Texas Healthcare Trustees
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Trustee Bulletin

A Funding Crisis Within a Pandemic

PREVENTING VIOLENCE IN THE HEALTH CARE WORKPLACE
Training, Facility Analysis, and Response

THE TRUSTEES' ROLE IN ADDRESSING THE WORKFORCE SHORTAGE
Maintaining Workforce & Staffing Continues to be a Significant Challenge

10 QUESTIONS BOARDS CAN ANSWER TO ADVANCE EQUITY
Now is the Time to Take a Step Back and Look at COVID-19's Impact

ENGAGING BOARDS IN DISRUPTIVE INNOVATION
Assess Potential Disruptors through Strategy Simulation

A FUNDING CRISIS WITHIN A PANDEMIC
1115 Waiver Faces a Potentially Permanent Rescission

The President's Message

A personal note: as I write this, I'm preparing to welcome a new baby girl to our family in just a few days, my second daughter. Hospitals have been a constant in the news cycle for the past couple of years because of the pandemic, but I feel the public forgets how essential hospitals and health systems are in supporting and caring for their communities.

It's difficult to look beyond COVID-19 and have strategic discussions about how to better care for your community, but as health care leaders you must still maintain a future-focus perspective and vision to help navigate your hospital through whatever it may face. This issue of the Trustee Bulletin provides several resources to help board members have those types of conversations on foresight and where to go next.

Our colleagues at the Texas Hospital Association have provided us with a update on the status of the 1115 Waiver, a funding mechanism that supports so many Texas hospitals and health care organizations. Much of the trustees' work on foresight involves having the right discussions and asking the right questions of the hospital's leadership team. This is why THT included several articles on innovation, workforce, equity and the questions you can pose in the boardroom to help facilitate those conversations.

We will continue to have these conversations (virtually or in person) at the *2022 Healthcare Governance Conference* on July 28-30 at the Omni Fort Worth. Registration and hotel reservations are open, **so reserve your spot today.**

I look forward to welcoming my new addition and welcoming you all back to our event in July. As always, visit www.tht.org for additional education and event details and to access our governance resources.

See you soon.

Amy Eskew is the President/CEO of Texas Healthcare Trustees.

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A Funding Crisis Within a Pandemic

The timing could not be worse as the 1115 waiver faces a potentially permanent rescission.

By Kim Carmichael

Medicaid supplemental payment programs finally received federal approval in late March, but the future of Texas' health care safety net remains far from certain as funding mechanisms for those programs are subject to further review and the 1115 waiver faces a potentially permanent rescission. The timing could not be worse, as health care providers grapple with the ongoing COVID-19 pandemic and related challenges.

In a state as large and diverse as Texas, millions of people depend on the state's health care safety net to address their health care needs – from routine services to chronic disease management to behavioral health care. Hospitals provide health care to anyone seeking treatment, regardless of their ability to pay, but often receive reimbursements far below the cost of providing care.

Last fall, crucial financing programs that raise Medicaid reimbursement rates closer to cost expired and newly proposed ones only received federal approval in late March, nearly seven months after they were originally slated to begin. The federal government now plans to audit the programs' financing methods. The future of the Medicaid 1115 waiver also hangs in the balance after federal authorities rescinded Texas' 10-year extension of the program in April 2021.

The months long absence of desperately needed funding and continued lack of clarity over the future of supplemental payment programs caused profound financial stress for hospitals responding to a continued public health emergency and countless pandemic-related challenges. The relief of recent approvals may be short-lived, as the programs must be renewed annually and are set to expire again in September.

Medicaid base reimbursement rates for Texas hospitals vary considerably by facility but typically fall well below the cost of care, only covering 65%-70% of cost on average. Hospitals' annual Medicaid shortfall runs multiple billions of dollars. Statewide Medicaid enrollment grew 27% during the pandemic to around 5 million Texans, with an additional 5 million Texans having no form of health coverage.

Texas health care providers are left to rely heavily on supplemental dollars to offset the costs of providing care to these populations. Rate enhancements that expired without replacement in September 2021 have cost hospitals at least $7 million dollars per day. Additional performance-based incentive payments have also expired, increasing the total supplemental payment amount unavailable to hospitals in 2022.

Meanwhile, the ongoing pandemic has strained hospital resources and compounded a pervasive nursing shortage, as nurse staffing agencies fill vacancies at often two to three times pre-pandemic rates. Extraordinary COVID-19 related expenses and the possible disruption of supplemental funding down the road would have catastrophic consequences for health care access in Texas, including hospital closures and decreased essential service lines.

The Texas Hospital Association has been leading a determined advocacy effort to ensure the lasting financial stability of our state's hospitals and health care providers. "It was foundational for the Texas safety net to receive immediate approval of proposed directed payment programs, as well as a permanent reinstatement of the 1115 waiver," said Jennifer Banda, senior vice president of advocacy and public policy at THA. "Beyond that, our state's entire health care system would benefit from meaningful Medicaid expansion and hospital reimbursements closer to the cost of services."

Care Dependent on 1115 Waiver

In early 2021, Texas was granted a 10-year extension on its Medicaid 1115 waiver, however, that extension was rescinded last April under a new federal administration. The state immediately filed suit in May over the recission, and on Aug. 20, 2021, a federal district judge issued a temporary injunction on enforcement of the recission. Since then, the Texas Health and Human Services Commission and Centers for Medicare & Medicaid Services have resumed extensive negotiations over the waiver and related payment programs.

