A Culture of Value-based Health Practices

• “The greatest difficulty in the world is not for people to accept new ideas but to get them to forget their old ones.”

John Maynard Keynes
Complexity Leadership for New Age

Challenging the Manager
In a New Age of Reform

Tim Porter-O’Grady, DM, EdD, ScD(h), APRN, FAAN, FACCWS
Building Better Partnerships for Sustainable Health

“Leadership is essentially a work in progress—a never-ending journey with facets and elements that add up to a broad and complex mosaic”

-From the Preface
Leadership In Nursing Practice
Changing the Landscape of Healthcare

“Leadership is essentially a work in progress—a never-ending journey with facets and elements that add up to a broad and complex mosaic”
-From the Preface

Order easily from Jones and Bartlett website
Rule # 1

If you don’t have a sense of humor
Why bother.......
Your husband is suffering from a very severe stress disorder. If you don’t do the following he will surely die. Each morning fix him a healthy breakfast. Be pleasant at all times. For lunch make him a nutritious meal. For dinner prepare an especially nice meal. No chores. No nagging. Oh yes, and make love several times a week. Do this for the next year and he’ll regain his health completely!
Your husband is suffering from a very severe stress disorder. If you don’t do the following he will surely die. Each morning fix him a healthy breakfast. Be pleasant at all times. For lunch make him a nutritious meal. For dinner prepare an especially nice meal. No chores. No nagging. Oh yes, and make love several times a week. Do this for the next year and he’ll regain his health completely!

What did the doctor say?

You’re going to die!
GUESS WHO?
I DON'T CARE
NO...NO...
I SAID I'VE GOT ACUTE ANGINA
The doctor would like a stool sample, a urine sample, and a sperm sample.

What did she say?

They want your underwear.
Choluteca Bridge, Honduras

Credit to Don Berwick
Humans and Technology are Linked
Social Media
“We can’t solve a problem with the same kind of thinking we used to create it.”

Albert Einstein, 1921
The 4 “Rivers” (Drivers) of Health Transformation

• From volume to value economics
• Models of accountable care (triple-aim)
• Interdisciplinary team decision/action
• User-driven technology
How Must Healthcare Be Different

Today

- Hospital-centric
- Doctor driven
- Provider-controlled
- Vertical decisions
- Compartmentalized
- Illness (tertiary)-based
- Wide variation
- Expensive

Tomorrow

- Population centric
- Member-centered
- Community-driven
- Collateral decisions
- Trans-disciplinary
- Health (primary)-based
- Comparable care
- Value-driven
How Must Nurses Be Different

Today
- Procedural
- Positional
- Subordinated
- Task/ritual/routine
- Volume of work
- Hospital-based
- Treatment/intervention

Tomorrow
- Evidence
- Mobile
- Partnered
- Impact/making a difference
- Value of practice
- Continuum-focused
- Health, patient-centered
Value-driven Practice

- Good infrastructure
- Fit process - outcome
- Know your user(s)
- Evidentiary

- Fiscal fit
- Knowledge capital
- Value equation
- Validation of value

Best Practice
Resource Engine
Passion For Care Excellence

Care
Ownership
Profession
Engagement
Leading In The 21st Century

Evidence: The Quest For Excellence

Driving Forces:
- Shortage
- Economics
- New Practices

Movement:
- Advancement

Core Components:
- Professional Environment
- Evidence Of Best Practices
- Shared Decisions
- Value-based Quality
- Quantum Leadership
Value Implies Evidence

- Direct relationship between effort & effect
- Change focus from “relationship” to “fit”
- Replication vs. sustainability
- Can effect be sustained with “least cost” choice
- The intersection between price, practice, priority
- Is it patient or population specific
Environment Forces/Complexity

