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SPECIAL SECTION

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ADVISORS' CORNER

Building an Outpatient Strategy for 2020 and Beyond

We Will Persevere

This time in history is revealing severe vulnerabilities of our global infrastructure. We want to take this opportunity to send out our deepest thanks and gratitude for the frontline care providers around the world who are putting themselves and their families at risk in order to care for critically ill patients. Patients who are people; people who make up the world's neighborhoods and communities; communities of humanity that connect across the world like pieces of a puzzle. We hope the silver lining in this will be our greater collective ability to trust each other and build relationships in new ways and for new reasons. That our love and understanding of humanity is stronger, and that we strengthen our ways of responding to crises and supporting those in need. We will strive to support healthcare leaders through this time and always, and we encourage all of our members to reach out to us to ask questions and share your stories and lessons learned.

Kathryn C. Peisert,
Managing Editor

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The Board and CEO Relationship: The First 120 Days

By Kimberly A. Russel, FACHE, Russel Advisors

Boards recognize that selection of a CEO is its most important duty. Most often, this is a lengthy process requiring an abundant amount of valuable director time. Upon appointing a CEO, it can be tempting for board members to congratulate themselves on a job well done and quickly return to the usual rhythm of board and committee meetings.

Kimberly A. Russel, FACHE
Chief Executive Officer
Russel Advisors

With annual healthcare CEO turnover consistently at 18 percent, unforeseen CEO turnover is a genuine risk for board consideration.[1] Media headlines offer many examples of unanticipated early CEO departures. Early exits from the CEO position are quite damaging to the organization, the board, and the involved CEO. Together, the board and newly appointed CEO have a shared interest in immediately solidifying this new relationship.

Early Demands and Priorities

The new CEO experiences an immediate crush of demands on his or her time. The CEO has many relationships to build within the organization and in the external community and region. Early communication with physicians and medical leadership is vital. The CEO is also devoting serious energy to the structure and selection of the senior executive team. Simultaneously, there can be pressing relocation logistics and family considerations.

Even for individuals who are promoted internally and/or do not face a geographic relocation, the constituencies of the CEO position are new and different—and as time-consuming as those experienced by external appointees. Developing board relationships can easily take a back seat to these other compelling time demands.

The breakdown of the board–CEO relationship is a major contributor to CEO turnover, so it is essential to establish an effective foundation. Developing the board and CEO interconnection should be the first priority for both the CEO and the board.

There is an expectation that the board chair will be in communication, early and often, with the CEO starting from the time of his or her acceptance of the position. There is often a time gap between CEO selection and the CEO's start date. The board chair and CEO-designee can use this interval to great advantage for a running start. The board chair should lead the board in its navigation of this new relationship while also serving as a trusted advisor to the CEO.

New CEO Onboarding Plan

The onboarding of a new CEO should be led by the board, or in some cases by the board's executive committee. This new and evolving relationship will be the bedrock for all future work undertaken by the board. The board and CEO will mutually benefit from a thoughtful plan of action, including timeframes, that results in the early establishment of a strong working relationship. The plan will establish a pathway for developing a relationship both inside and out of the boardroom, based upon mutual trust and collaboration.

Key Board Takeaways

- Understand that early exit is a legitimate risk of any CEO appointment; establishing an intentional plan will mitigate this risk.
- Commit to developing a written plan of action outlining each step of early board–CEO engagement.
- Recognize the CEO onboarding process requires serious time dedication for the board and new CEO.
- Acknowledge that an internally promoted CEO must undergo the same process.
- Focus time on clarifying mutual expectations.

Key elements of this plan of action include:

- One-on-one in-person meetings between each board member and the new CEO
- Establishment of mutual expectations, including key performance goals, for the CEO
- Determination of board–CEO communication channels
- Development of a financial authority limits policy
- Timeline and metrics for annual CEO performance evaluation
- Social and community strategy

The one-on-one meetings between each board member and the CEO are critical to build an effective working relationship based on trust. CEO selection processes typically include candidate interviews with small groups of directors and the full board. Other than the board chair and executive committee members, most directors have likely not had the opportunity for an individual meeting with the newly selected CEO. Preferably, these meetings should be held on the board member's own turf—home or office. Allocate up to two hours of time as these meetings are intended to be in-depth conversations. Suggested questions to discuss individually with each board member include:

- What are the organization's top current priorities today? In three to five years?
- What are the top three expectations of the CEO for year one?
- How can board meetings be improved?

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1 American College of Healthcare Executives, "Hospital CEO Turnover Rate 2018" (press release), May 30, 2019.

Measuring Differently to Create Well-Being in the Nation

By Somava Saha, M.D., M.S., Well-Being and Equity (WE) in the World and Well-Being in the Nation (WIN) Network

Ever wonder how we could:

- Be the wealthiest country in the world yet suffer from high rates of child poverty and epidemics of social isolation and deaths of despair?
- Have the "best" healthcare system in the world yet have such terrible health outcomes that our children and grandchildren today can expect to live shorter lives than we can?[1]

What does it mean to be a board member today in an industry (healthcare) that occupies one-sixth of the economy and drives half of bankruptcies in the country?

Since the journey from volume to value began 12 years ago, boards of healthcare organizations have been trying to figure out how to truly measure value. When we take a step back, it feels like we're missing the forest for the trees. The Triple Aim, with a combined focus on improved patient experience, population health, and cost has offered some direction, but many healthcare systems have replaced "clinical quality outcomes" with population health.

However, we know that access to care only drives 10–20 percent of health outcomes.[2] The reason for this is quite simple: a person might visit their doctor for one 15- to 30-minute visit a year—up to four times if they have a chronic illness. They will spend over 5,000 hours at home being healthy or not. We now know that 60 percent of health outcomes are driven by social, environmental, and behavioral determinants of health.[3] Some healthcare systems have begun in the last five years to address social needs. However, until recently, there has been no consistent way to measure these or to address them with partners in the community who hold resources for housing, transportation, etc.

To address this challenge, four years ago, the National Committee on Vital and Health Statistics (NCVHS) developed the framework[4] for the Well-Being in the Nation (WIN) measures to identify the domains that drive health outcomes (housing, transportation, economy, etc.). Supported by NCVHS, 100 Million Healthier Lives then worked with over 100 organizations and communities as well as patients and communities across sectors to identify measures that mattered. The recently released Well-Being in the Nation (WIN) measures offer our first community-level measures to assess population and community health, developed together between public health, healthcare, community, business, and other sectors.

What Are the Well-Being in the Nation (WIN) Measures?

The Well-Being in the Nation (WIN) Measurement Framework offers a set of common measures to assess and improve health, well-being, and equity.[5] These measures are divided into three sections:

1. **Core measures:** Nine core measures organized around the **well-being of people,** the **well-being of places,** and **equity**. These core measures include people-reported outcome measures and more traditional "objective measures."
2. **Leading indicators:** 54 indicators in 12 domains with great data availability based on what drives the well-being of people, the well-being of places, and equity (community vitality, health, housing, transportation, economy, etc.).
3. **Full flexible set** of promising measures such as social connection, sense of meaning and purpose, and perception of everyday discrimination—which offer some evidence of driving health outcomes.

