American Hospital Association™

Advancing Health in America

2022 National Health Care Governance Survey Report

AHA Trustee Services

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EXECUTIVE SUMMARY

Periodically since 2005, the American Hospital Association (AHA) has surveyed the nation's hospitals and health systems to develop a comprehensive picture of the state of health care governance structures and practices in the United States. Consistent with trends in a health care field that continues to undergo substantial transformation, the AHA's 2022 National Health Care Governance Survey report describes board structures, practices and focus areas that are continuing to evolve in the changing environment.

AHA collected survey data from 933 hospital and health system CEOs between November 2021 and March 2022. To provide a deeper longitudinal view, the survey gathered data on a variety of questions about board membership, structure and practices. Similar to the AHA's 2018 and 2014 surveys, the 2022 survey also examined findings across all respondents and by system, system subsidiary hospital and freestanding hospital boards.

New questions in the 2022 report delved into aspects of diversity, equity and inclusion as well as board practices during the COVID-19 pandemic.

To help boards and executives put the results into perspective, the 2022 report provides commentary on survey findings from an array of governance experts as well as sets of discussion questions to help boards reflect on survey findings in the context of their own structure and practices.

To help readers better understand the survey results and their implications for board work, this report is divided into nine sections:

- **Survey Methodology**, which describes survey design and process.
- **Board Composition**, which addresses board size, member voting status, emeritus board members and outside board members.
- **Board Diversity**, which describes the make-up of boards across the dimensions of diversity including race/ethnicity, gender, age, among others.
- **Board Structure**, including term limits and term length, board compensation, board committees, and board restructuring and support.
- **Board Selection**, which describes board member competencies, board member replacement and effort required to recruit board members.
- **Board Orientation and Education**, which addresses position descriptions, orientation and education practices.
- **Board Evaluation**, including assessment types and focus, use of assessment results and board member evaluation criteria.
- **Performance Oversight**, which focuses on executive oversight, accountability and organizational performance.
- **Board Culture**, which addresses board meetings, executive sessions and time commitment for board work.

Positive trends indicated by report findings include:

- Some progress in racial/ethnic diversity and gender diversity on boards.
- 91% of respondents said they are interested in identifying and engaging board candidates who represent diverse characteristics.
- Nearly 70% of all responding boards have engaged in restructuring efforts to improve their governance.
- The use of knowledge, skills and behavioral competencies to select board members has steadily increased in the past decade. This is considered a governance best practice.
- The use of a board portal, considered a governance best practice, has become more prevalent.

However, there are opportunities for improvement:

- A third of respondents did not use term limits.
- Survey results indicated a growing number of older board members and a declining number of younger members.
- More than 75% either did not replace board members during their terms or continued to reappoint them when eligible during the past three years, resulting in low levels of board turnover.
- 61% said they do not have a board member continuing education requirement.
- More than a quarter of boards did not do any type of assessment in the past three years.
- About half of all boards do not hold the CEO accountable for diversity, equity and inclusion goals as part of their performance review.

Boards and executives reflecting on the results of the 2022 survey can gain useful insights by comparing their own structures and practices with survey report findings and evaluating where they are rising to meeting the modern challenges of governing and what opportunities exist to improve their own performance and practices.

AHA extends its appreciation to the governance consultants who provided commentary to this report.

Please note that the views of commenters do not always reflect the views of the AHA.

SECTION 1

Survey Methodology

The American Hospital Association (AHA) developed the 2022 national health care governance survey. It builds on the results of previous national governance surveys conducted by the AHA in 2005, 2011, 2014 and 2018.

The current survey instrument, designed for completion by hospital and health system chief executive officers (CEOs), was sent via electronic mail to the CEOs of 5,232 nonfederal community hospitals and health systems in the U.S. Specialty hospitals, such as eye-and-ear and psychiatric hospitals, were not included.

Survey responses were collected between November 2021 and March 2022. A total of 933 CEOs responded to the survey (a 17.8% response rate). Overall, the respondents were generally representative of hospital bed size and geographic distribution in the U.S. (Figure 1.1). Not-for-profit organizations were somewhat overrepresented and investor-owned organizations were underrepresented in the survey results.

Figure 1.1 Survey Respondents Compared to All Hospitals

	Responders	Universe
Ownership		
Public	26%	20%
Not for profit	67%	56%
Investor owned	10%	24%
Total	100%	100%

	Responders	Universe
System		
System	61%	67%
Non-System	39%	33%
Total	100%	100%

Location		
Urban	60%	66%
Rural	40%	34%
Total	100%	100%

Region		
Territories	1%	1%
Midwest	31%	28%
Northeast	16%	12%
South	28%	40%
West	24%	19%
Total	100%	100%

Bed size		
< 100	54%	57%
100 - 299	35%	34%
> 299	11%	9%
Total	100%	100%

SECTION 2

Board Composition

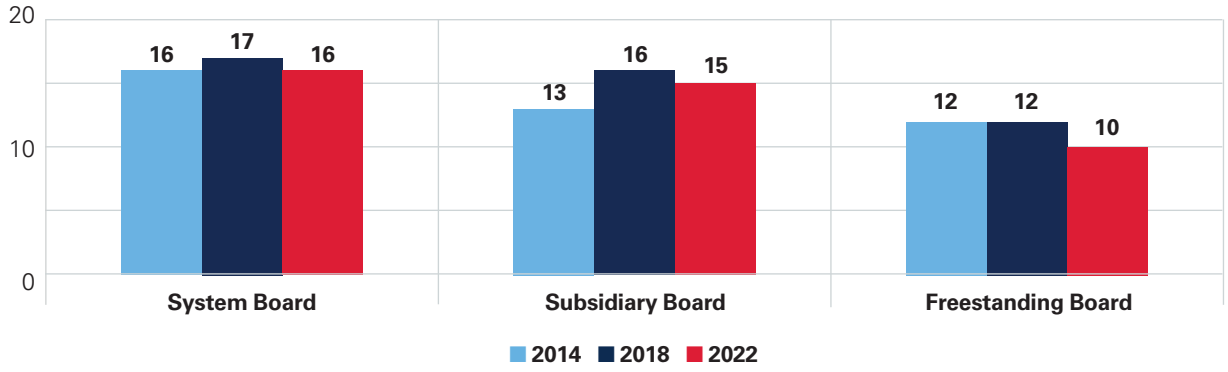
Data Points

Data from the AHA 2022 national health care governance survey indicate a decrease in board size. Boards report that more non-employed physicians have voting privileges than employed physicians. The percentage of system boards that include the CEO as a voting member has significantly increased. Inclusion of board members from outside the organization's service area has also increased.

Board Size

- In 2022, the average board size overall was 13 members, compared to 14 in 2018 and 13 in 2014 (Figure 2.1).
- The average size of all boards was smaller in 2022 than in 2018 (Figure 2.1) with freestanding hospital boards reporting the greatest change in size, averaging 10 members in 2022 and 12 members in 2018 (Figure 2.1).
- A subsidiary board is a hospital board within a health system that may or may not have fiduciary responsibilities..

Figure 2.1 Board Size

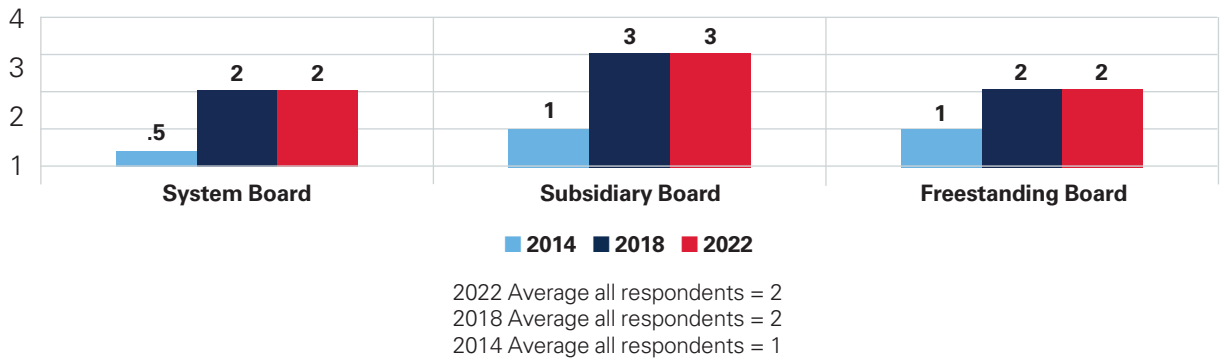


2022 Average all respondents = 13
2018 Average all respondents = 14
2014 Average all respondents = 13

Member Voting Status

- The average number of nonvoting members across all boards remained the same in 2022 as compared to 2018 with two nonvoting members for system boards, three nonvoting members of system subsidiary hospital boards, and two nonvoting members for freestanding hospital boards (Figure 2.2).

Figure 2.2 Average Numbers of Nonvoting Board Members



2022 Average all respondents = 2
2018 Average all respondents = 2
2014 Average all respondents = 1

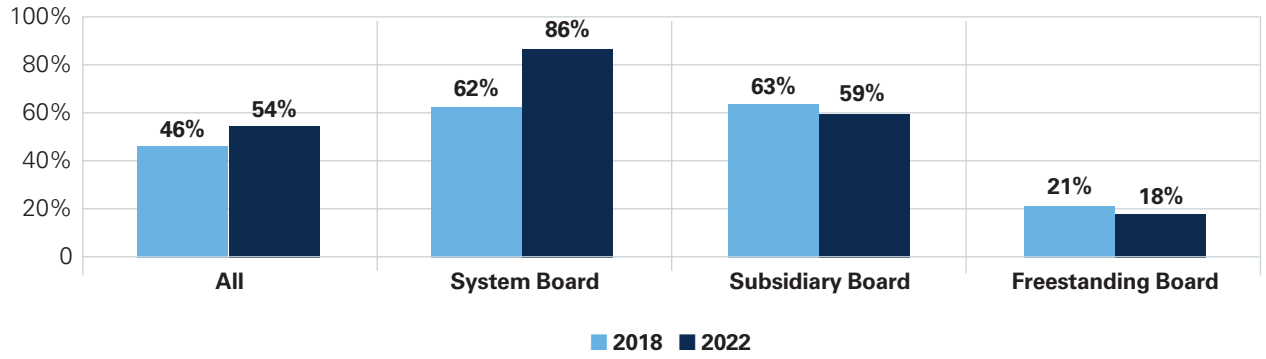
- On boards with physician members, respondents reported that on average, a higher number of physician board members *not* employed by the hospital or system had voting privileges than those who were employed. On average, system subsidiary hospital boards reported that more employed physician board members had voting privileges than those that did not (Figure 2.3).

Figure 2.3 Employment and Voting Status of Physician Board Members

Average number of physician board members ...	All	System Board	Subsidiary Board	Freestanding Board
Employed by your hospital/system a. Voting	1	1	2	1
Employed by your hospital/system b. Non - Voting	1	2	1	0
Not employed by your hospital/system a. Voting	3	2	2	3
Not employed by your hospital/system b. Non - Voting	0	0	1	0

- In 2022, 86% of system boards reported that their CEO was a voting member of the board compared to 2018 (62%), a significant increase. By contrast, system subsidiary boards and freestanding hospital boards reported a decline in the percentage of CEOs having voting status at 59% and 18%, respectively (Figure 2.4).

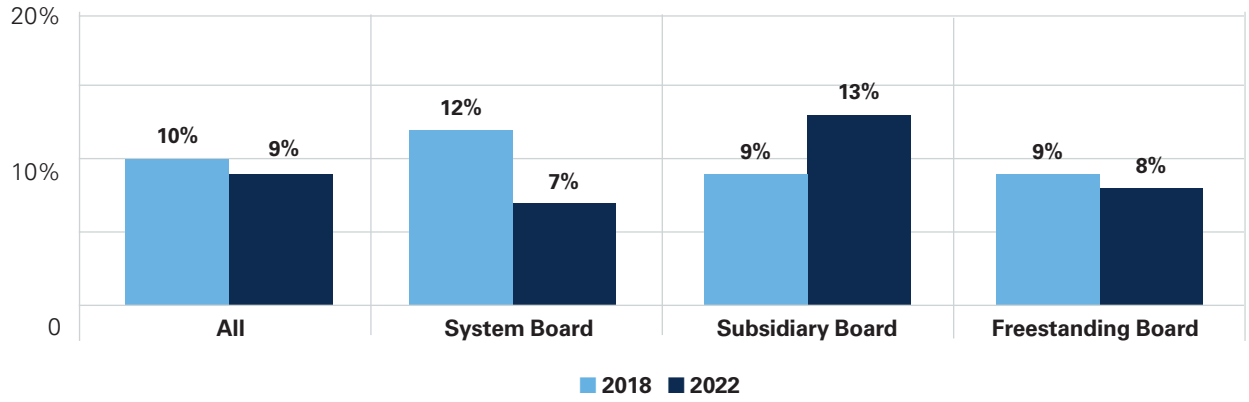
Figure 2.4 CEO as a Voting Board Member



Emeritus Board Members

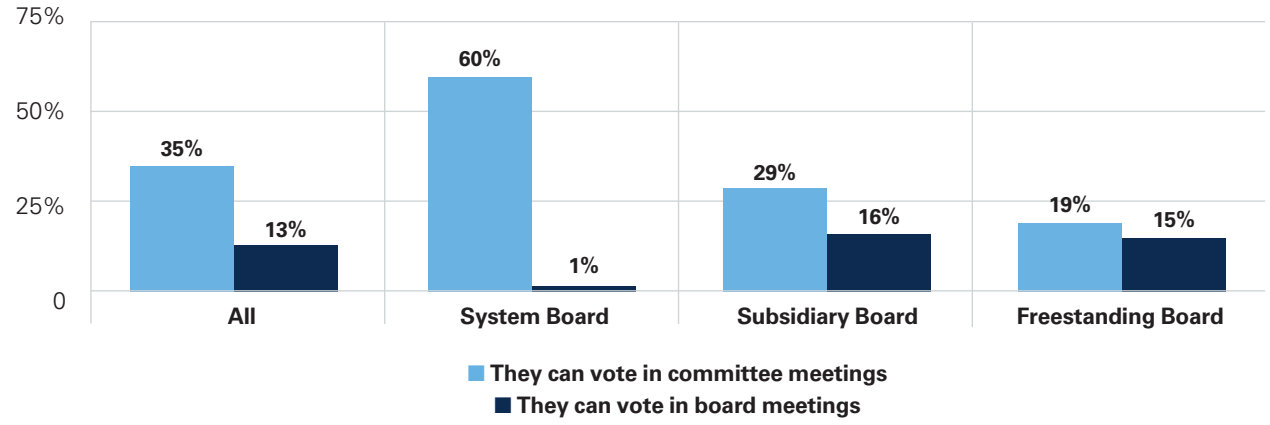
- As shown in Figure 2.5, system boards reported having fewer emeritus members in 2022 (7%) as compared to 2018 (12%). By contrast, system subsidiary hospital boards reported having more emeritus members in 2022 (13%) as compared to 2018 (9%).

Figure 2.5 Emeritus Member Voting Status



- Of those overall respondents who included emeritus members, 48% said they are able to vote in board and/or committee meetings (Figure 2.6).

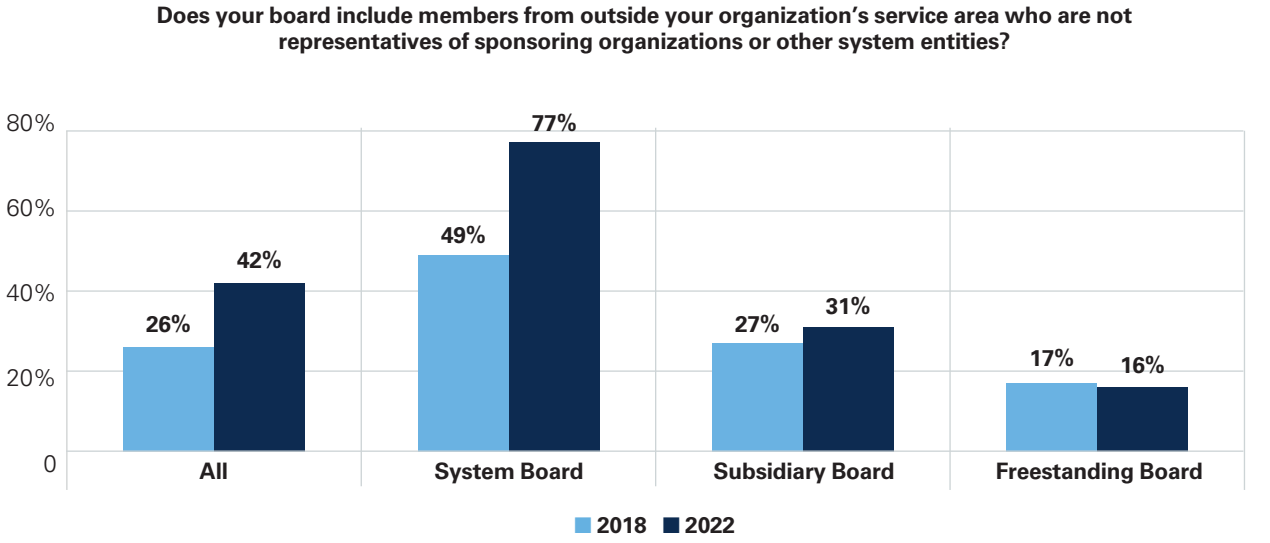
Figure 2.6 Emeritus Member Voting Status



Outside Board Members

- Overall, the percentage of respondents reporting having outside board members (those from outside the service area who are not from sponsoring organizations or other system entities) increased from 26% in 2018 to 42% in 2022 (Figure 2.7).
- More than three-fourths of system boards (77%) reporting having outside board members. Only 16% of freestanding hospital boards reported having outside board members (Figure 2.7).

Figure 2.7 Outside Board Members



Commentary on Board Composition

By Pamela R. Knecht, (pknecht@accordlimited.com), president & CEO, ACCORD LIMITED

Introduction

The size and composition of the board are critical success factors for effective and efficient governance. Boards must be small enough to encourage robust, candid discussions that engage all members. And smaller boards can often make more timely decisions in these complex times.

With fewer available seats, every board seat counts, so advanced boards are revisiting their approach to board composition. They are evolving from using a representational approach to utilizing a competency-based approach to board composition. This practice decreases conflicts of interest and increases the expertise and objectivity of the board.

In addition, the best boards ensure all members are on equal footing. To do that, they eliminate nonvoting members, change the voting status of emeritus members, and add their CEO as a voting member.

As a result, everyone in the boardroom can function as equally important partners in decision-making about how best to serve their communities.

Fortunately, the survey data show positive movement in all these key areas of board effectiveness.

Observations about Survey Findings

Too often, boards are too large and as a result, it is difficult for all members to contribute to important deliberations. Therefore, the survey findings about board size are encouraging. All types of boards have decreased in size and the average board size is now 13 (down from 14 in 2018). Freestanding hospital boards report even smaller boards; the average is 10 members. Ten members is a little smaller than most governance consultants recommend for freestanding boards. Perhaps there were more survey respondents from public/governmental hospitals, which typically have smaller boards (e.g., 7-9 members). In general, 11-13 members creates the right balance between being small enough for good engagement yet big enough to include needed competencies and diversity to perform their roles. (Note: There are separate sections in this report with the survey findings on board competencies and diversity.)

Another positive finding is that now 86% of system boards report that their CEO is a voting member of the board (versus 62% in 2018). In today's complex health care environment, CEOs and boards need to partner in understanding the critical issues facing the organization and in making decisions that are in the best interest of all those served. This partnering is easier when the CEO also is a voting board member. Unfortunately, this trend has not continued with subsidiary or freestanding hospital boards. They each reported a decline in the percentage of CEOs with voting status. CEOs are often barred from serving as voting board members in public/governmental hospitals/systems, so perhaps these results reflect a higher percentage of respondents from that type of organization.

A more neutral finding is that the average number of nonvoting board members stayed the same from 2018 to 2022 across all types of boards *(see table 1.3 for the details)*. This could be interpreted as good news — at least boards are not increasing the number of nonvoting members. Since boards often become confused about the role of their nonvoting members, it is not a commonly recommended practice today. It is better to have all board members be voting members who have equal voice in discussions and decisions. If the board would like to hear from certain types of people on (e.g., the Chief of the Medical Staff), they could be invited as guests. This practice helps to differentiate and clarify the role and authority of each person in the boardroom.

On a related note, system and freestanding boards reported they did not have any nonvoting, nonemployed physicians serving on their boards. Subsidiary boards replied that only one of their members was in this category. Perhaps in the future, subsidiary boards will follow the other boards in decreasing or retiring this older model of nonvoting board members.

It is important to mention that physicians should be involved in the governance of hospitals and health

systems. The key question is how to do that in appropriate ways, given that most physicians are now employed by those same organizations. Some of the governance-related concerns with physicians on boards and committees are that they are considered 'insiders' by the Internal Revenue Service (therefore not objective) and that they are simultaneously reporting to the CEO (as employees) and overseeing the CEO's performance (in their board capacity).

Another complicating factor is that in the traditional model of governance, physicians served on the board to be representatives of the whole medical staff, their own specialty, or their private practice. All voting board members (including physicians) have a legal, fiduciary duty to the mission, not to any constituency.

The survey results provide additional information on how hospital and system boards are balancing the need for the physician/clinician perspective with the above-mentioned concerns about physicians serving on boards. Across the three types of boards, the preferred approach seems to be having 2-3 *nonemployed, voting* physician board members. It is not clear from the data whether these physicians are on the active medical staff or from outside the service area altogether. Perhaps the next survey can shed light on that key question.

There may be a relationship between the finding about physician board members and another topic addressed by the survey — outside board members. Now, 42% of *all* boards have members from outside their organization's service area (versus only 26% in 2018). And 77% of system boards include outside board members (up from only 49% in 2018).

For instance, boards can 'kill two birds with one stone' if they look outside their service area for physicians or clinicians who have expertise in population health management or clinical integration. These individuals would not have the built-in conflict of interest / lack of independence issues of those on the active medical staff; they may bring ideas about best practices from elsewhere, and they could provide an objective perspective to board discussions.

The last topic in this section focuses on emeritus board members. There was a slight decrease in the percentage of all boards that have emeritus members (now 9%) and a significant decrease in the percentage of system boards with emeritus members (7% down from 12%). Again, the system boards are leading the way for other types of boards. As mentioned earlier, it is better if all board members have the same status — current, voting members. Exceptions for emeritus status adds to the number of people in the room and has the potential to confuse roles. System boards appear to have learned that allowing emeritus members to vote in board meetings is very confusing — only 1% allow that practice.

Other approaches to keeping valued individuals engaged are better. For instance, having a previous board member serve as a voting member of a committee, on the foundation board, or on an advisory council keeps them involved and contributing. It also clarifies roles for all those involved in governance.

