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Equity, Trust, and Population Health: Governance in a Rapidly Changing Climate

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What's Inside:

The Case for Transformation

In the United States, healthcare expenditures represent 18 percent of the gross domestic product ($4.3 trillion). Cost per capita is two times higher than many industrialized countries.[1] While there are several explanations for exorbitant spending, health inequities is a key contributor. According to a study by Deloitte, inequities account for $320 billion in annual spending and this figure could escalate to $1 trillion by 2040.[2] While hospitals and health systems cannot be solely responsible for addressing inequitable conditions that compromise health, they are lead actors in the ecosystem. As anchor institutions, they have the agency to influence a broader population health agenda—particularly in communities that have been historically marginalized.[3]

As governing bodies, boards should recognize that the institutions in which they serve operate in an ecosystem built on inequity and injustice. And providers are tasked with creating solutions to long-standing health disparities in populations that have been intentionally disenfranchised. For example, readmission rates and poorer outcomes after hospitalization are more pronounced in communities that have been redlined.[4] While this article focuses on broader systemic issues, efforts must continue within the walls of the medical institutions to uncover clinical bias and inequitable treatment

1 CMS, NHE Fact Sheet; Matthew McGough, et al., "How Does Health Spending in the U.S. Compare to Other Countries?," Peterson-KFF Health System Tracker, February 9, 2023.
2 Andy Davis, et al., "U.S. Healthcare Can't Afford Health Inequities," Deloitte Insights, June 22, 2022.
3 See the Healthcare Anchor Network: https://healthcareanchor.network.
4 Adrian Diaz, et al., "Association of Historic Housing Policy, Modern Day Neighborhood Deprivation and Outcomes After Inpatient Hospitalization, *Annals of Surgery*, December 2021.

based on characteristics such as age, race/ethnicity, religion, sexual identity, insurance status, and place of residence.

Each board is on its own learning curve. However, as board members assess their competencies, they must articulate how equity is a prerequisite for advancing the quality and safety agenda, as well as a broader population health strategy. Moving the needle requires boards to interrogate the status quo and engage in bold, generative dialogue that has promise for normalizing atonement, equity, and justice in governance practices.

Reflecting on History, Health, and Place

Whether it's inequality or systemic inequities, each community has a unique history, and that story has shaped the current environment. By engaging a local historian, boards can conduct retroactive analyses of local and federal policies and practices that disproportionately burdened specific populations.[5] This work can be done in conjunction with reflections of the organization's history and the role it may have played in causing harm. These approaches can help boards make sense of seemingly intransigent place-based health disparities as well as negative community perceptions that stem from historical events. For not-for-profit hospitals, historical analyses can inform the IRS-mandated community health needs assessment process, as well as help shape priorities outlined in hospitals' three-year implementation strategies.

Retroactive analyses can also help unearth contemporary vestiges of injustice—whether real or symbolic. For example, institutions throughout the nation have demonstrated atonement through courageous action. They have issued formal public apologies, renamed buildings, and removed physical icons that cause pain and do not reflect appreciation for diversity and the nation's founding values.[6] And in many cases, these iconic figures have been replaced with new representations of hidden figures who have sacrificed for a more perfect union—for all. These acts are key to building trust and fostering environments of care where patients are more comfortable with the services rendered.

5 Christopher King, et al., "Race, Place, and Structural Racism: A Review of Health and History in Washington, D.C.," *Health Affairs*, February 2022.
6 "List of Name Changes Due to the George Floyd Protests," *Wikipedia*, 2023.

Achieving Board Diversity

Board diversity inspires problem-solving, innovation, and enables the creation of strategic plans and institutional norms that are inclusive and culturally nuanced. However, persons of color only represent 13 percent of hospital and health system board members and cisgendered white males make up the majority.[7] According to The Governance Institute's 2021 Biennial Survey of Hospitals and Healthcare Systems, only 62 percent of boards report having ethnic minorities represented on the board.[8] This lack of representation undergirds the status quo, perpetuates blind spots, and sustains a legacy of distrust in the healthcare delivery system. Boards can make progress by being intentional and employing new recruitment and selection strategies to achieve a composition that reflects the rich and diverse character of the community.[9] For example, instead of board members identifying new members based on who they know, organizations can partner with community-based groups that have access to individuals who are likely to be outside of the existing board's orbit.

