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The Governance Institute Health System Quality Honor Roll 2022

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While improving quality in hospitals and health systems has been an industry focus for more than 20 years, progress has been slow but relatively steady. One of the primary goals of consolidating hospitals into health systems over the past decade has been to standardize care processes and protocols as a means to advancing efficiency, access, and outcomes. We have yet to see significant impacts of this consolidation in improving quality of care. The coronavirus pandemic represented a significant headwind on the quality front as system leadership, necessarily, pivoted into crisis management.

In an effort to regain a focus on quality, we conducted research last year to identify top-performing healthcare systems based on an algorithm we created from publicly reported and NRC Health data on hospital performance. The results were published in a paper entitled, "Improving Quality in Health Systems: How Do They Do It?"[1] While it is relatively easy to find comparative quality performance information on individual hospitals, we realized that there was little information on overall health system performance. Accordingly, we created a model that "rolled" up quality measures and identified a top decile of top-quality systems. We then conducted a survey of top leaders from a subset of those systems to gain insights on the key governance and leadership efforts they believe drove their success and presented our findings at 2021 Governance Institute Leadership Conferences.

1 Michael D. Pugh and Kathryn C. Peisert, "Improving Quality in Health Systems: How Do They Do It?," *BoardRoom Press* (special section), The Governance Institute, October 2021.

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This year, we took a slightly different approach that we think is both simpler to understand and more powerful. The CMS Star Ratings, while subject to ongoing criticism and refinement, are widely recognized. In fact, most other hospital quality and safety rating systems utilize a significant portion of the underlying CMS data in constructing their own proprietary metrics. We noted in reviewing last year's approach that the CMS Star Ratings appeared to be the leading indicator of performance and that rolling up other quality ratings did not significantly alter the outcome of our analysis. So, this year we decided to focus on the latest CMS Star Ratings to determine technical quality performance and use NRC Health's Market Insights data to gauge consumer perception of quality.

As detailed in the Research Methodology sidebar, we employed the most recently available set of CMS Star Ratings to generate a CMS Quality Rating and used NRC Health's Market Insights data to create a parallel Consumer Quality Rating, in each case rolling hospital-level data up into system-level indices. We then identified the multi-hospital systems (i.e., at least two hospitals) with greater than 25 beds that performed at least 1 standard deviation above the mean on *both* indices to create The Governance Institute Health System Quality Honor Roll – 2022. Nineteen (19) systems are included on this year's Honor Roll: nine small systems (two to four hospitals) and 10 medium-sized systems (five to 24 hospitals).

Research Methodology

This analysis of health-system quality focuses on CMS Quality Star Ratings data from the July 2022 reporting period and perceived quality as measured by the Overall Quality item in NRC Health's Market Insights (MI) national study: "How would you rate the overall quality of [your top-of-mind hospital]?" (1/1/2020 to 12/31/2021).

System-level roll-ups of CMS Star Ratings (CMS Quality Rating) were calculated using weighted averages based on hospital bed sizes; only hospitals with at least 25 beds were included. Corresponding system-level roll-ups of MI Overall Quality scores (Consumer Quality Rating) were calculated using weighted averages based on a hospital's number of Top-of-Mind mentions; only hospitals with at least 50 mentions were included. A cluster analysis was used to establish small (two to four hospitals), medium (five to 24 hospitals), and large (25 or more hospitals) system groupings, after which z-scores for CMS Quality Rating and Consumer Quality Rating at the system-level were generated both globally and within each group. We used principal component analysis (PCA) to combine CMS and Consumer ratings, rank ordering systems based on the PCA output. To highlight top systems, the Health System Quality Honor Roll only includes those that were at least one standard deviation above the mean for both their CMS Quality Rating and Consumer Quality Rating in the global analysis.

