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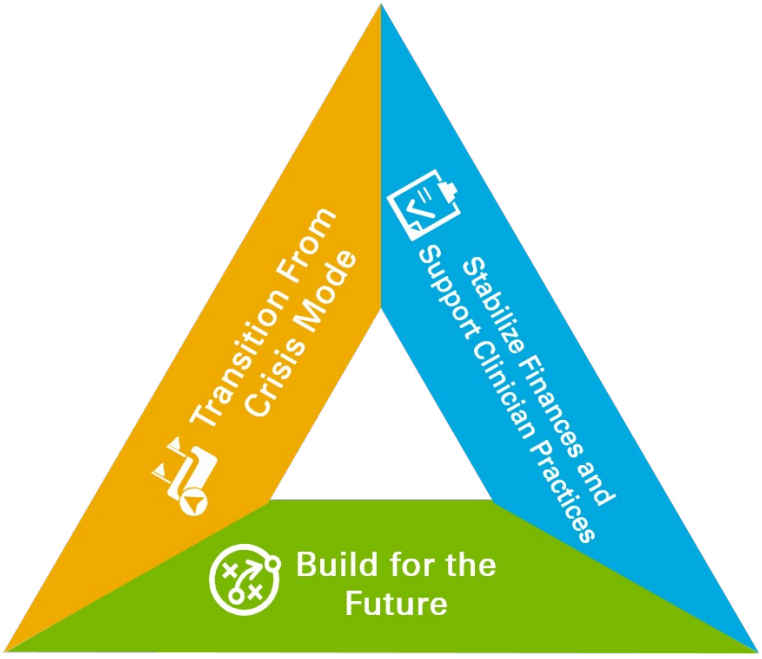
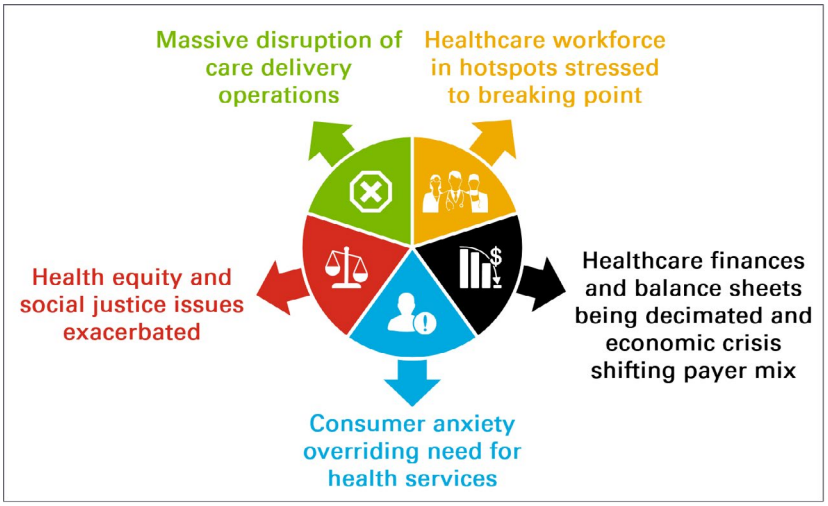
Emergence From COVID-19: Imperatives for Health System Leaders



Emergence From COVID-19: Imperatives for Health System Leaders

The COVID-19 crisis has brought great adversity, and our health systems and academic centers are responding with innovation. Policymakers have rapidly lifted myriad barriers to providing care in innovative and novel ways, and health systems have rapidly scaled up virtual care, hospital-at-home programs and home-based care. Telehealth video and phone visits have ballooned from the tens or hundreds to many thousands per day at major institutions, prompting rapid acceleration in digital patient engagement. Health systems with population health capabilities have used them to manage patients through the crisis. Those with health plans have benefited from the financial diversification. And those with well-developed post-acute programs have helped patients successfully through the transitions among hospital, skilled nursing and home.

