CEO VIEWPOiNT

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MARC GORELICK, MD,
PRESIDENT & CEO
CHILDREN'S MINNESOTA

"I always knew I wanted to go into healthcare," says Marc Gorelick, MD. "My mother is a nurse, worked hard and had crazy hours, but always seemed to enjoy it." He has arrived. Today Dr. Gorelick is president and CEO of Children's Minnesota, one of the largest freestanding pediatric health systems in the United States, with two hospitals, nine primary care clinics, seven rehabilitation and multiple specialty care sites. He joined Children's in March 2017 as president and chief operating officer. Dr. Gorelick previously served as executive vice president and COO of Children's Hospital of Wisconsin in Milwaukee. A pediatric emergency medicine physician by training, his prior experience includes faculty positions at Medical College of Wisconsin and University of Pennsylvania, and clinical and leadership roles at Children's Hospital of Philadelphia, AI DuPont Hospital for Children and Children's Hospital of Wisconsin.

His education includes an A.B. degree in history from Princeton University, an M.D. degree from Duke University, and a Master of Science in Clinical Epidemiology from the University of Pennsylvania. Dr. Gorelick trained in pediatrics at Children's National Medical Center, and in pediatric emergency medicine at Children's Hospital of Philadelphia. His interests include running, cycling and paddling, homebrewing, and playing the tuba.

Prior to becoming president and CEO of Children's Minnesota in 2017, you were president and COO there, after having been EVP and COO of Children's Hospital of Wisconsin. You are also a pediatric emergency medicine physician by training. How does that combination of operational and clinical background shape your leadership style and vision?

It's not a coincidence that a big percentage of physician executives have been ER physicians. ERs are at the nexus of a hospital, with patients coming through the front door and lots of interactions. So, systems-based training and interconnectedness surround the patient as soon as they arrive. Another reason I like emergency medicine is it forces you to make decisions at moments without complete information. You must get comfortable dealing with ambiguity under time pressure. As a CEO you make decisions with ambiguity and uncertainty, especially today.

Children's Minnesota is opening its first inpatient mental health unit this fall. Why now? How will its design and operation fit into your larger mission?

At Children's we've always cared for kids' mental health, by integrating mental health into clinics and other ambulatory sites. However, we've not previously offered inpatient mental health. The world is changing in this area too. Recently, we've experienced a huge increase in demand, a 30-percent jump in the ER for acute mental health crisis; 50 percent of those patients being admitted to the hospital. That is the need now, so we are addressing it. And inpatient mental health completes the continuum of mental health care for us.

Children's MN Minneapolis campus

St. Paul campus

Minneapolis, the state of Minnesota and the nation were all rocked by the murder of George Floyd in May of 2020. How does that event continue to impact Children's Minnesota and the community at large?

George Floyd Square at 38th Street and Chicago Avenue in South Minneapolis is 12 blocks from where I sit. It's right down the street. That tragic event raised awareness of systemic racism and inequities that unfortunately have been around a long time. In 2016 we did a community health needs assessment, asking what the top issues are that we face. In 2016 we knew that inequity created huge gaps in care and wellness for kids in our community, and specifically named systemic racism as a health risk. I was CEO for only a few weeks in 2018 when I signed the CEO Action Pledge on Diversity and Inclusion, a collaborative among companies to commit to improve diversity and equity. We were the first children's hospital to do so. Today more than 2,000 organizations have signed the pledge. Also in 2018, we hired our first equity and inclusion officer to help us determine how to measure inequities in our workforce and workplace. George Floyd's murder catalyzed an awareness of long-standing issues and spurred us to do everything we can every day to accelerate diversity, equity and inclusion.

Children's Minnesota recently launched the Collective for Community Health that will focus on partnerships to improve community health. How will the Collective work to address structural racism, health equity and the social determinants of health?

The Collective brings greater structure to our community health initiatives, including those around diversity, equity and inclusion, by serving as the interface between Children's Minnesota and the community. Within that ecosystem, for example, our Community Connect program screens young patients at the hospital and in clinics for social determinants of health. After launching Community Connect five years ago, we've screened 45,000 kids for SDoH. Our Community Connect program can help connect patient families to existing community resources, including food pantries and benefit programs, transportation services, legal assistance, housing support, early childhood education programs, employment search assistance and much more, using NowPow as our personalized community referral platform.

The Collective also engages in policy advocacy by bringing stakeholders together, raising awareness and leading strategic change in our community. You must identify community needs and build trust. That gets back to my roots as an ER physician: you're almost always going to encounter someone you haven't seen before. We serve communities that have historical inequities in not just health but legal and political access. It takes time to build trust, but we've made progress. We're seen as someone who is authentically present for medical care and other needs. Children's early years are especially critical for a person's health and success later in life. We want to be there.

Of course, everything we've mentioned occurred during the COVID pandemic. What do you think COVID changed in healthcare—or is continuing to change—that will be long-lasting?