In conclusion, the survey results indicate that health care governance is moving in the right direction, often led by system boards. Paying close attention to the board's size and composition results in boards that have the correct number and type of people who are appropriately objective and engaged as partners with the CEO in ensuring achievement of the mission.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Composition

- Does your board's size facilitate engaged participation by all board members?
- In order to ensure equal participation by all, has your board eliminated nonvoting members and emeritus members, and made the CEO a voting member of the board?
- How might your board benefit from the inclusion of outside board members (those from outside the service area who are not from sponsoring organizations or other system entities)?
- What opportunities exist to strengthen your board's composition to better serve your patients and communities?

SECTION 3

Board Diversity

Data Points

Boards report they are becoming more ethnically/racially diverse, a higher percentage of female members and a growing percentage of older members. More boards reported having at least one clinician on their board. Less than half of respondents are undertaking efforts to recruit millennials. Nearly all reported they are interested in recruiting diverse board members, and most indicated that the effort to do so is not difficult.

Board Race/Ethnicity

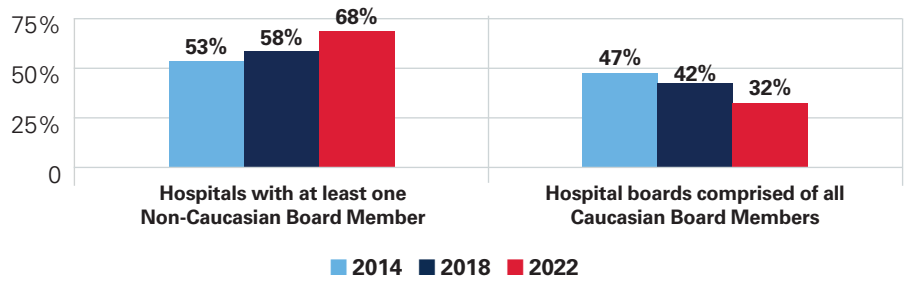
- System boards report the highest level of racial/ethnic diversity, with 26% of their members representing historically underrepresented groups in 2022, compared with 18% of system subsidiary hospital boards and 9% of freestanding hospital boards (Figure 3.1).

Figure 3.1 Voting Board Member Demographics

	All	System Board	Subsidiary Board	Freestanding Board
Race/Ethnicity				
White	80%	74%	82%	87%
Black or African American	10%	15%	7%	5%
Hispanic/Latino	5%	6%	4%	3%
Asian	3%	4%	3%	2%
American Indian or Alaska Native	1%	0%	1%	1%
Native Hawaiian or Pacific Islander	0%	0%	0%	0%
Other	2%	1%	2%	2%
Total	100%	100%	100%	100%
Gender				
Male	64%	63%	65%	65%
Female	36%	37%	35%	35%
Other	0%	0%	0%	0%
Total	100%	100%	100%	100%
Age				
35 or younger	2%	2%	2%	2%
36-50	17%	10%	23%	23%
51-70	63%	66%	62%	60%
71 or older	18%	22%	12%	15%
Total	100%	100%	100%	100%
Clinical Background				
Nurse	19%	16%	20%	21%
Physician	70%	80%	66%	59%
Other Clinician	11%	4%	13%	20%
Total	100%	100%	100%	100%

- Survey data indicate that today's system and hospital boards are becoming more ethnically/racially diverse, with 68% reporting at least one non-Caucasian member in 2022, compared with 58% in 2018 and 53% in 2014 (Figure 3.2).

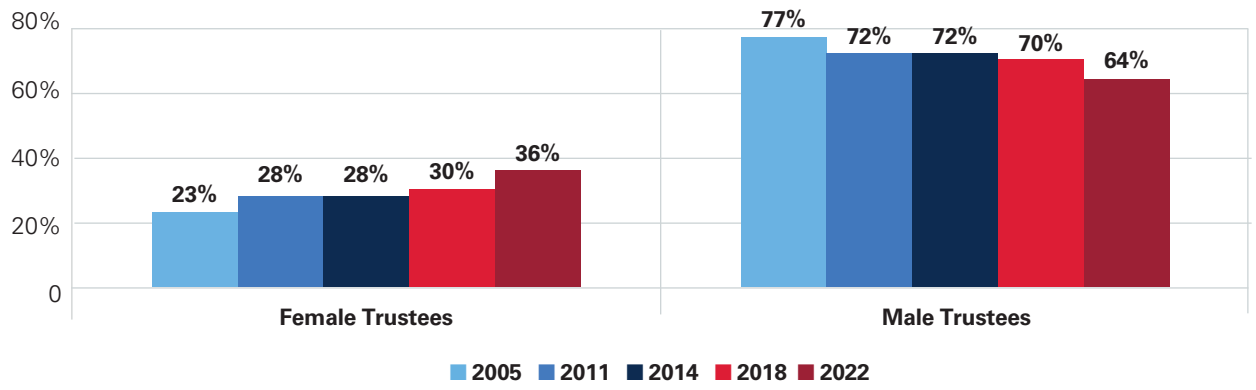
Figure 3.2 Systems and Hospitals with at Least One Non-Caucasian Board Member



Board Gender

- Gender diversity on boards has gradually increased over the past 17 years. In 2022, survey respondents reported 36% of their members were female, compared with 30% in 2018, 28% in 2014 and 2011, and 23% in 2005 (Figure 3.3).

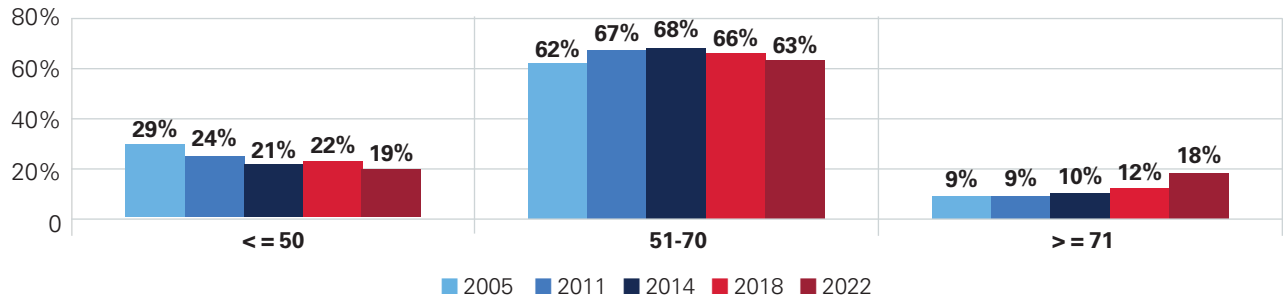
Figure 3.3 Board Gender



Board Age

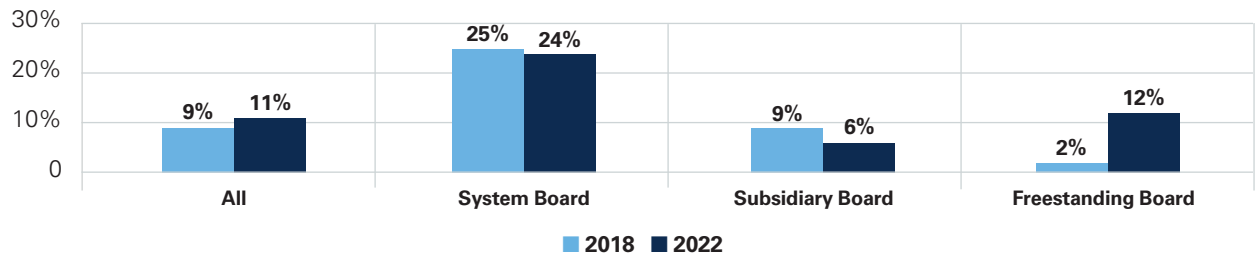
- As shown in Figure 3.4, survey data indicate that the percentage of boards with members age 50 or younger (19%) continued to decline compared to 2018 (22%), 2014 (21%), 2011 (24%) and 2005 (29%).
- In 2022, boards overall had a higher percentage of members age 71 or older (18%) than did boards in 2018 (12%), 2014 (10%), 2011 and 2005 at 9% each (Figure 3.4).

Figure 3.4 Board Age



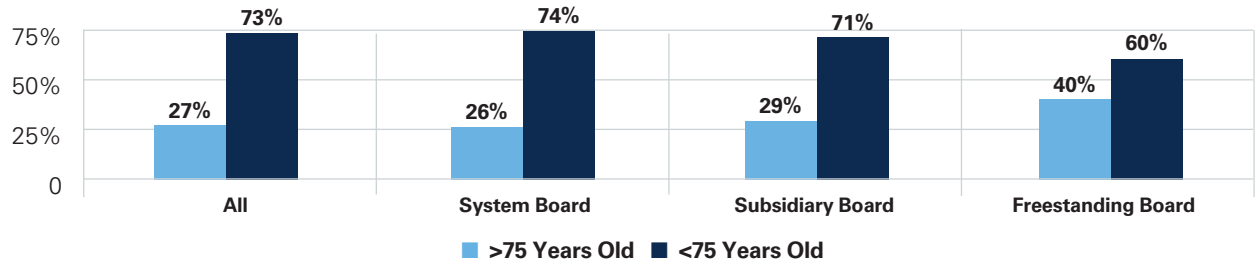
- In 2022, 12% of freestanding hospital boards reported having a board member age limit compared with only 2% in 2018 (Figure 3.5).

Figure 3.5 Board Member Age Limit



- Of those 2022 respondents overall that reported having an age limit, the majority (73%) indicated a maximum age of less than 75 years for board members (Figure 3.6).

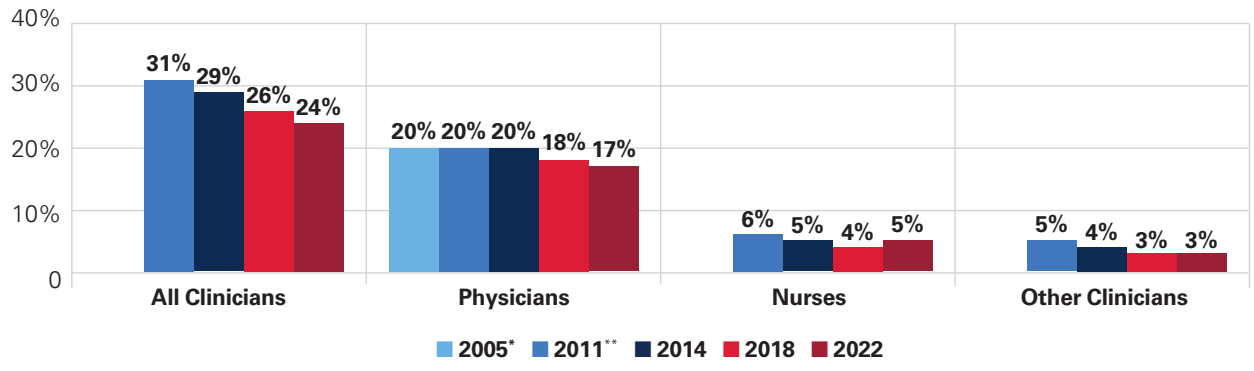
Figure 3.6 Maximum Age for Board Members



Clinician Board Members

- 2022 survey data show the percentage of board members who are clinicians continues to decline overall across most categories (physicians and other clinicians). There was a slight increase in the percentage of nurses on boards, up to 5% in 2022 as compared to 4% in 2018 (Figure 3.7).

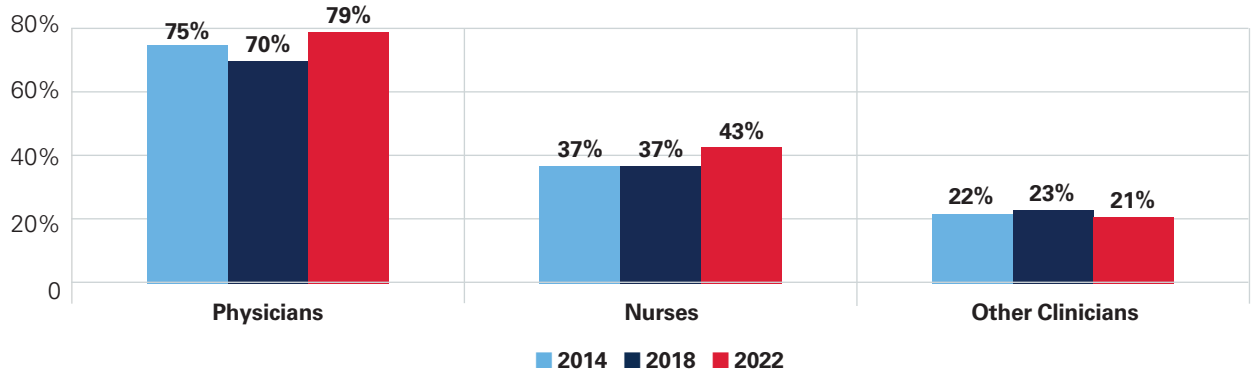
Figure 3.7 Clinician Board Membership



* The only data available in 2005 was for physicians
** 2011 was the first survey to ask about clinicians other than physicians

- A higher percentage of hospitals and systems (79%) reported having at least one physician board member in 2022, compared with 70% in 2018. Similarly, more respondents had at least one nurse on their board (43%), compared to 37% in 2018 (Figure 3.8).

Figure 3.8 Percentage of Hospitals with Clinician Board Members



- Overall in 2022, all board types increased the percentage of nurses on their boards. System subsidiary hospital boards and freestanding hospital boards reported fewer percentages of physician members in 2022 than in 2018 (Figure 3.9).

Figure 3.9 Board Composition by Board Type by Year

	System Board			Subsidiary Board			Freestanding Board		
	2014	2018	2022	2014	2018	2022	2014	2018	2022
Race/Ethnicity									
White	86%	83%	74%	86%	85%	82%	90%	91%	87%
Black or African American	7%	9%	15%	6%	6%	7%	4%	4%	5%
Hispanic/Latino	3%	4%	6%	3%	4%	4%	3%	2%	3%
Asian	2%	2%	4%	2%	2%	3%	1%	1%	2%
American Indian or Alaska Native	1%	0%	0%	0%	1%	1%	1%	1%	1%
Native Hawaiian or Pacific Islander	N/A	N/A	0%	N/A	N/A	0%	N/A	N/A	0%
Other	1%	2%	1%	4%	2%	2%	1%	1%	2%
Gender									
Male	76%	72%	63%	69%	70%	65%	72%	70%	65%
Female	24%	28%	37%	31%	30%	35%	28%	30%	35%
Other	N/A	0%	0%	N/A	0%	0%	N/A	0%	0%
Age									
35 or younger	N/A	2%	2%	N/A	2%	2%	N/A	3%	2%
36-50	12%	14%	10%	19%	22%	23%	17%	22%	23%
51-70	81%	73%	66%	70%	64%	62%	63%	62%	60%
71 or older	7%	11%	22%	11%	12%	12%	20%	13%	15%
Clinical Background									
Nurse	4%	13%	16%	6%	18%	20%	4%	17%	21%
Physician	26%	78%	80%	22%	73%	66%	17%	65%	59%
Other Clinician	2%	10%	4%	3%	9%	13%	5%	18%	20%

Diversity Recruitment

- As shown in Figure 3.10, more than half of all respondents (58%) reported that they had not undertaken efforts to engage millennials (individuals born between 1981 and 1996) in governance. System boards reported the greatest efforts to engage millennials (54%) as compared to system subsidiary hospital boards (39%) and freestanding hospital boards (31%).

Figure 3.10 Efforts to Engage Millennials in Governance

What efforts, if any, has your board/organizations undertaken to engage Millennials (individuals between the ages of 21-35) in governance?

	All	System Board	Subsidiary Board	Freestanding Board
Established a Millennial Council that can help identify potential board candidates	1%	1%	3%	1%
Specifically targeted Millennials when seeking new board members	26%	31%	22%	22%
Included Millennials as outside (non-board) members on board committees	10%	31%	13%	7%
Other	10%	10%	7%	5%
None of the above	58%	46%	61%	69%

- Overall, 88% of 2022 survey respondents reported that recruiting diverse members (age, race, gender, ethnicity, skill set on the board) required little to moderate effort (Figure 3.11).

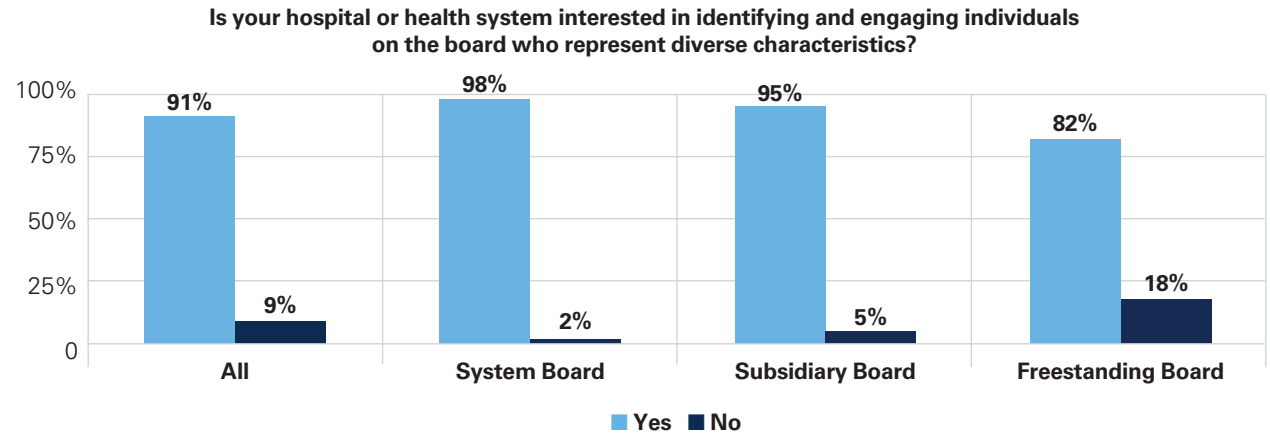
Figure 3.11 Effort Required to Recruit Diverse Board Members

On a scale of 1 - 5, how much effort is required to recruit diverse members (age, race, gender, ethnicity, skill set) on your board?

	All	System Board	Subsidiary Board	Freestanding Board
5 - extreme effort	6%	1%	8%	11%
4	6%	2%	5%	9%
3	31%	36%	28%	27%
2	31%	31%	34%	28%
1 - little effort	26%	30%	24%	25%

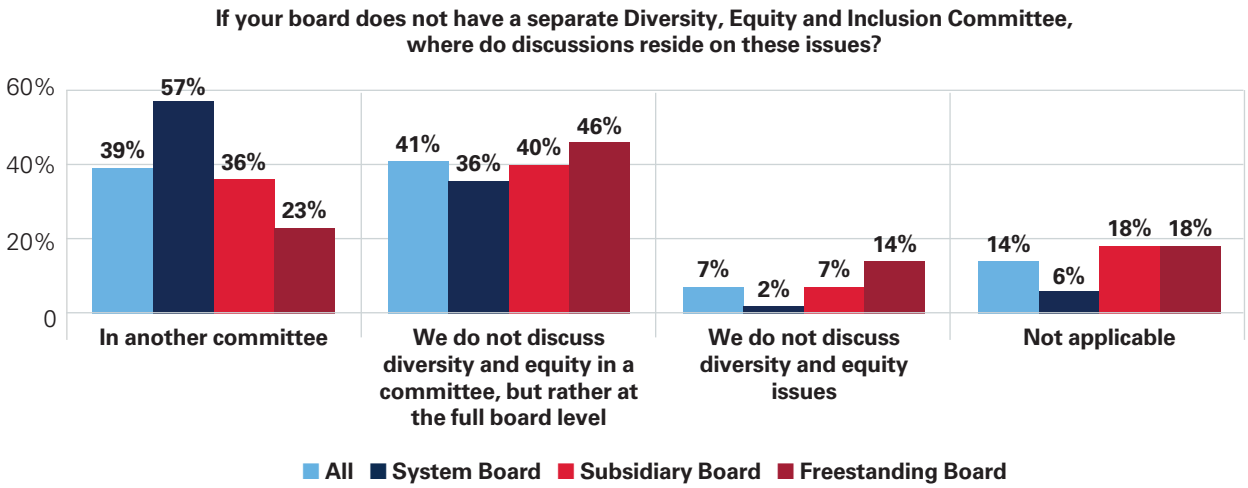
- Nearly all (91%) of 2022 survey respondents reported that they were interested in identifying and engaging individuals on the board who represent diverse characteristics (Figure 3.12).

Figure 3.12 Interest in Identifying and Engaging Diverse Board Members



More system subsidiary hospital boards (40%) and freestanding hospital boards (46%) reported that they discuss diversity, equity and inclusion (DEI) at the full board level, while system boards reported that these discussions occur in a committee (57%) (Figure 3.13).

Figure 3.13 Governance Discussion of Diversity, Equity and Inclusion



Commentary on Board Diversity

By Karma H. Bass, (kbass@viahcc.com), managing principal, Via Healthcare Consulting

Introduction

Health care organizations are in the midst of a painful and previously unimaginable transformation that necessitates its leadership take new and different approaches to its challenges.

One of these challenges is the lack of diversity among board members. Based on the results of the 2022 AHA Governance Survey, the governing boards of today's hospitals and health systems remain insufficiently diverse to adequately represent the patients and overall communities that our not-for-profit health care organizations serve.

Observations about Survey Findings

No Substantive Progress

A board's good intentions to diversify its membership don't absolve it from the need to achieve greater diversity. While this year's survey results show some changes, they are not enough. At the rate we're going, it will take approximately 20 years before hospital and health system boards accomplish the basic step of equal male/female representation. The racial and ethnic diversity of our boards is even more dismal. Our nation is now 40% comprised of Blacks, Latinos and other people of color. But our freestanding hospital boards are, on average, 9% nonwhite, our subsidiary boards are 18% nonwhite and our system boards are 2% nonwhite.

The important work being done by many health care organizations around diversity, equity and inclusion (DEI) will ring hollow unless an organization's leadership reflects its commitment. A board's diversity (or lack thereof) is a highly visible signal of the organization's true intentions around DEI.

Governance is about leadership, and leadership should be focused on doing the right thing. Making room at the table for people of color, women, millennials, the LGBTQ+ community, people with disabilities and others who have been historically marginalized is where today's boards should be focused. A lack of board diversity is not a minor concern, nor one that should be delegated solely to a committee. Addressing the need for greater diversity should be a focus for the entire board.

What's at stake is considerable. Not taking the time and doing the work to diversify the board could have harmful, long-term ramifications for the entire organization.

What's Not Working and What Is?

How do we make space at the table for other voices and new leaders? If boards are serious about increasing their gender, racial and ethnic diversity, they need to take proactive steps to increase the proportion of board members who represent their communities more closely.

