BoardRoom Press

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A SERVICE OF nrc HEALTH

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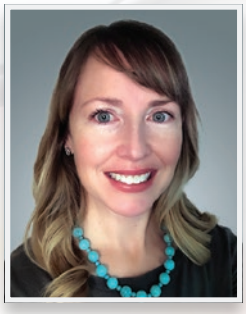

Climate Change Is a Determinant of Health

From the severe drought and wildfires in the West to the hurricanes and flooding in the South and Northeast, Americans are struggling. There are very few places to live in the U.S. today that do not have one or more major climate-based emergencies every year that displace thousands of people, destroy homes, and require billions of dollars of federal funding to fix. The result is a continuous loop of starting over that, over time, will have major effects on mental health and well-being, in addition to the loss of ability to accumulate wealth over time. Future generations of aging seniors that lack the years of savings and increasing property value many rely on today to help cover living expenses and healthcare at the end stage of life will create generations of aging poor that will crush our healthcare system.

The healthcare sector is currently responsible for 10 percent of U.S. greenhouse gases, according to the Health Care Climate Council. When we discuss the role of U.S. corporations in addressing ESG, the E is becoming more and more critical for the healthcare sector to address immediately. The business case is clear—similar to the need to address upstream costs of care by attending to community health needs, population health, social determinants of health, and equity/access concerns, if we were to find solutions to all of these things today, climate change will remain a significant barrier to health, due to our own pollutive practices. Please share your stories of how you are reducing your organization's waste and emissions. Email me directly, and/or continue this conversation with me and your peers on LinkedIn.

Kathryn C. Peisert,
Managing Editor

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An Outside-the-Box Approach to Addressing Social Determinants of Health

By David Kindlick, Virtua Health

AmericanCollege of HealthcareExecutives
for leaders who care®

As board chair for Virtua Health, southern New Jersey's largest health system, I've supported some bold plans for advancing our care to best meet the needs of our community. Some efforts, like building a cancer center or acquiring a neighboring health system, are more customary to endorse, as they are consistent with the core operations of a dynamic health system in a competitive market. Other initiatives, like the one to turn a decommissioned city bus into a supermarket on wheels to bring healthy, affordable food directly into neighborhood "food deserts," stand out as truly unique and meaningful decisions—ones that don't come in front of healthcare boards every day.

David Kindlick
Chairman of the Board of Trustees
Virtua Health

The takeaway from that "get-on-the-bus" decision, and all the incredible work that ensued, is that sometimes the most outside-the-box ideas are the ones that can have the greatest impact.

For context, Virtua Health is a comprehensive healthcare organization with roots that date to the 1880s. Its 15,000-person workforce, five hospitals, and 300 care locations provide a wide spectrum of services, from primary and urgent care practices to renowned and highly ranked cardiology and organ-transplantation programs.

Many things we do are considered critical and innovative to the region, but what truly sets us apart is a series of programs that directly impact the most vulnerable members of our community.

Helping Others "Eat Well" With Dignity

Virtua's supermarket-on-wheels is now the flagship of our three-pronged "Eat Well" initiative, outlined below. The Eat Well name is a purposeful extension of Virtua's mission to help people "Be Well, Get Well, and Stay Well."

- The **Virtua Mobile Farmers Market** launched in 2017 and quickly established itself as the largest hospital-operated farmers market in the nation. Registered dietitians and support staff visit daycares, senior centers, housing complexes, and places of worship to sell fresh produce at deeply discounted prices. This year-round program—operated from a 23-foot, customized van—offers locally grown fruits and vegetables whenever possible.
- Two **Virtua "Food Farmacies,"** or food pantries that enable physicians to "prescribe" free food to patients with diet-related chronic diseases and food insecurity and connect these patients to nutrition education and social support services.
- The **Virtua Mobile Grocery Store** is a 40-foot traveling store that offers fresh, healthy, and culturally relevant foods at below-market prices. In its first six months of operation, the Mobile Grocery Store helped to feed 1,700 people.

Collectively, this trio makes it easier for people with limited resources to prioritize their health. Many of the communities we serve have an abundance of fast-food establishments and convenience stores, but no entities offering food that is both healthy and affordable. Eat Well addresses the issue of cost by providing deep discounts on all products or, with the Food Farmacies, by supplying all groceries free of charge. In addition, the two mobile programs address transportation barriers by going directly into food desert neighborhoods.

Measuring Impact

With Eat Well, we aim to address the short-term need of getting healthy foods into people's homes, while also establishing healthy habits that can span generations. Our teams provide nutrition education, develop recipes, and make it simpler for folks to make good choices. Through these programs, we have encountered children who proudly proclaim they love to eat carrots and seniors who say they look forward to shopping with us every week.

The gratitude we receive often feels like ample proof that these initiatives are successful. Yet, as board chair, I know the board must hold the impact of these programs to the same high standards we apply to more traditional strategies. Our teams set goals, review metrics, and assess outcomes.

Here are just a few measurable examples of Eat Well's success:

- Eighty percent of customers reported they eat more produce and prepare more nutritious meals due to the Mobile Grocery Store, and 90 percent said they have more access to healthy food.
- Sixty percent of Mobile Farmers Market customers reported their health improved over 12 months.
- Participants in the Food Farmacy program reported a 33 percent increase in daily fruit and vegetable consumption on average.

