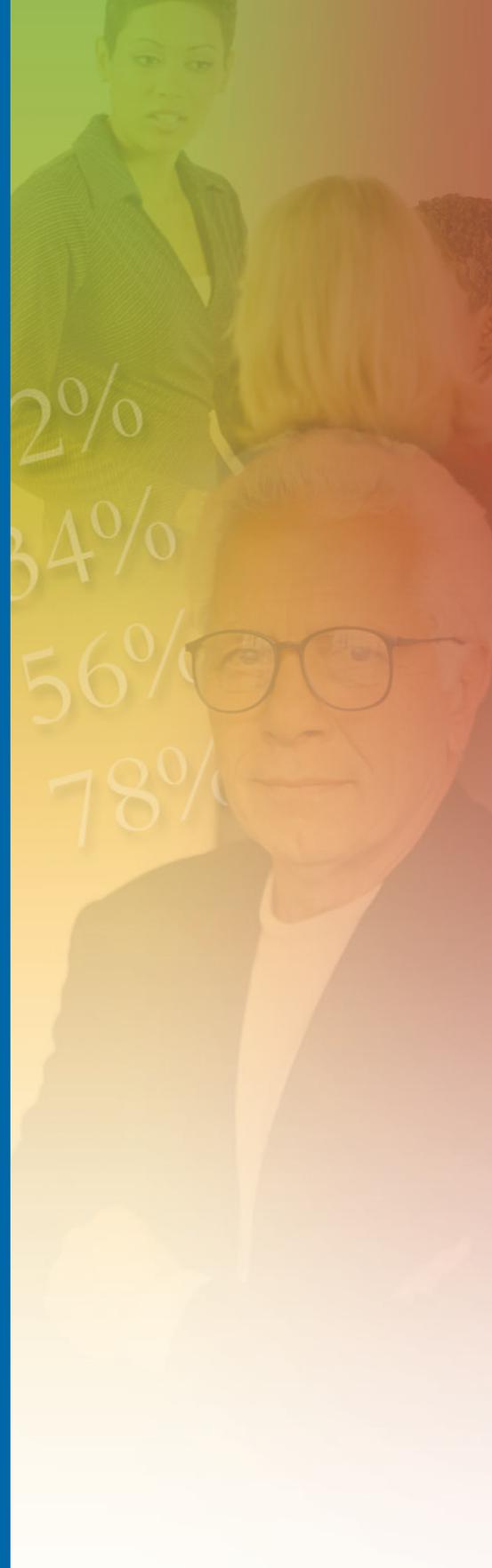


HOSPITAL GOVERNANCE:  
INITIAL SUMMARY REPORT  
OF 2005 SURVEY OF  
CEOs AND BOARD CHAIRS

Frances S. Margolin  
Samantha Hawkins  
Jeffrey A. Alexander  
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**HRET**  
HEALTH RESEARCH &  
EDUCATIONAL TRUST  
In Partnership with AHA

Transforming health care through research and education

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## INTRODUCTION

Board members are as conscientious and as giving a group as one could ever hope to find. Members of volunteer boards ... interrupt their personal and occupational lives to support something in which they believe. ...The personal drive of board members has accomplished formidable tasks. The perseverance of board members has surmounted seemingly intractable barriers. The patience of board members has outlasted drudgery. The generosity of board members has made the impossible possible.

— **John Carver**, *Boards that Make a Difference*

**T**he trustees of America's hospitals face tremendous challenges today. Hospitals strive to merge science, medicine, and the art of caring. They are some of the largest, most critical, and most complex organizations in the country. And in many communities, hospitals are the largest employer and a major economic driver.

Like boards in other sectors, hospital trustees are charged with the fiduciary and moral responsibility to ensure that the organization's assets are well managed. In light of scandals in the corporate and not-for-profit world, many hospital boards are re-examining their policies and procedures to assure that they are operating at the highest standard. At the same time, they face increasing scrutiny from regulators, payers, and the government on issues ranging from patient safety and quality and workforce diversity to billing and collection procedures. Where trustees once focused primarily on hiring the executive and on bottom-line financial results, today's boards are called upon to assume much broader oversight of hospital policies, performance, and community benefit.

In order to understand how trustees oversee hospital policy, good data are needed. To address this need, the Health Research and Educational Trust (HRET), in partnership with the American Hospital Association, Health Forum, and the Center for Healthcare Governance, surveyed hospital CEOs and board chairs of nonfederal community hospitals in the United States. This survey builds upon two previous surveys of administrators and trustees, conducted in 1989 and in 1997. Thus it is part of a longitudinal database, and the survey will be repeated periodically in the future. The database is a rich source of information for health care administrators, trustees, and scholars who want to examine these questions. Our ultimate goal is to improve the governance of nonprofit hospitals using evidence-based approaches to identifying the best governance practices.

### **What This Report Covers**

This report summarizes basic information about the state of hospital governance today. It contains information gathered from more than 1500 hospital CEOs and 900 board chairs in the spring and summer of 2005. Throughout the report, the information shown

**TABLE 1.1**  
**Survey Respondents vs. All Hospitals**

	All Hospitals	CEO Respondents	Board Chair Respondents
<b>Size</b>			
<100 beds	48%	51%	47%
100-299 beds	36	33	34
>= 300 beds	16	16	19
<b>Census Region</b>			
Midwest	29	35	37
Northeast	14	14	18
South	39	39	27
West	18	18	18
<b>Ownership</b>			
Not-for-profit	61	63	66
Private, for-profit	16	10	9
Public	23	27	25
<b>Location</b>			
Metro	55	46	50
Nonmetro	46	54	50
<b>Multihospital system</b>			
Nonmember	46	56	57
Member	54	44	43

has been weighted to represent the total population of U.S. nonfederal acute-care community hospitals. (See the appendix for more information on the methods used to collect and analyze the information presented here.) That is, the results you will see in sections 2 through 5 give a comprehensive overview of what is happening in hospitals available today.

First, though, it might be useful to give some comparisons between the respondents to the surveys and the hospitals that they represent. Overall, as shown in Table 1.1, the respondents are quite representative of their cohorts in terms of bed size, Census region, and hospital ownership. There is a slight overrepresentation of state and local government hospitals. Hospitals that are part of a multihospital system, investor-owned (for-

profit) hospitals, and hospitals in metropolitan areas are somewhat underrepresented, as well.

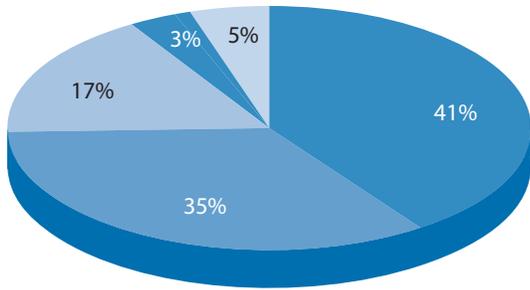
Figure 1.1 shows the CEOs' responses to the question, "To what higher board or authority is the hospital responsible?" As the chart indicates, of those hospital boards that are responsible to any higher board, by far the greatest number report to the board or management of a parent holding company or health care system.