Social

Policy

Economic

Knowledge Creation & Research

Practice Expertise

Clinical Values

Culture Of Care

Impact Outcome Or Change

Cybernetic Interface Of Innovation & Evidence

Innovation
- Enhance
- Advance
- Create

Cybernetic

Cyclical

Figure 1

Figure 1
Innovation & Evidence

- Nursing practice IS change
- Generating new knowledge
- Validating what we know
- Originate out of a relevant context
- "Just-in-time" use models
- Address "user" expectation
Build Sustainable \textit{Value}

- Move to measuring performance / outcomes
- Clear \textit{national protocols} for best practice
- Participate in good \textit{priorities and politics}
- The ability to change practices quickly
- Provide \textit{new ideas for sustainable solutions}
- Standardize excellence; customize service
From *Process to Synthesis*

**Critical Process**
- Newtonian
- Reductionistic
- Provider driven
- Process centric
- Interventional

**Critical Synthesis**
- Quantum
- Multi-lateral
- “User driven”
- Value centric
- Referent (continuous)
High Performing Hospitals

- Person-centered models—safety-embedded
- Culture of safety
- Good fit of professionals (recruit right)
- Point-of-service performance-driven
- Interdisciplinary / team service model
Low Risk Hospitals Do:

- Include family in initial assessment
- Provide 24/7 family access
- Make family members chief caregivers
- Have family present at/in procedures
- Interdisciplinary / team service model

Transparency
Ownership and Safe Care

- Must exist at the point-of-service
- Owners define quality/safety at point-of-service
- Value of feedback is peer-based
- Patients are included in the exchange
- Clinical judgment is valued, developed, supported
Its Hard (but not impossible) For Us To Become Flexible And Innovative
A Catalyst for Change
Accountable Care
In Health Reform

Sourced from John E. Jenrette, M.D
Rhonda Anderson, RN, DNS,
AHA
Issues

• The accountable foundations for health care delivery organizations
• A framework for value-based care
• Point-of-service driven structures
• Clinical Leadership Shared Governance
• Integration and Coordination
The PPACA and the “Shift” to Value-driven Health Care

• “Accountable Care”
  – Universal coverage
  – Access
  – Cost reductions
  – Improve quality

Coverage

Delivery
The Environment

• Proposals for “delivery functions”
  – “Accountable Care organizations”
  – “Health/Community Home”
  – “Personal Health Records”
  – “Continued Transparency Performance Metrics”
  – Integrated Services “one bill”

“Impact Centered”
Predictive Capacity Elements

Environmental Cycles/Shifts
(Window on the future)

Organizational Impact/Demand

System “Noise”

Impact Work & Culture

Demand For Adaptation/Change

Socio-Political

Technological

Economic

Constant Demand for Innovation
• Service
• Technological
• Structure & Relationships

Cyclical

Ever Shifting External Environment

Figure 1
Organizational Adaptation

External Demand for Accommodation/Change

Organizational Response

Measures
- Effective
- Works
- Positive Impact

Does it respond to environment?
Is it creative/innovative?
Does it work/sustain?

Relevant
Timely
Effective

Ever Shifting
External Environment

Figure 2
## Transition to “Health Impact”

<table>
<thead>
<tr>
<th>Variable</th>
<th>Provider-Oriented Organizations</th>
<th>Value-driven Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of delivery organization</td>
<td>• Health care production facility: aggregate &amp; manage essential resources</td>
<td>• Health care facility: improve health by reliably applying appropriate/collective evidence for each patient</td>
</tr>
<tr>
<td>Primary measures</td>
<td>• Transactions/Intersections</td>
<td>• Value/Health</td>
</tr>
<tr>
<td>Shared knowledge</td>
<td>• Individual (MD dependent)</td>
<td>• Team/Organizations</td>
</tr>
<tr>
<td>Clinical perspective</td>
<td>• One by one interactions</td>
<td>• System design and implementation</td>
</tr>
<tr>
<td>Accountability</td>
<td>• Individual</td>
<td>• Shared</td>
</tr>
<tr>
<td>Clinician’s skill set</td>
<td>• Clinical judgment</td>
<td>• Interdisciplinary interface</td>
</tr>
</tbody>
</table>
Benefits of Accountable Care

