Building a Governing Board Strategy on Diversity and Health Equity

Case Studies from the Field

AHA Trustee Services

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Introduction

Hospital and health system board members can be transformative leaders through a demonstrated commitment to health equity and diversity. As business and civic leaders who represent their communities, board members oversee the strategic direction for their health care organizations. As critical decision-makers, they can develop intentional strategies for improving health equity for their hospitals and health systems. Boards can begin by ensuring they are diverse in composition, thought, and skill set, with a clear duty of loyalty to the communities served. The board should develop a diversity strategy and ensure that health equity is included in their organization's strategic plan. Diligently executing a long-term strategic plan and monitoring success are equally important to ensure strategies create measurable impact in the communities served.

Prioritizing health equity has been top of mind for many executives and boards across the health care ecosystem, especially because research shows that a diverse and representative health care workforce improves patients' access to care, their perceptions of the care they receive and, most importantly, health outcomes. In particular, studies have indicated meaningful improvements in health outcomes when patients' health care teams mirror their personal characteristics.

Boards play a pivotal role in ensuring strategies and budgets result in actions to drive performance, impact, and measurable progress. Leaders from the American Hospital Association (AHA), the Black Directors Health Equity Agenda (BDHEA) and The Health Management Academy (THMA) interviewed nine executives and board members from health systems across the country to better understand how their respective organizations are prioritizing diversity and health equity and inclusion and demonstrating their commitment to health equity with actionable results.

Notable Trends in Board Diversity

From November 2021 through March 2022, the American Hospital Association (AHA) conducted a survey online of hospitals and health systems across the country to examine governance trends and practices. This 2022 Health Care Governance Survey Report (Governance Report) collected data from 933 hospital and health system CEOs. Overall, the respondents were generally representative of hospital bed size and geographic distribution in the United States.[1]

Consistent with trends in a health care field that continues to undergo a substantial transformation, the AHA's 2022 Governance Report describes evolving board structures, practices and focus areas. Below are a few key graphics from the Report that illustrate the state of board diversity today.

1 Not-for-profit organizations were somewhat overrepresented and investor-owned organizations were underrepresented in the survey results.

Board Composition by Board Type Across Hospital and Health System Boards: Race, Gender and Age Trends.

Figure 1: Board Composition by Board Type by Year									
	System Board			Subsidiary Board			Freestanding Board		
	2014	2018	2022	2014	2018	2022	2014	2018	2022
Race/Ethnicity									
White	86%	83%	74%	86%	85%	82%	90%	91%	87%
Black or African American	7%	9%	15%	6%	6%	7%	4%	4%	5%
Hispanic/Latino	3%	4%	6%	3%	4%	4%	3%	2%	3%
Asian	2%	2%	4%	2%	2%	3%	1%	1%	2%
American Indian or Alaska Native	1%	0%	0%	0%	1%	1%	1%	1%	1%
Native Hawaiian or Pacific Islander	N/A	N/A	0%	N/A	N/A	0%	N/A	N/A	0%
Other	1%	2%	1%	4%	2%	2%	1%	1%	2%
Gender									
Male	76%	72%	63%	69%	70%	65%	72%	70%	65%
Female	24%	28%	37%	31%	30%	35%	28%	30%	35%
Other	N/A	0%	0%	N/A	0%	0%	N/A	0%	0%
Age									
35 or younger	N/A	2%	2%	N/A	2%	2%	N/A	3%	2%
36-50	12%	14%	10%	19%	22%	23%	17%	22%	23%
51-70	81%	73%	66%	70%	64%	62%	63%	62%	60%
71 or older	7%	11%	22%	11%	12%	12%	20%	13%	15%
Clinical Background									
Nurse	4%	13%	16%	6%	18%	20%	4%	17%	21%
Physician	26%	78%	80%	22%	73%	66%	17%	65%	59%
Other Clinician	2%	10%	4%	3%	9%	13%	5%	18%	20%

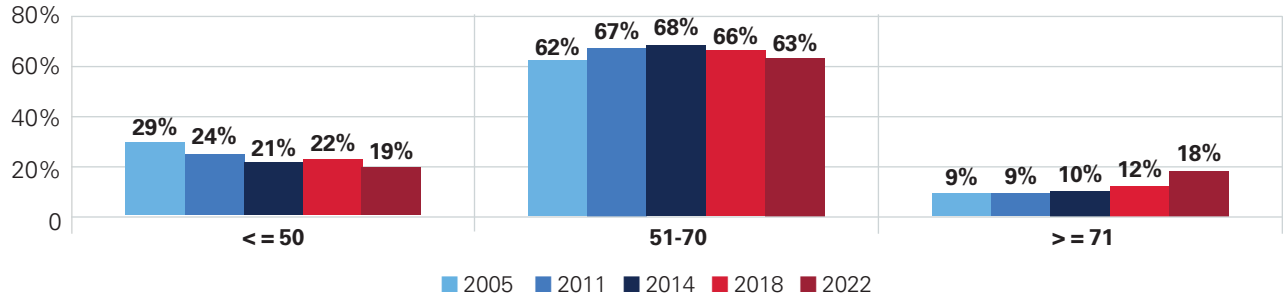
Participants reported more racial and ethnic diversity, along with a higher percentage of female members in 2022.Gender diversity on boards has gradually increased over the past 17 years. In 2022, survey respondents reported 36% of their members were female, compared with 30% in 2018, 28% in 2014 and 2011, and 23% in 2005 (Figure 1).While the increase in female representation on boards is positive over the last 17 years, the disparity between females and males still exists.

Various initiatives, mentorship programs and advocacy groups have emerged to address this gender gap, aiming to support and promote women into leadership roles within health care to include board membership.

Representation by Age Across Hospital and Health System Boards

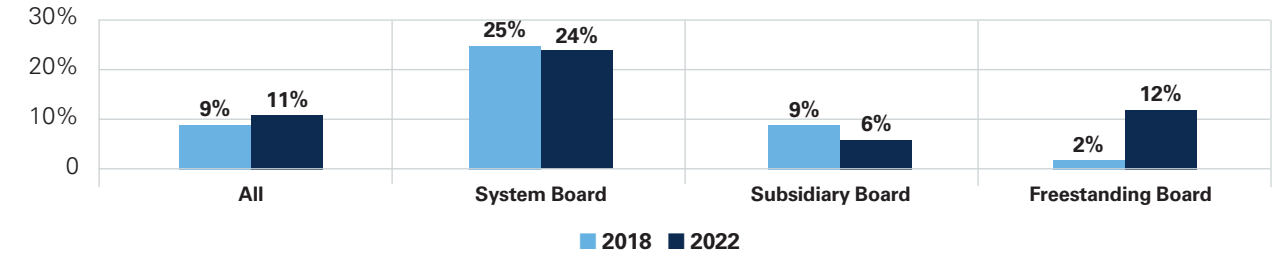
Similar 2022 AHA survey data also indicates that there is a growing percentage of older board members among hospitals and health systems. The percentage of boards with members ages 50 or younger (19%) has continued to decline compared to 2018 (22%), 2014 (21%), 2011 (24%) and 2005 (29%).

Figure 2: Board Age



In 2022, boards overall had a higher percentage of members age 71 or older (18%) than did boards in 2018 (12%), 2014 (10%), 2011 (9%) and 2005 (9%). In 2022, 12% of freestanding hospital boards reported having a board member age limit, compared with only 2% in 2018 (Figure 3).

Figure 3: Board Member Age Limit



While some progress is being made to diversify boards, much more needs to be done. Boards focused on diversity and health equity have different approaches. AHA, BDHEA and THMA collaborated to show examples of how hospitals and health systems are diversifying their boards and executing intentional strategies to advance health equity across the United States.

The following one-on-one interviews cover topics such as leadership, priority setting, measuring progress for diversity and health equity initiatives. The organizations highlighted in this resource stand out for their demonstrated commitments to diversity and health equity, widespread engagement and accountability across their executive leadership teams and boards, and meaningful long-term engagement with the communities they serve.

We hope this information will be useful to assist others in undertaking a comprehensive organizational approach to hardwiring diversity and health equity as a key component of their operations. Thank you to each of the interviewees for their time and for sharing their diversity and health equity journeys.