Challenges for Leaders

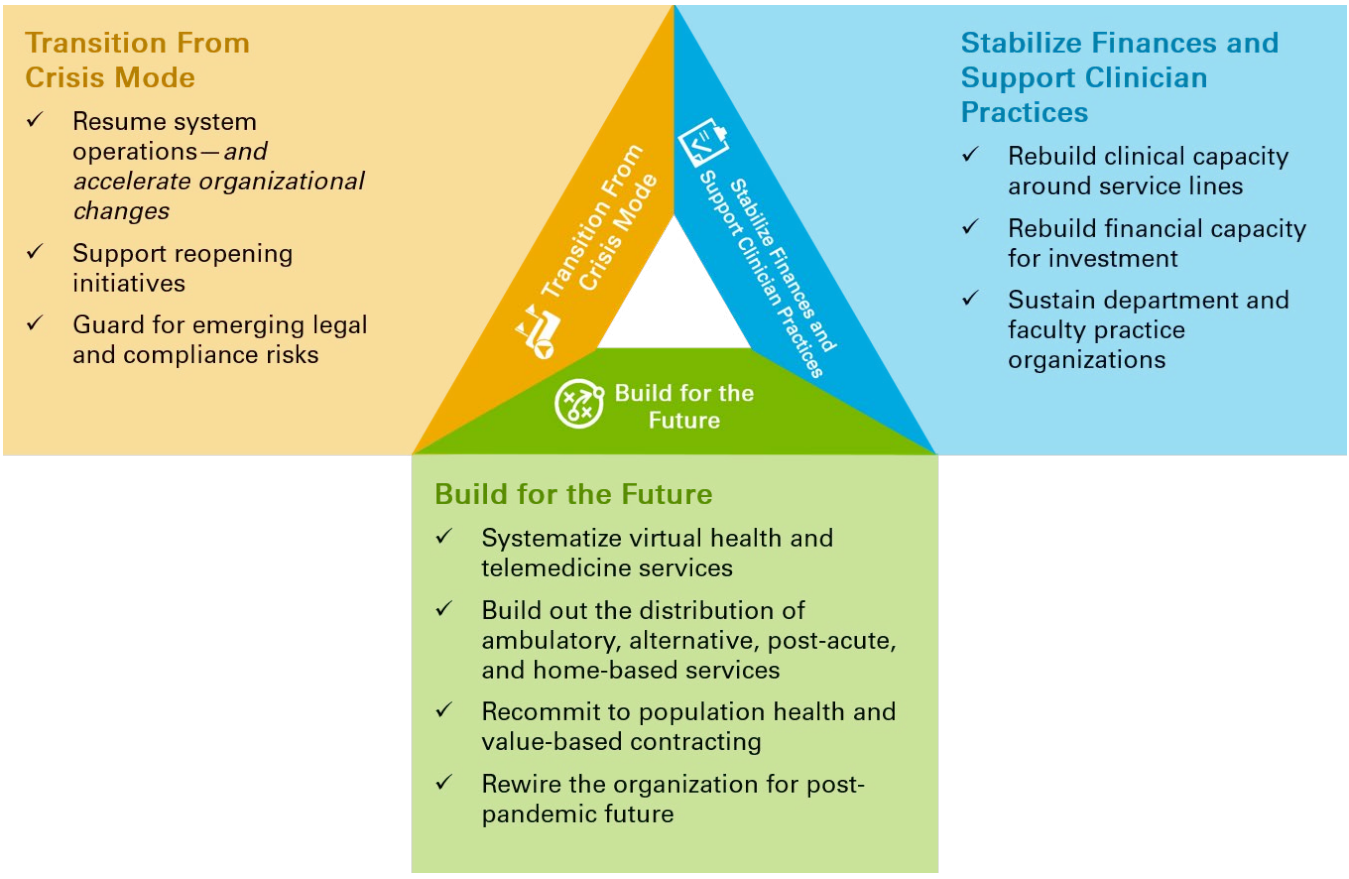


During the crisis, important changes have begun to be made in typically unwieldy health system organization structures. Operational and policy decisions have been made quickly and nimbly. Coordination and communication processes have been vastly enhanced under the pressure of immediate needs. The priorities of recent weeks have focused on protecting health workers, acquiring PPE and special supplies, ramping up telehealth, establishing COVID-19 units, managing clinic closures and reopenings, and myriad other complex undertakings. Every health system leadership team should challenge itself to self-assess its performance. How did we do? What could we have done better? Are we working effectively with our community on deep health equity and social justice issues? What changes in how we work should we keep—and accelerate? Emergence from the crisis offers the leadership of health systems and academic centers a profound opportunity to reflect on how to remake themselves as stronger, more effective, more engaged and more resilient institutions.[1]

The immediate imperatives are to safely resume elective clinical services, stabilize finances and support physician practices to get back to a semblance of normal operations. This work must occur while health systems are simultaneously continuing to manage COVID-19 cases, preparing for subsequent infection waves, engaging with the community to prevent further spread and preparing the organization for future unknowns. Clearly communicating the "new" experience that can be expected in accessing healthcare facilities for services is essential to alleviate patient anxieties and rebuild patient volumes. More fundamentally, successful post-COVID-19 strategy will be based on whether the health system is positioned as a leader for positive change within the community, and early steps to support safe reopening will be instrumental in achieving this objective.

A next priority is shoring up tertiary and quaternary services where academic health centers and large health systems have a natural advantage and which provide the margins that sustain academic and community missions. Service excellence and clinical integration will be essential ingredients. The collapse in current year financials and the dismal forecast for future margins will require rebuilding financial capacity for investment and near-term attention to realizing operational efficiencies, cost reductions and workflow realignments to facilitate throughput.

Imperatives for Health System Leaders



Longer term, the focus will be on building the next-generation distributed, highly interconnected, community engaged and extensively digital system of care, which will be the lynchpin of a resilient health system. This ambitious agenda will require rewiring the organization structure to align with the new priorities and emerging demands, and the need for greater resilience in the face of future black swan events.

Recommendations for Health System Leaders

Transition From Crisis Mode	
✓ Resume system operations—*and accelerate organizational changes*	Working toward more resilient models and accelerating organization change and high-performance teamwork should be constant themes as leadership teams reopen and rebuild.
✓ Support reopening initiatives	Embrace local/regional leadership responsibility with county and state health officials to accelerate return-to-work opportunities, including comprehensive health system reopening and community engagement to promote health equity.
✓ Guard for emerging legal and compliance risks	Conduct comprehensive risk and compliance audits to minimize post-apex litigation and compliance issues; develop comprehensive position and related strategy/tactics that inform response to emerging legal issues arising from pandemic response.
Stabilize Finances and Support Physician Practices	
✓ Rebuild clinical capacity around service lines	Plan, organize and implement program and service line efforts with precision.
✓ Rebuild financial capacity for investment	Reorient strategic plans to be financially accretive during a possibly extended period of disruption and industry realignment.
✓ Sustain department and faculty practice organizations	Align clinical enterprise governance, organization and funds flow to ensure long-term viability of the clinical departments.
Build for the Future	
✓ Systematize virtual health and telemedicine services	Prioritize building the capability to design and scale new digitally enabled care models that leverage telehealth and digital health technologies, and deploy those care models throughout the health system with the ability to refine and improve them continuously over time.
✓ Build out the distribution of ambulatory, alternative, post-acute and home-based services	Create a true system of care by developing and scaling ambulatory and home-based care capabilities and forming the necessary linkages and interdependencies with hospital and other site-based care.
✓ Recommit to population health and value-based contracting	Do not allow short-term disruptions in revenues and costs to derail the health system from advancing population health-centric care models and continuing efforts toward accountable care.
✓ Rewire the organization for post-pandemic future	Evaluate the performance of your organization during the crisis and make changes to strengthen the ability to successfully execute as the emergency fades.