The waiver's uncompensated care (UC) pool and managed care authority remain in effect through Sept. 30, 2022, and continue beyond that as long as the temporary injunction remains in effect. A permanent recission, though, jeopardizes about $32 billion in new funding.

All 1115 waivers must adhere to federal "budget neutrality" principles, meaning a state cannot spend more money with a waiver than it would without one. The waiver extension granted in January 2021 would have preserved about $11 billion in access to federal funding known as budget neutrality "room," or savings generated under the existing waiver that the state can bank and carry forward. These savings would have been otherwise lost if a new waiver had been issued.

"This preserved room allowed certainty in the amount Texas could spend going forward to expand existing supplemental payment programs and develop new programs to replace the expiring ones," Banda said.

If the outcome of pending litigation permanently invalidates the 1115 waiver, between $9 billion and $10 billion in annual payments to hospitals would cease while putting Texas back in danger of facing a budget neutrality cliff.

Additionally, the waiver extension creates a new non-hospital UC pool called the Public Health Providers – Charity Care Pool, providing about $500 million per year to local health departments and community mental health centers to offset uncompensated care costs for providing behavioral health services, immunizations, chronic disease prevention and other services to the uninsured. Thanks to the temporary injunction, the PHP-CCP received final federal approval and launched in 2021 but could be at risk under a permanent rescission.

While awaiting the outcome of pending litigation over the waiver, THA continues to advocate for its continuation to ensure hospitals can serve anyone who needs care regardless of their ability to pay.

Delayed Directed Payment Programs

Last fall, the state's Uniform Hospital Rate Increase Program (UHRIP) and Delivery System Reform Incentive Program (DSRIP) expired. These two longstanding Medicaid programs had provided more than $5 billion in rate enhancements and performance-based incentive payments to providers caring for Medicaid enrollees and low-income uninsured patients.

Texas proposed three DPPs in March 2021 to replace UHRIP and DSRIP that integrate their successes into Medicaid managed care. The new DPPs were intended to go into effect September 2021 for a seamless transition at the same time as UHRIP and DSRIP expired, but the proposed programs only received federal approval in late March.

The replacement DPPs include the Comprehensive Hospital Increase Reimbursement Program (worth $4.7 billion a year), Texas Incentives for Physicians and Professional Services ($600 million a year), and Rural Access to Primary and Preventive Services ($11.2 million a year). These DPPs offset below-cost Medicaid reimbursements while incentivizing improvements in care coordination, quality and access for Medicaid enrollees.

The DPPs described in the waiver extension were key to the DSRIP transition, and expenditure authority for the DPPs is tied to the budget neutrality room afforded under the current waiver extension. Texas and CMS's budget neutrality agreement would have carried forward existing funds and allowed new spending to improve quality of care and patients' access to services.

Texas and CMS agreed on nearly all features of the proposed DPPs, except for one method the state uses to finance the non-federal share of Medicaid supplemental payments, called a Local Provider Participation Fund (LPPF). Since 2013, LPPFs have been used without CMS objection to fund each of the state's hospital supplemental payment programs. However, for months LPPFs were the sole stumbling block to DPP approval. Immediately following CMS' approval of the DPPs on March 25, the U.S. Health and Human Services Commission notified HHSC of its intent to conduct an audit of Texas' LPPFs to determine if the arrangements are permissible and in accordance with applicable federal and state requirements.

Twenty-eight regional LPPFs are authorized in state statute and provide roughly $1.5 billion of the non-federal share of proposed hospital DPPs. Their existence also ensures ongoing provider participation in the Texas Medicaid system by allowing private hospitals to continue accessing federal matching funds to offset the cost of providing care to Medicaid enrollees or uninsured patients.

"Texas hospitals' supplemental payment programs that depend on the use of LPPFs are critical to sustaining care for low-income and uninsured Texans, especially during the ongoing pandemic," said Anna Stelter, senior director of policy analysis at THA. "Without supplemental Medicaid payments, Texans would be left with a broken health care safety net amid a devastating public health emergency."

Loss of LPPF-derived supplemental funding would have dire consequences for health care access in Texas. The state could experience hospital closures, particularly in rural areas; decreased essential service lines, including already reduced labor and delivery services and behavioral health; and reduced ability for hospitals to weather pandemic-related financial challenges, like skyrocketing labor costs.

Further, providers will look to offset larger-than-expected Medicaid underpayments from other revenue streams, putting upward pressure on local taxes and commercial health insurance premiums. This scenario

amounts to a "hidden tax" on many Texans. "The cost of Medicaid underpayment has to be passed along somewhere, and businesses, employers and insured individuals pay it," said David Tesmer, chief community and public policy officer at Texas Health Resources.

Advocacy in Action

THA actively advocated for a resolution to the delayed DPPs and continues to push for a reinstatement of the 1115 waiver, while working with federal and state authorities on a permanent solution to heath care providers' funding challenges.

In a Dec. 1 letter to the Texas congressional delegation, THA president and CEO John Hawkins laid out the impacts of the current impasse and potential repercussions of losing critical supplemental funding. "Hospitals need a short-term resolution that restarts the flow of DPP funds while CMS and Texas negotiate a long-term path forward for Medicaid supplemental payments and the 1115 waiver," THA's letter reads. "We respectfully ask you to remind CMS of the urgency with which funds to hospitals must restart to maintain current services, and how the lack of clarity on what future programs CMS is willing to approve is harming hospitals' ability to plan."

THA has also worked with several legislative offices to raise awareness of the situation and highlight an immediate need for action. Lawmakers from the Texas congressional delegation and both the Texas House and Senate recently submitted letters to federal agencies calling for a resolution to the DPP approval impasse and a reinstatement of the waiver.

