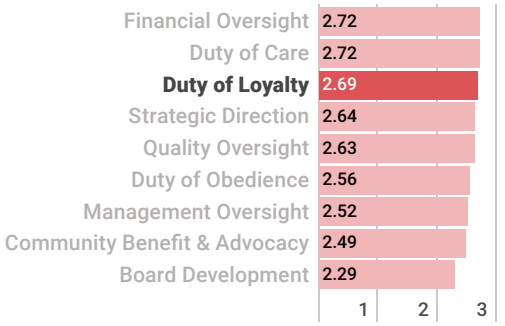
Duty of Loyalty—Key Points

- Duty of loyalty is rated second in performance (same as 2021 and 2019).
- Just as in 2021 and 2019, it is second in adoption; this is a significant increase since 2015 where it was rated sixth.
- Overall, adoption decreased for all duty of loyalty practices. The most significant drop in adoption was for: the board reviews and ensures that the Federal Form 990 information filed with the IRS meets the highest standards for completeness and accuracy (2.49 vs. 2.94 in 2021). All organization types experienced a decrease in adoption scores for this practice, but government-sponsored hospital scores declined the most (1.78 vs. 2.79 in 2021).
- The most-adopted practices were: the board enforces a conflict-of-interest policy; and board members complete a conflict-of-interest disclosure statement annually (same as in 2021 and 2019).
- The least-adopted practice was the board having a written policy outlining the organization's approach to physician competition/conflict of interest (same as in 2021), with government-sponsored hospitals having the lowest adoption and experiencing a decline in adoption (2.14 vs. 2.33 in 2021). Subsidiary hospitals with fiduciary boards had the most significant drop in adoption of this practice (moving from 2.85 in 2021 to 2.33 in 2023).

Board Performance Composite Scores
(All Respondents)

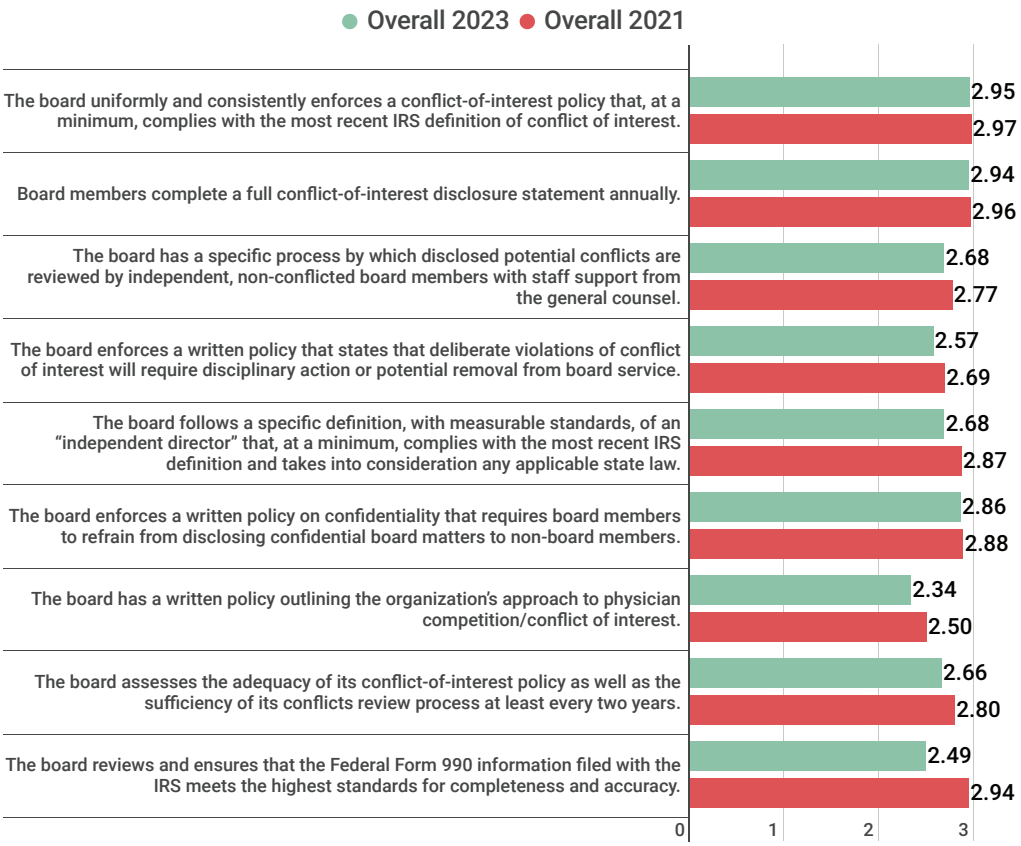


Adoption of Practice Composite Scores
(All Respondents)



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 Loyalty Composite Scores *(Adoption)*

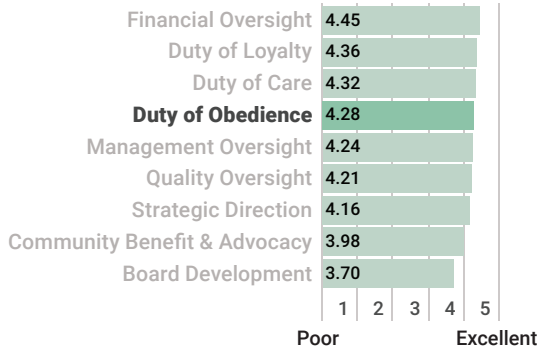


Duty of Obedience—Key Points

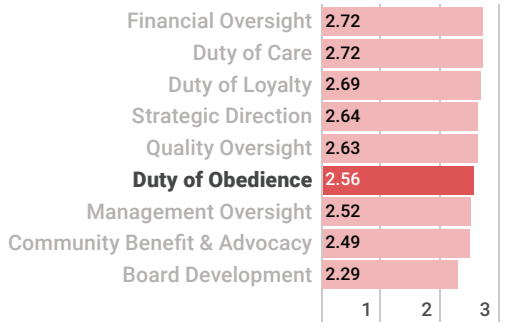
- CEOs gave boards' performance in duty of obedience the fourth-highest performance score—down one spot from 2021 when it tied with duty of care for third place).
- Duty of obedience is ranked fifth in adoption of recommended practices (up from sixth in 2021).
- Consistent with 2021 and 2019, the most highly adopted practice was: 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. Systems and independent hospitals had the highest adoption rates for this practice (2.98 and 2.90 respectively). Subsidiary hospitals were the only organizations to experience a substantial decline in scores—subsidiary boards with fiduciary duties scored 2.68 vs. 2.94 in 2021 and subsidiary advisory boards scored 2.53 vs. 3.00 in 2021.
- The least-adopted practice was: the board establishes a risk profile for the organization and holds management accountable to performance consistent with that risk profile. This is consistent with 2021, although that survey showed improvement in adoption for all organization types while our 2023 survey showed a decline for all organizations—subsidiary hospitals with advisory boards scores decreased the most (1.88 vs. 2.80 in 2021); 44% of advisory boards said this was not applicable to them.
- The only practice that increased in adoption was: the board has approved a "code of conduct" policies/procedures document, but only by one point (2.86 vs. 2.85).
- All other practices saw a decline, and the largest decrease in adoption were for the following practices:
  - Board members responsible for audit oversight meet with external auditors, without management, at least annually (2.44 vs. 2.77 in 2021); systems were the only organization that increased their adoption of this practice.
  - The board has established a direct reporting relationship with legal counsel (2.24 vs. 2.54 in 2021).
  - 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 (2.29 vs. 2.59 in 2021).
- Subsidiary hospitals with advisory boards scored the lowest in all 16 duty of obedience practices.

