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Leadership Imperatives: Where Do We Go from Here?

Highlights from ACHE's Virtual Leadership Symposium May 2023

The pandemic created new problems and deepened entrenched problems in the healthcare system. ACHE's Virtual Leadership Symposium May 9–10, 2023 focused on moving forward by sustaining the benefits that came out of the pandemic and working towards new leadership imperatives to solve problems with the same level of urgency and flexibility that healthcare leaders proved capable of during COVID. Below are some highlights and key takeaways for boards and senior leaders from the event.

Positive Innovations Out of COVID

The speakers enumerated several positive innovations and lessons learned from the pandemic, including the following:

- Telehealth has proven to be effective and efficient for certain types of care. Now, healthcare leaders must determine its role in an integrated and digitized delivery system where care is optimized, patient-centered, and customized in convenient, low-cost settings. Moreover, ensuring access to telehealth in rural communities without access to broadband remains a challenge.
- Organizations' ability to pivot quickly was proven through expanding telehealth capabilities and via swift development of crisis/isolation units and surge capacity. How can we leverage that energy and urgency to tackle some of the more entrenched problems that have anchored progress in healthcare?

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Workforce for the Future

By 2034, the industry is anticipating mass deficits in all medical specialties and especially in primary care. The workforce shortage is a specific and persistent challenge. One important piece to consider is that healthcare providers haven't done a good job telling the story about what will happen when there aren't enough doctors and nurses to care for patients.

People are leaving the profession or not joining it because the incentives are no longer what they were or what they hoped for. Physicians often feel like a cog in the system with expanding limits on control and autonomy. How do we change the incentive structure (beyond pay) to attract, retain, and perpetuate participation in providing clinical care? The aim is for your organization to be the most difficult place to find a job because it is the most rewarding—people don't want to leave.

Some key takeaways to help tackle the workforce crisis include:

- Workforce solutions need to include teams that have autonomy in figuring out how to do the work, which helps with engagement.
- We must redesign how we work, building in more human-to-human connections.
- Smarter use of technology for the things that don't require human cognition helps focus on where we need the critical thinking, creativity, and problem solving.
- We need mechanisms for siloed providers to communicate more often and talk about how to change things so they can work together better.
- Ideas and solutions should come from physicians, nurses, and staff; leadership's role is to determine how to spread the solutions faster.

Conducting an individual task analysis gets down to asking the fundamental questions of why something is done, ensuring that the right people are doing the right tasks with the right skill levels. This is a process that can expand capacity while enhancing workforce engagement and satisfaction.

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Tipping the FFS Scale to Value

While the pandemic placed a pause on the value-based care (VBC) momentum, presenters again challenged the audience to do more to tip the scales away from fee-for-service (FFS) and pave the way for VBC to become the dominant model.

To do this, health systems, hospitals, clinicians, and payers all need to be aligned on how the metrics are chosen, what the goals are, and how to achieve them. The first step is to standardize quality measures across provider groups, health systems, and payers. Data transparency needs to be accelerated as well: payers, systems, and providers need to see the same (strong, clean, valid) data so they can draw the appropriate conclusions from it.

Two-sided risk models can work but will require broad expansion of primary care providers (PCPs) who need data infrastructure support from systems. If health systems can provide an arrangement with a level of risk that incentivizes providers to be willing to join the integrated VBC model, PCPs will be the quarterbacks—and held most accountable. They need to have a good pulse in terms of the patient's lived experiences (especially the 80 percent of that related to SDOH). VBC allows us to think more comprehensively about each patient and aligns well with SDOH efforts. VBC can allow PCPs to spend more time with their patients, so they feel they can do what they were meant to do or practice in a way that is more aligned with connecting with patients, which will help alleviate burnout.

