BoardRoom Press

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Physicians as Partners in Health System Governance

What Should the Board Expect from an Interim CEO?

SPECIAL SECTION

Best Practices in Board Succession Planning

All Hands on Deck: Board Support of Employee Wellness in a Time of SARS-CoV-2

ADVISORS' CORNER

Keeping the Board's Eye on Quality during the Telehealth Boom

Back to Basics

While we get better at understanding and managing the coronavirus pandemic, the reality has settled in that this virus will be with us for some time to come. As we learn more about how to care for COVID-19 patients, keep our caregivers safe, and continue to support and educate the community about updates in public health guidance and new research, healthcare leaders must now return to their core matters at hand—leading as a board, ensuring high quality and safe care, and most importantly, updating and furthering the strategic plan and future vision.

This issue brings readers back to items of import that we at The Governance Institute are passionate about because of their proven track record to enhance board effectiveness and therefore, organizational performance. Now, more than ever in our history, sound and visionary governance and leadership is needed for our healthcare institutions, our patients, and our communities.

Kathryn C. Peisert,
Managing Editor

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Physicians as Partners in Health System Governance

By Terry M. Murphy, FACHE, and Gary Siegelman, M.D., M.Sc., Bayhealth

As healthcare organizations navigate complex change against a dynamic environment, physician leaders and board members are ever more important partners to implement change. Bayhealth utilizes various roles for physicians to be engaged in the system. The roles are well-defined and delineate board governance from operational governance. Both types of governance are intended to create a "shared voice" within the organization.

Board Governance

In the early 1980s, our system established a bylaw requiring at least 25 percent of our parent corporation's governing body be made up of members of the active medical staff. Currently, six of the 17 board members are physicians. The selection process is managed through the governance committee, and medical staff members are vetted with other community members to ensure their competency, alignment, and diversity meet the needs of the organization. As part of the cultivation of potential physician board members, there are purposeful discussions regarding the proper fiduciary responsibility and role of medical staff board members.

Physicians who serve on the board also serve on our executive, planning, performance improvement, and governance committees. Additionally, the performance improvement committee includes multiple non-director physicians who may have a strong interest in patient safety or system performance. All members have a voice and vote in final decisions or recommendations.

Our ACO is a regional collaboration with three other health systems. The ACO cares for roughly 45,000 attributed beneficiaries and takes both upside and downside risk. Our two seats on the board are filled by physicians who play a significant role in strategy and governance; physicians also have a major part in operational leadership of the ACO. Our clinically integrated network is physician-led at the board level, and again, is also operationally driven by physicians.

Medical staff physicians also participate in Delaware's health initiatives by serving as governing body members of the Delaware Healthcare Coalition, Delaware Health Information Network, American Hospital Association Regional Policy Board, Delaware Center for Health Innovation, and other bodies.

Operational Governance

In addition to engaging physicians through the traditional medical staff departmental chair positions, Bayhealth operates its service lines, performance improvement and safety initiatives, and medical group with a dyad approach, teaming our physician leaders with service-line executives. Meetings, decisions, strategic activities, clinical, and operational decisions are all reached and led with this approach.

Physicians in medical directorships, and with various appointments, are typically engaged because of the critical nature of the work. For example, our surgical services executive committee manages OR block time, scheduling, staff resources, and other key OR issues. Three physicians lead that group and are complemented by nursing and administrative leadership, all focused on having a highly efficient and safe OR for patients and staff. Clinical capital purchasing for the system is now prioritized annually by a physician-led group and guided by the system's strategic plan.

Physicians are also heavily engaged in areas of need such as the COVID-19 pandemic, in which our epidemiologists, primary care physicians, intensivists and hospitalists, emergency and trauma physicians, among many others, came together on a regular basis and contributed to the successful operation of not just clinical areas, but also our Incident Command Center and Coronavirus Management Team. This team of physicians also collaborated with Delaware's other health systems and hospitals to create a united front in managing the pandemic well.

About Bayhealth

Bayhealth is a 400-bed, two-hospital system located in central and southern Delaware. The organization has a medical staff of 500 practicing physicians, over 50 ambulatory sites, and employs 4,200 staff members. Bayhealth participates in a regional ACO, a clinically integrated network, and the Bayhealth Medical Group employs over 100 physicians both in primary and specialty care. Major service lines are in oncology, cardiovascular, orthopaedics and rehabilitation, women's and children's services, and neurosciences.

Key Board Takeaways

- Require that a certain percentage of board members are physicians.
- Provide physicians with operational governance opportunities, such as medical staff departmental chairmanships and dyad leadership approaches for service lines, performance improvement and safety initiatives, and medical groups.
- Support the engagement and development of medical staff members through a leadership development program.
- Commit to understanding and addressing physician well-being.

Physician Engagement and Leadership Development

Bayhealth supports the engagement and development of its medical staff members through the sponsorship of a leadership development program. This weekend program is becoming more focused on smaller groups of developing leaders, with case-based learning and expectations for participation and growth.

As an organization, we have also committed to understanding and addressing physician well-being. Our chief wellness officer, a role we have had in place since 2019, has led the initial work by identifying impediments to a comfortable and efficient work environment, and by establishing professional coaching and counseling resources for physicians who need support and assistance.

This team has also now established quarterly medical staff open forums to share the "state of the organization" and promote open conversations between the CEO and other administrative leaders with our physicians.

Overall, Bayhealth's efforts are predicated on the belief that strengthening the health of our community requires dedicated clinicians in partnership with other leaders and staff to identify and meet the population's current and future needs for preventive, acute, and chronic care.

The Governance Institute thanks Terry M. Murphy, FACHE, President and CEO, and Gary Siegelman, M.D., M.Sc., Senior Vice President and Chief Medical Officer, Bayhealth, for contributing this article. *They can be reached at terry_murphy@bayhealth.org and gary_siegelman@bayhealth.org.*

What Should the Board Expect from an Interim CEO?