See **Exhibit 37** on the next page.

Board Performance Composite Scores
(All Respondents)

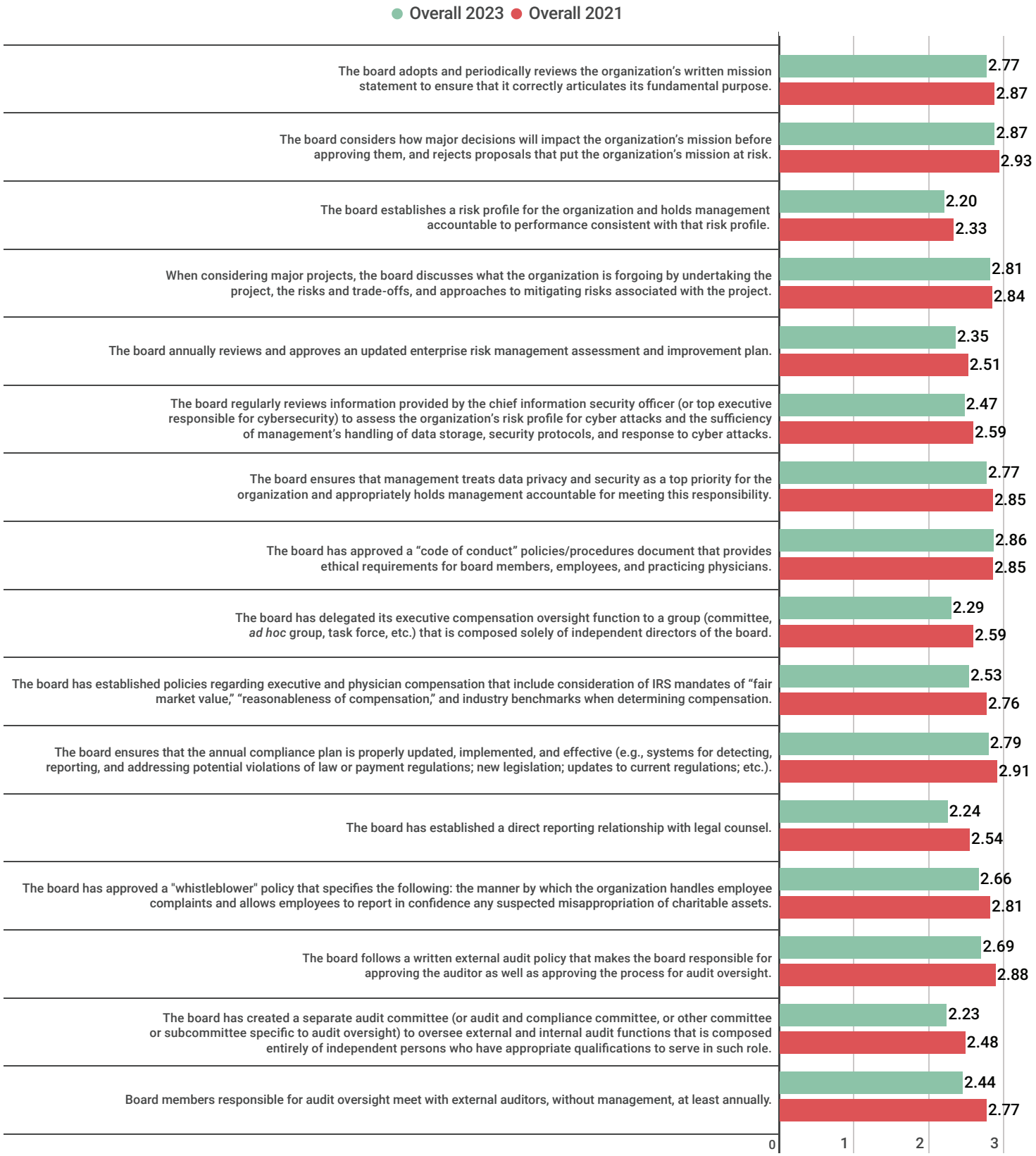


Adoption of Practice Composite Scores
(All Respondents)