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The 2022 Honor Roll

The Governance Institute is pleased to recognize the following health systems
(* indicates Governance Institute member organization, NRC Health customer, or both):

Small
Michigan Medicine, Ann Arbor, Michigan*
St Luke's Hospital Health System, Boise, Idaho*
Christ Hospital Health Network, Cincinnati, Ohio
University of Utah Health Care, Salt Lake City, Utah*
Hoag Health System, Irvine, California*
Cedars-Sinai Health System, Los Angeles, California*
NorthShore University Health System, Evanston, Illinois
Edward-Elmhurst Health, Naperville, Illinois
Nebraska Methodist Health System, Omaha, Nebraska

Medium
Mayo Clinic Health System, Rochester, Minnesota*
Avera Health, Sioux Falls, South Dakota*
Mass General Brigham, Boston, Massachusetts*
Stanford Medicine, Palo Alto, California
NYU Langone Health, New York, New York
Penn Medicine, Philadelphia, Pennsylvania*
Main Line Health, Berwyn, Pennsylvania*
Cleveland Clinic Health System, Cleveland, Ohio
University of Wisconsin Health, Madison, Wisconsin*
Northwestern Medicine, Chicago, Illinois*

Market Insights

NRC Health's Market Insights is the largest online healthcare-consumer perception study in the U.S., measuring the opinions, behaviors, and characteristics of more than 300,000 people annually. It provides current and historical data across key metrics including brand awareness and image, perceived quality, loyalty, and engagement as well as perspectives on issues such as access to care, interest in innovative care modalities, and health behaviors.

The Challenge of Ensuring Quality across Systems

Most systems we examined had at least one high performer (4 or 5 CMS Stars), but performance across the member hospitals of the system was variable. What sets systems apart on this year's Honor Roll is consistent high performance on CMS Star Ratings across all hospitals for which data was available, coupled with consistently strong consumer perceptions of overall quality.

The consolidation of hospitals into local, regional, and national health systems will likely continue across most healthcare markets, especially given challenges that were exacerbated by the COVID-19 pandemic. The benefits of system membership and consolidation translate to potentially greater access to capital, ability to consolidate overhead and support functions, access to payer contracts, and improved or stabilized financial performance. While the financial benefits of system development and consolidation have been clearly demonstrated, the promise of improved quality across health systems has lagged. Indeed, it is important to note that none of the large systems (25 or more hospitals) met the criteria for this year's System Quality Honor Roll, reinforcing the challenge of ensuring quality across many organizations. That said, it is also important to note that Unity Point Health* (Des Moines, Iowa) performed markedly better than its peers in the large-system category. While qualifying on the consumer perception dimension, performance was just below the one standard deviation cutoff for the quality dimension which, in our view, deserves an honorable mention.

Quality in healthcare has many dimensions including clinical quality, process quality, outcomes, patient experience, structure, and reputation. The 2022 CMS Star Ratings are based on 47 measures submitted by hospitals to CMS that touch on the dimensions of safety, clinical quality, patient experience and outcomes. While imperfect and subject to a variety of valid criticisms, over the past decade the CMS Star Ratings have gained broad acceptance as a useful and easily understood way of comparing hospitals and thus system performance. A 1-Star or 2-Star hospital is getting a clear signal that there are problems with care and that performance falls in approximately the bottom quartile of all hospitals. Conversely, a 5-Star hospital is in approximately the top 15 percent of hospitals in the country based on those same submitted indicators. The good news is that the number of hospitals rated as 5-Star has increased from about 2.5 percent of all U.S. hospitals in 2017 to 13.6 percent of hospitals in 2021.[2] An increased focus on quality at individual hospitals bodes well for improved system performance over time.

2 "Scoring Methodology," *Leapfrog Hospital Safety Grade,* Spring 2021.

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The Importance of Consumer Perceptions

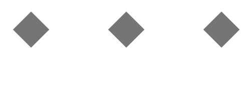
The Star Ratings do not provide insight on how individuals who may or may not have been patients perceive the quality of care provided by hospitals and systems. Indeed, consumer-level data is critically important because it reflects how communities think about the performance of their hospitals and systems. For that dimension of quality—market perception—we turned to data from NRC Health's national Market Insights study (see sidebar).

Our criteria for inclusion on this year's System Quality Honor Roll required performance one standard deviation above the mean for both the CMS Quality Rating and Consumer Quality Rating—a high bar. To reach that bar, systems had to consistently score 4–5 on the CMS Star Ratings and evoke a strong positive perception of the quality of care of hospitals within that system. As one might expect, some systems scored well on the CMS Star ratings, but had lower market quality perceptions which kept them off this year's Honor Roll. Conversely, some systems had high Market Insights scores—meaning they had a positive reputation in the market but their aggregate performance on the system CMS Star Ratings was low or inconsistent across the hospitals in the system.

