EXECUTIVE BRIEFING

Advisory Board

Six things CEOs need to stop doing in 2020...

...and what they should start doing instead

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RECOMMENDED FOR

Chief executives, strategy officers, transformation leaders

Welcome to 2020.
It's time to declutter.

Health care has always been good at adopting new ways of working. There are pilots that rally providers around discrete populations, virtual care options for rural patients, revolutionary clinical technologies, and more. Health care organisations consistently push for new approaches that lead to better cost, quality, access, and experience.

But as the adage goes, old habits die hard. Most health care organisations undervalue the fact that true transformation entails leaving some old—and often unproductive—ways behind, just as much as it requires adopting new ways of working.

Of course this is easier said than done. But as we settle into 2020, **it is more vital than ever that we stop pursuing activities that won't serve us in the future.** That will free up resources for success as we move forward.

Health care budgets are tightening, and governments are increasingly shifting risk onto providers. Organisations can no longer afford to devote precious resources to activities that will not benefit them in the interconnected, value-based world that they are heading towards.

In this briefing, we share some of these old habits that, once left behind, will make the world of health care a bit more manageable. And to match, we also offer an alternative for each—new ideas that systems have adopted in the wake of the old.

> **Read on to learn** the six things that CEOs need to stop doing in 2020—and what they should start doing instead.

Six things CEOs need to **STOP** doing in 2020...

01 Stop adding to your staffs' to-do lists without taking things off their plates.

02 Stop describing your culture in broad, universal, and ultimately unmeasurable ways.

03 Stop centralising your digital strategy in one place.

04 Stop staffing with the hospital first in line.

05 Stop paying lip service to partnering with primary care.

06 Stop chasing the perfect digital enterprise solution.

...and what they should **START** doing instead.

- Start conducting ‘stop doing’ audits.
- Start articulating your system’s values in a way that informs action and behaviour.
- Start unfencing your digital strategy (and centralise an intake process for new ideas).
- Start flipping the starting point to staff from the outside-in.
- Start codifying partnerships with a small set of trusted and willing GP partners.
- Start skewing towards narrow digital solutions over long-term investment plans.

01

STOP adding to your staffs' to-do lists without taking things off their plates.

It is no secret that hospitals and health systems are busier than ever. As improvement and change initiatives pile up, systems are left with dozens—or even hundreds—of work streams to handle simultaneously. And this is in addition to everyone's routine, day-to-day priorities.

These priorities trickle down to management and frontline staff, leaving them overwhelmed and fuelling burnout rates. This phenomenon represents a fundamental tension health care leaders are now feeling: How can we move toward the system of tomorrow while continuing to meet our day-to-day obligations, all without overburdening our employees?

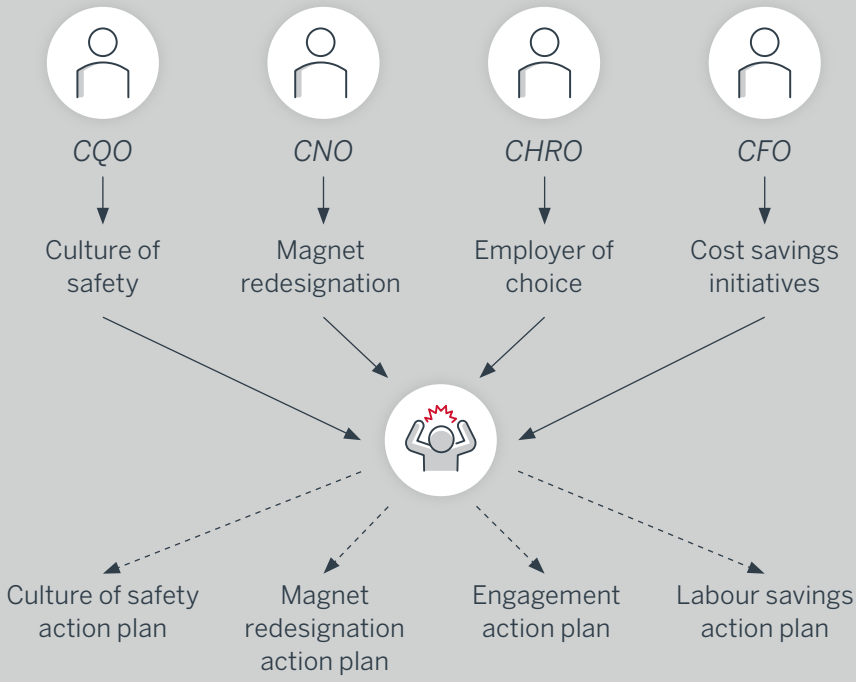
400

Number of annual change initiatives at one representative health care organisation

5–15

Number of individual change initiatives hitting a manager at any one time

Representative change initiatives from executives



START conducting 'stop doing' audits.

