BoardRoom Press

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Go Big or Go Home: A Board Framework for Strategic Planning of Big Ideas

Humanizing Price Transparency: How Boards Can Turn the Corner on a Major Patient Pain Point

SPECIAL SECTION

Maintaining Momentum: Collaborative Public Health on the Other Side of Crisis

Leveraging the Impact of Philanthropy through Strategic Project Selection

ADVISORS' CORNER

Hospitals Employing Physicians: Still a Sound Strategy If Done Right

A Bolder Agenda for the New Year

As you read our final issue of the year, I wanted to share with you some of the things we learned from our members. A critical part of our job is to listen, so that we can develop resources and programs that matter. First, many organizations are bringing board members back in person—whether all of the time, as much as possible, or continuing to provide hybrid options in certain scenarios. Relationship building, brainstorming, generative discussions, and overall engagement improve when people can be physically together. But some have to travel long distances to attend in-person board meetings and find that their time is better spent preparing for those meetings and attending virtually. We have learned about myriad creative ways our members are engaging virtual board members.

The other important theme is the need to refocus on best-practice governance—high-performing boards are more important now than ever, as regulatory scrutiny ramps back up around patient billing practices, charity care and community benefit calculations against tax-exemption, fiduciary duty fulfillment, appropriate use of CARES Act funds, and more. Our members are facing long-term, complex strategic challenges coming out of the pandemic that require deep intellectual capacity, outside of the box thinking, and unique creativity to solve. Having those engaged and passionate board members at the table is essential. One CEO told us that boards need to reexamine traditional assumptions and core philosophy—don't be afraid to paint the picture of the need for radical change and challenge their CEOs about what our organizations need to be doing differently and why.

As we move into a new year ripe with challenges and opportunities, we will continue to partner with you to educate your board members and equip them with tough questions and decision-making tools to identify and accomplish a bold agenda.

Kathryn C. Peisert,
Editor in Chief & Senior Director

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Attend in-person or virtually!
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Ritz-Carlton, Key Biscayne
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Scottsdale, Arizona

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Go Big or Go Home: A Board Framework for Strategic Planning of Big Ideas

By Ethan Feldmiller, M.H.A., and Maulik Joshi, Dr.P.H., Meritus Health

Not-for-profit hospitals and health systems have a duty to contribute in meaningful ways to the communities they serve. This greater purpose is highlighted directly within most organizational mission statements. The execution required to achieve the mission requires resources and those resources faced strain over the last two-plus years with COVID and its ramifications, which included profound staffing shortages and unprecedented burnout. Many healthcare organizations had sufficient funds built up for a rainy day, and that rainy day came in the form of the COVID-19 pandemic. In fact, there have been almost 1,000 rainy days since the pandemic started. Hesitancy to make significant financial investment is certainly understandable given the state of our world in recent years. However, despite these difficulties, many hospitals have the opportunity to make a huge impact for their community from their financial resources.

Considering the community health-oriented missions health systems have, the financial pressures that we have endured, and the greater need for health systems to not just tackle but lead community health, this begs the question: **what can we do now to drive a dramatic, meaningful impact within the communities we serve for better health?** Are there different ways and different magnitudes in which we should be utilizing our financial reserves to better achieve our missions in our communities? Carefully considering these questions is the first step for board members and leaders of healthcare organizations to reaffirm their commitments and prioritize initiatives that will serve the best interests of their communities.

Strategic Approaches to Community Investment

Big ideas do not grow on trees. Board members and healthcare leaders must take it upon themselves to aggressively pursue bold initiatives meant to improve the health of the communities we are intended to serve. In order to formulate large-scale initiatives backed by significant funds, board members and senior leaders must cohesively and strategically collaborate for the sake of an effective output. Leadership opinions can vastly differ from each other; therefore, it becomes paramount for leaders and governance to implement an effective process that simultaneously considers differing opinions, community benefit, and financial implications.

Such a process could begin by collecting around three ideas per senior leader that would require a sizeable financial investment (in the range of $100 million or one-third of your reserves) to dramatically impact both community health and the organization's goals. Additionally, each senior leader would need to submit a one-page proposal for each idea that highlights how they envision it impacting the mission, community health, and organizational finances. Each submitted idea would be presented amongst senior leadership and prioritized accordingly on a Financial and Community Benefit Matrix. Appropriate next steps and action plans are to be developed after thorough combined analysis by board members and senior leadership.

As senior leaders and board members, pose the question to your team: **what would you do with $100 million to best impact community health and finances?** What seems like a massively oversimplified approach has the potential to ignite the thought process for initiatives that could aid in shaping the health and well-being of an entire community for years to come. Soliciting the input of leadership should be the first step in a collaborative effort to properly utilize rainy-day funds. The goal of healthcare organizations is to provide adequate benefit to their communities while also maintaining financial stability. In order to attain this goal, we must occasionally venture into unknown territory and step out of our comfort zones.

Case Study: Meritus Health

Meritus Health, western Maryland's largest healthcare provider, is located at the crossroads of western Maryland, southern Pennsylvania, and the eastern panhandle of West Virginia. Meritus Health's mission is to improve the health of its community of over 200,000 people. With a team of over 4,000 people, Meritus Health includes 327-bed Meritus Medical Center, a 160-provider medical group, home health, and numerous other health and healthcare services.

Dave Lehr, the Chief Strategy Officer for Meritus Health in Hagerstown, Maryland, conducted an exercise among the organization's senior leadership to assess potential initiatives each individual felt could provide significant benefit to the Washington county community that Meritus Health serves. Each leader was given a hypothetical $100 million and was asked to list three specific ideas for community investment. The ideas were all collected and the rationale behind each was explained.

Each senior leader was given a total allotment of 12 points that were to be split evenly between the categories of "improving finances" and "improving health of the region." Leaders were then instructed to assign their points to the ideas collected. Once the divvying of points was complete, each idea was arranged into a grid with financial improvement measured along the y-axis and health status improvement measured along the x-axis (see **Exhibit 1** on page 10). The Financial and Community Benefit Matrix findings would go on to be presented before the strategic planning committee for further discussion.

