



American College of
Healthcare Executives
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Executive Employment Contracts and Performance Evaluations

Executive Summary



CEO Circle White Paper

2007

Introduction and Overview

Two useful tools have been developed during the past 75 years to assist CEOs in executing their accountabilities 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 2006 fax survey of ACHE affiliated hospital CEOs.
2. Features of contracts including the duration of contracts and the length of severance pay should termination occur.
3. The frequency of performance evaluations and the criteria used.
4. The impact of evaluation on compensation.
5. Attitudes of CEOs about their evaluation and who should be involved in the process apart from the board or their immediate supervisor.

There has been progressive growth in the proportion of CEOs who have a contract as well as the use of an annual evaluation process based on written criteria. Twenty-two percent of ACHE affiliated hospital CEOs had a contract in 1982, but the number jumped to 59 percent in 2006. In the first CEO evaluation survey conducted in 1983, 83 percent of hospital CEOs were evaluated at least annually and 46 percent had pre-established written criteria. By 2006, 95 percent of hospital CEOs reported they were evaluated at least annually and 79 percent had pre-established written criteria.

Background

Executive employment contracts are intended to delineate chief executive'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 for which the CEO will continue to receive full compensation if, for any reason, the board chooses to terminate him or her. The contract therefore is viewed as a means to ensure the chief executive is granted the needed authority to effectively lead the hospital.

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 fourth edition, *Contracts for Healthcare Executives*, was published in 2002 and remains 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, appraisals help the board agree on a set of objectives for the coming time period and then evaluate the CEO on achieving them at the end of the period. As a result, when the formal evaluation actually

takes place, there are no surprises and the CEO's compensation reflects accomplishing the previously agreed upon objectives.

Beginning with its 1984 monograph, "Evaluating the Performance of the Hospital Chief Executive Officer," ACHE has monitored both the prevalence of annual evaluations and the specific criteria used. The criteria have been altered over time, partly in response to the changing requirements of the role, the greater understanding of the hospital's role in society and the unique obligations of executives. The third edition of the monograph was published in 2003 and is also available through Health Administration Press.

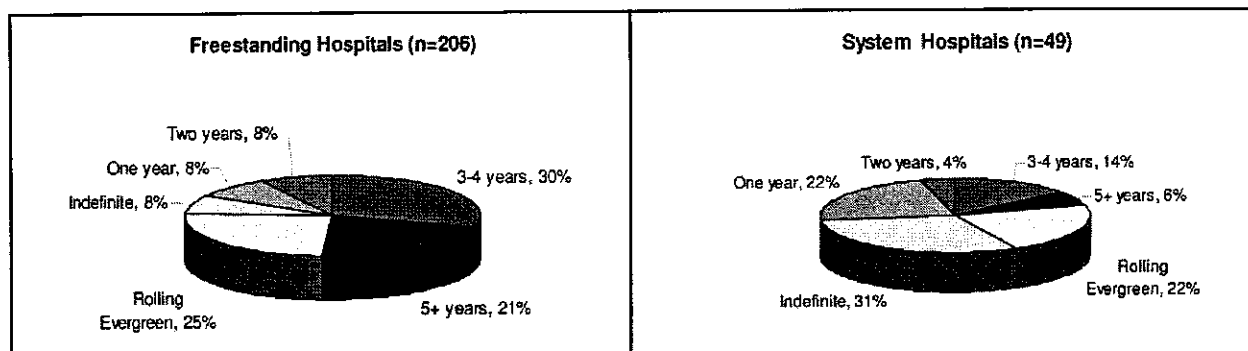
Methods

In November and December 2006, a three-page fax survey was sent to 995 hospital CEO affiliates of ACHE. We received 445 responses for a 45 percent response rate. A nonresponse analysis showed that there were no differences in responses by region. However, CEOs in freestanding hospitals, governmental hospitals, small hospitals with fewer than 99 beds and hospitals located in non-metropolitan and small cities were more likely to respond. Conversely, CEOs of system hospitals, investor-owned hospitals, hospitals with 100 or more beds and those located in large cities were less likely to respond. Since only 31 respondents headed investor-owned organizations, it is not possible to confidently generalize from their responses, and they are not reported separately.

