The Future of the Hospital

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We began writing this article about the future of acute-care hospitals one year ago. In developing our thesis, we interviewed dozens of hospital CEOs across the country. We analyzed emerging trends in care delivery and considered the need for inpatient services and capacity. We sought out examples of new, forward-thinking partnerships. Then the COVID-19 pandemic hit.

As months went by, we saw our nation's hospitals and front-line caregivers combat a devastating, unfamiliar virus. The lack of a coordinated federal response left states, municipalities, and hospitals to shoulder much of the work. The pandemic stressed the nation's healthcare delivery system to the tipping point. The effects of market fragmentation were visible as hospitals dealt with staff and supply shortages, facilities operating at capacity, and financial uncertainty.

Yet, the pandemic has served as a significant catalyst for change. The evolution of hospitals and health systems that was slowly but surely underway has been advanced by a decade. It has become clear that all but the most acute care is shifting out of the hospital setting. A combination of technological advances, government and commercial payer directives, improved delivery models, and patient preference will make this transition permanent.

Health systems are forging a path forward that focuses on population health and value-based care and no longer centers around acute-care facilities. Hospital leaders and boards of directors are becoming more inventive in their approach to planning for the future. Increasingly, this includes pursuing novel partnerships to access necessary resources and clinical acumen.

In this article, we will explore four types of partnership strategies hospitals and health systems are leveraging to succeed in the future post-pandemic environment:

- Large-scale consolidation
- Payers as providers
- Unique non-change-of-control affiliations
- Technological partnerships

These four trends came up time and again in interviews and will have a dramatic impact on the near-term future of acute-care hospitals.

Key Board Takeaways

- Hospitals may find themselves in different competitive environments as they emerge from the pandemic, with large competitors growing, payers succeeding in the provider arena, and new technologies gaining steam.
- Partnerships will continue to be a leading strategy for hospitals in 2021 and will take unique permutations in a post-COVID market.
- Board members and executives should evaluate a broad range of partnership opportunities to ensure their hospital's ability to succeed in the new healthcare paradigm and serve the needs of their communities.

Large-Scale Consolidation

The number of hospital and health system transactions has remained relatively flat year to year. The size of organizations engaged in transactions, however, has changed drastically. We are seeing larger health systems link-up with their even bigger peers to create expansive multistate networks. Several large, multistate transactions have been announced in the middle of the pandemic, including Sentara and Cone, and Lifespan and Care New England. Several other large-scale consolidations were announced in 2020 (e.g., Intermountain and Sanford, Advocate Aurora and Beaumont), but failed to close.

Transactions of this size will become the norm, not the exception. Even health systems with 10-figure revenues see growth as a necessity to optimize their clinical services, population health capabilities, health plan network, operational scale, and more.

In early 2019, two of the country's leading health systems, Dignity and Catholic Health Initiatives (CHI), joined together to form CommonSpirit Health, a system with more than 140 hospitals spanning 21 states.

"The focus was around creating a better, not bigger health system," said Peggy Sanborn, System Senior Vice President of Strategic Growth for CommonSpirit. "We take our size to enable a more efficient use of resources and a better way to scale innovation. That's where size has really had an impact."

The COVID-19 pandemic hit precisely one year after the formation of CommonSpirit and provided an all-too-real opportunity for the new system to stress test its capabilities.

"The amount of true innovation on delivery models, on self-sourcing for scarce resources like PPE, collaborating across the country, even to the point of being able to move workforce where we need it, has made a real difference," she said.

CommonSpirit is working to expand access to care and eliminate health disparities that have been exacerbated during the pandemic. The health system aims to "demonstrate that, even at scale, you can make [healthcare] very local and solve problems in local communities," Sanborn added.

In 2020, CommonSpirit expanded their partnership with Docent Health, a virtual care navigator platform. Through this partnership, more than 60 CommonSpirit care sites in 11 states have access to an AI-driven network that facilitates comprehensive care coordination, including referrals within the health system and to local community-based organizations. The platform allows CommonSpirit providers to engage the skills of local navigator partners to best serve the individual needs of their most vulnerable patients.[1]

System-level initiatives like this can reduce administrative burdens on individual hospitals, standardize best practices to improve patient outcomes, and generate improved financial returns that hospitals can reinvest locally.