Key Board Takeaways

- We as a country now have common measures for population health, social needs, and social determinants called the Well-Being in the Nation (WIN) measures, which are becoming a new standard.
- These measures, co-developed with over 100 organizations across sectors and communities, allow us to see the forest for the trees about what really matters for improving health and well-being.
- Key questions boards should ask their C-suites include:
  - » How are we measuring population health and equity?
  - » Is our system's measurement strategy aligned with the new Well-Being in the Nation (WIN) measures?

How Are People Using These Measures?

Since their release in June 2019, hundreds of organizations across sectors have begun to adopt the WIN measures, with major federal agencies aligning around them. They are getting integrated into Healthy People 2030 and have been adopted by groups as diverse as US News and World Report and Enterprise Housing Partners and many leading healthcare organizations. An interactive Web site with tools to support use and all available data down to the subcounty level is available at www.winmeasures.org.

continued on page 14

1 Well-Being in the Nation Network, "Well-Being in the Nation (WIN) Measures" (available at www.winmeasures.org).
2 J. Michael McGinnis and William H. Foege, "Actual Causes of Death in the United States," *Journal of the American Medical Association*, November 10, 1993.
3 Carlyn M. Hood et al., "County Health Rankings: Relationships between Determinant Factors and Health Outcomes," *American Journal of Preventive Medicine*, February 2016.
4 *NCVHS Measurement Framework for Community Health and Well-Being, V4,* National Committee on Vital and Health Statistics, 2017.
5 "Well-Being in the Nation (WIN) Measurement Framework: Measures for Improving Health, Well-Being, and Equity Across Sectors," Facilitated by 100 Million Healthier Lives with the National Committee on Vital and Health Statistics, 2019.

The New Healthcare Value Chain: Five Things Boards Need to Know

By Deirdre Baggot, Ph.D., and John Rudoy, Ph.D., Oliver Wyman Health and Life Sciences

The current healthcare value chain has been heading toward a sustainability crisis for years. Pieced together over generations, the unwieldy cluster of disparate processes, disjointed services, and duplicated efforts prioritizes convenience for providers over patients and is indifferent, at best, to cost. Now, we are in the midst of a wave of disruption, with a new generation of innovators setting their sights on healthcare's vulnerabilities and opportunities to gain a slice of the nation's $3.6 trillion annual healthcare expenditures.[1]

> "We have committed to a five-year transformation but only two of our 155 initiatives for 2020 have anything to do with our value transformation journey."
>
> *—Chief Strategy Officer, Western Regional Health System*

The convergence of the Centers for Medicare & Medicaid Services (CMS) transparency movement and technology advancements is creating vast opportunities for new market entrants. CMS has released more data on American healthcare consumption in the last three years than in the previous 30. Meanwhile, technological advancements are upending traditional approaches to patient care, and presenting new options for technology-enabled care that is much less about in-person office visits and more about convenient, virtual, and app-driven consumer experiences. New start-ups entering healthcare from other industries (think Google, Apple, and Amazon) are using their considerable expertise with both data and technology to shake up the healthcare value chain and demonstrate their commitment to delivering value and patient convenience in ways that traditional providers never have.

Hospitals and health systems remain as the hub of the healthcare industry, but if they settle for being bystanders, they will lose relevance and become commoditized as these new competitors transform healthcare delivery, upend traditional models of care and consumer relationships, and carve out their own essential roles.

This article highlights the top five issues boards need to understand about the new healthcare value chain.

Key Board Takeaways

- **Consumer expectations are changing.** Patients as consumers are expecting a fundamentally more convenient, friendlier experience. The traditional "the doctor will see you now" era in which patients dutifully wait in line and jump over obstacles to get care is at an end. Any strategy initiative undertaken by a provider needs to consider how the consumer experience can be streamlined and enhanced.
- **Moving to value is a necessity.** We are in a healthcare cost-sustainability crisis. If providers do not participate in solving it, they can expect catastrophe, drastic regulatory overhaul, or possibly both. The shift toward value has been slow until now, but providers can prepare while straddling the traditional and future worlds of reimbursement.
- **Providers need to expand their core competencies.** Data scientists, IT security experts, and scheduling engineers are job titles that do not typically come to mind when thinking through a health system organizational structure, but they are critical for the health system of the future. Along with significant infrastructure upgrades, individuals with these skills will be necessary to execute on key strategies over the next year and beyond.

1. The Traditional Role of Physicians Will Recede to Make Way for Convenience and Efficiency

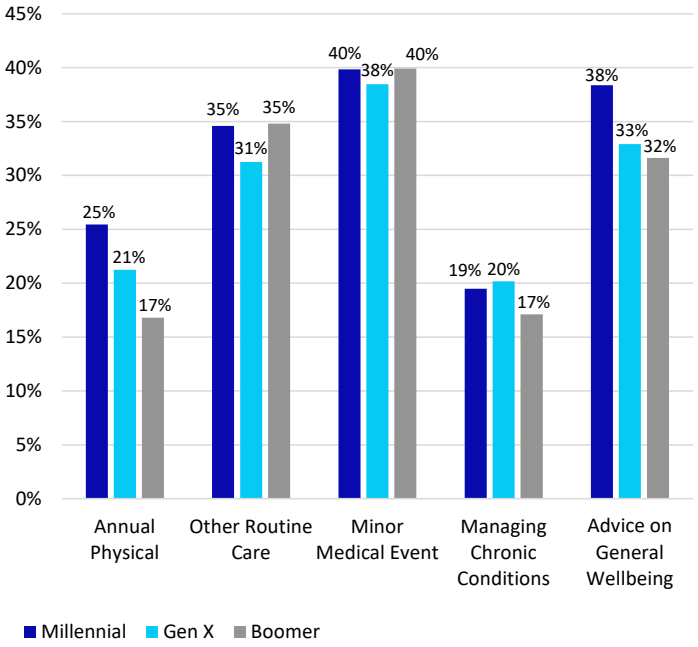
The traditional physician–patient relationship model has been a cherished constant in the U.S. healthcare system. New technology and changing demographics, however, are making that model less relevant. While baby boomer patients and physicians may continue to value face-to-face interaction, younger individuals are looking for a different approach. The loosening relationships between individuals and primary care doctors is already evident. A third of individuals aged 18 to 34 years do not have a primary care physician (31 percent) with another 7 percent unsure if they have a doctor or not. Of individuals aged 35 to 44 years, only three in four claim to have a doctor.[2]

This is not to say that younger generations are looking to forego care, but they do want something different—something more convenient. According to NRC Health's Market Insights national study of consumers, 17 percent of millennials have already had an e-visit with a doctor and 54 percent would be excited to do so in the future. Thirty-one percent have already used a clinic inside a retail setting or grocery story and half would be excited to receive treatment in such a setting in the future. According to Oliver Wyman's 2018 Consumer Survey of U.S. Healthcare, 25 percent of millennials would be willing to get an annual physical at a retail clinic or via telehealth.[3] Forty percent would

