GOVERNANCE

ACROSS *the* CONTINUUM

Leadership Accountability for Creating Healthy Communities

A Governance Institute Signature Publication

THE
GOVERNANCE
INSTITUTE

A service of NATIONAL RESEARCH
Corporation

GOVERNANCE

ACROSS *the* CONTINUUM

Leadership Accountability for Creating Healthy Communities

A Governance Institute Signature Publication

About the Authors

DAN F. SCHUMMERS IS CHIEF OF STAFF AT THE INSTITUTE for Healthcare Improvement (IHI). He has worked closely with IHI's president and CEO, Maureen Bisognano, and the IHI board of directors since he joined IHI in 2004. He coauthored three volumes in the series: *10 Powerful Ideas for Improving Patient Care* (Health Administration Press). Mr. Schummers holds a bachelor's degree in political science from the University of Chicago.

Contributing Authors

The author, the Institute for Healthcare Improvement, and The Governance Institute extend sincere thanks to the healthcare leaders who devoted their time to participating in interviews and reviewing drafts for this publication: Mary Brainerd, president and CEO, and Barbara E. Tretheway, senior vice president and general counsel, HealthPartners; Betsy Aderholdt, president and CEO, Genesys; George Kerwin, president and CEO, Bellin Health; and Keith Myers, president and CEO, LHC Group.

Mary K. Brainerd is president and CEO of Minnesota-based HealthPartners, the largest, consumer-governed, non-profit healthcare organization in the nation. Under her leadership and direction, HealthPartners has experienced record growth and is often recognized as a national leader in the healthcare industry. In her role, Ms. Brainerd leads more than 22,000 employees in the HealthPartners integrated system, which includes a care delivery system with more than 1,700 physicians at nearly 140 primary, specialty, and urgent care clinics, six hospitals, a large dental practice, 1.4 million members in top-rated medical and dental health plans, and HealthPartners Institute for Education and Research. Under Brainerd's leadership the organization has received numerous accolades for outstanding patient care, health plan service, and its charitable community work.

Barbara E. Tretheway is the senior vice president and general counsel for HealthPartners. In this role, Ms. Tretheway is responsible for providing comprehensive legal advice and direction to the management and governance of HealthPartners and its affiliated entities. She also is responsible for managing the legal, clinical, and enterprise risk management programs, business continuity planning, and sustainability programs of the organization. Prior to joining HealthPartners, Ms. Tretheway practiced law at Gray, Plant, Mooty, Mooty & Bennett, P.A. in Minneapolis. She was chair of the Health, Human Services, and Non-Profit Organizations Practice Group, as well as a principal in its Employee Benefits department. Ms. Tretheway graduated with a Doctor of Law (J.D.) degree from the University of Wisconsin Law School in 1988 (Order of the Coif). She is a Certified Employee Benefits Specialist. Ms. Tretheway is a member of the American Bar Association, Minnesota State Bar Association, Wisconsin State Bar Association, and American Health Lawyers Association. Ms. Tretheway is a member of the Finance Committee of People, Inc. Ms. Tretheway was an adjunct professor at the Hamline University School of Law.

Elizabeth (Betsy) L. Aderholdt is president and CEO of Genesys Health System, an integrated delivery healthcare system in Grand Blanc, Michigan, committed to leading the transformation of healthcare to improve health outcomes and patient and provider experience, while reducing overall healthcare costs. Ms. Aderholdt is a results-oriented, innovative, strategic leader who engages patients and families, associates, physicians, and the community in designing new models of care and in driving performance improvement. Her career in healthcare administration spans nearly 30 years. Prior to joining Genesys, Ms. Aderholdt served as president at St. Mary's Health Center in Jefferson City, Missouri, for five years. She also served at Carilion Health System in Virginia as the system-wide executive responsible for Primary Care Services; Piedmont Medical Center in Atlanta, Georgia; and SunHealth based in North Carolina. Genesys Health System has been a member of The Governance Institute since 1999.

George F. Kerwin, FACHE, is president and CEO of Bellin Health, and has served in his present capacity since 1992. Bellin is an integrated health system serving a population of 600,000 people in Northeastern Wisconsin. Bellin was an original member of the Quality Management Network, and is currently active in IHI's Triple Aim initiative. Mr. Kerwin is a fellow of the American College of Healthcare Executives, and a board member of the Green Bay Packers. He serves as chairman of the board of directors of the Wisconsin Collaborative on Healthcare Quality.

Keith G. Myers is cofounder of LHC Group and has served as chairman and CEO since 1994. He is a cofounder and serves on the board of the Partnership for Quality Home Healthcare. Mr. Myers received credentials from the National Association for Home Care and Hospice in 1999 and was granted credentials by the Healthcare Financial Management Association in 2005. In June 2003, Mr. Myers was named the regional Entrepreneur of the Year for outstanding performance in the field of healthcare services and was officially inducted as a lifetime member of the National Entrepreneur of the Year Hall of Fame in November of the same year. He has participated in the preparation of numerous home health policy white papers and presentations to members of both the U.S. Senate and U.S. House of Representatives.

Institute for Healthcare Improvement

THE INSTITUTE FOR HEALTHCARE IMPROVEMENT (IHI) IS A LEADING INNOVATOR IN health and healthcare improvement worldwide. For more than 25 years, IHI has partnered with visionaries, leaders, and frontline practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. Together, IHI and its partners build the will for change, seek out innovative models of care, and spread proven best practices. When it comes to raising the quality of health for all, IHI sees boundless possibilities, and though there are walls in front of us, IHI will not rest until healthcare reaches the other side. Learn more at www.ihi.org.

The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

The Governance Institute is a service of National Research Corporation. Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country. For more information about our services, please call toll free at (877) 712-8778, or visit our Web site at GovernanceInstitute.com.

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications, whether caused by The Governance Institute or its sources.

Table of Contents

Foreword

MANY YEARS AGO, I GAVE A PLENARY PRESENTATION AT A LARGE NATIONAL GOVERNANCE meeting to share best practices in governing during changing and challenging times. After the presentation, a few board members approached me to express their sympathy...sympathy that I had to work with such terrible hospitals, urging and engaging them to improve. So I asked these board members to tell me about their last several board meetings. They described fantastic presentations about growing volume and margins, and about acquisition of smaller hospitals and physician practices. I then asked about patient care, outcomes, and care across the continuum. They dismissed this as "clinical work," while also assuring me that the kind of variation I described in my talk "didn't happen" at their facilities and that their patients experienced only safe and effective care.

Times have thankfully changed. Board members today see their fiduciary roles in a much different light. When I visit boards these days, I ask them four questions:

1. Do you know how good your organization is?
2. Do you know where you stand relative to the best?
3. Do you know where the variation exists?
4. Do you know the rate of improvement over time?

I find that boards are now literate in every aspect and link cost and quality as a matter of normal governance.

Another welcome change I've seen is the powerful and growing voice of the patient. I rarely sit in on a board meeting that doesn't start with a story of a patient experience; some incredibly positive and affirming, and some devastating. The personal connection to the best of care and to the failures in all systems provides a renewed sense of purpose and connects the board and leadership team to the real implications of their strategic decisions.

It's once again a time of great change in healthcare. Mental models have shifted dramatically in the last several years. We've moved from an organizational focus, to seeing the vitality of the community. Models have shifted from ones where the physicians were seen as the primary customers, to models of care where leaders and staff work to co-produce health *with* patients.

The role of the board has evolved with the same speed. I've seen great impact when board members from industries outside of healthcare bring their business knowledge on Lean, customer service, production systems management, and strategy, and combine it with the knowledge and strong sense of their own community's assets. Boards now look well beyond the walls of their own institution to define their mission and goals.

As we move from volume-driven payment models to a value-driven system, and strive to achieve the Triple Aim of improved health, better care, and lower costs per capita, voices from all sectors of society are driving new ways to see value in healthcare. And, as you learn in these case studies, the voices of physicians and patients, when combined with the kind of visionary leadership described in this publication, show us the path to better care and better health in the 21st century.

Maureen Bisognano

Maureen Bisognano
President & CEO
Institute for Healthcare Improvement

THE HEALTHCARE INDUSTRY HAS HISTORICALLY BEEN (AND CONTINUES TO BE, IN many respects) a segmented, "cottage" industry with individual groups or types of providers serving patients in silos, addressing only one aspect of a patient's needs at a given time. Now, industry and policy movement continues to accelerate towards the need for care providers in all segments to integrate across the continuum and take responsibility for healthy communities. In order to sustain their organizations through this major structural shift, healthcare leaders need to develop provider capabilities to care for the "whole patient," in interdisciplinary teams of caregivers who communicate and share information, via convenient access points for the patient, with seamless transitions from one segment of care to the next.

Post-acute, sub-acute, and non-acute providers play an increasingly important role in acute care as outcomes are being tied to readmissions and value-based payments, increasing the importance of care coordination and creating joint accountability for patients across care settings. Due to this essential connection, all provider segments have a growing role to play in quality improvement and enhancing their ability to deliver patient-centered care at all points along the care journey. The healthcare industry can no longer focus on physicians and hospitals; providers across the continuum will be playing more equal roles in patient outcomes and value strategies. Achieving this kind of cultural transformation will require innovative leadership, as the boundaries of healthcare governance responsibility expand and evolve. To truly provide a community benefit and fulfill healthcare organizations' missions we must create value, delivering safe and patient-centered care in a coordinated, seamless system.

Healthcare leaders across the industry are confronting the Triple Aim challenge of improving overall health, enhancing quality of care and the patient experience, while simultaneously lowering costs. The Governance Institute's 2014 signature publication, in partnership with the Institute for Healthcare Improvement, provides philosophy, purpose, motivation, and method for healthcare leaders to realize and act upon their renewed accountability for creating healthy communities.

Jona Raasch
CEO
The Governance Institute
A service of National Research Corporation

Executive Summary

IN THE DECADE AFTER THE PUBLICATION OF THE LANDMARK Institute of Medicine (IOM) reports *To Err Is Human* (2000)[1] and *Crossing the Quality Chasm* (2001),[2] healthcare governing boards increasingly came to understand their fiduciary responsibility as broader than just financial stewardship. Healthcare boards are also responsible for the quality and safety of the care their institutions deliver. Large-scale initiatives and research during this time both showed that high-performing healthcare organizations tended to have engaged, informed, and educated governing boards. This era of expanding accountability and scrutiny in healthcare was mirrored in the corporate world after the bankruptcies of Enron (2001) and MCI WorldCom (2002), and the passing of Sarbanes-Oxley (2002).[3]

Since 2008, the boundaries of healthcare governance responsibility have expanded farther. The articulation of the Triple Aim by Berwick, Nolan, and Whittington in 2008[4] provided a simple, but challenging framework—simultaneously improving population health, improving the patient care experience, and reducing per-capita costs. The global economic recession and the passing of the Affordable Care Act in 2010 added urgency and momentum and highlighted the need for a holistic framework like the Triple Aim.

Healthcare organizations and their governing boards are now in a new era. Health systems are increasingly accountable for the overall health and well-being of the communities they serve, in addition to the quality and safety of the care they deliver. For years, healthcare organizations have recognized this shift and begun to respond. Most have rearticulated their mission and vision statements to reflect the new reality. Leading organizations are also pursuing novel strategies to engage in their communities to promote health and healthy lifestyles. Recognizing that the social determinants of health play larger roles in the overall health of the community than the care they deliver, more and more organizations are pursuing novel strategies to engage their communities in promoting health and healthy lifestyles.

Care is increasingly delivered in non-traditional settings—not only outside the walls of the hospital, but also outside the walls of the entire healthcare system. As such, careful coordination and true continuity of care are key elements of the 21st century healthcare system.

The role of effective healthcare governance in this new era has never been more important. Governing bodies find themselves in unfamiliar territory. Yet their commonly found attributes—community representation, business representation, patient and family representation, and physician representation—will allow them to respond to the new era effectively. Ensuring an effective response and the proper stewardship of the organizations they govern requires another broadening of their responsibilities.

To find out how innovative organizations are responding to healthcare's new era, we interviewed leaders from four organizations:

- HealthPartners (Bloomington, Minnesota)
- Genesys (Grand Blanc, Michigan)
- Bellin Health (Green Bay, Wisconsin)
- LHC Group (Lafayette, Louisiana)

We asked these leaders to discuss their organizations' response to the new healthcare environment. We also asked them to focus on how their governing bodies are adapting to the environmental changes in terms of their focus, composition, structure, and functions.

---

1   Committee on Quality of Health Care in America, Institute of Medicine (L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds.), *To Err Is Human: Building a Safer Health System*, National Academies Press, 2000.
2   Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academies Press, 2001.
3   J.E. Orlikoff, "Building Better Boards in the New Era of Accountability," *Frontiers of Health Services Management*, Vol. 21, No. 3 (Spring 2005), pp. 3–12.
4   D.M. Berwick, T.W. Nolan, and J. Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs*, Vol. 27, No. 3 (May–June 2008), pp. 759–769.

Three of the organizations are integrated health systems, and the fourth (LHC Group) is a national leader in partnering with healthcare systems to provide post-acute care. Together, these organizations are not meant as a representative sample. In a nation so demographically diverse, a representative sample may not exist. Our hope is that, in profiling these organizations and giving their leaders an opportunity to describe how their organizations are responding to the substantial changes in healthcare, other leaders can benefit from their experiences and thinking.

HealthPartners: Transforming Care Delivery

HealthPartners is an internationally respected leader in system-wide transformation. It has received acclaim for its breakthrough approach to caring for patients with diabetes and other chronic diseases. This approach and results, if effectively replicated nationally, could save the U.S. billions of dollars and dramatically improve outcomes for millions of patients.

HealthPartners has engaged in a steady expansion in recent years, carefully identifying partner organizations and pursuing formal affiliations. Its increasing presence in the region of Bloomington, Minnesota, is almost always welcomed due to its successful track record and attractive mission.

President and CEO Mary Brainerd and senior vice president and general counsel Barbara Tretheway spoke about HealthPartners' approach to governance, especially in light of the organization's recent spate of mergers. Some of the lessons that emerged from their account include:

- Make system-wide transformation an explicit board-level responsibility by creating or re-chartering a board committee with this sole focus. The committee should be responsible for developing appropriate measures, establishing a common language around the measures, and holding leadership responsible for progress against the measures. In executing these responsibilities, the committee should work with leadership closely, and leverage their collective expertise drawn from past and similar experiences. In the new era of cross-continuum governance and community health, the end goal should be health transformation.

- In pursuing joint ventures, affiliations, and mergers, alignment around strategic vision is paramount. For HealthPartners, the strategic vision has to be in service of the community. Structure must follow strategy.

- Maintain and utilize the deep community connections of existing governing boards. When affiliating with an organization, some degree of change in the board's composition is necessary, but maintaining as much of the existing community-based board as possible is key. Establishing true alignment requires listening to and learning from existing board members about the unique health needs and history of their community.

- Create productive and trusting relationships with other organizations long before considering formal affiliation. A positive track record of mutually beneficial collaboration and learning will make any merger easier to navigate in the short term, and more productive in the long term.

- The end goal of expansion and mergers should be community impact. Market power is important only as a means to improve community health and lower costs.

Genesys: Continuous Reinvention

Genesys is an integrated healthcare delivery system located in Grand Blanc Township, Michigan, just south of Flint. Genesys is a leader in pursuing the goals of the Triple Aim and was a participant in the Centers for Medicare & Medicaid Services (CMS) Pioneer Accountable Care Organization (ACO) program.

