BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards

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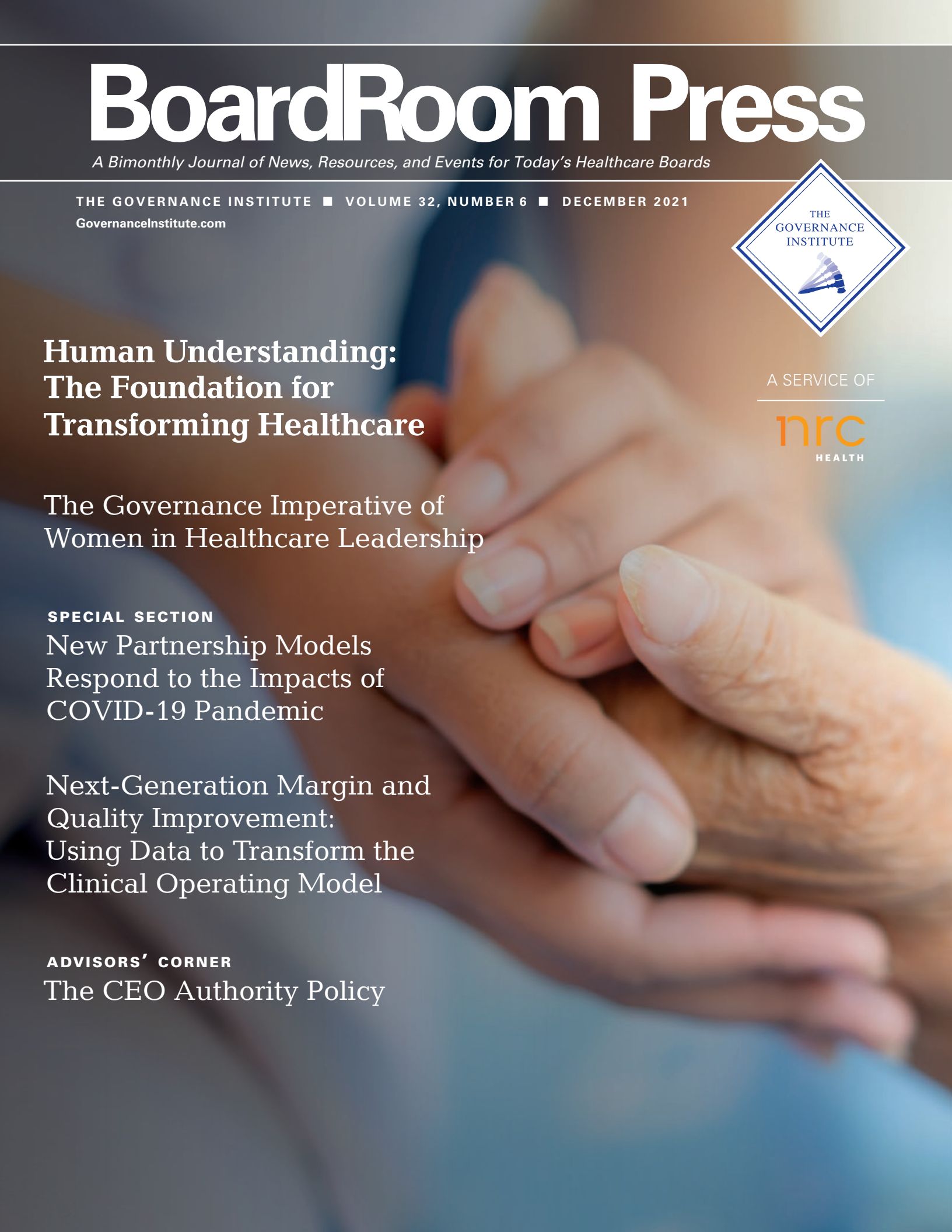

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Let's Get Back to Basics

My mother has advanced Parkinson's. Lately, she has been in and out of two different hospitals due to extreme blood pressure fluctuations and concerns of a stroke. We had different experiences in each hospital: one very poor, and one a little bit better. But in both places, the primary problem was poor communication, which impacted her length of stay and quality of care.

My mother is now in a skilled nursing facility at an assisted living community, receiving PT and OT every day until she can move into her apartment, where she will have 24/7 hospice care. But all of these things would not have happened if it were not for me and several other family members making phone calls, visiting daily, talking to the charge nurse, sending daily messages to the attending physician who took three days to call back, and then coordinating communication between the facility and her neurologist and cardiologist. The amount of time and energy and repeated conversations it has taken to get my mother the care she needs has been extreme. If we had not done this, she would remain in a bed and get weaker by the day with no hope of improving.

This is just the basics. While this may be a story about one patient, thousands of patients and their families deal with this every day. Short staffing is a huge factor, but it needs to be addressed. While we are discussing innovation, transformation, digital health, value-based care, and other amazing things, we still have a long way to go to cover the basics. I challenge you to focus your innovations on these things—these gaps that make a patient experience miserable, and that fail patients who do not have family advocates.

Kathryn C. Peisert,
Managing Editor

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Human Understanding: The Foundation for Transforming Healthcare

By Gregory Makoul, Ph.D., M.S., NRC Health

The need to humanize care has never been more apparent. The COVID-19 pandemic put patients in hospital beds, scared and separated from their loved ones. It also redefined outpatient care as virtual visits gained a stronger foothold, a positive yet stressful development. Leaders and people working on the front lines of care are exhausted and exasperated: In a recent survey of people working in hospitals, medical offices, outpatient clinics, nursing homes, assisted care facilities, and home healthcare settings, more than half of respondents reported feeling burnt out.[1] It's clear that many health organizations are struggling to meet the very human needs of people they serve and employ.

Gregory Makoul, Ph.D., M.S.
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But the imperative to humanize care is not new. Healthcare has become a series of transactions—a problem that predates COVID and negatively affects all involved, whether they are seeking or delivering care. Even potentially promising initiatives (e.g., digital front door) risk speeding up transactions at the expense of human and humane relationships. The missing link is understanding—and addressing—what matters to each person at the n=1 level, quite literally personalizing care by treating each patient as a unique person.