Transition From Crisis Mode

Resume System Operations—*and Accelerate Organizational Changes*

As health systems and research programs reopen and (incrementally) return to pre-COVID-19 activity levels, they must be hyper-focused on ensuring a safe environment, including formalized patient and staff testing protocols and implementing protocols to reassure anxious patients while at the same time operating within a new—constrained—economic reality. Most health systems will need to operate distinct "COVID-19-safe" patient care environments so as to expedite access and address consumer concerns regarding safety, likely resulting in a "90% economy"[2] for healthcare. COVID-19 testing at scale with a range of tests will be essential.[3] Extraordinary attention to patient communications and pinpoint attention to patient throughput and flow will be needed given requirements for enhanced safety protocols. These activities should be accompanied by a close evaluation of organizational and team performance during the crisis. Beneficial changes in organizational process including cross-organization communication, team process and nimble decision making should be accelerated. Where individuals have stepped up and shown leadership, new roles can be defined so they can continue to grow as leaders.

Critical Issues

- Rebuilding confidence and trust, welcoming patients back, and communicating to patients and communities that it is safe to seek routine and nonemergent healthcare services. Patient flow needs to be redesigned to include socially distant registration and check-in, effective PPE for patients and staff from screening through treatment, and specialized sanitation procedure subsequent to patient encounters.
- Providing—and communicating—a COVID-19-safe environment will require testing multiples greater than current levels. Some institutions are choosing to test their entire workforce.[4]
- High throughput management balanced with enhanced safety protocols to rapidly address backlogs of postponed cases in a balanced manner. Coordination of unit and operating room (OR) partitioning and duplication to provide asymptomatic patients COVID-19-safe assurance while simultaneously continuing to treat COVID patients.
- Workplace efforts to manage burnout while non-COVID-19 volumes ramp up to fill empty clinics and beds.

Priority Questions

- Do we have a service partitioning and patient flow plan that can assure patients a COVID-19-safe environment?
- How many tests per day can we do and how does that compare to second/third-wave estimates?
- Are we managing the burnout in our workforce effectively? Do we have the human resources for a full return to work?
- Do we have multiple contingency plans for maintaining elective operations in the event of significant subsequent waves?
  - Do we have a continuous executive and manager "lessons learned" process in place to appreciate the full dimensions of our response and organizational performance?

Recommendation: Working toward more resilient models and accelerating organization change and high-performance teamwork should be constant themes as leadership teams reopen and rebuild.

Transition From Crisis Mode

Support Reopening Initiatives

Restarting the economy as safely as possible is the top priority for state and local governments, which presents both opportunities and challenges for delivery systems. Health systems are pivotal partners for reopening efforts: They are often the largest employers in the region, they have the resources and expertise to manage infection control and reopen elective services, and they will prove pivotal in the ongoing need for continuous and expanded COVID-19 testing and contact tracing. In several states, leading health systems have assisted the public health authorities to clear testing backlogs. In a number of the announced university campus reopening plans, such as those at the University of Florida, UC San Diego and the University of Alabama, academic centers are leading these efforts with program organization, testing and contact tracing. Health systems will also partner with employers on return-to-work strategies as a form of direct contracting. The multistate membership-based primary care practice One Medical is offering this as a service to its employer customers,[5] while United Airlines has partnered with the Cleveland Clinic and Clorox in a program called "United CleanPlus" intended to "ease the fears" of nervous flyers.[6] Reopening also requires taking care to promote and ensure health equity, particularly with respect to broadening community-based testing, access for vulnerable populations, protection for frontline workers, and working closely with trusted community partners.

Critical Issues

- Health equity and social justice issues have been exacerbated and have come to the fore during the pandemic. Restarting the economy will also need to begin to address underlying issues that include access to healthcare and coverage issues.
- Health systems will need to continue to scale up testing capacity.
- Health systems will be asked to provide community-level testing beyond their workers and patients so as to support return-to-work efforts in their communities. Most Academic Health Systems (AHSs) also are safety net facilities, and they will need to consider how best to support vulnerable populations that are most susceptible to continuing infection spread. Engaging more broadly with FQHC's and community organizations will be an important dimension.
- Electronic tracking and contact tracing will become more prevalent. Health systems will need to determine whether to require the use of these by faculty and staff so as to better manage workplace infection subsequent waves. Planning for the careful integration of these tools by Human Resources departments should be an early priority.

Priority Questions

- Is our institution fully aligned with regional reopening initiatives?
- Are we able to expand our testing capacity to support community-based and/or campus requirements?
- Can we strengthen the relationships we have with FQHCs and rural centers so as to support enhanced testing and contact tracing in high-risk settings?
- What assistance should we be providing to independent physician practices affiliated with our health system to enable them to reopen more rapidly and effectively, in line with our own efforts?

Recommendation: Embrace local/regional leadership responsibility with county and state health officials to accelerate return to work opportunities, including comprehensive health system reopening and community engagement to promote health equity.

Transition From Crisis Mode

Guard for Emerging Legal and Compliance Risks

Rapidly changing guidance, temporary regulatory flexibilities, changes in employment law, payment revisions, and challenging operational and ethical issues require continuous attention and dedication from health system legal and compliance teams. Managing litigation risks related to staff support, patient care and regulatory issues arising from COVID-19 should be top of mind for all health systems.

