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Chief Executive Employment Contracts and Performance Evaluations

Division of Member Services, Research
American College of Healthcare Executives

CEO Circle White Paper
Winter 2012

Introduction and Overview

Two useful tools have been developed during the past 80 years to assist CEOs in executing their roles as leaders of hospitals. These tools are executive employment contracts and systematic performance evaluations. This white paper reports on:

1. The prevalence of CEO contracts and performance evaluations based on a 2012 survey of ACHE-affiliated hospital CEOs.
2. Features of executive employment contracts including their duration, the length of time during which severance pay will be received should termination occur, and whether pay will be continued if a new position is obtained.
3. The frequency of performance evaluations, who participates in evaluations, and the criteria used to judge CEO performance.
4. The impact of performance evaluations on compensation.
5. Attitudes of CEOs about their evaluation and who should be involved in the process.

Previous surveys conducted by ACHE between 1982 and 2006 showed progressive growth in the proportion of CEOs who had a contract and those who were evaluated at least annually. However that growth has leveled off and the statistics from 2012 are similar to those in 2006. Twenty-two percent of ACHE-affiliated hospital CEOs had a contract in 1982, with the number jumping to 59 percent in 2006. In 2012, 56 percent of CEOs surveyed reported that they had an employment contract. In the first CEO evaluation survey conducted in 1983, 83 percent of hospital CEOs stated they were evaluated at least annually and 46 percent had pre-established written criteria. By 2006, 95 percent of hospital CEOs reported that they were evaluated at least annually and 79 percent had pre-established written criteria. In 2012 a similar percentage of hospital CEOs reported receiving annual evaluations: 96 percent. Over the last six years there has been a small rise in the proportion of hospital CEOs being evaluated according to written criteria—85 percent of hospital CEOs in the 2012 survey said they had written performance evaluation criteria.

Background

As health reform unfolds, more and more hospital chief executive officers are faced with the need to make difficult and potentially unpopular decisions to ensure the sustainability of their organizations. In the current environment of risk and uncertainty, hospital CEOs need the freedom to make politically sensitive decisions and to be assured they will be treated fairly by their boards. Employment contracts and systematic performance evaluations are two mechanisms hospitals can use to retain qualified CEOs and empower them to take reasonable risks as needed in the execution of their responsibilities.

Executive employment contracts are intended to delineate the CEO's role in the organization and provide a method to reduce the likelihood that the CEO will be subject to arbitrary termination. The contract usually sets out a period during which the CEO will continue to receive full or partial compensation if, for any reason, the board chooses to terminate him or her.

The American College of Healthcare Executives has had a long tradition of supporting the value of executive employment contracts. As early as 1938 the Model Contract Committee published a preliminary report that highlighted the importance of the ultimate authority of the administrator in managing the hospital (subject to the rules and regulations of the governing board) and the power of the governing board to discharge the administrator. In 1968, James Ludlam, a partner in a law firm, was invited by ACHE to author an administrative brief on the subject, which was updated and reissued in 1978. In 1982, ACHE published its first full-length monograph on hospital CEO contracts. The fifth edition, Employment Contracts for Healthcare Executives, was published in 2010 and is available through Health Administration Press.

Systematic, objective CEO evaluation is a second mechanism used to help CEOs lead their hospitals effectively. Careful appraisal can facilitate good communication between the CEO's evaluators and the CEO. Ideally, the evaluators (usually the board) will agree upon a set of objectives for the coming time period, share them in writing with the CEO, then evaluate the chief executive at the end of that period. As a result, when the formal evaluation takes place, there are no surprises and the CEOs compensation reflects accomplishing the previously agreed-upon objectives.

ACHE has monitored both the prevalence of annual evaluations and the specific criteria used, beginning with its 1984 monograph, "Evaluating the Performance of the Chief Executive Officer." The criteria have changed over time, in response to the changing requirements of the role and an evolving understanding of the hospital's role in the community and society. The third edition of the monograph was published in 2003 and is also available through Health Administration Press.

Methods

In May 2012, a three-page survey was sent to 1,086 community hospital CEO members of ACHE. ACHE received 527 responses, for a response rate of 49 percent. A nonresponse analysis showed there were no differences in responses by geographical region. However, CEOs of freestanding hospitals, governmental hospitals and hospitals located in non-metropolitan areas and small cities were more likely to respond. Conversely, CEOs of system hospitals, investor-owned hospitals and those in large metropolitan areas were less likely to respond.