### **What This Report Does Not Cover**

This report is the first of a series that will be produced using results from the 2005 surveys. It presents basic information about hospital governance today. Questions such as how governance has changed over the last 10 or more years, or how certain governance practices

**FIGURE 1.1**

**Board Is Responsible To ...**



Board or management of a parent holding company or health care system	41%
The board is not responsible to a higher board	35
A unit of state, county, or local government	17
Board of a religious order or organization	3
Board of a university of college	0
Other	5

relate to hospital performance, along with other important questions, will be addressed in subsequent reports. For more information, see [www.hret.org/hret/programs/leadergovern.html](http://www.hret.org/hret/programs/leadergovern.html).

The report also focuses on the governance of individual hospitals, whether or not they are members of multihospital systems. It does not cover system-level governance structures and practices.

**How This Report Is Organized**

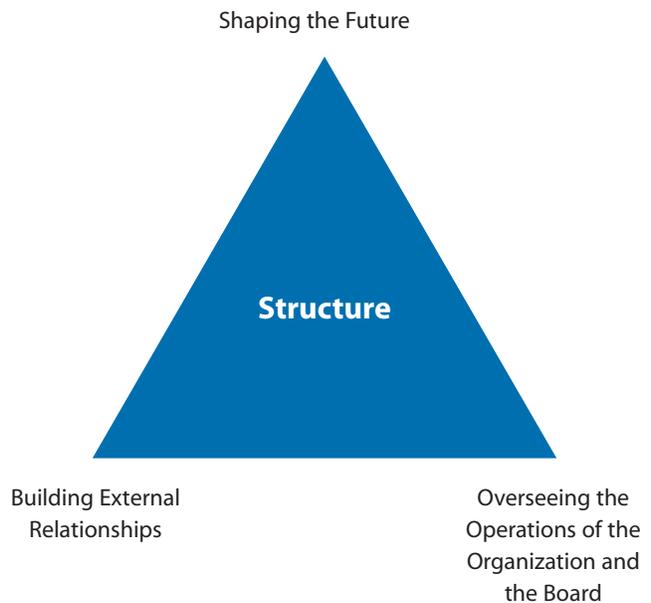
There are many ways to think about governance of any organization. One helpful model is shown in Figure 1.2, and it is used as a framework for the remainder of this report. As indicated in the model, the structure or architecture of the board is the central pillar upon which the board’s activities rest. The structure, covered in Section 2 of this report, includes such characteristics as the composition of the board, the committees, and meetings. These are means through which the board carries out its essential functions. These characteristics are relatively stable and do not change quickly over time.

Sections 3, 4, and 5 cover the activities of the board, divided into three essential responsibilities: overseeing the internal operations of the organization and the board (Section 3), building and maintaining relationships with the external stakeholders of the organization (Section 4), and shaping the future of the organization (Section 5). The activities that fall under each of these roles tend to be more responsive to the environment and change more rapidly than the structure of the board. Of course, individual boards will change on some dimensions, other boards on other dimensions, and some not at all.

Overseeing internal operations of the organization comprises such functions as financial oversight; board/management relationships; oversight of quality, safety, and clinical outcomes; other internal relationships including those with physicians; and the care and feeding of the board itself. Building and maintaining external relationships includes such activities as community and government relations and fundraising. Shaping the future encompasses not only strategic planning, but also the board’s role in shaping and maintaining the hospital’s mission and vision.

**FIGURE 1.2**

**Governance Model**



## BOARD STRUCTURE

If a board is to truly fulfill its mission . . . it must become a robust team—one whose members know how to ferret out the truth, challenge one another, and even have a good fight now and then.

— Jeffrey A. Sonnenfeld, “What Makes Great Boards Great,”  
*Harvard Business Review*

**H**ow the board is organized to do its work has an impact on its efficiency and effectiveness. This chapter will focus on five major structural characteristics of hospital boards: size, composition, term limits, meetings, and committees.

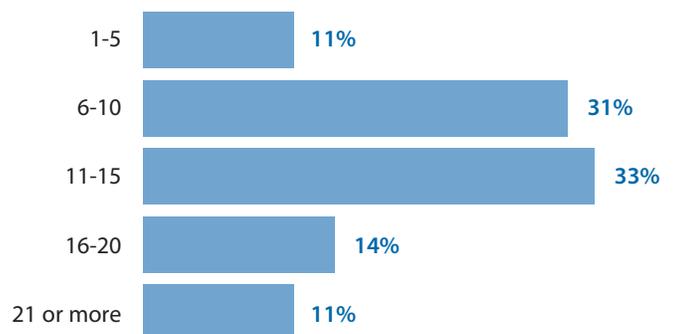
### Size

Hospital boards today have an average of 13 members, but there is great variation in size, ranging from 1 to 61. The median board size is 11; the modal board size is 7.<sup>1</sup> Figure 2.1 displays the array of hospital board sizes. The average number of members is somewhat greater in larger hospitals, in hospitals operating in the northeast, in not-for-profit hospitals, and in urban hospitals. The category with the largest average board size is hospitals with 300 or more beds, where the average number of board members is 18, almost twice the size of the average board in hospitals with fewer than 100 beds (10). There is an average of just under 1 vacant position on hospital boards. Almost all board positions carry voting privileges.

Depending upon the area in which the hospital is located, there are differences in board composition. On average, boards in urban areas have more members than their rural counterparts. The average board in an urban community has 1.5 members to every member of the average rural board. The category with the highest average number of female board members is rural hospitals.

FIGURE 2.1

### Hospital Board Size



<sup>1</sup> That is, half the responding hospitals have boards of 11 or fewer; half have boards of 12 or more; and more respondents report having boards with 7 members than any other number.

**TABLE 2.1**  
**Board Composition**

	<b>Board Positions (Including Vacancies)</b>	<b>Female</b>	<b>Non-Caucasian</b>	<b>51 Years or Older</b>	<b>Physicians</b>
<b>National Average</b>	<b>13</b> <b>100%</b>	<b>3.0</b> <b>23%</b>	<b>1</b> <b>9%</b>	<b>9</b> <b>71%</b>	<b>2.5</b> <b>20%</b>
<b>Ownership</b>					
Not-for-Profit	16	23%	8%	72%	19%
For-Profit	11	21%	18%	61%	40%
Public	8	27%	9%	74%	11%
<b>Location</b>					
Metro	16	22%	11%	72%	20%
Nonmetro	10	25%	6%	70%	21%

### Composition

A key attribute of any board is the degree to which it gives voice to the diversity of interests of its stakeholders. The blend of members' diverse experience and expertise helps determine the success of the board in guiding the mission of the organization. One important group is physicians, and of the average 13 board positions, 2.5 (or 20%) are held by physicians. Key factors in considering members to serve on a hospital's governing board are diversity and the community's make-up. Boards should reflect the communities in which they serve. Of the average 13 members, 23% are women and 9% are non-Caucasian. Of note is the fact that public and for-profit boards have a much higher percentage representation of non-Caucasian members than do not-for-profit hospitals. Table 2.1 displays information on board composition.

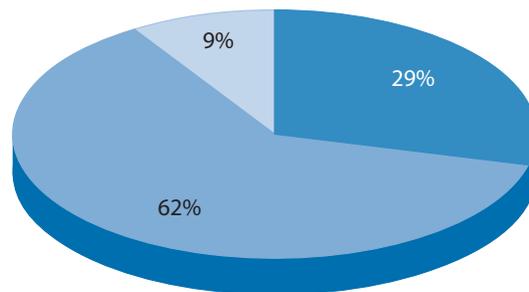
The greatest variation within hospital boards seems to be in age. The great majority of board members—71%—are 51 years or older. Figure 2.2 shows how boards break down in terms of age of their members.