Embrace the idea of 'letting go' to free up staff time and refocus it on only the most critical priorities. In practice, this means routinely quantifying staff workloads and time allocations, comparing workload trends with system priorities and objectives, and signalling what staff should deprioritise or stop. The audits have several benefits.

- They offer a format for staff to surface tasks and challenges that unnecessarily absorb their time.
- They signal to staff that their time is an executive priority.
- They give management visibility into any duplicative workstreams in place across the organisation.

Audits like these may look different from system to system, but there is a set of guiding principles to follow.

1. **Start with tasks isolated within a team.** You can act quickly to stop or deprioritise tasks that are contained within small groups. When a responsibility is spread across multiple teams or units, a more rigorous process will be necessary to determine a new/better way of working before deprioritising the old tasks.
2. **Communicate the audit's goal early and consistently.** Audits should be anchored to your goal of freeing up employee time to focus on their most important responsibilities. Otherwise, staff may see the survey as a part of a top-down audit of their performance that might lead to disciplinary action.
3. **Maintain strict confidentiality.** To keep your analysis objective and to ensure responses are honest, anonymity should be ensured.
4. **Don't over-audit.** Audits should be conducted about once a year. Any more often than that can be seen as too micro-managerial.

‘STOP DOING’ AUDIT IN BRIEF

What is it: A survey asking staff to estimate how they allocate their time throughout a workweek. It’s generally done through a free, online survey platform.

What’s in it: A list of job responsibilities/types of work (EHR input, improvement initiatives, clinical care, med rec, etc.) with blank spaces to write in the number of hours spent on each task per week. Also included is an ‘other’ category with a comment box to capture smaller or one-off responsibilities. Each employee’s hours should sum up to their total hours worked per week.

Who administers it: Executives, unit managers, and HR leaders create and deploy the survey. Executives take the role of lead communicator, announcing the survey, updates along the way, and its final results.

Who takes it: The survey can be administered at the team, unit, department, or organisation level, depending on organisational need. It can also be administered to employees of one type, such as all managers.

What they do with it: Survey administrators analyse the responses to identify trends, compare them to the organisation’s strategic priorities, and make a decision on what staff members can stop doing or deprioritise.

Example outcomes: Consolidating duplicative committees, separating out planning/improvement from day-to-day operational responsibilities, limiting action plan implementation to a small group, narrowing administrative tasks, sunsetting projects that are not in line with a system’s values or mission.

02

STOP describing your culture in broad, universal, and ultimately unmeasurable ways.

Given the tight labour market and the barrage of policy and consumer pressures that systems face, many organisations are understandably inclined to pursue a culture that tries to appeal to everyone.

But this strategy has drawbacks. Look at the real-life examples of system values below. They're all worthy goals, but they're also vague and hard to put into practice.

Example organisational values

Continuously improving	Committed to excellence	Passionate about our work
Consumer-oriented	Innovative	Pursuing the highest quality
Entrepreneurial	Teamwork matters	Respect for the individual

Systems that incorporate values like these may lack a clear articulation of who they are and where they're going because the values are so broad and generic. This makes it difficult to attract the talent to deliver on their most important goals. And riskiest of all, vague statements like these make it easy to pour resources into initiatives without a clear idea of what goal they are helping to accomplish.

START articulating your system's values in a way that informs action and behaviour.

Exemplary system leaders understand that culture is only as successful as its ability to drive and reinforce behaviours that benefit the organisation.

A best practice that we rarely see CEOs take is articulating specific behaviours that will indicate staff are exhibiting each value.

CASE EXAMPLE

Hywel Dda University Health Board

One system that has embraced articulated values is Hywel Dda University Health Board, an integrated social and health care board in Wales. Hywel Dda started a system transformation in 2015 to become a wellness system, and revamped their organisational values to more closely align with their future identity. They chose three values that clearly articulate their ambition of becoming a high-touch, high-service, and people-oriented system.

Working together to be the best we can be

Striving to deliver and develop **excellent services**

Putting **people** at the heart of everything we do

But Hywel Dda didn't stop there—they made sure to clearly outline what good and bad look like for each value. For good, there is a progression from 'core' to 'excellence.' And for bad, they list specific actions that demonstrate a failure to exhibit the value.

Our values cannot just be words on a page; they need to be in our **DNA.** They need to underpin everything that we do and should reflect the day-to-day behaviour of everyone in Hywel Dda.