The data showed there were some key differences reported by CEOs of freestanding hospitals versus those in system hospitals. Therefore, we report the responses of these CEOs separately. According to American Hospital Association, in January 2007 there were 2,983 freestanding hospitals and 3,313 system hospitals.

Figure 1

Duration of Executive Employment Contracts for CEOs



The importance of distinguishing between CEOs of freestanding and system hospitals is recognized by various observers of the field. For example, Clark Consulting and Hay Group, which report salaries of hospital executives, make this distinction. Indeed, freestanding hospital CEOs have unique role requirements, as they are required to develop their hospital's strategic plan and virtually all policies and practices. In contrast, system hospital CEOs must carry out policies prescribed by corporate headquarters and often report to a single corporate official, as well as to an (often advisory) community board. (Weil and Stam, 1986)

Findings: Contracts

1. Prevalence of Contracts and Evaluations

Surveys of ACHE affiliate hospital CEOs and others have shown progressive growth in the proportion of CEOs who have a contract. Twenty-two percent of ACHE affiliated hospital CEOs had a contract in 1982, but the number jumped to 59 percent in 2006. Thus, developing a CEO contract has become a much more common practice for those seeking strong, viable hospital leaders.

There is considerable variation in the percentage of freestanding versus system hospital CEOs who have employment contracts. While 80 percent

of freestanding hospital CEOs have a contract, only 28 percent of their system colleagues do. The larger systems are less likely than smaller systems to offer contracts. For example, only 16 percent of hospital CEOs in systems with 11 or more hospitals have a contract. In contrast, 43 percent of hospital CEOs in systems with six to ten hospitals and 56 percent of those in systems with one to five hospitals have a contract.

Moreover, there is some relationship between the type of ownership of the system and whether or not CEO contracts are offered. We learned that only 16 percent of CEOs in investor owned system hospitals had a contract, 27 percent of those in Catholic system hospitals and 39 percent of those in not for profit secular system hospitals, had one.

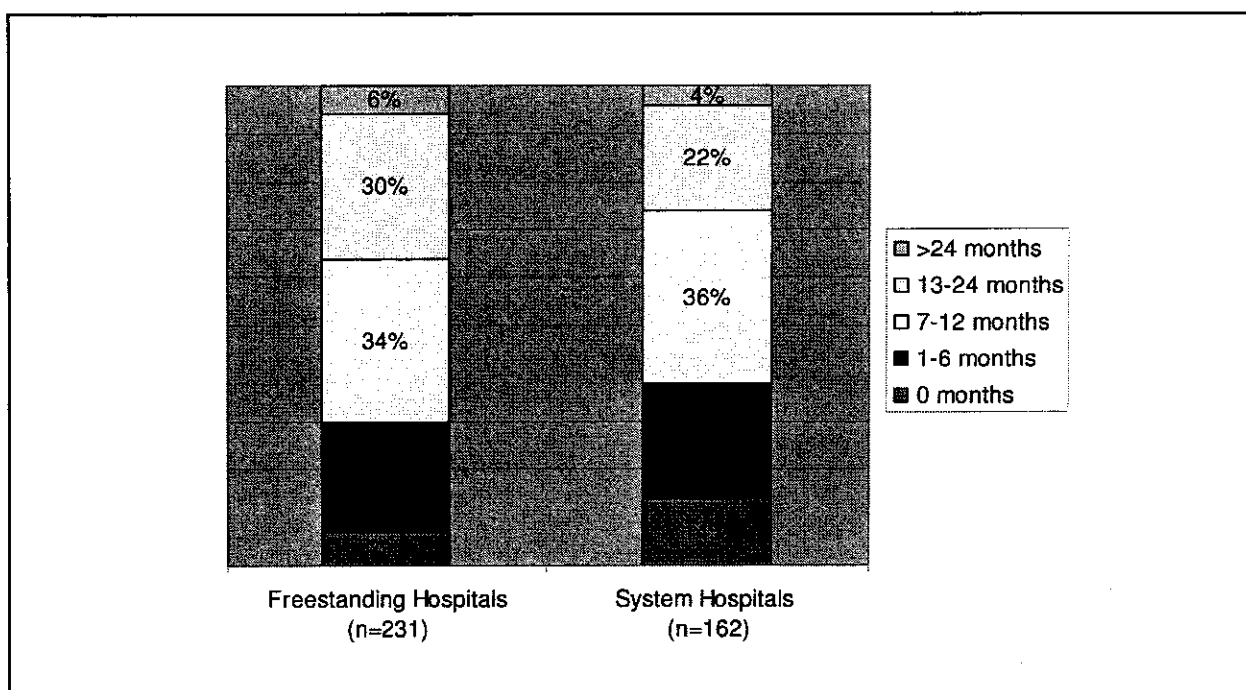
Finally, among CEOs of hospitals in systems, those that manage larger (200+ bed) hospitals are more likely to have a contract—44 percent compared to only 16 percent of those who manage smaller (1-99 bed) hospitals.