Funding Support

As a not-for-profit, Virtua relies on its philanthropic community to literally fuel our outreach efforts. For instance, we set a $4 million fundraising goal to cover

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Key Board Takeaways

To reduce food insecurity and improve health through population health programs, healthcare boards and leaders should consider taking the following steps:

- **Embrace bold ideas.** Sometimes the most unconventional ideas deserve the most attention.
- **Get out there.** If you want to be of service to people, serve them where they are. Identify ways to integrate into the community.
- **Listen to the people you serve.** Virtua routinely surveys its constituents to identify areas of greatest need. Our community surveys revealed food access as a critical need and an area in which we could make a substantial impact.
- **Establish advocates and allies.** Tap local leaders and other supporters who can help introduce you to the people you want to reach. Virtua owes a great deal to the teachers, pastors, government officials, and other advocates who welcomed us with open arms and minds.
- **Build trust through consistency.** Virtua's mobile programs visit the same locations week after week. This reliability establishes trust and builds ongoing care relationships.

Toxic Individualism and Its Impact on Our Healthcare System

By Jordan Shields, Rex Burgdorfer, and Casey Webb, Juniper Advisory

COVID-19 exposed competing forces within the missions of many standalone hospital systems. These forces include a rugged American individualism on one hand and the desire to efficiently meet the healthcare demands of their communities on the other. Both are valid considerations, but they are often in conflict. By definition, individual entities stand outside the safety of the collective, forging their own distinct paths to their own unique destinations. Efficiency, however, is most often associated with uniformity, consistency, scale, and centralized decision making. This article explores that tension and considerations for hospital boards as they work to best position their organizations in an evolving industry.

Headwinds and Industry Backdrop

Hospitals faced strong headwinds before the pandemic. COVID made matters worse, filling some hospitals with desperately sick, highly contagious patients, exhausting frontline staff, and overwhelming limited ICU and respirator capacity, while other hospitals sat empty with government-mandated elective surgery prohibitions that left beds vacant in anticipation of a surge that would not come for months, if at all. COVID also exacerbated existing hospital staffing issues, accelerated a shift to virtual care, and boosted new, private equity-backed competitors seeking to undercut hospital pricing by focusing on services that require minimal fixed capital.

The CARES Act sought to alleviate some of this pain and was remarkable in its swiftness and scope. That said, those funds have largely been exhausted and COVID's financial impact on the hospital industry continues. The American Hospital Association,[1] McKinsey,[2] Deloitte,[3] and others have all projected that the financial ramifications of COVID will linger for healthcare providers well after the pandemic is finally under control. While there is broad agreement that hospitals will bear a disproportionate share of this cost, there does not appear to be any meaningful federal support, further stressing an already stressed industry.

Implications and Costs of Individualism

A uniquely American refrain for facing such adversity is "when the going gets tough, the tough get going." This implies that the individual relies on him or herself and makes no mention of the collective or the help of neighbors. While bravery and perseverance are valuable traits that help us make our way in life, we should not idealize autonomy, instilling unrealistic expectations of attaining our goals solo, overlooking the fact that we benefit enormously from the help of others.

Individualism, which we define as focusing inward in the face of adversity, is understandable. However, we believe that this individualism has gotten so severe that it is becoming toxic to our well-being as a society and to our healthcare institutions. Hospital boards and management teams often list independence, in and of itself, as central to their missions. In response, the American Hospital Association added a section to their Web site titled "Preserving your hospital's independence" where they acknowledge this trend and gently point members towards its inherent risks.[4] While independence presents distinct pros and cons, independence itself is not necessarily a risk. The problem is that too often independence or individualism becomes the institution's goal, allowing the board to make compromises to patient care and their not-for-profit mission.

This tension most often occurs behind closed doors, but it occasionally makes it into the public eye. In 2010, Kaiser Health News reported on Boston's storied Quincy Medical Center stating, "Despite the financial strains, Quincy's executives say they're determined to preserve the hospital's independence. 'Healthcare is a local issue,' says [CEO] Kastanis. 'When physicians have a local hospital that they have a long-term relationship with, and they have some control as to how their patients are treated, that goes a long way in creating confidence among patients that they'll get good care.'"[5] Instead of joining one of Boston's strong systems, Quincy doubled down on independence, cutting services in the misguided belief that offering less care to the community as a standalone allowed it to serve its patients better than a system like Partners or Tufts could. Eventually the over 120-year-old institution filed for bankruptcy. By that time, few partners were interested in Quincy's hollowed out shell. While it was acquired by a for-profit system out of bankruptcy, toxic individualism had already taken its toll and it was too late to turn the facility around and it was closed soon after the sale.

While there are many anecdotes like Quincy's showing the risks of placing independence above patient care and access, the "cost" of individualism can also be measured at the industry level. In a June 2020 white paper, Juniper used statistical analyses to find that independent hospitals have lower acuity and fewer ICU beds than comparable system hospitals.[6] In other words, for two similarly sized and positioned hospitals, the hospital, on average that is part of a healthcare system, will offer higher level care and have more ICU beds. This was particularly striking because standalone hospitals nearly always list

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Key Board Takeaways

- While standalone hospital boards often focus on the perceived benefits of independence including local control, streamlined governance, and rapid decision making, they should not minimize the costs.
- Successful organizations understand the pros and cons of their structure and periodically revisit the inherent trade-offs.
- In the same way that strong standalones should only choose mergers that advance their missions relative to independence, hospitals that maintain independence are making a choice and should only do so with a full understanding of how their standalone status improves patient care over a partnership.

1 American Hospital Association, "Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19," May 2020.
2 Erica Hutchins et al., "Understanding the Hidden Costs of COVID-19's Potential Impact on U.S. Healthcare," McKinsey & Company, September 4, 2020.
3 Deloitte, "What Will Be the Impact of the COVID-19 Pandemic on Healthcare Systems?," June 2020.
4 American Hospital Association, "Preserving Your Hospital's Independence."
5 Arlene Weintraub, "In an Age of Consolidation, Some Community Hospitals Struggle to Remain Independent," Kaiser Health News, September 9, 2010.
6 Jordan Shields et al., *Assessing Hospital Preparedness for COVID-19 by Affiliation Status*, Juniper Advisory, June 2020.