The approaches we've been using to identify, recruit and retain nonwhite and female board members have not been working. The lack of results speaks for itself. I, for one, am not interested in waiting another 20 years to see if continuing to do what we've done will bring different results. If your board is serious about this work, I suggest consulting the many resources gathered by AHA on its Trustee Services page (trustees.aha.org). It is hard work, true, but not an impossible task.

The boards that have made significant strides in achieving diversity were dogged in their pursuit of it. They spent many hours in governance and nominating committee meetings designing transparent and thorough processes for identification and recruitment of qualified candidates from underrepresented groups. They had full-board conversations about work being done on DEI, as well. They made a clear statement of their intent in the form of policies, goals and communications to the organization's leadership. They had frank discussions about the board's current composition and areas of need. They were willing to change their approach or leave a board seat open if they had not found the best candidate.

New Approaches Are Required

Greater diversity will change the way the board does its work, and it should. In fact, boards should

reconsider how they structure their meetings, service requirements, and other ways of doing business to make board service more feasible and inclusive for the historically underrepresented groups of board members. Attracting and retaining the next generation of board members will require such sustained effort and a willingness to try new approaches.

It stands to reason that the current structure favors those who currently tend to serve. There are unintentionally exclusionary practices in the way we do governance now. These include overly frequent, overly lengthy board and committee meetings held during working hours. There is nothing sacred about having monthly board meetings that last an entire weekday afternoon.

In my 25 years of studying boards, I've never seen a correlation between board effectiveness and the number or duration of meetings. Other practices, like the requirement that board members serve on at least two committees, should be reconsidered as well since they may impose an unacceptable time burden to mid-career women, younger board members, or those with greater family, financial, or personal demands on their free time.

Boards need to retool themselves to attract the female and more diverse candidates they seek. The need to attract and retain more diverse and younger board members also should be viewed as an opportunity to reexamine what issues the board focuses on.

Talking about the business of the hospital or health system should no longer be the primary focus of board and committee meetings. The highly qualified professionals running our nation's hospitals do not need volunteer board members checking the math on their operating and financial calculations. They need thought-partners in reimagining the way their community receives its health care and envisioning what a healthy community looks like for them. If discussion at board meetings focus on what really matters for a community's health, it should not be difficult to capture the interest of the next generation of board leaders.

Don't Wait to Be Imposed Upon

Stakeholders of not-for-profit health care include the community, patients, employees, providers, unions, state attorneys general, as well as the local, state and federal government. These stakeholder groups are increasingly expecting accountability from health care organizations. We should expect this will include an evaluation of the board.

The racial, ethnic and gender composition of a board will be a factor these stakeholders consider when making assessments regarding the strength and fitness of the organization's leadership. If we cannot find a path to building more diverse boards — and soon — we should expect that it will be imposed on our hospitals and health systems by external stakeholder groups; with this will come much public castigation of the organizations that have failed to address such a glaringly discordant feature. Having a board of directors that is not representative of the community will be an institutional failing.

More importantly, the longer we wait to build the boards our organizations need and our communities deserve, the longer we will go without the broad range and depth of leadership that our important organizations need during these difficult times.

Bringing more people from marginalized and underrepresented groups to sit on our hospital and health system boards is only the first step. Boards must recognize that the purpose of diversity is transformation that leads to a more equitable, just, and healthy society. Tapping into the newest board members' experience, expertise and wisdom, we must be willing to retool how we practice governance. This may seem like a lot — and it is. But our communities and our patients deserve nothing less.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Diversity

- How does your board's diversity compare with the findings of the AHA's 2022 governance survey? How might similarities and differences between your board and others around the country influence the effectiveness of your organization's governance?
- Has your board had frank conversations about its current composition and areas of need?
- What are your board's quantifiable goals to diversify its membership?
- Does your board chair have access to a targeted orientation manual and/or coaching?
- Has your full board had at least one conversation about your organization's work on DEI? Has the board communicated its intent about DEI in policies, goals and communications to the organization's leadership?
- How could your board restructure current meeting practices and service requirements to make serving on your board more attractive to diverse candidates?

SECTION 4

Board Structure

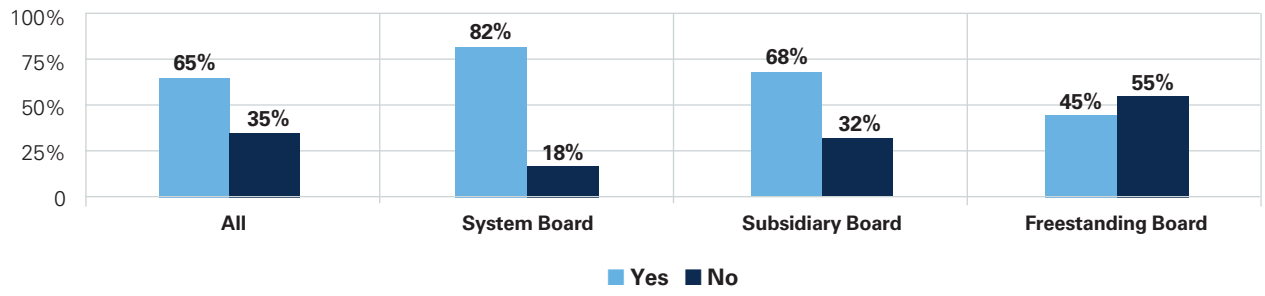
Data Points

One-third of all respondents reported they do not use term limits. The practice of compensating board members has doubled since 2022, particularly among system boards. The most common standing board committees are finance, quality and executive. Over two-thirds of all respondents indicated participating in specific board restructuring activities during the past three years.

Term Limits and Term Length

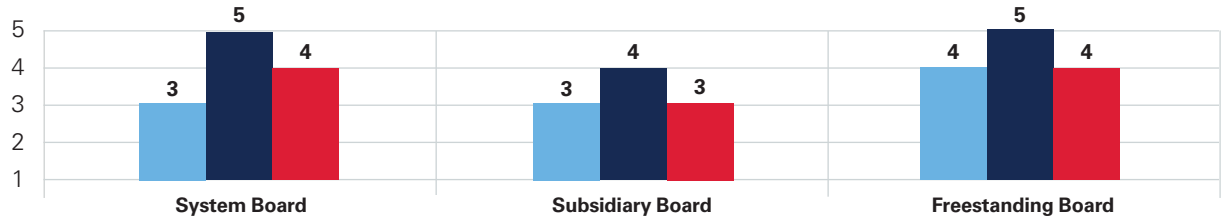
- Two-thirds (65%) of all respondents reported having term limits for their board members. Term limits were most prevalent among system boards (82%) and least prevalent among freestanding hospital boards at 52% (Figure 4.1).

Figure 4.1 Term Limits



- Across all respondents, the average board member term length was reported to be four years. System hospital subsidiary boards reported an average board member term length of three years (Figure 4.2).

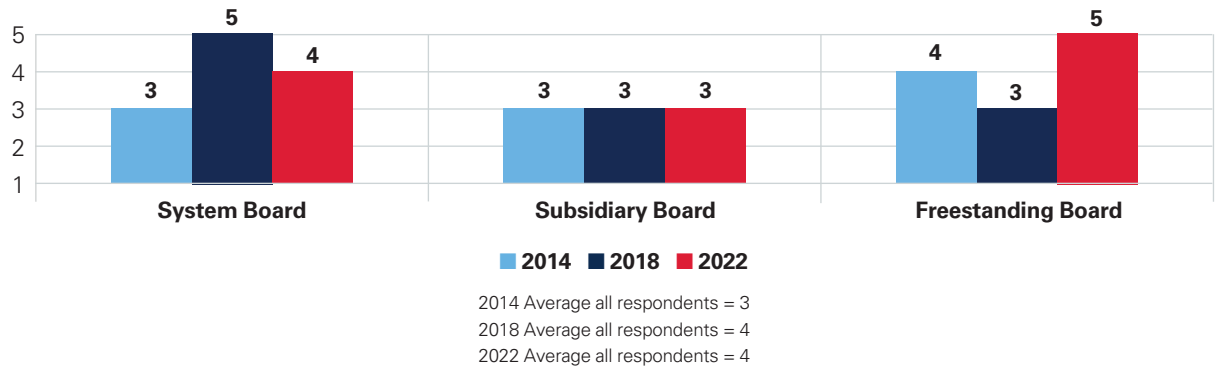
Figure 4.2 Average Board Member Term Length in Years



2014 Average all respondents = 4
2018 Average all respondents = 4
2022 Average all respondents = 4

- In 2022, freestanding hospital boards allowed their members to serve more consecutive terms (five) compared to four for system boards and three for system subsidiary hospital boards (Figure 4.3).

Figure 4.3 Maximum Number of Consecutive Terms on Average



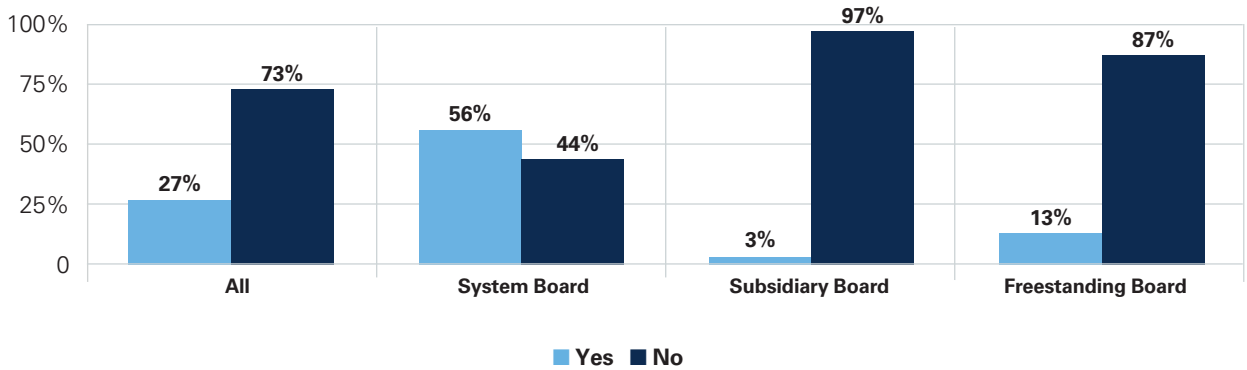
2014 Average all respondents = 3
2018 Average all respondents = 4
2022 Average all respondents = 4

Board Compensation

- The overall percentage of boards that compensate their members more than doubled in 2022 (27%), compared to 13% in 2018 and 10% in 2014 (Figure 4.4).
- Of those boards that reported compensating their members, system boards were most likely to do so at 56%, compared with 3% of system subsidiary boards and 13% of freestanding boards (Figure 4.4).

Figure 4.4 Board Member Compensation

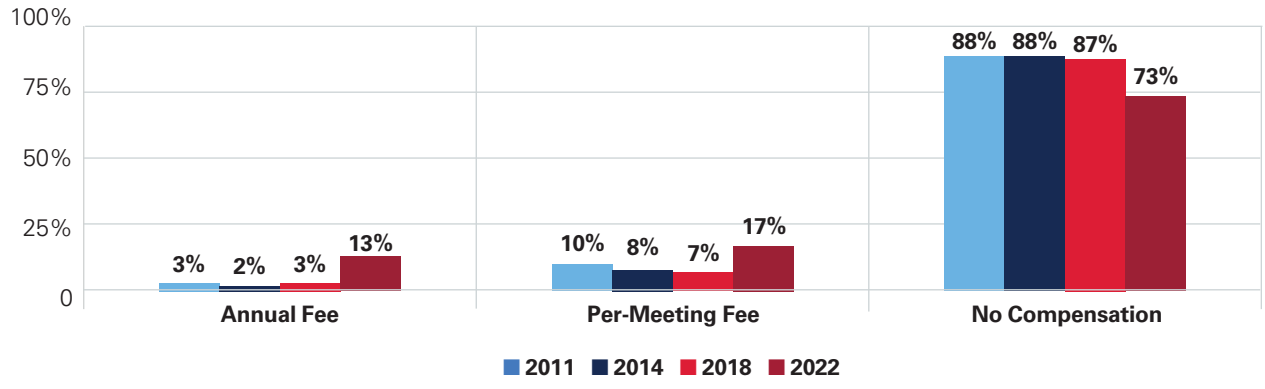
Do you compensate board members excluding reimbursement for out-of-pocket expenses?



2014 Average all respondents = 10%
2018 Average all respondents = 13%
2022 Average all respondents = 27%

- Of those boards who provide compensation, 13% reported they provide an annual fee while 17% said they offer per-meeting fees (Figure 4.5).

Figure 4.5 Type of Board Member Compensation by Year



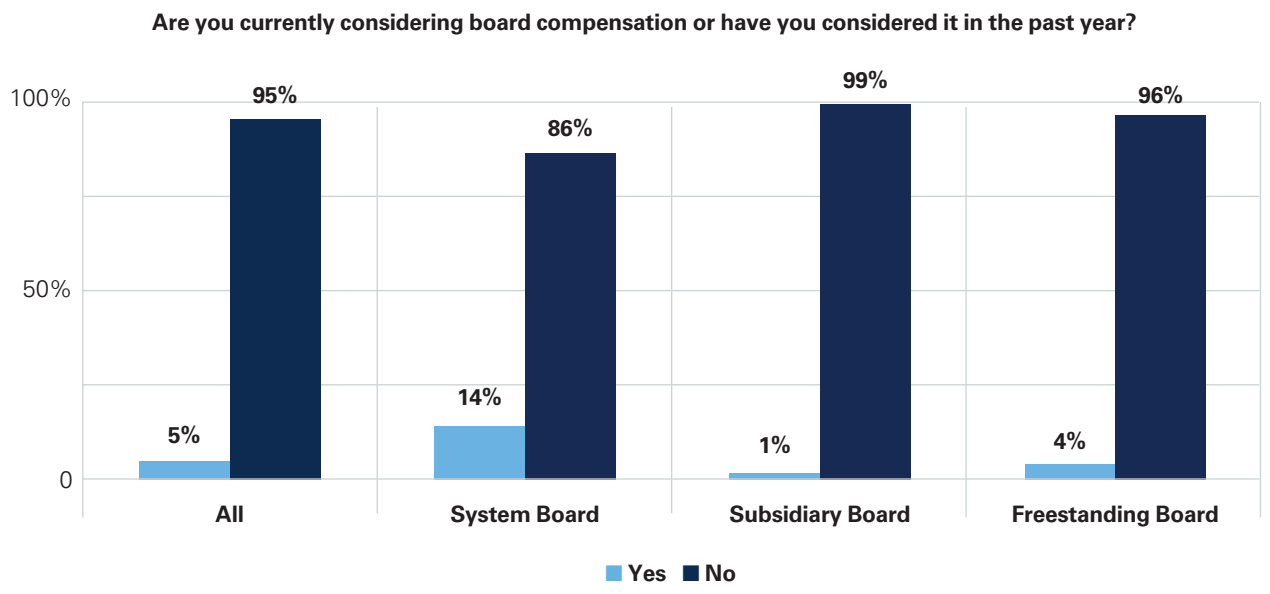
- In 2022, 44% of system boards reported they did not compensate their members, compared to 75% in 2018 and 92% in 2014 (Figure 4.6).

Figure 4.6 Forms of Board Member Compensation by Board Type by Year

	2014	2018	2022
Annual Fee			
System Board	4%	3%	34%
Subsidiary Board	3%	2%	0%
Freestanding Board	3%	2%	1%
Per-Meeting Fee			
System Board	4%	6%	43%
Subsidiary Board	6%	4%	0%
Freestanding Board	12%	12%	1%
No Compensation			
System Board	92%	75%	44%
Subsidiary Board	91%	94%	97%
Freestanding Board	85%	84%	87%

- System boards who have not provided compensation were more likely to consider doing so (14%) as compared to either system hospital subsidiary boards or freestanding boards at 1% and 4%, respectively (Figure 4.7).

Figure 4.7 Boards Considering Compensation



Board Committees

- The most common standing committees across all boards responding to the 2022 survey were finance (83%), quality (80%) and executive (74%). System boards reporting having the highest percentage of quality committees, 91%, compared to 78% of system subsidiary hospital boards and 70% of freestanding hospital boards (Figure 4.8).
- Audit/compliance, governance/nominating and executive compensation committees were far more common among system boards than hospital boards. Fundraising/development, strategic planning and workforce were more common among freestanding boards than boards in systems (Figure 4.8).

Figure 4.8 Standing Committees by Board Type

	All	System Board	Subsidiary Board	Freestanding Board
Finance	83%	99%	54%	86%
Quality	80%	91%	78%	70%
Executive	74%	88%	60%	70%
Audit/Compliance	60%	96%	32%	41%
Governance/Nominating	60%	90%	57%	48%
Executive Compensation	45%	79%	13%	29%
Strategic Planning	30%	25%	21%	41%
Community Benefit/Mission	18%	27%	18%	10%
Fundraising/Development	11%	7%	13%	67%
Workforce	7%	3%	5%	12%
Advocacy/Government Relations	6%	8%	4%	4%
Diversity, Equity & Inclusion	5%	6%	7%	4%
Enterprise Risk Management	4%	2%	5%	6%
Innovation	2%	1%	2%	2%
Cybersecurity	2%	1%	1%	3%
Other	31%	46%	18%	24%

- Overall, a higher percentage of boards reported having finance, quality, executive, audit/compliance and advocacy/government relations committees in 2022 than in 2018 (Figure 4.9).

Figure 4.9 Standing Committees by Year				
	2011	**2014**	**2018**	**2022**
Finance	83%	80%	76%	83%
Quality	75%	82%	77%	80%
Executive	68%	66%	66%	74%
Governance/Nominating	60%	60%	60%	60%
Audit/Compliance	51%	52%	47%	60%
Executive Compensation	36%	37%	31%	45%
Strategic Planning	44%	42%	35%	30%
Community Benefit/ Mission	14%	17%	21%	11%
Fundraising/ Development	18%	19%	12%	11%
Advocacy/Government Relations	4%	6%	4%	6%

- The percentage of system boards that reported having audit compliance committees increased to 96% in 2022 from 81% in 2018. The percentage of system boards that reported having a governance/nominating committee also increased to 90% in 2022 from 78% in 2018 (Figure 4.10).

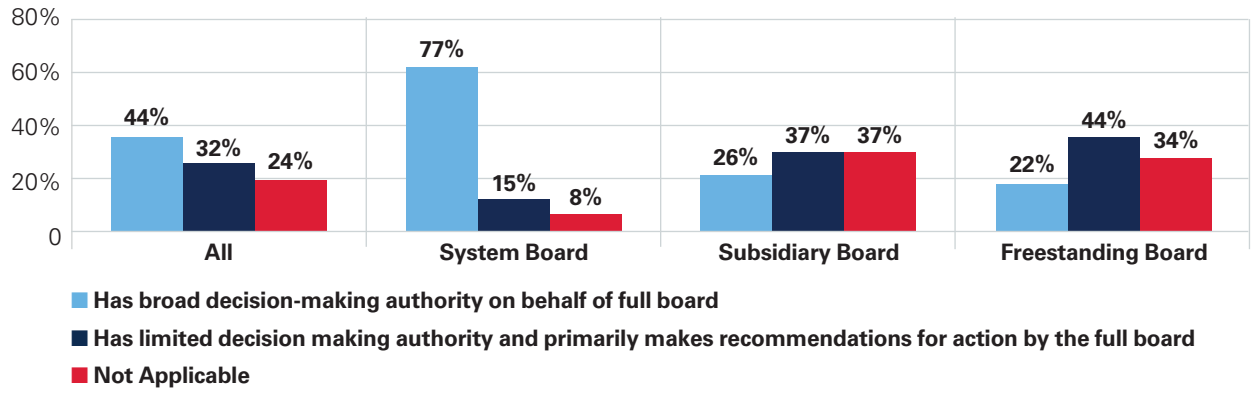
Figure 4.10 Standing Committees by Board Type by Year

	System Board			Subsidiary Board			Freestanding Board		
	2014	2018	2022	2014	2018	2022	2014	2018	2022
Quality	94%	91%	92%	87%	78%	78%	76%	70%	70%
Finance	98%	90%	99%	60%	56%	54%	85%	90%	86%
Audit/Compliance	21%	81%	96%	20%	30%	32%	13%	47%	41%
Governance/ Nominating	88%	78%	90%	56%	58%	57%	54%	54%	48%
Community Benefit/ Mission	20%	43%	27%	21%	22%	18%	18%	11%	10%
Diversity, Equity and Inclusion**	N/A	N/A	6%	N/A	N/A	7%	N/A	N/A	4%
Executive	86%	78%	88%	34%	59%	60%	51%	66%	70%
Strategic Planning	80%	35%	25%	58%	28%	21%	66%	42%	41%
Executive Compensation	52%	71%	79%	33%	12%	13%	44%	31%	29%
Fundraising/ Development	62%	14%	7%	20%	12%	13%	39%	12%	13%
Advocacy/ Government Relations	14%	6%	8%	7%	3%	4%	4%	4%	4%
Workforce*	N/A	6%	3%	N/A	5%	5%	N/A	10%	12%
Innovation*	N/A	1%	2%	N/A	0%	2%	N/A	1%	2%
Enterprise Risk Management*	N/A	5%	2%	N/A	5%	5%	N/A	5%	6%
Cybersecurity**	N/A	N/A	1%	N/A	N/A	1%	N/A	N/A	3%
Other**	N/A	N/A	46%	N/A	N/A	18%	N/A	N/A	24%
Other Clinician	2%	10%	4%	3%	9%	13%	5%	18%	20%

* Not asked in 2014 **Added in 2022

- Of the 2022 respondents that said their boards had executive committees, the percentage of system boards that allowed these committees to have broad decision-making authority on behalf of the full board (77%) was significantly higher than the percentages for hospital boards (Figure 4.11).

Figure 4.11 Executive Committee Authority



- A higher percentage of system boards (70%) reported having outsiders (nonboard members and nonstaff) as members of some board committees than did hospital boards (Figure 4.12). The percentage of all boards who have outsiders serve on some board committees increased to 47% in 2022 compared to 42% in 2018 (Figure 4.13).