BOARDROOM INTERVIEW 1

Luis Jose Maseda

Trustee, UMass Memorial Health

In this exclusive interview with Luis Maseda, trustee of the UMass Memorial Health board, we delve into the journey of central Massachusetts' largest health care system in pursuit of diversity and health equity. Maseda sheds light on the pivotal moments that marked the board's commitment to the community's well-being, highlighting key initiatives, strategies and measurable outcomes. Providing a comprehensive overview, Maseda emphasizes the importance of a data-driven, actionable strategy. Furthermore, he outlines ongoing efforts and plans aimed at advancing diversity, equity and inclusion within the health care system while underscoring their critical role in fulfilling the organization's "relentless" mission of healing and community service.

About UMass Memorial Health

UMass Memorial Health is the largest not-for-profit health care system in central Massachusetts, with more than 17,000 employees and 2,100 physicians, many of whom are members of UMass Memorial Medical Group. UMass Memorial Health is the clinical partner of the University of Massachusetts Medical School. The system includes HealthAlliance-Clinton Hospital, Marlborough Hospital, UMass Memorial Medical Center and Community Healthlink.

How did your board get started on its journey towards diversity and health equity?

Maseda: The journey of our board started approximately 20 years ago and the official marking of it would have been around 2000 when we established our Office of Community Affairs. The Office of Community Affairs had a clear mission of engaging our community and assuring that we were addressing our community as a whole over the following years. The next big tangible step where we translated intent into action and impact was the establishment of our anchor mission. How do we very directly leverage our contributions and our resources to the betterment of the community that we serve?

At UMass, we directed 1% of our investments to be community investments around areas that supported or addressed the social determinants of health. It's a significant amount — about $4 million is what that translates into. At least as great an impact, we also directed our nearly $1 billion in spending to prioritize supporting minority and women-owned businesses for our purchasing in the community, which has a great impact. It creates a virtuous cycle of employment and growth in the community.

That mission has so far deployed about a dozen meaningful investments. Everything from housing to the growth of local businesses and different educational initiatives in the service area for the hospital.

Following on from that—and noting that UMass is a very lean health care committed organization—everything starts with our establishment of strategy. Within that, how we support our community is where our diversity, equity and inclusion (DE&I) activities live, and they live there in a very actionable manner and from year to year different initiatives are established around three key areas.

Can you describe your board's work on diversity and health equity in 2023? Can you include if your board has a dedicated diversity and/or health equity committee?

Maseda: Our strategy has a distinct component of community engagement, and within that are our DEI activities. Those can be understood to be in

three significant areas: (1) patient care, (2) business integration and (3) compliance from a patient care perspective. We identify specific initiatives that are going to drive the narrowing or elimination of any disparities in care that we see.

This is very data-driven. It's very actionable. After our first year of doing this, we have a playbook that we know to be effective that gets implemented year on year, and we're able to measure the success of those programs. Patient care could be understood to address not only health care but also overall health and the healing of our patients. Our tagline is: the relentless pursuit of healing for our organization.

So there comes in community engagement and anchor mission. One of those initiatives worth noting is our community health organization, where we bring together various services that address the social determinants of health for our patients and make those connections within the community. From a business integration standpoint, that is where we address our hiring, the education and composition of our teams to ensure that we are representative of the community which we serve.

There are many things there that go into not only how we interact with each other as caregivers and staff, but how we treat our patients and more broadly how we engage and treat the stakeholders that come together around delivering health care and ensuring the health of our community.

Compliance is important, but as we do the right things by patient care—as we conduct our business integration in a holistic manner—compliance to some degree takes care of itself.

However, that is an important element of driving our business and we ensure that different regulations—whether it be federal, state, The Joint Commission—that we're very specifically ensuring those are addressed. At the very least, we want the good work that we're doing to be framed within the context of compliance as well.

Do you have a dedicated board committee and/or does the full board discuss the DEI work?

Maseda: It is a full board conversation. We do have a chief diversity, equity, inclusion, and belonging officer, so the initiatives are well represented from a leadership perspective and included in the strategic objectives. Also, as we flow those down to operational and tactical, it's a very lean health care approach to ensure that vision cascades all the way down to actionable measurable implementation in the business.

Can you talk about your board's plans for advancing diversity and health equity over the next year? How do those plans fit into the overall strategy?

Maseda: Starting at the strategy, they are a key element of our strategy. As I've mentioned earlier, for our community goals and objectives and vision, a lot of it is more of the same and improving upon what we've done.

I say more of the same cautiously not to in any way indicate that we have figured it out, but instead that we're building upon the good learning that's already taken place. We remain committed to our anchor mission. The direct impact that's happening in our communities, we remain committed to the different objectives of eliminating disparities in the care we deliver to the community and doing that in a very data-informed manner that is measured to ensure that the outcomes are achieved and we continue to do it with our community. It does take a village to ensure health in the community, so our central part in making sure that those resources are connected to the folks who need it most is a continued element of our success.

Can you talk about some of the outcomes that you've seen or a couple of programs that you wanted to share with our readers to showcase some of the great work that you've been doing?

Maseda: I'll be glad to. One of our initiatives was looking at the data to understand where the disparities exist and the data leads us to where the opportunities are and how we could best address them. The results are not obvious. From a health equity standpoint, we really take a fine brush to the situation rather than just trying to paint everything with a roller of inequity problems because it makes it actionable and it makes it useful.

So the example that I would offer in this case is: the first look at the data that we took was inpatient versus outpatient. Here we found that from an inpatient perspective, we had no measurable disparities or disparities that were within a statistical error.

However, in outpatient we saw a different picture and the picture that we saw was not necessarily consistent either. It was not accurate to make an assumption based on a particular outpatient element of care that for one race is consistently lower or consistently higher.

We really took that fine point to this to understand where we could have impact. The first area that we selected was well-child visit adherence. The disparities were evident and they were measurable. We know that preventive care addresses both health care and health equity issues. So that was a good area to pick to have high impact and there was a significant cohort in the community. We have 44,000 pediatric patients that we serve of which 14,000 are on Medicaid. It's a sizable population and a population clearly benefiting from Medicaid and requiring these interventions.

So what we aimed to do is simply reduce the disparities and adherence. The how we did it was by direct engagement of our primary care providers and the quality champions in different areas.

We coupled some direct incentives for participation in this initiative. We expanded and enhanced reporting. We are an Epic shop and again, data-rich. It's a recurring theme within how we drive results. We were able to add race, ethnicity and languages. From there we were able to get the reporting.

Once we have the data, we're able to report on the progress and what we saw in a diverse population, we were able to increase adherence from 59% to 70%. This was a substantive improvement in these well-child visits. The welcomed additional benefit was that for the entirety of the populations that we serve, we were able to bump those up by 6 percentage points.

This was a case where effort and focus benefited the entire community in an integrated and holistic manner. Then we said, well, we've closed this gap substantially. We've helped the entirety of our community. What are the additional things that we could do to improve in hearing the voice of our customer? In this case, specifically the voice of the patient. We found that access to parking at no charge to patients was a simple affordable thing that we could take on as a cost for our patients and drive additional adherence.

There is in the learning process of listening to that voice of the customer through this initiative an opportunity to see where we still have room for improvement. In addressing the root cause, we were able to further increase adherence by another 6%.

Now, I've been talking in percentages and sometimes the impact could get lost. The impact was 720 additional children who were able to get a well-child visit as we intended. That's one case study that I would offer that we looked at the data. Where to focus was not obvious. It cannot be intuited. It had to be driven and understood, and that was the first big initiative that developed the playbook that was in 2021.

In 2022, we selected osteoporosis screening for women and in 2023 we have another initiative.

Why is it important for boards to focus on diversity and health equity?

Maseda: It's central to our mission. And as I shared from UMass Memorial Health, our mission is a relentless pursuit of healing. That healing takes place in the community and its entirety. Through our different initiatives, through our focus on DEI, we are able to represent our community.

Literally, we are able to represent our community in our caregivers, in our staff, in our stakeholders as well as serve our community in a holistic manner. Perhaps the shortest way to answer is it's fundamental to the fulfillment of our mission.

What do you see as the biggest opportunity for boards to advance diversity and health equity over the next three years?

Maseda: Taking a holistic and systems-based approach, which is to say that we have DEI not

living in just one committee, one function or one organization. But how do we acknowledge it as an element of our strategy? Then, how do we integrate it throughout all elements of the delivery of care and community engagement?