This gap is evident in standard approaches to evaluating care. Experience measurement, born of good intention to drive improvement, gradually grew to define experience as a set of retroactive perspectives with limited impact. There is little value in focusing more attention on measures and scores than on the actual experience of people seeking and providing care. Once people become a box to check, a spreadsheet entry to aggregate, a workflow to accelerate, or a record to close, their humanity is subjugated to the bureaucracy of healthcare.

A Call to Human Understanding

The mechanical, transactional stance toward an innately human journey is hurting patients and draining care teams. Boards and senior leaders can change the trajectory by issuing a call to human understanding in everyday practice:

- A fresh, proactive approach that clearly shifts the focus from transactions to relationships.
- An approach that recognizes the humanity of all involved and acknowledges that most of life happens outside the care setting.
- A commitment to designing care around real-life needs. A realization that every person has a story, and that those stories must be heard.

Focusing on relationships means seeing patients as humans, not cases, problems, or diseases and, in parallel, remembering that the people who work on behalf of patients are human too. It means starting with *what matters to you* instead of *what's the matter with you*.[2] It's realizing that clinical care accounts for only 20 percent of health outcomes,[3] so we must broaden our sights, look beyond our walls, and meet people where they are. Relationships are predicated on listening and engagement, which combats the disconnected feeling that accompanies transactions. In short, we should be treating patients as unique people, recognizing that they may be part of a cohort, community, or population but never losing sight of them at the n=1 level. A great physician may have seen 1,000 patients with a certain diagnosis, but never forgets that every one of those people experiences the illness through their own lens. The organizing framework is deceptively simple: patients are people and people are different.

Key Board Takeaways

When it comes to humanizing care, the missing link is understanding—and addressing—what matters to each person at the n=1 level, personalizing care by treating each patient as a unique person. The board should consider and work with management to address the following questions:

- Do our marketing materials highlight human-centered care?
- Is our organization putting those words into action in everyday practice?
- Does everyone at our organization treat each patient as a unique person?

Embracing the call to human understanding elevates the experience and delivery of care for patients as well as care teams.

Measuring What Matters

Shifting the perspective to focus on relationships requires a different kind of measurement. At NRC Health, we combined scientific rigor and real-world experience to develop a measure that directly gauges the extent to which health organizations are meeting the needs of those they serve. A series of focus groups with diverse participants as well as two national surveys, each with more than 23,000 participants, and a set of pilot tests across a wide range of health systems generated a one-item measure of human understanding: *Did everyone treat you as a unique person?*

We view this measure as a means to humanizing care, not an end in and of itself. In other words, the score focuses attention on what should be happening. And the goal should be that human understanding is happening 100 percent of the time. The decision to reference "everyone" in the item is a direct result of views expressed within the focus groups as well as the national surveys. The vast majority of people expect that everyone, not just the care team, should treat them as a unique person. While care teams can do this by incorporating patient goals, needs, preferences, and abilities into care, everyone—whether clinicians, support staff, or executives—can do this by looking at patients when greeting them and paying attention to

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1 Ashley Kirzinger, et al., "KFF/*The Washington Post* Frontline Health Care Workers Survey," April 6, 2021.
2 Michael J. Barry and Susan Edgman-Levitan, "Shared Decision Making—Pinnacle of Patient-Centered Care," *NEJM,* March 2012.
3 "County Health Rankings Model," 2021. (Available at www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model.)

The Governance Imperative of Women in Healthcare Leadership

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

Never has the need for capable and resilient healthcare leaders been more evident. One of the highest priorities for governing bodies today is to ensure their organizations are led by those committed to carrying out the organizational mission, vision, and values, while providing strong leadership during times of crisis. In seeking to accomplish this, boards will need added vigilance in diversifying their leadership ranks to fully meet their organizations' promise to the communities they serve. Solid strategies focused on gender diversity must be top of mind. Research from McKinsey and others has documented that organizations with women leaders and board members financially outperform those without.[1] Studies published in *Harvard Business Review* have also shown that women tend to have leadership styles that foster trust and cooperation, critical qualities for functioning effectively in integrated health systems.[2]

Yet, data from ACHE's 2019 study on the topic showed women were underrepresented in the top ranks of leadership in healthcare organizations.[3] In comparative samples of men and women healthcare leaders, women held CEO positions at only 63 percent of the rate of men. Further, 30 percent of women, compared to 45 percent of men, held positions above vice president. Also, 19 percent of women, compared to 32 percent of men, who started at their current firms as vice presidents, had advanced to more senior positions at the time of the study.

Organizations that effectively attract and retain qualified women executives will have the advantage over others. The results of ACHE's study revealed three areas in which governing bodies can contribute to positioning their organizations for success in this regard.

Establish Gender Equity as a Governance Priority

First, the most critical element is the serious and sustained engagement of the board and senior leaders in effectively addressing gender equity in their workplaces. Strong, visible, and enduring commitment from the top ensures efforts at creating fair and equitable work environments for women are effective, consistent, and remain strong over time. As further reinforcement, ensuring women are represented on boards and committees has the dual benefit of aligning decision making with a key consumer stakeholder group, while providing role models for other women who may follow suit. According to The Governance Institute's 2021 biennial survey, the average number of women on hospital and health system boards is 3.7, with the average board size at 12.9.[4] While there has been progress, there is still a long way to go to get to full equality.

Create Quantifiable Strategies

Second, the adage "what gets measured gets done" holds true in gender equity. Boards can gain a better understanding of current performance by routinely and systematically using data to monitor progress and outcomes on recruitment, hiring, development, and promotion of women leaders, and by utilizing a segmented view in employee surveys.

One of the most important differentiators for women in our study was the presence of a zero-tolerance policy. These policies significantly and positively affect women's views of workplace gender equity, including higher satisfaction with their position and intent to stay at their current employer. Boards, however, should confirm that qualitative, confidential surveys are used to assess the effectiveness of such policies to ensure practice meets intent as many women do not report potential incidences for fear of repercussion or the stigma of doing so. Understanding how policies play out can be the defining moment for building an inclusive culture.

