BoardRoom Press

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

THE
GOVERNANCE
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HEALTH

The Importance of Revenue Resiliency

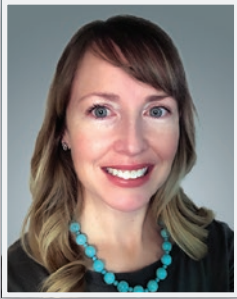## Trauma-Informed Leadership: The Time Has Come

SPECIAL SECTION

Building a Culture of Empathy to Advance Diversity and Equity

Two Key Opportunities: Boosting Employee Happiness and Meeting Higher Patient Expectations

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Scarce Healthcare and the Coming Age of Abundance

In Remembrance

The U.S. is now approaching 1 million lives lost from COVID, likely even more that have gone unreported or other deaths that were accelerated by COVID but not included in the count. In the midst of this, while new daily cases and hospitalizations continue to decline across the country, mask mandates have largely disappeared an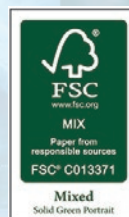d Americans are moving on with their lives. However, as all of us in healthcare are well aware, most areas of the country are still experiencing relatively widespread transmission rates.

We all want to move on and put this behind us. But our frontline healthcare workers won't be able to do that for some time longer. The trauma they have gone through and continue to bear will leave a lasting mark. We will not forget. We will not fail to learn from this and leave future generations better prepared. Our healthcare leaders have led the torch since March 2020, two years and counting. We can continue to lead and support, dig out of this place, and make bolder steps towards the future. This special issue of *BoardRoom Press* contains articles on poignant opportunities to lift us all out of the muck and draw a clearer line towards a new chapter.

Kathryn C. Peisert

Kathryn C. Peisert,
Managing Editor

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The Importance of Revenue Resiliency

By Lisa Goldstein, Kaufman, Hall & Associates, LLC

As we emerge from the COVID-19 pandemic, we face a changed reality. Expenses—particularly labor expenses—have reset at a higher level. Inflation is rising at rates not seen since the early 1980s. As the Federal Reserve tightens monetary policy in response to inflationary pressures, borrowing costs, which have been at historically low levels, will rise. The Fed's efforts to deflate a balance sheet that has grown to nearly $9 trillion may make capital markets more volatile.

Given these headwinds, the integral role of revenue resiliency in maintaining hospital margin and cash flow generation will only intensify. When the pandemic's operational disruptions weighed down income statements, balance sheet strength served as a counterbalance. Now that the balance sheet faces volatility of its own, healthcare leaders must renew their focus on operations and revenue generation.

This effort will be complicated by factors that pose their own challenges to revenue growth. This article examines these factors and their potential impact and suggests strategies to help build revenue resiliency.

Volumes Have Recovered, but Remain Below Pre-Pandemic Levels

While volumes showed a rebound in 2021 from 2020's steep declines, they remain below pre-pandemic levels. Kaufman Hall data show that, in comparison to calendar year 2019, inpatient discharges were down 8 percent in 2021, operating room cases were down 8.8 percent, and emergency departments visits were down 10.6 percent (especially significant, as many hospitals' discharges have historically come from the emergency department). Patient days was the one volume metric that showed positive growth—with a 1.3 percent increase over 2019—likely driven by longer stays for hospitalized COVID-19 patients and a higher case-mix acuity

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from patients who had delayed care early in the pandemic.

Higher-acuity care was a likely factor behind the fact that, even though most volume indicators remained below pre-pandemic levels, gross operating revenue (without CARES funding) grew 10.4 percent in 2021 compared with pre-pandemic numbers from 2019. Add-on payments for COVID cases also contributed to this growth. Acuity may have begun trending downward in the second half of 2021, however, and the growth in gross operating revenue was almost matched by a 9.9 percent growth in total expenses in 2021 as compared with 2019.

As we move past the Omicron surge of infections, the question of future variants, their severity, and their potential impact on volume recovery remains an unknown, especially in areas with low vaccination rates. Also worth noting is that inpatient volumes were softening even before the pandemic struck: In 2019 the volume of discharges was down 1.5 percent over the previous year.

Changing Demographics Will Limit Price Elasticity

Demographic trends will create headwinds for revenue growth over the longer term. Since passage of Medicare legislation in 1965, life expectancy in the U.S. has increased from just over 70 years to almost 79 years. Medicare now pays for 14 years of a typical beneficiary's healthcare, as compared with five years when the law was passed. At the same time, birth rates have fallen and the percentage of the population age 65 and above has grown. By 2030, the U.S. Census Bureau projects that the U.S. will have crossed two demographic turning points: The percentage of the population 65 and older will pass 20 percent, and older adults will outnumber children for the first time in U.S. history.[1]

As the population ages, Medicare and Medicare Advantage will comprise a greater portion of hospital revenues, limiting price elasticity with rates that are largely non-negotiable. Growth in Medicaid and the move to Medicaid managed care by nearly all states also will foster greater price inelasticity. Kaufman Hall data show that the change is already underway: On a combined basis, Medicare, Medicaid, and their related managed care structures rose from 59 percent of hospitals' gross patient revenues in 2018 to 66 percent in 2021.

While Medicaid cuts were largely absent in recent state budget sessions due to increased federal funding, we anticipate that many states will revisit Medicaid budgets in coming legislative sessions. The anticipated Medicare sequestion of 2 percent was delayed through March 31, 2022, with the cut reduced to 1 percent through June 30, 2022, allowing hospitals three more

Older adults will outnumber children for the first time in U.S. history.
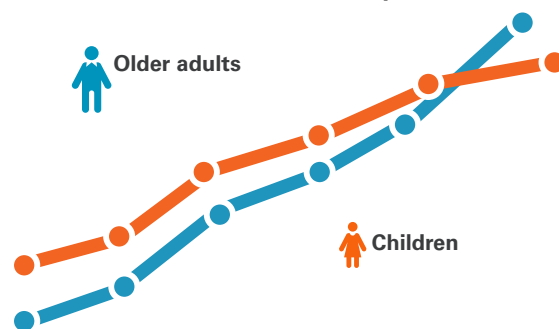
1   Jonathan Vespa, Lauren Medina, and David Armstrong, "Demographic Turning Points for the United States: Population Projects for 2020 to 2060," U.S. Census Bureau, March 2018, revised February 2020.

