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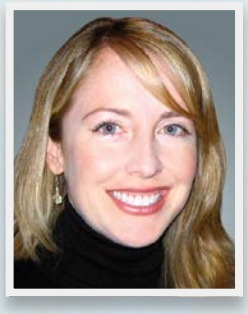

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Finally, we would like to send our thoughts and best wishes to all of our members for a safe, healthy, and peaceful holiday season. Our hearts go out to anyone who has been affected by a natural disaster or human tragedy this year, as there have been too many. Our hopes are high for a merrier and brighter new year.

Kathryn C. Peisert, *Managing Editor*

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Opioid Abuse: The Board May Help Solve the Problem

By Randy Jernejcic, M.D., Janet L. Miller, Esq., and Thomas F. Zenty III, University Hospitals of Cleveland

Opioid abuse is a problem that pervades our society. Healthcare organizations cannot solve all of the issues, but they can help influence opioid prescribing practices. While these actions will support efforts to reduce opioid abuse, board members can better assist hospitals and health systems in contributing to a solution by learning more about the issue and what the community is doing to find solutions and creating expectations for the organization to execute internal and external solutions. The following ideas will help boards ensure that appropriate policies and procedures are implemented by management to address opioid matters.

Understand the Issue

The Centers for Disease Control and Prevention reports that U.S. clinicians wrote more than 191 million opioid prescriptions in 2017, translating to 58.7 prescriptions per 100 people.[1] While that is the lowest the rate has been in 10 years, the CDC also stated that in 16 percent of U.S. counties, enough prescriptions were dispensed such that every person who lived in those counties could have obtained an opioid prescription.

Understanding the statistics will help the board assess the community's needs and how this issue may need to be addressed within its hospital or health system. The board should consider the opioid issue, including related risks, as a part of its agenda. The following provides some insight regarding approaches the board can take:

1. **Learn about the issue in the community**. Opioids are available from multiple legal sources, including dentists and veterinarians, as well as illegal street sources. Knowing about these potential sources, and learning how addicted patients obtain opioids, will give boards a better understanding of how this can have an impact on their hospitals, as well as employed and affiliated personnel.
2. **Develop a plan for board oversight**. The board can exercise its duty of care by asking management probing questions about policies and procedures, supporting management's investment in tools for tracking and data analytics, and requesting regular updates. By encouraging focus on a "solution," boards may find ideas arise beyond management of prescriptions. For example, at University Hospitals (UH), our discussion led to the creation of the UH Pain Management Institute, which provides a holistic approach to pain management. This Institute brings together providers throughout the UH system and across multiple disciplines to optimize patient care. Since board members are key participants in the strategic planning and budgeting process, boards can encourage management to think about their treatment approaches while remembering that opioids still serve as a necessary pain management option for many patients.
3. **Participate in board education around opioid abuse and encourage the organization to develop a comprehensive education program**. We organized a quality retreat during which we provided education to our boards about opioids and addressed opioid prescribing practices and programs to manage them. We also reviewed the Controlled Substance Toolkit we developed for our employed and affiliated clinicians and support staff. The toolkit contains policies and procedures, FAQs, patient–provider controlled substance agreements, referral resources, third-party educational resources, an overview of the auditing process, and escalation resources. Additionally, we hold education programs for affiliated clinicians and provide continuing medical education (CME) credit. We include opioid education in the programming for residents, fellows, and new hires as well. For our patients, we use personalized, prepared discussions at point of care.
4. **Exercise the board's authority to privilege medical staff**. As boards carry out their duty to privilege medical staff, approve medical staff bylaws, and authorize privilege forms, they should ensure that the criteria includes expectations for appropriate opioid prescribing. The board can exercise its authority by refusing to privilege or revoking the privileges of medical staff members who do not follow appropriate opioid prescribing guidelines or otherwise fail to meet regulatory requirements. For example, many states have a prescription drug monitoring program (PDMP) where opioid prescribers are required to check a patient's controlled substance history and can subsequently identify patients who may be misusing opioids. If the board, working with the medical staff, were to require that medical staff members must disclose their reports as part of the credentialing process, it may allow for a better assessment of prescribing practices and patterns over a given period of time. Another aspect of privileging is to assess how

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Key Board Takeaways

Healthcare boards should consider asking the following questions to ensure management has solid policies, procedures, and processes in place:

- Have our hospitals/physicians been named in a lawsuit alleging opioid over-prescribing?
- Does anyone track prescribing practices of physicians who are privileged at our hospital? What actions do we take if a clinician is over-prescribing per applicable medical standards?
- Do we have prescribing guidelines? Do we have a way to audit for compliance with those guidelines? Do we have a process for reporting instances of clinician over-prescribing that do not meet state or internal policy requirements?
- What is our process for educating prescribers on the laws and our guidelines for prescribing opioids or alternative solutions for pain?
- Do we tie credentialing or revoke prescribing privileges for clinicians who are non-compliant with our opioid prescribing expectations/guidelines?
- Do we have technology that identifies patients at risk for opioid misuse?
- Do we have a scorecard that tracks our opioid management practices?

1 U.S. Opioid Prescribing Rate Maps, Centers for Disease Control and Prevention, 2006–2017 (available at http://bit.ly/2PhB0XI).

Current Standards for Board Diversity

By Michael W. Peregrine, McDermott Will & Emery

Incorporating diversity into the composition of the board and its committees is, by this point, a recognized governance best practice. It is a duty that should be formally recognized in the charter of the board's nominating committee.

But the near saturation-level emphasis on diversity threatens to obscure the underlying value to the organization of a diverse board, and how such diversity relates to other elements of the board's workforce culture oversight obligations. Informed board orientation on the scope of the practice, the rationale for its implementation, and its relationship to other fiduciary duties can mitigate against this risk.

Rationale for "Best Practice"

Both of the leading statements of governance principles—Business Roundtable (BRT) and the "Commonsense Principles" series—strongly endorse the establishment of diversity standards for governance.

For example, BRT recommends that boards "develop a framework for identifying appropriately diverse candidates that allows the nominating/governance committee to consider women, minorities, and others with diverse backgrounds as candidates for each open board seat." The Commonsense Principles series recommends that directors have "complementary and diverse skill sets, backgrounds, and experiences," and that director candidates be drawn "from a rigorously diverse pool."

Similar support is provided from across the corporate spectrum, including asset managers, institutional asset owners, employee groups, public policy organizations, and other stakeholders. These and other, similar groups and organizations are placing significant pressure on companies with which they have influence to address board diversity and to demonstrate support for gender diversity improvements.

Then there is the statutory effort, as represented by the new California law that requires *public* companies headquartered in the state to maintain a prescribed level of gender diversity. The new law provides for an escalating level of women on the board, with at least one woman member by December 31, 2019, and by December 31, 2021, at least two women (for boards with five or fewer directors) and three women (for boards with six or more directors). Penalties are applicable for non-compliance.

The Scope of Diversity

Hospital and health system directors should be aware that most of the relevant descriptions of this best practice seek to extend diversity in a broad sense and not just to matters of gender. This reflects an expectation that the value provided by those with experience with the company's business should be balanced by the ideas, insights, and contributions provided by those who offer other experiences. Oftentimes, those different experiences reflect unique matters of ethnicity, race, and other elements of diversity.

