Governance & Executive Leadership Trends Across Leading Health Systems
Prepared for WittKieffer
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Report Overview and Profile of Participating Health Systems

To better understand health systems’ governance priorities and practices, The Academy conducted research on Leading Health System (LHS) approaches to governance and executive leadership. The Academy captured executive perspectives across 25 unique health systems representative of a significant share of the LHS market.

**Participants by Size (TOR)**
- Small: <$2B - 12%
- Medium: $2-5B - 40%
- Large: >$5B - 48%

**Participants by Region**
- 16% Northeast
- 28% Midwest
- 16% West
- 40% South

**Participants by Academic Status**
- 20% Academic Medical Center (AMC)
- 80% Non-AMC

- **Respondent Roles**
  - Chief Executive Officer
  - General Counsel / Chief Legal Executive
  - Board Chair
  - Regional Chief Executive Officer
  - Hospital President
  - Director of Corporate Governance
  - Board Liaison
  - Executive Assistant / Governance Secretary

Note: Total Operating Revenue (TOR): Defined as all revenue derived from both patient care and health plan (if applicable)
Health System Strategy Pushes Boards to Evolve

Governance Modernization Slow but in Progress

Throughout 2020, the COVID-19 pandemic paused many health system strategic initiatives. But in recent months, the impact of the pandemic shifted from disruption of services to the acceleration of strategy in many areas, including telehealth, health equity, diversity, equity, and inclusion (DEI), and consumerism.

As part of this acceleration, health systems recognize that their governance structures are no longer designed to fully support their strategic vision. Most health systems are committed to updating their governance model, including redefining who should serve on the board as well as modernizing outdated structures that no longer support their recruitment goals or effectiveness in the rapidly changing environment. While health systems are making progress, change is slow. It will take several years before changes made now are fully realized.

Common Avenues for Modernizing Board Governance

- Setting Diversity Goals
- Expanding Recruitment Processes
- Updating Governance Policies & Procedures
- Focusing on Inclusion During Onboarding
- Evolving Board Communication & Education
- Reviewing Performance Evaluations
Board Priorities Aim to Modernize Governance Models

**Board Structures Evolve to Support Health System Strategy**

The push to modernize governance and better align with health system strategy is reflected in LHS’ top 2021 board priorities. Today’s priorities have a specific strategic focus on the people and processes needed to keep pace in a rapidly evolving industry.

**Yet Boards Fall Short on Operationalizing Goals**

As LHS boards aim to modernize their governance models, most are experiencing a disconnect between their goal-setting and implementation. Boards have set clear goals on diversity, recruiting, and health equity, but have yet to implement many changes that support operationalizing these goals. Until boards take steps to update the policies and procedures impeding their progress, change will continue to be slow.

Later in this report we discuss opportunities for boards to update their governance structures to meet their future goals.

<table>
<thead>
<tr>
<th>Top 2021 Governance Priorities</th>
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<tr>
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<td>2</td>
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<td>4</td>
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<tr>
<td>5</td>
</tr>
</tbody>
</table>
Diversity Goals Outpace Progress.

Boards are defining diversity broadly, seeking to add both thought diversity and demographic diversity to their boards. With the dual goals of adding new strategy expertise and better representing the communities they serve, boards are recruiting new members with a wide array of technical competencies, as well as members with traditional demographic markers of diversity (e.g., race/ethnicity, gender, age, socioeconomic status). While boards have made decent progress diversifying their panel of strategic expertise, demographic diversity remains stagnant.

Recruitment Challenges Slow Evolution.

To meet diversity goals, boards are rethinking their approach to recruitment. Boards still overwhelmingly rely on personal networks to identify board candidates, limiting the diversity of their candidate pool. Furthermore, lack of prioritization among myriad diversity goals complicates boards’ ability to refine their search and build a robust candidate pipeline. Boards are actively working to overcome these challenges but haven’t universally solved them.

Modernizing Board Structures Accelerates Progress On Goals.