By Kimberly A. Russel, FACHE, Russel Advisors

The American College of Healthcare Executives reported a hospital CEO turnover rate of 18 percent at the time of its last survey in 2018.[1] Many are predicting even higher rates of CEO turnover in coming years due to pandemic-related burnout. In the future, the field will undoubtedly experience both planned and unplanned CEO turnover. As a result, many boards will elect to appoint an interim CEO as a bridge during the permanent CEO recruitment and selection process.

The CEO turnover story at each healthcare organization is unique. Turnover may occur due to an unexpected event such as the serious illness or even sudden death of a CEO. Perhaps the CEO has been recruited to another job. A board may initiate turnover due to underperformance of the incumbent CEO. Or perhaps the CEO's departure has been planned (such as a retirement), but the search for a permanent CEO is still ongoing. The underlying reasons that created the open CEO position will inform the board's approach to the interim period.

Examples of Expected Accomplishments of the Interim CEO:

- Implement needed leadership personnel changes.
- Complete major information technology upgrades.
- Oversee capital construction projects.
- Prepare the organization for change management.
- Lead a financial turnaround.
- Stabilize internal morale.
- Divest programs/service lines.

What should the board expect from an interim CEO? In the distant past, boards considered an interim CEO to be a placeholder—keeping the seat warm until the arrival of a permanent CEO. As the healthcare environment has become more complex, boards now have higher expectations of interim CEOs.

Given the dynamic healthcare environment, very few (if any) organizations can hit pause during a CEO search. Although the board will necessarily focus its attention on seeking a permanent CEO, the board must first thoughtfully consider the organization's leadership needs between two key points in time: the departure date of the incumbent CEO and the arrival date of the permanent CEO.

Continuing Forward Momentum

Once the board makes the decision to appoint an interim CEO, the board should regard interim leadership as an opportunity. The board has every incentive to maximize the benefit of this leadership interval. Appointing an interim CEO not currently employed by the organization can provide the board with an experienced leader who can approach the position with a fresh set of eyes. Appointing an insider executive as the interim CEO brings an understanding of current culture along with a pre-existing relationship with the board. Regardless of the board's selection of an external or internal executive, the interim CEO can provide a period of stability for the workforce while a formal search for a permanent CEO is undertaken. With the board as his or her ultimate client, the interim CEO has a unique opportunity to evaluate current and anticipated challenges facing the healthcare institution.

Key Board Takeaways

- Regard the interim CEO interval as an organizational opportunity.
- Remember that a skilled interim CEO allows the board sufficient time to thoughtfully conduct the search for a permanent CEO.
- Clarify the top-three expected achievements for the interim CEO.
- Use the interim period to create needed internal change and empower the interim CEO accordingly.
- Ensure that the interim CEO is effectively performing the job and laying the groundwork for the permanent CEO to be successful.
- Expect stepped-up communication with the interim CEO.

The board's responsibilities when appointing an interim CEO include:

- **Clarify the board's top-three expected accomplishments of the interim CEO**. It is critical for the board to arrive at consensus on priorities for the interim leadership period. When interviewing a prospective candidate for the interim CEO position, boards will be asked about the expected outcomes of interim leadership. If the board is unable to come to consensus, a skilled external facilitator may be helpful. (See sidebar for examples of expected interim CEO accomplishments.)
- **Confirm the interim CEO's authority levels**. The board should revisit its CEO Authority Policy. Many organizations retain the existing financial, strategy, and personnel-related authority levels for the interim CEO, although often additional communication to the board about key decisions is required during the interim period.
- **Articulate the board's communication expectations from the interim CEO**. What mode and frequency of communication does the full board expect from the interim CEO outside of regularly scheduled board meetings? Is there a need for a routine touch-base with board leadership? Most boards will require more frequent CEO updates during the interim period.

continued on page 11

1 American College of Healthcare Executives, "Hospital CEO Turnover Rate 2018" (press release), May 30, 2019.

Best Practices in Board Succession Planning

By Lawrence D. Prybil, Ph.D., University of Kentucky, and Larry S. Gage, J.D., Alston and Bird, LLP and Alvarez & Marsal, Inc.

A growing body of evidence from studies in the health, business, and other sectors show the quality of governance has material impact on the success of the organizations for which they have legal responsibility. These studies demonstrate there is linkage between how effectively boards fulfill their fiduciary duties and various measures of organizational performance.[1] Effective boards tend to make better decisions in shaping the organization's strategies and monitoring its performance with the goal of continuous improvement.

Numerous factors influence the effectiveness of corporate boards. Among the key determinants are the board's size, how it is structured (e.g., the number and nature of standing committees), how well board and committee meetings are led, the quality of staff support, and the extent to which the board's culture nurtures constructive deliberations and builds trust.[2] These factors are important and warrant ongoing attention by board and executive leadership. However, there is broad accord among experts that the *composition* of boards—their collective expertise, diversity, and independence—is decisive in determining board effectiveness.[3]

In short, there is abundant evidence that *board effectiveness* has substantial impact on organizational performance and that *board composition* is a principal determinant of board effectiveness (as depicted in **Exhibit 1**).[4] Given the importance of board composition in this equation, it is surprising that board succession planning—the process through which the needs for board talent are determined and future board members and board leadership are selected—is not given more attention and priority, both in organizational policies and practices and in governance studies.

This article demonstrates why succession planning is a fundamental and vitally important governance duty and—based on available evidence and our experience in serving on, studying, and advising many boards—identifies a set of best practices in board succession planning.

