AHA Associates, Bringing Value Podcast

Balancing Technology & Human Need to Transform the Workforce Experience

Kathleen J. Wessel: We're at the precipice of an exciting era in which the entire healthcare leadership team can play a key role in changing how healthcare is delivered, transforming both work and the experience for clinical care teams. Welcome to AHA Associates: Bringing Value, a podcast from the American Hospital Association. In this series of podcasts, we speak with AHA Associate Program business partners, check in on their efforts and learn how they support AHA hospitals and health system members. Today I'm happy to welcome Accenture's Dr. Scott Cullen, Managing Director and Health Provider Lead. And Sally Hurt-Deitch, Executive Vice President for Nursing and Operations Infrastructure for Ascension. At Accenture, Scott's teams are examining how to balance short- and long-term solutions to the clinical workforce shortage. And Ascension is working to implement these solutions to benefit their workforce. Ultimately, in order to achieve success, hospitals and health systems will need to focus on the intersection between technology and human need. Scott and Sally, welcome to the podcast.

Dr. Scott Cullen: Thank you. It's great to be here.

Sally Hurt-Deitch: Thank you.

Kathleen J. Wessel: Can you start by telling us how your organizations work together? And Sally, I'll hand that off to you.

Sally Hurt-Deitch: Thank you. Well, again, I think, number one it would be very important for you to recognize that Ascension and Accenture's names are so closely aligned, that it was very easy for us to pick Accenture as our partner. But we started looking at our organizations almost eight months ago. Scott and I have been working together on how do we really take organizations that are coming out of two years of a very difficult period of time because of COVID and how do we look at the organization, what we call our ministry, and really evaluate where there are opportunities. And whether those opportunities are in the way that we used to do things or that we need to do them differently, evaluating all of our ministry-wide functions, and if those are really still in the best place or the right place they need to be. And making sure that we are providing that effective and efficient leadership all the way down to the communities we serve. It has been a really fantastic partnership, and I think Scott and I have learned a lot from each other.

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Dr. Scott Cullen: I couldn't agree more.

Kathleen J. Wessel: That's great. Here where we sit at AHA, we're very familiar with the workforce challenges members are facing, and we too are also leveraging the expertise of Accenture, so we also appreciate that. Can you maybe for our listeners help expand on the patterns we're seeing in workforce today?

Dr. Scott Cullen: Sure. Well, as most of your audience already knows, I'm sure, you're experiencing three X minimum agency spend increase on labor cost. And also seeing the accrual of an increasing workforce deficit, particularly for the nursing side. What not everybody may be as familiar with or as top of mind is the external demographic forces that we're looking at—the 60- to 90-year-old age cohort is going to grow by 46% between now and 2030. That's a staggering number. While at the same time, the segment of the age band that has been caring for that segment is going to shrink by 30%. On top of the existing nursing workforce crisis, just at a broader demographic level, we're going to see massive demand grow, and we're going to see constraints on our ability to help serve those populations. And for us, that leads us to conclude that there's no traditional hiring solution to this workforce issue. We're going to need to look at very different approaches to how we're delivering care.

Kathleen J. Wessel: Sally, what are some of the challenges you're seeing in Ascension?

Sally Hurt-Deitch: Scott hit the nail on the head. I mean, the reality is we saw, whether we call it the great resignation, whether we see that movement from nurses that were providing care in the hospitals that moved out of the space. Primarily really starting in, it was July, August of last year that kind of crescendoed all the way through the Omicron surge. And so, we're seeing agency spend having to fill positions with contract labor. The other piece that I think is more shocking to many people and our own internal research has shown is that what we consider our COVID cohort, those clinicians that were being trained during the pandemic or when the initial shutdowns occurred, that those that matriculated out of programs when they came into the workforce, only about 7% of those were practice ready.

And the added cost of, now I've got to look at how do I redefine my training programs? How do I look at onboarding? How do I create residency opportunities? And really look at the upskilling for an entire group of people that really had very limited access to providing hands-on patient care. And so that, I think, is the other challenge that we're seeing also at this time, in addition to a workforce that's become very mobile and has really taken a very different approach in how they look at the way that they are employed.