Next Steps

At The Governance Institute, our ongoing goal is to expand research and understanding about how actions at the board and senior leadership level result in tangible improvements in organizational performance, including and especially, quality. In the months ahead, we plan to interview leaders and board members from the 2022 Honor Roll to gain insights on what these systems do to ensure high-quality care across their systems, the role of governance in those efforts, and what efforts they are pursuing to build their market brand as high-quality healthcare systems. We will be publishing a series of short papers on what we learn. Stay tuned!

The Governance Institute thanks Michael D. Pugh, President, MdP Associates, LLC; and William England, Ph.D., Strategic Analyst, and Gregory Makoul, Ph.D., M.S., Chief Transformation Officer, Human Understanding Institute, NRC Health, for contributing this article. They can be reached at michael@mdpassociates.com; wengland@nrchealth.com and gmakoul@nrchealth.com.



Hospital and Health System Governance for the Future of Value-Based Care

By **Eric Weaver, D.H.A., M.H.A., FACHE, FACMPE, FHIMSS,**
Executive Director, *Institute for Advancing Health Value*

Now is the time for hospital and health system boards to fully commit to a value-based care transformation strategy. The deteriorating financial performance of hospitals and health systems has prompted ratings agencies, the American Hospital Association, and other industry insiders to warn that current conditions are not sustainable. This colossal downturn, coupled with the unsustainable financial trajectory of the entire fee-for-service-dominated American healthcare industry, are canaries in the coal mine signaling a looming financial meltdown. Adverse institutional impacts can only be ameliorated if hospital boards truly embrace the tenets of the "Quintuple Aim"—a value-based focus on health equity; clinician well-being; and the pursuit of better health, improved outcomes, and lower costs. This prioritization of governance is an investment that has the potential to be a game changer, not just for the health system, but for society as well.

The move to value-based care is just as much a moral imperative as it is an economic one. Improving care delivery for purposes of improving population health and health equity should be of paramount concern in the post-pandemic era. Governing boards must respond to the elevated national awareness of health inequities in our country following the COVID-19 pandemic. Board members must serve with resolve and determination to right the wrongs of the past. Inequities in underserved and marginalized communities are longstanding and can no longer be tolerated. The recognition of the inequality created by disparities in care has been greatly magnified under the microscope of the pandemic, and this cultural zeitgeist for health equity is not just a fleeting moment in time. There will assuredly be consistent pressure on boards for accountability to address health disparities in the years to come, and this will be a force multiplier for health system value transformation.

The landscape of the healthcare industry is changing at a hyper-accelerated rate. It is hard enough for hospital executives to make sense of industry signals as daily

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consumers of healthcare intelligence, but the role of a board member may be even more challenging due to learning curve challenges and an ever-collapsing window for strategic planning. The pace of industry disruption is unprecedented, and the gestalt of the new value paradigm is difficult to understand for those not following the movement underway. Conventional thinking anchored to an incumbent fee-for-service business model will not bring about organizational sustainability. If they have not done so already, board members need to become educated in the tenets of value-based care to understand why adopting financial risk in a health system's revenue portfolio will be necessary to ensure population health and equitable health outcomes.

➜ Key Board Takeaways

- Recognize that the long-term financial sustainability of your health system is dependent on value-based payment adoption.
- Become informed on the severity of health disparities in your community and hold your hospital or health system accountable to a health equity strategic action plan. COVID-19 has irreparably changed the healthcare operating environment and brought about an elevated societal awareness of preexisting health inequities. Health equity has now emerged as the new focal point in value-based care.
- Stay educated on the value movement:
  - CMS aims to transition all Medicare beneficiaries to accountable care relationships by 2030; however, employer-based value-based disruption will likely happen much sooner.
  - The new ACO REACH program for traditional Medicare beneficiaries will be a tipping point for health equity transformation in the value movement.
- Prepare your health system to deliver care in a more "asset-light" model in the future.
- Don't wait. Value transformation takes time and requires significant capital investment in infrastructure. The time to act in preparedness for the emerging value economy in healthcare is now.

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Strategically Planning for Value-Based Care Adoption

The transition to value-based care is inevitable, and hospitals and health systems not prepared will experience irreparable and catastrophic damage to their business viability. Although the exact timing of mandated risk-based payment models is a "best guess," there is sound evidence that we are approaching an inflection point in the value movement. At a national economic level, the macro-pressures to transform a $4 trillion healthcare system at a proportional cost of 20 percent of GDP will be unrelenting in the years to come. This is especially true when considering the current inflationary environment and global stressors, coupled with looming insolvency of the Medicare trust fund and a "silver tsunami" of aging baby boomers.

