BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards

THE GOVERNANCE INSTITUTE ■ VOLUME 30, NUMBER 6 ■ DECEMBER 2019
GovernanceInstitute.com

THE GOVERNANCE INSTITUTE

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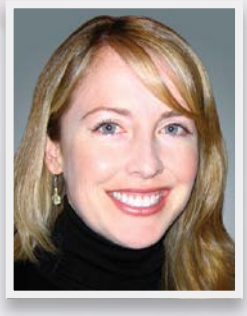

Reminiscing and Looking Forward

Looking back over the 20 years since IOM published *To Err Is Human,* the industry is lamenting our lack of progress in improving quality and patient safety. We have moved the needle, but not far enough. We still need to improve the measures we use and how we track them. We need to narrow down the measures to those that are truly meaningful and show us how we are really doing. We need to remove technological constraints that get in the way of measuring properly. Payers need to collaborate on metric reporting requirements so that providers aren't scrambling to report different numbers to different people for no good reason.

Our challenges as board members continue and will do so well into the future. For this last issue of the year we gathered articles that demonstrate the ongoing transformation of healthcare delivery, while also emphasizing the board's and senior leadership's important, difficult, yet exciting role in shaping this transformation. We do have solutions at hand, though they may be for the long term and not quick fixes. We must not be short-sighted when seeking to take action. We must look forward but act now to build responsible systems for the long term.

Kathryn C. Peisert, *Managing Editor*

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Transforming Care for Our Medicaid Patients

By Rhonda M. Medows, M.D., Providence St. Joseph Health and Ayin Health Solutions

There are more than 72 million people—or one in five Americans—who are enrolled in Medicaid. But they are far more than just a statistic. Each one of these 72 million (and growing) is a person with a story:[1]

- Theo grew up in an economically disadvantaged neighborhood in San Francisco, with high rates of asthma and infant mortality, gun violence, and industrial pollution. Growing up, he and his family were fortunate to have their basic health needs met through Medicaid, and today he is a college graduate and successful businessperson. "Our health outcomes shouldn't be determined by our ZIP code," he says.
- Chauntal was driving near her home in California when a semi-truck slammed into her car. She lost her left hand on impact. She recently had aged out of coverage on her parents' insurance and was faced with huge medical bills. Medicaid helped her begin the difficult journey of getting her life back.
- Margot is in her mid-70s and lives in Washington state. She has several chronic conditions and is able to live in a skilled nursing facility only because of Medicaid. She loves to help her fellow residents—reading to them, stopping by for a visit, and making sure their needs are met.
- Becky, 35, lives in Alaska and is the mom of Sawyer, five, who has developmental delays and autism. Becky and her family have private insurance but depend on Medicaid to supplement the cost of Sawyer's many ongoing therapies.

These and many other stories compel us at Providence St. Joseph Health (PSJH) to forge new paths to better manage care and services for this vulnerable population. As a Catholic ministry, we believe that health is a human right and that healthcare access and coverage is the path to each person's healthiest life.

How We Are Transforming Medicaid

In 2016, Providence St. Joseph Health embarked on a bold journey to improve the way we care for our Medicaid populations. Our guiding star became "Everyone deserves a healthy chance"—whole-person care using the right care, in the right setting, and addressing the social determinants of health.

Our key goals in this critical work are to:

1. Improve quality and patient experience
2. Reduce healthcare costs
3. Improve health outcomes
4. Create healthier communities
5. Ensure financial sustainability

We adopted a population health approach to Medicaid to ensure that our strategy is informed by data and our interventions are effective. We examine which interventions improve health outcomes, are sustainable, and make adjustments as needed.

Addressing social determinant factors and strengthening community partnerships is an important, but often overlooked, component of improving health outcomes.

Working across a Broad Spectrum to Achieve a Single Goal

We defined six focus areas for successfully managing care for our Medicaid-covered population, in partnership with providers, payers, community resources, and innovators:

1. **Access**: To better manage costs and sustain programs, patients must have access to care in the appropriate venue, including ambulatory sites, home health services, and digital health solutions.
2. **Care management and coordination**: Managing care for complex populations requires a comprehensive, enterprise-wide system that coordinates care among clinical teams, home health, and mental health providers, and provides connections to community-based services.
3. **Hospital and transitional care**: This patient population often has chronic illnesses that are progressive and that require wraparound services. This means involving care managers, skilled nursing facilities, and rehabilitation programs.
4. **Recognizing special populations**: There are many subsets of the Medicaid-covered population, and we must focus on their specific needs. This includes mental healthcare and services for expectant mothers and their children.
5. **Strategy and evaluation**: Medicaid-covered regulations vary by state and often are subject to change. This requires a Medicaid strategy that must be regularly evaluated and shared.
6. **Policy and advocacy**: We are a voice for our patients, and health systems must work with their states' Medicaid agencies to help shape policy and funding. When available, we seek to actively transform care by participating in select Medicaid waivers in every state where PSJH has a presence.

Ensuring Financial Sustainability Is Key

It's important that the work we do to serve Medicaid patients is financially sustainable. We've made significant operational improvements, including providing on-site Medicaid enrollment, validating patient eligibility for Medicaid prior to and at the time of service,

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Key Board Takeaways

- Keep the people you serve at the forefront of your business and fiduciary decisions. Know and share their stories when possible.
- Regularly evaluate the organization's Medicaid strategy. Medicaid is a lifeline and a safety net; how you serve this large population always can be improved.
- Understand and contribute to the organization's strategy for integrating social determinants of health into clinical planning for Medicaid-covered populations.
- Support and participate in community partnerships that help address basic human needs.
- Be informed about Medicaid regulations in the states served by your organization. Invite the government affairs team to discuss challenges and opportunities, including waivers and innovations.
- Tell the government affairs team about your area(s) of expertise that tie to Medicaid and/or population health. The team will reach out to you when there are opportunities for you to become involved and can coach you on advocacy with officials.

1 Each of these stories can be found at http://bit.ly/33moKIc.

Financial Oversight: Three Assumptions That Boards Should Reevaluate

By Joseph J. Fifer, FHFMA, CPA, Healthcare Financial Management Association

Assumptions are an integral part of business, widely used in areas ranging from accounting to project management to strategic planning. Yet, assumptions have negative connotations, perhaps because people can be quick to make them and slow to change them. In business (unlike, say, physics), assumptions are based on data that is continually changing, which means they should be reevaluated frequently. As board members know all too well, the healthcare environment is very dynamic. Are the assumptions that underlie governance decisions keeping up with the pace of change? Here are three common assumptions that are ripe for reevaluation.

Assumption #1: The Chargemaster System Isn't Perfect But It's Here to Stay

The chargemaster has served as the hospital price list since the early 1950s, when indemnity insurance became commonplace. Nearly 70 years later, the health insurance industry and consumers' financial responsibilities for healthcare have undergone tectonic shifts but the chargemaster remains firmly entrenched. When the subject of chargemaster reform comes up, healthcare leaders often dismiss it by saying that charges don't matter because very few people actually pay chargemaster prices. Thanks to the prevalence of charity care and discounted prices, that is largely true.

But charges *do* matter. Dismissing consumers' concerns about charges undermines trust in hospitals and health systems, which has been edging downward for years. Despite all the attention to patient experience, the *financial* experience is often glossed over. The reality is that large, seemingly indefensible differences between charges and actual prices, coupled with consumers' uncertainty about their financial responsibility in the typical purchase situation, breeds mistrust that can negate positive perceptions of a patient care experience.

This will be a big ship to turn. Charges are hardwired into the payment system. Among other linkages, many contracts between hospitals and health plans are structured based on discounts tied to charges and have been that way for decades. As a result, charges are intertwined with hospital revenue streams in ways that will take time, perseverance, and innovative thinking to unwind. As the drumbeat of negative media coverage of hospital charges grows louder, management by (public relations) crisis becomes less tenable.