### Term Limits

While some hospital boards are adopting term limits for their members and officers, many still do not have any limits, either on length of term or number of terms that can be served. Looking at private not-for-profit and for-profit hospitals (but not public hospitals, whose boards are elected or appointed), the average length of a one-term appointment of officers is 2 years.

**FIGURE 2.2**

### Board Composition by Age



<=50	29%
51-70	62
>=71	9

**TABLE 2.2**  
**Hospitals with Term Limits for Board Officers and Members**

	Limit on Length of One Term	Limit on Number of Terms
<b>Board officers</b>		
All	79%	52%
Not-for-profit	80	53
For-profit	69	46
<b>Other board members</b>		
All	84	65
Not-for-profit	85	67
For-profit	77	54

However, 21% of CEOs report there is no limit on the length of the officers' term. The average length of a one-term appointment of other board members is 3 years, but 16% of CEOs report there is no limit on length of a one-term appointment for board members, suggesting that board members may either serve at the pleasure of the CEO or board chair or until they resign.

A much greater percentage of hospitals report that there is no limit on the number of terms a board member or officer may serve. Table 2.2 presents more information on term limits. While there is only minimal difference between not-for-profit and for-profit hospitals in the length of terms or number of terms allowed for those with limits, not-for-profit hospitals are more likely to have limits than their counterparts.

## Meetings

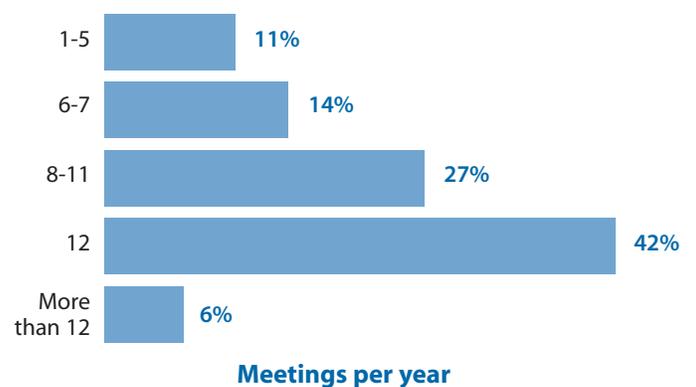
Figure 2.3 displays how often hospital boards meet. Hospital boards tend to meet more often than boards in the business sector,<sup>2</sup> with almost half of hospital boards (48%) meeting monthly or more. Not surprisingly, the meeting frequency of boards of private, for-profit hospitals is closer to that of their business peers, with 43% meeting 7 times per year or less, and only 28% meeting monthly or more often. Frequency of meetings also varies by both bed size and locality. Hospitals with less than 100 beds and those in rural locations are much more likely to meet monthly or more often than larger hospitals or those in urban locales.

## Committees

Almost all boards operate to some extent through committees. Only 9% of respondents reported that they did not have any of the 16 committee choices listed in the survey. The average number of committees was 8, with a few boards (3%) having all 16 listed. Most boards have an executive committee, averaging 4 members. Figure 2.4 displays the average percentage of hospitals reporting having various separate or combined committees.

**FIGURE 2.3**

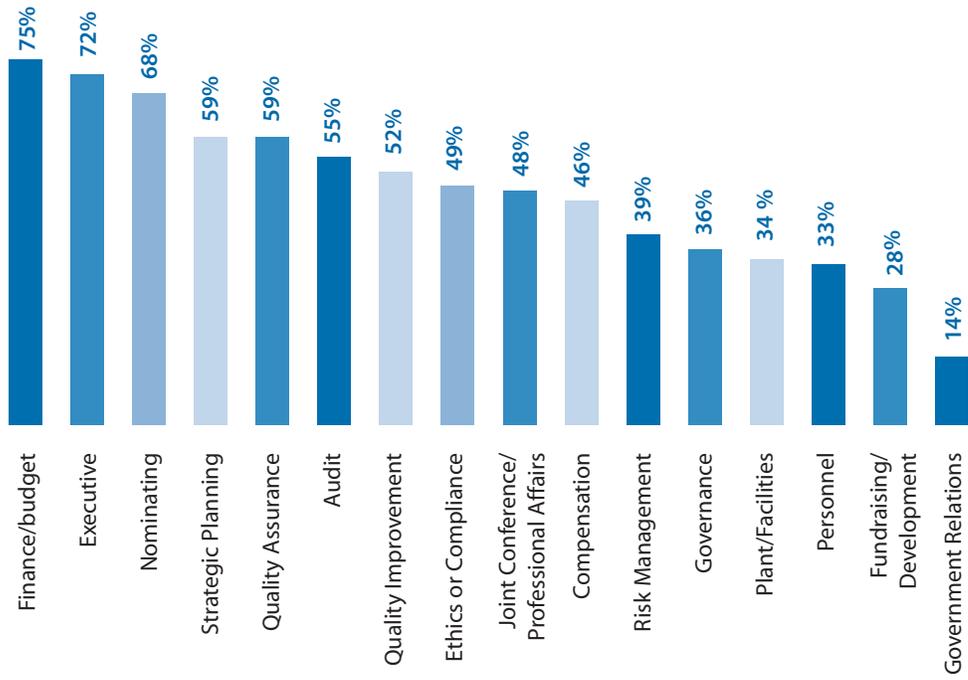
### Hospital Board Meeting Frequency



<sup>2</sup> According to a 2005 survey conducted by the National Association of Corporate Directors, the average annual frequency of full corporate board meetings is 6 times per year.

FIGURE 2.4

### Board Committees



## OVERSEEING THE OPERATIONS OF THE HOSPITAL AND ITS BOARD

Precisely because the nonprofit board is so committed and active, its relationship with the CEO tends to be highly contentious and full of potential for friction. Nonprofit CEOs complain that their board “meddles.” The directors, in turn, complain that management “usurps” the board’s function. This has forced an increasing number of nonprofits to realize that neither board nor CEO is “the boss.” They are colleagues, working for the same goal but each having a different task.

— Peter F. Drucker, *Managing for the Future*

For many people, the first set of responsibilities that comes to mind when one thinks about boards, including hospital boards, relates to providing oversight for the internal operations of the hospital and of the board itself.

### Executive Oversight

The CEO is, or should be, the sole employee who reports to the board, even though in most cases the CEO is a member of the board himself or herself. As shown in Table 3.1, the role played by the CEO on the board varies by ownership type and whether or not the hospital is part of a system, with the CEO much more likely to be an officer or voting board member in for-profit hospitals and in hospitals that are members of a multihospital system. The relationships between the board and top management tend to be formalized, with 62% of CEOs having written employment contracts

with the board of their hospital or its parent organization, and 55% having a written incentive compensation agreement.

The overwhelming majority of hospitals, 86%, use a formal process for evaluating CEO performance based on predetermined objectives or criteria, and this is true for all categories of hospitals examined. The criterion most frequently given considerable weight or considered absolutely critical in CEO performance evaluation was hospital financial performance, as reported by both the CEOs and the board chairs.