Of course, this is not to say that all standalone hospitals and small health systems will join larger peers. Standalone community systems that can manage costs and deliver exceptional quality will continue to have success. However, the pressure on hospitals without network strength will continue to mount and their partnership options will decrease as

1 "CommonSpirit Health Closes Care Gaps with Personalized, Community-Based Care Navigation in Partnership with Docent Health" (press release), October 14, 2020.

mid- to large health systems focus on expansion opportunities that are meaningful to their ever-increasing scale. Expect more vertical and horizontal transactions between healthcare's biggest participants.

Blurring Lines Between Providers and Payers

The pandemic exposed several levels of disorganization within the country's healthcare delivery system, and no one was watching closer than commercial health insurers. Private insurers control $1.2 trillion of national healthcare spending and have many levers to pull to direct where those dollars are spent.

Payers have already become formidable providers of care. UnitedHealth is the largest employer of physicians in the U.S. and Anthem, Centene, Health Care Service Corp. (BCBS), and Humana all own large physician practices of their own. Payers can best manage cost by guiding members to owned providers, most commonly for primary care and ancillary services. As more care migrates from inpatient to outpatient settings, these payer-backed physician competitors will continue to take an ever-larger bite out of hospital revenues.

It is not just on the care delivery side that payers are finding opportunities. Unique examples of payer-provider collaborations have been materializing over the past year. In 2020, UnitedHealth's Optum formed a relationship with Boulder Community Health (BCH) in Boulder, CO to provide BCH with revenue cycle management, data analytics, and population health support. Optum inked a similar arrangement with John Muir Health in Walnut Creek, CA in 2019.

"Health systems are unique in the sense that we feel we have to do everything. We are in one of the most complexes industries out there. Less complex industries have already pared it down. This partnership takes some things and removes them from our plate so we can concentrate on our core competencies: patient care, the wellness of our community and providing high value," said Dr. Robert Vissers, President and CEO of BCH.

The two organizations have found shared culture and values as they formalized their relationship in the midst of the pandemic. In addition to the financial benefits they hope to achieve together, Dr. Vissers sees exceptional potential for the partnership to affect the health of those BCH and UnitedHealth serve.

Beyond traditional service line or health technology partnerships, some hospitals are creating integrated affiliation structures that stop just short of an acquisition or consolidation. Such partnerships can provide important clinical and operational benefits but, by design, are not intended to last into perpetuity. Boards should contemplate how an affiliation will unwind to ensure their organization is not left in the lurch at the end of its term or is forced into a giveaway because the two entities are inextricably entwined.

"Our scale diminishes our ability to translate our high quality and low cost into great affordability for patients." he said. "If we are more aligned with a payer we can use our value to provide better care to their members. This sets a platform for really interesting wins for the payer, for us on the provider end, and most importantly for our patients and community."

Payers' efforts to build care delivery systems will persist and the number of non-traditional relationships between payers and providers will grow post-pandemic. Providers will continue to seek similar affiliations in order to leverage payers' well-honed capabilities and counteract the diversion of traditional hospital revenue streams.

More Unique Affiliation Structures

Providers crossed geographic and competitive barriers to support one another during the pandemic. The extraordinary collaboration experienced in 2020 demonstrates the benefit of network breadth and depth. It also may lead to neighboring hospitals exploring new ways to work closely together, or even combine, to improve their efficiency in serving the same communities.

Not only did hospitals collaborate with their peers, but they also linked up with public and private institutions such as universities and leading employers in their regions to address pressing issues, including supply chain and data analytics. The relationships formed during this time could prove essential to community health systems in the future.

"The smaller systems that are successful into the future are going to have partnerships on some level. They are not going to be able to survive just on their own expertise, capital and technology," said Flo Spyrow, President and CEO of Northern Arizona Healthcare (NAH) in Flagstaff, AZ. That does not mean that smaller systems' only option is to join a larger organization. Instead, she recommends that providers take a broader perspective in "developing key partnerships in order to shore up their strengths and make them very competitive."

Beyond traditional service line or health technology partnerships, some hospitals are creating integrated affiliation structures that stop just short of an acquisition or consolidation. Increasingly, hospitals are seeking new relationship structures to preserve this collaboration, gain some benefits of scale, and mitigate the stress caused by the pandemic, while also maintaining local autonomy. Implicitly, another goal of many of these affiliations is to develop broader clinical networks to provide services and contract jointly.

While there are certainly significant benefits to be had by developing affiliation relationships, there is often a limit to their outcomes.

"The amount of benefit you can get from a light affiliation is light. The deeper you go in an affiliation model, the more benefit there is to all parties. It is scaled very geometrically," said Sanborn.