Board members should realize that the chargemaster system was not built for today's environment and be open to proposals for change.

Assumption #2: With Regard to Price Transparency, Compliance with Regulations Is Enough

Consumers can easily find prices for virtually anything online. They can find chargemaster prices online too, in accordance with regulations from the Centers for Medicare & Medicaid Services. However, these byzantine lists are not helping consumers. Finding a specific price in a chargemaster list is like finding a listing in a phone book written in another language. Even if the consumer finds the right listing, it will not reflect the discounts applicable to their health plan and contract or their cost-sharing provisions. Posting chargemaster lists simply compounds perceptions that hospital prices are difficult, if not impossible, to understand.

It's not surprising that healthcare providers have not been as responsive to consumer concerns about price transparency as other industries have. It just hasn't been a priority for providers. While many—if not most—health systems have C-suite executives overseeing a team effort to monitor and improve patient satisfaction and engagement, anecdotal evidence suggests that few of those executives have revenue cycle issues on their radar. Additionally, the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey doesn't address the patient financial experience. Doubts about consumers' propensity to use price information for shopping purposes have also made it easy to put price transparency on the back burner.

Key Board Takeaways

The assumptions that underlie governance decisions should be reevaluated periodically, especially as the pace of change continues to accelerate. The time is right to question three assumptions related to financial oversight:

- The chargemaster system is here to stay. Developed in an era when consumers paid few of their own medical expenses, chargemasters are not as permanent a fixture as they may seem.
- Compliance with price transparency regulations will meet consumer needs for price information. Regulations, such as the requirement to post charges, don't necessarily serve consumers well. To be consumer-centric, hospitals must go beyond compliance.
- Cost accounting deals with technicalities. Actually, without close alignment between cost accounting capabilities and the organization's strategic needs, the financial viability of the entire organization may be at risk.

Here is the bottom line: Consumers want to know their out-of-pocket prices. Board members can facilitate that by ensuring that efforts to improve patient satisfaction and patient experience include the patient's financial experience.

Assumption #3: Cost Accounting Is Primarily a Technical Accounting Specialty

Board members need to understand accounting well enough to read and comprehend financial statements. But there is much more to accounting and it has significant implications for governance. For example, cost accounting is an area that is vitally important in today's environment. The actual cost of providing patient care is still hard for many organizations to figure out. Without a handle on cost, how can hospitals develop rational pricing or defensible prices? How can they ensure ongoing financial viability at the enterprise level?

Many hospitals and health systems still rely on traditional cost accounting methods, such as ratio of cost to charges (RCC). RCC is the equivalent of using a blunt force object when precision is required. As a CFO can explain in detail, RCC doesn't capture enough

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The Neighborhood Community Hospital: A Diminishing Societal Fixture

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

Almost every community in the United States has at least one general hospital. Since the early 20th century, hospitals have been at the epicenter of the healthcare universe. Communities without a hospital are typically considered underserved and the importance of such facilities to local populations can be seen in the designation of many sole provider institutions as critical access hospitals. According to the American Hospital Association (AHA), there were 5,260 active community hospitals in the country in 2017.[1] While community hospitals may appear ubiquitous, their number has declined by more than 12 percent since 1975. The decline in hospital beds has been even more dramatic. The AHA reported more than 1.4 million hospital beds in 1975 and about 799,000 staffed beds in community hospitals in 2017, a decrease of more than 40 percent. As this article will highlight, the sustainability of community hospitals in the decades ahead is on an even more tenuous track than in the recent past. Drivers for the demise of community hospitals have historically been financial, but equally important going forward will be a dramatic diminution in the utility of the traditional four-walled inpatient facility.

One of the most important responsibilities of a hospital board is strategic planning. Any comprehensive planning effort should include examination of the competitive environment as it exists currently, in the near future, and in the more extended future. In a recent presentation at a Governance Institute Leadership Conference, Governance Institute advisor Mark Grube from Kaufman Hall described this as "now, near, and far" planning. Many community hospitals are overwhelmed by the challenges of today and struggle just to plan for changes in healthcare expected in the next three to five years. Nevertheless, as stewards of assets critical to the well-being of their communities and with institutional commitments to meet the broad health needs of their local populations, community hospital boards should also have a careful eye on the long-term horizon. As the famous hockey player Wayne Gretzky was reportedly taught, "Skate to where the puck is going, not where it has been." There is accumulating evidence that the long-term outlook for the neighborhood community hospital is a future in which most such hospitals will not be needed. If this outcome is probable, then it is not too soon for hospital boards to start preparing to meet their community health needs without the use of an acute care physical facility for overnight patient stays.

This special section describes the drivers behind declining inpatient hospital beds, strategic issues for boards to consider, and opportunities for transforming the care delivery model to shift care to where patients need it most. (For purposes of the discussion that follows, a community hospital means a secondary or limited tertiary care facility that provides inpatient services but does not typically have the full range of medical and surgical specialties. These hospitals may occasionally receive referrals from smaller facilities but are more often a source of referrals to large regional tertiary care institutions or quaternary care hospitals. These are neighborhood hospitals that may range from several dozen to several hundred beds and typically serve a well-defined community rather than a broad region.)

Drivers of Change

If many more communities will not have a local hospital in the future,

Key Board Takeaways

It is unlikely that all community hospitals, especially those facing declining hospitalization rates and high fixed costs, can be sustained into the mid-term future despite the best efforts of dedicated boards and administrators. There are many factors undermining the sustainability of the traditional community hospital, including a worsening financial climate, a growing physician shortage, patient demand for care delivered at home, disruptive technologies, consolidation through mergers and acquisitions, and the entry of aggressive new players in the healthcare arena. Today's community hospital boards should:

- Plan now for a possible future in which they oversee health services that do not include an acute inpatient hospital facility. In doing so, they should strive to achieve a "soft landing" for communities that will be impacted by the loss of inpatient beds. They should also work to preserve community board oversight of the new health services that will proliferate in the absence of a local hospital.
- Dedicate time at board strategic planning retreats to exploring worst-case scenarios that involve closure of their acute care inpatient hospital.
- Spend significant time (inside and outside of board meetings) learning about disruptive new technologies that will transform healthcare. In particular, attention should be paid to telemedicine and mobile health advances that will facilitate the shift of care away from the inpatient hospital.
- In the face of a worsening physician shortage, engage with physician executives and medical staff leaders to understand how to strengthen practitioner recruitment and retention. It will be difficult to maintain a community hospital without key specialties to support it.
- Anticipate the impact of an abrupt change to value-based reimbursement in the next few years. This will typically entail giving much more serious attention to how medical and health services will be delivered outside the walls of the hospital and helping pave the way for sustained services even if the hospital ultimately requires closure.
- Reflect on the possibility that they may one day oversee a panoply of healthcare services that do not include an inpatient acute care hospital. If community boards don't take on this task, then local healthcare is likely to be driven by distant actors, including for-profit, investor-driven entities that may give little attention to unique local needs and characteristics.

1 This number includes all non-federal, short-term general, and other special hospitals. The number of non-government not-for-profit community hospitals was 2,968.

what are the drivers of this change? Multiple factors are contributing to the demise of the community hospital. These include financial pressures to reduce overall healthcare spending, the consolidation of hospitals into ever-larger health systems, the growing shortage of healthcare practitioners, the advent of new or greatly improved digital technologies, changing patient expectations for access to care, and the entry of new players into the healthcare services sector. Let's unpack these drivers one by one.