Beyond recruitment efforts, boards are targeting their internal processes and structures to accelerate their progress toward a strategic, diverse, and effective board. Modernizing governance policies, onboarding and inclusion practices, educational services, board communication, and performance evaluations offer opportunities to unlock a future-focused, strategy-driven governance model.
Diversity Goals
Outpace Progress
Boards Seek Experts to Navigate Healthcare Complexity

Boards Seek Strategic Experts, Board Experience No Longer Required

As health system strategy continues to evolve, there is a heightened focus on recruiting board members from a wide range of competencies beyond traditional areas of expertise (e.g., finance, legal, human resources). New board members are expected to provide targeted guidance in areas of strategic interest to each health system.

LHS boards seek candidates with expertise in mergers and acquisitions (M&A), digital technology, multicultural marketing, disruption, consumerism, health equity, and more. Health equity expertise is particularly valuable to health systems as CEOs and other C-suite executives place increasing urgency on forming a system-wide health equity strategy.

While prior board service is a plus, it is not a must-have for new members. Board chairs are now placing a higher value on creative thinking and ability to be a productive and engaged board member capable of navigating an increasingly complex healthcare landscape.

“People may say you need a lot of board experience but that’s not totally true. You need to know how to operate in the board room. We really just want to include the best minds around.” – Board Chair

Diversifying Board Competencies Takes Time

While boards push for wider skillsets, one-third (34%) of board members still have traditional backgrounds such as finance, strategic planning, or prior governance experience.

Physicians, nurses, health policy consultants, and professionals with other healthcare backgrounds continue to comprise the majority of LHS board members. From 2019 to 2021 there was a 7% increase in executives from another health system on boards, indicating greater interest in applying governance learnings from peers to enhance strategy.¹

Slowly, boards are adding professionals with expertise in consumerism (6%), workforce (7%), diversity & inclusion (5%), and health equity (3%). Boards also expressed interest in recruiting leaders with community engagement, real estate, and business innovation backgrounds, but haven’t added these skillsets at scale.

¹ Academy Proprietary Database 2015-2021
Health Equity Expertise Underrepresented Despite High Priority

Health Equity a Top Strategic Priority Coming out of the COVID-19 Pandemic

The COVID-19 pandemic brought long-standing social and racial inequities to the forefront of public health and healthcare delivery. Racial and ethnic minorities were at higher risk of adverse outcomes from COVID-19 as several communities were hit harder than others, particularly people of color and non-English-speakers. While many factors such as poverty, inadequate access to health services, and social determinants of health play a role in these disparities, healthcare organizations across the country are committed to addressing these issues.¹ In 2021, 78% of LHS report that their health system has a health equity strategy. This is a noteworthy shift from prior years when social determinants and population health were general topics of interest but lacked the specificity and urgency of today’s focus on health equity.

“All the civil and social unrest put a spotlight on what we’re seeing. We were experiencing two pandemics: COVID-19 and racial inequity.” – Regional Chief Executive Officer

Health Equity Experts Missing from Boards

Most LHS are in the early stages of developing a long-term strategy to address health equity. Given the relatively new focus on health equity, several board chairs shared that they are still trying to understand the board’s role in supporting their organization’s health equity strategy. They are working closely with executive leaders to develop objectives and define metrics to determine the state of health disparities within their communities and set goals to achieve health equity.

A couple health systems have taken steps such as creating a health equity committee at the board level or designating health equity as a strategic pillar at their organization. But to date, only 3% of LHS board members have expertise in health equity and health disparities, presenting an opportunity to recruit future candidates to drive health equity strategy.


Examples of Board Action on Health Equity

- Creating a health equity committee or combining health equity with another committee (e.g., community and population health) to develop a system-wide health equity strategic plan
- Recruiting board members with health equity and health disparities expertise to lead strategy
- Developing goals, objectives, and metrics to assess health disparities and health equity initiatives within the health system
- Providing ongoing board education on health equity and community health disparities
Racial & Ethnic Diversity Slow to Change

Board Member Diversity Remains Stagnant for Most Minority Groups

Universally, LHS report a commitment to elect board members that better reflect the communities they serve. Racial and ethnic minorities comprise nearly 40% of the U.S. population, and the U.S. Census expects minorities to represent the majority of the population by 2060. LHS boards remain predominantly White and are only marginally more diverse than S&P 500 boards.1,3,4