Basic Best Practices in Board Succession Planning

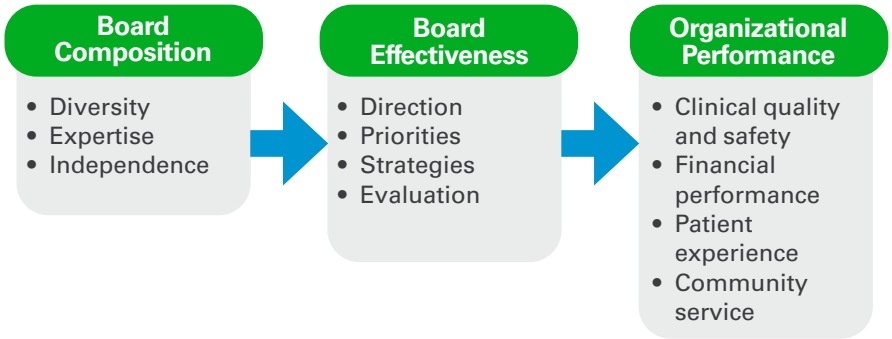
There is substantial evidence that leadership succession planning—both for CEO *and* board members—is spotty in the healthcare field. For example, a study conducted by the American College of Healthcare Executives in 2014 found that only 52 percent of America's hospitals routinely conduct succession planning for CEO positions.[5] Similarly, The Governance Institute's 2019 biennial survey of hospitals and healthcare systems showed that only 44 percent of the participating organizations had a written, current CEO and senior executive plan in place.[6] A lack of succession planning exists in other sectors as well. A global survey of over 5,000 board members in multiple sectors conducted during 2015 and 2016 found that only 46 percent of the companies they governed had a formal planning process for CEO succession.[7]

Key Board Takeaways

The effectiveness of governing boards has a substantial impact on the long-term success of healthcare organizations. Evidence shows that the most important factor affecting board performance is board composition—the board's collective commitment, diversity, expertise, and independence. The board should:

- Have a well-designed board succession planning process. This is instrumental in creating and maintaining excellence in board composition. Unfortunately, formal board succession planning occurs in only about half of America's hospitals and systems.
- If you do not have a well-developed board succession planning process in place, create one by adopting, installing, and sticking with the nine best practices outlined in this article. These practices require buy-in and ongoing efforts by board and executive leadership, but they are straightforward and doable. If instituted and maintained, these practices will have a positive impact on the board's composition and effectiveness and, over time, on the performance and success of the organization for which it has legal and moral responsibility.

Exhibit 1: Linkage Among Board Composition, Board Effectiveness, and Organizational Performance



1 See, for example, G. Tyge Payne et al., "Corporate Board Attributes, Team Effectiveness, and Financial Performance," *Journal of Management Studies,* June 2009; Thomas Jha et al., "Hospital Board and Management Practices Are Strongly Related to Hospital Performance on Clinical Quality Metrics," *Health Affairs,* August 1, 2015; Hongjin Zhu et al., "Board Processes, Board Strategic Involvement, and Organizational Performance in For-Profit and Non-Profit Organizations," *Journal of Business Ethics*, 2016.

2 David Nash, William Oetgen, and Valerie Pracilio (Eds.), *Governance for Health Care Providers: The Call to Leadership,* Boca Raton, FL: CRC Press, 2008.

3 See, for example, Ross Millar et al., "Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research," *The Milbank Quarterly*, December 2013; Jana Oehmichen et al., "Who Needs Experts Most? Board Industry Expertise and Strategic Change—a Contingency Perspective," *Strategic Management Journal,* March 2017; and Jared Landaw, "How Diverse Is Your Board, Really?" *Harvard Business Review*, June 11, 2020.

4 Lawrence Prybil et al., "Building the Case for Including Nurse Leaders on Boards," *Nursing Economics,* July/August 2019.

5 Kevin Groves, "Examining the Impact of Succession Management Practices on Organizational Performance," *Health Care Management Review,* October/December 2019.

6 Kathryn Peisert and Kayla Wagner, *Transform Governance to Transform Healthcare: Boards Need to Move Faster to Facilitate Change*, 2019 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

7 J. Yo-Jud Cheng et al., "Your CEO Succession Plan Can't Wait," *Harvard Business Review*, May 4, 2020.

With respect to *board* succession planning, unfortunately this important governance task is often ignored.[8] A study of 14 of our nation's 15 largest non-profit systems completed in FY 2013 found that only six of these 14 systems (43 percent) had some form of succession plans in place for both board and CEO positions.[9] The Governance Institute's biennial survey had similar findings, with only 42 percent of boards saying they use an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs. Yet, today's environment demands secure board leadership, planned in advance, in order to be successful.

Effective succession planning must consist of more than simply tapping into the same traditional "old friend networks" whenever a board vacancy occurs. Boards must take account of the full range of experiences, personal characteristics, and skills needed on a successful governing board. This, in turn, requires attention both to the qualifications of each potential member *and* the needs of the board as a whole. In a high-performing board, each board member should be expected to possess integrity, passion for the organization's mission, and willingness to ask probing questions. Dedication to attend board and committee meetings, be well-prepared, and participate actively in the deliberations is essential.

Therefore, the process through which board members are identified and appointed is important to the organization's long-term success. We recognize there are some boards that already have highly effective leadership succession policies and processes. However, based on published information and our joint experience in working with numerous and diverse boards, we believe there are a set of practices that would be beneficial for many boards and their organizations to adopt:

1. **Board understanding and commitment to succession planning**. Board education and understanding is essential in building support for any board policy or initiative. There is abundant evidence that a large proportion of hospital and health system boards are not actively engaged in formal succession planning for board positions. If a board believes its composition is an important determinant of its effectiveness, the place to begin is board education and strong commitment to creating and maintaining a strong succession planning program. The board's commitment should be expressed in the organization's bylaws, a formal policy statement, and/or in the board's charter.
2. **A board policy establishing term limits: both the length of board member terms and a formal limit on the number of consecutive terms a member can serve**. Defined term limits are essential to effective succession planning. Their existence—in combination with board commitment to balance new appointments with the retirement of longtime directors—enables the introduction of needed experience, expertise, and fresh thinking. Without them, boards gradually can become too large and/or stale. Of course, careful attention must be given to the timing of term expirations to avoid losing an overly large number of valuable board members in any given year.
3. **Board-approved statement of the basic qualifications for all board appointees and a position description for board members**. All boards should establish, periodically review, and, if indicated, refine a definition of the fundamental characteristics and values that *all* board members should possess. This statement should provide the initial screen against which all potential candidates for board appointment are assessed and become an integral part of a formal position description for board members. The position description needs to clearly spell out the basic role and responsibilities of all board

What Are Some Tools of Effective Succession Planning?

