HealthLeaders Virtual Roundtable
Healthcare System of the Future: CEO

HEALTHCARE SYSTEM OF THE FUTURE: POST-COVID STRATEGIES

Hospitals and health systems are seeing a shift in operations as we move to a post-COVID-19 world. Growth strategies are evolving, communications are becoming more consumer-centric, and the landscape of care continuum continues to change.

Executives working towards the healthcare system of the future will take learnings and innovations from the pandemic and apply them to their organization's strategies to ensure they don't fall behind. Executives will build upon and create new growth strategies, they will switch their focus to be more patient centric, care will be inside and outside the walls of the hospitals, they will be open to more partnerships, and will continuously work to repair staffing issues.

In this roundtable, a panel of executives discusses these topics and more on how the current healthcare system is changing.

John Becker (Vizient SME)
Group Senior Vice President
Sg2 and Intelligence
Skokie, Illinois

Kreg Gruber
CEO
Beacon Health System
Elkhart, Indiana

John Haupert
CEO
Grady Health
Atlanta

Ketul J. Patel
CEO
Virginia Mason Franciscan Health
Division President, Pacific Northwest
CommonSpirit Health
Seattle

Annette Walker
President
City of Hope, Orange County
Irvine, California

Melanie Blackman (Moderator)
Strategy Editor
HealthLeaders

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HIGHLIGHTS

HealthLeaders: *What are your organization's growth strategies coming out of the pandemic, has the pandemic altered them? What are your top incentives for growth?*

Ketul Patel: In 2016, CHI Franciscan and Virginia Mason Medical Center signed a clinical partnership agreement. Several years into our relationship, and right before the pandemic, our collective boards decided to enter into formal discussions about becoming one organization. We initiated this several months before the pandemic.

We have many learnings from the pandemic, particularly building more virtual capabilities and focusing on our outpatient presence. As a new system, we have geographies that we don't cover, and part of our growth strategy is to ensure that we're creating capacity and access for patients where we historically didn't have services around Virginia Mason Franciscan Health.

Annette Walker: COVID did not disrupt our growth strategies. It disrupted some of our current business, particularly because, for cancer, we are dealing with a decline in primary care screenings. Cancer centers across the nation are still challenged by these declining numbers.

There are two things that we're doing as an organization that are different from other academic or NCI cancer centers. City of Hope's mission is to eradicate cancer, and we know that access to the super-specialist academic environment is limited to people who can travel to the academic center. We believe that more people who have cancer need access to this intellectual capital. Our move to Orange County is an example of how we are changing the way we work with the community and community providers, providing them more immediate access to breakthrough treatments and innovative clinical trials.

Another primary strategy is "Access Hope." Access Hope is national and we have nearly three million enrollees across the country. City of Hope works with employers and insurance companies to provide a second opinion or direction on cancer treatment. For instance [if an employee] wants a second opinion, they can either [meet] physically or remotely. We work with their current community oncologists and review their diagnosis and care plan, making sure they're on the highest recommended protocols that sometimes are not available to community providers because the research environment isn't typically accessible.

John Haupert: As a large urban safety net, our growth strategies may look a little different because we're in a state that did not expand Medicaid. Thirty percent of our patients have no funding whatsoever; 25 percent are Medicaid, 25 percent are Medicare.

Because of the type of institution we are, we have to have profitable growth strategies in order to fund the mission, and so it's a trade off. We're always investigating with our academic partners, which are Emory School of Medicine and Morehouse School of Medicine. Those clinical services that are underrepresented in this market, and at a quaternary level, need to be further researched and exploited. The next horizon for us is [partnering on] different areas within neurosciences, particularly epilepsy care.

A big part of our strategy goes back to maintaining health for those who have limited access to health. We're doing a lot of health improvement through the use of artificial intelligence, whereby we do a complete socio-economic, social determinant inventory on every patient. Within the artificial intelligence engine is bounced up against all of the clinical indicators, whether or not they are taking their prescriptions, whether they've picked up their prescriptions, on and on. That then issues to our ambulatory centers alerts on a daily basis to those patients who are more at risk of not following up on care and deteriorating. We created a program called "Integrated Mobile Health," and the mobile health teams then go to those patients' homes to partner with them to assure that they are staying on track of their health.

Kreg Gruber: Beacon [is] a small, regional system, about 7500 employees, a few hospitals, a large medical group spread across the northern Indiana-southern Michigan region. We have six strategies. We pay a lot of attention to all of them. We use the term "smart growth." We don't just grow for growth's sake, we are thoughtful and diligent about it. It has to be meaningful. It has to make a difference in our communities. It has to be for all the right reasons.

