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Chief Executive Employment Contracts and Performance Evaluations: Current Practices

Division of Member Services, Research
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Introduction

ACHE has long held the position that employment contracts for hospital leaders benefit both healthcare organizations and the leaders who hold them ("Terms of Employment," 2013; American College of Healthcare Executives [ACHE], 2010). Pairing employment contracts with regular performance reviews using well-defined criteria helps ensure that organization objectives are met while being fair to all individuals involved ("Evaluating the performance," 2013; ACHE, 2010).

Employment contracts benefit healthcare organizations in a number of ways. First, they provide protections that allow CEOs to act to ensure the success of the hospital even when those decisions may be uncomfortable or controversial. Particularly in the current uncertain healthcare environment, CEOs must be able to confront politically sensitive issues, take calculated risks and institute disruptive change in their hospitals for the good of patients and the other stakeholders they serve.

Second, employment contracts clearly set out the employment relationship between the CEO and board or system and form the basis of future performance reviews. These contracts can also provide for an orderly transition in the event that the CEO leaves the organization. Succession planning and setting the stage for a smooth transition to new hospital leadership is as or more important than it has ever been. Estimated hospital CEO turnover has remained at 18 percent over the past three years; among the highest rates calculated over the last two decades. Employment contracts have two other important benefits: they demonstrate the organization's commitment to fair treatment of the CEO and signal to all stakeholders that the CEO has the backing of the system or governing body. By their nature, these contracts can help attract and retain competent leaders (ACHE, 2010).

Employment contracts also benefit hospital CEOs. In particular, they: (1) provide some financial stability in the event of termination and can check hasty action by the board or system management in the event of a short-term controversy or conflicting expectations, (2) formalize the relationship between the CEO and the organization and clarify major responsibilities and accountabilities, (3) underscore the CEO's role of chief strategist empowered to make difficult decisions and take calculated risks as needed and (4) set out the parameters for setting objectives and priorities and the evaluation process (ACHE, 2010).

For hospitals and their top executives to be successful, CEOs and the boards or executives to whom they report must have a common and clearly understood set of expectations about CEO responsibilities and how CEO performance will be evaluated. Such expectations may be specified in the employment contract, a formal job description, a statement of performance expectations, criteria for receiving incentive payments or other documents. Consistent communication between CEOs and those to whom they report about the extent to which the CEO is meeting those expectations, including regular performance reviews, helps ensure alignment between CEO actions and organizational objectives and avoids misunderstandings that can have serious consequences for both the executives and the organizations.

This white paper was written by Leslie A. Athey, director, Research, American College of Healthcare Executives.

In January 2017, ACHE conducted a survey of hospital CEOs to better understand the prevalence of CEO employment contracts and the terms of those contracts. The survey also investigated how often and with whom performance reviews occurred, and criteria for setting both salary and incentive compensation. This study built on the work of similar studies conducted by ACHE in the past (ACHE, 1995; 2007; 2008; 2012). In 2017, of the 1,832 CEOs of community hospitals who received the survey, 663 responded resulted in an overall response rate of 36 percent.

All CEOs included in the survey were ACHE members. CEOs of hospitals that were part of multihospital systems, larger hospitals and those in metropolitan areas were less likely to respond to the survey. CEOs of investor-owned hospitals were less likely to respond to the survey than average, while CEOs of state and local government hospitals were more likely to respond.

Findings of the survey are included in the following section. Results are presented separately for leaders of hospitals that are part of multihospital health systems ("**MHS hospitals**") and independent hospitals or those that were the only hospital in a health system ("**single hospitals**"). The numbers of CEOs responding to the survey in these two categories were 373 for MHS hospitals and 290 for single hospitals.