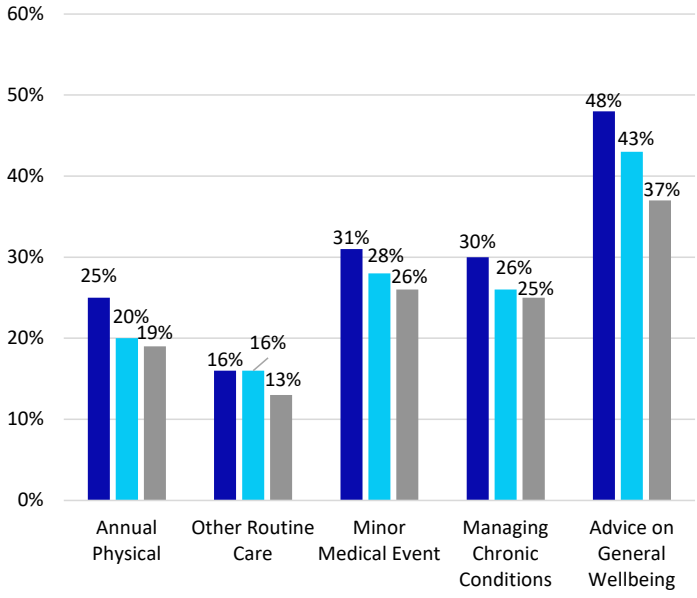
1 2019 National Health Expenditure Accounts, Centers for Medicare and Medicaid Services.
2 NRC Health's Market Insights consumer survey, 2019.
3 John Rudoy et al., *Waiting for Consumers*, The Oliver Wyman 2018 Consumer Survey of U.S. Healthcare.

Exhibit 1: Consumers Are Growing More Comfortable Getting Services—Especially Routine and Transactional Ones—through the New Front Door

Percentage of respondents who would consider getting each type of care through a retail clinic



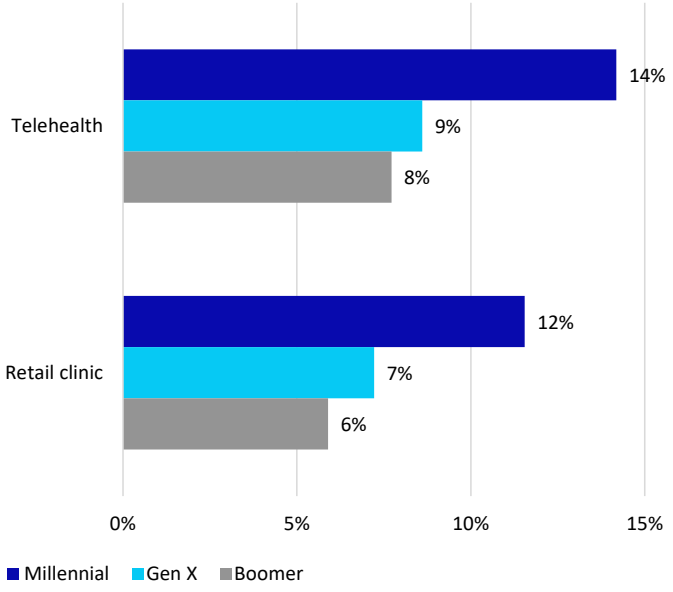
Percentage of respondents who would consider getting each type of care through telehealth



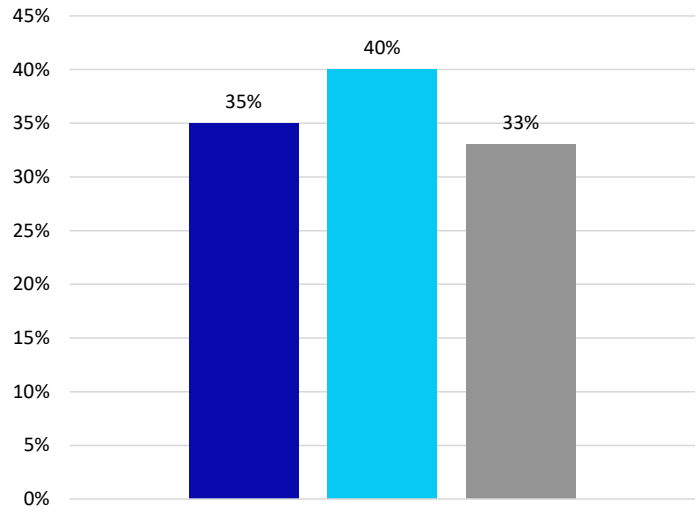
Source: 2018 Oliver Wyman Consumer Survey of U.S. Healthcare.

Exhibit 2: Uptake of New Care Settings Remains Slow, but Those Who Use New Settings Tend to Like Them

Percentage of respondents who reported receiving care in this setting over the past 12 months



Percentage of respondents who say the retail clinic experience was at least somewhat better than the standard doctor's office



~10% of each group reported the experience was somewhat worse

Source: 2018 Oliver Wyman Consumer Survey of U.S. Healthcare.

be comfortable receiving treatment for a minor medical event at a retail clinic, and 31 percent are willing to receive treatment through telehealth. Nearly half (48 percent) would be willing to get general guidance on health and well-being through telehealth (see **Exhibit 1**).

Although uptake remains relatively low (only 14 percent of millennials and 8 percent of boomers reported using telehealth in the past year) accelerated engagement is expected. Of those millennials who had used retail or telehealth, 35 percent liked it at least somewhat better than the traditional office experience, with fewer than 10 percent liking it less (see **Exhibit 2**).

For providers thinking that they can count on the boomers sticking with their traditional preferences for the next few years, once boomers experience more convenient access points they are just as enthusiastic about them as their millennial counterparts: 33 percent of boomers liked the new access points better, and fewer than 10 percent liked them less.

While adoption will vary geographically, in-office diagnostics are being replaced by mail-order and app-enabled solutions that offer convenience, and in many instances, improved access and better clinical outcomes. In some areas of the country, boutique medical groups are already offering patients subscription access to physicians where interaction between a patient and their provider is largely via text.

> "The administrators tell me that I don't need to see my patient because their cancer is in remission. What administrators don't understand is that seeing my well patients gets me through my day."
>
> *—Generation X oncologist at a midwestern community hospital*

For the younger, digital native generation of physicians, this model is being welcomed, but for more senior physicians, this less personal approach to patient care is profoundly difficult and viewed as a tremendous loss. Forward-thinking leaders are getting out in front of this change by engaging physicians in care delivery redesign and helping them embrace the shift to a more tech-enabled, convenience-focused approach. Consumers should not have to experience long delays in physician waiting rooms, labyrinthine quests for the hospital outpatient lab or X-ray department, and interminable pharmacy lines. Organizations that get this right will undam a wave of pent-up demand, improve patient experience, and reap the rewards.