Financial Drivers

Community hospitals across the United States continue to struggle financially. The high fixed cost of keeping a hospital open is increasingly at odds with the broader value-improvement mandate that's becoming central to U.S. healthcare policy. Moody's 2019 Outlook shows revenue growth for hospitals will continue to decline under pressure from weak inpatient volume and low reimbursement payments. As healthcare costs breach 20 percent of GDP, there is little reason to believe these financial pressures will abate. Closures have been greatest for small rural hospitals, with nearly a hundred shutting their doors since 2010.[2] According to the consulting firm Navigant, more than a fifth of the nation's rural hospitals are near insolvency.[3] National Public Radio recently reported that more than 700 hospitals are at risk of closure across the country as they become financially unsustainable. About 800 U.S. hospitals have closed since 1990 and the closure rate is increasing.[4]

Often, when a hospital closes, local physicians and other providers leave the immediate area, creating an acute shortage of medical services. Local employment usually suffers as well, contributing to poorer health status in the community. Unfortunately, the boards of these hospitals usually have not planned for the aftermath of a closure, have failed to consider other service models not based on a local hospital facility, and have not explored the range of outpatient services that could be maintained in the absence of a hospital.

Urban safety-net hospitals also face jeopardy. The recent closure of Hahnemann University Hospital, a large academic hospital in Philadelphia, is an example of the financial challenges such institutions face. While urban hospital closures rarely leave communities without an alternative nearby hospital, access can be a problem for poor, uninsured, and underinsured patients.

The rise of suburban surgical centers and mergers of healthcare providers has led to shorter hospital stays, fewer patients, lower insurance reimbursements (especially for patients covered by Medicare and Medicaid), and a thinner bottom line for struggling urban non-profits.

> Moving care out of the hospital continues to be problematic under fee-for-service reimbursement. But the tenacious grip fee-for-service has maintained on reimbursement is continuing to slip.

In 2018, Bloomberg News reported that out of roughly 6,000 public and private hospitals nationwide, 8 percent are at risk of closing, "with another 10 percent considered weak." The Web site reported that shutdowns in both rural and urban communities are likely to continue for the foreseeable future, at a rate of 30 per year according to AHA.[5]

Moving care out of the hospital continues to be problematic under fee-for-service reimbursement. But the tenacious grip fee-for-service has maintained on reimbursement is continuing to slip. A group of major payers and providers, the Health Care Transformation Task Force, said its members had more than half their business tied to value-based arrangements in 2018 and are aiming to hit the 75 percent mark by the end of 2020. The steady migration to value-based reimbursement (e.g., global budgets, bundled payment or shared-savings deals, etc.) is moving more and more care into the outpatient setting. Recently, United Healthcare, a commercial insurer with nearly 50 million covered lives, ramped up its prior authorization policy intended to shift outpatient surgeries to lower-cost settings outside of the hospital. This is the latest in a series of efforts from insurers to direct patients to lower-cost settings removed from the hospital.

Increased virtual, outpatient, or home visits can mean decreased utilization of bricks-and-mortar facilities and a consequent loss of important revenue. As new reimbursement models continue to migrate away from fee-for-service, the financial rationale for an inpatient acute care hospital facility with high fixed costs will progressively erode.

Consolidation

Merger and acquisition activity in the hospital sector has been robust for many years. Historically, not-for-profit health systems were not acquisition-minded, but they have shown strong interest in expansion in recent times. In 2019, Rick Pollack, AHA President and CEO, issued a press release justifying this ongoing trend: "Mergers have become one of the critical means through which hospitals can provide their communities with high-quality, convenient, and cost-effective care. The benefits of mergers allow hospitals to create connected networks of care and keep the focus where it belongs: on improving care for the patient."[6] Hospitals' competitors are no longer one another, but rather new and deep-pocket players ranging from Walgreens and CVS/Aetna to Google, Apple, Amazon, and United Healthcare. According to consultant Ken Kaufman, mergers allow health systems to develop the scale to compete with new entities flooding the healthcare marketplace. "The normal response of any company in any industry in this situation would be

2 Ninety-seven (97) rural hospitals have closed since 2010 according to the University of North Carolina Cecil G. Sheps Center for Health Services Research.
3 David Mosley and Daniel DeBehnke, *Rural Hospital Sustainability: New Data Show Worsening Situation for Rural Hospitals, Residents*, Navigant, February 2019.
4 Caitlin Carroll, "Impeding Access or Promoting Efficiency? Effects of Rural Hospital Closure on the Cost and Quality of Care," NBER Working Paper, National Bureau of Economic Research, March 19, 2019.
5 Cristin Flanagan, "U.S. Hospitals Shut at 30-a-Year Pace, With No End In Sight," Bloomberg News, August 21, 2018.
6 AHA, "New Research Confirms: Hospital Mergers Reduce Costs, Enhance Quality of Care for Patients" (press release), September 4, 2019.

to seek scale in an effort to meet this different level of competition and adjust to a new business model. That is exactly what is happening among hospitals stakeholders." Kaufman sums up the challenge as follows: "The competitors that hospitals face are not just large, but are also among the smartest organizations on the planet. These companies draw on a huge amount of data, apply sophisticated analytics, and have the capability to develop radically new tech-enabled care and digital connections. This is the state of play today. Scale is the platform that will allow hospitals to acquire the resources—such as more working and intellectual capital, and significant digital capability—to compete in this brand-new healthcare marketplace."[7]

While most hospitals join larger systems in hopes of maintaining their physical presence in the community, this expectation is increasingly unreasonable. In the years ahead, it is likely that multi-hospital health systems will be compelled to shed acute care hospital facilities and consolidate care in fewer, centrally located, highly sophisticated tertiary and quaternary care sites. This trend might be accelerated by some health systems' increasing use of micro-hospitals. These 20–30 bed facilities are much like critical access hospitals, but they rely heavily on virtual consultation and protocol-driven care. Remote monitoring and home virtual care are utilized to prevent patient returns to the facility. Historic community hospitals in many health systems will evolve into outpatient platforms or be demolished as they become expensive, outdated albatrosses encumbering health system flexibility and care delivery innovation.

Practitioner Shortage

Someone once said that a hospital without doctors is just a hotel with bad food. Yet it is becoming increasingly difficult for hospitals to recruit physicians to their medical staffs. It is hard to keep the hospital doors open without general surgeons, a primary care base that provides referrals, and medical specialists to utilize the technology currently aggregated within hospital walls. Yet even hospitals in the most desirous locations are finding it difficult to recruit personnel as baby boomers retire in large numbers. Current shortages of physicians are challenging the ability of the U.S. healthcare system to provide patients with timely, appropriate care. This is a problem that is going to get significantly worse.

The AMA Physician Masterfile shows that more than 40 percent of physicians in the U.S. are 55 years or older. Currently 46 percent of general surgeons are over the age of 55 and over 50 percent for orthopedic, thoracic, urologic, and plastic surgeons. Surgeons in rural areas tend to track even older. Some medical specialties likewise trend older with 73 percent of pulmonologists, 60 percent of psychiatrists, and 54 percent of non-invasive cardiologists 55 or older.[8] A recent report from the American Association of Medical Colleges (AAMC) projects that physician demand will grow faster than supply, leading to a projected total physician shortfall of between 46,900 and 121,900 physicians by 2032.[9]

As older physicians retire, their replacements largely shun private practice and seek employment opportunities. As competition for physicians continues to grow, community hospitals are finding it harder to generate the capital for physician employment and to sustain the financial "losses" from carrying large numbers of contracted practitioners. This has been one motivation for community hospitals to merge into larger entities with more resources that can be devoted to provider recruitment and retention. Hospitals aren't just competing with one another for scarce physicians. Many new players have entered the healthcare marketplace who are anxious to retain physician services. The largest employer of physicians today in the United States is Optum, a unit of United Healthcare. Private equity firms have been buying up physician practices in various specialties ranging from urology and orthopedics to emergency medicine and dermatology. Some large employers are hiring their own doctors to treat their workforces, as are retailers offering physician health services directly to the public (e.g., Walmart, Walgreens, and CVS/Aetna).