Improving Quality in Health Systems: How Do They Do It?

By Michael D. Pugh, MdP Associates, LLC, and Kathryn C. Peisert, The Governance Institute

While it is relatively easy to identify high-performing hospitals utilizing publicly available ratings such as the CMS Star rating system or Leapfrog's safety ratings for individual hospitals, it is not as easy to look at multi-hospital system quality performance.[1] CMS, Leapfrog, HCAHPS, and NRC Health Market Insights surveys all look at individual hospital performance as opposed to system-level performance. At The Governance Institute (TGI), we were curious to try and identify which multi-hospital systems might be considered top performers in quality then seek to understand what drives that performance. What do these systems do from a leadership and governance perspective to deliver "top decile" quality and safety performance across their system?

This research project was driven by our review of research studies and news reports over the past several years indicating that the rapid consolidation of hospitals into larger systems industry-wide has not yet revealed expected improvements in quality, cost, or standardization of care. Indeed, when we embarked on this project, we found that very few, if any, systems in the datasets we analyzed showed consistent quality across *all* of their hospitals. The assumption of critics is that growing health systems "generally have not done much yet to achieve consistent operational processes, clinical protocols and outcomes, and patient experience across all their facilities."[2] Some studies are in dispute about whether systems have been able to demonstrate improvements in quality and cost to benefit patients.[3] There have been several reports of rising prices as consolidation increases due to systems' better ability to leverage better rates from payers.[4] Finally, other research shows that integrated health systems do have what it takes to raise the bar, but we have to be patient to see the results.[5]

However, we do know that achieving "systemness" as far as standardization of clinical protocols, reducing or eliminating unwarranted variation, and maintaining a similar level of quality across the system's service lines, is a marathon process, not a sprint. While hospitals that are part of a system can benefit from the system's resources, clinical expertise, and economies of scale, each individual care site has its own challenges to tackle, which may be different from a sister hospital across town or yet another hospital across the county or state line in a larger system. Our work with systems reveals that while the benefits of systemness might not be showing in the data yet, they are working diligently to ensure acceleration of these efforts such that we can anticipate seeing better results in the near future. Some are further along on this journey than others. Our aim with this article is to demonstrate important actions taken at the leadership and governance level that have helped to drive quality at some of the higher-performing systems in the U.S.

Methodology

Utilizing the CMS Hospital Compare database[6] and TGI data resources, we identified multi-hospital systems with at least three listed hospital facilities. We then created a system "star" score[7] based on the weighted reported inpatient bed count from each CMS scored hospital to identify a cohort of "top-performers." From this group, we identified 37 systems with a weighted star score greater than 4.0, a cutoff point that was approximately equal to top-decile

Table 1. Top Health Systems Included in the Study

System	Number of Beds in System	Number of Reported Hospitals in System	CMS Weighted Star Score	Average Leapfrog Grade	Average HCAHPS Score	Market Insights Quintile
Bellin Health	161	3	5.00	5.00	4.00	5.00
St. Luke's Health System (Boise, ID)	895	8	4.84	5.00	4.00	4.00
Intermountain Healthcare	1965	23	4.76	5.00	3.94	4.00
St. Luke's University Health Network	1058	8	4.38	4.88	3.38	3.00
Duke Health (AKA Duke University Health System)	1430	3	4.33	5.00	4.00	5.00
Atlantic Health System	1382	5	4.25	4.40	2.80	3.00
Main Line Health	1060	4	4.03	4.50	4.20	5.00

1 For the purposes of this article, the term "quality" encompasses safety, outcomes, experience, and value.
2 Harris Meyer, "Health Systems Are Working to Live Up to Their Name," *Modern Healthcare,* May 11, 2019.
3 See e.g., Alex Kacik, "Monopolized Healthcare Market Reduces Quality, Increases Costs," *Modern Healthcare,* April 13, 2017; and for a counter argument, Monica Noether, Ph.D., and Sean May, Ph.D., *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis,* Charles River Associates, January 2017, and their 2019 update, *Views from Hospital Leaders and Econometric Analysis—An Update*.
4 Leemore Dafny, et al., *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, Harvard Business School, May 31, 2018.
5 William B. Weeks, M.D., Ph.D., M.B.A., et al., "Potential Advantages of Health System Consolidation and Integration," *The American Journal of Medicine,* Vol. 128, Issue 10, October 1, 2015; pp. 1050–1051.
6 We utilized the most current CMS data available from October 2019.
7 CMS displays hospital performance based on a rating of one to five stars. For purposes of our analysis, five stars = 5, four stars = 4, etc.

performance using our algorithm for all systems. We then checked Leapfrog, HCAHPS, and NRC Health Market Insights performance and eliminated systems with uneven performance across multiple rating systems. Finally, we winnowed our final selection down to healthcare systems that had an existing relationship with TGI and invited system senior leadership to participate in an online leadership survey focused on identifying drivers of system-wide quality and safety performance. Seven healthcare systems responded to our invitation and 24 senior leaders from the invited systems (two to five senior leadership respondents per system) participated in the survey.

The seven systems that responded to our invitation are generally top performers across multiple public quality rating systems. **Table 1** (on the previous page) is sorted by CMS Weighted Star Score and displays system size and system average performance across CMS, Leapfrog, HCAHPS, and Market Insights rating systems.[8]

Leadership and governance behaviors as well as quality structure are critical to achieving system-wide high-quality performance.

Key Findings from the Survey

There is no single "silver bullet" that drives consistent system-level quality and safety performance. In the survey we sought to explore with system-level leaders what they think are the most important drivers of quality and safety performance as reflected in public ratings and rankings. That said, it does appear from the survey results that leadership and governance behaviors as well as quality structure are critical to achieving system-wide high-quality performance:

- 100 percent of respondents indicated that system-wide quality and safety results were reviewed monthly by the senior leadership team.
- 92 percent of respondents indicated that they have local quality governance committees and functions that report up to a system-level quality committee.
- Two-thirds of the respondents indicated that they review external quality ratings and comparisons with their system-level boards or quality committees either monthly or quarterly, and the remainder of the respondents indicated such review takes place at least annually or periodically/as needed.