To provide relevant information for CEOs in different types of organizations, the data also were analyzed based on hospital size classified in three categories: **small** (less than 50 beds), **medium-sized** (from 50 to 149 beds), and **large** (150 or more beds). These designations of "small," "medium" and "large" are for the purposes of this study only. Further, differences among three ownership types: investor-owned, not-for-profit and state or local government hospitals, also were examined. Because the bulk of the investor-owned hospitals in the survey were MHS hospitals, comparisons involving this particular type of ownership were made for MHS hospitals only. Where survey results differed by size or ownership type, those differences are noted in the text.

Findings

The Hospital CEO Role

As healthcare systems are evolving, so is the role of the CEO. To better understand the responsibilities that might be reflected in their employment contracts, study respondents were asked about what other responsibilities they held in addition to overseeing the hospital about which they were being surveyed. The results are shown in Figure 1. About half, 53 percent, of hospital CEOs answering the survey held multiple leadership responsibilities. Leaders of MHS hospitals were more likely to hold additional responsibilities than leaders of single hospitals (59 percent versus 44 percent).

One-quarter of CEOs of MHS hospitals in the study reported that they also served as CEO of at least one other hospital. Eleven percent said that they held both the roles of hospital and health system CEO. Roughly 10 percent of MHS hospital CEOs in the study reported having the additional responsibility of serving as regional or market executives, 9 percent oversaw other healthcare facilities (e.g., nursing homes), 9 percent led service lines, and 8 percent held other executive positions in the health system.

Almost one-quarter, 22 percent, of CEOs of single hospitals reported that they also led other healthcare facilities. Sixteen percent reported that they held the roles of both hospital and health system CEO.

Figure 1. Percent of hospital CEOs holding additional responsibilities, by hospital type

	CEOs of:		
Additional responsibilities held by hospital CEOs in the study	All hospitals	MHS hospitals	Single hospitals
CEO of one or more other hospitals	17%	25%	6%
CEO of other healthcare facilities	14	9	22
CEO of health system	13	11	16
CEO of service line	7	9	5
Regional or market executive	7	10	2
Other system executive	5	8	2
No additional responsibilities	47	41	56
(Number of responses)	(653)	(368)	(285)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Hospital size. Perhaps not surprisingly, the larger the MHS hospital, the more likely it was that the hospital CEO oversaw more than one hospital. Almost one-third, 31 percent, of CEOs of large MHS hospitals reported that they served as CEO of more than one hospital, as opposed to 24 percent of those leading medium-sized MHS hospitals and 13 percent of those leading small MHS hospitals. CEOs of larger MHS hospitals were also more likely to hold the role of health system CEO. One-fifth, 20 percent, of CEOs overseeing the largest-sized MHS hospitals reported that they also served as health system CEOs, as opposed to 4 percent of CEOs heading smaller MHS hospitals.

The case was similar among single hospital CEOs. The larger the single hospital, the more likely the hospital CEO was to report that he or she also oversaw other healthcare facilities. Thirty percent of CEOs overseeing large single hospitals reported that they also led other facilities, as opposed to 24 percent of those heading medium-sized single hospitals and 15 percent heading small single hospitals. CEOs of larger single hospitals were more likely to also have the role of CEO of the health system. A little more than one-third, 38 percent, of CEOs overseeing large single hospitals reported that they also served as health system CEOs, as opposed to 16 percent of those heading medium-sized single hospitals and 5 percent heading small single hospitals. (Data not shown.)

Prevalence of Employment Contracts and Their Benefits

The prevalence of CEO employment contracts has changed little since ACHE performed a similar study on this topic in 2012. Overall, in 2017, 56 percent of CEOs in the survey reported they had an executive employment contract with their organizations. Contracts were more common among CEOs of single hospitals (77 percent) than among CEOs of multi-hospital system hospitals (39 percent).

Executive employment contracts clearly conferred some employment benefits. Those with contracts were more likely to have a formal severance agreement with their organization (91 percent) than those without a contract (48 percent). Further, those with contracts were more likely to have voluntary termination clauses as part of their severance agreements. Such clauses allow CEOs to voluntarily terminate their employment for good reason and still receive their severance pay. About a third, 33 percent, of CEOs with executive employment contracts reported having such a voluntary termination clause, as opposed to 16 percent of those without a contract.