To better reflect their communities, LHS boards will need a marked increase in Black, Hispanic, and Asian members. From 2019 to 2021, LHS boards showed some progress with a 7% increase in Black board members.1 But notably, Asians and Hispanics represent only 1% and 3% of board members, respectively, and are projected to be two of the fastest growing populations in the U.S.5

![Board Member Race/Ethnicity Across LHS and S&P 500](image)

Board Chairs Remain Predominantly White

The proportion of board chairs who identify as a racial or ethnic minority (29%) has increased by 10% from 2019 to 2021.1 In 2021, less than one-quarter (23%) of board chairs identify as Black/African American and only 6% of chairs identify as Hispanic/Latino. Trends in gender are similar with only 11% of board chairs identifying as female. Among female board chairs, 6% are also minorities.

As boards redefine their succession plans, they may also evaluate whether their internal pipeline of potential board chairs reflects the diversity they seek for their membership at-large.

![Reported LHS Board Chair Demographics (2021)*](image)

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1 Academy Proprietary Database 2015-2021
2 2019 United States Spencer Stuart Index
3 2020 United States Spencer Stuart Index
4 U.S. Census, Demographic Turning Points for the United States: Population Projections for 2020 to 2060

*Percentages exceed 100% due to rounding
Gender and Age Diversity Trail Behind Stated Goals

Boards Skew Older, Missing Younger Voices

Several board chairs indicated interest in bringing on younger board members who could offer a different perspective on the market. To date, nearly two-thirds (66%) of board members are still 60 or older with almost no under 40 representation. More than one-third (35%) of the U.S. workforce are millennials (age 24-40) who are often cited as major influencers in health care trends, such as consumerism. Looking ahead, LHS boards may need to weigh the trade-offs between electing more seasoned executives versus the value in including younger voices as they seek to elect a next-generation board.

Boards Remain Male Dominated

Gender diversity is a board recruitment priority, and some progress has been made over the last 10 years. In 2021, about one-quarter (27%) of LHS board members identify as female compared to 13% in 2015. While this increase is promising, the trend must continue if boards hope to achieve equal representation. As boards seek to capture a wide range of experiences and perspectives, there is a critical need to reassess succession planning strategies to increase female representation.

Age Breakdown of LHS Board Members

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% of Total Board Members</th>
</tr>
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<tbody>
<tr>
<td>75+ Years</td>
<td>6%</td>
</tr>
<tr>
<td>60-75 Years</td>
<td>60%</td>
</tr>
<tr>
<td>50-59 Years</td>
<td>28%</td>
</tr>
<tr>
<td>40-49 Years</td>
<td>6%</td>
</tr>
<tr>
<td>31-39 Years</td>
<td>1%</td>
</tr>
<tr>
<td>&lt;30</td>
<td>0%</td>
</tr>
</tbody>
</table>

Female Representation Across LHS and S&P 500 2008-2021

<table>
<thead>
<tr>
<th>Year</th>
<th>LHS Female</th>
<th>S&amp;P 500 Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>16%</td>
<td>27%</td>
</tr>
<tr>
<td>2013</td>
<td>18%</td>
<td>28%</td>
</tr>
<tr>
<td>2015</td>
<td>20%</td>
<td>27%</td>
</tr>
<tr>
<td>2017</td>
<td>22%</td>
<td>28%</td>
</tr>
<tr>
<td>2018</td>
<td>24%</td>
<td>27%</td>
</tr>
<tr>
<td>2019</td>
<td>24%</td>
<td>28%</td>
</tr>
<tr>
<td>2020</td>
<td>26%</td>
<td>28%</td>
</tr>
<tr>
<td>2021</td>
<td>27%</td>
<td>27%</td>
</tr>
</tbody>
</table>
Recruitment Challenges
Slow Evolution
Succession planning is a fundamental structure to board sustainability. Yet as LHS boards look to improve racial, ethnic, and gender representation and include candidates with new competencies they are reaching an impasse—they have yet to build a robust pipeline of candidates to fill board seats. Furthermore, boards and nominating committees identified several challenges impeding the development of a successful pipeline and ultimately board diversity goals.