Develop Women Leaders from Within

Third, strong leaders need to be developed. The board should understand the organization's talent development strategy to create a pipeline of promising, prepared executives. An effective talent management program that includes women executives can be a pathway to increased engagement and job satisfaction for executives and clinicians alike.

The most effective tactics found in ACHE's study include rotations for senior executives, formal sponsorship, mentoring, stretch assignments, external professional development, and ensuring diversified slates for promotion opportunities. Such opportunities benefit women executives and clinicians and can be effective avenues in the race for talent and retaining staff. To expand resources for women, many organizations are also supporting national efforts

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Key Board Takeaways

To help frame the conversation around gender equity strategies, boards should ensure they are monitoring the right metrics and engaging in a dialogue with the senior leadership team to explore how their efforts can be improved. Questions may include:

- How strongly is our organization committed to gender equity? What does our data suggest about our ability to recruit, retain, and advance women within the organization?
- What does our current board composition look like? How does board composition compare to what we know about our patient population and the community we serve?
- Do we have the right mechanisms in place to identify women candidates for governing roles including committee assignments?
- How well do climate surveys inform and provide insights on the effectiveness of how policies, such as zero tolerance, work in practice?
- What talent development strategies have the organization undertaken to ensure gender equity? What is working and what is not? Are goals to diversify talent established?
- How else can the board support the senior leadership team in cultivating gender equity?

1 Susan Birk, "Women in Leadership," *Healthcare Executive*, American College of Healthcare Executives, November/December 2019.
2 Corinne Post, Boris Lokshin, and Christophe Boone, "Research: Adding Women to the C-Suite Changes How Companies Think," *Harvard Business Review*, April 6, 2021.
3 *Addressing Gender Equity in Healthcare Organizations*, American College of Healthcare Executives, Summer 2019.
4 Kathryn Peisert and Kayla Wagner, *Advancing Governance for a New Future of Healthcare*, The Governance Institute's 2021 Biennial Survey of Hospitals and Healthcare Systems.

New Partnership Models Respond to the Impacts of COVID-19 Pandemic

By Anu Singh, Kaufman, Hall & Associates, LLC

The COVID-19 pandemic has put significant operational and financial constraints on many hospitals and health systems. New partnership models can help ensure that organizations have the capabilities they need to sustain and grow their core businesses *and* expand the services they offer to the community.

Impacts of the Pandemic

Few industries have felt the impact of COVID-19 more than healthcare. In the early months of the pandemic, hospitals and health systems faced precipitous declines in volume. Kaufman Hall's *National Hospital Flash Report* data showed that in April 2020, discharges fell 30 percent compared to the prior year, while emergency department visits were down 43 percent. Physicians' offices similarly saw volume declines of 30 to 79 percent across a range of practice areas, according to estimates from the Commonwealth Fund. The situation has improved, but Kaufman Hall's data for September 2021 show that discharges are still 9.5 percent below pre-pandemic levels and ED visits are down 11 percent.[1] The average per physician subsidy (or investment) for employed physicians as of Q2 2021 had gone down to $232,583 from a pandemic high of $294,073 in Q2 2020, but it remained 16.5 percent above the last pre-pandemic quarter (Q4 2019).[2]

Despite some improvements, healthcare organizations and their workers have paid a heavy cost. Infection surges have continued to strain the resources of hospitals across the country. One hundred percent of the respondents to Kaufman Hall's *2021 State of Healthcare Performance Improvement* survey reported that they faced issues with clinical staff, including burnout, difficulty filling vacancies, wage inflation, and high turnover rates.[3] These issues are adding significantly to health systems' costs. An analysis by Premier found that hospitals and health systems are spending $24 billion more per year on qualified clinical labor than they did prior to the pandemic.[4]

Workforce problems extend beyond clinical staff. Ninety-two percent of respondents in the Kaufman Hall performance improvement survey are having difficulties recruiting and retaining support staff in critical areas, including dietary and environmental services; many are increasing base salaries, offering signing bonuses, or paying for more overtime hours. These challenges are accelerating the need for legacy systems to rethink "access" and "care" in entirely new dimensions.

One significant growth area during the pandemic was digital health. For many hospitals and health systems, however, the rate of growth created by the pandemic was unanticipated and much work will be needed to improve the customer experience and integrate digital health services more fully within the organization's overall operations. Before the pandemic, it seemed there might be a few decades until population segments that expect mobile and digital health solutions would be high users of services, but the pandemic catalyzed technological adoption by older age cohorts as well.

Although the growth in digital health helped maintain contact with patients, it was unable to overcome one of the most prevalent side effects of the pandemic: social isolation. Behavioral health needs—which were a significant issue before the pandemic began—have been magnified. Polling by the Kaiser Family Foundation, for example, found that during the pandemic, four in 10 adults in the U.S. reported symptoms of anxiety or depressive disorder, up from one in 10 before the pandemic.[5] More than half of older adults reported feeling isolated from others in June 2020, compared with 27 percent who reported feelings of isolation in 2018, with potential long-term impacts on memory, mental and physical health, and longevity.[6] Growing isolation among the elderly is both calling attention to the need for home health services and increasing the demand.[7]

Key Board Takeaways

- Because of the impacts of the pandemic, boards and senior leaders are naturally focused on sustaining the organization's core business. But the pandemic resulted in a growing population of patients that need help in high-touch specialty services including behavioral and home health.
- With constrained resources and workforce shortages, expanding services might seem to come at the expense of the core business. But it does not have to be an either/or decision that is difficult to resolve.
- Hospitals and health systems can move from "or" to "and" by pursuing strategic partnerships that enable them to focus on their core business strengths while also expanding services to the community by:
  - » Defining the core business
  - » Identifying areas for expansion
  - » Determining the necessary degree of control
  - » Determining the optimal structure for the strategic partnership through key considerations including ownership, financial commitment, governance, clinical decision making, and branding

Moving from *or* to *and* With Strategic Partnerships

In sum, the pandemic's impacts thus far include:

- A tightening financial vise for hospitals and health systems, which are caught between decreased revenues and rising expenses.
- Staff shortages that threaten to hamper both recovery and growth of core services.