Figure 4.12 Outsiders on Board Committees

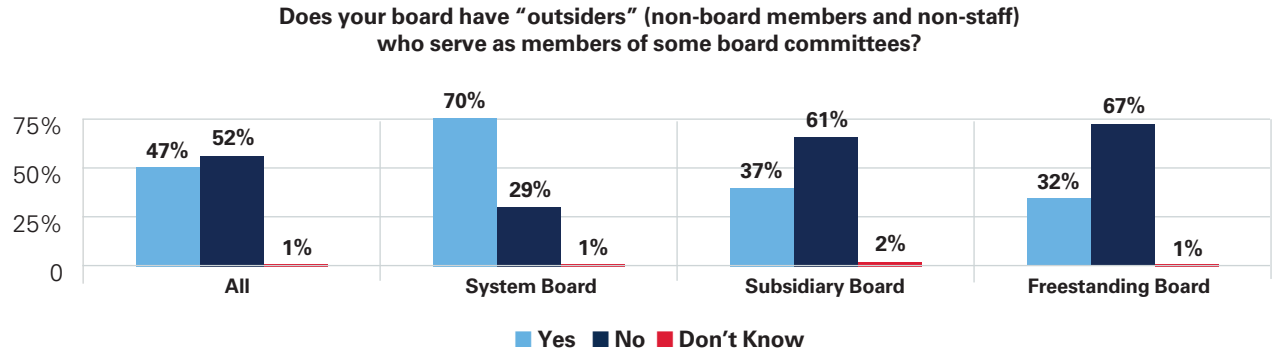
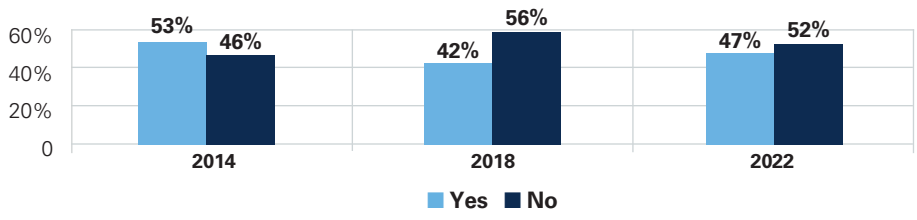


Figure 4.13 - Outsiders on Board Committees by Year



Board Restructuring and Support

- 2022 survey data indicate that 69% of all boards have engaged in specific board restructuring activities in the past three years. A higher percentage of freestanding hospitals (49%) reported not engaging in any board restructuring activities than did systems at 14% (Figure 4.14).

Figure 4.14 Board Restructuring in the Past Three Years

	All	System Board	Subsidiary Board	Freestanding Board
Sought new board member skills/ competencies	59%	78%	56%	42%
Added board committees	23%	38%	14%	13%
Redefined authority among system & subsidiary boards	21%	41%	18%	4%
Reduced board size	16%	29%	11%	7%
Reduced the number of board committees	12%	17%	11%	6%
Expanded board size	8%	7%	10%	8%
Eliminated all board committees	0%	0%	0%	1%
None of the above	31%	14%	30%	49%

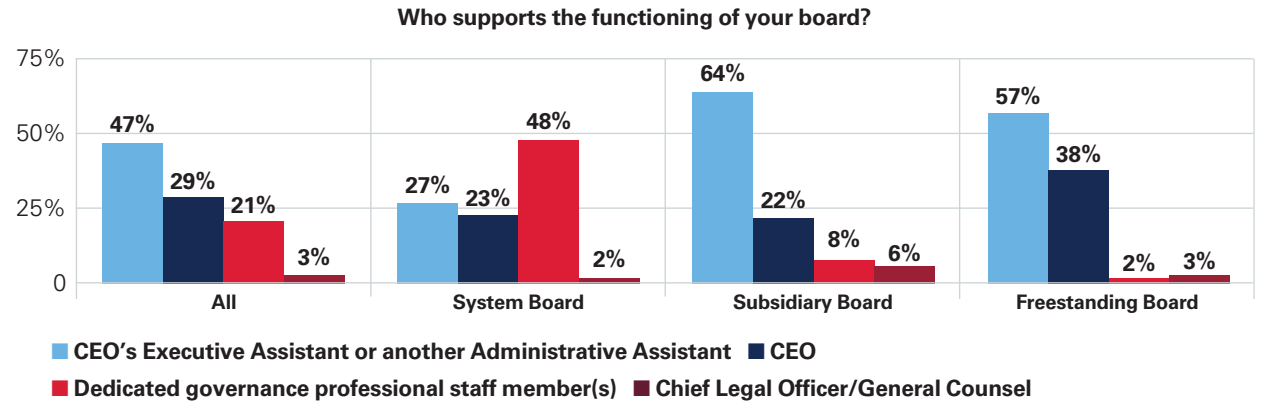
- Among all boards, the most common board restructuring activity in 2022 was to seek new board member skills and competencies at 59%, compared to 2018 when this activity was reported by 48% of respondents (Figure 4.15).

Figure 4.15 Board Restructuring in Past Three Years by Year

	2018	2022
Sought new board member skills/competencies	48%	59%
Added board committees	16%	23%
Redefined authority among system & subsidiary boards	12%	21%
Reduced board size	11%	16%
Reduced the number of board committees	12%	12%
Expanded board size	11%	8%
Eliminated all board committees	1%	0%
None of the above	33%	31%

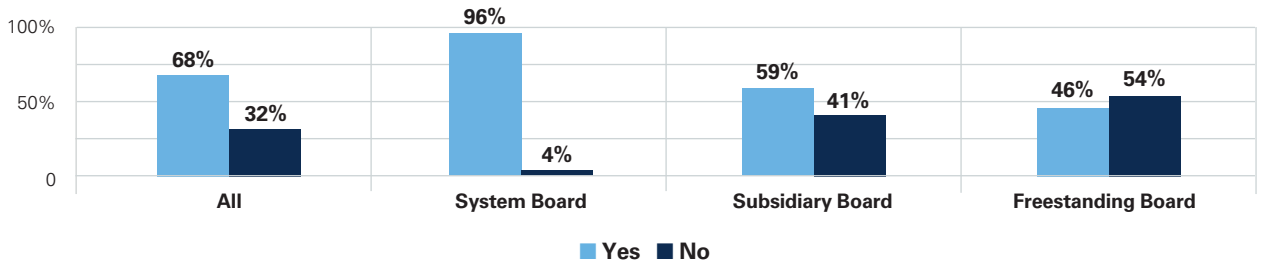
- The highest percentage of respondents overall in 2022 reported that the CEO's executive assistant or another administrative assistant (47%) or the CEO (29%) supported board function. Higher percentages of system boards (48%) reported having a dedicated governance professional staff member(s) provide board support than did hospital boards (Figure 4.16).

Figure 4.16 Board Support Staff



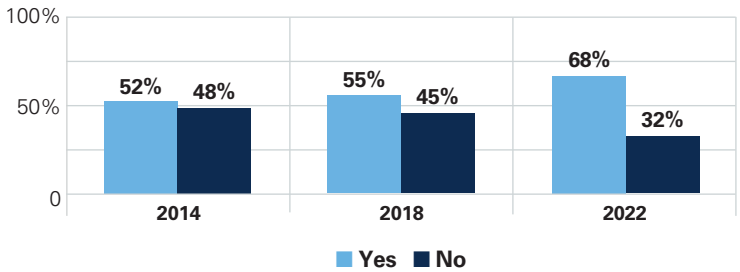
- Over two-thirds of all respondents (68%) reported using an electronic board portal. Nearly all systems (96%) said they use a board portal (Figure 4.17).

Figure 4.17 Use of a Board Portal



- The prevalence of using an electronic board portal has grown steadily, at 68% in 2022, up from 55% in 2018 and 52% in 2014 (Figure 4.18).

Figure 4.18 Use of Board Portal by Year



Commentary on Board Structure

By Jamie Orlikoff, (j.orlikoff@att.net), president of Orlikoff & Associates and the national adviser on governance and leadership to the AHA

Introduction

What a board does is clearly more important than how it does it. The outcomes a board generates matters more than the structures that support the work of the board. Form, after all, should follow function. Yet, it is undeniable that inappropriate, outmoded or limiting governance structure is one of the most common causes of ineffective governance function. Equally true is that thoughtful, well-designed governance structure facilitates effective governance function.

Governance structure is a broad category that arguably involves all aspects of the form of a board or boards and the mechanisms that frame the engagement of the board with its members and leaders. But, as this section clearly demonstrates, the category of board structure is not static as new technologies and new cultural imperatives create new structural forms and norms.

Although there is much debate on what the ideal governance structures are for health care organizations, one thing is clear from this section of the 2022 survey results: board structures are changing to both confront 21st century challenges and keep pace with technological innovations and societal changes.

Observations about Survey Findings

By far the most striking and significant results of this section relate to the exponential growth in the number of boards that provide cash compensation to their members. Figure 4.4 shows that the overall percentage of boards that compensate their members more than doubled in 2022 compared to 2018, from 13% to 27%. By comparison, the growth in compensation from 2014 to 2018 was a much more modest 3 percentage points: from 10% in 2014 to 13% in 2018.

More significantly, the most explosive growth in compensation was found in system boards, with 56% of systems board providing some type of compensation to their members (Figure 4.4). 34% of system boards reported payment of an annual fee to their members in 2022, an order of magnitude increase from the 3% of systems that did so in 2018 (Figure 4.6)! The fact that a clear majority of system boards engage in a practice that is still regarded as controversial and a matter of significant debate is quite noteworthy. What might be driving this trend? What could the functional impact of the structure of board compensation be?

Governing a system of hospitals is much more complex than governing a freestanding hospital. The larger the system the greater the complexity. And, in addition to hospitals most large systems are now comprised of different organizations and businesses, such as insurance companies, physician groups, skilled nursing facilities, ambulatory surgery centers and many others. Governing such an integrated delivery system is much more complex than even a multi-hospital system. This is one likely reason for the growth of compensation of board members of systems: it is an increasingly complex and demanding job that requires board members with specific and uncommon skill sets.

Another reason relates to the fact that large, complex, multi-billion-dollar systems increasingly find themselves competing with publicly traded companies for board member talent. Adding to that challenge is the recent concept of "Director Distraction" which emerged from pension funds, investor groups and regulators. These groups increasingly scrutinize boards of publicly traded companies to assure that their members do not serve on an excessive number of boards, as it is now recognized that they cannot do so and be reasonably expected to do a good job. As recently as 20 years ago, it was common for individuals to serve on eight or more corporate boards simultaneously. With the passage of Sarbanes-Oxley Act in 2002, and the growth of corporate governance best practices and board member accountability, this practice is increasingly monitored and frowned upon. Also, the growing liability and reputational risk for corporate

board members has caused individuals to be more discerning in assessing and accepting invitations to join corporate boards, further constraining the pool of potential board members. Finally, significant compensation of publicly traded company board members is the norm. It is likely that these factors are significant drivers of the growing trend of compensation of not-for-profit health care system board members.

It also is likely the explosive growth in compensation of health system board members heralds the death of the traditional model of hospital governance. This model, going back to the days of Ben Franklin, has several implicit components: voluntary (uncompensated) trustees; community-based governance; minimal-to-manageable time commitments; lack of standardized or mandatory training; diffuse and variable accountability of both boards and their members; long tenure and lack of term limits; and a tolerance for conflicts of interest on the board in service of community relationships. As health care systems evolved directly from hospitals, they naturally adopted this traditional model of governance into the initial models of system governance.

But the fact that most system boards (56%) now compensate their members while most freestanding hospital boards (87%) do not suggests that it is time to explicitly recognize that this old model is not conducive to the effective governance of systems (Figure 4.4). So does the fact that 82% of system boards had term limits for their board members in 2022 compared to only 45% of freestanding hospital boards (Figure 4.1). Further, the traditional model is not relevant to the broad societal, economic and demographic changes and challenges or to those daunting and disruptive pressures unique to the health care environment.

But, if the significant growth in system board member compensation suggests the emergence of a new model of governance, it begs the question: will compensation stimulate better governance? There is no data to suggest that the structure of board member compensation in and of itself will improve the function and outcomes of governance. In fact, some argue that compensation could paradoxically weaken not-for-profit health system and hospital governance by diverting board member loyalty away from the mission and the fulfillment of fiduciary duty, and toward seeking and maintaining financial reward for serving on the board.

However, it is logical to assume that compensation in exchange for accountability can drive more effective system governance. And this may be part of the emerging new model of governance: the routine and robust evaluation of the performance of individual system board members pursuant to the renewal of their terms. In other words, if boards are willing to pay their members, they may also be more willing to "fire" them for substandard performance. This implies the further professionalization of the role of governance of the system, and in time the hospital, via board member and leader job descriptions, performance objectives and evaluation, formal feedback, and, as stated, a willingness to terminate or not re-appoint to additional terms of office for failing to fulfill defined duties.

Strong indications of the emergence of a new model of governance can also be seen throughout this section of the survey results, and again are led by systems. In addition to board member compensation and term limits, 96% of system boards reported having an audit and compliance committee in 2022, up from 81% in 2018 (Figure 4.10). Also noteworthy is that 86% of system boards engaged in board restructuring efforts to adjust their structures for greater efficiency and effectiveness in the three-year period from 2018 — 2022 (Figure 4.14 and 4.15). And, nearly all systems, 96%, used an electronic board portal in 2022 to provide information, facilitate communication, offer real-time governance education and monitor board member preparation and engagement (Figure 4.17).

Effective governance is a delicate latticework of interrelated structural, functional and cultural factors. To change one of the many variables within these categories in the belief that the others will not be affected is naive. To change one of the variables without thinking through the whole process, the whole gestalt, of governance can be deleterious to governance and to the system or hospital being governed. The good news reflected in this section

is that the vast majority of systems and a significant proportion of hospitals are attempting to improve governance through integrated efforts that address many of the variables addressed in this and other sections of the survey results.

Taken in total, these trends support the conclusion that the boards of health systems are leading the way in the structural creation of a new model of more professional governance. Hopefully, this will in turn generate measurable improvements in governance effectiveness that will drive better performance of systems and hospitals and result in better health care for the communities they serve.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Structure

- Are your board members provided compensation for their service? If so, has that compensation improved the quality of governance? How?
- If you are opposed to the concept of compensating members of the board of not-for-profit hospitals and health systems what are the reasons for the opposition, or your concerns regarding compensation?
- If your hospital or health system does not currently provide compensation to its board members, are you considering it? If so, why? If not, why not?
- Has your board created new board committees, merged committees, or eliminated board committees in the recent past? Why? What was the outcome of these structural changes?
- If you had a "magic wand" and could remodel your board, what would you change and why (consider board size, number and type of board committees, compensation, time spent on governance, number of boards)?

SECTION 5

Board Selection

Data Points

Nearly all system boards use competencies in board member selection while nearly two-thirds of freestanding hospital boards do not. More than 75% of all respondents indicated that no board member had been replaced or not been re-appointed when eligible over the past three years. Over half of boards report that it requires the same effort now to recruit new board members compared with three years ago. Over two-thirds of respondents indicated that recruiting millennials requires the same or less effort than recruiting other age cohorts for board service.

Board Member Competencies

- In 2022, 61% of all respondents reported that their selection committee used an approved set of knowledge, skills and behavioral competencies for selecting all board members. Nearly all system boards (91%) reported using competencies for all board members, as compared to system subsidiary hospital boards at 54% and freestanding hospital boards at 35% (Figure 5.1)
- Higher percentages of system boards reporting using competencies for selection of board chairs (18%), committee chairs (16%) and committee members (8%) than did either system subsidiary hospital boards or freestanding hospital boards (Figure 5.1).

Figure 5.1 Use of Competencies

Does your board or board's selection committee use a set of approved knowledge, skills and behavioral competencies for selecting the following?

	All	System Board	Subsidiary Board	Freestanding Board
Yes, for all board members	61%	91%	54%	35%
Yes, for board chairs	18%	35%	12%	6%
Yes, for committee chairs	10%	16%	9%	6%
Yes, for committee members	11%	15%	9%	7%
No	37%	8%	45%	62%

- Overall, the use of competencies by all boards has increased steadily since 2011, with 42% using competencies in 2018 compared to 61% in 2022 (Figure 5.2).

Figure 5.2 Use of Competencies by Year				
	2011	**2014**	**2018**	**2022**
Yes, for all board members	32%	35%	42%	61%
Yes, for board chairs	5%	7%	7%	18%
Yes, for committee chairs*	N/A	N/A	5%	10%
Yes, for committee members*	N/A	N/A	6%	11%
No	40%	42%	57%	37%
Don't know**	28%	21%	N/A	N/A

*Not asked in 2011 or 2014

**Not asked in 2018 or 2022

- As indicated in Figure 5.3, across all 2022 survey respondents, the top five knowledge, skills and behavior competencies used to select board members were: knowledge of business and finance (62%); strategic orientation (59%); community orientation (52%); innovative thinking (41%); and collaboration (34%).
- System boards (35%) included quality and safety expertise among their top five competencies; hospital boards did not (Figure 5.3).

Figure 5.3 Top Five Competencies for Board Member Selection				
Indicate the top 5 essential knowledge, skills and behavior competencies you used most recently when selecting board members.				
	All	**System Board**	**Subsidiary Board**	**Freestanding Board**
Knowledge of business and finance	62%	68%	53%	59%
Strategic orientation	59%	82%	36%	34%
Community Orientation	52%		78%	65%
Innovative Thinking	41%	58%		
Collaboration	34%	37%	32%	30%
Impact and influence			32%	
Professionalism				30%
Quality and safety expertise		35%		

- Of the small percentage of hospitals and systems that use competencies to select board chairs, Figure 5.4 shows that the top five knowledge, skills and behavior competences were: past governance experience (46%); community orientation (41%); collaboration (40%); strategic orientation (34%); and knowledge of business and finance (32%)

Figure 5.4 Top Five Competencies for Board Chair Selection

Indicate below the top 5 essential knowledge, skills and behavior competencies you used most recently when selecting board chairs.

	All	System Board	Subsidiary Board	Freestanding Board
Past governance experience	46%	60%		37%
Community Orientation	41%		52%	43%
Collaboration	40%	42%	36%	34%
Strategic orientation	34%		37%	28%
Knowledge of business and finance	32%		37%	34%
Complexity management		44%		
Systems thinking		39%		
Achievement orientation		36%		
Impact and influence			34%	

Board Member Replacement

- Some 76% of 2022 survey respondents overall reported that no board member had been replaced or not been re-appointed when eligible over the past three years (Figure 5.5). That percentage remains unchanged from 2018 data (Figure 5.6).

Figure 5.5 Board Member Replacement in Past 3 Years

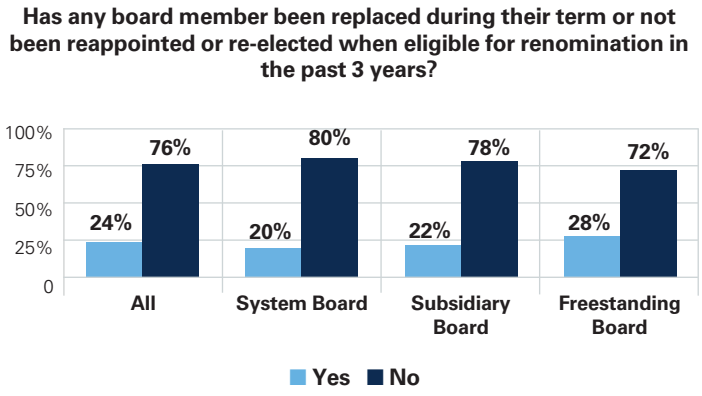
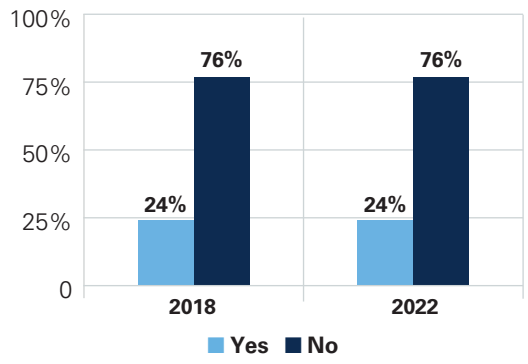
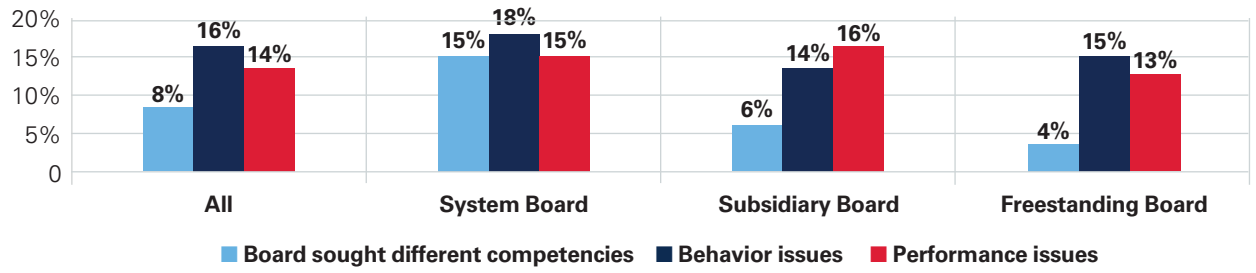


Figure 5.6 Board Member Replacement in Past 3 Years by Year



- Of those who did replace board members in the past three years, higher percentages of system boards did so because of behavioral issues or because they were seeking new competencies than did hospital boards (Figure 5.7).

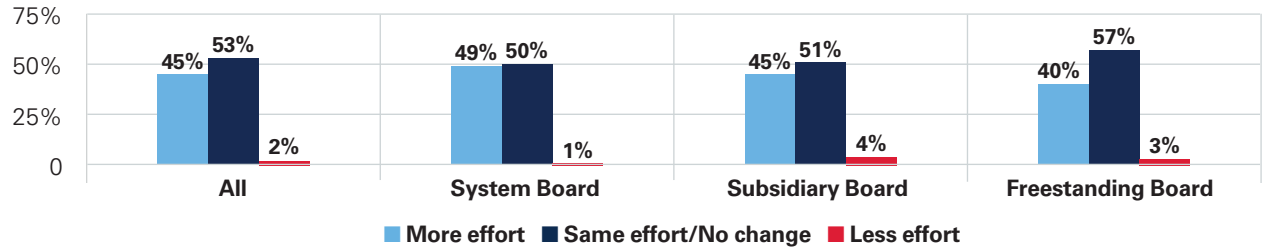
Figure 5.7 Reasons for Board Member Replacement



Effort to Recruit Board Members

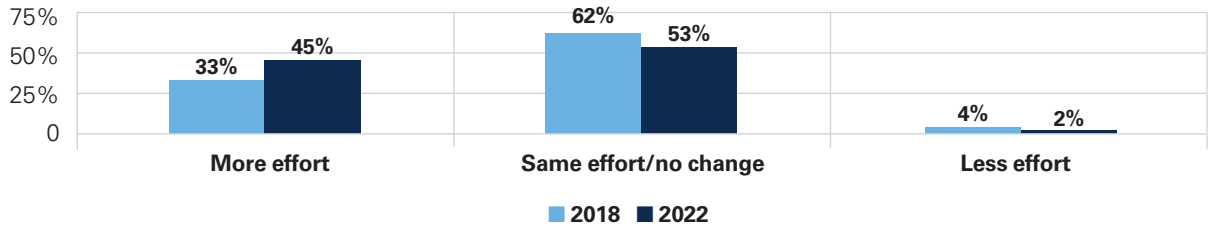
- Nearly half of system boards (49%) indicated that recruiting new board members now requires more effort compared to three years ago (Figure 5.8).