Younger doctors coming behind the retirees and who will have practices based wholly or partially in the hospital will be selective in where they locate. They will seek out hospital employment where they can utilize the latest technology, where they have enough colleagues to mitigate burdensome call schedules, where a critical mass of fellow specialists creates a professionally stimulating work environment, and where there is reasonable financial stability. These attributes will not characterize many community hospitals, which will have increasing challenges in terms of physician recruitment and retention.

Disruptive Technologies

In the coming years, there will be an increasing drive to provide healthcare at home. The technical ability to deliver hospital-level care at home exists today. However, an aggressive shift to hospital-level homecare has been limited by reimbursement issues and in

7 "Kenneth Kaufman: Why Hospitals Need Scale," AHA Insights and Analysis, December 18, 2018.
8 Merritt Hawkins, *Physician Supply Considerations: The Emerging Shortage of Medical Specialists*, 2017.
9 Association of American Medical Colleges, *2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, April 2019.

some areas by poor broadband Internet access. The slow migration away from fee-for-service has made transitions of care more difficult. Nevertheless, as the move to value-based reimbursement accelerates and telehealth technology improves, there will be a seismic shift in the locus of care.

This shift is already well under way aided by improvements in remote telemonitoring. Contessa Home Recovery Care is a company created to "…combine all the essential elements of inpatient care in the comfort of the patient's home." According to the company's Web site, "Contessa brings together evidence-based home recovery care models for acute care, post-acute care, and surgical procedures with administrative support…and our proprietary technology platform." The company offers a turnkey solution to provide at-home hospital services for hospital partners and payers. Among the investors in Contessa is BlueCross BlueShield Venture Partners. According to the company, its current partners also include Mount Sinai Health System (New York), Ascension's Saint Thomas Health (Tennessee), and Marshfield Clinic Health System (Wisconsin).

Marshfield Clinic Health System offers a home recovery care program that allows patients to receive care at home, rather than in the hospital, for conditions like congestive health failure, pneumonia, cellulitis, deep vein thrombosis, chronic obstructive pulmonary disease, and urinary tract infections. "Instead of the patient being cared for in the hospital, they're admitted to their home," says Marshfield's CEO, Susan Turney, M.D. "Healthcare nationally is amending patient care models to bring care closer to the patient and closer to the home. We see this as a great option for those people in our communities who can benefit from recovering in their homes." A Recovery Care Coordinator organizes and communicates care with the patient's doctor(s). Treatment is provided via telemedicine and home visits by a registered nurse who can take vitals, administer IV medications, and do physical assessments. A registered nurse is available to patients 24/7 as needed. Patients talk to their doctor(s) daily through use of a computer tablet provided by the Marshfield Clinic.

Another example is the Hospitalization at Home (HaH) program run by Mount Sinai. Most of the patients enrolled in this program first arrive in the hospital's emergency department and are screened to see if they meet the medical and social criteria for triage to the HaH program. Johns Hopkins' Hospital at Home program found that total costs of care were reduced by 19 percent and only 2.5 percent of 323 patients in a pilot study required transfer to the hospital from home.

Some health systems have created mobile units to facilitate hospital care outside its four walls. The University of Colorado Health has created a mobile stroke unit that is dispatched to patient homes. A specialized ambulance is equipped with a small CT scanner, point-of-care testing capabilities, and virtual care access to stroke specialists to provide remote diagnosis and prehospital administration of thrombolytic treatment. This is an example of tertiary care delivered in a non-hospital setting.

> As changes in technology and reimbursement accelerate the trend to treat patients with low-acuity conditions in alternative settings, fewer secondary and tertiary care hospitals will be needed to care for given populations. This is a radical shift from pulling patients into the hospital to sending care out.

Geisinger Health System has instituted a community paramedicine program it calls the "Mobile Health Team." It utilizes well-trained paramedics and EMTs to care for patients with congestive heart failure in their homes. They can assess patients and if necessary, administer IV diuretics and other patient-centered interventions.

Such programs allow the hospital to be reserved for patients needing the most expensive technology and intensive support while the less compromised patients are treated in alternative settings. As changes in technology and reimbursement accelerate this trend, fewer secondary and tertiary care hospitals will be needed to care for given populations. This is a radical shift from pulling patients into the hospital to sending care out.

In his book, *Deep Medicine,* cardiologist and futurist Eric Topol, M.D., expounds on the power of an ongoing revolution in deep learning and

Case Example: One Brooklyn Health System

One Brooklyn Health System (OBHS) brought together three local safety net hospitals—Brookdale University Hospital Medical Center, Interfaith Medical Center, and Kingsbrook Jewish Medical Center—to form a unified system to preserve and enhance access to healthcare services in Brooklyn. In 2016, the NYS Department of Health commissioned a feasibility study that proposed a roadmap to transform the health system, and in 2018 Governor Andrew Cuomo announced that OBHS would receive $664 million as part of the "Vital Brooklyn" initiative. The plan included developing a robust primary care network, partnering with community health centers, investing in a health information technology system, and carving out clinical niches for each of the three hospitals:

- Converting Kingsbrook Jewish Medical Center from an inpatient facility into a medical village with a mix of outpatient, emergency, and post-acute care services.
- Increasing Brookdale University Hospital Medical Center's inpatient capacity by 100 beds and undergoing renovations supporting its role as a regional trauma center.
- Updating Interfaith Medical Center's emergency department and developing a psychiatric emergency program to support the integration of behavioral health and primary care.

The OBHS mission is to provide greater access to high-quality medical care and keep its communities healthy through an integrated care system that respects the diversity of its communities and addresses both the health needs and the unique factors that shape them.

For more information, see *The Brooklyn Study: Reshaping the Future of Healthcare* (available at http://bit.ly/2Q2FoJj) or visit their Web site at https://obhs.org.

artificial intelligence to upend medical practice.[10] A huge inventory of new players, start-ups, and Fortune 500 companies is pouring into healthcare to take advantage of this revolution. New technology from wearable sensors to robotic caregivers will challenge the need to provide care in hospital settings. Hundreds of companies are currently focused on how to deliver healthcare services of varying complexity to where the patient is located (i.e., home) rather than transporting the patient to where healthcare technology has been historically aggregated (i.e., the hospital).

Many of these companies (e.g., CareSkore, HealthEC, VitreosHealth, and Lightbeam Health Solutions) use predictive analytics to support population health management. How can this impact hospitals? Currently about 60 percent of Americans die in the hospital, although 80 percent indicate a preference to die at home. A shortage of palliative care physicians means that less than half of the patients admitted to hospitals needing palliative care receive it.[11] Predicting when someone will actually die is critical to whether or not a patient can die at home. Numerous studies have shown that doctors have an extremely difficult time making such predictions. However, new algorithms driven by advances in neural networks and artificial intelligence are having remarkable success at such predictions. As companies pursue the goal of predicting the time of mortality, it becomes likely that many more people could die at home, further emptying hospital beds and reducing the need for a neighborhood inpatient facility. Artificial intelligence isn't just making huge strides at predicting mortality. It is achieving amazing accuracy at predicting length of stay, unexpected hospital readmission, kidney failure, bleeding complications after surgery, and more. The result will not only be better care, but less time in the hospital for patients.