Ensuring it's a holistic and systems-based approach, ensure that it's acknowledged in the strategy. Understand how that strategy is deployed throughout different touchpoints and different elements of care in the community. Ensure they are measurable. Ensure that there is reporting associated with those measures to track progress and then both incentivize and hold the team accountable to its accomplishment.

Does your board have a dashboard for all of the health equity and diversity work?

Maseda: Yes, we do. There are drivers and there are outcomes. Achieving health equity and outcomes and what we would measure are the drivers that lead to those outcomes. Those drivers of health equity are represented through different areas of the strategic and operational plan that come together to result in those elements of diversity, equity and inclusion.

There is a DEI dashboard that you pick up, and that's the title of it. The data could be sorted and absolutely represented like that and it is and it is understood. However, the broader one you would see represented is across the different elements of that operational plan to ensure that we address the social determinants of health and to ensure that from both our inpatient and outpatient services that we have reduced or eliminated the disparities. We could continue down the list of different metrics that drive towards that.

It's really about focusing on the actions and the results will take place if we've understood how those things are interrelated or correlated correctly.

Do you hold your CEO accountable for health equity and diversity? Are you holding them accountable for anything DEI-related in terms of outcomes?

Maseda: The most direct answer is yes. Is one of the scores just DEI? It would not show up like that in the evaluation. However, referring to my prior answer, the elements that will result in a diverse, equitable, inclusive organization and engagement of our community, those are represented. Going back to having a disciplined data-driven view, the risk of just saying is the CEO committed to DEI is a little too difficult to drive to action and accountability just by that big idea. Instead, we deconstruct that into what DEI means from a measurable, accountable standpoint.

When did you start on the UMass board and what role do you have (if any specific role) on the DEI strategy?

Maseda: It's been about 10 years or so that I first started my journey in service of UMass and its mission. I've progressively been asked and provided an opportunity to serve in different boards. So that's happened over the last 10 years. I've contributed to various committees.

There isn't a DEI committee. With those touch points that are identified drivers of what will result in our understanding and definition of DEI on the community engagement side, there are community health boards. Midway through my tenure, I became close to those initiatives and those drivers. The short answer is yes. I've been given opportunities from a committee standpoint to contribute and participate in the drivers that we have identified that will result in our goals.

James Liggins

Vice Chair and Board Member, Bronson Healthcare

This interview with James Liggins delves into Bronson Healthcare's extensive journey towards diversity, equity, inclusion, and health equity in southwest Michigan and northern Indiana. Commencing 15 years ago with the establishment of a dedicated strategy and department, Bronson progressively integrated these principles into its core values, culminating in the appointment of a chief diversity officer directly reporting to the CEO. Liggins highlights how their organization aligned community health efforts with diversity initiatives, integrating an equity lens into their operations.

The impact of COVID-19 reinforced the need for equity-driven approaches, prompting Bronson to embed these values within foundational documents and discussions at various committee levels. Liggins emphasizes the board's commitment to holding the CEO accountable for diversity and equity while outlining plans to advance these values within their strategic plan, ensuring alignment across all facets of the health care system. He stresses the importance of data collection and analysis in developing a comprehensive health equity dashboard and underscores the pivotal role of leadership, particularly the board, in driving these initiatives forward.

Looking ahead, Liggins advocates for greater board diversity as a catalyst for advancing equity and encourages organizations to persist in their journey, regardless of their current stage, fostering continued progress and unwavering commitment to these crucial values.

About Bronson Healthcare

Bronson Healthcare serves patients and families throughout southwest Michigan and northern Indiana. Offering a full range of services from primary care to advanced critical care, Bronson Healthcare's goal is to provide their community with the right care, at the right time, in the right place. It is locally owned and governed. Annual outreach and charitable care amounts to more than $138 million in community benefits. With over 9,000 employees, more than 1,500 medical staff members, and 757 licensed inpatient beds, Bronson is the largest employer and leading health care system in the region.

How did your board get started on its journey toward diversity and health equity?

Liggins: Our journey started a decade and a half ago. We started out by creating a standalone strategy and department, which included hiring a chief diversity officer for the first time, who reported directly to the CEO of our organization.

That was a milestone for us as an organization to recognize the need for that type of department and to recognize that there needed to be a senior-level officer position from there. That person began to build out the organization of the equity or diversity department. They single-handedly built that organization as a whole—hiring staff, filling out the structure, and then immediately focusing on aligning the work the office was doing with our Community Health Committee. The executive liaison for the Community Health Committee was the chief diversity officer. They aligned the community health needs assessment and our work with our community health improvement plan, specifically being infused with an equity lens.

We began to integrate equity, diversity, and inclusion

into our definition of quality. That was a very key moment for us to understand that our ability to serve our community in a high-quality fashion included our ability to fully be able to understand the dynamics associated with diversity, equity, and inclusion and health equity as a goal for us. This was very systematic. I was part of it, where we integrated the DEI into our values, our mission, and our vision statements. We also took the initiative, equity lens, and equity pledge from the AHA. The board really bought into that concept and focused on that.

COVID-19 happened, and then we had real-time data, which really reinforced the work that we were doing, showing all these disparities that are happening with people with various demographics, and various comorbidities that can be specifically traced back to those demographics and social determinants of health. So, it provided us with an impetus to say from there that we will make equity and inclusion foundational and intentional in all our work. That was from the board all the way down to our committees, our charters. As a board, we made sure that all our charters and foundational documents expressed our equity, diversity, and inclusion values as well.

Can you talk a little bit more about your board's work on diversity and health equity in 2023? Can you include if your board has a dedicated diversity and health equity committee and how your diversity and health equity discussions happen at the committee level, at the full board level, or both?

Liggins: Those discussions happen at a lot of different levels for us. It starts at the board level. We have a system board at our hospitals. We talk about equity, diversity, and inclusion and have oversight over those initiatives and values, particularly when it relates to our Quality and Safety Committee and how it relates to our Community Health Committee.

Those are the committees that really have a focus on our diversity and equity inclusion efforts. What we did this past year, including in 2023, was finish our strategic planning, which we call our plan for excellence. We fully integrated, for the first time within our strategic plan, our values with respect to diversity, equity, and inclusion. They were afterthoughts like footnotes in our previous versions, and we said we want this to be a true pillar of our strategic plan as we move forward. This year, part of our work has been making sure that this is integrated into our strategic plan, and it cascades down into every area of our organization. That is not to say that we have everything right, but it is to say that we have gone a long way to making these values part of our culture here at Bronson.

Do you hold your CEO accountable for diversity and health equity?

Liggins: Yes, it is a part of our underlying goals for our CEO. The question of whether we tie it to compensation or not is yet to be seen. We have to go through a period where we really focus on diversity and equity inclusion in the actual compensation part of the discussions. We just finished our last compensation package for the CEO.

You should note that our CEO is an African American male for the first time ever. We have been blessed as a community and blessed as a health system to have someone who has as one of these pillars — equity, diversity and inclusion within the field as a whole.

The answer is yes, and we are working on it and looking through it. We are continuing to discuss how to hold the executives accountable for those values as well. That has yet to fully materialize at this point, but we are having some discussions about that too.

It sounds like the board will drive that strategic plan and make sure that the C-suite is accountable for meeting the goals in that strategic plan.

Liggins: Yes. We have already completed our strategic planning process and put it as one of the pillars of our values with respect to diversity, equity and inclusion.

Can you talk about your board's plans for advancing diversity and health equity over the next year? And how do those plans fit into the system's overall strategy?

Liggins: We have four primary areas in our strategic plan: people, access and experience, quality, and growth and financial health. With respect to people, we focus on ensuring interculturally competent staff and medical staff that meets our mission and reflects our communities. With respect to access and experience, we focus on optimizing system resources to meet the access needs of our community.

Previously we had a vision that was exceptional health care for every person, and that was our way of addressing equity. However, our new CEO added "made easier for every person" to the vision. The idea there is really access. How do we remove the barriers of access and make it easier for every person, regardless of demographics, to be able to access high-quality health care?

In quality, which I am the chair of our Quality and Safety Committee, we have focused on decreasing inequitable disparities and birth outcomes based on age, race, ethnicity, language, location, and other demographics as well. Because we cannot be too broad, we have decided to go as far upstream as we can to get the biggest impact on the system with respect to quality and health equities as well.