For example, BRT's perspective is that more diverse boards—including directors who represent the *broad range of society*—will strengthen corporate governance. In addition, the newly released Commonsense Principles 2.0 specifically added reference to *diversity of thought* as a critical element of diversity. Furthermore, matters of age (and especially, relative youth) are increasingly playing an important role in the composition of the governing board.

The "Business Case"

There is a consistent theme across all variations of the board diversity best practice that diversity along multiple dimensions and backgrounds serves to strengthen the performance of a board of directors. As BRT emphasizes, "The diversity of thought and perspective within our society accounts for much of its resilience and strength—and it adds to the abundance of good decision making. Differing perspectives and maintaining respect for the individual enable Americans, as well as American corporations, to prosper."

Key Board Takeaways

- Make sure that diversity criteria are incorporated into the board nominating committee process.
- Confirm that the nominating committee applies "diversity" to include matters of ethnicity, age, and background, as well as gender.
- Ensure that the board is aware of the data supporting the perspective that diversity strengthens the performance of the board.
- Evaluate the board turnover record and the effect it may have on opportunities for increasing board diversity.
- Recognize that addressing diversity issues can be a bridge to confronting concerns with gender equity in the workforce.

Beyond matters of improved governance, some studies and reports correlate improved financial performance with greater gender and racial diversity on the board. They reflect a perspective that corporate leadership teams and shareholders value benefit from broad, deep perspectives and backgrounds. While there remains some debate on this point, there is increasing consensus that corporate decision making and talent acquisition are likely to improve within a corporate culture that supports diversity in backgrounds and perspectives.

As the CEO of asset manager BlackRock has stated, "Boards with a diverse mix of genders, ethnicities, career experiences, and ways of thinking have, as a result, a more diverse and aware mindset. They are less likely to succumb to groupthink or miss new threats to a company's business model. And they are better able to identify opportunities that promote long-term growth."

Timing Counts

Public discourse on board diversity has been re-energized by the enactment of the new California law, and by renewed pressure from asset managers and institutional asset owners. *The Wall Street Journal* reports that boards are using vacancies to add women and other diverse members. Indeed, new studies show that only one company is left in the S&P 500 with an all-male board. In that regard, a new Spencer Stuart study also links lower board turnover rates in

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The Road to Transformation: Reflections of Healthcare Leaders

By Kevin Barnett, Dr.P.H., M.C.P., and Stephanie Sario, M.Sc., Public Health Institute

This article shares the experiences of board members and senior leaders of hospital and health system participants in the Alignment of Governance and Leadership in Healthcare (AGLH) program, a collaborative project of the Public Health Institute, The Governance Institute, and Stakeholder Health. AGLH was funded by the Robert Wood Johnson Foundation, and has been institutionalized by The Governance Institute as an ongoing program. The central theme of AGLH is to build a common vision and practical roadmap on the journey to healthcare transformation through robust engagement of board members.

AGLH Background and Impetus

In the eight years since the passage of the Affordable Care Act, hospitals and health systems have been engaged in an ongoing struggle: balancing the imperative to maintain a positive margin while building the capacity to thrive in a future where the financial incentives are to keep people healthy and out of acute care facilities. The dynamics vary widely in states and communities across the country, driven at the macro level by factors such as whether their state has expanded Medicaid, and at the micro level by factors such as local demographics and payer mix. At the core, future success for hospitals and health systems will require a substantial expansion in focus, moving beyond the delivery of medical services to become community-engaged institutions with a core business strategy to treat illness *and* to work strategically with others to improve health.

The impetus for the formation of the AGLH partnership was a series of conversations between the leadership of The Governance Institute, Stakeholder Health, and the Public Health Institute. Stakeholder Health is a learning collaborative of over 50 health systems that have come together with a shared commitment to build healthy communities through engagement of diverse community stakeholders. Over the last five years, these systems have convened at both regional and national meetings, launched new initiatives, and shared best practices in multiple publications, Webinars, and broadcast interviews.

In the course of this work, it has come to light that while healthcare leaders are committed to transformation, management and governance structures, functions, and competencies are still tied to the acute medical care delivery paradigm. In such a scenario, a CEO may see the imperative for bold transformation, but she/he is operating in an institutional environment where financial incentives, management and clinician skill sets, and board priorities are driven by legacy concerns. In such an environment, forward-thinking senior leaders are challenged in their efforts to get senior clinical and administrative leaders aligned, and to get board members to support bold steps that involve unknown risks and are outside the focus on the delivery of acute care medical services.

The gap between the knowledge base of current board members and the breadth of issues to be addressed in the transformation of healthcare in the U.S. is substantial. In the last 10 years, The Governance Institute has hosted special sessions with board members to introduce them to issues and opportunities in population and community health, and responses by many is that these sessions were their first exposure to the topic. The core hypothesis of AGLH is that more intensive exposure to these issues is needed; exposure that provides opportunity for dialogue, reflection, and guided strategy development among teams of board members and senior leaders. Such exposure and dialogue helps to set the stage for robust engagement on an ongoing basis, enabling boards to play a more dynamic role in determining what kinds of calculated risks are necessary and appropriate to build a promising future.

Key Board Takeaways

On the road to healthcare transformation, boards will need to take a systems approach to building population health capacity:

- Review board competencies and structures (e.g., board committees) and take necessary action to support focused review of population health strategies and civic engagement.
- Establish protocols that prioritize board dialogue, review, and input to senior leadership (e.g., 80 percent dialogue, 20 percent presentation).
- Develop a roadmap and systematically assess progress towards objectives to build internal population health capacity.
- Integrate periodic review of progress (e.g., report cards) across departments and facilities and implement quality assurance (QA) refinements.
- Establish ethics of engagement and accountabilities as appropriate to ensure senior leadership is focused on civic engagement and leveraging institutional investments.

At the core, future success for hospitals and health systems will require a substantial expansion in focus, moving beyond the delivery of medical services to become community-engaged institutions with a core business strategy to treat illness *and* to work strategically with others to improve health.

AGLH Design

In recognition of the need for focused engagement, a partnership was formed between The Governance Institute, Stakeholder Health, and the Public Health Institute, and the AGLH initiative was designed, generously funded by the Robert Wood Johnson Foundation, and initiated in August 2014. A total of three two-day intensives were held as pre-conference sessions prior to Governance Institute Leadership Conferences in Boca Raton, Florida, and Nashville, Tennessee. Invitations were sent to the broader Governance Institute membership, Stakeholder Health membership,

and to other hospital and health system leaders with whom AGLH colleagues had networking relationships. Each participant organization was required to bring at least one senior leader (i.e., CEO, CFO, CMO, or EVP) and at least three board members from individual hospitals and/or at the health system level. After enrollment, at least one call was scheduled with teams to provide an overview of the purpose and approach, outline expectations of participants, and answer any questions.

The two-day intensives were led by peer leaders in the field; the intent being to engage participants with colleagues who are also board members and senior leaders of hospitals and health systems with direct experience in taking the kinds of bold steps needed in the path towards transformation. The sessions were a mix of content presentations, team work sessions, learning exercises, and large group discussions.