Historically, the region in which Genesys resides—Genesee County—has been defined by the corporate presence of General Motors (GM) and the union presence of the United Auto Workers (UAW), both of which started in Flint. The financial troubles suffered by GM and the community-rattling decline in auto manufacturing employment cast a long shadow over the region. As a result, change and continuous reinvention are in the DNA of Genesys.

Pressures from a dominant single employer, strong labor unions, and significant managed care penetration motivated healthcare leaders in the region to rethink a strategic vision for delivering sustainable healthcare. This led to radical restructuring including the combination of four previously distinct hospitals into one new facility. What emerged is an aligned system covering the continuum of care committed to improving the health and well-being of the surrounding community.

President and CEO Betsy Aderholdt spoke about how Genesys revitalized this strategic vision and how Genesys' governing board shifted its focus and sense of responsibility. At the heart of Genesys' governance approach is an understanding that they are the stewards of an indispensable community asset. Their focus is on how best to use that asset in light of the unique and changing health needs of their community, and how to most effectively engage with other key community assets to co-produce health in Genesee County. Lessons that emerged from Genesys' story include:

- Overcoming the barriers between silos to create a seamless system of care should be the goal of leadership and governance alike.
- Bring together community stakeholders, medical stakeholders, health system leadership, and health system governance to think through how the health system can be a vital community asset.
- In creating and articulating a system-wide strategic plan, ensure that the vision is driven by the broadest possible view of health and the care continuum.
- Create governance structures designed to evaluate the community's health needs and map the community's assets. Consider a new board-level committee such as Genesys' Advocacy Committee.
- Ensure physician engagement.
- Consider all types of engagement in multi-sector community health alliances: leadership, participation, advisory, etc.
- Work with all stakeholders to develop partnerships focused on managing and improving population health.
- "Don't resist change, lead it."

Bellin Health:
Fostering a Culture of Health from Within

Bellin, an integrated healthcare delivery system headquartered in Green Bay, Wisconsin, is known for both its exemplary hospital and for a unique and highly successful approach to improving employee health and lowering employee health coverage costs.

Bellin developed a model called Business Health Solutions, based on an initiative that started within Bellin more than 10 years ago. Faced with increasing competition, shrinking budgets, and runaway health coverage costs, Bellin's leaders designed a system to evaluate their employees' health and its impact on their costs of providing coverage. They fostered a culture of health within the organization and tied premium discounts to completion of health risk appraisals and to improvements in health. The results were remarkable. They reduced the cost of employee health coverage by a third in just two years. Over the first eight years, they saved an estimated $13 million in coverage costs for their workforce. Just as remarkable were the measurable improvements in employee health. Bellin was among the

first organizations in the nation to design and apply a model that achieved the goals of the Triple Aim.[5]

Recognizing that their situation was anything but unique, Bellin leaders then took their innovative approach into the community. They worked with local businesses—first just a few, and later hundreds—to design shared goals for employee health and customized care models that promised not just a slowdown in the growth of health coverage costs, but an actual reduction. In the companies that use Bellin's full model of consumer-driven health plans, onsite services, health risk appraisals, and attendant incentives, healthcare costs run 20 percent below national averages.[6]

Bellin was an early innovator in the area of promoting employee health, and now the idea is everywhere. Bellin's president and CEO, George Kerwin, spoke about how Bellin's governing board has contributed to the organization's success. Some of the lessons that emerged from Bellin's story include:

- Employee health should be a key focus for all healthcare organizations. It can lower health coverage costs, improve productivity, and serve as a model for all organizations in the community.
- Think about new and innovative ways to bring health improvement strategies into the community (e.g., employee health promotion programs, health services located onsite at local businesses and institutions).
- Consider longer terms for board members to deepen community connections and create a constancy of purpose (or find other ways to keep emeritus board members engaged, such as an advisory council or committee service).
- Patient and family member participation on boards and board committees is essential.
- Though few organizations have figured out the best set of measures for population health and community well-being, establishing objective measures around these areas and holding leadership accountable is a central responsibility for governing boards.
- Governing board members' community connections can help identify innovative ways to make an impact on community health.
- Engage family practice physicians in governance since their professional mindset is already focused on keeping people healthy.
- Business leaders have unique insights into the costs of poor population health. Leverage these insights by including such leaders on governing boards to make new connections and design new initiatives.
- In an era of increasing affiliations, cross-continuum care delivery, and moving beyond the traditional walls of hospitals and health systems, be mindful of brand strength and reputation.

5   M. Bisognano and C. Kenney, *Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs*, Jossey-Bass Publishers, 2012.
6   *Ibid.*

- Consider and pursue all types of roles in multi-sector community health alliances.

LHC Group: Focusing on Health at Home

LHC Group, located in Lafayette, Louisiana, is one of the leading post-acute care organizations in the U.S. By providing home health, hospice care, long-term acute care, and community-based services to thousands of patients across 26 states, LHC Group focuses on one of the most important priorities in the era of community health: keeping people healthy at home.

Representative of the cooperation now required for true cross-continuum care, LHC Group understands its core role as one of partnership. It seeks to improve the quality of life in the U.S. through the services it provides and the partnerships it establishes with healthcare systems. LHC Group defines its purpose as "it's all about helping people." As hospitals and health systems increasingly see their mission as improving and supporting health (in addition to delivering high-quality care), post-acute providers, as essential partners in the continuum of care, should see their goals similarly. While acknowledging the broad continuum of care, of which LHC Group's agencies are a part, president and CEO Keith Myers sees the hospital-based health systems as the centers of healthcare in their communities. As such, LHC Group has carefully supported hospital and health system brands in its affiliations and joint ventures, rather than focusing efforts on creating LHC Group brand strength.

For Myers, the surest path to success under the new population health models is objective measures of quality. The shift in what quality of care means (and how it's measured) that hospitals went through in the past decade is increasingly understood by post-acute care organizations. Further, the organization has emphasized the need for certain expertise on the governing board, such as academic and healthcare policy, and helping LHC Group's board navigate the industry changes is a crucial duty for senior leadership. Finally, LHC Group's focus on effective and productive partnerships with health systems requires an expertise in interacting with external governing boards.

Lessons learned from LHC's leadership and board experience include:

- "Post-acute" may not be the right label for the services provided by skilled nursing facilities, home health agencies, inpatient and outpatient rehabilitation facilities, and long-term acute care facilities. In today's healthcare environment, these essential parts of the health continuum should be viewed as both upstream and downstream players, with as much responsibility for keeping patients out of the hospital as they have for caring for patients after a hospital stay.
- Objective quality measures, such as rehospitalization rates, are essential. Subjective measures are also important, but success in an increasingly competitive market requires transparent evaluations of quality against objective measures.

- For organizations that seek to improve health through partnerships with existing health systems, be wary of emphasizing a separate brand. Hospitals and health systems are essential community assets, and focusing on the clinical, patient-focused care collaboration of the hospital and health system partnership can be the most effective strategy for improving health across the continuum.
- A central responsibility for senior leadership is to establish systems and processes that allow governing boards to adequately respond to the changes sweeping through healthcare. It is important to devote time to address the changes as part of the strategic planning process and seek outside expertise to present views that may differ from management's.
- Since the move away from fee-for-service payment models is happening slowly, leadership teams and governing boards need to continue to operate and govern effectively in the current model while at the same time collaborating on innovations to respond to new care-delivery and payment models.
- For organizations that operate through partnerships, tending to the interactions between governing boards, and deriving the most informative and actionable information from those interactions, are essential.

Introduction

IN AN INTERVIEW FOR *THE JOINT COMMISSION JOURNAL ON Quality and Patient Safety* published in December 2006, Dr. Donald Berwick, then president and CEO of the Institute for Healthcare Improvement (IHI), said, "I think we should declare 2007 'The Year of Governance'..."[7] Earlier that summer, IHI had concluded its groundbreaking 100,000 Lives Campaign—a first of its kind effort to engage more than 3,000 U.S. hospitals in saving lives by lowering their mortality rate. The campaign's approach to lowering in-hospital mortality centered on the reliable implementation of six evidence-based interventions (e.g., medication reconciliation to prevent adverse drug events, proper care for heart attacks, "bundled" processes for eliminating certain hospital-acquired infections). The campaign was also set up as a learning structure—a network of connected organizations whose collective experience in the initiative provided a rich source of knowledge about how to bring about transformative improvements, including how governing boards

contributed to these improvements. It was this knowledge Dr. Berwick was referring to when he declared that 2007 should be the "Year of Governance."

At the time of the interview, Dr. Berwick and IHI were gearing up for the launch of the successor initiative to the 100,000 Lives Campaign. The 5 Million Lives Campaign, launched in late 2006, aimed to engage even more hospitals to prevent five million instances of patient harm. The 5 Million Lives Campaign included the six interventions (or "planks") from the first campaign and added six more, including a plank on governance leadership called "Get Boards on Board." The experience from, and analysis of, the 100,000 Lives Campaign showed that the organizations demonstrating the most outstanding work, irrespective of which intervention they were working on, shared common characteristics, "including clear aim setting and prioritization, transparent measurement, investment in building quality improvement capacity, and mindfulness of the role that every stakeholder in the care process has in driving improvement."[8] In most cases, these core characteristics were supported and driven by an informed and engaged governing board that understood its role in ensuring safe and high-quality care. Not only was this kind and level of board engagement essential to success within a healthcare organization, but Berwick asserted it was also an essential and missing element to solving the nation's most intractable healthcare problem—the broad spread and implementation of proven best practices. His quote from *The Joint Commission Journal* interview ends with:

> "...[We must] start to put back on the table of the boards not just a request, but an absolute sense of obligation, that learning who does better and then doing at least that well is central to proper stewardship of healthcare. Until leaders own that problem, I don't think spread is going to happen. The buck stops in the boardroom."[9]

The idea Berwick articulated was not new in 2006. For years, innovative thinkers had argued that the delivery of safe and effective healthcare relied on engaged, informed, and accountable governing boards. The roots of this knowledge go back as far as management theory, but events at the turn of the current century played a catalyzing role.

Catalysts for Change

In 1999, the Institute of Medicine (IOM) published what may be its most famous report. *To Err Is Human: Building a Safer Health System* caused a firestorm in healthcare and in the general

---

7   Paul M. Schyve, "An Interview with Donald Berwick," *The Joint Commission Journal on Quality and Patient Safety*, Vol. 32, No. 12 (December 2006), p. 666.

8   5 Million Lives Campaign, *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide*, Institute for Healthcare Improvement, 2008. (Available at www.ihi.org.)

9   Schyve, 2006.

public. Many, including the media, focused on the report's estimate that as many as 98,000 people died annually from preventable medical errors. The evidence that healthcare facilities were not only unsafe, but dangerously so, and were responsible for nearly 100,000 avoidable deaths each year, stunned the industry and the country.

Two years later, the giant energy company Enron imploded. A year after that, MCI WorldCom surpassed Enron as the largest bankruptcy filing in U.S. history. Mismanagement, outright fraud, and failures in governance were at the heart of both collapses. These failures "heightened public consciousness about the importance of governance and have also raised the bar on what is required, acceptable, and considered best-practice governance performance.... [Healthcare is in a] new era of board accountability, scrutiny, and reform that imposes significant new burdens and challenges on boards, and board members."[10] Some of this "new era" stems from Congress' response to the Enron and WorldCom scandals—the passing in 2002 of what is known as Sarbanes-Oxley (officially the Public Company Accounting Reform and Investor Protection Act). Sarbanes-Oxley created strict financial governance requirements for all for-profit public companies. While no equivalent law has been passed for not-for-profit organizations, scholars have persuasively argued that not-for-profit healthcare organizations should learn from Sarbanes-Oxley and apply the lessons to their own boards. Irrespective of actual legislation, almost all agreed that healthcare organizations were indeed in a new era of accountability. More and more, thanks to influential scholars and leaders in healthcare, fiduciary responsibility and accountability were understood as applying to far more than just financial matters.

The same year as the 2002 Enron scandal, IOM published its follow-up report, *Crossing the Quality Chasm: A New Health System for the 21st Century.* This report didn't generate the same buzz as *To Err Is Human,* but many consider it the more important and ultimately more influential report. Its authors laid out six aims for the 21st century health system—a system that delivered care that is safe, effective, patient-centered, timely, efficient, and equitable. The report also made clear how crucial a role senior leadership must play:

> "The role of leaders is to define and communicate the purpose of the organization clearly and establish the work of practice teams as being of highest strategic importance. Leaders must be responsible for creating and articulating the organization's vision and goals, listening to the needs and aspirations of those working on the front lines, providing direction, creating incentives for change, aligning and integrating improvement efforts, and creating a supportive environment and a culture of continuous improvement that encourage and enable success."[11]

The *Quality Chasm* report also emphasized the importance of governance development: "Training and development for both management and governance should recognize the important role these groups play in collaborating with clinicians to make possible the types of changes needed for the health system of the 21st century."[12]

Throughout the decade following *To Err Is Human* and *Crossing the Quality Chasm*, much of the scholarship on healthcare governance focused on helping everyone in the industry understand that a healthcare governing body's fiduciary responsibility includes not only the financial health and vitality of the organization, but also the quality and safety of the care delivered to patients. In the current decade, healthcare organizations and systems have come to understand that this responsibility is even broader, and now comprises not only the delivery of healthcare but also the *health* of the populations they serve. If 1999 to 2008 was the dawn of a new era of accountability for quality and safety, 2008 to today is the dawn of a new era of accountability for population health and vitality.

---

10 J.E. Orlikoff, "Building Better Boards in the New Era of Accountability," *Frontiers of Health Services Management*, Vol. 21, No. 3 (Spring 2005), pp. 3–12.

11 Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C., USA: National Academies Press, 2001.

12 *Ibid.*

Exhibit 1. Healthcare Spending as a Percentage of GDP, 1980–2011

Percent
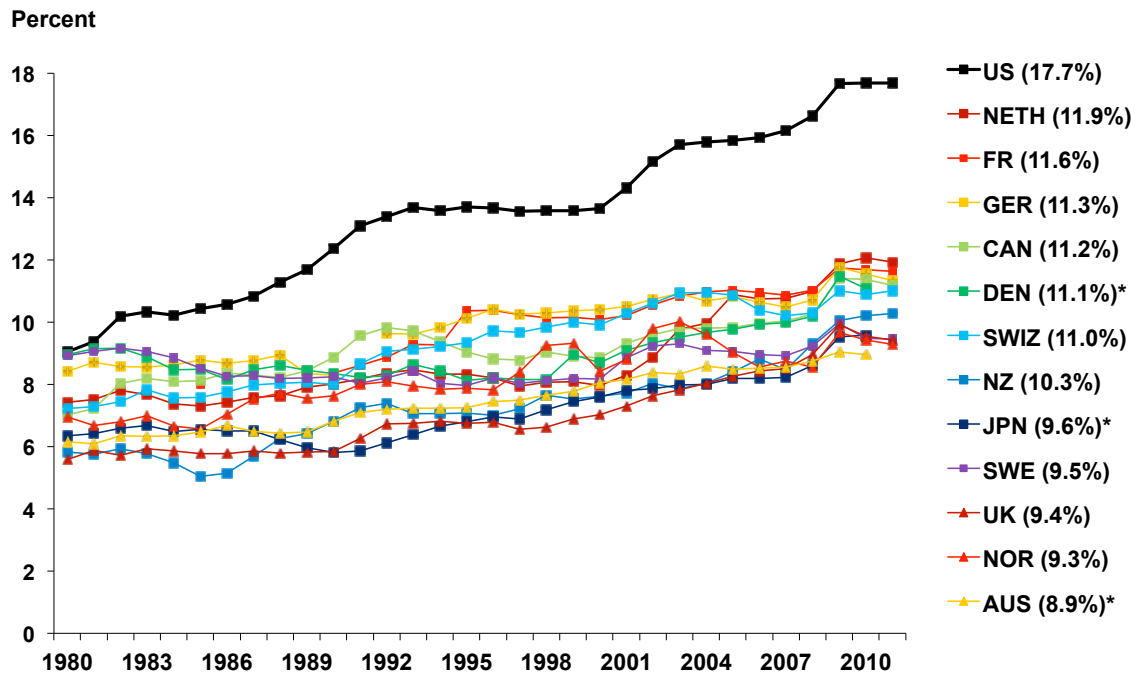
Notes: * 2010; GDP refers to gross domestic product.
Source: OECD Health Data 2013; chart compiled by The Commonwealth Fund.