Top challenges to recruitment include:

1. **External Factors:** As board diversity efforts gain traction across the industry, board chairs are concerned that highly-qualified minority candidates will have many organizations vying for their participation and are unsure of whether they will be able to secure the right talent in an increasingly competitive recruitment environment.

2. **Outdated Policies and Procedures:** Outdated policies and procedures (e.g., extended terms, no age limits) restrict seat availability, as well as participation accessibility. Organizations are starting to make progress here and this is discussed in further detail in the next section.

3. **Ambitious Diversity Goals, Wide-ranging Definitions:** Boards are aiming to diversify wide-ranging demographic parameters and technical competencies simultaneously. But with limited board seats, it will be nearly impossible to meet such ambitious goals without better defining their diversity objectives.

4. **Legacy Practices:** Most boards are still relying on their own peer networks to identify new candidates. Confining recruitment efforts to internal circles limits reach to a larger pool of candidates both inside and outside their service region.

The remainder of this section provides additional details on challenges 3 and 4, and how boards are addressing them.
Board Diversity Is Widely Defined but Lacks Prioritization of Goals

Improving board diversity is a universal priority among CEOs and board chairs: 83% of boards have a strategy to increase board diversity. Boards are also committed to educating themselves on diversity issues: 89% of boards have an education strategy on diversity & inclusion. Yet there remains a stark disconnect between boards’ diversity goals and their ability to operationalize and implement strategy.

Boards are defining diversity in the widest possible sense without a clear prioritization plan—complicating their recruitment process. Boards are looking to diversify their board composition on demographic metrics including race/ethnicity, gender, age, socioeconomic status, and location, as well as professional expertise. Underpinning each of these metrics is a desire for greater thought diversity on the board with a specific emphasis on recruiting for new technical competencies such as expertise in M&A, digital technology, consumer experience, health equity, and more. Despite extensive diversity “wish lists”, boards may only be filling one or two seats at a time, increasing pressure to find candidates who meet multiple metrics of diversity in order to make progress.

Operationalizing Board Diversity Goals Can Improve Recruitment Efforts

To modernize the board, health system leaders, board chairs, and nominating committees should focus on refining their diversity recruitment strategy, including:

- Clearly defining diversity intentions and goals to better understand target candidates for future board service
- Prioritizing among the many skillsets, expertise, and demographics that may be missing from the boardroom
- Developing specific metrics and timelines for diversity goals
- Using a competency matrix during recruitment efforts

83% have a recruitment strategy to increase board diversity
89% have a board education strategy on diversity & inclusion
Traditional Practices Slow Recruitment Efforts

Traditional Recruitment Methods Hinder Progress

One of the longest standing recruitment methods for new board members (both at LHS and other boards) is tapping the personal networks of current board members. While personal networks may seem like a good place to start, solely relying on peer referrals limits candidate pools and often stunts efforts to diversify boards. Executives with diverse backgrounds may not be part of the well-established networks feeding the board’s pipeline of new directors, unless board members have already committed to diversifying their peer networks.

Boards See Value in Casting a Wider Geographic Net

One way health systems are changing this is by searching for candidates outside of their immediate service areas. In 2021, 9% of LHS boards included members from across the U.S., a 3% increase from 2019.1

The search for regional and national executives represents a departure from traditional practices. Boards are recognizing the value in bringing on new members that can provide wider viewpoints and fill gaps in strategic expertise irrespective of location.

Boards are also looking to revamp succession planning and have a “bench” of candidates assembled for when the time is right to onboard new members. Board chairs generally agree that they don’t want to invite new members into board service when a seat becomes available without developing relationships with them beforehand. As boards look nationally for new candidates, leaders will need to engage with potential candidates frequently to build the succession pipeline.