What 'good' looks like

Examples of behaviours that show values are being met:

CORE

- You offer support to your colleagues when it appears it is needed.
- You care about the public perception of the organisation.

ADVANCED

- You champion the Health Board externally.
- You proactively manage the environment to ensure safety and wellbeing of patients and people.

EXCELLENCE

- You proactively recognise and celebrate successes.
- You always ensure you are actively participating in discussions.

What 'bad' looks like

Examples of behaviours that show values are ***not*** being met:

- You provide care that is inappropriate to the patient.
- You ignore colleagues who need support.
- You withhold positive comments that would benefit others.
- You do not offer support for people.
- You do not take responsibility to ensure a safe environment for people.
- You do not play an active part at events/meetings.

These 'behaviour mappings' are now embedded across different parts of the system. These lists are included on each staff member's annual review. If someone is consistently failing to demonstrate values, the Organisational Development team steps in to help address the deficiency. Further, all interviewees for leadership positions are given a values exercise to ensure they are a strong cultural fit.

03

STOP centralising your digital strategy in one place.

Digital is becoming the new normal. Across almost every facet of health care, digital tools serve as enablers that can help us achieve our cost, quality, access, and experience targets. Yet, many organisations continue to isolate their digital strategies from other priorities that can and should be enabled by digital solutions.

Does your strategic plan look like this?

CLINICAL STRATEGY
- Centres of excellence
- Integrated health & social care
- Upper quartile performance

QUALITY STRATEGY
- Well led
- Patient experience and safety
- Improving outcomes & effectiveness

ORGANISATIONAL DEVELOPMENT STRATEGY
- Workforce sustainability
- Staff experience
- Transformation

FINANCIAL STRATEGY
- Medium-term financial plan
- Outstanding business partnering
- Financial reporting
- Department improvement plan

ESTATES STRATEGY
- Strategic site development programme
- Addressing backlog maintenance

DIGITAL STRATEGY
- Digital landscape
- Digital intelligence
- Digital workforce

COMMUNICATION & ENGAGEMENT STRATEGY
- System co-design
- Engagement model

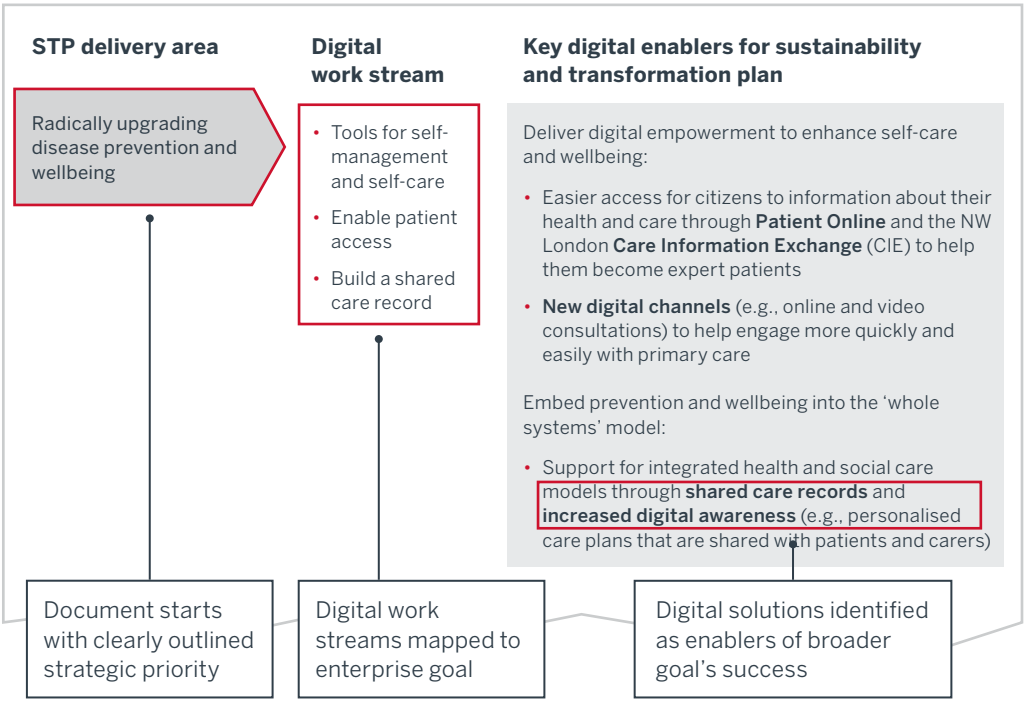
RESEARCH STRATEGY
- Increasing visibility & awareness
- Celebrating success
- Increasing equity of access
- Growing our collaborations

On first thought, it makes sense to keep a large and technically complex effort like digital transformation separate, to give it the time and attention it needs. But this isolates the work, leaving digital efforts disconnected from other critical organisational priorities.