Critical Issues

- Legislation and guidance have been rapidly developed during the crisis and have changed over the short time periods after emergency programs were enacted, resulting in lack of clarity around obligations of provider organizations with respect to accepting government funds and potential related risks under the False Claims Act.
- New waiver authorities and guidance are being released daily, if not more frequently, which have sweeping implications for health system compliance programs and policies and procedures.
- Federal and state guidance is not always in sync or may be changing on different timelines.
- As large employers, major real estate holders and the frontline COVID-19 response service providers, health systems need to navigate a suddenly even more complex legal landscape.

Priority Questions

- Have we evaluated the legal and regulatory requirements of participating in COVID-19 relief funding programs?
- What is the impact of reporting some aspects of our COVID-19 response as charity care and/or community benefit or failing to do so?
- Are there any unforeseen risks from COVID-19 response that we need to be considering, such as:
  - The potential for false statements in connection with certifications required to accept federal funds and the associated auditing and reporting requirements and audit strategies related to making use of temporary regulatory flexibility around workforce, care locations and administrative oversight—federal, state;
  - Lawsuits and federal and state agency action related to staff (adequacy of PPE, testing) and potential discrimination against patients based on race or economic status (admission, testing, etc.); and
  - Federal and state investigations regarding infection control practices?
- Which components of regulatory flexibility—e.g., telehealth, alternative care settings—provided during the public health emergency will be retained post-pandemic, and what are the compliance issues we should be monitoring, such as:
  - Income tax implications of temporary arrangements entered into under Stark waivers, e.g., assistance to physicians constituting taxable income;
  - Ensuring that arrangements addressing emergency capacity are not determined to result in market collusion;
  - Addressing privacy implications of expanded use of telehealth and alternative care settings;
  - Developing reopening plans that ensure safety and standards of care and mitigate negligence claims including a comprehensive review of operating, financial and compliance policies in the "post-public health emergency" world;
  - Refining programs and services as required to address removal of temporary flexibilities, seeking assistance in how to "undo" contracts or other arrangements entered into under the Stark waivers, or understanding of the risks associated with not undoing them; and
  - Assessing the legal and regulatory environment relative to anticipated health system consolidation, e.g., antitrust, deal terms, as new affiliation, partnership and acquisition, as opportunities are identified?

Recommendation: Conduct comprehensive risk and compliance audit to minimize post-apex litigation and compliance issues; develop comprehensive position and related strategy/tactics that inform response to emerging legal issues arising from pandemic response.

Stabilize Finances and Support Physician Practices

Rebuild Clinical Capacity Around Service Lines

Academic centers and large health systems make the vast majority of their margin on a small subset of services and cases paid by commercial plans, which then subsidize their losses on most other cases and from government payors. These few cases are typically high-complexity cancer, heart, neurosurgery and neurology, orthopedics, and transplant and are typically procedural in nature. The reluctance of consumers to travel will further erode international and national draw but also increase the potential for recapturing cases currently migrating out of state or region for care. As states begin to reopen, there will be tremendous competition for these high-margin, high-acuity cases, necessitating an intensive focus on program and service line effectiveness. Simultaneously and due in part to productivity incentives, tertiary hospitals will rapidly fill with backlogged cases that might be better seen in an alternative site—or could have been a preventable admission. Academic centers will need to facilitate the greatest access combined with excellent clinical management if they are to maintain and build their competitive position. Health systems will seek to capitalize on their clinically integrated networks and information systems to bring patients back into their service lines. Independent hospitals and practices will be the likely losers in this competition.

Critical Issues

- Health system finances will be dependent on capturing (elective) volumes in programs of distinction, which will necessitate superior performance in service line management.
- During the several months of the most intensive phase of the pandemic (between four and six months) significant numbers of patients deferred regular screening, diagnostic evaluation or treatments, resulting in a significant backlog of services to be delivered as states and health systems reopen. Accelerating the ability to see patients effectively will be an important priority for leading health systems.
- Backlog surgical cases will likely exceed OR capacity, resulting in potentially lengthy wait times for patients, who may choose to seek care elsewhere.
- Significant changes in the surgical schedule—including running ORs later and over the weekend—may be required to meet patient demand for medically necessary procedures and to address pent-up demand.
- Ambulatory surgical centers (ASCs) will be advantaged given the likely reluctance of patients to be treated at hospital facilities.

Key Questions

- Do we know what our backlog is in each program and have an approach to manage it?
- Do we have an oversight structure in place to manage backlog?
- Are we prepared to sustainably maintain our telemedicine services in our programs? Have we integrated fully as multidisciplinary care teams for our service lines?
- Where is our surgical capacity located, and how much ambulatory surgical capacity can we bring on line? What is our ability to extend our OR schedules?

Recommendation: Plan, organize and implement program/service line efforts with precision.

Stabilize Finances and Support Physician Practices

Rebuild Financial Capacity for Investment

Health systems are experiencing steep revenue and income declines due to the margin lost from elective services deferred to provide capacity for COVID-19 patients. AHSs and large health systems are individually losing hundreds of millions and collectively billions of dollars as their revenue has plummeted while they maintained most of their cost structure. Moody's estimates that the postponement of elective services reduces not-for-profit hospital revenue by between 25 percent and 40 percent per month. CARES Act funding has provided a modest benefit, on the order of 10 percent to 20 percent of lost revenues for some institutions. Hospitals and health systems are not expecting a V-shaped recovery. In addition to lost revenue due to pausing electives, health systems are simultaneously expecting a significant shift in payer mix to Medicaid and uninsured resulting from the spike in unemployment. Unlike many independent hospitals, most academic health systems and larger health systems have sufficient liquidity to survive through this crisis. Indeed, the largest health systems have so much cash on their balance sheets that they are drawing media scrutiny (and ire) for receiving stimulus support.[7] However, their ability to invest will be severely curtailed, and for many leaders the top priority will be to rebuild the balance sheet. Many institutions have reduced nonessential expenses, announced compensation reductions for leadership, instituted salary freezes, implemented voluntary or forced furloughs and reduction in hours, and halted retirement contributions, and are pausing capital investments. Further cost reductions will likely be necessary, extending to reengineering service delivery, tightly managing the revenue cycle, cancelling planned capital projects and taking a sharper view of expansion initiatives.