**Financial**
- Higher Patient Margins
- Medicare Shared Savings
- Payor Incentive Payments
- Clinical-Financial Alignment

**Clinical Care**
- High Quality of Care
- Clinical Care Systems
- Patient-Centered Delivery
- Positive Quality Reporting
- Hospital-Physician Integration

**Patient Experience**
- Improved Outcomes
- Higher Patient Satisfaction
- Positive Patient Experiences

**Competitive**
- Strong Market Position
- Strong Payor Bargaining
- Strong Physician Alignment
- Capacity Realigned
- Ready for Health Reform Population
ACO Core Competencies

Shared

Provider

Provider Payment Model

Consumer Education

Wellness Services

Actuarial Expertise

Performance Measures

Strategic Partner

Assembly of Appropriate PCP Base and Care Model

Enhancement of Evidence-Based Protocols

Prioritizing Target Savings Opportunities

ACO Governance Structure

Plan Design

Legal Compliance

Marketing of Services

EHR Implementation

Claims Processing

Accounting Validation for Payments to Physicians

Utilization Management Capabilities

Information Technology

Disease Management

Education Training
Managing 5% Drives 50%
## Increasing degree of alignment between physicians and hospitals required for success

<table>
<thead>
<tr>
<th>Increasing Primary Care Reimbursement</th>
<th>Declining Specialist Reimbursement</th>
<th>Medical Homes</th>
<th>Bundled Payments</th>
<th>Accountable Care Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing emphasis on primary care for coordination of care and reduction of inpatient admissions</td>
<td>Declines in payments for many specialty services, including cardiac care</td>
<td>Designated provider or team provides comprehensive healthcare management and patient navigation</td>
<td>Providers receive a single payment for an “episode of care” defined as the typical inpatient stay plus required post-discharge care</td>
<td>Organized groups of providers accountable for the overall health of a population of Medicare beneficiaries; ACOs manage all the healthcare needs for a defined, per-capita payment</td>
</tr>
<tr>
<td>Primary Care Providers (PCPs) will receive payment increases to bring payment more in line with specialists</td>
<td>Limits on revenue opportunities from ancillaries and physician-owned services</td>
<td>Better coordination of care for patients with multiple healthcare needs</td>
<td>No later than 2013, Medicare will begin bundled payment pilot programs for episodes of care through 30 days post-discharge; Medicaid programs may begin bundled payment demonstration payments</td>
<td>If ACOs realize cost savings through more efficient care, the ACO will be eligible to keep a portion of these savings</td>
</tr>
</tbody>
</table>
AHRQ Care Coordination Ring

Must have available in all settings - - Care Delivery & Care Coordination including:

• Population Management & Outreach
• Screening and Prevention
• Acute intervention and Referrals
• Diagnosis and treatment
• Chronic Disease management
• Palliation and EOL Care
Centerpieces of the Next Steps

• Collaboration
• Information
• Integration

The role of the nurse is to coordinate, integrate, and facilitate the stakeholders in the health journey
1. Enhance Access and Continuity of Care
2. Identify and manage patient populations
3. Plan and manage care
4. Provide self-care and community support
5. Track and coordinate care
6. Measure and improve performance
7. Template of the future
# Healthcare Analytic Adoption Model

