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FEBRUARY 2021 | healthcare financial management



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PRESSURE INJURIES
SHOULD BE A
PRIORITY FOR
HOSPITALS

HOW TO
SELF-AUDIT
340B PROGRAM
COMPLIANCE



JENIFER JAEGER, MD:
WHY IT'S NEVER BEEN MORE
IMPORTANT TO ADDRESS SDOH

8

RECOMMENDATIONS
TO IMPACT
SDOH



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Cover photograph Marshall Clarke

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hfm® supports the mission of the Healthcare Financial Management Association by serving as a key resource for individuals involved in the financial management of healthcare.

Editorial Position

hfm® is written and edited principally for finance professionals in health service organizations all along the continuum of care, including hospitals and health systems, managed care and accountable care organizations, physician organizations, outpatient service centers, and post-acute care providers. It also is directed to professionals in law firms, accounting firms, banks and consulting firms that have an interest in healthcare finance. hfm® covers the full range of topics related to healthcare finance. Key topic areas include strategic planning, hospital-physician alignment, payment, revenue cycle, patient financial services, enterprise risk, business intelligence, information systems, network development, accounting practices, leadership development, management issues, legislative and regulatory issues, capital finance, cost management, consolidation and affiliation, and emerging financial trends.

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The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 64,000 members in 64 chapters, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. Membership in HFMA provides opportunities to attend educational seminars and conferences, to access technical and management information, to obtain professional certification, to interact and network with colleagues and to gain other professional benefits. For information about annual membership dues, which include a \$30 allocation to hfm®, contact Member Services at (800) 252-HFMA, ext. 2.



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‘Here Comes the Sun’



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Done! Over! 2020 is behind us!

What a long, strange trip it has been. Are you ready to get back to normal in this new year? Me, neither. I’m just ready to get back to anything other than shut-downs. The “reset” of 2020 wasn’t all bad. For many, it meant an inconvenience or a change of habits. For others, it was a nice retreat from the busyness of life. Yet for others, it exacerbated hardships.

There are so many perspectives, but there’s one thing most would agree is a good thing: We have vaccines! To be sure, they won’t solve all our problems, and there remain many distribution-related issues that need to be resolved. But one thing vaccines *will* solve is our need for human connection. We humans are meant to socialize, to gather and learn and grow and enjoy all of the things that make life rich and fulfilling, like music. “Here Comes the Sun” is the iconic Beatles song with George Harrison on vocals — a cool vibe and maybe a song for 2021.

“Little darling, it’s been a long cold lonely winter. Little darling, it feels like years since we’ve been here.”

There is much to celebrate about the vaccines and their development. There was an intriguing article in *New York* magazine by David Wallace-Wells, titled “We had the vaccine the whole time” (Dec. 7, 2020). The article has many interesting storylines, but three things emerge.

First is that these vaccines were created faster than any in the history of mankind. Most vaccines in the past arrived about the time the disease had already swept through the population and only served as a way to close the door on its coming back.

Second, through a humanitarian act, Chinese scientist Yong-Zhen Zhang (umm, Nobel Peace Prize, please) released the genetic sequence of the virus to the public in January 2020. And within two days, Moderna created their vaccine! This was Jan. 13, 2020 — one week before the first confirmed case in the United States. Maybe this vaccine thing *can* go faster.

Third, scientists believe it is possible that vaccines can be created proactively to deal with 90% of all viruses we may ever experience.

“Little darling, I feel the ice is slowly melting. Little darling, it seems like years since it’s been clear.”

This story has an important lesson for us about embracing the possibility of acting faster when it comes to our own healthcare finance work. What can we get done in two days that used to take weeks or months or years?

“Here comes the sun. Sun, sun, sun, here it comes.”
Peace. ■

hfma Your Challenge.
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Empowering patients in a time of crisis

There's no doubt the pandemic has dramatically altered the business of healthcare. Hospitals and health systems nationwide have continued to rack up staggering financial losses throughout 2020, directly related to COVID-19 and a shutdown of non-emergency surgical procedures for a period of time.

American consumers haven't fared any better. According to an October 2020 study by The Commonwealth Fund,¹ approximately 14.6 million individuals and their dependents lost employer-sponsored health insurance by mid-year 2020. Although there now is light at the end of the tunnel with vaccines and treatment, clearly it will take time for Americans to recover financially. In light of these challenges to their communities, healthcare providers have opted to alter their approach to patient collections, specifically looking for solutions to make out-of-pocket costs affordable by allowing payment plans.

Healthcare organizations are expanding patient payment methods due to COVID-19

52.6%

are offering more payment alternatives

52.2%

offering more online self-service options

On the whole, healthcare organizations are working to provide more technology-driven, compassionate and non-contact payment options and methods. These are helpful to preserve patient and staff safety and recognize the challenging financial circumstances that many patients face.

Payment plans are a key area of focus

When hospital and health system leaders were asked what tactics were the most crucial in maximizing patient out-of-pocket financial responsibility, a few options stood out: allow payment plans, provide better upfront estimates and increase payment education.

“To achieve the appropriate balance of patient experience and securing payments, we think offering payment installment options is a good approach. It's important to keep the patient paying something, even if it's a small amount.”

—RCM Leader

Why are new payment strategies so important?

Although there are many reasons to expand payment strategies, healthcare leaders surveyed believe the most important reasons are to:

- 1 Recognize financial hardship and demonstrate compassion
- 2 Educate patients
- 3 Improve the likelihood to pay

More than **1 in 4** respondents (27.4%) indicate that the reasons behind expanding their strategies have to do with recognizing patients' financial hardship and demonstrating compassion, illustrating a desire to empower patients during this difficult time.

About the survey

- Conducted online survey September 2020
- 117 HFMA members responded to the survey
- Revenue cycle management, patient financial services, patient access and operational leaders participated in the survey
- Hospitals, health systems, other providers were among those represented in the survey

1. Frostin, P., Woodbury, S.A., *How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?* The Commonwealth Fund, Oct. 7, 2020.



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3 questions with Strategy SVP Mary Mirabelli: HFMA's new e-learning platform



BRAD DENNISON
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Earlier this year, a team within HFMA began looking at how to upgrade the online education experience for members. With the backdrop of a global pandemic and the halting of live events, it was clear that online learning would be more critical than ever, and HFMA's system was due for an upgrade.

In January, HFMA debuted its new e-learning platform, so I sat down with HFMA Senior Vice President of Strategy Mary Mirabelli, who led the charge, to talk more about the new system and what members can expect.

1 What drove that decision to switch learning management systems?

Mary Mirabelli: Our system was more than seven years old, which in technology terms is pretty outdated. It didn't have a lot of the functionality that today's learners really need or expect. So we needed something that looked contemporary and would allow us to transform how we do online education and do a better job of helping people learn. This meant really learning about trends in online education and choosing the right vendor partner. We evaluated about 20 different systems before settling on one.

2 What can members expect from the new platform?

Mirabelli: In the older iteration, it was really confusing and hard to find what you were looking



HFMA's new learning management system has a contemporary look, and better organization and navigation.

for, so now before you even get into a course, you'll find much better organization and navigation. The catalog will all be in one place and easier to search. You'll also get personalized suggestions for learning paths and courses. We've added a gamification aspect, too, so learners can earn trophies and status in the system.

One of the aspects of the new system we're very excited about is the ability to white-label courses to our Enterprise member organizations. Among other things, they'll be able to use our tools to do simulations where employees demonstrate skills and employees will get real-time feedback from their managers.

3 What's the future of online learning for HFMA?

Mirabelli: Right now we're focused on porting content from one system to the other, so while it will be a much-improved experience, we'll be going back and refreshing many courses in 2021. However, we've already done overhauls of two important courses, including "HFMA's Business of Health Care®" and "Denials Management." Those two modules are good examples of what we're capable of moving forward.

Thinking long term, this new system is perfectly designed to meet the challenges today and tomorrow. Given where we are with this pandemic, there will have to be more online learning, and our system will be more interactive and more engaging and allow us to embrace the way members want to learn today. ■

About the author

Brad Dennison is the director of content strategy at HFMA.



Visit HFMA's e-learning platform FAQs page by visiting hfma.org and clicking on the "My eLearning" tab.



Mary Mirabelli led the overhaul of HFMA's LMS.

New Jersey and Hudson Valley Chapters collaborate to host a magical virtual event

The two HFMA chapters recently shared details of how they worked together to set up a virtual social event for their members, featuring magician Garrett Thomas.

JENNIFER NOVOSELETSKY
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Sixty HFMA chapter members were able to network and socialize during the collaborative event, which the New Jersey and Hudson Valley Chapters hosted on Aug. 26.



Magician Garrett Thomas performs a magic trick for the New Jersey and Hudson Valley Chapters during their joint event.

EXECUTING THE EVENT

There were multiple calls, meetings and conferences to set up this event, said Nicole Rosen, HFMA New Jersey board member and chair of the Chapter's communications and networking committee. Once both of the Chapters' Boards approved the event, they locked in the date, sent out a save-the-date flyer to get members excited and put together an agenda, said Rosen, a business development leader at Acadia in Morristown, New Jersey.

THE MAGIC BEHIND THE ENTERTAINMENT

The idea for a magician came from Hudson Valley Chapter's Sarah Brainard, whose uncle knows Garrett Thomas and suggested him. Splitting the cost of hiring Thomas helped make the event more cost-effective.

GREATER HEARTLAND PLAYS NAME THAT TUNE WITH ITS MEMBERS

Finding something different and fun to draw members in helps bring a sense of community to this Chapter. After a virtual trivia night, one member suggested a *Name That Tune* event to keep the momentum going.

"And the rest [is] history," said Connie Stimpson, vice president of partner engagement for Senex in Indianapolis, and HFMA Greater Heartland Chapter president for 2020-21. "We utilized a DJ with professional equipment for *Name That Tune*," said Stimpson. "This helped to circumvent some sound issues that can occur with Zoom."

HOW TO LEAVE THEM WANTING MORE

For other chapters interested in hosting a similar event, Stimpson suggested the following:

- Have a sponsor pick up the expense for entertainment.
- Practice ahead of time with games like trivia for any glitches that might occur.
- Use networking dollars normally used for live events to pay for mailing prizes to winners of virtual events.

CMS says it plans aggressive price transparency enforcement

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CMS has notified hospitals that they should expect aggressive enforcement of new price transparency rules, including via audits slated to start in January.

CMS's notice, issued on Dec. 18, stated that beginning in January the agency planned to audit the websites of "a sample of hospitals" to determine compliance with the requirements, which took effect Jan. 1. It also said it planned to investigate rule-related complaints that it receives and to review "analyses of non-compliance."

One compliance approach adopted by hospitals, especially lower-revenue organizations, involves using averages of health plan rates for all services, equipment and drugs. But CMS officials participating in a Dec. 8 webcast with hospitals described that approach as non-compliant with the new rule.

In response to CMS's apparent opposition to the rate-averaging approach, hospitals are working with their attorneys to devise a legal defense for its use, industry advisers said. ■

New legislation seeks to take unwelcome surprises out of patient billing

After on-and-off negotiations that spanned the 2019-20 congressional term, the bipartisan, bicameral No Surprises Act was included in a sweeping legislative package that became law in late December.

There could be far-reaching effects when the main provisions begin in 2022.

The primary aim of the law is to ensure patients have to pay only their in-network cost-sharing amount, including deductibles, for emergency care and in nonemergency situations when choosing an in-network provider isn't an option.

Out-of-network providers will be prohibited from balance-billing patients unless they follow strict notice-and-consent procedures. Those include providing an estimate of charges at least 72 hours before the delivery of services.

To resolve payment for out-of-network bills, the first step will be negotiations between providers and insurers that can last up to 30 days. If negotiations fail, a baseball-style arbitration process will be utilized, with the arbitrator required to choose one side's offer rather than landing on a compromise figure.

The arbitrator will rule based on:

- Median in-network rate
- Information related to the provider's training and experience
- Market share of the parties
- Previous contracting history of the parties
- Complexity of the services provided ■

— Nick Hut, HFMA senior editor

\$17-\$20B

Estimated reduction in health plan payments if new surprise-billing legislation had included a rate-benchmarking approach instead of arbitration to resolve out-of-network payment disputes, according to the American Hospital Association

Haven to dissolve after 3-year effort to lower combined employee healthcare costs

Three years after the CEOs of Amazon, Berkshire Hathaway and JPMorgan Chase launched Haven Healthcare, the joint venture is shutting down at the end of February. Haven is a Boston-based not-for-profit entity whose goal was to lower healthcare costs for the three companies' combined 1.2 million U.S. employees.

"In the past three years, Haven explored a wide range of healthcare solutions, as well as piloted new ways to make primary care easier to access, insurance benefits simpler to understand and easier to use, and prescription drugs more affordable," the Jan. 4 dissolution statement read.

The joint venture's dissolution reflects the complexities involved in delivering employee healthcare, which along with the cost of U.S. care delivery, is a topic that has garnered much

1.2M

Number of U.S. employees combined under the Amazon, Berkshire Hathaway and JPMorgan Chase & Co. Haven venture

attention from industry analysts. (See, for example, the Eye on Washington column by Gail Wilensky, PhD, "Status check on Haven's ambitious healthcare venture," published in the October 2020 issue of *hfm*.)

The end of Haven does not mean an end to the three companies' healthcare-focused efforts. "Moving forward, Amazon, Berkshire Hathaway, and JPMorgan Chase & Co. will leverage these insights and continue to collaborate informally to design programs tailored to address the specific needs of their own employee populations," the statement said.

Industry observers should stay tuned to see what new initiatives and innovations might yet arise from Haven's ashes. ■

— Deborah Filipek, HFMA senior editor

Medicare phases out the inpatient-only list, backs off further 340B payment cuts

Medicare will phase out the inpatient-only (IPO) list over three years but won't implement further cuts that were proposed for the 340B discount drug program, according to a CY21 final rule issued in December.

The CMS Outpatient Prospective Payment System final rule confirmed the elimination of the 1,700-procedure IPO list over three years, starting with 300 primarily musculoskeletal-related services in 2021. The IPO list will be completely phased out by 2024.

"The services on the inpatient-only list are often complex and complicated surgical procedures that require the close care and coordinated services provided in a hospital inpatient setting," Tom Nickels, executive vice president

300

Number of primarily musculoskeletal-related services that will be removed from the inpatient-only list in 2021

for the American Hospital Association, said in a written statement.

For procedures removed from the IPO list, CMS will "indefinitely" exempt them from site-of-service claim denials under Medicare Part A, eligibility for referrals to recovery audit contractors (RACs) for noncompliance with the 2-midnight rule and RAC reviews for "patient status."

CMS backed off its proposal to pay for drugs acquired under the 340B program at average sale price (ASP) minus 28.7%. Instead, Medicare will maintain the 2018 formula of ASP minus 22.5%. ■

About the author

Rich Daly is a senior writer/editor in HFMA's Washington, D.C., office. Follow Rich on Twitter: @rdalyhealthcare.

Odeza: Driving engagement through patient-centric digital communications

How do you help healthcare organizations?

At Odeza, we partner with health systems to create a seamless patient communications experience across all points of contact. Our platform delivers artificial intelligence (AI)-assisted digital communications through two-way SMS, voice, email, live chat and web-based chatbots. Unlike other companies in the marketplace, we provide a fully unified consumer communication experience that fosters patient acquisition, access, retention and payments, as well as improved population health.

Using our technology, healthcare organizations can execute on-demand messaging, blast communication campaigns and automated marketing programs. The solution is easy to implement and integrates with leading electronic health records (EHRs) and customer relationship management (CRM) applications. It automatically incorporates data from patient outreach activities and communications into a health system’s EHR or CRM application, offering real-time reporting and analytics.

What are some of the biggest challenges you see currently affecting healthcare organizations?

From our perspective, there are three main trends facing organizations right now. First is the pressure to reduce costs due to COVID-19. The pandemic has created catastrophic financial challenges for U.S. health systems. Consequently, they are looking to curb expenses by reducing administrative labor costs and consolidating vendors.