Trauma-Informed Leadership: The Time Has Come

By Lawrence McEvoy II, M.D., Epidemic Leadership

Trauma-informed healthcare has been contributing to patient care for some time now as insights from neuroscience, behavioral science, epidemiology, and clinical research help us understand that psychic trauma impacts both patients' present and future health as well as their care experience. The pandemic exposed the reality that patients have been traumatized in ways that impact their health beyond our previous awareness. There has also come the glaring insight that healthcare personnel themselves encounter trauma while doing their jobs. For leaders to be able to facilitate the kind of performance and vitality that patients and clinical personnel alike require, it's time to start thinking about a new skillset: trauma-informed leadership.

Understanding Trauma in the Workplace

Going back to our knowledge of "shellshock," our historical clinical understanding of trauma tended to frame an anomalous response to trauma rather than consider the prevalence and impact of trauma in so many people's lives. Over the last 25 years, however, a deeper understanding of the effects of psychic trauma have helped us better understand the impact. We have learned to shift from "what is wrong with people" to "what has happened to people" and to awareness of how trauma—big and small—can influence our present and future health as well as our participation in and interpretation of the care experience.

The pandemic has underscored a long-ignored reality: working *in* healthcare is traumatizing. Media reports of assaults to healthcare workers and violence at school board meetings emphasize the era we are in, as do rising numbers of substance use disorders, suicide, and anxiety among both patients and healthcare workers. Some of the statistics around recent events are staggering. A study by Yale University showed that rates of depression (14 percent), anxiety (16 percent), PTSD (23 percent), and alcohol use disorder (43 percent) all soared for healthcare workers during the pandemic.[1] Whatever statistics we use, the message is clear: the people taking care of patients are suffering.

When we think about trauma, we often think about graphic and disturbing events, but there are "little traumas" that happen in the more polite confines of healthcare organizations that have their cumulative effect. In a traumatized world, where many are working through an endless press of tasks with other stressed people, the "mini-traumas" of stressed relationships stacking on top of earlier insults add up.

Author Gretchen Schmelzer, writing on the prevalence of workplace trauma in early 2020, before the pandemic got going, defines trauma as "an experience or event that overwhelms your capacities to depend upon or protect yourself."[2] The longer such experiences persist, the more we shift our thought and behavior patterns to protect ourselves. She points out that most repeated traumas—whether domestic violence, bullying in the schoolyard, or continued denigration at work—are relational traumas between people, not rare events like earthquakes or catastrophic storms. These traumas embedded in our relationships affect our ability to self-regulate our mood—think about going to a day of work with a person who repeatedly criticizes you. But, more importantly, relational traumas undermine "our trust and belief in relationships…and this is important because leadership is first and foremost a relationship, and relational traumas affect our ability to work with and lead others."[3]

Walk around any healthcare organization, and you will see the telltale signs of post-traumatic behavior as people respond to unhealthy relational patterns in protective ways. Demonstrating behaviors of "fight, flight, or freeze," people may respond to hierarchical power by undermining, organizing opposition, displacing anger, avoiding conflict, or simply keeping their head down and out of the way. I once had a CEO screaming so loudly at me in forwarding an idea he opposed that his veins were bulging, and I have had other leaders confess they were raised by abusive parents. We see countless people refuse to speak up with valuable perspective or information because, at the root of it, it is simply too frightening to venture an idea that might compromise their social safety as they saw it. Recently, when I was working with an executive team, the CEO froze with tears streaming down her face as a routine feedback exercise took her back to a junior high moment when she was publicly humiliated by a teacher. People in healthcare organizations carry whatever big or small trauma they have experienced in their personal lives, including now the collective pandemic experience, but they also carry the trauma of how they have been treated by leaders and colleagues.

Leading in Traumatized Environments

As arresting as the headlines are about clinician suicide, increasing overdose deaths, or mental health symptoms in healthcare workers, the more subtle reality is present among us every day. In order for healthcare to be effective and contributive—to improve quality, decrease cost, enhance the patient experience, and retain talent and solve labor shortages—we are tasked with putting together an unbelievably complex web of relationships in the middle of a traumatized population of workers and

1   Rachel Hennein, Emma Mew, and Sarah Lowe, "Socio-ecological Predictors of Mental Health Outcomes among Healthcare Workers During the COVID-19 Pandemic in the United States," PLOS ONE, February 2021.
2   Gretchen Schmelzer, "Trauma Impacts Leadership. Heal It with Emotional Intelligence," Teleos Leaders, March 5, 2020.
3   *Ibid.*

Building a Culture of Empathy to Advance Diversity and Equity

By Kimberlydawn Wisdom, M.D., Henry Ford Health System

The nation's hospitals and health systems are facing an uncomfortable truth laid bare by the coronavirus pandemic—one that has been whispering under the surface for decades and is now shouting at us: that the healthcare we provide to Americans is not equitable, and that Americans who are not white have poorer health outcomes than white Americans, even after adjusting for socioeconomic, education, and other factors. Today, healthcare leaders know they must meaningfully address diversity, equity, and inclusion (DE&I), and then take it further to reaching the level of social justice. The forgotten "E" from the IOM's acronym, STEEEP, must now take center stage in all our work, and especially our work related to quality and patient experience. A term coined in 2008 is that "Quality and equity are two sides of the same coin."[1]

But in comparison with our decades-long efforts to improve quality, working to achieve equity in healthcare is relatively new. COVID and the many incidents of police violence against Black Americans in 2020–2021 have galvanized people in healthcare. It is a rocky and unsettling journey but one that must be taken. Henry Ford Health System (HFHS) has been tackling equity for decades and we have learned a lot in the process. The journey doesn't have to be so long or unsettling if healthcare leaders borrow from the playbooks of those who have already walked in these uncomfortable shoes.