Policy changes will need to continue to support the VBC path, including CMS's continued expansion of ACO and capitation models. The next step needs to be a multi-payer model, to bring consistency under a larger umbrella so more people can be integrated into an ACO. Local policy changes can be most effective, within smaller regions or at the state level, where stakeholders are focused on outcomes of a certain population and can make those changes more rapidly.

The following three action items are imperative for health systems to accelerate their own VBC path:

1. Build a data-driven culture.
2. Create an integrated team of stakeholders (providers, executives, and payers) to define goals and standardize metrics.
3. Invest in technology and infrastructure to leverage data and scale providers and resources to reach more people and make more rapid changes.

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A Renewed Focus on Equity

ACO Reach is an equity-focused model that incentivizes providers to think about communities that are underserved and harder to reach. Data needs to be stratified to help identify these groups. It is here where the role of SDOH comes into play: how do we make sure health systems are doing what they need to for these groups?

VBC will help address equity but it's just part of the solution. The financial incentive to deliver care to underserved communities might not be enough in dollars alone. We need resources and providers, especially in rural communities. New tools to scale VBC models into all communities via different mechanisms will be needed.

There is a patient awareness component to this as well: the general public considers the PCP to be a resource only when they have a problem or illness. The new VBC models will require educating the public so that consumers see their PCPs as a wellness resource.

Beyond Telehealth to Digital Health

The key to a wellness model is figuring out how to communicate more frequently with our patients; digital health can serve as this bridge. New digital health tools will help health systems find those who are deteriorating and need an intervention before they need to go to the hospital. We can use technology that is more affordable and can touch more people via automated AI, such as automated phone calls that escalate to a care coordinator when triggered. ACOs can use their integrated infrastructure and digital tools to determine who to touch and how to prioritize.

Creating an Inclusive Culture

Because of the above challenges, leadership in healthcare has become more difficult and complex, revealing a need to manage talent purposefully and evolve skills to handle the continuing uncertainty ahead.

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Purposeful leaders create an inclusive culture by leading with humility, authenticity, generosity, and vulnerability, even during the worst times. They lead by example with executive action and commitment. They also require their leadership teams to lead by example and hold them accountable to that. Transparency and vulnerability need to be shared across the executive team.

Model: Purposeful Leadership

Purposeful leaders connect their individual purpose to broader team and organizational goals. They fulfill the five specific commitments of purposeful leadership:

1. Inspire.
2. Engage.
3. Innovate: create change with competitive distinction.
4. Achieve: results from creating structures and processes, aligning resources so teams can accomplish goals effectively.
5. Become: commitment to continually develop as a leader (mindsets, values, character, biases).

What we think and what we feel drives what we say and do.

The common thread is inclusion. Purposeful leaders encourage a culture where people can speak up regardless of their experience and background. They show empathy and concern for others.

Three organizational drivers that have a positive impact on inclusion:

1. Executives lead by example.
2. Leaders discover team members' unique strengths.
3. Everyone practices inclusive meetings.

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Tying It Together: The Role of the Board and Senior Leadership

Boards need to support their senior leadership in removing barriers and implementing solutions to these complex challenges. Despite our urge to get back to "normal," previous solutions and traditional strategies may not work in this post-COVID environment. Boards need to engage in candid, transparent discussions with their senior leadership team on the following questions:

1. Does our new strategic plan look too much like our old (pre-COVID) one? What are we doing differently to tackle different kinds of problems?
2. What more can we do to integrate automated digital solutions into our care delivery systems to streamline workflows and reduce burnout?
3. How can digital solutions help us accelerate value-based care and equity?
4. What partners and stakeholders do we need to bring to the table (or have different kinds of conversations with) to accelerate our VBC journey, expand our SDOH impact, and enable our communities to see us as a wellness resource to tap into on a more regular basis to support health and prevent illness?
5. What strategic conversations can we have with our payers to enable us to change our delivery models faster without eroding our financial stability?
6. How can we create and sustain a culture of urgency to tackle these problems with the level of innovative agility that we did to address COVID?

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