Moving Beyond Personal Networks for New Member Recruitment

Health system leaders, board chairs, and nominating committees should focus on new ways to identify the right potential candidates, such as:

- Leveraging search firms to identify individuals who may fill board needs (e.g., new competencies, DEI goals)
- Expanding searches beyond immediate geographic region
- Building mentoring relationships with younger candidates of diverse backgrounds
- Consulting community partners for recommendations on highly-qualified candidates

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1 Academy Proprietary Database 2015-2021
Modernizing Board Structures
Modernizing Board Governance Is Key to Evolution

As health systems strive to unveil a next-generation board, they are evaluating whether their existing governance model enables or impedes their future goals. Many LHS determined that overhauling their governance framework is necessary to unlock greater efficiency and support future evolution.

In some cases, boards are finding that historical contracts or outdated bylaws restrict forward progress, for instance by limiting the number of seats available for new members. In other cases, boards are restructuring which authorities and decision-making powers live locally (e.g., on a regional or hospital board) and which are reserved for the system’s corporate board. Some health systems have updated these arrangements to reserve strategic and fiduciary responsibilities at the system level and award “advisory” status at the local level. Underpinning these changes is the goal of ensuring that board members at all levels are matched to appropriate levels of authority and accountability.

LHS can update their governance model in a variety of ways, including modernizing board policies and procedures to keep board composition fresh; adopting inclusive practices during onboarding and beyond; utilizing multiple communication channels that make board participation more accessible; providing ongoing board education; and ensuring evaluations recognize high-performing board members. The remainder of this section outlines how LHS are approaching their modernization.

Structures to Evolve LHS Board Governance

- **Governance Policies & Procedures**
  (e.g., board size, term limits, age limits)

- **Onboarding & Inclusion**
  (e.g., mentorship, committee placement)

- **Board Communication & Education**
  (e.g., meeting and information sharing practices)

- **Performance Evaluations**
  (e.g., CEO and board member evaluations)
Board Sizes and Prior Commitments Restrict Recruitment Goals

**Most Boards Report No Plans to Add New Board Seats**

LHS board sizes range from 11 to 25 directors with an average of 18 directors on their corporate boards, representing no change in board size from 2019.¹ This is nearly twice the size of S&P 500 boards.⁴

The majority (88%) of health systems report no plans to change their number of board seats over the next 1-3 years. The remaining 12% plan to increase board size by one or two seats.

**Reserved Board Seats Restrict Recruitment Efforts**

Several health systems shared that they are bound by legacy contracts that designate a certain number of seats for ex-officio members, community or faith leaders, and other representatives from previously acquired hospitals or health systems. Throughout prior M&A activity across non-profit health systems, board seats have historically served as a currency by which participating entities exert their continued influence.

As health systems seek to bolster their strategic expertise, prior commitments that reserve board seats pose an ongoing recruitment challenge. Without adding new board seats, boards will need to rely on other turnover mechanisms (e.g., mandatory age limits, term limits, planned retirement from board service) to refresh their board composition.

“We have some historical structural issues that make it difficult for us to meet DEI metrics. About half of our board is ex officio. We don’t have control over people in those seats. It gives us a limited set to meet all our diversity expertise.” – Chief Legal Officer

¹ Academy Proprietary Database 2015-2021
³ 2020 United States Spencer Stuart Index
Updating Policies Can Open Seats for New Board Members

Term Limits: Most LHS boards allow members to serve 3-year terms with eligibility for 4-5 consecutive terms, effectively allowing the opportunity for 12-15 years of service. Ultimately, these practices stack the board with long-tenured members. Applying more stringent term limits would allow boards to frequently refresh their board composition, ensuring their member pool is continually evolving to meet their strategic needs.

Age Limits: Nearly half (41%) of LHS boards have defined age limits (ranging 70-76 years), representing a significant 30% increase from 2019 when just 10% of LHS reported a mandatory age limit for their board.1 This improvement is still a stark contrast to S&P 500 boards – 70% of which have a mandatory age limit.3

Adopting mandatory age limits offers another opportunity for boards to open the door for younger board members. While board composition has historically skewed older, health systems are starting to see the value in onboarding younger members with fresh ideas and perspectives and are increasingly using mandatory retirement ages as a lever to open new seats.