Like with many change initiatives, building it into the culture is the key and it must be driven from the treetops to the grassroots. At HFHS, we have used a strong focus on accountability to get things done. We wanted to take a critical look at what we were doing, and ask ourselves, is this truly best practice in this space? The many national awards we have applied for or received over the years have not been about the recognition, but rather the discipline of determining where we are, and then to sharpen what we do every day, as it is forever evolving.[2]

This special section describes some key actions and initiatives we have undertaken at Henry Ford to build a culture of empathy to advance DE&I and take us to a place where we can achieve social justice. It includes key questions board members can ask their management teams about how to look at equity and social justice from the top down, implement accountability to make an impact, and to move from a culture of empathy to putting that empathy into action. Afterall, compassion, which is one of our core values, is empathy in action.[3]

What Is Equity?

When we bring up the topic of equity in our training sessions, many ask, "Shouldn't we just treat everyone equally, and aren't we already doing that?" But equity and equality are not synonymous terms. Treating everyone equally, when each might be at a different starting place, does not result in equal or equitable outcomes. Equity is ensuring people have the best opportunity for a favorable outcome, accounting for where they are starting from. Ultimately, we want to move from equity to justice, which is where barriers are removed and liberation and justice are achieved (see **Exhibit 1**).

In our equity evolution at Henry Ford, we went from "treat everyone the same" to "treat people the way you want to be treated." Today, that has evolved to "treat people the way *they* want to be treated." In order to do this, we must understand their cultural differences and personal preferences. This is where developing human understanding plays a critical role—treating each patient as an individual and not another data point. Does a Native American need a medicine bag

Exhibit 1. Equality vs. Equity

EQUALITY   EQUITY   LIBERATION
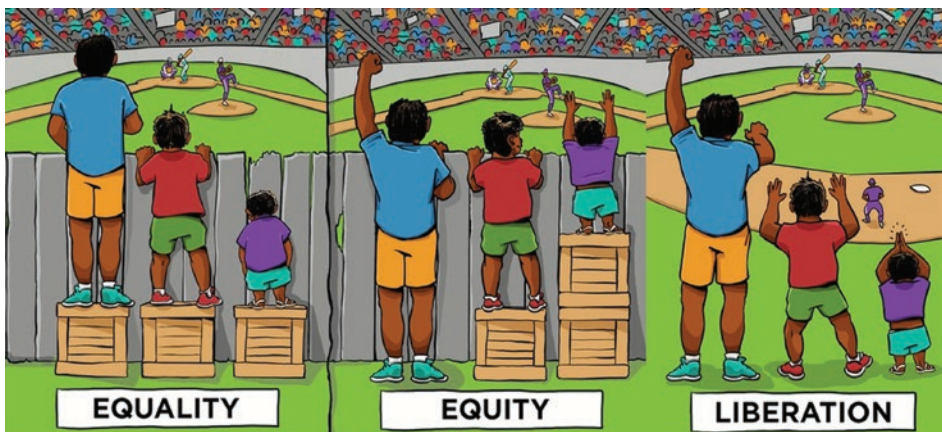
1   Joseph Betancourt, et al., *Improving Quality and Achieving Equity: A Guide for Hospital Leaders,* Massachusetts General Hospital, 2008.
2   Henry Ford Health System has been the recipient of countless awards, recognitions, and grants related to its health equity and quality work, including the Baldrige Award. More information can be found at www.henryford.com/about/quality.
3   Stephen Trzeciak and Anthony Mazzarelli, *Compassionomics: The Revolutionary Scientific Evidence that Caring Makes a Difference*, Studer Group: Pensacola, FL, 2019.

Exhibit 2. Weathering and Allostatic Load

High Allostatic Load →

Persistent stress overtaxes the body's regulatory mechanisms.

Stress hormone, cortisol, turns fat into sugar. Unused sugars are often then re-stored as fat in the midsection.

Unused fat can damage heart, kidney, and other organs.

High blood pressure and heart rate can lead to hypertension and enlarged heart.

Chronic stress can shrink the hippocampus and affect memory.

Higher levels of depression and anxiety.

on their stomach or their foot during surgery? We need to be cognizant of those important preferences and strive to accommodate those requests, where possible, to facilitate their healing journey.

Equity is the outcomes and results of our diversity and inclusion efforts. Empathy is the feeling we are aiming for through this cultural transformation. Once we all share that feeling, then we can drive towards compassion, which is empathy in action.[4]

> " Equity is the outcomes and results of our diversity and inclusion efforts."
>
> —Dr. Kimberlydawn Wisdom

The Moral Imperative

The Henry Ford equity journey began in the 1980s with the establishment of free FQHCs and school-based clinics serving diverse populations through NIH and CDC grants. Gail Warden, current President Emeritus, was President and CEO at Henry Ford at the time. He had been trained in public health and provided me the opportunity to be the founder and director of the Institute on Multicultural Health in 2002. The Institute's mission is to align with HFHS strategic priorities and goals as we:

- Conduct and facilitate research, quality improvement, and demonstration projects focusing on health and healthcare disparities and disseminate outcomes locally, regionally, and nationally.

- Develop community-based initiatives that engage, convene, and empower diverse stakeholders to work towards collaborative and sustainable solutions for equity in health/healthcare.
- Provide training and consultation to enhance the individual and organizational cultural competence of the healthcare system including employees, researchers, providers, and leaders; and to build organizational capacity for integration of interventions that will achieve healthcare equity.

