

# Trustee Insights

INTERVIEW



## How You Can Advance Your Board Diversity Strategies

Baystate Health CEO Mark Keroack discusses how health care boards play essential role

**BY SUE ELLEN WAGNER**

recently spoke with Mark Keroack, M.D., about the importance of community partnerships, diversity efforts and board diversity recruitment strategies.

Mark is the president and chief executive officer of Baystate Health, headquartered in Springfield, Mass.

**Sue Ellen Wagner:** Please describe Baystate Health's role in

*diversity and include any community partnerships that your organization is engaged in to strengthen these efforts.*

**Mark Keroack:** When looking at any initiative that we embark on, we always start with our mission, which centers on community health. Because of the segregation by race and ethnicity in Western Massachusetts, for us to really fulfill our mission of taking care of all the communities we serve, we need to address health care disparities by race and ethnicity.

We've been studying this for many years and sponsor a public health institute that has articulated the differences between various communities in life expectancy and chronic disease prevalence. We have made big investments in population health and accountable care in Western Massachusetts to address these disparities. Adjusting our care delivery to the different communities we serve has been critical to being successful.

Over and above care delivery, the next generation of talent in Western Massachusetts is going to be more and more diverse. Springfield already is a "majority-minority" community, and for us to be a place where people want to come to work, we're going to need to be seen as inclusive and welcoming to people from all different backgrounds.

If you look at our current 2025 strategy, being a workplace of choice is the top overall priority.

Diversity, equity and inclusion are the first of the initiatives under workplace of choice, so DEI has a very high profile in the organization. We believe that both systemic and institutional racism is a public health threat, and therefore it is part of our mission to address these issues.

There are a number of initiatives that the health system has embarked on to learn and improve in these areas. It starts with data: We are putting a lot of effort into reliably obtaining race, ethnicity and language data, for employees and for our patients, so we can know where discrepancies are occurring. We are using those data to feed a dashboard, which we will use to display specific key performance indicators for DEI.

In the wake of the George Floyd murder and as a result of a lot of recent scholarship in the African-American community, the idea of structural racism is now more broadly appreciated. It means that there may be policies or practices in an organization that people aren't even aware of that have a biased effect by race and ethnicity. When I first heard these arguments, I went back to my background in quality improvement and said to my team, "Okay, let's assume the existence of systemic bias, conscious or unconscious, and let's start looking." So we started a structural inclusion committee, which is multidisciplinary and diverse. The group is currently looking at 20 different policies and procedures, and indeed it has found that there are some policies and procedures that have a differential impact by race and ethnicity that need to be addressed.

For example, a strict enforcement of time and attendance policies for people who take public transportation has a differential impact, and therefore it is a biased policy in its execution. Similarly, we are looking at job descriptions with overly rigorous educational or experience requirements. These may be biased against applicants of color. So we are going through these policies and trying to find out how we can mitigate those effects or eliminate them outright.

In addition to the work on systemic inclusion, we are doing broad-based employee training on DEI, using ideas advanced by Donna

of doctors, nurses and leaders are from those groups. So we have a gap that we're trying to close, and we're being incented to close it. There also are incentives for the top leaders to reduce turnover among all employees from those underrepresented minorities as well.

I mentioned before some of the issues around health care disparities and the role of social determinants of health. We are participants in a Medicaid accountable care organization, or ACO, for 44,000 lives in Greater Springfield. We are responsible for all aspects of the health of that group, with a global expense budget of \$270 million. We are partnering with social service agencies to deal with issues of housing insecurity, food insecurity, transportation, behavioral health, legal services and other needs. All of these social issues impact health outcomes and health spending. The work has created a strong focus on wellness and the role of economic opportunity in fostering overall health.

The final area I'll mention is that we have joined the [Healthcare Anchor Network \(HAN\)](#), a group of leading health systems — which now numbers 60 from across the country — that have come together and agreed to pursue specific goals to advance social justice. We have leveraged our membership in HAN in our home city of Springfield, in partnership with the local economic development council and other large employers, to commit as a group to measurable goals in diverse procurement, diverse hiring and advancement, advocacy for various issues of social justice, and place-based investment.

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Hicks, who has authored books on the subject of the inherent dignity of all individuals. This broad-based training also includes coaching and intervention when that is asked for or needed.