Hospital ownership. CEOs of investor-owned hospitals were less likely than leaders of not-for-profit or state and local government hospitals to have employment contracts. The bulk of investor-owned hospitals in the study were MHS hospitals. Among them, 15 percent of CEOs of investor-owned MHS hospitals reported having an employment contract, as opposed to 44 percent of CEOs of not-for-profit MHS hospitals and 50 percent of CEOs of state and local government MHS hospitals.

Durations of Employment Contracts

Survey respondents holding employment contracts were asked about the durations of their initial employment contracts. The results are shown in Figure 2. There is little difference between the responses from CEOs of MHS hospitals and single hospitals. The most common duration for initial employment contracts was three years, reported by 40 percent of CEOs in the survey. The next most commonly reported duration was one year (22 percent), followed by five years (15 percent), then two years (12 percent). Eight percent of CEOs reported an initial contract duration of greater than five years.

Figure 2. Reported durations of initial employment contracts, by hospital type

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Three years	40%	36%	43%
One year	22	28	19
Five years	15	11	18
Two years	12	9	13
More than five years	8	13	5
Four years	2	3	2
(Number of responses)	(364)	(143)	(221)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Sixty-eight percent of CEOs of MHS hospitals and 57 percent of CEOs of single hospitals with employment contracts reported that their contracts included an evergreen provision. The evergreen provision automatically renewed or extended the CEO's contract for a specific time period, assuming that neither the CEO nor board gave notice of intent not to do so. Durations of the contract extension periods under the terms of the evergreen provisions reported by survey respondents are shown in Figure 3. The results are essentially the same for CEOs of both MHS and single hospitals. Most, about 59 percent, of all CEOs in the survey with evergreen provisions in their contracts reported an extension period duration of one year. The next most commonly reported extension period duration was three years (15 percent), followed by more than three years (9 percent) and two years (8 percent). Seven percent of CEOs reported that following the initial contract period, their contract was renewed indefinitely until terminated.

Figure 3. Reported durations of employment contract extension periods under evergreen provisions, by hospital type

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
One year	59%	59%	60%
Three years	15	13	17
More than three years	9	12	7
Two years	8	4	10
Until terminated	7	9	6
Other	1	2	1
(Number of responses)	(223)	(97)	(126)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Prevalence of Severance Agreements

Almost three-quarters, 72 percent, of CEOs in the survey reported that they had a formal severance policy or agreement related to their position. The proportion of those with severance agreements was somewhat higher among CEOs of single hospitals (76 percent) than among CEOs heading MHS hospitals (69 percent). As noted above, the prevalence of severance agreements was greater among CEOs holding an executive employment contract.

Hospital ownership. CEOs of investor-owned MHS hospitals were the least likely to report having formal severance agreements with their organizations than CEOs of other types of MHS hospitals. A little less than half, 44 percent, of CEOs of investor-owned MHS hospitals reported having formal severance agreements related to their positions. This figure was 68 percent among CEOs of state or local government MHS hospitals and 75 percent among CEOs of not-for-profit MHS hospitals. (Data not shown.)

Terms of Severance Agreements

CEOs with formal severance agreements related to their positions were asked about the number of months of severance pay they would receive in the event of involuntary termination without cause. The results are shown in Figure 4. The most commonly reported duration for receiving severance upon involuntary termination without cause was one year, reported by 42 percent of CEOs in the study. CEOs of single hospitals were somewhat less likely than their counterparts in MHS hospitals to receive a full year of severance; 34 percent of single hospital CEOs reported that their severance agreement provided one year of severance while this figure was 48 percent among CEOs of MHS hospitals. The proportion of CEOs of single hospitals who reported receiving only six months of severance (27 percent) was higher than the proportion among CEOs of MHS hospitals (11 percent). The “other” category in the table in Figure 4 included a number of different arrangements including different

durations of severance pay ranging up to 36 months, receiving severance for the balance of the contract, and provisions taking into account potential change of hospital control.