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

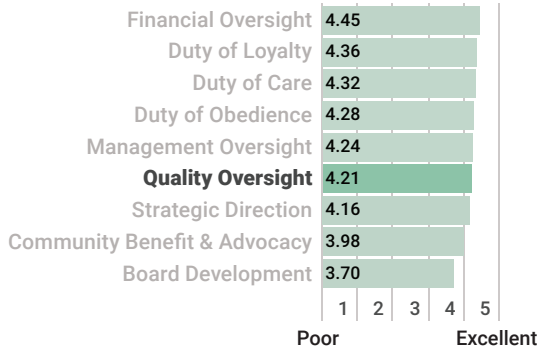


Quality Oversight—Key Points

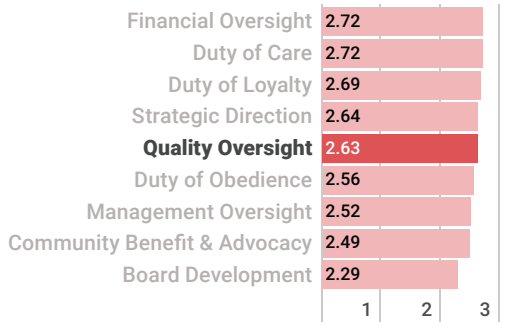
- CEOs gave boards' performance in quality oversight the sixth-highest rating (the same ranking as in 2021).
- Quality oversight is ranked fourth in adoption of practices (same as in 2019).
- The most highly adopted practice was: the board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.
- The practice with the lowest adoption and also the greatest decline in adoption was: the board allocates sufficient resources to developing physician leaders and assessing their performance (2.17 vs. 2.53 in 2021). All organization types significantly decreased adoption in this area.
- Practices that have been shown to improve quality of care (process of care and/or risk-adjusted mortality)* are:
  - Establishing a board-level quality committee *(systems have adopted this practice more than other types of organizations, although all organizations' adoption decreased)*
  - 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)*
  - Requiring new clinical programs/services to meet quality-related performance criteria *(this practice is adopted across all organization types, with subsidiary hospitals with fiduciary boards having the highest adoption scores)*
  - Devoting a significant amount of time to quality issues/discussion at most board meetings *(this practice is adopted across all organization types; subsidiary hospitals with advisory boards have the highest adoption scores and were the only organizations that increased adoption)*
  - Participating in development/approval of explicit criteria to guide medical staff appointments, reappointments, and clinical privileges *(independent hospitals and government-sponsored hospitals showed the highest adoption of this practice and were the only organizations that increased adoption)*
  - Including objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation *(systems have the highest adoption scores, although lower than in 2021; government-sponsored hospitals were the only organizations to increase adoption of this practice)*
  - Challenging recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff *(all organization types decreased adoption of this practice)*

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

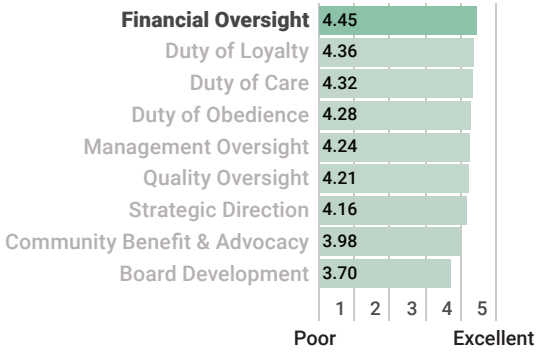
* As reported in: Larry Stepnick, *Making a Difference in the Boardroom: Updated Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2014; Larry Stepnick, *Making a Difference in the Boardroom: Preliminary Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2012; H.J. Jiang, et al., "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, et al., "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 38. Quality Oversight Composite Scores *(Adoption)*

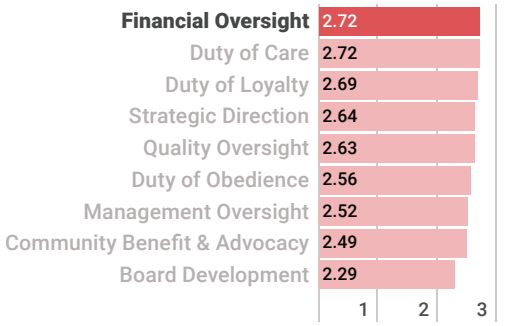
Financial Oversight—Key Points

- CEOs again gave boards' performance in financial oversight the highest performance score (4.45 out of 5).
- Financial oversight is also ranked first in adoption of recommended practices (tied with duty of care).
- Although there is still broad adoption of recommended practices in financial oversight across all organization types, scores did decrease for all six practices.
- The biggest decline in adoption was for: the board annually reviews and approves the investment policy (2.51 vs 2.78 in 2021). This was also the least-adopted practice for all organization types, except systems, which highly adopt this practice. For systems, the least-adopted practice was 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.
- The highest adoption overall was for: the board is sufficiently informed and discusses the organization's annual capital and operating budget before approving it. (All organization types have generally adopted this practice, except subsidiary hospitals with advisory boards.)
- Systems had the highest-level of adoption in most practices, scoring above 2.90 in all but one practice. Subsidiary hospitals with advisory boards had the lowest adoption, scoring below 2.00 in four of the practices.

Board Performance Composite Scores
(All Respondents)

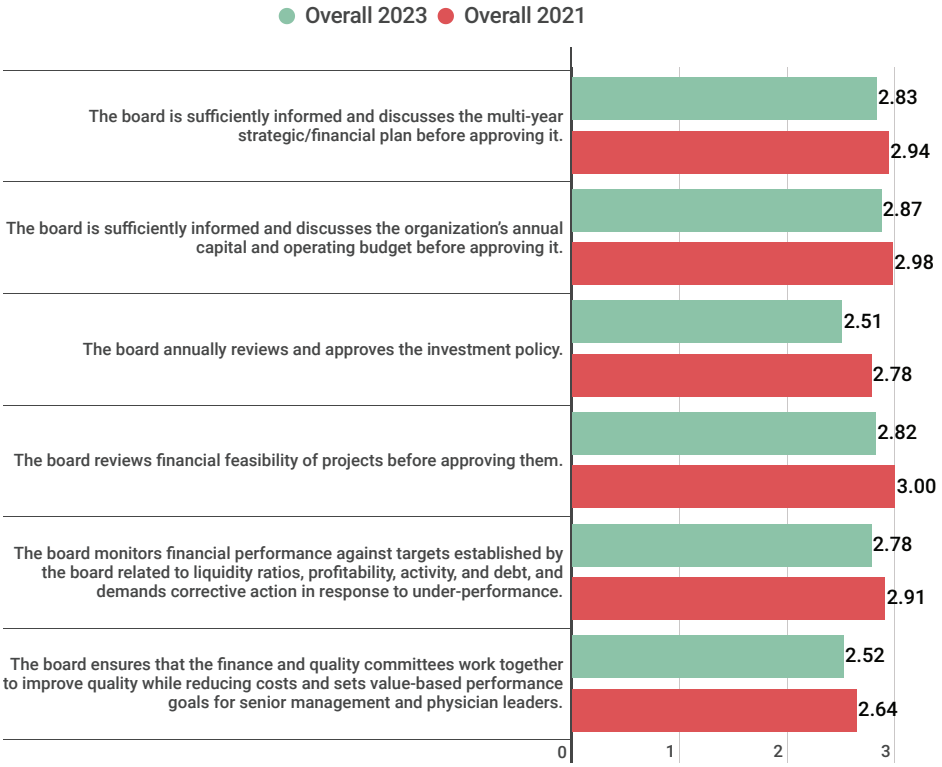


Adoption of Practice Composite Scores
(All Respondents)



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

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



SPECIAL COMMENTARY

Finance and Strategy Are Inseparable

John Fink, Partner, ECG Management Consultants

For nearly four years, the resiliency of our hospitals and health systems has been challenged. We've moved from one crisis to the next. Boards have focused on what is needed to overcome the immediate adversities facing their organizations. But boards should always continue their primary role of evaluating and guiding long-term strategies to position their organization for the needs of tomorrow. Survey results indicate that only one-third of boards spend greater than 30% of their meeting time in active discussion, deliberation, and debate about strategic priorities. And only 5% of boards meet The Governance Institute's recommendation of dedicating 50% of meeting time to strategic discussion.