THA and partner associations activated all fronts in pushing for approval of DPPs, including retroactive payment to Sept. 1, 2021, arguing that Texas hospitals would lose rate increases on all services to managed Medicaid enrollees since that date. A prolonged delay in DPP approval created uncertainty as to whether Texas could implement hospital rate increases at all in state fiscal year 2022. THA and member hospitals were pleased that CMS not only approved the proposed DPPs, but did so retroactively to the beginning of state fiscal year 2022.

Medicaid coverage expansion for low-wage working Texans would provide a solution for the current financial strain experienced by hospitals, but only when coupled with a waiver. Out of the 5 million uninsured Texans, only about 1.2 million would be covered if Medicaid was expanded. The remaining 3.8 million uninsured residents would still seek care in hospitals, and hospitals must provide emergency care regardless of ability to pay.

THA is advocating for continuing a strong UC pool to offset providers' unreimbursed charity care. Texas hospitals have been in regular discussions with HHSC on the need to move forward with the UC pool as prescribed under the terms of the January 2021 waiver extension, which calls for uncompensated care payments of at least $3.9 billion annually over the next 10 years.

An important element in THA's advocacy efforts for financial stability for Texas hospitals will continue to include a push to raise hospitals' base Medicaid reimbursement closer to the actual cost of services, as well as federal funding for extraordinary pandemic staffing costs.

Behavioral health care needs have been heightened by the pandemic. THA recently submitted suggested interim charges to legislative offices and HHSC that recommend studying the availability of inpatient behavioral health care, review related uncompensated care costs, and pursue a waiver of the Institutions for Mental Diseases exclusion, which prevents Medicaid reimbursement for acute inpatient psychiatric care for working-age adults.

Regardless of litigation over reinstatement of the 1115 waiver and further review of LPPFs, Texas hospitals are committed to providing the best quality care to all patients. THA encourages thoughtful discussions to ensure the needs of Texas' growing population will be met

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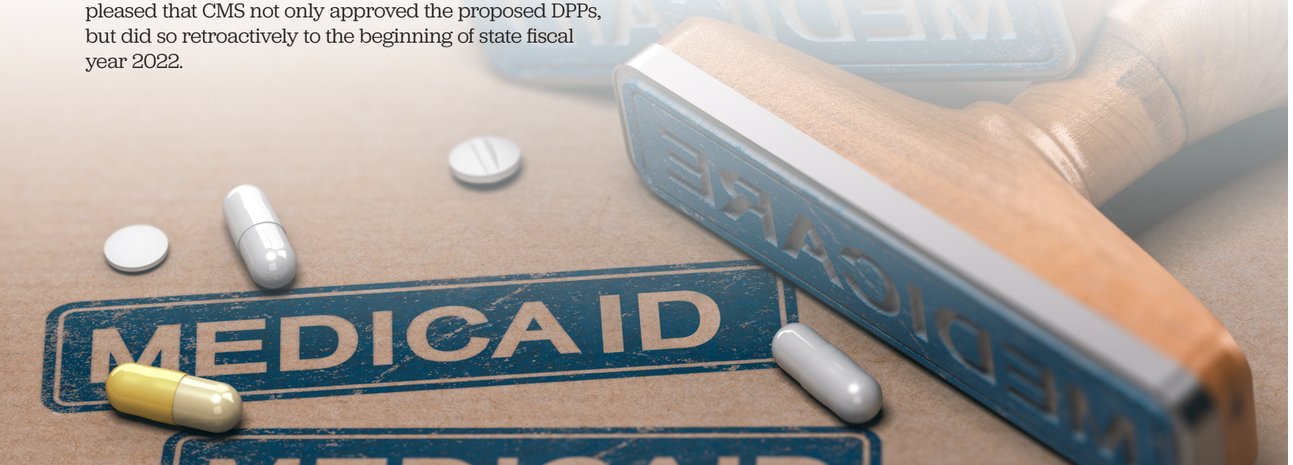
Kim Carmichael is the Director of Advocacy Communications for the Texas Hospital Association.



THT Certified Healthcare Trustees

Congratulations to our *new* Certified Healthcare Trustees!

New Trustees (Dec. 1, 2021 - March 31, 2022)

Michael Carter, board secretary, Parker County Hospital District
Bobbie Lou Collom, RN, board member, North Runnels Hospital
John Frantz, board member, Moore County Hospital District
Gary Jacob, board member, North Runnels Hospital
Abby King, board member, OakBend Medical Center-Jackson Street Campus
John C. Nelson, vice chairman, Hunt Regional Medical Center Greenville
James Penn, board member, Texas Scottish Rite Hospital for Children
Dr. Carmen Purl, board member, Moore County Hospital District
Dr. Emily M. Weber, chief nursing officer, HCA Houston Healthcare Southeast

Congratulations to our *renewing* Certified Healthcare Trustees!

Renewing Trustees (Dec. 1, 2021 - March 31, 2022)

Bill Johnston, chairman, Peterson Health
Glenda O'Neal, secretary/treasurer, Limestone Medical Center
Robert L. Schmerbeck III, board member, Peterson Health
Martha L. Stanton, vice president, Limestone Medical Center

THT's Certified Healthcare Trustee designation is earned through a program designed to make health care board members better leaders and show their commitment to good governance to their hospital and community.