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 8</td>
<td>Cost per Unit of Health Reimbursement &amp; Prescriptive Analytics</td>
<td>Contracting for &amp; managing health</td>
</tr>
<tr>
<td>Level 7</td>
<td>Cost per Capita Reimbursement &amp; Predictive Analytics</td>
<td>Taking more financial risk &amp; managing it proactively</td>
</tr>
<tr>
<td>Level 6</td>
<td>Cost per Case Reimbursement &amp; Data Driven Culture</td>
<td>Taking financial risk and preparing your culture for the next levels of analytics</td>
</tr>
<tr>
<td>Level 5</td>
<td>Clinical Effectiveness &amp; Population Management</td>
<td>Measuring &amp; managing evidence based care</td>
</tr>
<tr>
<td>Level 4</td>
<td>Automated External Reporting</td>
<td>Efficient, consistent production &amp; agility</td>
</tr>
<tr>
<td>Level 3</td>
<td>Automated Internal Reporting</td>
<td>Efficient, consistent production</td>
</tr>
<tr>
<td>Level 2</td>
<td>Standardized Vocabulary &amp; Patient Registries</td>
<td>Relating and organizing the core data</td>
</tr>
<tr>
<td>Level 1</td>
<td>Data Integration – Enterprise Data Warehouse</td>
<td>Foundation of data and technology</td>
</tr>
<tr>
<td>Level 0</td>
<td>Fragmented Point Solutions</td>
<td>Inefficient, inconsistent versions of the truth</td>
</tr>
</tbody>
</table>
Nurses Role

Patient & Family

- Personal Health Record
- Patient Portal
- Health Risk Assessment
- Patient Engagement & Activation
- Population Health Impact

- Assess
- Onboard
- Link
- Document
- Continuum
Care Transformation Model
Clinical Systems

Advanced Primary Care
Under Patient-Centered Health Home

- Prevention & Wellness
- Point of Care Analytics & Clinical Decision Support
- Gaps in Care
- Population Management & Chronic Care Registries
- Home Visiting Teams
- Generic Prescribing Program
- Cost Effective Medical Management & Utilization of Services (SCP, Ancillary)
- Access, Same Day Appointments, e-Visits
- Patient Satisfaction & Loyalty
- Provider & Office Staff Satisfaction

Patient & Family
- Personal Health Record
- Patient Portal
- Health Risk Assessment
- Patient Engagement & Activation
Nurses Role

- Prevention
- Primary care
- Counseling
- Referral
- Outcome
- Continuum

Advanced Primary Care
Under Patient-Centered Health Home

• Prevention & Wellness
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• Access, Same Day Appointments, e-Visits
• Patient Satisfaction & Loyalty
• Provider & Office Staff Satisfaction
Care Transformation Model
Operational Systems and Structure

Advanced Primary Care
Under Patient-Centered Health Home

- Point of Care Analytics
- Role Charters
- Additional Staffing (Providers)

- Work Flow Redesign & Process Changes
- Education of Staff, PCPs, Team
- Measurement Sets, Dashboards

- Adequate Primary Care Base
- Financial Modeling

Patient & Family
- Value Based Benefit Design
- Benefit Design to Steer Patients
- Enrollment in Model (Attribution)
- Engagement
Care Transformation Model
Clinical Systems

**Medical Group & Health Care System**
Enterprise Level Activities

- PCP/SCP Incentives & Clinical Guidelines
- Pay for Value/Outcomes
- Initiatives & Impact
- Measurements
- Hospitalists, Post Discharge Follow-Up Programs

- ER Avoidance Programs
- Urgent Care
- End of Life (Palliative Care)
- Patient Satisfaction & Loyalty

- Transition of Care
- Provider Satisfaction
- Behavioral & Mental Health

**Advanced Primary Care**
Under Patient-Centered Health Home

- Prevention & Wellness
- Point of Care Analytics & Clinical Decision Support
- Gaps in Care
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- Generic Prescribing Program

- Cost Effective Medical Management & Utilization of Services (SCP, Ancillary)
- Access, Same Day Appointments, e-Visits
- Patient Satisfaction & Loyalty
- Provider & Office Staff Satisfaction

**Patient & Family**

- Personal Health Record
- Patient Portal
- Health Risk Assessment
- Patient Engagement & Activation

- Care management (Acute, Chronic, Inpatient, SNF)
- Health Coaching (Shared Decision Making)
- Care management (Acute, Chronic, Inpatient, SNF)
- Health Coaching (Shared Decision Making)
Nurses Role