Second, today’s healthcare consumers are seeking care on their own terms. They want a prompt, seamless experience and digital

touch points. And research shows they are willing to pay for it.¹ Much like their buying decisions, provider selection is increasingly based on factors such as convenience, comfort, availability and flexibility. According to a recent survey, 82% of patients would switch providers over a bad experience.² That can translate to a 10% to 20% loss in revenue for healthcare organizations.³ As technology advances in other areas, people expect to see the same in healthcare. Maximizing convenience and ease of access is now mission critical to compete in the modern healthcare economy. This requires providers to reexamine how they attract new patients, engage them consistently and retain their loyalty. Providers who don’t accommodate changing expectations for a more consumer-like experience jeopardize revenue and competitive advantage.

Underlying the first two trends is the problem of provider underutilization. Unfilled appointment slots cost money. When you combine this issue with no-show rates that can reach up to 30%, revenue becomes unpredictable.⁴ In fact, one estimate indicates that the total cost of missed healthcare appointments is more than \$150 billion a year.⁵ An anticipated provider shortage, projected over the next decade, will only compound the problem. This perfect storm of factors will surely have revenue implications for providers, and patient health and safety ramifications as well.

How does your platform help address these challenges?

Addressing the financial impact of COVID-19. In 2020, Odeza worked hand in hand with customers to automate the delivery of millions of digital communications, including sharing the latest available

1. "The healthcare shift: The transformation to consumer centricity," *The Prophet*, accessed Jan. 7, 2021.
 2. Wagner E., "Insights into what patients really want from providers," *Salesforce blog*, Jan. 5, 2020.
 3. Lagasse, J., "Losing patients to other providers can cost some healthcare facilities up to 10 percent of their revenue," *Healthcare Finance News*, Nov. 9, 2018.

4. Gier, J., "Missed appointments cost the U.S. healthcare system \$150B each year," *Health Management Technology*, May 2017.
 5. Ibid.

Figure 1. Business impact of email blast campaigns

Campaign Name	Completion Date	# of Patients Reached	Business Impact
COVID-19 preparation: Halting elective surgeries	Mar 15, 2020	28,000	4,500 hours of labor cost savings (due to automating patient outreach)
Telehealth awareness: Primary and specialty care	Apr 10, 2020	450,000	24% increase in telehealth visit volume (between April 10, 2020 – May 8, 2020)
Back to normalcy: Open for business	May 26, 2020	525,000	29% increase in provider utilization (between May 26, 2020 – June 23, 2020)
Care gap follow-up: Cancellations and no-shows	Jun 10, 2020	200,000	25% increase in rescheduling rate (between June 10, 2020 – July 8, 2020)

Source: Odeza

information on the virus. For example, we helped health systems deploy a series of targeted email blast campaigns related to halting elective surgeries, boosting telehealth awareness, communicating whether an organization was open for business and following up on cancellations and no-shows. (See Figure 1).

As the country begins COVID-19 vaccine rollouts, Odeza is ready to partner with customers to automate immunization communications using a patient's preferred communication channel, such as SMS, voice or email. Our Consumer Chat solution can also cost-effectively manage call volume for patient outreach and customer support centers by leveraging a digital chatbot and live chat capabilities through a pop-up window on an organization's website or portal.

Statistics show more than 41% of customers expect live chat on a website.⁶ That percentage jumps to 50% for mobile visitors. Odeza's digital chatbot uses conversational AI to assist consumers with website navigation, appointment scheduling, symptom checking and triaging to the appropriate care setting. The live chat component provides an option to instantly chat with a human agent affiliated with the health system.

Odeza helps healthcare organizations eliminate labor costs by automating manual patient communication workflows – in some cases cutting the cost of outreach by 30% to 50%. Similarly, by digitizing print mail communications, our customers can deliver population-wide messages at a fraction of the cost and time. Our platform also

6. MacDonald, S., "25 reasons live chat can help you grow your business," SuperOffice, Jan. 4, 2021.

decreases vendor costs. For instance, we can replace early-out vendors using payment reminders, which can increase the self-pay collection rate. An organization may not need a propensity-to-pay vendor if they use our platform because our solution automates all patient payment outreach using HIPAA-compliant texts, voice calls and emails.

Responding to rising consumerism. While patient portals were healthcare's first foray into bi-directional patient communication, adoption rates remain low because people would rather communicate via their preferred communication channels. Our unified set of digital tools helps health systems improve multi-channel communication by augmenting their existing patient portals.

Short post-visit text surveys ask patients to rate their experience. Positive reviews trigger a prompt to share a review and point the user to all major online review sites. Negative reviews give organizations an actionable opportunity to evaluate performance and initiate a workflow tool that guides staff through service recovery strategies. Our customers have seen an 80% to 95% increase in positive online reviews after implementing this feature.

Tackling provider underutilization. Odeza's platform drives appointment volume and reduces no-shows by automating appointment communications. For instance, our technology will send appointment confirmations, reminders and waitlist opt-in texts to patients immediately after an appointment is scheduled. If an earlier appointment becomes available, a waitlisted patient is

notified via text. Individuals are able to see their doctor faster, and healthcare organizations avoid costly unfilled appointment slots. In addition, our solution connects with patients about unscheduled referrals, orders, and follow-ups, optimizing the providers' schedules and closing clinical care gaps.

What are some considerations for healthcare leaders when choosing this type of solution?

Make sure your potential partner:

- Reviews your organization's current patient engagement initiatives and develops a roadmap that builds on those activities
- Offers a comprehensive, unified platform that addresses multiple use cases across the patient journey – a more cost-effective and scalable approach than pursuing a series of point solutions
- Has proven expertise in delivering a seamless, bi-directional platform that integrates with your EHR in real time, ensuring that patients and care teams are in sync at every care touchpoint

How can healthcare providers learn more about your organization?

To learn how we can elevate and optimize your patient and consumer communications strategy, visit us at odeza.com. ■



In this Business Profile, Dan Melillo, founder and CEO of Odeza, talks about using an integrated digital

communications platform to deliver a seamless patient experience that drives operational efficiency, reduces costs and boosts revenue.



Odeza's digital communication platform unifies, simplifies and automates patient outreach with two-way texting, voice, email, live chat and web-based chatbots. The digital health company's scalable AI-assisted technology seamlessly integrates with existing systems and EHRs/CRMs, bridging points of contact to reach today's highly connected healthcare consumer.

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U.S. hospitals face bleak future after difficult 2020

The past year was challenging for hospitals, with little likelihood of substantial improvements any time soon.



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Many hospitals faced financial challenges in 2020 as they were compelled to focus almost exclusively on treating COVID-19 patients

while having to defer all elective surgery for at least two months. Because hospitals largely rely on revenue from elective surgery to offset the costs of lower-paid services, being unable to schedule elective surgeries had significant financial consequences for many hospitals.

Meanwhile, delayed and deferred treatments began to compromise the health of patients with severe coronary disease and cancer. The full effect of the delayed treatment for these patients is not likely to be fully known or measurable until sometime in the future.

DISPROPORTIONATE EFFECTS

Some types of hospitals were especially hard-hit by the pandemic, with the intensity of the impact having been determined by the types of patients they tend to admit. Safety-net hospitals have probably been most hard hit, given their high proportions of indigent and socially vulnerable patients. It is no surprise that these hospitals would be most affected, because even before the pandemic, many were already reporting they were that financially pressed.

Beyond existing financial challenges these hospitals have faced since before 2020, the past year had a disproportionately adverse impact on them simply because they had a disproportionate share of COVID-19 admissions. This reality reflects the fact that the disease most easily spreads in poorer communities and communities housing large numbers of multigenerational family units — the communities primarily served by safety-net hospitals.

ADDING TO THE FINANCIAL STRESS

Noncompliance with COVID-19 safety protocols by many Americans will likely exacerbate the difficulties facing hospitals. In the first weeks of 2021, hospitals have been bracing for the surge of patients from heedless Christmas/New Year's celebrations, after having just finished coping with a post-Thanksgiving rise in patients with COVID-19. Despite repeated warnings by public health officials regarding the dangers of families and friends gathering together for in-person events, airports reported the holidays saw the largest numbers of people traveling through airports since the start of the pandemic. Because many of these gatherings were held indoors, given the inclement weather in most parts of the country, the surge in COVID-19 cases was expected to be greater than it was in the summer and early fall when gatherings could be outside.

The increase in hospitalized patients is coming at a time when hospitals had for a long time already been reporting mounting financial stress. An HFMA survey of 309 hospitals and health systems in late 2008 found:

- 17% of the organizations reported a debt offering failure.
- 38% reported an increase in the cost of debt.
- 70% expected to reduce spending for medical technology.
- 72% expected to reduce new construction.
- 53% expected to reduce operating expenditures.

In November 2020, based on an analysis of 900 hospitals, Kaufman Hall reported that, even with federal relief, the mean operating margin for hospitals had declined almost 19% from January through October 2020.^a

Moreover, as the nation approached the year's end, coronavirus-related hospitalizations surpassed 60,000, with 17 states reporting record numbers, and the outlook was for this alarming rise in hospitalizations to continue into 2021.^b

OUTLOOK MIXED FOR 2021

Despite these trends, a few promising developments are occurring. Mortality rates from COVID-19 have been dropping over time as older populations, the most vulnerable to death, are now representing a smaller share of COVID-19 admissions. At the end of March, the median age of admission was 46; by the end of August it was 38.^c The result has been a reduced use of ventilators, reduced hospital stays for those admitted and reduced mortality rates.

Nonetheless, the advantages associated with admissions of younger COVID-19 cohorts, on average, appear to be offset by a late-year decline in the effectiveness of strategies that had been used with success for treating the large numbers of COVID-19 admissions. By mid-November, 11 states had more than 80% of all their hospital beds filled with patients with COVID-19 and 18 states had more than 80% of their ICU beds filled with such patients.^d These experiences are especially problematic in rural areas, which tend to have fewer staffed ICU beds than rural areas — 11 per 100,000 versus a U.S. average of 27 per 100,000.

131,889

Number of hospitalizations in the U.S. due to COVID-19 on Jan. 8, 2021



In addition to declining operating margins, many hospitals are also reporting significant staffing shortages. In some cases, the shortages have resulted in the need to move patients. There also are widespread reports of health professionals being required to quarantine after testing positive for COVID-19.

A LONG AND DIFFICULT ROAD AHEAD

As 2021 begins, the challenges from COVID-19 are clearly getting worse before they get better. On Jan. 8, the number of patients with COVID-19 hospitalized on a given day nationwide reached 131,889, eclipsing the record set in the last week of 2020.^e Rhode Island has had to open a field hospital, and Atlanta has reopened a field hospital. As COVID-19 cases climb in the start of 2021, the country is likely to see a continued rise in hospitalizations for the foreseeable future, because for most people it takes five to seven days after exposure to begin to show symptoms.

The availability and distribution of vaccines is the most hopeful development the nation has seen through this terrible pandemic. But it remains uncertain when the vaccination process will help turn the corner of COVID-19 and restore any approximation of normalcy. ■

a. *National Hospital Flash Report*, Kaufman Hall, November 2020.

b. Almasy, S., Maxouris, C., and Hanna, J., "Coronavirus hospitalizations in US reach an all-time high with more than 60,000," *CNN Health*, Nov. 10, 2020.

c. Horwitz, L.I., et al., "Trends in COVID-19 risk-adjusted mortality rates," *Journal of Hospital Medicine*, Oct. 23, 2020.

d. Berlin, G., et al., "Challenges emerge for the U.S. healthcare system as COVID-19 cases rise," McKinsey & Company, Nov. 25, 2020.

e. The COVID Tracking Project, "US currently hospitalized," *The Atlantic*, Data accessed, Jan. 8, 2021.

About the author

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of the Health Care Financing Administration, now CMS; and a former chair of the Medicare Payment Advisory Commission.

Navigating the unimaginable: A COVID-19 panel discussion with senior financial executives

Hospitals and health systems have seen transformative change since the start of the COVID-19 public health crisis.

The pandemic's impact on operational priorities and strategic directions for three health systems was talked about by their respective CFOs during a panel discussion moderated by Stephen Thome, principal, Grant Thornton. The following is an excerpt.

Stephen Thome: From a leadership perspective, what were the biggest challenges you faced in responding to COVID-19 initially?

Fred Hargett: As a member of our health system's senior leadership team, it was important to project optimism in the face of the tremendous uncertainty and unknowns. Early on, we made a conscious effort to provide hope and inspiration to our team members, recognizing that they had to come to work and feel supported and cared for, despite all that was going on. We have continued to focus on the positive and strive to maintain balance, which involves taking a long-term perspective and avoiding knee-jerk reactions.

Matt Cox: A crisis of this scope and scale is something that none of us have gone through before. Although we could draw from previous experiences, we have had to make unique decisions. And some of those included spending large amounts of money on things like ventilators and personal protective equipment (PPE). Personally, I had to be generous about opening up operating

and capital budgets — probably more than I would be comfortable doing in normal circumstances. I had to trust my colleagues and believe that we were doing the right thing, even though the right thing would ultimately end up putting us in a loss position. I also had to find ways to collaborate with, support, educate and influence other leadership team members remotely. I couldn't just stop by someone's office and have a conversation. I had to be able to communicate over virtual platforms and meaningfully connect through a computer screen.

Keith Kasper: In this type of situation, people are watching you as a senior leader. If you appear agitated, it affects everyone in the organization. Projecting a level of confidence is essential but hard. Being honest and over-communicating across the enterprise has been critical. It takes guts to go on a Zoom call with 700 to 1,000 employees and answer questions, but you have to do it. It gives people a sense of comfort that we might not have all the answers, but we're doing our best, and we will get through whatever is going to come.

Thome: Are there changes your organizations have made that will continue? Going forward, how do you see your organization being different competitively and operationally?

Kasper: We've accelerated our technology adoption by about five to seven years. Although we had elements in place before

the start of the pandemic in terms of new electronic health record (EHR) functionalities and telemedicine, we saw limited patient and provider uptake. That all changed in March. For example, we went from 1,000 virtual visits a week to 35,000, and we've settled in at about 30% of the latter number, which I think we'll continue.

Cox: We have seen benefits in having a little more than 50% of our revenue come through our internal health plan. Our organization is probably unusual in that we are on track to beat our operating margin targets for the year, where most integrated delivery systems probably aren't going to do that. As we've seen the value in having our own plan and continue to refine our ability to manage patient populations, I think we are accelerating our movement along the risk continuum.

Thome: Are there specific strategic initiatives that you can focus on now while still in the COVID-19 environment?

Cox: About a year ago, we rolled out robots in our largest facilities to help move supplies, meal trays and the like. And we have benefited from having these during the pandemic as we dealt with labor shortages. As a result, we have been working from a strategic standpoint to ramp up automation and process improvements that will help us ultimately lower costs and reduce our reliance on labor. We've also continued our work around transparency and meeting the pending January 1 deadlines related to

transparency, personalization and digitization. We did consolidate some of our other strategic priorities. Before COVID, we were tracking 25 initiatives, and we narrowed that list down to six, increasing our focus on those critical areas for six months. And we met our goals. Two days ago, we had a virtual planning retreat and picked new initiatives for the next six months.

Hargett: We did something similar, concentrating on four initiatives. Revisiting our capital plan was necessary to realign priorities. For example, before COVID, we were focused on building brick-and-mortar hospitals and bed towers because people were moving to our communities and suburbs, and we needed to remain competitive. But we paused a lot of that building and redirected spending to digital consumer engagement and activation strategies to make sure our communities knew we were open and safe and how to access care. We're now spending capital on expanding telehealth, patient activation and consumer engagement capabilities. Although we're starting to revisit some of the brick-and-mortar spending, we're rethinking the size of facilities, the footprint, the location and what we will actually need.

Kasper: The gap between struggling providers and those that are doing better continues to widen, and the public health crisis has only made that gap larger. While I don't know if we'll see more mergers and acquisitions over the long term, the pandemic is definitely increasing the pressure on struggling providers to divest some of their service offerings.

For us, this creates an opportunity. We have a lot of fiercely independent hospitals around here, and they're not as fiercely independent today as they were a year ago. We've taken the opportunity to help them, such as by offering PPE and other administrative or programmatic assistance, because we think those efforts will pay dividends in the future.

Thome: Where do you think the industry's workforce strategies are headed over the next five years?

Hargett: In March, we sent 7,000 back-office employees home to work with laptops in about two weeks. And we're still remote to this day. We've announced corporately that team members who can work from home should continue doing so through June 2021. At the same time, we are implementing a plan to reduce our back-office facility space by 35% to 40% over a three-year period.