A key element of one of the early exercises was the completion of a self-assessment tool to assist teams in determining their organization's relative progress in specific areas such as data systems development, care redesign, financial innovations, and integration of community benefit and population health management.[1] The purpose was to create a safe space to move beyond generalized discussions to a deeper examination of structures, functions, and progress to date in each area. At the end of the intensive, teams completed an action plan as a template for potential steps to take upon their return.

The three AGLH intensives brought together teams and individual representatives from **43 hospitals and health systems**, including national systems and their subsidiaries, multi-facility regional systems, urban academic health centers, and stand-alone rural hospitals. Examples of national systems and subsidiary participants included Catholic Health Initiatives, Trinity Health, and Ascension. Regional systems ranged from UMass Memorial Health System and University of Vermont Medical Center to Mountain States Health Alliance, Carilion Clinic, and Wake Forest Baptist Medical Center. Examples of stand-alone rural hospital participants included Beatrice Community Hospital and Bartlett Regional Hospital. A total of **16 teams agreed to participate in a series of six bimonthly follow-up calls** to document progress, challenges, and emerging lessons in the implementation of action plans, and for the AGLH team to share best practices, tools, and insights from the field. Fourteen of those teams are highlighted in this article.

Focus of AGLH Engagement and Documentation

The purpose of the extended engagement of AGLH intensive participants was to highlight specific actions taken by hospitals and health systems to **a) implement institutional systems changes** that formalize efforts to build population health capacity within their organization, and actions taken to **b) expand engagement with external stakeholders** to address the social determinants of health (SDH). The AGLH program provides a framework to document how they formalize their commitment to address SDH and engage board members and key leaders across sectors to better align and focus in communities where health inequities are concentrated.

The purpose is to increase knowledge and contribute to the acceleration of healthcare transformation in the field by documenting steps taken by hospitals and health systems to build population health capacity. This article highlights experiences to date, key actions taken, the importance of this work in the current policy environment, strategies for initiation, adoption and scaling in diverse environments, suggestions regarding transitioning from volume to value in the delivery of healthcare services, and identifies opportunities to align resources to build momentum in the field.

The framework for documentation of specific actions taken by AGLH teams is outlined below.

Institutional system changes to build population health capacity:

1. **Leadership and board engagement**: board members/C-suite are engaged to build understanding, secure input, and assure strategic investment; a matrix of desired board competencies[2] is developed, a self-assessment is conducted, and a recruitment process is initiated.
2. **Establish new structures to give focused attention to emerging priorities**: establish a population health subcommittee of the board for more critical review of community benefit resource allocations and relevance to population health management.
3. **Develop new roles/functions**: establish at-risk compensation (ARC) tied to population health objectives, develop new responsibilities for senior leaders, create new senior leader positions, form new planning structures, and incentivize clinician engagement.
4. **Align functions across organizational departments/elements**: align business strategy planning and charitable mission review; establish forums for exchange of ideas among clinicians, community health, finance, human resources, and facilities management and the design of comprehensive strategies.

1 To view the self-assessment tool, go to www.governanceinstitute.com/AGLHAssessmentTool.

2 For example, epidemiology, community and economic development, social policy, education, information technology, scenario planning, urban planning, and collaboration with community-based organizations; Also see Kevin Barnett and Stephanie Sario, "The Board as Think Tank: Moving Beyond Legacy Roles in a Time of Transformation," The Governance Institute, October 2016.

5. **Build data capacity to make the population health business case**: share GIS-coded data on preventable utilization patterns to align accountable care organization (ACO) strategies and community benefit programming and develop dashboards for ongoing data review across departments.

Expand engagement with external stakeholders:

6. **Mobilize action through strategic partnerships**: actions to build community capacity to better address priority needs and shared investment in a management/monitoring structure to address SDH at scale.
7. **Invest in external infrastructure for ongoing collaboration**: e.g., establish and direct ongoing resources in external entities that serve as focal points for co-investment by diverse stakeholders and share ownership for health.

Framework of Actions: On the Transformation Journey

Initial data was obtained from responses from hospital senior representatives and board members to the AGLH self-assessment tool completed during the intensives. The tool examines the level of organizational activity in seven distinct areas:

1. Board engagement in population health
2. Data systems and measurement
3. Financing/payment models
4. Delivery system redesign
5. Community benefit/community health (internal)
6. Community health (intersectoral collaboration)
7. Policy development

Additional qualitative data to clarify activities documented in the queried domains were secured from teams through follow-up conference calls with hospital/health system representatives. Additional written materials and extensive insights were provided by AGLH participants in the course of follow-up team calls.

The significant diversity of participant hospitals and health systems (e.g., size, focus, and governing structures), local and regional dynamics, and state regulatory environments, among other unique characteristics, makes it difficult to generalize about which specific strategies may be applicable to others in the field. Nevertheless, the many actions taken by these healthcare organizations will inform deliberations by others into options to address the two overarching themes for the AGLH initiative: a) to implement institutional systems changes that focus on the formalization of commitment to population health and addressing the social determinants of health, and b) to build a framework of shared ownership with diverse external stakeholders.

A core message of AGLH is an encouragement to move beyond the "one-off" project mentality to build a roadmap that identifies the specific internal and external structures and functions that reflect a serious and ongoing commitment to build population health capacity and address the SDH in our communities.

List of Key Acronyms

Below is a list of acronyms and associated definitions for the types of healthcare organizations that participated in the AGLH program:

MR	**Multi-regional health system**
SR	**One or more local facilities as a subsidiary region within a larger health system**
MF	**Multi-facility regional health system**
IF	**Independent, individual facility**

Institutional Systems Changes to Build Population Health Capacity

Leadership and Board Engagement

Examples of leadership and board engagement *before* participation in AGLH intensive:

- **Trinity Health Of New England (MR)**: Established a board resolution to pursue healthcare equity goals and diversity at the organizational level. The resolution is part of the regional level's healthcare equity goals addressing diversity, cultural competence training, and tracking of race, ethnicity, and language data.
- **UMass Memorial Health Care (MF)**: Community and population health is a central component of board member orientation. Since 2013, the health system has made a conscious effort to create a more diverse board and move towards population health. Key criteria in recruitment are expertise in population health, gender diversity, and racial and ethnic diversity.

Examples of leadership and board engagement *after* participation in AGLH intensive:

- **Beatrice Community Hospital (IF)**: Allows its board and providers time to be educated on issues like building capacity for population health, with attention to unique dynamics in being a rural stand-alone hospital. A key focus in the wake of the intensive is to identify and discuss specific steps in building capacity. As a rural hospital with limited resources, leadership emphasized the need to first focus on chronic disease management.
- **Catholic Health Initiatives (MR)**: Discussion with the board has been positive. There is a clear

philosophical shift in focus, but much of the bandwidth is taken up with practical considerations of how to bring a large, geographically dispersed system together. There has also been a positive shift in language from population health management to healthy populations and communities. CHI has been well on the path to transformation prior to its participation in AGLH. That said, its leadership indicated that participation in the initiative helped solidify the path and resolve among its board and senior leadership.