Critical Issues

- Hospitals and health systems are experiencing large financial losses due to COVID-19 and are likely to see these exacerbated through 2021 and beyond by payer-mix shifts due to an economic recession. These factors will result in dilution of balance sheet strength.
- The short-term priority is to ensure adequate cash flow to maintain operations and address existing debt covenants. For health systems, as is the case for many companies nationally, "cash is king."
- CARES Act funding will be important but only one component of a financial recovery plan.
- Intensely close attention to financial operations and a comprehensive reevaluation of all strategic priorities will be essential. Pre-COVID-19 strategic investments including acquisitions will need thorough review.

Priority Questions

- What is our cost-reduction program and how much will it yield? Are we making deliberate decisions regarding continuation or closure of nonprofitable programs and locations?
- Do we have enough liquidity to address near-term requirements? Should we explore measures to improve cash, including real estate asset management?
- Can we accelerate our system integration and improve our operating results by eliminating redundancies?
- Are all our investments and potential acquisitions accretive at this time? If not, should we proceed? What is the post-COVID-19 strategic rationale?
- Should we consider merger to strengthen our access to capital?

Recommendation: Reorient strategic plans to be financially accretive during a possibly extended period of disruption and industry realignment.

Stabilize Finances and Support Physician Practices

Sustain Department and Faculty Practice Organizations

Successful academic health systems are characterized by strong clinical departments, which have robust finances and reserves, and are growing clinically and academically. The pandemic has hit clinical departments especially hard, as their clinical revenue has evaporated and they are burning through their reserves. Financial viability is further stressed by research and academic funding delays and program cancellations. Many practices also face the need to pay back Medicare advanced payments. Due to affiliation restrictions, faculty practices have generally not been eligible for Paycheck Protection Program (PPP) federal stimulus loans for small businesses. As departments and faculty practices exhaust their resources, they will increasingly turn to their affiliated hospital and health system for financial support. Now is the time to complete the transition to the highly aligned clinical enterprise with transparent funds flow, excellent accountability systems and well-considered decision processes. Those not organized in this manner should consider the current crisis as an important opportunity to do so, as ensuring that departments and the faculty practice emerge robustly will be essential to the health system's and medical school's ability to weather the next chapter.

Critical Issues

- Faculty practice plans (FPPs) are experiencing decreased cash flow from elective procedures, reduced office visits and ancillary revenue decline. RVU-based faculty compensation plans are likely to result in sharply lower compensation during the current and coming fiscal years.
- Ongoing financial losses for clinical departments in a largely fee-for-service payment schema on already low-margin businesses make (even favorable) Medicare advanced payment loans a challenging proposition.
- Consumer reluctance to advance even their needed appointments and procedures will combine with payer mix changes related to the dramatic increase in unemployment to cause continuing financial distress.
- In addition, non-COVID-19 research funding may be constrained; university funds will be stressed by the delays in campus reopening; and philanthropic support may or may not be forthcoming, all of which will create uncertainty in the financial forecast.

Priority Questions

- Are we fully taking advantage of all FPP funding opportunities? Such as:
  - Medicare Advance Payments (check)
  - CARES Act "Provider Relief Fund"
  - Medicare and Medicaid payment enhancements
  - Small Business Administration PPP and Main Street Lending Program loans
  - Health system provided low- or no-interest loans to departmental practices under coronavirus Stark waiver flexibility
- Are we prepared for a rapid reopening with an orientation to the high-volume clinical management needed to address the backlog of appointments and procedures required by our patients?
- Are we accelerating the development of a more integrated and aligned clinical enterprise in terms of management, governance, operational efficiencies and funds flow?
  - Amongst the clinical departments so as to build a more sustainable group practice that supports all its constituents
  - With the health system in order to align into a comprehensive and financially stronger clinical enterprise

Recommendation: Align clinical enterprise governance, organization and funds flow to ensure long-term viability of the clinical departments.

Build for the Future

Systematize Virtual Health and Telemedicine Services

Out of sheer necessity, many health systems have quickly stood up or rapidly expanded telehealth offerings to enable continuity of care to patients who are unable or unwilling to receive in-person care due to social distancing requirements or other limitations or constraints. Initial data show an exponential increase in telehealth utilization with some health systems seeing a 10x–100x increase in average daily telehealth volume from pre-pandemic levels. Health systems have made years of progress in advancing their telehealth capabilities in mere weeks, and it is clear that virtual care is here to stay for the long term. However, health systems will need to quickly transition their telehealth programs from "crisis mode" and fundamentally rethink how they deliver care in the future by designing, testing and scaling digitally enabled care models that meaningfully improve patient experience and clinical outcomes at a lower cost.