When we first went remote, I worried about data security and privacy, as well as staff productivity off-site. But, so far, our metrics indicate that team productivity and engagement is higher than it was pre-pandemic. This crisis has fundamentally changed U.S. business culture, forcing us to realize that we all don't have to go into the office to get things done. Especially for younger professionals who don't seem to care as much about those traditional ways of doing business, the remote work trend is here to stay.

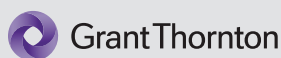
Kasper: We are also much more successful at remote work than we imagined we would

be. I don't expect we will ever return to where we were, and we need to make sure this new model is sustainable. At the same time, we have to have enough latitude to accommodate those who do want to work in an office because people's home situations are different. The fact that we're pushing things out to next summer gives us the time to understand the dynamics better and ensure employees have what they need to be effective, regardless of their work location.

Cox: One thing we're starting to work through is how we maintain our culture with people working from home. I've told my staff to intentionally touch base with people, and I'm doing this myself, with prescheduled meetings to check in and maintain relationships. I've also encouraged my staff to take a few minutes before the start of team meetings to talk to people about non-work things to recreate the time around the water cooler. This focus on collaboration and relationship-building is crucial because the biggest risk we have around the work-from-home shift is whether we can maintain our compassionate, productive culture. ■

Matt Cox is CFO for Spectrum Health System in Grand Rapids, Michigan, **Fred Hargett** is executive vice-president of Novant Health in Charlotte, North Carolina, and **Keith Kasper** is CFO of PennMedicine in Philadelphia.

This article captures a portion of the CFO panel at the Large Systems Controller Council Virtual Fall Meeting, of which Grant Thornton is a sponsor.



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features

COVER STORY EXPERT REVIEWED FEATURES

Dalton Tong, longtime
healthcare finance leader and
HFMA member.

PHOTOS BY MARSHALL CLARKE

LOOKING FORWARD ON HEALTHCARE INEQUITY

Dalton Tong, a longtime healthcare finance leader — and likely the first Black member of the HFMA National Board — shares his story and suggests ways colleagues can improve opportunities within healthcare and across society for Black people and other minorities.

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After waves of racial unrest broke across the country in 2020, healthcare organizations and leaders have renewed their focus on the effects of racism and racial disparities. As healthcare leaders look for actions to address those challenges and health inequity issues, Dalton A. Tong, FHFMA, CPA, MBA, 70, shared his experiences and vision of how the sector can help.

Following 50 years serving in various roles in healthcare finance practice and education, Tong sees progress and improvements, as well as the need for new efforts to bolster low-income, minority patients and attract more Black professionals into the field.

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Tong's hard-won insight on the challenges and opportunities for improvement stems from nearly 30 years of working in various healthcare finance and leadership roles in the Baltimore-Washington, D.C., region followed by two decades instructing new generations of students on the intricacies of healthcare finance.

The insight also stems from his roots in Guyana, in South America, where his mother raised him and his three sisters. Growing up without access to running water and substantial meals, Tong worked to advance through education. At 14, he obtained international certification to teach local high school students and only later was able to obtain his own high school diploma at night school, while working during the day.

In 1970, at the age of 20, Tong immigrated to the U.S. to study accounting at the University of Baltimore. Within months of starting college, he took a part-time accounting clerk job at South Baltimore General Hospital.

Three decades later, Tong would serve as the director of the University of Baltimore's honors accounting program and as a senior professional faculty member of Johns Hopkins University.

"I have come from a faraway place to a point in my life where I can reflect back," Tong said.

Reflecting in public did not come easily to the modest Tong, but instead followed the prodding of his adult daughters to share his story and insights and — hopefully — to inspire others to follow in his footsteps.

"Why do Black students want to go to engineering school? They see Black astronauts," Tong said. "Why do they want to go to medical school? Why do they want to become lawyers? They see pictures, they see evidence of the investments and the rewards. Healthcare finance should do the same thing."

WHAT HEALTHCARE FINANCE CAN LOOK LIKE TO MINORITY PROFESSIONALS

Tong recalls that for his first job in a hospital, his "office" was in a hallway near the bathroom entrance. It was a strange arrangement that only later drew Tong's reflection.

"I was insensitive to what was happening then," Tong said. "When I reflect now, I can see some unconscious bias perhaps that may have been at work, or perhaps there was some consciousness about [my] desk location to say, 'Here's this young Black guy who is here with us. Let's put him where he belongs.'"

“

I had achieved all of this stuff, but there were times where I would go to meetings and, being the only Black person, I was so ostracized and couldn't chat with people.”

But Tong continued to pursue his education and professional training, and within 10 years had risen to vice president of finance for the 500-bed teaching hospital.

"I went from the restroom to the boardroom in a few years at that place," Tong said. "Therein resides the satisfaction, I suppose."

The hospital also invested in Tong, including funding his participation in a Harvard executive education program.

In 1985, Tong went on to become CFO of Greater Southeast Community Hospital. Six years later he became CFO of Greater Southeast Healthcare System, based in Washington, D.C., its COO in 1992 and its CEO two years after.

"That has probably happened to a lot of people, [but] we don't talk a lot about it among Black people in healthcare," said Tong of his career trajectory.

Tong talks about coming to "an intersection of success and loneliness" at one point in his career.

"I had achieved all of this stuff, but there were times where I would go to meetings and, being the only Black person, I was so ostracized and couldn't chat with people," Tong said about his time as a mid-level executive. "I may have had a suit and tie [like everyone else] in the room, but I was not even recognized. I had arrived, man, but you're still very lonely."

HOW THINGS HAVE CHANGED

The healthcare sector has changed over time in some important ways.

That low point in Tong's professional outlook was followed by what he describes as "gradual inclusion."

Tong attributes part of that improvement to his involvement with HFMA.

HFMA's then-CEO, Dick Clarke, reached out to Tong in the early 1990s, by which point Tong had served as president of HFMA's Washington, D.C., Chapter, about rising to serve as a chapter liaison representative for Washington, D.C., North Carolina and Virginia.

"Dick took an interest and ensured that I felt I belonged in the organization," Tong said.

Tong rose to serve on the HFMA National Board for two terms, spanning 1993 to 1995. Although the Association does not have records on the race of Board members, Tong is believed to be the first Black member of the Board. When HFMA created a National Diversity Task Force in the early 1990s, Tong served as chairman for three years.

CONTINUING RACIAL CHALLENGES IN HEALTHCARE

The societal climate for minorities, including their health status, is a continuing challenge, but there are opportunities for finance leaders to drive improvements.

Tong has long reflected on the rise of racial concerns in U.S. society and sees a variety of ways that the healthcare industry, including finance, can help address those. For instance, Black people are twice as likely to be uninsured as white people, according to a U.S. Census Bureau report. That can pose a significant financial barrier to care.

“We’ve made tremendous progress, but at the same time there is still a void of attention that needs to be addressed,” Tong said. “It’s a malignancy, but it is potentially curable.”

Tong cited the need for metrics with which to measure progress over time. However, sharp disagreement among those who want to address inequities in healthcare remains about those metrics, such as total number of minority and women employees versus numbers in leadership specifically.

In healthcare, racial inequities are starkest in the indigent population, which remains the case despite the Affordable Care Act having ameliorated the situation somewhat, he said.

“People go to bed and the nightmare they have is waking up the next morning to find they have no healthcare insurance,” Tong said. “Availability and access issues will continue to be on the radar screen because they have eluded us. Sustainable access, sustainable availability.”

Another priority for healthcare in efforts to reduce racial disparities is addressing the cost of care, he said.

“We need to find leaders who can imagine ways to bring together the right, unbiased minds devoid of political instincts, but just caring minds who can sit down and begin to imagine what a utopia healthcare system might be like,” Tong said. “It’s very possible, but it’s not going to be easy.”

Tong said healthcare CFOs can better stand up for others by first standing up for themselves.

“They would have to be at least as courageous as others have been in insisting that they have a voice at the table, not just pencil pushing and looking at numbers, and helping leaders to understand the impact of those numbers,” Tong said.

The lesson came from his own experience when he aimed to move beyond his organization’s numbers to find ways to convey their meaning.

Training can allow finance professionals to distinguish between needs and wants, target efficiency, engage in optimality and drive toward good choices.

“The CFO is in the pivotal position. They control the money, and if they are listened to, they can then share their

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Dalton Tong’s storied career in healthcare

Dalton Tong’s 50 years in healthcare finance practice and education include a steep rise through the ranks of organizations. Some of his career highlights include:

South Baltimore General Hospital

- **1970:** Accounting clerk
- **1973:** Chief accountant
- **1975:** Controller
- **1980:** Vice president of finance

Greater Southeast Community Hospital

- **1985:** Vice president and CFO

Greater Southeast Healthcare System

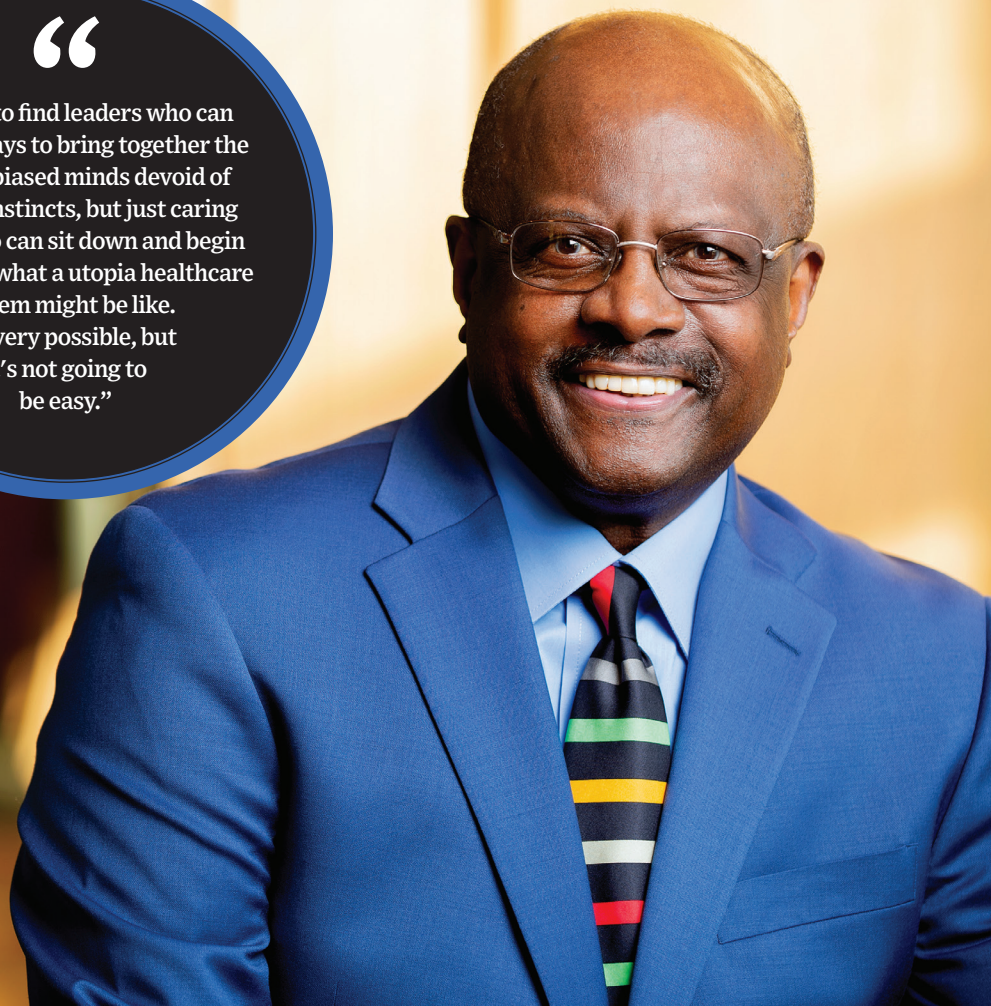
- **1991:** Vice president of finance and CFO
- **1992:** COO
- **1994:** CEO

University faculty positions

- **1999:** Senior professional faculty at Johns Hopkins University
- **2006:** Adjunct faculty member at Towson University
- **2009:** Director of the accounting honors program at University of Baltimore

“

We need to find leaders who can imagine ways to bring together the right, unbiased minds devoid of political instincts, but just caring minds who can sit down and begin to imagine what a utopia healthcare system might be like. It's very possible, but it's not going to be easy.”



professional discipline to get boards and communities to buy into what, at times, could be a sacrifice,” Tong said. “But ultimately, it would allow a sustainable outcome that would make for a better product.”

Major systemic change likely will mean some form of rationing, Tong said, because there is a scarcity of resources. That scarcity will require CFOs to make choices, and changes may entail less spending on personnel and more spending in technology.

“How much we spend, where we spend money, how we staff and where we staff for optimal results [are all key decision areas],” Tong said.

Technology, such as better diagnostic and therapeutic technologies, may mean fewer people are required to drive outcomes. That can be both a challenge and an opportunity.

“That might be a value-added presence that a CFO might have. If they can imagine a future that is so different, and if they can help plan for the acquisition of the response to that future, it will help sustain their organizations in ways that weren’t heretofore imagined,” Tong said.

Healthcare CFOs also can help address racial disparities in health status by focusing on prevention and wellness in the community. Those were significant priorities when Tong was a leader at Greater Southeast Healthcare System.

“We went into community clinics, we prepared young teenage mothers for interventions before their babies were born because when we didn’t do that, we saw the results: Sick babies in our NICU units costing a lot of money,” Tong said.

Initiatives also included outreach to barber shops, where the health system encouraged Black men to receive blood pressure checks while they were getting haircuts.

THE CRITICAL CHALLENGE OF ATTRACTING MINORITIES TO HEALTHCARE FINANCE

Even though there are no active barriers to opportunities for Black people and other minorities in healthcare finance, growing their ranks within the industry segment will require a commitment from organizations to pique the interest of potential recruits.

Initiatives that can help minority recruitment efforts include scholarships, the sharing of anecdotes by finance members from different demographic groups and initiatives to create access.

“If organizations can create ways to make that happen, to make students have an interest in becoming part of the organization, it will go a long way,” Tong said.

Tong has aimed to follow that advice during teaching stints at multiple colleges, where he has urged young Black students to consider careers in healthcare finance.

“I would say, ‘Here is an opportunity waiting for you in healthcare finance. Even though you don’t see a lot of faces that reflect the composition of that industry, feel free to venture into it, and I am here to help you,’” Tong said.

Having more minority members in healthcare finance may result in improved empathy for the situations faced by patients who cannot afford their care.

“Having people at the front line in the hospitals, the business counselors and the debt collectors, etc., showing a little bit of patience might help,” Tong said. “A lot of that might go against the grain of the economic objectives of the organization, the profit imperative. If you can find people who can manage that profit imperative with some dose of empathy here and there without collapsing your organization, it would make for a good outcome.”

Beyond a lack of broad insurance coverage, health inequities are driven by divergences in the availability of healthcare.

Initiatives that can help minority recruitment efforts include scholarships, the sharing of anecdotes by finance members from different demographic groups and initiatives to create access, Tong says.

“It is one thing to access it. It’s another thing to ensure there are the right capabilities in these institutions,” Tong said, referring to hospitals that serve large low-income minority populations.

He highlighted the need to reverse the increasing technological gap between suburban hospitals and inner-city facilities. That way, no matter where healthcare facilities are located, they would have capabilities like high-quality neonatal intensive care units.

“I’ve worked in urban healthcare in Washington, D.C., and Baltimore, and I can tell you, [for] the poor population, there [was] a difference in the care they got at the time,” Tong said. “There was a difference in care because they have no insurance to command that care.”

That challenge applies beyond the uninsured to patients enrolled in Medicaid.

Medicaid “provides some level of health subsistence, [but] it is not the optimal care that the same person with a bad liver or gall bladder is going to get out in a county somewhere,” Tong said. “I loathe saying that, but it is the reality.”

Tong urged healthcare finance professionals to lead in addressing societal inequities and healthcare disparities.

“We should let people know that [for] this problem we call the healthcare problem, the solutions reside with people who matriculate and come out of the healthcare financial ranks,” Tong said.

Tong said some were not surprised that he became a health system CEO after serving as a CFO because of the insights the finance role provided.