When asked about the most important factors driving performance, two-thirds of the respondents chose either *leadership focus* or *organizational culture* as the most important factor driving quality and safety performance across their system. The *quality management system* was chosen by four respondents as the most important factor and two respondents chose *board expectations* as the most important factor. Interestingly, only one respondent chose *financial resources* as a top factor.

Respondents were also asked to list other key factors that are key drivers of quality and performance in their systems. Comments generally fell into categories of leadership behaviors, execution of strategies,

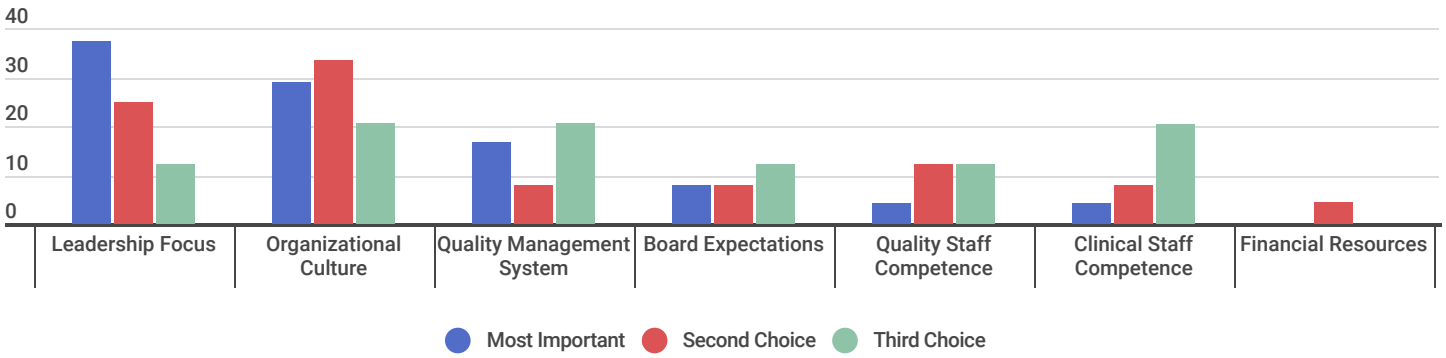
The Governance Institute's Recommended Board Practices for Quality Oversight

The following practices are recommended for adoption for most types of hospitals and health systems. In the context of systems, some of the practices listed below would take place at the system-board level, while others might take place at both system and local levels, while others might occur only at the local level, depending on how the system has set up its oversight structure for quality (and in regards to structure, no two systems are the same!).

1. The board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.
2. The board requires all hospital clinical programs or services to meet quality-related performance criteria.
3. The board annually approves and at least quarterly reviews quality performance measures for all care settings, including population health and value-based care metrics (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) to identify needs for corrective action.
4. The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.
5. The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).
6. The board has a standing quality committee.
7. The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.
8. The board, in consultation with the medical executive committee, participates in the development of and/or approval of explicit criteria for medical staff recommendations for physician appointments, reappointments, and clinical privileges, and conducts periodic audits of the credentialing and peer review process to ensure that it is being implemented effectively.
9. The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.
10. The board allocates sufficient resources to developing physician leaders and assessing their performance.
11. The board ensures consistency in quality reporting, standards, policies, and interventions such as corrective action with practitioners across the entire organization.

8 We used simple averages rather than weighted averages in this stage of the study since not all hospitals affiliated with each system had scores in all categories. Further, we converted Leapfrog letter scores into a five-point scale (A = 5) and used quintile cutoff points for comparing average Market Insights scores (5 = top 20 percent).

Most Important Factors Driving Quality and Safety, *N=24*



use of measurement and data, engagement of physicians and frontline staff, and/or specific improvement methods or processes. Examples of responses include:

Leadership Behaviors

- High reliability organization (HRO) principles to shape how individuals, teams, and leaders behave and how we design our systems and processes to improve quality and prevent safety events.
- System CEO sees quality as top priority.
- Highly engaged board that challenges us to fulfill our vision of being a model healthcare system.
- Organizational commitment to eliminate harm.
- We strive to have quality and safety discussed as much as finance and we work to be sure that the operating system has a focus that has quality and safety leading their work.
- Transparent communication.

Measurement

- Visibility and drilldown into data focusing on process measures driving outcome measures.
- Focus on key quality measures targeted at payer/regulatory metrics.
- Consistent use of data scorecards.
- Steadfast reliance on measuring performance against best practice outcomes; no excuses!!!

Strategy

- Having a strategic focus on quality and safety.
- Our safety and quality performance program is driven by our mission, "helping people live the healthiest lives possible," and is aligned strategically as part of the system's focus on our fundamentals of extraordinary care: safety, quality, equity, experience, access, stewardship, and engaged caregivers.

Method or Process

- Defined, standardized approach to our culture of safety and a system view to decreasing variation while building process.
- Continuous improvement methodologies are employed to drive change with an emphasis on engaging frontline caregivers in the process and standardizing across the system.
- Constant investment in continuous improvement; willingness to learn from best practices.
- Ability to remove bureaucracy of process to timely implementation of improvements.
- Leveraging accomplishments and experiences from within our 11-campus health network.
- Delineated responsibilities across the system and within individual sites, along with a transparent tiered escalation process for issues, ensures alignment, scalability, and accountability across the system.
- Time for frontline staff to participate in quality and safety initiatives.