What it Takes to Become a CHT:

- Serve a minimum of one year as a board member for a hospital or health care system.
- Complete a minimum of 24 hours of continuing education from an approved provider within the last three years and provide proof of attendance.
- Pass the CHT Exam with a score of 70% or higher
- $125 initial fee

What it Takes to Renew Your CHT:

- Renew your certification within 90 days of the expiration date.
- Submit proof of 12 hours of approved, attended continuing education.
- $100 renewal fee

INSURICA HEALTHCARE

Preventing Violence in the Health Care Workplace

Workplace violence in the health care industry has been declining, but that doesn't mean it's completely absent from hospitals and other medical clinics. According to the Bureau of Labor Statistics, almost half of non-fatal injuries from occupational assaults and violence occur in health care and social services settings.

Who is most at risk? Statistics indicate that nurses were the most likely victims of assault, most of which are committed by a patient on an employee. Other assaults occurred between a stranger and an employee, and between two or more former or current co-workers. Given the risks, there is an imperative need for health care facilities to establish violence prevention policies to protect their employees.

According to the Occupational Safety and Health Administration (OSHA), health care facilities should instill a violence prevention program as part of their larger safety and health program. This program serves to reduce the severity and frequency of injuries that employees face, track the facility's progress in reducing violence and decrease the threat of violence to employees' safety. Specifically, the program:

- Outlines a clear policy detailing that violence including verbal and nonverbal threats, will not be tolerated in the workplace
- Eliminates the chance that individuals would seek revenge on an employee for reporting violence
- Encourages employees to report violent acts quickly
- Outlines a plan to maintain safety in the workplace
- Explains management concerns for employee physical and emotional health
- The goal of such a program is to guarantee that:
- Employees comply with and support a violence-free workplace
- Employees feel comfortable reporting violence

TRAINING

When designing violence prevention programs, orchestrate prevention training that is mandatory for all employees. According to OSHA, training is a key element in violence prevention, as the employees receive extensive information about how to conduct themselves in the workplace in the event of violence. They are also formally warned about the no-tolerance policy, in the event that they feel like instigating a fight down the road. Essentially, the intentions of the facility are made extremely clear in the training session.

In addition, by getting to know staff members who are part of the violence prevention initiative, employees may feel more comfortable reporting injuries or threats in the event that they occur. The training may include:

- An explanation of the violence policy and program initiatives
- Encouragement to report threats or violent incidents
- Tactics for preventing or reducing hostile situations, conflict or anger
- Ways to manage anger
- Suggestions for how to resolve conflicts without violence
- Suggestions for how to reduce stress and relax
- Outlining the security procedures for the facility
- Self-defense tips
- Ways to assist a victim in need of support

FACILILTY ANALYSIS

OSHA also recommends that a health care facility conduct an analysis of records, security measures and trends regarding violence. By doing an analysis, management can identify the recurring threats to their employees, security breaches of any kind and ways to protect their employees in the future. Health care facilities are particularly hazardous, according to OSHA, because of the following:

- Medications and money available in the pharmacy area (robbery target)
- Employees must work evenings in potentially high crime areas
- Employees are exposed to sometimes violent, mentally unstable patients
- Patients may be uncooperative or combative at times
- Rooms may contain furniture or items that could potentially be used as a weapon against employees

After conducting an analysis of the facility, management should install additional safety controls, including:

- Increase lighting in high risk areas such as patient rooms, isolated treatment areas or outside the facility
- Install metal detectors to alert security staff if patrons are bringing guns or knives into the facility
- Install plexiglass windows around the pharmacy check-out window to minimize the threat of theft
- Use safety devices such as alarms, panic buttons, cameras, two-way mirrors, key-card access systems and hire security personnel
- Install curved mirrors at hallway intersections
- Train staff on how to recognize hostile situations and behavior
- Increase staffing in the evenings or in places where patients may become violent
- Encourage employees to carpool so they arrive and depart in groups
- Provide a complimentary shuttle service or security guards to escort employees out of the building
- Explain the zero tolerance policy for violence to patients
- Have relationships with the local police and alert them of the emergency action plans in the event of violence
- Gather previous records of patients to determine if they pose threats to employees
- Design a program to deal with violent and combative patients including:
  - Arrange furniture in such a way to prevent the staff from becoming trapped in the room
  - Place minimal, lightweight furniture in the rooms without any sharp corners
  - Affix the furniture to the floor
  - Remove excess clutter from the rooms, especially items on countertops that could be used as weapons
  - Make sure that there is a second exit, if possible, in patient rooms for employees in the event that the patient becomes violent
  - Require that employees implement a buddy system when treating high-risk patients so they are never alone

RESPONSE TO VIOLENCE

In the event that a violent act is committed in the facility, employees need a supportive management staff to rely on to get through the trying time. To ensure that employees receive the support they need, the health care facility should establish a response team to deal with the situation.

This team is responsible for providing medical care for the injured employee(s) and counseling after the fact.

OSHA also requires that facilities fill out an OSHA Form 300 within eight hours of the incident to document all work-related injuries if three or more employees were hospitalized. By documenting violence, OSHA and the facility can determine the severity of the incident and determine how the situation can be prevented in the future.

Remember that it is the facility's responsibility to take steps to protect its employees from violence and maintain a safe working environment.

The Trustees' Role in Addressing the Workforce Shortage

By Amy Eskew

Maintaining appropriate levels of workforce and staffing continues to be a significant challenge for hospitals. Before the COVID-19 pandemic, Texas faced a significant physician and nursing shortage, particularly in rural communities. A 2019 report from the Texas Center for Nursing Workforce Studies projected that the demand for nurses between 2018 and 2032 would increase by nearly 40%, while supply was projected to grow by only 30.5%. This shortage has been further accelerated and exacerbated by a now two-year pandemic, which has caused nursing staff to leave the industry or shift around like never seen before. The American Hospital Association's 2022 Environmental Scan reports that the annual rate of turnover in emergency, ICU and nursing departments has increased from 18% pre-pandemic to 30% in 2021.