“I had my hands on some buttons, and I knew where the resources resided; I had a discipline that I cultivated about measuring and understanding needs and wants,” Tong said. “HFMA in its programs and education can cultivate a society of solution-makers, who can then be mobilized around the country to make a difference in these situations when we encounter them.” ■

About the author

Rich Daly is a senior writer/editor with HFMA’s Washington, D.C., office.



EXPERT REVIEWED

How hospitals benefit by preventing hospital-acquired pressure injuries

By one estimate, about 17,000 lawsuits related to pressure injuries are filed annually.



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Hospital-acquired pressure injuries (HAPIs) affect 2.5 million patients per year in the United States. With the cost of treating a single instance as high as \$70,000, and because many payers, including Medicare and Medicaid, are not covering them, the business case for prevention is apparent.^a HAPIs also are the second most common hospital lawsuit claim after wrongful death, claiming 60,000 patients each year, according to a study published by *Ostomy/Wound Management*.^b Although the health-related complications associated with PIs are high, there have been no comprehensive assessments of PI costs, including both direct and indirect costs, on an individual hospital basis.

THE FINANCIAL CASE FOR PRIORITIZING PREVENTION

In the United States, PIs are scored by stage, and nearly half of all PIs can be categorized as late-stage (Stages 3, 4 or unstageable), according to the *Ostomy/Wound Management* study.

a. Collaborative Healthcare Patient Safety Organization, "By the numbers: CHPSO pressure injury data," Aug. 4, 2017.

b. Bauer, K., Rock, K., Nazzal, M., Jones, O., and Qu, W., "Pressure ulcers in the United States' inpatient population from 2008 to 2012: Results of a retrospective nationwide study," *Ostomy/Wound Management*, November 2016.

Hospitals face financial burdens due to CMS regulations around HAPIs. They may receive no payment for incremental treatment costs of HAPIs.



Late-stage PIs take months or longer to heal and require additional resources to treat infectious complications. Some consequences that lead to additional cost include readmissions, increased lengths of stay (LOS) and clinical resources like antibiotics, diagnostic tests, procedures (e.g., debridement) and use of wound care disposables. In 2007, CMS estimated that each late-stage PI added \$43,180 in costs to a hospital stay, while other estimates exceed \$100,000.^c

Hospitals also face financial burdens due to CMS regulations around HAPIs. They may receive no payment for incremental treatment costs of HAPIs, which CMS and many commercial health plans consider preventable. Hospitals with higher readmission rates and hospital acquired conditions (HACs), commonly seen in HAPI patients, are penalized by various CMS Quality Care Programs. Nearly 80% of hospitals receive some form of penalty.^d

c. CMS, "Medicare program; changes to the hospital inpatient prospective payment systems and fiscal year 2009 rates; payments for graduate medical education in certain emergency situations; changes to disclosure of physician ownership in hospitals and physician self-referral rules; updates to the long-term care prospective payment system; updates to certain IPPS-excluded hospitals; and collection of information regarding financial relationships between hospitals," *Federal Register*, Aug. 19, 2008; and Brem, H., Maggi, J., Nierman, D., et al., "High cost of stage IV pressure ulcers," *The American Journal of Surgery*, October 2010.

d. Rau, J., "Medicare eases readmission penalties against safety-net hospitals," *Kaiser Health News*, Sept. 26, 2018.

MODELING THE COST OF HAPIS

In order to fully address the risk of HAPIs, hospitals need to develop novel preventive solutions to augment current treatment approaches. To assess the cost effectiveness of any HAPI prevention or treatment protocol, an assessment of the financial impact of HAPIs on an individual hospital or hospital system is needed.

A model of the annual costs associated with HAPIs at the individual hospital level, using actual hospital characteristics, HAPI-related costs and outcome variables obtained from literature sources is evident in the exhibit on page 26. Input variables included bed size, occupancy rate, high-risk beds, PI incidence and the incremental cost of late-stage HAPIs (See the exhibit for a complete list of model inputs used to calculate the figures below).

The potential budgetary impact due to reduction of HAPI incidence rates at a medium-sized hospital archetype (based on CDC benchmarks) of 344 beds was evaluated using this model. For

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60,000

Annual patient deaths as a result of HAPIs

17,000

HAPI lawsuits filed annually

\$5 million

Potential annual savings of a medium-sized hospital with a 50% reduction in HAPIs

this analysis, occupancy rate was fixed at 65% and the average initial PI incidence was set at 3.6%.^e

In the base case scenario, this medium-sized hospital would experience 644 HAPIs and 146 readmissions within 30 days due to HAPIs each year, with estimated costs totaling \$10.4 million annually. Leaving all other variables constant, a 50% reduction in the HAPI rate would result in a potential savings of over \$5 million. That level of reduction (322 HAPIs) is equivalent to preventing less than one HAPI per day on average. Therefore, even a small reduction in daily HAPI incidence can substantially impact a hospital's costs, improve patient outcomes and reduce LOS for these patients, creating additional capacity for additional inpatient cases and revenue.

e. Bergquist-Beringer, S., Dong, L., He, J., Dunton, N., "Pressure ulcers and prevention among acute care hospitals in the United States," *Joint Commission Journal on Quality and Patient Safety*, September 2013.

Base case model inputs

For the example base case analysis, the indicated values were set for each variable.

Model inputs	Value
Hospital size (# beds)	Medium: 344 beds
Occupancy rate (medium)	Medium: 65%
Pressure injury (PI) incidence rate	3.6%
Units adopted	100% of high-risk beds
PI reduction from high-risk beds	99%
High-risk patient %	40%
Readmission rate	22.6%
Stage 1 incidence % of Total PI	16.0%
Stage 2 incidence % of Total PI	38.0%
Late-stage incidence % of Total PI	46%
Unstageable incidence % of Total PI	7.0%
Stage 1 PI treatment cost per case	\$2,000
Stage 2 PI treatment cost per case	\$8,000
Late-stage PI treatment cost per case	\$18,000

Even a small reduction in daily HAPI incidence can substantially impact a hospital's costs, improve patient outcomes and reduce LOS for these patients.

Notably, these hypothetical reductions do not consider potential CMS penalties that may be reduced by a decreased HAPI rate, but it is clear that reducing HAPIs can greatly increase an institution's chance of avoiding such penalties. Also, newer measures such as days institutionalized or days in the community or lost workdays would be dramatically impacted by improvements in dealing with HAPIs.

CONCLUSION

Poor clinical outcomes for patients and a substantial financial burden for U.S. hospitals are the concerns related to HAPIs. Hospital leaders should evaluate the costs associated with HAPIs and examine the savings possible through HAPI-specific prevention efforts. ■

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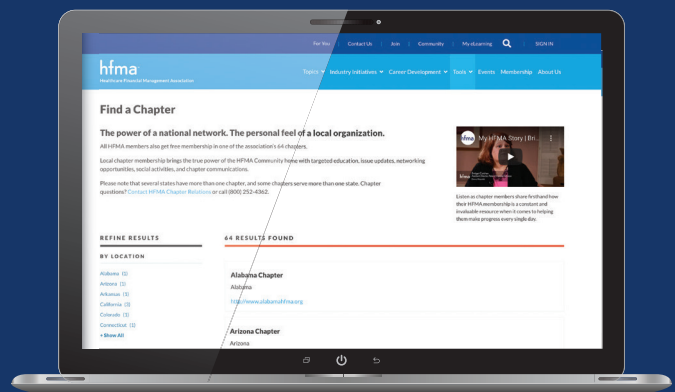
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EXPERT REVIEWED



340B Program success depends on the quality of self-auditing

It is imperative that healthcare organizations participating in the 340B Drug Pricing Program perform self-auditing of their compliance with the program if it is to continue to deliver its important benefits.



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The 340B Drug Pricing Program plays a critical role in U.S. healthcare by helping to improve the quality of healthcare services in rural communities and communities serving a disproportionate share of indigent patients. It does so by giving participating organizations access to essential pharmaceuticals at a reduced price. This benefit helps them stretch financial resources in an environment of constant pressure from rising expenses and decreasing payment.

However, the 340B Program has become a target of some lawmakers due to a lack of transparency around savings and variability in the application of program rules. This scrutiny from lawmakers, coupled with actions of pharmaceutical companies to challenge the program, makes it imperative that health systems and other 340B Program participants act now to ensure they have a robust 340B compliance program in place, with effective self-auditing capabilities.

340B PROGRAM CHALLENGES

Pharmaceutical manufacturers, including Merck, Sanofi, Novartis and AstraZeneca, recently entered the fray by taking increasingly aggressive positions against core 340B Program elements, including limiting access to the program's pricing on certain drugs and contract pharmacy

locations. Although some lawmakers and the U.S. Department of Health and Human Services have released statements condemning the manufacturers for these actions, the near-term outcome will likely be increased scrutiny around the compliance aspects of the 340B Program, including diversion and duplicate discounts.

It therefore is more important than ever that 340B-covered entities use their resources wisely, including not only the savings generated by 340B, but also the time and human capital resources that they devote to ensuring 340B Program compliance. Spending time initially by planning and assessing 340B compliance risk can set the stage for more effective and efficient self-audits, which are imperative for ensuring program compliance. The value of these audits can be considerably enhanced by implementing a targeted approach in transaction audits that focuses on transactions with specific attributes.

340B SELF-AUDITS: PURPOSE AND METHODS

To satisfy program requirements for 340B participation, a covered entity must maintain auditable records documenting compliance. In 2019, The American Hospital Association (AHA) called upon 340B hospitals to sign a “Commitment to Good Stewardship Principles,” which included a commitment to continuing rigorous internal oversight of the program. This oversight was to include conducting internal reviews to ensure that the hospital’s 340B Program meets the program rules and guidance set forth by the Health Resources and Services Administration (HRSA).

Overall, the 340B compliance audit plan should focus on four broad areas:

- 1** Eligibility to participate in the program, including adherence to the group purchasing organization (GPO) prohibition for disproportionate share hospitals

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5 key 340B self-audit questions and considerations

Following are key questions 340B-covered entities should address when implementing a targeted 340B audit approach.

1 What populations of dispensations should I target (top drugs, locations, physicians)?

2 How often should I perform transaction testing (quarterly, monthly, weekly)?

It is important to remember that your answer to this question should drive the date range of dispensations in your sample. With weekly auditing, the sample should be from the previous week’s dispensations, and with monthly or quarterly auditing, it should be from the past month’s or quarter’s dispensations, respectively.

3 What sample size should I use for targeted audits? The size will depend upon the organization and the resources available to devote to self-audits. It also may depend on the organization’s level of comfort with adequate documentation and number of findings in self-audits.

4 What sample size should I use for random audits? Risk still exists in the remaining population of dispensations, and covered entities should address that risk through random sampling. However, most of your sample should be targeted to specific risk.

5 Who else should be involved throughout the organization? Whether or not you have a 340B analyst performing audits in your organization, members of health system leadership and pharmacy employees should be involved in follow-up with department managers to help drive accountability.

Sample 340B self-audit targeted audits scheduled for one month

Week	Population	Sample Size
Week 1	Outpatient infusion location	10
Week 2	Top drug by savings	10
Week 3	Physician No. 1 (w/private practice)	10
Week 4	Open – to be determined based on risk	10

2 Accuracy of information listed in the Office of Pharmacy Affairs Information System records

3 Diversion (i.e., ensuring that 340B drugs are not provided to ineligible patients)

4 Duplicate discounts (i.e., manufacturer providing both a 340B discount and a Medicaid drug rebate for the same drug), which the hospital can prevent by accurately reporting to Medicaid how it is billing the program for 340B drugs

Transaction testing. The most frequent method of 340B auditing is transaction testing, which also requires the bulk of time. Transaction testing is designed to address the risk of diversion. Its overall purpose is to ensure that patients receiving medications under 340B meet HRSA’s patient definition of *eligible recipients* and that the covered entity maintains auditable records to support the patients’ eligibility.

HRSA published guidance in the *Federal Register* in 1996 clarifying the criteria for what constitutes a *patient* for purposes of the 340B program.^a These criteria include the following:

a. HRSA, “Notice regarding Section 602 of the Veterans Health Care Act of 1992 Patient end entity eligibility,” *Federal Register*, Oct. 24, 1996.

- The patient is an outpatient.
- The covered entity maintains records of the patient’s healthcare.
- The patient receives healthcare from health-care professionals employed or contracted by the covered entity (i.e., responsibility of care remains with covered entity).
- The patient receives healthcare services beyond simply the dispensation of a drug.

The order or prescription also must originate in a 340B-eligible location (within the four walls of the covered entity or in a registered child site).

Random sampling. Although self-auditing by covered entities can vary in amount and frequency, the methods tend to be the same: Most 340B-covered entities select a random sample of a certain number of 340B dispensations within a particular date range (i.e., quarter, month, week) to confirm that the dispensation meets the foregoing criteria.

Although random sampling is needed to address risk in an entire population, covered entities face a challenge in performing enough testing relative to the total number of dispensations to adequately address the risk of noncompliance. For example, if a health system audits 25 records per month out of a total population of 25,000 eligible dispensations (0.1%), random sampling provides little value.

Targeted sampling. When assessing risk in a large population, targeting specific transactions with certain attributes provides a greater assurance that errors will be detected.

Implementing a targeted audit approach requires assessing risk of various subgroups of the organization’s dispensations. These subgroups could include specific drugs, specific locations and specific physicians. A targeted, risk-based audit approach ensures the organization spends time more meaningfully, and is not simply auditing to satisfy a requirement.

For instance, if a hospital has a *clean-site* outpatient infusion center (i.e., all patients

receiving care meet the *patient* definition), the risk of diversion is low. In such a location, each patient receiving care meets all aspects of the 340B patient definition. The only inventory carried by the outpatient infusion center would be 340B inventory, with the exception of crash-cart medications that would be purchased at the wholesale acquisition cost (WAC). With risk being low, there is no need to spend a significant amount of time on this area for self-audits.

This conclusion assumes, however, that the 340B processes have been evaluated and are fully understood at the infusion center. If processes in place are inadequate or inconsistent, risk may be elevated and more testing may need to be performed.

It is here that random sampling can provide some valuable information, despite its general limitations. If the random samples over a certain period generate findings in certain procedural areas of the hospital or certain child sites, that information can be used to inform targeted risk assessments of those locations.

The same concept applies for evaluations of specific drugs and of specific physicians who write prescriptions not only within the hospital but also in their private practice down the street.

HOW TO ASSESS 340B COMPLIANCE RISK

Assessing risk for 340B noncompliance should be based on two elements:



Sample 340B self-audit schedule for overall sampling, targeted and random, for one month

Week	Targeted sample	Random sample
Week 1	10	5
Week 2	10	5
Week 3	10	5
Week 4	10	5
Monthly Total	40	20

12,722

Number of covered entities participating in the 340B program as of Oct. 1, 2017

Source: House Committee on Energy & Commerce, "Review of the 340B Drug Pricing Program," January 2018



- The magnitude (or materiality) of a potential compliance issue
- The likelihood of a potential compliance issue

The first step is to perform risk assessment to determine which specific populations you will target. Although the specific areas of focus will vary among health systems, your assessment should consider the following key populations or areas.

Top drugs by savings. You should identify which drugs are driving the bulk of your 340B savings and assess the magnitude and likelihood of potential compliance issues for these drugs.

Locations by risk. If you are performing self-audits frequently on a random basis, you will likely find that certain departments, procedural areas and child sites are more prone to potential compliance issues. These locations tend to be relatively more complicated areas, such as outpatient surgery and hospital areas that operate on different systems (e.g., paper versus electronic charting).

Specific physicians by risk. In a contract pharmacy- or entity-owned pharmacy environment, a significant risk exists around filling prescriptions under 340B that were written in an ineligible location. This situation arises when a physician may be on the credentialed provider list for your hospital but also operates and sees patients in a separate private clinic. If the physician discharges a patient from your hospital and

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The benefits of automating 340B compliance

A 340B-covered entity can potentially gain huge benefits from incorporating audit automation into its 340B compliance program. The vast numbers of records in 340B audit populations call for some level of audit automation and validation of computer-

generated reports to effectively address risk in the population. Covered entities also can use automation to enhance their approach to targeted auditing. Adopting computer-assisted auditing techniques or designing simple matching of specific attributes from different data sets can help to validate 340B dispensations and can allow the audit team to spend its time on records with a higher likelihood of an issue.

then sees the patient in their private practice and writes a prescription for that patient, filling that prescription under 340B may expose you to noncompliance risk.