The moral imperative is the first "why" that drives our equity efforts—it is simply the right thing to do. The intersection of medicine and public health is where the true transformation can occur. We have seen this in the past, and most recently we saw these two sides come together in real ways during the pandemic. Hospitals and health systems now must determine how to continue and enhance this

partnership to achieve equity, building the scaffolding to enable this collaboration to happen naturally, systemically, and permanently.

Three Henry Ford chief executives cover about a third of our organization's history, and all three have played integral roles in our equity journey, in part by focusing on our moral imperative. Gail Warden (CEO from 1988–2003) helped conceptualize what we do, Nancy Schlichting (2003–2014) helped operationalize it, and Wright Lassiter, our current President and CEO, is helping to institutionalize evidence-based efforts so the programs and culture will remain intact, be sustained as well as spread and scale.

Cultural and Social Imperative

Henry Ford leaders were moved to action out of personally witnessing the profound physical effects of inequity in the communities we serve, of which, unfortunately, most Americans are unaware. Weathering is the term for the culmination of cumulative trauma or stress from a lifetime of micro-aggression and discrimination. Cortisol levels increase; it leads to hypertension and other chronic conditions. It goes deep into your biology and telomeres (the compound structure at the end of a chromosome) are shortened. When people are discriminated against and not valued, it has a biological impact. Understanding micro-aggression and related elements are key when building a culture of empathy. This became the root of our cultural and social imperative to find solutions (see **Exhibit 2**).

Stressor → Reaction to Stress → Wear & tear on body & organ systems → Reduced optimum health → Increased sensitivity to stress →
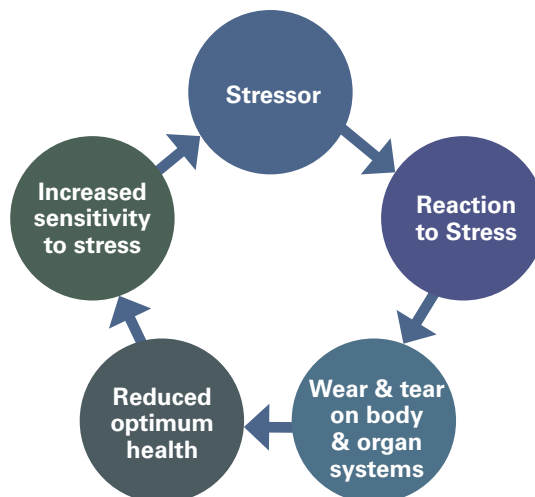
4   *Ibid.*

Quality Imperative

A few years after the IOM published *Crossing the Quality Chasm,* they released *Unequal Treatment,*[5] which reported significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. The research indicated that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services.

In order to gain traction on my broader efforts to lift equity to the top of our list of priorities, I realized that we needed to link quality with equity—it is one of the six IOM aims in its definition of quality. I reached out to our Chief Quality Officer at the time, Dr. Bill Conway, to collaborate. We started the Healthcare Equity Campaign in 2008 in response to a growing national emphasis on healthcare disparities and in recognition of the need to link this focus to our emphasis on quality in a sustainable manner.

One year prior, several leaders had convened to review diabetes quality data by race and ethnicity and uncovered the need to improve the process for collection of these data due to known inaccuracies. An initial focus of this effort was to form a taskforce to recommend ways to more accurately collect race and ethnicity data directly from patients in a manner consistent with national standards. We could then more clearly identify, understand, and respond to disparities that might be occurring in the care provided at HFHS as we could then use the data to stratify quality indicators. Another focus was to build awareness of the need to collect race, ethnicity, and preferred language (REaL) data and to stratify quality data by these factors. However, no avenues existed to share information with employees about the existence of disparities and how to address them; and if employees were not aware of the problem in the first place, how would they become motivated and engaged to address them? The Healthcare Equity Campaign was thus created to provide such opportunities.

The Campaign's goals were to increase knowledge, awareness, and opportunities to ensure healthcare equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large; and to link healthcare equity as a key, measurable aspect of clinical quality.

This overarching goal was achieved through three phases over three years (2009–2011):[6]
- Phase I: Raise awareness among employees about social determinants of health, and health and healthcare disparities.
- Phase II: Implement tools to improve cross-cultural communication and collaboration; plan for review of quality metrics by race, ethnicity, and primary language.
- Phase III: Integrate changes into system processes, policies, and procedures to ensure sustainability and accountability; develop a process for continuous monitoring of quality metrics by race, ethnicity, and primary language and for intervention.

Equity Initiatives

HFHS has created and/or participated in many different equity initiatives across its decades-long journey. Some of the most notable are summarized below. (More information can be found on these and other initiatives at www.henryford.com.)

Community Health Workers (also known as "Promotores") have been a central model, playing a part in and enabling most of the equity initiatives at HFHS, including those described below. These workers are individuals who have a high school diploma or equivalent and are already natural helpers in the community. They become trained as frontline public health workers who focus on social determinants of health, wellness promotion, and enhancing care coordination, taking a population health approach to extend care beyond hospital walls. With the help of a CDC grant and many others over the last 20 years we now have a CHW Hub that employs 22 Community Health Workers. The Michigan Community Health Worker Alliance (which HFHS helped establish and is an inaugural member) trains them, and the Hub acts as an anchoring unit for integration and deployment of CHWs across the entire system. CHWs have played a central role in all our equity initiatives. CMS analyzed

Start a WIN Network in Your Community

Infant mortality had been a concern in Detroit for years, and we were struggling to move the needle (150–200 infants were dying in Detroit every year before their first birthday, a rate far higher than many developing countries). But this was a regional problem. We couldn't do it to the extent it needed to be done on our own. We brought together the four CEOs of competing healthcare organizations in Detroit (Detroit Medical Center, Oakwood Health, St. John Providence, and HFHS) to serve as leaders, strategists, funders (with Kellogg, Kresge, and the Robert Wood Johnson Foundation initially), communicators, and implementers, along with public health, community, and academic partners, to address infant mortality. What became apparent almost immediately was the absolute commitment of each of these leaders to get the job done.