As a board member, you may feel like your efforts to address the issue are sidelined. Understandably so, as staffing is a management function, falling within the purview of the CEO or hospital administrator. There are, however, things you can do as a hospital board member to support your leadership and organization to help address staffing levels. The following is a list of actions you can take as a board member and important discussion questions to help address this ongoing challenge.

Look at the Data

Understand how staffing and demographics were already changing in your community and if they continue to do so during the pandemic. Prior to 2020, many communities saw an influx of growth or outward migration. Texas was particularly impacted by substantial population growth over the past several years. This is a key factor in staffing has a key role in staffing in not only understanding the availability of labor in your area, but also what resulting population changes may mean for the amount and type of staff your organization needs. It's important to have these conversations as a board as you look to the future staffing sustainability of your organization.

Discussion questions may include:

- How did our population look prior to the pandemic and what significant changes have we seen?
- What labor/workforce changes did we see before the pandemic compared to now?
- What if certain staff don't return to the community?
- Are there new service lines or staffing models we need to explore to meet the needs of our community?
- Are we beginning to see changes in care delivery or in alternative care settings?
- What does our employee satisfaction data indicate about the workplace? What are the trends in employee morale?

Resource Allocation

Staffing costs and salaries are a central component of COVID-19-related staffing shortages. According to the AHA 2022 Environmental Scan, nationally, hospitals and health systems are paying $24 billion more per year for qualified clinical labor than pre-pandemic.

The board's primary responsibility is to ensure that resources are allocated appropriately to meet the organization's needs. The board may need to re-evaluate the current workforce budget to allow the CEO to adjust as needed to properly staff the hospital or enhance current retention programs. This may lead to difficult conversations in determining where financial resources are best spent.

Discussion questions may include:

- Does the hospital currently have hiring incentives or staff retention initiatives in place?
- What financial adjustments might need to be made to those initiatives in the one, three or five years?
- What non-financial benefits have we explored or offered?
- What programs do we provide to support the emotional well-being of the staff?
- What has resulted from any adjustments made, are we seeing progress in hiring or retention?

Community Partnerships

Another important aspect of attracting and retaining staff is making sure the community can meet their needs. This may be addressed through affordable housing, economic opportunities and development. Serving on a hospital board means you are a link between the organization and the community; this is particularly true for elected board members. In this important role, trustees can help facilitate introductions and establish relationships with key community leaders to ensure the community can support and welcome new staff and residents.

Discussion questions may include:

- What is appealing to residents about our community?
- What are the challenges of bringing new talent into this community?
- What agencies, organizations or non-profit groups could help address these challenges?

Be Supportive

Governing and managing are separate but complementary functions. Governance looks forward, sets expectations and provides responsible oversight. Management works to meet expectations, achieve performance goals and manage the hospital's daily activities. Be supportive of the management and CEO during these particularly challenging times and help keep an eye forward toward the future. As was often discussed last year, there's no going back to a pre-pandemic time, we are headed to a "new normal" or "next normal." The bottom line is that health care will look significantly different as we enter the endemic and though some of the same challenges like staffing may linger, they may not have the same solutions as originally envisioned.

Amy Eskew is the President/CEO of Texas Healthcare Trustees.

10 Questions Boards Can Answer to Advance Equity

Now is the time to take a step back and look at COVID-19's impact

By Somava Saha, M.D., Dora Barilla and Karma H. Bass

Successful hospitals and health systems need strong medical staffs to attract patients, deliver high-quality care, promote institutional reputation, and ensure a steady revenue stream. However, a growing physician shortage is making it harder to recruit clinicians, doctors have become more mobile and are spending less time at any single hospital, the prevalence of practitioner burnout is creating a less-engaged clinical workforce, and an explosion of physician employment by non-hospital entities (e.g., private equity-sponsored groups and insurers) is weakening traditional doctor-hospital bonds.

COVID-19 has served as a wake-up call to the inequities experienced by underserved and historically marginalized populations.

As some of the world's most accomplished clinical experts continue to develop therapeutics, treatments and vaccines for combatting the pathogen, health care leaders need to plan for the long road to recovery and resilience in their local communities. Now is the time to step back, take a long, hard look at the impact of COVID-19 and ask: How did we get here, and what needs to change?

Shifting Community Stewardship

Resolving inequitable health outcomes requires health care organizations to shift their focus within the community to make sure they are providing care services and contributing to community conditions in a manner that is equitable – not equal – for all populations. COVID-19 has forever changed our communities and should compel governing boards to understand the nuances of inequities in their communities, broaden the reach and resolve of their organizations, and restore trust in their organizations.

This means a governing board should understand the pandemic's impact on all populations within its community, the efficacy of its organization's response, and the organization's capacity for improving that response.

Here we outline 10 questions that can serve as critical conversation starters for trustees in directing organizations toward actions that lead to genuine, systemic and sustainable positive change for populations that have suffered the most from health care inequities.

The Impact of COVID-19

1. In what ways did health inequities show up among the populations within our community, and what drove those inequities?

It is important to know the COVID-19 infection and mortality rates for all populations within your community – stratified by race, age, gender, location and such. This information also should include the type of care these populations received. Who is hospitalized, and who is not? Who received treatment in the intensive care unit? Who was put on a ventilator? It also is important to examine the differences in the outcomes among these groups and their root causes.