Committing to Intentionality and Unlearning

While achieving board diversity is important, diversity alone, is not the silver bullet for building trust or upending negative perceptions caused by a legacy of harmful practices. COVID-19 illuminated these nuances as well as many flaws in public health and healthcare delivery systems, such as institutions' inability to effectively partner with communities that are disproportionately burdened during times of crises. In a commitment to health equity, intentionality and unlearning are key as boards are performing in a broader ecosystem that has systemically normalized inequitable policies and practices—whether intentional or unintentional. As part of the journey towards equity, boards must reimagine institutional cultures that publicly demonstrate humility; adopt new language; eliminate ivory tower, paternalistic approaches; and recognize the importance of neutralizing or shifting power. For example, instead of creating a program "for the community," hospitals will "co-create programs with the community" or instead of "adopting" a non-profit organization, hospitals will "partner" with non-profit organizations.

7 Morgan Haefner, "'We've Made No Progress': Healthcare Boards 87% White, Leverage Network Study Finds," February 23, 2021.
8 Kathryn Peisert and Kayla Wagner, *Advancing Governance for a New Future of Healthcare*, The Governance Institute's 2021 Biennial Survey of Hospitals and Healthcare Systems
9 For more on how boards can accomplish this, see *Building a More Diverse Board*, The Governance Institute, Fall 2018.

Broadening Performance Indicators

Since health status is mostly shaped by social, political, economic, and environmental forces outside of clinical care, there is an opportunity for institutions to augment common scorecard indicators with measures that extend beyond direct clinical care. Hospitals and health systems are uniquely poised to use their voices and resources to shape policy and improve the structural conditions of distressed communities. Performance measures may be organized by core functional areas commonly monitored by boards, and may be contextualized as strategic components of a comprehensive population health agenda. Examples include but are not limited to:

- **Human resources:** local hiring practices and career progression incentives for employees who reside in specific jurisdictions
- **Operations:** purchasing and procuring services with local businesses housed in distressed neighborhoods
- **Finance:** community benefit and community health improvement investments
- **Patient care:** strategic partnerships and volunteerism with community-based organizations that provide patient wraparound services or have missions that influence policies and practices that promote equity

→ Key Questions for Boards

- Can we articulate how equity is a prerequisite for advancing the quality and safety agenda, as well as a broader population health strategy?
- Do we have protected time, resources, and expertise to conduct historical analyses and engage in meaningful dialogue?
- Do we know the history of our organization and the origins of the names associated with the facility (i.e., names of buildings, rooms, streets, etc.)?
- How can we partner with community-based organizations to recruit and yield board members from underrepresented populations—particularly those who reside in historically disenfranchised communities?
- Do we have access to expertise to help us conduct critical audits of existing norms, practices, and our broader environment to identify issues that are inconsistent with our commitment to equity and inclusion?

Governance in a Rapidly Changing Climate

Health disparities are measurable differences in health status or health outcomes across comparable populations. These outcomes occur when inequities exist—meaning one population has more access to resources and opportunities than the other. A legacy of policies, practices, and social norms that stripped segments of the population from "access" helps explain contemporary disparities in health. To undo the damage, all sectors of society must reflect on their histories and identify and dismantle contemporary practices that sustain the status quo. However, the work must be orchestrated from the top. In light of new and emerging value-based payment models, the proliferation of disruptors and innovation in the healthcare landscape, and public demands for equality and accountability, this is a critical moment for boards to reconceptualize their responsibility in a dynamic and rapidly changing world.

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Philanthropy as a Strategic Imperative

By **Alice Ayres**, President and CEO, *Association for Healthcare Philanthropy*

For many years, philanthropic support of hospitals was seen as a "nice to have." Margins were tight by corporate standards, between 5 and 8 percent between 1995 and 2016,[1] but our institutions were surviving. Not so any longer. The pandemic brought about unsustainable changes to the hospital financial model on both the revenue and the expense sides. According to a January 2023 Kaufman Hall report, the only month in 2022 when hospitals saw a median positive margin was December—and that was only 0.2 percent.[2] And, while the federal government provided financial assistance through the CARES Act in the first two years of the pandemic, the mood in Washington has changed, making additional government assistance unlikely.

As a board member, you know the statistics. Procedures that would have been inpatient before the pandemic are moving to outpatient, and volumes for many of the more lucrative inpatient cases are never expected to return to their pre-pandemic levels. Expenses have also increased substantially: the cost of supplies and prescription medications is up by more than 15 percent, and wages for clinical staff have risen 10 percent. Additionally, staffing levels are woefully low, increasing retention costs, reducing the number of available beds, and leading to delays in post-acute placement.[3]

The most progressive hospitals and health systems recognize that they must adapt and identify every possible opportunity to increase revenue from all sources. The most strategic have diversified, investing in everything from generic drug producers to health plans. One alternative viable revenue stream for all the country's healthcare organizations, from smaller rural standalone hospitals to multi-state health systems, is philanthropy.