2. Traditional Growth Drivers Remain Critical but Require New Commitment

Market movement in 2019 was driven primarily by the innovation economy. Pioneers like Onduo with the diabetes population, CityMD in urgent care, and ChenMed with primary care for seniors have reimagined healthcare's front door and are making substantial headway in many markets. However, chasing innovation while letting traditional, but still critically important, growth drivers

languish is short-sighted. Access and referral management remain relevant and significant, but will demand a different vision and more resources to meet the higher bar and more complex expectations of healthcare consumers.

Consumers will no longer tolerate waiting 24 days to make a first-time appointment with a physician, a figure that has increased from 18 days in 2014, nor should they (see **Exhibit 3**).[4] And this goes beyond the issues of consumer experience; wait times for first oncology appointments increased from 21 to 29 days between 2003 and 2014, and this additional wait time significantly increased mortality (see **Exhibit 4** on page 10).[5] To compete in markets with innovators, traditional hospitals and systems must commit to solving their access problems in 2020 by setting and achieving ambitious goals, such as same-day access for select services and always accommodating a consumer's preferred modality.

Many organizations have lost their sense of urgency about patient access, while some never got beyond using it as a buzzword. A true access strategy requires building new competencies and committing to a range of initiatives, including developing streamlined scheduling templates and processes managed through a centralized team, shifting to team-based care models that push advanced practice providers to work at the top of their licenses, enabling access virtually and through convenient retail sites, and optimizing clinic operations and throughput. Success in these initiatives will require major changes in physician behavior, which will rely partially on shifts in incentives, but also, perhaps more importantly, in cultural changes. Success will also require a workforce with contemporary skill sets, from engineers and scheduling experts, to organizational effectiveness experts and leaders willing to challenge their organizations' longstanding cultures.

Referral management is another lever well known by health system leaders but often executed sub-optimally. Tellingly, referral management is often referred to as leakage, but this undervalues and mischaracterizes the true aims of referral management. Yes, one outcome of effective referral management should be reduced leakage and higher system revenue, but referral management becomes even more critical as health systems commit to value-based care and improved consumer experience. Referral doesn't just mean keeping patients in network. It means providing a seamless, consistent experience within the network and, when patients need to go out of network, maintaining contact and continuity so that they easily slip back in network when possible.

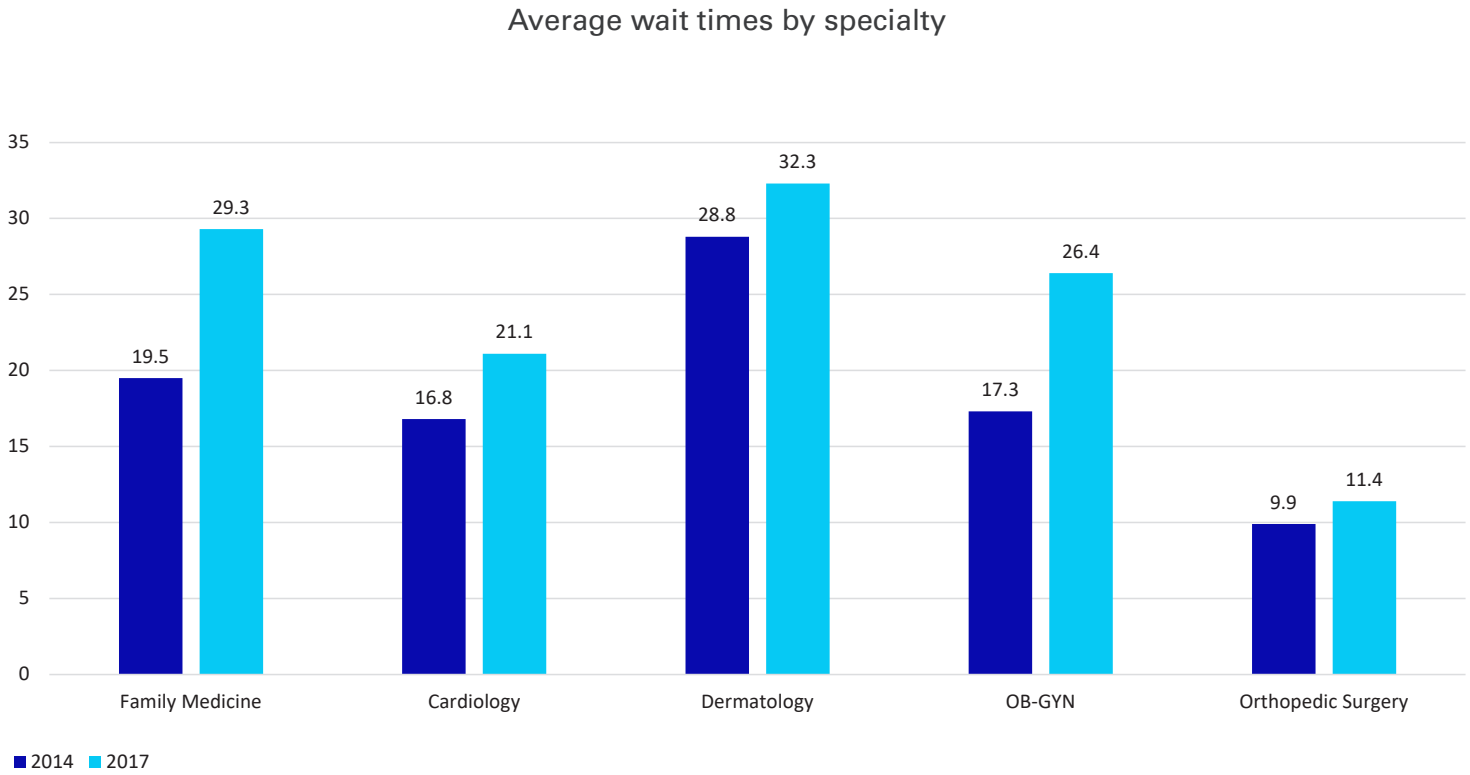
Effectively managing the quality of care and the patient experience requires that health systems track where patients go for care, both internally and externally. At the clinical operational level, care teams must have transparency into where their patients are receiving care to manage quality and total cost of care over time.

> "The last thing I would have ever thought I would be doing is a post C-section incision check on my patients using tele-visit methods, but that is what my patients expect. They do not want to come into the office to have their incision checked when they can be at home focused on nursing their newborn. I get it."
>
> *—OB-GYN, West Coast*

Investing in an improved referral management strategy is a critical move both for near-term 2020 results and long-term sustainability. This means building the infrastructure and capabilities for an integrated referral management system. It also means

4 Merritt Hawkins, 2017 Survey of Physician Appointment Wait Times.
5 Alok A. Khorana et al., "Time to Initial Cancer Treatment in the United States and Association with Survival Over Time: An Observational Study," PLOS ONE, March 1, 2019.