The data showed there were some key differences reported by CEOs of freestanding hospitals versus those in system hospitals. Therefore, for many items we report the responses of these CEOs separately. According to the American Hospital Association, in January 2012 there were 2,084 freestanding short-term, general medical/surgical, nonfederal hospitals and 2,590 system hospitals of the same type.

There is precedent for considering CEOS of freestanding and system hospitals separately, particularly when discussing conditions of their employment. Examination of the data collected in ACHE's 2006 study of executive employment contracts and performance reviews also led to separate reporting of results for freestanding and system hospital CEOs. In addition, the Hay Group, which reports salaries of hospital executives, makes a distinction between these two types of organizations when they report compensation statistics. The differences may be due in part to the differences in roles and responsibilities of CEOs in freestanding and system hospitals. CEOs of freestanding hospitals are required to develop their hospital's strategic plan along with all policies and practices. System hospital CEOs, on the other hand, must carry out policies prescribed by corporate headquarters and report to a more senior corporate official and possibly an (often advisory) community board (Weil and Stam, 1986).

Findings: Contracts

1. Prevalence of Contracts

While the proportion of hospital CEOs with employment contracts has increased since ACHE began conducting surveys on this topic in 1982, the statistics have changed little since the last survey in 2006. In 2012, 56 percent of hospital CEOs surveyed reported having an employment contract, as opposed to 59 percent in 2006.

There is considerable variation in the proportion of CEOs with contracts between freestanding and system hospitals. While 80 percent of freestanding hospital CEOs have a contract, only 32 percent of their system colleagues do. Further, the larger the system, the less likely it is that the CEO holds a contract. Twenty-one percent of CEOs of hospitals in systems with 26 or more hospitals have an employment contract. This is in contrast to hospitals in systems with from 6 to 25 hospitals where 30 percent of CEOs have contracts, and in systems with 1 to 5 hospitals where 55 percent of CEOs hold contracts.

Within systems, a relationship also exists between the type of ownership of the hospital and the prevalence of CEO employment contracts. Investor-owned hospitals are the least likely to offer contracts, with only 20 percent of their CEOs holding them. By contrast, 33 percent of CEOs in religiously-affiliated

Table 1. Duration of executive employment contracts for CEOs

Duration of Contract	Freestanding Hospitals (n=210)	System Hospitals (n=85)
One year	10%	16%
Two year	9	8
Three to four years	29	12
Five or more years	21	13
Rolling or evergreen	20	28
Indefinite	11	22

hospitals have contracts, and this figure is 41 percent for secular not-for-profit hospitals.

Finally, those CEOs who manage small hospitals within systems are least likely to have contracts. Nineteen percent of CEOs who oversee small system hospitals (1 to 99 beds) have contracts, while this figure is 43 percent for mid-size hospitals (100 to 199 beds) and 40 percent for larger hospitals (200 or more beds).

2. Contract Duration

Of those with a contract, the most common type of contract was rolling or evergreen, where the contract runs for a specific time into the future (usually 1 to 2 years), with no formal termination date. CEOs of freestanding hospitals tend have longer contracts and contracts with specified durations than CEOs overseeing system hospitals. CEOs of freestanding hospitals are most likely to have three-year contracts (with 25 percent selecting this response), followed by rolling or evergreen contracts (20 percent), followed by five-year contracts (17 percent). By contrast, CEOs of system hospitals are most likely to have rolling or evergreen contracts (28 percent), followed by indefinite contracts that continue until they are terminated (22 percent), followed by one-year contracts (16 percent) (see Table 1).

3. Salary Continuation/Severance Agreements

According to the survey, if a CEO under contract is terminated, his or her current salary is continued for an average of 14.2 months, with a median of 12 months. However, these numbers mask differences between freestanding and system hospital CEOs. Those at system hospitals expect to receive pay following termination for an average of 14.8 months, as opposed to 13.9 months for freestanding hospital CEOs (see Table 2).