Our board also has asked that we develop specific management goals for DEI. About 200 top leaders at Baystate Health and I have specific targets for diversity among nurses, doctors and leaders. Currently, about 25% of our workforce comes from underrepresented minorities in medicine, which for us means Black and Latinx, while only 10% to 15%

Our investments in disadvantaged communities predate the HAN project. For many years, we have supported a charter school and an after-hours program for Springfield public high school students to develop a pipeline for diverse students to pursue health care careers. We are learning that when we dig into DEI, it shows up in multiple, different areas, not only within our own organization among patients we're trying to care for, but also across the community as a whole.

**Wagner:** Please explain the board's role in diversity and how it builds on the system's diversity strategy.

**Keroack:** We have done a lot of work to improve the diversity of our board. When I became the CEO in 2014, our board of 20 had one person of color and three women. The board chair (the sole African American) and I had some heart-to-heart conversations about this, and he introduced me to publications about white male privilege. It does flip your world on its head when I looked at the DEI issue not so much as the problems of underserved populations, but rather unearned advantages that I enjoyed by virtue of being a white man.

We began with an interesting approach at our governance committee that focused on a single selection. We have a competency-based approach to governance and track about a dozen different competencies that we feel are important

to be represented on the board. We were looking for someone with a strong financial background. I remember it coming down to two individuals, one who was white and the other a person of color. The governance committee initially felt that the white person was just a bit stronger in finance.

Then the conversation took a very interesting turn. We asked if the reason for the perceived difference was because of our intrinsic biases. We wondered if perhaps we looked at it a different way, we

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might say that both candidates more than met the threshold for financial competency, after which the diverse candidate would be seen as bringing additional value to the board.

We've continued to follow this two-step process for the past few years, and it has helped us look with fresh eyes on diverse candidates. Diversity is not in itself a competency, but rather an added value for individuals fulfilling our other competency needs.

As a result of this approach, we have gone from one to six people of color and three to eight women on our board of 20. Having greater

diversity on the board has changed the conversation dramatically and has enabled us to anticipate issues that we would not have anticipated years ago.

**Wagner:** Can you explain the board competency model you referenced that is used to recruit new board members and how impactful it is to recruitment strategies?

**Keroack:** There are a number of different dimensions. We look for individuals with standard competencies like finance, accounting, health care operations, IT and legal. Recently we added some new ones which do not show up on everyone's list: knowledge of the social services and social determinants of health, because we are getting involved in addressing health disparities; individuals with an insurance background, because we are taking on more and more risk; and people with large organizational expertise, because we

are pursuing initiatives in organizational culture change.

We also cover a wide variety of geographies, so we strive for viewpoints from those regions. Our service area includes both rural and urban areas across multiple counties. We try to triangulate all of these considerations, hopefully finding people who bring more than one competency to the table. While we are trying to address all these various competencies, the issues of DEI are consistently on our minds.

**Wagner:** Is there anything else that you want to add that we might

have missed in the questions, or any advice that you want to give folks who are looking at developing a diversity, equity and inclusion strategy?

**Keroack:** We have a number of employee resource groups. They represent a variety of different stakeholders, including Black employees, Latinx employees, LGBTQ+ employees, women professionals, military veterans, young professionals, disabled individuals and people from different cultures. These groups get together and support each other by networking. They also advise their members on career advancement.

The groups also hold celebrations. After the murder of George Floyd in the spring of 2020 for example, the Black employees group began organizing to celebrate Juneteenth in 2021. They brought in a national speaker and sponsored

walking tours through downtown Springfield, which turns out to have been a major stop on the Underground Railroad and a center for abolitionist thought before the Civil War. It was terrific that we had this group leading on that, and we were well prepared when the new federal holiday was proclaimed.

The final point I would make on the whole area of diversity, equity and inclusion is that we have started many initiatives, but I still think we have a long way to go. These are very difficult issues to tackle. While I think we have made some good progress on improving board diversity and on addressing health disparities in underserved neighborhoods, we are just getting started in tackling institutional racism.

When I speak with other leaders around the country, I have found very few that have a clear road map on how to do it. I would recom-

mend to all leaders the [toolkits](#) that the AHA is putting together to help address these issues. DEI is important work, and we are approaching it in a spirit of learning and improvement. I believe it will be a strategic advantage for any organization in the future to be seen as diverse, equitable and inclusive.

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*For more resources on diversity, health equity and inclusion, visit the [Trustee Services website](#). To download the Health Equity Resource Series toolkits, visit the [Institute for Diversity and Health Equity website](#).*

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*Please note that the views of the interviewee do not always reflect the views of the AHA.*