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Healthcare leadership lessons from COVID-19

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Contrary to the conclusions of the Global Health Security Index report in 2019 that ranked US as the most prepared nation to respond to a biologic crisis, our response to the pandemic has been anything but ideal.[1] The pandemic has been particularly detrimental to the frail residents of the post-acute and long-term care settings (PALTC). Among other factors, experts believe that poor policymaking, an ageist culture, and lack of leadership were to be blamed.[2–4]

Effective leadership during a crisis entails several key attributes, for example, transparent, but compassionate communication; agile action and change of course as needed.[5] Beyond practicing these attributes, geriatric leaders in the PALTC can benefit from the recently published advise of healthcare leaders from diverse settings. Some of the vital leadership areas they should prioritize include:

1. Social (or moral) determinants of health: Dr. Don Berwick has urged leaders to fix the “repair shop” culture of care that has ignored the social determinants of health, thus exacerbating health disparities.[6] He argues that beyond funding and advocacy, leaders need to invoke the “moral law within”. They need to push for individuals and organizations to take on issues such as health as a human right, climate change, prison and criminal justice reforms, homelessness, and hunger. He calls upon healthcare teams to go beyond being *healers* but *mend the torn fabric of communities*, by being vocal, by writing, by voting, and by organizational-level funding of the above-mentioned initiatives. One effective way to enhance the social determinants causes by the PALTC leaders could be to actively participate, personally and to encourage other colleagues in the work being done by professional associations in this regard.
2. Systematic ageism: The inherent ageism worsened the pandemic-inflicted harm for older populations. To counter this, a consortium of editors of the nation's major gerontological journals advised to promote two key attributes of the seniors, that is, wisdom and resilience. They urged for inclusive research, engagement of geriatric experts in organizational decisions, and for policymakers to be cognizant of, and design personalized messaging and solutions for addressing needs of older adults.[3] PALTC leaders need to create an awareness among their teams on how overt and occult behaviors and language may contribute to an ageist narrative. They should advocate for proactive and comprehensive geriatric education and assessments to counter ageist approaches and replace them with proactive philosophies of care.[7]
3. Promotion of national and healthcare trust: Social trust has steadily declined in America, where the majority are “distrustful of others when they first meet them”. In a key essay, David Brooks presented data on decline of societal and how it has been a barrier to thriving and prospering society by promoting inequality.[8] A parallel decline in healthcare trust has stemmed mainly from disconnect between clinicians and needs of their patients, and poor transparency of healthcare costs.
   Regaining healthcare trust will need re-establishing the clinician- patient relationship. Some strategies include for clinicians to prepare with intention before the visit, listen intently, prioritize what matters most to patients, connect with patient's story, while acknowledging barriers and exploring and validating

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emotional cues.[9,10] At an organizational level, PALTC leaders should prioritize the assessment and improvement of trust (e.g., using Net Promoter Scores), and if trust is broken, there should be systems for swift accountability and a remedial plan.[11]

4. Bidirectional Communication: The majority of online resources promote information that misguides about COVID-19. PALTC Leaders should invest in "info-surveillance" and when needed, implement brief educational and mentoring interventions.[12] Effective healthcare delivery, particularly in a crisis requires leaders to decentralize authority, empower a broad network with strong communication systems to promote timely decision-making.[13] *Fusion-cell* approach, used by the navy presents an excellent model.[10] Prerequisites include a simple digital platform, stern meeting schedule, broad audience, clear agenda for open conversation, and welcoming everyone to provide input. PALTC leaders should learn from the Project ECHO that represents such an approach and early signs of its value have already emerged.[14]
5. Process-based Innovations: The pandemic has promoted technology use, for example, almost 100-fold increase in telehealth utilization,[15] but caution is needed. Simply adding tech-based solutions can drive up costs and staff burden. PALTC Leaders should also promote low-tech and process-based innovations.[16] These productivity-enhancing solutions, for example, care protocols, competency ladders, efficient team rounding, not only create efficiencies but reduce burnout. Leaders should incentivize teams (with frontline input) to devise and adopt process-based innovations through nudges, for example, social recognition, share-savings programs etc.

The pandemic has put healthcare leaders, particularly those in the PALTC, in focus. Beyond addressing day to day issues, they will have to practice and master skills that provide proactive solutions to complex issues that have infested our healthcare systems for decades. As Harry Truman once said, "Progress occurs when courageous, skillful leaders seize the opportunity to change things for the better". The opportunities are clear, but do we, the PALTC leaders have the courage to respond?

CONFLICT OF INTEREST

Author has no relevant conflict to disclose.

AUTHOR CONTRIBUTIONS

Dr. Arif Nazir contributed fully to this manuscript.

SPONSOR'S ROLE

None.

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