When we look back at the history of healthcare in this country, most of our institutions' founding stories are ones of charitable giving. People came together

1 See Trendwatch Chartbook 2018, Table 4.1
2 Kaufman Hall, "National Hospital Flash Report: January 2023."
3 Kaufman Hall, "2022 State of Healthcare Performance Improvement: Mounting Pressures Pose New Challenges," October 2022.

to ensure that everyone in the community had the very best healthcare possible, regardless of ability to pay. That same thing happens every day today. In AHP's *2022 Report on Giving*, healthcare delivery organizations from across the United States reported more than $7 billion in total funds raised through philanthropy in FY2021 alone.[4]

Even with that backdrop, some organizations worry that asking for help from the community will be seen as a sign of weakness. In reality, the opposite is true. The strongest of our health systems have professional fundraising teams who, in partnership with clinicians and administrators, identify and accept an average of over $100 million per year in charitable gifts from individuals, foundations, and grants. They invite people to further their missions, they ask people to invest in the future of healthcare in their communities, and, as a result, they weather storms like this latest financial crisis with more resilience than organizations that do not invest in philanthropy.

Redefining Philanthropy

So how do we redefine the conversation? First, we need to talk about philanthropy as an investment—as one of the critical levers that sustains a healthcare institution. We need to understand charitable giving as an expression of partnership from individuals in our communities. We need to accept the community's support as a mark of their confidence in our ability to consistently deliver a critical service to our community: the best healthcare—and health—possible.

Specifically, as a healthcare board member or senior leader, you can:

- Identify the return on investment of philanthropy in your organization. For the average hospital in AHP's annual survey, every dollar invested in the work of the philanthropy team returns $4 in charitable giving.[5] That is a 75 percent margin.
- Familiarize yourself with the concept of "revenue equivalency"—the amount of revenue required from different revenue streams to generate the same amount of profit. For example, $100 in charitable investment generates an average of $75 in profit for a typical hospital. A hospital with the current median margin of 0.2 percent would need to generate an additional $3,600 in patient revenue to yield the same $75 profit as that $100 in charitable contributions.

4 AHP, *2022 Report on Giving*.
5 *Ibid.*

- Ensure that management is investing in the fundraising team. The relative profitability of philanthropy means that, at a time when we are looking for places to cut costs, it makes sense to invest in the fundraising team. AHP's 2022 Salary Report shows that while the median salary for a philanthropy FTE is $97,000, the median funds raised annually by that FTE are nearly $713,000.[6]
- Make giving by every fiduciary and fundraising board member mandatory to signal the confidence leadership has in the direction of the institution. This expression of strength gives donors confidence in investing in the organization, which leads to both more and larger gifts.
- Review your social network and identify people who may want to invest in the hospital or health system and thus the future of great healthcare for your community. Share those names with the hospital's fundraising team and develop a strategy to invite those individuals into the work of the organization.
- Invite the chief philanthropy executive to join board meetings and share results, and also share ways that you as a board member can help.
- Offer to make calls to thank donors, write thank-you notes, or host thank-you events.

→ Key Board Takeaways

- Ensure the board is educated on the significant revenue returns that can come from philanthropy.
- Invite the chief philanthropy executive to join board meetings to share the impact of current philanthropy efforts, as well as ways that board members can help boost donor giving and engagement.
- Review your social network and identify people who may want to invest in the hospital or health system. Share those names with the fundraising team and help develop a strategy for inviting those individuals into the work of the organization.
- Be supportive. For example, offer to help engage donors, communicate the impactful work of the organization, and thank donors for their contributions.

6 *2022 AHP Salary Report U.S.*

Conclusion

Philanthropic support of hospitals takes many forms. For some grateful patients, giving to support the service line that healed them is a way to say thank you and to ensure that other people benefit from the same clinical excellence. Others wish to donate to naming a building to honor a loved one. Increasingly, we are seeing individuals and corporations give to support community health efforts. These gifts transform communities, reduce the impact of negative social determinants of health, and ensure that people have as many healthy days, outside of the acute care setting, as possible. Regardless of the form they take, all these gifts, and the donor intent behind them, are remarkable investments in our work and the ultimate compliment of our role in the community. It is high time we recognize philanthropy as a mark of stature and the strategic imperative that it is.

The Governance Institute thanks Alice Ayres, President and CEO, Association for Healthcare Philanthropy, for contributing this article. She can be reached at alice@ahp.org.

Leadership Oversight of Corporate Compliance Becomes More Involved

By **Michael W. Peregrine**, Partner, *McDermott Will & Emery*

A flurry of recent court decisions and regulatory initiatives combine to recast elements of the hospital and health system's compliance program, and the corporate leaders responsible for its oversight. This recasting can be readily accomplished through the engagement of leadership and the guidance of the general counsel, teaming with the chief compliance officer.