The length of time that the salary continues after termination also appears to be related to

Table 2. Number of months CEO would receive current salary if terminated by hospital type

Duration of Severance Pay	Freestanding Hospitals		System Hospitals	
	Contract (n=208)	No Contract (n=48)	Contract (n=83)	No Contract (n=165)
0 months	4%	31%	4%	17%
1-6 months	23	15	8	24
7-12 months	32	33	48	34
13-24 months	32	13	35	11
>24 months	4	0	2	0
Negotiable or undetermined	5	8	2	15
Mean†	13.9 months	7.7 months	14.8 months	8.8 months
Mean, Contract and No Contract Combined†	12.8 months		11.0 months	
Mean, All Hospitals†	11.9 months			

† Includes only those cases where duration of severance pay was specified

hospital size. CEOs managing large hospitals (200 or more beds) under contract expect to receive 19.2 months of severance pay, on average; whereas CEOs managing small hospitals under contract expect to receive only 9.5 months of severance pay on average (see Table 3).

Regardless of the hospital setting, CEOs with contracts expect to receive severance pay for longer periods that those without contracts. On average, CEOs without contracts expect to receive 8.5 months of severance pay, 40 percent less than their colleagues with contracts.

Among freestanding hospitals, CEOs without contracts expect to receive 7.7 months of severance pay on average, and CEOs of system hospitals expect to receive 8.8 months. The duration of severance pay in the absence of a contract is also related to the size of the hospital, with larger hospitals paying salaries under a severance agreement for longer periods of time. CEOs of large (200 or more bed) hospitals without contracts expect to receive 12.5 months of severance pay while CEOs of midsize hospitals (100 to 199 beds) without contracts anticipate receiving 8.5 months of pay and those leading small hospitals (1 to 99 beds) expect to receive 6.3 months of severance.

Finally, 43 percent of CEOs indicated that their salary payments under the severance agreement would continue in full if they took a new position, and 16 percent would continue to receive the difference between their old and new salaries. However, this varies for those with and without a contract. In freestanding hospitals, if the CEO has a contract, 47 percent would receive their full salary and 20 percent would receive the difference between their old and new salaries if they took a new position. If the CEO does not have a contract, only 19 percent would receive their full salary, and 19 percent would receive the difference. Among system hospitals, if the CEO has a contract, 55 percent would receive their full salary and 20 percent would receive the salary difference. If the CEO does not have a contract, only 40 percent would receive their full salary and 9 percent would receive the salary difference.

Table 3. Number of months CEO would receive current salary if terminated by hospital size

Duration of Severance Pay	Large Hospitals (200 or more beds)		Midsize Hospitals (100 to 199 beds)		Small Hospitals (1 to 99 beds)	
	Contract (n=95)	No Contract (n=59)	Contract (n=75)	No Contract (n=50)	Contract (n=121)	No Contract (n=104)
0 months	2%	10%	0%	22%	7%	25%
1-6 months	0	10	12	24	37	27
7-12 months	31	41	47	40	36	27
13-24 months	57	24	32	10	14	5
>24 months	7	0	4	0	1	0
Negotiable or undetermined	3	15	5	4	5	16
Mean†	19.2 months	12.5 months	15.2 months	8.5 months	9.5 months	6.3 months
Mean, Contract and No Contract Combined†	16.9 months		12.4 months		8.2 months	

† Includes only those cases where duration of severance pay was specified

Findings: Performance Evaluations

1. CEO Performance Evaluations

Another important mechanism for supporting the hospital CEO is their performance evaluation. According to ACHE's policy statement: "One of the most important responsibilities of a hospital or health system's board is the development and implementation of a documented, well-designed, ongoing process for providing feedback to the CEO and measuring progress on achieving objectives. Such a process increases communication between the board and the CEO, which ultimately improves the functioning of the organization." (ACHE, 2008).

In the 2012 survey, 96 percent of CEOs reported that they received performance reviews at least annually, and only one percent reported that they are never reviewed. Even though about the same proportion of CEOs in freestanding and system hospitals receive annual evaluations, fewer CEOs leading freestanding hospitals (82 percent) reported that their performance was evaluated using preestablished written criteria than did system hospital CEOs (89 percent).