The Next Era

Three events, all in 2008, helped usher in our current era. One was global, one was national, and one was seemingly small but transformative.

The first event was the near total collapse of the U.S. financial industry and the global recession instigated by the crisis. Well before the events of 2008, the issue of healthcare costs had been a crucial focus for improvement. Research undertaken and published by The Commonwealth Fund had repeatedly shown that the U.S. spends far more on healthcare (per capita) than economically comparable nations (see **Exhibit 1**). Moreover, the outcomes of U.S. healthcare lag far behind our peer nations. The citizens and companies in the U.S. are paying far too much and getting too little value in return. In a stable economy with consistent growth, this still would be an existential problem. But in a shrinking and highly volatile economy in 2008, the need to get value from the more than two and a half trillion dollars the U.S. spends annually on healthcare became even more vital.

The second event occurred in the midst of the economic crisis. The election of President Obama in November 2008 heralded significant changes to the U.S. healthcare system. Central to President Obama's campaign was a promise of healthcare reform. The official campaign platform runs nearly 40 pages

and has more than 25,000 words, but near the top is a promise of "Affordable, Quality Healthcare Coverage for All Americans." The platform goes on to specify the elements of this promise:

- Covering all Americans and providing real choices of affordable health insurance options
- Shared responsibility
- An end to insurance discrimination
- Portable insurance
- Meaningful benefits
- An emphasis on prevention and wellness
- A modernized system that lowers cost and improves the quality of care
- A strong healthcare workforce
- Commitment to the elimination of disparities in healthcare
- Public health and research
- A strong partnership with states, local governments, tribes, and territories
- A strong safety-net
- Empowerment and support of older Americans and people with disabilities
- Reproductive healthcare
- Fiscal responsibility[13]

13 2008 Democratic Party Platform, August 25, 2008. (Available at www.presidency.ucsb.edu/ws/?pid=78283.)

Few would argue that these were inappropriate goals, but the debate over whether national legislation was the best approach to realizing the goals was long, bitter, and divisive (and still ongoing). The election of President Obama provided a mandate to pursue a legislative approach, and after a historic fight in Congress, the Affordable Care Act (ACA) became law in 2010. Though key elements of the law have been delayed, and one (the required expansion of Medicaid) has been overturned by the Supreme Court, the ACA has nonetheless ushered in sweeping changes to how we deliver and pay for healthcare in the U.S. (Many of these changes are the focus of this publication.)

The third crucial event of 2008 garnered few headlines and caused no global economic calamities. But its effect on healthcare—especially governance—has been profound. For years, Dr. Donald Berwick, Tom Nolan, Ph.D., and Dr. John Whittington had collaborated to improve the quality, safety, and efficiency of healthcare—from the microsystem level to the national level. Like most people engaged in improvement, these three innovators were frustrated by the slow pace of change (in the face of proven approaches) and the piece-meal approach to improvement. They had each observed groundbreaking changes in individual organizations and systems—changes that, if broadly adopted, would improve care and health, and slow the growth of, or even reduce, costs. But the approaches lacked integration. What Berwick, Nolan, and Whittington sought to create was a framework for a coherent whole—a holistic approach that would simultaneously improve all of what an effective healthcare system should provide. In May 2008, they published an article in *Health Affairs* titled, "The Triple Aim: Care, Health, and Cost."[14]

Part of the Triple Aim's attraction comes from its elegant simplicity—three goals, simultaneously pursued and measured. Though simply stated, the inclusion of health (of a defined population), and costs (per capita) with care delivery (which had until this point been the principal focus of improvement) was transformative. No longer would merely the efficacy of a process improvement be measured; now the effectiveness (measured by its simultaneous impact on health and cost) of improvements

would be the focus. The authors limited their scope in the article to the U.S. healthcare system, but in the years since publication, organizations all over the world have adopted the Triple Aim as their guiding framework. The simplicity of the framework, and its popularity, belie the enormous challenges it reveals. The authors knew that very few, if any, healthcare organizations or systems were set up to effectively integrate all three aims. The Triple Aim requires fresh thinking and a deep understanding of context in order to be a successful strategy; it requires cooperation within existing structures of competing and often conflicting interests.

In the case studies that make up this publication, the Triple Aim's impact on what governing boards should pay attention to, and be responsible for, is significant. It has, in one sense, completed the picture of what true stewardship of a healthcare organization means. If the journey started 15 years ago with an effort to expand fiduciary responsibility from maintaining a healthy bottom line to ensuring high-quality and safe healthcare delivery, the Triple Aim marked a crucial new milestone—asking leadership and governance to also assume responsibility for a population's health and its use of common resources.

Expanding the Continuum

Six years after the events of 2008, we are at yet another crucial moment in healthcare. The emergence and spread of accountable care organizations (ACOs) and the slow but steady decrease in the dominance of fee-for-service payment systems in the U.S. represent another sea change. The Governance Institute's 2012 signature publication on payment reform[15] addressed many of the key changes, both current and forthcoming, in payment structures, and the scholarship and resources available to ACOs is robust and rapidly growing. The focus of this publication is therefore on the high-level changes that both drive, and are driven by, factors such as payment reform and ACOs. But the changes described in the cases that follow are also driven by a new understanding of what it means to be broadly accountable for the care and health of the populations that healthcare organizations serve.

For most healthcare organizations, population health is new territory. It has usually been the responsibility of municipal and state-level public health departments. Yet healthcare has eagerly embraced this new opportunity to engage in keeping people healthy in their communities, as often expressed in their mission statements. More and more, healthcare organizations are articulating their mission as one of responsibility for community

14 D.M. Berwick, T.W. Nolan, and J. Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs*, Vol. 27, No. 3 (May–June 2008), pp. 759–769.

15 G. Brown, S. Corneliuson, and C. Heideman, et al., *Payment Reform, Care Redesign, and the "New" Healthcare Delivery Organization* (Signature Publication), The Governance Institute, 2012.

health. Below are the current mission or vision statements of the four organizations profiled in this publication:

- HealthPartners: *To improve health and well-being in partnership with our members, patients, and community.*
- Genesys: *Genesys will be recognized as the premier, values-based healthcare system in the region by focusing on the needs of people in their pursuit of health and well-being.*
- Bellin Health: *Bellin Health is a community-owned, not-for-profit organization responsible for the physical and mental health of people living in Northeast Wisconsin and the Upper Peninsula of Michigan.*
- LHC Group: *We will improve the quality of life in the United States by transforming the delivery of healthcare services.*

These statements are highly laudable and, fortunately, not uncommon.

Taking accountability for the health and well-being of communities requires thinking about healthcare delivery and the boundaries of the healthcare system in the broadest possible sense. Hospitals, long the central focus of health systems and their governing bodies, are now seen as just one part of the larger continuum of healthcare delivery. In this new era, it is primary care, not acute care, that is viewed as perhaps the most important part of the continuum. Recent years also demonstrate that focusing on post-acute care is necessary[16] for those seeking to create what the authors of the *Quality Chasm* report called the "21st Century Healthcare System." Leading healthcare organizations also see new frontiers; healthcare delivery and health promotion are moving into retail stores, into businesses, and into schools. The continuum of care seems to get larger every day, and with it so does the importance of careful care coordination among, and reliable care transitions between, the different parts of the continuum.

The shift in accountability for overall health and well-being necessitates another, even more expansive understanding of a continuum, one in which healthcare itself is just a participant. The continuum of *health* involves nearly every aspect of modern life, from individual behavior to governmental institutions. The social determinants of health are the true drivers. It is easy for healthcare professionals and leaders to get frustrated when exemplary care fails to make a significant impact on health. But the best leaders turn their frustration into motivation to determine the ideal role for hospitals and health systems to play in the larger continuum of health. Healthcare providers have an essential role here, not only in the direct impact on health through care delivery, but also as central players in

the community. LHC Group CEO Keith Myers describes healthcare systems as being like churches, in terms of both their role and how they are viewed by their communities. Leadership and governing bodies of healthcare organizations must understand their expanded role in this new era if they are going to be able to reinforce their ambitions of being responsible for health.

An example of how healthcare organizations can play a role in the continuum of health is by leading the charge to fully understand their communities' health needs and assets. Health systems obviously have a unique window into the health and well-being of their communities. Yet even the best systems, with the proper focus on routine primary care and preventive services, only interact with a portion of the populace. Healthcare organizations should therefore play a leading role in mapping out the unique health needs of their communities. They should also play a role in mapping out the health *assets* within their communities that can be leveraged to promote health and well-being. Only by fully understanding both needs and assets can a community effectively collaborate to identify ways to improve overall health.

The shift in accountability for overall health and well-being necessitates another, even more expansive understanding of a continuum, one in which healthcare itself is just a participant. The continuum of *health* involves nearly every aspect of modern life, from individual behavior to governmental institutions. The social determinants of health are the true drivers.

Healthcare governance has an indispensable role here. As representatives from the community, and in so many cases, as owners of community assets, governing bodies should prioritize both health needs assessments and health assets mapping. Board members of healthcare organizations have a unique opportunity to identify linkages between community assets and to design new methods of collaboration. Healthcare boards can bring all the disparate elements of a community together around a common goal of health. This publication points to some examples of how pioneering boards are taking advantage of this special and vital opportunity.

Serving as a director or senior leader in a healthcare organization is

---

16 A. Chandra, M.A. Dalton, and J. Holmes, "Large Increases in Spending on Post-Acute Care in Medicare Point to the Potential for Cost Savings in These Settings," *Health Affairs*, Vol. 32, No. 5 (May 2013), pp. 864–72.

more complex than ever. It's also more important than ever. The organizations profiled here do not collectively make up a representative sample—such a sample would need hundreds of organizations, and it may be that, in the U.S. healthcare system, there is no such thing as a representative sample. Local customs, cultures, demographics, and histories all play crucial roles in how an organization understands how it can best serve the community in which it exists. The four case studies present innovative, leading-edge organizations that are still figuring out how to adequately respond to the ground moving beneath their feet. It is our hope that by telling their stories, and drawing out the applicable lessons, all healthcare organizations will learn what they, and their governing boards, might try to do to be effective and successful in this new era.

HealthPartners: Transforming Care Delivery

HEALTHPARTNERS, HEADQUARTERED IN BLOOMINGTON, Minnesota, is an integrated healthcare system that provides both healthcare services and health plan financing and administration. It is the largest consumer-governed, non-profit health organization in the U.S., serving more than 1.5 million medical and dental health plan members and employing more than 22,500 people. Its multispecialty group practice, Care Group, comprises more than 1,700 physicians, including 750 primary care doctors spread out among more than 50 primary care clinics. HealthPartners operates six hospitals in the Minneapolis/St. Paul region and western Wisconsin, and has a partial ownership stake in another. Its mission is, "To improve health and well-being in partnership with our members, patients, and community." Its vision is, "Health as it could be, affordability as it must be, through relationships built on trust."

A Transformational Journey

HealthPartners is widely recognized as a leading innovator in the system-wide transformation of healthcare delivery. A significant portion of this reputation is owed to its visionary president and CEO Mary Brainerd. HealthPartners' journey of transformation has its roots in a long history of continuous quality improvement, but certain events helped propel the organization forward. As it was for so many, the IOM report *To Err Is Human* was an eye-opening and alarming call to action. Yet for HealthPartners, the IOM's follow-up report, *Crossing the Quality Chasm*, had a far more profound effect. Brainerd described it as "...such a powerful description of the things standing in the way of delivering the care that everyone who goes into healthcare intends to deliver." Nancy McClure, senior vice president of HealthPartners Medical Group and Clinics, called the *Quality Chasm* report a "seismic shift," saying, "We knew it the minute we read it—the *nanosecond* we read it—that the six [IOM] aims would give us a framework going forward." Another key event in HealthPartners' transformation journey was more personal. Brainerd dealt

with a serious health problem and her experience with the way care was delivered to her as a patient cemented her belief that the way forward was to create a coordinated system instead of fragmented and separate sets of services. This is exactly what HealthPartners did.[17]

Infrastructure and culture changes made at HealthPartners to transform care delivery and coordinate care across the community include:

- Wide-scale implementation of an electronic medical record, improving both communication and coordination.
- Permeating throughout the organization the idea that the patient experience is at the very heart of their work.
- Establishment of a new Care and Health Transformation Committee of the board, to establish measurable goals for care and health transformation (and by having such a committee, to embed the goal of system transformation into the organizational culture).
- Carrying out of a series of mergers to better coordinate care across the community though a common mission and vision, use of a common EMR, creating shared goals, standardizing protocols, and a cross-organizational committee focused on experience, health, and affordability system-wide.

Transforming care delivery has been HealthPartners' goal for more than a decade. When leaders started to plan for ways to achieve this goal, they quickly realized they needed to effect changes to both their infrastructure and their culture. Among the first infrastructure changes they pursued was the wide-scale implementation of an electronic medical record, improving both communication and coordination. They also implemented approaches based on the idea that the patient experience was at the very heart of their work. As so many healthcare leaders know, these kinds of structural changes need complementary cultural changes as well, in order to succeed. One of the ways HealthPartners' leaders went about changing the culture was by making changes to a key existing structure—their governing board.

Throughout the years in which healthcare governing boards came to understand their direct role in ensuring the delivery of high-quality, safe, and patient-centered care, many organizations created and chartered new board committees—two common examples are quality and safety committees,

---

17 To learn more about HealthPartners' journey and the remarkable results they have achieved, see M. Bisognano and C. Kenney, *Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs*, Jossey-Bass Publishers, 2012.

and patient and family advisory committees. HealthPartners' leaders, with their laser-like focus on system transformation, felt that they needed a board-level committee that reflected this, so they created a new Care and Health Transformation Committee. (It is worth noting that in later years, HealthPartners renamed this committee the Health Transformation Committee when they adopted the Triple Aim as their framework for redesigning the care delivery model.) The new committee was charged with establishing goals for care and health transformation. The committee is responsible for developing appropriate measures and establishing a common language around the measures. As with most governance-level changes, learning is collaborative—the senior leadership team learns *with* the board committee about which targets to set, how high to set them, and how to effectively and efficiently track progress. Brainerd emphasized that like quality and safety, establishing a board-level committee embeds the goal of system transformation in the culture of the organization. This kind of structural change heads off the mistaken impression that the senior leaders are merely working on someone's "pet project." In discussing the original impetus for the new committee, Brainerd noted, "To hold a whole organization accountable for results, the board really needs to know—and have a role in determining—how we are making the changes."