TESTING VOLUME AND FREQUENCY

Once you have developed a list of targeted areas for auditing, you should determine the amount of records to test and the frequency with which you will test the population. You should consider this with the overall schedule and resource time you have available over a 12-month period (or whatever period is specified in your audit plan). Leave room in the schedule to perform audits on other populations that present themselves during the year as having elevated risk. The exhibit on page 30 provides a sample one-month schedule.

It also is important to maintain an element of random sampling to address the risk in the rest of the population, and judgment is required to determine the amount and frequency of the random sampling. The exhibit on the previous page provides an overall schedule for a covered entity performing weekly transaction audits, both random and targeted.

The benefits to employing this audit approach go beyond clarifying priorities and spending time in areas with higher risk. Among additional benefits, this approach can enable you to:

- More easily identify systemic issues causing 340B compliance concerns
- Aggregate more meaningful feedback to be shared with department managers and leaders
- Identify clinical documentation issues or inconsistencies that may exist only in one department or for one particular drug
- Provide information useful for educating providers about drug diversion risk
- Identify billing inconsistencies

CONCLUSION

By implementing a targeted self-audit approach, you can ensure your organization is focusing on what matters with respect to 340B compliance. There are many added benefits to implementing targeted auditing, including driving accountability and efficient deployment of resources. Designing a targeted audit plan for your organization requires an initial time commitment, but the efficiency and effectiveness gained from that time spent is well worth the investment. ■

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SDOH: An emerging population health priority

Tracking social factors that interfere with individuals' ability to remain healthy has long been a concern for healthcare providers. Only now is the nation beginning to see viable solutions for addressing this concern.



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In recent years, both public health and not-for-profit organizations have increasingly been focused on addressing social determinants of health (SDOH) and their impact not only on each individual's overall wellness but also on the ability of people to access healthcare services.^a It has been a focus of CMS's Healthy People 2030 effort, which has made a broader audience aware of SDOH issues.

Up until now there has been a lack of coordinated investment in these "upstream" issues, and a lack of a standard approach for addressing SDOH in community and clinical settings.^b

WITH A NEW ADMINISTRATION COMES A NEW FOCUS

But we may be at a tipping point in the market given the new Biden administration's support for strengthening the Affordable Care Act (ACA). With the growing interest of Medicare Advantage (MA) and state Medicaid programs in paying for outcomes, there is an increased focus on strategies that address social needs as a way to contribute to improved health outcomes and help control unnecessary healthcare utilization.

For example, Michigan now requires Medicaid plans in the state to submit a multi-year SDOH

plan. CVS Aetna's 2021 MA plans will focus on total health and SDOH benefits. Anthem likewise is expanding MA benefits that target SDOH and is increasing by 20% the number of counties where it offers MA plans.

MUCH WORK YET TO BE DONE

Addressing SDOH also is an enormous undertaking. The overall concept of SDOH comprises at least a dozen factors, including:

- Lack of affordable housing and utilities
- Food insecurity
- Gender inequity
- Racial discrimination
- Lack of or limited health insurance
- Adverse workplace conditions
- Substance abuse and mental health issues
- Threats to personal safety

SDOH options that have been found to reduce utilization of both inpatient acute care services and emergency departments (EDs) include:

- Providing supportive housing for mentally ill people who would otherwise be homeless
- Helping adults with chronic conditions and low incomes access food stamps or supplemental nutrition assistance programs (SNAPs), or providing them with home meal delivery
- At the state level, classifying community-based services as covered Medicaid benefits so the state can receive federal matching

a. Garrett, D., Hwang, A., Pierce-Wrobel, C., "Social determinants of health: a public health concept in conflict," *Health Affairs Blog*, May 30, 2018.

b. Billioux, A., et al, "Standardized screening for health-related social needs in clinical settings," *National Academy of Medicine Perspectives*, May 30, 2017.

funds that cover the cost of signing people up for social programs

- Using value-based payments for SDOH interventions, thereby giving providers latitude to offer beneficiaries cash or vouchers for one-time out-of-pocket emergencies related to things like transportation, utility costs and more consistent access to food

Progress has been slow to date, but there is reason for optimism. In a recent report, the Robert Wood Johnson Foundation concluded, “While none of the tools at states’ disposal can single-handedly resolve underlying gaps in the societal safety net, they provide important opportunities to offer social support that will have direct impact.”^c

Organizations also are stepping in to help drive progress. The newly formed National Alliance to Impact the Social Determinants of Health (NASDOH) is a national advocacy organization of healthcare industry stakeholders — both payers and providers — that aims to focus national attention on SDOH to improve health and well-being while reducing long-term spending on healthcare. NASDOH has noted that current silos of federal spending programs in health and social services limit program integration at federal, state and local levels and allow few opportunities for collaboration and innovation. To help address this challenge, the alliance has issued SDOH recommendations to the Biden transition team (see the sidebar at right). These recommendations could see some traction, based on the incoming administration’s voiced leanings around healthcare policy, including support for expanding and improving the ACA.

SDOH INITIATIVES

Many current initiatives illustrate the various ways SDOH efforts have been gaining traction recently. The following are just a few prominent examples.

c. Manatt, Phelps & Phillips, LLP, “Medicaid’s role in addressing social determinants of health,” Robert Wood Johnson Foundation, Feb. 1, 2019.

The Leadership Initiatives Support Corporation (LISC). LISC is a national community development organization that is partnering with healthcare systems such as Sentara and its Optima Health Plan to build affordable homes and apartment projects in low-income urban areas. LISC is in the middle of a 10-year, \$10 billion national effort to connect community investments to healthcare gains. In addition to housing and jobs creating commercial real estate, LISC has invested in over 100 healthy food projects, grocery stores and farmers markets, and over 90 health projects, including healthcare centers. Under the partnership

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8 ways to impact SDOH

The National Alliance to Impact Social Determinants of Health has submitted the following recommendations to President Biden’s transition team:

- 1 Make SDOH a new national priority.
- 2 Use program funding to sharpen SDOH focus across the executive branch.
- 3 Enhance prioritization and coordination of SDOH within the U.S. Department of Health & Human Services.
- 4 Improve regulatory assessment of SDOH policy changes.
- 5 Use a healthcare financing mechanism to support SDOH activity.
- 6 Revitalize public health, a key SDOH partner.
- 7 Modernize data infrastructure to support SDOH data-sharing.
- 8 Support research and development to address SDOH.

\$157M

Funding allocated for CMMI's five-year SDOH effort, called the Accountable Health Communities Model

terms, Sentara will contribute \$50 million to finance the partnership goals, and LISC has committed to matching the investment from public and private sources so as to deal with social issues that cannot be tackled inside a healthcare facility's walls.

Colorado Hospital Association (CHA) partnership with Carrot Health. The CHA recently completed a study with Minneapolis-based Carrot Health, Inc., reviewing data from all CHA members to map the correlation of SDOH with ED utilization and hospital readmissions in the state. The analysis identified key underlying factors driving super-users of EDs, including food insecurity, housing instability and discord at home.^d The study developed a methodology to allow CHA members to identify:

- Significantly high-risk populations
- Optimal intervention opportunities
- Efforts most likely to produce the greatest ROI

The Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities Model. Launched in 2016-17, this initiative is a five-year, \$157 million SDOH effort being conducted in 29 urban and rural communities across the nation to assess whether systematically screening for and addressing SDOH can reduce healthcare costs and utilization among Medicare and Medicaid beneficiaries. A

d. Carrot Health, Inc., *Case study: Mapping the correlation between emergency department utilization and SDOH*, Accessed Dec. 9, 2020.

screening tool has been developed to identify patient needs in five different areas, which can be addressed through community services (i.e., housing instability, food scarcity, transportation difficulties, utility needs and personal safety). The tool is streamlined enough to be incorporated into clinical workflows with results that can be used in a patient's treatment plan as well as to make referrals to community services.

The Oregon Accountable Health Communities (AHC) study. Funded through Oregon Health Sciences University, the AHC study is part of the CMMI demonstration that provides screening for Medicare and Medicaid beneficiaries in 50 communities across the state, linking them with social services to address appropriate SDOH problems. Personalized assistance in navigating Oregon's 211 info social services system is provided for high-risk clients. By coordinating closely with Oregon Coordinated Care Medicaid program, which operates under a CMS 1115 waiver, AHC can secure cash payments for such items as emergency transportation, utilities or legal services not covered in the larger CMS study. In an interview, the AHC project director, Anne King, reported that SDOH problems increased 50% due to the pandemic, but that the program has been able to "seamlessly" address these problems by switching from in-person to mainly virtual client contact.

The Utah Alliance for the Determinants of Health. Another noteworthy SDOH effort, this three-year demonstration program in Utah was launched in 2018 by Intermountain Healthcare and several community partners, which have invested \$12 million to address SDOH needs of Medicaid recipients in two counties in northern and southern Utah. Key program elements are:

- Developing countywide care teams to bring community and clinical resources together
- Connecting individuals electronically with clinical and social service providers
- Partnering with Unite Us, a technology company, to build a data system linking health and social service providers

Assuming the results from 2020 are positive, Intermountain plans to roll out Alliance program elements, including its data system, across the communities it serves.

ProMedica partnership with LISC Toledo.

ProMedica, a regional health system based in Toledo, Ohio, serving 28 counties in southeast Michigan and Ohio, has worked for more than a decade to address the social, economic and community factors impacting health in the communities it serves. ProMedica's focus on SDOH has sparked a comprehensive effort to stabilize the area's aging affordable housing stock, revitalize a predominantly low-income neighborhood and strengthen Toledo's economic base by investing in downtown improvements. In 2017, ProMedica entered a 10-year partnership with LISC Toledo to provide \$20 million in grants for community programs and services and an additional \$25 million to develop affordable housing.

DATA-DRIVEN APPROACH TO ADDRESS SDOH

One underlying principle has emerged from current SDOH initiatives: Success depends on developing clear and measurable objectives. This effort starts with understanding a community's demography, geography and population health data to chart a path for improvement.

Screening for social needs is still not standard clinical practice in many health systems. In many communities, the absence of established pathways and infrastructure, coupled with perceptions of lack of time to make community referrals, are barriers sufficient to prevent clinicians and their staffs from addressing health-related social needs at all, according to a 2017 report of the National Academy of Medicine.^e The report discusses the Accountable Health Communities Model that

e. Billioux, A., et al., "Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool." Discussion paper, National Academy of Medicine, *Perspectives: Expert Voices in Health & Health Care*, May 30, 2017.

CMS is testing to ascertain whether systematically addressing the health-related needs of Medicare and Medicaid beneficiaries impacts their total healthcare costs and improves health. Standardized screening is deemed to be an essential tool for this purpose.

For example, Pro-Medica uses an "Anchor Dashboard" with 10 metrics to understand the implications for health of its non-clinical investments.^f The Anchor Dashboard includes:

- Economic and community development
- Education and job creation
- Thriving business and equitable employment
- Personal finances
- Social determinant screening
- Hunger
- Housing
- Infant mortality
- Arts/cultural development
- SDOH research

An important lesson learned from the many SDOH experiments is that community organizations can effectively work across the siloed borders that have traditionally divided health services and social services. What is required is that shared data and tools be employed systematically to work toward common goals, including reduced avoidable healthcare utilization.

Advocating for the coordination and integration of SDOH into the healthcare delivery system, especially for Medicare and Medicaid populations, will be a critical step in advancing this effort, and it is a step likely to gain support under the incoming Biden administration. ■

f. Oostra, R., Zuckerman, D., and Parker, K., *Embracing an anchor mission: ProMedica's all-in strategy*, ProMedica and the Democracy Collaborative, May 2018.

About the author

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COVID-19 magnifies **impact of SDOH** on U.S. healthcare system

“We are learning social determinants of health and health equity are inextricably linked, and that they represent a crisis today that runs alongside the COVID-19 pandemic. So if there’s one useful thing to come out of the pandemic, it’s that it has highlighted the urgent issues that need to be addressed.”

— Jenifer Leaf Jaeger, MD, MPH



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The critical importance of addressing social determinants of health (SDOH) to help reduce disparities in both health and healthcare was a central theme that Jenifer Leaf Jaeger, senior medical director for HealthEC, explored in a recent conversation with *hfm*. Here, we provide an excerpt of that conversation. (Read more of this interview with Jaeger in the online February 2021 issue of *hfm* at hfma.org/hfm.)

1 Why has the issue of tracking and addressing SDOH become so much more important today?

Jaeger: It’s pretty clear that COVID-19 disproportionately impacts persons with underlying chronic diseases such as congestive heart failure or coronary artery disease, COPD, diabetes and obesity, in addition to advanced age. But what we have also witnessed early in the pandemic within the U.S. is that Black Americans are at a much higher risk of severe infection and death compared to whites. And this appears to be because they are at *increased* risk for these underlying chronic conditions. We see risk tracking along poor health overall for people in poverty, and that is a reflection of SDOH.

2 What falls under the heading of SDOH?

Jaeger: Many people will tell you SDOH is new in the conversation. And it’s really not. In 1998, the World Health Organization [WHO] published a paper, *Social determinants of health: The solid facts*, and they addressed the fact that there are issues beyond healthcare or one’s genetics that actually impact health. And 20-some-odd years later, we have made, I would say, a minuscule attempt at being able to address this issue. WHO defines *social determinants* as, “the conditions into which people are born, grow, live, work, and age.” And these circumstances are shaped, WHO says, by the distribution of money, power and resources at the global, national and local levels. That summarizes a lot, because it encompasses the political, socioeconomic, cultural and physical environment.

Consider medical care, including both quality and access. It’s estimated that medical care only accounts for about 10% to 20% of the modifiable contributors to health outcomes, meaning length and quality of life for an entire population.

As a physician, I got into this field because I wanted to improve the health and well-being of individuals, and my impact, although certainly important, really is a small aspect of it. We talk

about behaviors such as smoking, diet, exercise, alcohol or substance use, and that accounts for another 30% of what shapes a person's health and outcomes.

But the social or economic factors, which constitute SDOH, account for roughly half of the impact on health and well-being. So you're looking at education and employment, and that's different from income. You have high-risk areas in which people are working where there are toxic substances. And then there's family and social support. For instance, we know senior isolation is a major risk factor during COVID. And then we also look at the physical or built environment, including water and air quality, housing and transportation, and that's about 10% of what shapes health and outcomes.

So all told, SDOH account for nearly 80% of an individual's health and well-being. So that's why we need to address them. And neither healthcare nor public health can do it alone. To really effect change on chronic disease management, and SDOH, we all need to work in tandem: Medical care must go hand in hand with attention to the social determinants to really have an impact.

3 What can hospitals and health systems do to address this problem? Can you give an example?

Jaeger: Just look at senior isolation. We know it's a health risk that affects about a quarter of seniors over the age of 65. And we know isolation is a risk factor for poor aging outcomes, development of cognitive decline, even Alzheimer's disease and actually contributes to worsening medical conditions and even death. Recent statistics show \$6.7 billion in additional healthcare costs annually due to social isolation of seniors.^a And COVID-19 has only exacerbated the impact. Since our seniors are an at-risk population, to protect them, we've isolated them to an even greater extent and said families can't come to

visit. And they are now also told, "If you don't need to go to the hospital, don't, because of risk of exposure."

The problem is, many seniors use going to the doctor as a social event. They're chatting with the people in the waiting room. They're chatting with the person who checks them in and the nurses, and they talk about their kids and show their photos. So there's a lot more to doctor visits than just medical care.

But what we're seeing now with COVID-19 is that we have isolated these individuals.

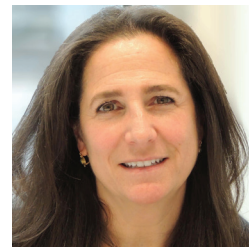
One of the ways that we can start to address this issue is by using population health management and health IT to perform telehealth.

So how do we identify all the individuals over the age 65 who are at particular risk and then help them access telehealth services? That requires risk stratification, which involves data analytics to identify who is at risk. That requires being able to pull in all the data, including ZIP codes, to identify where they are, so we can then reach out to them and do SDOH assessments of their risk of food insecurity, whether they have economic issues and are unable to pay for their health, or whether they have any problems with access to their medications. These are just a few of the assessments you can do.