2. How has COVID-19 affected different segments of our workforce?

Early on it became clear how the virus was affecting the physical and mental well-being of the health care workforce. For good reason, much attention was placed on the toll the pandemic was taking on front-line workers – mainly physicians and nurses.

But is important to know how the pandemic has affected all employees' overall well-being. Housekeeping, maintenance and food service staff, for example, also were working extra shifts and may have had increased expenses, such as for child care, because of the additional work. It is important to ask about workers who are struggling, get to know their stories and what support they are receiving, and find out what it will take for them to thrive.

3. What did we learn about the needs of our community and how will we use this information to strategize and shape our efforts to advance health equity?

Beyond effective medical care, the pandemic has revealed other unmet needs – especially with food and housing – of community members disproportionately

affected by the pandemic. This kind of information on community needs should be incorporated into reports distributed regularly to the board to better inform decision-making about community benefit and other community investments. The ongoing dashboard of data that boards regularly review should identify community members disproportionately affected and organizational initiatives and investments that positively affected these populations. The data also should inform decision-making that leads to decreased health inequities.

Organizational Capacity to Address Health Inequities

4. To what extent does the composition of our board, administrative leadership and workforce reflect the populations within our community that are experiencing inequities?

To better understand and meet the needs of its community, a health care environment should include people who truly represent that community and bring that lived experience into day-to-day operations and strategic planning in all areas, including governance, leadership and workforce.

It is important to understand, however, that diversity is not solely about having people from diverse racial and ethnic backgrounds join your board. Trustees should be valued not only for their age, gender, color of their skin or any other demographic characteristic, but also for what they can offer to advance equity and well-being in your community. They should view equity as a core value of any work and be able to persuade others that change is needed.

5. Is our governance process truly equitable, and do we have the culture to enable genuine change?

Diversity efforts are not complete when diverse board members are seated. The board itself has to be ready to embrace equity and understand what contributed to inequitable systems and what it takes to achieve equity. Diverse members who understand what causes inequities should have genuine influence within the board to effect change.

Decision-making processes, board leadership appointments and board culture should be transparent, foster inclusion and allow everyone to add their voice. Processes should facilitate honest conversations that leave room for dissent. This type of learning journey requires each trustee, no matter their original viewpoint, to support and advocate for health equity, even if it feels uncomfortable. We cannot facilitate change without being willing to be changed.

6. What board competencies are required to advance equity?

Competency to advance health equity is twofold: understanding your organization's history of being trusted or mistrusted in the community, and having the skills to confront those community perceptions and address any lasting impact.

To what extent has race, place, income and other historical drivers of health inequity played a role in any mistrust that your community may have for your organization? Does your board understand how the organization may have contributed to this legacy of mistrust? Has your board gone through a process of understanding its own history and relationship with the community?

Understanding the community conditions that affect health is key to addressing health equity. Does your board have public health and social needs expertise complementing traditional board competencies such as finance, legal and real estate? Have you examined data to address inequities in your organizational policies?

7. Do the reports that our board regularly reviews include data that has been stratified to reveal the inequities that exist in our community?

Community needs data that is stratified by age, race, place (census tract or zip code), gender, income level and other factors will help to delineate the inequities various populations are experiencing. Boards should have a process to evaluate this data, set strategic goals based on the data, and regularly review the data at meetings

as part of the board's core quality improvement process, because equity is a key component of quality.

The Response

8. How can our organization's time, resources and talent be used to advance equity?

Organizations that are forward-thinking in advancing equity use their resources to reverse the impact of historic discriminatory practices in their communities. Practices such as exclusionary zoning, or "redlining," placed on certain populations by government and private entities resulted in disinvestment in these communities and ultimately led to some inequities, such as in income and education, which we see today. Advancing equity requires a commitment to understanding such past discriminatory practices and fostering practices that will reverse their impact.

For health care organizations, this means investing in their communities beyond care delivery, and into workforce, hiring and purchasing pipelines that bring dollars back into the community. These kinds of investment, known as anchor strategies, bring direct benefits to historically underserved populations. How are operating dollars at your organization being used to invest strategically to advance equity, including providing living wage jobs, sourcing vendors who are local to the community, locating a facility where it can best serve those in need and hiring low-income, minority workers from the community?

9. Which community organizations have been most effective in responding to the community needs heightened by the pandemic, and how is our organization partnering with them?

In many ways, COVID-19 has served as a stress test, exposing the weak and strong points in our social systems. Which organizations within your community stepped up to fill in the gaps to meet immediate needs? Who had and built trust with local communities? It is important to partner with community organizations that provide services that help fill immediate needs. Likewise, it is important to form partnerships with organizations that provide similar or related services or input that will have a longer-term, sustainable impact on conditions within a community that resulted in such need. A food pantry will supply groceries to fulfill immediate needs, but a retailer might offer a program to hire community members, or a local bank might facilitate a small business loan for a woman-owned or minority-owned local business.

Investing in equity means investing in programs that address short-term needs and that contribute to the long-term health of your community. Who are these partners? What do they need from your organization to be successful in providing short-term services and long-term investments that support underserved populations and enable the community to thrive?

10. How is our organization using the lessons from COVID-19 to strengthen its long-term resilience against the next crises?

After a crisis, resilient organizations take the time to retool, institute changes that mitigate weaknesses and better prepare for the next crisis. How has your organization used what it has learned from the pandemic to develop a strategy that builds capacity, not just for mitigation and preparedness, but for long-term resilience that includes built-in protection for underserved populations? Have you mapped out and modeled the strategic investments that could most improve health equity in the short, medium and long term as you would any other business plan?