Figure 5.8 Effort Required to Recruit New Board Members Compared to 3 Years Ago



- Of all respondents to the 2022 survey, 45% reported that new board member recruitment required more effort, as compared to 33% of respondents to the 2018 survey (Figure 5.9).

Figure 5.9 Effort Required to Recruit New Board Members Compared to 3 Years Ago by Year



- According to 2022 survey data, system boards (36%) reported that recruiting millennials to the board requires more effort than recruiting other age cohorts as compared to system subsidiary hospital boards at 25% and freestanding boards at 26% (Figure 5.10).

Figure 5.10 Effort to Recruit Millennials Compared to Other Age Cohorts

Compared to other age cohorts, on a scale of 1-5, how much effort is required to recruit Millennials to your board?

	All	System Board	Subsidiary Board	Freestanding Board
Extreme effort - 5	17%	17%	18%	17%
4	12%	19%	7%	9%
Same effort - 3	27%	18%	33%	31%
2	22%	17%	31%	21%
Minimal effort - 1	21%	29%	11%	21%

- Some 70% of 2022 survey respondents overall reported that recruiting millennials for board service requires the same or minimal effort than recruiting other percentage cohorts compared to 2018 data at 65% (Figure 5.11).

Figure 5.11 Effort to Recruit Millennials Compared to Other Age Cohorts by Year

Compared to other age cohorts, on a scale of 1-5, how much effort is required to recruit Millennials to your board?

	2018	2022
Extreme effort - 5	17%	17%
4	19%	12%
Same effort - 3	26%	27%
2	12%	22%
Minimal effort - 1	27%	21%

Commentary on Board Selection

By Todd Linden, (tlinden@lconsult.org), partner of Linden Consulting, adviser for GHI governWell™ and CEO emeritus of Grinnell (Iowa) Regional Medical Center

Introduction

Common sense would suggest that any team, group or board performance would in large part be best based on the abilities, skills, knowledge and motivation of the members of the group. High performing health care executive teams spend significant efforts to recruit, retain and develop their members. Health care governing boards would certainly expect their CEOs to excel in building their teams, yet as the 2022 AHA governance survey results indicate, many boards do not demand the same efforts in building their own teams. Today's health care challenges require high performing boards made up of individuals who collectively bring the talent necessary to govern the highly complex hospitals and health systems for which they are responsible.

Observations about Survey Results

Board Member Competencies

Although the use of board approved competencies has consistently increased since the 2011 survey, their use is barely over half (61%) for all respondents. Health system boards pull that average up significantly with 91% utilizing competencies when selecting board members, just over half (54%) for subsidiary boards and a paltry 35% for freestanding hospital boards. Hospital boards would be outraged if the hospitals they govern failed to use competencies for selecting hospital personnel or medical staff. The low percentages reported by freestanding hospitals for board use of competencies needs board attention going forward.

Arguably, serving as the board chair of a freestanding hospital, health system or subsidiary board is one of the most significant roles for any health care organization. Yet, when it comes to selecting board chairs, use of approved knowledge, skills and behavioral competencies are rare with only 35% of system boards using them and almost nonexistent for subsidiary boards (12%) and for freestanding hospital boards (6%). The survey indicates that use of competencies for committee leadership and membership are even lower. This begs the question, how do most hospital boards choose their leadership, if not competency-based? Although the survey shows improvement from previous years, these numbers are surprisingly low and is clearly another area for improvement going forward.

For the boards that do report using competencies for member selection, the top three essential knowledge and skills areas included: knowledge of business and finance, strategic orientation, and community orientation. While innovative thinking and collaboration barely made the list, only health system boards had quality and safety coming in at 35%. When it comes to board chair competencies, past governance experience topped the list for all respondents, with similar ratings for overall board selection.

Board Member Replacement

Using a typical bell curve on performance by individuals of any group, it would be reasonable to believe that about a quarter of the group are high performers, half are in the middle and a quarter rate as low performers. Yet, when it comes to health care board member replacement, over three-quarters of all survey respondents reported not a single member replacement. That same percentage indicated that if a member was eligible for re-appointment, it was automatic. It is safe to assume many boards have sub-par board members who continue to serve because boards simply tolerate this low performance or lack a mechanism for culling their boards. These statistics have not changed since the 2018 report and are another indicator of the challenges all health care organizations seem to be facing with board member selection issues.

Efforts to Recruit Board Members

Perhaps one of the top reasons health care boards of all sizes do a relatively poor job with use of competencies for selection and rarely replace low performing board members is the difficulty in recruitment in general.

Nearly half of system boards (49%) indicated that recruiting new board members requires more effort than three years ago. Although a bit less for subsidiary boards (45%) and freestanding boards (40%), these are still high numbers and likely to go higher as the time commitment, complexity and significant issues facing America's health care organizations will most certainly increase in the coming years. Although one might imagine it would be more difficult to recruit younger board members, the survey seems to indicate it is not more difficult to find millennials than other age cohorts.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Selection

- Does your board utilize a board approved set of knowledge, skills and behavioral competencies for board member selection? If not, why not?
- If your board does currently use competencies for board member selection, how do your competencies compare to those noted by boards in the AHA governance survey?
- Does your board use competencies for board leadership selection? If not, why not and if so, how do your competencies compare to the AHA survey?
- Does your board have a process for removing or replacing poor performing members? If not, why not?
- Is it automatic for board members to serve additional terms if eligible, regardless of performance? How might you consider ways to make continued board service performance based?
- How difficult is it for your board to recruit the board members? What new ideas do you have to recruit members with the skills, knowledge and behaviors that would improve the overall performance of the board?
- Does your board represent the diversity of the communities you serve? What can be done to make it more representative of your community?

SECTION 6

Board Orientation and Education

Data Points

Nearly a third of all boards do not have position descriptions for any type of board role. Most boards reported having a formal orientation for new board members but not for new board chairs. Systems indicated they were providing formal board education on a quarterly basis to their members while hospitals reported an annual frequency.

Position Descriptions

- Nearly one-third (32%) of 2022 survey respondents overall reported they did not have position descriptions for board members, the board chair or committee chairs (Figure 6.1).

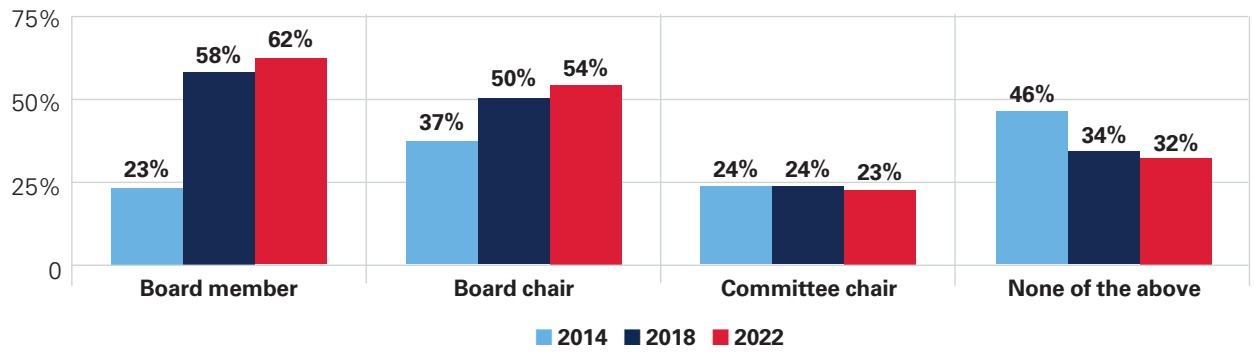
Figure 6.1 Use of Position Descriptions

For which of the following positions does your board have job descriptions?

	All	System Board	Subsidiary Board	Freestanding Board
Board member	62%	76%	56%	53%
Board chair	54%	59%	48%	49%
Committee chair	23%	28%	20%	20%
None of the above	32%	19%	38%	40%

- Higher percentages of overall respondents to the 2022 survey reported having board member (62%) and board chair (54%) position descriptions than did respondents to both the 2018 and 2014 surveys (Figure 6.2).

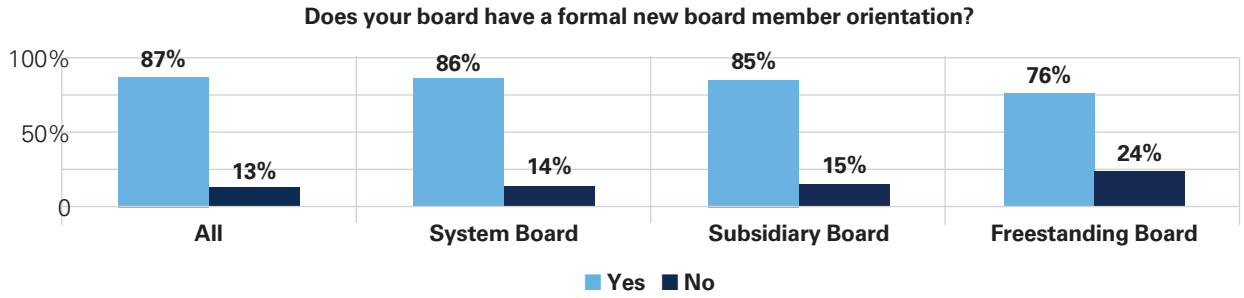
Figure 6.2 Use of Position Descriptions by Year



Orientation

- For the 2022 survey, 87% of all respondents reported having a formal orientation for new board members. This compares with 82% in 2018 and 97% in 2014 (Figure 6.3).

Figure 6.3 New Board Member Orientation



2014 Average all respondents = 97% 2018 Average all respondents = 82% 2022 Average all respondents = 87%

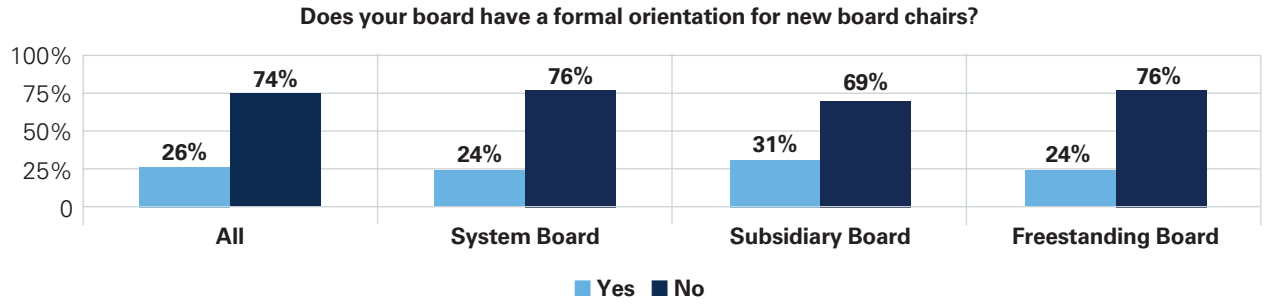
- As Figure 6.4 indicates, the highest percentages of respondents overall reported including the following activities in their new board member orientation: meeting with CEO and/or senior leadership team (96%), health care governance orientation (89%), and health care orientation (78%).
- The least reported orientation activity, across all types of boards, was formal mentoring with a senior board member (Figure 6.4).

Figure 6.4 Elements Included in New Board Member Orientation

	All	System Board	Subsidiary Board	Freestanding Board
Meeting with the CEO and/or senior leadership team	96%	93%	93%	94%
Health care governance orientation	89%	94%	82%	88%
Health care orientation	78%	71%	79%	85%
System/hospital orientation	77%	98%	85%	45%
Facility tour	61%	27%	82%	89%
Meeting with the board chair	57%	50%	71%	56%
Community served	29%	15%	43%	36%
Formal mentoring with a senior board member	24%	26%	23%	22%
Other	6%	2%	7%	11%

- Nearly three-quarters (74%) of respondents to the 2022 survey indicated they did not have a formal orientation for new board chairs (Figure 6.5).

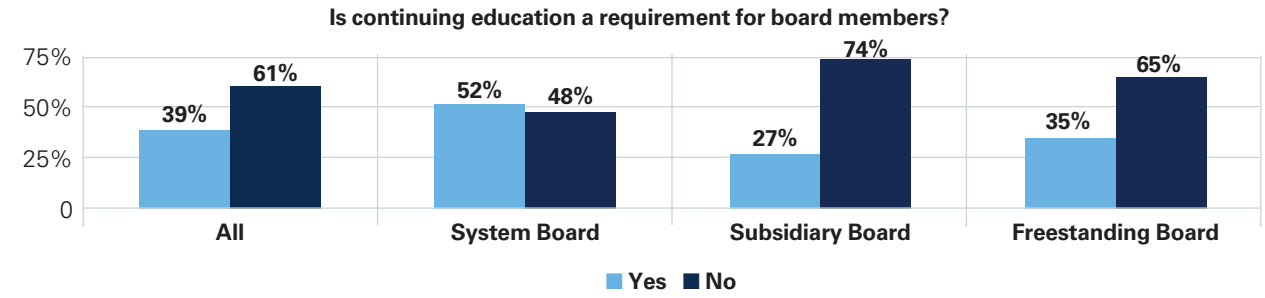
Figure 6.5 New Board Chair Orientation



Board Education

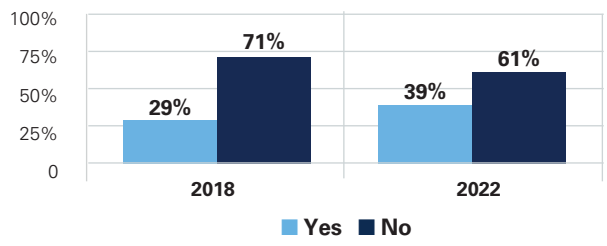
- System boards (52%) were more likely to have a board member continuing education requirement as compared to system subsidiary hospital boards at 27% and freestanding hospital boards at 35% (Figure 6.6).

Figure 6.6 Board Member Continuing Education Requirement



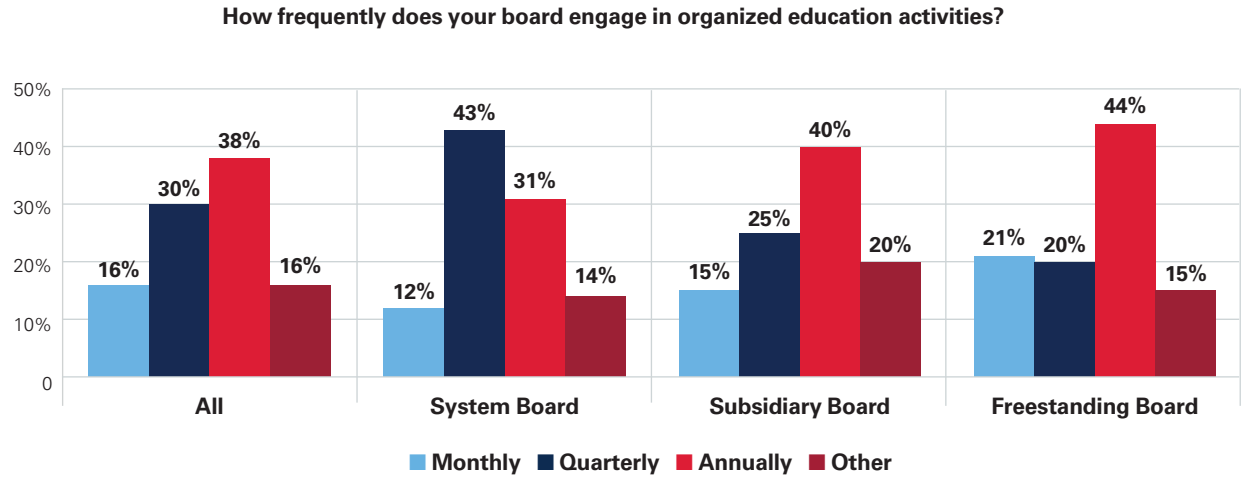
- In 2022, 61% of all survey respondents reported they did not have a board member continuing education requirement, compared to 71% of 2018 survey respondents (Figure 6.7).

Figure 6.7 Board Member Continuing Education Requirement by Year



- When asked about frequency of organized education activities, systems (43%) reported that these activities occurred quarterly. System subsidiary hospitals (40%) and freestanding hospital boards (44%) indicated that their boards most frequently engage in organized education on an annual basis (Figure 6.8).

Figure 6.8 Frequency of Organized Board Education Activities



- The highest percentage of 2022 survey respondents overall (76%) reported that continuing education for their boards is delivered at board/committee meetings (Figure 6.9).
- Nearly all system boards reported that their board members engage in both boardroom/committee meeting education (91%) and self-directed education (91%) on a regular basis (Figure 6.9).

Figure 6.9 Delivery of Board Education

How do board members engage in continuing education?

	All	System Board	Subsidiary Board	Freestanding Board
At board/ committee meetings	76%	91%	68%	67%
Self-directed (articles, online resources, etc)	72%	91%	56%	62%
At board retreats	57%	72%	52%	45%
At outside conferences	56%	64%	34%	62%
None of the above	4%	1%	4%	6%

- The highest percentage of 2022 survey respondents overall (89%) reported receiving an educational briefing on compliance issues from legal counsel, followed by briefings on trustee conflicts of interest/ independence at 75% (Figure 6.10).

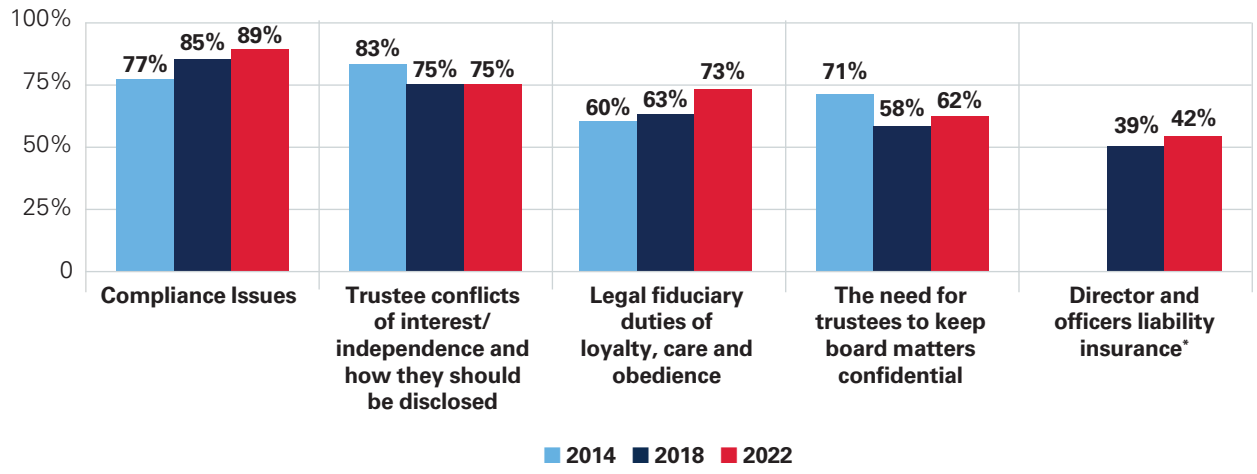
Figure 6.10 Legal Counsel Briefing Topics

On which of the following does your board periodically receive an educational briefing with legal counsel?

	All	System Board	Subsidiary Board	Freestanding Board
Compliance issues	89%	95%	87%	81%
Trustee conflicts of interest/ independence and how they should be disclosed	75%	81%	73%	71%
Legal fiduciary duties of loyalty, care and obedience	73%	83%	66%	66%
The need for trustees to keep board matters confidential	62%	70%	57%	55%
Director and officers liability insurance	42%	46%	33%	42%

- Higher percentages of respondents overall in 2022 reported receiving briefings from legal counsel on compliance issues and fiduciary duties than in 2018 (Figure 6.11).

Figure 6.11 Legal Counsel Briefing Topics by Year



*Not asked in 2014

Commentary on Board Orientation and Education

by Barbara H. Lorsbach, (blorsbach@governwell.net), president, GHI governWell™

Introduction

Boards do not become excellent by chance. They become outstanding by purposefully practicing key leadership behaviors that work together to ensure effectiveness. Findings from the AHA 2022 governance survey provide a keen glimpse into board leadership behaviors during one of the most compelling circumstances in recent history—the COVID-19 pandemic. Crisis situations and innovation both require motivated, knowledgeable trustees who understand how to think and lead in a rapidly changing and challenging environment. Fundamental to the ability to lead, adapt and innovate is a commitment to learning. Through effective use of board orientations and ongoing education, trustees are better prepared to fulfill their vital leadership roles.

Observations about Survey Findings

The first step in an effective board orientation and education process should happen before an individual is offered an invitation to serve on the board or decides to run for election. Trustee candidates who receive a written description of board roles and responsibilities are better able to assess the level of commitment that will be needed if selected or elected to serve. Frequently when there is role confusion or unfulfilled responsibilities, the lack of a position description is the root cause of the problem.

In 2022, survey results show that nearly one-third (32%) of the responding organizations did not have position descriptions for board members. System board members were the most likely to have job descriptions (75%). For freestanding hospital and system subsidiary hospital boards, slightly more than half reported using position descriptions. The likelihood that board and committee chairs will have position descriptions to guide and orient them in their responsibilities is lower than for board members. Only 54% of respondents use board chair job descriptions. Even fewer, 23%, had position descriptions for committee chairs.

Trustees are fully accountable for their decisions and fulfillment of their responsibilities beginning with day one of their board term. Many will admit it takes at least one if not more years for most trustees to truly gain the depth of knowledge and understanding needed to be an effective board member. Trustees may be thrust into board service with insufficient orientation and little or no ongoing governance education. Even organizations with sound orientation programs in place may need to reconsider how to best prepare new board members for the work and responsibilities of today's board.

Despite the demands of the pandemic, survey data indicate that 87% of all boards reported providing a formal new board member orientation. This percentage is higher than in 2018 when 82% of respondents reported using board orientations but notably lower than in 2014 when 97% of boards reported providing a formal new member orientation.

An initial orientation session should give new trustees a broad, high-level understanding of the organization, the health care environment and the issues they will be expected to address as board members. Nearly all, 96%, of the organizations that reported providing a new board member orientation also indicated that their orientation included meeting with the CEO and/or the senior leadership team.

An orientation to health care varied among hospitals and health systems. With the pace of change and innovation, it was surprising that not all new board members received this important component of an effective orientation program. Freestanding hospital and system subsidiary hospital boards were more likely than system board members to receive a health care orientation — 85%, 79% and 71% respectively. This may be because experience in health care was a clearly articulated requirement in the board member position description and/or was an attribute that was strongly considered in selecting board members. If not, there could be potential gaps between roles and knowledge regardless of the size of the health care organization and the type of board.