Figure 4. Months of severance that would be received upon involuntary termination without cause, by hospital type

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
12 months	42%	48%	34%
6 months	18	11	27
18 months	15	16	14
24 months	13	15	12
Depends on length of service	3	5	1
3 months	3	2	4
Other	6	4	8
(Number of responses)	(460)	(244)	(216)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Almost all respondents, 83 percent of CEOs in MHS hospitals and 91 percent of CEOs in single hospitals, reported that their severance pay was based on their salary only. No CEOs in the survey reported that their severance was based solely on their incentive, but 17 percent of MHS hospital CEOs and 8 percent of single hospital CEOs reported that their severance would be based on a combination of salary and incentive pay.

Among those with formal severance agreements with their organizations, there was little difference between the types of benefits provided to CEOs of MHS hospitals and leaders of single hospitals during the severance period for involuntary termination without cause. Figure 5 shows the prevalence of each type of severance benefit, by hospital type. About two-thirds, 63 percent, of CEOs in the survey reported they would receive health benefits during the severance period, followed by life insurance (37 percent) and disability insurance (29 percent). Only 2 percent of respondents mentioned another type of benefit not listed in the survey questionnaire. These other types were varied, but included such items as a car allowance and being compensated for unused leave pay. Roughly one-third (35 percent) of CEOs reported that no benefits would be provided during their severance periods.

Figure 5. Percent of CEOs receiving each type of benefit during their severance period for involuntary termination without cause, by hospital type.

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Health insurance	63%	63%	62%
Life insurance	37	37	36
Disability insurance	29	28	29
Other benefits, not listed	2	1	2
No benefits provided	35	35	36
(Number of responses)	(449)	(235)	(214)

Figure 6 shows how often, and to what extent, severance pay would be continued if the CEO obtained a new position before the end of the severance period. A little more than half of CEOs in the study, 57 percent, said they would receive their full severance after taking on a new position. This arrangement was a little more common among CEOs of single hospitals (62 percent) than among CEOs of MHS hospitals (52 percent). Roughly one-fifth of respondents leading either type of hospital said they would lose their severance when they took a new position. Some CEOs reported an arrangement that fell between these two extremes: eighteen percent of CEOs of MHS hospitals and 12 percent of single hospital CEOs said they would receive only the difference between their old and new earnings if they took a new position before their severance period was complete.

Figure 6. Percent of CEOs receiving some or all of their severance after obtaining a new position, by hospital type.

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Severance continues in full	57%	52%	62%
Severance does not continue	22	21	22
Severance continues, but only the difference between old and new earnings would be paid	15	18	12
Severance continues, but is only guaranteed for part of the severance period	6	8	4
(Number of responses)	(456)	(241)	(215)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Survey respondents were asked whether their severance agreement included a provision for "voluntary termination for good reason." Such a provision would allow CEOs to voluntarily terminate their employment for good reason, but still receive their severance. "Good reason" included a material change in pay or responsibilities, required relocation, change in reporting relationships and similar things. A little more than a quarter, 28 percent, of CEOs responding to the survey said that such a provision was included in their severance agreements. There was little difference between MHS and single hospitals; the proportion of CEOs leading MHS hospitals who reported having a "voluntary termination for good reason" clause in their severance agreements was 25 percent; among CEOs of single hospitals this figure was 31 percent. As noted above, those with employment contracts were more likely to have this ability to receive their severance after voluntarily terminating their employment for good reason.

Hospital size. The likelihood with which CEOs of single hospitals reported having a "voluntary termination for good reason" clause in their severance agreements varied with hospital size. The larger the hospital, the more likely the CEO was to have such a voluntary termination clause in his or her agreement. Roughly half, 52 percent, of CEOs of large single hospitals reported having a voluntary termination clause in their contracts, as opposed to 39 percent of CEOs in medium-sized single hospitals and 14 percent of CEOs of small single hospitals.