The first indication of change arose in a January 23, 2023, preliminary decision in a shareholder derivative action against McDonald's Corporation. The Delaware Court of Chancery ruled that stockholders may hold non-director corporate officers liable for failure to exercise their oversight obligations with respect to compliance risks facing the company. (In this case, the compliance risk was an executive culture of sexual harassment.) Previously, the Delaware courts had attributed such oversight duties only to board members. In jurisdictions that recognize or rely on Delaware law, this decision will have the effect of increasing the obligations of corporate officers to establish and maintain corporate compliance plans and other forms of risk information systems.

The second indication of change occurred in the March 1 decision of the same court, in the same case, to dismiss the shareholder derivative litigation against McDonald's directors. As to the oversight claim, The Vice Chancellor concluded that the plaintiff's complaint did not support an inference that the directors ignored the allegations of sexual harassment, when the record indicated that directors responded to the allegations with specific action.

What was particularly interesting for hospital and health system directors was the conclusion of the court that the oversight obligations of officers and directors apply to what he described without definition as "the compliance risks of the corporation" rather than the more "limited mission-critical risks of the corporation" standard, which had been introduced only a few years ago in a previous case interpreting *Caremark*. According to the Chancery Court, the concept of "compliance risks of the

corporation" is more expansive than the "mission-critical risks" standard—meaning, thus, that the oversight duties for officers and directors are similarly more expansive.

This becomes particularly relevant with the third indication of change: the announcements on March 2 and 3 by the Department of Justice of important new corporate compliance initiatives aimed at preventing corporate fraud. These new initiatives apply to hospitals and health systems, as well as to other companies—and they should be taken seriously by boards and the executive leadership team as part of their responsibilities to ensure an effective compliance plan.

Under the Biden Administration, the Department of Justice has sought to invigorate corporate criminal enforcement. On March 2, Deputy Attorney General Lisa O. Monaco announced two new policies intended to underscore the Justice Department's commitment to finding the right incentives to promote and support a culture of compliance within corporations:

1. **Voluntary self-disclosure program**: The first of the new policies is an approach to promote voluntary self-disclosure when companies discover misconduct. The underlying premise of this policy is that the Department of Justice will not seek a guilty plea where a company has voluntarily self-disclosed, cooperated, and remediated the misconduct. However, in order to take advantage of the benefits of the voluntary self-disclosure policy, timeliness of response will be critical. Accordingly, there is value in briefing the board—or at least the audit and compliance committee—on the highlights of the new policy and the decisions that the board may be called to make in terms of deciding whether to participate.
2. **Promoting compliance through compensation and clawback programs**: The second policy is an effort to drive compliance-promoting behavior through approaches to executive compensation and the use of clawbacks. Going forward, as part of the investigative process, the Department of Justice will examine corporate compensation programs for signs of measures by which both executives and employees are personally invested in promoting compliance through direct and tangible financial incentives. Assistant Attorney General Kenneth A. Polite, Jr. expanded on this effort in a separate presentation on March 3, in which he encouraged companies to develop compensation-related compliance criteria to reward ethical behavior and punish and deter misconduct.

In that same speech, Polite announced a related compliance focus on a corporation's approach to the use of personal devices as well as various communications platforms and messaging applications, including those offering ephemeral messaging. The

Justice Department's concern is that, as appropriate, business-related electronic data and communications can be preserved and accessed.

For many officers and directors of hospitals and health systems, these various developments will seem like "legalese" and they will be inclined to "leave that stuff to the lawyers and compliance officers." Except that, if those officers and directors are to be true to their new (in the case of officers) and expanding (in the case of director) compliance oversight obligations, they will take these new developments seriously and focus closely on the related briefings they receive from their legal and compliance advisors.

→ Key Board Takeaways

Board members should ensure that they are aware of the recent changes related to corporate compliance, including:

- Corporate officers now have the same board information reporting system oversight responsibilities as do the board of directors.
- That oversight responsibility extends to the full range of compliance risks of the organization.
- The Department of Justice introduced two new corporate compliance initiatives related to voluntary self-disclosure and promoting compliance through compensation and clawback programs. These compliance guidelines should be taken seriously by the organization, including the board.
- The ultimate organizational response to the new guidelines will require collaboration between certain board committees and the officers with whom they work.

Of particular governance importance in this scenario is the collaboration that will need to occur horizontally amongst several implicated board committees, and the executives that staff them, if the new compliance guidelines are to be effectively adopted. The audit and compliance committee will typically have primary responsibility for exercising oversight of corporate compliance (and working with the general counsel and compliance in doing so). However, the nature of the new

compliance guidelines suggests that any organizational response will likely require coordination with the executive compensation committee, the HR committee, and the information technology committee and the executives they work with.

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