START unfencing your digital strategy (and centralise an intake process for new ideas).

Executives should instead follow the mantra 'digital is part of every strategy' when pursuing digital transformation. See the example below for what this looks like on paper for one system in England. There is an organisational priority, followed by specific work streams, and then digital enablers to help get them there. The power of this strategy is that it starts with what matters most to the organisation and ensures you invest only in digital solutions that serve those goals.

North West London Sustainability and Transformation Partnership Strategic Plan



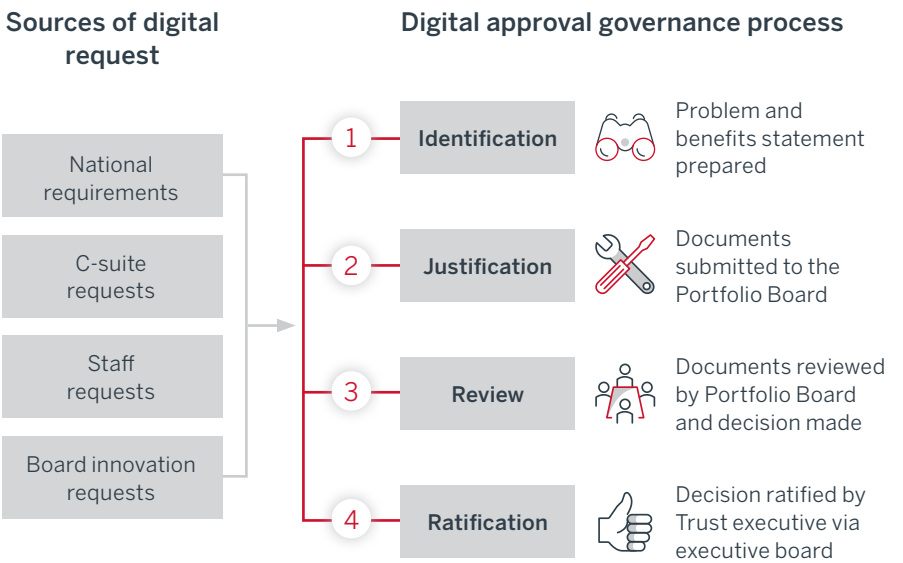
This shift comes with a consequence, though. Once you begin viewing digital as a key component in all priority areas, every team and division can start putting forward digital requests they feel could solve their biggest challenges.

CASE EXAMPLE

Salford Royal NHS Foundation Trust

Salford Royal, a hospital in England, went through a period of receiving too many digital investment requests. At one point they had to choose between about 40 requests, all of which were deemed important by some group within the organisation.

To overcome this, Salford Royal created a process to streamline how requests are submitted, assessed, and approved. This process guards against any bias over who sent the request, narrowing in on which requests are truly high-priority or strategically relevant enough for investment. Two teams then review all requests. First, the Portfolio Board, a multidisciplinary team of digital leaders, vets requests to ensure they meet standards and determine if the request is aligned with broader priorities. Second, the executive board serves as a final check, reviewing all projects that have been approved by the portfolio board to confirm relevance and strategic value.