- Coordination
- Interdisciplinary
- Partners
- Evidence
- Outcome
- Impact
Care Transformation Model
Operational Systems and Structure

Medical Group & Health Care System
Enterprise Level Activities

- Clinical Support Infrastructure for Care Management Teams & Programs
- IT Infrastructure (EHR, Care Management Platform Analytics – Clinical Decision Support, E-Prescribing, Predictive Modeling Tools)
- Financial Incentives
- Measurement Sets & Operational Tools
- Integration of Best Practice and Clinical Guidelines

Advanced Primary Care
Under Patient-Centered
Health Home

- Work Flow Redesign & Process Changes
- Education of Staff, PCPs, Team
- Measurement Sets, Dashboards
- Point of Care Analytics
- Job Descriptions
- Additional Staffing (Physician Extenders)
- Adequate Primary Care Base
- Financial Modeling

Patient & Family

- Value Based Benefit Design
- Benefit Design to Steer Patients
- Enrollment in Model (Attribution)
- Engagement

- Network Development
- Contracts (PCP/SCP)
- Participation Criteria, Report Cards, Monitoring & Corrective Action Plans
- Health Care Team Education

- Financial Incentives
- Measurement Sets & Operational Tools
- Integration of Best Practice and Clinical Guidelines

- Clinical Support Infrastructure for Care Management Teams & Programs
- IT Infrastructure (EHR, Care Management Platform Analytics – Clinical Decision Support, E-Prescribing, Predictive Modeling Tools)
Care Transformation Model
Clinical Systems (Partnership)

Accountable Care Organization
- Medical Groups & Health Care System
  - Enterprise Level Activities
  - PC-MH Functions
- Hospitals
  - Service Line Integration
  - Medical Staff Alignment
  - Incentives for Efficiency & Lean Six Sigma
  - Quality (SCIP, Leap Frog)
  - Safety

Medical Group & Health Care System
Enterprise Level Activities
- PCP/SCP Incentives & Clinical Guidelines
- Pay for Performance Initiatives and Outcomes Measurements
- Hospitalists, Post Discharge Follow-Up Programs
- ER Avoidance Programs
- Urgent Care
- End of Life (Palliative Care)
- Patient Satisfaction & Loyalty
- Transition of Care
- Provider Satisfaction
- Behavioral & Mental Health

Advanced Primary Care
Under Patient-Centered Medical Home
- Prevention & Wellness
- Point of Care Analytics & Clinical Decision Support
- Gaps in Care
- Population Management & Chronic Care Registries
- Home Visiting Teams
- Generic Prescribing Program
- Cost Effective Medical Management & Utilization of Services (SCP, Ancillary)
- Access, Same Day Appointments, e-Visits
- Patient Satisfaction & Loyalty
- Provider & Office Staff Satisfaction

Skilled Nursing Facilities
- SNFists
- On-site Case Management
- Efficiency Rating Systems
  - "Preferred Facilities"

Ancillary Services
- Free-Standing ASC & Diagnostic Testing Centers

Home Care
- Home Safety Visits
- Post Discharge Visits
- Home Health Coordinator of Services

Hospice
- Transitions (CHF, COPD, Frailty Syndrome, Dementia)

DME
- Integration & Oversight with Care Management

Patient & Family
- Personal Health Record
- Patient Portal
- Health Risk Assessment
- Patient Engagement & Activation
Nurses Role

- Clinical Model
- Seamless
- Effectiveness
- Metrics
- Community
- Health
- Impact sustain
Transformation Model
Operational Systems and Structure

**Accountable Care Organization**
- Medical Group – Hospital "Systemness" & Network Development
- Medical Staff Alignment
- Governance & Legal Structure
- Financial Incentives & Alignment (Shared Savings, Bundled Payments, Partial Cap, Full Cap)
- Measurement Sets & Targets
- Health Plan Role for Incentives, Payment Models and Data Exchange