Figure 3.1 shows the full array of criteria and the percentage of CEOs and of board chairs who rated each one of considerable weight or absolutely critical. These results show that there is a great deal of congruence in the relative priority given to these

**TABLE 3.1**  
**Official Capacity of CEO on Hospital Board\***

	<b>Chair, President, Vice Chair of Board</b>	<b>Full Voting Member, Nonofficer</b>	<b>Ex Officio, Nonvoting Member</b>	<b>Observer/ Staff Only</b>	<b>Does Not Attend</b>
Total	5%	36%	38%	21%	1%
<b>Ownership</b>					
Not-for-Profit	6	45	34	14	1
For-Profit	11	62	25	2	1
Public	0	4	51	45	0
<b>Multihospital System</b>					
Member	5	48	31	15	0
Nonmember	5	26	43	26	1
*Totals may not equal 100 due to rounding.					

criteria by the CEOs and board chairs responding to these surveys.<sup>3</sup> However, there are a few distinct differences, notably the much greater likelihood that the board chair will find community health and managed care activity to be critical factors in the CEO evaluation.

### Physician Relations

The role of the physician on the board as a member who can bring an important perspective and knowledge base to discussions is a critical one, and most boards do have physician members, seemingly all of whom have active medical staff privileges at the hospital. For hospitals responding to this survey, boards include an average of 2.5 physicians, which is about 20% of the average board membership (13 board positions). In addition, in 11% of hospitals, the Chief Medical Officer is a voting member of the board. The Medical Staff President is a voting member at 22% of hospitals responding. (See Table 3.2 below.)

### Organizational Performance

A critical responsibility of hospital boards is overseeing the hospital's performance along many dimensions, and boards commonly review a wide variety of performance-related data. Figure 3.2 displays the types of data routinely reviewed by hospital boards. It is clear that financial data are by far the most commonly used, but quality/safety and patient satisfaction data are also used by more than 9 out of 10 boards.

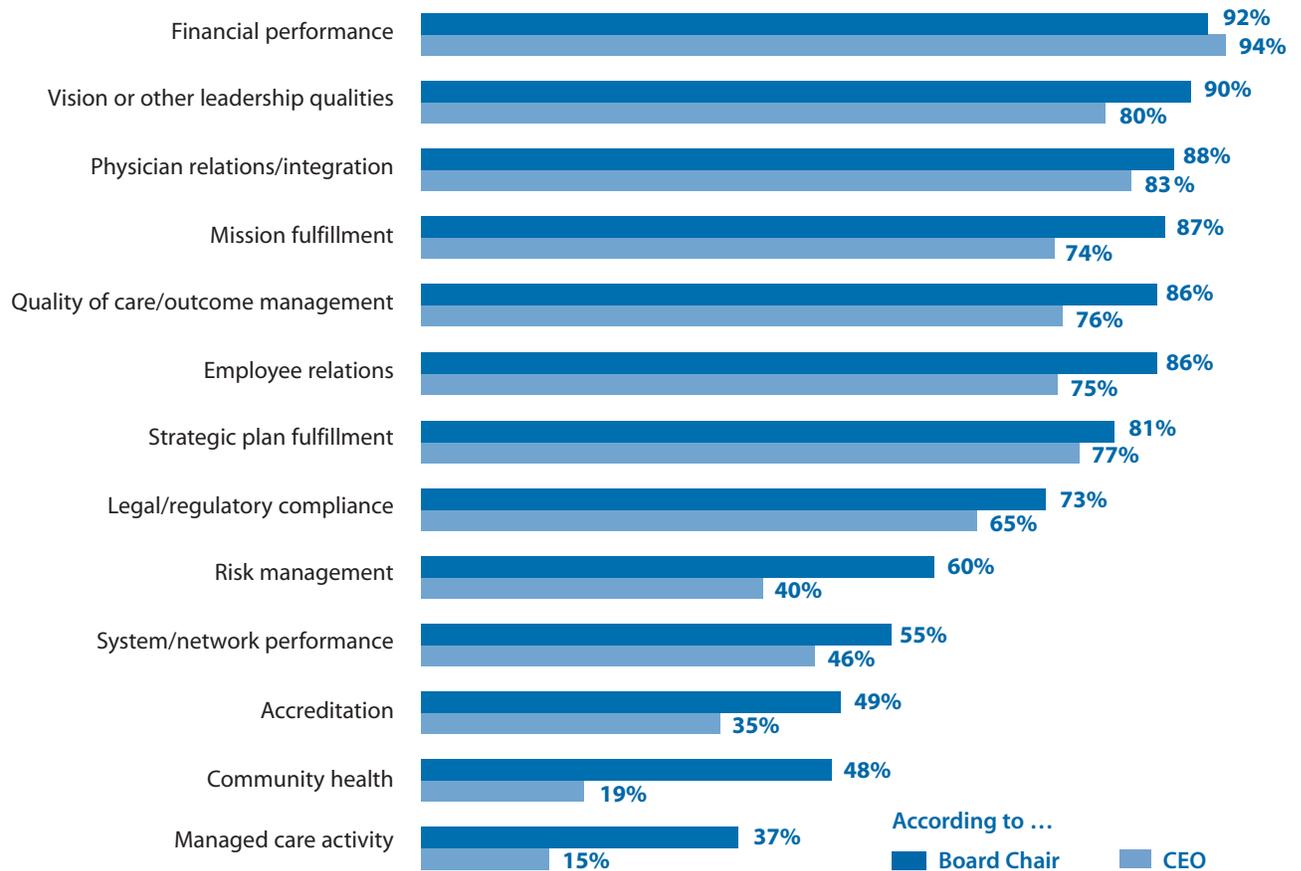
Of all the measures considered, community health status measures are among the least likely to be reported to and reviewed by the board, with only 31% of CEOs saying that they do so.

Although boards review many types of data, just under two-thirds (65%) of hospitals evaluate their own performance in relation to established benchmarks or standards. Hospitals that do use benchmarks use a variety of standards in their evaluations. Figure 3.3

<sup>3</sup> These results do not pair CEOs and board chairs from the same institution and should not be interpreted to mean that there are discrepancies between individual CEOs and their board chairs. Rather, the results reflect the differences between the CEO respondents, taken as a group, and the board chair respondents, taken as a second group.

FIGURE 3.1

**Criteria for CEO Performance Evaluation Receiving Considerable Weight or Considered Absolutely Critical**



displays the types of benchmarks that CEOs say their hospitals use in evaluating their performance. Figure 3.4 displays the groups with whom benchmark data are shared by those hospitals that do in fact use benchmarks.

**Board Operations**

A useful mechanism to help board members develop their skills and competencies as effective trustees is a board Governance committee. Only about one-third (36%) of boards reported that they do have a

Governance committee to help focus their efforts on board performance improvement and leadership development.