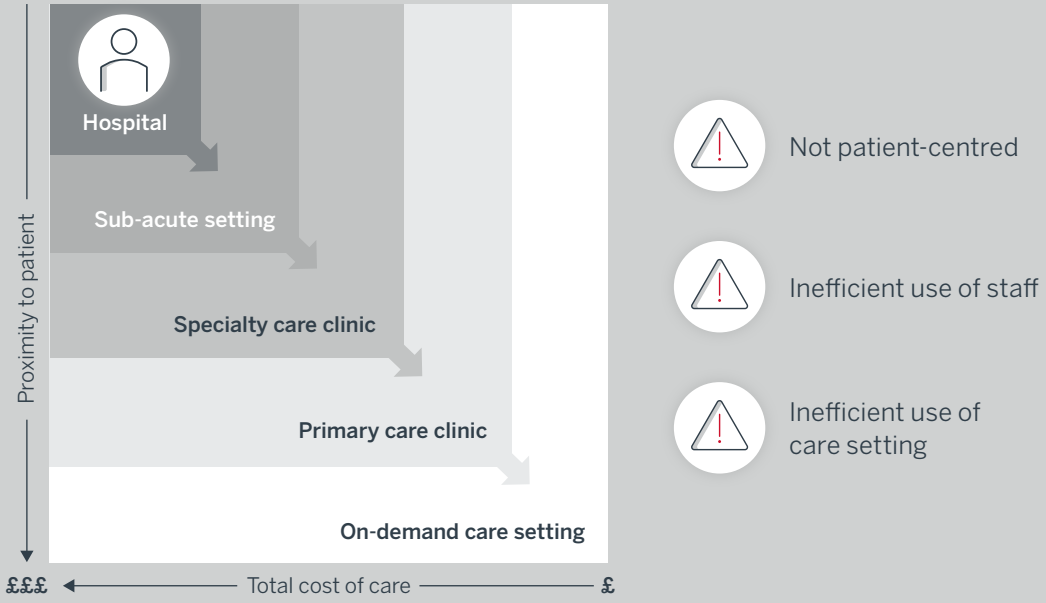


04

STOP staffing with the hospital first in line.

Health systems' top staffing priority is generally building up their acute care workforce. We refer to this conventional approach to workforce planning as 'inside-out': refining inpatient care models, and then designing cross-continuum and outpatient models that complement inpatient staffing.

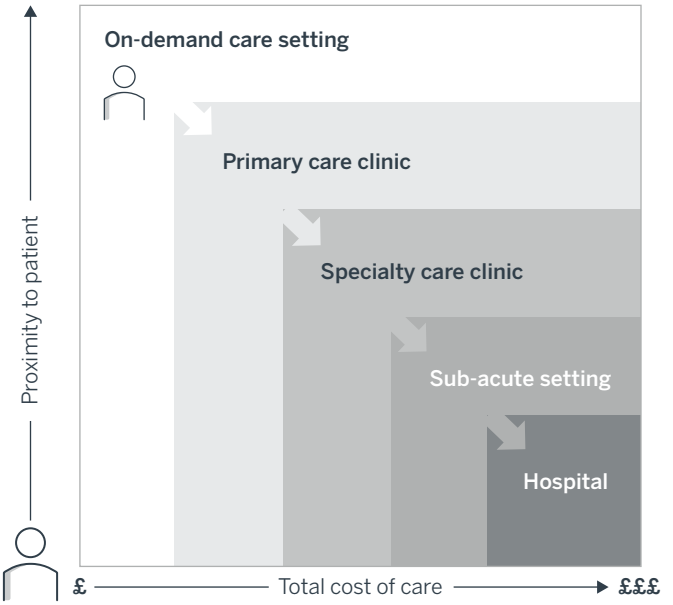
But staffing this way creates a tension. We're moving to a model in which hospitals are part of systems that aim (or are mandated) to provide clinically and cost-appropriate care in the most appropriate setting. The inside-out approach undermines this model, as it locks systems into a costly, hospital-biased workforce for years to come.



