HealthLeaders Virtual Roundtable
Healthcare System of the Future: CFO

WHERE DO HEALTHCARE FINANCE EXECUTIVES GO FROM HERE?

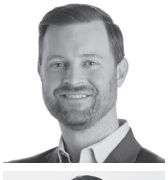
As hospitals and health systems emerge from the COVID-19 pandemic, there will likely be a fundamental reexamination of care delivery and what consumers expect from the industry.

Provider finance executives will be tasked with positioning their organizations for the most sustainable trajectory based on restoring diminished patient volumes and containing costs that ballooned over the past year.

In this HealthLeaders Roundtable, the panel discusses how provider organizations can maintain their margins across all sites of care.

Carlos Bohorquez
Chief Financial Officer
El Camino Health
Mountain View, California

Denise Chamberlain, CPA, MAEd
Chief Financial Officer
Edward-Elmhurst Health
Naperville, Illinois



Brandon Clark
Executive Vice President of Corporate Development
Equality Health
Phoenix, Arizona

Anthony Colletta, CPA
Chief Financial Officer
Westmed Medical Group
Rye Brook, New York

David Ertel
Chief Financial Officer
Vizient, Inc.
Irving, Texas

Jack O'Brien (Moderator)
Content Team Lead
HealthLeaders
New York, New York

HIGHLIGHTS

HealthLeaders: *Where does your organization currently stand from a financial perspective, and what are your strategies for maintaining margins across various sites of care?*

Denise Chamberlain: We think we've turned the corner. We measure our results, excluding subsidies, each month to see where we're going to be going forward when those subsidies aren't here anymore. So, we're looking at our volumes and our revenues and our expenses. We kind of feel like we sort of turned the corner a couple of months ago in terms of being able to at least break even. It's a little bit bumpy. We actually had an all-time record month in the history of the health system in April, and then excluding subsidies in May we barely broke even. So, it's a little bit bumpy, but we were consistently losing money every month, excluding subsidies.

Volumes are not where we were [pre-pandemic], but when you look at the trends, we are slowly trending back to where we were. Chicago fully opened recently, so I think that that's going to be a big driver to start getting that pent-up demand back.

Anthony Colletta: [Westmed] was hit hard like everyone else was. During the height of the pandemic, we had seen patient volumes decrease as low as 30% of our normal [levels], but we took measures to control costs. That was one of the biggest things to monitor in terms of making sure we had enough cash on hand, as well as managing other cash outflows, to cover our necessary expenditures.

Unfortunately, we did have a round of furloughs that we had to do—but many of those roles were able to be reinstated once patient volumes returned to normal and elective surgeries were reintroduced. We closely monitored overtime and had to bring down physician compensation, but all of those measures helped us get through. We did have some government subsidies as well that helped us stabilize our financial position.

One of the challenges that we're going to have to deal with is this transition from furloughing staff to not having enough staff. That's become our biggest focus and that's going to be a delicate balance that we're going to have to handle as we're trying to control costs, but we know we're going to have to invest in our labor force. With the struggle to retain and attract talent, we're going to have to invest in that. We're going to monitor turnover; we're going to invest in benefit programs, competitive compensation, and make sure we're at or above market. Those are all going to cost money. We're going to have to find savings elsewhere to ensure that we can address those issues.

Carlos Bohorquez: We've rebounded well from the pandemic, but that being said, I see a lot of headwinds related to revenue. We're having conversations with the payers, and the year-over-year increases we saw historically are a thing of the past. In some cases, what they're offering doesn't even cover our annual expense inflation.

Part of my conversations with the leaders of our organization is explaining why we've done historically well, financially speaking, but also educating the leaders about why we need to manage variable expenses and gradually become more efficient without compromising care and quality. We are reexamining a number of contractual relationships with an eye on improving services and asking our vendor partners how they can help us deliver care in a more efficient manner. This doesn't mean that we don't value the relationships that we have with vendors, but it's never a bad thing to have organizations compete for our business.

A lot of our partners have stepped up related to rates and services. In some cases, we've made some difficult decisions as far as changing relationships, but if you articulate the why and if you explain to the rest of the organization the potential benefits, it's a lot easier to change or modify relationships than to reduce services or FTEs.

David Ertel: Where do you see the collaboration between payers and providers going post-pandemic?