Even under growth and financial health, we have addressed our equity pillars, focusing on stewarding our system resources to best meet community needs through purposeful growth and partnership. Then additionally, increasing margin and preparing for value-based care while safeguarding quality and equity.

I was on the Finance Committee when we were having these discussions, and the question became that in our charter, we do not say anything about equity. We had to talk about how we cover equity with respect to finances. It forced us to have intriguing and goal-progressing conversations where we thought through what equity means for our system. We are still having those conversations.

Does your board have a dashboard for health equity?

Liggins: We do have a health equity dashboard, and I do not mind talking about it because it was a part of the journey. Candor is the gathering of data because I was just surprised at how much information we do not collect. If we do collect it, it is not collected in a consistent way to give us a real base of data to be able to begin analyzing.

A big part of our journey was collecting the data before we even talked about putting together a dashboard — a system that helps us collect the information we need. We are an Epic system, so we began to utilize the various modules in Epic to gather information. A big part of it was convincing people in our organization that the collection of data, of that specific type of data, was important.

There was an educational journey to help people understand that we have to know where the gaps are for access and services to be able to design policies, procedures and programs that address those disparities. The next part of it was the analysis. Creating that system was intricate for us in the collection of data and analyzing the data. From the analysis side, we were able to put together an equity dashboard. I do not know if it is fully implemented and utilized at this point, but that is where we were at from the data.

With our community needs surveys and our plans, which address some areas of equity and access as well, we were able to put together this beginning form of our equity dashboard. Now that implementation is still ongoing, how do we hold ourselves accountable to these goals and metrics? That is another level of communication and organization that we are working toward.

Can you tell us why it is important for boards to focus on diversity and health equity?

Liggins: In my experience, to fully integrate the values of diversity, equity and inclusion into an organization the size of even small health systems, the leadership must be the driving force. If the leaders are not the driving force, it doesn't become integrated into the cultural DNA of the organization. I find that leaders or the board leads at the top; in most organizations, it's top-down. The board and then the CEO speaks directly or rather reports directly to the board. It sends an exceptionally strong message throughout the entire system, and

I dare say throughout the entire community, when the board focuses on diversity and health equity because it becomes a priority for the organization. It insulates against it being a flavor-of-the-day trend. If you have one person, one executive, that it's their mantra and passion, it does not become a part of the organization as a whole. It is easy when that person leaves for it to begin to fade. My answer is that to really ingrain equity, diversity, inclusion, and health equity into the system as a whole, it needs to come from the board level.

Did you have one champion on the board or a group of people? How did you get this support to make that a priority?

Liggins: It has been a growing organic process for us, and I cannot say it is one person. The previous CEO was a visionary, making sure that prior to leaving, we had in place a chief diversity officer, who was a VP-level officer, and a department that was fully beginning to develop and progress. That CEO had a lot of support from the board for that as well, so it was not just one person. Although the CEO was a visionary, making sure that that was a priority, the board fully supported it.

I am not saying that you will not encounter some barriers along the way, but the more people, the more leaders, the more board members, and the more executives who can support these directives, the better off the organization, the better off your progress and your journey will be.

What do you see as the biggest opportunity for boards to advance diversity and health equity over the next three years?

Liggins: The biggest opportunity is making diversity, equity, and inclusion an important part of your recruitment for the board. It sends a strong message throughout the organization. It also begins to reinforce that what you are going to find is great, better board decisions with better diversity in the board.

The biggest opportunity for boards to advance diversity and health equity is to make sure that they are living what they are trying to accomplish because you can say all you want that you want your organization to be diverse, and that health equity is a priority. However, if I look at the organization and the top level is not diverse, then your words do not match your actions and do not appear genuine.

If you want to make headway in that area, that focus internally is also having the board take some assessments of diversity on their path and where they are individually on that spectrum as well. As you begin to do that, you begin to educate yourself on where your blind spots and your deficiencies are.

As a board member, you also begin to understand the importance of getting that outside perspective. If you want the biggest bang for your buck as a board, making sure that your board members are diverse will take you a long way.

Are there any additional comments you want to provide, questions or answers that we did not get to but that you wanted to make sure are included in your case study?

Liggins: Bronson's journey is unique to Bronson. This is the formula that appears to be working and the path that has worked for us. There are a number of ways to get started and to be successful. Even though I am a proponent of our way - it works really well - but at the end of the day, no one should be discouraged just because they're at a different place in the journey. The question is, is there the motivation and the resolve to continue down that path?

You may be somewhere else on the journey. It does not mean that's it, you are not making progress, so I encourage people to make sure that their resolve and motivation stay strong.

Jacqueline Ortiz

Vice President, Health Equity and Cultural Competence, ChristianaCare

Bettina Tweardy Riveros

Chief Health Equity Officer and Chief Public Affairs Officer, ChristianaCare

Logan Herring, Sr.

Chief Executive Officer, The WRK Group
Board Member, ChristianaCare

This interview captures ChristianaCare's concerted effort towards diversity, equity, inclusion, and health equity, tracing its roots through the visionary leadership of Janice Nevin, M.D., president and chief executive officer, and the pivotal roles played by key stakeholders. Jacqueline Ortiz highlights the holistic integration of equity into every facet of ChristianaCare's operations, emphasizing its inextricable connection with quality and strategic planning. Logan Herring brings an insightful perspective, stressing the importance of community representation and active engagement in decision-making processes. Bettina Tweardy Riveros spotlights the importance of a consistent organizational focus on authentic community engagement, and how this informs ChristianaCare's approach to robust financial health for long-term sustainability and growth.

The dialogue showcases ChristianaCare's proactive approach to health equity predating COVID-19, outlining their multifaceted strategies involving community engagement, workforce diversity initiatives, and resident education to deepen understanding and promote inclusivity. The discussion evolves to reveal the organization's forthcoming plans, focusing on building internal capacity, narrowing disparities, and aligning advocacy efforts for sustainable growth and continued commitment to health equity.

Additionally, the conversation underscores the financial and societal impact of investing in health equity, emphasizing the necessity for boards to champion these initiatives amid evolving challenges within the health care landscape.

About ChristianaCare

Based in Wilmington, Delaware, ChristianaCare is one of the largest health care providers in the mid-Atlantic region, serving all of Delaware and parts of Pennsylvania, Maryland, and New Jersey. ChristianaCare is a not-for-profit teaching health

system that includes three hospitals with more than 1,200 beds, a home health care service, preventive medicine, rehabilitation services, a network of primary care physicians and an extensive range of outpatient services. ChristianaCare is recognized as a regional center for excellence in cardiology, cancer, orthopedics and women's health services, as well as for its Level I trauma care and Level III neonatal intensive care (both highest capability).

Can you tell me about how the board got started on its journey towards diversity and health equity?

Ortiz: I have been at ChristianaCare now almost 12 years. Equity and diversity have always been very central, even predating our current president and CEO Dr. Janice Nevin. But it really became a bold initiative under Dr. Nevin's leadership. This is an important story for health systems across the country. It has to be spearheaded by upper-level leaders. Dr. Nevin has been critical on that front, in supporting the work, in investing in it, and in elevating health equity by bringing on Bettina as chief health equity officer eight years ago as her direct report on the executive team.

Tweardy Riveros: Dr. Nevin asked me to join ChristianaCare as chief health equity officer — one of the first roles of its kind in the country — in 2016 after we worked closely together on the Delaware Health Care to implement the ACA [Affordable Care Act] and address health care needs and state policies to advance access to high quality, affordable health care.

In January 2016, we began a new phase in our health equity journey at ChristianaCare, with a real focus on addressing disparities in health care delivery and outcomes, identifying the needs of our at-risk communities, and addressing the social drivers of poor health outcomes. We were very intentional in building a social care infrastructure at ChristianaCare as part of our health equity vision, including social screenings and referrals, community health workers, and community partnerships to address non-clinical barriers to health. Our health equity work demands a close collaboration with population health, with our inclusion and diversity team, and with our clinical enterprise. From the beginning, Dr. Nevin has been a visionary leader in supporting this work and our board has fully embraced the commitment to health equity.

Herring: I came on to the board a couple of years ago. I bring a unique perspective to the board. When you look at the deep correlation between poverty and health outcomes and the work that we're doing in the Riverside neighborhood of northeast Wilmington, our goal is to break down those intergenerational cycles of poverty which lead to those health outcomes. I bring that perspective to the board, and I bring a more youthful perspective to the board. I am the youngest board member, growing up in the city of Wilmington as well.