Performance Evaluation

ACHE recommends regular and frequent communication about performance and expectations between CEOs and those to whom they report (ACHE, 2010). Survey respondents were asked how often they received an overall performance evaluation, which was defined as an evaluation of performance separate from any determination of incentive payments. The results are shown in Figure 7. Almost all CEOs in the study, 91 percent, reported receiving an annual overall performance review. Other arrangements were infrequently reported.

Figure 7. Frequency of CEO performance reviews as reported by survey respondents, by hospital type.

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Once per year	91%	92%	89%
Less often than every two years	3	1	5
More than once per year	2	3	1
Once every two years	2	2	3
Never	2	1	3
(Number of responses)	(646)	(358)	(288)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Figure 8 shows how often CEOs reported that different members of the organization participated in their overall performance evaluations. CEOs of MHS hospitals were most likely to report being reviewed by system executives, while CEOs of single hospitals were more likely to be reviewed by all or some members of the hospital board. CEOs of both types of hospitals were almost equally likely to be reviewed by medical staff leadership or medical staff (reported by about 17 percent of respondents) and other members of their management teams (reported by about 15 percent of respondents).

Figure 8. Percent of CEOs reporting that the different organization members listed participated in their overall performance evaluations, by hospital type

	CEOs of:		
Organization member participating in overall performance review	All hospitals	MHS hospitals	Single hospitals
The full hospital board	50%	36%	67%
Some, but not all, ***hospital*** board members (e.g., Compensation Committee members, Executive Committee members)	23	20	28
Health system executives (including regional executives)	44	75	4
The full health system board	4	4	3
Some, but not all, ***health system*** board members (e.g., Compensation Committee members, Executive Committee members)	5	5	4
Others on the management team	15	15	14
Medical staff leadership or staff physicians	17	17	16
Community leaders	2	3	< 0.5
University officials (e.g., Provost)	< 0.5	1	0
Other, not listed	1	1	1
(Number of responses)	(626)	(350)	(276)

Relationship of Overall Performance Evaluation to Compensation

Survey respondents were asked how their overall performance evaluation related to determination of their compensation. The results are shown in Figure 9. Forty-three percent of CEOs heading all types of hospitals in the study reported that their overall performance evaluations determined their salary, and an almost equal proportion, 45 percent, reported that their overall performance evaluation determined their incentive pay. Almost one third, 30 percent, said their performance evaluation had no bearing on the amount of their salary or incentive payment.

Figure 9. Percent of CEOs reporting how overall performance evaluations determined the different components of their compensation, by hospital type

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Overall performance review determines salary	43%	43%	42%
Overall performance review determines size of incentive pay bonus	45	46	44
Compensation is not linked to overall performance evaluation results	30	28	32
(Number of responses)	(623)	(346)	(277)

Factors Considered in Overall Performance Evaluation

Survey respondents were asked which of a specific list of factors were considered in their overall performance reviews. The results are shown in Figure 10. Between 80 and 90 percent of CEOs reported that, during their overall performance evaluation, they were rated on leadership qualities, relations with physicians, employee satisfaction and/or engagement, financial performance, legal or regulatory compliance, clinical quality, patient satisfaction and/or engagement and patient safety. CEOs of single hospitals were more likely to have been evaluated on relationships with their boards (88 percent), promotion of the hospital to their community (86 percent) and service to the community (82 percent), than their counterparts in MHS hospitals (74 percent, 77 percent and 72 percent, respectively). CEOs of both MHS hospitals and single hospitals were about equally likely to be evaluated on their ability to develop business or increase their market share (on average 76 percent). Maintaining a culture of diversity and inclusion was named by roughly half of all CEOs in the study as a factor considered in their overall performance reviews.