Kathleen J. Wessel: Yeah. And every organization is just stretched in so many different directions, some just not even contemplated previously. Scott, based on your work at Accenture, you've outlined four fundamental areas that hospitals and health system leaders can take to address these challenges and the time horizons both near and far. Will you walk us through that strategy?

Dr. Scott Cullen: Sure. Happy to speak about that briefly. I mentioned earlier that we have this workforce constraint, right? And that's going to be with us for at least a decade, if not longer.

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We're going to need to change the nature of the work and how it gets done. And that means several different things. One is expanding the labor pool. Sally also mentioned labor force readiness. There's going to need to be much more facile ways to upskill that workforce. And then also we're going to need to bring technology to the table in just a radically accelerated way. There's no other way to solve the problem. And then what that implies finally is that we're going to need much more change-enabled organizations, leaving aside the fact that we know changes have been accelerating in healthcare.

The more technology you bring into the picture, that further accelerates change because you're now sort of subject to Moore's Law around how quickly technology changes over time. It's something of a double whammy there. In the short term, leaving aside the capacity issue, we also need to reduce the frontline pain because our attrition problem relates to some key pain points. One of the things that is going to help improve retention, reduce burnout, is supporting those in top of license practice wherever possible. Now, Sally is probably going to touch on the fact that defining top of license is also important in this. But fundamentally what we see is that the key pain points are you've got a lot of repetitive low value tasks—clinical documentation as always is still a big pain point--and then what I call high friction coordination. Which is just sort of being the traffic cop in a care team amongst a variety of different people. And it's all asynchronous and it's really difficult to do that, but it isn't necessarily a top of license behavior that's necessary there. And then finally, with all the travelers and the contract workforce that Sally eluded to earlier. Plug in skills gaps for those people, even leaving aside the less experienced hires. Even for our travelers coming in, they don't know where all of the stuff is. They don't know that when you put in a central line here, it's different from the way that we put in a central line at the last. So, even though in addition to that, we're also going to have to think about the traditional hiring strategies too, they're not going to solve the problem, but they are essential still. It's still table stakes to be able to optimize your recruitment to better target candidates and to figure out how we're going to bring on the workforce that we can bring on in the short-term. In both cases, and both in near and long-term, there are really basically three things you can do, right?

And this probably isn't going to be a surprise to anyone, but our perspective is that you're going to need to shift tasks as appropriate from clinical staff to not a clinical staff. You're going to need to automate what you can automate. And then ultimately, we're going to need to build that resiliency that I mentioned earlier around making our organizations more change enabled. Around task shifting in the near term, we can increase the resource pool. We can use talent even from other sourcing. So, outsourcing some tasks, looking at lower cost options to provide some of that support. And then in the longer term, probably self-service enablement for patients and their caregivers is also another route toward changing the model. And actually, in spite of what some folks might think, we have studies that demonstrate that. That actually can improve patient satisfaction, improve family satisfaction when they're more in control of the information exchange that goes on.

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In the short-term, the automation piece, we know that there's an opportunity to improve ambient listening to support that document patient piece. But then in the longer term, we want to bring more and more artificial intelligence into the process to enable communication and better coordination of services. The resiliency piece in the near term, obviously there's opportunity to retrain leadership and management around providing a more psychologically safe environment to better support autonomy for those at a top of license, et cetera. And then in the longer term, considering what are more flexible work and compensation arrangements that we can bring to the table? How can we build career paths that are more adaptable, more flexible, yet still keeping people within the organization? Because that's our goal ultimately. I've just spent a lot of time talking. Let me pause there and get Sally’s thoughts as well.