Exhibit 3: Wait Times for New Appointments Are Unacceptable across a Range of Specialties, and Have Only Grown in the Past Several Years



Source: 2017 Merritt Hawkins Survey of Physician Appointment Wait Times.
Surveyed across Boston, Portland, OR, San Diego, Philadelphia, Denver, Minneapolis, Los Angeles, Washington, D.C., Atlanta, Seattle, New York, Detroit, Miami, Dallas, Houston

being prepared to upend long-standing out-of-network referral patterns that are not optimal from a quality, experience, cost, or revenue perspective.

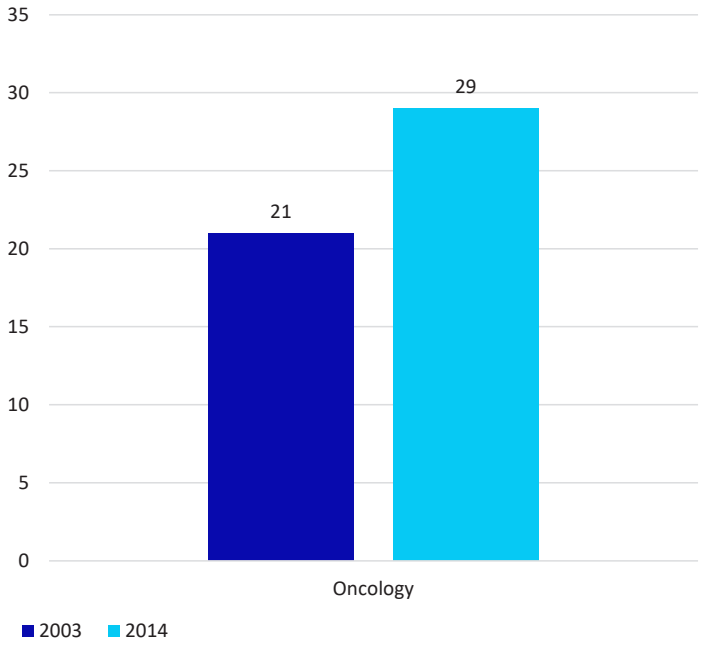
3. Implementing a New Agile Operating Model Provides Substantial Opportunities for Immediate Margin Impact

Over the last decade and a half, major hospital service lines, such as cancer, orthopedics, and cardiovascular, have seen significant patient outmigration as more care is provided in an outpatient setting. Rates of inpatient stays have plummeted 20 percent between 2000 and 2015. In the meantime, ambulatory surgery center utilization increased by 10 percent in the one-year period between 2015 and 2016.[6] Yet few organizations have taken the time to examine this trend

6 Ruirui Sun, Zeynal Karaca, and Herbert S. Wong, "Trends in Hospital Inpatient Stays by Age and Payer, 2000–2015," Statistical Brief #235, Healthcare Cost and Utilization Project, January 2018.

Exhibit 4: Wait Times for First Oncology Appointments Are Also Unacceptably High and Growing, and Have a Measurable Impact on Mortality

Time to first appointment



Hazard rations/Week of delay

1.005–1.035

Depending on cancer site

Source: Alok A. Khorana et al., "Time to Initial Cancer Treatment in the United States and Association with Survival Over Time: An Observational Study," PLOS ONE, March 1, 2019.

and adapt their operating model to a more distributed approach to care. Hospitals and systems that redesign their inpatient settings to manage this new reality and create better connections across disciplines and settings to maintain value and relevance will see immediate and dramatic positive margin impact.

Cardiac rehab is a good case study of how hospitals have lagged in redesigning inpatient settings as care patterns change. Cardiac surgery average length of stay (LOS) nationally has been cut in half over the last 10 years, yet many providers have not adapted their cardiac rehab programs to align with a shorter LOS. Given that patients are not ready for cardiac rehab until stabilized, and many are now discharged soon after stabilization, what should cardiac rehab look like in the hospital setting? Many hospitals have avoided addressing this issue, maintaining a robust rehab unit that is overbuilt and overly costly relative to what patients need. When traditional and siloed hospital department structures have lost relevancy but are allowed to remain, the drag on the bottom line—especially for many small and mid-size hospitals—makes competing on value impossible.

Breast cancer is an example of how an expanded vision of service lines is necessary to best serve patients. Today's breast cancer patients are cared for by the oncology service line

team, but chemotherapy side effects may require cardiology intervention, behavioral health support, and general women's healthcare. Traditional service lines are no longer nimble enough to support these needs efficiently. An ideal approach would reflect a more whole-patient, consumer-centric approach, with multiple access points supported by tech and app-enabled scheduling and communication.

Modernizing the operating model is not easy, but organizations that have done so have freed up 10 to 15 percent or more of operating margin, which can then enable strategic investments elsewhere in the organization.

4. Providers Need a Path to Value That Allows Them to Thrive in the Transition

The payer side of the healthcare equation is increasingly impatient to accelerate the shift to value. Employers and health insurance companies are looking to manage costs and reward outcomes over productivity, and CMS continues to demonstrate a commitment to pushing the American system to value. Nevertheless, the pace of change over the last decade has been glacial. Technological and administrative systems to enable value-based reimbursement are still not where they need to be, and most providers do not have the clinical models necessary to succeed under value-based arrangements.

This creates a tricky landscape for providers. Moving too quickly toward a value-based model before the rest of the market is ready could destroy demand. Entering early-stage agreements with payers that amount to accepting lower reimbursement will not only rob hospitals and health systems of revenue but it could position them as commodities—as the lowest bidders that will be trapped into competing purely on cost.

5. Artificial and Collaborative Intelligence Goes Mainstream to Impact Workforce Planning

AI undoubtedly has a central role in the future of healthcare but misconceptions, early hiccups, and its sheer complexity have created noise that may scare healthcare leaders away from this critical competency.

How to Prepare for the Shift to Value

Providers need to invest in value-based reimbursement tools, but investments also must be directed toward modernizing care models and improving consumer-centricity. Investing in new care models that improve outcomes and present consumer-friendly front doors are sustainable and scalable strategies that can work in this transition period between volume- and value-based systems. The specific care models providers should focus on will depend on their patient populations. Some may choose to focus on lower-acuity medical home models that emphasize primary-care-based coordination, team-based care, and accessibility commitments for all patients. Others may focus on condition-specific models, such as oncology care models that ease patient navigation through all of their care needs, cancer-related and not, ensuring care is not derailed by confusion, comorbidities, or lack of clinician coordination. Still others can focus on general extensivist models that apply high-touch clinic and home-based care to older, polychronic patients to avoid acute episodes whenever possible. None of these models are simple to implement, but they yield significant benefits to those who invest the resources and effort.

Health systems also need to invest in technology and staff to measure outcomes from an experience, quality, and total patient cost perspective. These metrics will increasingly matter to consumers, payers, and government agencies, but many providers currently do the bare regulatory minimum today and are ill-equipped to prove their effectiveness.

> AI should be viewed not as a replacement for human thought but as an aid that ultimately allows clinicians to spend more time on the creative work and personal connections that make a career in medicine worthwhile.