Brandon Clark: I think the tailwinds that have been described are accurate, as far as both the payer and provider perspectives in advancing value-based care strategies. I'm just not convinced that it's ever going to arrive passively. There are too many tectonic plates that have to arrive to make a fundamental business model shift from fee-for-service to value. It's not a small step, it's not even a big leap, it's a "pull up the moving truck, we're changing houses" kind of change, and that has to happen purposefully.

It's incumbent on all healthcare providers—ambulatory, integrated delivery systems, and inpatient systems—to evaluate and develop an opinion on the business plan outlook of a true, purposeful,

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> —Denise Chamberlain, CPA, MAEd , Chief Financial Officer
> Edward-Elmhurst Health, Naperville, Illinois

forceful shift driven by the provider into a value-based care strategy. Because the danger is having a toe in the water for another 10 years, then being in the same place when the next unforeseen event happens and fee-for-service dips.

Bohorquez: I don't disagree, Brandon. You don't want to be the first and dive into the deep end until you have developed the capabilities to effectively manage risk or value-based reimbursement. You also don't want to be left behind where everybody else is. Going back to California in the 90s, a lot of organizations, especially hospitals, took capitation [risk] and they lost their shirts. So, the shift has to be gradual, it has to be methodical.

Ertel: What has been the experience of your organizations from a telehealth perspective during the pandemic, and what do you see post-pandemic? How do you get paid for it?

Colletta: Once COVID hit, it accelerated our telehealth offerings. It was something that we had started before the pandemic, but our telehealth offering was concentrated within our urgent care service line until the pandemic increased demand for virtual care services during stay-at-home orders, while in-office visits were not an option for most.

We saw it as a way to get our infrastructure set up to cover an entire organization where you have 300 physicians who can go onto this platform and utilize it when they weren't beforehand.

Additionally, patients who had never tried [telehealth] before were much more hesitant to do it in the beginning. They were getting their feet wet with this. But it gives providers other options. I want to say roughly 20% of our visit volume at the height of the pandemic became virtual visits. That dropped off, towards the fall of 2020, and it's been pretty steady around 5% since then. It's up to us regarding how we want to continue using [telehealth].

Do we want to invest further in it? I see it completely as a complement to traditional, in-office care. [Telehealth] can't replace all care, but you can use it as a way to keep in touch on a more frequent basis with your patient base.

Chamberlain: Anthony, we had a similar experience here. The stickiness has been a little bit better with our numbers. At the height of the pandemic, we were as high as 70% (albeit on very low total volumes) for telemedicine. Now we're down to around 10% to 12%, so I think we're a little bit higher than you, but I think we're starting to mandate that our physicians set a goal to get a percentage of the volume up.

Part of the reason we're doing it is that we have long-term leases, so it's not like we can just close up some offices. But I think we are looking at it as a way to increase capacity because we were at capacity in a lot of our real estate and we were going to have to be looking for new sites in order to hire physicians. So, I think we're going to be looking at [telehealth] as a way to increase capacity in the current real estate that we have.

HealthLeaders: *How do you adjust to changing consumer preferences related to care delivery?*

Bohorquez: We discuss this internally when we think about strategy and physician network deployment. The one thing that I would say we struggle with is that we have been a hospital-centric system and we're looking to gravitate more towards the integrated delivery system with the physician [component]. But again, it's important to develop that connection with patients. Otherwise, they can pick up the phone tomorrow and go with somebody else that might be affiliated with a different hospital.

Hopefully, we can create user access points of care so that they don't have to come to the hospital for routine tests or we can establish a larger geographic footprint with primary care specialists offices, which are closer to where they work or live.

We want to make it as easy as possible for [patients] to access care, get copies of their bills, and pay their bills. Obviously, clinical quality is critical, but what I hear is that the younger generation wants ease, connectivity, and digital [capabilities]. The cost of providing care is a lot less in the outpatient setting or the ambulatory setting; if we don't acknowledge that and continue to be focused on the four walls of the hospital, then we will be left behind. That is our biggest risk, and again, we've made some good progress in creating that connection with the patients, but it's still an ongoing challenge.

Colletta: I think that access is key; that's something that we focus on. We've had to look at our scheduling and say to a lot of our doctors, "OK, do you have availability to see patients that need on-demand access quickly with not much lead time? Are you available in the evenings or on weekends? Do you make yourself available for them?" We've incentivized our physicians who have that access and it's one of the drivers for the bonus that we pay out at the end of the year, if they have a certain accessibility. That's a big thing.