Sally Hurt-Deitch: Yeah, I think Scott, all of those pieces are key. And I think fundamentally though, and maybe the way we've taken all of the work and the knowledge of Accenture and said, "Okay, how are we going to apply that and really evaluate that within Ascension?" And so first I would say for us, one of the key learnings and thought processes was, you can't look at this in a traditional productivity manner of saying, this is how we measure productivity and it's an industry standard, and this is how we're all going to do it. Because if you truly want to reinvent our delivery system to get to this top of license type of practice, you first have to understand what top of license means. And while everybody says that what does that actually mean that the registered nurse should be doing to be top of license? We are taking the approach of, and really letting our ministries and our facilities innovate from this lens. Because if I take productivity out of the mix and say, "Okay, it's not the traditional metric. I want to look at what is it costing me to provide the care? What is my total labor cost of care to take care of any patient within our system?" And from there, how do I look at driving my total labor cost of care down by evaluating different models and different options? The second point to that is, we at Ascension do not believe that you can redesign some model and say, "Here's the Ascension model, put a stamp on it and deploy it everywhere." We do not believe that works. We believe that we have to be able to innovate in our ministries and do things differently.

So, I'll give you a couple of examples of things we've done. In some of our Florida facilities, we have actually piloted the use of putting pharmacy techs on our nursing units to actually do medication passes, to do medication reconciliation—to really do that evaluation of the medications—which frees the nurse from doing that individual med pass to actually pulling up and looking at, let me do the evaluation of the patient, the medication regimen that they are on. How that is trying to, if I look at their clinical profile and the problem list, how are all of these things tying together so that I can give a better picture to the physician of what we're seeing in the clinical setting? That's one example. Another example, in our Alabama market, we actually took nurse practitioners, acute care nurse practitioners, and placed them in our emergency rooms.

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And most people would say, “Well, that's going to cost you more.” Yes and no, because what we were seeing was, again, a lack of nurses that were emergency department trained, right? And lack of experience. So, if I put in a nurse practitioner who can function in a charged capacity but can also function to be that mentor preceptor leader for new nurses, the knowledge and the ability for them to teach and instill from a practice standpoint far exceeds what a traditional charge nurse would be able to do because of their advanced practice knowledge. We've also taken that approach in looking at how do we upskill more quickly the emergency department staff and new nurses that are coming into that area. A third example would be in Oklahoma, where their availability of LVNs is very different than my availability in New York. In really looking at that kind of LVN team model, which has been very much discussed across industry and for us, old nurses remember it from way back when, but again, works in that community because of our accessibility. We've taken all of the pieces that Scott has said at just looking number one at workforce, and where do you have to start, to how can you start talking about these things and letting people experiment, but within a focus on what is it costing me to provide this care versus just what are my man hours and what is my traditional productivity metric?

Kathleen J. Wessel: Great. What changes do you hope to see in the workforce? And have you noticed any improvements based on the changes you've made so far?

Sally Hurt-Deitch: Yeah, we've noticed actually quite a few changes. And I think there's certain key pieces you would look at. First, if I look at turnover during the pandemic, and what was occurring across US hospitals. Average nursing turnover was close if not over 30% for most organizations, which is something that none of us had really ever seen before. And so, what we are seeing is the normalization of that curve and it actually becoming and trending back down to more of a normalized capacity. Now, how much of that is that we're coming out of the pandemic, possibly? I do believe though, there's also a group of nurses who did start traveling that have all kind of said, I'm going home. And wanting to kind of stabilize their lives and how they're working.

The other component to that, I believe though, is because of the innovation and then there's other pieces that Scott's even touched on, the technology components. How do you look at enabling our staff through ambient tech, ambient listening? How do you look at different compensation methodologies? The teacher-type pay off I'm going to work for nine months, but pay for 12, or taking sabbaticals. We've introduced a lot more flexibility into the way that we do scheduling for our workforce because of the need that really was identified and highlighted throughout the pandemic. And then the last piece that I would point to is you have to kind of bridge compensation with the model that you're using and how you're looking at your labor cost to what does education look like and what does that bridge look like moving forward? Whether it's continuing education or how do you look at the sterile processing tech and how do I upskill them from that to become a surgical tech, from a surgical tech to becoming a surgical nurse? We've created an entire bridge to allow our staff to move in that direction very intentionally, giving them a roadmap and the support to do that.

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Kathleen J. Wessel: These are all great examples. Really tactical moves that have a pretty big impact. I hate to say finally, but finally, I want to close on a topic that we've touched on briefly in this conversation. How can hospitals and health systems integrate technology with human ingenuity? And what does that intersection look like?