The explicit responsibilities of the Health Transformation Committee are as follows:

- To assure implementation of the Triple Aim as an organizing principle for improving health.
- To assure integration of capabilities that improve care and health across the continuum of care.
- To communicate the importance of health improvement, care system redesign, performance, and medical management.

"To hold a whole organization accountable for results, the board really needs to know—and have a role in determining— how we are making the changes."

—*Mary Brainerd, President & CEO, HealthPartners*

The emphasis on improving health (not just care) and improving both care and health across the continuum are notable. This emphasis perfectly reflects the new environment all healthcare organizations now find themselves in—an environment in which their responsibility, both perceived and actual, is broader than it has ever been. Brainerd cited the creation of the Health Transformation Committee as the most important structural change HealthPartners made to further its mission. Yet this committee exists only within the overarching HealthPartners board (though its responsibility is for the entire system). HealthPartners' expansion in recent years tells another story of how a leading organization is responding to the new healthcare environment.

Growing (in) the Community

On January 1, 2013, HealthPartners and Park Nicollet Health Services announced the completion of the combining of their two organizations (under the HealthPartners name). This new affiliation was one of the most significant in the history of the organization as it brought Methodist Hospital (a 426-bed hospital operated by Park Nicollet since 1993) under the HealthPartners umbrella. Other recent affiliations and combinations include Amery Regional Medical Center in Amery, Wisconsin (2014), Lakeview Health in Stillwater, Minnesota (2011), Hudson Hospitals & Clinics in Hudson, Wisconsin (2009), and Westfields Hospital in New Richmond, Wisconsin (2005).

This series of mergers was driven by HealthPartners' understanding of how crucial care coordination, especially among primary care, specialty care, and acute care, is to healing and promoting health, as well as to the patient experience. In each of these affiliations, HealthPartners brought to bear its own unique experiences in infrastructure and culture change, but each affiliation also taught the organization lessons about the importance of aligning around a common mission and vision. Some of the ways these mergers and affiliations contributed to more coordinated care include: use of a common electronic medical record (EMR); sharing and simultaneously pursuing the goal of standardizing to the science first, and then customizing to the patient; the development of common protocols, which are then embedded in the common EMR; and creation of a cross-organizational committee focused on experience, health, and affordability (system-wide). As Brainerd put it, "they learn from each other, and then they learn together."

Anyone who has taken part in the articulation, or re-articulation, of an organization's mission and vision statements knows how carefully the words are chosen. HealthPartners' mission includes the words: "well-being," "partnership," and "community." Its vision statement is even more telling: "Health as it could be, affordability as it must be, through relationships built on trust." In pursuing an expansion, HealthPartners sees its role as bringing this vision to the communities it serves.

Barbara Tretheway, senior vice president and general counsel at HealthPartners, began her interview for this publication with a pointed statement: "We are in the business of serving the community." A focus on what's best for the community is the guide for the HealthPartners board as it examines potential new affiliations and tends to existing ones. For centuries, local healthcare governing boards have been composed of key members of the community. Some have argued that this approach carries risks in the new environment. Innovation might be stifled. Strong ties to the community can make boards conservative and slow-moving.[18] Despite the risks, Brainerd and Tretheway believe that boards deeply rooted in their communities are essential. This belief can be seen in the way in which HealthPartners formally establishes the boards in many of its new partnerships. When entering into a formal affiliation, HealthPartners typically adds a small number of senior leaders to the newly formed board. But in each case, they retain much of the community-based

---

18 Orlikoff, 2005.

board. One benefit of this approach is that the experience and wisdom of the existing board enables the new HealthPartners board members to learn more about the community (e.g., which specific initiatives or changes will be welcomed and have the greatest potential for impact). The central challenge is achieving true alignment around goals.

In one way, the new healthcare environment has made achieving alignment around mission in new partnerships easier for HealthPartners. The shift from healthcare organizations articulating their mission as one of delivering high-quality and safe care, to one of promoting health and well-being, is attractive. This is especially engaging for community board members, who may now see the role of the organization they govern as essential to the overall health of *their* community. A challenge posed by the new environment is that some boards may not be accustomed to having the stakes raised in this way. They may also not be accustomed to aggressive aim-setting and scrutiny around a new set of health-related metrics. Tretheway, however, argued that clear goal setting and measurement aid alignment. She noted that providing a summary of results against targets is an essential oversight tool for boards and enables them to see how a set of initiatives or changes are affecting high-level targets.
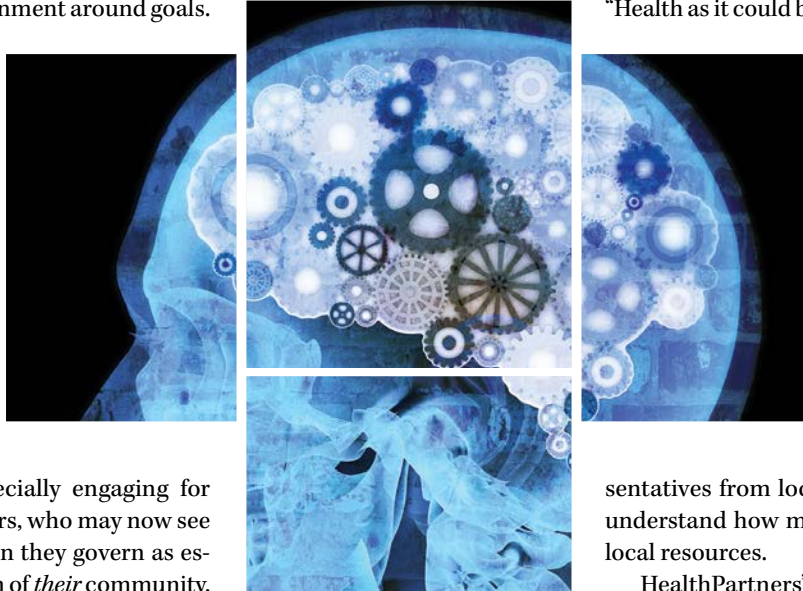
HealthPartners tracks more than 140 quality and health metrics. They measure chronic illness outcomes and preventive services in addition to the more traditional in-hospital metrics around safety and inpatient quality. HealthPartners works with its community-based boards to determine which "dots" to measure and which of those are the most important. Uniformity around how health-related goals are measured is also important. Many of the individual metrics are rolled up into high-level measures on both safety and health that are shared with the board to help evaluate impact and success.

Healthcare leaders and staff often, and justifiably, complain about the sheer number of things they have to measure. A results-focused board can feel the same way. One way to mitigate this burden is to contextualize the key metrics in an easy-to-grasp framework. The Triple Aim (improve the patient experience of care and the health of populations at lower per-capita costs) has done this for hundreds of organizations, including HealthPartners. The Triple Aim is embedded in the first duty of the Health Transformation Committee—"Assures implementation of the Triple Aim as an organizing principle for improving health"—and reflected in the vision statement, "Health as it could be, affordability as it must be, through relationships built on trust." Since both HealthPartners and healthcare community boards are in the "business of serving communities," understanding that there is a common pool of community resources available to pay for healthcare is essential. Community boards typically have representatives from local businesses, who acutely understand how much healthcare draws from local resources.

HealthPartners' commitment to maintaining a strong community connection in the boards of its new affiliations can be seen not only in how it goes about forming the new partnerships, but also in how it chooses its new partners. For Tretheway, mergers and affiliations "can't just be about getting bigger." They are about shared common goals. In some ways, HealthPartners' formal affiliations are just inflection points along a continuum of collaboration and partnership. Affiliating with neighboring organizations isn't about increasing market share, it's about leveraging existing partnerships toward goals that both organizations prioritize and are pursuing. Increasing market share does often reduce redundancies and creates efficiencies that align perfectly with the now universal goal of more affordable healthcare.

In pursuing new affiliations, strategic alignment is just as important as consensus around mission and vision. For Brainerd and HealthPartners, this is essential work that needs to happen before a deal is struck. The reasons that two organizations are combining need to be mutually understood. Agreeing on a common set of measures to evaluate success creates strategic alignment. The structure of any one affiliation may not inform another, but the essential goal of strategic alignment, both with each other and with the needs and wishes of the community, is common to all. As Tretheway noted, "structure must follow strategy."

Each new affiliation is also an opportunity to establish a positive track record in coming together around common goals. Brainerd and Tretheway emphasize partnership, listening, and learning. There will always be some degree of salesmanship and persuasion around why HealthPartners' vision is what it is, but striking the right balance between persuasion and open-minded listening is key. Emphasizing how the organizations can be more effective together than apart is always important. HealthPartners also encourages the boards of organizations with which they are affiliating to draw on their community roots and speak

up about how they view their community's needs and interests. Brainerd recalled several instances of "extraordinarily brave CEOs and board members of our affiliated groups saying, 'Giving up independence and autonomy is a very difficult decision to make. This affiliation with HealthPartners is what is in the best interest of the community,' and really standing up for it."

Establishing a positive track record in relationships prior to formal affiliation is another important strategy for HealthPartners. "With some of the more recent mergers, we've had a relationship with the organizations in those communities for a long time and I think that has helped," Brainerd explained. "In Wisconsin, which is an area where we've grown quite a bit, we had relationships for seven, eight, or nine years, where we've been providing management services or were working on community health together." Patience is crucial according to Brainerd. "If you take the time to grow a trusting relationship with the organizations, they may be more willing to give up autonomy in order to build a better version for the future."

As a mission-driven, non-profit organization, HealthPartners' reason for expanding is to increase community impact—to improve community health and lower costs. For Tretheway, it is "the ability to bring all of the creativity and passion together"—to leverage the collective talents of the organization and its affiliates "so that best practices are able to be spread over 1,000 square miles. It's the ability to really move the needle in communities where that just might not be possible without collaboration."

Brainerd agrees. "I think the opportunity for impact in the market is much greater and I know that many times, merger or consolidation work happens with an end in mind of market power," she says. "Our end in mind is Triple Aim results with a particular focus on more affordable healthcare, and I think we're at a scale that can help make those things happen."

Lessons from HealthPartners

- Make system-wide transformation an explicit board-level responsibility by creating or re-chartering a board committee with this sole focus. The committee should be responsible for developing appropriate measures, establishing a common language around the measures, and holding leadership responsible for progress against the measures. In executing these responsibilities, the committee should work with leadership closely, and leverage their collective expertise drawn from past and similar experiences. In the new era of cross-continuum governance and community health, the end goal should be health transformation.

- In pursuing joint ventures, affiliations, and mergers, alignment around strategic vision is paramount. For HealthPartners, the strategic vision has to be in service of the community. Structure must follow strategy.

- Maintain and utilize the deep community connections of existing governing boards. When affiliating with an organization, some degree of change in the board's composition is necessary, but maintaining as much of the existing community-based board as possible is key. Establishing true alignment requires listening to and learning from existing board members about the unique health needs and history of their community.

- Create productive and trusting relationships with other organizations long before considering formal affiliation. A positive track record of mutually beneficial collaboration and learning will make any merger easier to navigate in the short term, and more productive in the long term.

- The end goal of expansion and mergers should be community impact. Market power is important only as a means to improve community health and lower costs.

Genesys: Continuous Reinvention

GENESYS IS AN INTEGRATED HEALTHCARE DELIVERY SYSTEM located in Central Michigan and headquartered in Grand Blanc, just south of Flint. The Genesys system comprises an acute care hospital (Genesys Regional Medical Center), a rehabilitation unit, a skilled nursing facility, home health, residential and outpatient hospice, ambulatory care centers (including after-hours clinics), and a 220,000 square-foot athletic center located on the main hospital campus. One hundred and sixty independent primary care physicians and 400 specialists are integrated clinically and financially with Genesys through a physician–hospital organization (PHO) that assumes full-risk managed care contracts. In recent years, the system has increasingly leveraged co-management companies to bring specialists into the leadership fold (e.g., cardiovascular, surgical, ortho-neuro, podiatry). In total, the system engages and aligns over 5,000 employees, physicians, volunteers, and community partners, all working toward a common mission of improving the health and well-being of their community. Although Genesys Regional Medical Center is described by the organization as their readily recognized "flagship," CEO Betsy Aderholdt describes Genesys as a complete continuum of care anchored by an exceptionally strong primary care physician base.

A History of Constant Change

Genesys traces its history back to the foundation of St. Joseph Hospital in Flint in 1920. The city of Flint is the county seat of Genesee County and, in the 1920s, was at the heart of the booming automotive industry as the birthplace of General Motors (GM). The histories of Flint, Genesys, and GM are all deeply intertwined. As GM grew, the population growth quickly strained the existing healthcare infrastructure, setting off a recurring pattern of local hospitals and clinics reaching capacity and needing replacement by more and larger facilities. Flint reached its peak population of 200,000 in 1960, but by the late 1960s, the city began to suffer from the same problems afflicting other American cities—depopulation, disinvestment, and urban decay. Yet throughout this period, GM remained as the economic backbone of the community. In the 1980s, everything changed.

In 1978, GM employed approximately 80,000 workers in the region. By 2010, that number fell below 8,000. The devastating socioeconomic effects of GM's departure from the community have been chronicled in a variety of media, but one often overlooked legacy of GM's history in Genesee County was the extensive health and educational systems it once necessitated, and then left behind. The other legacy of Flint's history is the familiarity its people have with change. Not slow or gradual change, but severe, life-altering change. In many ways, this helped prepare the employees and leaders of Genesys when similar changes came to healthcare in the decades to come.

In the early 1990s, with GM gone, the healthcare system in Genesee County had too many hospital beds, too much inpatient capacity, and was inefficient. In 1992, St. Joseph Health Systems took courageous action, filing a Certificate of Need with the state to consolidate its existing 908 beds and build one, 379-bed hospital in Grand Blanc Township. The system renamed itself Genesys Health System and began work on the new, state-of-the-art hospital. From 1992 to 1997, the four hospitals in the system (renamed Flint Osteopathic Campus, Genesee Memorial
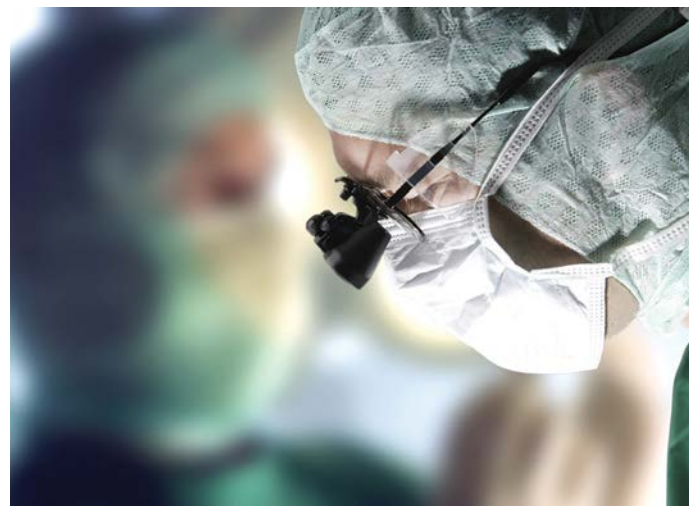
Campus, St. Joseph Campus, and Wheelock Memorial Campus) operated as Genesys Regional Medical Center. On February 15, 1997, the new hospital opened, immediately consolidating the four older hospitals. In 1999, the Sisters of St. Joseph (Genesys' founding sponsors) joined their ministry with the Daughters of Charity to create Ascension Health, now the largest non-profit health system in the U.S. Genesys continues as part of the overall Ascension system and continues to evolve.