2. Who Participates in the CEO's Evaluation

CEOs of freestanding hospitals are more likely to be evaluated by the full board (69 percent) than system hospital CEOs (53 percent). About 70 percent of system hospital CEOs reported that system officers contribute to their evaluation. CEOs of system hospitals are also more likely to be evaluated by others on the management team (21 percent) than CEOs of freestanding hospitals (11 percent). These statistics are consistent with the different reporting structures for CEOs in freestanding and system hospitals. Overall, 11 percent of hospital CEOs are evaluated by staff physicians. This proportion varies by type of hospital ownership and is higher in religiously-affiliated hospitals (20 percent) and lower in investor-owned hospitals (6 percent). Overall, only three percent of hospitals CEOs are formally evaluated by community leaders.

3. Evaluation Criteria

The criteria used in evaluating freestanding and system hospital CEOs are quite similar. In the list of 19 factors that might contribute to the CEO's evaluation, the largest single contributor for both freestanding and system hospitals was "net operating margin (bottom line)" (see Table 4).

The next most frequently mentioned factor was "quality of care," followed by "patient satisfaction." Physician relations, planning and leadership qualities also contributed to the CEO's evaluation. About 92 percent of the CEO's evaluation is based on institutional success, about 2 percent is based on community health status and the remainder is based on aspects of professional role fulfillment such as continuing professional education, representing the profession, mentoring and using ethical methods to achieve goals.

Even though the criteria used to evaluate CEOs in freestanding and system hospitals are similar, there are two areas where differences are noted. First, net operating margin contributed less to the evaluation of CEOs of freestanding hospitals (with freestanding hospital CEOs estimating that this factor made up 23 percent of their evaluation) than system hospital CEOs (26 percent). Second, and consistent with their differing roles, planning contributed more to the evaluation of CEOs of freestanding hospitals (8 percent) than system hospital CEOs (5 percent).

The criteria used to evaluate CEOs leading both freestanding and system hospitals can be modified over the course of the evaluation period for 47 percent of CEOs. This is a lower

Table 4. Relative contribution of factors contributing to hospital CEO evaluation

	Freestanding	System
INSTITUTIONAL SUCCESS		
Net operating margin (bottom line)	23%	26%*
Planning (e.g., updating strategic plan)	8	5*
Human resource management (e.g., employee turnover, employee engagement)	5	6*
Quality of care	15	16
Allocating financial, physical and humans resources (e.g. planning for capital equipment, developing the budget, developing contractual relationships)	3	3
Compliance with regulations (e.g., Joint Commission)	3	3
Influencing legislation and regulations	1	1
Promoting the hospital to the community	5	3*
Patient satisfaction	10	10
Physician relations or engagement	8	7
Fundraising	1	1
Leadership qualities such as communication, integrity, judgment and sensitivity	6	7
Board relations	4	4
TOTAL, INSTITUTIONAL SUCCESS	92	92
COMMUNITY HEALTH STATUS		
Processes to improve community health (e.g., percent immunized against flu)	1	1
Outcomes demonstrating community health (e.g., infant mortality)	1	1
TOTAL, COMMUNITY HEALTH STATUS	2	2
PROFESSIONAL ROLE FULFILLMENT		
Continuing professional education	1	1
Representing the profession (e.g., appointments held)	1	1
Sharing leadership experiences with others (e.g., mentoring)	1	1
Ethical methods employed to achieve goals	1	<1*
Other criteria	3	3
TOTAL, PROFESSIONAL ROLE FULFILLMENT	7	<7

** t test difference between means p < .05*

figure than reported in 2006, when 60 percent of hospital CEOs expected their evaluation criteria could be subject to change over the evaluation period. In freestanding hospitals this varies by size. While 39 percent of CEOs managing freestanding hospitals with more than 100 beds can have their evaluation criteria modified during the year, this rises to 56 percent among small (1 to 99 bed) hospitals.

4. Evaluation's Impact on Compensation

In a majority of cases, the outcome of their performance evaluation had tangible effects on the CEO's compensation. Thirty-five percent of CEOs reported that both their salary and bonus were tied to their evaluation, while 28 percent reported that only their salary was related to their evaluation and 19 percent reported that only their bonus was tied to their evaluation. Only 17 percent reported that neither their salary nor their bonus were linked to their evaluations.

5. CEO's Attitudes About Fairness

The vast majority of CEOs surveyed—82 percent—felt that their current appraisal process is fair. Only six percent disagreed that the process was fair, and the remaining 12 percent were neutral about their evaluation. CEOs in large (200 or more bed) freestanding hospitals were particularly satisfied with the fairness of their evaluation—96 percent agreed that their appraisal process was fair.