AI should be viewed not as a replacement for human thought but as an aid that ultimately allows clinicians to spend more time on the creative work and personal connections that make a career in medicine worthwhile. Machines will replace simple processes, such as surgery prior-authorizations, and collaborate with humans, for example, by making complex diagnoses. Machine will not, in the near term, function as substitutes for skilled physicians. The promise of this generation of AI is to help clinicians better use data and drive the rationalization and evidence-based commitment that we need, while allowing physicians to spend more time being human.

Despite the potential of AI, valid concerns should not be ignored. Data security cannot be taken for granted, and the outputs of AI processes require real expertise to be properly interpreted. A new data-oriented wing of the healthcare workforce will be needed to manage these challenges.

High-profile AI failures, such as treatment paths that were determined based on patients' races or diagnoses that were affected by irrelevant labels on X-rays, have generated skepticism among patients and clinicians. AI adoption will not be barrier-free, but incorporating it at a deliberate pace and with the collaboration of physician leaders will mitigate loss of confidence when inevitable stumbles occur.

Hospitals and health systems will not become barn-storming innovators overnight. But as the new healthcare value chain asserts itself, impediments to efficient, effective, and cost-sensitive healthcare delivery using traditional care approaches will become increasingly untenable. In 2020 and beyond, health systems cannot afford to take a wait-and-see approach and risk being designated as the provider of last choice in their market. As we enter a new decade, the timing is right to shed what no longer works or is irrelevant, and take a fresh look at the opportunities on the horizon.

The Governance Institute thanks Deirdre Baggot, Ph.D., Partner, and John Rudoy, Ph.D., Principal, Oliver Wyman Health and Life Sciences, for contributing this article. *They can be reached at deirdre.baggot@oliverwyman.com and john.rudoy@oliverwyman.com.*

Rising Demands of the Modern Healthcare Consumer

By Brian Wynne, NRC Health

As leaders at many healthcare organizations will attest, the consumerist revolution isn't coming for healthcare—it has already arrived.

Where hospitals and health systems of years past could rely on a stable body of customers to draw in revenues, today's customers have proved to be much less reliable. According to research from NRC Health, nearly 40 percent of healthcare consumers report *no* loyalty to their healthcare providers,[1] and 80 percent of them are willing to switch providers over convenience factors alone.[2]

> If hospitals and health systems are to generate sustainable loyalty from their customers, they must not only respond to the emerging trends of consumerism, but also *anticipate* the consumer evolution that has yet to come. Much of that effort begins in the boardroom.

These trends should not be mistaken for fickleness. They instead reflect a savvier, more empowered, and far more discriminating customer base—one that healthcare leaders need to attract and retain to secure their organizations' financial futures. If hospitals and health systems are to generate sustainable loyalty from their customers, they must not only respond to the emerging trends of consumerism, but also *anticipate* the consumer evolution that has yet to come. Much of that effort begins in the boardroom.

Drawing from NRC Health's 2020 Consumer Trends Report,[3] this article reviews the emergent demands of the modern healthcare consumer, including 1) the urgency of access concerns, 2) the generational divide in service preferences, and 3) the importance of well-executed follow-up after care encounters.

The Primacy of Access

Access to care is a pre-eminent byword both in public-policy discussions and among organizational leadership. Though they seldom use the phrase, healthcare consumers are concerned about access, too.

Among the concerns raised within NRC Health's database of more than two million patient comments, issues related to access are some of the most frequently cited. More than 60 percent of patient comments mention some kind of access issue—whether that involves appointment availability, registration and check-in, or wait times.

Such "front-door" encounters set the tone for a customer's experience with a hospital or health system. They often represent the organization's only opportunity to make a first impression, and they can be a major contributor to patients' opinions of the experience as a whole. As such, these early moments of the care experience can be tremendously influential in future decision making: 51 percent of consumers believe convenient access is the single most important factor driving their care decisions.[4]

The converse is also true. Statistical analyses of patients' comments reveal that positive sentiments about access strongly correlate with future consumer loyalty. If a patient leaves a positive comment about admission or registration, they're 46 times more likely to be a promoter for a healthcare brand, compared with patients who leave a negative comment.

However, one major impediment to access remains intractable for consumers and healthcare organizations alike: the cost. In fact, 28 percent of patients have deferred a necessary care appointment because they couldn't afford it—up from 22 percent in 2018. Rising relative costs are likely to put more pressure on the quality of the care encounter. As consumers shoulder a higher price-burden for services, they will be even less likely to tolerate experiences that fall below their expectations.

Key Board Takeaways

- **Ask about access.** Focus on the first impression your organization makes on consumers, and consider every avenue in which that impression is made. How long do patients have to wait for their appointments? In the waiting room, how long must patients wait before seeing a provider? Are there redundancies in the check-in paperwork? Are digital appointment-setting tools available, easy to find, and accessible? Answers to these questions play an outsized role in consumers' evaluation of their providers.
- **Meet every generation.** Carefully consider the demographic mix of your organization's patient population. Is your hospital/health system equipped to meet the digital-first demands of younger consumers? Are non-digital modes of access similarly robust?
- **Follow up.** How does your organization handle discharge? Is every patient receiving a post-discharge call? Does your organization have the capacity to manage that process? The more your organization can do to clarify next steps for the consumer, the more satisfied your patients will be with the discharge experience.

1 NRC Health, *2020 Healthcare Consumer Trends Report* (available at https://nrchealth.com/resource/2020-healthcare-consumer-trends).
2 Sara Lehman Laskey and Steve Jackson, *Effortless Care Experiences*, NRC Health, October 18, 2018.
3 NRC Health, *2020 Healthcare Consumer Trends Report*.
4 Les Masterson, "Convenience More Important to Patients Than Quality of Care, Survey Finds," *Healthcare Dive*, January 7, 2019.

A Challenging Generation Gap

Today's organizations can expect to cater to, at the least, five distinct generations of adult healthcare consumers. In any industry, this world-historic breadth for a customer base would present tensions. In healthcare, those tensions are particularly acute.

First, consider modes of healthcare consumption. For younger generations, digital and telehealth services are appealing avenues for receiving care. In fact, 69 percent of millennial and Generation Z consumers are likely to choose a provider based on the availability of digital services, while 61 percent of them will switch providers over a subpar digital experience.

At first, the cost-effectiveness, scalability, and convenience of digital delivery might seem like ideal solutions for every healthcare system. However, that leaves older generations out: only 4 percent of older adults have ever used telehealth services, and a full 80 percent of them express misgivings about doing so.

More discrepancies arise when we consider how generations feel about different aspects of the care experience. For instance, 63 percent of baby boomers' comments about billing are positive, while 65 percent of millennial and Generation Z billing comments are negative; similarly, 75 percent of boomers' comments about appointment scheduling are positive, while only 50 percent of millennial and Generation Z consumers feel the same.