Perhaps the disconnect is in the way boards view their discussion of financial reports and/or the focus or facilitation of those discussions. A 10-minute review of financial performance should generate at least a 20-minute discussion about strategy. Finance and strategy are interconnected and inseparable. It should not be possible to consider the current or future financial position without discussing short- and long-term strategic implications. Likewise, any discussion about strategic plans or priorities must incorporate the financial implications to the organization.

Given today's financial challenges, hospital boards should ensure adequate strategic discussion about financial topics like reimbursement/payer strategy, capital investment priorities, and market consolidation. Or would it be a financial discussion about these strategic topics?

Reimbursement/Payer Strategy

Many factors influence improvements in commercial reimbursement to hospitals. Unfortunately, increases in the cost to hospitals of providing care is only a secondary factor. The hospital's bargaining power is paramount. From 2013 through 2018, the average annual increase in commercial reimbursement of 3.2% more than doubled the average inflation rate of 1.5%. In contrast, for the first three years of this decade, the average inflation rate of 4.6% has more than doubled the average increase in commercial reimbursement of 1.9%.

Payers are not experiencing the same financial hardships as hospitals. Over the past 10 years, insurance premiums have grown an average of approximately twice the increase in reimbursement to hospitals. However, health plans are not offering substantial rate increases to health systems. Health plans are concerned about losing members and increases in utilization, and they are using the transparency data required by hospitals to their advantage during negotiations.

Finance and strategy are interconnected and inseparable. It should not be possible to consider the current or future financial position without discussing short- and long-term strategic implications. Likewise, any discussion about strategic plans or priorities must incorporate the financial implications to the organization.

Hospitals should plan for a multi-year process to achieve the rate increases many need to reach parity with recent cost increases. Hospitals should reopen contracts and pursue terms that address rates, care management fees, and investments in public health. In addition, hospitals will be best served by partnering with payers on commercial and Medicare Advantage products to secure more of the premium dollar in value-based contracts.

Capital Investment Priorities

Many hospitals have pulled back capital investments to weather the storm of the past three years. But delaying modernization of facilities and equipment can jeopardize strategic positioning and result in market share losses, difficulty recruiting new physicians and staff, and credit rating declines. Furthermore, many health systems need to expand capital investments in ambulatory networks, hospital-at-home capabilities, and technology to position for the continued increase in consumerism in healthcare.

Boards need to ask:

- What strategies will improve operating margin so we can pay for the cost of replacing aging infrastructure?
- Do we need to rationalize or eliminate some services to afford capital investments in areas that hold greater promise of future growth?
- Should we move more services from the hospital to ambulatory locations, where capital investment and ongoing operating costs are lower?

Long-range financial plans need to be updated and run against multiple future volume and revenue stream scenarios based on strategic initiatives that would be implemented ahead of, or alongside, the capital spend.

Market Consolidation Strategy

Every health system—regardless of financial condition—should have a consolidation/affiliation strategy, and it is a topic that should be routinely discussed by the board. Frequently, hospitals choose to remain independent for too long, and larger health systems overlook merger and acquisition opportunities that complement their broader strategies.

Hospitals and health systems that consider partnerships before conditions deteriorate to a point of financial distress do so from a position of strength, which broadens their partnership options. Rarely do hospitals seek affiliations because of a single event. More commonly, a combination of forces and market factors make an affiliation necessary. Boards

Hospitals and health systems that consider partnerships before conditions deteriorate to a point of financial distress do so from a position of strength, which broadens their partnership options. Rarely do hospitals seek affiliations because of a single event. More commonly, a combination of forces and market factors make an affiliation necessary. Boards must identify the early warning signs to improve performance or to position the organization for a partnership while it still has significant value.

must identify the early warning signs to improve performance or to position the organization for a partnership while it still has significant value.

The following financial indicators that often appear in a financial report to the board may indicate a strategic discussion about market consolidation may be appropriate:

- Flat or declining net patient revenue
- Increasing bad-debt expense (>10% to 15% increase from prior period)
- Weak operating cash flow margin (<6%) and downward trend
- Depreciation outpacing capital expenditures (2 consecutive years)
- Low days cash on hand (<90 days) and downward trend

The key is for the board to be proactive and take the steps necessary to avoid stumbling into a weak position where affiliation options are limited.

Sharing Your Strategic Perspective

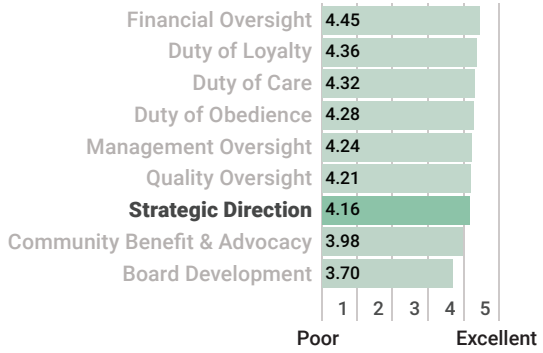
The exceptional financial challenges faced by hospitals to begin this decade have altered the roles assumed by many boards and forced them to rethink their approach to governance. Some boards have begun to meet more frequently and are using virtual meeting platforms. Many adopted more flexible governance policies and procedures to allow for more timely and decisive decision-making. And the challenges brought on by high growth in expenses without commensurate increases in reimbursement have encouraged boards to devote more time to reviewing financial performance.

But the board's focus on improving financial performance cannot be made to the detriment of discussion about the strategic priorities of the organization. Rather, a review of financial condition should lead directly to questions about strategic direction and initiatives that will bolster or secure financial performance. ■

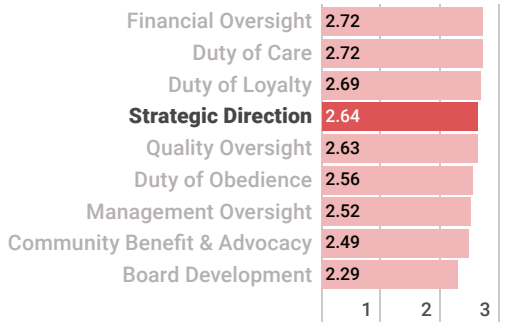
Strategic Direction—Key Points

- CEOs gave boards' performance in setting strategic direction the third-lowest rating (4.16 out of 5; the same rating as 2021).
- Strategic direction is ranked third in adoption of practices (up from fifth in 2021 and sixth in 2019).
- The most highly adopted practice was: the full board actively participates in establishing the organization's strategic direction (with an overall score of 2.85).
- Similar to previous reporting years, the practice of focusing on strategic discussions during board meetings has the lowest adoption. As with previous surveys, more systems have adopted the practice of focusing on strategic discussions during board meetings compared to all other types of organizations.
- Overall, adoption scores decreased in every strategic direction practice, but the greatest decline was for: the board requires management to have an up-to-date medical staff development plan that identifies the organization's needs for ongoing physician availability (2.27 vs. 2.50 in 2021). This is notable since in 2021, this practice saw the greatest increase, moving up from 2.38 in 2019. Systems experienced a significant decline in this practice at 2.17 (down from 2.59 in 2021 and 2.39 in 2019).