I'm also a part of the Governance and Nominating Committee, where I can amplify the need to have more people with different perspectives. The community most affected by the decisions that ChristianaCare makes in these boardrooms are those that I'm closest to on a day-to-day basis. I really appreciate the opportunity.

I don't represent the entire community of Wilmington, of Riverside, but I do represent to the best of my ability the communities that are deeply affected by the decisions that are made in those boardrooms. I'm happy to be a representative of the communities from which I come.

It's interesting that you had a commitment structurally and across the organization to health equity that predated COVID-19. How does that inform the way that the work gets operationalized versus some of the trends that you might see across the country when it comes to health systems? How do you describe the work of the board around equity and diversity?

Ortiz: It's really interesting. We don't have a diversity or equity committee on the board, but that's purposeful because equity is not a standalone activity. At ChristianaCare, we fundamentally incorporate equity into everything that we do.

For us, the very work around providing high quality health care is absolutely intertwined with equity. There is no quality without equity. When I report

to the board on health equity, I'm reporting to the Quality Committee. That is unique at ChristianaCare. We really try to incorporate it in everything that we do, and as a fundamental component of everything that is discussed, just as equity is fundamentally incorporated into our five-year strategic aspirations.

Herring: When I think of equity, I think about what's needed for a particular demographic in order for them to achieve equality. It's not about everyone getting the same thing. Last week with my organization, we started a new practice where when we meet with funders, we bring those most impacted by the funding into the meeting. We're asking for forgiveness, not asking permission.

Last week, we brought in an employee or partner with a significant funder as we were talking about workforce development, so those funders could listen to those being most impacted. I think often we try to make people in our community into science experiments. "If we do this, then we will achieve these results." One thing I don't want to take credit for is the success of the community. I continue to elevate that in these conversations, whether it be with board members, our staff, or partners.

The interesting thing is when I think about how we're approaching this now and making it a standard practice, I think about how ChristianaCare was leading this work a number of years ago. They were meeting with our teams and asking what we wanted. What best way can we serve you? I look at that as an example. That's how you embed it within the organization. ChristianaCare has been doing that since I've been working with them.

Tweardy Riveros: When we do our Community Health Needs Assessment, we listen to the community. We have town halls. We are very intentional in meeting with young people out in the community, including in Wilmington, including in under-resourced and disinvested communities. We see them as strong allies in driving improvements in the health of our community.

Health equity could be the North Star for all health systems across the country. What is better than a vision to ensure that every person has their best opportunity for health? That's why health equity needs to be embedded across all parts of the organization and threaded through all initiatives. Health equity has been part of our annual operating plan goals and strategic plan from the first year I got here, including defined health equity goals. We have continually built on our progress and now health equity is a central component of our strategic plan, which includes six aspirations. The first one is to end disparities.

Herring: I think it's also important to realize when you make mistakes. We come in with these notions of how to deliver services. I recall when we opened the Coker Family Resource Center in a partnership with ChristianaCare at Kingswood Community Center, we opened a hub within our Community Center. We fitted it out. We renovated it. We opened the doors to our community so they can come and receive access. It was virtual. You would have a nurse practitioner, and then they would have a virtual meeting with the doctors. One of our neighbors said when the doctor came out, "Oh, you're not afraid to touch me now!"

And so, as we think about health equity, we think we're going to provide virtual care, so you don't have to travel. In some people's minds, they think we don't want to be in close proximity because we're afraid they might get us sick. Unless you're listening to the community and you're willing to put your ego aside and be flexible enough to say, alright, we need to change things because we're listening.

I think that was a great example. I use that example all the time, even with our staff. We may think we're doing the best thing, but until we go out and try it and be willing to change because the community tells us, that's not the best way to serve them.

Where do conversations on diversity and health equity get centralized across the board?

Herring: From a board member's perspective, you have to have the talent and the people to be able to serve the community best. A lot of times when we talk about health equity, diversity, equity, inclusion and all those buzzwords, we're thinking about what takes place in a boardroom or in the C-suite. What ChristianaCare intimately understands is the landscape of health care these days and what it

takes to be able to serve the community best. When I look at the growth strategy of ChristianaCare, being willing to not just be content with where you are but looking for the best physicians, the best caregivers, bringing on certain skill sets, and building capacity so we can better serve the core of our community. We need to do that, and we need to be ahead of the field. What we don't want to do is sit content, and then in three to five years become obsolete, and then eventually fold.

I'm learning so much being a part of that boardroom. I think that's another way we address health equity is making sure we have the appropriate people and the right people on the seats on the bus to be able to serve the community best.

Ortiz: 2023 is a combination of two things. First is building infrastructure to advance our ability to do equity work. This is something that health systems may underestimate. It is not enough to have two or three experts that are leading specific interventions. You must start building capacity within the system. We have to build capabilities into folks to be able to do the actual work with methodology.

And that is easy to overlook in the sense that you just assume that people will be able to do it as part of the work that you do in health care. For us, it's been preparing for NCQA [National Committee for Quality Assurance] accreditation in health equity. That's just a very interesting way to look at your infrastructure internally in terms of your policy, your programs, language access, diversity programs, including the diversity and inclusion of folks from different communities on your staff. That's been great.

The second half of the year is about our plan to move ahead to narrow disparities and outcomes in targeted areas. It's around preeclampsia, hypertension, surgical readmissions, and stage of cancer diagnosis for breast and lung. There are very specific reasons why we picked those four areas. We're forming multidisciplinary teams that will not only be creating a portfolio of interventions over the next four years but will focus in on making substantial progress on narrowing disparities year over year.

Ortiz: We've got the building blocks and the foundation for it now. We use improvement methodology to scope out specific interventions with evaluation structures around them.

Erin Booker is our chief biopsychosocial officer. This is again one of those creative roles where Dr. Nevin has led the way. Erin and I collaborate on this work in the sense that we connect the work of health equity with the actual operations in the Medical Group in ways that are very innovative. On those strategic aspiration targets, we've got teams that include both clinicians and community health workers and data folks and patient experience team members. There are remarkably interesting configurations of how you think about this work in multiple dimensions moving forward. And we do the same with population health. We report that into the board.

We have invested in our staffing around health equity. We have a group of 20 in-person interpreters in multiple languages, including Spanish, ASL, Mandarin, Bengali, and Hindi. We've got a team of program managers and specialists both in health equity and cultural competence. They are primarily responsible not only for leading initiatives in those four areas, but also for leading advisory committees, for example around disabilities and race-based medicine.

Tweardy Riveros: I also want to add more detail around our inclusion and diversity initiatives. At ChristianaCare, we've also invested in an Inclusion and Diversity team, which now has six members. The team includes a Chief Diversity Officer who's also Vice President of Talent, Pamela Ridgeway. Notably, we have an Inclusion and Diversity data analyst because it is really important to have those capabilities on the team.

In workforce, we established goals to increase the number of minorities and people of color in Director and above positions. We established a goal to achieve growth in hiring of individuals who identify as having a disability and to achieve growth in the hiring of underrepresented minorities — as defined by the Association of American Medical Colleges — into attending physician roles. In the workplace, we're also updating HR policies, ensuring education is inclusive, and providing mentorship to caregivers. There's a very comprehensive approach to inclusion and diversity, and that team reports back to the

executive cabinet and also to the board with respect to our progress on those goals. The board support has been tremendously important.

Herring: ChristianaCare has been a partner, giving our teens and young adults that go through our workforce pipeline experiences in the medical field.

One other thing, we do tours every two weeks of the work we're doing in the Riverside neighborhood. Without fail, there are about six to eight residents from ChristianaCare that come and tour because I think a big part of this is understanding the community that you're serving. Getting close to the community as you're being educated and informed as you come into these fields is key.

Ortiz: Our resident orientation at ChristianaCare includes a four-hour poverty simulation in which each of our residents participates in an exercise in which we double down on saying —this is the community you will be serving. This simulation is not a game. Obviously, this is not a true experience with poverty, but it gives them a sense of the stress that families experience on a week-to-week basis. It gives them a sense of those choices that you must make between paying utilities and paying for insulin. We have very intentional and concerted efforts for our residents to go out and really make sure they understand where folks are coming from for care.