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Key Board Takeaways

Board Strategic Planning of Big Ideas Process

- Leaders are to identify 10 to 15 *big ideas*. The big ideas must be in the magnitude of $100 million (or about one-third of your total reserves) to be invested and with the goal to dramatically impact the organization's mission and community health.
- For each big idea, leaders develop a one-page proposal that highlights what the initiative is and how it impacts the mission, total cost, and financial benefit.
- Present each big idea among senior leaders.
- Senior leaders vote and prioritize.
- Plot the ideas on a Financial and Community Benefit Matrix.
- Share the big ideas grid at a board strategic planning meeting for discussion.
- Collectively decide on any next steps, as appropriate, to take to the next level.

Humanizing Price Transparency: How Boards Can Turn the Corner on a Major Patient Pain Point

By Ryan Donohue, NRC Health

Healthcare has been through a lot: a global pandemic, the great resignation, and incredible financial constraints. As an industry, it feels like we have been on a nearly three-year brink. We need a break.

And when it comes to price transparency, we won't be getting one. The deafening call for clearer pricing is like the bully who is waiting for us at the final bell. It's not a new challenge; healthcare costs have always been mysterious, punishing, and begging for correction. COVID-19 served as a master distraction, but our industry can't hide from the tide of anger over inflation and lack of affordability of virtually everything. Plus, lack of price transparency hurts patient care. The anxiety over not knowing what they will owe is a dark thread along the care journey: it promotes inaction and deferment of care, clouds over the quality of care, tangles up decision making, and creates a beginning-to-end boogeyman for weary patients to contend.

This isn't lost on Washington. While COVID surged through hospitals and health systems, the federal government kept a focused eye on price transparency. In January 2021, the CMS Hospital Price Transparency Rule went into effect requiring hospitals and health systems to post their standard charges for the items and services they provide.[1] In July 2022, the Transparency in Coverage Rule also took effect requiring health plans and issuers of group or individual health insurance to begin posting pricing information for covered items and services.[2] Never has there been more attention pointed toward pricing. Is the attention driving action?

Where We Stand on Current Efforts to Promote Price Transparency

In October, Turquoise Health released their first "Price Transparency Impact Report" tracking compliance with the Hospital Price Transparency Rule. Most hospitals (76 percent) have posted a machine-readable file and most included negotiated rates (65 percent). The report showed routine procedures like CT scans and mammograms were the most "shopped for" procedures. Renowned healthcare commentator Paul Keckley observed: "These results are impressive: participation appears 'robust'…[assuring] deeper analytics potentially linking transparency to changes in price competition, insurance premiums, and outcomes will be forthcoming."[3]

But progress has been slow and healthcare leaders continue to drag their feet. Keckley cautiously notes two barriers remain in the way of more transparency: consumer behaviors (two out of three have never "shopped" for healthcare) and transparency alone may not bring prices down, they are high everywhere and consumers seem less sensitive to healthcare pricing in general. Without more drastic measures from Washington—price controls, for example—the transparency movement remains a slog.

The High Stakes Blame Game

A chief contributor to slow progress is while nearly everyone agrees healthcare pricing should be more transparent almost no one agrees exactly how to bring this about, and who should go first. Insurers have drawn a bright line to healthcare pricing to convince members they are on their side, but most members lack an engaged relationship to their insurer and don't trust them. Hospitals and health systems have blamed insurers and other stakeholders (e.g., pharmaceuticals) for higher prices, but they seem uninterested in sharing their own pricing dynamics. The government is throwing its weight around but not moving any mountains. And most media seem content to stir the pot and run occasional price shock stories for clicks and views.

The stakeholder on the outside looking in? The patient. Look at price transparency through a powerful prism: the family budget. Since World War II, if other household expenses rose as much as healthcare, consumers would now pay $55 for a dozen eggs, $48 for a gallon of milk, and $134 for a dozen oranges.[4] And we thought inflation was bad now. Consumers have noticed the healthcare squeeze because its prices are extraordinarily dangerous to their livelihood. Patients are generally helpless here. Shopping for care remains difficult so their only real cost lever is to reduce or avoid care. A heartbreaking strategy.

Key Board Takeaways

- Price transparency needs new voices to accelerate and board members are a strong choice.
- Lack of price transparency is a community issue: nine in 10 consumers find it difficult to compare healthcare prices; something they desperately want to do.
- Lack of price transparency is a specter of inequality: poorer consumers and those with higher deductibles often search in vain for pricing information and support.
- Price transparency completes organizational and clinical quality: how can we say we are great at what we do if consumers cannot calculate value until weeks or months after receiving care?

The Role of the Board in Advancing Price Transparency

Someone needs to intercede on behalf of the patient. A group with understanding and experience in non-healthcare pricing and considerable influence inside a trusted healthcare organization: the board.

In my recent book *Patient No Longer: Why Healthcare Must Deliver the Care Experience that Consumers Want and Expect,* I argue that healthcare organizations must humanize the issue of price transparency and realize behind every bill is a person. When we focus on real people, this issue becomes incredibly clear: transparency is our fight to lead. According to NRC Health's Market Insights study, 97 percent of Americans want to know the prices for their tests, exams, and even a minor surgical

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1 See www.cms.gov/hospital-price-transparency.
2 See www.cms.gov/healthplan-price-transparency.
3 Paul Keckley, "Price Transparency in Healthcare: Will it Matter?," Keckley Report, October 24, 2022.
4 "5 Strong Price-transparency Lessons NRC Health Say Consumers Can Teach Hospitals," *Becker's Hospital Review,* June 15, 2021.

Maintaining Momentum: Collaborative Public Health on the Other Side of Crisis

By David Jarrard, Jarrard Phillips Cate & Hancock, Inc.

We can't stop now. The COVID pandemic began as—and remains—an extraordinary public health crisis. It also presents us with a historic opportunity to advance public health, as long as we choose to continue absorbing the lessons it has taught us.

But while we are all still learning, action doesn't stop. Board members are being asked to make decisions now that are sure to be deeply consequential to the vitality of the organizations with which they are entrusted, and to the communities those organizations were built to serve.