Key actions over the past decade at Genesys have leveraged both the health system and its community partners to increase integration of care and improve health:

- A gradual shift (over a few years) in the board members' perspective of their role from that of governing a hospital to stewards of an entire system of care and population health managers
- Implementing a new strategic plan/vision emphasizing:
  » A culture of high reliability, Lean process improvement, collaboration and teamwork, integrated electronic health records, and safe and seamless handoffs from one level of care to the next
  » Creation of new models of care to maintain and promote health while lowering costs
  » Leveraging partnerships with educational institutions to prepare future healthcare providers and educate the public
  » Working with community partners to create new biotechnical jobs in the community and redefining the community's economy by leveraging the Genesys campus for job creation, research, and education
- Ensuring the right structure and composition of the system board in order to achieve the strategic goals; specifically engaging more physicians at the governance level and re-chartering the Advocacy Committee to focus on community needs and build relationships in order to more quickly identify opportunities to partner and integrate
- Clinically integrating the athletic center into medical protocols, enabling patients to meet with health coaches and design personal fitness programs; allowing local schools access to the center; and integrating activities at the center for residents of assisted living facilities
- Creating alliances with local and regional health coalitions, agencies, and other organizations to complete a single community health needs assessment for the entire community, as well as a common set of priorities and developing partnerships to address the identified needs

A New Era

Betsy Aderholdt, current president and CEO of Genesys Health System, describes the decade after the 1997 opening of the new Genesys Regional Medical Center as a relatively quiet period. Four hospitals, each with a long history and unique culture, came crashing together. Aderholdt said it took about 10 years for the dust to settle, and for leaders and staff to assimilate the remarkable change they experienced. In times of such drastic change, people tend to hunker down and stick to what they know and understand best. In healthcare, that means silos—already a fundamental problem throughout the industry. For Genesys, the goal was to break down the silos, both within the new hospital itself and between the new hospital and the Genesys continuum of care organizations, to become a true health *system*. Getting to this goal required changes at the senior leadership level and, crucially, at the governance level.

It is critically important to move beyond the myopia of the hospital as central to the health system, to a comprehensive understanding of the hospital as only a player, though a key player, in a system of healthcare. Governing across the continuum in today's new era requires another shift—a far broader view of the health system as a player in a community of health needs and assets.

Creating a vital new vision at Genesys began with a key gathering of approximately 45 individuals—community members, physicians, and a small handful of hospital executives. Genesys leaders recognized that they were entrusted with a vibrant set of assets within the health system, and had access to an equally vibrant set of assets in the community. Reaching out to their community, they stressed that the beautiful new hospital, designed and built to deliver patient-centered care, wasn't a Genesys asset alone—it was the *community's* asset. The health system executives positioned themselves as stewards of this asset, and collaboratively went about establishing a 25-year vision for the hospital, the continuum of care, its 400-acre campus, and the community.

For the three-day gathering, Genesys employed a professional facilitator—the same facilitator engaged by their parent organization, Ascension, when it was dealing with a similar, if far larger, combination of organizations. Throughout the three-day gathering, Genesys' board was front and center. Together, the senior leaders, community representatives, physicians, and board members created a strategic vision that guides Genesys today. But articulating the vision was just a first step. Leaders immediately went to work educating staff in all parts of the

Exhibit 2. Genesys VisionScape

GENESYS
HEALTH SYSTEM
OF THE FUTURE

- Excellence in safety, quality, patient experience
- Patient-centered, Lean improvement methodology
- High Reliability
- Physician alignment/integration: Co-Management Companies—Heart, Ortho/Neuro, Surgery
- Integrated EHR: Achieved Phase 1 Meaningful Use = 20+ clinical IT systems; moving to Phase 2 Meaningful Use
- Building capacity in the Continuum of Care
- Designated exclusive provider for PACE in Genesee County—Program for All-Inclusive Care for the Elderly

GENESYS
HEALTHWORKS

- Triple Aim: Improving health, patient experience, and cost of healthcare
- Keeping patients well is as important as treating them when they're sick
- Improving care transitions across the Continuum of Care
- Nationally recognized population-based care model
- Genesys PHO named CMS Pioneer ACO

GENESYS
LEARNING INSTITUTE

- Continual innovation and research
- Training healthcare providers of the future
- Educate public about population health management, disease management, wellness, health
- Create 4,000+ new biotechnical jobs
- Partner with institutes of higher learning: UM/Flint, MSU, Kettering, Mott, Baker
- Becoming regional and national learning lab for Ascension

CAMPUS & COMMUNITY
REVITALIZATION

Shape and revitalize our community through development of Health Park property and projects in 15-mile radius:
- Health Park—become the southern "anchor" point in a Genesee County regional life sciences economic cluster
- Health Park—partner with complementary organizations that bring their own financing
- Influence developments in Flint and Genesee County
- Downtown Flint Health Center; PACE

Source: Genesys Health System. Updated April 2014.

system—"chipping away at the silos every quarter," in Aderholdt's words—about why the strategic vision was so critical to the community, and how and why it would work. They asked themselves and their employees, "How can we align more of our departments, more of our systems and processes, more of our stakeholders to support the new vision?" Aderholdt cautioned against rushing through such a unifying process, noting that it takes years. Today, seven years after they first agreed on the new strategic vision, Aderholdt is confident that the Genesys board sees themselves as a governing body for an entire system of care and as population health managers. "When we started out," she says, "they would have described themselves as the governing board for the hospital."

This shift in the Genesys board members' understanding of their stewardship role is emblematic of what governing across the continuum of care requires today. It is critically important to move beyond the myopia of the hospital as central to the health system, to a comprehensive understanding of the hospital as only a player, though a key player, in a system of healthcare. Governing across the continuum in today's new era requires another shift—a far broader view of the health system as a player in a community of health needs and assets. Genesys' strategic vision aimed to convey that very view.

Genesys calls its strategy "VisionScape," which is illustrated in **Exhibit 2**. At its heart is a belief that Genesys, in partnership with its physicians and community, is on a journey toward improved health and well-being. They divide VisionScape into four quadrants:

- The Health System of the Future
- Genesys HealthWorks
- Genesys Learning Institute
- Campus/Community Revitalization

The Health System of the Future quadrant emphasizes the need for innovation and the need to move beyond the hospital to build needed capacity in the continuum of care. The strategy in this quadrant stresses a culture of high reliability, Lean process improvement, collaboration and teamwork, integrated electronic health records, and safe and seamless handoffs from one level of care to the next as the path to genuine integration. Genesys HealthWorks aims to create new models of care, focused on maintaining and promoting health rather than on treating disease. HealthWorks' new models are charged with achieving the Triple Aim of improving population health, improving the patient experience of care, and lowering costs. The Genesys Learning Institute leverages partnerships with

the strong educational institutions in the region to prepare healthcare providers of the future; to educate the public about disease management, wellness, and health; and to work with community partners to create 4,000 new biotechnical jobs in the community. The Campus/Community Revitalization quadrant focuses on redefining the community's economy by leveraging the Genesys campus for job creation, research, and education.

Genesys' strategic vision is a prime example of responding to the new environment in healthcare. Its expansive view, and clear understanding of a health system as a community asset and part of a larger care continuum, can serve as a model for all healthcare organizations.

Changes to Governance Structure and Composition: Understanding Needs and Assets

Once they articulated the new strategic vision, Genesys leaders and the board engaged in the hard work of ensuring alignment and creating the structures to support the vision. Among their first projects was ensuring that the governing board had both the right structure and the right composition. Leaders and board members together agreed that engaging more physicians was a critical first step. In the previous section on HealthPartners, CEO Mary Brainerd and senior vice president Barbara Tretheway emphasized the importance of maintaining strong community ties within a governing board. Genesys leaders felt the same way, and they also knew that alignment within the health system depended on increasing the level of engagement with physicians. They turned to a consultant, Dr. Eric Lister, to facilitate this process. Lister, a psychiatrist by training, employed an approach that focused on boardroom excellence, executive leadership excellence, quality and safety, and most importantly for Genesys, physician relations. Aderholdt explained that they didn't want

their community-based board members to be "intimidated or feel as though they needed to abdicate their responsibility for quality, safety, and patient experience to the trained clinicians at the boardroom table." She was concerned about lay board members withdrawing and disengaging from important discussions about quality of care, feeling as though they might have little to add to the conversations. Lister helped board members see their engagement in patient care discussions as a needed check and balance that enriches the board's deliberations with physicians. The number of physicians on Genesys' board committees grew from a "sprinkling" to 12.

Aderholdt pointed to one crucial change to a board committee as an ideal example of the kind of governance structure changes necessary in healthcare's new era. Genesys' board had an Advocacy and Culture Committee charged with looking at internal culture issues and how the system could influence health policy externally. It wasn't a popular committee and was viewed as a bit dysfunctional and misdirected. Leaders recognized that in order to meet the goals of their strategic vision, especially in the arena of HealthWorks (see previous page), they needed to better understand the unique health needs of the community. They re-chartered the Advocacy and Culture Committee as the Advocacy Committee. The new committee focused on community needs and was populated with new members who understood these needs acutely. They recruited committee members from the leadership of the area's free clinic, a local federally qualified health center, and the Crim Fitness Foundation, an organization that seeks to cultivate fitness as a community and family value. They also engaged representatives from local schools and colleges. The result was transformative—for the board and the organization. (See **Exhibit 3** for a sample scorecard the Advocacy Committee uses to measure progress on community initiatives.)

Exhibit 3. Advocacy Committee Scorecard, March 2014

No Measurement
Achieving Target
Threshold
Below Target

Metrics					
SO#	Strategic Objective	Executive Sponsor	AH Scorecard Measures	Initiatives March 2014	Notes/Comments
8	Implement Initiatives addressing community health needs	Andy Kruse	*Programs for those in poverty *Develop Community Engagement Plan	PHS	
				CHAP	
				Cardiac Screenings	Screenings set for April 24 & 30
				CHH	
				Pace	
				Lactation Clinic	
				Centering Pregnancy	
				ACP	

Source: Genesys Health System.

Exhibit 3. Advocacy Committee Scorecard, March 2014 (continued)

Project Healthy Schools

	Measurement	Target/Actual	Measurement to Begin
1	Self-reported assessment of fruit and vegetable consumption	Pre-Post improvement	Academic school year
2	Self-assessments of daily activity	Pre-Post improvement	Academic school year
3	Self-assessment of screen time	Pre-Post improvement	Academic school year
4	Self-assessment of fast and fatty food consumption	Pre-Post improvement	Academic school year
5	Self-assessment of beverage choices	Pre-Post improvement	Academic school year

CHAP (Short-Term Outcome Measures-Process Milestones)

	Measurement	Target	Measurement to Begin
Process	Identify pilot sites	3	End of FY14
	Secure funding	$350,000	End of FY14
	Conduct community readiness survey		

CHAP (Draft Long-Term Outcome Measures)

	Measurement	Baseline/Target	Measurement to Begin
Quality	Well-child visit rates		
	Lead testing rates		
	Asthma measures		
Utilization	ED/1,000 rate for eligible populations		
	ED/1,000 rate for CHAP clients		
	IP rate/1,000 for overall eligible populations		
	IP rate/1,000 for CHAP clients		
Access	Number of CHAP practices open to new Medicaid		
	No-show rate		
Delivery	Number of CHAP referrals		
	Level of service delivered (H,M,L)		
Satisfaction	Client satisfaction		
	Provider satisfaction		
Patients	Increase preventive care		
	Decrease cost		
	Increased access		

Source: Genesys Health System.

Exhibit 3. Advocacy Committee Scorecard, March 2014 (continued)

Cardiac Screenings

	Measurement	Target/Actual	Measurement
1	Number of screening dates	2/1	FY14
2	Number of students screened	/145	FY14

CHH (Commit to Healthy Hearts) Cardiac Prevention Programs

	Measurement	Target/Actual Q1	Measurement to Begin
1	Screen all participating students at GB High School for SCD and CV risk	750/	First wave of 350 is Nov to mid January 2014; second wave begins Feb-April 2013
2	Offer Fit Kids 360 healthy lifestyle intervention to students identified at risk for cardiovascular disease	Estimated ~200 students and their families are eligible. Target is 20% of eligible families will participate	First wave of 100 eligible kids begins late January to March; Second wave begins

Lactation Clinic

	Measurement	Target/Actual	Measurement to Begin
	CLINIC		
1	Number of clinic visits available in physician/ lactation consultant clinic	10 month/	Immediate
2	Number of lactation consultant phone triage support calls		Immediate
3	Number of lactation consultant clinic visits		Immediate
	HOSPITAL		
	Lactation visits in hospital	**(Target/Actual)**	**Immediate**
4	Move toward Baby Friendly Status (10 steps)	Initiate Baby Friendly Application	1.1.2014
5	Move toward Baby Friendly Status (10 steps)	5 of 10 steps by July 1, 2014	1.1.2014
6	Move toward Baby Friendly Status (10 steps)	Investigate feasibility of and develop BF exit survey to capture data	1.1.2014
7	Percent Infants initiate breastfeeding	68%/	Measure monthly
8	mPINC score (Hospital Maternity Practices in Infant Nutrition and Care)		Measure quarterly to track improvement
	COMMUNITY		
9	Develop breastfeeding resource guide (with BF Coalition)		Completed
10	Develop breastfeeding wheel (with BF Coalition)		Near complete
11	Engage community to improve BF via GFHC Health Improvement Committee		Completed

Exhibit 3. Advocacy Committee Scorecard, March 2014 (continued)

Advance Care Planning (Short-Term Process Measures from 9 Pilot Sites)

	Measurement	Target	Measurement to Begin
1	Participation in ACP facilitation	>50% of patients invited to participate in ACP facilitation will agree to schedule appt with facilitator	9/1/2013–5/1/14
2	Completion of Written ACP	>50% of those who participate in ACP Facilitated Discussion will complete a written plan	9/1/2013–5/1/14
3	Patient/advocate Satisfaction	Patients and Advocates will rate the ACP discussion on average >3	9/1/2013–5/1/14
4	Storage of AD in medical record and availability to providers	The patient's documented preferences will be communicated to the patient's physician and stored in MI Health Connect Database	9/1/2013–5/1/14

Advance Care Planning (Long-Term Outcome Measures)

	Measurement	Target/Baseline	Measurement to Begin
1	Increase the % of written AD at the time of death; availability; appointment of agent	x/29.5%	3/1/2016
2	Reduce hospital deaths by 10% over baseline		3/1/2016
3	Increase hospice admission by 10% over baseline		3/1/2016
4	Increase median hospice length of stay by 10% over baseline		3/1/2016
5	Increase transfer of patient preferences to medical orders		3/1/2016
6	Increase family reports of discussion		3/1/2016
7	Individuals rate a high level of satisfaction with facilitation		3/1/2016

Centering Pregnancy

	Measurement	Target/Actual Q1	Q1
1	Increased patient knowledge about pregnancy and readiness for delivery	90% of participants will demonstrate increased knowledge based on pre and post surveys	
2	Decreased pre-term births	A significant number of patients will demonstrate improved birth outcomes compared to women in traditional care	
3	Decreased low weight births		
4	Increased breast feeding rate	90% of participants will attempt to breastfeed	
5	Increased satisfaction prenatal care	90% of participants will be satisfied with prenatal care	

An example of the committee's new approach can be seen in the way Genesys uses one of its principal assets—the 220,000 square-foot athletic center located on the same campus as Genesys Regional Medical Center. The Advocacy Committee recognized a community need and facilitated the clinical integration of the athletic center into medical protocols. Aderholdt explained that physicians can now say to a patient, "I am writing you a prescription to go to the athletic center, meet with a health coach, and co-design programming to improve your fitness." The committee also thought through ways for local schools to use the athletic center—a potentially crucial link, given the cuts to physical education programs affecting so many public schools in the community. Genesys is currently working on a pilot program to integrate activities at the athletic center for residents of assisted living facilities.