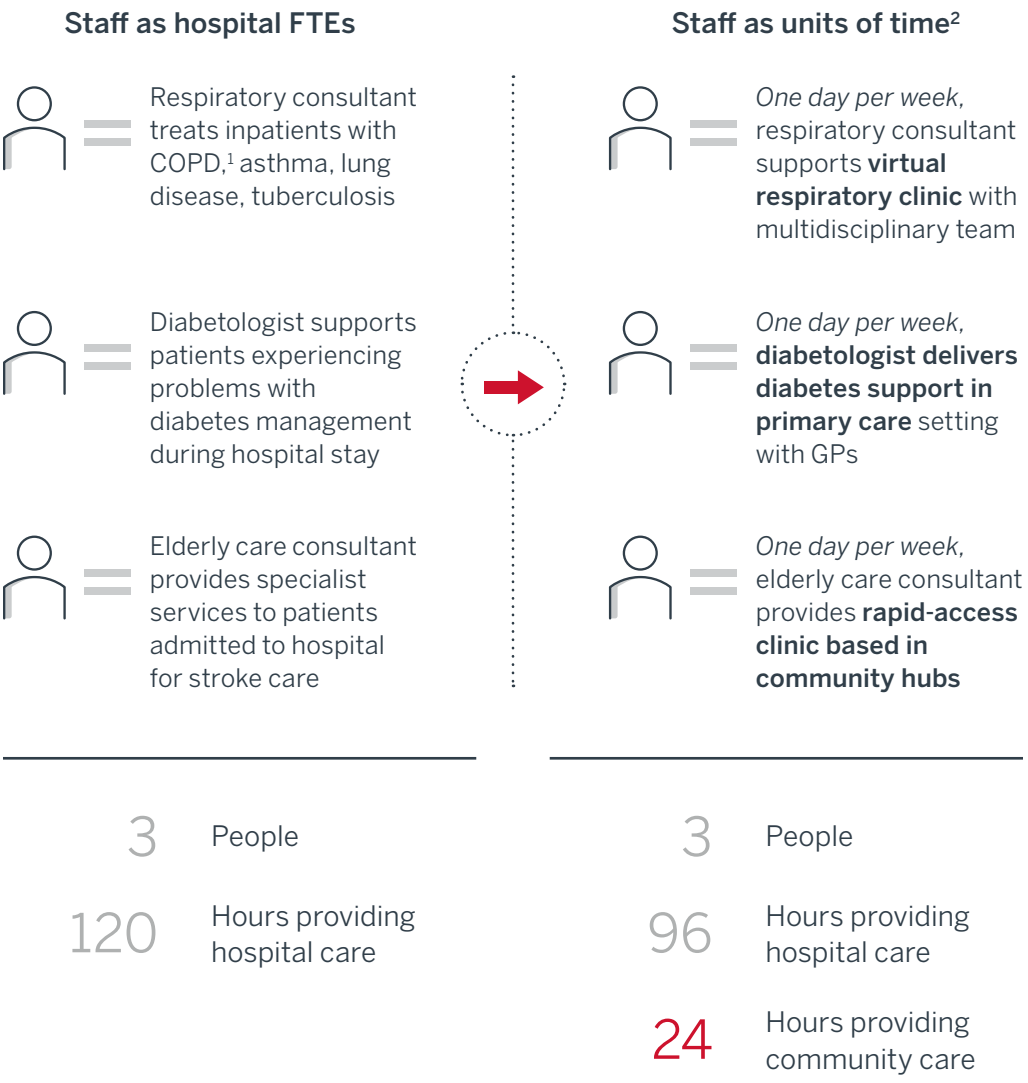
Continuing to use a hospital-first staffing approach means that a system's non-acute entry points will become chronically under-staffed. This limits their capacity and leads to patients being diverted to the ED unnecessarily.

START flipping the starting point to staff from the outside-in.

The ideal approach—staffing from the 'outside-in'—does just the opposite. It involves first staffing to improve patient access outside the four walls of the hospital by expanding capacity to bolster care coordination and limit unnecessary acute care. Then, systems staff moving down the line, leaving the hospital—the most expensive location to staff and furthest away from the patient—until the end.



When you embrace this mindset, your staffing priorities will change. The natural conclusion is an outsized number of vacancies that must be filled in the community to expand capacity with appropriately-trained staff. One way systems begin to solve this is not by launching hiring processes for community roles from scratch, but first looking inward and shifting portions of acute staff time into the community.



1) Chronic obstructive pulmonary disease.
2) Illustrative scenario, assumes each FTE works 40 hours per week or five eight-hour days.

05

STOP paying lip service to partnering with primary care.

Globally, health systems are being urged to form integrated networks. Most are borrowing best practices from their peers, but some are still following old patterns that don't work. One of the most common misperceptions is that systems can build integrated care networks without first elevating the role of primary care.

Admittedly, improving primary care is hard work. GPs are paid differently than their acute or specialist counterparts. Plus, the current primary care model isn't set up to manage integrated care. Most GPs see patients only during standard business hours and aren't available to be the first point of contact for care. Further, many GP practices are small businesses without the resources to expand their care teams or patient access.

Because of these hurdles, many system executives forge ahead without empowering primary care as a leader in an integrated model. But that approach limits how much a system can succeed as a network. No hospital can deflect unnecessary ED demand, manage longitudinal illness, or modify referral streams without building capacity and trust with their GP partners. In other words, **primary care serves as the linchpin of network development.** Any system-wide improvement efforts that don't engage GPs as true partners won't reap the full benefits of integration.

START codifying partnerships with a small set of trusted and willing GP partners.

Systems that succeed in integrated network development have something in common: they all place outsized time and energy on building relationships with primary care groups. But they do this in a targeted way. Instead of focusing on quantity, spreading out and passively approaching every GP in the area, they pick a small set of practitioners with whom to focus their efforts.

Generally, these GPs are the most forward-thinking and innovative, and the least likely to be bothered by political tension from years past. Once the GPs are on board, they can serve as pilot sites for new care models and as advocates to other GPs who are more sceptical about partnering.

CASE EXAMPLE

Gold Coast Hospital and Health Service (HHS)

One system that succeeded here is Gold Coast HHS, a large health system in Australia. In 2016, they had a vision for an integrated health system that would address the needs of their complex, high-risk patient population through collaboration with primary care. They started by spending 18 months solidifying buy-in from clinicians across the continuum, driving change management for GPs and specialists involved, and obtaining funding from a variety of local, state, and federal bodies.