It's an important moment: Health systems are evaluating who they are, what they do, and how they do it. They are asking questions about what is essential to fulfill their missions. At the same time, external scrutiny from multiple fronts is challenging business models, casting skepticism on the intent and operations of provider organizations and threatening tax exemptions.

With those necessary decisions looming large and questions abounding from every corner, it's vital that organizations have a clear story about how each is providing care and fulfilling its mission. At the center of that story is how the organization not only serves patients but contributes to the larger idea of health.

Here, then, is the opportunity to take lessons from the pandemic. This article focuses on four imperatives:

- How reframing the idea of "public health" can start the process towards a more efficient, cost-effective healthcare system with better outcomes.
- The value of partnerships in pursuing public health as a means to achieve those efficiencies, and the importance of coming to a mutual understanding of each stakeholder's strengths and weaknesses so all are operating at their best and highest.
- The vital role of health systems as engines of public health, as well as the myriad benefits these provider organizations can reap from that work.
- Questions to help board members begin to unpack the role of their specific organization in the pursuit of public health.

Imperative One: Let's "Rebrand" Public Health

The idea of public health doesn't need to be redefined but, perhaps, rebranded. The pandemic showed us that it's more than a short-hand reference to government-run clinics and programs. It must be, especially as federal funding for public health has seen minimal increases over the past decade or more (see sidebar showing key public health-related CDC grant distributions in 2010 vs. 2020).

Instead, public health is very literally, the health of the American public. It's an overarching idea in the way we think of population health or the wellness of the community. It is an element of prosperity, since health and socioeconomic status are so closely intertwined. Failures in public health reverberate well beyond the confines of neighborhoods or specific populations—a fact that has always been true but became unavoidable in recent years.

Regardless of how we wish state and federal dollars might be allocated, hospitals and health systems have a key role in extending the reach of whatever funds are available.

Public health starts before a patient enters a hospital and continues after they leave. It both influences and is influenced by education, nutrition, and socioeconomic factors. With that broad perspective, it becomes immediately clear that public health is a collective and collaborative effort. From there, we can more effectively identify the strengths and weaknesses of each stakeholder and assign responsibility for the various pieces of the pursuit of public health. Ultimately, by putting each organization in a position to achieve their best and highest good, we will create a more efficient and equitable healthcare system. As we will address later, perhaps the best and highest good for hospitals and health systems is to be the engine for change. Larger organizations are perfectly positioned to serve as conveners in the work without having to execute on all the work.

Key Board Takeaways

Below are questions to ask management to evaluate and advance your organization's public health initiatives.

Establishing the Commitment:

- How much responsibility does our organization have to improve the health of those in our community?
- How committed are we to doing so?
- Do we have a plan and metrics established for addressing and measuring the health of our communities?
- Do we know who we need to partner with to make an impact?
- Are we ready to take those steps today?
- If not, when will we be ready and what needs to happen to get ready?

Elevating the Effort:

- How do we measure our investment in public health?
- What is our organizational structure, and who is responsible for our public health partnerships?
- Are there efforts we carry in-house that could be more effective through community partners?
- How are we collecting feedback from our community?
- What support do we have available for uninsured and underinsured patients?
- What health issues do we see most often present to our emergency department(s) that could be prevented upstream?

Later in this article we define practical ways for board members to challenge and lead their organizations on public health. It's worth pointing out here the unique opportunity and responsibility board members have in convening the stakeholders. With feet planted squarely in both the organization and the community, boards have a key role to play bolstering relationships and serving as metaphorical translators between the community and hospital as everyone works to juggle the work and business of delivering care.

Imperative Two: Let's Leverage the Power of Partnership

The pandemic taught us, again, that established health systems with big legacy brands, geographic stretch, multiple access points, and significant

revenue streams are uniquely positioned to be the convener for effective public health partnerships.

In short: no one else can do it, and the benefits of it reach your patients, your community, your brand, and your mission.

The pandemic offers no shortage of illustrations, both positive and negative, that exemplify the value of a collaborative public health system and the role of hospitals in it.

"The means to how we operate within the public health system has changed," said Stephanie Willding, CEO of Chicago-based CommunityHealth. The organization Willding leads is one of the largest volunteer-based healthcare providers in the country, delivering myriad free services to traditionally unseen and underserved patients. Founded in 1993, CommunityHealth's services now include dental, pharmacy, and care across more than 20 specialties. Their care team provided nearly 22,000 visits in 2021, including 5,500 via telehealth.

The urgent, unprecedented, unrelenting first six months of COVID-19 sent the typical ways of healthcare stakeholders interaction and collaboration "out the window," she said. "The culture of scarcity that permeated healthcare at every level during those first days led to remarkable sharing of resources and removal of barriers to the core mission of simply delivering care to patients however and wherever possible."

That's not to say that everything went perfectly. Brian Haile, CEO of Nashville-based Neighborhood Health, noted that there were moments of friction. His organization is a community clinic carrying a Primary Care Medical Home

The American Rescue Plan of March 2021 allocated $7.6 billion for community health centers to keep them afloat during the pandemic. That one-time bolus of funds was in addition to ongoing CDC grants awarded each year for various initiatives.

Key Public Health-Related CDC Grant Distributions:

	2010	2020
Vaccines for Children	$3,242,292,083	$3,609,007,752
Chronic Disease Prevention and Health Promotion	$646,416,920	$806,050,054
Public Health Preparedness and Response	$736,979,167	$635,647,162

Source: CDC Grant Funding Profiles (https://fundingprofiles.cdc.gov/Category/Category).

certification from the Joint Commission. It serves all residents, regardless of their ability to pay. In 2021, Neighborhood Health's more than 40 clinicians in physical, behavioral, and dental health provided more than 90,000 visits to over 30,000 patients in 10 locations across Nashville.

During the pandemic, Haile and his team served a diverse population, including many individuals experiencing homelessness. There were several instances, he said, of these patients being evaluated in an ED and diagnosed with COVID-19, then discharged with no resources other than a bus pass. Public health providers had no chance to step in and assist. The consequences for community spread and the outcomes for the individual patients were not hard to imagine.