Formal mentoring was the least reported orientation activity across all types of boards. Only approximately 25% of boards reported providing a mentoring program. This percentage has remained unchanged since 2018 and demonstrates a missed opportunity for new board members.

Great boards have great board leadership. The chair is not only a role model for members of the board and executive team but is responsible for ensuring that board members function as a cohesive team capable of acting efficiently and effectively in the best interests of the hospital or health system. The 2022 survey data indicate many health systems and hospitals limit their orientation program to just board members. Overall, only 24% of respondents had a formal board chair orientation even though the role of the board chair is one of the critical governance leadership positions.

Every board member, not just some, must have a common level of understanding of critical issues and developments, and their implications for the organization. Well-planned educational efforts lead to better decisions based on broader knowledge and insights; increased capacity to engage in challenging and productive governance dialogue; and the ability to think beyond conventional wisdom. Although nearly all 2022 survey respondents reported that their board members engaged in continuing educational activities, less than half (39%) reported having a formal continuing education requirement. The percentage has increased somewhat since 2018 when 29% of survey respondents reported that their board members had a continuing education requirement.

Board members usually have varying levels of awareness and knowledge of the issues discussed and the decisions made at board meetings. Survey respondents reported using a combination of educational formats, including board/committee meetings, self-directed learning, and board retreats and outside conferences. Other educational findings that stood out included:

Boards differed in how often they engaged in organized educational activities. Annually organized education was the most common; 16% of boards engaged in monthly educational activities and 30% quarterly.

System boards reported using both educational activities at board meetings and self-directed educational resources (91%). Subsidiary and freestanding boards also reported a mix of formats but less often.

Only 57% of hospitals and health systems overall reported engaging board members in continuing education during board retreats. The pandemic required social distancing and resulted in greater use of virtual meetings, which may explain the relatively low use of retreat formats.

Trustee conflict of interest and independence, disclosure and compliance issues were reported as the most frequent topics during briefings provided by legal counsel to boards.

Legal counsel briefings on the need for trustees to keep board matters confidential were reported by 62% of survey respondents.

Education empowers boards to make decisions that help their organizations expand their ability to save lives, improve patient care, enhance the clinical experience and improve community well-being. Passing on knowledge and general awareness are not enough. While survey data show hospitals and health system boards are moving in the right direction, there are many opportunities for boards to continue to elevate their commitment to learning as an essential leadership responsibility.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Orientation and Education

- How do your board's educational practices compare with the AHA 2022 governance survey results?
- What are the three most critical issues confronting your board in the next year? What educational activities are needed to ensure that all board members are knowledgeable and understand these issues?
- Does your board have an annual governance education plan?
- Does your board chair have access to an orientation and/or coaching?
- How would your board benefit from making participation in education a condition of board appointment and/or reappointment?

SECTION 7

Board Evaluation

Data Points

More than a quarter of all boards reported that they had not used any type of assessment with boards, committees, members or chairs in the past three years. Those boards conducting a full board assessment used results to improve board performance. The most common individual board member performance criterion was "meets the board and committee attendance requirement."

Assessment Types and Focus

- Some 27% of 2022 survey respondents overall reported not using, in the past three years, any of the following types of board assessments: full board, board member, board chair or board/committee meeting (Figure 7.1).

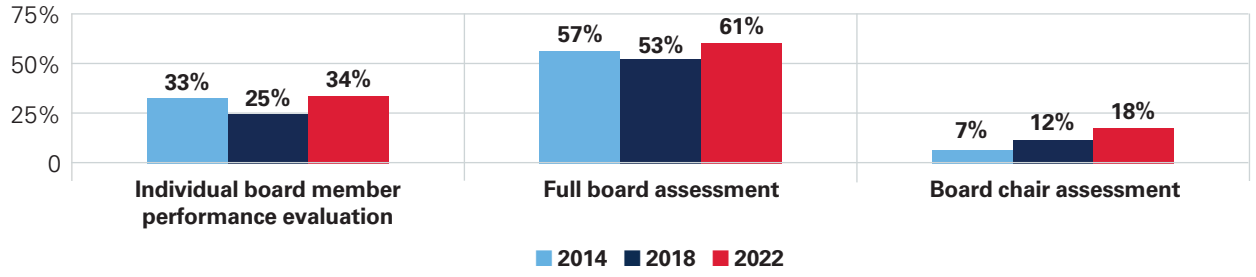
Figure 7.1 Use of Governance Assessments

Which of the following types of assessments has your board used in the past three years?

	All	System Board	Subsidiary Board	Freestanding Board
Full board assessment	61%	83%	50%	46%
Individual board member performance evaluation	34%	62%	14%	18%
Board chair assessment	18%	38%	7%	4%
Board meeting evaluation	44%	81%	22%	21%
Committee meeting evaluation	27%	54%	11%	10%
None	27%	4%	39%	43%

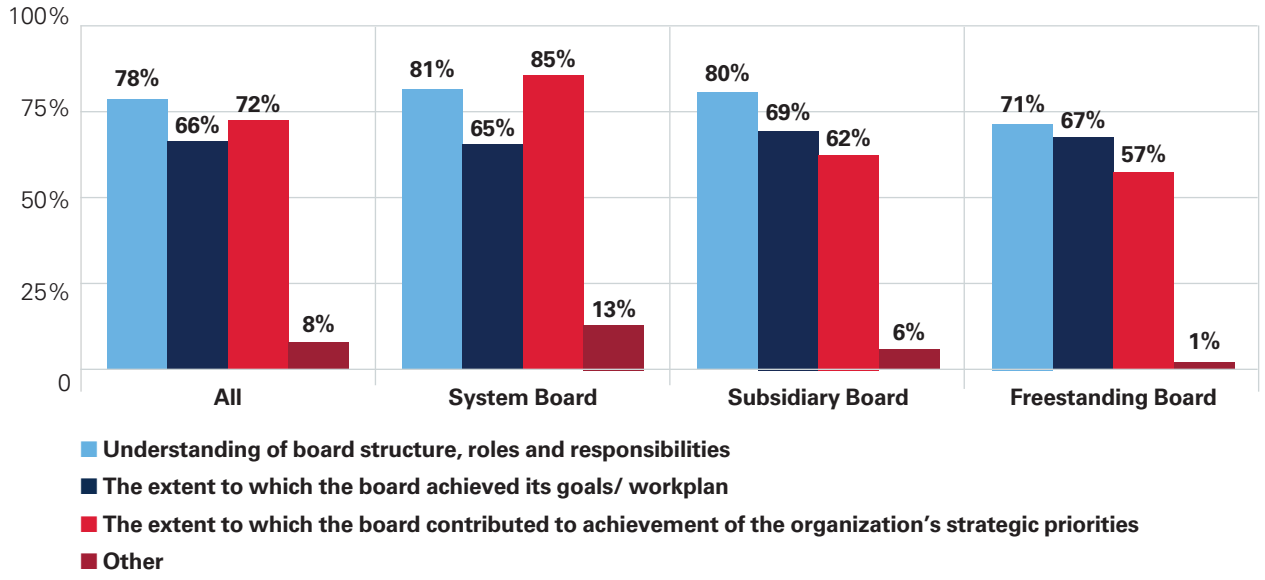
- Greater percentages of respondents to the 2022 survey reported conducting both board member and full board evaluations than did respondents to the 2018 survey (Figure 7.2).

Figure 7.2 Use of Governance Assessments by Year



- As shown in Figure 7.3, of 2022 respondents overall that conducted a full board assessment, the highest percentages said the assessment focused on understanding board structure, roles and responsibilities (78%) and the extent to which the board contributed to achievement of the organization's strategic priorities (72%).

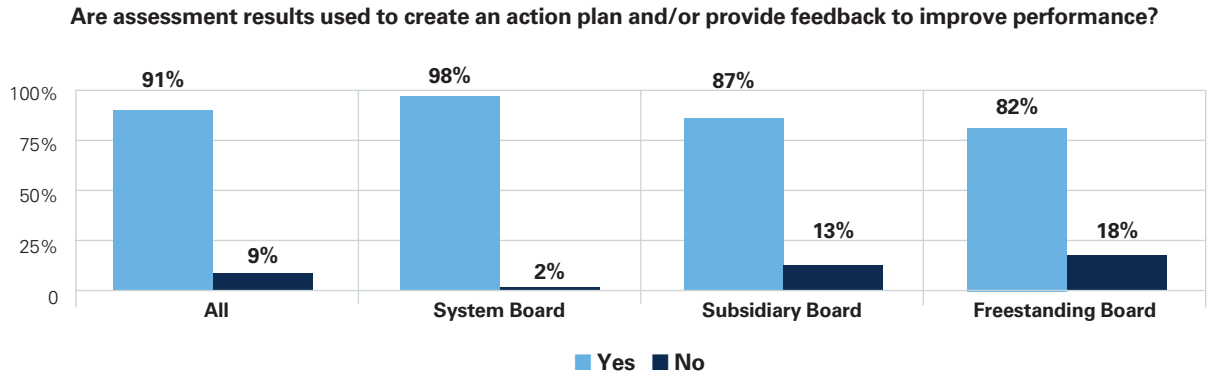
Figure 7.3 Focus of Full Board Assessment



Use of Assessment Results

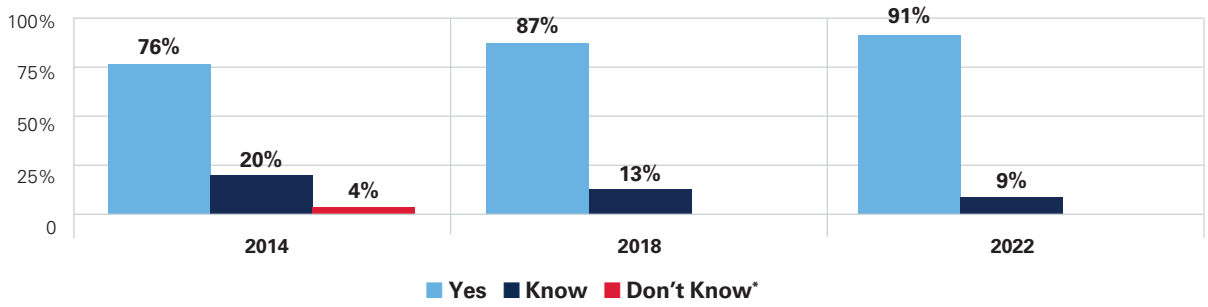
- The vast majority of overall respondents to the 2022 survey (91%) reported they used assessment results to create an action plan and/or provide feedback to improve performance (Figure 7.4).

Figure 7.4 Use of Assessment Results



- A higher percentage of 2022 survey respondents overall (91%) reported using assessment results to improve board performance compared to 2018 survey respondents (Figure 7.5).

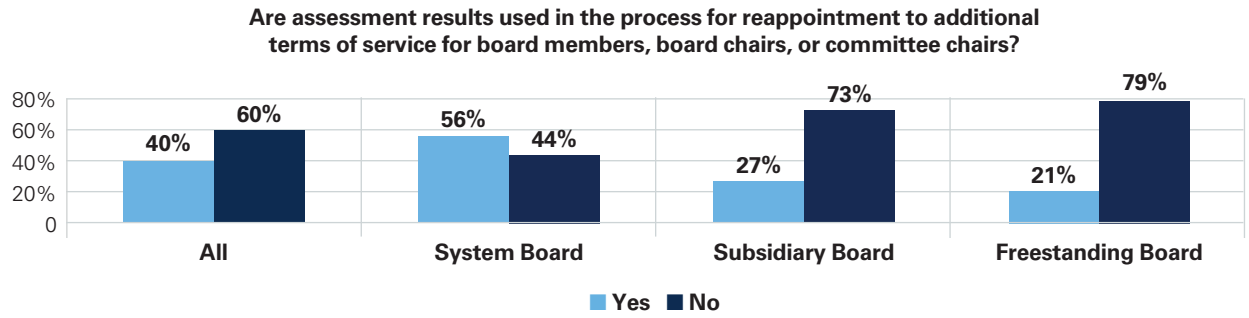
Figure 7.5 Use of Assessment Results by Year



*Not an option in 2018 or 2022

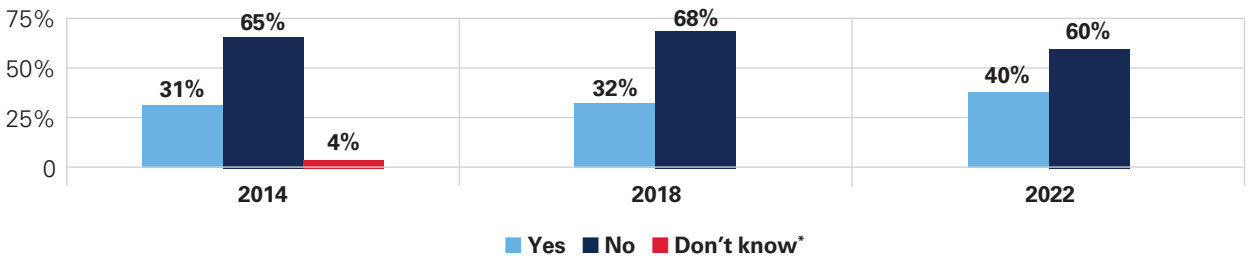
- Some 60% of overall respondents to the 2022 survey did not use assessment results in the process for reappointment of board members, board chairs or committee chairs (Figure 7.6).

Figure 7.6 Use of Assessment Results for Reappointment



- In 2022, more boards overall (40%) included assessment results in board member or board/committee chair reappointment as compared to 2018 (Figure 7.7).

Figure 7.7 Use of Assessment Results for Reappointment by Year



*Not an option in 2018 or 2022

Board Member Evaluation Criteria

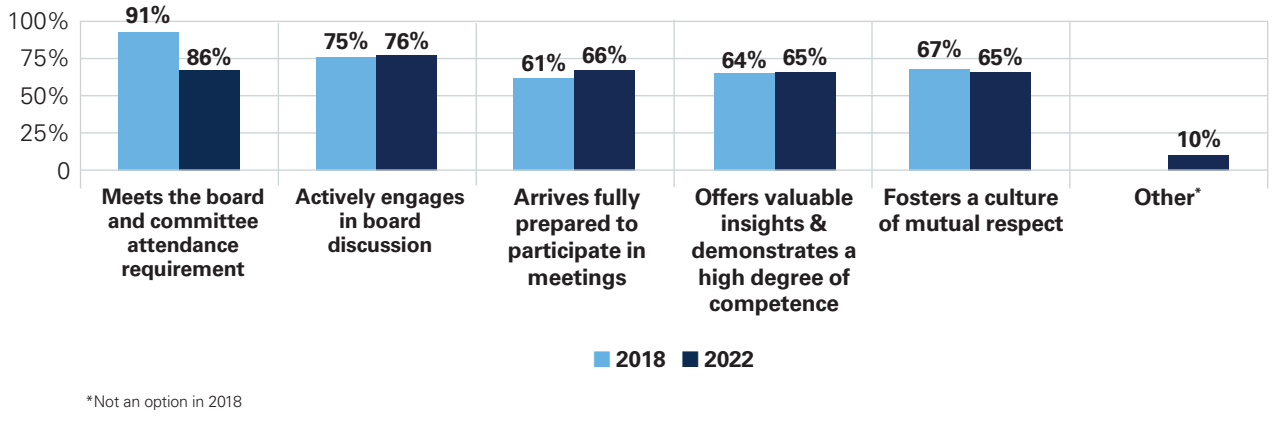
- Some 86% of 2022 respondents overall report "meets the board and committee attendance requirement" as a criterion used to evaluate individual board member performance (Figure 7.8).
- System boards indicated they used "actively engages in board discussion" (90%) and "arrives fully prepared to participate in meetings" (87%) as criteria for individual board member performance evaluation than did hospital boards (Figure 7.8).

Figure 7.8 Criteria for Individual Board Member Performance Evaluation

	All	System Board	Subsidiary Board	Freestanding Board
Meets the board and committee attendance requirement	86%	91%	85%	78%
Actively engages in board discussion	76%	90%	68%	65%
Arrives fully prepared to participate in meetings	66%	87%	54%	50%
Offers valuable insights & demonstrates a high degree of competence	65%	78%	61%	53%
Fosters a culture of mutual respect	65%	78%	64%	51%
Other	10%	8%	9%	13%

- 2022 survey results for criteria for individual board member performance evaluation were similar to 2018 results (Figure 7.9).

Figure 7.9 Criteria for Individual Board Member Performance Evaluation by Year



*Not an option in 2018

Commentary on Board Evaluation

By Barbara H. Lorsbach, (blorsbach@governwell.net), president, GHI governWell™

Introduction

Lead by example. It is a principle that is foundational to nearly all leadership models. The AHA's 2022 governance survey results show notable strengths as well as persistent weaknesses in the extent to which health system and hospital boards lead by example when evaluating their own performance. Boards must be agile, astute and highly competent in carrying out their responsibilities and duties. They face significant leadership challenges, including constant vigilance in oversight of quality and service excellence, financial shortfalls, ensuring the recruitment and retention of a strong workforce as well as understanding changing community needs and consumer preferences. Boards will be successful in dealing with these issues if they understand the most critical components of leadership effectiveness and successfully evaluate their own leadership.

Observations about Survey Findings

In the same way that the board is responsible for oversight of continuous quality improvement, it also is responsible for ensuring continuous improvement of its own performance. To accomplish this, the board should regularly self-assess. According to the AHA governance survey, 61% of hospital and health system boards conducted a full board assessment in the past three years. Of boards that assessed themselves, a notable 90% used the results to create an action plan or feedback to improve performance. These boards put their results to work to achieve actionable and measurable governance gains.

While the majority of organizations reported conducting a board assessment, survey data also indicated that more than 25% of all boards reported they had not used any type of assessment in the past three years — not full board assessments, individual board member assessments, board chair or board or committee meeting evaluations. This finding is shocking given the scopes of responsibility and authority of health system and hospital boards. With so many aspects of a board's oversight role relying on evaluating and monitoring performance across the organization, the fact that many boards do not use the same standard of excellence to hold themselves accountable is a persistent weakness highlighted by the survey results.

When boards do conduct assessments, full board assessments were the most frequently reported form of evaluation. 83% of system boards, 50% of system subsidiary hospital boards and 46% of freestanding hospital boards reported conducting board assessments in the past three years. A full governance performance assessment (board self-assessment) uses a combination of quantitative and qualitative measurements of board performance. Effective assessments enable boards to identify leadership roles and responsibilities that the board performs well and areas that have the greatest potential for improvement. The assessment process facilitates the development of initiatives and strategies to improve leadership performance.

Survey data indicated that leadership characteristics evaluated in full board assessments vary across types of boards that conducted them. Key findings included:

- Board members' understanding of board structure, roles and responsibilities were the most frequently assessed governance characteristics. Seventy-eight percent reported assessing their board's governance practices in these areas.
- System and system subsidiary hospital boards more frequently assessed members' understanding of board structure, roles and responsibilities than freestanding hospitals (80% compared to 71%).
- Assessment of the extent to which the board contributed to the achievement of the organization's strategic priorities was the second most frequently evaluated. System boards were more likely to assess their contributions (85%) as compared to system subsidiary hospital boards (62%) and freestanding hospital boards (57%).

- Overall, only 66% of hospitals and health system boards that conducted assessments evaluated the extent to which the board achieved its goals and/or work plan.

The second most frequently conducted assessments were board meeting evaluations. Still, less than half (44%) of hospitals and health systems indicated that their boards used this type of assessment. Whereas 81% of system boards evaluated their board meetings, only approximately 20% of system subsidiary hospital and freestanding hospital boards did so. Committee meetings were even less likely to be evaluated.

Given that meeting evaluations are the easiest form of assessment to conduct, the low level of use of this governance practice raises questions as to why boards do not evaluate their meetings. Is the issue a lack of time, discomfort with providing feedback or a lack of awareness of the importance of doing so? All three can be factors. In failing to evaluate meeting effectiveness boards and committees miss out on the ability to improve outcomes and increase board member engagement.

An individual performance assessment is an important part of the governance assessment process. The ability to reflect on one's own strengths and areas that could benefit from intentional improvement efforts is a hallmark of an outstanding leader. However, this leading governance practice is one that has not been widely embraced by the field. In 2022, only 34% of survey respondents reported conducting individual assessments. In 2018, the percentage declined to only 25% before trending upward again in 2022.

For the hospitals and health systems that did evaluate individual board member performance, the criteria most frequently included were board and committee attendance, whether the trustee actively engaged in board discussion, preparation for meetings, the ability to offer valuable insights and the extent to which the board member fostered a culture of mutual respect.

Regular evaluation of the board's performance is a core part of the accountability process. Boards that pay close attention to their own performance will find that their governance processes will improve, their leadership skills will be enhanced, and the quality of their governance decision-making and strategic focus will be sharpened. Most importantly, boards that conduct a self-assessment set a leadership example that then cascades down through the entire organization as it strives for excellence.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Evaluation

- How does your board hold itself accountable for continuous leadership improvement?
- Does your board conduct a governance assessment annually? Bi-annually? If not, what are the barriers to using this governance best practice?
- If your board conducts a self-assessment, is it anonymous allowing trustees to express their opinions and ideas freely and candidly for governance change?
- Does the full board review the results of the assessment, discuss their interpretation of the findings, and determine potential areas for necessary board improvement?
- Does your board conduct a brief meeting evaluation at the end of each board and committee meeting?
- What are the reasons your board does or does not conduct peer assessments? How might board performance improve if individual members' performances were evaluated?

SECTION 8

Performance Oversight

Data Points

Approximately half of all boards do not hold the CEO accountable for diversity, equity and inclusion goals in their performance review. Most boards reported that they use an authority matrix to define management versus governance oversight and accountability for various types of decisions. Some 90% or more of respondents said they use clinical quality, service/satisfaction, financial and patient safety metrics to evaluate organizational performance.

Executive Oversight

- The highest percentage (41%) of 2022 survey respondents overall reported that the board had updated its CEO succession plan within the last year (Figure 8.1).

Figure 8.1 Timing of CEO Succession Plan Update

When did your board last update its CEO succession plan?