Dr. Scott Cullen: It falls down into what can you do that streamlines the way things are done now, versus how can you radically innovate? In the category of what can you do to streamline now, we're looking at things like just improving user interfaces and applications to do the job that they need to be done more effectively. And when you bring in a pharmacy tech, as opposed to the nurse, you now need a more use case-specific user interface and functional profile for what the pharmacy tech is using in some cases, as opposed to what the nurse was doing. There's this kind of application optimization piece, but then, when we start thinking more aggressively about automation and task shifting as an efficiency play, but then into transformation and innovation, we start moving into how do we become more predictive?

How do we become predictive about workflow? How do we become predictive about staffing? We're exploring digital twins right now, for example, of the individual patient combined with digital twin of the facility to model forward-looking scenarios to use clinical understanding to optimize operational processes. A lot of people think that if we build clinical digital twin models, that's for clinical decision support. That may be the case. And there are also some scenarios around that when you're using big data sets.

But the reality is that the vast majority of patient experience is dependent on operational decision making. And even outcomes clinically are often related to what appear to be operational decisions. Getting people out of the hospital quicker, getting them the right care that they need at the right time. That is driven 80% by operational decision making, not clinical decision making.

And so having the clinical model to then better drive operational decisions is a key component I think of where we can go. You know predicting bottlenecks, improving outcomes, avoiding adverse incidents, and avoiding days and delays, et cetera. And then ultimately, we want all of that to improve the patient and the clinician experience. We have to think about, especially it's come to the fore much more now than it was, but we have to start treating the clinician and the patient as a dyad to some extent, right? As both our customers in this process of how to optimize experience.

Kathleen J. Wessel: Sally, any other thoughts on that?

Sally Hurt-Deitch: It's interesting because I can remember five years ago saying to somebody, when you start looking at artificial intelligence or as these pieces have really been introduced or starting to be introduced into healthcare, what that would mean for the future of not only nursing, but really for any of our clinicians? And once that technology becomes validated, it really theoretically will be a game changer because that truly to me is when you get to top of license. Imagine whether it's the way we train our physicians, so interns and residents, and their decision-making being validated by something else, or nurses.

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Maybe I'm not going to need as many registered nurses as we think of it in the here and now, but I need more people that can do tasks, that can start IVs, can draw blood, can administer medications.

Where I need the nurse's thought process is to then pull up and it is that. It truly is, again, that higher level of what they were taught in nursing school to do, to look at the entire assessment of the patient from all of their lab and their radiology results, and what kind of meds are they on, and what is their nursing problem list and how are we preparing them through the continuum of care to the next place, right? How am I a partner and team member with my physicians to give them the information they need to make the right decisions? I think it really does become the game changer over time; it will be and hopefully it's not actually that far away from everything that I've seen.

Dr. Scott Cullen: I think it's coming. And one thing we should probably bear in mind too is that 10, 15 years ago, if we were talking about automation or task replacement for nursing on the floor, there would've been a lot of people who had gotten upset about that. You're just trying to remove nurses. You're just trying to take them out of the equation. The reality is the situation is that for the next 10 years at least, we're going to need to keep every nurse that we have and give them superpowers through this automation capability.

Sally Hurt-Deitch: That is correct. Because all of the data shows that even by 2025, which is only three years away, we will be deficit 450,000 nurses across the United States. This is in three years. The belief that we're trying to take the nurse out of being a nurse couldn't be farther from the truth. I need the nurse to elevate and be and work at truly top of license in order for us to survive by the time we get to 2025 and don't have as much. As we look at this, the reverence of humankind, that is where we're pointing to and our responsibility as stewards of the organization.

Kathleen J. Wessel: I mean honestly, we can continue this discussion for probably hours, but alas, we are on a podcast, so, I really hesitate to draw this short. But I so appreciate you joining me for today's discussion and sharing your takeaways with other AHA members. For our listeners, if you'd like to learn more about programs that we've discussed today, please visit us at sponsors.aha.org. This has been an AHA Associates: Bringing Value Podcast brought to you by the American Hospital Association, and thanks for joining us today.

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