As you are advancing diversity and health equity in 2024, how do those plans fit into the overall strategy that you all have established?

Tweardy Riveros: The health care ecosystem is under incredible stress and facing significant challenges. That is driven by inflationary pressure, by workforce challenges, and by costs and supply chain challenges. We're seeing many health systems reporting negative margins. We see continued pressure on the government reimbursement front, which is especially critical given that our payer mix is close to 70% Medicare and Medicaid.

So, when we think about what we need to achieve to fulfill our mission and to meet our responsibilities as stewards of this organization, we are very mindful of the need around driving growth in a very responsible way. We're driving that growth to invest back into the community, to invest back into community access to care, and to invest back into health equity and diversity and inclusion initiatives. With smart growth we can improve the health of all members of the communities we serve.

Herring: Much of our board meetings are focused on business strategy. As you see across the country, the health care industry is facing a lot of pressure. When we talk about business strategy, we have some of the best business minds that you know in this area, in the boardroom.

We talk about that payer mix. When we talk about growth strategies, we're looking at what areas can provide a healthier payer mix. Medicaid only reimburses 75% of the total cost to provide health care.

Now we're looking at what we can do from our advocacy level to diversify the revenue. All these things strengthen the core of ChristianaCare too. We're very much from a board level looking at the business strategy to make sure that we have the financial sustainability, the capacity, and the skill sets to be able to best serve the community.

Tweardy Riveros: We've got a math problem, frankly, with 80% of our operating expenses subject to inflation and 70% of our revenue coming from government payers — Medicare and Medicaid — which don't cover the cost of providing the care. And the reimbursement that hospitals and health systems do receive is facing threatened cuts due to increased federal budget pressure. The math just doesn't work. And yet, it is absolutely critical that we invest in health equity.

Ortiz: I hope that in most health care organizations in the United States, they're not thinking, "Gee, can we afford to do health equity?" When you're not focused on under-resourced communities, you're paying for it. If you're not looking at it, you're not quantifying it. But that doesn't mean you're not paying for it.

As an example, for 2.5 years or so, we've been doing work on narrowing disparities on postpartum readmissions. There's been a substantial reduction. We had a 2:1 ratio when we started that work. So, African American women were being admitted after

giving birth at twice the rate of white women. We implemented a series of interventions and narrowed that disparity by 63%.

Now, if you quantify that impact from preventing those readmissions, that was a savings to the system of $312,000 and change. It's improving care across the board because readmissions improved for everybody. In addition, in narrowing that disparity with better care and more targeted interventions around that one community, what you achieve is also financial. There's more value to that work.

You're improving the health of the community and of your bottom line. This is the work that allows you to achieve better quality and better performance.

Tweardy Riveros: We can't afford not to invest in health equity as a system. Frankly, as a country, if we don't get in front of the burden of chronic disease—especially for disinvested communities—we will continue to pay the highest dollar amount as a country in acute care settings. We have the board support to invest in health equity to drive quality and to drive improved health outcomes. We have the value-based reimbursement structure that CMS continues to evolve. That framework provides the reimbursement structure that makes this work scalable not just at ChristianaCare but across the country.

What do you see as the biggest opportunity for boards on diversity and health equity across the next three years?

Herring: I understand this intimately as a practitioner. You have to listen to who is facing these issues every single day and then see as a board how we can partner with the operations team to best support what needs to be done.

Ortiz: We have a five-year strategy that's already begun. From the board, what's really important is doubling down and staying the course on the strategy moving forward. The way that we do that year to year is through those strategic focus areas that are reflected in our annual operating plan goals. It's the selection of those goals that need to move forward. We put our money where our mouth is. Staying the course on a multi-year strategy is essential so that you're not shifting direction every 12 months. That includes budget support and focusing on community investment, health equity, and inclusion and diversity.

Tweardy Riveros: The other opportunity I want to reinforce from the board perspective is that we will have increasing challenges at the federal level and to some extent at the state level. We need to communicate effectively as health care organizations. Support around that advocacy agenda and that communication agenda to tell the story around health care and the risk to the community of losing access to acute care services throughout this country is essential. We must effectively tell our stories as an industry on behalf of the communities we serve.

The second place where the board is critical is that growth agenda. It is about diversifying our revenue, expanding access to meet the needs of the communities we serve, and ensuring that ChristianaCare has a stable financial future so our patients and the community can count on us to be here providing high-quality care for the long term.

BOARDROOM INTERVIEW 4

Mae Douglas

Board Chair, Cone Health

This interview delves into Cone Health's journey toward diversity and health equity as explained by Mae Douglas, who has served on the board for several years and is currently the chair. She traces the organization's evolution, particularly in relation to health equity, emphasizing pivotal moments during leadership transitions and the onset of the pandemic.

Douglas details the comprehensive approach undertaken by Cone Health, highlighting the absence of a dedicated committee for diversity and health equity, as the responsibility is integrated throughout the organization. She elaborates on the systemic strategy implemented through the Center for Health Equity and its alignment with the board's role across various committees.

The discussion also touches upon metrics for accountability, performance evaluations, and plans for advancing diversity and health equity within the health system's overall strategy, notably focusing on community partnerships and workforce development initiatives.

Additionally, Douglas emphasizes the significance of the board's role in advocating for health equity, economic development, and combating legislative challenges that impact health care systems. Throughout the conversation, she underscores the importance of leadership dynamics, collaboration, and leveraging influence to further the cause of health equity in the coming years amid complex financial and legislative landscapes.

About Cone Health

Cone Health is a not-for-profit health care network serving people in Alamance, Forsyth, Guilford, Randolph, Rockingham and surrounding counties across North Carolina. As one of the region's largest and most comprehensive health networks, Cone Health has more than 150 locations, including five hospitals, six ambulatory care centers, three outpatient surgery centers, seven urgent care centers, two retirement communities and more than 120 physician practices. These include primary and specialty care through Cone Health Medical Group and Triad HealthCare Network.

Can you tell us a little bit about how your board got started on the journey towards diversity and health equity?

Douglas: I joined the Cone Board in 2018. Over the last five years, Cone has developed a comprehensive health equity strategy. It has been wonderful to see the progression before and after the pandemic. Of course, during the pandemic the board had several discussions to ensure communities of color had access to vaccines. The system partnered with several organizations, such as churches, social/civic organizations and nonprofits, to ensure vaccines were accessible. They also deployed mobile units to neighborhoods to reach as many people as possible. Over the past five years, we have built an entire ecosystem around health equity, and it's been wonderful to see the progress.

I started as chair in 2021 at the same time that Dr. [Mary Jo] Cagle started as CEO. After the pandemic, the board had numerous conversations about the health disparities seen during the pandemic. Dr. Cagle was very clear that health equity was going to be a priority and set the tone for the entire system.

Can you describe the board's work on diversity and health equity in 2023? Specifically, can you tell us if you have a dedicated diversity or health equity committee of the board?

Douglas: There is not a diversity/health equity committee of the board. What I like about Cone's model and approach is that the entire organization has responsibility for diversity/health equity.There has been a Center for Health Equity established under the leadership of the chief clinical officer and in partnership with the chief strategy officer. There is an infrastructure with staff, clear roles, expected outcomes and funding in order to carry out the work. There is a DEI staff role that is part of the center with a dual reporting to the chief people and culture officer.

It's been a five-year journey and in 2023 Cone communicated the comprehensive strategy and has developed an ecosystem that previously included individual components that are now integrated and connected throughout the region.

What is starting to happen now is that health equity is part of all the board committee work. There are discussions in the Strategy Committee, People and Culture Committee, Patient First (quality) Committee, Resources and Risk (finance) Committee and the Community Partnerships and Philanthropy Committee.

So, I actually like the fact that we don't have one designated committee because I think the expectation from Dr. Cagle is that we are all accountable to improve the health of our communities.

How do you think about accountability both for the board, but then also thinking about Dr. Cagle as CEO?

Douglas: Healthy communities is one of the four strategies for Cone. Health equity falls under that strategy. Dr. Cagle and her executive leadership team are all assigned to one of the four areas. That means there are discussions at every board meeting about the strategy, it is included in the metrics for how the executive leadership team is measured and is part of Dr. Cagle's performance evaluation.