Instead of trying to get all 100+ GP clinics in the area on board at once, Gold Coast focused their efforts on a subset of 14 practices that expressed interest.

Gold Coast sought to develop a care compact to codify the partnerships. Gold Coast met with each of the 14 practices individually to review the agreement line-by-line, working to understand the unique needs and requests of each GP. They went through multiple iterations of the agreement with each practice to arrive at a single compact that laid out roles, responsibilities, and protocols for the integrated care model.

Key data points

18 mo.	6 mo.	1
Length of pilot development	Time spent in GP negotiations	Version of the compact enacted with 14 GP practices

CARE COMPACTS IN BRIEF

Definition: Formalised agreements between GPs and specialists that designate referral protocols, care transition expectations, and respective care management responsibilities. Also known as service agreements, transition of care records, or care coordination agreements, these documents are not legally binding contracts.

Benefits:

Patients

- More coordinated care experience, with needs and preferences met regardless of site of care or treating provider
- Unnecessary or duplicative testing avoided

Providers

- Improved information sharing and clarity in management responsibilities, with an emphasis on closing the loop
- Improved efficiency (example: pre-visit tests and labs completed)
- Tighter network of trusted, high-quality partners with similar values

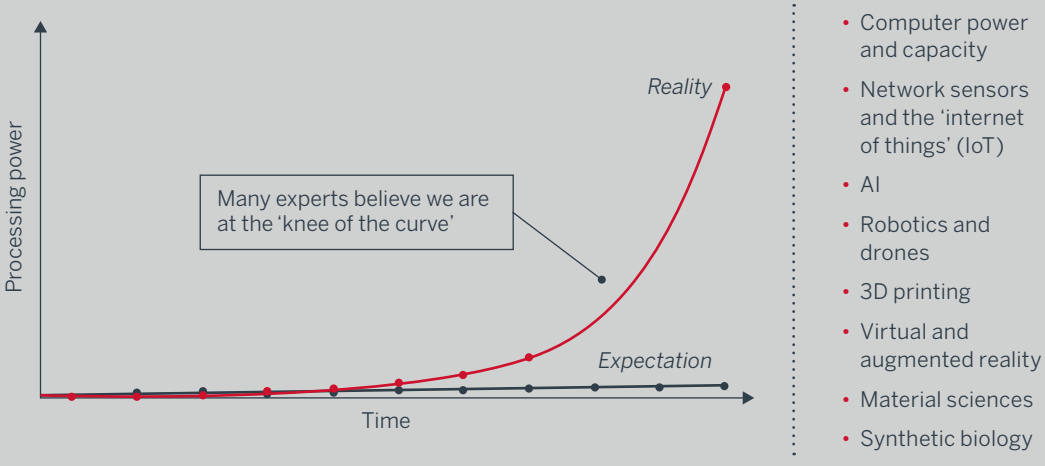
06

STOP chasing the perfect digital enterprise solution.

We sometimes expect that digital transformation will be linear. We have a starting point and an end goal. We think that if we just follow our five-year plan and implement that 'perfect' digital solution, things will eventually come into fruition.

But this approach doesn't take into account the exponential pace of change in IT. As processing speeds and technological discoveries advance, we are introduced to new, revolutionary technologies that make our initial plans obsolete partway through implementing them.

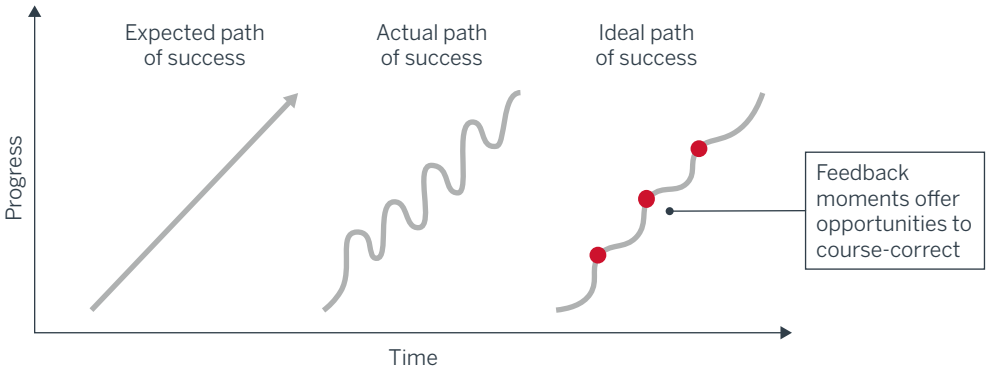
Moore's Law generalised



To place all your bets on a flagship digital solution with a long-term implementation horizon is to try to win a rigged game. Doing so can be a waste of time, money, and energy—and it can close an organisation off to future digital opportunities because all of their resources are tied up in the current plan.