**Board Recruitment and Selection**

Board members, as a group, should have a depth and breadth of knowledge and skills, as well as commitment to the hospital. A board that has a diversity of personal strengths is in a better position to oversee the hospital and maintain its compact with its community. After

**TABLE 3.2**  
**Role of Physician Leaders on the Board**

	Voting Member	Nonvoting Member	Not a Member
Chief Medical Officer	11%	44%	31%
Medical Staff President	22	30	7

**FIGURE 3.2**

**Data Routinely Reported to and Reviewed by Boards  
(for All Board Chair Respondents)**

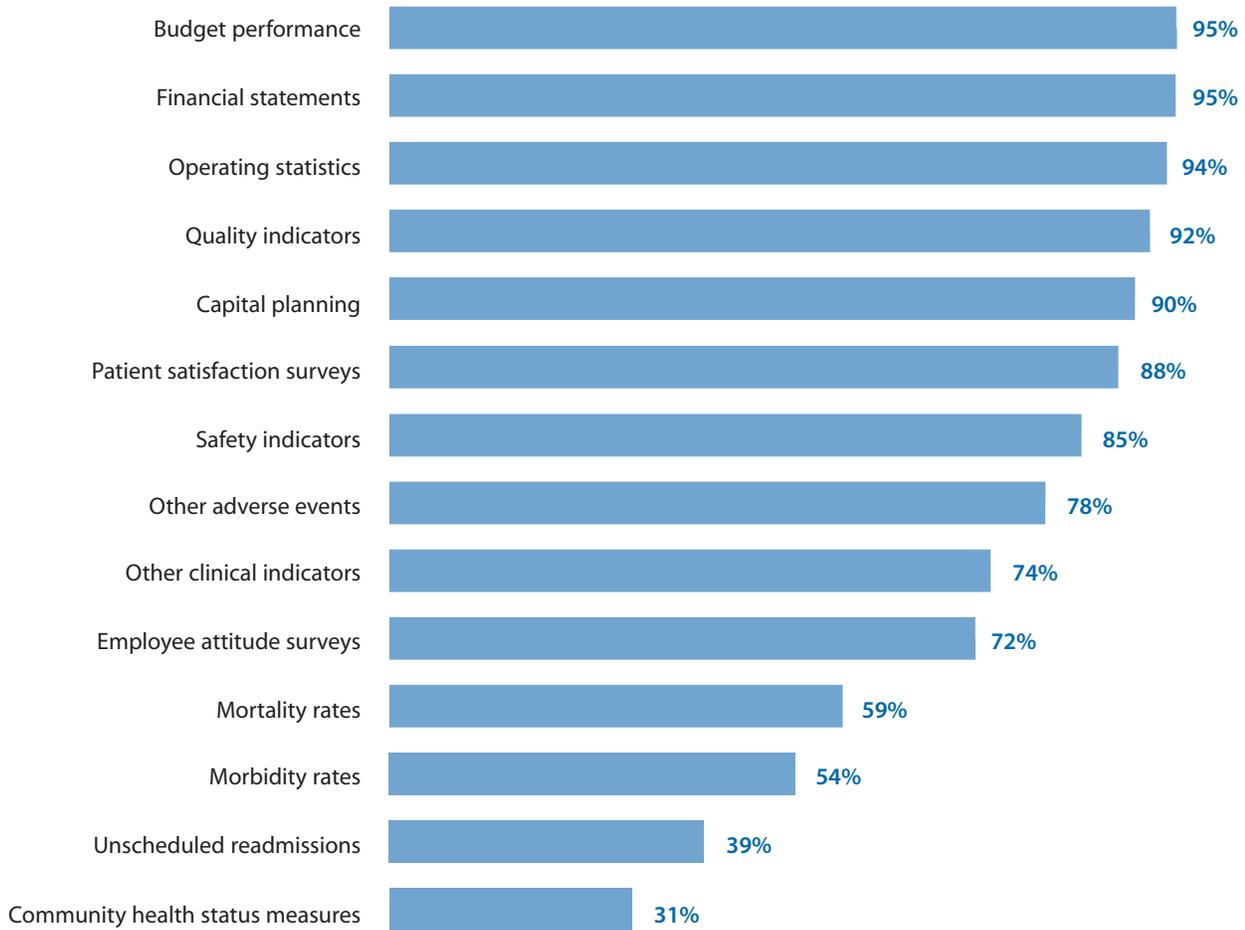


FIGURE 3.3

### Benchmark Data Used by Hospitals in Performance Evaluation (for Hospitals that Use Benchmarks)

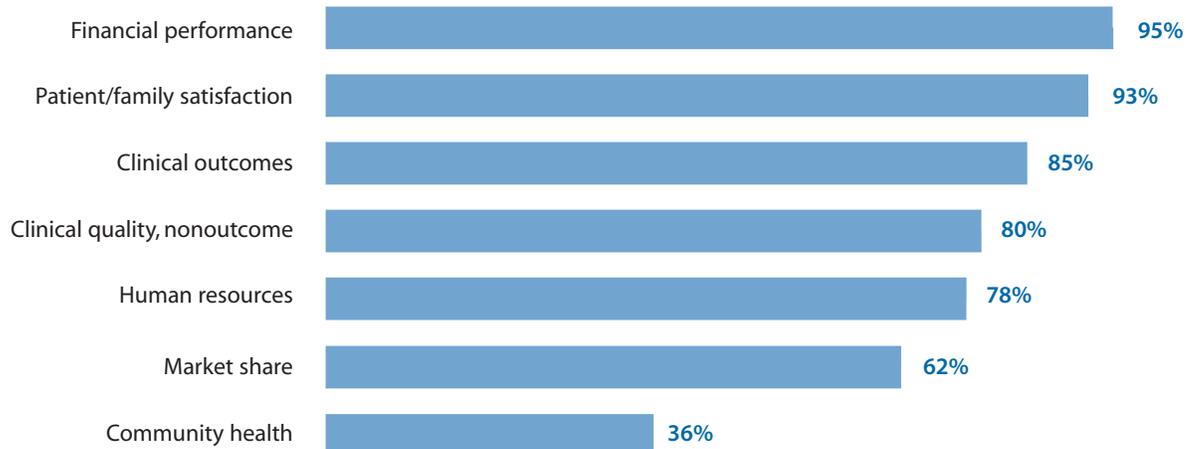
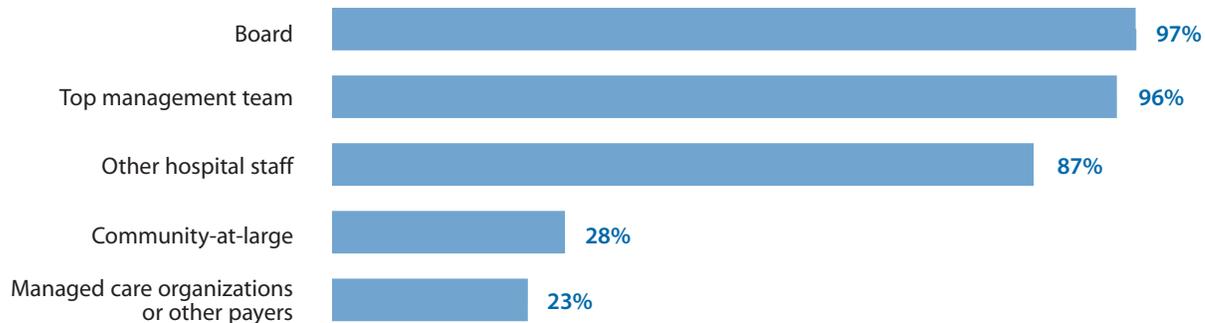


FIGURE 3.4

### Groups with Whom Benchmark Data Are Shared (for Hospitals that Use Benchmarks)



community leadership, the criterion most often listed as an absolute requirement or as receiving heavy emphasis in choosing new board members was “values consistent with those of the board.” The next two criteria were financial or business acumen and time availability. CEOs and board chair respondents were notably consistent in the relative priority given to these criteria. Specific knowledge and skill sets, such as insurance knowledge, managed care knowledge, and legal skills, were much less likely to be priorities. Table 3.3 shows the complete array of board member criteria for not-for-profit and investor-owned hospitals.