> Today, remote monitoring, wearables, faster wireless communication devices, robust EHR platforms, virtual health visit capabilities, and eventually, prescriptive intelligence are making it less necessary for patients and physicians to always interact within the four walls of a hospital or clinic. Whereas such technology previously was reserved for the purpose of providing care in the most remote areas, an entire industry is increasingly leveraging the power of "mobile health" to connect patients with providers.
>
> —*Jennifer Wiler, M.D., Hir J. Harish, M.D., and Richard D. Zane, M.D., in "Do Hospitals Still Make Sense? The Case for Decentralization of Healthcare,"* NEJM Catalyst, *December 20, 2017*

Case Example: Carolinas HealthCare System Blue Ridge-Valdese

In 2013, Carolinas HealthCare System Blue Ridge (CHSBR) brought in a new CEO, Kathy Bailey, whose first task was to assess the system's business model and identify areas of weakness. One identified weakness was a decreasing need for inpatient beds, especially at the system's Valdese hospital. This hospital was only eight miles from its larger Morganton hospital, which was resulting in a direct duplication of services. With an average daily census hovering around 10, leaders knew they had to make a tough choice. Consultants who were working with the board and senior management at the time presented four different options for the Valdese location:

1. Keep as is
2. Create a specialty hospital
3. Reinvent the facility for outpatient care
4. Completely close

A task force was developed to consider each option and come up with a recommendation. Ultimately the board approved the task force's plan to turn the Valdese inpatient, acute-care hospital into an outpatient care site. Today, the facility has a full-service, 24-hour emergency department, outpatient surgery, and upgraded cancer treatment center, advanced diagnostic imaging, laboratory services, a wound healing center, and physician practices.

While the future of healthcare is hard to predict with all the changes in reimbursement and regulations, Bailey and the board believe this was absolutely the right decision for the system. "We knew this was going to be difficult. We knew it would be hard to get people to understand. But we knew for the survival and long-term viability of our system it was the right thing to do," Bailey said.

Patient Expectations

Easy access to care has always been a priority for patients. The fragmented nature of U.S. healthcare requires patients to run to multiple locations as they tend to various acute and chronic conditions. Precious time must be taken from work and home life to pursue such care, which is characterized by long wait times, scheduling frustrations, and transportation challenges. When patients are ill enough to require hospitalization, they are separated from caring family members and familiar and comforting surroundings. It is no wonder that the promise of healthcare delivered at home is so appealing. As Americans increasingly shop from home, bank from home, get their entertainment at home, telecommute from home, and "dine out" at home with quick restaurant deliveries, is it any wonder that so much attention is moving to healthcare at home. The 1990s and early 2000s saw many traditional hospital services move to outpatient diagnostic and surgicenters. The coming decades will see many more hospital and medical care services move into the home or into patients place of employment. Freestanding emergency rooms may become more ubiquitous, but will triage all but the most difficult and urgent

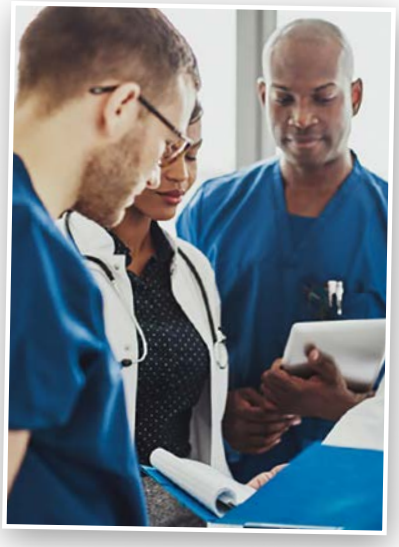
10 Eric Topol, *Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again*, New York: Basic Books, 2019.
11 Anand Avati et al., "Improving Palliative Care with Deep Learning," BMC Medical Informatics and Decision Making, December 12, 2018.; Jackie Snow, "A New Algorithm Identifies Candidates for Palliative Care by Predicting When Patients Will Die," *MIT Technology Review*, November 28, 2017.

problems to settings other than acute care hospitals. Where hospitalization is clearly indicated, patients will expect to go to centers with stellar reputations for quality and safety, a full spectrum of specialists, and the latest technology. Instead of thousands of acute care hospitals, perhaps 400–500 high-end, regional medical centers will provide this kind of care. Stays will be short as patients are quickly moved back into home settings where they can be monitored and cared for surrounded by family members.

New Players

It is not surprising that 21st-century entrepreneurs, investors, and innovators have not turned their attention to sustaining a 20th-century hospital model. While hospitals struggle to adapt to changing times, they may simply be the wrong infrastructure on which to build for the future. That seems to be the conclusion of corporations like Berkshire Hathaway, Amazon, and J.P. Morgan, which have formed a consortium known as "Haven" to change the healthcare paradigm. A quick survey of their executive team reveals no one with hospital management expertise. Haven leadership includes CEO Atul Gawande, a surgeon and writer on healthcare; Vice President of Clinical Strategy Sandhya Rao, known for his background in population health; COO Jack Stoddard, a seasoned health-tech executive; Chief Technology Officer Serkan Kutan, previously the CTO of ZocDoc, a doctor-booking app; Dana Gelb Safran, who will run analytics projects, from Blue Cross Blue Shield in Massachusetts; and David Smith, an executive hired from United Health's Optum unit. Gawande has described his new company as being an "ally" to doctors, insurance companies, and patients. Left out is any mention of hospitals.

Haven and many other large companies are moving to reduce healthcare costs for their employees through selective contracting with hospitals for needed services. These companies are looking for lower costs and clear evidence of high-quality care. Such contracting will accelerate the shift of care to larger, regional hospitals that have volumes that will support cost-effective delivery and superior outcomes. Employees of these companies will pass by their local community hospital to go directly to these "centers of excellence." Numerous new companies have formed to assist large employers (and also payers) in their selection of such centers, utilizing large databases of information, the latest in informatics, and predictive analytics.



Strategic Opportunities for Community Hospitals

Community hospitals are not standing still in today's challenging environment. Most have moved aggressively into the outpatient sphere—expanding ambulatory facilities, opening community-based office practices, investing in freestanding surgical centers, and more. This trend will and should continue. Furthermore, many hospitals have begun to explore population health initiatives and more far-seeing organizations have experimented with "hospital at home" models.

Many community hospitals are recipients of telemedicine services, but others have become providers of telehealth services. This is an important activity that brings content to patients rather than expecting patients to come to the hospital or its facilities.

A practice trend seen in some institutions with large numbers of employed doctors is movement toward practice co-location. Many community hospitals have employed physicians in geographically disparate office settings. This may be because they have maintained practices they acquired in their historic settings or because they seek multiple access points for patient convenience. However, co-locating specialists, primary care physicians, and ancillary services (e.g., lab, radiology, pharmacy, patient education, and counseling support) in a single location provides a powerful delivery platform for non-hospital-based care. Such offices provide one-stop shopping for patients, allow for greater care integration among physicians, and are more efficient and cost-effective than a string of traditional doctors' offices. Large group practices such as Kaiser and academic group practices (e.g., Penn Medicine of the University of Pennsylvania Health System) have long delivered care out of such facilities.

In other communities, hospitals have begun to explore repurposing of their bricks-and-mortar legacy facility. Converting inpatient beds to rehabilitation or skilled nursing units may provide a purpose and remuneration for acute care hospital floors with a negligible census. Today, many communities have far greater need of inpatient behavioral health beds than acute care medical and surgical beds. Sometimes hospitals have been able to identify partners with whom they can collaborate on such conversions.

Questions Worthy of Board Consideration

In today's challenging environment, it is natural for board members to feel like the little Dutch boy trying to save the day by putting his finger in the dike. All

their energy is going into plugging one leak after another. If their community hospital can take a step forward in its struggle to stay viable, it is easy not to notice that it has also taken two steps backward. The realities facing every hospital are different and some have more potential for sustainability than others. Nevertheless, board members must assess their situation with their eyes wide open.