These generation gaps give conflicting signals about where hospitals and health systems should prioritize their resources. The right allotment will depend on the generational distribution of a given organization's patient mix. However, as demographics shift, millennials will soon emerge as the single largest generation of healthcare consumers—and healthcare leaders should plan their futures accordingly.

Take the Experience as a Whole

Though generations can clash on their specific expectations from healthcare organizations, on certain points they starkly align.

One point in which all demographics agree is in a broad satisfaction with their providers. In 2019, 85 percent of consumers' clinician-related comments were positive. That should be heartwarming news for leaders concerned with loyalty, since 56 percent of consumers believe that a "good previous experience" is the most important driver of continued patronage of a health system.

Just as universal, however, is dissatisfaction with another aspect of the healthcare encounter: discharge. Only a minority of patients, of any age, expressed satisfaction with the discharge process. (Millennials and Generation Z consumers appear to feel this most acutely, with 70 percent of their discharge-related comments being negative.) Consumers in every demographic report complaints with discharge. Issues include confusion about medication, inability to schedule follow-up appointments, and struggles to follow post-discharge instructions. As a *final* impression from health systems, it appears that discharge leaves much to be desired.

As demographics shift, millennials will soon emerge as the single largest generation of healthcare consumers—and healthcare leaders should plan their futures accordingly.

Further, if discharge (or any other part of the care experience) goes wrong, healthcare organizations have only an extremely narrow window of opportunity within which to recover from a service error. A full 75 percent of consumers expect to hear from providers within *two days* of a service problem; after just one week, 66 percent of consumers say that any unaddressed issues are "irreparable."

Rising to the Challenge

Healthcare consumers' demands may seem imposing and sometimes even contradictory, but they present considerable opportunity for forward-thinking leadership. When empowered consumers raise their expectations, standards of service will (and should) follow, and those organizations that rise to meet those standards will emerge as all the more valuable to their customers.

In healthcare, as in every business, understanding and fulfilling consumer demands is the singular, enduring advantage. Board members would do well to bear that in mind as they continue to steward their organizations into healthcare's consumerist future.

The Governance Institute thanks Brian Wynne, Vice President and General Manager, NRC Health, for contributing this article. He can be reached at bwynne@nrchealth.com.

The Board and CEO Relationship…

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- What are director communication expectations between board meetings?
- What is the board's definition of CEO success?
- What should not be changed at the organization?
- Rank on a scale of one to five the current level of engagement among the board.
- Who should the CEO meet with in the community?

Gathering this information will enable the CEO to formulate his or her initial priorities for presentation first to the board chair and/or executive committee, followed by discussion with the full board at an early board meeting. The written plan of action should evolve from this boardroom discussion and should include clarification of expectations between the parties. The establishment of a board policy clearly outlining the CEO's financial authority limits is an essential component of the plan. The plan should also specify standards for communication between board meetings, including board consensus on a standard communication mode. The priorities can then be translated into CEO annual performance goals and associated metrics.

The new CEO is advised to communicate clearly to internal constituencies that he or she will be spending significant blocks of time with board members during the first weeks of his or her leadership. The CEO should emphasize to internal audiences that this time commitment is foundational in aligning vision and preparing for the organization's future.

The path ahead for healthcare organizations is only accelerating in complexity, risk, and uncontrollable external factors. Solidifying the board–CEO working relationship in the first 120 days of a CEO's appointment will provide the understructure for the challenging work ahead.

The Governance Institute thanks Kimberly A. Russel, FACHE, Chief Executive Officer of Russel Advisors and Governance Institute Advisor, for contributing this article. She can be reached at russelmha@yahoo.com. For more information around facilitating an orderly transition to new leadership, see The Governance Institute's Elements of Governance® publication, Succession Planning, Third Edition.

Measuring Differently…

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There are five common ways people are using these measures:

1. Coaching with an individual patient
2. Risk stratification at the practice level to rapidly diagnose who needs what and at the population planning level to understand what resources might be needed for different populations
3. Identification of equity populations
4. Evaluation of programs and an understanding of what drives the greatest improvements in overall outcomes related to the well-being of people, the well-being of places, and equity
5. Community health needs assessment and population-level surveillance

One of the measures that has received the greatest interest among early adopters is Cantril's ladder, which depicts a simple ladder where the bottom represents one's worst possible life and

the top represents one's best possible life. A person is asked how they would rate their lives today and in five years. It turns out that this highly validated measure has been administered 2.7 million times, correlates with morbidity, mortality, worker productivity, and cost, and is useful for risk stratification.

Clinicians report that this measure is easy to administer and leads them to have meaningful conversation with patients. The measure translates easily to percent of people thriving, struggling, and suffering. This has been very helpful in evaluating a range of programs and in assessing risk and the need for additional supports for individuals who are at risk of poor outcomes. In addition, groups are using other WIN measures (mental health, food insecurity, housing insecurity, ability to afford an emergency expense, social connection, etc.) to understand the impact of their direct programming and policy on these measures as well as overall well-being and life expectancy outcomes.

The WIN measures offer a powerful way to regain perspective about what really matters in improving health and well-being with an equity lens.

The Governance Institute thanks Somava Saha, M.D., M.S., Founder and Executive Lead, Well-Being and Equity (WE) in the World, and Executive Lead, Well-Being in the Nation (WIN) Network, for contributing this article. She can be reached at somava.saha@weintheworld.org.

Building an Outpatient Strategy…

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1,500 HealthHUBs nationwide by the end of 2021.[8]

Building a Successful Outpatient Strategy

Hospital and health system leaders that still are immersed in an inpatient world are in the wrong business model—they need to completely rethink their approach to outpatient services. Outpatient care no longer should be measured in terms of its "downstream" impact on acute inpatient care. Providers instead should turn their attention upstream, and recognize that the most significant activity for a future-focused health system is occurring in the outpatient realm.

Hospital and health system leaders that still are immersed in an inpatient world are in the wrong business model—they need to completely rethink their approach to outpatient services.

First, boards and senior leaders should assess whether their organization has the capabilities and infrastructure needed to compete in the evolving outpatient environment. These include:

- **A variety of access points:** Including both digital access points such as virtual care and direct patient–provider communication and feedback offerings, as well as convenient physical sites such as retail clinics and urgent care centers
- **A consumer-focused culture:** Including C-suite support and leadership in ensuring that all services and strategies center on meeting and exceeding consumers' needs and expectations
- **Robust data and analytics capabilities:** Including building a comprehensive database to track consumer data, and to use those insights to shape organizational strategies

Following a capabilities assessment, hospital leaders should identify their organizations' competitive strengths and weaknesses. This requires conducting a thorough assessment of the market, including current and potential future competitors, market needs, and the organization's service portfolio.

With this information, healthcare leaders can identify strategic priorities, and better shape decisions on how, when, and where to allocate resources, as well as what services or initiatives should be scaled back or phased out entirely. Ultimately, healthcare leaders must identify what their organization does better than anyone else in the market, and thus where they have the most competitive advantage in meeting the current and future needs of their community.