Regardless of the difficulties, "That's never acceptable," Haile said. He and his peers in the public health community were able to lead development of a rapid-response approach that included specialized shelters, organized under a single phone number, where individuals could isolate and recover. The program helped patients obtain appropriate care more rapidly while also reducing pressure on hospitals—who understandably need to turn beds quickly in ED settings once a patient has received care. Those programs, though, need to be built into the healthcare system, not created on the fly during a crisis or disregarded as unnecessary or someone else's responsibility.

Hospitals continue to be challenged with volume pressure and staff turnover. "We need to build a system that can cope with the stress," said Haile. That means getting everyone around the table to hash out details and assign responsibilities. Otherwise, in the crush of a crisis, balls will be dropped, phone calls not made.

Imperative Three: Let's Activate Health Systems to Facilitate the Work

Early in the pandemic, every organization needed to find partners, even informally, who could supplement their deficiencies. Larger providers, for example, were better positioned to secure supplies and PPE than smaller ones. Community-based providers had the advantage of being present in neighborhoods in a more granular, personal way than even local hospitals.

"Larger systems and even health departments recognized they weren't on every street corner, whereas we had the people and the ability to distribute much-needed supplies," Willding said. "We collectively addressed the issue."

Later, during the first waves of vaccine distribution, those established relationships were effective in running vaccination clinics in untraditional sites across the country—from church parking lots to stadiums. "It was a monumental effort," Willding said. "We saw the most beautiful aspects of collaboration. Here you have a church hosting a vaccine center, a community-based organization handling scheduling, outreach, and promotion, even going door to door, then you have a health center like CommunityHealth putting its brand on the event and staffing it, and a hospital system providing staff and supplies."

Bottom line: Community healthcare providers neither expect nor want hospitals to do it all. This is a clear lesson and encouragement for boards.

Although your organization may be the largest or most visible, you're not alone. That knowledge frees a hospital to step back when needed and bring in another provider better suited to serve in that moment.

"The hospital can be the venue for the public health response, but not the provider of the public health response," said Haile. "We don't expect the hospital to be responsible for shelter, feeding, and ongoing care." Instead, hospitals need to provide a foundation, a place for the conversations to happen and a space where patients can be assessed and cared for until community health providers can step in. Hospitals should be a place to convene the right people and keep things moving.

The Gains to Be Had

Investing in public health has benefits in terms of equity, reputation, and business success—factors critical to boards who are looking at long-term futures of uncertain finances and increasing scrutiny by media, regulators, and legislators.

Just because hospitals may best serve as the engine or the convener doesn't mean they won't, or shouldn't, benefit for stepping up on public health in tactical ways, too. Willding's example of vaccine distribution reveals the benefit in partnering and co-branding. Shared, transferred trust creates a stronger whole that can more readily effect change while also putting each brand—in this case each provider organization—in front of new constituents.

Equity

Critically, this moves your system towards a core goal of health equity. Pointing back to the legwork that went into vaccine distribution, Willding said, "This is also how we build better equity in healthcare access and quality access. It's going block by block and enlisting the trusted messengers and partners to do the work rather than necessarily the larger organization who may or may not have a presence in that neighborhood."

For healthcare leaders and boards looking to deploy their organization's precious resources most effectively, achieving equity requires a strong health equity department. Giving teams resources and prioritizing their work allows them to interface closely with existing community-based organizations and safety-net providers. Willding said that process "is how we can replicate some of the incredible things we were able to achieve during the darkest moments of the pandemic."

Reputation

Hospitals and health systems today are under scrutiny for billing practices, financial-assistance policies, and charity care. Boards considering the long-term impact of this spotlight are directing leadership teams to scrutinize policies, operations, and communications materials and make changes to eliminate any financial harm to patients. This vital step aligns operations with mission. If done thoughtfully, investments in public health may also be used in the charity care discussion. Hospitals illustrating this community investment gain trust, understanding of their value, and successfully address any questions about tax exemptions.

Strong public health partnerships can also help repair historical damage. Working with trusted community partners elevates the larger organization by demonstrating its commitment to and investment in reaching and serving communities that have been mistreated or underserved. The mission of care involves a duty to the public at large, but there is an added weight to treating the deep wounds inflicted on many minority or marginalized communities by the healthcare system.

Finally, this work can help build the hospital's reputation internally. Just as with external audiences, a visible, well-resourced public health initiative shows employees the commitment to fulfilling the mission. This, in turn, allows them to feel a deeper connection to and engagement with their employer. Satisfaction, retention, and employer reputation will all grow as a result.

Business

Used effectively, the relationships between hospitals and public health organizations and community partners are vital to financial and operational efficiency.

It can be easy to view public health entities as cost centers that someone else carries the burden for. But again, as seen throughout the pandemic, these organizations are the tip of the spear, showing up where people are to deliver the sometimes small yet vital service that prevents downstream costs. For hospitals and health systems, supporting this care is worthwhile because public health entities can operate in ways they cannot.

Providers like CommunityHealth and Neighborhood Health have financial efficiency built into their models, which takes the pressure off hospitals and health systems. While a healthier community means a lower patient census at the hospital, which presents revenue challenges, so does caring for uninsured patients with complex co-morbidities. Keeping those individuals out of emergency departments and ICUs by delivering care at the clinic down the street, ultimately, saves money and lives. Put simply, reducing ED volume with blood pressure monitoring, prenatal care, vaccine clinics, and good diet is good business because it frees resources for other patients. Though thought of as important, yet under-resourced places, community clinics and federally qualified health centers (FQHCs)—the safety nets catching those who fall through the cracks—are in fact key pillars of healthcare in the U.S.

It Can Be Done

Additional public examples prove the reputational, equity, and financial value of investing in public health. In 2016, the CDC published a series of remarkable case studies through the Community Health Improvement Navigator.[1] For example:

- A partnership between Massachusetts General, the Boston Public Health Commission, a local coalition built to combat substance abuse, and other groups helped reduce opioid overdoses and drug deaths by 50 and 78 percent, respectively, during the mid-2000s.
- In Hennepin County, MN, a coalition of hospitals and public health organizations reduced ED visits by 20 percent in just one year through a safety-net ACO that brought together medical care, behavioral health support, and social services.
- In Los Angeles, the department of health led development of a supportive housing program that provided stable housing and easily accessible health services for patients

1 To view the Community Health Improvement Navigator, visit www.cdc.gov/chinav/case/index.html.

experiencing homelessness. The program led to dramatic reductions in ED use and massive cost savings.