1 Kaufman Hall, *National Hospital Flash Report*, September 2021.
2 Kaufman Hall, *Physician Flash Report*, August 2021.
3 Kaufman Hall, *2021 State of Healthcare Performance Improvement: COVID Creates a Challenging Environment*, October 2021.
4 Mari Devereaux, "Hospitals Spending $24B More per Year on Clinical Labor," *Modern Healthcare*, October 6, 2021.
5 Nirmita Panchal, et al., "The Implications of COVID-19 for Mental Health and Substance Use," Kaiser Family Foundation, February 10, 2021.
6 University of Michigan National Poll on Health Aging, "Loneliness Among Older Adults Before and During the COVID-19 Pandemic," September 2020.
7 Seth Joseph, "Home Health Care Is a Bright Light During COVID-19 With an Even Brighter Future," *Forbes*, August 5, 2020.

- A growing population of patients that need help in high-touch specialty services, including behavioral health and home health.

In this environment, boards and senior leaders are naturally focused on sustaining the organization's core businesses. They may be concerned that, given the constraints on resources, expanding the services they offer to their communities would come at the expense of their core businesses. At the same time, these hospitals and health systems may be struggling to provide certain core services or face growing needs for specialty services in their communities, and risk losing patients to competitors. Healthcare leaders may feel they must make an either/or decision that is difficult to resolve.

Hospitals and health systems can move from *or* to *and*, however, by pursuing strategic partnerships that enable them to focus on their core business strengths *and* expand the services they offer to the community, while differentiating their value for consumers, employers, and other key stakeholders. The key questions in determining strategic partnership goals include:

- What do we define as our core services? Where are we facing capabilities gaps in providing these services?
- Where do we want or need to expand our services? Do we have the resources to expand these services on our own?
- What degree of control do we need to maintain as we expand services?

Some hospitals and health systems have already begun asking these questions, and the answers are appearing in new partnership models across a range of services and partner organizations.

Defining the Core

Boards and senior leaders can take several approaches to defining core businesses. Health systems with a presence in multiple markets might begin by considering their relative strength in these markets. In which markets is the health system maintaining or growing market share? Are there any markets in which market share is declining or where growth prospects seem limited?

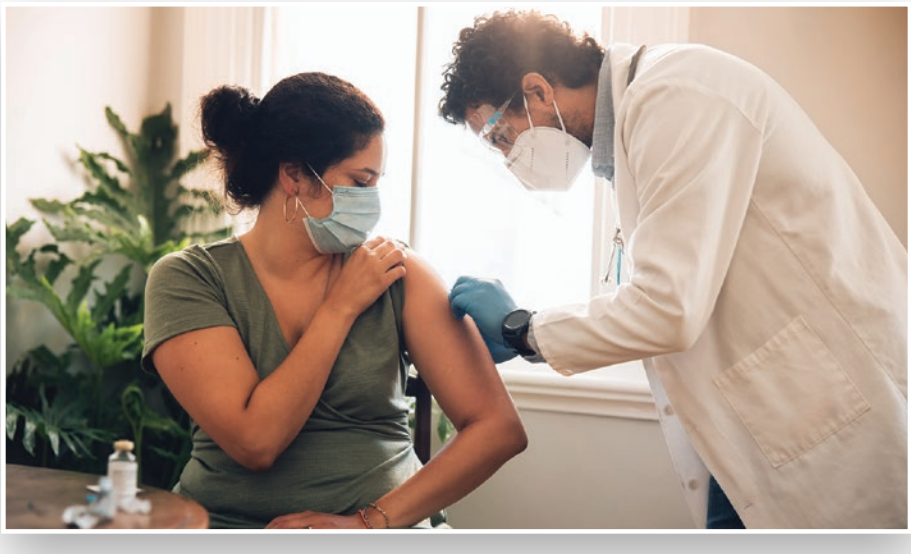
Answers to these initial questions are appearing in a trend we described as the "benefits of regionalization" in Kaufman Hall's *M&A Quarterly Activity Report* for the second quarter of 2021.[8] On the one hand, we see health systems building depth in their local markets and breadth by partnering with health systems that have a strong presence and complementary capabilities in adjacent geographies. On the other hand, we see health systems divesting facilities in markets where they do not have a strong presence and using the resources from these divestitures to strengthen their presence and capabilities in core markets. This is perhaps the dominant trend in traditional mergers and acquisitions between hospitals and health systems since the pandemic began.

Another approach identifies core businesses through an analysis of service lines. Here, key questions include:

- What do we do well and what do we not do well?
- Are there services where we underperform but that are nonetheless critical to our mission?
- Are any of the services we offer becoming commoditized, limiting our ability to distinguish ourselves from our competitors?
- Are there any services that expose us to ongoing performance risk, capital claims, or other drags on organizational resources?

These questions will help health system leaders identify services that they could exit or monetize to enhance the resources available to other core services.[9] But they will also help identify core services that the health system might need to bolster. Service areas where the health system underperforms but that are critical to its mission are likely to be core business areas where the organization needs to build capabilities. Capability gaps may be especially prevalent in areas that require specialized skills or employ different staffing models, such as behavioral health, home health, and post-acute care.

Once capability gaps in core business services have been identified, boards and senior leaders can consider whether they are best strengthened internally, through an acquisition, or through a strategic partnership.



Identifying Areas for Expansion

Innovation, technological change, and demographic change have not been stopped by the pandemic—in some areas, they have been accelerated. Boards and senior leaders must remain attentive to areas where services could or should be expanded. These decisions affect both the ability of patients to easily access

8 Kaufman Hall, *M&A Quarterly Activity Report: Q2 2021*, July 8, 2021.
9 As discussed in Courtney Midanek, "Portfolio Optimization Strategies to Build Resiliency," *System Focus,* The Governance Institute, April 2020.

needed services and the hospital or health system's competitive strength and position.

