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The Resilient Health System Operating Model

Organizational strategies and new avenues for value creation in health care

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Introduction

The Resilient Health System Operating Model

Health care systems are facing the leadership challenge of navigating between the benefits of scale and the added operational complexities that can come with size. The pandemic fundamentally altered consumer behavior and expectations while reshaping traditional health care service delivery models. Large systems can experience delays in decision-making amid layers of review and internal deliberations. Add to this the entry of nontraditional provider competitors and technology disruptions and it becomes an imperative for health systems to continuously examine and improve operational and governance models. This Knowledge Exchange e-book examines how health system leaders are changing governance, decision-making and their operating models for the future.

10 WAYS health system executives are building a robust governance and operating model

1. Design your governance structure for where you want to be in the future and for growth.
2. Activate your operating model to align the organization to execute your playbook.
3. Create system committees and set clear approval authorities to move to one corporate culture.
4. Develop matrix-defining key accountabilities and decision rights across the organization.
5. Amplify physician and nurse leaders in the organization to have decision rights regarding the vision, strategy and priorities as well as the pipelines of the C-suite.
6. Empower decision-making bodies to be agile and move strategy forward.
7. Set a timeline, process and an approval process for all major initiatives.
8. Bring new voices and diversity onto the board — a mix of out-of-market people while keeping a balance of market people and skill sets.
9. Implement innovative care models, invest in automation to streamline work and move to a global workforce model.
10. Evaluate governance and operating structure yearly against strategy (what you are trying to achieve) and top organizational risks.

Participants

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MODERATOR MICHELLE HOOD *(American Hospital Association):* **As your health system has become more complex through acquisitions, organic growth, new sites of care delivery and partnership with other stakeholders in our ecosystem, how have you modified your day-to-day decision-making and operating models, and what has been the impact on your organizational structures?**

MATT HEYWOOD *(Aspirus Health):* Health system size is relative to your market; it's not a dollar number. It's what you need to be effective and viable. When I joined Aspirus, I said, 'Give me some time to show you that you can be a viable organization independently. Then if it's not possible, we'll look for a partner.'

First, we needed to revamp the governance structure because the existing structure was not designed for the future or for growth. The governance structure must be built for where you want to be. We had an understanding of the design we needed for future success before we went forward, and that it would be about a 10-member board. It would have one physician representative, an employed physician rather than a private practice physician, because that would be a conflict of interest. We have strict conflict of interest policies and procedures, and we make sure that board members think about the system first, not their specific constituents.

Then, we created system committees of the board: quality, finance, audit and compliance, compensation, and governance. We meet monthly because we're growing rapidly. We also increased management's authority and decreased the items the board must approve, allowing the board to focus on strategy and high dollar commitments. When you are growing five times your size in less than 10 years, you need a thorough but efficient approval process. Our board committees are responsible for the whole system. We also created local/regional boards, with very clear approval authorities and rights. Once you do that, your governance structure helps ensure that the right decisions are made in the right manner.

Underneath that, we created corporate councils that comprise key constituents from the whole system, regardless of title, to develop recommendations from a system perspective. All major initiatives have a timeline, a process and approvals. Then, outcomes are rigorously monitored.

CHRIS ROTH *(St. Luke's Health System):* We put in a robust system that evaluates both governance at the board level and operational governance at an executive level. At the executive level, it's evaluated every year through two lenses: first, our strategy and what we're trying to achieve; and second is organizational risk. Then, annually, we discuss with our board the top 10 risks and evaluate the structure. For example, this assessment identified culture and workforce as a top organizational risk, which led us to set up a board committee to expand our compensation committee to address culture and workforce — it's now called the culture, compensation and workforce committee.

In the area of operational governance, we have executive committees, management committees and councils. The definition of those groups is important — what they can and can't do in terms of decision–making. We evaluate and then change membership every year based on need, and once you start doing that, it becomes a lot easier culturally because the expectation of change has been established.

St. Luke's has a robust clinically integrated network, a new startup with the health plan and the existing delivery system. The question we are currently addressing is: What should the governance and operating struc-

MATT HEYWOOD | ASPIRUS HEALTH

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ture look like with these three integrated entities of delivering care, connecting care and funding care?

MIKE SLUBOWSKI *(Trinity Health):* We're a $24 billion national system in 26 states with regional scale in some markets but not in others. An organization is not functioning as a system unless you're leveraging your skill, learning, innovation and scale and you are implementing common platforms. That's been an important part of our work together. We have a system board of 15 members, regional boards and integrated regional and multilocation operations, and we have created four service areas for support and administrative functions nationally. That's a new phenomenon for us.

We have an executive leadership team for the system, but partner with our regional CEOs as the ministry leadership council. We meet virtually three times a month and have in-person sessions every couple of months. We fly everybody in because we think that face time is important.