Engagement

- Physician engagement and participation.
- Medical staff leadership.
- Strong alignment between medical staff and hospital leadership.
- Professional training and professionalism. Choosing the right people with the right commitment.

Table 2. Common Management Approaches to Focus and Align Quality/Safety with Daily Work

Tactic/Effort	% Respondents
Annual performance objectives	88%
Strategy execution	83%
Routine operational performance reviews	83%
Leadership rounding	75%
System leadership/management incentive compensation plans	71%
Recognition systems	71%
Physician compensation plans	54%
Annual budgets	25%
Hospital/functional unit incentive compensation plans	21%
Other (please specify): • Regular quality and patient safety updates given at our various board and board committee meetings and in all management and departmental meetings • Goals cascade based upon organizational strategic objectives and actionable internal data • HRO culture • Annual quality awards	17%

- In addition to the overall culture, I believe provider desire to constantly improve care and willingness to cooperate and help each other achieve these goals is an important ingredient.
- Ownership by frontline staff.

Creating a leadership focus on desired quality and safety results requires discipline and structure. Respondents were asked to identify which management approaches were commonly used in their organizations for creating focus and alignment and integrating quality and safety performance into the daily work of management. Not surprisingly, respondents indicated wide use and integration of management methods and systems to drive performance (see **Table 2** on the previous page).

Respondents also utilize a wide range of quality improvement frameworks and methods for improving performance. All respondents routinely use root cause analysis and over 70 percent cite using HRO principles. Lean, IHI Model for Improvement, Lean/Six Sigma were each listed by over 50 percent of the respondents as common approaches for improvement within their systems.

Just as respondents use a wide range of tools and methods, they also utilize wide networks of knowledge sources and expertise in the quality and safety efforts. Seventy-five percent of the respondents indicated that they look to the Institute for Healthcare Improvement (IHI) and/or the Joint Commission as a source of guidance. However, that is not exclusive. Respondents provided a long list of other external resources including consulting firms, regional collaboratives, and local associations as sources of knowledge and help. Finally, respondents were asked to provide in their own words the key factors that enable high levels of quality and safety performance in their system and explain why.

Lessons Learned

From the survey responses and descriptive results, the following 10 ideas emerge as key drivers of system-wide quality and safety performance:

1. Unequivocal board commitment and executive leadership focus.
2. A commitment to excellence—wanting to be the best—with a focus on patients at the center. HRO is a commonly used framework.
3. Clear expectations and goals for quality and safety performance are set by the board and senior leadership.
4. Patient safety is an organizational and leadership priority and a demonstrated cultural value.
5. Quality and safety are seen as strategic and aligned with the organizational mission.
6. Management process and structures are designed to deliver quality and safety results. There is a process of systematic review of performance against targets/goals.
7. There is system-wide use of measurement, data, and transparency.
8. There is significant engagement of physicians, clinicians, and frontline staff in quality and safety efforts.
9. They have invested in creating capacity for improvement. Methods, process, and structure exists to support the efforts.
10. They celebrate success.

We had a chance to talk to Jack Lynch, CEO of Main Line Health, about the role of the board in supporting leadership efforts to deliver high quality and safety performance. Lynch said that Main Line has four themes that are the basis of their strategic plan and integrated into the governance function of the board:

1. Eliminate harm
2. Top-decile quality performance
3. Equity for all
4. Affordability

One of the things Lynch and his team did early on was to develop a quality and safety scorecard that is the equivalent of the financial statement presented to the board. Organized by the four themes listed above, metrics are reported at every board meeting and reviewed in depth at every meeting of the system board's Quality, Safety, and Equity Committee.

Transparency is critical. Lynch said, "Boards have to understand that bad things do happen. There is not an event that is so bad that I am not going to tell the board. We present our root-cause analysis and our action plans, and the board asks questions about our plans and how we are going to ensure that such an event does not happen again." Lynch gave an example of an incident involving the use of a new catheter that was unfamiliar to staff and its use resulted in harm to a patient. When reported to the board, the board did not focus on why that incident happened but instead wanted to know how the organization was going to ensure that when new devices and equipment are used anywhere in the organization that staff are properly trained.

Finally, Lynch said, "You can never stop asking, why?" He expects the board to hold him and his management team accountable for safety and quality performance. He said, "If the board does not hold leadership accountable, then it is unlikely that leadership will hold management accountable and unlikely that management will hold staff accountable."

Discussion Questions for Boards and Senior Leaders

As you share these findings with your board, the following questions are intended to help generate strategic-level discussion resulting in concrete actions your board and senior leadership can take as a result of these findings:

1. How does our system compare? What is our "composite score" using an algorithm similar to the one used in the study?
2. How might governance and leadership create increased organizational focus on delivering quality and safety results?
3. If we were to evaluate our efforts against the 10 key drivers listed above, where are we strong and where are there gaps in our efforts?
4. What is our quality strategy and where do we need to focus our efforts over the next year?

The Governance Institute thanks Michael D. Pugh, President, MdP Associates, LLC, and Kathryn C. Peisert, Managing Editor, The Governance Institute, for contributing this special section. *They can be reached at michael@mdpassociates.com and kpeisert@governanceinstitute.com, respectively.*

Understanding Mental Health in the Context of the Pandemic

By Somava Saha, M.D., M.S., Well-Being and Equity (WE) in the World and Well-Being in the Nation (WIN) Network

Pandemic times have wrought a heavy toll on mental health in America, with working-class adults, people identifying as Black/Latinx, LGBTQ youth, unpaid caregivers, and people who had previously experienced trauma paying the greatest costs. At the same time, this moment offers an opportunity for real system change in the way we plan for and deliver mental and social health services for those at greatest risk of not thriving.