In addition to the best practices identified in this article, below are some of the key *tools* used by high-achieving hospitals and systems:

- **Governance and nominating committee**: The process starts with the appointment of an effective governance and nominating committee whose composition principally includes experienced, longer-serving board members.
- **Dedicated staff support**: The committee (and the board) should be supported by a member of the executive team who has board support as a major component of his/her job.
- **Skills matrix**: The committee and staff should make use of a "skills and experience" matrix to identify high-priority "gaps" to be filled when the terms of current board members expire.
- **Feeder boards**: Some systems make effective use of subsidiary and foundation boards to identify and get to know potential future recruits.
- **Committee membership**: High-performing hospitals and systems also add highly qualified non-board members to certain standing board committees and *ad hoc* work groups.
- **Member education**: Education and training of board members—both for onboarding new members and for all members on an ongoing basis—is done regularly by successful boards; in these educational programs, they involve experienced board members with diverse skills who devote time to educate other members in their areas of expertise.
- **Mentors**: Longer-serving board members take the time to mentor newer and incoming members in systems with effective succession planning.
- **Recruiters**: Some non-profit boards (especially health system boards) have begun to use headhunters, much the way they are used to recruit directors in the corporate world.
- **Compensation**: A minority (around one in 10) of non-profit hospitals and systems compensate board members. Boards should discuss whether compensation is appropriate for their board members and if so, why.
- **Ongoing role for retiring board members**: While term limits are important, successful organizations also can provide opportunities for retiring board members to continue to contribute their skills and experience.

8 The Governance Institute, *Board Leadership Succession Planning*, March 2017.
9 Lawrence Prybil et al., *Governance in Large Non-Profit Health Systems,* Commonwealth Center for Governance Studies, Inc., 2012.

members. This document must also be shared and discussed thoroughly with all potential board candidates.

4. **Standing board committee to lead board succession planning**. To ensure the board's commitment to effective succession planning is sustained, leadership responsibility should be assigned to a specific standing board committee and codified in that committee's charter (usually the governance committee). The charter should clearly define the committee's role, duties, and authority for the succession planning program and specify the decisions that will be reserved to the full board. As an illustration, **Exhibit 2** is the charter of the governance committee of Penn Medicine Lancaster General Health in Lancaster, Pennsylvania.[10] It is recognized that—even when a hospital or health system board has fiduciary responsibility for the organization it governs—the final authority to appoint and remove board members may be vested in a higher authority (e.g., a governmental body that owns the organization or a religious sponsor). In all cases, the decision-making process should be spelled out in the committee's charter.
5. **Assessing the board's evolving needs for talent**. The standing committee that is given lead responsibility for board succession planning should be expected to maintain up-to-date information about current board members, their background, and their terms to use in planning for future board appointments. With that foundation, the committee can and should institute an ongoing process for assessing the board's evolving needs for experience, expertise, and diversity in a dynamic environment and employ this information deliberately in a) setting clear *priorities* for new board appointments and b) systematically identifying highly qualified persons whose qualifications meet the board-approved standards for *all* board members *and* match these *current* priorities well. To be effective, this must be a proactive, continuous process—not a once-per-year event—and recognize that a new range of experience and skills, beyond those traditionally needed, are becoming desirable for boards in meeting contemporary challenges. (See sidebar "New Skill-sets for Board Members.")

Exhibit 2: Sample Governance Committee Charter: Penn Medicine Lancaster General Health

Membership

Members of the Governance Committee shall be appointed annually by the Chairperson of the Lancaster General Health Board of Trustees, in consultation with the Vice-Chairperson of the Lancaster General Health Board and the Chief Executive Officer. The membership shall include: the Chairperson of the Board of Trustees, the Chief Executive Officer, and additional members selected from the Lancaster General Health Board of Trustees or affiliate boards. The Chairperson of the Board of Trustees shall appoint a Chairperson of the Governance Committee.

Charge of the Governance Committee

The Governance Committee (the "Committee") shall assist the Board of Trustees (the "Board") in fulfilling its oversight responsibility relating to proper and effective governance of Lancaster General Health ("LG Health") and each of its affiliates.

Responsibilities of the Governance Committee

The Committee is responsible for each of the following matters:

1. On an annual basis prior to the Annual Meeting of the Board in September, review the Board composition for LG Health and each of its affiliates for which it is responsible for nominating board members. The Committee may develop nominations at other times of the year if vacancies occur. The Committee shall develop a slate of nominees to fill each of the vacancies on each of the boards. The Committee shall also review each of the Board Committees, assess their membership, and make recommendations for their membership. In making its nominations, the Committee shall be guided by a desire to seat boards and committees with diversity of thought and competency. In considering appointments to the LG Health Board, it shall be mindful of the Position Description approved by the Committee for Board Members.
2. The committee is responsible for planning for the succession of Chairpersons and Vice-Chairpersons for the LG Health Board and each of its affiliates. As used in this Charter, the term "plan for the Succession" shall include identifying suitable candidates for these positions, recommending specific actions to develop individuals to be prepared to hold such offices in the future, and in the case of the LG Health Board, nominating individuals to fill these offices.
3. The Committee shall plan for the succession of Chairpersons for each of the standing committees of the Board.
4. The Committee shall maintain a competency and diversity matrix as it plans for filling Board Chair, Vice Chair, Trustee, and Committee positions. It shall work throughout the year to identify talent for the Board and Committees.
5. The Committee shall, on its own or through a subcommittee, consultants, or other designees, periodically as necessary review and make recommendations regarding the corporate structure of LG Health, and all of its affiliates. This may include reviewing documents such as bylaws and charters, and making appropriate recommendations.
6. The Committee shall, by itself or through one or more designees, periodically review the Bylaws of LG Health and its affiliates in order to assure that these documents are current. In addition, the Committee shall review and approve any other major changes proposed to the Bylaws.
7. The Committee shall, consider and recommend actions for the orientation, continued education, and development of the members of the Board of LG Health and its affiliates.
8. The Committee shall periodically conduct, through itself or its designees, Board and Board member evaluations for LG Health and its affiliates in order to assess Board effectiveness, and make recommendations for improvement as appropriate.

Approved 03-21-19: LG Health Board of Trustees

10 See also The Governance Institute's best practice governance committee charter template at www.governanceinstitute.com/templates.

New Skillsets for Board Members

While non-profit hospital and health system boards will continue to seek members with traditional health-care board skillsets—such as finance, business, medicine, real estate, and law—effective succession planning today also must reflect the importance of other 21st-century disciplines, such as:

- Enterprise management
- Cybersecurity
- Digital health and telehealth
- Epidemiology
- Population health
- Nurse Leadership
- Operational improvement (Lean, Six Sigma)
- Social media communication
- Robotics
- Nanotechnology
- "Big data"
- Environmental science

6. **Creating and maintaining an inventory of highly qualified candidates as a foundation for identifying nominations**. *A continuous process* of defining a board's evolving needs for talent, setting priorities, and maintaining an *up-to-date* inventory of potential candidates whose characteristics could meet those needs is a core duty for the committee with lead responsibility to make nominations for board appointments. The direct knowledge and relationships of committee members can and should be augmented by reaching out to individuals or firms known by committee members to have high levels of knowledge, expertise, and contacts in an area(s) the committee has placed priority for a new board appointment(s). The committee should be expected to look proactively beyond the local setting and persons the members already know in the process of seeking potential candidates to include in the inventory. Proper staff support is essential to assist in building, maintaining, and keeping the inventory current and complete.
7. **Interviews with selected candidates for board appointments**. Interviews with persons who are selected by the committee to be on the "short list" of potential candidates to gain more insight and determine their level of interest and potential availability for being nominated for a board appointment should be an integral step in the process of developing nominations. Both members of the committee and the CEO need to participate in these interviews. It is very likely that those who will not be nominated at that particular time can be excellent candidates for appointment to a standing board committee or work group *and* become part of the inventory for consideration as a nominee for a *future* board appointment.
8. **Limiting the number of *ex officio* board members**. With respect to the size of hospital and health system boards, the trend for several years has been toward decreasing the number of voting members. It is The Governance Institute's view that "depending on the type of organization and type of board, between 10–15 members is the ideal size to balance out nimbleness in decision making against the right variety of background and perspectives and having enough members to populate board committees."[11] Other authorities concur.[12] The Governance Institute's biennial survey found the average board size was 12.4 members.[13] Streamlining boards often requires downsizing and this can be challenging. One way to meet this challenge is to limit the number of *ex officio* or "constituency-based" board members. Having a large number of *ex officio* directors raises the question of whether a board is representational rather than strategic. The CEO, chief of the medical staff, and the leader/representative from an owned/employed physician group are the most common voting and non-voting *ex officio* positions according to The Governance Institute's 2019 survey.
9. **Building a process for identifying candidates for board leadership roles**. The identification of highly qualified candidates for board and committee *leadership roles* is a critically important function. Providing advice and assistance in this process should be included in the charter of the board committee leading the board succession planning program. The basic duties of this committee will position it well to conduct this process and nominate persons for leadership roles. Systematic attention to board and committee leadership is essential in ensuring smooth leadership transition and effective board operations.

Closing Remarks

The composition of governing boards—the members' collective diversity, expertise, and independence—and the culture they create in working together are key determinants of board effectiveness. In most hospitals and health systems, the board's composition is shaped by the existing succession planning process—whether it is purposeful and systematic or unfocused and informal—yet only about half of America's healthcare organizations have formal board succession planning programs in place. Boards that have not already done so should take a fresh look at how they have traditionally selected board members and consider amendments that reflect contemporary best practices in board succession planning.

The Governance Institute thanks Lawrence D. Prybil, Ph.D., LFACHE, Community Professor, College of Public Health, University of Kentucky, and Larry S. Gage, J.D., Senior Counsel, Alston and Bird, LLP, and Senior Advisor, Alvarez & Marsal, Inc., for contributing this article. They can be reached at lpr224@uky.edu and larry.gage@alston.com. Thanks also to Penn Medicine Lancaster General Health for allowing their board's governance committee charter to be included in this article as an illustration.

Additional Resources

The Governance Institute has several resources and templates to support your board in recruitment and board leadership succession planning, including:

Board Recruitment
(Intentional Governance Guide)
Board Leadership Succession Planning
(Intentional Governance Guide)
Board Member Job Descriptions
Sample Governance Committee Charter

11 2019 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute, p. 1.
12 See, for example, *Building an Exceptional Board: Effective Practices for Health Care Governance*, AHA Center for Healthcare Governance, 2007, p. 13.
13 2019 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute, p. 7.

All Hands on Deck: Board Support of Employee Wellness in a Time of SARS-CoV-2

By Linda Brady, M.D.