Critical Issues

- Health systems have needed to scale telehealth offerings over a period of days and weeks during the COVID-19 pandemic out of sheer necessity and in many cases have "bolted on" telehealth capabilities.
- Providers will need to assess whether their current emergency telehealth infrastructure will meet future needs and if not, make the necessary changes to ensure that telehealth and digital health platforms are designed, configured and integrated to support long-term clinical and operational requirements.
- Health systems will need to move beyond early telehealth offerings such as virtual urgent care to fundamentally rethink the way they deliver care and design clinically proven digitally enabled care models that effectively integrate remote and in-person care and demonstrably improve quality and outcomes. These models will vary by specialty, condition and setting of care, and each will have its own unique clinical and financial value proposition.
- In most health systems, providers have not received adequate training in how to most effectively deliver care remotely and will need to be trained or retrained in the most effective telehealth care delivery techniques.
- In response to COVID-19, telehealth reimbursement has increased dramatically in Medicare, commercial plans and Medicaid; though in many cases these reimbursement changes may be temporary.
- Additional regulatory flexibilities such as enforcement discretion of the HIPAA rules and cross-state licensure are tied to federal and state public health emergencies and are unlikely to be sustained long term.

Priority Questions

- Do we have telehealth and digital health platforms that can be scaled and seamlessly integrated with our electronic health record (EHR) and other core systems to effectively and comprehensively meet our clinical and operation needs for the next five years?
- Do we have sufficient expertise in telehealth and digital health within our organization or do we need to bring in new talent?
- What steps are we taking to redefine our relationships with patients and families by communicating with them on a proactive basis through new digital technologies in support of their efforts to improve their health status?
- Do we have the clinical redesign capability and resources necessary to reimagine how we deliver care in a manner that fully leverages all that telehealth and digital health have to offer?
- Once new digitally enabled care models are designed, tested and validated, do we have the operational capability to disseminate and scale these models consistently throughout our clinical enterprise?
- Do our primary payors provide adequate reimbursement for telehealth services? Do we need to renegotiate any of our commercial contracts to ensure temporary telehealth coverage is sustained in the future?
- Have we fully aligned our telehealth and digital health platforms with our post-COVID-19 consumer engagement and branding strategies?

Recommendation: Prioritize building the capability to design and scale new digitally enabled care models that leverage telehealth and digital health technologies and deploy those care models throughout the health system with the ability to refine and improve them continuously over time.

Build for the Future

Build Out the Distribution of Ambulatory, Alternative, Post-Acute and Home-Based Services

During the COVID-19 emergency, many health systems, especially those in hot spots, have needed to rapidly establish the ability to provide care on a distributed basis. In some cases, this takes the form of hospital-at-home programs in which hospital-level care is provided in the home by leveraging home-based care, remote sensor technology and traditional video telehealth. In other cases, systems may be providing primary or chronic disease care in the home. While these models have primarily been expanded due to social distancing restrictions, many providers have long sought to expand their ambulatory and home-based offerings for cost and patient convenience reasons but have not done so due to unattractive reimbursement. During the crisis, payors—and especially Medicare—have afforded unprecedented flexibility to provide care in nontraditional locations. Health systems should seize this moment to rethink their care delivery models by developing and expanding clinical services on a distributed basis and in the home. In doing so, health systems should challenge themselves to seamlessly integrate these services into existing facility-based service portfolios to ensure that the resulting system of care is greater than its component parts.

Critical Issues

- Many hospital systems have aggregated the component parts of an integrated delivery system, but few have seamlessly integrated these assets into a true system of care that is greater than the sum of its parts.
- Independent physician practices, ambulatory surgery centers and imaging centers are in significant financial distress due to decreased cash flow from reduced office visits and elective procedures.
- Care will increasingly move from institutional settings—hospitals, long-term care facilities and ambulatory clinics—into the home.
- Over the past decade, hospital-at-home programs have demonstrated strong outcomes and high patient satisfaction, evolving as monitoring and remote consult technologies—and consumer expectations—have advanced. But so far, reimbursement has lagged behind. In response to COVID-19, reimbursement for home-based-care models has increased dramatically under Medicare, commercial plans and Medicaid, though in many cases these reimbursement changes may be temporary.
- Health systems will need to develop their distributed ambulatory and home-based networks in concert with their digital platforms (see imperative #7).
- Given the challenges and limitations of institutionally based post-acute and long-term care, it seems that more and more of this care will be provided in the home. While ensuring strong partnerships with long term care (LTC) and post-acute care facilities is critical, it is equally essential to envision a future in which a significant share of this care is provided at home.

Priority Questions

- Do we have a strategy for sustaining and scaling the delivery of care in alterative settings after the pandemic, with a focus on home-based primary and chronic disease care, remote monitoring, and hospital at home?
- Does our current financial model support a strategy for sustaining and scaling delivery of care in alternative settings? If not, how can we evolve our financial model so that a robust platform of distributed clinical services is financially accretive?
- Do we have sufficient ambulatory and home-based clinical capacity now, or do we need to acquire, recruit and/or contract for that capacity?
- Do we have the right system culture, operational infrastructure and processes in place to enable a broadly distributed system of care?

Recommendation: Create a true system of care by developing and scaling ambulatory and home-based care capabilities and forming the necessary linkages and interdependencies with hospital and other site-based care.

Build for the Future

Recommit to Population Health and Value-Based Contracting

Over the past decade, health systems have been testing different value-based contracting models in support of the Triple Aim framework. The public health emergency period has exposed cost structures and drastically reduced revenues for hospitals, physician practices and many ancillary service providers, which will likely temporarily derail current value-based models, as regional benchmarks, quality metrics and even patient attribution have to be reconsidered and reset to avoid negative and unintended consequences. Clinicians in Alternative Payment Model value-based arrangements are deeply concerned that they will incur substantial losses as a direct result of COVID-19.[8] At the same time, they have been better prepared, with more completely developed telehealth infrastructure, established connectivity with social workers and therapists, and enhanced relationships and tools to serve patients in their homes. This period has also placed a spotlight on health disparities, community-level variations in access and health status, and the criticality of addressing social determinants of health, demonstrating the need for—and power of—nimbler and patient-centric access to healthcare services, underscoring the benefit of a stronger population health infrastructure and payment model.