> "Hospitals are entering a period of declining financials. As a result, I see the focus again on the bottom line and not enough focus on community outcomes. I think it is imperative for board members to hold health systems accountable to the communities we serve and to keep the focus on patient service, patient outcomes, and community health."
>
> *—Thomas Nygaard, M.D., Vice Chair, Board of Directors, Centra Health*

Imperative Four: Let's Take Action as a Board

Broadening your perspective on public health can help recenter your organization on the mission of care. At the same time, boards are tasked with guiding their organizations and leadership teams towards decisions that benefit patients, the community, and the hospital itself. How then do the ideas above play out for board members? Here are a few steps to take and questions to ask.

Don't assume. Don't take it for granted that your organization is using its existing relationships as effectively as it could. Don't assume that the operational details perfectly match the mission. Ask questions and direct leadership teams to evaluate and audit so that everyone understands what's truly happening on the ground.

Walk the halls. Just asking for information isn't enough. Board members need to be physically present. Haile suggested board members ask the leader and team to walk them through the process their uninsured nephew might go through to understand what that experience would be. That process would also include looking over materials, seeing printed copies, and checking for resources in other languages. The point, Haile noted, is not to point fingers if there are gaps, but to figure out where the gaps are so they can be remedied. "And if things are good, then you get to use a lot of superlatives," he added. With these small details in place, the handoffs between hospital and community resources will be far more effective.

Know those affected. Willding said that a valuable question for a board to ask itself when beginning to evaluate the organization's work in public health is, "What do we know about these communities?" When looking at high-needs zip codes, board members and their leadership teams need to visit to learn. And, to figure out who they already have relationships with on the ground, rooted in those communities.

Convene early. Bring community leaders, public health officials, and local clinics together to build a plan. Don't wait to create a shiny initiative with a comprehensive plan and then ask others to fill the gaps.

Come with humility and openness. Listen first. Recognize the providers and community organizations that have been doing the good work on the ground. They have the expertise and the community's trust. Invite the community to help create the plan. Ask how the hospital or system can give support rather than ask others to give theirs.

Take practical lessons. Simplify. While regulations and best practices should of course be followed, there are ways to achieve more through simplicity. Consider managing diabetes and high blood pressure. While there are apps and remote patient monitoring services available, many vulnerable populations don't have reliable access to broadband internet.

"We give them a manual blood pressure cuff, train them to use it through a simple video, then show them how to log their numbers in a branded notebook they can review with the clinician during their next visit," Willding said. "Our hypertension management at CommunityHealth is incredible because we approach it from a low-tech, cost-efficient, and community-based perspective."

Doing the small, simple things is yet another area where larger providers can learn from public health organizations, but also support them in the work. Pens and notebooks are cheap, after all. In short, said Haile, providers need to "Take 'yes' for an answer and do the things that will result in people getting care," regardless of how or from whom.

We all know that momentum can be difficult to maintain. The next crisis hits, the imperative for ongoing change fades, a sense of accomplishment masks the ongoing need for improvement. While nothing discussed here is easy, there are relatively basic questions to be asked, steps to be taken, and meetings to be held that can add quiet energy to the process of keeping public health front and center.

Simplifying and Saying Yes

Both Willding and Haile pointed out the simplicity that community clinics can bring to healthcare, and the lesson this can be for larger providers. Haile talked about decision paralysis, with too many hospitals offering vulnerable patients photocopy-of-a-photocopy sheets listing clinics and community organizations that might not be up-to-date. It's too much, he said. "Giving people a sheet of information with lots of information and qualifiers—'You need to profess certain religion, or you need to be employed,' for example—only ensures that they won't take the next step."

Instead, hospitals need to create materials that are widely applicable and understandable, with just a few options so people can make a choice and take action. That helps both the public health system and the hospitals and prevents frequent fliers at the ED, Haile said. And yes, while there will be compliance and legal considerations, Haile—an attorney himself—suggested that they will be readily resolvable. Legal issues are vital to deal with, but not an excuse to avoid taking action.

The Governance Institute thanks David Jarrard, President & CEO; David Shifrin, Senior Manager, Content Marketing; Sheila Biggs, Vice President; Courtney Kelsey, Associate Vice President; and Savannah Collier, Advisor of Jarrard Phillips Cate & Hancock, Inc., for contributing this article. David Jarrard can be reached at djarrard@jarrardinc.com.

Leveraging the Impact of Philanthropy through Strategic Project Selection

By Betsy Chapin Taylor, FAHP, Accordant

Key Board Takeaways

- How can we create clear, consistent, and collaborative processes to pressure test and prioritize charitable funding priorities?
- In considering our organization's strategic imperatives, what plans would likely move and motivate the investment of community donors?
- When we consider the healthcare organization's areas of clinical strength, are there areas of excellence that donors would be more inclined to support?
- How can we collaborate more effectively with the foundation board or development council to identify potential funding priorities with adequate time for the identification and engagement of potential donors?
- Who are the physician and clinician leaders who are well positioned to be advocates and storytellers to share the case for support in their area of expertise?
- What priorities enable an appropriately sized financial goal that balances simultaneously being audacious and achievable?

Healthcare organizations face historic financial fragility given a perfect storm of labor and supply cost increases alongside anemic volumes and reimbursements. Yet, a pressing need to invest in strategic capital and programmatic initiatives remains in order to maintain the physical plant, keep up with evolving medical technology, pursue growth opportunities, and more. Therefore, healthcare organizations must be increasingly judicious in how each dollar from all available sources is utilized to leverage impact.

Today, most health systems and hospitals proactively pursue philanthropy—voluntary, charitable giving from individuals, corporations, and foundations—as a low-risk, alternative revenue resource. Yet, many fail to use charitable revenue effectively. Too often, philanthropy is used to support "extras" and "nice to haves" rather than core, strategic priorities. However, that must change for board and executive leaders to capture the true potential of philanthropy.