Can you talk about the board's plans for advancing diversity and health equity over the next year? How do those plans fit into the hospital or health system's overall strategy?

Douglas: Since healthy communities is one of the four focus areas in our strategy, it's been very helpful to have a better understanding of how to segment health care delivery based on the needs. We have also become more focused on social determinants and its resulting impact of health and the partners we can work with to support patients.

The other area I want to comment on is Cone's culture and how that has driven its success. Cone has very high employee and provider engagement as evidenced by its annual surveys. That gets translated into the every day operations in how they interact with each other, with patients and serve in the community.The board is currently doing its own culture work as well to evolve with the system.

One of the partnerships that Cone has is with North Carolina A&T, which is the largest HBCU (historically Black college and university) in the nation, right here in our region. We entered into a Memorandum of Understanding (MOU) with them related to workforce development and addressing some of the talent shortages everyone is experiencing. Other community partnerships will also be an integral part of developing health equity solutions.

How do you think about the role that you all play within the ecosystem of North Carolina and beyond in terms of your partnerships specifically?

Douglas: Thankfully, Cone has a great reputation locally and throughout North Carolina. We've done a really nice job coming out of the pandemic creating a clear strategy internally and of course that gets communicated to external audiences as well.

As with most health systems, we have a lot of influential people on our board. So, I think that our voices matter. We have seen the results with various projects/initiatives with local and county governments and having been able to influence policy at the state level.We have some of the smartest, most committed, engaged board

members I have worked with on a nonprofit board. We have the normal tensions that any board has.

But, coming out of the pandemic and previous merger discussions, I think we have a strong board because of the amount of time spent together having courageous and difficult discussions about the future of Cone. The current board selected Dr. Cagle as CEO and most of us worked with her as COO and I think that has strengthened board/staff relationships. I feel that our board is in accord.

As Chair, I am fortunate to lead this board. Dr. Cagle and I were in sync from day one on improving the diversity of the board. We have the most diverse board in Cone history. She and I are now in the process of interviewing new board members, and I am very ecstatic with our new board candidates and the contributions they will make.

Are there any observations or insights you would offer from the way that she's approached leadership for the organization that you think others could learn from?

Douglas: That is a perfect question because leadership is key to organizational success and results. Dr. Cagle has a collaborative, facilitative style. She has a clear vision for the system and is a very skilled storyteller and I've seen employee groups and others engaged as she paints the picture of Cone's future. Since she is a physician, she deploys rounding throughout the region as a way to get direct feedback from all levels of the system. The Executive Leadership Team and we as a board also round so we have visibility and hear feedback about the operations of the system. Dr. Cagle is also not afraid to push the system beyond its comfort level and normal ways of working and is tough when needed.

Dr. Cagle and I agree that we are in our respective roles for such a time as this. We don't know why we have been brought together, but it's working. I think the system, our board, and our communities are the beneficiaries of our relationship.

Why is it important for boards to focus on diversity and health equity?

Douglas: Whether you are a small town, a mid-size community like Greensboro or a large city, it has to do with serving the community and being an economic engine for the region.

Greensboro has gone through a lot of economic transitions from a textile-based economy to a more diversified economy. So, while textiles are not dominant any longer, Cone's size and presence provides employment in addition to being the health care provider. It goes back to what I referenced earlier about healthy communities for everyone. Greensboro is now a BIPOC (Black, Indigenous people of color) community. We are 51% minority. So, our demographics have shifted. And the data indicate that the life expectancy in zip codes where these communities reside can be as much as 15 years less when compared to other parts of Greensboro. Cone has an important role in improving the health of our communities of color because it benefits everyone.

I think that we as board members have to be advocates for health equity. Because Cone has such high credibility and a great reputation, we have to continue to use our voices as many did in North Carolina for Medicaid expansion. It took ten years. But it happened. I think we still have to have that kind of advocacy for our community.

What do you see as the biggest opportunity for boards to advance diversity and health equity over the next three years?

Douglas: I would say use our influence and our voice—locally, with state legislatures, and nationally. There is an attack on health systems. The next three years are probably going to be some of the most difficult. For nonprofit health systems, we're not getting increases in reimbursements. There are more options for consumers. We're still experiencing impacts from the pandemic and regaining financial stability. The Cone board is staying focused on strategy, making sure the system is hyper-focused on providing quality care, monitoring the external marketplace and challenging the system to remain competitive in its services and the ways in which we connect to the communities we serve.

Mark Davidoff

Board of Directors Member, Corewell Health

Carlos Cubia

Chief Inclusion, Equity, Diversity and Sustainability Officer, Corewell Health

Tina Freese Decker

President and Chief Executive Officer, Corewell Health

This interview with three executives sheds light on the board's journey towards diversity and health equity within Corewell, emphasizing its intrinsic link to the organization's mission and vision. Tina Freese Decker underscores the pivotal role health equity plays in transforming health care from treatment to wellness and highlights the board's commitment to embedding this focus across the entire organization. Mark Davidoff outlines the establishment of a dedicated health equity committee from the inception of the integrated system, emphasizing the ongoing nature of diversity, equity, inclusion, and health equity efforts. Carlos Cubia outlines the organization's comprehensive strategy to aligning its approach to care delivery and innovation with the evolving needs of the populations they serve.

The discussion delves into the board's strategic plan, highlighting the adoption and implementation of a comprehensive health equity strategy, the creation of health equity councils, and the collaborative approach involving various departments and committees. The executives stress the continual conversation around health equity within board meetings and the integration of DEI and health equity lenses into decision-making processes. They advocate for slow, deliberate progress, emphasizing the importance of earning trust, seeking understanding, and fostering transparency while navigating challenges and driving impactful change within the health care landscape.

About Corewell Health

Corewell Health is a not-for-profit health system that provides health care and coverage with an exceptional team of 60,000+ dedicated people including more than 11,500 physicians and advanced practice providers and more than 15,000 nurses providing care and services in 21 hospitals, 300-plus outpatient locations and several post-acute facilities, and Priority Health, a provider-sponsored health plan serving more than 1.3 million members.

How did your board get started on its journey toward diversity and health equity?

Freese Decker: The journey toward diversity and health equity has been a systemwide imperative,

and it's directly connected to our mission and vision. We believe it is critically important for the people we serve every single day – our patients, our communities, our team members and our health plan members.

As an integrated health system, we're focused on transforming health care from treatment to wellness. Focusing on health equity is central to our efforts on prevention and helping people live their healthiest life possible. We want people to achieve their greatest health potential. I love that our board recognizes this importance, has a committee focused on health equity and raises this important topic in our discussions. It sends a strong message to our entire organization of the value and the importance of health equity.

Davidoff: I joined the board on Feb. 1, 2022, when the legacy systems came together, after the integration to become Corewell Health. Those who were designing governance at that time were creating the standing committees of the board. Health equity was one of the very few standing committees, so from the inception of the new system, we were already reinforcing the importance of this cultural and institutional commitment. This was not just a task force, and it wasn't a "check-the-box" item on our agenda. We worked on the committee charter for six months with conviction because we understood as a board that these topics of diversity, equity, inclusion and health equity are an ongoing, evolving set of paradigms that we will be continually working on to improve.

We've got all the right people around the table, and we have a commitment to continue the hard work.

Can you describe some of the work that the board is doing in 2023 around health equity? You reference specifically having a dedicated health equity committee?

Davidoff: As I described before, the committee first came together in 2022 with the formation of the new health system. There's been a lot of learning for all of us because the legacy components of the system might have been at a different place regarding this commitment, but we now have come together with a sense of cohesion about how we're going to spend our time together and how we're going to have an impact on the governance perspective on this.

The committee drafted a strategy that was adopted by the board, and now we're into the implementation phase which focuses on creating a foundation for health equity across the system. Then we will focus on specific areas to improve the quality of life of the people we serve.

We've also established health equity councils, one across the system and then by region. We have our people closest to the front lines driving this work because they're the ones who understand it. A common thread of this is having a sense of empathy and being able to put ourselves in the shoes of others.

Can you tell us how the committee work and discussions go up to the full board and then what happens at the full board regarding your DEI strategy?

Davidoff: The system-wide health equity committee has a work plan for the year, including discussing the strategy we've agreed to at every system board meeting. The committee's report is reviewed and discussed, and we're constantly seeking the board's input and perspective. Our DEI strategy is continuously discussed at the board level.