A couple of years ago, we designated a community division, consisting of our medical groups, freestanding ambulatory surgery centers, freestanding imaging centers, specialty pharmacies, home care, hospice and Program of All-Inclusive Care for the Elderly. We have two operations leaders at the system leadership level: one is responsible for the community division and one for the hospital division. It's a matrix relationship, but we have somebody focused more clearly on the areas that we're trying to grow.

MARLON LEVY *(VCU Health System):* Although by statute a separate health system authority, VCU Health is, for all intents and purposes, a public hospital that is separate from the university. We have our own 21-member board appointed by the General Assembly, State Senate, and the Governor. We apply significant effort in keeping our board closely informed on the issues facing health systems such as ours. My approach has been to ensure the subject matter experts on our management team work closely with the committee chairs on the board.

We don't have specific urgency around scale; we've grown because the system has been managed well. We have an 850-bed academic medical center and three much smaller hospitals. The urgency is more around geographic diversification — growth and balance for a true hub-and-spoke model to keep our academic medical center premier but lessen its relative reliance in our financial portfolio. Our North Star is being able to serve all of the patients who come to us seeking care.

LYNN GONSOR *(Accenture):* Having decision-making bodies in place is an important organizational capability and advantage. There are many systems that struggle with it and don't have the decision-making structure to be agile. Once it is in place, you can use it to move strategy forward.

Studies have been done on cultural attributes that would indicate or correlate with financial performance. The research found that no single cultural attribute correlated with financial performance. It was the degree to which individuals said that their culture was strong. If it's strong, you can turn people on a dime. That's what a strong culture does.

Decision-making is one of the most visible attributes of culture. How decisions are made allows the lead-

MIKE SLUBOWSKI | TRINITY HEALTH

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ership team to control the organization's destiny. Another critical part of activating an operating model, or an outcome of it, is that the leadership team can help align the organization and prepare it to execute. Now you have a playbook.

HOOD: Shared decision-making models have been around for some time. For example, dyad and triad management models have become more common. What decision-making and operational models are you using? Have these changes had implications for your approach to leadership development?

LISA SHANNON *(Allina Health):* As our strategy is based on the strengths of our distinctive clinical programs, we have needed to restructure, empower and integrate our clinical leaders, physicians and nurses into our organizational structure. We have the classic organizational structure, dyads and triads, but now we're elevating and amplifying physician and nurse leaders in the organization to have decision rights related to our vision, strategy and priorities. We're also finding ways to engage them in developmental roles within our structures and the pipelines of our C-suite.

ROTH: We have a robust dyad model in our clinical areas and service lines. In one of our service lines, we found that we were missing the mark, so we established a physician-led executive committee, a dyad committee — typically three administrators and three physicians, including our executive medical director. They're empowered to inform things like facility planning, decision-making and regional strategy.

HEYWOOD: Currently, we are a limited dyad model. We're realigning the medical executive committee structure, like the chief medical officer role, into the structure of our medical group, which is mainly employed.

HOOD: How have your longer-term strategic goals influenced how you think about operating models? How have you engaged your board in this strategic thinking for building and ensuring a vibrant operating model?

SHANNON: In reviewing our governance structure, the future requires acceleration of our vision and maintaining agility against continued industry and community challenges. Our board has leaned into looking at how quickly we can make decisions and become nimble. Right now, we're taking a step back at the advice of our board chair and asking, 'What is the minimum necessary, responsible governance structure to ensure management capacity in support of our mission and service to the community?'

Over the next eight to nine months, we're going to look critically at not only the number of committees but the way we meet, the length of the meetings and governance decision rights. It's been awhile since we've done that.

HOOD: What does the operating model of your revised leadership group and their intersection with the board look like?

SHANNON: The intersection is intentional clinical participation in the board, not necessarily from the leadership team. We have been intentional about bringing new voices on the board. For the first time, we have three board members who are out of market that bring deep health care experience — a former CEO, a current chief nursing officer and a former human relations chief executive from a large national system.

LYNN GONSOR | ACCENTURE

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ROTH: We conduct a formal assessment annually. The executive council, which I lead, reviews it. Our board has visibility and provides input. Its members often ask: 'Where is this issue being addressed in the organization? Where are those decisions being made?' It's become a healthy and meaningful process.

HOOD: Workforce continues to be a big issue for all of us. The way we work is different today from what it was prepandemic, and it probably will change more in the future. Many of you are introducing different team models and different approaches to integrating virtual workers. How do you accelerate technology utilization in support of extending the workforce? As this workforce challenge continues and we do this work differently and outside the four walls of our organizations, how do you think this might affect your operating model and decision-making processes?