- **Cheshire Medical Center (SR)**: Established a new, specific population health metric for the Cheshire Medical Center (CMC) Monthly Organizational Performance report to the CMC board. The metric is the number of new population health written agreements signed with external stakeholders. This links achieving specific objectives of their Community Health Improvement Plan (CHIP) through engagement with partner organizations and businesses in the community. The organization has also adopted an equity standard (income level) in analyzing and reporting population health data for its CHIP work.
- **Centura Health (MR)**: Implemented a system of educating boards on the connection of community benefit and value-based medicine. Since the AGLH initiative, the system has prioritized ongoing engagement with community boards.
- **Mercy Health System (SR)**: Revamped its quality committee with written charters outlining roles and responsibilities "providing oversight of system-wide coordination and integration of related care unit performance improvement activities in alignment with the overall MHS vision and strategic plan."
- **Mountain States Health Alliance (MF, now known as Ballad Health**[3]**)**: A merger with Wellmont Health System to create Ballad Health was approved by Virginia and Tennessee. Part of the requirements associated with the merger are to significantly expand population health capacity and oversight. The new board includes 11 voting board members with three *ex-officio* voting members including the Executive Chair/President of the health system, the Chief Financial Officer of the health system, and the President of East Tennessee State University. Ballad also created a population health and social responsibility committee of the board. This committee membership includes a representative from the Shriners Foundation, the School of Public Health at East Tennessee State University, local Department of Health representation, other community organization leadership, several physicians, and executive staff.

Establish New Structures

Examples of new structures formed *before* participation in AGLH initiative:

- **Carilion Clinic (MF)**: Established a diversity group looking into the disparities of health among different populations in the community. This group is managed by the CEO and executive team.
- **Cheshire Medical Center (SR)**: Revamped the Cheshire Health Foundation (CHF) into a separate board, distinct from the operational governance board of the hospital, to be more than just a fundraising committee and begin to focus more on addressing the SDH and population health.
- **Mercy Health (MF)**: Established a Mercy Community Health Program/Community Benefit Advisory Board under a community health collaborative infrastructure to deliver programs and services in the community.[4] It exists as a 501(c)(3) in the organization that is composed of external stakeholders.

Examples of establishment of new structures *after* participation in AGLH initiative:

- **Centura Health (MR)**: Revamped its community benefit advisory committee to leverage the lessons learned though the AGLH initiative. The new committee will include seven to 10 key people within the regional level possessing key competencies that support alignment opportunities across the system, lifting specific innovations, and looking for ways to replicate or scale innovations.
- **Mountain States Health Alliance (MF, now known as Ballad Health)**: Creating the Department of Population Health Improvement to be overseen by the population health and social responsibility committee. It committed $75 million to population health improvement over the next 10 years.[5] The Department of Population Health Improvement will collect/analyze data related to the

3 For more information on Ballad Health, see www.balladhealth.org/about-us.
4 To view the community health collaborative infrastructure, see http://bit.ly/2K6xzgC.
5 *Ballad Health Population Health Improvement Plan: Capacity and Preparedness Assessment and Recommendations*, Conduent Business Services, LLC, 2017 (available at http://bit.ly/2FqcajQ).

overall health of the people of the region it serves.
- **Saint Agnes Medical Center (SR)**: Established a mission and community benefit committee to "monitor and review the Community Benefit Ministry Financial Activity and provide oversight of their community benefit implementation plan, monitoring progress towards goals and targets on a quarterly basis." The board is adding community members and recently added representation of Poverello House, a non-profit organization that provides shelter, support services, and programs for homeless people.

Integration and/or Development of New Functions

An example of integration and/development of new functions *before* participation in AGLH initiative:
- **New Hanover Regional Medical Center (MF)**: Selected 18 people in all levels of the organization to represent and develop plans of promoting more diversity within the organization. As of 2016, four women were promoted to VP positions.[6] The health system also created a yearlong leadership program that trains 15 individuals in the organization, channeling informal leaders into more formal leadership roles.

Examples of integration and/development of new functions *after* participation in AGLH initiative:
- **University of Vermont Medical Center (MR)**: Improving population health was made a priority through hiring a Senior Vice President for Quality and Population Health and Senior Vice President of Policy and Prevention.
- **Trinity Health Of New England (MR)**: Established a Regional Vice President for Health and Well-Being and Chief Health Equity Officer position, with responsibilities to formulate institutional policies to support health equity, educate clinicians, and lead public policy advocacy efforts in the region. This work is supported by local ministry leadership and the person in this role serves as a member of the CEO's presidential leadership team. As a member of the leadership team, the VP CHWB and Chief Health Equity Officer continues to keep matters related to health equity, population health, diversity and inclusion, as well as supplier diversity in the minds and routine dialogue of the senior leaders of the Regional Health Ministry.

Align Functions across Organizational Departments/ Elements

An example of alignment across key organization elements *before* AGLH participation:
- **UMass Memorial Health Care (MF)**: Convene community board members frequently to work together and determine which strategies work best for the community in a way that aligns with the system.

Examples of alignment across key organization elements *after* AGLH participation:
- **Carilion Clinic (MF)**: Integrated Vision 2020 in its organizational strategic plan with a focused section on healthy communities that includes reducing spending on employee plan(s), reducing the cost of care for populations, reducing readmissions, smoking cessation, and diversity/inclusion in the workforce.
- **New Hanover Regional Medical Center (MF)**: Reorganized its organizational chart and structure to align with the continuum of care and strengthen links between the physician and administrative leadership. In 2017, the organization launched Leading Our Community to Outstanding Health[7] with a transformative mission statement to move the organization beyond the legacy image of a big hospital. This has been approved by the board.
- **Catholic Health Initiatives (MR)**: Launched the Total Health Road Map implementation phase with a grant from the Robert Wood Johnson Foundation to align a new mission statement and strategic plan embracing the goal of improved population health, well-being, and equity.[8] Through this initiative, it is implementing and evaluating a scalable and sustainable approach for addressing total health through integration of CHI's systems of care, effective partnerships with community-based organizations, and expansion of leadership competencies and accountabilities.
- **UMass Memorial Health Care (MF)**: Formal integration of the concept of an anchor mission into the strategic plan in three phases. Key recommendations include making the "social determinants of health a fundamental priority as means to improve population health and adopt a policy-oriented mission in the short-term while concurrently improving data collection in order to add place-based investment in the near future."

Build Data Capacity to Make the Population Health Business Case

Examples of efforts to build data capacity *before* AGLH participation:
- **Bartlett Regional Hospital (IF)**: Developed a dashboard presentation with quality staff, focusing on behavioral health and care transitions. The hospital lacked good population health data.
- **Trinity Health Of New England (MR)**: Established a Health Equity Dashboard to measure progress. The system plans to measure national pace around screening of smoking and BMI/obesity using CDC behavioral database on smoking, comparable CDC database on BMI, and looking at the same drill down for Massachusetts and Connecticut. Among the challenges are the lack of interoperability across provider organizations, but this serves as an important starting point. Understanding the linkage between awareness and incentives, the system's ministries continue to include measurable clinical interventions in the priority strategic aims. These aims tie back to the communities the system serves and the providers who care for patients each day.