As your board reflects on the impact of COVID-19 and your organization's response, consider how the choices your organization makes today might build the vital conditions all communities need to be resilient in facing the next shock that comes. These vital conditions include belonging and civic muscle, access to humane housing, reliable transportation, basic needs for health and safety, and access to lifelong learning and a thriving natural environment.

Advancing Health Equity

The COVID-19 pandemic has illuminated and exacerbated health inequities. If those inequities were once partially shielded by ignorance, misguided decisions and overt racism, the pandemic has pulled pack the curtain entirely to reveal a system that leaves far too many people vulnerable to poor health and life outcomes.

By asking the right questions, health care boards can help their organizations enact changes that foster healing, restore trust, advance equitable care and pave the way to better health and well-being for all individuals in their communities.

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Gerard Magill, Ph.D., Ph.B., professor, Center for Global Health Ethics, Duquesne University

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Engaging Boards in Disruptive Innovation

A strategy simulation can be effective for assessing potential disruptors

By Jean Ahn and Mark A. Keroack

The health care marketplace is threatened with disruption by a variety of novel national competitors that are the products of mega-mergers. These include Optum-DaVita, CVS-Aetna, Walmart-Humana-Kindred and others. Boards of trustees need to understand the threats posed by these market disruptors and craft specific strategies to ensure continued fulfillment of the missions of their organizations.

As a means of engaging its board regarding the sudden profusion of disruptive competitors, Baystate Health (based in Springfield, Mass.) used a simulation-based learning exercise at its annual board retreat in May 2018. Extending scenario playing and simulation-based learning into the realm of strategy allows for robust, interactive board education. The approach takes advantage of trustee knowledge and expertise from other industries that have themselves had to deal with nontraditional disruptive competition. Engaging trustees in this manner contributes to enhancing the caliber of health system strategy and may suggest specific next steps.

The learning exercise was extremely well received at the board's annual retreat. Led by Baystate Health's chief strategy officer, chief executive officer (CEO), and chief financial officer, the "Deal or No Deal?" strategy simulations served to heighten awareness of potential future realities. In addition, this simulation approach allowed Baystate Health to leverage the strategic perspectives and competitive instincts of its trustees who are leaders in other competitive industries (such as banking, financial services, insurance, energy, academia and materials handling).

Five-step Process

Boards of hospitals and health systems may also benefit from Baystate Health's approach for assessing potential disruptors. (See the checklist on page one to determine if the approach is appropriate for your organization.) "Simulation," writes David M. Gaba of Stanford University, "is a technique – not a technology – to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner" (Simulation in Healthcare, 2007).

Working in close collaboration with the CEO and Strategy Committee of the board of Baystate Health, the chief strategy officer developed a set of simulation exercises that successfully met the envisioned goals of environmental level-setting and strategic planning.

Following an environmental assessment earlier in the year to members of the leadership team and board, the following steps were pursued:

STEP 1: Preparing background profile documents. The strategy team had earlier developed four- to six-page profiles of several disruptive mega-merger competitors over the course of three to four months. The briefs included key summary statistics of the merging entities, including foundational statements, maps, financial summaries, noteworthy programs, accomplishments and partnerships. These were supplemented with traditional SWOT (strengths, weaknesses, opportunities and threats) analyses developed by the strategy team, both for the disruptive competitors and for the health system itself. The relevant background profile documents were provided to the board as pre-retreat homework readings. Hospitals and systems may wish to adopt a similar template for profiling competitive disruptors in their own service areas.

STEP 2: Preparing realistic scenario briefs. Four mega-merger competitors were selected because they already had a presence in the health system's primary service area and therefore were more than just hypothetical potential competitors. Expanding upon the background profiles that outlined the four disruptive competitors' existing footprint and assets in the local market, the chief strategy officer took the lead in developing scenario briefs that imagined realistic possible short-term encroachment strategies by the disruptors that attacked niche parts of the health system's continuum of care. The resulting encroachment challenge served as the basis of the "Deal or No Deal?" simulation exercises. Participants in the simulation needed to wrestle with the following question: Does the health system attempt to partner with the disruptor (Deal) or try to compete and defend against the disruptive competitor on its own (No Deal)?

STEP 3: Designating teams. The CEO and chief strategy officer selected four sets of opposing teams to address the "Deal or No Deal?" question. Each pairing included four trustees who represented the potential mega-merger competitor (the trustee "disruptors") and three or four Baystate Health senior leaders who represented the health system (the management "defenders"). Collectively, each team of trustee disruptors and management defenders negotiated to determine if a deal could be reached, as outlined in the scenario briefs. Each disruptor team was led by a trustee who also sits on the Strategy Committee of the board, and who therefore was already familiar with the competitive disruptors under discussion. To ensure a variety of perspectives, each team included at least one clinician (a physician or nurse), an individual with a finance or business development background and a board member with a non-health care background.

STEP 4: Fine-tuning the meeting agenda. Four hours were allotted to the competitive disruptor session at the annual board retreat. During the first hour, a representative from an investment banking firm summarized the national competitive landscape and provided a high-level overview of the various competitive disruptors. The remaining time was spent specifically on the simulation exercise, with time allotted for (a) an initial small-team orientation huddle, (b) a negotiation session between each set of trustee disruptors and management defenders, (c) a decision-making session by each set of teams, followed by (d) team report-outs and a discussion facilitated by the chief strategy officer and chief financial officer, with feedback from the investment banking firm representative.