	All	System Board	Subsidiary Board	Freestanding Board
Less than a year ago	41%	74%	13%	28%
At least 1 year ago, but less than 2 years ago	10%	8%	10%	12%
At least 2 years ago	11%	10%	11%	12%
Don't know	10%	2%	18%	12%
N/A - Board does not have a formal CEO succession plan	28%	6%	48%	36%

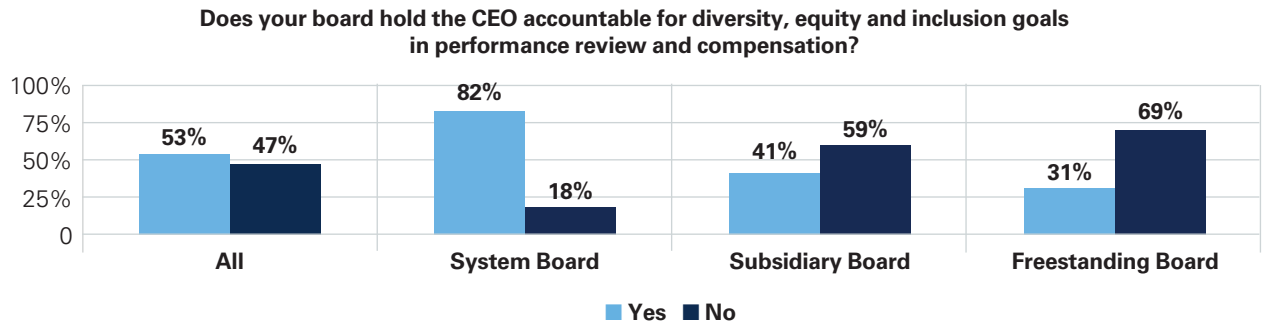
- 2022 survey data indicated that the percentage of respondents reporting their board does not have a formal CEO succession plan has declined steadily since 2018 and 2014 (Figure 8.2).

Figure 8.2 Timing of CEO Succession Plan Update by Year

	2014	2018	2022
Less than a year ago	18%	19%	41%
At least 1 year ago, but less than 2 years ago	7%	12%	10%
At least 2 years ago	6%	9%	11%
Don't know	14%	10%	10%
Board does not have a formal CEO succession plan	55%	49%	28%

- Nearly half (47%) of all 2022 survey respondents reported that their boards do not hold the CEO accountable for diversity, equity and inclusion goals as part of their performance review and compensation (Figure 8.3).

8.3 CEO Accountability for Diversity, Equity and Inclusion Goals



- When asked how their board oversees executive leadership development, 63% of 2022 survey respondents overall reported that the board ensured executive leadership development was a key priority for the CEO (Figure 8.4).

Figure 8.4 Executive Leadership Oversight

How does your board oversee executive leadership development?

	All	System Board	Subsidiary Board	Freestanding Board
Ensures that executive leadership development is a key priority for the CEO	63%	67%	52%	66%
Ensures candidates for executive leadership positions interact with the board at meetings, retreats and other forums	52%	58%	49%	47%
Reviews executive leadership development plans for specific positions at least annually	25%	33%	15%	23%
Other	19%	26%	19%	11%

Accountability

- Nearly all systems (90%) indicated that their boards had an authority matrix or policy delineating management versus governance oversight and accountability for various types of decisions (Figure 8.5).
- The use of an authority matrix has increased overall from 69% in 2018 to 75% in 2022 (Figure 8.6).

Figure 8.5 Use of an Authority Matrix

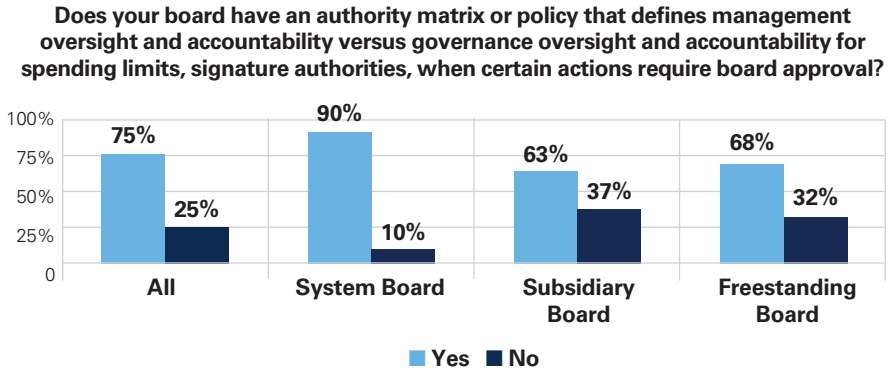
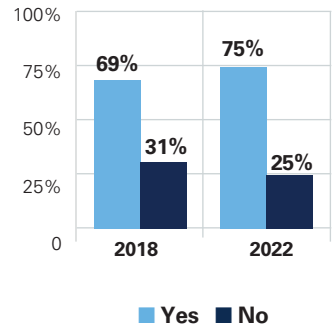


Figure 8.6 Use of an Authority Matrix by Year



Organizational Performance

- When asked which types of metrics and objectives the board uses to evaluate organizational performance (Figure 8.7), the highest percentages of 2022 survey respondents overall cited the following: clinical quality (95%), service quality/patient satisfaction (93%), financial performance (92%) and patient safety (90%).
- As indicated in Figure 8.7, use of diversity and health equity metrics and objectives represented the lowest percentage of responses overall and for hospital boards.

Figure 8.7 Use of Metrics/Objectives to Evaluate Organization Performance

Does your board use precise and quantifiable metrics and objectives to evaluate organizational performance in the following areas?

	All	System Board	Subsidiary Board	Freestanding Board
Clinical quality	95%	99%	97%	89%
Service quality/patient satisfaction	93%	99%	92%	87%
Financial/capital allocation/ investment performance	92%	95%	91%	90%
Patient safety	90%	96%	94%	81%
Employee satisfaction	83%	96%	83%	67%
Achievement of strategic priorities	75%	87%	72%	65%
Physician engagement/satisfaction	60%	72%	62%	46%
Community/population health	54%	75%	51%	32%
Diversity and Health Equity	44%	77%	35%	15%
Other	2%	1%	1%	2%

- The majority of respondents to the 2022 survey overall (86%) indicated they considered the results of the organization's community health needs assessment (CHNA) in developing the strategic plan (Figure 8.8). Some 86% of overall respondents to the 2022 survey reported using CHNA results in strategic plan development, compared with 81% in 2018 (Figure 8.9).

Figure 8.8 Use of Community Health Needs Assessment Results in Strategic Plan Development

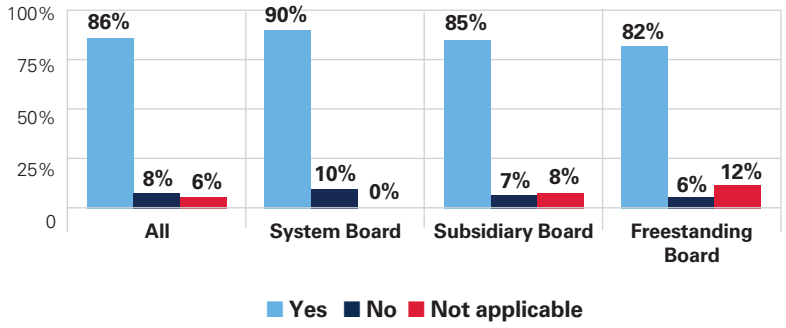
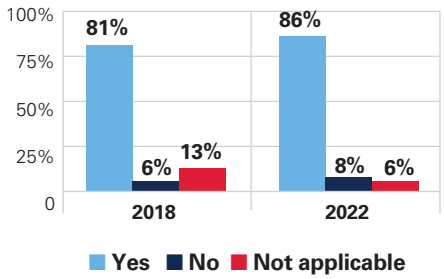


Figure 8.9 Use of Community Health Needs Assessment Results in Strategic Plan Development by Year



Commentary on Performance Oversight

By Kimberly A. Russel, (russelmha@yahoo.com), chief executive officer, Russel Advisors

Introduction

The board's relationship with its CEO directly impacts the health care organization's success in meeting the mission and vision. The details underlying the structure of this crucial relationship are revealed in this section of the survey. The survey data provide insights that will help boards carry out their oversight responsibilities while simultaneously supporting the CEO's effectiveness. This branch of the survey examines how the board carries out its performance oversight role with respect to both the CEO and the organization. The "how" includes CEO succession planning, executive leadership development, the use of a board policy clarifying governance and executive roles and the measurement of overall organizational performance. For the first time, the survey delves into CEO accountability for the organization's diversity, equity and inclusion goals. The survey also probes the linkage between identified community health needs and the strategic plan.

Survey findings for these elements generally show positive governance gains. As this survey covers the pandemic period, the improvement is particularly noteworthy. However, along with the positive progress in several aspects of performance oversight, the survey highlights several key areas in need of further board attention.

Observations about Survey Findings

As the pandemic transitions to the endemic phase, every board should be aware of national and regional CEO retention and turnover trends. Not surprisingly, health care CEO retirement announcements in 2022 are ubiquitous and the executive search industry predicts continuing high levels of CEO turnover. These market realities make it imperative for boards to double down on CEO succession planning and associated internal executive development. The survey demonstrates strong attention to CEO succession planning from health system boards with 74% reporting an update to the CEO succession plan within the past year.

The survey reveals a very concerning governance weakness for freestanding boards, with only 28% reporting an update to its CEO succession plan within the past year (and only an additional 12% reporting an update within the past two years). Boards that are not addressing CEO succession are placing their organizations at undue risk.

Closely related to CEO succession planning is the board's role in executive leadership development oversight. Boards must understand that high-performing health care executives are in high demand. The board will mitigate the impact of executive turnover by establishing a clear expectation that the CEO prioritize internal executive leadership development. The leadership development strategy should include specific action plans, stretch experiences and other professional development opportunities.

The survey reports strong progress (63%) among all boards in ensuring that executive leadership development is a key CEO priority. However, there is room for improvement in crafting more interaction opportunities between key board members and other executive leaders as only 52% report this practice.

Finally, a troubling survey outcome is that only a minority of boards (25%) are reviewing leadership development plans for specific key executive roles. It is appropriate to delegate oversight of executive leadership development to a board committee. Ideally, the designated board committee should receive a high-level overview from the CEO regarding the status of each key executive's leadership development plan. The summation of this work will provide the board with an accurate understanding of the level of ready versus still developing talent within the organization.

A welcome addition to the survey is a glimpse of the movement of boards to hold the CEO accountable for organizational DEI goals. In this instance, accountability is defined as including DEI results in the CEO's annual performance assessment and compensation package. Because this is the first year for this survey question, the 2022 data serves

as a baseline. DEI strategies are in various stages of development across all health care organizations. However, including DEI results in the CEO's compensation design is a further step that most subsidiary and independent hospital boards have yet to implement. In contrast, most system boards (82%) report this accountability practice in place.

The use of an authority matrix or similar policy distinguishing management authority from governance oversight is a vital tool that supports a strong relationship between the board and CEO. The authority matrix provides clarity to all parties and is a proactive step that prevents misunderstanding and miscommunication. The survey reveals strong progress in this area with 75% of all boards having an authority matrix or policy (compared to 69% in 2018).

The consistency of results between the 2018 and 2022 surveys for the use of specific metrics of organizational performance is surprising due to the intervening pandemic years. Anecdotally, many boards and CEOs reported stepping away from these metrics for executive compensation purposes in 2020 and 2021 due to the unanticipated pandemic impact. Perhaps the 2022 survey represents boards returning to pre-pandemic organizational performance metrics. There is also strong consistency between 2018 and 2022 related to the selection of metrics used for evaluation purposes, with clinical quality, service quality, financial performance and patient safety universally adopted by nearly all (at least 90%) survey respondents.

The survey indicates that the majority of boards (86%) incorporate community health needs assessment results into strategic plan development. This is a particularly important finding as the pandemic has highlighted the importance of deep connections between hospitals and their local communities.

Given the challenging external factors that face our nation's hospitals and health systems, the board's approach to its performance oversight responsibilities remains in the spotlight. As health care organizations in 2022 are reporting disappointing financial and quality results due to pandemic-related challenges, will boards have the fortitude to continue to set high standards and to expect strong performance from hospitals and health systems?

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Performance Oversight

- Has your board assigned CEO succession planning and executive leadership development to a designated board committee? Is the board (or its designated committee) up to date on the health care CEO and executive market?
- Has your board established an annual cadence to update the CEO succession plan? If not, why not and what is the plan for the board to tackle CEO succession planning?
- Has your board reinforced to the CEO his or her accountability for internal executive development? How is the board providing oversight?
- Has your board clarified to the CEO its expectations related to DEI strategies?
- Are the organizational performance metrics selected by the board in sync with the board's expectations for high performance?

SECTION 9

Board Culture

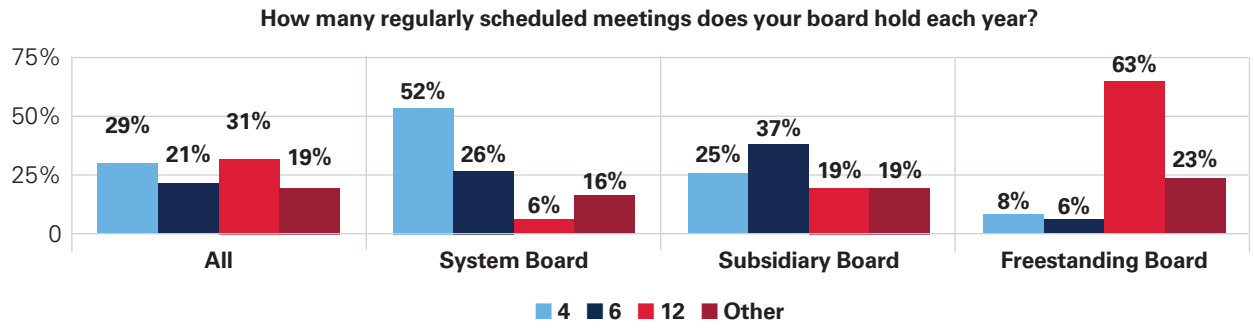
Data Points

A significant majority of respondents to the 2022 survey have not increased the number or length of their board meetings in the past three years. Half of systems reported their meetings now last five hours or more. A majority, some 65%, report spending 50% or less of board meeting time in active discussion, deliberation and debate. More than half of all boards reported no change in the time spent on board activities in the past three years.

Board Meetings

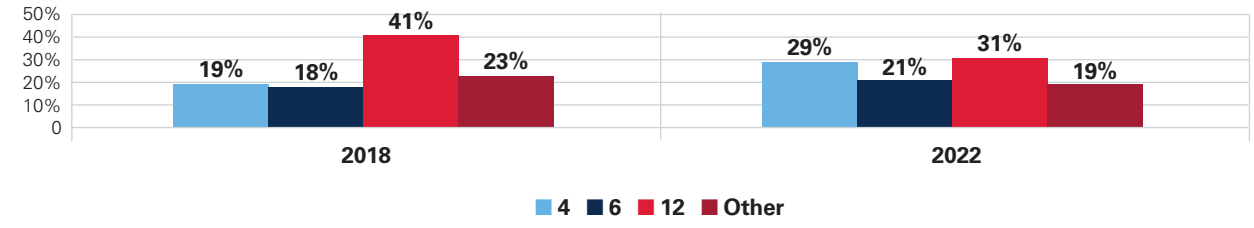
As indicated in Figure 9.1, the highest percentage of system boards (52%) reported holding four regularly scheduled meetings each year. The highest percentage of system subsidiary boards (37%) reported holding six meetings per year. The majority of freestanding hospitals (63%) reported their boards held 12 regularly scheduled meetings each year.

Figure 9.1 Number of Regularly Scheduled Board Meetings Each Year



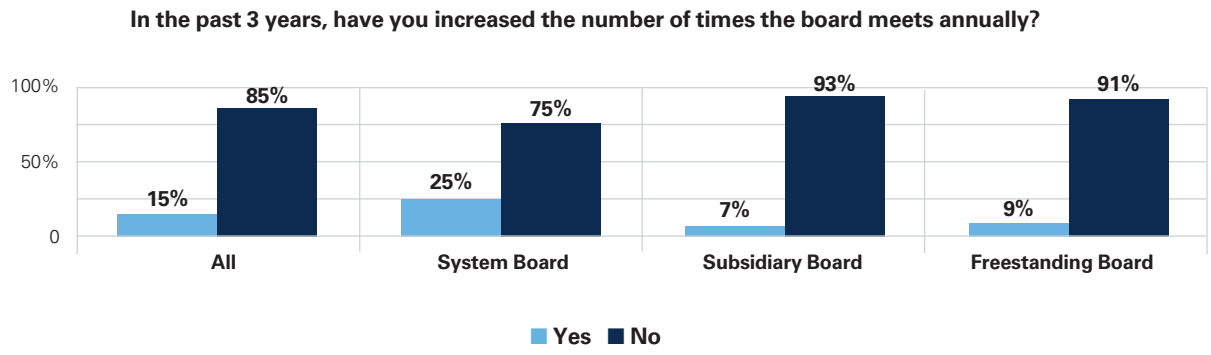
- Of all respondents to the 2022 survey, a greater percentage (29%) reported holding four regularly scheduled board meetings per year, while fewer (31%) reported their boards held 12 regularly scheduled meetings in comparison to 2018 survey results (Figure 9.2).

Figure 9.2 Number of Regularly Scheduled Board Meetings by Year



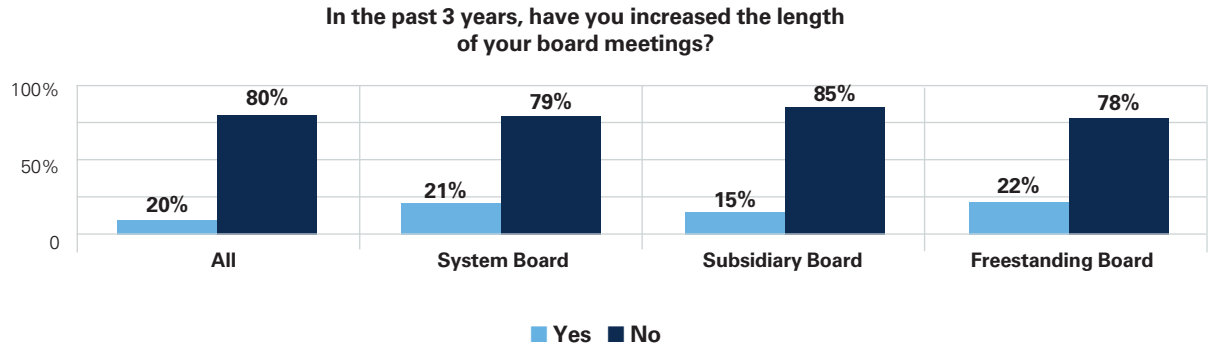
- The majority of overall respondents to the 2022 survey (85%) reported that in the past three years they had not increased the number of times the board met annually (Figure 9.3).

Figure 9.3 Increase in Number of Board MeetingsAnnually in Past 3 Years



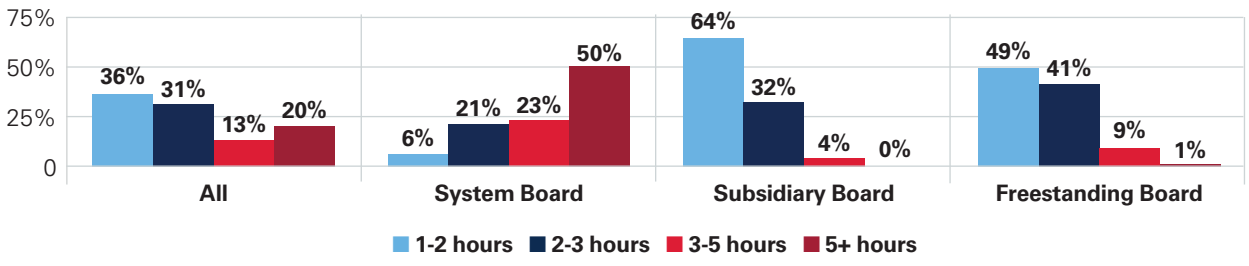
- The majority of overall respondents to the 2022 survey (80%) reported not increasing the length of board meetings in the past three years (Figure 9.4)

Figure 9.4 Increase in Board Meeting Length in Past 3 Years



- The highest percentages of hospital boards (both system subsidiary and freestanding) reported a typical board meeting lasts one to two hours. The highest percentage of system boards (50%) reported that a typical board meeting lasts five hours or more (Figure 9.5).

Figure 9.5 Length of Typical Board Meeting



- In 2018, the highest percentage of systems (31%) reported that a typical board meeting lasted two to three hours, while in 2022 the highest percentage of systems (50%) reported their board meetings lasted five hours or more (Figure 9.6).

Figure 9.6 Length of Typical Board Meeting by Year						
	System Board		Subsidiary Board		Freestanding Board	
	2018	2022	2018	2022	2018	2022
1-2 hours	25%	6%	59%	64%	51%	49%
2-3 hours	31%	21%	35%	32%	40%	41%
3-5 hours	22%	23%	7%	4%	9%	9%
5+ hours	21%	50%	0%	0%	1%	1%

- When asked about board meetings during the COVID-19 pandemic (Figure 9.7), the highest percentages of respondents overall to the 2022 survey reported that they met virtually (75%) or met using a hybrid model (54%).

Figure 9.7 Board Meeting Frequency During Covid-19 Pandemic (March 2020-2022)				
During the COVID-19 pandemic (March 2020 to present) has your board:				
	All	System Board	Subsidiary Board	Freestanding Board
Met more frequently	30%	60%	9%	13%
Met less frequently	5%	2%	6%	8%
Met virtually	75%	76%	79%	72%
Met in-person	23%	5%	16%	47%
Met using a hybrid model	54%	43%	51%	67%

- The highest percentages of 2022 survey respondents overall and across all board types reported that they spend greater than 25% but less than 50% of board meeting time in active discussion, deliberation and debate (Figure 9.8). The same was true of respondents to both the 2014 and 2018 surveys (Figure 9.9).