Examples of efforts to build data capacity *after* AGLH participation:
- **Mercy Health System (SR)**: Developing a data system across healthcare providers to support the coordination of strategies to address SDH. The

6 "Five NHRMC Leaders Promoted to Vice President" (press release), New Hanover Regional Medical Center, October 25, 2016 (available at http://bit.ly/2FrgpeR).
7 Philip Brown, "NHRMC on a Mission," New Hanover Regional Medical Center, January 25, 2017 (available at http://bit.ly/2TgLk0r).
8 *Total Health Road Map Planning Initiative Final Report,* Catholic Health Initiatives, 2017 (available at http://chitotalhealthroadmap.net).

core intent is to work collectively and raise the ambition of efforts in the community benefit/community health space. Work is just coming together with an evolving set of capabilities. Seven health systems, three health departments, and several non-profits are involved.

- **New Hanover Regional Medical Center (MF)**: Using EHR/Epic and working with a team of people on its clinical informatics and accountable care metrics. Also working in partnership with Community Care of North Carolina (CCNC) on analytics to support case management, risk adjustment scores, and others that can allow them to be impactful. The organization has other good initiatives that appear to be opportunities, but it has to pilot them on a limited basis with an eye towards scaling successful efforts. In addition, there are new data analytics available through a relationship with Coast Connect Health Information Exchange (CCHIE) and a move towards more simple analytics. Participating in CCNC has provided the system with good predictive analytics for Medicaid data. It is looking into whether they are applicable to other populations.
- **UMass Memorial Health Care (MF)**: Data collection is robust within the community benefit department. The health system is tackling this in two phases: converting the system into Epic, and then assisting community health clinics in implementing Epic to streamline data sharing.

Expand Engagement with External Stakeholders

Mobilize Action through Strategic Partnerships

Examples of mobilizing action through partnerships *before* AGLH participation:

- **Bartlett Regional Hospital (IF)**: Partners with the Juneau Housing First Project, an affordable housing project and Front Street Community Health Center to address homelessness in the Juneau, Alaska, region.[9] Additionally, a Juneau Housing First collaborative addressing housing and homelessness was created and has become a "powerful example of a community pulling together to address a critical social issue." The coalition is a partnership of local agencies and non-governmental organizations serving the region's most vulnerable residents. The housing project houses a community health clinic that provides integrated primary health, mental health, and substance abuse treatment services to all in need, and space for other local non-profit agencies and interested retail partners.
- **Beatrice Community Hospital (IF)**: Collaborated with the Public Health Solutions District Health Department,[10] a district health agency serving the rural population in Nebraska, to survey five county groups with other hospitals. The board has committed to $100,000 for three years to support the community health needs assessment process. The hospital noted the importance of building partnerships not just with public health, but relationships with different stakeholders as well. The challenge is that the hospital is still in a system that is paying primary care doctors for seeing people and being graded based on seeing patients.
- **Carilion Clinic (MF)**: Made a commitment to expand relationships with partners and create stronger metrics by organizing a group of different stakeholders that work on initiatives in that community. The organization held a number of focus groups with different stakeholders to come up with six initiatives or strategies, and a scorecard. For a particular zip code, it will measure impacts on health behaviors. For SDH, the system is looking at high school graduation rates, unemployment rates, etc.

Examples of mobilizing action through partnerships *after* AGLH participation:

- **New Hanover Regional Medical Center (MF)**: Continuing to develop programs in partnership with diverse stakeholders to align strategic interests in population health efforts. Several community initiatives are in play including a community paramedic program, partnership with a local organization on behavioral health, collaboration with a local university on workforce development, United Way on funding for local programs around population health, Blue Ribbon Commission around youth violence, and the South East Area Education Center providing training, education, and resources to healthcare professional in the region. Several initiatives are beginning to unify these different areas, but it is a gradual process where the organization still needs to build trust with different stakeholders. It is reconvening a communications task force to disseminate information on work that has been done and what it expects to be next steps.
- **University of Vermont Medical Center (MR)**: Has successfully implemented an initiative to reduce preventable utilization through comprehensive strategies that integrate care coordination strategies with investments in supportive housing. This is an important early experiment where UVMC has already documented savings of $1 million per year due to reduced preventable utilization.[11]

Invest in External Infrastructure for Ongoing Collaboration

An example of leveraging resources through expanded engagement *before* AGLH participation:

- **Trinity Health Of New England (MR)**: Established the Curtis T. Robinson Center for Health Equity, establishing a formal platform to engage stakeholders across sectors to build regional commitment to address racial and health inequities. The organization also made a significant investment in the development of the North Hartford Triple Aim Collaborative (now located at the United Way) to bring together multi-sector partners to achieve the goal of improving the well-being of North End residents by 2020. One of the most significant hospital community partnership initiatives was undertaken in an effort to address the fresh food desert in North Hartford. While the Joan Dauber Food Bank provides

9 "Juneau Housing First Project—Addressing Homelessness," Juneau Community Foundation (available at http://bit.ly/2RYTFEB).
10 See http://bit.ly/2TiIVC6.
11 Russ Rubin, "The University of Vermont Medical Center Saves Over $1 Million through Award-Winning Community Partnership," Public Health Foundation, August 15, 2017 (available at http://bit.ly/2OJwPi1).

significant assistance to families, especially children and seniors who are unable to make it to a more conventional location, the health system knows that a food bank is not enough to address the healthy food scarcity. Moreover, it understands that this is not an effort it can undertake alone or even as a single regional health ministry. By leveraging Trinity Health's low-interest loan program, it was able to participate in what is referred to as stacking to help make investments in its communities' needs more appealing to civic investors.

Examples of leveraging resources through expanded engagements *after* AGLH participation:

- **Trinity Health Of New England (MR)**: Implemented a Supplier Diversity Program to improve diversity in the supply chain process and created a Regional Coordinator position to provide support across the region around supplier diversity issues and manage regional diversity programs within the supply chain. As an initial effort, having a coordinator was sufficient, but to truly engage leadership and hold the organization accountable to the board, the CEO established a Regional Supplier Diversity Council under the direction of the Vice President, Chief Health Equity Officer, and with the support of the Senior Vice President for Mission, Regional Director of Supply Chain Management, and members from the Trinity Health Office of Diversity and Inclusion. The goal is to, whenever possible, leverage and lead the way in the use of local diverse suppliers that may partner with the system's national vendors to strengthen their place in the market while providing Trinity Health Of New England the best service at the best price in support of its mission.
- **University of Vermont Medical Center (MR)**: Built a regional partnership with three health systems and seven public health agencies to scale and coordinate comprehensive strategies to improve population health. The groundwork for the regional partnership was established with alignment in prior community health assessments, and the recognition that more in-depth and ongoing work was needed to produce measurable and sustainable results.
- **Cheshire Medical Center (SR)**: Merged the Council for Healthier Communities, Healthy Monadnock Advisory Committee, and the Greater Monadnock Public Health Network into a unified entity renamed the Leadership Council for Healthy Monadnock.[12] The Council's aim is to engage the community in the development and implementation of a comprehensive approach to improving population health outcomes for the 33 towns of the Monadnock Region.
- **Carilion Clinic (MF)**: Carilion Clinic has a long-term investment partnership with Healthy Roanoke Valley (initiative of the United Way Roanoke Valley) that is a coalition of 50-plus health and human service providers working on challenges identified by the most vulnerable—uninsured, low-income, and underserved across the Valley—that "enables 160 community partners to transcend organizational boundaries, sharing leadership, expertise, and resources to activate a set of shared goals for community improvement. Community partners include stakeholders representing health and human services, schools, housing, businesses, governments, and other non-profit organizations."