### Board Education

Being a valuable and productive member of a hospital board requires not only time and willingness to serve but also a working knowledge of health care delivery and financing, as well as community concerns and general business practices. Consequently, most new hospital board members can benefit from specific education, and more than half of all CEOs (58%) reported that their hospital has a formal education program for board members, with 35% reporting that the hospital has a specific budget line item for board member education. A much smaller percentage (12%) have a specified annual educational requirement for their board members.

Within the board meeting itself, an average of 20% of the meeting is devoted to education, provided either by the CEO, other internal staff, or outside experts or consultants. Board chairs reported that they spent an average of 2.4 hours per month on board education. Figure 3.5 displays the ways in which board members receive education.

### Board Compensation

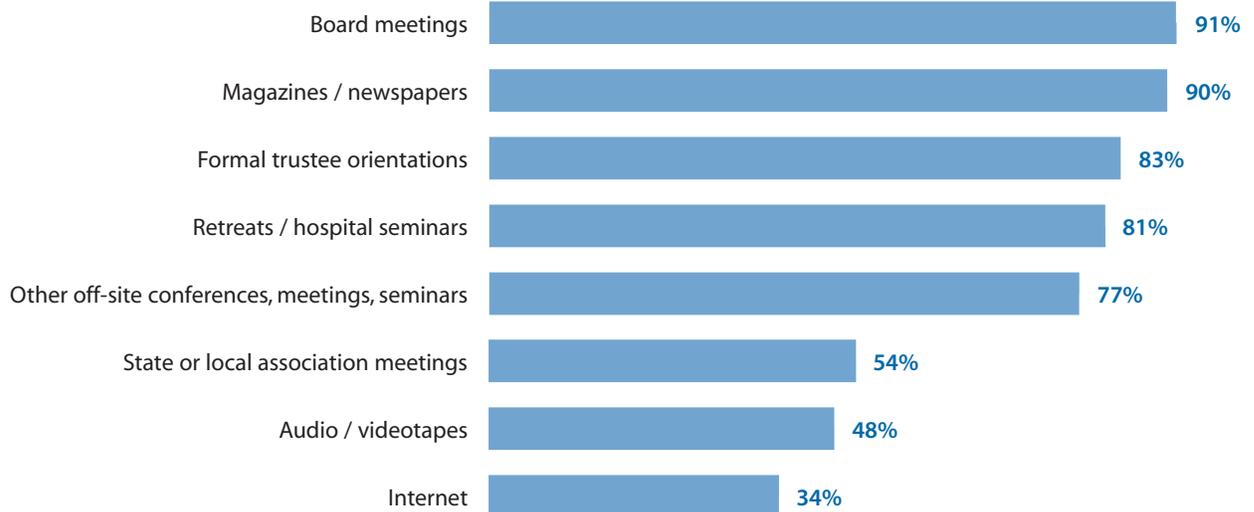
Today the question of compensation of board members for their service on the board is being raised with increasing frequency. Overall, only a small percentage of

TABLE 3.3 Criteria for New Board Members Receiving Heavy Emphasis or Considered an Absolute Requirement*		
According to ...	CEOs	Chairs
<b>Constituencies</b>		
Community leadership or representation	74%	81%
Patient representation	17	19
Faith community representation	8	15
Payer/purchaser representation	2	4
<b>Knowledge and Skill Sets</b>		
Financial/business acumen	56	63
Strategic planning / visioning	36	49
PR skills	21	33
Educational background	21	31
Previous board experience	21	26
Quality management	12	26
Clinical practice	13	13
Safety/quality	11	19
Fundraising ability	11	15
Conflict management skills	6	11
Technology	5	7
Legal skills	4	6
IT expertise	4	5
Insurance knowledge	3	3
Managed care knowledge	1	4
<b>Other Assets</b>		
Values consistent with board's	68	75
Time availability	47	58
Political influence	22	19
* Does not include public hospitals, whose board members are often elected or appointed by public officials.		

boards provide their members with a set annual fee, a per-meeting fee, or both, for their service on the board. A much larger percentage reimburses expenses for travel to board meetings (23%) and/or educational conferences (78%). However, there are significant differences among categories, particularly by hospital ownership type.

FIGURE 3.5

**How Board Members Receive Education**



According to... Board Chair

TABLE 3.4

**Board Member Compensation or Reimbursement**

	Annual Fee	Per-Meeting Fee	Travel Expenses	Ed'l Expenses
<b>Total</b>	<b>3%</b>	<b>10%</b>	<b>23%</b>	<b>78%</b>
Not-for-profit	2	4	22	81
For-profit	2	21	11	49
Public	5	19	31	83

**Board Evaluation**

About two-thirds of boards (67%) have a formal process for evaluating their own performance based on predetermined objectives or criteria. Of those boards with a formal self-evaluation process, 74% evaluate the

full board only, and 27% evaluate both the full board and the individual directors. The great majority (86%) of boards with formal evaluations perform the evaluation annually.

## BUILDING AND MAINTAINING EXTERNAL RELATIONSHIPS

All of the human systems (organizations, groups, communities) that make up the society and the world are increasingly interdependent. Virtually all leaders at every level must carry on dealings with systems external to the one in which they themselves are involved—tasks of representing and negotiating, of defending institutional integrity, of public relations. As one moves higher in the ranks of leadership, such chores increase.

— [John W. Gardner](#), *On Leadership*

Some of the board's most important responsibilities are to create and maintain external relationships. In fact, many believe that maintaining community trust and confidence is the single most important responsibility of a board, from which all other responsibilities flow.

### Community Relationships

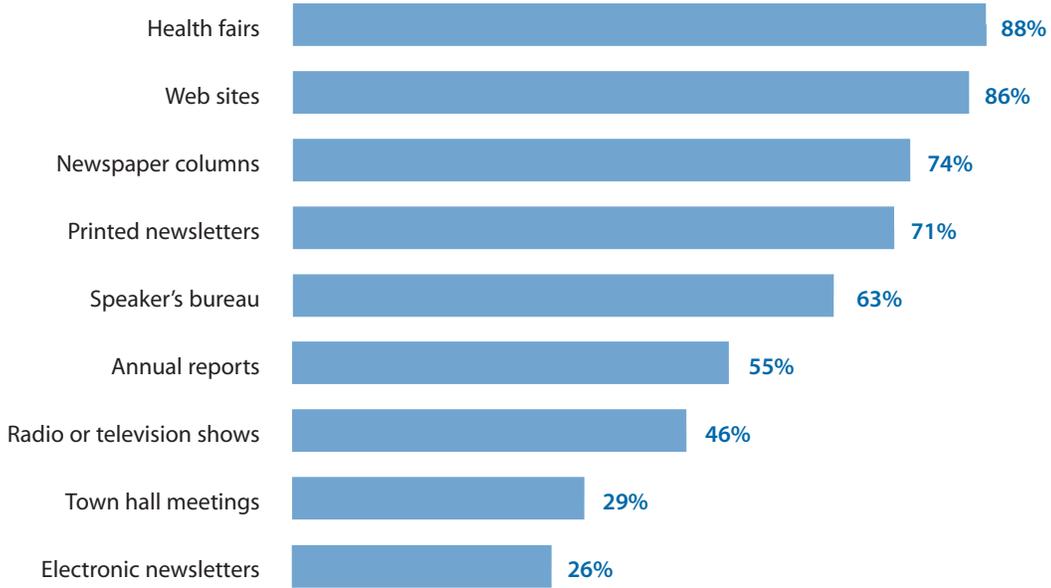
Attention and accountability to community appears to be relatively high on the list of priorities for CEOs and board chairs. On the most basic level, as one might expect, most CEOs (88%) and board chairs (92%) live in the community that is the primary service area of the hospital, with a somewhat higher percentage of CEOs of hospitals within systems (15%) than CEOs of hospitals that are not part of systems (11%) living *outside* their primary service area. Of 1488 CEOs that answered the question, 463 (that is, almost one-third) report that they have at least one board member drawn from outside that community.