Many boards will hope for the best and give sustainability a full-court press. Innovation, flexibility, determination, and luck may carry the day. They should nevertheless be doing some thinking about a worst-case scenario. The challenge for the board of a threatened community hospital is to recognize when their local institution has an untenable long-term future and is likely to require closure or conversion into some other type of facility. Board members should engage in some discussion with management regarding how this should be accomplished, including exploration and development of additional care platforms other than the traditional inpatient hospital.

Some boards are punting on this planning issue by merging into large health systems. This passes the challenge on to the system board. However, multi-hospital system boards have many communities to worry about and may not give adequate attention to a "soft landing" for neighborhoods where they must eventually close a hospital. Such mergers may delay the day of reckoning, but ultimately just pass the buck to different decision makers.

Board members will have to resist the desire of physicians and administrators to purchase the latest and greatest of every technological breakthrough that comes down the pike, piling money into a hospital facility that has a limited future. Keeping up with the Jones's in the hospital world may be the quickest way to a rapid demise.

How can board members stay abreast of rapid changes in healthcare that will impact their options for deploying hospital or health system resources? Management should regularly produce reading lists of important articles in the health press that describe some of the drivers enumerated in this special section that are impacting the future of their hospital. Board members can also educate themselves through attendance in conferences where they not only hear knowledgeable speakers, but also can network with colleagues who are likely facing similar challenges. Some portion of every board meeting might be devoted to discussing a particular trend impacting hospital survival.

Board strategic planning retreats should carve out time to consider the options for downsizing the hospital and creating alternative care platforms for the community. These may be "back pocket" plans that are only pulled out when necessary, but chance favors the prepared mind. In such planning sessions, board members may consider the use of a facilitator who can force them out of hospital groupthink and push them to consider life without their local hospital resource.

Communities have a lot riding on the future of their local hospital. It may be the largest employer in the area and a critical source of well-paying jobs. Alternative health facilities may only be available at considerable distance. Closure may see out-migration of medical professionals and leave a community with a dearth of medical resources. Yet all of these things can be mitigated with thoughtful planning and foresight. This will only occur if board members are willing to accept the real possibility that they may need to supervise a controlled shut down or conversion of the facility.

An important consideration is that boards of local not-for-profit hospitals have always had a fiduciary responsibility to look out for the best interests of their communities. Most of the new players aggressively entering the healthcare space and seeking to displace hospitals are private or investor-driven enterprises with no community roots and no public service mission. The demise of a local community hospital can leave the public exposed to services that are driven solely by a profit motive and determined by distant investors and management. To avoid this future, community hospital boards should work hard to ensure they become stewards of the new healthcare delivery models in their region, the purveyors of technology-driven changes in services, and the deployers of professional resources that will be needed by their neighbors in the decades ahead.

The healthcare landscape of the future will look very different than in years past. There will certainly be fewer hospitals and their departure will be part of an evolution that hopefully will bring greater cost-effectiveness, quality, and patient accessibility to healthcare. Community hospital boards can and should play an important role in shaping this future.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

The Board's Role in Diversity and Inclusion

By Deborah J. Bowen, FACHE, CAE, American College of Healthcare Executives

Awareness of diversity and inclusion in the healthcare field—particularly among the leadership ranks—is increasing. Recent research, however, underscores the fact that there is still more work to be done. For instance, the U.S. Bureau of Labor Statistics reports that while 75 percent of the hospital workforce are female, just under one-third of healthcare institutions are led by women, according to the American Hospital Association's 2017 Annual Survey and the American College of Healthcare Executive's member files.

In addition, a 2019 Korn Ferry survey of C-suite healthcare executives reveals that 55 percent of respondents believe women have been passed over for a promotion in their organizations.[1] Nearly two-thirds (64 percent) of respondents rank career development programs for women in their organizations as fair, poor, or nonexistent, and 76 percent say their organizations lack sponsorship programs to help women healthcare leaders advance. The experience of women in healthcare today highlights the need for continued efforts to promote more diversity and inclusion in the field.

Furthermore, McKinsey & Company has produced reports documenting the association between an organization's success and the prolific inclusion of diverse leaders in executive and governance roles.[2] One report drew from a data set of more than 1,000 organizations to conclude that "companies in the top-quartile for gender diversity on their executive teams were 21 percent more likely to have above-average profitability than companies in the fourth quartile. For ethnic/cultural diversity, top-quartile companies were 33 percent more likely to outperform on profitability." The study also noted that "companies with the most ethnically/culturally diverse [governing] boards worldwide are 43 percent more likely to experience higher profits."

Healthcare governing boards can play an important role in making sure diversity and inclusion are strategic priorities. Following are steps board members can take to help foster a more diverse and inclusive organization.

Knowledge Is Power

Include discussion about diversity and inclusion on board agendas. Discussing these issues at board meetings will help emphasize their significance and increase momentum with real initiatives that will effect change. A recent ACHE gender study highlights the importance of making this issue a priority. The study found that in order to remain competitive in today's healthcare field, organizations must attract top-performing women leaders. Boards can play an important role in ensuring the organization invests in the necessary tools and resources, and that it cultivates a culture that ensures *all* leaders can reach their fullest professional potential.

> Discussing diversity and inclusion at board meetings will help emphasize their significance and increase momentum with real initiatives that will effect change.

Boards can also encourage senior leadership to promote career development programs for women and diverse workers, such as mentorships. According to the ACHE gender study, nearly 85 percent of respondents cited mentoring as having been important to their career advancement. When leaders have access to such opportunities, the difference is seen in the positive effect on their careers and on the organizational culture as a whole. Mentoring in particular can help organizations build "bench strength," creating a path to the C-suite for future generations. Ensuring female-to-female mentorship opportunities or mentorships between members of other diverse groups is especially paramount.

Key Board Takeaways

Boards can play an important role in promoting diversity and inclusion in the healthcare field. Some examples of actions board members can take are:

- Include discussions about diversity and inclusion on board agendas.
- Encourage senior leadership to promote career development programs for all workers, such as mentoring.
- Request data from senior leadership about diversity and inclusion within the organization.
- Help ensure audits about hiring, assignment, development, and promotion programs are conducted.
- Ensure diversity on the board itself.

Invest

Just as they educate themselves about economic impacts on the field and the latest in innovative technologies that can strengthen the organizations they govern, directors can take the same approach with diversity and inclusion in the healthcare workforce.

To gain a better understanding of their organizations' demographics, board members should work with senior leadership to access this

1 April 2019 Korn Ferry survey of nearly 200 CEOs, CHROs, and other members of the C-suite at healthcare systems and hospitals across the United States.
2 Vivian Hunt et al., *Delivering through Diversity*, McKinsey & Company, January 2018.

information. They can also help ensure audits are conducted of hiring, assignment, development, and promotion programs to make sure all workers in the organization are treated equally and paid fairly. In addition, the board can request and use data to evaluate the extent to which the organization's leadership team reflects the community it serves, particularly in more ethnically diverse communities.

A recent McKinsey & Company survey highlights the consequences of not addressing diversity and inclusion.[3] The study found that while only 26 percent of white women in the healthcare industry hold C-suite-level positions, this number is even worse for women of color, who hold just 4 percent of C-suite-level positions. The study notes three emerging problems that result in fewer diverse women being represented in healthcare leadership: hiring and advancement practices, institutional barriers that allow underlying biases to persist, and a daily work environment that does not promote an inclusive and supportive experience for all employees. When organizations can better understand and address these challenges, they can more effectively promote diversity among their workforce.

Having access to organizational data about diversity will help the board and senior leadership determine appropriate courses of action to address inequity and promote diversity. It can also help boards ensure that CEOs and their leadership teams have the resources to recruit and retain diverse candidates. Boards can also help make sure important initiatives such as postgraduate fellowships, mentoring experiences, and professional development are properly funded, as these are often some of the first things to go when budgets are tightened.