The pandemic has accelerated several care delivery models, including digital and hospital-at-home models. Many hospitals and health systems had experimented with digital health but had to quickly ramp up their capabilities when demand for digital access soared early in the pandemic. Hospitals and health systems must now determine whether demand for digital services will remain high or grow, and how they can improve access to digital services that may have been quickly put into place during the pandemic. Again, a key question will be whether to develop and enhance digital health capabilities independently or seek a strategic partner.

Hospital-at-home received a significant boost as well, as hospitals and health systems sought ways to keep inpatient beds free for the most acute patients when COVID infection levels surged, while still ensuring that other patients with less acute needs received the care they required. This is a model where hospitals and health systems may seem well-positioned to push out their own capabilities into a new service area; the question will be whether they have the resources available to do so.

The pandemic also saw significant demographic shifts as remote work arrangements—some of which are likely to remain permanent—enabled individuals to move to suburban areas, smaller cities, or fast-growing population hubs in states such as Florida, Texas, and Arizona. Population growth may make new service lines financially sustainable or necessary to meet community needs. Adding these service lines will require investments, including in new clinical expertise; a strategic partnership with an independent physician group is a possibility here.

Determining the Necessary Degree of Control

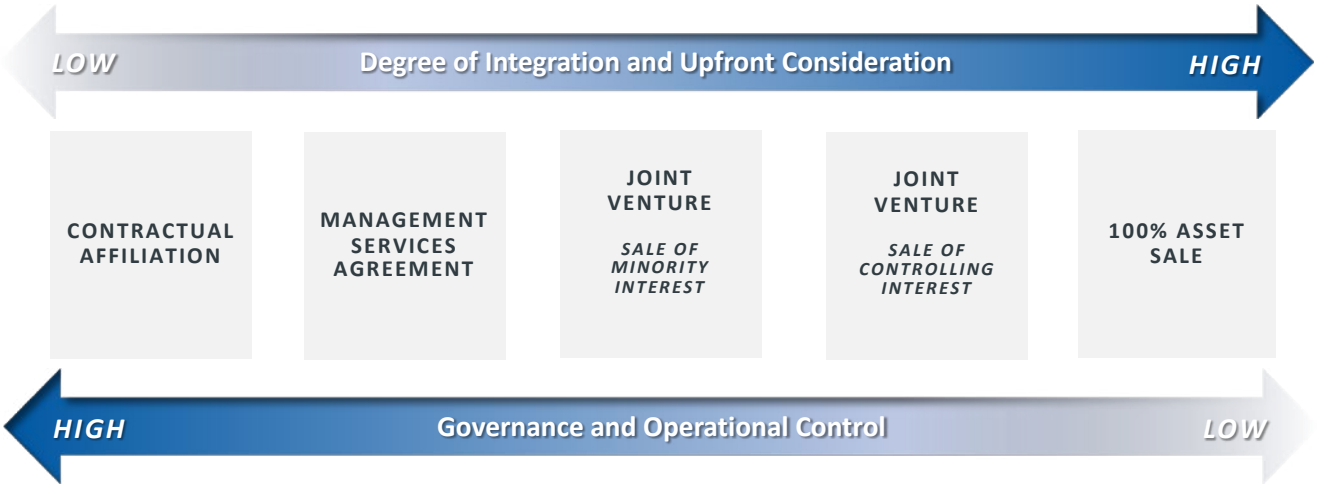
Health systems have traditionally sought to maintain a high level of control across all facets of their operations: framing a decision to expand in terms of "build or buy" was representative of this desire to maintain control. But a wide range of partnership options lie between "build" and "buy," and these may very well be more attractive to potential strategic partners that have desired capabilities but also wish to maintain their autonomy. From the health system perspective, allowing partners to maintain more autonomy may mean less integration, but also a lower upfront investment in the partnership. **Exhibit 1** illustrates this dynamic across a range of partnership structures; more tightly integrated structures typically require a higher

Key Questions for Decisions on Control

Health system leaders should approach potential partnerships with an understanding of the degree of control they believe they will need in the partnership. Key questions in reaching this understanding include:

- How important is this partnership to achieving our strategic goals? If this partnership does not materialize, are there other options available to us?
- Does this partner have capabilities that we do not, which could uniquely be obtained through this partnership?
- Will this partnership have any disruptive impacts on our current operations (e.g., staffing models, community relations, etc.)? What will be the potential costs of addressing these impacts?
- Are there core decisions we must be able to control or drive, but others we would be willing to cede to a partner? If that is the case, could a minority interest partnership with key supermajority or reserved rights still meet our needs?
- What is the desired length of the partnership? What is our backup plan if the partnership does not succeed?

Exhibit 1. The Dynamic Between Integration and Control



Source: Kaufman, Hall & Associates, LLC

investment by one partner and a loss of control by the other.

The question of control has become more significant as potential strategic partners offer an increasing number of options to consider. Independent physician practices, for example, might choose to partner with a health system, a health plan, or any number of start-up companies that are experimenting with new physician practice models that offer more attractive practice arrangements and shared equity opportunities. Digital health vendors might align with a health system, a retail pharmacy's clinics, or a health plan or large employer. Skilled specialty service operators can directly compete with health systems or partner with them.

Health systems should approach all potential strategic partnerships with an understanding that control is not an assumption, but a point of negotiation. The goal is to find the balance between integration, investment, and control that enables both partners to achieve their goals and optimize the chance of a successful partnership.