There are many different ways that boards relate to their communities, including both formal and informal activities of individual board members as well as formal structures or processes created to engage the community and provide input to board deliberations. Board chairs spend an average of 5.5 hours per month acting as hospital ambassador to the community, which is more than any other single chair activity reported. In addition, more than 20% of hospitals have a separate community advisory board that provides input to the governing board.

In general, the survey results suggest that community relationships, defined as “improving mechanisms for demonstrating accountability and benefit to community,” are quite low on the priority list for improvements ranked by either CEOs or board chairs. This may indicate either that community relationships are perceived as strong and not in need of change or simply that other topics are of greater concern.

FIGURE 4.1

**Outlets for Regular Outreach to the Community**



Along with bringing the community's perspectives to the hospital, another important role of the board is to report back to the community what the hospital is doing. As shown in Table 4.1, only 28% of hospitals that use benchmark data regularly share that data with the community at large.<sup>4</sup> Although there are no large differences among categories, the hospitals that are most likely to share benchmark data with their community are the largest hospitals, those with 300 or more beds (34% of the large hospitals that use benchmarks).

**TABLE 4.1**  
**Sharing of Benchmark Data with Community at Large (for Hospitals that Use Benchmarks)**

<b>Total</b>	<b>28%</b>
Not-for-profit	29
For-profit	26
Public	28

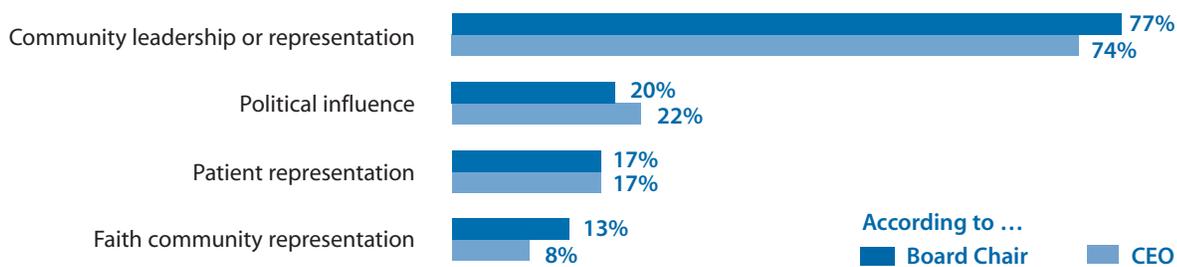
Whether or not they share benchmark data, boards do use a wide variety of means to provide regular outreach to the community, as shown in Figure 4.1. Hospitals are adopting new means of reaching the community—

notably web sites—as well as more traditional means, such as health fairs, newspapers, and newsletters, to provide information to their community stakeholders.

<sup>4</sup> Recall also that less than 65% of CEOs reported that their hospital uses any benchmark data at all.

FIGURE 4.2

### Importance of Community Representation as Criterion for New Board Members



#### Board Recruitment and Selection

Both CEOs and board chairs consider it important to have board members who bring the perspective of the users and local residents to the board. Figure 4.2 shows how often community-related criteria were given heavy emphasis or were considered an absolute requirement for board membership in the past year. Community leadership or representation was the single criterion most frequently rated critical by both groups of respondents, and in almost every category of hospital as well. (See Table 3.3 for the complete list of criteria covered.)

#### Government Relationships

Relationships with both local and state government and the local community are critical to a hospital’s ability to address its patients’ needs and sustain its position as a key community institution. There were fewer reports that boards have a committee on government relations than any of the other 15 committees listed (see Figure 2.4 on page 9), though boards may assign this function to other committees or handle it in another way.

#### Fundraising

For most not-for-profit hospitals, fundraising is a common responsibility of the board, and 35% of not-for-profit hospital boards have committees devoted to fundraising or development. As representatives of key community constituencies, board members have ties and contacts that can be used to bring the hospital’s message to the community and use that message to elicit contributions. This was borne out by common practice; 42% of not-for-profit boards reported that fundraising ability received heavy emphasis or was an absolute requirement for new board members. In addition, board chairs report that they spent an average of 1.6 hours per month on fundraising activities.

## S H A P I N G   T H E H O S P I T A L ' S   F U T U R E

The only justifiable reason for organizational existence is the production of worthwhile results. Worthwhile results always relate to the satisfaction of human needs. Whose needs, which needs, and what constitutes “satisfaction” are the unending, subjective quandaries confronting a board. Resolving the important, even existential value dilemmas inherent in these questions is the very heart of leadership in governance.

— **John Carver**, *Boards that Make a Difference*

**O**ne of the most important responsibilities of any organization’s board is to define the organization’s mission and provide strategic direction that helps it fulfill that mission.

### **Strategic Planning**

Almost three out of five hospitals (59%) have Strategic Planning committees. There are differences between hospitals that are members of systems and those that are not, with system members (51%) less likely to have Strategic Planning committees than hospitals that are not members of systems (65%). Of all categories studied, for-profit hospitals were least likely (30%) to have Strategic Planning as a specific separate committee or combined with another committee purpose.