Being able to easily schedule, see which providers are available, and go on an app on your phone [is important]. We developed an app two years ago, and that changed how we schedule. We're looking to supplement as much as possible. That's a cost savings opportunity as well. The more self-service we're able to put in the hands of all our patients, the less of the cost that we're going to have to put into a call center, a front desk, and other related support services. Those are all things that the patients tend to prefer for the most part.

If we can get [patients] in the door, get them settled with a primary care physician, and create a good experience for them, then you have them as a patient going forward. We realize that it's tougher now, there's a lot more factors

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—Carlos Bohorquez, Chief Financial Officer, El Camino Health, Mountain View, California

"There is a big challenge to engage patients effectively in a digital platform. There is a digital overload factor from texts, phone calls, emails and more."

—David Ertel, Chief Financial Officer, Vizient, Inc., Irving, Texas

going into it, but we're trying to take into consideration how to make the patient experience better overall.

Clark: One of the things [Equality] does is disproportionately work with Medicaid populations. Though we've had some trial and error with that population, we've found one of the best digital health strategies is also one of the most simple: We SMS text.

We started and stopped with an app. We found that the conversion rate into the app, and then the stickiness factor within the kind of proprietary environment of the app, was too big of a hurdle and wasn't worth the trouble.

We could, obviously, correspond differently in the HIPAA-sensitive context with an encrypted application, but we took a look and reengineered our messaging as well as the content that we were pushing out to members. This basically sanitized it of PHI and started offering connective assistance through text message. It has had a far greater uptake and took a lesser investment threshold to go live. It's something we can A/B test and iterate every day with little to no code.

One thing we've developed is our own application that effectively overlays the text message history into our care management system. We've found that to be effective and almost silly given how simple it is. As we've seen, other platforms kind of emerge that are similar. Our employee health benefits plan just rolled out 98.6, a virtual text messaging [platform]. It's the same concept; it's texting but specifically to a third-party provider group. Within our employee benefits plan, it's been well received by our own teams and used especially among the younger generations.

Ertel: As I listened to this conversation as well as [Atrium Health Chief Transformation Officer Dr. Rasu Shresthra's] opening keynote, it struck me that it's a big challenge to move up the hierarchy in terms of that kind of clinical engagement through whatever digital platform it is. Something as simple as texting is a challenge. Between phones, text messages, and email, I think there is the overload factor.

HealthLeaders: *Looking at a post-pandemic world, how are you and your respective organizations examining functions that can be done remotely or don't require being in the office every day?*

Chamberlain: In December 2019, we rented and furnished a new office space, moved almost 1,000 people in, and sent them all home in March 2020.

We are working through what our new policies are going to be. Personally, I think there is a benefit to having people come into the office and work side by side, especially for things like brainstorming, being creative, and talking through difficult projects and decisions. Even with the routine work, there's a benefit too.

If I hire somebody and they never set foot in the building, they never get a sense of our unique culture. Over the long term, if we continue to just let anybody that wants to work from home work from home, we're going to see higher turnover and lower engagement.

We are already talking with our legal team about figuring out how we can have people work for us from multiple states, because once you're remote it doesn't matter who your employer is and it doesn't matter where you live. We're going to start losing people to other companies, so we're going to need to be able to increase our talent recruiting pool to be able to recruit from other states.

Clark: We have similar themes at Equality Health in Phoenix. We just issued our first back-to-work communication in June and we'll be phasing back for the same underlying reasons Denise described around culture, the value of collaboration, and the pace of innovation in person versus virtually.

We just don't believe that it can be done over Zoom® in perpetuity. I think we're kind of, from a business planning standpoint, bracing for what that means from an employee turnover perspective. We don't want to lose talent, but we're also aware that the surrounding market attitudes around telecommuting have shifted dramatically and individuals who may value the remote work lifestyle more than they value the culturally aligned principles that we're describing are going to have more options than they ever had before.

I'm getting comfortable with this concept of "the great turnover" that some are expecting in the second half of this year. Consultants are telling us that whatever your turnover rate has been historically, you should probably double it as far as your short to mid-term outlook. There's going to be probably a pretty significant shuffling of deck chairs as far as people and seats go, but I think it's a calculated risk-reward.

I think there is still room for hybrid and work-life changes coming out of the pandemic, I don't think it has to look exactly like it did pre-pandemic, but I also think we're fooling ourselves if we can say we can collaborate and innovate via Zoom like we do when we're all around the whiteboard.

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—Brandon Clark, Executive Vice President of Corporate, Development, Equality Health, Phoenix, Arizona

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