We didn't skip a beat during the pandemic. We're actually coming out of the pandemic stronger

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than when we went in, and I give a lot of credit to our strategy process and cycle that we go through, and our ability to be more than a one-agenda organization during the pandemic.

Over the past few years we shifted our focus as demonstrated by the capital dollars resources we're putting into the outpatient delivery system. We started as predominantly an inpatient organization, revenue still weighted in that regard but catching up quickly on the outpatient side has more care moves in that direction. That's one of the things that we saw with the pandemic, was a shift to the non-inpatient settings for care and people either not seeking that type of care through the EDs and other services, but wanting to get their services in a much lower touch type of mechanism. Whether that's digitally through telehealth, whether that's texting, phone calling, e-mailing through a portal, all of those sorts of things.

John Becker: When you think about growth in evaluation and management (E&M) visits, we're saying that all of that is virtual moving forward. The growth is sitting in the digital enablement of those patient interactions.

Number two, it's off campus, right? We all started as inpatient entities, but so much of the volume is outpatient mainly because of ease of access. We want that lower touch, easier access care.

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Annette, you mentioned a lot of organizations are looking to find new patients. Often you can do that through novel partnerships directly with employers. That ability to work with employers differently to meet the distinct needs of their patients (employees) is another growth avenue.

It's interesting, even though there are distinctly different organizations represented in these four, there is convergence around where you're seeing growth. COVID just pulled forward a lot of change that was already in healthcare; it accelerated it.

HealthLeaders: *Where are you finding growth? What novel ways are you finding growth and creating growth?*

Haupert: [We're in] one of the fastest growing markets in the country, and so the health systems here are being heavily fueled by population growth. But if you look market wide, there's a number of competing health systems and it's still kind of an arms race to who's going to outdo who with the latest.

We always look at the leading edge from the academic work we're doing to how we translate that academic work into a true clinical program. That's one of the great parts of being affiliated with a place like Emory School of Medicine.

Gruber: What we have in common, John, is we're the safety net for our area even though we're not an academic center. We're an hour and a half into Chicago, two hours to Grand Rapids, two and a half to Indy. We're a level II trauma center that acts like a level I, and we're it.

We do the same thing where we have the opportunity to provide those higher level services. We accentuate those for growth, focused on the quality of providers and outcomes of care.

The other thing that we started doing is when we began to initiate all the digital means of access, we also began installing a customer relationship management system (CRM system). What we're doing is tying that into our wellness initiatives and using that data to be in contact with our patients to manage their care, which then stimulates growth for services, screenings, and all those sorts of things.

Patel: All of us have great plans, but a critical challenge we have now is staffing. We're moving in a direction of more creative solutions, which is needed in terms of addressing staffing shortages without compromising care. For example, right before the pandemic, we were one of only five systems in the country at the time to launch what we called the "Mission Control Center." Using artificial intelligence, the control center was implemented primarily as a way to map our patient's care journey through our system and address any challenges that we had around occupancy and throughput.

But where it's actually continued to expand is through a program that we're calling, "Our Virtual Companion" where we have over 150 clinicians and IT professionals monitoring patients at over 850 beds at our facilities across the Puget Sound. For example, we have a care manager monitoring six patients—it's another set of eyes and an opportunity for patients to communicate in a digital way to staff. We're using that program now to potentially scale it in other divisions throughout CommonSpirit Health.

Gruber: I have not talked to a single leader in healthcare right now over the past probably year that [staffing] isn't in their top three concerns and issues. Just today, we spent our executive team meeting [discussing] one of our strategies called "Great Work Place" and within that and we just made a decision [where] we're not going to leave it to an academic to get us the results we need. We need to figure that out.

We're in the first steps of essentially paying for nursing school. This program will take up to 100 students and we're going to pay for their school and guarantee them jobs, because we're

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Seattle

just treading water and we're not getting ahead. We have over 250 openings right now, and we're not going to get there unless we take these bold strides get young people to commit to these professions and keep them in. It's going to start with nursing, but I guarantee you we're going to be in multiple different [disciplinaries.]

Walker: I think there's another challenge of the pandemic that hasn't fully manifested itself yet. It could be positive or negative, but the ability for workers to be remote is a dramatic change. Talent generally stayed in larger urban areas, and I that's not going to be the case for many of our jobs now.