2. Contract Duration

Of those with a contract, the typical length of the contract is three to four years. Freestanding hospital CEOs have longer term contracts than

Figure 2

Number of Months CEO Would Receive Current Salary If Terminated



system hospital CEOs. Thus, 30 percent of freestanding hospital CEOs said their contract was for three or four years and another 21 percent said their contract was for five or more years. In contrast, only 14 percent of system hospital CEOs had a three- or four-year contract, and 6 percent of them said their contract lasted for five or more years. (See Figure 1)

In addition, 25 percent of freestanding hospital CEOs and 22 percent of system hospital CEOs had “rolling” or “evergreen” contracts, which run for a specific time into the future (usually 1-2 years) with no formal termination date. Another eight percent of freestanding hospital CEOs had “indefinite” contracts, while fully 31 percent of system hospital CEOs had this arrangement whereby the contract continues until it is terminated.

3. Salary Continuation/Severance Arrangements

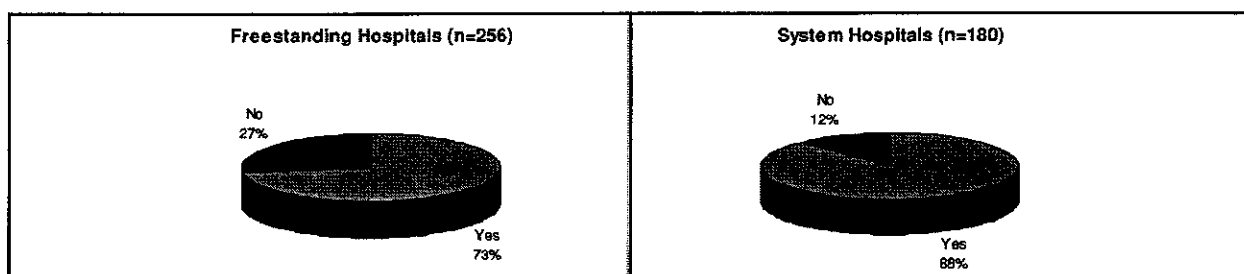
According to the survey, if a CEO under contract

is terminated, current salary is continued for a mean of 15.1 months and a median of 12 months. However, these average figures obscure differences when comparing freestanding and system hospital CEOs. Those at freestanding hospitals are likely to receive pay for 14.8 months versus 16.3 months for system hospital CEOs; furthermore, CEOs in nonprofit settings would continue to receive their salary if they were terminated for a longer period than those in governmental organizations. The mean number of months that the nonprofit CEO’s salary would continue is 14 compared to 10 for governmental hospitals.

The length of time that salary continues after termination also appears to be directly related to the size of the hospital the CEO manages. Among small (1-99 bed) hospitals, CEOs would, on average, receive salary for 11 months. Among medium-size hospitals (100-199 beds) they would receive their salary for 17 months.