Board Performance Composite Scores
(All Respondents)

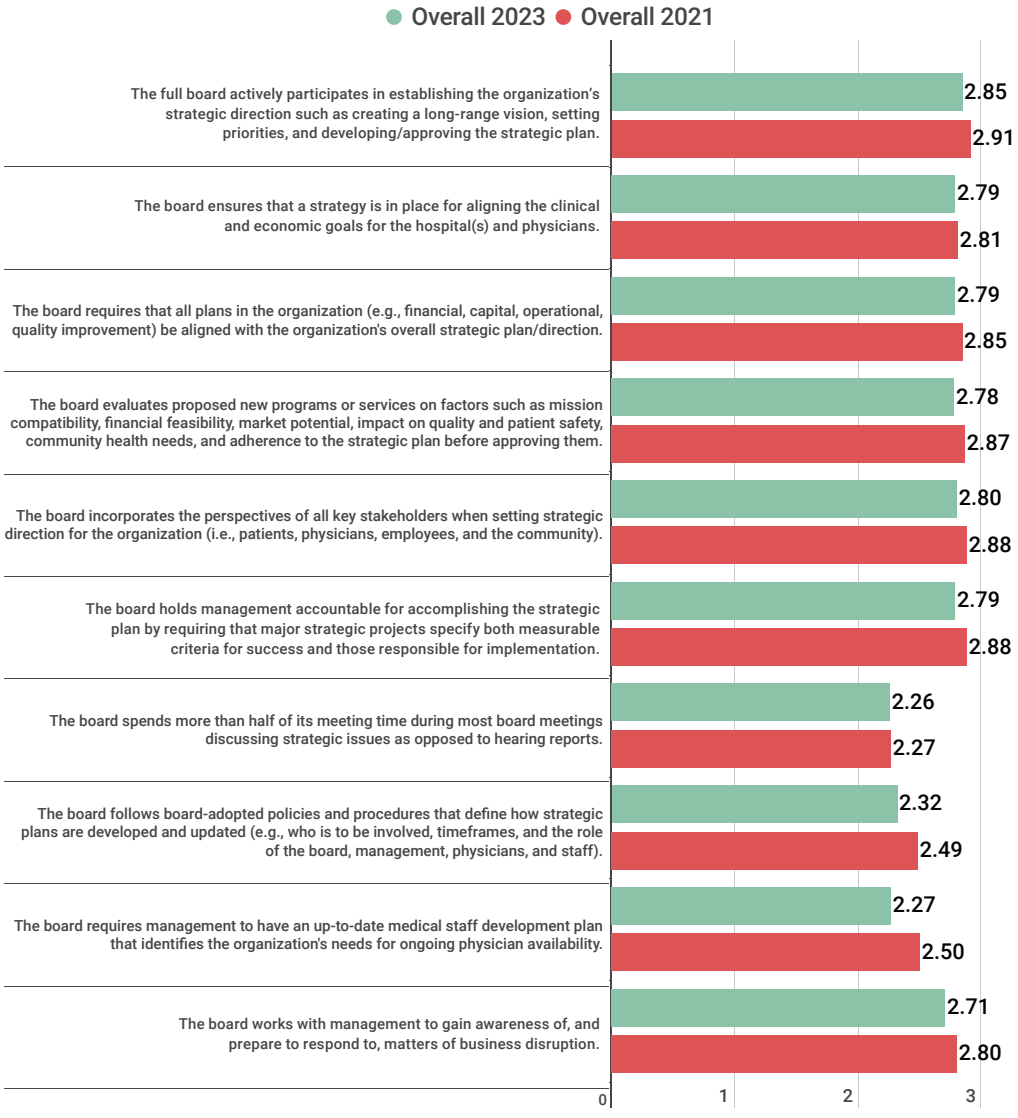


Adoption of Practice Composite Scores
(All Respondents)



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 40. Strategic Direction Composite Scores *(Adoption)*

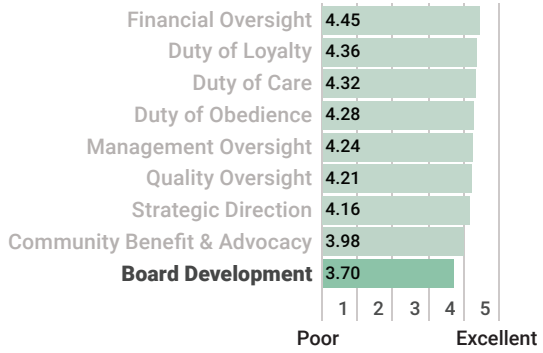


Board Development—Key Points

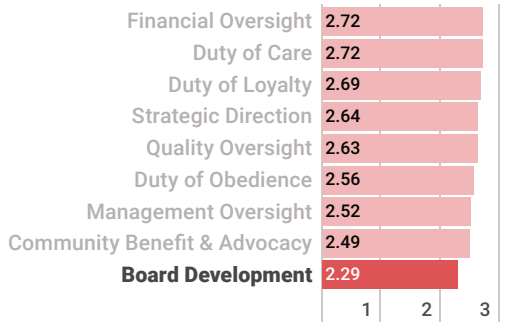
- CEOs again gave boards' performance in board development the lowest rating (3.70 out of 5; this rating has decreased from 3.82 in 2021 but is still higher than 2019 where it scored 3.62).
- Board development is also ranked last in adoption of practices (same as surveys from 2013–2021).
- Although adoption scores were increasing in 2021, this year all practices saw a decline in scores overall. The most significant decline was for: 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)—2.49 vs. 2.79 in 2021. It appears that systems and subsidiary hospitals with advisory boards are still mostly adopting this practice (both had adoption scores of 2.76). Government-sponsored hospitals had the lowest adoption and experienced the greatest decline (1.91 vs. 2.69 in 2021).
- The most highly adopted practice was: 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 continue to be the most likely to use a formal orientation program for new board members.
- The least-adopted practices for board development were:
  - The board uses a formal process to evaluate the performance of individual board members. This was also the least-adopted practice in 2021 and 2019. Systems scored the highest and had a slight increase in adoption (2.03 vs. 1.98), and government-sponsored hospitals had the lowest adoption (1.61).
  - The board uses agreed-upon performance requirements for board member and officer reappointment. This practice declined from 2.11 in 2021 to 1.92. Government-sponsored hospitals had the lowest adoption (1.64).