Directing philanthropy to the highest and best strategic use begins with a change of philosophy. Simply, if the organization has a clear strategy, why would leadership ever choose to fund initiatives that fall outside that plan? With that in mind, charitable dollars should not be seen as "budget expansion" but as "budget offset." This not only better meets the needs of the organization but also aligns with intentions of donors who wish to see their dollars directed to smart, strategic, high-impact initiatives. So, all potential charitable funding priorities should already be reflected in existing strategic plans, master facility plans, capital plans, operating budgets, and similar that have been endorsed by board and executive leadership.

Beyond identifying what is included in existing plans, board and executive leaders must recognize some funding priorities are more salable and will attract more donor investment. Donors generally prefer to invest in efforts that directly improve patient care; this means organizations should prioritize initiatives that elevate patient clinical outcomes and experience rather than basic replacements and infrastructure needs. Many donors seek to build upon areas of strength, so healthcare organizations should also focus on opportunities within clinical service lines with demonstrated success, capability, and capacity. Donors also tend to fund projects that are relatable and understandable to them—so it is often easier to secure investment for areas like oncology, pediatrics, and cardiology that impact broad swaths of people in any community. However, it should also be noted many donors are not risk averse and are willing to make investments in bold initiatives that have the power to transform care—so organizations should not be reticent to bring forward innovative ideas.

There is also value to understanding "who" is giving. Particularly in adult, acute care hospitals, the vast majority of charitable giving comes from former patients and their family members who have experienced the organization's mission in action. Further, patients consistently say their physician is the person with the most influence on their decision to give. Thus, there is value in considering which physician partners would be inclined and positioned to share the clinical and mission rationale for investment in their service line. When an organization has the choice between a project with a clinician champion or one that does not, the project with a champion is always better positioned for success.

Board and executive leaders can operationalize better selection of charitable funding priorities as a renewable source of competitive advantage. Successful organizations foster an agile and respectful collaboration between the community board and foundation board to harness the insights, influence, and objectives of both groups. Success also stems from having the right executive and clinical leaders to vet, prioritize, and green light potential projects and from using a quantitative approach that cuts through organizational red tape and politics. Organizations must commit to surfacing and prioritizing projects at least annually—though many run a selection process multiple times each year both to keep up with evolving opportunities and to ensure projects have an ample runway for donor engagement and solicitation.

Once an organization implements strategic project selection, it is also the right time to narrow the number of decision makers who can access philanthropic funds. Too often, a large cadre of executives, directors, and managers have access to restricted charitable funds associated with their service line, department, or area of influence. This positions philanthropic funds as slush funds to pay for items and initiatives that often circumvent the due diligence of a normal budget process. If philanthropy is going to be a core revenue source to power the organization's most important plans, it should be protected and cared for with the same level of thoughtful oversight as the organization's operating income, investment income, or similar.

Hospitals and health systems have a significant opportunity to utilize philanthropy as a sustainable and growing revenue source to advance their most important plans. Therefore, it is essential for boards and executives to proactively identify, prioritize, and articulate the value of capital and programmatic initiatives that could benefit from philanthropic funding to advance the healthcare organization's true vision of potential.

The Governance Institute thanks Betsy Chapin Taylor, FAHP, CEO, Accordant, for contributing this article. She can be reached at betsy@accordanthealth.com.

Go Big or Go Home…

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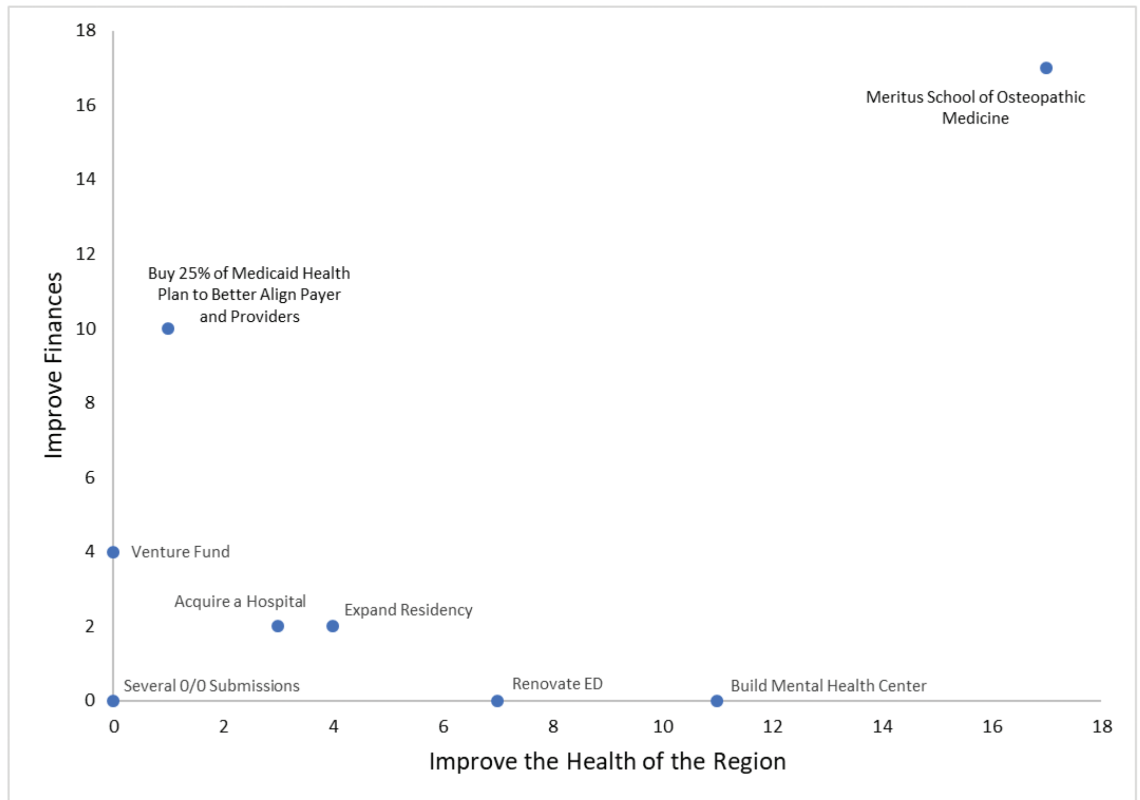
The development of the Financial and Community Benefit Matrix provides a simple yet effective way for healthcare organizations to evaluate priorities and illustrate what leaders within the organization feel will bring the most prosperity to the community. Ideas, opinions, and economic factors are in constant flux; therefore, these types of exercises should be conducted on a regular basis (perhaps every two years) to emphasize forward, agile thinking. Each healthcare organization is driven by their mission and it is our responsibility to illustrate this drive to our communities.