Summary/Emerging Lessons

When launching AGLH, a key question was whether and under what circumstances might hospital and health system leaders be ready to move beyond generalized discussions[13] about population health? There was general agreement that hospital and health system leaders are cautious about what venues are appropriate for their board members. Most boards are voluntary bodies, and leaders may be reluctant to ask for more of their time, particularly if the focus is on topics they may view (in legacy terms) as beyond their purview. Our experience in AGLH has been that there are a number of singular, and in some cases, multiple factors or conditions present that have led hospital and health system leaders to engage, including:

- A visionary champion for population health/SDH in senior leadership who is supported by the CEO (in some cases, it was the CEO).
- One or more board members who are champions for population health/SDH, and are looking for ways to support the organization.
- CEOs who see the importance of moving beyond legacy board dynamics; that robust engagement and new sets of competencies are needed to support transformation.
- Systems in states that have implemented the Medicaid expansion and/or that have payers interested in moving towards risk-based reimbursement models.

12 See https://healthymonadnock.org/council.
13 Most often limited to a focus on care management for a panel of patients in a risk-based contract.

- A new leader seeking to build a strong working relationship with his/her board, or an existing leader of a newly configured board after a merger or acquisition.

Given continued uncertainty in the federal policy environment, an array of anticipated challenges and opportunities will confront the leadership of hospitals and health systems in the next few years. Challenges ahead include, but are not limited to, the following:

- Continued downward pressure on reimbursement for inpatient care, particularly for treatment of preventable conditions
- Rising costs for equipment, pharmaceuticals, and provider charges/practices
- Provider disengagement, burnout, and retirement, particularly those in safety-net institutions and many others serving rural populations
- Increased public scrutiny into significant (and often difficult to explain) variations in charges for procedures and the charitable expenditures by tax-exempt hospitals
- Increased demand for treatment of chronic illness and care transitions for the "silver tsunami" of retirees of the baby boomer generation
- Increased demand for comprehensive approaches to address structural challenges such as the opioid epidemic, mental illness, housing and food insecurity, and income inequality
- Sustained focus on necessary institutional reforms in the context of mergers, acquisitions, and monopolistic practices by larger players in regional marketplaces

In such an environment, leadership that leverages the breadth of internal expertise and strategically engages external stakeholders is essential. In short, there is an imperative for a new form of leadership; one that is prepared for a future with hospitals as cost centers for acute care delivery within larger health improvement systems that are seamlessly integrated into the fabric of communities. Operationalizing such a

vision requires skills and competencies not previously recognized and required in the healthcare arena. It also requires a systematic approach, moving beyond a project mentality to clearly articulated strategies and roadmaps, with built in, proactive review at multiple levels (i.e., governance, management, and operations) that support periodic course corrections. Emerging opportunities for a new generation of health improvement system leaders include, but are not limited to, the following:

- Build new interdisciplinary approaches to team-based care that effectively leverage the expertise of clinicians with more robust engagement of frontline workers,[14] with explicit focus on expanding the scope of interventions to the community level.
- Establish clear accountabilities (with metrics) for how the organization will address the social determinants of health at the clinical and administrative senior leadership level, ensuring capacity to translate vision into community practices.
- Build ongoing partnerships with government public health agencies that support population and community level design, development, and monitoring of the impact of comprehensive strategies that focus hospital and diverse stakeholder resources in communities where health inequities are concentrated.
- Mobilize the creativity of potential leaders throughout the organization with a call for ideas, contributions, and strategies to address emerging priorities,[15] and the establishment of a system to vet, integrate, and reward progenitors.
- Establish a process to assess and supplement board competencies to accommodate the imperative for transformation, and reformulate the role of the board of directors as a "think tank"[16] that participates in the systemic change process, working with senior leadership to design, monitor progress, and support the bold changes needed to restructure and refocus these large, complex, organizations.

The table has been set by hospitals and health systems that recognize the imperative for bold action. There is no longer any question that we need to move beyond a system of pernicious incentives for the delivery of acute care to one where we strategically leverage resources to improve health and well-being in our communities. Are we ready to proceed?

The Governance Institute thanks Kevin Barnett, Dr.P.H., M.C.P., Senior Investigator, and Stephanie Sario, M.Sc., Program Manager, Public Health Institute, for contributing this article. They can be reached at kevinpb@pacbell.net and ssario.phi@gmail.com.

14 Including, but not limited to social workers, community health workers, promotores, peer mental health workers, and home care workers.
15 Ranging from strategies to build health workforce diversity and purchasing practices that support local vendors to reducing organizational carbon footprint and community investment strategies.
16 Kevin Barnett and Stephanie Sario, "The Board as Think Tank: Moving Beyond Legacy Roles in a Time of Transformation," The Governance Institute, October 2016.

Building Cultures of Safety—Together

By Deborah J. Bowen, FACHE, CAE, American College of Healthcare Executives

Keeping patients safe from harm has always been and remains a key priority for healthcare organizations, their leadership, and their boards. While much has been achieved to improve safety, preventable medical errors continue to occur at hospitals and health systems in alarming numbers. Though not an official cause of death in the U.S., if it were, medical errors would rank third, according to a 2016 study by Johns Hopkins Medicine. Clearly there is room for improvement, and healthcare boards play a vital role in this quest.

As healthcare organizations strive to achieve the ultimate goal of zero harm, CEOs and board members—together—should address patient safety. Senior leadership and healthcare boards must collaborate to cultivate and sustain cultures of safety throughout their organizations.

Improving healthcare safety requires leaders who are committed and take a stand to achieve the highest standards of safety. Strong leadership involves balancing core values while consistently raising the bar for excellence. The American College of Healthcare Executive's leadership development expertise, coupled with the Institute for Healthcare Improvement and the National Patient Safety Foundation Lucian Leape Institute, offers healthcare leaders the foundational tools to measure, build, and sustain a culture of safety in the workplace.

This article explores key areas healthcare boards can focus on in conjunction with senior leadership to help make safety an unrelenting priority within the institutions they govern.

Establish Safety as a Strategic Priority

Accountability for safety is shared jointly between CEOs and boards, with both charged with establishing a culture of safety within the organization. In addition to providing oversight of safety efforts, board members and senior leadership must communicate clearly to staff and patients that safety is a core organizational value.

One way to achieve this is by including safety among an organization's strategic priorities. In addition to having well-thought-out safety goals, board members and senior leadership should discuss and consider formally listing safety in organizational mission and vision statements. Doing so can further stress the importance of safety to staff, patients, and the community.

An important first step in including safety in the organizational vision or mission is conducting a thorough assessment of the organization's current safety landscape. Board members, working with senior administrative and clinical leadership, can review safety-related areas such as:

- Current safety practices
- Safety metrics
- Clinician attitudes and perceptions
- Patient and family member experiences
- External trends or events affecting the healthcare field and safety efforts

Using information gleaned from this analysis can aid senior leadership and boards in developing an organizational vision or mission that includes safety as a core value.

Strive for Transparency

Board members, along with senior leadership, are responsible for ensuring a mechanism is in place for reporting and recording organizational safety metrics and issues. In addition to having a thorough understanding of how safety measures and harm events are reported out to the community and internally among staff members, board members share responsibility for continued safety transparency.