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Technology-Centered Partnerships

The pandemic drove many clinical services outside of acute-care hospitals. It is unlikely that all will return. Both commercial and government reimbursement models, which had been tilting away from hospital-based services, are getting even more sophisticated and are incenting patients to receive care outside of hospitals.

Inpatient care and surge capacity will remain high priorities, but hospitals are doubling-down on new ways to care for patients in the lowest acuity settings. A primary objective for most hospitals is to gain emerging technical competencies that will allow them to better serve their communities' health needs in outpatient facilities or virtually. These capabilities can be obtained through collaborations with other organizations or acquired outright.

NAH serves a sweeping rural area covering 50,000 square miles. The health system views telehealth capabilities as a critical component of its strategic plan. An early adopter of remote monitoring technology in 2012, NAH is exploring alliances with rural providers across its market to provide home visits for patients being monitored in more isolated areas.

"We are thinking about partnerships on a much broader basis than how we thought about them in the past. I think that's a really positive change for rural healthcare," said Spyrow.

The growth of NAH's remote monitoring program will serve as the bridge as the health system develops more robust "hospital-at-home" services. However, the growth of these services will have an impact on how NAH approaches the construction of a replacement facility for its flagship hospital.

"We are looking leaner from a hospital perspective. We believe that a lot of care that can be given outside will be driven outside, but we need high acuity, technology-equipped rooms. We need flexibility to move between med-surg to more high-level care. We need that flexibility to have double or triple the number of ICU beds at any point in time than we might have on the average," said Spyrow.

Technological evolution is imperative for hospitals as they strive to provide quality care for their patients at the right time and in the lowest acuity setting. It is also critical to meet consumers' rising expectations and remain competitive in their markets.

Unlike acute care with high barriers to entry, the migration of care outside of hospitals invites new competitors. Hospitals must be poised to leverage technological advances to meet consumers' preferences and expectations.

"We're going to have Walmart, Amazon, CVS, and others that are competing and going to be attempting to cherry pick certain patient populations or certain services," said Christian Lagier, Cofounder and Managing Director of TechSpring, a healthcare technology innovation center created by BayState Health, a system based in Springfield, MA. "That means consumerism is here to stay, and for us at BayState, it is an absolutely pivotal cornerstone of our go-forward strategy."

TechSpring employed horizon planning and multidisciplinary fusion teams of staff and outside experts to help BayState and other health systems that contract with them to ramp-up their technical capabilities when the COVID-19 pandemic hit. The digital resources hospitals stood up rapidly in response to the pandemic are now, in many cases, being viewed as permanent care delivery solutions.

"Right now, 70 percent of our primary care visits are virtual. Many people have had an experience of virtual care and use of technology. People have had that experience and that genie probably cannot go back in the bottle," said Lagier. However, he cautions, health systems must bring their patients along for the journey, ensuring that they can access digital tools and have a level of comfort in using them.

Hospital-at-home and other technological initiatives will gain steam as health systems develop the technology, staffing, reimbursement mechanisms, and critical patient mass in this arena. But savvy providers won't take this business for granted. Unlike acute care with high barriers to entry, the migration of care outside of hospitals invites new competitors. Hospitals must be poised to leverage technological advances to meet consumers' preferences and expectations.

Final Thoughts

Facing unprecedented pressures, hospitals and health systems have demonstrated, time and again, their critical role as cornerstones of the communities for whom they care. The strategies healthcare leaders implement in the coming years to uphold their mission to serve will be bolder and broader than in the past.

Reimbursement models, consumerism, the ongoing shift of care outside of acute facilities, and growing resource needs have been recent catalysts for change in hospitals. The experience of a global pandemic has only served to amplify these drivers and the collective understanding that a material evolution must occur in our nation's healthcare delivery system to ensure the health of all populations. The renewed need to develop coordinated networks of care will spur ongoing market consolidation through M&A and other progressive, yet looser, partnerships.

Most non-ownership exchange arrangements have one goal: to improve operating and clinical performance while retaining governance control (i.e., remaining independent). However, most transactions in which some level of ownership is transferred, whether through a joint venture or membership substitution, can bring about significant benefits. These include cost containment, access to capital, clinical expertise, and scale.

Sustainability versus varying degrees of autonomy will be the largest subject of discussion in boardrooms over the next decade, as directors re-center their organizations post-pandemic and assess strategies that leverage scale and collaboration to develop the systems of wellness and care of the future.

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