Figure 3

Proportion of Hospital CEOs Who Are Evaluated With Pre-established Criteria



Among large hospitals (200 + beds), the CEO's salary continues, on average, for 19 months.

Overall, having a contract contributes to a longer severance agreement. As shown in Figure 2, CEOs without a contract could expect, on average, to receive their salary for 8.2 months, 46 percent less than the mean for CEOs with a contract.

Among freestanding hospitals, those without a contract could expect to receive their salary for an average of seven months; those in a system hospital receive their salary for an average of eight and one-half months. Those without a contract also show lower duration of salary continuation depending on the size of their hospital. Small-hospital CEOs without a contract can expect an average of six months salary, midsize-hospital CEOs can expect eight months salary while large-hospital CEOs might receive their salary for a year after termination. These data show that contracts not only serve to specify the role the CEO is to perform, but also carries over to the kinds of remuneration he or she can expect if termination occurs.

Finally, half of the CEOs indicated their salary continuation agreement would be valid even if they obtained a new position. But again, this percentage varied greatly by whether or not the CEO had negotiated a contract. In freestanding hospitals, if the CEO has a contract, 58 percent would receive their termination pay even if they

took a new job. But only 30 percent of CEOs without a contract would enjoy this benefit. Among system hospitals, 52 percent of CEOs with contracts compared to 40 percent of those without one would continue to receive their pay if they obtained a new position.

Findings: Performance Evaluations

1. CEO Performance Evaluations

In addition to an executive employment contract, a second mechanism that supports hospital CEOs is their performance evaluation. As stated by an ACHE ad hoc committee that authored a 1982 monograph on contracts for hospital CEOs, besides executive employment contracts, "Annual reviews of executive performance based on explicit and measurable criteria derived from organizational goals also are essential to development and enhancement of the interdependent functions of governance and management" (ACHE, 1982). At the time of the 1983 survey, 83 percent of hospital CEOs reported they were evaluated annually and 46 percent had pre-established written criteria. By the 2006 survey, 95 percent of hospital CEOs reported they were evaluated at least annually and 79 percent had pre-established written criteria. Only two percent of CEOs are never evaluated, compared to 1983 when 17 percent stated they were never evaluated.

Table 1

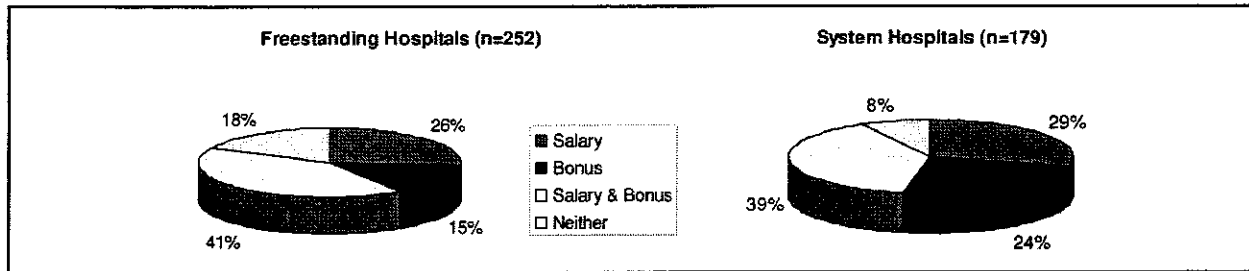
Relative Contribution of Factors Contributing to Hospital CEOs' Evaluation

	Freestanding (n = 171)	System (n = 152)
Institutional Success		
Net operating margin (bottom line)	23	28*
Quality of care	13	15
Patient satisfaction	8	10*
Physician relations	10	7*
Planning (e.g., updating strategic plan)	10	5*
Human resource management (e.g., employee turnover rate)	5	6
Leadership qualities, such as communication, integrity, judgment and sensitivity	7	8
Promoting the hospital to the community	5	3*
Allocating financial, physical and human resources (e.g. planning for capital equipment, developing the budget, developing contractual relationships)	4	4
Compliance with regulations (e.g., JCAHO)	3	4
Fundraising	1	1
Influencing legislation and regulations	1	1
Community Health Status		
Outcomes demonstrating community health (e.g., infant mortality)	1	1
Processes to improve community health (e.g., percent immunized against flu)	1	1
Professional Role Fulfillment		
Other criteria (please specify)	2	2
Ethical methods employed to achieve goals	2	1
Representing the profession (e.g., appointments held)	1	1
Sharing leadership experiences with others (e.g., mentoring)	1	1
Continuing professional education	1	0*
Total (should equal 100%)	100%	100%

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

Figure 4

Does the CEO's Evaluation Impact Compensation?