A Look at the Numbers

A CDC study in June 2020 revealed that 40.9 percent of 5,470 respondents reported an adverse mental or behavioral health condition—31 percent reported depression, 26 percent reported trauma disorders like PTSD, 13 percent began or increased their level of substance use, and 11 percent had considered suicide in the past 30 days.[1]

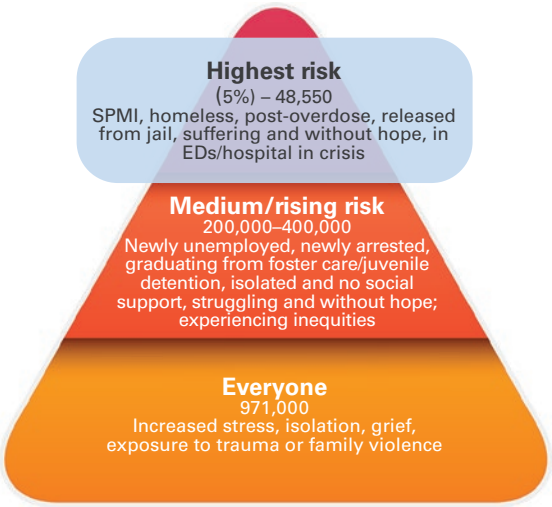
The hardest hit were young people 18–24 (63 percent reported depression or anxiety, 24 percent substance abuse, and 25 percent have contemplated suicide) and Black and Latinx people who had the highest rates of suicidality (and also the highest rates of employment change, COVID-19, and impact from the racial reckoning around police brutality)—but they were not alone. Twenty percent of essential workers and 30 percent of unpaid caregivers considered suicide in the last month. Those who had experienced trauma before experienced a worsening of mental health disorders. By the end of the year, we saw a 23 percent increase in overdose deaths and an estimated 30,000 additional deaths of despair (deaths from alcohol, drug use, and suicide), especially among working-class adults—a catastrophically accelerating epidemic overlying a pandemic.[2]

Strategies to Take Action

In Delaware, the Division of Substance Abuse and Mental Health (DSAMH), which worked with WE in the World to apply a population health approach to their planning for mental health and addictions services in 2019, used that approach to anticipate in advance the demand for mental health care and supportive services. They divided their population of people with mental health and addictions into the top 5 percent at highest risk, those at medium/rising risk, and everyone. They had already used human-centered design to understand what was happening with each population. They identified who might fall into each group and what could happen in the context of the pandemic to each group. This resulted in the population health triangle in the exhibit below.

DSAMH developed strategies for each risk group in the context of the pandemic, ones that any healthcare system could take on. Recognizing that congregate settings such as shelters for many of those who are in the highest risk group would be closing their doors, they developed an agreement with a hotel in each of their three counties to obtain rooms at discounted rates and began delivering mental health services there. They diverted people from emergency rooms and police pickups into mental health crisis treatment.

DSAMH care managers proactively reached out to highest risk and rising risk groups and, using a simple well-being screener developed using the Well Being In the Nation (WIN) measures, identified who was thriving, struggling, or suffering; needed support with finances and social needs; felt hopeless; and needed additional peer support and social connection.[3] A team of care managers made warm connections to 2-1-1 for those with social needs, COVID testing and primary care, and virtual 12-step groups and mental health services. They created proactive transition support for people coming out of emergency rooms and prisons so that people had the medical and social supports they needed to thrive.



Recognizing that not everyone would feel comfortable reaching out to the traditional healthcare system and that they would likely not be able to meet the demand for additional support, DSAMH implemented an online peer-to-peer platform called the Support Wall staffed in part by both usual wall guides and culturally concordant, bilingual peers supported by Healthy Communities Delaware. This platform offers 24/7 support, including wall guides who are medically trained. Demonstrated through referrals for people on wait lists for mental health care in Ontario, this platform had substantial evidence showing that it works.

The impact of all of this in Delaware was substantial. By taking this approach, they watched the percentage of people suffering come down from 25 percent back to 5 percent, close to the pre-pandemic baseline of 3.5 percent. Unlike

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Key Board Takeaways

- Applying a population health approach can help healthcare systems proactively rather than reactively approach a high-risk group with substantial improvement in outcomes.
- Boards need to support their organizations in strategic exploration of new modalities that can support the need for mental health treatments for the whole population.
- The pandemic offers an opportunity to redesign our system of mental health and social well-being in a way that supports everyone to thrive.

1 Mark Czeisler et al., "Mental Health, Substance Use, and Suicidal Ideation during the COVID-19 Pandemic," Morbidity Mortality Weekly Report, CDC, August 14, 2020.
2 Also see Mental Health America, "The State of Mental Health in America 2021."
3 To find out more about the Well Being In the Nation Measures, see Somava Saha, "Measuring Differently to Create Well-Being in the Nation," *BoardRoom Press*, The Governance Institute, April 2020.

An Outside-the-Box Approach…

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the cost of creating and operating the Mobile Grocery Store for its first five years. Thanks to many generous supporters, we are confident in our ability to achieve this level of support for a program that is so well-received and already showing impact.

In my conversations with potential donors, I encourage them to think of the Eat Well programs as an investment in the long-term health and wellness of our neighbors. We are confident that by helping people eat well, we can reduce rates of hypertension, diabetes, obesity, and other diet-related diseases that limit people's quality of life. The results may not be instantaneous, but they are truly profound.

Creating Healthy Communities

Virtua is a leader in community outreach in ways beyond food access. We operate two other specially converted vans—one providing pediatric services and the other offering mammography. Both cater to clients with limited or no health insurance and transportation challenges. Virtua also operates a two-campus therapy program for children who have emotional, behavioral, or psychiatric challenges.

I'm proud to have a voice in an organization that has dedicated itself to being a force for good, prioritizing population health in ways that are often seen as beyond the scope of a health system. If you find yourself in southern New Jersey one day, be on the lookout for some of our exciting, traveling services.