Critical Issues

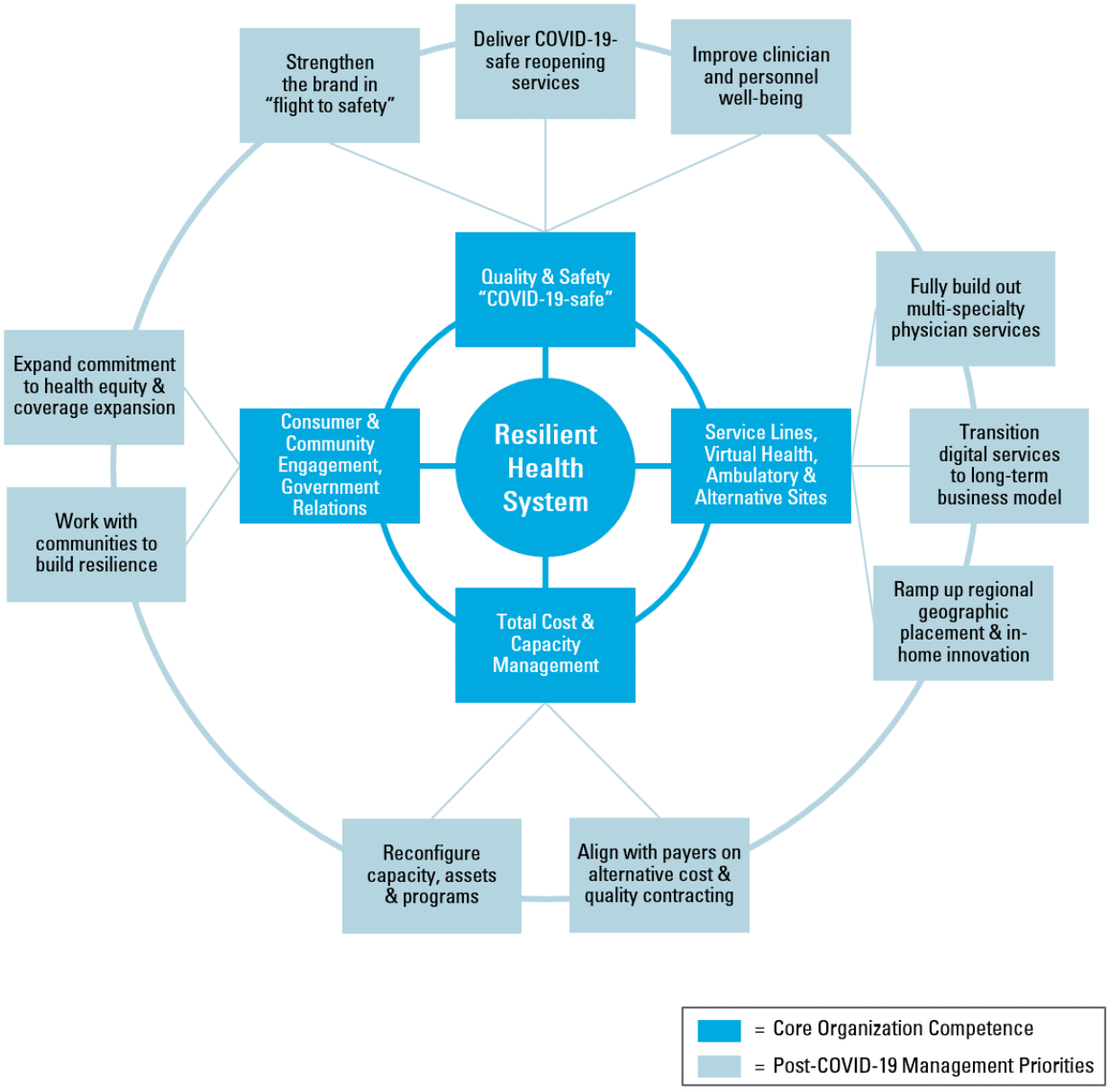
- The pandemic and resulting financial crisis in healthcare necessitate evaluating the COVID-19 impact on at-risk entities with downside risk arrangements, though the impact will vary greatly depending on regional circumstances and the contracting model specifics.
- Quality targets and reporting deadlines as well as provision of preventative care will be hugely disrupted; cost-savings targets will be missed, and efforts to amend benchmarks are likely to be distorted, which will have implications for the next 12–24 months.
- At a macro level, the faults of the current U.S. healthcare payment model—where hospitals cannot survive without high-margin procedures and supplemental payments and many patients, from the underinsured to those with high-deductible plans are hesitant to seek treatment due to lack of clarity in out-of-pocket costs—are brought into sharp focus due to the current emergency, raising larger questions about how care should be paid for.

Key Questions

- What is our process to systematically evaluate our current value-based contracts and renegotiate with payers for the near term as well as to rethink our risk approach for the midterm?
- How can health system population health investments be leveraged to develop data-driven and community-based-resource informed abilities to "cohort" vulnerable patients, including the elderly and those with chronic diseases, and provide targeted resources to support those groups?
- What elements must be included in contracts going forward, including risk corridors and emergency clauses?
- How should we rethink our total cost-of-care models given alternate settings of care and telehealth? Do we have the necessary data analytics and financial modeling capabilities?
- How should we leverage the recent disruptions to redesign our care models and radically rethink consumer convenience?
- How do we leverage our current population health investments, and where and how should we expand our capabilities to identify and meet the care needs of our most vulnerable populations?

Recommendation: Do not allow short-term disruptions in revenues and costs to derail the health system from advancing population health-centric care models and continuing efforts toward accountable care.