Even though about the same proportion of CEOs in freestanding and system hospitals receive evaluations, fewer CEOs leading freestanding hospitals (73 percent) than those in systems (88 percent) said they were evaluated with pre-established written criteria. (See Figure 3)

2. Evaluation Criteria

The criteria used in evaluating freestanding and system hospital CEOs are quite similar. For example, in the list of 18 factors that potentially contribute to the CEO's evaluation, the largest single contributor for both freestanding and system hospital CEOs was "net operating margin (bottom line)." These results mirror those reported for CEOs of *Fortune* magazine's America's Most Admired Companies industry list (Epstein and Roy, 2005).

The next most frequent mentioned factor was "quality of care" followed by "patient satisfaction" (Table 1). Physician relations and planning (e.g., updating the strategic plan) also contributed to the CEO's evaluation. About 92 percent of the CEO's evaluation is based on institutional success, 2 percent is based on community health status and the remainder is based on professional role fulfillment, such as using ethical methods to achieve goals, representing the profession or on such factors as mentoring and their con-

tinuing professional education.

While the criteria used in evaluating CEOs in freestanding and system hospitals are generally quite similar, there were two areas where differences were noted. First, net operating margin contributed less to the evaluation of freestanding hospital CEOs (23 percent) than system hospital CEOs (28 percent). Second, and consistent with their different roles, planning contributed more to freestanding hospital CEOs' evaluation (10 percent) than system hospital CEOs (5 percent).

The criteria used in the CEO's evaluation for about 60 percent of both groups can be modified during the course of the evaluation period. In freestanding hospitals, this varies to some extent by size. For example, while about just over half of CEOs in hospitals with more than 100 beds can have their evaluation criteria modified during the year, this rises to 74 percent among small (1-99 bed) hospital CEOs.

3. Evaluation's Impact on Compensation

In the great majority of cases the CEO's evaluation has very tangible effects on his or her compensation. Overall, 40 percent of respondents stated both their salary and their bonus were tied to their evaluation. An additional 27 percent said only their salary was tied to their evaluation, while another 19 percent said only their bonus was tied to it. Fourteen percent of respondents said neither their salary nor their bonus was tied to their evaluation. This was

more often the case among freestanding hospital CEOs—18 percent of whom said there was no formal link between their evaluation and their compensation, compared to eight percent of system hospital CEOs. (See Figure 4)

4. CEO's Attitudes About Fairness

Asked to express their feelings about their evaluation, the vast majority—77 percent—agreed their current appraisal process was fair. Only 10 percent disagreed that their current appraisal process was fair, while the remaining 13 percent were neutral about their evaluation. This was true for both CEOs in freestanding and system hospitals. CEOs in large (200+ bed) freestanding hospitals were particularly satisfied with the fairness of their evaluation—86 percent said their evaluation was fair.

5. 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. Since it can be very difficult for many executives to obtain candid feedback from their supervisors, multisource feedback can be very enlightening. In fact, many executives are surprised by how their actions and behaviors are perceived by others (Graddick and Lane, 1998).

To examine the idea that additional groups should be involved in CEO evaluation, we first asked the CEOs if they should be evaluated by others on their management team. Overall, 49 percent of the respondents approved of this, 25 percent were neutral and 27 percent disapproved.