So, the Women-Inspired-Neighborhood (WIN) Network Detroit[7] was built in 2011 to decrease infant mortality. We started "hardwiring the safety net" by implementing a group visit model for prenatal care. Since the outset, we have delivered over 650 babies from vulnerable women with high likelihood of poor birth outcomes, and they are now delivering full term and over 95 percent are initiating breastfeeding. The WIN Network also contributed to the drop in infant mortality in Detroit reported in April 2021. The CHW Hub has been core to this model, mentoring pregnant women during home visits and connecting them with resources and support, and engaging fathers to participate in education. Social networks have helped with communication and raising awareness. The program is designed to be spread and scaled across the country—its next iteration became WIN Network: Cleveland and we hope many more are to come.

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5   Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* National Academies Press, 2003.
6   Healthcare Equity Campaign, *2009–2011 Final Report*, Henry Ford Health System.
7   Learn more details about this program at www.winnetworkdetroit.org.

the ROI of CHW programs and has found that they are associated with improved quality and reductions in healthcare utilization and spending up to $20,000 per patient over a three-year period.

The Racial and Ethnic Approaches to Community Health (REACH) program, made possible with $5 million in funding over five years by CDC to our affiliated FQHC, leveraged CHWs to recruit African Americans with Type 2 Diabetes for screening and trials, along with participation in diabetes prevention. This was part of a larger community screening program called the African American Initiative for Male Health Improvement (AIMHI) that received state and federal funding to screen for diabetes, hypertension, and heart disease as well as glaucoma testing. For every test that was conducted, if the patient required treatment as a result of the screening, the system provided the treatment regardless of the individual's ability to pay—driven by our moral imperative. Other initiatives were born out of this imperative as well.

WIN Network is an initiative that empowers women in neighborhoods to help identify people and families who are in need of help.[8] It is a scalable program involving expansive community partnerships and has been replicated successfully in other cities. This is one example of how Henry Ford has accelerated the sharing of information and learning opportunities for others, to help shorten their equity journey. WIN Network Detroit began with a focus on reducing infant mortality and in a relatively short period of time, we saw

an incredible difference in the numbers (see sidebar for more information).

More recently, the organization implemented a "Ban the Box" influence campaign, first by removing the checkbox on our own job applications asking whether a person has been convicted of a felony. Instead, applicants are asked if they are willing to submit to a background check. The change allows every job applicant to have the chance to be considered. Once we banned the box at Henry Ford, we expanded our efforts out into the community with other employers, showing them our success and influencing them to do the same.

Shaping a New Strategy

In September 2021 we completed a five-year DEI and social justice (DEIJ) plan, focusing on the mission of Equity for All. We presented the plan to the board, and all senior-level executives were involved in creating the plan, which concretely outlines our commitments to four pillars: anti-racism and social justice advocacy, diverse workforce and inclusive culture, community empowerment, and healthcare equity (see **Exhibit 3**).

The role of leadership is critical—often it comes down to the firm decisions of leaders to make things happen. For example, when we wanted to begin collecting self-reported race and ethnicity information from patients up front, many well-intended people felt it would be too uncomfortable and burdensome because we were already collecting financial information at the point of service. Nancy Schlichting, then-CEO, said, "No, we have to start it

now." She made the decision despite middle managers feeling that it would be too disruptive. She knew it wasn't either or—it had to be both.

Partnerships are the other critical piece of the empathy-in-action puzzle. You absolutely cannot take this journey alone. We had been part of many national collaboratives, from the IHI Pursuing Equity Initiative to the CEO Action for Diversity & Inclusion Pledge to the AHA #123forEquity Campaign.

Local partners that have been essential to our efforts include:
- Food banks and farmers' markets
- Faith-based organizations
- Schools
- PPE suppliers
- Senior centers
- Local businesses/employers
- Public health department
- Policymakers

In Closing: The Business Imperative

Looking forward, U.S. hospitals and health systems now have a business imperative for DEIJ, via social determinants of health. If the quality/equity coin could have a third side, this is it. Meeting social needs will be key for value-based contracts. Healthcare today is still largely reactive, and we need to become proactive, but we lack data to understand community trends and analyze gaps and barriers. We need to get better at collaboration to serve patients more holistically across organizations and document outcomes effectively.

For our next push at Henry Ford, we are building community information exchange by creating a network of partners to leverage technology, facilitate referrals and care coordination, and then gather the data to document outcomes and harness it for proactive community planning. Community Health Workers are again at the core of this effort. We are pushing the envelope. Not everyone is comfortable, but we know it's the right thing to do. Empathy started our journey, but empathy in action—compassion—is where we are going.

The Governance Institute thanks Kimberlydawn Wisdom, Senior Vice President, Community Health, Equity & Wellness and Chief Wellness & Diversity Officer, Henry Ford Health System, for contributing this article. She can be reached at kwisdom1@hfhs.org.

Exhibit 3. Our DEIJ Mission: Equity for All

Anti-Racism & Social Justice Advocacy
We commit to rejecting and eliminating all forms of bias, racism, and violence within our organization and communities.

Diverse Workforce & Inclusive Culture
We commit to serving as a trusted leader in healthcare with a broadly diverse workforce who feel valued, respected and a shared sense of belonging to the HFHS community.

Healthcare Equity
We commit to achieving equity in clinical outcomes and experience to empower patients to achieve optimal health and well-being.

Community Empowerment
We commit to fostering effective partnerships and collective action that creates and sustains health in historically marginalized communities.