Figure 10. Percent of CEOs reporting whether their overall performance evaluations considered each of the factors listed, by hospital type

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Leadership qualities such as communication, integrity, judgment	90% (619)	90% (345)	89% (274)
Physician relations, satisfaction and/or engagement	86 (613)	85 (340)	88 (273)
Employee satisfaction and/or engagement	86 (623)	86 (346)	85 (277)
Financial performance	85 (633)	86 (353)	85 (280)
Legal and regulatory compliance	84 (607)	82 (339)	87 (268)
Clinical quality	82 (632)	82 (352)	82 (280)
Patient satisfaction and/or engagement	82 (634)	83 (354)	81 (280)
Safety of care	81 (628)	81 (352)	80 (276)
Board relations	81 (610)	74 (337)	88 (273)
Promoting the hospital to the community	81 (609)	77 (337)	86 (272)
Serving the community, including activities to improve community or population health	77 (612)	72 (340)	82 (272)
Business development or market share growth	76 (614)	75 (344)	77 (270)
Culture of diversity and inclusion	50 (579)	53 (327)	46 (252)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Some respondents wrote in additional factors considered in their overall performance evaluations. The most common additional responses were: achievement of specific goals, completion of key initiatives or strategic plan objectives (mentioned by 39 respondents); exhibiting the culture or core values of the organization (mentioned by 9 respondents); ability to work well within the system and supporting system goals and objectives (mentioned by 7 respondents) and meeting personal or professional development goals (mentioned by 6 respondents).

Determination of incentive pay

Survey respondents were asked about the factors considered in the determination of their incentive pay. The results are shown in Figure 11. The different factors are presented in descending order of the frequency with which they were named by all CEO respondents. The most frequently reported factors, in descending order of frequency of mention, were financial performance (mentioned by 69 percent of CEOs overall), patient satisfaction and/or engagement (66 percent), clinical quality (65 percent), safety of care (58 percent), employee satisfaction and/or engagement (49 percent), business development or market share growth (41 percent) and physician relations, satisfaction and/or engagement (35 percent). CEOs of MHS hospitals and CEOs of single hospitals named the same top seven factors, and in the same order. However, the proportions of CEOs of MHS and single hospitals citing each factor were quite different. The proportion of MHS hospital CEOs saying that any of these seven most frequently reported factors were used in the determination of their incentive pay ranged from a high of 80 percent to a low of 40 percent. By contrast, among CEOs of single hospitals, the proportion saying that the seven most frequently reported factors were used in the determination of their incentive pay ranged from a high of 55 percent to a low of 29 percent. Less than 20 percent of CEOs of either type of hospital named any of the other factors listed in the questionnaire, beyond the seven most frequently chosen, as important in determining the amounts of their incentive payments.

Hospital size. The frequency with which specific factors were used to determine incentive pay varied somewhat with hospital size. The larger the hospital, the more likely it was that the CEO reported that clinical quality, safety of care, and patient satisfaction and/or engagement were considered in determining his or her incentive pay. This was true for CEOs of both MHS hospitals and single hospitals. Among MHS hospital leaders, those heading larger hospitals also were more likely to mention business development or market share growth as a factor considered in determining the amount of their incentive compensation. Among single hospitals, the larger the hospital, the more likely the CEO was to report that financial performance and physician relations were among the factors used to determine his or her incentive compensation. In addition, employee satisfaction and/or engagement was more likely to be considered in determining incentive pay of CEOs in large single hospitals than in small or medium-sized single hospitals. (Data not shown.)

Hospital ownership. Among MHS hospitals, CEOs of investor-owned hospitals were more likely than leaders of not-for-profit or state or local government hospitals to have the amount of their incentive dependent on business development or increase in market share (63 percent versus 43 percent for not-for-profit hospitals and 30 percent for state and local government hospitals), physician relations (65 percent versus 36 percent for not-for-profit hospitals and 27 percent for state and local government hospitals) and good performance regarding legal or regulatory compliance (29 percent as opposed to 11 percent for not-for-profit hospitals and 13 percent for state and local government hospitals). On the other hand, CEOs heading not-for-profit and state or local government hospitals more frequently had service to the community as a factor setting their incentive compensation (23 percent and 15 percent, respectively) than did leaders of investor-owned hospitals (5 percent). (Data not shown.)