See **Exhibit 41** on the next page.

Board Performance Composite Scores
(All Respondents)

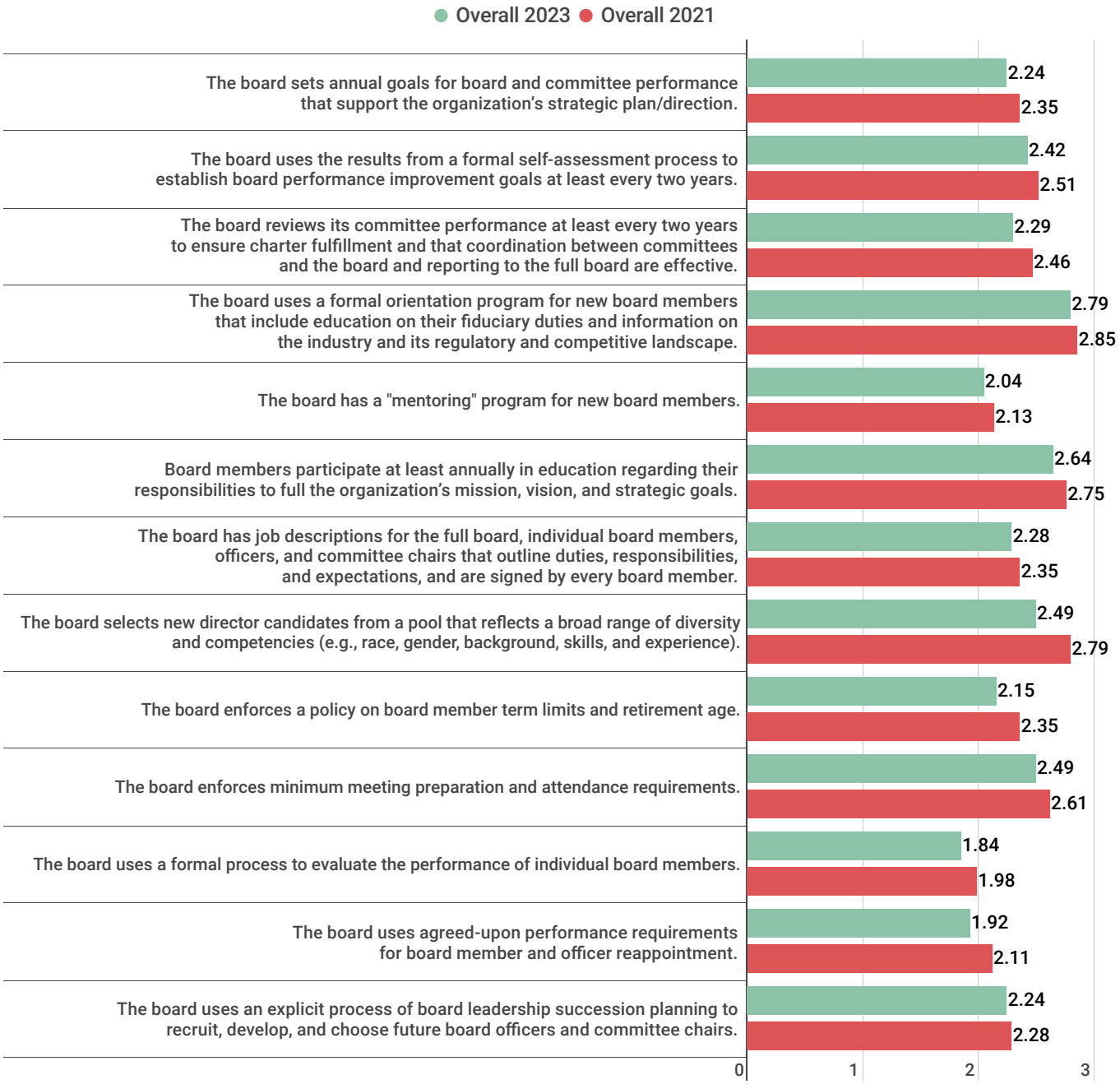


Adoption of Practice Composite Scores
(All Respondents)



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 41. Board Development Composite Scores *(Adoption)*



SPECIAL COMMENTARY

Governance in Turbulent Times

Michael D. Pugh, President, MdP Associates

COVID, culture wars, turnover, disengagement, clinical disillusionment, and financial challenges are making governance of America's hospitals and health systems challenging if not downright hard. This year's biennial survey of governance practices reflects significant uncertainty in C-suites and boardrooms. In virtually every board performance category, responding organizations reported lower overall performance scores than in 2021 and generally lower than even a decade ago. Best practice adoption scores are down across the survey. Can it be that we have not made much progress in improving governance over the past decade? I don't think that is the case. Some may be normal survey variation, but it also may be that leaders find it hard to report governance excellence if the hospital or health system is struggling.

It has been almost 25 years since the IOM published its reports on quality and safety in U.S. hospitals.[3] Hospital boards in the 1990s rarely viewed quality and safety performance as important as financial performance and governance practices of the times reflected that reality. Finance and quality are on more equal footing now; progress has been uneven. In this year's survey, approximately 75% of hospitals reported having a board quality committee but only 43% rated their governance oversight of quality as excellent. That is a noticeable gap compared to the 57% governance excellence rating for financial oversight and 47% governance excellence rating for management oversight. In all but one category of quality governance practices, reported adoption of individual best practices was lower in 2023 than in 2021. (The one exception was the reporting of employee engagement/satisfaction metrics to the board.) That is no surprise given the aftermath of the "great resignation" and the ongoing staffing challenge that almost all hospitals and healthcare systems continue to experience.

> Boards should consider increasing their focus on improving governance in the four lowest-ranked categories: quality, strategy, community benefit/advocacy, and board development.

What I have written thus far is the obvious. Financial oversight ranks first out of nine categories—as it has done every survey—followed by the three fiduciary duties (loyalty, care, and obedience) and management oversight. We are proud of our financial reporting and our boards do an excellent job of avoiding conflict of interest, taking due care in making decisions, and following the bylaws while keeping a close eye on our management practices. However, governance excellence across these five categories is not likely to provide a clear path out of the swamp. Instead, boards should consider increasing their focus on improving governance in the four lowest-ranked categories: quality, strategy, community benefit/advocacy, and board development.