Illustrative Post-Pandemic Management Agenda



This diagram provides an illustration of how to align post-pandemic organization-building efforts. At the center is the organization-building objective: enhanced resiliency in preparation for the continuing demands of COVID-19 and future unknowns. Immediately linked, and drawing from the lessons of pandemic operations, critical competencies span multiple teams and organizational units within the system. Each of these in turn drives post-pandemic projects that enable enhanced resiliency while simultaneously strengthening the organization's ability to sustain its long-term missions and emerge as a stronger institution.

Build for the Future

Rewire the Organization for Post-Pandemic Future

Health system strategy post-COVID-19 will seem familiar: Build a diversified and distributed health system. Achieve regional scale. Optimize commercial insurance and manage network leakage. Keep costs down and throughput high. Connect with your patients and engage deeply with the community. Transition from bricks and mortar to digital and leverage the power of analytics. So what will be different? For one, the execution risk just got substantially greater. Patient concerns about hospital care may linger, requiring institutions to rethink their "hub and spoke" distributed care models. Hospital acquisition just became riskier than digital, home and ambulatory expansion. Dilutive acquisitions that consume capital will be less viable. Consumer unwillingness to travel may render national Centers of Excellence strategies less relevant. The benefits of "system-ness" will seem greater. Diversification of revenues will take on increasing value, from capture of the premium dollar to enhanced commercialization and venture activity. Clinician and staff morale emerging from the crisis may be low, and significant attention must be paid to optimizing their experience. Heightened understanding of the interrelationship between health equity and social justice will necessitate a more activist agenda on the part of boards and health system leadership, underpinned by excellent analytics and research on disparities. Combined with weakened finances resulting from the crisis, the complexity of managing these issues will put a very significant premium on successful execution and excellent teamwork. Creating a new agenda that inspires positive energy will be imperative. Leaders should rewire their organization to emphasize essential competencies and formalize a management agenda for emergence that accelerates system development while concurrently maintaining organizational gains realized during the crisis.

Critical Issues

- Organizational silos inhibit effective response. Academic health systems benefit from clinical enterprise alignment and integration.
- Partnership is more powerful than parochialism. The health equity issues that surfaced during COVID-19 require active partnership with trusted community leaders and institutions.[9]
- Culture trumps strategy. Never has this maxim been truer than during the current crisis and looking toward the future. The hallmarks of the best institutional responses during the crisis have been strong and ethical leadership, effective teamwork with competence at every level, caring for every person in the organization, and decisive and wise use of scarce resources.

Priority Questions

- How has our organization performed during the crisis? What have we learned about our system and our community during the crisis? Which parts of our system were resilient and which were not? How do these lessons inform our future organization development?
- What steps are we taking to define in a new way our relationship with the communities we serve? Are we taking responsibility as an important leader in strengthening the neighborhoods most immediately surrounding us by supporting food security efforts, availability of housing, employment opportunities, and education and training programs?
- Where are there silos that we need to breakdown so as to optimize our ability to fully recover and thrive in the "new normal"?
- How well did we perform on health equity issues? Did we serve our diverse populations well? Provide interpretative services when needed?
- Are we well organized into teams aligned with pivotal elements of our organization so we can emerge with greater strength post-COVID-19?
- Have we successfully managed the cultural transition to a highly digital system, or will we rapidly revert once the emergency fades?

Recommendation: Evaluate the performance of your organization during the crisis and make changes to strengthen the ability to successfully execute as the emergency fades.

[1] See the articulation of this point of view in "How Academic Health Systems Can Move Forward Once COVID-19 Wanes"; Steven D. Shapiro, MD; Paul B. Rothman, *JAMA*. Published online May 20, 2020. https://jamanetwork.com/journals/jama/fullarticle/2766527.

[2] https://www.economist.com/briefing/2020/04/30/the-90-economy-that-lockdowns-will-leave-behind.

[3] See, for instance, https://www.apsf.org/novel-coronavirus-covid-19-resource-center/preoperative-covid-testing-examples-from-around-the-u-s/#stanford.

[4] "Coronavirus: Stanford Health Care hospitals resume almost all procedures after widespread employee testing," *The Mercury News*, May 4, 2020. https://www.mercurynews.com/2020/05/04/coronavirus-stanford-health-care-hospitals-resume-almost-all-procedures-after-widespread-employee-testing/.

[5] 10X Genomics and One Medical announced the two organizations are partnering to pioneer a path toward the safe return to work by deploying a comprehensive approach to COVID-19 testing, digital employee symptom screening, and seamless access to remote and in-person care. https://www.sfchronicle.com/bayarea/article/Bay-Area-companies-grapple-with-challenges-of-15307153.php.

[6] https://www.united.com/ual/en/us/fly/travel/united-cleanplus.html.

[7] "Wealthiest Hospitals Got Billions in Bailout for Struggling Health Providers – Twenty large chains received more than $5 billion in federal grants even while sitting on more than $100 billion in cash," *New York Times*, May 25, 2020. https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html.

[8] "Could coronavirus derail the decades-long shift to value-based care?" Healthcare Dive, April 15, 2020. https://www.healthcaredive.com/news/could-coronavirus-derail-the-decades-long-shift-to-value-based-care/575938/; "The Risk of Remaining in the Medicare Shared Savings Program During the COVID-19 Pandemic," R. Mechanic, Health Affairs Blog, May 30, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200528.214278/full/.

[9] "Why is my community suffering more from COVID-19?"; M. Fair, MD, MPH, Senior Director, Health Equity Partnerships and Programs, AAMC, May 20, 2020. https://www.aamc.org/news-insights/why-my-community-suffering-more-covid-19.

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