As healthcare costs continue to rise, alternative models are gaining traction, and CMS aims to transition "the vast majority of Medicaid beneficiaries into accountable care relationships by 2030."[1] While this doesn't sound like an aggressive timeline to reach full penetration for value in the Medicare program, it is possible that the industry will reach a critical mass well before that time. The CMS agency responsible for testing ways to inject more value in healthcare programs is actively trialing mandatory payment models, and information is forthcoming by end of year for us to learn just how aggressive mandated policies will be in the years to come. Additionally, there is a significant reengineering of pay-for-performance models to include health equity as a key financial measure for success, and that will eventually lead to a requirement that all hospitals conduct disparities impact assessments and health equity reports to monitor whether institution-level policies proactively reduce health disparities. The tipping point for health equity is the ACO REACH payment model, which begins next year.

The federal pressure on hospitals to adopt value-based payment is just one high-magnitude vector to consider in board-level strategic planning. Another, and even more pressing force, are self-insured employers. In thinking about this transition to value-based care and changes that are happening to the revenue profile of health systems, boards also need to think about the impact of commercial contracts shifting more towards risk-based payment. Employer-sponsored health insurance has risen 54 percent since 2009.[2] The employer healthcare market was already dysfunctional and ineffective in producing value in health, with "poor health" costing employers $530

1 Chiquita Brooks-LaSure and Daniel Tsai, "A Strategic Vision for Medicaid and the Children's Health Insurance Program (CHIP)," *Health Affairs,* November 16, 2021.

2 Kaiser Family Foundation, "Benchmark Employer Survey Finds Average Family Premiums Now Top $20,000" (press release), September 25, 2019.

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billion on top of the $880 billion they already spend in premium dollars.[3] Hospitals will soon no longer be able to rely on lucrative commercial insurance contracts to subsidize losses on the public pay side. Employers have been the "sleeping giants" for far too long; they have now awakened and are ready to hold the healthcare industry accountable for cost and quality outcomes. Direct-to-employer contracting, bundled payments for episodes of care, centers of excellence in regional hubs, direct primary care, and intensive benefit redesign will soon be the norm.

The last factor boards should consider in value-based strategic planning is the move to asset-light care delivery models. As care becomes more virtualized and hospital procedures shift more and more into the ambulatory setting (or home?) the "hospital of the future" will need to be *asset*-light. In this model, the focus would be on providing higher levels of emergency, medical, and surgical care, with capacity weighted toward more intensive patient management. The acute care facility would be supported by a network of connected and expanded ambulatory resources (outpatient surgery, post-acute care services, home care—all enabled by remote monitoring technology). In the advent of value-based care with more of an emphasis on ambulatory care and consumerism, the role of an inpatient hospital will invariably change where it is no longer at the pinnacle of care, but instead a provider on the continuum.

Value transformation takes time. It requires significant capital investment in infrastructure, and the culture change in care delivery will take years. If your board has not begun thinking about its value-based care adoption strategy, now is the time!

The Governance Institute thanks Eric Weaver, D.H.A., M.H.A., FACHE, FACMPE, FHIMSS, Executive Director, Institute for Advancing Health Value, for contributing this article. He can be reached at eric.weaver@wgu.edu.

3 Bruce Japsen, "Poor Worker Health Costs U.S. Employers Half Trillion Dollars A Year," *Forbes,* November 15, 2018.

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Assessing Hospital Financial Viability in a Period of Economic Disruption

By **Adam Davis,** Vice President, *Juniper Advisory*

Operating environments for hospitals and health systems are vastly different when comparing 2021 to 2022. The enduring impacts of the COVID-19 pandemic have caused operational disruptions that have severely strained the U.S. healthcare system and outlasted roughly two years' worth of government stimulus. The stark difference in just one year brings to the forefront questions surrounding how providers, with informed guidance from their boards and management teams, can adapt with focused operational and strategic priorities, and perhaps pursue novel partnerships.

The State of the Industry

After the pandemic began in early 2020, healthcare operators entered a period of uncertainty and financial distress as state and local governments mandated the deferral of elective procedures and shut down key sectors of the economy. However, hospitals and health systems rebounded nicely in 2021 as the mass production and rollout of vaccines seemed to signal the start of a return to normalcy.

