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LEADING THROUGH 2020'S CHALLENGES

Leadership Management Strategies for
Hospital and Health System Executives

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The COVID-19 pandemic has left many health care organizations reeling financially, even as they continue to innovate while addressing surges and the changing community care needs in areas like behavioral health and substance use.

Throughout this crisis, hospitals and health systems have learned many important lessons about expediting decision-making, the importance of funding technology to help facilitate rapid scaling of telehealth services and how to design virtual care spaces optimally for a better patient and provider experience. Some also have reexamined their cybersecurity efforts, as threats have risen during the pandemic. The value of strong community partnerships also has been pivotal, as provider organizations work to advance population health, improve access and reduce disparities.

KEY TAKEAWAYS

- 1 Disparities in care, including but not limited to access and the needs of the community, continue to be prioritized by health care leaders as they team with public and private organizations to tackle challenges.
- 2 Leaders are looking to information technology infrastructure to achieve financial stability and deliver cost-effective care while confronting cybersecurity challenges.
- 3 Telehealth will continue to be an essential area of emphasis to provide a better virtual care experience for providers and patients.

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MODERATOR: *(Andy Shin, American Hospital Association):*
What have you learned from the challenges of 2020. Has COVID-19 created any unexpected opportunities? What insights have you and your leadership team garnered?

DEBORAH VISCONI *(Bergen New Bridge Medical Center):*
 We were in New Jersey's epicenter in Bergen County, N.J., on March 4 when COVID-19 first hit. Two weeks later, we saw our first cases. Among the opportunities we capitalized on were implementing telehealth and technology platforms to help manage care for our communities. We would have been deliberating about how to implement telehealth for months, but the pandemic forced us to advance our thinking, planning and ability to reach a much larger and broader population than we would have otherwise. We opened up telehealth to our behavioral health population and our substance-use disorder population in addition to the acute care and medical community.

We sit on 62 acres of Bergen County property with 1 million square feet of hospital space. It's amazing how little space that seemed, especially when you're trying to create private rooms and ensure that all infection control parameters are in place. We partnered with the Army Corps of Engineers, which built three alternate care facilities on our property with 130 medical-surgical beds. They were not COVID-19-specific beds, so we used the beds in the hospital for COVID-19 patients.

The third major thing we did was implement a robust testing program. We obtained the latest tests available, including the PCR [polymerase chain reaction] saliva test from Rutgers, the antigen test and other rapid tests. We partnered with

our county to implement a mobile testing program, prioritizing communities of need. We took COVID-19 testing out to the communities, which we still do today, and have tested about 125,000 Bergen county residents.

ALICIA HARKNESS *(Guidehouse Health):* We saw unexpected public-private partnerships. For example, we've been supporting leading contenders in COVID-19 vaccine development with various mission-critical initiatives. Many partners worked together, from pharmaceutical companies to scientists to the U.S. government. Some of the public-private partnerships proved to be a catalyst, providing the resources to accelerate innovation.

CHARLES LUCORE *(St. Francis Hospital):* It's always about the people. Our culture is one of respect and caring, but COVID-19 solidified the leadership team. I've only been here about two years; formerly, I was president and CEO of HSHS St. John's Hospital in Springfield, Ill. Even though I'm from the Northeast, I spent more than 30 years in the Midwest. But I had a relatively new leadership team, and the challenges related to COVID-19 brought us closer together. We became more aligned and worked as a team, breaking down silos that you typically see. COVID-19 also made us lead by example. It was important to be out there on a daily basis with our colleagues. Our census peaked on Good Friday at about 90%.

I learned things that allowed us to be more responsive on personal protective equipment (PPE) distribution and utilization, and telehealth. We wanted to keep our nursing communication, which rates above the 95th percentile overall, at that exceptional rate. When the state and the health system suspended visitation, it was challenging

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to address how family members would communicate with the critically ill and still provide the support of mind, body and spirit for which Catholic Health Services is known. That was important to the people and it allowed us to be more responsive as a leadership team.