To that end, board members can ensure quality data is readily available to patients and the community on the organization's Web site and in public places throughout hospitals and other healthcare facilities. Boards and leadership also can consider engaging patients and their families in shared decision making regarding safety goals and initiatives. All of these steps go a long way toward establishing trust among the board, senior leadership, staff, and the community.

Think Beyond Metrics

Board members are responsible for reviewing patient safety data such as metrics during board meetings. A streamlined approached is best, in which harm events per 1,000 patient days, adverse events per 100 admissions, and percent admissions with an adverse event are measured. The Institute for Healthcare Improvement's Global Trigger Tool is one resource to consider to measure overall harm in a system.[1] For a foundational understanding of concepts, another resource is the Agency for Healthcare Research and Quality. Though safety metrics should remain a standing item on board meeting agendas, directors should consider taking a step beyond looking at metrics and include patient stories in their safety discussions.

Hearing about patients' safety experiences, whether they are positive or negative, puts a human face on safety's importance and may even spark new ideas for organizational initiatives and priorities. One practice to consider is reviewing the number and names of all patients and staff who experienced harm

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Key Board Takeaways

As organizations continue to strive toward achieving the ultimate goal of zero harm, board members and CEOs need to work—together—to address patient safety. Some key actions they can take include:

- Mentioning safety in organizational mission and vision statements
- Encouraging transparency by making quality data readily available to patients and community members online and in public places throughout healthcare facilities
- Engaging patients and their families in shared decision making regarding safety goals and initiatives
- Reviewing patient stories about safety at every board meeting
- Incorporating a section about safety into board self-assessments
- Including board members on quality and safety committees
- Taking the "We Lead for Safety" pledge

1 See http://bit.ly/2JRquAj.

Opioid Abuse…

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the medical staff member has complied with internal policies and processes. At UH, we developed a structured audit, re-education, and escalation process to reinforce accountability. All of our caregivers understand the consequences for non-compliance, which may involve revoking prescribing privileges or credentialing altogether.

5. **Encourage the hospital or health system to join forces with others in the community**. University Hospitals is one of five hospital systems collaborating for solutions as part of the Northeast Ohio Hospital Opioid Consortium.[2] The Consortium's mission is to significantly reduce the impact of the opioid epidemic by sharing and implementing evidenced-based practices, promoting policy changes, and increasing prevention efforts. Our goal is to share data and accurately measure the impact of our efforts. Consortiums of various groups have formed across the U.S. Individually hospitals may have a strong program, but by working together they can do so much more.
6. **Support management's investment in technology to enhance efficiency**. We recently embedded the Ohio Automated Rx Reporting System (OARRS) reporting tool (a required PDMP in Ohio) into our electronic health record, a project endorsed by our board. Patient caregivers can now see information about a patient's prior use of controlled substances before issuing a prescription. We also launched a computer platform that uses algorithms to evaluate patient pain needs and risk factors for addiction or opioid-use disorder as they transition out of the hospital. We are hoping this platform will facilitate care navigation to alternative, non-pharmacologic pain treatment modalities.

Conclusion

Boards of directors can, in conjunction with executive management, create a culture that values quality care and compliance. By setting the tone at the top, board members, engaging with their medical staff and medical executive committee, can make a significant impact. Boards should **encourage** broad-based education, community collaboration, and innovative thinking; **examine** the data; **enforce** accountability; **ensure** investment in tools that help to assess risks and ensure policies are followed; and **enquire** regularly. It's critical that the board helps create a culture for the organization that mandates responsible opioid prescribing practices.

The Governance Institute thanks Thomas F. Zenty III, CEO, University Hospitals; Janet L. Miller, Esq., Chief Legal Officer and Corporate Secretary, University Hospitals; and Randy Jernejcic, M.D., VP of Clinical Integration, University Hospitals, and Physician Chair, Northeast Ohio Hospital Opioid Consortium, for contributing this article. Dr. Jernejcic can be reached at randy.jernejcic@uhhospitals.org. For more information on University Hospitals, go to www.uhhospitals.org.

2 For more information, see http://bit.ly/2RPIgYP.

Current Standards for Board Diversity

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the S&P 500 with lower opportunities to increase diversity.[1]

For these and other reasons, hospitals and health systems that have failed to take meaningful steps towards incorporating diversity considerations into the director nomination process risk reputational harm and other critical response. They will be true "outliers."

But as to Non-Profits?

It may be true that much of the movement on diversity has arisen from the public sector, and from best practices compilations traditionally associated with the public company sector. But that's not to suggest that these themes of board diversity don't apply equally to large non-profit organizations, including hospitals and health systems. The perceived governance benefits from a broadly diverse board are not limited to form of corporate status or industry sector. The public company orientation of some of the policy discussion is no excuse for precluding full board consideration of diversity issues.[2]

An Important Bridge

Increased board focus on governance diversity also provides an important bridge to its consideration of broader workforce culture matters. Of particular relevance in this regard is "gender equity" and board support for the promotion of women within the organization. A well-publicized component of this is the "onliness" factor; i.e., where there is only one or possibly two women "in the room" (or in the boardroom, as if the women members of the board reflected a board-determined quota).

Conclusion

Hospital and health system leadership is well-advised to ensure that the board's nominating committee is aggressively incorporating matters of diversity, across the spectrum, in its identification of potential directors and committee members. The failure to do so could expose the organization and the board to significant criticism and could actually serve to limit the effectiveness of the board due to its failure to incorporate diverse perspectives in its membership.

The Governance Institute thanks Michael W. Peregrine, Partner at McDermott Will & Emery LLP, for contributing this article. He can be reached at mperegrine@mwe.com.

1 2018 United States Spencer Stuart Board Index (available at http://bit.ly/2DR3txd).

2 For more information on strategies and tactics for increasing diversity on hospital and health system boards, see *Building a More Diverse Board, A Toolbook for Healthcare Boards and Executives,* The Governance Institute, Fall 2018.

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of any sort in the organization since the previous board meeting. Overall, boards should spend at least as much time discussing safety and quality at board meetings as they do reviewing financials.

Board members should also consider joining organizational quality and safety committees to further their knowledge and oversight of related initiatives. In addition, participating in quality, safety, and culture-related events, such as those held during Patient Safety Awareness Week, is a great way for directors to publicly demonstrate their support for safety.

Focus on Knowledge

An engaged and educated healthcare board is an effective healthcare board. In addition to reviewing safety metrics at every board meeting, board members should consider accompanying CEOs on executive rounding to gain a better understanding of the organization's safety culture and to communicate and support the organization's safety agenda.

Boards also may want to include a section devoted to safety on their board and individual self-assessments to test knowledge and understanding of safety and to identify educational opportunities. Finally, board members should regularly review safety science and culture-related news and research, focusing on areas such as systems engineering and just culture.

Safety must be a chief factor in how healthcare boards make decisions. Continually learning about safety will go a long way toward ensuring the commitment to a culture of safety is an utmost priority for the organization.