The Governance Institute thanks David Kindlick, Chairman of the Board of Trustees, Virtua Health, for contributing this article. He can be reached at dakindlick@gmail.com.

Toxic Individualism…

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"becoming a Band-Aid station" among their top concerns when considering partnerships and the analysis found that by pursuing individualism those facilities were depriving their communities of higher acuity services and facility investments.

A recent study by Charles River Associates and the AHA correlated the quality of care, cost, and accessibility with scale.[7] That is, systems with higher volume and the ability to institute system-wide standards and protocols can produce better outcomes—access improves, costs come down, and quality rises. While it is just one study showing positive results of hospital consolidation and may be in contrast to prior studies and news reports, we believe it should not be ignored.

Perhaps the largest cost of individualism is its impact on the industry as a whole. The country's thousands upon thousands of standalone hospital companies dilutes the talent pool for executives and board leadership. Small facilities compete in the marketplace for executives with large systems. When a standalone is successful in developing or recruiting a topflight CEO, the impact of that individual is severely limited by the scope of that small organization. The same is true for board members, other executives, and clinical leadership. The small organizations either have a talent deficit or they are hording talent that could impact more lives at a larger organization. Similarly, a fragmented industry results in the lessons from inevitable mistakes and hard-fought victories not being broadly shared to develop best practices. Each hospital and small system is forced to learn on its own.

Looking Forward

A positive outcome of COVID is that it forced many health systems to evaluate the hub-and-spoke model. When those models were instituted, many in the 1990s, the spokes fed the higher acuity, higher margin hubs. Today, there is an inverse trend. The hubs are incentivized to keep patients in the spokes—close to home, in lower-cost settings, and without clogging up quaternary centers. This bodes well for the future of hospitals that are part of multi-facility systems that want to grow their business, prominence, and place in the world—not through the outdated, ruggedly independent Marlboro Man model, but part of a network that is stronger than the individual parts.

As we stated above, individualism can be a worthy goal, but only if it is secondary to the healthcare mission of the organization. We will continue to have thriving standalone facilities for decades, outperforming their peers on cost, quality, and patient satisfaction. That said, it is incumbent on standalone boards to periodically revisit the question of what benefit they are providing communities in return for the measurable cost of individualism. Those boards that decide to pursue partnerships, which is different than being forced to sell as we described in the Quincy example above, have a heavy burden. They need to do the hard work of vetting potential partners and pursuing relationships and structures that ensure lower cost, higher quality, and integrated healthcare for their communities for the decades to come.

While it is a near certainty that we will continue to see consolidation in the notably fragmented hospital industry, what that consolidation means to local communities is far from certain. Holding on to independence at all costs results in cut services, quality problems, and closed hospitals. At the same time, mergers are not a panacea, and it is the responsibility of board members and executives to ensure that the transactions they may choose to pursue leave their organizations stronger for the generations that follow.

The Governance Institute thanks Jordan Shields, Rex Burgdorfer, Partners, and Casey Webb, Executive Director, Juniper Advisory, for contributing this article. They can be reached at jshields@juniperadvisory.com, rburgdorfer@juniperadvisory.com, and cwebb@juniperadvisory.com.

7 Sean May, Monica Noether, and Ben Stearns, *Hospital Merger Benefits: An Econometric Analysis Revisited*, American Hospital Association, August 2021.

Understanding Mental Health…

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the rest of the country, where overdose rates increased by 23.2 percent in 2020, Delaware's overdose rate increased slightly by 3.6 percent. It took hard work and a coordinated, creative approach across sectors—people giving away Narcan at the food bank, as an example. However, Delaware demonstrated that real improvement in population health outcomes with an equity lens and a focus on those who were not thriving was possible.[4]

Pandemic times offer great challenges, but they also offer enormous opportunities to redesign the system to work better for people. Our system of mental health care has never worked well for people in the middle of the night, accounted well for lack of social supports, or the inevitable loss of income that comes along with mental health and addiction issues. Groups like Well Being Trust and Mindful Philanthropy are coming together in this moment to offer new frameworks such as Healing the Nation,[5] which bring together changes in healthcare, community, and policy to create a better system. Boards need to ensure their organizations are prepared to support these strategic shifts. This moment in time offers us an opportunity to connect the dots and create a better, more resilient system that supports everyone to thrive, with the healthcare and peer supports we all need in our lives.

The Governance Institute thanks Somava Saha, M.D., M.S., Founder and Executive Lead, Well-Being and Equity (WE) in the World, and Executive Lead, Well-Being in the Nation (WIN) Network, for contributing this article. She can be reached at Somava.saha@weintheworld.org.

4 Delaware case study developed with contribution from Elizabeth Romero, former Chief of DSAMH.
5 See https://healingthenation.wellbeingtrust.org.

Physician Leadership

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results across the care continuum. Reallocation of a relatively small amount of dollars can reap tremendous rewards in a stronger primary care backbone for most health systems.

Promoting Effective Physician Leadership

It is important for board members to understand how physician leadership is organized in their hospital. The board should periodically ask senior management to explain how it has rationalized the existing cohort of physician leaders to promote role clarity and accountability. As physician leadership roles proliferate, the board needs to press to understand whether only more silos, bureaucracy, and fragmentation have been created.

Board members should also inquire whether new cohorts of physician leaders have received adequate training to perform optimally. For example, many service line medical directors have been put into these new roles without fully understanding or mastering the tools at their disposal for optimizing service line functioning. Newly elected medical staff leaders often assume their roles without the knowledge to perform challenging responsibilities for credentialing and peer review. Most hospitals do not have well-developed internal professional development resources for physicians and the common practice of sending doctors to outside programs for leadership education has waned during the COVID-19 pandemic.