Figure 9.8 Board Meeting Time Spent in Active Discussion, Deliberation and Debate

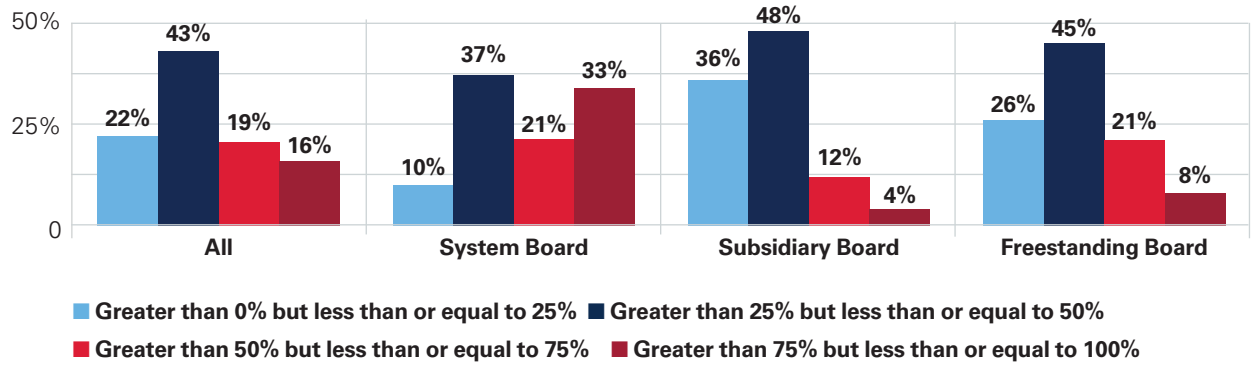
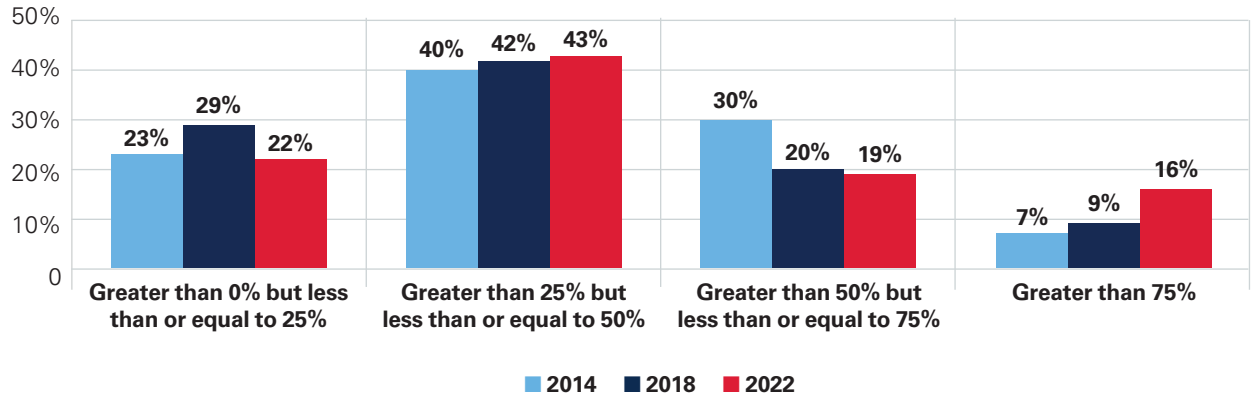


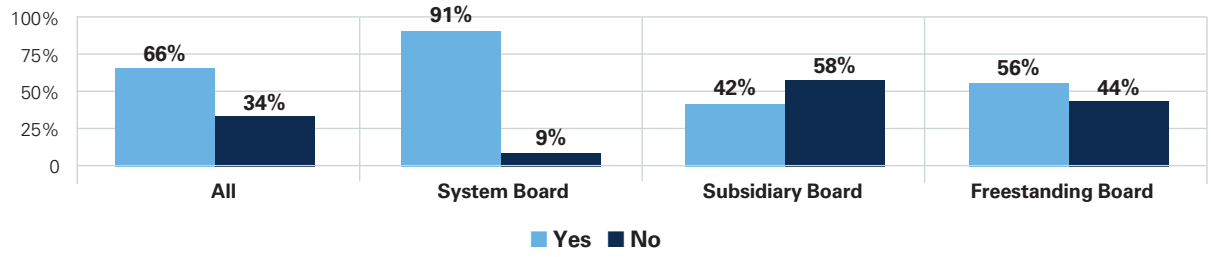
Figure 9.9 Board Meeting Time Spent in Active Discussion, Deliberation and Debate by Year



Executive Sessions

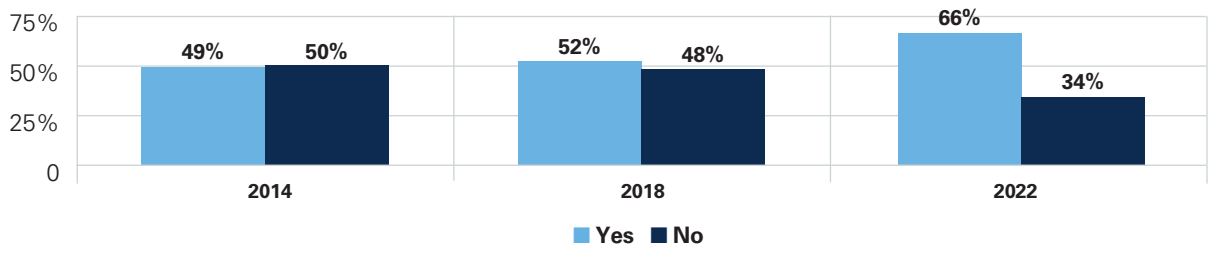
- Some 91% of systems reported they routinely include an executive session in the agenda of every board meeting. In comparison, 56% of freestanding boards and 42% of system subsidiary hospital boards reported this approach to executive sessions (Figure 9.10).

Figure 9.10 Executive Session on Every Board Meeting Agenda



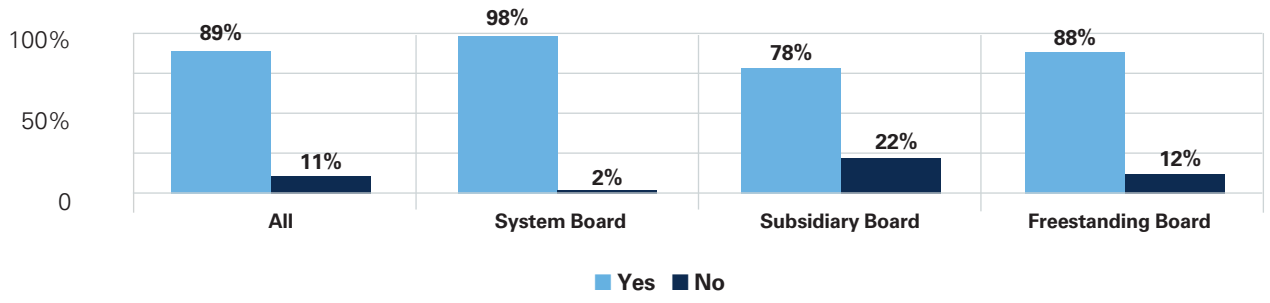
- In 2022, 66% of overall survey respondents reported they routinely include an executive session in the agenda of every board meeting as compared to 52% in 2018 and 49% in 2014 (Figure 9.11).

Figure 9.11 Executive Session on Every Board Meeting Agenda by Year



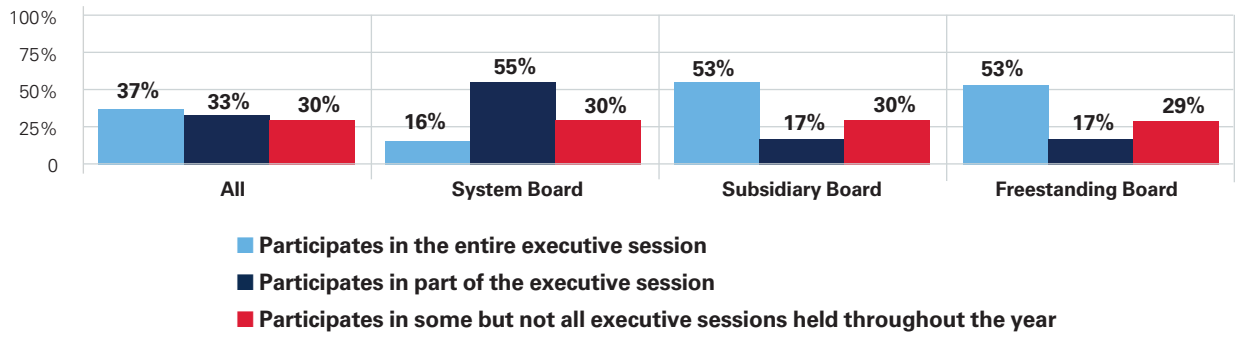
- Of 2022 survey respondents that did have executive sessions, the majority of all respondents and respondents across all board types said the CEO participates in at least a portion of these sessions (Figure 9.12).

Figure 9.12 CEO Participation in Any Portion of Executive Sessions



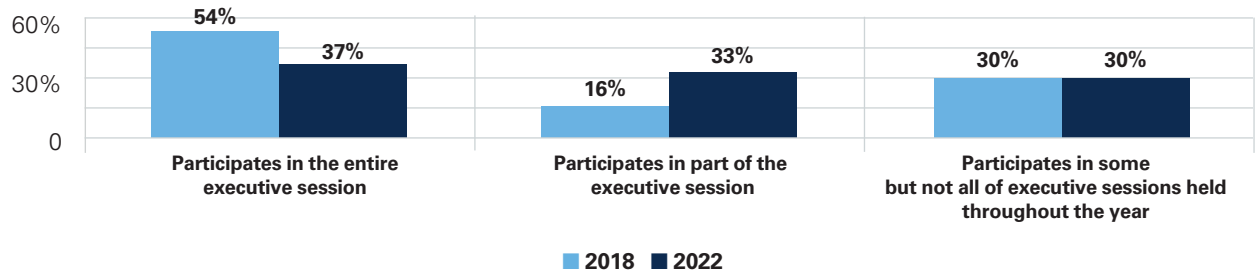
- A majority of hospital boards (53%) indicated that the CEO participates in the entire executive session as compared to 16% of system boards (Figure 9.13).

Figure 9.13 Level of CEO Participation in Executive Sessions



- A higher percentage of respondents to the 2022 survey overall (33%) reported that the CEO participates in part of the executive session than did respondents in 2014 (16%), as shown in Figure 9.14.

Figure 9.14 Level of CEO Participation in Executive Sessions by Year



- Excluding executive performance evaluation and executive compensation, more than 84% of respondents reported that the CEO is present for executive session discussions about all other topics (Figure 9.15).

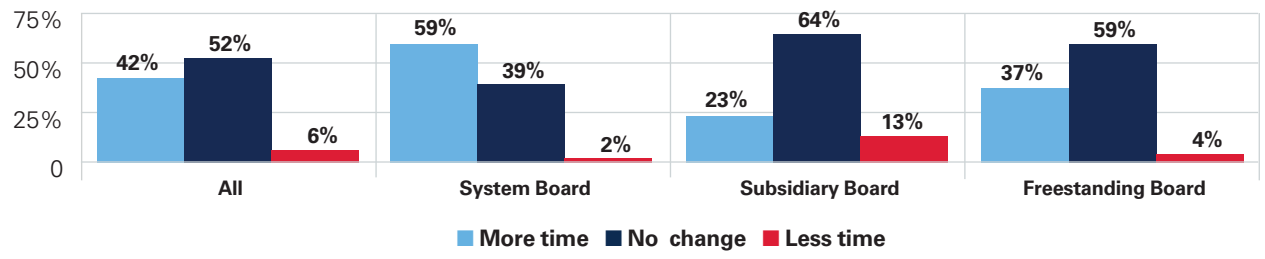
Figure 9.15 CEO Participation in Board Executive Sessions by Topic

	All	All	System Board	Subsidiary Board	Freestanding Board
Financial performance of the health system/ hospital(s)	CEO Present	99%	99%	96%	99%
	CEO Not Present	1%	1%	4%	0%
Clinical or quality performance measures	CEO Present	99%	100%	98%	99%
	CEO Not Present	1%	0%	2%	1%
General strategic issues/ planning	CEO Present	99%	100%	98%	99%
	CEO Not Present	1%	0%	2%	1%
Board development	CEO Present	98%	99%	97%	98%
	CEO Not Present	2%	1%	3%	3%
Board recruitment and selection	CEO Present	95%	99%	95%	92%
	CEO Not Present	5%	1%	5%	9%
Board evaluation	CEO Present	94%	98%	95%	89%
	CEO Not Present	6%	2%	5%	11%
Board member performance evaluation	CEO Present	90%	96%	87%	84%
	CEO Not Present	10%	4%	13%	16%
Executive performance evaluation	CEO Present	26%	16%	29%	37%
	CEO Not Present	74%	84%	71%	63%
Executive compensation	CEO Present	24%	19%	23%	29%
	CEO Not Present	75%	81%	77%	71%

Time Commitment

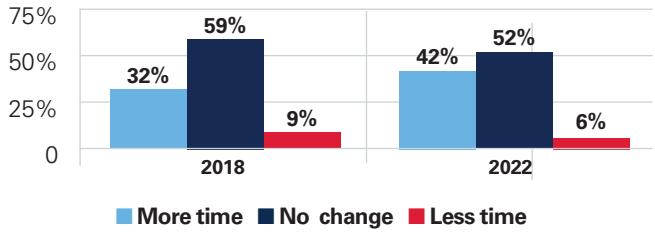
- System boards (59%) reported that they were spending more time on board work and related activities compared to three years ago. Hospital boards reported no change in the amount of time spent on board activities (Figure 9.16).

Figure 9.16 Time Spent on Board Activities Compared to Three Years Ago



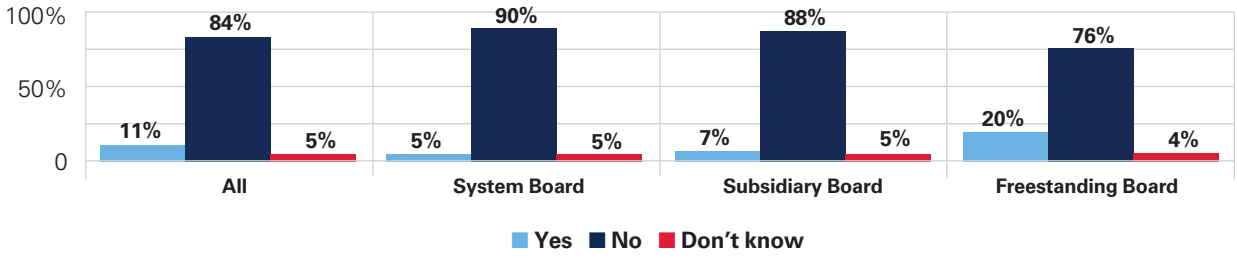
- Some 52% of all 2022 survey respondents reported no change in the past three years in the amount of time spent on board activity, as compared with 59% of all respondents in 2018 (Figure 9.17).

Figure 9.17 Time Spent on Board Activities Compared to 3 Years Ago by Year



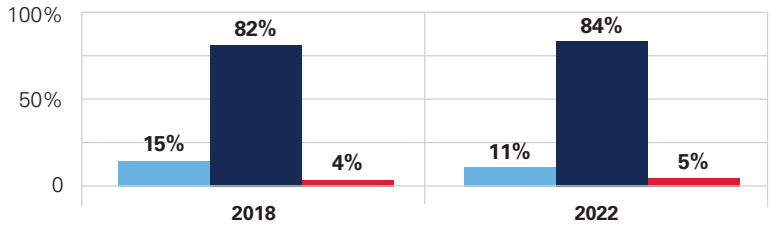
- As Figure 9.18 shows, in 2022 a higher percentage of freestanding hospitals (20%) indicated that board members had voiced concerns about time commitments associated with board service than either system subsidiary hospitals (7%) or systems (5%).

Figure 9.18 Board Member Concern About Board Service Time Commitments



- Fewer respondents overall to the 2022 survey (11%) reported that board members had expressed concerns about time commitments associated with board service as compared to 2018 respondents (11%) overall (Figure 9.19).

Figure 9.19 Board Member Concern About Board Service Time Commitments by Year



Commentary on Board Culture

by Jamie Orlikoff, (j.orlikoff@att.net), president of Orlikoff & Associates and the national adviser on governance and leadership to the AHA

Introduction

The culture of a board can be defined in a variety of ways, from "the way we do things around here" to "shared patterns of meaning" to the "things that shape our thoughts, attitudes and behaviors." Language is often regarded as an expression of the culture of any group, as is the decision-making process and the mechanism of rewarding and excommunicating members of the group. Culture helps a board define itself to its own members, to the other leaders of the organization and to the stakeholders of the organization.

Culture frames the way a board deals with conflict, both internally and between the board and the CEO and clinical leaders. It determines how a board deals with dissent and disagreement within its ranks: does it recognize and encourage respectful disagreement and use it as creative tension to drive better decisions, or does it avoid dissent to maintain the false comfort of unanimity? The culture of a board determines what it focuses on, as well as what it ignores.

Because of its many, varied and amorphous characteristics board culture is one of the most challenging aspects of governance to measure. Hence the focus in this section on one of the most foundational aspects of board culture — how a board spends its time. As a board only exists when it is meeting, the study of board meeting frequency, length and participation (who is in the meeting and when) provides a foundational perspective of governance culture and how it is changing.

One of the most significant aspects of the culture of a board, or any group, relates to how it responds to a crisis. This is when the true character of a board is revealed. This survey was uniquely influenced by the most significant health care crisis in living memory. The COVID-19 pandemic has had seismic impacts on U.S. society, its health care system, and its governance. Hospitals and health systems were needed as never before by America during the pandemic, and for them to function meant that their boards needed to meet to govern them. Governance during the emergency of the pandemic is presumably vastly different than governance during the "normal times" that preceded it. How, or if, hospital and system boards adjusted their meeting practices reflected their cultural approach to the reality of the pandemic, as well as their ability and willingness to adapt to new meeting technologies and the challenges they presented.

Observations about Survey Findings

From March of 2020 to the beginning of 2022, how boards adjusted their approach to meetings was as interesting as it was varied (Figure 9.7). Only 13% of freestanding hospital boards increased the frequency of their meetings during this period, but 60% of systems boards did. Only 5% of system boards met in person during this period, but 47% of freestanding hospital boards continued to do so. Most boards adapted by using technology to facilitate their meetings during periods of pandemic-induced social isolation, with 72% of all boards meeting virtually, using a video conference meeting platform at least once during this period. Seventy-six percent of system boards met virtually, as did 72% of freestanding hospital boards.

Having a board meeting either by virtual or in-person formats was not an exclusive binary choice, as the pandemic introduced and elevated a new cultural term into the governance lexicon: the hybrid meeting. In a hybrid meeting some of the members of a board are together in-person in a meeting room, while other board members participate virtually. Freestanding hospital boards were more likely to use hybrid meeting models (67%) than were system boards (43%).

So, to broadly summarize: most system boards chose to meet more frequently (60%), and to conduct their meetings virtually (76%); only 5% of system boards held in-person meetings during this period. Conversely, most hospital boards kept the same meeting frequency as they had prior to the pandemic (79%), held in-person

meetings (47%); and were more likely to use a hybrid meeting models (67%). What might explain these differences and how might this reflect different cultures of system versus hospital governance?

First, regarding meeting frequency, freestanding hospital boards have historically met more frequently than system boards. This is due to several reasons, but a major one is the fact that hospital boards must perform regular oversight of the medical staff credentialing function, while most system boards do not. These survey results are consistent with the historical trend, with 63% of freestanding hospital boards meeting 12 times per year, compared to 78% of system boards meeting six times a year or less (Figure 9.1). So, the fact that system boards increased meeting frequency during the period of March 2020 through the end of 2021 likely reflected their need to become more engaged during the emergency of the pandemic than their regular meeting schedule allowed. Freestanding hospital boards, on the other hand, were likely able to accommodate the need for increased pandemic-driven board oversight into their regular, more frequent meeting cadence.

The fact that system boards held significantly fewer in-person meetings than freestanding hospital boards may be explained by the fact that systems cover, and system board members tend to come from broader geographic areas than freestanding hospitals and their board members. Freestanding hospital board members tend to live in the more geographically compressed community served by the hospital. Hence, it was likely easier logistically (with no plane travel or long drives, and no overnight hotel stays necessary) to convene in-person meetings for the hospital boards than for the system boards. It is also possible that system boards were more comfortable with and had better access to virtual meeting technology and adopted it earlier than freestanding hospital boards.

More controversially, it is also possible that system boards were composed of members who were more attuned to and accepting of the science of COVID-19 and its transmission and were therefore more unwilling to meet in person - for both personal health and leading by example reasons - than some of the freestanding hospital boards. This could be due to a variety of factors including: different selection criteria and board composition practices for system boards compared to freestanding hospital boards; less community-specific political and social pressure on system board members than on members of freestanding hospital boards; the broader, multi-community perspective required of system boards which may generate a greater tendency to think about population health versus individual rights; and many others.

Whatever the reasons, it is clear from the significant differences in pandemic-related meeting frequencies that the culture of freestanding hospital governance is different from that of system governance. It is left to future surveys to determine if these different cultures will converge over time, or if they will remain distinct, and possibly grow more so.

Other questions also remain that will relate to the culture of governance in the near future. For example: Are hybrid board meetings inherently less effective than either all in-person or all virtual meetings? Some believe that this is true because of variation in participation and engagement between those members who attend in-person and those who attend virtually. The thinking goes that the in-person attendees can chat during breaks and meals and can be more attuned to the "buzz" and meeting energy and "what the real issues are" than can those who attend virtually. Some boards are so convinced of this that they have adopted policies prohibiting hybrid meetings and require all members to participate in meetings the same way if their participation is to be counted toward meeting attendance requirements.

Another question relates to the effectiveness of alternating meeting models. Here, a board might schedule some of its meetings to be held in virtual format, and others using an in-person model. The preliminary thinking here is that the virtual meetings would be held more frequently, but of shorter length, and focus on the more routine and required tasks of governance. Then, the in-person meetings would be interspersed between the virtual meetings, be held less often, but for longer periods of time and focus on more strategic and generative issues and discussions.

Similarly, some boards are already experimenting with other meeting approaches involving board committee meetings. Here, most of the board committee meetings are held virtually, with one or two held in-person at the beginning of the year when there are new members for orientation purposes.

It remains to be seen how board meeting structure, frequency, duration and model (virtual, in-person or hybrid) will evolve over time. But its evolution is clearly underway and will proceed rapidly. Why? The survey shows that 59% of system boards and 37% of freestanding hospital boards reported that their members were spending more time on governance work (Figure 9.16) compared to three years ago. Further, 20% of freestanding hospital board members expressed concerns about growing time commitments associated with board work (Figure 9.18). It is therefore a foregone conclusion that the integration of new technologies like virtual meeting platforms and board portals (Figure 4.17 and 4.18) will both support and change board culture in the future.

Please note that the views of commenters do not always reflect the views of the AHA.

Discussion Questions on Board Culture

- How would you describe the culture of your board to a board member from another hospital or health care system?
- What are three positive aspects of the culture of your board? What are three negative aspects of the culture of your board? Is there a plan to maintain the positive and minimize the negative aspects of your governance culture?
- How is the culture of your board different because of the pandemic? What differences do you regard as positive and why? What differences do you regard as negative and why?
- How did virtual meetings impact the culture of your board? How will your board incorporate virtual or hybrid meetings into its meeting practices going forward?
- If your board plans to incorporate virtual or hybrid meetings into future practice, what steps will be taken to maintain existing practices that are supportive of your culture?
- If your board or board leaders are spending more time on governance than in the recent past, is this and its impact on the culture of the board being regularly assessed by the board or a board committee?
- Does your board have a statement of the desired culture of the board? If not, what do you think such a statement should include?

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