**Medical Group & Health Care System**
**Enterprise Level Activities**
- Clinical Support Infrastructure for Care Management Teams & Programs
- IT Infrastructure (EHR, Care Management Platform Analytics – Clinical Decision Support, E-Prescribing, Predictive Modeling Tools)
- Financial Incentives & Measurement Sets & Operational Tools
- Integration of Best Practice and Clinical Guidelines

**Advanced Primary Care Under Patient-Centered Health Home**
- Work Flow Redesign & Process Changes
- Education of Staff, PCPs, Team
- Measurement Sets, Dashboards
- Point of Care Analytics
- Job Descriptions
- Additional Staffing (Physician Extenders)
- Adequate Primary Care Base
- Financial Modeling

**Patient & Family**
- Value Based Benefit Design
- Benefit Design to Steer Patients
- Enrollment in Model (Attribution)
- Engagement

**Key Activities**
- Contracting (Evaluate Ancillary Services; SNFs, Home Care)
- Facility Evaluation (ASCs)
- "Sales" & Marketing
- Strategic Planning
- Network Development
- Contracts (PCP/SCP)
- Participation Criteria, Report Cards, Monitoring & Corrective Action Plans
- Health Care Team Education
- Financial Modeling
- Measurement Sets & Targets
Shared Governance

- T-D model
- Specific/collective
- Board/Clinical
- Credentials
- Team metrics
- P-O-S Linkage
- Community linked
- Triple-aim impact
Our Approach to Delivering Your Success Throughout the ACO Continuum

Your Goals and Desired Results

Strategic Assessment
Financial Risk Management & Provider Workflow
Structure & Technology
Strategy & Goals

Capabilities Assessment
- Payer Incentive Opportunities
- Managing Financial Risk
- Contract Support
- Capabilities, Gaps, Build, Buy or Partner
- Reporting Environment, IT Systems, HIE & Data Integration
- Governance and Clinical Leadership
- Benchmarks, Target and Reporting
- Care Improvement Opportunities

OPERATIONALIZE

Workflow, Change Management & Culture
Population and Care Management Approach

Project Management Implementation

Financial Success
Care Coordination and Patient Engagement
We all really ARE Leading A Revolution
Leadership’s New Social Compact

Building Sustainable Partnerships

"Change IS"

Predictive / adaptive capacity
Positive deviance
Translational (it works)
Point-of-service ownership
Intersectional Innovation

Consumer Interface (Users drive)

User control
Family role (primary health)
Evidence-driven leader

- Leader elements:
  - Objective
  - Outcomes oriented
  - Digital “savvy”
  - Accountability-based
  - Expectation-driven
  - Ap. Inquiry-grounded
Evidence-based leadership

- **Foundations**
  - Hard facts and culture of truth
  - Fact-based decisions
  - Work as unfinished prototype
  - Always look behind the line
  - Have no intractable beliefs
  - All work is a learning journey
Evidence-based leadership

- Issues:
  - Past practice
  - Policy and procedure
  - Faulty evidence
  - Role awe
  - Ritual & routine
  - Lots of experience
Understanding Relationships

- What potential becomes reality, depends on the relationships created between multiple elements:
  - people
  - events
  - the moment
- None of us exists independent of our relations with others.
- Neither the system nor the individual is the more important influence of behavior.
- Each organism in a system maintains a clear sense of its individual identity within a larger network of relationships that help shape its identity.
ORGANIZATIONS AS A SYSTEM

**Understanding Relationships**

- The Web of Relationships in Organizations.
- Power is the capacity generated by our organizational relationships.
- Developing Relationships
  - Quality not quantity
  - Look everywhere
- Assessing an organization’s capacity for healthy relationships.
REFLECTIVE QUESTIONS

- Where is order to be found?
- How do complex systems change?
- How do we create structures that are flexible and adaptive, that enable rather than constrain?
- How do we simplify things without losing what we value about complexity?
- How do we resolve personal needs for autonomy and growth with organizational needs for prediction and accountability?
LEADER IMPLICATIONS

- Accept chaos as an essential process by which natural systems, including organizations renew and revitalize themselves.
- Share information as the primary organizing force in any organization.
- Develop the rich diversity of relationships that are all around us, as to energize our teams.
- Embrace identity and vision as an invisible field that can enable us to recreate our workplaces and our world.
How to Live in a Quantum World?