8   See www.winnetworkdetroit.org.

Two Key Opportunities: Boosting Employee Happiness and Meeting Higher Patient Expectations

By Nicholas J. Webb, Leader Logic, LLC

As we exit the COVID-19 pandemic, healthcare leaders are facing massive disruptions in virtually every aspect of their organizations. This disruption is the result of a wide variety of powerful forces. They include the pandemic itself, which has ushered in what I call the C-19 economy. We are also seeing rapid technological advances, significant changes in the way patients view healthcare, and disruption in clinical and patient value and economic models. Consumers expect far more from healthcare, as they now see it as a consumer product. They want faster delivery, painless exchanges, higher quality, price transparency, and far better clinical experiences. They have grown to embrace and expect the illusion of personalized service from the software algorithms that respond to their online searches and inquiries, and now they want a similar experience in healthcare.

These are significant challenges. But every challenge brings new opportunities. We know from history that disruption brings both *destruction* and *invention*. As the saying goes, "Out with the old and in with the new!" It's a brutal process that divides the survivors from the victims and the winners from the losers. In 2022 and beyond, boards of directors can leverage disruption and encourage their leaders to deploy on a strategic triage plan focusing on two key opportunities: transforming the organization's culture to focus on employee happiness and providing patients with the consumer experience they expect. These twin efforts can be summed up as Happiness as a Strategy (HaaS).

1. Focus on Employee Happiness

Why should boards be focused on employee happiness? For two reasons: happy workers are more productive and healthcare employees—from the front desk to the operating room—care about their own happiness more than ever.

If any board member needs proof of the desire of employees in the C-19 economy for career happiness, look no further than the Great Resignation. According to the U.S. Bureau of Labor Statistics, four million Americans quit their jobs in July 2021.[1] Resignations peaked in April and remained historically high for several months, with a record-breaking 10.9 million open jobs at the end of July. According to July 2021 Gallup research, 48 percent of employees are actively looking to make a change.[2]

The good news is that *employee happiness is good business.* Numerous studies have shown that happy employees are more productive. For example, an extensive study into happiness and productivity found that workers are 13 percent more productive when happy. Conducted in the contact centers of British telecoms firm BT over a six-month period by Jan-Emmanuel De Neve (Saïd Business School, University of Oxford), George Ward (MIT), and Clement Bellet (Erasmus University Rotterdam), the study revealed when workers were happier, they worked faster by making more calls per hour and, importantly, converted more calls to sales.[3]

Employees are looking for much more than just a paycheck. Research by Wrike says more than 50 percent of U.S. and U.K. employees are choosing to be happy over their paycheck size. As the report, *From Positivity to Productivity: Exposing the Truth Behind Workplace Happiness*, reveals, many of today's workers say doing meaningful work is the most critical factor in being happy. For them, it even ranks higher than their compensation.[4]

For healthcare organizations competing in the tight C-19 labor market, this means a lot. As long as you provide a competitive wage, you can create an environment that will attract the very best employees who demand a happy workplace. They will choose your organization instead of being another cog in the wheel of some other.

Boards need to intervene when contemporaneous and proven cultural transformation systems are not implemented. CEOs often look at pay and benefits alone as the primary determinants of attracting and keeping great talent. It is critical to exit this legacy philosophy and move towards a cultural transformation, as today's workforce is more concerned with the quality of work life than pay and benefits.

2. Make Patients Not Just Healthy But Happy

In the old days, healthcare providers enjoyed a *doctor-centered delivery model.* This meant the service provided by the physician was so valuable and specialized that the patient felt grateful to receive it and was willing to endure inconvenience, delays, and high prices to get it. Many doctors were accustomed to making their patients wait to see them, and then charging them for the privilege.

Thanks in part to the Internet, patients have changed their expectations. They have taken the medical profession off its pedestal and put it side-by-side with other significant consumer service purchases, like accountants or personal

1   U.S. Bureau of Labor Statistics, "Job Openings and Labor Turnover Summary," December 2021.
2   Vipula Gandhi and Jennifer Robison, "The 'Great Resignation' Is Really the 'Great Discontent,'" Gallup, July 22, 2021.
3   University of Oxford, "Happy Workers Are 13% More Productive," October 24, 2019.
4   "New Wrike Happiness Survey Reveals that Over 50 Percent of U.S. and U.K. Employees Chose Job Happiness Over Paycheck Size" (press release), May 7, 2019.

The Importance of Revenue Resiliency
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months before the sequester resumes.[2] At the same time, increased federal spending and a very high national debt raise the possibility of further material Medicare reductions, similar to the Balanced Budget Act of 1998.

As the population continues to age, health systems' ability to rely on commercial rates for revenue growth will wane. On average, commercial revenues represented only about one-fifth (20.5 percent) of gross patient revenues in 2021. Most hospitals are price takers, not price setters, which means that they have limited bargaining power when negotiating rate increases with commercial payers. Some hospitals anecdotally report recent, more favorable negotiations with commercial payers than in prior years, partially driven by the optics surrounding payer profitability levels during 2020. But as enrollees seek more care in 2022 and payer profit margins ebb, we expect the next round of negotiations to be tougher and more contentious.

Building Revenue Resiliency
Moving forward, a revenue strategy based on volume growth will be risky, especially if it is too reliant on recovering inpatient volumes. Building revenue resiliency will require diversification of both revenues and payments.

Revenue diversification. Revenue diversification will be key to revenue resiliency, especially growth in outpatient services such as ambulatory surgery, urgent care centers, imaging centers, and other sites of care. Several factors should give urgency to this effort. Kaufman Hall data show that the 2021 inpatient to outpatient adjustment factor actually contracted by nearly 1 percent compared to 2019 levels; this indicates that patients are either seeking outpatient services outside of the hospital's ecosystem or delaying outpatient care. We know the pandemic greatly increased telehealth use and intensified a trend toward "do-it-yourself" healthcare.[3] Non-traditional competitors have been active in these and other spaces; hospitals and health systems will need a speed-to-market approach as non-traditional competitors quickly build their presence in outpatient services, particularly in high-growth markets with large, commercially insured populations.