The recovery in 2021 appeared to put the worst of the pandemic in the rearview, but subsequent COVID-19 variants, including Delta and Omicron, resulted in new waves of cases. The rise in caseloads created a protracted strain on revenues and contributed to enduring escalated demand for nursing staff and contract labor. The wide swath of operating challenges in 2022 is not only stressing hospitals' profitability but also testing the resiliency of their balance sheets. Economic policy changes have also impacted the hospital sector; federal relief has dried up and, after over a decade of near-zero interest rates, the Federal Reserve has raised them, increasing borrowing costs.

Exhibit 1 demonstrates profitability deterioration for both operating margin and operating EBITDA margin between 2021 and year-to-date 2022. The percentage decreases range from roughly 280 to 450 basis points across each of the broad rating classifications of AA, A, and BBB.

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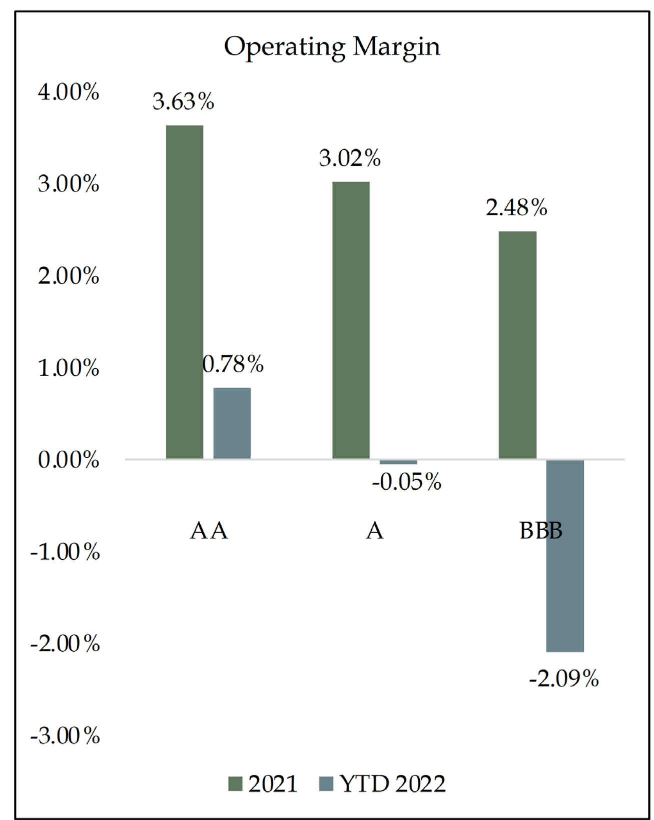
Exhibit 1: Decreasing Operating Margin and Operating EBITDA Margin



Source: Fitch's *USPF Healthcare: 2022 Medians Webinar,* August 18, 2022.

Considerations for Boards of Directors

It will be important for hospital and health system boards and management to assess a range of options when guiding the organization through periods of uncertainty. Although portfolio returns were robust in 2021 and years prior, they have, in many cases, flipped from positive to negative so far in 2022. Weaker operations combined with dilutive investment earnings impair providers' debt service coverage ratio (DSCR), a closely watched performance benchmark by creditors. While this metric might appear to be simplistic (net income available for debt service ÷ maximum annual debt service), there is significant complexity involved when trying to improve either side of the ratio. There are a variety of "levers" available to health systems and hospitals that can improve DSCR related to both the income statement (affecting the numerator) and balance sheet (affecting the denominator) demonstrated in **Exhibit 2**.

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Exhibit 2: Levers for Improving DSCR

Net Income Available for Debt Service

- Revenue growth:
  - Accretive capital investing
  - Service line expansion
  - Revenue cycle improvement
- Expense management:
  - Renegotiate contracts
  - Optimize staffing

divided by:

Maximum Annual Debt Service

- Restructure debt:
  - Extend final maturity
  - Lower interest rate
  - Create level payments
  - Amend credit documents

While boards should consider the different options to improve DSCR listed in Exhibit 2, many providers have already exhausted the most obvious alternatives. For example, debt restructuring tactics were deployed when borrowing costs were at historic lows prior to 2022. Further, near-term capital spending plans might be challenged due to supply chain disruption and ongoing volatility in investment portfolios. Therefore, formulating alternative strategies, like developing strategic partnerships, offer operators new options as they strive to deliver quality care, sustain their workforces, and remain robust contributors to their communities.