Hold Leaders Accountable

Governing boards can help set the tone that diversity and inclusion are priorities, and can foster an organizational culture that reflects it. This starts by ensuring diverse men and women are equally represented on the board itself. Of course, factors such as expertise and skills should be the top consideration when recruiting new members to the board.

Boards also play an important role in making sure the CEO and other senior leaders are held accountable, via performance evaluation systems, for diversity and inclusion efforts and are setting the appropriate organizational tone related to these issues.

> Women and minorities still remain underrepresented in leadership positions, which is where more effort can be made to level the playing field.

Benefit for All

The issue of diversity and inclusion in the healthcare workforce continues to garner more attention, particularly with regard to gender inequity in the field. But women and minorities still remain underrepresented in leadership positions, which is where more effort can be made to level the playing field.

As with all key organizational initiatives, momentum begins at the top. When healthcare governing boards make addressing diversity and inclusion a priority, the entire organization, its staff and its patients—and the healthcare management field overall—benefit.

The Governance Institute thanks Deborah J. Bowen, FACHE, CAE, President and CEO of the American College of Healthcare Executives, for contributing this article. She can be reached at dbowen@ache.org.

3 *Women in the Workplace 2018*, Lean In and McKinsey.

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specific costing, reflect time studies, or appropriately handle indirect costs.

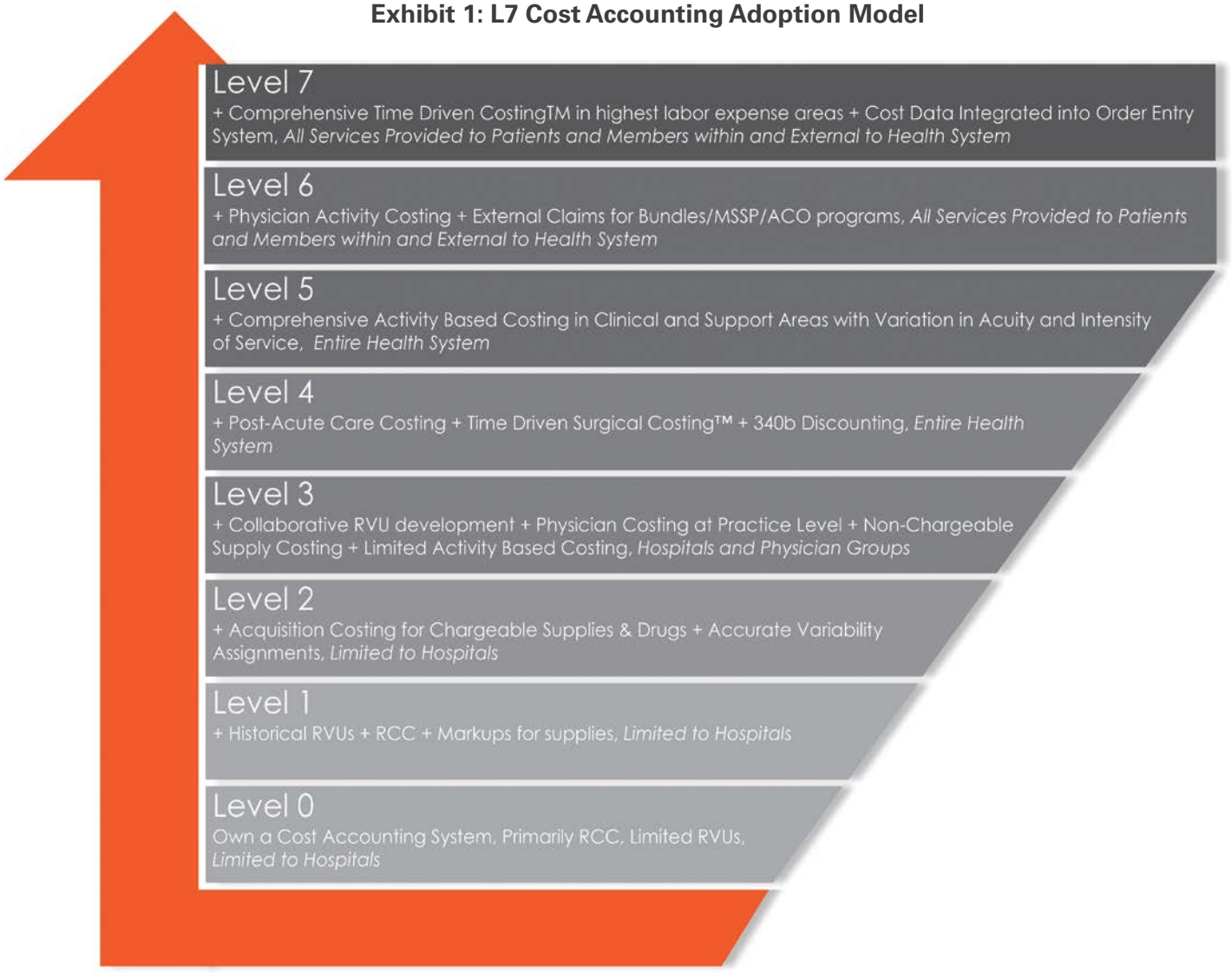
Although CFOs and other finance leaders understand the limitations of RCC, there is little guidance about cost model components or the scope of costing for those providers who are venturing beyond RCC to advanced cost accounting methods. Cost accounting needs vary, depending on where an organization is on its value journey. In other words, organizations that are managing population health will want to cost out all services provided to patients and members, both within and external to their organization. They have very different needs than organizations that are interested in costing only at the hospital level or costing for hospitals and physician groups.

The L7 Cost Accounting Adoption Model creates a roadmap for the actions required to ensure that a provider organization's cost accounting approach meets its strategic needs (see **Exhibit 1**). It's built on the premise that provider organizations are all over the map when it comes to both their ability to deliver care across the continuum and their willingness to assume risk for the total cost of care. The model can also be used to benchmark capabilities against peers. Finance leaders can use this model to improve their ability to manage the total cost of care and deliver more value to patients and other care purchasers. The tool can be a catalyst for a dialog between finance professionals and board members about the alignment between the organization's cost accounting capabilities and its strategic needs.

Assumptions can easily outlive their relevance in a dynamic environment like healthcare. Board members can add value by encouraging the group to pause and take a fresh look at the assumptions that serve as the foundation for governance decisions.

The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, President and CEO, Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org.

Exhibit 1: L7 Cost Accounting Adoption Model



Transforming Care…

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improving clinical documentation, and using value-added reimbursement structures. PSJH assisted over 45,000 uninsured patients apply for and receive Medicaid coverage during the past year. We've improved financial services and reimbursement recovery for Medicaid fee-for-service and managed Medicaid programs.

Recipe for Success Requires a Key Ingredient: Partnerships

Getting the best outcomes in Medicaid managed care is a big job that begs for more cooks in the kitchen. Even as a large, not-for-profit organization spanning seven states, we cannot attempt to solve this issue alone. Medicaid's success is everyone's collective success.

PSJH has been able to educate, learn from, and positively influence policy makers, our government leaders, industry experts, and recipients of care by engaging them in meaningful discussions. We have strengthened our community partnerships—in areas such as homelessness, food insecurity, and social isolation—so that, together, we can coordinate care for poor and vulnerable populations.

Turning the Corner on Medicaid

I'm pleased to say that our approach to transforming Medicaid is working. PSJH reduced the unpaid cost of Medicaid and other means-tested government programs from $1 billion in 2017 to $932.4 million in 2018, all while increasing access to care and services, exercising expert population health management, and providing high-quality care.