Tools for the Journey

Patient safety can be addressed most effectively through a dedicated, persistent organizational focus and with senior leadership and board members working together. To help frame their continued work in this critical area, the American College of Healthcare Executives and the IHI/NPSF Lucian Leape Institute, in partnership with several renowned healthcare organizations and safety and leadership experts, developed *Leading a Culture of Safety: A Blueprint for Success.*[2] This important resource provides healthcare organizations the research, tools, and strategies they need to make marked progress toward zero harm.

In addition, ACHE is encouraging all healthcare leaders to take a pledge to commit to creating a culture of safety, assessing their current safety measures, and implementing a set of steps to help advance their organization's journey toward safety. Board members can consider taking the "We Lead for Safety" pledge alongside their organizational senior leadership to further underscore safety efforts. Both the blueprint and information about taking the safety pledge can be found at ache.org/safety.

When boards are knowledgeable about and champion safety within their organizations, the focus on safety flows down to senior leadership and cascades throughout all levels of an organization. Working together, healthcare boards and senior leadership can move the needle farther toward achieving zero harm within their organizations.

The Governance Institute thanks Deborah J. Bowen, FACHE, CAE, President and CEO of the American College of Healthcare Executives, for contributing this article. She can be reached at dbowen@ache.org.

2 American College of Healthcare Executives, IHI/NPSF Lucian Leape Institute, *Leading a Culture of Safety: A Blueprint for Success,* 2017 (available at http://bit.ly/2zGZEWL).

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The Second "Tight": Practice Oversight

The second "tight" in this approach is oversight of the transformation process through regular and objective CEO performance evaluation. The board hired the CEO to build and lead a management team that can deliver high performance today while also carrying out the long-term vision. In implementing a robust CEO performance evaluation process, the board articulates its approach to compensation; quantifies annual CEO expectations consistent with the board's long-term vision; monitors CEO performance and provides feedback at least quarterly; and conducts an annual formal review.

To ensure the board rewards both current performance and progress toward transformation, annual CEO performance metrics should tie directly to the five-year goal destination metrics. In addition, the board may choose to assess the CEO's ability to anticipate future obstacles and navigate the organization through periods of disruption. Traditional, hospital-centric metrics may not accurately reflect whether the organization is moving toward transformation.

Transformation requires coordination and mutual respect between gifted directors and managers who understand their unique roles in the process. The board should endorse the notion of tight-loose-tight, allowing the CEO to build and lead a team that can deliver results and holds itself accountable.

Transforming an organization is never easy. To be successful requires being flexible when obstacles inevitably arise and being willing to change course if something is not working. Effective boards set a course for where the organization should go, allow management to navigate there, and regularly assess progress along the way. Using this approach, healthcare organizations can prepare to thrive in a future that may look very different from our current environment.

The Governance Institute thanks Marian C. Jennings, President, M. Jennings Consulting Inc., and Governance Institute Advisor, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com. Portions of this article were first published in the article "The Board's Role in Transformation," which appeared in the May/June 2018 issue of Healthcare Executive.

Supporting Transformation: Clarifying the Roles of Governance and Management

By Marian C. Jennings, M.B.A., M. Jennings Consulting, Inc.

Every day we hear a new story about a company or technology that has transformed its industry (Uber, Amazon, Google, Netflix). Each of these transformations has left a path of shuttered or severely damaged businesses, or even an entire industry, in its wake.

However, what ultimately led to the demise of these failed businesses—think once-dominant retail chain Sears, which recently filed for bankruptcy protection, or a long list of other beleaguered big-box retailers—is poor management and a lack of effective board oversight. Without a clear vision, strong leadership to execute the strategies to get there, and an effective board oversight process, transformation is unlikely or impossible. Given the unrelenting uncertainties in healthcare, strategy alone does not guarantee a successful future. Continued uncertainty can lead to anxiety, and the desire to exercise control can lead to unproductive micromanagement.

To be successful, the board and senior management must work together to lead transformation efforts from the top of the organization. Board members need to understand and commit to developing an adaptable organizational culture: this involves adopting an approach to exercising governance that is "tight-loose-tight." With this approach, the board sets a clear strategic vision for transformation (the first "tight"), while allowing management latitude in how to implement that vision (the "loose"), and while appropriately and actively overseeing annual CEO expectations and performance (the second "tight") consistent with the organization's transformation imperative.

The First "Tight": Set Strategic Intent

What might transformation mean for your hospital or health system? What would a transformed organization look like in five years—in terms of its strategic positioning, quality of care and patient satisfaction, value proposition to patients, brand, partnerships, size and scope of services, organizational structure and culture, and financial performance? How should the organization stay the same? How must it be different?

Rather than making vague statements about its intentions to change, the board should generate a short list of six to 10 macro-level, concrete, and objective strategic metrics, otherwise known as "destination metrics." Performance against these metrics will allow the organization to measure how well it has achieved its intent. Each destination metric completes the sentence, "By 2023, our organization will have demonstrated/achieved _____." Some examples might be:

- "…25 percent growth to at least 300,000 unique patients served over the past year."
- "…recognition as an IBM Truven Top 100 Hospital."
- "…doubled external research funding for the health system."

Strategic destination metrics such as these will help the board articulate what transformation will look like, and the metrics may then be used to track CEO and organizational performance expectations for progress toward the longer-term vision.

To ensure the board is thinking strategically about transformation, meetings should incorporate more time for generative discussions. Generative thinking is courageous and addresses existential questions about the organization; challenges assumptions and conventional wisdom; identifies potential market disruptors or "wild cards"; and focuses on what the organization would look like once transformed. In a generative discussion, board members might ask:

- What does our organization value above all else?
- What makes our organization unique?
- With how much and what kinds of risk is our organization comfortable?
- How must we change to give our patients what they value—access, affordability, convenience, customer service, quality?

The "Loose": Allow Management Flexibility

Strategic planning in today's changing healthcare environment requires leadership to be flexible and agile in executing the strategic plan. Once the board approves the plan (with tangible strategic metrics) and an associated strategic financial plan, it should allow management leeway to determine the "hows"—that is, the specific strategies and tactics that will be used to implement the plan. The board should require frequent updates on progress toward achieving performance metrics. Of course, the board needs to also ensure that management continues to consult the board when required, for example, for initiatives with a cost above a specified dollar threshold or if major initiatives need to be reconsidered, redirected, or jettisoned.

To hold management accountable as well as to ease any anxiety that may result from granting management latitude to execute the plan, the board should, via its executive compensation committee, set annual CEO performance expectations consistent with the long-term transformation imperatives. At the same time, transformation is never a rationale for poor financial performance. The board must expect stable, profitable performance during transformation. The board also should ensure that its meeting agendas and committee charters balance a focus on current performance with the requirements for future success.

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Key Board Takeaways

- Articulate a short list of six to 10 macro-level, tangible "destination metrics."
- Routinely incorporate time for generative discussion into board meetings.
- Grant management latitude in implementing the strategic plan, while using a disciplined process of setting and monitoring annual CEO performance expectations.
- Reassess your traditional approach to CEO performance evaluation to ensure you are rewarding not only today's high performance but tomorrow's transformation. CEO performance metrics should tie directly to the five-year destination metrics for the organization.
- Transformation is never a rationale for poor financial performance. Hold management accountable for stable—even profitable—financial performance along the way.
- Anticipate some failures but be quick to acknowledge what is not working and make effective course corrections.