You also need to assess any medical issues they have had over the past year that have been deferred but can no longer be deferred. So for example, oncology services, with staging, biopsies and MRIs and various other procedures are not emergent, unlike a heart attack or a car accident, but they're not elective either. There's a whole population of chronic diseases that needed to be managed while folks were in isolation.

4 How do you reach out to people who have technological challenges and are unable to access telehealth?

Jaeger: Calling them is at the lowest level of technology, certainly. Even if they're not sophisticated in telehealth and they don't know how to use their computer, you can call them on the telephone and speak to



► Jenifer Leaf Jaeger, MD, MPH, emphasizes the need to address social determinants of health, which are compromising the well being of growing numbers of people amid the coronavirus pandemic.

a. Flowers, L., et al., "Medicare spends more on socially isolated older adults," AARP Public Policy Institute, *Insight on the Issues*, November 2017.

\$6.7B

Additional healthcare costs to the U.S. healthcare system annually due to social isolation of seniors

them, identify what their issues are and then seamlessly refer them to other areas — dental or medical health, behavioral health or community resources — to address SDOH.

One way to address these issues is for community-based organizations to establish programs for seniors to learn how to use the internet and engage with telehealth. While still maintaining appropriate distancing, seniors would also be provided social interaction, could be given masks and information regarding how to keep themselves safe and have their needs regarding access to food, medication refills, etc., addressed. I don't know that anybody has done this work, but I would say that it would be cheaper for health insurance companies to actually provide a laptop to every individual who doesn't have one and pay for the training to avoid unnecessary emergency room, hospital and ICU visits and a worsening of chronic conditions. Treating these avoidable medical issues is probably a lot more expensive than laptops. I would love the opportunity to crunch some numbers and provide some strong data to various payers, including Medicaid and Medicare.

I would imagine that there would be both cost savings *and* improved healthcare. And since CMS has expanded access to telehealth services for Medicare beneficiaries, seniors can receive a wider range of medical services without traveling to their providers.

The advantages of investing in telehealth for this purpose are huge. Being able to have a face-to-face meeting through the use of a computer with an elder allows the provider or care manager to get a peek into their environment. Are they dressed and showered? Do they look

like they haven't gotten out of bed in three days? Do they require social support?

Then you need the seamless coordination that is the whole point of population health management — being able to pull in clinical data and seamlessly connect individuals to needed community resources. I think that kind of immediate real-time evaluation and response is critical now.

5 How can hospitals or health systems begin to build the networks necessary?

Jaeger: There are a number of different programs that hospitals can get into. Boston Medical Center, for example, has gotten involved in developing housing projects for their at-risk and vulnerable population that's at risk for homelessness. So they're actually in the business of building homes, and that's not what you would normally think of as the mandate for a hospital. That level of involvement is not available to a small hospital, of course. But any hospital or clinic can join forces with the community programs that already exist to gain more awareness of the SDOH-driven needs in the community and begin to address them.

Remember, though: If you don't even ask the question, you can't know the answer. There's an approach called the Hunger Vital Sign, which came out of Children's Health Watch and Boston Children's Hospital that addresses this point. It's two questions that correlate with a high likelihood of food insecurity within the past month. But most pediatricians or internists don't take time to ask the necessary questions, such as, "Do you think you might have to go without something in order to feed your family this week?" If we would make a point of asking that question, we could start to identify where those issues are, and that would enable us to work with the local food bank.

Prince George's County Health Department in Maryland offers a great example of using SDOH in assessments and analytics to risk stratify and then address the issues they have found working with community partners. They use analytics and population health management to identify the 10% of the population that represents



SDOH Resources

- Office of Disease Prevention and Health Promotion, *Healthy People 2030 Framework*. [Site last updated Oct. 8, 2020.]
- Magnan, S., *Social Determinants of Health 101 for Health Care: Five Plus Five*, National Academy of Medicine, Oct. 9, 2017.

AI, automation and RPA: How health systems are designing the revenue cycle of the future

80% of hospital readmissions and non-urgent emergency department visits. Working with their community and having community health workers embedded within the health department to do contact and outreach, perform assessments and make referrals, they have been able to reduce hospital utilization by 22%, including emergency room observation and inpatients, and reduce costs by 17% to achieve a nearly half a million dollars of savings in six months. They were able to improve health outcomes and reduce costs simply by addressing SDOH. It's really powerful.

6 How can organizations begin to address SDOH?

Jaeger: It starts with communication and education regarding the importance of addressing SDOH to improve health and well-being. If you can then demonstrate cost savings, so it's sustainable, that's even better.

Tying it back to COVID, it's not surprising that there's a growing awareness of issues of health disparities and the Black Lives Matter movement — which is so much more than a movement. It's important to stress that the virus doesn't know what color you are or what gender, sexual orientation or nationality you are. But it does recognize vulnerability. You can look at the data for seasonal influenza and any number of chronic diseases, and you can see these disparities.

So we need to raise people's awareness of these issues. It is an idea whose time has come. ■

Jenifer Leaf Jaeger, MD, MPH, is senior medical director for HealthEC. Prior to joining HealthEC, she was director, Infectious Disease Bureau and Population Health, for the Boston Public Health Commission, and previously held executive-level and advisory positions at the Massachusetts Department of Public Health, New York City Department of Health and Mental Hygiene and the U.S. Centers for Disease Control and Prevention.

About the Author

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How will artificial intelligence (AI), automation and robotic processing automation (RPA) fit within the revenue cycle of the future — and what steps are hospitals and health systems taking now to design the revenue cycle of the future? During this HFMA Digital Annual Conference roundtable, sponsored by Simpler, revenue cycle leaders shared insight. Here are four takeaways from that discussion.

Vendor capabilities around AI and RPA vary widely. "It's a little bit of the 'Wild West' out there: Everybody's talking about AI, and there are not a lot of places yet that are really doing it well," said Robert Dewar, vice president and chief revenue officer, Geisinger. "We have a company that is performing autonomous coding in the emergency department for us, and that's our initial foray into AI, but we're also looking at other applications, such as on the back end around insurance follow-up."

Claims status and prior authorization top revenue cycle use cases for RPA. "A lot of our focus with RPA has been on the authorization side — not only statusing authorizations, but also checking to see if a service requires authorization through RPA and actually submitting information for the authorization through RPA," said Stephanie Wells, system vice president, revenue cycle/HIM, Ochsner Health. "That's huge for us to save a lot of work there. We're also moving our claim statusing to RPA not only from the hospital side, but also the physician side. We hope that the learnings from these efforts

will inform our work around predictive analytics."

RPA can present unique challenges for revenue cycle teams. "One of the RPA challenges we've faced has been workflow readiness," said Mary Beth Remorenko, vice president, revenue cycle, Partners HealthCare. "Some of our revenue cycle workflows were not documented, so we've spent a lot of time during the RPA evaluation process in documenting workflows. It's very similar to a process improvement project, determining all the steps involved, and we've had some lessons learned along the way, such as when there are 10 exceptions that we hadn't known about. We've learned a lot about the importance of process mapping and evaluating all of the steps involved in our revenue cycle workflows."

A plan for bot maintenance is critical. "One of the challenges with RPA is that it requires controls in place to ensure any changes in process, systems or external websites (i.e., payer websites) are constantly up to date; otherwise, it may essentially bring the bots down, resulting in interrupted operations and requiring hours and hours of maintenance to get them back up," said Mark Norby, revenue cycle chair, Mayo Clinic. "We're finding that some of the newer bots can be maintained and developed with a lesser skillset. That saves time for the end users — our revenue cycle operational peers — while also reducing the time required to keep the bots up and functioning."

View the full roundtable discussion at [hfma.org](https://www.hfma.org).

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Reducing costs to collect while improving net patient revenue

As healthcare organizations continue to navigate their financial recovery from COVID-19, what does recovery look like for hospitals and health systems – and how are revenue cycle teams responding? In this roundtable from HFMA Annual, sponsored by Ensemble Health Partners, four healthcare revenue cycle leaders share their insight on action steps that have improved performance during the pandemic. They also share their strategies for understanding their cost to collect, protecting revenue integrity and more.

What are volumes looking like in your region, and what do the trends suggest for the future?

Jana Danielson, vice president, revenue cycle, Nebraska Medicine, Omaha, Neb.: “Within Omaha and our surrounding region, our volumes, along with those of everyone else, went down with COVID-19. The majority are back to normal, and we are anticipating increases in some areas. Certainly, I think we all anticipate a significantly maintained increase in telehealth services. I’m still waiting for long-term information as to how telehealth volumes are going to look in the future. But overall, volumes have pretty much come back, with some in-person clinic visits shifting to telehealth. And so we’ve recovered in that regard, probably a little bit quicker than we anticipated.”

Robert Flannery, CPA, senior vice president, CFO, UW Health, Madison, Wis.: “Many of our volumes have

returned to pre-pandemic levels. We’re seeing some positives from an operating room (OR) perspective. We don’t know if a bit of that might be backlog. We think most of that was dealt with in May or in June, but we’re still keeping an eye on OR volumes to see whether those increases will be sustained over the next six to eight weeks. We are seeing lower volumes in our emergency department (ED); there, we’re probably trailing last year’s numbers by about 10%. Our in-person visits are down, but we’ve made up for that from a telehealth standpoint. Currently, about 20% to 25% of our visits are incorporating some type of telehealth structure. We’re really trying to figure out exactly what telehealth is going to look like over the long haul. Some large national health plans have indicated that the telehealth payment policies that were in place during the public health emergency may be scaled back.”

Christy Joliff, vice president, revenue cycle enterprise, Northern Light Health, Brewer, Maine: “We are seeing things return to normal. I think the ED is the one place that is still a bit below average. We were doing a lot of telehealth, but that has really been dialed back, and patients are coming in-person, for the most part. But for those of you following the pandemic totals, the state of Maine has been relatively untouched, so while there is certainly a lot of concern about COVID-19, there are not a lot of cases. Things here are starting to reopen and get a little bit back to

normal. Now, of course, our concern is that there will be another surge. What that means for the future is anybody’s guess.”

Scott Johnson, FHFMA, MBA, executive vice president and CFO, St. Luke’s Hospital, Chesterfield, Mo.:

“Volumes have recovered to about 95% of where they were pre-COVID-19, and we’re hearing that is true of others in our market. Of course, there are some services that have recovered better than others. Patients are clearly wary of coming into the hospital, as our outpatient services and centers are much busier than our inpatient services. Our urgent care centers are quite busy again, but our EDs are still well short of historical volumes. We are uncertain what this means for the future, but suspect greater use of outpatient settings will likely continue, and telehealth will continue to be used increasingly. Both of these trends existed pre-pandemic but seem to have accelerated.

“For us, telehealth was almost nonexistent for years, although we had explored specific needs such as telestroke when we ran into a temporary shortage for stroke treatment capabilities. When the pandemic hit, our primary care doctors suddenly realized they weren’t going to see their patients in their offices, and of course, they were worried about maintaining their patient panels. We scrambled to put together a solution in a hurry, and a couple of vendors stepped up nicely to help us with that. The doctors really embraced telehealth. The bigger challenge we faced was getting patients comfortable with

telehealth, because the patients don't use this technology every day, so there was a learning curve. Today, our telehealth volumes for primary care visits are down to 10% or so, which makes me a little skeptical about the long-term implications for telehealth for primary care. It tells me that people would still rather be seen in the office. But the truth is, it's hard to get people into the office for primary care visits because there aren't enough primary care physicians. We're seeing more nurse practitioners and physician extenders handle these visits.

"All of this makes me wonder: Are we seeing an increase in urgent care visits for all the right reasons or the wrong reasons? Are people using urgent care the way it was intended and decreasing unnecessary ED use, or are they using urgent care because they can't get an appointment with their primary care physician?"

What steps have you taken to offset revenue losses and cash flow reductions from the pandemic?

Joliff: "For the most part, the steps we've taken to offset revenue losses and decreased cash flow have involved reductions in staff — not furloughs, but rather, not filling open positions as we experience turnover. We've been cross-training some folks in areas like customer service and patient registration. We did have some people volunteer to go on furlough at the start of the pandemic, but those numbers were very low."

Flannery: "In May and June, we did have some temporary base pay reductions in place for our physicians and leadership team. We also flexed our staff in April and May when volumes were down, and when volumes started to pick back up, the flexing stopped. In revenue cycle, we've done a good job of making sure that the services that are being provided are being captured and that we have the appropriate documentation so that we can get paid appropriately for the services that have been delivered to patients. We're also looking at denials and making sure that we're not sacrificing revenue we are entitled to."

Danielson: "We did forego market and merit adjustments, which would normally occur in July, and we've certainly had a lot of conversations around what capital spend is going to look like based on what we have available to spend. Certainly from a revenue cycle perspective, we had specific teams that were focused on ensuring revenue capture processes were in place for all of the changes that came with COVID-19 — collection codes and all of those types of things — so we did not miss out on any opportunities to ensure proper revenue was coming in. We have an audit process and a mechanism where providers see their individual information on a monthly basis, and we've used that method to communicate changes as they are occurring or pertinent information. And we keep an eye on denials, which is something we've always looked at, protecting net revenue that

HFMA Roundtable Participants



JANA DANIELSON is vice president, revenue cycle, Nebraska Medicine, Omaha, Neb.



ROBERT FLANNERY, CPA, is senior vice president, CFO, UW Health, Madison, Wis.



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KEVIN THORNBERG is senior director, client partnerships, Ensemble Health Partners, Cincinnati, Ohio.

CHRISTY JOLIFF

is vice president, revenue cycle enterprise, Northern Light Health, Brewer, Maine.

is coming in the door and making sure there isn't any unnecessary leakage."

Johnson: "We're very proud that St. Luke's has never had layoffs, and we didn't during COVID — we staffed to our volumes, and we found that we needed more employees in certain areas, such as to screen at our entrances — but, you know, April was downright scary. It was frightening as we put projections together. We didn't know when or if we were going to come out of that financial distress. It was comforting to see the Fed respond very quickly with the stimulus. Now, we're going to have to reconcile that and see if we actually deserve to keep all of those funds. I think a lot of hospitals won't, because the recovery has been pretty good going into June and July, and of course we shouldn't have money that we aren't entitled to from a safety and stability standpoint. But now we are heading into a resurgence of COVID, so who knows."

Kevin Thornberg, senior director, client partnerships, Ensemble Health Partners: "I was curious: Does anyone have an example of an innovation or process improvement that the pandemic forced your organization to consider or accelerate, given that the slowdown in volume has provided you the opportunity to focus on things that may provide benefits post-pandemic?"

Johnson: "When elective surgeries began to start back up, we launched an online scheduling tool that has helped us schedule patients more quickly and accommodate more patients while still maintaining social distancing protocols. It's a tool that has been very successful for us, not just in scheduling surgeries, but also in scheduling rehabilitation after surgery. That has been a tremendous help to us in meeting patients' needs and in our financial recovery."

Joliff: "We've been able to accelerate a work-from-home model, which we had talked about for many years. In addition to the increased productivity we've seen, we've also been able to save money on leases. I think a lot of organizations that were nervous about making the move to a remote work model and put it off because other things took precedence, and suddenly we had to figure it out, and it has gone relatively well."

Flannery: "As someone who has worked in healthcare for 30-plus years, this whole idea of transitioning from volume to value and right care, right place, right time has really taken off during the pandemic. It has accelerated the deployment of telemedicine. Even providers who were staunchly opposed to telemedicine are embracing it faster than we would have expected. We're having conversations with payers around telemedicine reimbursement: Should the copay for telemedicine be different than the copay for in-office care? I won't say where we're at with that, but from my perspective as a patient and a father of two daughters, being able to conduct a dermatology appointment with my daughter in our living room is so much more satisfying than having to drive to an appointment with my daughter, park in a parking ramp, go up or down X number of levels to the clinic, and that sort of thing, even if the copay is the same. The convenience factor is really significant. Telemedicine also has expanded our ability to provide mental health services, which were solely understaffed. To say, 'We're going to pay less for these visits because you don't have the brick and mortar' really misses the point."

There are some disruptors that the pandemic has brought to healthcare that have enabled us to view opportunities in

a different format. When you talk about ED volumes being down, do you think it's because people don't want to come to the ED because they are afraid of exposure?