Compensation: Only 33% of LHS report compensating board members. Offering some form of compensation increases the attractiveness of board service and broadens the type of candidates willing and able to serve. Compensation may prove a particularly valuable tool to recruit new members as competition for highly-qualified candidates intensifies.

1 Academy Proprietary Database 2015-2021
2 2020 United States Spencer Stuart Index
Integrating Inclusion into Operations Key to Reaping Diversity Benefits

Inclusion Starts with Onboarding

As boards diversify, a test of their success will be how quickly new members are onboarded and empowered to be productive members of the board. Following the momentum on diversity, board chairs are actively thinking about how to promote inclusion and a sense of belonging as they train new members. Inclusion requires being mindful of new board members’ experiences to ensure they feel fully comfortable participating in board dialogues and activities.

Methods to foster inclusion and accountability include:

- Informal mentorship – pair new members with seasoned board members
- Committee assignments – place new members on high visibility committees (e.g., compensation, finance) which in turn provides fresh perspectives and affords new board members the opportunity for immediate exposure

Inclusion Also Requires Accessibility

Beyond onboarding, health systems have an opportunity to reinforce inclusive practices in the ways they convene and share information. As boards aim to recruit younger members, members who may not live in the immediate service area, and other non-retired executives, they may consider structuring board meetings and information sharing with an eye toward accessibility. Examples of accessible board practices include:

- Virtual convening
- Shorter board meetings
- Weekend retreats
- On-demand educational services

LHS explored these practices out of necessity during the pandemic and normalized new convening and information sharing practices. Boards should consider retaining these to make participation and ongoing education more accessible for new and non-local members.

Boards Can Retain Communication Norms Driven by COVID-19

Almost half (44%) of LHS boards use a hybrid meeting format, with a combination of virtual and in-person meetings throughout the year. Many board chairs confirmed this was a pandemic-related change and they plan to resume in-person meetings. Several reiterated the benefits of meeting in person: establishing rapport among the group and connecting over “hallway” conversations that don’t occur naturally through virtual platforms.

However, some continuation of virtual meetings may improve boards’ ability to include new members for whom regular in-person meetings would prohibit participation (e.g., non-local executives, younger working executives with family obligations).

### Board Meeting Formats

<table>
<thead>
<tr>
<th></th>
<th>% of LHS</th>
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<tbody>
<tr>
<td>Virtual</td>
<td>22%</td>
</tr>
<tr>
<td>Hybrid</td>
<td>44%</td>
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<tr>
<td>In-person</td>
<td>33%</td>
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Modernizing Board Structures

Integrating Inclusion into Operations Key to Reaping Diversity Benefits
Boards Use Multiple Platforms to Educate Members

Similarly, boards have multiple avenues to deliver educational services and are not confined to providing educational opportunities during regular meetings. Over half (55%) of LHS boards conduct educational services during meetings and separately as well.

Several board chairs stated that the COVID-19 pandemic has changed the way they share information - board members are communicating more frequently outside of board meetings through email, conference, and video calls to stay abreast of health system priorities.

Examples of Board Educational Opportunities

- Health system financial updates
- Health disparities and health equity guest lectures
- Community needs assessment report-outs by regional and hospital boards
- Hospital investments and community initiatives briefs by executive leadership
- Diversity, equity, and inclusion seminars

Boards Continue to Shorten Meeting Length

Boards meet 5 times per year on average (not including an annual retreat). A quarterly meeting cadence is most common (56%), followed by bi-monthly (39%), and monthly (6%). Board meetings typically last 2-4 hours (56%). Abbreviating board meeting times is a trend that has stayed consistent over the last few years. The proportion of board meetings over four hours fell from 62% in 2017 to 43% in 2019 and 39% in 2021, while 2-4 hour board meetings have increased from 25% to 56% in the same time frame.¹

“One of our board members asked, ‘Can you explain inclusion to me? I don’t know what that is.’

I gave an analogy about inviting people to the table and making their voices heard. From that point on, the board got it. A lot of people want to figure this out, they just don’t know where to begin.”