Figure 11. Percent of CEOs reporting whether each of the factors listed were considered in the determination of their incentive pay, by hospital type.

	CEOs of:		
	All hospitals	MHS hospitals	Single hospitals
Financial performance	69% (633)	80% (353)	55% (280)
Patient satisfaction and/or engagement	66 (634)	80 (354)	49 (280)
Clinical quality	65 (632)	80 (352)	46 (280)
Safety of care	58 (628)	70 (352)	42 (276)
Employee satisfaction and/or engagement	49 (623)	58 (346)	38 (277)
Business development or market share growth	41 (614)	45 (344)	35 (270)
Physician relations, satisfaction and/or engagement	35 (613)	40 (340)	29 (273)
Serving the community, including activities to improve community or population health	18 (612)	19 (340)	18 (272)
Leadership qualities such as communication, integrity, judgment	15 (619)	15 (345)	14 (274)
Legal and regulatory compliance	14 (607)	15 (339)	14 (268)
Promoting the hospital to the community	12 (609)	10 (337)	15 (272)
Board relations	11 (610)	10 (337)	13 (273)
Culture of diversity and inclusion	8 (579)	10 (327)	6 (252)

Data are reported in descending order of frequency for all hospital types, not the order in which they appeared in the survey questionnaire

Some survey respondents wrote in additional factors considered in the setting of their incentive pay. The most frequently contributed responses were: achievement of specific goals, completion of key initiatives or strategic plan objectives (mentioned by 46 respondents); and ability to work well within the system and supporting system goals and objectives (mentioned by 21 respondents).

Perceived Fairness of Appraisal Process

CEOs responding to the survey were asked to score the extent to which they agreed with the statement: "I feel my current appraisal process is fair" on a scale of 1 to 5, where 1 was "strongly disagree" and 5 was "strongly agree." The results were very similar for CEOs of all types of hospitals and, in general, most CEOs felt their current process was fair. CEOs in the survey gave an average rating of 3.91, with approximately 10 percent strongly disagreeing or disagreeing with the statement, about 17 percent giving a neutral response and about 73 percent either agreeing or strongly agreeing with the statement.

Discussion

The main goal of this white paper was to provide information on the prevalence and descriptions of hospital CEO employment contracts and performance reviews as they currently exist in healthcare. Any CEO entering into a relationship with a new organization, or any who feel the need to revise the relationship with their current organization, should strongly consider negotiating an employment contract that spells out terms for a wide variety of situations, including termination, and do what is necessary to ensure clarity of the points on which his or her performance will be evaluated. Executive recruiters, lawyers or other third parties can be helpful in starting these potentially awkward conversations between potential leaders and the organizations looking to hire them (ACHE, 2010).

In Figure 12, we have included a suggestion of some key elements that should be included in a hospital CEO employment contract (ACHE, 2010). Ultimately, however, the contract needs to meet the needs of the parties involved and lead to a mutual understanding of the arrangements to which both parties have agreed. Among the many considerations in development of a contract include that conditions under which salary, benefits, incentive payments and reimbursements will be awarded under all circumstances should be clearly delineated. The contract should spell out the conditions for termination, either voluntary or involuntary. Especially with the reorganization of provider organizations into health systems, provisions for material changes in the CEO's role due to organizational changes should be considered in the contract. CEOs are advised to consult their own legal counsel before signing a contract (ACHE, 2010). Additional considerations regarding both executive contracts and performance reviews can be found in the References and Additional Resources section at the end of this white paper.

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Figure 12. Some Key Elements of a CEO Employment Contract

ACHE does not specify exact benefits that might be negotiated between the CEO and board or organization, but we do suggest that the following key items be raised in negotiating a contract and added to the contract as agreed.