Interesting variations appeared when we contrasted freestanding and system hospital CEO responses. Fewer freestanding hospital CEOs approved of the idea—43 percent compared to 56 percent of system hospital CEOs. Conversely, 33 percent of the freestanding hospital CEOs disapproved of

being evaluated by their management team versus 17 percent of system hospital CEOs. It may be that system hospital CEOs are more accustomed to evaluations which may be required by corporate headquarters and their regional offices.

Less than a majority approved of being evaluated by medical staff. Overall, 45 percent of the hospital CEOs approved and 30 percent disapproved of their being evaluated by physicians on the hospital's medical staff. Again, some differences are evident between CEOs of freestanding and system hospitals. Fewer CEOs of freestanding hospitals (42 percent) compared to system hospitals (49 percent) approved of physicians becoming involved in their evaluation. Conversely, 35 percent of freestanding hospital CEOs disapproved, compared to only 24 percent of system hospital CEOs who disapproved of this idea.

Fewer still approve of the idea that CEOs should be evaluated by community leaders. Only 25 percent approved of this idea and 47 percent disapproved of it. Apparently, CEOs do not believe that persons outside the hospital would provide an equitable assessment of their contributions to the organization which, as shown above, comprise more than 90 percent of the criteria used for their present evaluation.

Conclusion

We have examined two key mechanisms to support innovative and decisive leadership in today's hospital—executive employment contracts and systematic evaluation of the CEO's performance. Executive employment contracts are used to attract and retain key management personnel and provide financial protection and incentives to executives in strategically important and highly vulnerable positions. Because the role of the CEO has evolved over time—increasing in scope and complexity—the hospital is now a more integrated organization that requires talented leadership to ensure the provision of high quality care, access for the community and

financial health. The advantage of the executive employment contract is that it formalizes the relationship between the governing board and CEO, thus permitting strong and innovative leadership for the hospital. Based on this rationale, it is not surprising that contracts have grown in prevalence so that in 2006 they were in effect in 80 percent of freestanding hospitals.

Executive performance evaluation also is integral to the governance and executive management process. Recognizing the critical importance of the role, nearly every hospital now conducts an evaluation of their CEO. In fact, today, CEO evaluation is evolving to become an ongoing process. For example, boards are often encouraged to meet without the CEO in executive session at least once or twice a year or as often as after every board meeting. Some suggest that board feedback should be anonymous so that the board members feel they can express themselves without retaliation, generating more accurate ratings (Silva and Tosi, 2004). Such executive sessions can serve the board CEO relationship well, as long as the board chair accepts the responsibility to manage this process

and briefs the CEO after each session about the essential elements of the discussion. Sometimes, CEOs are brought in after executive sessions so that the CEO can respond, clarify and if necessary, follow up on board recommendations. (Larson, 2007).

Ultimately, the main issue related to evaluation is whether or not the evaluation is conducted in a way that will enhance the CEO's and, by extension, the organization's performance. One of the main purposes in establishing a well understood process of performance evaluation is to avert the possibility that judgments will focus on controversial situations, which might be subjective, time bound, poorly informed or politically motivated. An additional purpose is to establish a reliable way to avert crises through timely communication of information. The CEO has the primary responsibility for initiating and developing the performance management process. In so doing, the CEO and board must recognize that each hospital has its own, unique culture and the CEO evaluation should be tailored to fit the needs of that organization.