JAMES DOVER *(Avera):* We're in a four-state region and we're worried about having enough nurses by 2029 due to our growth. In our situation, we had to run the algorithm: How many are retiring, what's their age, how many are we recruiting, where are we recruiting from and how many nurses is each university in South Dakota graduating this year/next year? This complex algorithm indicated that we'll be short 600 nurses by 2029. Since 85% of the nurses we employ were born, raised, and trained in South Dakota, then we must go upstream with the universities and achieve higher output. Our retention rate is good, so it is all about partnerships with the colleges that graduate nurses and enhancing their ability to spool up more graduates.

BO BOULENGER *(Baptist Health South Florida):* We did the same thing, but we also went to our state legislators and asked for assistance with the caregiver shortage. We received significant support from the state, as well as through partnerships with other organizations to increase our talent pipeline and provide upskilling opportunities. The goal is to bolster our workforce with more graduates, nurses teachers, professors of nursing, allied health professionals, technicians and more.

The pandemic was a stressful time for caregivers across the world. The first year, we had around a 30% turnover rate. It was a real concern and retention became an essential focus area for us. I'm proud that we have been able to provide wonderful opportunities within our health care system and turn that around. Many of our efforts at Baptist Health have been successful — our current vacancy rate for nurses is at about 4%.

SLUBOWSKI: Within the four walls, let alone outside the four walls, it's always about people, process, technology and culture. When we jump onto some new technology and processes, we forget about the people and the culture or don't put as much emphasis on those. As an example of systemic change, no one is going to be a floor nurse for 30 years anymore. A new graduate nurse will spend a year or two on the floor, take that experience and move on, earn a master's degree to become a nurse practitioner and work in a clinic.

So we went all-in on an initiative we call "Together Team," which is our new care model of the floor nurse, a licensed practical nurse (LPN) or a certified nursing assistant (CNA) and the virtual nurse, and they work as a three-person team. They are assigned seven to eight patients. Our experience with this

LISA SHANNON | ALLINA HEALTH

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new model, supported by information technology (IT) has been that we've been able to retain the floor nurses a little longer because they're supported by an experienced nurse on the team. The LPN or CNA gets to practice at a higher level. We've been able to retain nurses who were going to leave the workforce because they couldn't handle the physical demands, but they still wanted to do nursing, and they are now virtual nurses (400 of them). The patients and the families like it. There's time to teach teach patients and to do discharge planning and have discussions with them. It's a big cultural change when you introduce a nursing team model. Many nurses have grown up in the primary care nursing model where they must do everything, versus a team approach to care.

HOOD: How does it change the leadership approach for those teams?

SLUBOWSKI: Nursing leaders need to be on board from Day 1. The infrastructure to support the team requires clinical informatics and IT staff. It's important to create these relationships and partnerships as well as new operating steps.

It takes discipline to keep the nursing team model in place. For example, if on the night shift, somebody from our three-person team is pulled because we're shorthanded somewhere else, the model breaks down and we don't achieve the same benefits with nurse retention, quality and patient/family engagement and satisfaction.

RUSS GRONEWOLD *(Bryan Health):* From a leadership standpoint, it's all about clarity. Early on, when we started bringing in hybrid workers and virtual workers, we said, 'Here's the clarity of your role,' but we didn't articulate that well enough to the folks who were on-site full time. We have some virtual staff, but more staff are hybrid, and we've had to become very clear about what days you're going to be on-site and what happens when you are. What are the expectations from both sides and who enforces those expectations?

C. WRIGHT PINSON *(Vanderbilt University Medical Center):* In Nashville, we know that there are 70,000 jobs today that we can't fill. We can't solve that without getting everybody on board. I want to emphasize the importance of joining together with outside organizations. A key to trying to solve the workforce issue is reaching out to the city and state governments as well as chambers of commerce and figuring out coalitions to bring educational institutions together with different industries and employers.

HOOD: Also, how about flipping that to look at your communities and how many people within your communities are underemployed? They're working entry-level jobs when, with a little bit of advancement opportunity, they could take some steps up the ladder.

PINSON: Maybe half of the problem could be solved by work ladders and retraining people appropriately, as the education and certification we need in health care jobs is higher than most industries. But we also know there's another half; we're going to have to do something differently as there are not people available.

GONSOR: In terms of talent, the low-hanging fruit largely has been picked in terms of trying to engage the workforce differently and creating efficiencies. What we're starting to see in health care are strategies that have happened already in other industries. In health care, it's innovative care models and looking end to end at how care is delivered to make sure people are operating at the top of their licenses. That's taking the box, picking it up and shaking it, not just tweaking it a bit. But how can we do this differently?

Another piece is automation and there's a lot that can be automated. It takes some investment up front, but how can automation streamline the system? And lastly, offshoring of the workforce like what we see in consumer products or life sciences — IT, marketing and even research and development are offshoring. We're seeing the move to a global workforce model, not just local. ●

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