1. **The role of the CEO.** The contract should include a description of the duties of the CEO in very general terms. It is unwise to list specific duties, as the CEO should be involved in every area of hospital operations. Moreover, the contract needs to specify how the CEO's role changes with changing circumstances.

2. **Salary.** The CEO's salary, and the process by which it will be adjusted in the future (e.g., as a result of annual performance reviews) should be clearly stated in the contract.

3. **Compensation for time out of the hospital**. Compensation for time the CEO spends away from the hospital, such as vacation, sick leave and out-of-hospital business including attending professional or hospital association meetings should be set out in the contract.

4. **Memberships.** The contract should specify when dues for professional associations, service organizations or clubs will be paid for by the organization. Memberships reimbursed by the organization should be reasonably related to the interest of the hospital and be approved by the chairman of the board.

5. **Liability insurance.** The hospital should include the CEO under its general liability insurance policy for any acts done in good faith during the course of his or her duties. This is essential since CEOs are often named in lawsuits.

6. **CEO benefits.** Other benefits for the CEO should be laid out in the contract, including group life, health and travel accident insurance; automobile allowance and retirement plan.

7. **Termination and severance.** The contract should specify the length of time that the CEO will continue to receive his or her salary if the board decides that the CEO's services are no longer required, and to what extent these benefits are offered if the CEO accepts another position before this time period elapses. Included here are continuing group life and health insurance, outplacement services or any other benefits the CEO will receive during the severance period. The contract should stipulate that if the CEO accepts severance benefits, the organization will be protected from future litigation from the CEO. The contract should name any situations where the severance agreement would not apply, such as the CEO being charged with a criminal offense.

   Who can terminate the CEO's contract, what level of agreement is required from the board or other executives to take this action and what constitutes official notice of termination (e.g., notice in writing) should be clearly specified in the employment contract.

7. (cont'd)

The contract should clearly specify that the CEO is expected not to compete with the employer during the term of the contract and for a specified period of time following termination of employment. The contract should clearly define what is meant by "competition." The contract should make it clear that either during employment or thereafter the CEO is enjoined from disclosing confidential information to outsiders without the express written permission of the employer. Finally, the contract should include notification that terminated CEOs are not to recruit other key executives to leave the hospital and become part of ventures that exclude the hospital for a specified period of time.

The contract should also specify termination policies in the event that the hospital merges or closes, or the board substantially changes the duties of the CEO. Further, the contract should make clear the conditions under which severance would continue, or not, should the CEO voluntarily terminate his or her employment.

8. **Protocol for changes, extensions and notice of intent not to renew.** What constitutes a legitimate change to, or extension of, the agreement should be specified in the contract. For example, ACHE's model contract (ACHE 2010) contains the stipulation that amendments need to be made in writing and be signed by the chairman of the board. Similarly, mechanisms for contract extensions or notices of intent not to extend the contract should be spelled out in the document.

9. **Contract primacy, applicability and other contract clauses.** There are a number of stipulations that often appear in contracts that are expected to be included in the contract between the CEO and the employing organization. The agreement should clearly state that the current contract supersedes prior contracts. The contract should also include the conditions under which the agreement remains in force. For example, the contract should include a statement to the effect that if some part of the contract is declared invalid or unenforceable by a court of law, the remainder of the contract still remains in effect. Additionally, ACHE's model contract includes a statement that if the hospital changes its corporate structure or is sold, the contract remains in force. The contract should also contain some provision for what occurs should the CEO die, particularly with respect to the passing of compensation or benefits to his or her estate or heirs. Finally, the contract should specify which state laws apply to the agreement; this is usually the state where the hospital is located.

Adapted from American College of Healthcare Executives. (2010). *Contracts for Healthcare Executives*. (5th ed.). Chicago, IL: Health Administration Press. For more information, please see the model contracts contained in this publication.

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