Board Dialogue with Physician Leadership

Most boards include one or more medical staff officers as voting or non-voting members who give reports at most board meetings. However, it is important for board members to hear about physician matters that go beyond the medical staff's responsibility for credentialing and peer review. In recent years, it has become customary for the Chief Medical Officer, if this position exists, to attend board meetings as a member of senior management. While this individual is often expected to channel the input of the entire cohort of hospital physician leaders, the board should consider more direct communication from time to time. For example, many hospitals employ a significant percentage of medical staff members and often have a physician leader at the head of the employed physician group. A direct report from this doctor on a periodic basis can allow board members a better understanding of how well the hospital is tending to the concerns of this critical group of doctors. In a similar fashion, hearing directly from a physician Chief Quality Officer can give board members greater insight into the hurdles hindering overall improvement in physician performance. Alternatively, directors could dialogue directly with a broader range of physician leaders through various working committees of the board. Contact with the board will help energize and empower physician leaders who often feel insufficiently heard by the hospital's non-physician administrative staff.

Successful hospitals and health systems build strong physician communities that are attractive to new practitioners and retain current doctors by creating stimulating, engaging, and supportive professional environments. An essential element is well-prepared physician leaders who are deployed throughout the organization in thoughtful roles. The board owns the ultimate responsibility for ensuring its hospital has such leadership.

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

Physician Leadership: Are the Right Number of Chefs in the Kitchen?

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

Key Board Takeaways

- Ensure the hospital has a strong physician community to support its activities and sustain its future.
- Understand the critical role of adequate physician leadership in promoting engaged practitioners who can transform care in support of hospital objectives.
- Challenge management to explain its physician leadership strategy. This includes what new roles are being created and how they are being coordinated to ensure clear lines of accountability.
- Explore whether adequate funding is being directed to physician leaders at all levels of the organization. Also, be sure management has created a strategy for the training and development of new physician leaders.
- Ask the medical staff to reduce its physician leadership ranks where they create problematic redundancies, such as when historic medical staff department chair roles overlap with new service line medical directorships.

Successful hospitals and health systems need strong medical staffs to attract patients, deliver high-quality care, promote institutional reputation, and ensure a steady revenue stream. However, a growing physician shortage is making it harder to recruit clinicians, doctors have become more mobile and are spending less time at any single hospital, the prevalence of practitioner burnout is creating a less engaged clinical workforce, and an explosion of physician employment by non-hospital entities (e.g., private equity-sponsored groups and insurers) is weakening traditional doctor–hospital bonds.

To counter these trends and meet multiple other needs, hospitals and health systems have invested more and more heavily in physician leadership. For most of the 20th century, hospitals turned to the organized medical staff for such leadership. In the 21st century, the organized medical staff is an anachronistic model, poorly suited to our rapidly evolving healthcare world. Medical staff leaders are usually transient in their roles, often inexperienced in leadership, poorly trained in management tasks, not always aligned with institutional goals and needs, and constrained in the time they can give to what are largely volunteer roles. For these reasons, new physician leadership roles have been proliferating in hospitals. This article looks at the growth in physician leadership roles and how boards can help promote effective physician leadership in their organizations.

A Growing Group of Physician Leaders

The board should take an interest in the new ranks of physician administrators. Historically, the organized medical staff has been a direct report to the board through its elected leaders. When the board needed to take the pulse of the physician community or hold someone accountable for critical delegated duties, such as credentialing or quality monitoring of practitioners, it could dialogue directly with medical staff officers. However, the growing cadre of new physician leaders (e.g., Chief Medical Officers, Vice Presidents of Medical Staff Affairs, and Chief Quality Officers) are considered hospital management and are directly accountable to the CEO rather than the board.

The benefit of adding more physician leaders into the hospital environment should be obvious. Where hospital nursing has always had an extensive management infrastructure, the hospital's physician community is just starting to achieve something similar. However, the creation of additional leadership jobs with new titles is too often being done without sufficient thought by hospital executives. Often, new physician leadership roles come with poorly defined job parameters, inadequately delineated accountabilities, and unclear authority to make needed decisions. Responsibilities are frequently overlapping, and it is common to find confusion regarding the role of medical staff leaders versus that of hospital-employed physician leaders.

A good example of this occurs in hospitals where the board and management have promoted the creation of multidisciplinary service lines. When such service lines are instituted, the historic role of a medical staff specialty department chair becomes unclear or unnecessary. Yet too few hospitals eliminate medical staff departments as they ramp up service lines. Service line medical directors and medical staff department chiefs often end up perplexed about which of them is accountable for managing challenging colleagues when they manifest quality or conduct concerns. If neither addresses the concern or it is managed inadequately, the problem colleague can end up requiring the board to consider the painful task of imposing a restriction on privileges or termination of membership.

Adding physician leadership is an expensive proposition and should be carefully considered. In the past, it was often believed that such leaders needed to stay in part-time practice to retain credibility with colleagues. More recently, the demanding portfolios of physician leaders and the extensive management training required to master these roles has led to the prevalence of the full-time "physician executive." While high-level physician executives are necessary, commonly missing are clearly defined physician leadership roles on the front lines of clinical care. These should be part-time positions for doctors heavily engaged in the care of patients. But such practitioners should receive adequate time and training to be able to provide daily, "in the trenches" guidance, coaching, instruction, and mentoring to their colleagues. Such leaders are critical to transforming outdated modes of care delivery.

Senior management is usually under pressure to control expenditures and adding additional physician leaders in clinical offices, employed specialty groups, and specialized inpatient units may be seen as fiscally impractical. Board members should challenge such assumptions and carefully weigh the cost–benefit balance to further growth in the ranks of physician leaders. This is especially true in the ranks of primary care practitioners who, if effectively led, are critical linchpins in any effort to reorganize clinical care to yield superior

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