STEP 5: Follow-up on next steps. Based on the key ideas that emerged from the team report-outs and discussion, the chief strategy officer summarized and highlighted the next steps for follow-up, which included an endorsement from the board of trustees to identify and prioritize capital partners for outreach and partnership discussions. Conversations with competitive disruptors are currently underway regarding possible partnerships (including those related to primary care transformation).

Lessons Learned

The Baystate Health Board of Trustees uniformly reported that they had received valuable education from the simulation approach, which was more interactive and engaging than a traditional informational presentation. Through the simulation process, the trustees gained key insights regarding the disruptive competitors by directly assuming the identities of the disruptors themselves, and by imagining how they might think and behave in the local market. One Baystate Health trustee remarked later, *"This activity brought the opportunities and threats to life and gave me a deeper appreciation of the crossroads at which health care now stands."*

The exercise also provided a valuable perspective to the senior leadership team on what it is like to compete and negotiate with strategic thinkers from outside the health care space. Most importantly, the exercise allowed the trustees and senior leadership team alike to spend time thinking through what the system will need to do should an envisioned scenario present itself. As a result, the board came away with a new appreciation regarding the health system's competitive strategy, and generated several ideas for considering partnership strategies with potential competitive disruptors.

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Carmen Purl, MD

Moore County Hospital District

Hometown: Sunray, Texas
Occupation: Family Physician
Family: Husband David, three children and six grandchildren
Hobbies/Interests: Snow skiing, fly fishing and off-roading (ATVs)

As a Board Member

Most rewarding: I have really enjoyed developing relationships with fellow board members and the executive leaders of our hospital.
Most challenging: We have had two huge challenges and it is difficult to say which one would take the prize as most challenging: First a major expansion with remodel/new construction- challenged with a very difficult situation with the general contractor and plagued by delays and substandard work. And now, dealing with COVID-19 as a county that was one of the first "hot spots" in Texas and has continued to have daily issues with meeting overwhelming needs in a rural location.
Biggest surprise: The biggest surprise is how little the tax base is used to support the hospital. I honestly didn't realize that local taxes amounted to such a small amount of the budget and how restricted those funds are.
Proudest moment for you/your board: Praying for our nurses and doctors and staff amid the COVID-19 pandemic and the support we provide them.
Valuable lesson: I am learning more and more about how leadership and influence affect the health and wellness of our community.
Your Board's Priorities for 2022: Survival. I kid you not. There is a storm cloud looming on the horizon for all rural hospitals. We have made all the preparations possible and appear to be in a strong position to weather the storm, but the challenge will be tremendous.
Why become a Certified Healthcare Trustee? I want to be a strong contributor to the hospital board and I need tools and education to be that member.

About Me

My background: I was raised in Amarillo, and I have been a Board-Certified Family Physician since 1988. I dedicated my entire career to serving in underserved areas, specifically rural hospitals in the Panhandle. I have been in Moore County since 2000. I also travel to other countries to serve communities in disasters and underserved areas.
My childhood ambition: To be a doctor.
My favorite person (living or not!): Without a doubt my husband.
Last place I traveled: Bahamas after the hurricane. It was a beach, but not like it sounds.
What are you currently reading? I just finished "Change Your Questions Change Your Life" by Marilee Adams
My favorite place in Texas: Right here in Sunray, watching our spectacular sunsets.

Robert L. (Bob) Schmerbeck, III

Peterson Health, Kerrville

Hometown: Kerrville, Texas
Occupation: Retired Insurance Agent, but still serve as a consultant, advisor and mentor
Family: Incredibly patient wife of 46 years, Shirley, three accomplished children and seven extraordinary grandchildren
Hobbies/Interests: : Collecting western art, volunteering with my Rotary Club and church

As a Board Member

Most rewarding: The seamless transition to a new CEO, who was following a legend who had led Peterson for two decades. Cory Edmondson is a charismatic leader with exceptional people skills. He is good for our organization.
Most challenging: Like all health care providers, the challenges and opportunities that arose due to the COVID-19 Pandemic. Our 1,000 plus team members were health care heroes in every sense of the word and lived out our mission of exceptional, compassionate, patient-centered care, every day for two years.
Biggest surprise: The unqualified success of our capital campaign to build a new ambulatory surgery center and retrofit our current ambulatory service center. Kerrville is an incredibly generous community.
Proudest moment for you/your board: There have been multiple events to celebrate. We continue to be recognized and awarded by various credentialing and certifying organizations. In 2022, we were certified as a Level IV trauma center and our CFO, Lisa Medovich was named one of the top 50 CFOs in rural health care in the United States. Our trophy case needs more shelves.
Valuable lesson: Health care is an industry like no other. As laymen, you must put aside your vocational experience and preconceived notions, they are useless in this setting.
Your Board's priority areas for 2022? Commence construction on our new ambulatory surgery center, and work with other community leaders to address the growing affordable housing shortage for our staff.
Why become a Certified Healthcare Trustee? If you truly want to contribute to the mission and vision of the entity you are serving, you must gird yourself with as much education and information as possible. THT is an invaluable partner with us in that quest.

About Me

My childhood ambition: I've always been accused of being an overachiever! I have always been interested in contributing to society and being the best I can be at whatever I do.
My favorite person (living or not!): My hero was my great uncle who was killed in France during World War I at age 24. His brief but exemplary life, witness and sacrifice touched hundreds of people and his legacy lives on to this day.
Last place I traveled: Normandy, France.
What are you currently reading? I just finished reading "Greenlights" by Matthew McConaughey.
My favorite place in Texas: Kerrville, of course, it's all right here.