If people can be recruited from a wider range of competing organizations, regardless of location, it's going to further strain the availability as well as the stability of our teams. Having that workforce stability is as important as filling a position.

Every time you add a new person a team changes, or you've got a learning curve when new people come in. There's going to be volatility that could go either way and it depends on your location if you experience an upside on it or a downside.

HealthLeaders: *How have you used or planned to use partnerships, collaborations, or M&A to execute your growth strategies and fixing issues such as staffing?*

Gruber: In our region there is probably three independent small facilities and we're in the final steps of having one join our health system. It will be our first across the state line into Michigan venture: Three Rivers Health. A well-run organization that has reached the point where they need a partner and we did all the work and diligence and it makes sense for us. It's in an adjacent market to us. We have things that we can help them with to stabilize their own community and keep patients, because they have an out migration of that county [where] 78 percent leave that county for care, and we know we can help them and keep a lot of people closer to home.

We continue to work with independent physician groups that exist. We're at the final stage of ambulatory surgery center with an independent orthopedic group. We've got some other interesting structures we developed with some of our employed and independent physicians on what we call "governance counsels" and their co-management, game-sharing agreements are kind of wound up inside of those, and those have been successful for us.

Haupert: A lot of discussions on new partnerships is with post acute care. One of the things we saw in Atlanta is we all experienced an increase during the COVID pandemic in length-of-stay because it became more and more difficult to get placement for patients in the post acute environments. We are reexamining those relationships and even determining if we need to reignite our own home health license and go back into that business ourselves.

Patel: We have over 300 sites of care and Virginia Mason Franciscan Health has the most in the state, but there's more opportunity to grow in the state, and the reality is that given our size, scale, and being part of CommonSpirit, we intend to continue to expand.

Much like other organizations, we're evaluating the post-acute care space. Within CommonSpirit, we have a division that's focused on post-acute and we're assessing if we can expand services in our state. We're also looking at health at home. That's a new venue for us within CommonSpirit but we're trying to utilize some of the relationships that we built historically.

Walker: I have never been prouder to be part of the industry than during the COVID pandemic.

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Among not-for-profit organizations, we set a standard for working together and less competitively to meet the needs of community.

However, we still have work to do. In our community, there are significant gaps in access to education, advanced degrees, and jobs that create the future teams we want serving in our hospitals. We're not the only industry to have this gap. Many employers have the same challenge, and we have to include these populations that are an extraordinary resource.

Leaders and most of the CEOs in Orange County are working together to create internships, partnerships, and sponsorships, to help the underserved communities increase high school graduation and college enrollment rates. These efforts ensure success and develop a bigger population to meet our staffing needs, as well as elevating the health of the community. Income and education are the two factors most closely tied to health, and if we can impact them in a different way, there will be many benefits.

Becker: One of the things we're tracking carefully is the private equity money entering. Your ability to partner with some of these independent physicians now to keep care local and to control the front door is going to be key because the adage goes, if you're not talking to the physicians, someone with for-profit money is because they see short term arbitrage here. And while they can exit their investment with a return, the local health care systems remain, sometimes to pick up and reassemble the pieces.

I also loved this idea of competitors collaborating around COVID local market needs. It's a challenge to think how you can work differently, maybe even around community health needs assessments and other shared market needs moving forward. So rather than everyone making the same investments, how do you work together around community health to make investments together to raise the tide.

HealthLeaders: *Are you moving outpatient settings to a retail operation, or are you investing in other avenues of patient care?*

Haupert: We have a network of ambulatory health centers, and we modified the design of that to be "comprehensive care centers" which take multi-specialty and procedural capability into the market instead of just primary care. So now our centers are multi-specialty, heavy on behavioral health as well, and then some are outfitted to be able to do GI procedures, [with] extensive imaging capability. And here again, usually positioned in areas of greatest need but here again, to fund the mission we have placed several in communities where it's a higher Medicare mix and a senior mix that we already relationships with. And so we've been capturing more of the Medicare market.

Walker: It's not on our agenda because it doesn't fit our model. However, at my last organization, we embraced the concept because there was a big consumer demand for the retail experience. Of course, that was before the telemedicine boom. I think telemedicine exceeds the typical retail operation in terms of convenience or accomplishes 90 percent of it.

Patel: We might be skipping past retail, but what we are doing as a national family is expanding our digital strategy, specifically, how we connect with people at home. We're calling it the "digital front door." There's significant innovative work occurring around this strategy. Additionally, we have deeply invested in Epic and Cerner around the country and are ensuring our ambulatory sites are connected throughout the enterprise.

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