6. Multisource Evaluation

Beginning in the early 1990s, a number of Fortune 50 corporations modified their executive performance appraisal plans to include multisource (360-degree) feedback, among other changes (ACHE 2007). Since then, 360-degree feedback has become a more common and recommended practice for evaluating senior executives and helping them become more effective in their organizations (e.g., Zenger, Folkman and Edinger, 2011). Such a review, however, needs to be carefully designed to ensure that the feedback obtained is appropriate and balanced (e.g., Zenger and Folkman 2012).

To explore CEO opinions on who should contribute to their performance evaluations, we first asked CEOs if they felt they should be evaluated by their full board. Seventy-five percent of CEOs agreed that the full board should contribute to their review. While the response was similar between freestanding and system hospital CEOs, opinions varied by hospital size. CEOs of small (1 to 99 bed) and midsize (100 – 199 bed) hospitals were more likely to agree they should be evaluated by the full board (79 and 76 percent, respectively). CEOs of large (200 or more bed) hospitals were less likely to agree that the full board should participate in their review, with 68 percent agreeing with this statement.

There was less agreement with the idea that others on the management team should contribute to the CEO's evaluation. Forty-six percent of CEOs who answered the survey agreed that the CEO should be evaluated by others on the management team, while 24 percent disagreed that other management team members should be involved in their review and 31 percent were neutral on the topic. There were interesting differences in the feelings of freestanding and system hospital CEOs on this subject. A larger proportion (54 percent) of system hospital CEOs felt that other managers should contribute to their review than CEOs leading freestanding hospitals (38 percent).

CEOs were also divided about whether physicians on the hospital staff should contribute to their review. Overall, 48 percent of CEOs agreed that they should, while 24 percent disagreed with the idea and 28 percent were neutral on the topic. Again there was a difference between CEOs managing freestanding versus

system hospitals, with 55 percent of system hospital CEOs agreeing that staff physicians should contribute to their review and only 41 percent of CEOs leading freestanding hospitals agreeing that this should be the case.

Finally, a much smaller proportion of CEOs felt that community leaders should have a voice in their evaluations. Only 16 percent of CEOs surveyed agreed that they should be evaluated by community leaders, while 49 percent disagreed and 35 percent were neutral on the subject. A larger proportion (21 percent) of CEOs managing system hospitals believed that community leaders should be involved in their evaluation than CEOs leading freestanding hospitals (11 percent).

Conclusions

More than ever, hospital CEOs need to know they have the backing of their governing boards as they steer increasingly complex organizations through an environment characterized by risk and uncertainty. Further, good communication and shared understanding of objectives and expectations between chief officers and governing boards are essential to well-functioning organizations. Two mechanisms that support hospital CEOs to carry out their accountabilities and foster effective relationships between CEOs and their boards are executive employment contracts and systematic performance appraisals.

Well-designed employment contracts offer benefits both to senior executives and the organization that employ them. They provide protections for CEOs, allowing them the freedom to make difficult and politically sensitive decisions. Contracts clearly define the employment relationship between the CEO and the organization, expectations of the CEO and how the CEO is to be evaluated. These features of the contract protect the CEO from arbitrary termination and bring objectivity to the organization's decision to retain or dismiss the senior executive. Executive employment contracts also provide financial protection to the CEO in the case of termination. ACHE's 2012 study clearly shows that the existence of an employment contract positively affects the existence and duration of severance pay. Finally, an employment contract makes it clear to staff and the community that the CEO has the support of the governing board (ACHE, 2010).

Although employment contracts are common in freestanding hospitals, only about a third of CEOs in system hospitals reported having an employment contract in 2012 and this proportion has not changed over the past six years. However, those CEOs who do have a contract with a system hospital appear to have, on average, more favorable financial arrangements should termination occur than their colleagues in freestanding hospitals.

Executive performance evaluations are integral to the process of governing and administering hospitals. Annual reviews of CEO performance have been ubiquitous in hospitals for some time (ACHE, 2007). The existence of written performance criteria help establish a common understanding of performance objectives between CEOs and governing boards and prevent surprises at the time of the annual review. The existence of written performance criteria is also common and, since ACHE's 2006 survey, the proportion of CEOs who report having documents describing their review criteria has risen slightly. Further, in 2012 fewer CEOs reported that their performance criteria were subject to change over the reporting period than in 2006.