Additional Considerations for Structuring Strategic Partnerships

As illustrated in Exhibit 1, strategic partnerships can take many forms, from a fairly loose contractual affiliation to a more tightly integrated joint venture. The optimal structure will depend on several key considerations, including:

- **Ownership**: This consideration is always important, but particularly so if the partnership will require acquisition or construction of new facilities or assets. If there will be co-ownership of assets, what are the provisions for unwinding ownership interests if the partnership dissolves? If assets are owned primarily by one partner, what will be the other partner's commitments to the partnership?
- **Financial commitment**: Financial commitments might be structured in different ways, depending on such factors as which partner's core capability is the focus of the partnership or the relative financial strength of the partners. The partner whose core capability is the service line that the partnership is structured around may put up most of the capital, or two relatively equal partners might share the upfront financial commitment to a new partnership. In other cases, the larger partner might provide most of the upfront financial commitment but structure the partnership so the smaller partner can gradually contribute and build equity in the partnership and its assets. Members of an independent physician group, for example, may not want an upfront draw on their salaries or assets in an ambulatory strategic partnership with a larger health system, but may be very interested in an arrangement that allows them to build equity over time in the partnership's assets.
- **Governance**: If the partnership involves formation of a new entity, as is the case in many joint ventures, the partners will want to determine the number and roles of each partner's representatives on the governing body that oversees the new entity. The number of representatives will often reflect the ownership interests of the two partners, while the respective responsibilities of the partners will help determine roles. Supermajority or reserved rights for the minority interest partner may partially or fully mitigate concerns around decision making, particularly regarding clinical decision making.
- **Clinical decision making**: In partnerships between healthcare providers, the question of who will have final decision-making authority over patients' care pathways, referrals, discharges, etc. should be determined in advance. This is an area where questions of control, discussed above, may be particularly sensitive; clarity will be essential to the long-term health of the partnership.
- **Branding**: Several options are possible here. The partners might keep their separate brand identities, combine them, or create a new brand entity for a new venture. In certain areas, such as digital health, a vendor might offer a "white label" solution that brands services under the health system's name. In this case, the partners will need to consider what structural protections should be in place for the "name brand."

Conclusion

Strategic partnerships offer opportunities for hospitals and health systems to sustain and grow their business in an environment where many resources are under pressure. As partnership options grow, rethinking questions of control can help organizational leaders structure new partnership models that are attractive to potential partners and further both partners' strategic goals.

The Governance Institute thanks Anu Singh, Managing Director, Kaufman, Hall & Associates, LLC, for contributing this article. He can be reached at asingh@kaufmanhall.com.

Next-Generation Margin and Quality Improvement: Using Data to Transform the Clinical Operating Model

By Daniel DeBehnke, M.D., M.B.A., Premier Inc.

Over the last almost two years, hospitals and health systems have been tested repeatedly by the COVID-19 pandemic. Through all the tragedy and challenges, they have also been attempting to transition to value-based care. Navigating a pandemic and a fundamental shift in how care is delivered and reimbursed are massive undertakings by themselves; doing both at the same time represents a challenge that not many organizations would sign on for.

Throughout all of this, hospitals and health systems have continued to work with razor-thin margins. We know that the expenses required to deliver high-quality and reliable care continue to rise at a rate not matched by revenue. Furthermore, the pandemic has exposed the vulnerabilities of the supply chain and the volatility of the labor market.

In an effort to take back some control, many hospitals and health systems have invested heavily in technologies that support their clinical operating model. These include electronic health records (EHRs), enterprise resource planning (ERP) platforms, data warehouses, and various analytics platforms. Despite health information technology offerings being more advanced than ever before, lots of organizations remain data rich and information poor. Hospitals and health systems are finding that the return on these investments has not been realized and data remains fragmented with key stakeholders overwhelmed by the volume of data and reporting burden. Many are leaning heavily on their EHRs, attempting to get the most from their investments, but we know they are not designed to provide the data insights required to truly drive organizational change.

It's becoming increasingly clear that there isn't a singular technological answer. Success will require integration of various data-sources and analytics to provide meaningful insights. This may require third-party platforms to provide integrated analytics.

First-generation margin improvement efforts were often departmentally led initiatives, which many times failed to engage providers and operated in silos. These efforts were successful in harvesting some low-hanging fruit in areas including labor and supply chain, but more difficult transformational changes have been elusive and initiatives have not been sustainable. The "second curve" in margin improvement will need to focus on decreasing unwarranted clinical variation and transforming the clinical operating model. Healthcare boards and senior leaders are now realizing that the next generation of margin and quality improvement efforts will require clinically driven operational solutions coupled with a customized technology platform. The success of this transformation will be determined by our ability to ensure it is clinician-led.

A Holistic Approach to Redesigning the Clinical Operating Model

There exist key value drivers that are "levers" that can be pulled for driving margin and quality improvement. Initiatives in the areas of population health/value-based care, workforce optimization, clinical operations and patient throughput improvement, strategic revenue redesign, pharmacy, supply chain, the physician enterprise, purchased services, and more can drive out unnecessary cost and improve outcomes. Each of these value drivers has an impact on the work that clinicians do every day and what patients and families experience as they interact with the health system. True clinical redesign requires an understanding that each of these "levers" does not exist in isolation and impacts or is dependent upon other value drivers. First-generation margin improvement efforts often focused on these levers in isolation. For example, launching a "workforce" or a "length of stay" initiative, without fully appreciating the interconnectedness and its impact on sustainability.

Key Board Takeaways

- Has your management team sized your organization's potential margin improvement opportunity and translated that into a budget target and improvement plan?
- Is your management team focusing on operating model redesign and clinical variation reduction as a way to improve quality and drive margin improvement in key programs, service lines, and DRGs?
- Do you have the analytics and business intelligence platforms and expertise to provide meaningful insights to drive change? Are you "data rich and information poor"?
- Are your management and analytics teams able to visualize provider-level variation in cost to deliver care and resource utilization *and* link that variability to clinical outcomes?
- What is your governance structure and provider engagement plan to execute on clinical variation reduction and operating model redesign?

Clinical Variation Reduction

Next-generation margin and quality improvement uses data and analytics to identify internal clinical variation beginning at a high level (service line, program, and/or DRG) and eventually providing granularity at the provider level. Engagement of clinicians in the process allows determination between warranted and unwarranted variation, with initiatives then being focused at driving out the unwarranted.

Take, for example, a health system that determines through internal variability comparison that there is potentially an opportunity to reduce costs in DRG-470 (major joint replacement). Using advanced analytics and business intelligence, they can show

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Human Understanding…

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what they say. These seemingly mundane behaviors make a huge difference. It's not too much to ask and, of course, leaders should do the same for people working in their organizations.