Effectively building out existing or new outpatient services requires intense focus on:

- **Cost**: Transforming the organization's cost structure to ensure that services can be delivered at a sustainable and competitive price point
- **Access**: Making services available when and where patients want them
- **Experience**: Understanding the many needs and interests of the consumer—physical, financial, emotional—and placing them at the center of decision making across the organization

Boards have a critical role to play in leading their organizations through the transition to a more outpatient-focused model of care. Without a competitive outpatient delivery system, hospital-based providers risk being left with a shrinking portfolio of increasingly obsolete inpatient services.

Board members should educate themselves on the many disruptive forces affecting today's legacy healthcare providers, including current and emerging competitors looking to upend and completely reshape traditional care delivery models. Directors need to also work with executive leaders in reviewing the organization's current capabilities, assessing how the organization needs to change, and deciding what capabilities are needed to realize that change.

The ultimate goal is to ensure a future role for the nation's hospitals and health systems in an evolving and uncertain healthcare environment—even if that future role requires remaking the hospital mold entirely. True transformation will require many hard choices, with no guarantees of success. The only certainty in healthcare is change, and the hospitals of the future likely will be very different from the hospitals of today.

The Governance Institute thanks Mark E. Grube, Managing Director and National Strategy Leader, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article. He can be reached at mgrube@kaufmanhall.com.

8 CVS Health, "CVS Health Announces Significant Expansion of HealthHUB to Deliver a Differentiated, Consumer Health Experience" (press release), June 4, 2019.

Building an Outpatient Strategy for 2020 and Beyond

By Mark Grube, Kaufman, Hall & Associates, LLC

The sheer level of disruption hitting healthcare is unprecedented, as countless competitors move in seeking a piece of the $3.6 trillion industry.[1] These competitors vary widely in size, scope, composition, and strategy, but they share a common target: *outpatient care*.

The potential repercussions for legacy healthcare providers are significant. Hospitals rely on outpatient care as a growing portion of their overall revenues. The gap between inpatient and outpatient revenues has narrowed in recent years. The American Hospital Association estimates hospitals' annual net outpatient revenue at more than $470 billion,[2] equal to about 95 percent of inpatient revenues.

Emerging competitors range from behemoths such as Walmart, CVS Health, and Amazon, to segmented disruptors such as Oak Street Health, ChenMed, and Iora Health. They come in many forms: urgent care chains, retail clinics, physician super groups, free-standing imaging companies, telehealth providers, and primary care providers. Right out of the gate, these companies hold a major advantage over the nation's 6,000 hospitals—they are unburdened by the high operating and facility costs of the hospital infrastructure.

The core question for hospital and health system leaders is: How do you compete and win in the outpatient space in today's disruptive environment?

Vulnerabilities of the Legacy Model

Hospitals and health systems across the country are vulnerable. Outpatient services for Medicare patients grew from 34 percent of hospital revenue in 2002 to 48 percent in 2017 (see **Exhibit 1**)—the erosion of inpatient revenue likely would be more significant for commercially insured patients. On a volume basis, Medicare outpatient visits have grown 43 percent in 10 years, while inpatient discharges have declined 20 percent.[3]

Even as outpatient revenues close in on surpassing inpatient care for share of hospitals' total revenue, many leaders remain fixated on an inpatient model. Hospital outpatient services continue to be viewed as ancillary, while new competitors are approaching such services with a principal focus. Hospital and health system leaders must pivot their perspectives if they hope to have any chance of competing in the new business model.

Disruptive competitors recognize that expectations are changing across healthcare, as employers and healthcare consumers demand higher levels of care quality and convenience at lower costs. Healthcare consumers are increasingly activated in researching and comparing providers, as they carry a greater share of total healthcare costs and find a greater variety of options to choose from. Consumer shopping activity is particularly high for "shoppable" outpatient services—such as advanced imaging and outpatient surgery—which can comprise as much as 25 percent or more of a hospital's contribution margin.

Competitors such as Optum and CVS Health are targeting services for the 60 percent of Americans with one or more chronic condition,[4] a population that accounts for more than 75 percent of U.S. healthcare spending.[5] CVS Health, for example, has announced multiple initiatives, including a new cardiovascular disease and pilot readmission prevention program,[6] and clinical trials for a home kidney dialysis device.[7] The company recently opened three HealthHUB locations in Houston designed to help individuals manage chronic conditions, and quickly announced plans to open an additional

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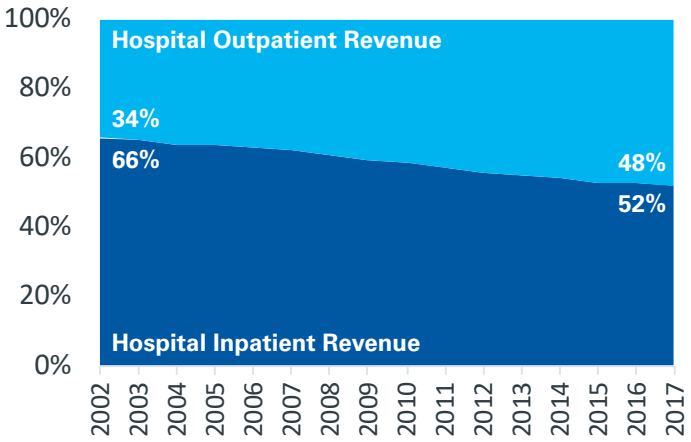
Key Board Takeaways

Amidst unprecedented competition, senior leaders and directors should develop a comprehensive outpatient strategy to position their organizations for an evolving business model. Key steps include:

- Assess organizational infrastructure needed to compete in an increasingly outpatient environment, such as variety of access points and data and analytics capabilities.
- Identify the organization's competitive strengths and weaknesses with a thorough market evaluation.
- Identify strategic priorities, with intense focus on improving access and experience and lowering costs.

Ultimately, leaders must identify what their organization can do better than anyone else to meet the current and future needs of their community.

Exhibit 1: Total Hospital Inpatient and Outpatient Revenue, 2002–2017 (All U.S. Hospitals)



Source: Kaufman Hall proprietary analysis of Medicare Cost Report Data.

1 CMS, "National Health Expenditures 2017 Highlights" (available at https://go.cms.gov/2xCwYRB).
2 Tara Bannow, "AHA Data Show Hospitals' Outpatient Revenue Nearing Inpatient," *Modern Healthcare*, January 3, 2019.
3 Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy Report to the Congress*, March 2019.
4 Centers for Disease Control and Prevention, "Chronic Diseases in America," National Center for Chronic Disease Prevention and Health Promotion, October 23, 2019.
5 Altarum, "Cost and Quality Problems: Chronic Conditions," Healthcare Value Hub, 2019.
6 Morgan Haefner, "CVS Debuting Health Programs a Month After Acquiring Aetna: 4 Things to Know," *Becker's Hospital Review*, January 9, 2019.
7 CVS Health, "CVS Health Announces Start of Clinical Trial for New Home Hemodialysis Device" (press release), July 17, 2019.