First, quality is much bigger than CMS ratings and scorecards. Ultimately, it is about organizational culture and engagement of staff and clinicians. Quality performance and organizational culture are interdependent. Organizational culture is driven by leadership behaviors and governance expectations, *regardless of the current challenges faced.* Culture-shaping requires changes in leadership behavior as well as new and different investments. Want to restore joy in the work of clinicians? Boards should ensure that governance intent is backed by investment in physician leadership development and a clinical enterprise that provides connections, affiliation, social context, and meaning for clinicians—a professional context that, for the most part, has been lost over the past 40 years.

Second, strategy and community benefit are closely linked. Michael Porter's work from the 1990s is still relevant; strategy is still about competitive positioning and addressing the forces that impact an organization's ability to be profitable and meet its mission. Strategy must also be linked to mission and purpose. Here are three strategic-thinking questions every non-profit hospital and health system board should periodically ask:

1. What healthcare services matter the most to the communities we serve and how do we know?
2. Is the care we provide equitable across all people we serve?
3. What healthcare needs exist in our community that we should consider addressing?

In turbulent times, strategies for preserving or achieving financial stability tend to overwhelm strategies for addressing community needs and community benefit. Governance excellence in strategy is ensuring that there is a balance between mission and margin and that short-term financial decisions do not derail longer-term strategic positioning.

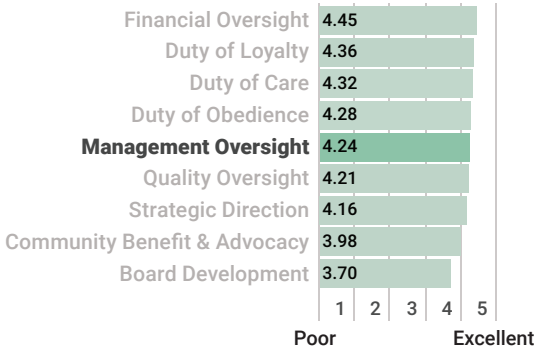
Finally, invest in board development. We need to be more creative in how we address this. CEOs should "double down" on governance development if they want the board to have their back. A knowledgeable and strong board is key to surviving turbulent times. ■

3 Institute of Medicine, *To Err is Human: Building a Safer Health System,* National Academies Press, 2000; and *Crossing the Quality Chasm: A New Health System for the 21st Century,* National Academies Press, 2001.

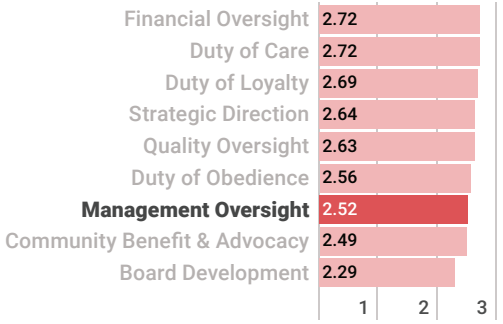
Management Oversight—Key Points

- CEOs gave boards' performance in management oversight the fifth-highest performance rating (4.24 out of 5; same rating as 2021).
- Management oversight is ranked sixth in adoption of practices (same as in 2021, when it tied with duty of obedience).
- All practices decreased in adoption since 2021, with the biggest decrease in the board seeking independent (i.e., third-party) expert advice/information on industry comparables before approving executive compensation (2.55 vs. 2.86 in 2021). All organization types saw a significant decline in adoption.
- The least-observed practice continues to be maintaining a written, current CEO and senior executive succession plan; just as in 2021 and 2019, systems are much more likely than other organizations to have this plan in place.
- The highest adoption overall was for: the board follows a formal, objective process for evaluating the CEO's performance.
- Subsidiary hospitals with advisory boards scored noticeably lower than other organization types in management oversight practices, with adoption scores of 2.00 or less.

Board Performance Composite Scores
(All Respondents)

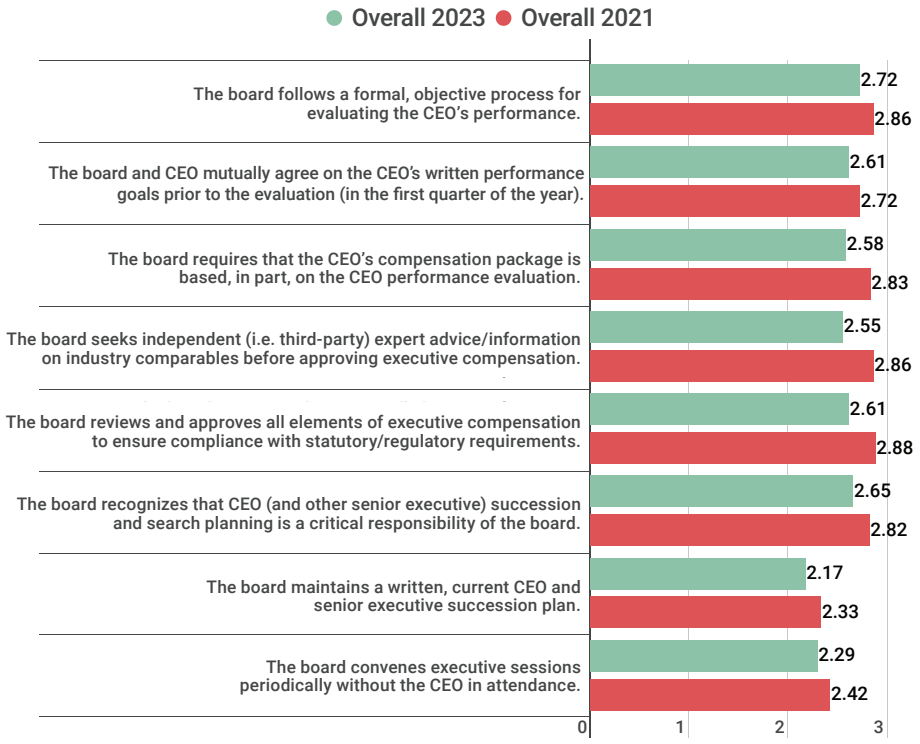


Adoption of Practice Composite Scores
(All Respondents)



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

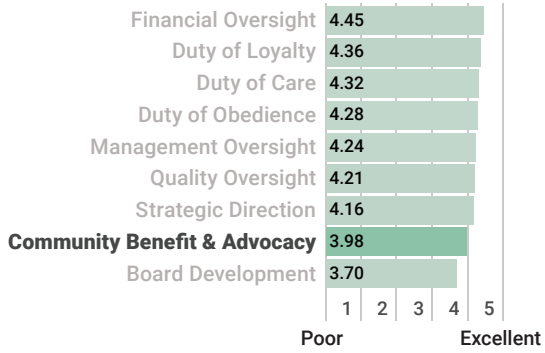
Exhibit 42. Management Oversight Composite Scores *(Adoption)*