Key Board Takeaways

Boards will need to take action to address the inevitable employee burnout and wellness concerns caused by SARS-CoV-2. Boards can begin by asking the following questions:

- What are the inequities that our staff and workforce face in their communities and lives? What is our role to address these?
- What are we doing to protect the physical and emotional health of our employees?
- Do we have someone designated as a wellness officer? If so, is that individual an integral part of the crisis response team?

Prior to SARS-CoV-2, the 21st century ushered in severe acute respiratory syndrome (SARS, 2003), H1N1 influenza (2009), Middle East respiratory syndrome (MERS-CoV, 2012), and the Ebola (2014–2016) and Zika (2016) viruses. Each has its unique features and prescriptions for prevention, containment, and treatment. The United States was largely spared, therefore never fully testing the systems and preparatory measures that need to be in place.

While we should have comprehended the day would assuredly arrive when the United States would not go unharmed, most hospitals and health systems were not fully prepared for the current SARS-CoV-2 pandemic. Healthcare institutions and their fiduciaries must now directly address and prepare for the enormous emotional toll blanketing healthcare workers as a universal sequela of this pandemic.

Health of the Workforce

Burnout prevention and wellness promotion is a serious issue that healthcare leadership teams have been grappling with and responding to through education, research, and calls for action. Documented is the increasing prevalence of symptoms of burnout among healthcare workers (e.g., emotional exhaustion, depersonalization, and lack of a sense of personal accomplishment). The consequences for healthcare organizations include increased rates of staff disengagement and turnover; staff shortages; lower staff satisfaction, morale, and patient experience scores; and at the far end of the spectrum, risks to quality and patient safety.[1] In recognition of the essentiality of healthcare workers and the quality of their experience, the Institute for Healthcare Improvement added a fourth aim, the joy of work, to the well-established Triple Aim.[2]

Staff stress and burnout predated SARS-CoV-2, but this has served as an accelerant, placing the matter in sharp relief. Many, if not the majority, of our healthcare workers are confronted with unprecedented levels of suffering and loss—of their patients, colleagues, friends, and families. In order to protect their loved ones from the risk that they pose as caregivers of COVID-19 patients, many are choosing to isolate themselves, thus compounding their experience of loss, stress, trauma, and exhaustion. In public health terms, this is a pandemic within a pandemic.

Early on, institutions, local and state governments, and industry associations in the most highly affected regions advocated, competed, and, at times, publicly pleaded for supplies of protective patient equipment (PPE), ventilators, testing capacity, and staff. Not having the tools and resources needed magnified employees' feelings of uncertainty, confusion, fear, and stress, and left them feeling powerless.

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While this crisis has disrupted the healthcare industry and those who work in it, it can also serve as an opportunity for seismic shifts in organizational culture. Even the most well-performing organizations can seize this chance for improvement. Crisis requires leadership that is agile and adapts to circumstance. It calls for "all hands on deck," and the board can best lend its hand through active participation, guidance, and oversight (for example, listening to employees, gathering their feedback, working with management to uncover issues, and creating an action plan for implementing positive changes, as discussed more in this article).

Common Threads: Transparency, Communication, and Engagement

In interviews I conducted with eight healthcare professionals (including physicians, nurses, and board members) about their experience during this time, the need for transparency, widespread communication, and employee participation in decision making were recurring themes. While forever valuable, these approaches can provide an indispensable and secure anchor particularly in the initial stages of a crisis when varying degrees of upheaval, confusion, and shifting information accuracy permeate the organization.

Widespread, frequent, and candid communication throughout the organization led by the CEO is key. The board requires it, as do employees. It is a reassuring framework that fosters trust and minimizes disruption. An integrated strategy of response must include a communication plan that complements but does not overtake or interfere with the needed mode and speed of intervention to the crisis at hand. As well, the board's role is not meant to supplant that of management but rather to be identified as that of the torchbearer for the overall direction of the organizational response.

The Equity Gap Affects Hospitals Too

Embedded in staff stress and burnout is the matter of inequity and disparities. The inequities in the social determinants

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1 Thomas P. Reith, "Burnout in United States Healthcare Professionals: A Narrative Review," *Cureus*, December 4, 2018.
2 Jessica Perlo et al., *IHI Framework for Improving Joy in Work,* Institute for Healthcare Improvement, 2017.

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of health have been laid bare by this pandemic: discrimination, gaps in healthcare access, economic stability, education, housing, and food security have placed Black, Latinx, and other historically disadvantaged populations at disproportionally greater risk of infection and death from the virus. Also exposed are the preexisting social vulnerabilities to the health of workers in healthcare organizations.

We may all be in the same storm, but we are not in the same vessel; some have ships and some have rowboats, revealing the vastly different experiences and outcomes for the "have" and "have nots" of the healthcare workforce in this pandemic. I provide a thumbnail sketch of the experience of frontline providers from two New York City hospitals, a "have" and "have not" facility. Both hospitals are members of large health systems—one well-positioned financially; the other not.

The "have" institution had, either through inventory or the ability to obtain it, relatively adequate supplies of PPE, the financial means to hire costly travel nurses, and per diems to staff for the surges in demand for critical care beds. Staff shortages or absences due to illness were not widespread. Stress and disruption, although unquestionably present, appeared, at least on the surface, contained.

The "have not" institution did not have the same elasticity and suffered major shortages of PPE and staff with higher occurrences of illness and absences due to COVID-19, thus compounding the staff shortage problem. One provider with whom I spoke had contracted COVID-19 and was unable to be tested by their place of employment. Due to staff shortages, this provider felt pressure to return to work before being fully recovered. The sense of uncertainty and fear was more palpable, as was the perception that the system could have better supported its affiliate.

These thumbnail sketches are just that, and are not meant to generalize but rather highlight the need for in-depth case studies from which we all can learn and benefit.

On a macro level, these reports offer a distinctly different experience, yet both organizations cited significant opportunities for improvement in processes reflective of the common threads cited previously: transparency, communication, and employee engagement.