Payment diversification. Despite policies that have incented the industry to move to value-based payment, the industry remains largely fee-for-service, with providers paid based on volume and acuity. The pandemic exposed vulnerabilities of the fee-for-service system and we have seen new interest in diversification of the "payment portfolio." We anticipate accelerated movement toward value-based payment models that will lessen dependence on volumes as the primary revenue driver.

The two traditional drivers of revenue—volumes and price—are both under pressure. To build revenue resiliency, hospital and health system boards and senior leaders must seek new areas of growth and new payment models in the months and years ahead.

The Governance Institute thanks Lisa Goldstein, Senior Vice President in the Treasury and Capital Markets practice and Thought Leadership team at Kaufman, Hall & Associates, LLC, for contributing this article. She can be reached at lgoldstein@kaufmanhall.com.

2   The Protecting Medicare and American Farmers from Sequester Cuts Act, Public Law 117-71, December 10, 2021.
3   Betsy Morris, "The New Trend in Healthcare: Do-It-Yourself," *The Wall Street Journal*, January 11, 2022.

Two Key Opportunities…
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injury lawyers. The days of assuming that the delivery of safe and efficacious care justifies any unpleasant consumer experience are over. Each and every year, when they seek care, patients have more choices, and they will make the choices that deliver the highest transparent value and experience.

For example, the Deloitte 2020 Survey of U.S. Healthcare Consumers found that many patients are increasingly willing to tell their doctors when they disagree with them.[5] They are using virtual visits more than ever before and are using technology for health monitoring. But perhaps most of all, a trusted clinician relationship remains paramount. Patients value doctors who listen to them, care about them, don't rush, and provide clear communication.

Happy Employees= Happy Patients
The best organizations in healthcare realize that you can't have happy patients when you have unhappy employees. As people-powered enterprises, we need to do a far better job of delivering exquisite experiences to our employees and our patients alike.

Patients have no way to determine clinical efficacy, and will consider your value based on their personal experience and how they feel about it. Employees also have more options today than ever before. They are leaving good companies for great companies. To become a great company, boards are encouraging the implementation of integrated HaaS plans to build growth and future readiness while delivering on the promise of their clinical missions.

The Governance Institute thanks Nicholas J. Webb, CEO of Leader Logic, LLC, for contributing this article. He can be reached at nick@nickwebb.com.

5   David Betts, et al., "Are Consumers Already Living the Future of Health?," Deloitte, August 13, 2020.

Trauma-Informed Leadership…
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patients. That web of relationships must depend on and drive healthy patterns of relating if it is to have any hope of sustaining our organizations, let alone positively impacting the health of our battered and divided communities.

We don't learn how to lead traumatized people in the technical disciplines of finance, IT, or even medicine or nursing. Nonetheless, we have a growing body of research and practice to guide our leadership learning on leading in traumatized environments. Taking this approach can help improve relationships and decision making, and help develop a healthy culture throughout the organization.

To better lead in traumatized environments, healthcare boards and senior leaders should:[4]

1. **Realize** the impact of trauma on leaders, employees, and populations as well as potential paths for recovery and resilience. As a board, educate yourselves about the effects of trauma on patients, healthcare workers, and leaders.

2. **Recognize** the signs and symptoms of trauma in leaders, teams, staff, patients, and families. Survey your organization for markers of traumatic history and effects which flow through the work environment.

3. **Respond** by fully integrating knowledge about trauma into leadership development, practice, policies, and procedures. Commission a trauma-informed approach to leadership development with strong sponsorship from executive and physician leadership.

4. **Lead** to actively prevent *re-traumatization* and to create a healthy organizational culture. Monitor a systemic approach to creating a leadership culture that supports healthy relational patterns that minimize the reverberations of traumatic experiences.

Starting now, leaders of the future will think, act, and interact on a traumatized human landscape, internally and externally. That reality does not mean every day is some sort of shocked sobfest. It means bringing the idea of trauma-informed leadership into full view. It is time for leaders to learn how and where trauma is at work—in themselves, their teams, and their organizations. This includes learning to self-regulate the responses to triggers that remind us of past personal and professional traumas, being empathetic about what has happened to others, and understanding how trauma impacts our social ecosystem at work, and using that knowledge to better lead the workforce.

The Governance Institute thanks Lawrence McEvoy II, M.D., President and CEO, Epidemic Leadership, for contributing this article. He can be reached at larry@epidemicleadership.com.

4   Dave Tweedy, "Trauma Informed Leadership: An Approach for Healthcare," USC Price.

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desire to view ratings and reviews prior to using, doctor was number one.[3]

Digital abundance: The pandemic pushed healthcare into the virtual world and crammed a decade's worth of innovation into a few months. Virtual health experiences are lauded by consumers (74 percent were satisfied with their telehealth visit during COVID)[4] and hospital-at-home models are pushing more care into the home and out of traditional delivery settings. Doctor consultations are comfortably online as clicks begin to match bricks.

Physical abundance: It is possible, and likely, we could see more patients in traditional physical settings. NRC Health's Market Insights reveals 16 percent of consumers aren't sure when to resume healthcare activities. The postponement of preventative care over the past two years is leading to "catch-up appointments" and possible complications and future needs for care. Lockdowns

may have ignited an invisible crisis of mental health that will require much needed resources in the coming months and years. Population growth also means more physical healthcare. The spread of care to the outpatient setting, the advent and fast spread of urgent care, and the growing convenience of innovative primary care models will continue to push healthcare outside its traditional comfort zone.

Are we prepared for an age of abundance? How much do we even acknowledge our scarcity? It's time to use this lens to examine our business model top to bottom. If the industry is spreading out, how do we lead the shift instead of getting swept up? Ask any consumer and they will tell you access is difficult. Start there. Are we accessible to our consumers? What are the biggest stumbling blocks? We often work backwards from the all-encompassing patient experience. Instead, start in

the minds of consumers. You would be amazed at what a simple improvement like online scheduling can do for the entire patient journey.