Boards should thus conduct a holistic organizational review by analyzing both the health system or hospital's current financial situation and viability going forward. In addition, understanding local and regional market dynamics, particularly competitive pressures, will help illuminate the strategic needs of the organization, and clarify how it can continue to thrive.

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Juniper will often recommend (among other approaches) an analysis of strengths, weaknesses, opportunities, and threats (SWOT) to help guide boards and management teams in their organizational review. **Exhibit 3** provides a high-level grid of a sample SWOT. This is one way to jumpstart more tailored strategic discussions between board members, management teams, and other various stakeholders.

Exhibit 3: Sample SWOT

Strengths	Weaknesses
• Good position in a good market • Strong balance sheet • Primary care network • Cost and quality position • Strong brand awareness • Select new facilities	• Declining market share • Operating performance • Inability to access balance sheet • Competitors in market • Size of organization compared to others • Aging facilities; deferred capital spending
Opportunities	**Threats**
• Reverse market share loss with targeted capex • Leverage partnership(s) to achieve scale, increase volumes, and access capital • Optimize EMR • Strengthen relationships with employers	• Inability to access capital to address weaknesses or achieve opportunities • Accelerating competition in market • Macro-changes to healthcare landscape disadvantage community hospitals

Whether a SWOT or other method of formulating a strategy is contemplated, the goal is for boards to construct a list of key objectives for the organization, which helps inform whether they have exhausted the operational levers noted earlier, or should otherwise consider a partnership. Regardless of the path selected, the best course of action must not only maximize the benefit to the health system or hospital, but also the communities it serves. If a partnership process is preferred by the board, they would have a variety of transaction options available to them, where some may be more desirable depending on the unique needs of the organization.

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➜ Key Board Takeaways

- The hospital industry is experiencing heavy disruption in 2022, causing boards and management teams to assess operational improvements and new strategies.
- Revenue enhancement and expense reduction techniques can improve profitability and debt profile structures (i.e., bolster debt service coverage) to satisfy key stakeholders, but these methods might have already been deployed.
- There are operating stressors that are becoming structural in the industry, including labor expenses, putting pressure on providers' workforce integrity.
- Boards and leadership teams should conduct a comprehensive organizational review to be able to evaluate a wide range of strategic options.
- Industry research indicates that increased scale can accrue a host of benefits to organizations that need additional resources to capitalize on marketplace opportunities, defend against competition, access capital, and reduce their cost base.
- Strategic and operational decision making ultimately must not only balance the economic viability of providers but also the healthcare needs of the communities they serve.

Looking Ahead

Innovation and revamped operational and strategic priorities, perhaps focused on new partnerships or affiliations, will be required to remain viable in the near-term. Increased scale is becoming a stronger consideration for boards and senior leaders, as providers work to combat headwinds, continue to thrive as an organization, and service the community with quality care. Our research suggests that larger revenue bases correspond with higher credit ratings, and therefore lower borrowing costs, which is consistent between the big three rating agencies (Moody's, S&P, and Fitch). Scale also allows systems to reach preferred agreements with payers and de-risk balance sheets through debt profile diversification. In addition, consolidated resources could mitigate balance sheet deterioration if cash flow is weak, allowing providers to execute strategic capital needs and remain competitive.

Operating pressures show no sign of waning for the remainder of 2022 and will likely continue at least through 2023. Inflation is still a prevalent issue in the economy and if it does not decline soon, the Federal Reserve may continue to raise interest rates, thereby further increasing borrowing costs and creating more volatility in equity markets. As a recent *Wall Street Journal* article noted, hospitals must "permanently

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reset" their pay expectations for nursing as the supply-demand mismatch for RNs becomes a structural component of the sector, meaning elevated labor expenses are here to stay.[1]

Ultimately, boards need to carefully consider a variety of strategic options as they steer the decision making and financial planning for hospitals and health systems. If leadership teams have exhausted most or all of their operational and capital improvement plans, it might be appropriate to consider partnerships that would result in increased scale and better position the organization to meet its objectives and needs of its communities.

The Governance Institute thanks Adam Davis, Vice President, Juniper Advisory, for contributing this article. He can be reached at adavis@juniperadvisory.com.