COVID accelerated a number of initiatives and trends that we were seeing before 2020. Healthcare consumerism, for example, didn't just start during COVID. But it accelerated it, as it did telehealth,

which we've been talking about for years. We've also been dealing with workforce shortages for a long time. All of a sudden, March 2020 occurs and people awaken to these issues that have been brewing sometimes for decades. We see COVID as more of a catalyst to long-term change.

Dr. Marc Gorelick speaking at launch of new inpatient mental-health unit.

You recently launched a blog called "Progressive Pediatrics," in which you take stands on issues such as gun violence and the disproportionate impact of climate change on communities of color. How does your blog advocate for change that can improve the health of children and families?

The blog addresses a lot of issues that affect kids that are external to Children's Minnesota such as the social determinants of health and similar factors that would benefit from policy change. We screen patients in our clinics for SDoH, but we're not addressing the root causes, which are systemic issues of racism, poverty and inequity. I feel an obligation to address these policy issues, and while they're political by definition, they don't have to be partisan. So, a good deal of my blog addresses public health issues such as climate change or gun violence that evidence shows affect children's health.

One of the distinguishing characteristics of children's hospitals compared to non-children's hospitals, is their engagement with the patient's family members. With the current focus on patient engagement, consumer-centric care and community health, what can children's hospitals teach other hospitals and health systems about engaging the patient, family and community?

With children's hospitals, adults and kids are always part of the family ecosystem. Patient-centeredness is family centeredness. All six domains of quality outcomes as defined by the Institute of Medicine—effectiveness, safety, timeliness, efficiency, patient-centeredness and equity—depend on engaging the family ecosystem. You need to make patient-centeredness part of your core quality initiative.

A key element in that strategy for us is family participation in rounds. We always have such options, including family rounding and nursing handoffs, because a parent knows their child more than anybody. We have a robust Families as Partners program, which gets family input on strategic planning, digital adoption advocacy and student training. We incorporate families a lot. And we also make sure families who participate in Families as Partners reflect the diversity of the community.

In a similar vein, we have entered a new era of digitally-enabled consumer-centered health and wellness. As a physician, how do you view trends such as mapping the patient/consumer journey and applying digital to the identified gaps in that journey? Is it even possible to map this journey given that healthcare is so complex, and every person is unique?

To be honest, as an industry we use complexity and the variability of people as an excuse to *not* map the patient journey. Complexity, however, makes it more of an imperative to map. In healthcare it's important to map the course of a person's life—even in the ER—so we can understand what patients need and reduce complexity.

We have myriad opportunities to reduce the complexity for consumers through digital technology. For example, in the marketplace, consumers face a complicated choice of insurance. Use technology to make that choice simpler. We have lots of opportunities to get systematic and more convenient. Standard doesn't mean uniform or identical. We can assign personas to patients with certain conditions who have commonalities. So, we can customize for individuals within a standardized framework. Coincidentally, the meeting I just had before this interview was to discuss our roadmap for digital engagement.

For most health-system CEOs, the workforce crisis is at the top of the list of priorities. Staff shortages, burnout, and retention and recruitment challenges are all converging. What has Children's Minnesota experienced in this area and how are you addressing this crisis?

Our experience has been very similar to other health systems: staff shortages, members of our workforce experiencing burnout, competition for workers. We're all looking at short-term tools to recruit and retain.

Two thoughts: One, burnout is not new. I published a paper on burnout in 2014, in which I addressed it as a systemic issue, not a personal failure. For a long time, we were concerned with questions such as, "How do we counsel, seek help, help caregivers cope better with stress?" People experience burnout not because they can't cope with stress, but because the work environment is stressful. It's a system issue. At the end of the day, people simply can't do their job the way they want to and should, and that increases the stress level. Give them tools to do their job within a redesigned environment. Use continuous improvement principles and technology to enable people to have a better experience. It's a systemic issue that demands systemic change.

Two, some of this is demographic. How do we build new pipelines—not just for current needs—but also for the workers of tomorrow? We're partnering with other organizations. We've had a four-year partnership with St. Catherine's University to explore how we can work with middle and high schools in the Twin Cities to increase the number of kids going into nursing and other health professions. The University of St. Thomas has a new Morrison Family College of Health, which includes a nursing school and programs for social work and psychology, focused on diversifying the healthcare workforce and preparing those people for whole-person health of the future. I'm on their advisory board.

Minnesota has a reputation as a collaborative state in healthcare. Is that still true and how does it manifest itself in today's changing healthcare landscape?

I think it is true. We're pretty collaborative in Minnesota. Leaders of the nine largest health systems met at least weekly during COVID to discuss how we could collaborate to fight infections, share best practices and level-load patients. That has carried over. We're still competing with each other, but also collaborating through entities such as the Morrison Family College of Health at the University of St. Thomas, which I mentioned, for a workforce pipeline in nursing, social work, psychology and health exercise. We don't want to compete for workers but on quality of health and wellness for patients and consumers.