The re-creation of Genesys' Advocacy Committee reflects one of the key responsibilities for governing across the continuum in healthcare's new era. Healthcare organizations are in a unique position to identify and understand the broader health needs of their communities. They see, first hand, the consequences of poor population health. While not all healthcare organizations are blessed to have assets like a large athletic center located on a hospital campus, many do, and those that don't still have special and applicable knowledge about what would benefit community health the most. A governing board with representatives from both the community and the healthcare sector is ideally positioned to evaluate needs, and either match those needs to existing assets (either from within the system or through a community partner), or think through which assets need to be created.

Engaging the Community

Governing boards with a strong, data-driven understanding of community health needs can also help their organizations effectively engage in another of today's key responsibilities—participation (and often leadership) of multi-sector health alliances.[19] Fortunately, most healthcare organizations have long recognized the role they can play in large-scale community health programs, and Genesys is no different. In Genesee County, the Greater Flint Health Coalition has been leading a community-wide effort to address local health needs for more than two decades. Originally formed in 1992, the coalition has engaged with legislators to ban smoking in public places, created an educational task force that helped reduce the number of unnecessary Cesarean births, and worked to increase awareness about diabetes. In 1996, GM and the United Auto Workers union (UAW, also born in Flint) approached the coalition to identify ways to work together to address the health needs of GM and UAW workers and retirees. That same year, the coalition formally incorporated as a 501(c)(3) non-profit with a dual mission to improve the health status of Genesee County residents and

to improve the quality and cost-effectiveness of the healthcare delivery system. Betsy Aderholdt serves on the coalition's broad-based 34-member governing board.

Aderholdt said healthcare organizations don't always need to play leadership roles in these kinds of health alliances. Healthcare leadership teams and governing boards should view participation in community health alliances as opportunities to learn about how the larger community sees its health needs and assets. As an example, rather than work in a silo to meet the ACA requirement of completing a Community Health Needs Assessment, Genesys participated with the Greater Flint Health Coalition to complete a single health needs assessment for the entire community. All coalition member organizations, including the two competing health systems in the county, use this same data assessment and findings for planning purposes. The shared Community Health Needs Assessment creates a common set of priorities across all coalition members and facilitates the development of partnerships to address identified needs. This collaborative approach conserves community resources and creates a platform for focused systemic change across the whole community—a critical success factor for those engaged in population health management. Driving this alignment deeper into Genesys' organization, Genesys' Advocacy Committee established its internal metrics and measurement systems based on the coalition's Community Health Needs Assessment and generated objectives and tactics that were ultimately incorporated into the Genesys annual strategic plan and operating budgets.

Participation in community health alliances also provides opportunities for health systems to effect change. Aderholdt describes one such opportunity regarding end-of-life care. In their work as a CMS Pioneer ACO, Genesys identified, as so many communities have, that improving end-of-life care has enormous

19 L.R. Hearld and J.A. Alexander, "Governance Processes and Change within Organizational Participants of Multi-Sectoral Community Healthcare Alliances: The Mediating Role of Vision, Mission, Strategy Agreement, and Perceived Alliance Value," *American Journal of Community Psychology*, Vol. 53, Vol. 1–2 (March 2014), pp. 185–197.

potential to enhance patient experience and reduce costs. Genesys leaders realized that to have the necessary impact, a community-wide approach rather than a siloed Genesys Health System-only approach was needed. So, they devised a solution: they introduced Gundersen Health System's (La Crosse, Wisconsin) award-winning and highly influential Respecting Choices® advance care planning program to the Greater Flint Health Coalition. Genesys donated funding from their own Genesys Health Foundation to support the project and assisted the coalition in fundraising for the remaining balance. The coalition adopted the program with full support of all three health systems in the region. Crucially, Genesys did not implement the program alone, but instead used the community health alliance to influence implementation of this change throughout the community.

Another key role Aderholdt sees for Genesys within the Greater Flint Health Coalition is leveraging its growing expertise on population health. Genesys' experience as a CMS Pioneer ACO provided real-world learning on how healthcare organizations should think about linking available resources rather than owning and operating all components of the delivery system themselves. A key lesson was the importance of bringing various parts of the care continuum together. Specifically, Genesys' emergency department (ED) and the local federally qualified health center (FQHC) worked together on a program to refer patients who came to the ED for non-emergency needs to the FQHC and, through them, connect these patients with a patient-centered medical home. This approach helped improve continuity of care and reduced the overreliance on emergency care for lower-income patients. Genesys learned that managing population health is both about understanding needs and assets, and about building relationships. Aderholdt explained that the board's Advocacy

Committee focused on "relationship building—developing an understanding of what each other is doing and more quickly identifying opportunities to partner and integrate."

Probably the best example of how Genesys understands its role in fostering community health is in its use of its own campus. Recall that an entire quadrant of Genesys' VisionScape strategic plan is devoted to Campus/Community Revitalization. Genesys Regional Medical Center sits on 400 acres, conveniently located just off a highway. To date, Genesys has only developed about 30 percent of the land, which includes the hospital, the athletic center, a small outpatient imaging center, a medical office building, an ambulatory surgical center, and a greenhouse operated by the Genesys volunteers. Leaders are careful about not overdeveloping the land since the beautiful green space is pivotal in creating a desired healing environment and the miles of wooded walking trails are an often-enjoyed community asset. To ensure they develop the property wisely, they have developed a master plan for the property and are thoughtfully seeking the right opportunities to engage partners to develop the campus as a community asset. They are collaborating with the large number of local colleges (one of the legacies of GM's significant presence in the area) and schools of public health to develop training programs focused on population health. They are also working with local engineering schools to develop a life science research, innovation, and development center. Recognizing the growing unmet needs of an aging local citizenry, Genesys is partnering with another organization to build a state-of-the-art Continuous Care Retirement Community on the campus to replace the existing skilled nursing facility, independent living, assisted living, hospice, and memory care facilities. And Genesys, in partnership with the Veterans Health Administration (VA),

is exploring building the first VA retirement home in Eastern Michigan as part of this complex as well.

In all of these opportunities, the level of Genesys' financial ownership varies. Aderholdt believes control should be a lower priority than effective integration and alignment around Triple Aim goals. The board understands this as well. Aderholdt commented, "Our board views the health system's assets as a valuable set of tools to improve the health of the community. They say, 'We've got a desirable property, we've got patients and physicians and students, we've got unique population health management capabilities as part of this health system. How can we leverage them all to bring other people with investment dollars into our area who want to create jobs and work with us to innovate new programs, new products, and processes?'"

Be Ready to Change

Aderholdt's final comments recalled the region's turbulent history. "At one point, Genesee County had one of the highest per-capita incomes in the country, and now it has one of the lowest. Here, we know that the environment can change in dramatic ways. Although challenging, it can also be liberating to be at the bottom of economic and health indicator rankings because you know you have to do things differently, you have to try new things. It compels you to take risks. This community's experience fosters a leadership mindset of 'don't resist change, lead it' because it can be devastating if you aren't paying attention to what's changing in the marketplace and you aren't continuing to reinvent yourself. Our community's context is that you have to innovate to survive and Genesys' mission is to be a vital presence in this community for generations to come."

She linked this recognition directly to the work of the board—noting that healthcare boards need to understand how they must continue to add value in an environment where the old models are crumbling. Governance needs to keep up, not be static, and courageously let go of familiar models and mindsets. The result of failing to do so is irrelevancy.

Lessons from Genesys

- Overcoming the barriers between silos to create a seamless system of care should be the goal of leadership and governance alike.
- Bring together community stakeholders, medical stakeholders, health system leadership, and health system governance to think through how the health system can be a vital community asset.
- In creating and articulating a system-wide strategic plan, ensure that the vision is driven by the broadest possible view of health and the care continuum.
- Create governance structures designed to evaluate the community's health needs and map the community's assets. Consider a new board-level committee such as Genesys' Advocacy Committee.
- Ensure physician engagement.
- Consider all types of engagement in multi-sector community health alliances: leadership, participation, advisory, etc.
- Work with all stakeholders to develop partnerships focused on managing and improving population health.
- "Don't resist change, lead it."

Bellin Health: Fostering a Culture of Health from Within

BELLIN HEALTH IS AN INTEGRATED HEALTHCARE DELIVERY system headquartered in Green Bay, Wisconsin. The Bellin system comprises Bellin Hospital (a 167-bed, acute care, multi-specialty facility), Bellin Medical Group (which includes more than 90 primary care physicians as well as nurse practitioners and physician assistants), both inpatient and outpatient psychiatric centers, a fitness center, sports medicine and rehabilitation services, the Bellin College (educating Baccalaureate and Masters students in nursing and radiologic technology), a home health agency, and Bellin Health FastCare (a group of retail health clinics located in food and department stores). While Bellin Hospital has been widely and routinely recognized as one of the nation's top hospitals, Bellin Health is perhaps best known, especially in recent years, for its groundbreaking work to improve employee health and lower costs.

The Importance of Employee Health

Bellin's commitment to community health runs throughout its nearly 100-year history in Green Bay and Northeast Wisconsin, but its recent innovations in employee health as both an end and a means to cost reduction has made the system an international exemplar. Internal necessity was the mother of Bellin's invention. Faced with increasing competition in 2000, CEO George Kerwin had to make some painful cuts, including the elimination of positions and certain services. In 2002, Kerwin and his CFO ran the numbers on their employer-provided healthcare, and were dismayed by an anticipated 30 percent rise in the costs of coverage.[20] This is a very familiar dilemma for virtually every company in the United States that provides their employees with health insurance. But rather than looking to new plans that might merely limit services and shift costs to their employees, Bellin leaders chose a different path. They started by digging into the underlying sources of their healthcare costs. In *Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs* (2012), Kerwin recalled, "We realized we needed to get better information about the way we were spending the dollars, and we also realized that people using the health benefit needed to be more invested in the benefit, be more invested in their own health."[21] As a healthcare delivery system, Bellin was positioned to not only encourage their employees to be healthier, but also to work with them directly to improve their health.

The effort began with health risk appraisals (HRAs). Leaders asked all employees to take an HRA, incentivizing the request with a promise that those who completed it would not have their premiums increased the following year. Senior leaders complemented this drive for more and better health data with frequent conversations about why they were pursuing this approach and about the vital importance it held for individual employees and the overall system. Armed with the data (more than 90 percent of employees completed an HRA), Bellin created a system of insurance premium discounts tied to the HRA scores. They also offered significant discounts to employees who, along with their spouses, completed all appropriate tests and screenings. Combined with a push to get all employees engaged in primary care and preventive services, Bellin was creating a new culture of health for all its employees.[22]

The following steps taken at Bellin Health since 2002 have uniquely positioned the organization to improve the health of its community:

- Creating an internal health and wellness incentive program for its employees, to lower the cost of providing health coverage while also improving the health of its workers. Beginning with data from health risk assessments, insurance premium discounts were tied to HRA scores; discounts were offered for completion of preventive screenings and participation in primary care services.
- Building a new line of business for the system by taking this employee wellness model out into the community and thus helping to improve population health and lower costs across the community. The complete model includes a consumer-driven health plan, onsite services, HRAs, and incentives.
- Early adoption and development of a robust primary care system in the 1990s that has continued today.
- Longer terms for board members to create a more knowledgeable board; Bellin also enjoys unique longevity on the senior leadership team. While longevity can stagnate an organization, when treated carefully as at Bellin, it has created a dynamic that supports a strong constancy of purpose and desire to invest in the future.
- Inclusion of more patients and family members on the board and board committees, as well as engaging family practice physicians in governance to make healthcare more patient-centered.
- Venturing into measuring population health and care coordination metrics at the board level, refining the measures as more is learned about health needs and strategic priorities.

The results of Bellin's innovative approach were remarkable. Without rationing or significant cuts in benefits, the cost of their employee health coverage fell by a third in just two years. Engaging their employees in their health also reaped benefits—HRA scores improved. Throughout a decade in which healthcare

---

20 Bisognano and Kenney, 2012.
21 *Ibid.*

22 *Ibid.*

costs rose steadily and individual health status declined across the country, Bellin bucked the trends, saving an estimated $13 million and measurably improving the health of its employee population over the first eight years of the program. This would be an engaging and educational story even if Bellin had stopped at the boundaries of its own system. But Kerwin and his leadership team—including Randy Van Straten, vice president of business health, and Peter Knox, executive vice president—saw an opportunity to spread their model. They would bring their approach to local businesses in the Green Bay area—helping to improve population health and lower healthcare costs, while simultaneously building a new line of business for the system.[23]

Bellin began offering what it now calls Business Health Solutions to companies throughout its region. To date, Bellin has worked with over 2,500 companies and its model (which sometimes includes actual onsite care delivery within businesses) is employed in more than 75 sites. When the full model (consumer-driven health plan, onsite services, HRAs, and incentives) is applied, healthcare costs run as much as 20 percent below national averages.[24]

Bellin was an early innovator in the area of focusing on employee health and bringing healthcare services directly to businesses, and the approach has spread. Healthcare organizations committed to population health and integrating care across the continuum increasingly recognize the imperative to engage their patient populations outside the traditional walls of their hospitals and systems, and into the communities they serve. Bellin was also ahead of the trend when it came to emphasizing primary care. In the 1990s—an era of consolidation for hospitals and systems in the U.S.—Bellin declined to sell off its business or combine with a larger entity, and instead focused on building a robust primary care system to support its patients' health. By the late 2000s, the healthcare industry came to realize the critical importance of primary care and most large, hospital-based systems were investing in it. Kerwin ascribes Bellin's early adoption to a bit of luck, but it's clear that accurate foresight is part of Bellin's DNA. And that foresight is, according to Kerwin, partially attributable to their governance focus, structures, and composition.

Governance at Bellin

CEO George Kerwin describes Bellin Health as a "very typical community-owned organization" with deep community roots that stretch back 100 years. Bellin selects board members from an entity called the Bellin Corporation—a group of 60 people from the community, many of them past board members. Through the Bellin Corporation, they maintain connections with past (or "emeritus") board members, often bringing them back to serve on board committees. Both the corporation and the Bellin governing board represent a cross-section of the greater Green Bay community. The board works to ensure that physicians are also well represented. Kerwin noted that Bellin's governing board has a long history of recognizing the importance of healthcare in the community, and recognizing that a community-based board is in the best position to make decisions about care delivery that will benefit community health.