Although 360-degree evaluations are a well-established means for evaluating senior executives in many industries, less than a quarter of the hospital CEOs in the survey reported that they were evaluated by others on the management team or staff physicians. However, almost half agreed that these other members of the organization's staff should participate in the senior executive's review.

Elements of an Executive Employment Contract

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

1. 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 CEO's role changes with changing circumstances.
2. The financial terms of the contract, specifically the CEO's salary. New salary levels should be set forth in a letter to the CEO from the board chairman, which is incorporated into the initial contract.
3. 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.
4. Dues for professional associations, service organizations or clubs paid for by the hospital. Membership should be reasonably related to the interest of the hospital and should be approved by the chairman of the board.
5. 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. Other insurance benefits are often included here, such as group life, health and travel accident. Also considered here are the automobile and retirement plan for the CEO.
6. 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. Included here are continuing group life and health insurance and outplacement services. Exceptions from this provision relate to the CEOs being charged with a criminal offense
7. If the board substantially changes the duties of the CEO then the provisions relating to termination become effective.
8. If the hospital merges or closes, the termination provisions apply.
9. If the CEO voluntarily initiates his or her departure, then termination provisions do not pertain.
10. If the CEO accepts severance benefits, the hospital is then protected from future litigation by the CEO.
11. The CEO is enjoined from disclosing confidential information to outsiders without the express written permission of the employer.
12. 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.
13. Terminated CEOs are not to recruit other key executives to leave the hospital and join ventures that exclude the hospital.
14. Extending the contract can be accomplished by a letter of agreement.
15. The contract supersedes prior contracts.
16. Amendments to the contract should be stated in writing.
17. If some part of the contract is declared invalid or unenforceable by a court, the remainder of the contract still remains in effect.
18. If the hospital changes its corporate structure or is sold, the contract remains in force. Also, if the CEO dies, his or her benefits inure to the benefit of the estate or heirs.
19. The state where the hospital is located dictates which law is applicable.

Adapted from: Foundation of the American College of Healthcare Executives. (2010). *Employment contracts for health care executives: rationale, trends, and samples* (5th ed.). Chicago, IL: Health Administration Press.

References and Additional Sources

American College of Healthcare Executives. (2008). *Policy statement: evaluating the performance of the hospital or health system CEO*. Retrieved from http://www.ache.org/policy/ceo-perf.cfm

American College of Hospital Administrators. (1982). *Contracts for hospital chief executive officers: A report of the ad hoc committee on contracts for hospital chief executive officers*. Chicago, IL: ACHE

Foundation of the American College of Hospital Administrators. (1984). *Evaluating the performance of a hospital chief executive officer: A report of the ad hoc committee on evaluating the performance of the hospital chief executive officers*. Chicago, IL: Foundation of ACHE

Foundation of the American College of Healthcare Executives. (2003). *Evaluating the performance of the hospital CEO*. (3rd ed.). Chicago, IL: Foundation of ACHE

Foundation of the American College of Healthcare Executives. (2007). *Executive employment contracts and performance evaluations*. Chicago, IL: Foundation of ACHE

Foundation of the American College of Healthcare Executives. (2010). *Employment contracts for health care executives: rationale, trends, and samples* (5th ed.). Chicago, IL: Health Administration Press.

Weil, P.A., & Stam, L.M. (1986). Transitions in the hierarchy of authority in hospitals: Implications for the role of the chief executive office. *Journal of Health and Social Behavior, 27(2)*, 179-192.

Zenger, J,H., & Folkman, J.R. (2012, September 7). Getting 360 degree reviews right. *Harvard Business Review Blog*. Retrieved from: http://blogs.hbr.org/cs/2012/09/getting_360_degree_reviews_right.html

Zenger, J,H., Folkman, J.R., & Edinger, S.K. (2011). Making yourself indispensable. *Harvard Business Review*, October 2011, 85-92.

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CEO Circle White Paper
2012

American College of Healthcare Executives
One North Franklin Street, Suite 1700
Chicago, Illinois 60606-3529