- Chief Executive Officer

¹ Academy Proprietary Database 2015-2021
Committees Can Enable Priorities and Inclusion

LHS boards have an average of seven committees on their corporate board, representing no change from 2019. Most boards (82%) report no plans to change the number of board committees over the next 1-3 years. The remaining 18% of boards plan to increase their number of board committees.

Board committees are vital to board strategy as they reflect the key functions and priorities of the board. Committee assignments offer development and exposure opportunities to board members. As LHS evolve they may consider:

1. **Creating new committees reflective of evolving strategic priorities**

   Diversity, equity, and inclusion are clear priorities across LHS but only 11% of boards have a committee dedicated to DEI strategy and initiatives. As health systems clarify their long-term strategy, boards may consider adding new committees focused on new priorities.

2. **Shuffling committee assignments among members**

   Since most boards report no plans to change the number of committees, they can be intentional about regularly shuffling committee placements to include new board members with fresh perspectives. In some cases, this means assigning new members to traditionally high-profile committees (e.g., finance, governance, executive) without requiring a period of extensive board service.

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1. Academy Proprietary Database 2015-2021

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Committee Structures Across LHS

- Audit
- Compensation
- Governance & Nominating
- Finance
- Compliance
- Executive
- Investments
- Patient Care, Quality & Safety
- System Strategy & Planning
- Board Education & Development
- Diversity, Equity, and Inclusion

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Note: Multiple board committee functions may be represented on the same committee:
- 44% have combined Audit & Compliance Committee
- 6% have combined Audit & Compensation Committee
- 6% have combined Audit & Finance Committee
- 1% have combined Finance & Investments Committee
Outsourcing Performance Evaluations Ensures Continued Progress

**CEO & Board Performance Appraisals**

Performance evaluations are a critical opportunity to affirm whether management and governance leaders are consistently meeting expectations to help health systems deliver on strategic goals.

All boards have formal evaluation processes for their CEO, and 94% have a formal evaluation process for their board members. Traditionally, evaluations are conducted through internal surveys.

Notably boards conducting member evaluations externally increased from 26% to 40% from 2019 to 2021.¹ Nearly all CEO evaluations remain internal.

**External Evaluations Bring Objectivity**

Boards already recognize the value in bringing outside expertise to serve on their board and increasingly show willingness to consult external experts in their evaluation processes as well.

External evaluations may serve as an objective method to assess performance and determine whether boards are making progress on stated goals. This shift reflects a positive step to promote accountability and ensure boards avoid stagnation.

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¹ Academy Proprietary Database 2015-2021

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**CEO Evaluations**

- Conducted internally: 94%
- Conducted externally: 6%

**Board Member Evaluations**

- Conducted externally: 40%
- Conducted internally: 60%
Methodology
# Health System Governance Benchmarks

## Structure & Composition

<table>
<thead>
<tr>
<th></th>
<th>LHS 2019¹</th>
<th>LHS 2021¹</th>
<th>S&amp;P 500 2020³</th>
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</thead>
<tbody>
<tr>
<td>Average Corporate Board Size</td>
<td>18</td>
<td>18</td>
<td>10.7</td>
</tr>
<tr>
<td>Max Board Size</td>
<td>28</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Standing Committees</td>
<td>7</td>
<td>7</td>
<td>4.2</td>
</tr>
<tr>
<td>% of Boards with Defined Board Member Term Limits</td>
<td>80%</td>
<td>83%</td>
<td>6%</td>
</tr>
<tr>
<td>Average Board Member Term Length</td>
<td>3 years</td>
<td>3 years</td>
<td>1 year</td>
</tr>
<tr>
<td>Average Number of Board Meetings (per year)</td>
<td>6</td>
<td>5</td>
<td>7.9</td>
</tr>
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## Evaluation & Compensation

<table>
<thead>
<tr>
<th></th>
<th>LHS 2019¹</th>
<th>LHS 2021¹</th>
<th>S&amp;P 500 2020³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Annual Board Assessment</td>
<td>100%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Conduct Annual CEO Assessment</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Provide Compensation to Board Members</td>
<td>43%</td>
<td>33%</td>
<td>100%</td>
</tr>
<tr>
<td>Utilize External Resource for Board Evaluations</td>
<td>26%</td>
<td>35%</td>
<td>21%</td>
</tr>
</tbody>
</table>