One of the biggest opportunities concerned our facility. We're on a small plot of land in Long Island and our hospital can't be any higher than three stories. We are constrained in terms of our physical plant and campus. As we transitioned to a smaller number of COVID-19 cases, we were allowed to empty the hospital units so we could terminally clean, repaint and refresh. We did a total facilities overhaul and then in the summer, surveyors from Magnet and The Joint Commission performed a joint recertification. COVID-19 afforded us this opportunity. We were always at 93% to 95% capacity my first year, so we could never do as much with the physical plant as we wanted to do.

RICHARD HART (*Loma Linda University Health*): We're completing the construction of a new \$1.3 billion hospital that's been 10 years in the planning and six years in building, but we'll take possession in about a month. The COVID-19 impact didn't help. We're also on a 10-year journey toward "One Loma Linda" — moving from several different boards to a common board for the whole system, and tying the university and hospital closer together.

COVID-19 has accelerated our coming together. It has forced our system to be more interdependent and more collaborative because of all the

pressure points that exist. We've been able to define all health professional students as essential workers so that they're back on campus. We can't meet face to face in classes, so they complete coursework digitally, but they can be in labs and in the hospital by following regular hospital protocols. We sit between Riverside and San Bernardino counties. They have doubled their COVID-19 patients in the last two weeks, so there is concern as to where it goes from here.

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— Richard Hart, M.D., DrPH —

MODERATOR: What lasting changes do you think we will see from COVID-19 as opposed to immediate responses that won't continue?

VISCONI: One thing that is going to grow as a result of COVID-19 is the need for behavioral and mental health care in our communities. We're seeing a 30% increase in our behavioral health volume coming through our emergency department (ED). We're also seeing an increase in substance-use disorders, alcohol-related in particular, coming in through the EDs and individuals with those types of comorbidities. The technology and telehealth absolutely will stay and continue to grow.

We've learned so many great things initially from a clinical care point of view that I'm not sure we will go back to the way things were. Certainly, some of the waivers and things that were put in place by regulators were helpful. Hopefully those will stay, but we suspect that they may go back to the way they were. Our care for the elderly and the long-term care population will look different. There's going to be more of a movement toward at-home care for people.

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HART: We have been discussing how to design clinical space for telehealth use, because using exam rooms so that a doctor can talk to a patient is not cost-effective. We're looking at another clinical building design in which a whole floor is utilized with more cost-effective telehealth use with privacy and confidentiality. About 50% of cardiology patient visits are now via telehealth, and dermatology is shifting more to visual communication. It's interesting to watch the different disciplines decide what their optimal proportion of telehealth might be.

LUCORE: A tremendous opportunity has developed around improving access, regardless of the environmental conditions. As a clinician, I believe in being able to get the right care in the right place at the right time. And, as Richard points out, there's a substantial number of visits that can be accomplished using telehealth without having somebody spend time in a waiting room. This helps to promote patient privacy, and it gives us the ability to impact our cost structure. Obviously, the bricks and mortar ambulatory setting will be different. There's definitely a place for expansion. Insurers should embrace it because, especially in rural areas, there is a potential to affect transport cost and other areas to improve the cost structure.

And certainly, insurers did very well with the pandemic because their medical-loss ratios changed significantly because there were fewer people seeking care unless it was an emergency. I see this as a tremendous opportunity to provide care in a way that will be better for patients and likely better for providers.

HARKNESS: We must normalize the use of predictive analytics to avoid health crises. We were involved in an initiative to reduce suicides in the veteran population, and it's amazing what you can do with data to predict a crisis and accelerate engagement with those who are potentially at risk. At the same time, cybercriminals are ex-



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ploting the pandemic's reliance on virtual care and data assets. Providers are now looking for weaknesses in their systems so they can reduce threats.

HART: One of our concerns is that much of the emphasis we've placed on population health issues over the last four or five years has been short-circuited now at a time when many of those populations need care the most. Whether it's behavioral health, access to care, specific population health issues, or whether it's the environment, nutrition or safe places to exercise, we're going to have to get back into that world a bit more — probably with more limited resources, but it is important as it ever was.