I have done a few polls during recent presentations—including Leadership Conferences hosted by The Governance Institute—to get a sense of how leaders think their organizations are doing when it comes to human understanding. The poll question is a straightforward modification of the human understanding measure, simply asking: *Does everyone at your organization treat each patient as a unique person?* The response options are "no," "somewhat," "mostly," and "definitely." In responding to the poll, CEOs and board members highlighted considerable room for improvement. In fact, the highest "definitely" score in any of the polls was 6 percent, and at least some of the people who gave that response were from the same organization. Even if patients report that it happens more often, and I expect they will, the opportunity to position human understanding as the north star is huge.

Bottom Line

Hospitals and health systems prioritize human-centered care in mission statements, billboards, and Web sites. Achieving human understanding requires putting the words into action in everyday practice. If everyone treats patients as unique people, both the experience and delivery of care are likely to be elevated for patients as well as those providing and supporting their care. Moreover, human understanding may well be the rate-limiting step for health equity: treating patients as individuals, rather than types or groups, is the key to transcending transactions, conveying respect, meeting needs, and developing relationships that promote better health and more equitable healthcare. Embracing the call to human understanding puts health organizations on the path to reinvigorate the care we want to provide and, when needed, receive.

The Governance Institute thanks Gregory Makoul, Ph.D., M.S., CEO, PatientWisdom, NRC Health, for contributing this article. He can be reached at gmakoul@nrchealth.com.

The Governance Imperative of Women…

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and investing in scholarship opportunities focused on advancing leaders. The hospitals and health systems in The Equity Collaborative, part of The Carol Emmott Foundation, are examples of leading healthcare organizations that have pledged their support toward fully inclusive gender equity within their own walls and across the field. While senior leaders are responsible for hardwiring such efforts through performance and development systems day to day, boards can monitor overall success and ensure efforts are supported and funded.

Moving Forward Together

Ultimately, the inclusion of women leaders in the C-suites and boardrooms of healthcare organizations can both improve organizational performance and better meet the needs of the communities we serve. ACHE surveys and other reputable studies document that, while progress has been made in achieving gender equity, there is still considerable opportunity. Governing boards are in the unique position to set top-down objectives and strategies to achieve greater parity. Deliberate application of data-driven policies that are regularly evaluated by governing boards will help reduce equity gaps. In addition, creating concrete talent development plans that build a pipeline of strong leadership candidates steeped in organizational culture and values will help develop successful women leaders at all levels. Including clinical and other frontline members of our workforce may also improve an organization's ability to recruit and retain key personnel. Through this comprehensive approach, healthcare governing boards can create a competitive advantage that will serve patients and communities well.

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

Next-Generation Margin…

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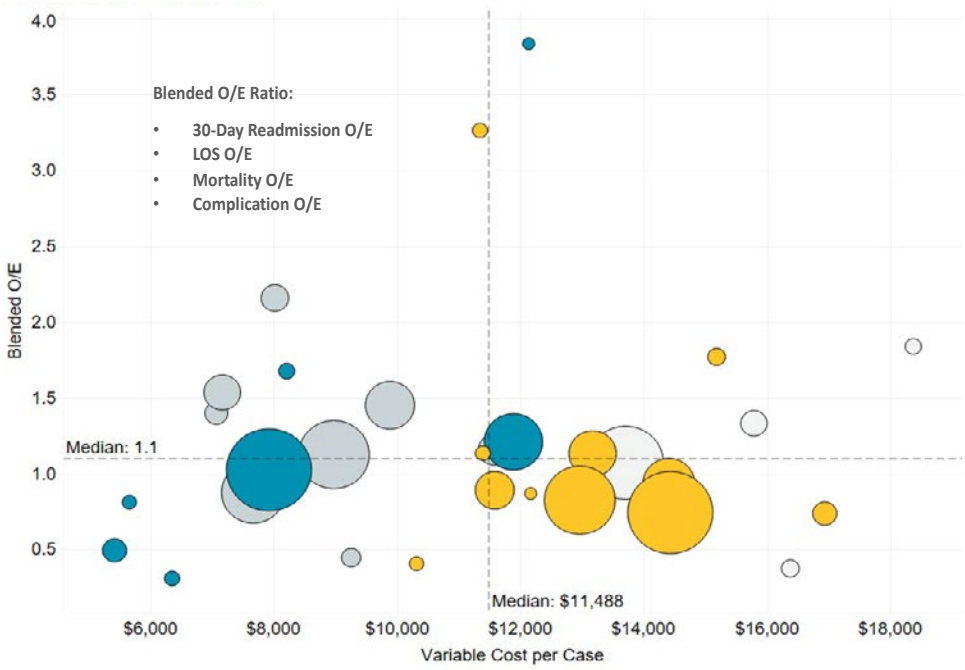
individual surgeon-variable cost per case indexed to a blended observed/expected (O/E) outcome metric that includes length of stay, readmissions, complications, and mortality (see **Exhibit 1**). In the data representation in Exhibit 1, each bubble is an individual provider with the size of their bubble being case count and the shading of the bubble being practice facility. The data begins to tell the story of the interaction (or lack thereof) of the cost to deliver care with surgical outcome. The data shows the opportunity to provide quality care (as measured by the blended outcome O/E) at potentially a lower cost/case. The next level of data analysis would be directed at determining the root cause of the cost/case variability. Is it supplies and implants? Pharmaceutical use? Blood use? Imaging? Length of stay? This next level of analytics allows the providers to then develop initiatives to drive down cost/case while maintaining and improving quality of care. Linking back to the value drivers listed above, a successful margin and quality improvement initiative in this example may require pulling "levers" in pharmacy, supply chain, and clinical operations and could result in an impact on workforce, physician enterprise, and service line strategy.

Exhibit 1. Analyzing Surgeon-Variable Cost Per Case for Major Joint Replacements



Source: Premier Inc.

Conclusion

Providers who are ready to move to the second curve of margin improvement are committing to removing unwarranted clinical variation and hardwiring changes into their clinical operating model. Moving to this second curve requires accurate and timely insights that drive improved, safer, and more reliable care. With the right data, integrated analytics and business intelligence, and a clinically focused, technology-enabled redesign model financial sustainability can be a reality. The board plays an integral role in assisting management in aligning strategies and obtaining tools, technology, and the human capital required to build organizational capacity for system redesign.