What will the healthcare landscape look like in five and 10 years?

I'm comfortable making decisions, but not sure about making predictions. COVID has been an accelerator for some trends over the next five to 10 years. One is consumerism. Healthcare has become more personalized. That's occurring with genomics in medicine but also with seeking care the way we want it when we want it. Everybody's path is different and we have to figure out how to accommodate the different journeys. In the past, we just put everybody into a box.

Two, we will have greater and greater focus on SDoH and equity, which will become a dominant and central point of value-based care.

Three is workforce. I think the Millennials get a bad rap. I think they're really mission driven. I see this in my kids. I really do find them to be motivated by noble ends. That's what we need in healthcare.

– Chuck Appleby, Editor in Chief

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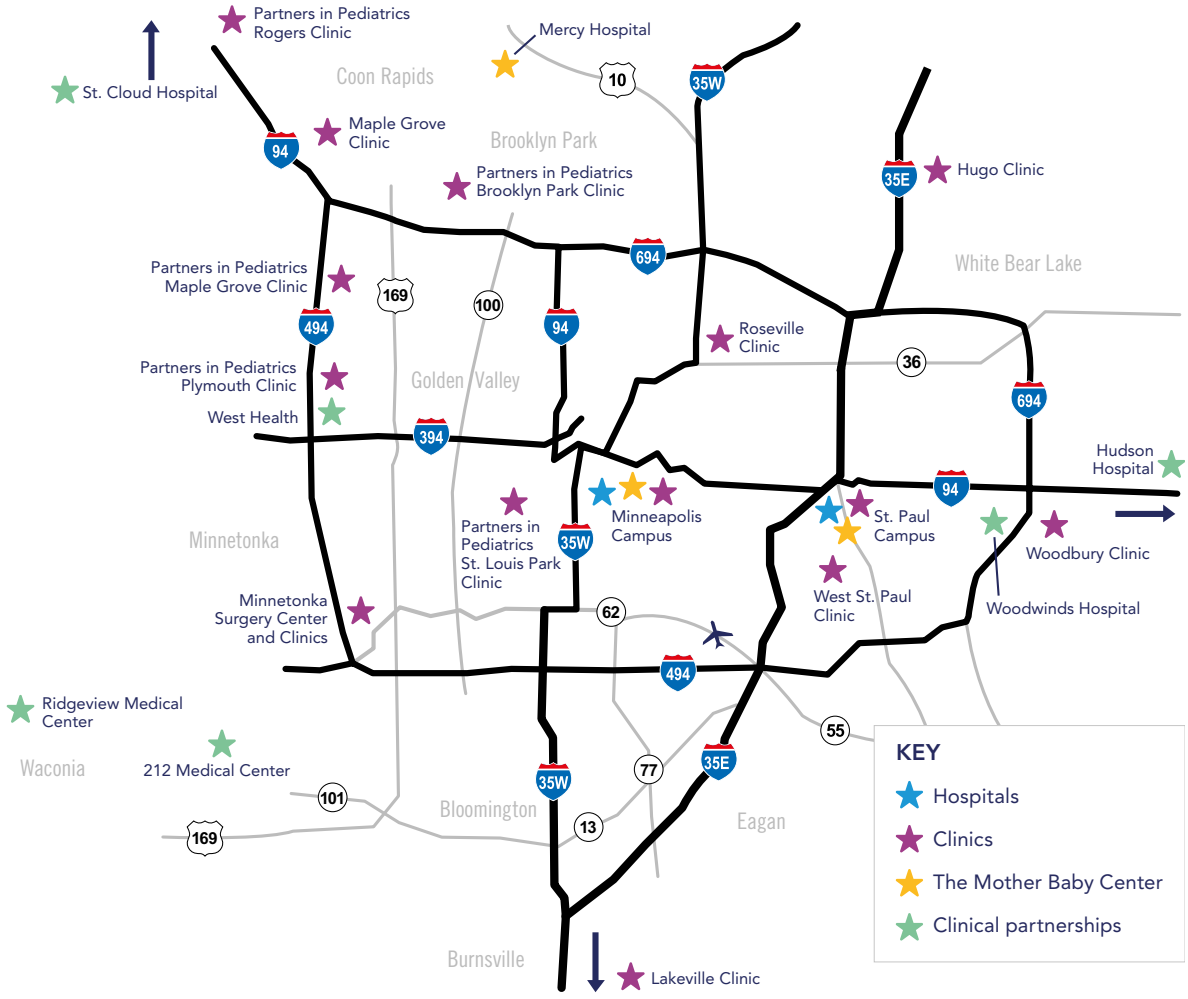
Children's Minnesota

OUR LOCATIONS

To learn more about all Children's Minnesota locations, including primary and specialty care clinics, and The Mother Baby Centers, visit childrensMN.org/locations-all.



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