We're facing what's called the digital divide. How many of our families and children don't even have Wi-Fi access here in California because we have large expanses of desert and in the South. There is value in face-to-face visits to establish contact, but more can be done now digitally and cost-effectively. During this last six months the diversity, equity and inclusion issue also has been powerful. We have been blessed on our campus to have a lot of passion and engagement on this issue. It's also enabled us to take an educational approach to help everybody understand that we have blind spots, and we have to develop cultural humility and understand how we are perceived in different settings. We have a diversity counsel on campus

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that I chair as president and we adopted a system of having people tell their personal stories in multiple public venues.

VISCONI: What came about because of COVID-19 was a heightened awareness of some disparities in communities. After looking at our Community Health Needs Assessment that we completed this year, we saw opportunities that lay within the region. The mobile testing program that we launched focused on communities that are densely populated and lacked access to testing. In the second phase, we added a primary care physician to the mobile testing unit as well as gave people flu vaccines. Another thing we recently did was partner with the New Jersey Reentry Corporation (NJRC) to become the provider of choice to thousands of prisoners who were released back into the community the day after the presidential election. We're taking care of these people through a telehealth platform that links each individual with the NJRC. They use one of our iPads in their office to connect with one of our providers electronically. Many of the individuals who were released only had a two-week supply of medications. Some were on medication-assisted treatment programs and otherwise would have run out of their medicines and been on the street. Helping them manage their medications has lessened crime, mortality and an unnecessary use of EDs.

MODERATOR: How are you training or equipping your workforce differently to adapt to these new technologies or to engage patients in new and different ways? How are you thinking about transforming that aspect of your organization now and in the future?

LUCORE: Our medical education is related to advanced practice providers or nursing schools utilizing our facility. We don't have a graduate medical education program. From a nursing perspective, we are focused on PPE utilization, infection prevention, etc. From a behavioral health standpoint, although we don't have behavioral health here, telehealth has become important in both the ambulatory and the acute care settings, especially for triage screening in EDs.

VISCONI: We have 32 psych residents here who did not know how to deal with the COVID-19 pandemic. It became part of the way we

educated our residents and, quite frankly, our attending psychiatrists because they were also panic-stricken. That was a huge cultural change and evolution for our group. At the beginning, the psych residents were storming my office. They all wanted to stay home and take care of patients from home. How do you manage patients when we start getting COVID-19-positive behavioral health patients? This was a learning curve for them because they are residents and have to be here. They're direct care providers. That was a new phenomenon for all of us. These are patients who have behavioral health issues. We made them wear masks or stay in their rooms, and had to curtail the group visits and the therapies that would be a normal part of healing.

MODERATOR: Are you hearing other things from the field that are now being emphasized?

HARKNESS: Once considered a luxury as an investment, enabling advanced technologies into our health environment is now becoming an imperative or a necessity. Many of the technology

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— Alicia Harkness —

so we can identify and target some of the more vulnerable populations in our communities. COVID-19 has caused us to look at what we can do differently. We already work collaboratively and hand in glove with our county, not only because we’re county-owned, but, also because it is supportive of the work we do. And as a county asset, it’s important for us to have this partnership as well as others in the community such as mental health providers so that we have a warm handoff when patients leave the hospital.

projects that we have seen health systems execute, whether it’s artificial intelligence, the cloud, robotic process automation or outsourcing, have been accelerated because of the consumer demand for a virtual experience and the need to improve the caregiver experience. We’ve also given a lot of thought to balancing remote and office work including how to flex services within a health system when an organization is limited to only emergent services.

MODERATOR: With the hypothesis that there will be more employer and hospital partnerships, commercial payer and provider collaboration, possibly moving toward providers accepting more risk to achieve financial sustainability, how are you thinking about these issues?

LUCORE: In the next few decades, we will need to invest significantly in information technology (IT) infrastructure. When you talk about the health system-federal partnership, and the parties are looking to control their expenses, IT is always the next target.

VISCONI: We are looking to do things differently with some payers in community outreach programs and to help us increase our bandwidth



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