1 David Wainer, "Traveling-Nurse Bubble Bursts," *The Wall Street Journal*, July 27, 2022.

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High-Touch in a High-Tech Healthcare World: Lead the Way Forward with a Human-Centered Approach

By **Lucy Leclerc, Ph.D., RN, NPD-BC,**
Chief Learning Officer, **Kay Kennedy, D.N.P., RN, NEA-BC, CPHQ,** Chief Executive Officer,
and **Susan Campis, M.S.N., RN, NE-BC,** Chief Wellness Officer, *uLeadership, LLC*

Remaining "high-touch" in the evolving and reactionary world of high-tech healthcare, workforce shifts, and fluctuating patient acuities requires an equally creative solution. Human-Centered Leadership in Healthcare (HCL-HC) fills the gap in healthcare's enduring use of borrowed and non-healthcare-specific approaches to leadership. In contrast to traditional, transactional, or "the way we have always done it" ways of leading, human-centered leadership brings forth a relational style aligned with complexity, caring, and systems theory. If the pandemic has shown the healthcare world anything, it is that leadership must have a balanced focus between metrics and recognizing the humanity and health of each team member. Hospital executives and boards can set expectations for patient experience, zero harm, and decreased length of stay, but without a healthy team and work environment, these metrics will persistently fall short.

Our team is actively working to demonstrate that the essential skills to achieve highly prized metrics are the skills of relational leadership. HCL-HC provides a method for leadership that harnesses the power of the shared human experience. This style of leadership is based in research with actionable and structured tactics to guide leaders in:[1]

- Modeling self-care, self-awareness, mindfulness, and well-being.
- Emanating energy outward to their teams through making connections, empowering the workforce, and recognizing the humanity in others.
- The result is a culture of excellence, trust, and caring.

1 Kay Kennedy, Lucy Leclerc, and Susan Campis, *Human-Centered Leadership in Healthcare: Evolution of a Revolution*, Morgan James, New York, 2021; Lucy Leclerc, Kay Kennedy, and Susan Campis, "Human–Centered Leadership in Healthcare: A Contemporary Nursing Leadership Theory Generated via Constructivist Grounded Theory," *Journal of Nursing Management*, Vol. 29, Issue 2, March 2021.

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This article shares exemplars and real-world results of how human-centered leadership, when implemented as a long-term solution and way of being, positively integrates high-touch in our high-tech world. The shared human experience translates to the patient experience. If we start by facilitating a shared human experience between our leaders and our teams, the cascading effect on patients and communities follows.

How to Be a High-Touch Leader

Virtual this, virtual that. Even before the pandemic, technology was seeping its way into almost every part of our lives. Healthcare was pacing with the rest of the world, but the pandemic pushed us into warp speed and turned traditional face-to-face interactions into Web-mediated patient visits with providers, family visits with acute-care patients, remote work, and an onslaught of applications and patient portals to serve these seismic shifts. Nurses and providers felt the heaviness of losing the ability to hold a patient's hand. Patients longed to be on the receiving end of a compassionate human interaction. Many hoped and longed for a return to "normal." That clearly didn't happen and as we venture forward in a peri-pandemic world, a reckoning of sorts is happening. How do we lead the way forward ensuring we share the human experience with our patients and employees? Now, more than ever, we need to retain both! Below we explore four ways to be high-touch in a high-tech world.

1. It Starts with You

Unfortunately, healthcare leaders are known for their mythical ability to work 90 hours a week, forgoing sleep, exercise, family time, relationships, and spiritual connections. Is this a sustainable way of being? What message does this send to the teams you lead? Does it give your team permission for self-care if they see you not caring for yourself? Persistent data and evidence over the past few peri-pandemic years show burnout and stress as two of the most significant reasons for staff and leaders to leave their role, and perhaps their profession.[2] Why, in an industry designed to care for humans' health and well-being, do we do such a poor job of modeling the way?

2 American Organization of Nurse Leaders (AONL), "AONL COVID-19 Longitudinal Study, August 2021 Report: Nurse Leaders' Top Challenges, Emotional Health, and Areas of Needed Support, July 2020 to August 2021"; Chaunie Brusie, "Survey of Healthcare Workers Reveals High Levels of Burnout, Stress, and Thoughts of Leaving Their Jobs," Berxi, June 14, 2022.