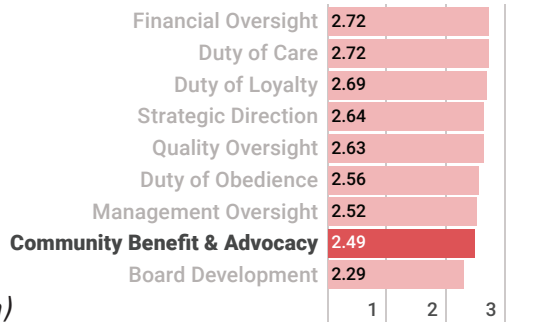
Community Benefit & Advocacy—Key Points

- CEOs gave boards' performance in community benefit and advocacy the second-lowest performance rating (3.98 out of 5; same rating as in 2021 but down from 4.12).
- Community benefit and advocacy is ranked second to last in adoption of practices (same as 2021 and 2019).
- All practices decreased in adoption since 2021 except one: the board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors). This practice was also the one most adopted overall.
- The practices that had the biggest decrease were:
  - The board works closely with general counsel to ensure all advocacy efforts are consistent with tax-exemption requirements (2.26 vs. 2.62 in 2021).
  - The board provides oversight with respect to organizational compliance with IRS tax-exemption requirements concerning community benefit and related requirements (2.61 vs. 2.94 in 2021).
- The least-observed practice was having a written policy establishing the board's role in fund development and/or philanthropy. This has remained one of the least-observed practices in all oversight areas for several reporting years.

Board Performance Composite Scores
(All Respondents)



Adoption of Practice Composite Scores
(All Respondents)



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

Advisory Board Practice Adoption

The list below reflects the practices that have been widely adopted by the 20 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** online. **Appendix 2** (online) shows the percentages of respondents that indicated a practice was "not applicable for my board." The composite scores for this group of boards in **Appendix 3** do not include the N/A responses. The practices below were the only ones that were applicable to *all* advisory boards.

2023 vs. 2021 Comparison: In 2021 this list had 19 practices; this year, we had a larger sample size (20 vs. 9 in 2021) that reflects wide adoption of only three practices. 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 Care

- Board members receive necessary background materials and well-developed agendas within sufficient time to prepare for meetings.

Duty of Loyalty

- The board enforces a written policy on confidentiality that requires board members to refrain from disclosing confidential board matters to non-board members.

Quality Oversight

- The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).

Analysis of Results

This year's results show that adoption of our list of recommended practices, for the most part, continues to be widespread. However, overall performance scores are lower this year for *all* fiduciary duties and core responsibilities. This is not overly surprising given the substantial headwinds hospitals and health systems have endured the last few years. Historically, systems have had the highest levels of performance and that continues to be true. They have the highest board performance composite scores and the highest percentage of "excellent" and "very good" rankings across the oversight areas.

Although performance and adoption scores did decrease slightly overall, all organization types are continuing to score their performance highly in financial oversight, which is encouraging to see given the financial stress hospitals and health systems are facing due to numerous issues such as rising workforce expenses, inflationary pressure, declining reimbursement rates, and volumes below pre-pandemic levels. Duty of loyalty practices also continue to be highly adopted. This shows that boards are maintaining their focus on conflict-of-interest issues. Duty of care remains high in performance and moved up to the top of the list for adoption. Boards are being diligent about ensuring they have the information they need (background materials, agendas, management and/or other expert insight, etc.) before making impactful decisions. There has been a steady, small decrease in adoption of duty of obedience practices over the years. Boards continue to be committed to protecting and carrying out their organization's mission. In future years, we hope to see more boards that have established a risk profile holding and management accountable to that—it is now critical for leadership to predict, identify, and monitor risks and ensure responses are aligned and coordinated.

> Some organizations may have retreated from community health efforts when other major challenges (e.g., pandemic crisis management, financial, and workforce) took center stage.

While strategic direction remained low in performance and adoption scores dropped, it did move up the ranks in adoption (third vs. fifth in 2021). We are pleased to see that boards are actively participating in establishing the organization's strategic direction, but boards are not spending nearly enough time at meetings discussing strategic issues. We encourage boards to spend half or more of their meeting time on strategy, to ensure that discussions are generative and robust, and to address any barriers to achieving this goal.

While management oversight scores improved in 2021, this year they dipped back down. The least-observed practice continues to be maintaining a written, current CEO and senior executive succession plan. We consider this practice a strategic imperative—no board can afford to not be fully prepared for the departure of their chief executive and other critical members of the leadership team. Having talented, visionary leadership is a must to successfully move the organization forward.

Community benefit and advocacy is still low in both performance and adoption scores, even with the knowledge across the industry tying factors outside the hospital setting (housing, finances, food insecurity, employment, etc.) to patients' health outcomes and increasing total cost of care. Some organizations may have retreated from these efforts when other major challenges (e.g., pandemic crisis management, financial, and workforce) took center stage.

Board development remains at the bottom of the list for both performance and adoption scores. This is a key area of opportunity for boards looking to enhance their performance—and therefore, their organization's performance. There are still many key practices where

performance is low such as setting agreed-upon performance requirements for board member and officer reappointment, having an effective board leadership succession planning process, establishing a mentoring program for new board members, and having term limits. 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.

With many scores declining this year, we hope that 2025 will bring improved performance and adoption of our recommended practices. Now, more than ever, boards will need to be bold and perform at their best so that they can effectively lead their organizations in this increasingly disruptive industry.

Most and Least Observed Practices

Many of the recommended practices tend to be either in place or under consideration by respondents. We identified the ***most observed practices***[4] for all respondents except those who selected "not applicable in our organization." Only four practices met the criteria, which is a much shorter list compared to previous years (each practice is marked with an asterisk because they were also on the 2021 most observed list):

Duty of Care

- Board members receive necessary 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.*

With many scores declining this year, we hope that 2025 will bring improved performance and adoption of our recommended practices. Now, more than ever, boards will need to be bold and perform at their best so that they can effectively lead their organizations in this increasingly disruptive industry.

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.*

We also identified the practices that have been adopted by the ***least number*** of respondents. Three practices met the criteria (the practice with an asterisk was also on the 2021 least observed list):

Board Development

- The board uses a formal process to evaluate the performance of individual board members.*
- The board uses agreed-upon performance requirements for board member and officer reappointment.

Community Benefit & Advocacy

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

Appendix 3 (online) shows composite scores for most and least observed practices overall and by organization type, comparing 2023 and 2021.

4 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.

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