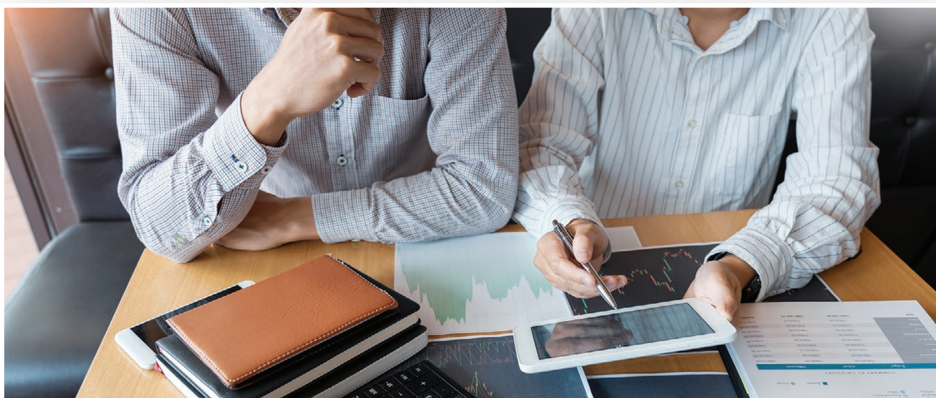
For Meritus Health, the Financial and Community Benefit Matrix yielded an initial discussion in the development of Meritus Medical School. The school received the most points among the senior leaders and, as evident in the matrix, was thought to have the most benefit on each axis—community benefit and finances. This process and framework facilitated by the utilization of the Financial and Community Benefit Matrix provided a tremendous accelerant to thinking big and different. One year after this strategic planning process, Meritus Health is investing $160 million to build Meritus School of Osteopathic Medicine to train physicians to serve rural underserved areas like our community.

Exhibit 1: Subset of Meritus Health Financial and Community Benefit Matrix (November 2021)



Conclusion

Regularly evaluating the thought processes behind the implementation of bold community initiatives should remain at the forefront of board members' thinking as we steadily emerge from the trials and tribulations thrown at us over the past few years. In an effort to raise up the communities we serve, there must make haste to create positive momentum that dramatically impacts those we are intended to serve. Thomas Jefferson once said, "With great risk comes great reward." Taking a leap of faith with significant organizational funds always presents undeniable risk. Understanding this risk brings about the necessity to look back on lessons learned throughout the pandemic, internalize them, and implement innovative exercises to strategically brainstorm, communicate, and initiate high-priority initiatives with the highest degree of benefit. Healthcare organizations must collectively emphasize our commitment to the communities we serve, just as they did to us amidst the COVID-19 pandemic. Again, what would you do with $100 million? Rainy days do not last forever, and the time to act is now.



The Governance Institute thanks Ethan Feldmiller, M.H.A., Administrative Fellow, Meritus Health, and Maulik Joshi, Dr.P.H., President and CEO, Meritus Health, and Adjunct Faculty, University of Michigan School of Public Health, Department of Health Management and Policy, for contributing this article. They can be reached at ethan.feldmiller@meritushealth.com and maulik.joshi@meritushealth.com.

Humanizing Price Transparency…
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procedure. For major surgery, 91 percent still want to know the price.

Consumers hunger for pricing information so intensely it could change their future utilization patterns:

- Three in four would choose a provider who shares prices over one who doesn't
- Half would switch to a more affordable doctor—even if they knew little about them
- Half would switch to a more affordable hospital

Consumers single out doctors and hospitals in particular: 45 percent believe doctors and hospitals don't want to share their prices and 41 percent believe doctors and hospitals are waiting for the competition to share prices first. The onus is on those who provide healthcare to step up.

Healthcare boards should do two things soon. First, have a conversation about this topic that includes answering an honest question: do we know what we charge and why? Second, start considering a mechanism for sharing at least a few prices to start. Consumers are particularly interested in:

- Total cost of care, out-of-pocket costs, and costs covered by insurance for specific procedures
- A comparison of out-of-pocket costs for different care options (e.g., urgent care vs. ER care)
- The ability to contrast out-of-pocket costs for in-network and out-of-network providers

In healthcare, consumers want what they want everywhere else: the best possible service for an affordable price. If they could compare pricing, consumers would be better prepared and feel more certain about their care. They could focus on other issues like healing and staying healthy.

Whoever joins the consumer in this fight will eventually come out on top. Every healthcare organization is struggling to reconnect with patients post-COVID and the board has a uniquely powerful path to advance this issue. Ultimately, the ability to pivot and reach today's consumers (and tomorrow's patients) lies in telling the truth. The future success of healthcare organizations relies on an old to-do but more price transparency in healthcare has the ability to give providers and patients a fresh start.

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

Hospitals Employing Physicians…
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underlying this model is that physicians will only work productively when given financial incentives to do so. The actual result is often burned-out practitioners, dissatisfied patients, diminished quality of care, more disruptive practitioner conduct, and staff turnover. To design a more rewarding compensation model, involve employed practitioners in the process. Rather than addressing productivity lapses through financial punishment, hospitals should invest in physician leaders who can manage the problem collegially to achieve appropriate expectations.

This raises another important tactic to strengthen hospital–physician relations. Hospitals must adequately invest in physician leadership. While it is important to provide relevant education to new medical staff leaders and to a hospital's physician executives, attention should also be paid to developing physician leaders on the front lines of clinical practice. This is where most employed doctors spend their time and where they need a colleague who can promptly address their daily concerns as well as provide coaching and guidance.