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Think about the heart. During the first part of the heartbeat, the heart fills itself with blood, oxygen, and nutrients. The second part sends blood, oxygen, and nutrients out to the rest of the body. If the heart doesn't get what it needs to function, the rest of the body will not be able to function. The first and most basic way to illustrate a human-centered, high-touch approach to your team and to your patients is to model the way in regard to self-care. If the leader prioritizes harmony between work and self-care, while expecting the same from staff, this gives the team permission to fill their proverbial cup first. As a leader, my mantra was to be sure each person on my team knew that I and the organization supported them in being sure that they and their family's needs were addressed first so that when they showed up for work, their minds were "in the game."

➜ Key Board Takeaways

Boards should help set a culture of human-centered leadership from the top and encourage management to:

- Practice self-care, self-compassion, and self-awareness as a role model for their teams.
- Support their teams with respect, kindness, empathy, and empowerment.
- Create forums (e.g., councils or committees) where employees and patients can share new ideas and contribute to organizational innovation.
- Unify their teams around a shared vision and mission.
- Recognize the connection between employee and patient experience—happy employees will take better care of patients.

2. Be a Connector

A central part of the human experience is the ability to connect, network, and develop relationships. Human-centered leaders seek to create unity in the community. To do that, we need to shift from a top-down to an inward-outward approach. Shared decision making (you may know it as shared governance) is not just for healthcare teams—it can and should include patients and families as well.

First, consider shared decision making as an invisible architecture for your organization. Imagine a way of being in which the employees are empowered to not only identify the problems, but also the solutions. As a leader, I know I don't have

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all the answers but those who are knee-deep in the work do. When leaders create a psychologically safe space, team members not only offer the solutions, but they also own them.

Second, shift from a paternalistic view to a patient-centered view of the world. Build an advisory council comprised of patients, families, and community members. Do a "tracer" with a patient and their family from the time they arrive in your parking lot. You might realize a lot of small wins to improve the way patients feel welcomed and "touched" as they move through your organization.

3. Empower the Workforce

Leading with the intention to help your team members and patients be the best version of themselves is a primary goal of leaders at any level of the organization. As we adjust to our Web-based ways of being, consider how you can uncover innovative ideas from within your teams that harness the human touch in the high-tech world. For example, a number of organizations around the country are taking ideas from their nurses to create roles such as the Virtual Nurse Mentor. The idea is to pair experienced nurses with newly licensed registered nurses (NLRN), but the catch is that mentors are connecting with their mentees using technology. The Virtual Nurse Mentors receive training in a relational leadership approach such as HCL-HC and apply the lessons learned in their virtual meetings with the NLRNs. The idea is to foster retention while nurturing the NLRN as they transition into a peri-pandemic healthcare setting.

4. Recognize Humanity in Others

We believe that recognizing the humanity in ourselves and others makes us JEDIs. Yes, we said JEDI. Just like the knights in Star Wars who are trained to guard peace and justice, so too are human-centered leaders champions of justice, equity, diversity, and inclusion (JEDI).[3] The shared human experience with patients and staff starts with the basic and quite simple approach to be mindful of how we are simultaneously very different, yet the same. This is another opportunity to harness your inner architect to create a structure as strong and robust as the steel beams holding up your physical building.

3 For more information on the role of the board and senior leadership in integrating JEDI efforts into the strategic plan and organizational culture, see The Governance Institute's Webinar, Somava Saha, "How to Become a JEDI: A Strategic Approach to Creating a Diverse, Thriving, & Just Organization," September 2022.

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Consider integrating JEDI into your values but not just as a marketing ploy to check the box. For example, what if your organization began a journey to become a LGBTQ-friendly hospital. There are currently more than 250 healthcare facilities designated as "Leaders in LGBTQ+ Healthcare Quality."[4] Maybe the first step is to do an assessment of your organization. Perhaps your shared governance councils can tackle this alongside the most people-focused department in your hospital, Human Resources.

Human-Centered Leadership in Healthcare is a structured approach, a philosophy, a theory, and a way of being. Healthcare boards can model this style of leadership and support senior leaders and management in creating a human-centered culture. It's an idea that's time has come.

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4 Human Rights Campaign, "Healthcare Equality Index 2022: Promoting Equitable and Inclusive Care for LGBTQ+ Patients and Their Families."

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