Joliff: "We have seen volumes in our walk-in care clinics increase, and our thinking is that those are people who would have originally gone to the ED who decided against it and went to a walk-in clinic instead. Our secondary thinking is that this is probably where they really belonged all along. It makes sense that this shift has taken place because consumers are afraid to go to the ED, but I can't say that we've trended that."

Danielson: "I agree. We're seeing the same pattern, with an increase in walk-in clinic volumes and a decrease in ED volumes, but we haven't analyzed it to explore whether the two are correlated."

Regarding RCM outsourcing, have you taken a single-vendor approach or a best-in-breed approach? What were the reasons behind your approach?

Danielson: "Generally, we do like to stick to a single-vendor approach. There is not a lot that we outsource from a true operational perspective. Our partnerships are generally around exploring ways to prevent revenue leakage, and our standard operational processes, such as patient access, HIM and PFS, are maintained internally. That's not to say we wouldn't look for a best-in-breed solution if our needs were to change, but this set up is what we currently have in place from a vendor perspective."

Johnson: "We try diligently to make full use of our integrated systems and the

tools they have built in. Where we need to outsource, we generally will use the best vendor available for the service or tool needed, usually for basic functionalities that the EHR and billing systems don't typically provide, such as bad debt, claim scrubber and coding. The vendors are so specialized these days, it is often difficult to find one that can meet most of our unique revenue cycle challenges. We have looked at several vendors associated with revenue cycle automation, mostly to stay up-to-date with what is being offered in this space for hospitals. We recently worked with a vendor for low-dollar insurance balances but that was for a very limited engagement. Other vendors in our community have discussed their patient financing options with us, but St. Luke's interest-free payment plans work quite well so there really hasn't been a need to outsource these."

Joliff: "The vendors that Northern Light uses were here when I got here. I have looked at adding a few on the back end — more auditing types of vendors, looking at zero-dollar accounts, reviewing for missed insurance to see if we still have opportunities to collect on insurance that we didn't know

about, that sort of thing. Historically, my modus operandi has been to bring things in internally wherever possible and to use small-balance vendors or early out vendors on occasion. I tend to rely on the vendors I've worked with before and that I know did a good job for me."

Flannery: "Much of our work is done in-house, but we do work with some vendors, such as a zero-balance-type vendor and vendors that can supplement our staff in areas such as prior authorization when we're getting behind. We tend to use a vendor instead of staffing up in situations such as that. We network with others: 'You seem to be doing well in this space. Who do you use?' And we make decisions based on whether the vendor has been a good partner for an organization that we are familiar with, even if the vendor isn't necessarily best-in-breed."

Do you include factors such as full benefits, administrative overhead, depreciation, patient accounting software, IT infrastructure and support in your calculation of total cost to collect? Why or why not?

Danielson: "All of the above. I calculate the total cost to collect; I include the software and I exclude it to see, from a technology perspective, what the difference is. This helps me keep a pulse on both sides."

Joliff: "Northern Light doesn't have a cost-to-collect calculation. That is on my list of things to try to accomplish in the next year. In my last position, I was never really able to get a cost-to-collect figure that I could benchmark against. We calculated one based strictly on the folks who reported through the revenue cycle vice president, which did not even include HIM. As a result, our calculation was very much an internal calculation that we use to determine whether we are improving."

Thornberg: "It is Ensemble's honor to work with health systems in the best of times and stand by their side in the worst of times. We appreciate the discussion and the insights here. New challenges and old challenges complicate today's landscape. We are happy to continue to share information, expertise and insights around revenue cycle to help those in healthcare do what they do best." ■



Ensemble Health Partners is a leading innovator in revenue cycle management, helping health care providers improve financial outcomes and patient experiences with an unrivaled depth of expertise and best-in-class technologies. Ensemble offers full revenue cycle outsourcing as well as a comprehensive suite of health care financial management point solutions. With clients spanning the U.S. and Europe, we have been helping to improve health care outcomes for millions of patients while saving hundreds of millions of dollars for health care providers. We are committed to bringing every provider that we support to the peak of revenue cycle excellence. Our approach forges true partnerships that dive deep into the details to find solutions and deliver results that last. Recognized with multiple industry awards and as a Becker's Healthcare Top Workplace, Ensemble is setting a new standard for provider support services - redefining the possible in health care by empowering people to be the difference. For more information, visit www.EnsembleHP.com.

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columns

LEADERSHIP INTEGRATION PHYSICIAN PERSPECTIVES PODCAST PEOPLE
HONOR ROLL THANK THE REVIEWERS FROM THE PRESIDENT

How to use influence to enhance your powers of persuasion in the workplace

Giving orders may be necessary at times, but leaders are more effective if they establish credibility, reliability and empathy and know how to connect with people individually.



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Do you have questions or topics you'd like Jill to address in a future article? Email **Nick Hut**, HFMA senior editor, at nhut@hfma.org.

Remember when you were thinking about becoming a manager? You probably imagined that such a role would translate into the ability to get things done. To make change.

To deal with the things you know could be better.

You'd have the title and therefore the power to make all of that happen.

Then you became a manager and realized it's much more complicated. Your title indeed gives you some clout. In fact, classic social-science research calls it *legitimate power*: the ability to make demands of others based on your rank.^a

But you're leading human beings. People don't wake up each morning hoping they'll be pushed around by bosses who believe their titles have made them commanders. People have needs, interests, goals, personalities and challenges.

Ordering people to do things is a tool in your management kit, but it's one that should be used sparingly — in times of urgency or as a last resort (see the sidebar on page 47).

A better option is another tool you may have had long before you had the power of management: influence.

a. Mind Tools, "French and Raven's Five Forms of Power: Understanding Where Power Comes from in the Workplace."

ESTABLISHING INFLUENCE

Influence is the ability to engage, inspire and persuade. It's built on your track record of four factors.

Credibility. You know what you're talking about. You do your homework. You see the big picture. You're a straight shooter who tells the truth and can be trusted.

Reliability. You follow up on your promises. There's consistency in your actions and beliefs. People can feel safe in predicting how you'll respond. If you shift your thinking, you share your reasoning to ensure people aren't whipsawed by your changing perspectives.

Empathy. You see the world through the eyes of others. Whether you are a formal manager or a colleague serving as a project leader, you're a gifted symphony conductor. You may not play all the instruments, but you know what it takes to get the best out of each one. People believe you *get* them and what it takes to do their work.

When you have influence, you can persuade people without ordering them around. You can move people from resistance to acceptance. You can turn *Why?* into *Why not?* You can help people see possibilities they may have missed. You can

motivate them to step up, lean in and even take the lead.

Think about a time you had a talk with your boss and left having volunteered to take on a responsibility. Minutes after the meeting, you said to yourself, “How did that just happen? I was there for a conversation and left with an assignment. And I volunteered for it!”

Your boss used influence.

It started with one of you talking about a problem or challenge. The boss asked you questions. You talked about your experiences and insights. The boss listened. Asked more questions. You made suggestions. The boss focused on one suggestion and asked you more about how to make it work. Soon, you were sketching out a plan, or offering to. And your boss happily agreed — and offered support.

That’s influence. It’s working on a shared vision of a challenge or opportunity and then finding the other person’s point of entry. Where can they come into this picture in a way that they hadn’t envisioned, but you had?

UNDERSTANDING 6 APPROACHES TO PERSUASION

Influence requires that you understand and care about what motivates others. Some people are moved by cold, hard data, for example. Others by emotion. So, how do you know what approach to use and what moves others?

One of the best-known researchers and writers on this topic, Robert Cialdini, says there are six principles of persuasion:^b

- 1 Reciprocity.** You’ve done something for me, so I’ll do something for you.
- 2 Scarcity.** I want in on something because not everyone gets to be.
- 3 Authority.** I want in because the smartest or most accomplished people are behind it.
- 4 Consistency.** I’ve done something similar before.

b. Influence at Work, “Principles of Persuasion,” 2020.

Considerations for when persuasion falters

What if no amount of persuasion works and you still need to get something important done?

That becomes the rare situation when giving an order is a viable option. You provide clear direction and explain why this request is non-negotiable. You tell the person you regret having to be this direct, but it’s for the good of the team and the organization.

Remember, though, that using blunt force too often means you have deeper issues to deal with. Do you have the right people on the team? Do they see you as credible, reliable and empathetic enough that you have influence?

Leaders who regularly invoke their power to get things done risk prompting one of the most dangerous phrases you can hear from your employees: “Just tell us what you want.”

If you hear that repeatedly, it means that your priorities aren’t clear or consistent, that people fear your response if they make a mistake or that they believe no matter what their ideas are, yours will always prevail.

It means you prefer demonstrating your power instead of learning — and earning — the rewards of influence.

5 Liking. Darn it, you’re so nice, I can’t say no.

6 Consensus. I see a bandwagon and jump on.

When you know people well, you know which of those principles to apply in your persuasion quest. But remember, this isn’t about trickery. You won’t persuade a soul if they think you’re trying to manipulate them rather than seeking to inspire, connect or engage with them.

They’ll most certainly be persuadable, however, if they think you genuinely have their best interests at heart. ■

About the author

Jill Geisler is the Bill Plante Chair in Leadership & Media Integrity, Loyola University Chicago, and a Freedom Forum Institute Fellow in Women’s Leadership.

The patient's role in innovation

Do you want to know what your patients are thinking?
Try asking them.



**JEFF HELTON, PhD,
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So many ideas we have on how to improve healthcare come from our running into issues that we see a need to address — things like staffing, technology, supply chain. No doubt that some of the best ideas have started in a “why don’t we do . . .” context to improve our processes. Regina Herzlinger, a leading healthcare management researcher with the Harvard Business School, posed a six-factor framework for evaluating how innovation really addresses challenges we see in the industry.^a Many of the ideas in Herzlinger’s research touch on things that immediately come to mind: How do we get paid? How do we work innovation through our accountability structure? How do we leverage technology? Herzlinger mentions one more stakeholder we don’t often consider in innovation — the patient. Maybe it is time to examine the patient’s role with innovation.

CHOOSING TECHNOLOGY OVER HUMANITY

Many innovations in healthcare seem to start with some technology idea. The electronic health record (EHR) is an easy example of that idea. We make great investments in technologies to refine documentation of care, and increase

reimbursement, order tests more efficiently, optimize care options and hopefully improve care.

But what is the patient’s view of such investments? Often, they are left looking at the top of a clinician’s head as data is typed into a computer. The face-to-face interaction between the patient and caregiver gets lost in the pursuit of a technical improvement in care.

I’m not here to suggest we dispose of those technologies. The improved quality and quantity of data we gather will definitely inform ways we can make better clinical decisions. But from the patient’s perspective, have we improved care?

As a caregiver for elderly parents, I see many patient interactions that really don’t show much care, at the expense of using technology. I’ve seen us lose that personal contact with a provider who was focused on a computer screen (it seems like they often try to hide behind that screen). We’ve had many office visits where we tap on some screen with no idea why. Yeah, I have an unfair advantage working in the industry, but why should my parents rely on me to explain (especially when the provider does not know that I speak “healthcare”)? What can we do to make innovation a valuable thing in the eyes of our patients?

HFMA’s Value Project Report, *Building Value-Driving Capabilities: Performance Improvement*, calls for us to evaluate processes and seek out ways to improve patient engagement.

a. Herzlinger, R.E., and Schulman, K.A., “Diffusion of global innovations in health care: How to make it happen,” *Health Management Policy and Innovation*, 2017.

Herzlinger's article asks the question: "How does the consumer perceive the value of innovation?" Well, I'm hard pressed to see sometimes how our patients see innovation as another step to improve the process of care. Have we ever asked the patient how we could do things better?

Sure, we ask questions pertaining to things like those HCAHPS scores because our value-based purchasing payments hinge on such feedback. Obviously, there are boundaries on how much the industry can change certain things as infection control, medication administration and insurance procedures still provide the *checklist* for good care. Perhaps we can find better ways to integrate that checklist into the care process and, while we're at it, determine what's in it for the patient. If you ask me, that's an innovation right there.

We have to start with an idea of the patient experience. Are there steps in a process or things we ask the patient to do that seem right to us but at the same time detract from the patient's experience? Probably so. Requiring multiple signatures on multiple forms that patients likely have repeatedly filled out with the same information seems a necessity in the revenue cycle. Perhaps there's a way to make that process less of a burden for the patient and possibly for the patient access team as well.

ASK THE PATIENT

HFMA's Value Project Report *Building Value-Driving Capabilities: Performance Improvement* calls for us to evaluate processes and seek out ways to improve patient engagement.^b

While much of the discussion focuses on getting the patient engaged in their care, there is also encouragement to convene a patient council to get input on patient perceptions of care and processes of care. Why not extend that discussion a little further to ask the question, "What do we do that annoys you?" It works well in

^b. HFMA, *Building Value-Driving Capabilities: Performance Improvement*, 2012.

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The number of hospitals and health systems that sponsored the research for HFMA's Value Project Report

healthy interpersonal relationships, so why not in healthy provider-patient relationships?

While that HFMA Value Project work is a few years old now, it still rings true to me today. Let's think about how we get the patient involved in innovation.

Many of the best process improvements I have seen as a senior executive have come from thoughtful suggestions of the front-line staff serving our patients. Reaching across the counter, the exam table or the bedrail and asking our patients for input is another good way to improve processes.

Although we can't *fix* everything, perhaps we can do a better job of explaining to patients about processes or streamlining the processes to make them easier on everyone. Process improvement innovations are not just the mechanical adjustment to an assembly-line series of steps. They are also getting the best from our people and giving the best to our patients.

Our teams give us great innovations. It is time now to expand our innovation team by one more position and bring the patient into the team. Let them help us not only find the next great innovation, but also help us define the value for the patient in that next innovation. ■

About the author

Jeff Helton, PhD, FHFMA, CMA, CFE, is a lecturer in the MBA-Health Care Administration Program at the University of Colorado Denver and a member of HFMA's Southern California Chapter.

Medicine should be for mind, body and spirit

Experience is teaching us that the COVID-19 pandemic has been an assault not only on our health but also on our spirit.



**MARTIN H. BLUTH,
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I recall sleeping at my grandparents' house as a young child of six or seven. Their house was always bright and crisp. Everything in its place, yet welcoming and exciting. We sat down for dinner, and due to a "grasp malfunction," I spilled an entire pitcher of *borscht*, a purple, Eastern European drink derived from beets, on their clean white tablecloth.

Did I mention that the tablecloth was *alabaster* white?

Within seconds, the purple liquid penetrated the tablecloth like a gaping wound. Time stopped, as did my breathing. My body was frozen, and my mind and consciousness anxious and confused. I had no idea what would happen next.

To my surprise, my grandfather paused, looked at me, smiled and said, "I always thought that tablecloth needed a little more color." With that, all my tension melted away and my spirit soared.

Since then, I have come to understand that the elation I felt was not merely from being spared punishment. Rather, it was what I would later come to know as a tangible connection with the very spirit, force or essence of life. Painters, writers, artists and sculptors have all attempted to capture the human spirit in their creations.

THE FOUNT OF MEANINGFULNESS

The spirit is not just an imaginary construct, nor is it consigned only to the world of religion. It is a very real, ever-fluid and arguably palpable aspect of being human that reflects how we interface with the experiences of life. The human spirit is inextricably linked with emotion — dampened by fear, pain and suffering and liberated by understanding and joy. A soaring spirit is often a *raison d'être*, tantamount to living a full and complete life.

TREATING THE SPIRIT

Today, some 45 years after my *borscht* debacle, the human *spirit* and its effects on disease manifestation and maturation are increasingly becoming a staple of medical treatment in some healthcare arenas.

Attention to the human spirit in the context of medicine has matured over the past two decades. Some have posited that the spirit provides the essential link between a patient's presenting problem and the patient's need for effectively treating that problem. The idea is that patient-centered medicine should view the patient's spiritual needs as an integral component of high-quality care.^a

In today's epoch of COVID-19, the wake of spiritual havoc cannot be overstated. Although many healthcare organizations have post-COVID-19 clinics that tend to the physiologic, organ-centric manifestations of the disease, not all tend to the *spiritual* crippling that COVID-19 has caused. A patient's broken spirit can be a result of the amalgam of economic, clinical, psychosocial and/or political ruin exacted by the pandemic.