The Governance Institute thanks Daniel DeBehnke, M.D., M.B.A., Vice President-Chief Physician Executive, Advisory Services, Premier Inc., for contributing this article. He can be reached at daniel_debehnke@premierinc.com.

The CEO Authority Policy

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that in today's healthcare world, there are occasional situations when rapid action and decision making do not conform with policies that were created for the routine business environment. For example, in the early days of the pandemic, there were many CEOs who made on-the-spot crucial financial commitments (such as acquisition of scarce personal protective equipment) that were critical elements of patient and employee safety. With a trusting relationship and appropriate communication between the board and CEO, there will be an understanding that doing the right thing for patient care will always outweigh a written policy. Coloring outside of the policy lines should not be the norm, but when it happens, the board should resist a rigid approach and instead seek to understand the bigger picture.

Final Thoughts

A positive and productive CEO–board relationship is a precursor to a hospital or health system's overall success, including delivering on its mission. The CEO authority policy is an underappreciated communication device that ensures the board and CEO are in sync on decision-making expectations. This collaborative policy is a tool that can prevent unfortunate misunderstandings between chief executives and the governing body.

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

The CEO Authority Policy

By Kimberly A. Russel, FACHE, Russel Advisors

Establishing clear expectations and a pattern of frank communication between boards and CEOs sets the stage for a healthy and productive relationship between governance and the C-suite. As any experienced board member or CEO will confirm, this level of clarity and transparency usually does not transpire on its own. A combination of tools and governance practices underly this result. The board's CEO authority policy is an essential tool that assists the board and CEO in achieving a common understanding of the sometimes-gray line between chief executive and governance responsibilities.

The CEO authority policy is a board document that defines the financial and decision-making jurisdiction of the CEO. As with most situations, the conversation that occurs between board leaders and the CEO to develop the policy is as important as the final written document.

First Steps

For a newly appointed CEO, the creation of the CEO authority policy is an early priority. Even boards with CEOs who have been in office for a long period of time should attend to establishment of this policy. A thoughtful development of this essential policy can prevent serious future misunderstandings between boards and CEOs.

The board may wish to delegate the initial formation of this policy to either its executive committee or finance committee, with the full board ultimately approving the policy. Writing the policy should be a collaborative venture with the CEO and will initiate healthy dialog between the CEO and board leadership.

As a starting point, review the organization's bylaws for a description of board-reserved powers and delineation of the chief executive's role and overall authority.

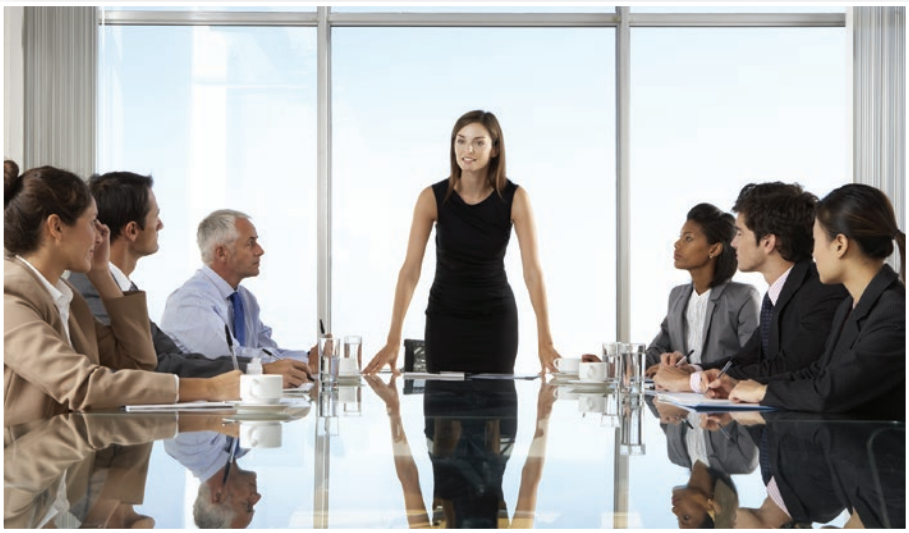
Scope

When contemplating the content of this policy, think more broadly than only financial levels of authority. The policy should address each of these decisions:

- Capital expenditures
- Operating expenditures
- Debt
- Land and real estate acquisition and disposal
- Litigation settlements
- Contractual authority (including managed care contracts)
- Joint venture and legal partnership establishment and dissolution

The CEO authority policy may have different levels of authority for budgeted versus unbudgeted expenditures. Some boards also add a section that describes the protocol for reimbursement to the CEO for his or her professional development and travel expenditures (usually the CFO or General Counsel signs off on these expenditures, which are also commonly reviewed by the organization's audit firm during its annual audit).

As the policy discussion continues, consider a range of authority levels.



Key Board Takeaways

- Approach the development of a CEO authority policy as a collaborative effort between the board and CEO.
- Begin with a bylaws review.
- Broaden the policy beyond financial elements.
- Ensure that the final product is an effective policy that will contribute to mutual understanding of the governance and chief executive roles.

For example, some items will be fully delegated to the CEO and some matters will require action by the board. For other policy elements, fully delegated CEO authority works well accompanied by a requirement for an informational notification to the board (or a designated board committee such as the finance committee) prior to the action. Another alternative is CEO action followed by communication to the board (or board committee).

Too Little or Too Much Authority?

An obvious question revolves around how much authority a board should grant its CEO. Not surprisingly, the answer is "it depends." For an interim CEO or a rookie CEO, the board may wish to retain more authority—with the intention to ramp up authority levels over time as trust and credibility levels grow.

For an experienced CEO with an established relationship of trust, the board should grant maximum authority levels. For example, if a particular capital project or expenditure is included in the organization's board-approved budget, it is generally both inefficient and redundant for the board to require an additional review of the expenditure at another board meeting. The more authority granted to the CEO, the more board time will be reserved for strategic matters and generative governance. Like all board policies, the CEO authority policy should be reviewed periodically and updated accordingly.

One Caveat

When a board establishes a policy, it rightly expects compliance. However, CEOs and boards should recognize

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