I would like to think that the American healthcare system is turning the corner on Medicaid. We know the public's understanding and appreciation of the many types of people served by Medicaid has grown.

We believe that health is a human right. How we improve the program and achieve better outcomes is the opportunity and challenge before us. We share a responsibility to know these populations, care for them, and ease their way to better health.

Providence St. Joseph Health also is part of the Medicaid Transformation Project, a national effort to transform healthcare and related social needs for the most vulnerable. Through this initiative, PSJH partners with 16 other health systems to identify, develop, and scale financially sustainable solutions that improve the health of underserved individuals and families in their communities. Find out more at http://bit.ly/2p1NJSo.

The Governance Institute thanks Rhonda M. Medows, M.D., President, Population Health Management at Providence St. Joseph Health and CEO of Ayin Health Solutions, for contributing this article. She can be reached at rhonda.medows@providence.org.

Tips to Transform the Rural Hospital…

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Telehealth care at UMMC includes primary care office visits via computer, tablet, or smartphone; remote patient monitoring; and, most notably, access to 35 kinds of specialty care statewide. The center is connected to over 200 locations across Mississippi, all but six of which are with organizations that are not part of the medical center. Some providers at the center offer only telehealth visits, while most provide a combination of virtual and in-person visits.[7]

Avera Health, in Sioux Falls, South Dakota, has grown eCARE, a suite of telemedicine services, over the last two decades to address some of the challenges of rural healthcare, eventually becoming its own separate revenue source for the health system.[8] Among these telemedicine services is Avera's eCARE ICU, which provides 24/7 ICU monitoring services for rural hospitals by connecting hospitals to intensivists. Avera describes this service as "basically air-traffic control for intensive care patients."[9]

Early telehealth attempts often were hindered by spotty or nonexistent reimbursement by payers. Now, in part due to advocacy from rural health organizations, Medicare is slowly evolving to reimburse for telehealth, including virtual check-ins between patients and clinicians by phone/electronically, remote evaluation of videos or images, standalone telephone consultations with rural health clinics or FQHCs, telehealth wellness visits with additional time for complex patients, and telehealth services as part of a basic benefit for Medicare Advantage plans or Shared Savings Programs.[10]

Conclusion

Transforming the business model of any organization is never easy. Given the challenges unique to rural health, these organizations must be ahead of the curve to keep their doors open. Boards play an essential role in identifying the risks of not changing and showing the courage to innovate and transform to continue their tradition of service to their communities, albeit using new models and approaches.

The Governance Institute thanks Marian C. Jennings, President, M. Jennings Consulting, Inc., and Governance Institute Advisor, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com.

7 The University of Mississippi Medical Center Web site: www.umc.edu.
8 Donna Farris "Forging Rural Health Care Links," Health Progress, January/February 2015.
9 Avera eCARE Web site: www.averaecare.org.
10 Sema Verma, "Putting our Rethinking Rural Health Strategy into Action," CMS blog, May 8, 2019.

Tips to Transform the Rural Hospital Business Model

By Marian C. Jennings, M.B.A., M. Jennings Consulting

From volume to value. From fee-for-service to global payment. From episodic care to population health management. These are just a few of the ways the healthcare industry is struggling to transform itself. Perhaps unfairly, rural and critical access hospitals (CAHs) are learning that they need to take giant steps to transform their business model merely to keep their doors open.

Over 60 million Americans live in rural communities.[1] Twenty-one (21) percent of 430 rural hospitals across 43 states are at high risk of closing.[2] While dire, many of these organizations have found ways to rethink how they do business. This article presents tips and takeaways for boards at rural hospitals and health systems to reorient and transform their organizations not only to survive but thrive.

Tip #1: Imagine a 2025 Landscape Very Different from Today

Governance that facilitates transformation anticipates an extremely different future. One way to begin thinking "transformationally" is to answer the question, "Considering trends already underway, if I were going to start from scratch, how would I build this?" If your mission is some variation of "to improve the health of our community," a hospital-centric healthcare model unlikely would be the most effective approach.

Study after study confirms that medical care is but a small factor or "determinant" of health status. There is general agreement that health behaviors (such as exercise, tobacco use, healthy eating, and alcohol and/or substance abuse) and environmental factors (such as adequate housing, access to affordable and nutritious food, and transportation) play greater roles in determining health than does traditional medical care. Because of this, forward-thinking healthcare organizations strive to address social determinants of health while recognizing that no organization can address all of society's ills. You should identify the role your organization can and should play for those issues most affecting your community. For each area, clearly articulate how you should respond: as an advocate? organizer/coordinator of community resources? provider of "seed money"? direct service provider?

Tip #2: Advocate for New Payment Models That Support Transformation

An article in *Modern Healthcare* relays a story about a Southeast Arizona community in which the only area hospital, a CAH, closed. Jim Dickson, the CEO of the nearest hospital, Copper Queen Community Hospital, proposed building a freestanding emergency department there with other essential services such as radiology, a lab, a clinic for visiting specialists, and a physical therapy office. However, Arizona's Medicaid program had lowered the basic fee for freestanding EDs (in response to activity in more urban markets), making his proposed ED financially non-viable.

Instead of giving up, Dickson successfully lobbied state Medicaid officials to make an exception for rural providers, which allowed him to open the freestanding ED staffed by just an emergency physician and nurse practitioner. The facility now sees as many as 1,100 patients a month. About the project, Dickson said, "If you focus a rural hospital on inpatients, you are dead in the water. If you focus on outpatient and primary care, you will be successful."[3]

While admirable, some forward-thinking ideas such as Dickson's are difficult to implement in a fee-for-service payment environment that rewards inpatient hospital care. However, some states such as Maryland already have moved to a global payment model, while Pennsylvania currently has a Medicare demonstration program to pay 30 rural hospitals under a monthly global budget so that members can "retarget their services."[4] Lauren Hughes, M.D., Deputy Secretary for Health Innovation at the Pennsylvania Health Department said, "With a more stable cash flow, rural hospitals can step back and say this service line we rolled out for volume is not aligned with what the community needs, and now we can shift to behavioral health and substance abuse treatment."

While inaugural participants in the program continue to provide inpatient care as they develop population health strategies and reduce costs, some participating hospitals are expected to move away from offering inpatient care altogether. Since the Pennsylvania project launched, 36 other states have expressed interest in launching similar global budgeting demonstrations.[5]

Tip #3: Leverage Telehealth

Telemedicine has come a long way since healthcare's first small-scale dalliances with emerging technologies. Now there is a National Centers of Excellence designation for Telehealth, currently with two centers in the U.S. One of these is the University of Mississippi Medical Center (UMMC), located in a state with the greatest physician shortage in the country and the highest rates of diabetes, low birth weight, and death from heart disease.[6]

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Key Board Takeaways

To help steer rural health providers toward transformation, board members can:

- Recognize the risks of not transforming/changing.
- Advocate at the local, state, and federal levels for rural healthcare, including payment changes that will reward transformation.
- Identify which social determinants of health are most critical in your community and articulate the organization's role in helping to address them (you cannot do everything!).
- "Keep an ear to the ground" for demonstration programs like Pennsylvania's that will allow the organization to try out new ideas with less risk.
- Be creative about technology and partnerships.
- Focus investment on the future, not the past, of the organization.

1 United States Census Bureau (available at www.census.gov).
2 David Mosley and Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents*, Navigant, February 2019.
3 Harris Meyer, "Reexamining Policy," *Modern Healthcare's* InDepth series, *Rethinking Rural Healthcare*, June 9, 2018.
4 Meyer, June 2018.
5 *Ibid.*
6 Rachel Arndt, "The Growth of Telehealth Improves Continuity of Care in Rural Communities," *Modern Healthcare,* June 9, 2018.