

# The Road to Transformation: Reflections of Healthcare Leaders

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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.

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## 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.<sup>1</sup> 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:

- 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<sup>2</sup> is developed, a self-assessment process is initiated.
- 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.
- 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.
- 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.



<sup>1</sup> To view the self-assessment tool, go to [www.governanceinstitute.com/AGLHAssessmentTool](http://www.governanceinstitute.com/AGLHAssessmentTool).

<sup>2</sup> 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 ThinkTank: 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:

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

**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<sup>3</sup>):** 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.<sup>4</sup> 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 through 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.<sup>5</sup> 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](http://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.<sup>6</sup> 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<sup>7</sup> 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.<sup>8</sup> 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.<sup>9</sup> 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,<sup>10</sup> 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 place 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.<sup>11</sup>

### 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/2TilVC6>.

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/2OJwP11>).

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.<sup>12</sup> 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<sup>13</sup> 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.

<sup>12</sup> See <https://healthymonadnock.org/council>.

<sup>13</sup> 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,<sup>14</sup> 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,<sup>15</sup> 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”<sup>16</sup> 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? ●

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<sup>14</sup> Including, but not limited to social workers, community health workers, promotores, peer mental health workers, and home care workers.

<sup>15</sup> Ranging from strategies to build health workforce diversity and purchasing practices that support local vendors to reducing organizational carbon footprint and community investment strategies.

<sup>16</sup> Kevin Barnett and Stephanie Sario, “The Board as ThinkTank: Moving Beyond Legacy Roles in a Time of Transformation,” The Governance Institute, October 2016.