## Recruitment & Succession Planning

<table>
<thead>
<tr>
<th></th>
<th>LHS 2019¹</th>
<th>LHS 2021¹</th>
<th>S&amp;P 500 2020³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity of Board Members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Minority Board Members</td>
<td>20%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>% Female Board Members</td>
<td>27%</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>% Female Board Chair</td>
<td>19%</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td>% of Board Members &lt;50 years old</td>
<td>9%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Boards with Mandatory Retirement Age</td>
<td>10%</td>
<td>41%</td>
<td>70%</td>
</tr>
</tbody>
</table>

## Continuing Education & Retreats

<table>
<thead>
<tr>
<th></th>
<th>LHS 2019¹</th>
<th>LHS 2021¹</th>
<th>S&amp;P 500 2020³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Board Retreat</td>
<td>1.5 days</td>
<td>1.5 days</td>
<td>-</td>
</tr>
<tr>
<td>Frequency of Board Retreat</td>
<td>Annual</td>
<td>Annual</td>
<td>-</td>
</tr>
<tr>
<td>Board Education &amp; Development Committee</td>
<td>5%</td>
<td>17%</td>
<td>0%</td>
</tr>
</tbody>
</table>

¹ Academy Proprietary Database 2015-2021
³ 2020 United States Spencer Stuart Index
Methodology

In May and June 2021, The Academy gathered qualitative and quantitative insights from executives across the LHS market on governance priorities and practices. This report integrates findings from Academy research conducted between 2015 and 2021 in order to assess the evolution of governance trends over time, using S&P 500 data as benchmarks where relevant. The study respondents represented 25 unique health systems across a range of executive roles including: Chief Executive Officer, Board Chair, General Counsel/Chief Legal Executive, Regional Chief Executive Officer, Hospital President, Director of Corporate Governance, Board Liaison, and Executive Assistant/Governance Secretary. The 25 health systems have an average Total Operating Revenue (TOR) of $6.3 billion and own or operate 432 hospitals.

This sample is representative of the largest 150 health systems in the U.S. The largest 150 health systems were classified as those with the highest TOR, as validated by 2019 health system financial statements and The Academy’s 2021 proprietary database.

Academy Project Team

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- Anne Herleth, Senior Director, Research & Advisory
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The Academy brings together Leading Health System (LHS) and industry executives to collectively address healthcare’s biggest challenges and opportunities.

**Leading Health Systems by the Numbers**

- 150 Health Systems
- 500+ C-suite Executives
- 1,600+ Health System Leaders

**How We Serve Members**

- **Convene exceptional peer groups** that facilitate meaningful relationships and knowledge exchange
- **Create world-class leadership development** designed to prepare next generation healthcare leaders
- **Produce original research** leveraging member insights on healthcare’s greatest challenges and opportunities
- **Deliver custom insights and actionable intel** supporting new partnership growth between industry and health systems
- **Facilitate high-impact partnership arrangements** between health systems and industry

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>Outpatient Admissions</th>
<th>Total Physicians</th>
<th>Total Operating Revenue (TOR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>77%</td>
<td>75%</td>
<td>77%</td>
</tr>
</tbody>
</table>
About WittKieffer

WittKieffer is a global executive search firm with 50 years of experience serving organizations dedicated to improving the quality of life. We are industry experts skilled at creating tailored solutions that suit each of our clients, and our depth of experience includes work with both market leaders and market disruptors. Our team features professionals with experience in the sectors we serve, further enhancing our alignment with clients’ missions and goals and our ability to recruit leaders with the best mix of skills, experience, vision and character. We also have a presence in major markets around the world, allowing us to draw on a global pool of candidates and to serve clients wherever their talent needs may be. We are ranked among the Forbes top recruiting firms and Hunt Scanlon’s list of the Top 10 executive recruiters in the U.S.

For more information, please visit https://www.wittkieffer.com

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