In my New York City experience, "have not" institutions generally serve a greater proportion of socioeconomically challenged minority communities with concomitantly high percentages of Medicare and Medicaid coverage relative to the higher-reimbursing third-party insurers. Frequently, these communities suffer the health disparities associated with inequities in the social determinants of health. Considering that healthcare institutions are among the largest employers in a community, it stands to reason that a meaningful number of the employed healthcare workers live in the surrounding community served by the organization. Of import for future study is a comparison of the rates of illness, morbidity, and mortality of workers in hospitals that serve communities with a higher incidence of social determinants of health inequities and resultant health disparities. How might the rates of illness among hospital employees, principally those at the lower end of compensation, job security, and power, mirror that of the community?

While in the midst of this pandemic, regardless of where your community lies on the spectrum of viral transmission and activity, there is still time to listen, incorporate knowledge gained, formulate an action plan, and prepare for what lies ahead—whether it be this or the next crisis.

Board Actions and Takeaways

As boards lead their organizations through this pandemic, they should commit to an initiative to strengthen and improve the organization and its culture by incorporating lessons learned from this crisis into a strategic action plan. To do this, they can use tools presently in the board toolbox:

- Have the board committee responsible for quality oversight invite representatives of provider/employee focus groups at all levels of the organization to meetings to listen and learn from their experiences and consider implementing their recommendations.
- Obtain board education about experiences and lessons learned from other organizations within and beyond healthcare; for example, the successful interventions undertaken to care for short- and longer-term physical and mental health needs of the heroes of 911.
- Request a culture of safety survey be conducted whenever feasible for feedback from providers and employees.
- Conduct a blameless root-cause analysis of significant problems uncovered to determine the fundamental elements around which change is to be centered.
- With management, formulate an action plan to implement the changes.
- Communicate the plan to employees and provide an opportunity for feedback.
- Incorporate the final action plan into the board strategic planning process.
- Communicate the finalized plan to providers/employees.
- Measure success.

In conclusion, I paraphrase a provider from one of the "have" organizations: while the frontline heroes appreciate the recognition and appreciation heaped upon them, it will ring empty without a bona fide debriefing and implementation of true solutions in response to lessons learned.

The Governance Institute thanks Linda Brady, M.D., Former President and CEO of Kingsbrook Jewish Medical Center in Brooklyn, NY, for contributing this article. Dr. Brady is currently a consultant whose interests center on issues of governance. She can be reached at lbradykjmc@aol.com. The author would also like to express her sincere appreciation to the individuals who gave their time and candor for the interviews that helped shape this article.

What Should the Board Expect...

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The Interim CEO Role

Upon appointment, the interim CEO should conduct an immediate organizational assessment. The interim CEO is much like an internal consultant in performing this evaluation. The goal is to determine needed actions to prepare the organization for the permanent CEO. The results of the assessment should be shared with the board. Ideally, the findings will confirm the previously determined top priorities for the interim CEO. It is not unusual, however, for the assessment to uncover other issues needing attention that were not anticipated by the board.

In preparing the healthcare organization for its next leader, the interim CEO is often faced with tackling difficult challenges and decisions, such as leadership changes on the executive team or financial cuts. Empowering the interim CEO to take these actions can provide needed runway time for the new CEO. The permanent CEO will benefit from a clean slate to begin his or her new administration.

The interim CEO can also play an important role in the recruitment process for the permanent CEO. Of course, the board retains full responsibility for the search and selection process. However, the interim CEO can serve as an informal advisor to the board. For example, as the interim CEO continues to learn more about the organization and its opportunities, he or she can provide an opinion about the specific leadership skills and experiential background that will be needed from the permanent CEO. Candidates for the permanent position will also value the interim CEO's frank perspective on the organization's current situation. The interim CEO becomes a key contributor to the permanent CEO's orientation to the organization.

As the board implements its CEO search communication plan to key constituency groups, the interim CEO is well positioned to emphasize the board's key messages to internal staff. The interim CEO can help reduce organizational anxiety about the search by reinforcing the board's communication points about the progress of the search.

In most cases, the community engagement of the interim CEO will be significantly less than that of the permanent CEO. The interim CEO will most likely focus attention on internal matters. With this reality, the interim period is an ideal time for the board to target its own external community connections.

Board Focus

The most important governance responsibility is to recruit and select a CEO with the experience and talent to lead the pursuit of the healthcare organization's mission and vision. Having an interim CEO armed with a clear board-approved agenda will create a sufficient window for the board to conduct a thoughtful and intentional search for its next CEO.

The Governance Institute thanks Kimberly A. Russel, FACHE, Chief Executive Officer of Russel Advisors and Governance Institute Advisor, for contributing this article. She can be reached at russelmha@yahoo.com.

Keeping the Board's Eye on Quality...

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Now "Zoom fatigue" is a thing. And, according to the Telebehavioral Health Institute, many healthcare practitioners, thrust into delivering teletherapy without adequate time and skill, are struggling under the strain.[1] Here are some causes of Zoom fatigue:

- The inability to use the full range of non-verbal signals and cues that you typically take for granted during in-person meetings.
- The self-consciousness some people feel seeing themselves during a video call.
- The need to maintain a fixed posture and position to keep yourself in view of your device's camera encounter after encounter.
- The inability to mentally or physically escape, even briefly, which is frustrating because being on camera all the time compels nonstop concentration.

Many boards have been holding virtual meetings this year and board members will be familiar with some of the frustration of the videoconference format. They should also imagine what it is like to have potentially dozens of patient encounters a day in this format. Medical staffs should be encouraged to talk about these stresses and explore ways to ameliorate the negative consequences of daily telehealth work shifts.