As we emerge from the dark cloud of COVID-19 it will be fascinating to watch where healthcare goes. No one holds all the answers but be certain the pull is away from the scarcity of the hospital setting and into the home: where patients live. Will hospitals and health systems take the first steps to improve access, communication, and follow up to advance what they offer to the patient? Or will patients continue to wade through the desert of traditional healthcare in search of an oasis?

The Governance Institute thanks Ryan Donohue, Solutions Expert, Consumerism, NRC Health, and Governance Institute Advisor, for contributing this article. He can be reached at rdonohue@nrchealth.com.

3   NRC Health, Market Insights Survey, 2020.
4   *Ibid.*

Scarce Healthcare and the Coming Age of Abundance

By Ryan Donohue, NRC Health

As an industry, healthcare is tough. Despite the challenge of the COVID-19 pandemic, the pressure to shift to value over volume, unrelenting workforce shortages, and more healthcare presses on. Why is it—through this gauntlet of challenges that might end another industry outright—that healthcare seems to advance and even grow? Well, we may not constantly count the many advantages of healthcare, but they are always present and run deep and strong.

The advantage I want to expose is *scarcity*. By design, healthcare is scarce. It isn't easy to find. I grew up in a town of 25,000 residents. There were thousands of streetlamps, hundreds of mailboxes, dozens of gas stations, 10 grocery stores, more bars than there should have been, and exactly one hospital. And despite it being the only place where acute care could be had, it wasn't a place you wanted to go. Unless you worked at the hospital or were very sick, you stayed away from that place like it was the haunted house on the hill.

My colleague Greg Makoul calculated and shared how little of our lives we spend receiving healthcare in a 2021 Governance Institute Webinar: 1.2 percent of our lives in an inpatient setting and 0.2 percent in an outpatient setting. Unless we battle a rare condition or develop a serious chronic illness, we spend over 98 percent of our lives outside of healthcare. Healthcare experiences are rare, just as they are designed to be. Consider the certificate of need: a barrier to new hospital construction unless it's deemed necessary. Imagine if a fast-food restaurant was required to obtain such a certificate. Healthcare is an incredibly unique industry for myriad reasons but not the least of which is how truly clandestine it is to the people around it.

The Strategic Advantage of Scarce Healthcare

Scarce healthcare is more than a reality, it's a strategic advantage. Famed business thinker Michael Porter wrote at length about scarcity as a bulwark in a competitive business landscape. Porter argues that most organizations either need to differentiate or be a cost leader to thrive, unless their buyer is considered a narrow target. He calls this the "focus strategy" and it's described as follows: "the generic strategy of focus rests on the choice of a narrow competitive scope within an industry. The focuser selects a segment or group of segments in the industry and tailors its strategy to serving them to the exclusion of others."[1] Whether hospitals and health systems truly chose this strategy is debatable, but it's clear that traditional healthcare delivery has a narrow target audience—the vast majority of people aren't in need of a hospital stay right now. Those who do, don't have many choices. This allows healthcare brands to focus on this audience and provide a rare set of services. In fact, Porter argues that the power of the focus strategy is you don't necessarily have to achieve high levels of differentiation or cost leadership in order to be effective—if what you offer is scarce.

In healthcare, the power of scarcity can cut both ways. Look no further than the nursing shortage. Nurses have been able to leave their hospital of employment, sign with a nurse staffing firm, and earn three times or more what they were before as a "traveling nurse." Ironically at times they can return to the same place they left, albeit with a hefty raise. Currently our nurses are scarce and that makes them quite valuable.

Healthcare's overall scarcity has never been more evident than during the past two years. Empty beds personified the shutdown of traditional healthcare. Healthcare was, for large parts of 2020 and 2021, either unavailable or undesirable to the would-be patient. The pandemic also highlighted the limitations of the traditional hospital-based care system. Many hospitals and health systems either were prevented from playing a major role in COVID-19 testing and vaccination or chose not to get as involved as they could. Like many consumers, I received my vaccination in a grocery store. My family got tested countless times in the parking lot of an empty Sears store. Since March 2020, CVS Health has provided nearly 30 million COVID tests.[2] The distinct boundaries of traditional healthcare delivery continue to deliver potential opportunities for non-hospital brands to steal share and create new experiences.

For hospitals and health systems, the once powerful advantage of scarcity may be eroding. I co-design NRC Health's Market Insights—the largest survey of U.S. healthcare consumers. One of the central questions I ask when I pour over results from 300+ markets is: will healthcare remain scarce, or is there a possibility of an age of abundance coming to healthcare in the future? If abundance is on the way, COVID-19 led the charge.

Three Areas of Coming Abundance in Healthcare

Psychological abundance: National focus has intensified, the pandemic made healthcare a daily consideration, and the industry still needs to be "fixed" according to mainstream media coverage. The coming battle for price transparency will buoy coverage post-pandemic. Healthcare is on the minds of seemingly everyone. When consumers were asked which professional they would most

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Key Board Takeaways

- Examine your strategic plan through the dichotomy of scarcity vs. abundance and determine where you have benefited from scarcity.
- Analyze your competitors (which may not entirely consist of traditional healthcare organizations) and determine where they benefit from scarcity and how that may erode.
- Make a plan to defend your scarcity advantage while also capitalizing on a more abundant future (e.g., access to your employed doctors has been acceptable and kept telemedicine usage low, but future demand means you will need to start nudging doctors and building bandwidth).
- Pick or prioritize one initiative that increases the abundance of healthcare in your community.
- Appoint a board member with experience in an industry that has seen its traditional advantages erode (banking, travel, etc.) and tap them to analyze your goals from their unique lens.

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1   "Porter's Generic Competitive Strategies (Ways of Competing)," University of Cambridge, IfM.
2   Anoop Kumar, "COVID Test CVS: 29 Million Tests Since Opening Our First," Fox24x7, January 11, 2022.