- Learn how to facilitate process.
- Become savvy about how to foster relationships.
- Learn how to nurture growth and development.
- Become better at listening, conversing, and respecting one another’s uniqueness.
New Rules for Leading Professionals

Translate knowledge
Applied practice
Virtual
Synthesis
Demonstrated
Lifelong

Thinking behind the thinking
Evidence-driven practices
Diagnosis of underlying systems & processes
Judgment

Cyclical Adaptation
Double Loop
Cyclical Adaptation

Relatedness
Intersecting
Interacting
Complex (CA/RS)
(micro-macro systems)
New Leader Realities

Tipping point.....
New Leader Realities

Creative Destruction
New Leader Realities

Leaders have no friends
Managing professionals, not employee work group
Knowledge workers are faithful to the work not the workplace
Knowledge work is capital investment
New Leader Realities

Structure creates context for behavior
New Leader Realities

Managing mobility, not people
Who owns this (and setting tables)
New Leader Realities

Boundary Spanning
New Leader Realities

Abandon process for value
New Leader Realities

Leaders do not decide
New Leader Realities

You can’t incentivize moral leadership
New Leader Realities

Sustainability over stability
New Leader Realities

Alignment not motivation
New 21st Century Leader Skills

- Quantum leader skills
  - Willingness
  - “Setting the table” (gathering)
  - “Tough love” language
  - Confronting dependencies
  - Leading “movement”
  - “Storytelling” the journey
  - Making sense of the “noise”
  - Making the journey safe
New Language Of Leadership

- **Vulnerability** to the risks
- **Approachable** to others
- **Intuition** and good predictive/adaptive
- **Empathy** with passion and truth
- **Care** about the work of healthcare
- **Skill**-transformation and transfer
The “Not True”

- **Surrender attachment to:**
  - Motivating others
  - Owning other’s issues
  - Charismatic imaging (ego ID)
  - Creating dependencies
  - Employee work group “ism”
  - Directing and controlling
  - Parentalism
  - Non-accountability structures
Implication for Leaders

- Ownership & outcome
- Motivation
- Initiatives & incentives
- Alignment & trajectory
- Structure and behavior
- Leading professionals
- Context & dynamics
Five Emergent Principles for Leading the New Professionals

- In a technological world, staff must be designers not merely implementers.
Five Emergent Principles for Leading the New Professionals

If you manage professionals the same way you manage employee work groups; you will always get employee work group outcomes.

Art Kleiner, MIT
Five Emergent Principles for Leading the New Professionals

- Professionals are accountable, not responsible:
  - What difference did I make?
  - What value did I advance?
  - What impact did I have?
Five Emergent Principles for Leading the New Professionals

- There is no evidence without relationship:
  - Intersection
  - Convergence
  - Synthesis
No one can predict the future. We can only choose to respond to the demand for change out of which we shape our future. The only way to predict the future is to create it!

Kevin Kelly: MIT
What could be worse than being blind?
That would be seeing and having no vision!

Helen Keller
New Model of 21st Century Health

- Capacity
- Tools
- Connection
- Control

“User” Centered 21st Century Practice Competence Health

- Population-based
- Health Prescriptive
- Sustained / Safe
- Resource Sensitive
- Socio-political Priority

- Mobility/Synthesis/Access
- Inter-disciplinary
- Early Engage/Facilitate
- Techno-Clinical

- Genomics
- Virtual / Telecom
- Pharma/Nano
- Mobile