An important attribute of Bellin's governing composition is constancy. "Our board doesn't turn over like most boards do," Kerwin said. "There is a healthy turnover, but the terms are very long." The result is, in Kerwin's words, "a very knowledgeable board." Properly educating a health system board, especially those members without a clinical background, is a core responsibility for senior leaders and a vital behavior for successful organizations. That said, board education can take time away from other vital behaviors such as effective thought partnership. Kerwin said, "We're not constantly trying to educate the board; they, in essence, become educated along with us as we're going through issues." Bellin's current board chair, for example, has held the position for 10 years, and served on the board for 20. This longevity is reflected in senior leadership—Kerwin himself has been at Bellin for more than 40 years, and has been its president for more than 20. Kerwin acknowledged the risk, saying, "It can stagnate an organization…." But he wouldn't have it any other way, noting that "…[longevity] can also create a dynamic that supports a strong constancy of purpose. We know why we're here. We can look forward with a fair amount of history and I think that's been one of our strengths in evolving the organization." Longevity and constancy also help Bellin to be conservative in a manner that understands and respects the past. This can be especially helpful when external change is great and there is uncertainty about the path forward. As Bellin's competition increased in the 1990s, and options for consolidation and affiliation proliferated, the board and senior leadership were on the same page. They resisted "overextending themselves" and instead focused on building their primary care business, "putting the pieces together," Kerwin said, "that we felt would, in the future, enable us to deliver the types of services that are in demand today."

23 Bisognano and Kenney, 2012.
24 *Ibid.*

Bellin's practice of creating a common past through long terms for board members also helps them take risks and be more effective in their forward-thinking. Their emphasis on building primary care, particularly in a payment environment that doesn't support it, was a gamble. "A board is naturally going to focus on financial performance," Kerwin said. "When you have a board like ours that understands more than just that, they become much more willing to forego immediate strong financial performance in order to invest in the future." Investing in the future is also aided by the community connections within the board. Kerwin values "…having that local board with an attitude of 'well, we're paying a lot of this [healthcare] bill anyway, so we want to invest in making sure the system is effective in the future.'"

The broad effort to make healthcare more patient-centered is arguably the most impactful development in the industry in the past 25 years. In describing the benefits of increased patient and family engagement at the governance level, leaders often point to the value of putting a human face on common metrics used to measure quality and safety (e.g., harm and mortality). But having patients and families represented on boards and board committees is just as essential to thriving in today's new era, with its focus on continuity, coordination, and population health. So it wasn't surprising that when asked about the most important change to board composition during his tenure, Kerwin pointed to the concerted effort to include more patients and family members.

If the essential function of governance is to hold leadership accountable, then determining which metrics will be used to measure performance is equally essential. For governing bodies or organizations trying to succeed in healthcare's new era, the process of selecting metrics is a key challenge. Leading organizations understand that they are no longer just accountable for the quality and safety of the care they deliver, but for the health and well-being of those they serve. It is easier to hold leadership accountable for a proxy measure of quality and safety, such as an adjusted mortality ratio, than it is to hold them accountable for the health of a population. The social determinants outside the health system's control will always play a larger role than the ways in which care delivery itself will affect health. This challenge might compel some organizations to shy away from establishing objective metrics around population health and community well-being, but not Bellin. Which isn't to say that Bellin, or any other organization, has really figured out what and how to measure. Kerwin explained that you have to "start rather crudely and refine the measures as time goes on." (See **Exhibit 4** on the next page for a sample snapshot of Bellin's strategic scorecard.) But having robust patient and family participation at the governance level brings essential voices to the table. Patients and families, rooted in the community, will, at the very least,

offer informed opinions about what strategies employed by the health system might work best. Their connections to community institutions and other assets enable them to imagine and design ways of linking those assets to the health system in new and productive ways.

Another group that has unique insights into the ways in which health systems need to provide care across the continuum are family physicians. Having family practice physicians engaged in governance is a "dream" according to Kerwin. He explained, "That's how they're trained. That's the way they think—in terms of managing people and keeping people healthy."

Because of the new challenges in today's era, Kerwin also stresses patience at the governance level. At Bellin, the board knows that measuring things like population health and care coordination are new to the leadership team. Kerwin said, "They understand that and they understand where we want to go." Once again, the constancy and longevity within Bellin's board allows for patience, due to their familiarity with the organization's successful track record.

Kerwin is also grateful for the strong business presence on the Bellin board. In the past, recruiting board members from the business community was a best practice mainly because Bellin sought their financial and managerial acumen. While that expertise is still crucial, today's new era creates an additional need for engaging business leaders. They have a unique perspective on how today's health challenges affect economics. They know firsthand how spiraling healthcare costs can stifle and weaken businesses. They know how poor employee health, worker injuries, and frequent absenteeism can drag down productivity. It was business leaders who argued for a more comprehensive accounting of healthcare costs—one that included reduced productivity and lost days of labor. It's not unusual for workers to spend more waking hours at their place of employment than they do at home, so business leaders have a special and crucially important understanding of the health needs in communities.

Patients, families, and leaders from business have important insights into another new area of focus for organizations committed to caring across the continuum: brand strength. As healthcare systems extend the services they provide beyond their walls and into non-traditional sites, as Bellin did in both its Business Health Solutions services and its retail FastCare clinics, maintaining and strengthening brand is increasingly important. Kerwin explained, "When you think about the importance of a brand that people relate to, view positively, learn to trust, know what to expect from—we need all those characteristics of a good brand in healthcare. Fifteen years ago, having a good brand was important, but it was very much targeted to clinical services that were [primarily] hospital-based. Today, that's totally different. All the things you would want from any other retail product you want increasingly from a health system." Consumer perception

Exhibit 4. Bellin Health Strategic Measures Using Scorecards

Status	Indicator	Current Value	Target	SPC Alert	Updated
	SYSTEM SCORECARD > A PATIENT FAMILY CUSTOMER CENTERED				
✕ ☑	Scorecard 2014: A. Likelihood of Recommending	84%	84%		Dec 2013
✕	Scorecard 2014: B. BMG Panel Size	107635	116000	[chart]	Dec 2013
✕	Scorecard 2014: C. Coordination of Care-Care Pathways in Place	1	4		Jan 2014
✕ ☑	Scorecard 2014: D. Number of Strategic Partners	10	15		Dec 2013
	SYSTEM SCORECARD > B ENGAGED STAFF AND PARTNERS				
▽ ✓	Scorecard 2014: A. Employee Engagement Overall	81%	81%		2013
☑	Scorecard 2014: B. Physician Engagement Measure	80.7	TBD		2012
✕ ☑	Scorecard 2014: C. Employee Safety - Mod Factor	0.85	0.83		2013
✕ ☑	Scorecard 2014: D. Bellin Employee HRA Scores Overall	79.4	79.5	[chart]	2013
	SYSTEM SCORECARD > C IMPROVED HEALTH OF THE POPULATION				
✕ ☑	Scorecard 2014: A. Risk Adjusted Mortality Rate	1.35	1.00		CY2013 Q2
✕ ☑	Scorecard 2014: B. Hospital Clinical Quality Measures	67.4%	80.0%		Sep 2013
▽ ☑	Scorecard 2014: C. Primary Care WCHQ Ranking	3.80	2.50		Nov 2013
★ ☑	Scorecard 2014: D. Avoidable Patient Harm Events	0	7		2014
✕ ☑	Scorecard 2014: E. Employer HRA Scores Overall	78.5	78.6	[chart]	2013
★ ☑	Scorecard 2014: F. Community-Poor or Fair Health	12%	15%		2012
	SYSTEM SCORECARD > D GROWTH AND PROSPERITY				
★ ✓	Scorecard 2014: A. Total Revenue	$420	$388	[chart]	Dec 2013
✕ ✓	Scorecard 2014: B. Cost to Produce	3121	2920		Dec 2013
★ ✓	Scorecard 2014: C. Operating Margin	10.44%	3.99%	[chart]	Dec 2013
★ ✓	Scorecard 2014: D. Total Margin	14.91%	5.23%	[chart]	Dec 2013
✕ ✓	Scorecard 2014: E. Value-Based Revenue	4.28%	16.00%		Dec 2013
★ ☑	Scorecard 2014: F. Strategic Partner Healthcare Spend	30.6	19.5	[chart]	Dec 2013
★ ✓	Scorecard 2014: G. Per-Capita Healthcare Cost	$4,230	$4,485		2013

Bellin's system scorecard is driven by individual brand scorecards to define and measure progress toward achieving strategies. Focus of measures involves primary care growth, physician and staff engagement, improving the health of the population including clinical quality (which impacts financial performance), and financial measures. The system scorecard drills down to the department level to show clear accountability. For more detailed information and definitions of the measures on this scorecard, contact The Governance Institute at kpeisert@GovernanceInstitute.com.

research conducted by National Research Corporation emphasizes this point: in a survey of over 250,000 healthcare customers in 2010 (the most recent year available), when answering the question, "How important are the following factors in selecting your healthcare?," 91 percent of respondents cited "reputation of hospital" as the most important, above consideration of quality and patient satisfaction report cards as well as "hospital participates in insurance plan" and "your doctor recommends."[25]

Business-based board members and patients and families offer knowledge and guidance from both sides of the brand-strength equation. Business leaders can look to their experience in creating brands and brand loyalty, and patients and families can speak to how and why they choose brands and stick with them. Succeeding in healthcare today often means offering a broader and broader range of products and services, and consequently, the importance of an organization's brand also increases.

Engaging the Community

Bellin's decision to work with local employers to improve employee health and reduce costs through Business Health Solutions already demonstrates the kind of community engagement necessary in healthcare's new era. But it's only one type of engagement, and not necessarily something all healthcare organizations want to do or are prepared to do. Kerwin also sees the importance of playing a different role. Describing Bellin's role in the Business Health Solutions work, he said, "We're the integrator. We know our role and we have to take the initiative. In other initiatives, we are participating. We are actively involved, our competitors are involved, different segments of the community are involved, and we're a participant. We don't control it; we advise and help in whatever way we can, but it's different than

being the integrator. In this case, other community-wide organizations are acting as the integrator and that works fine. We have to be able to be as excited about that type of initiative, invest in it financially, and have it as an objective. [We need to see it] as important as how we are doing in surgery…the determinants of health require that; they are influenced in a lot of different directions, not all of which we are controlling."

Kerwin encourages his board members and the organizations they represent to also engage in the community in varying ways. "It's difficult sometimes," he said, "because you want to run the world."

Lessons from Bellin Health

- Employee health should be a key focus for all healthcare organizations. It can lower health coverage costs, improve productivity, and serve as a model for all organizations in the community.
- Think about new and innovative ways to bring health improvement strategies into the community (e.g., employee health promotion programs, health services located onsite at local businesses and institutions).
- Consider longer terms for board members to deepen community connections and create a constancy of purpose (or find other ways to keep emeritus board members engaged, such as an advisory council or committee service).
- Patient and family member participation on boards and board committees is essential.
- Though few organizations have figured out the best set of measures for population health and community well-being, establishing objective measures around these areas and holding leadership accountable is a central responsibility for governing boards.
- Governing board members' community connections can help identify innovative ways to make an impact on community health.
- Engage family practice physicians in governance since their professional mindset is already focused on keeping people healthy.
- Business leaders have unique insights into the costs of poor population health. Leverage these insights by including such leaders on governing boards to make new connections and design new initiatives.
- In an era of increasing affiliations, cross-continuum care delivery, and moving beyond the traditional walls of health systems, be mindful of brand strength and reputation.
- Consider and pursue all types of roles in multi-sector community health alliances.

25 Ryan Donohue, *Brand Equity in Healthcare: The Impact of Branding in a Changing Healthcare Landscape* (White Paper), The Governance Institute, Summer 2011.

LHC Group: Focusing on Health at Home

LHC GROUP, HEADQUARTERED IN LAFAYETTE, LOUISIANA, IS one of the leading post-acute care organizations in the U.S. By providing home health, hospice care, long-term acute care, and community-based services to thousands of patients, LHC Group focuses on one of the most important priorities in the era of community health: keeping people healthy at home. LHC employs more than 9,600 people in approximately 340 locations spread across 26 states. Roughly half of its agencies are wholly owned and managed, with the other half governed jointly by LHC Group and a partnering hospital or health system. LHC Group has distinguished itself in the field of home health and post-acute care by pursuing the goal of having 100 percent of its agencies accredited by The Joint Commission. Representative of the cooperation required for effective cross-continuum care, LHC Group understands its core role as one of partnership. It seeks to improve the quality of life in the U.S. through the services it provides and the partnerships it establishes with healthcare systems. LHC Group defines its purpose as "it's all about helping people."

"Post-Acute" Care in the Era of Community Health

Keith Myers is cofounder of LHC Group and has served as chairman and CEO for 20 years. One of the first points he made about the work of LHC Group is that "post-acute" really isn't the right label. He sees the label as a relic of the hospital-centric, fee-for-service model of care delivery that is being slowly replaced by population management and risk-based models. "Post-acute" denotes just that—the care provided to patients *after* a hospitalization. Keeping people healthy, whether at home or in other facilities, and *preventing* hospitalizations, should be the focus—and it is for LHC Group.

Myers defines his agencies' work as focusing on "everything outside the hospital." This is a crucially important shift in mindset for every organization that provides care under the "post-acute" label. As hospitals and health systems increasingly see their mission as improving and supporting health (in addition to delivering high-quality care), post-acute providers, as essential partners in the continuum of care, should see their

goals similarly. Population management models, as well as achieving the Triple Aim goal of lower per-capita costs, require organizations to identify, as early as possible, those patients at the greatest risk of a hospitalization or rehospitalization. Myers sees the work of "post-acute" care organizations as being both upstream and downstream—preliminary and "post-acute."

LHC Group has employed the following strategies, making it unique among its peers for improving health across communities:

- A focus on objective measures of quality and better coordination of care across the continuum.
- An emphasis on developing partnerships with acute-care organizations in order to improve quality and health (rather than promoting LHC Group as its own brand, LHC partnerships help promote the hospital or health system brand as they are seen as the centers of healthcare in their communities).
- LHC's governing board recognizes its increased role and importance as post-acute spending increases and the industry intensifies its focus on parts of the healthcare continuum outside the hospital. The LHC board membership maintains deep academic and policy expertise. In addition, LHC's senior leadership team emphasizes its own crucial responsibility of helping the board navigate through these changes. Finally, the governing board interacts directly with senior management teams and boards of LHC's partner organizations, which creates transparency and opportunities for learning in both directions.
- An annual strategic planning retreat devotes significant time to the shift from fee-for-service to population management and risk-based models of care and payment. Views are also presented from outside experts such as audit and consulting firms.

For Myers, the surest path to success under the new population health models is objective measures of quality. The shift in what quality of care means (and how it's measured) that hospitals went through in the past decade is increasingly understood by skilled nursing care, home healthcare, rehabilitation care, and long-term acute care organizations. Under the fee-for-service model, a hospitalization for a patient being cared for at home or in a facility, while regrettable, wasn't necessarily seen as a quality defect. The role for these organizations was to deliver quality care to patients, and when a hospitalization or rehospitalization was deemed necessary, to facilitate the admission promptly. The new environment of population health management and risk-based payment models upends the old understanding. Under the new models, reducing rehospitalizations is a proxy measure for quality care. Myers acknowledges that using

Myers noted. While also acknowledging the broad continuum of care, of which LHC's agencies are a part, Myers sees the hospitals and health systems as the centers of healthcare in their communities. LHC Group intends to emphasize keeping the hospital brand in its joint ventures. "That's something that works well for us and we wouldn't have it any other way," Myers said. "I'll tell you this, it can be a deal killer with hospitals and health systems. If you go to them with a joint venture strategy and suggest using your own brand, even if the management team agrees, when it gets to the governing board, it doesn't sell well." This humility also reflects LHC Group's focus on better overall care and health, and better coordination of care across the continuum for its patients.