Freese Decker: There are health equity strategic conversations and education at the system board and at every other board that we have, plus the health equity councils. Carlos Cubia, our chief inclusion, diversity, equity and sustainability officer, is embedding health equity and DEI in everything that we do. It may not always be listed on the agenda, but the themes, the importance and the elements of health equity are tied into our conversations. Health equity is embedded into our work every day.

Cubia: In addition to the systemwide health equity committee, which Mark chairs, we have a health equity subcommittee which is assigned to each of the respective regions; and we have a community health activity committee. There are many team members around the organization who are working

on this, but it all reports up into one area, and then we share that cascade across the organization.

We want DEI to be at the center of everything we do. When we are making decisions, we ask, "Have we considered DEI? Have we considered health equity?" That is our guiding light to move forward with how we provide care, how we make decisions, and the programs, practices, and procedures we put in place. It is a very collaborative effort.

Can you talk about the board's plans for advancing diversity and health equity across the organization next year? How does that fit within Corewell Health's overall strategy?

Cubia: We rolled out our overarching health equity strategy for the organization, and it is centered on three major areas: maternal and infant health, cardiovascular health, and behavioral and mental health.There are so many click-downs underneath each one of these areas, it's a monumental task.

We work with our DEI team because we feel that you can't do health equity if your DEI agenda isn't strong. They go hand-in-hand. The collaboration between all the departments within this organization has to come together to really tackle this. It's not something that we're going to do in a quarter or in a year. This is going to take time because we want to get it right, but there will be milestones along the way that we can share and celebrate.

As you think about the role of boards generally, why would you say it's important for boards to be focused on diversity and health equity?

Freese Decker: We know that diverse experiences and perspectives really shape what we do and make our health care outcomes even better. It also improves the business outcomes that we have as an organization. Equity is just as important as all the other elements that go into safety and quality because it's about providing people with what they are looking for, which is their healthiest life possible. It's important that the board focus on this to set the stage for the tone for the entire organization. It's important that we recognize what we need to do to improve people's health and have those diverse perspectives. A focus on health equity is critical.

Davidoff: As a board, when you want to measure what's important, you look at how you're spending your time, and we can do this. As leaders, we have to be engaged and intentional, we have to be consistent with our commitment and our passion for this work, and that can only happen through conversation, discussion and learning in the boardroom.

Cubia: If you look at the data and the research, they show that the population is changing dramatically and drastically, and the people who are experiencing health inequities are becoming the majority.

If we don't address those inequities and understand that population and demographic or know what their needs are and how to address them, we're going to continue to see rising costs and more health care needs for those individuals. To the extent that we understand diversity, we embrace it, and we start to identify with those communities. It will better equip us as a system to be prepared to provide the necessary care that's going to help to improve situations versus just improving catastrophic situations. Plus, it will help us better understand who we are caring for and who our patients and constituents will be in the coming years.

So, what do you see as the greatest opportunity for boards to advance diversity and health equity over the next three years?

Davidoff: Our greatest opportunity is to stay together and collaborate. We have an amazing opportunity as a system, and with Tina as our leader, to really set the bar not only for our health system in Michigan but across the country in the way we tackle complicated, difficult issues that have real life-changing results. We're going to stay fully engaged and be prepared to share and teach others how to get this work done and how to make a difference.

Cubia: My advice is to go slow and not rush through this, while understanding that there's a lot that goes into this work. Don't try to do it alone. There are partners out there that you can really tap into and work collaboratively with to develop solutions that can be beneficial to those whom you are trying to make a difference. Don't get frustrated when you run into roadblocks because they're going to be out

there. Not everyone embraces this work, but it is important and meaningful. Stay the course and don't give up.

Freese Decker: It's about continuing to earn and build trust. You have to stay together and collaborate and go slow. You have to build and earn that trust with the board, with team members and with the community about what you're trying to do. And to do that, you have to take the time to listen, be curious and seek to understand versus coming in with solutions first.

We also learned that it's okay to not know all the answers. But we work together to figure them out. We don't have to have all the solutions to the problems we're trying to solve. But being upfront that we're working on them, and then holding ourselves transparently accountable is important. We want to make health better for all.

Summary

The comprehensive insights gathered from these interviews with health care leaders and board members shed light on the multifaceted approaches organizations are undertaking to prioritize diversity and health equity within their operational frameworks. These interviews show a shared dedication to fostering inclusive health care systems.

It is important for boards to see and understand data that links diversity efforts to better patient outcomes and care. Organizations must remain vigilant in times of constant change to provide continued, equitable care for the populations they serve. They must make sure that health equity is embedded in the operation of their organizations, leading to equitable and improved outcomes.

Discussions centered on the trajectory of these institutions' journeys, emphasize the pivotal roles played by dedicated committees, integrated strategies, and community engagement. Insights highlighted the evolution of these initiatives, spanning several years and encompassing multifaceted strategies to embed health equity into the organizational DNA. **These leaders emphasized the importance of data, board-level commitment, and holistic community-centered approaches as fundamental cornerstones in advancing health equity.**

The discussions underscored the significance of collaborative partnerships, workforce development, and a steadfast commitment to transforming health care systems from treatment-focused models to holistic wellness approaches, ensuring equitable access and outcomes for all individuals and communities. Each interview emphasized a strong commitment to health equity, underlining the integration of diversity and health equity into the fabric of the organization's culture and strategy.

I'm a Board Director. Where Do I Go Next?

Five steps every board director can take

1. Recognize the opportunity to play a role.
2. Understand the business imperative.
3. Assess where your organization is.
4. Ask strategic questions to help your organization prioritize health equity and measure progress.
5. Share your progress with others.

Source: Prioritizing Health Equity in the Board Room, BDHEA/Deloitte Consulting

Where Does My Organization Go from Here?

Prioritize consistent learning focused on diversity and health equity at the board level.

Regardless of where your organization is on its journey, opening the boardroom to discussions about diversity, equity, inclusion, and health equity is a crucial step for change. Whether it's asking about metrics, setting goals for community partnerships, or understanding the composition of staff, engaging in regular dialogue at the board level is critical. Identifying a specific champion at the board level helps to ensure follow-through on diversity initiatives and conversations.

Pick a mechanism for accountability that works best for your organization.

The topics reviewed in board meetings reflect the organization's critical strategic priorities. Many organizations integrate conversations at the board level on diversity and health equity within committees, with some electing to create a specific diversity or health equity committee to ensure accountability. A dedicated committee serves as a vehicle to address specific roadblocks impacting outcomes for both patients and employees and a team accountable for measuring and monitoring results. Identify the tools your board will deploy to ensure organizational progress toward long-term strategic priorities, including considerations on executive compensation and governance tactics for fully leveraging each member's expertise.

Promote transparency in your organization's learnings and continued growth.

Many organizations are monitoring the progress of their diversity and health equity work in-house. The power of change is the ability to share and learn collectively. How is your organization sharing success stories in-house and with other organizations? Consider where you can serve as a thought leader to other health care organizations and share your stories.

About Us

American Hospital Association

www.trustees.aha.org

The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members come together to form the AHA.

Through our representation and advocacy activities, AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. Our advocacy efforts include the legislative and executive branches and include the legislative and regulatory arenas.

Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends.

Black Directors Health Equity Agenda

www.bdhea.org

Founded in 2020, the BDHEA unites a preeminent and formidable group of health care leaders, board directors, and educators from across the country with a common mission: to transform the health care industry by closing the gap in care, talent, research, and policies for the Black community and, in turn, improve treatment outcomes, innovation, and care for the entire nation. Their membership includes physicians, nurses and health care workers.

The Health Management Academy

www.hmacademy.com

Since 1998, the Health Management Academy has cultivated the premier membership-based community of health care's most influential chief experience officers from top U.S. health systems as well as decision-makers from innovative industry companies.

The Health Management Academy cultivates exceptional peer groups, providing original market insights, world-class leadership development programs and novel member alliances to more than 2,000 health system senior executives and 200 industry organizations.

Their industry-leading programs and solutions enable their member companies as they facilitate meaningful relationships, navigate strategic transformation and address critical industry issues with disruptive solutions.

Additional Resources

American Hospital Association Resources

Black Directors Health Equity Agenda Resources

The Health Management Academy Resources

For more details on the 2022 AHA Governance Report from AHA Trustee Services, click here.