Elements of an Executive Employment Contract

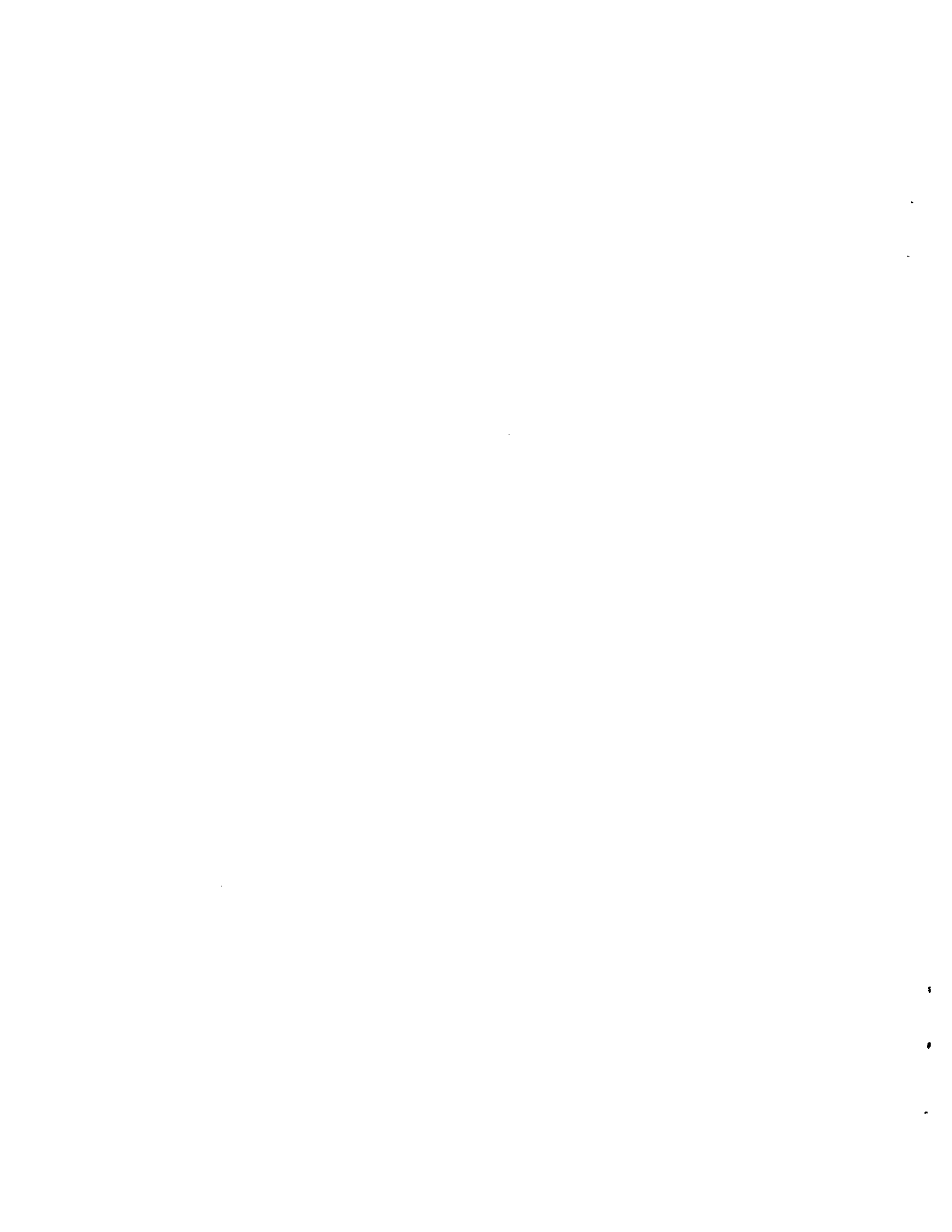
ACHE does not specify exact benefits that might be negotiated between the CEO and Board, but we do suggest that the following items are raised in negotiating a contract.

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 or if the hospital merges or closes then the provisions relating to termination become effective.
8. If the CEO voluntarily initiates his or her departure, then termination provisions do not pertain.
9. If the CEO accepts severance benefits, the hospital is then protected from future litigation by the CEO.
10. The CEO is enjoined from disclosing confidential information to outsiders without the express written permission of the employer.
11. 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.
12. Terminated CEOs are not to recruit other key executives to leave the hospital and join ventures that exclude the hospital.
13. Extending the contract can be accomplished by a letter of agreement.
14. The contract supersedes prior contracts.
15. Amendments to the contract should be stated in writing.
16. If some part of the contract is declared invalid or unenforceable by a court, the remainder of the contract still remains in effect.
17. 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.
18. The state where the hospital is located dictates which law is applicable.

Adapted from *Contracts for Healthcare Executives, Fourth Edition*, American College of Healthcare Executives, Health Administration Press, 2002

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