"Post-acute" denotes just that—the care provided to patients *after* a hospitalization. Keeping people healthy, whether at home or in other facilities, and *preventing* hospitalizations, should be the focus. The LHC agencies' work focuses on "everything outside the hospital."

"Post-Acute" Governance in the Post-Reform Era

Increases in post-acute care spending and the intensifying focus on the parts of the healthcare continuum outside the hospital mean that governing boards of post-acute (or "extra-hospital") care organizations have a growing relevancy and responsibility. It's important for these boards to see this importance in the context of the changing healthcare environment. For Keith Myers, helping LHC Group's governing board navigate the changes is a crucial duty for senior leadership.

rehospitalization rates as a proxy for quality is controversial, but he also acknowledges that it's what the current environment, and market, demand. LHC Group has welcomed the shift.

A defining characteristic of healthcare's new era is the growth in spending outside the hospital. The market for organizations like LHC Group is both growing and increasingly competitive. Staying relevant and competitive requires understanding quality as objectively measurable. Myers has observed organizations with poor rehospitalization rates gloss over the problems and point to less objective quality measures. Myers noted that "objective quality is what drives the success of our organization every day. It's what validates us; it drives our marketing strategies; it's why we convince referral sources that we're a better choice than others in the market; it's how we convince hospital systems to enter into a joint venture with us."

Success for LHC Group is also driven by a particular, and perhaps surprising, business strategy related to their brand. In the previous section on Bellin Health, CEO George Kerwin pointed to the growing importance of a health brand, especially in an environment in which health systems are interacting with patients in new and more numerous ways (e.g., retail clinics and fitness centers). Myers also understands the crucial importance of brand strength, but for him, the crucial brand is the health system's, not LHC Group's. "Most companies that do what we do come up with a brand," Myers explained. "They have a brand and they establish an identity and want people to come and be loyal to their brand. We never have that strategy. Our 'brand' is the brand of our hospital partners."

This view is attributable in part to LHC Group's understanding that hospitals and health systems are significant community assets. "They're almost like the church in many communities,"

LHC Group begins each year with a strategic planning retreat. And since 2011, each of these strategy sessions has devoted significant time to the shift from fee-for-service to population management and risk-based models of care and payment. Myers emphasizes that it's important to present a broad view of the changes, so in addition to presenting management's view, LHC Group engages external experts such as audit and consulting firms to broaden the board's exposure to different perspectives on the environmental changes and their impact on its business. LHC Group is fortunate to have former Congressman Billy Tauzin and former Senator John Breaux on its board. Tauzin, who also served as CEO of PhRMA, and Breaux bring direct experience in the healthcare policy debate, as well as crucial community experience in LHC Group's home region of Louisiana. Myers also points to the addition in 2010 of Kenneth E. Thorpe, Ph.D., professor and chair of the department of health policy and management at Emory University's Rollins School of Public Health, to LHC's board. Professor Thorpe co-directs Emory's Center on Health Outcomes and Quality and had direct experience in another era of significant change in healthcare, serving as deputy assistant secretary for health policy in the U.S. Department of Health and Human Services from 1993 to 1995, during which time he was responsible for the financial estimates and program impacts of President Clinton's healthcare reform proposals. According to Myers, Thorpe is a permanent educator for both the rest of the board and for senior management.

Having deep academic and policy expertise is a key governance asset for LHC Group, and helps mitigate a common risk for healthcare boards in this time of profound change. Myers warns against presenting the new environment's changes, especially payment changes, as total and immediate. The risk is that governing boards can become alarmed that the system they have understood for so long is gone or soon will be. Myers points out that the shift, while significant, is not comprehensive. He commented, "If you start talking about a risk-based model, [the board] may immediately start thinking that the whole operating model is changing and that the financial security of the institution is threatened." But fee-for-service is still the dominant model in the U.S. The experts with which Myers has consulted note that even for the markets in which risk-based models have the most penetration, the split between fee-for-service and population management is still around 50–50. The key point, for Myers, is that "you have to be able to operate in both models." Educating the board, from within and with outside experts, to ensure they are able to govern both models effectively is a crucial responsibility for leaders.

LHC Group's focus on effective and productive partnerships with health systems requires an expertise in interacting with outside governing boards. Myers explained that while there is little interaction between the LHC Group governing board and the governing boards of the health systems with which LHC Group partners, the senior management team's interaction with these boards is direct. When LHC Group forms a joint venture, the new governance structure usually includes representatives of LHC Group management and representatives of the health system's leadership. The governance of the joint venture always reports to the board of the health system, however.

This dynamic creates opportunities for learning in both directions. Myers said that in instances where LHC Group forms a joint venture in smaller markets (e.g., markets with 150-bed hospitals), it's quite possible the governing board of that smaller system or hospital is less familiar with risk-based models of payment. It is therefore the responsibility of the LHC Group's representatives to bring their knowledge of the new models to the partnership. This includes knowledge about the context of the changes in the larger healthcare environment, and also how the changing models have affected the ways in which LHC Group operates and evaluates its own agencies. The objective quality measures LHC Group uses to evaluate itself serve as models for how the smaller hospitals evaluate progress against the goals of the partnership.

For LHC Group's part, ideal interactions with the governing boards of their hospital partners convey important aspects of perception and evaluation. Myers explained, "What we're looking for from the board members on the hospital side is to guide us in a few areas. How are we [i.e., the post-acute facilities and services] perceived in the community in terms of quality and customer service? How are we perceived by other parts of the hospital? Are we responsive enough? What and where are the opportunities to do a better job? Really, I want them to tell us the things that no one else wants to tell us."

Myers' desire for this kind of information is emblematic of the need for candid and transparent interactions between the different parts of today's continuum of health. In instances of direct interaction between governing boards, those boards should be responsible for this kind of open and honest accounting, just as they are responsible for open and honest conversations with their own senior leadership teams.

Engaging the Community

With a presence in over half of U.S. states, LHC Group engages with a large number of communities. But in markets where they have a joint venture partnership, they do so always under the rubric of the existing health system. This humble, under-the-radar approach was reflected in the way they engaged with and supported the community around their corporate headquarters in Lafayette, Louisiana. However, according to Myers this humility became a liability. "We did a lot for the community, but we didn't want anyone to know that, and what happened was the community gave feedback that as successful as we were, we weren't giving enough back to the community." It was LHC Group's board that helped navigate the organization out of this conundrum. The board's guidance to Myers was that it was okay—preferable, in fact—to stop trying to hide LHC Group's community support. As a result, they engaged publicly with the United Way. Myers noted that LHC Group "didn't do anything different, we just started being a little more public about what we did. It's interesting to see how important that has been."

Lessons from LHC Group

- "Post-acute" may not be the right label for the services provided by skilled nursing facilities, home health agencies, inpatient and outpatient rehabilitation facilities, and long-term acute care facilities. In today's healthcare environment, these essential parts of the health continuum should be viewed as both upstream and downstream players, with as much responsibility for keeping patients out of the hospital, as they have for caring for them after a hospital stay.

- Objective quality measures, such as rehospitalization rates, are essential. Subjective measures are also important, but success in an increasingly competitive market requires transparent evaluations of quality against objective measures.

- For organizations that seek to improve health through partnerships with existing health systems, be wary of emphasizing a separate brand. Hospitals and health systems are essential community assets, and focusing on the clinical, patient-focused care collaboration of the hospital and health system partnership can be the most effective strategy for improving health across the continuum.

- A central responsibility for senior leadership is to establish systems and processes that allow governing boards to adequately respond to the changes sweeping through healthcare. It is important to devote time to address the changes as part of the strategic planning process and seek outside expertise to present views that may differ from management's.

- Since the move away from fee-for-service payment models is happening slowly, leadership teams and governing boards need to continue to operate and govern effectively in the current model while at the same time collaborating on innovations to respond to new care-delivery and payment models.

- For organizations that operate through partnerships, tending to the interactions between governing boards, and deriving the most informative and actionable information from those interactions, are essential.

Conclusion

HEALTHCARE ORGANIZATIONS AND THEIR GOVERNING boards are moving into a new era in which they are increasingly accountable for community health and well-being, in addition to delivering high-quality and safe care. As the organizations profiled demonstrate, there are many unique ways to respond to this shift and generate successful results. Many organizations have begun by updating their mission and vision statements to reflect the new reality. This is an important first step to developing strategies and goals that will engage communities in improving their health and well-being. The challenge for all organizations is to narrow down the multitude of strategic options and determine how they can be most effective in their communities by focusing on the areas of most critical need, which may be different for each community.

A common lesson learned from each organization profiled in this publication is that, despite the national discussion about how to create value in the care delivery system, healthcare remains local. Governing boards are facing new challenges and are tasked with determining new and appropriate metrics to measure new goals around population health and preventing hospitalizations. Boards with community representation, business representation, patient and family representation, and physician representation will enable their organizations to respond to the new challenges more effectively.

Broadened governance responsibilities require a new mindset. First, the hospital or health system should be viewed as a key asset to the community, one in which the community wants to invest and partner with; and second, traditional categories of healthcare settings need to change in order to create essential connections and care coordination across the continuum. The example provided by Keith Myers at LHC Group demonstrates this point—that "post-acute" care should actually be focused on "everything outside of the hospital." There are likely other labels or categories of healthcare settings that limit possibilities for expanding the purpose and role of healthcare organizations across the care continuum. Today's boards cannot limit their own thinking by limiting their mindset to beliefs held in the previous era.

Another key lesson from the four organizations profiled in this publication is that their innovations, new approaches, and successes have been applied and achieved in what might best be called a "transitional" phase in how healthcare is paid for. Risk-/value-/population-based payment models are increasing, but fee-for-service remains dominant. Most healthcare organizations are currently working in both models. Seeing that success is possible within the boundaries of both types should encourage organizations to move ahead without worrying that one approach will be undermined by a change in payment systems. That said, programs and initiatives that focus on enhancing health are almost guaranteed to be rewarded by value-based payment models and should be a focus of organizations as those models become increasingly common.

Finally, the experience of all four profiled organizations underscores the importance of an organizational culture that embraces change. Change represents opportunity and it must be welcomed and incorporated as a core element of the organizational culture.

Success in the new healthcare environment takes a sound strategic plan with the broadest possible view of the care and health continuum. Begin with reassessing the organization's mission and vision, and then determine a new purpose and goals, if necessary. This may require a reassessment of the organization's identity or role in the community. It is important to identify community organizations that can help define areas of community need on which to focus by providing necessary data and other demographic information. Also look to community organizations that could serve as potential partners. Then work with payers to develop metrics to measure the determinants of health and health improvement for the community need areas. Those metrics will shape the initiatives and activities the board and management team will use to meet the strategic goals.

Below is a summary of the major lessons learned from each organization profiled in this publication:

- Make system-wide transformation an explicit board-level responsibility by creating or re-chartering a board committee with this sole focus. The committee should be responsible for developing appropriate measures, establishing a common language around the measures, and holding leadership responsible for progress against the measures. In executing these responsibilities, the committee should work with leadership closely, and leverage their collective expertise drawn from past and similar experiences. In the new era of cross-continuum governance and community health, the end goal should be health transformation.
- In pursuing joint ventures, affiliations, and mergers, alignment around strategic vision is paramount. The strategic vision has to be, ultimately, in service of the community. Structure must follow strategy.
- Maintain and utilize the deep community connections of existing governing boards. When affiliating with an organization, some degree of change in the board's composition is necessary, but maintaining as much of the existing community-based board as possible is key. Establishing true alignment requires listening to and learning from existing board members about the unique health needs and history of their community.

- Overcoming the barriers between silos to create a seamless system of care should be the goal of leadership and governance alike.
- Create governance structures designed to evaluate the community's health needs and map the community's assets. Consider a new board-level committee such as Genesys' Advocacy Committee.
- Think about new and innovative ways to bring health improvement strategies into the community (e.g., employee health promotion programs, health services located onsite at local businesses and institutions).
- Consider longer terms for board members to deepen community connections and create a constancy of purpose (or find other ways to keep emeritus board members engaged, such as an advisory council or committee service).
- Patient and family member participation on boards and board committees is essential.
- Establishing objective measures for population health and community well-being, and holding leadership accountable, is a central responsibility for governing boards. These measures will change and improve over time as boards become more well-versed in population health structures.
- In an era of affiliations, cross-continuum care delivery, and moving beyond the traditional walls of health systems, be mindful of brand strength and reputation.
- Consider and pursue all types of roles in multi-sector community health alliances (e.g., leader, partner, owner, advisor).
- A central responsibility for senior leadership is to establish systems and processes that allow governing boards to adequately respond to the changes sweeping through healthcare. It is important to devote time to address the changes as part of the strategic planning process and seek outside expertise to present views that may differ from management's.
- Since the move away from fee-for-service payment models is happening slowly, leadership teams and governing boards need to continue to operate and govern effectively in the current model while at the same time collaborating on innovations to respond to new care-delivery and payment models.
- For organizations that operate through partnerships, tending to the interactions between governing boards, and deriving the most informative and actionable information from those interactions, are essential.

References

Berwick, D.M., Nolan, T.W., and Whittington, J. "The Triple Aim: Care, Health, and Cost." *Health Affairs*, Vol. 27, No. 3, May–June 2008, pp. 759–769.

Bisognano, M. and Kenney, C. *Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs.* San Francisco, CA: Jossey-Bass Publishers, 2012.

Brown, G., Corneliuson, S., and Heideman, C., et al. *Payment Reform, Care Redesign, and the "New" Healthcare Delivery Organization* (Signature Publication). San Diego, CA: The Governance Institute, 2012.

Chandra, A., Dalton, M.A., and Holmes, J. "Large Increases in Spending on Post-Acute Care in Medicare Point to the Potential for Cost Savings in These Settings." *Health Affairs*, Vol. 32, No. 5, May 2013, pp. 864–72.

Democratic Party. 2008 Democratic Party Platform (August 25, 2008). (Available at: www.presidency.ucsb.edu/ws/?pid=78283.)

Donohue, R. *Brand Equity in Healthcare: The Impact of Branding in a Changing Healthcare Landscape* (White Paper). San Diego, CA: The Governance Institute, Summer 2011.

Hearld, L.R. and Alexander, J.A. "Governance Processes and Change within Organizational Participants of Multi-Sectoral Community Health Care Alliances: The Mediating Role of Vision, Mission, Strategy Agreement, and Perceived Alliance Value." *American Journal of Community Psychology*, Vol. 23, No. 1–2, March 2014, pp. 185–197.

Institute for Healthcare Improvement, 5 Million Lives Campaign. *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide.* Cambridge, MA: Institute for Healthcare Improvement, 2008. (Available at www.ihi.org.)

Institute of Medicine, Committee on Quality of Health Care in America (Kohn, L.T., Corrigan, J.M., and Donaldson, M.S., eds). *To Err Is Human: Building a Safer Health System.* Washington, D.C.: National Academies Press, 2000.

Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academies Press, 2001.

Orlikoff, J.E. "Building Better Boards in the New Era of Accountability." *Frontiers of Health Services Management*, Vol. 21, No. 3, Spring 2005, pp. 3–12.

Schyve, P.M. "An Interview with Donald Berwick." *Joint Commission Journal on Quality and Patient Safety*, Vol. 32, No. 12, December 2006, p. 666.