### **Board Development**

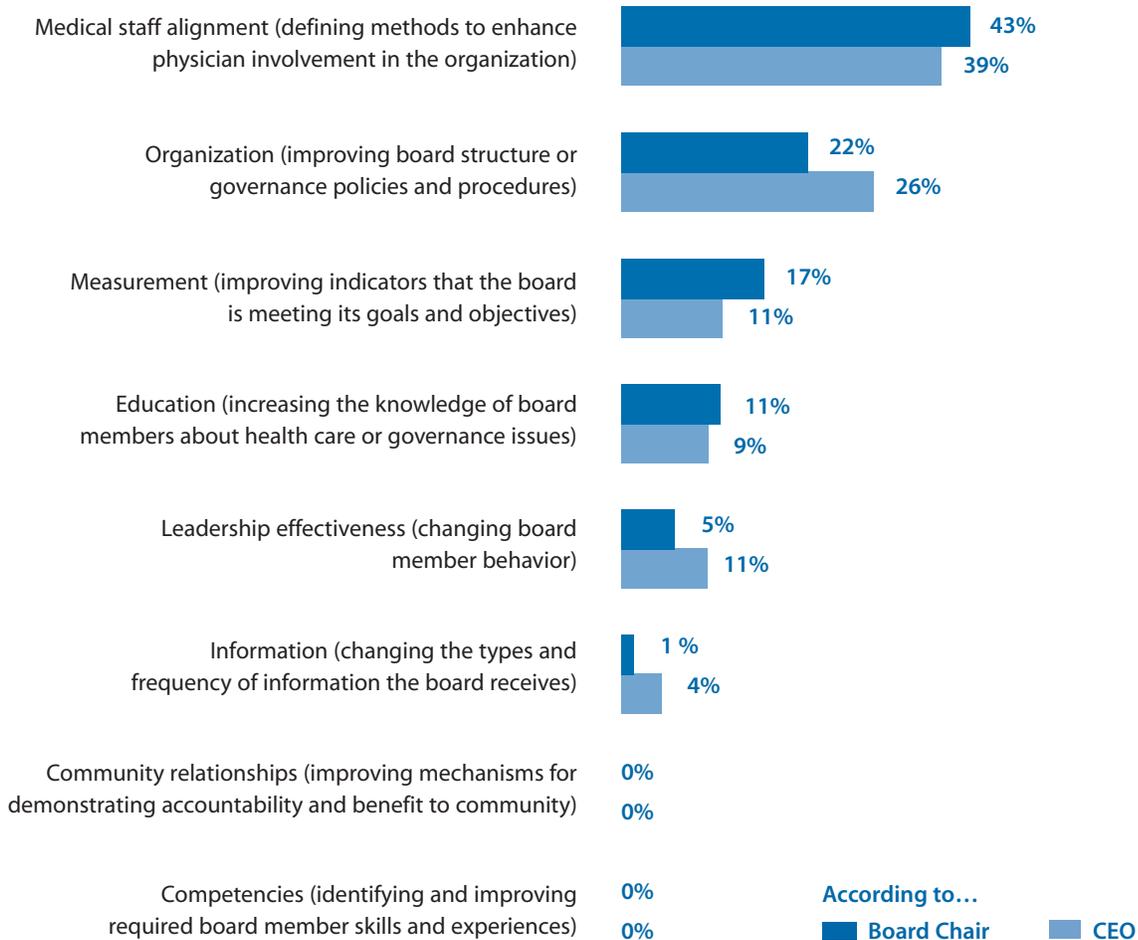
When CEOs and board chairs were asked about how much emphasis was given to specific criteria for recent board member selection, the two areas that were by far

the most likely to receive heavy emphasis or be an absolute requirement across all categories of hospitals were “community leadership” and “values consistent with those of the hospital.” These relative rankings held across all categories of hospitals, that is, based on size, region, ownership, and membership in a system, indicating the universal importance of these attributes in hospital governance. Across all hospitals, 68% of CEOs and 72% of board chairs gave strong emphasis to consistent values.

In contrast, only 36% of CEOs and 49% of board chairs marked “strategic planning/visioning” as receiving heavy emphasis or being an absolute requirement for recent members of the board. While this was more frequently mentioned than many of the specific skill sets or knowledge areas (see Table 3.3), it was cited with less frequency than financial acumen. Again, this finding held across categories.

FIGURE 5.1

### Most Important Way in Which the Board Might Change or Improve Over the Next 3 Years



As shown in Figure 5.1, when asked about the most important way in which the board might change or improve over the next three years, CEOs and board chairs were largely in agreement in relative rankings, with the largest percentage of each identifying medical staff alignment as the single most important area for change. This was followed in both groups by

improvements in the board structure or governance policies. It is interesting that a much larger percentage of CEOs than board chairs chose leadership effectiveness, that is, changing behavior of board members, as an area in need of improvement.

FIGURE 5.2

**Selected Criteria for CEO Performance Evaluation Receiving Considerable Weight or Considered Absolutely Critical**



**CEO Leadership**

CEOs and board chairs also were asked about the criteria used in the most recent evaluation of the CEO. Among the choices were “mission fulfillment,” “strategic plan fulfillment,” and “vision or other leadership qualities.” The results suggest that these qualities are emphasized in the CEO evaluation as well

as in board member selection, though financial performance remains the number one criterion. Figure 5.2 shows the percentages of CEOs and board chairs who rated each criterion as having “considerable weight” or being “absolutely critical.”

## CONCLUSION

Power and its use is one of the central concerns of trustees. The essential definition of the trustee role is that trustees, as a body, hold all of ultimate (legal) authority. However they do not use power operationally, that is, they do not administer. They use their legal power to secure information and to monitor and control the operational use of power. This is the central issue of trusteeship: trustees hold ultimate power but they do not use it operationally. Yet they are responsible for its use.

— **Robert K. Greenleaf**, *Servant Leadership*

This report gives a snapshot of the state of hospital governance: its structure, its understanding of its responsibilities, its key relationships, and its role in creating the future for individual health care organizations. What this report does not cover is the unique functioning of system boards, for-profit and public boards, as well as other categories such as community access hospitals, academic medical centers, etc. Future reports will target some of these other governance structures to enable a deeper understanding of how governance functions, given the diversity and complexity of health care organizations.

In addition, other reports will tie specific governance practices and characteristics to organizational performance. Thus the data from these surveys and other sources will enable us to make statements about what are truly best practices, and in what circumstances. This report, along with future reports, the report of the HRET Blue Ribbon Panel on Healthcare Governance, and the resources of the Center for Healthcare Governance, can be taken together to help define the future of excellence in hospital and health system governance.

## A P P E N D I X

### **Survey Methodology**

A team consisting of staff from the Health Research and Educational Trust, the Center for Healthcare Governance, Health Forum, and the American Hospital Association, along with governance researcher Jeffrey A. Alexander, PhD, University of Michigan, developed two survey instruments. The first instrument, designed to be answered by each hospital's Chief Executive Officer, was based on the survey instrument used in the mid-1990s in an American Hospital Association governance study. That instrument, in turn, was based on one used in 1989. The CEO survey included all factual information about the structure and operations of the board. Domains included Governance and Organizational Context, Board Composition and Organization, Committees, Board / Management Relationships, Operations, and Accountability. In this report, all data reported are results of the CEO survey unless otherwise noted. A second instrument, more focused on perceptions, was developed for hospital board chairs. Several questions were asked of both the CEO and board chair.

The two separate questionnaires were mailed to the Chief Executive Officer of all nonfederal community hospitals in the United States (n = 4865). Specialty hospitals, such as eye and ear and psychiatric hospitals, were not included. The CEOs were requested to pass the appropriate survey on to their board chairs. Respondents were able to respond by filling out the hard copy survey or using an on-line version of the survey instrument.

Responses were collected during the spring and early summer of 2005. A total of 1587 CEOs and 906 board chairs responded. This represents a response rate of 33% for CEOs and 19% for board chairs. The data were merged with descriptive information on each hospital from the American Hospital Association Annual Survey of Hospitals. For purposes of this report, data were weighted to reflect the national hospital population on five variables: ownership, bed size, Census region, metro/nonmetro location, and whether or not the hospital is part of a multihospital system. More detail on the weighting procedures is available from the authors. Readers should note that weighting does not eliminate the possibility of nonresponse bias; that is, the CEOs and board chairs who responded may differ in unknown ways from those who did not respond.

In addition, readers should note that the results presented in this report do not pair CEOs and board chairs from the same institution. Therefore, results comparing CEO responses and board chair responses should not be interpreted to mean that there are discrepancies between responses of individual CEOs and their board chairs. Rather, the results presented reflect the differences between the CEO respondents, taken as a group, and the board chair respondents, taken as a second group.



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