A BROADER REALM OF TREATMENT

How does one deal with this problem? How does one treat the spirit?

a. Yawar, A., "Spirituality in medicine: what is to be done?" *Journal of the Royal Society of Medicine*, October 2001; Karff, S.E., "Recognizing the mind/body/spirit connection in medical care," *AMA Journal of Ethics*, October 2009.

It is not always straightforward. Diagnosing and treating spiritual conditions requires a quite different approach from something like diagnosing polymorphic ventricular tachycardia when an EKG demonstrates *Torsade de pointes*. Treating the spirit requires listening for the silences in between the sentences, demonstrating empathy, appreciating the subtleties of the dialogue and respecting a patient's cultural uniqueness. Holding the hand of the patient and even crying with them can affect their spirit in beneficial, nonlinear ways.^b Some may consider such behavior inappropriate, but others consider it to be a testament to a healthcare worker's humanity.

Such behavior does not connote an effort to cultivate patient *friendship*, which some believe detracts from healthcare professionalism. Rather, it acknowledges a reality that nurturing a patient's spirit can foster empowerment and healing in ways that we are just beginning to appreciate.^c

RECOMMENDED ACTIONS

Healthcare financial leaders can advocate for the following three areas of action to promote a focus on treating the spirit in healthcare.

1 Endeavor to understand how patients experience a medical condition and its impact on their lives and spirit. An improved understanding of the patient's mind-body-spirit connection can foster improved clinical outcomes.^d In the very least, patients want to be treated with compassion and empathy, and it should be considered as a core part of an organi-

zation's mission and culture to show respect for patients' humanity and spirit. Moreover, where possible, demonstrating these values should incorporate high-profile support and commitment of the organizations' leaders.

2 Interface, where applicable, with community advocacy groups to better understand patients' cultural, religious and economic issues. This effort can help identify common elements that can streamline crucial resources toward benefiting a majority of patients from such sectors.

3 Pursue healthcare-focused forums with select constituencies, including clergy, disease-specific associations and foundations and other non-allopathic entities, relevant to the hospital's focus. The objective of these activities should be to introduce healthcare practitioners and students to different modalities of thought on the human spirit and its effect on medicine to broaden and inform their awareness of this issue and its full diversity.

THE ONLY PATH FORWARD

COVID-19 has been the bearer of unique and ubiquitous concerns that affect us all and that are causing many of us to face unprecedented difficulties. Yet amid this crisis, we should remember it is the spirit of our humanity that enables us to prevail and soar toward greatness, and this spirit is timeless. My grandfather provided me with an early glimpse of the power of the spirit, and that reality has constantly informed my own practice to this day. ■

About the author

Martin H. Bluth, MD, PhD, is the founder of Bluth Bio Industries, professor of pathology at Wayne State University School of Medicine, laboratory director for Accutox Medical Diagnostic, global medical director for Kids Kicking Cancer.

b. Shepard, K., "Why it's okay to cry with patients and their families," *TravelNursing.com*, Accessed Dec. 30, 2020; Gulland, A., "Is it okay to cry in front of patients?" *The BMJ Opinion*, Dec. 15, 2014.

c. Puchalski, C.M., "The role of spirituality in health care," *Baylor University Medical Center Proceedings*, October 2001.

d. Taylor, E.J., *Spiritual care: Nursing theory, research and practice*. Upper Saddle River, NJ: Prentice Hall, 2002.



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Finance podcast host

The risk of losing women in the workplace

A year ago, things were looking good for working women. At the end of 2019, for the first time in a decade, the number of women in the workplace surpassed the number of men.^a But the pandemic has women leaving the workforce in droves, and according to a recent McKinsey report, more than one in four women are contemplating “downshifting their careers or leaving the workforce completely.”^b Recently, two McKinsey employees — who are also mothers — joined us on the podcast to discuss their experiences and what they hope to see in the future.



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Elizabeth Newman: I think it’s really important to recognize that if the number of women actually left the workforce that had been thinking of it this year, it would be more than the number of female college graduates and graduate students. So when we talk about why we’re talking about solutions and why we’re trying to share and encourage other working parents and other women to find ways and strategies to stick with it, it’s truly because we believe [losing that] talent within the industry could be incredibly detrimental to everyone.

Annie Kurdziel: There’s this odd default that exists. That somehow women are going to be the ones if there’s a moment of decision of who stays home; the default clearly is still there, given what we’re seeing and given the numbers that exist. It’s not always the right answer. Maybe for some

people, it is [the right answer], but for some people, it’s really not. I can’t see a way in which we don’t emerge from COVID with more honest conversations about what it takes to make sure that women and moms are supported in the workforce so we retain the best talent, and we retain people that are going to continue to make amazing contributions to the world.

Newman: Going back to what this may look like in terms of long-term solutions — because we know that there is a light at the end of the tunnel — most companies think that a lot of jobs can be performed remotely. A lot of companies think they’re going to moderately or significantly cut business travel. Eight in 10 employees say they want to continue to work from home more than they did before COVID-19, and 70% of companies think remote work will allow them to hire and retain diverse talent. All of that is, I think, a very positive perspective on how we can emerge with solutions that help women and working parents more in the future. ■

a. Schneider, A., Hsu, A., and Horsley, S., “Multiple demands causing women to abandon workforce,” NPR, Oct. 2, 2020.
b. McKinsey & Company, “Women in the workplace 2020,” Sept. 30, 2020.

HFMA Lonestar Chapter member Cowling joins AHA board as new trustee



Phyllis Cowling has been an active HFMA member for many years, serving in various leadership roles.

Phyllis Cowling, president and CEO of United Regional Health Care System in Wichita Falls, Texas, was elected by the American Hospital Association (AHA) to fill a vacancy on its board of trustees for one year, effective Jan. 1, 2021. The Board of Trustees is the highest policy making body of the AHA and has ultimate authority for the governance and management of its direction and finances.

“Over the past several years, I have developed great respect and appreciation for the policy development and advocacy work of the AHA,” said Cowling in a press release. “As such, I’m honored and excited at the opportunity to serve on the AHA board of trustees.”

Throughout her career, Cowling has been an active member of the HFMA Lone Star Chapter and served in various leadership roles at the organization’s local, regional and national levels.

Cowling also served as Chair of the board of trustees for the Texas Hospital Association in 2018, in addition to her ongoing involvement on

several boards and committees within Wichita Falls. Her years of service with HFMA include the following roles:

NATIONAL LEADERSHIP

- Chair, 2002-2003
- Member, Board of Directors, 1997-2003
- Member, Executive Committee, 1999-2003
- Chair-elect, 2001-2002
- Secretary/Treasurer, 2000-2001
- Chair, Council on Career Development, 1998-1999
- Chair, Board of Examiners, 1997-1998
- Member, Board of Examiners, 1994-1997

REGIONAL/STATE LEADERSHIP

- Chapter Liaison Representative, 1996-1997
- Chair, Texas Coordinating Council, 1994-1995

CHAPTER LEADERSHIP

- President, Lone Star Chapter, 1992-1994
- Officer/Director, Lone Star Chapter, 1988-1992

Snyder retires from Oklahoma Hospital Association

Rick Snyder, FHFMA, has announced his retirement from the Oklahoma Hospital Association (OHA) in Oklahoma City, Oklahoma, effective Jan. 1, 2021. Snyder, who was director ex-officio 2019-20 for the Oklahoma Chapter, served most recently as OHA’s vice president of finance and information services.

He was previously a member of the Sunflower (Kansas) Chapter, where he was president 1993-94 and received the Medal of Honor in 1998. ■



Rick Snyder has served the Sunflower and Oklahoma Chapters for years and is now enjoying his retirement.

To have your professional announcement published in People, contact Senior Editor Erika Grotto at egrotto@hfma.org.

A proactive approach to comprehensive clinical asset management helps healthcare systems maintain financial health

In healthcare, being proactive is key. Taking the necessary steps to prevent an illness is more efficient and more affordable than finding a cure. Following that notion, TRIMEDX's proactive approach to comprehensive clinical asset management helps thousands of healthcare systems improve their financial health.

By Carly A. Mullady Cowan

With a focus on optimizing inventory to meet current and projected patient demand, TRIMEDX CFO Chris Dunkerley said the business's experience at more than 3,700 locations shows that the average health system may own more types of certain medical devices than needed and may replace devices more often than needed — even before this equipment reaches its full useful life.

Now, particularly amid a pandemic, this focus is critical.

“With COVID, there's falling revenue, which means less money is available for capital,” Dunkerley said. “Understanding how to put some scrutiny and diligence in how you use capital is paramount.”

TRIMEDX helps health systems evaluate their use of medical devices to maximize their budget. They begin by determining the appropriate number of medical devices needed per site of care, considering patient volumes and utilization rate of those devices.

“How much equipment do you have? How much equipment do you need? Prove it,” Dunkerley said. “You don't want money tied up in inventory you're not using.

“You need to understand the financial impact, and make sure you are not constantly needing to spend [money]

and replace assets without understanding what you have already.”

TRIMEDX developed a proprietary algorithm called the RUDR ScoreSM, which identifies medical equipment that should be replaced, upgraded, dispositioned or reallocated (to other sites of care). Assets are evaluated using objective data including benchmarks, leveraging the number of devices needed per patient volume, device specific utilization data, potential for impact to patient safety, including cybersecurity risk and more.

A score is assigned to each individual device and appropriate actions can then be taken to optimize inventory levels, which in turn can defer capital investments on medical equipment, making scarce capital dollars available for strategic initiatives and reducing operating expenditures.

“Doing more with less can have a huge impact,” Dunkerley said. “With less equipment, operational costs go down. If you have 10 CTs operating at 60% and want to get to 80%, drop one CT at the same location.

“From an operational standpoint, you're not buying new equipment. You're only maintaining nine instead of 10.” He said this is significant for cash flow and net income in addition to providing insights that can be used in future strategic planning initiatives.

“Our goal is to really keep equipment alive. We are able to responsibly extend useful life and not impact patient safety.”

— Chris Dunkerley, CFO, TRIMEDX

Dunkerley acknowledged the emotional element associated with equipment needs but says data should be a bigger factor in the decision-making process.

Another aspect of TRIMEDX’s proactive and comprehensive approach to clinical asset management is their focus on extending equipment beyond its expected (or standard) useful life.

“Our goal is to really keep equipment alive,” Dunkerley said. “We’re not saying, ‘This is old. Let’s replace it. We are able to responsibly extend useful life and not impact patient safety or availability of equipment. Prevention is better than a cure.’”

A robust preventative maintenance program ensures every device is touched annually, leveraging data and history to identify an individual service plan for equipment. These plans include training and certifying technicians (if applicable), the ability to remotely monitor critical equipment to identify behavioral anomalies and through machine learning to predict potential issues and proactively dispatch a work order for a technician to initiate a repair even before an issue occurs.

This high-touch maintenance and repair program, along with access to quality parts through their global supply chain,

allows TRIMEDX to extend medical equipment’s useful life by 30% with minimal disruption to patient care or unplanned downtime.

TRIMEDX’s suppliers are audited to ensure quality and provide access to parts for years beyond when an original equipment manufacturer would continue to supply parts.

Medical equipment manufacturers define “end of service” as the time after which they will not guarantee access to their own parts. Even if a piece of equipment may have several years of useful life remaining, the manufacturers will not use third-party parts.

When an original equipment manufacturer sets a useful life at eight years, TRIMEDX has been able to increase that life to 12 or 13 years.

With one client, TRIMEDX was able to extend the useful life of their CTs and increase their average age by 14%. This resulted in the value of the CTs, which exceeded the depreciated life, to increase by 48%.

“Those subsequent years, you’re not worrying about depreciation. You’re not buying new equipment. Your net income goes up,” Dunkerley said. “It’s a huge opportunity.” ■



TRIMEDX is an industry-leading, independent clinical asset management company in the United States delivering comprehensive clinical engineering services, clinical asset informatics and medical device cybersecurity. We help healthcare providers transform their clinical assets into strategic tools, driving reductions in operational expenses, optimizing clinical asset capital spend, maximizing resources for patient care, and delivering improved safety and protection. TRIMEDX was built by providers, for providers, and leverages a history of expert clinical engineering with data on 92% of all active medical device models.

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Honor Roll: HFMA awarded 1,022 certifications in Q4 2020

HFMA offers seven certifications for members to validate their expertise and demonstrate their commitment to the profession. The certifications are as follows: Certified Healthcare Financial Professional (CHFP), Certified Revenue Cycle Representative (CRCR), Certified Specialist Accounting & Finance (CSAF), Certified Specialist Business Intelligence (CSBI), Certified Specialist Managed Care (CSMC), Certified Specialist Physician Practice Management (CSPPM) and Fellow of the Healthcare Financial Management Association (HFHMA), which supersedes CHFP.

HFMA proudly helps more than 64,000 healthcare finance

professionals successfully transform their careers with various benefits including the ability to achieve certifications. We see hundreds of members earn certifications each month, and we are sharing HFMA's Honor Roll of all individuals who have been certified in the fourth quarter of 2020.

This list is accurate as of Jan. 6, 2021, for individual members in good standing who earned a certification October 2020 through December 2020. If you were recently certified, but do not see your name on this list, your membership has lapsed.

To renew your membership today, visit hfma.org/membership/overview.html.



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Robert Anderson
Erika Andrews
Anderson
Jacob Barefoot
Olga Barone-Allan
Robert Barrientos
Cody Barrow
John Bartolovich
Jamie Beaudin
Margot Berg
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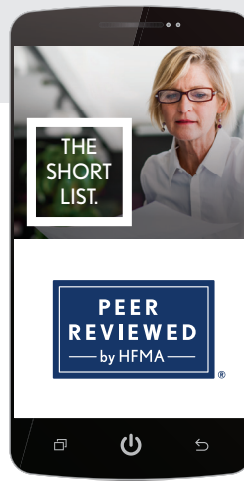
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Haven and the dynamics of transformational change



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In some ways, it's not surprising that Haven, the high-profile company launched three years ago by Amazon, Berkshire Hathaway and JP Morgan Chase, has called it quits.

Haven is the latest in a long line of frustrated power brokers that have failed to "fix" healthcare, which is, without a doubt, the most complex industry in the United States. Fragmentation, the bifurcation between public and private insurance and amorphous transactions that involve multiple parties make healthcare a uniquely challenging industry.

According to an analysis by *The Wall Street Journal* from Jan. 7, Haven struggled, in particular, with the lack of cost and price transparency and the challenges of collaboration among groups with different needs. Sound familiar? It should. It's a variation on evergreen issues that have been a source of frustration to all legacy healthcare stakeholders.

Nevertheless, it's imperative that our nation figure out how to reduce the total cost of care and rein in the growth of healthcare spending. The country's economic viability depends on it. Finance leaders should not be breathing a sigh of relief because a potentially gargantuan disrupter has left the stage. Quite the opposite — Haven's entrance and exit signal a tremendous unmet need and acute market demand for transformational change. Numerous others are working tirelessly to disrupt what everyone agrees is a misaligned and maladapted healthcare delivery system.

Finance leaders should take a page from the playbook of physician executive Zeev Neuwirth, MD, author of *Reframing Healthcare: A Roadmap for Creating Disruptive Change*. Neuwirth's vision is a reoriented, consumer-centric and humanistic healthcare system that substantially improves how consumers purchase, utilize, experience and benefit from it. His profound insights and compelling market discernment clearly illustrate that the digital technology and retail disrupters entering healthcare are not just consumer-oriented but actually consumer obsessed. If legacy healthcare stakeholders don't realize that, Neuwirth says, they'll become increasingly less relevant. His examples underscore that it's already happening. (By the way, I don't think healthcare has heard the last from Amazon, in particular.)

Neuwirth's ideas about reframing healthcare should be adopted and operationalized — using relevant, accurate and timely data to improve quality and safety, advance the consumer relevance of traditional healthcare delivery and put spending growth on a sustainable trajectory. Legacy stakeholders can't wait for others to do it for them. Nor should they attempt to run out the clock on fee-for-service payment and legacy business models. Business school case studies are replete with the disastrous outcomes of that conservative strategy.

Consider this: Haven brought the resources of three extremely powerful and iconic businesses to bear on transforming healthcare value. Haven's downfall may have been that it did not grasp the opportunity and need to frame a new approach and create next-generation business models. Recognize this turn of events as a signal, and see it as an opportunity — an opportunity to seize the moment and create a new healthcare, while we still have the runway to make it happen. ■



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