START skewing towards narrow digital solutions over long-term investment plans.

We've come to understand that the ideal digital transformation path looks more like this:



This path embraces the fact that digital technology is a rapidly evolving terrain. Narrow, focused investments allow us to progress and learn in an iterative manner. An organisation can move forward but correct course when necessary, without wasting huge sums of money or effort.

In practice, this involves pumping the breaks on big-ticket digital investments without much rigour behind them. Instead, prioritise fundamental principles to guide digital improvements.

Four guiding principles to improve digital execution

Know what your end users want

Incorporate diverse perspectives—including clinicians, patients, and families—to ensure digital solutions meet the needs of all users.

Polish processes before digitising

Optimise current technology and manual processes before investing in new resources.

Invest in solutions that fit your organisation

Critically assess technology investments—no matter the size—to make sure they solve problems and work in your specific environment.

Don't overcommit to one defined path

Seek out investments or develop capabilities that will allow you to add and scale capabilities as needs change and technology improves.

We know adopting new ways of working is not easy.

Breaking old habits is hard at first. What is familiar needs to be replaced. But it is necessary, and Advisory Board is here to help.

We can help you tackle these new and potentially uncertain work streams through a variety of research programmes dedicated to searching the world for best practices and adapting them for your local context.

Idea

Impact

Strategy

Global Forum for Health Care Innovators

- Population health management
- Cross-continuum partnerships
- Integrated delivery systems
- Disruptive innovation
- Funding and policy changes
- Consumerism

Quality and operations

Clinical Best Practice Collaborative

- Care coordination
- Patient flow
- Complex patient care
- Person-centred care
- Unwarranted care variation
- Highly reliable care

People

Workforce Best Practice Collaborative

- Staff engagement
- Change management
- Workforce planning
- Alignment & accountability
- Leadership excellence
- Nurse resilience

Clinical business units

Service Line Advisor

- Cardiovascular
- Orthopaedics
- Radiology
- Neurosciences
- General surgery
- Oncology
- Imaging

Information technology

Global eHealth Executive Council

- Clinical IT systems
- IT business alignment
- Business intelligence and analytics
- IT-enabled integrated care
- Telemedicine
- Emerging technologies

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Select resources from the Global Forum for Health Care Innovators

Research publications: Blueprints for best practice replication

Accountable Care by Any Other Name
The case for transformation

Health systems are transforming partnership models to improve patient care and manage population health. But many of these efforts have stalled as stakeholders debate how to name and frame this transformation. In this briefing, we clarify the eight mission-critical features of a successful integrated population health model, regardless of what the model is called.

The Primary Partnership
Working with GPs to transform care

As cost, quality, and access pressures mount, health systems have to team up with primary care to handle complex patient demand in the community. But to do this, primary care needs the resources and scale hospitals and payers can provide. This report teaches chief executives and strategy leaders how to partner with primary care and reconstruct their delivery model.

Creating System Citizens
Sustaining 'systemness' through stakeholder engagement

No matter where an organisation is along their path to system integration, there are several areas on which to focus. This briefing focuses on one of the most important: creating system citizens. In it, we map out the ways organisations can build stakeholder affinity for the system through four targeted and sequential engagement strategies.

Resources: Plug-and-play tools to embed change at your organisation

Care Transformation Readiness Assessment: This tool helps shape and refine strategy by identifying organisational strengths and weaknesses, as well as commissioner readiness.

Partnerships and Affiliations Diagnostic: This tool identifies proven means for working through gaps between strategic imperatives and organisational capabilities.

Retreats: Facilitated day sessions to turn strategy into action

Care Transformation Strategy Retreat: This executive retreat provides a platform for learning how best to prepare for the uncertainty, disruption, and upheaval within health care today in order to imagine, design, and offer next-generation health care services.

M.A.P. Partnership Retreat: This strategy retreat is a five-hour workshop designed to reframe your approach to partnerships, create a short list of innovative partnership opportunities, and inform execution with strategic partnership tools.

Future-Proofing your Care Strategy Retreat: This half-day workshop aims to answer two questions. First: What do we want to become as an organisation in the next 5–10 years? Second: How are we going to make that transformation while still delivering on our day-to-day priorities? You'll end the day with a new understanding about how to enable transformation, concrete moves to make at your organisation, and metrics to measure progress.

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