The board should consider monitoring the hospital's new telehealth expansions through a risk management lens. While the pandemic persists, waivers of liability have been granted in many states and latitude has been widened to facilitate telehealth. However, once the crisis wanes it is unlikely that the plaintiff bar will forgo the opportunities presented by telehealth to bring lawsuits. Counsel should be asked to consider the implications of telehealth as part of the hospital or health system's enterprise-wide risk management efforts. Telehealth provides unique dangers with regard to privacy, data protection, compliance with shifting regulatory requirements, public expectations, and so forth.

The coming years will inevitably bring unforeseen technological breakthroughs, new disruptive paradigms, and additional national health crises. How effectively the board deals with the dramatic shift to virtual care and distance medicine will be a harbinger of its ability to weather future challenges of a similar nature and keep its eye focused on the quality of care it delivers to its community.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

1 Marlene M. Maheu, "Zoom Fatigue: What You Can Do About It," Telebehavioral Health Institute, June 11, 2020.

Keeping the Board's Eye on Quality during the Telehealth Boom

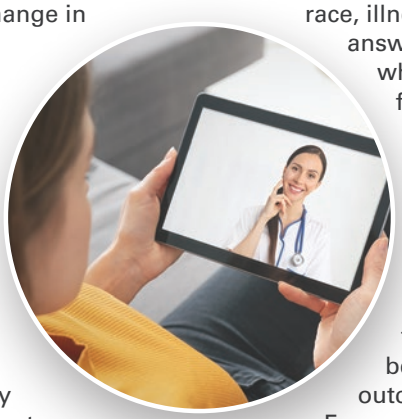
By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

The ongoing COVID-19 pandemic has triggered many hospital governing bodies to step back and reassess their strategic plans and initiatives, priorities, and resources. Boards are also looking at the changed healthcare landscape and asking if they should be doing anything different in their oversight of quality. One area ripe for scrutiny is the rapid expansion of telehealth being delivered directly by hospitals and health systems.

The coronavirus has generated a huge demand from both providers and patients for various forms of "distance medicine." In the face of the pandemic, many of the traditional regulatory hurdles to telemedicine have been removed and with them the protections they were intended to provide. Elimination of burdensome regulations has been beneficial in spurring the growth of telehealth options to protect both patient and healthcare providers. The option to treat patients through telehealth has huge potential to increase access to care and reduce costs. But these lost regulatory barriers were also tools to ensure that this fast-developing delivery modality was rolled out thoughtfully and patients were not inadvertently harmed in the process. As a result, it is important that hospital boards monitor the quality of care resulting from this sea change in healthcare delivery.

The Board's Role in Monitoring Telehealth

Where should board members direct their attention if they wish to understand the impact of their telehealth initiatives? Initial inquiry might begin with basic infrastructure. Many hospitals have rushed to set up the necessary digital tools to facilitate telemedicine without necessarily vetting the strengths and weakness of the products being pushed by telehealth vendors. The quality of care delivered can be impacted by the capabilities of these telecommunication platforms to carry data, record information, provide user-friendly interfaces, and mesh with existing electronic health records. Some systems require patients to have a computer or smartphone and the sophistication to link the patient appropriately to a telehealth provider. Yet many poor patients lack this equipment and older patients in particular may not have the computer literacy to take advantage of more challenging telehealth hookups.



Board members should keep in mind that the premise that telehealth enhances access to care and reduces costs is assumed but not proven. With little reimbursement for telemedicine until recently, the impetus to collect data to understand the impact of virtual medical care encounters has been anemic. The National Quality Forum has not endorsed a single telehealth-specific quality measure. However, this should not stop hospitals from looking at elements of quality and value that will help to clarify the impact of telemedicine. The rapid rise in numbers of telemedicine visits can provide hospitals with a trove of informative data if they are willing to collect and analyze it. For instance, demographic data about those receiving virtual visits (e.g., zip code information, race, illness, and age) can help answer questions about whether care is actually facilitating access equitably. Are patients who can't afford unlimited phone minutes missing out on telehealth options? What about older patients who are easily intimidated by technology? Data can be collected to research outcomes and effectiveness. For example, are patients who receive telehealth visits more likely to have follow-up visits in the ED or be readmitted to the hospital than those receiving traditional office visits? Developing patient-reported outcomes measures specific to a telehealth interaction is clearly an area ripe for attention. Currently, many health systems use patient experience surveys for telehealth encounters, similar to what a patient receives after an in-person visit.

The hospital board (or its quality subcommittee) also needs to pay attention to how the hospital prepares practitioners to deliver telehealth. Most doctors have not had specific training in how to monitor and provide care using virtual modalities. Very few hospitals specifically privilege doctors and nurse practitioners for telemedicine based on established criteria to ensure they can do so competently. Boards can help in these efforts by challenging their medical staffs to develop robust orientations to telemedicine and begin to think hard about how they can assess the skills of medical staff members to ensure they deliver virtual care capably. As this work is performed, policies and procedures should be developed to provide appropriate guiderails to this growing activity.

Effectively managing the unique stresses on practitioners who are suddenly providing large quantities of care through telemedicine will also be a new area of focus. A year ago, many board members had not heard of Zoom.

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Key Board Takeaways

As telehealth continues to expand, the board should monitor the quality of care resulting from this rapid change in healthcare delivery. This includes taking the following steps:

- Consider whether the telehealth infrastructure is hindering the organization's ability to provide high-quality care. For example, does the platform provide a user-friendly interface that makes it easy for patients to connect with a telehealth provider?
- Leverage data to better measure and understand the quality outcomes and effectiveness of telehealth encounters at your organization.
- Ensure that the necessary training is taking place so that doctors are prepared to effectively deliver telehealth. Challenge the medical staff to develop robust orientations to telemedicine and assess the skills of medical staff members to ensure they deliver virtual care capably.
- Encourage the medical staff to talk about "Zoom fatigue" and what can be done to improve daily work experiences.
- Monitor the hospital's new telehealth expansions through a risk management lens.