Hospitals with a significant number of employed practitioners should consider organizing them as a semi-autonomous multidisciplinary group practice. If designed properly and well-executed, this model provides doctors with an appropriate degree of autonomy over their professional lives. It combines some of the strengths of the private practice model with the resources and benefits provided by an integrated delivery system. Large group practices have a track record of delivering higher quality care and greater professional stimulation.

Any hospital interested in strengthening its bond with its employed doctors must address the epidemic of physician burnout. Three in five physicians reported at least one manifestation of burnout in the winter of 2021–2022. (In a similar timeframe, one study also found satisfaction with work-life integration dropped from 46 percent in 2020 to 30 percent in 2021 and average depression scores rose from 50 to 52 percent.)[3] Too many hospitals have tackled this problem by focusing only on efforts to strengthen practitioner resilience and mindfulness. But evidence suggests that health systems that want to make a more meaningful dent in these statistics need to make structural, systemic changes to the way they conduct business.[4]

Hospitals don't need to cede the employment of physicians to insurers, private equity firms, or health system competitors. Any hospital can create a rewarding professional home for its physicians and advanced practice providers. For motivation, just look at the success many hospitals have had with nurse retention when they create and invest in "magnet programs." It is always hard to move away from the status quo, but it happens when concerned board members step up and challenge their institutions to do better.

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

3 Tait Shanafelt, et al., "Changes in Burnout and Satisfaction with Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic," *Mayo Clinic Proceedings,* Vol. 97, Issue 3, March 2022.

4 While there are many resources that provide suggestions, a particularly useful one is *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being,* Washington, D.C.: National Academies Press, 2019.

Hospitals Employing Physicians: Still a Sound Strategy If Done Right

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

Key Board Takeaways

Board members should challenge hospital and medical staff leaders to develop an exceptional professional home for employed physicians and advanced practice providers. Tactics to promote greater retention and engagement of employed practitioners include:

- Revising compensation methodologies with less emphasis on productivity incentives
- Organizing employed physicians into a multidisciplinary group practice structure
- Investing in physician leadership on the front lines of clinical care
- Reducing practitioner burnout by making systemic, structural changes in clinical care activities

Most hospitals today are struggling to maintain the workforce vital to their operations. When it comes to the physician workforce, there are several approaches hospitals can take to meet their needs. Through most of the 20th century, hospitals simply affiliated with doctors in private practice by appointing them to their medical staff organizations. In the 1980s and early 1990s, as managed care companies became significant players in the healthcare marketplace, hospitals flirted with the direct employment of physicians. This was mostly employment of primary doctors who could funnel "covered lives" to their employer in a competitive marketplace. Often this new hospital–physician dynamic played out poorly and by the late 1990s hospitals in many parts of the country were divesting themselves of these new employees.

As the 21st century got underway, hospital employment of physicians once again became common. This reversal was largely driven by physicians who were struggling in private practice and sought out hospital support. Private practice was left behind either because the challenges of keeping a small business afloat had become too stressful, there was an inability to recruit and hire new colleagues, or the practice had become financially untenable. Furthermore, many younger physicians found that private practice did not match their lifestyle preferences and desire for a better work-life balance. Through the first and second decades of this century hospital employment of physicians has grown steadily.

Employment of physicians is a costly addition to hospital budgets. Nevertheless, hospitals have multiple motivations that justify the expense:

- To retain essential current members of the medical staff who might otherwise leave the community
- To enhance recruitment efforts to fill needed vacancies in the hospital's medical staff development plan
- To bolster essential or high-reimbursement service lines and ensure adequate call-coverage in critical specialties
- To expand market share by establishing new practices and locating them strategically
- To prevent an erosion of market share by competitor health systems willing to aggressively recruit and employ physicians
- To prevent third parties from becoming dominant employers of physicians who then contract them back to the hospital at unfavorable terms
- To command the market power to raise fees

In 2000, nearly 60 percent of physicians were in independent practice, but that number has dramatically declined. The percentage of U.S. physicians employed by hospitals, health systems, or other corporate entities grew from 62 percent in January 2019 to nearly 74 percent as of January 2022.[1] The high prevalence of practitioner burnout, further exacerbated by the pandemic, has been a significant driver of this ongoing shift to employment.

Today, in a diminishing swath of the country, competition to employ doctors is between a hospital and local private practice options. More significant has become competition between hospitals and various third-party players. According to Avalere Health, from 2019 to 2021, hospitals and health systems saw a 9 percent growth in physician practice acquisitions, while corporate entities (e.g., insurers and private equity firms) saw an 86 percent growth.[2] Hospitals and corporate entities now own 53.6 percent of physician practices—hospitals own 26.4 percent and other corporate entities own 27.2 percent. Currently, the single-biggest employer of physicians in the nation is the Optum division of the UnitedHealth Group.

Creating a Rewarding Workplace for Physicians

While most hospitals now employ significant numbers of physicians and advanced practice providers, most are doing too little to hold on to these valued practitioners. Turnover rates are high, approaching 50 percent at seven years of employment. In general, physician engagement scores don't seem to improve or correlate well with increased hospital employment. Handing out roses on Doctors' Day is simply not going to cut it if the goal is to have a stable, high-functioning physician workforce.

Board members should ask hospital and medical staff leaders what they have been doing to create an attractive professional home for medical practitioners. Such a home would provide physicians a reasonable degree of autonomy and a sense of control over their clinical lives, create an appealing work-life balance, build a spirit of professional collegiality, and provide intellectual stimulation often lost to physicians once they leave their academic training institutions. Such a professional home would facilitate greater practitioner–patient interaction with fewer administrative burdens and less demand for numbing throughput.

What efforts should board members be looking for to distinguish their institution from others that hire doctors? A reasonable starting point is to reassess how employed physicians are paid. The current prevailing model is based on productivity and places physicians on a treadmill of days packed with short, unfulfilling patient visits. The assumption

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1 Avalere Health, "COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2021," Physicians Advocacy Institute, April 2022.

2 For an overview of the corrosive effect of private equity's entrance into healthcare, see Laura Katz Olson, *Ethically Challenged: Private Equity Storms U.S. Health Care,* Baltimore, MD: Johns Hopkins University Press, 2022.