Preparing for a Post-COVID-19 World

Key Considerations for Academic Health Systems

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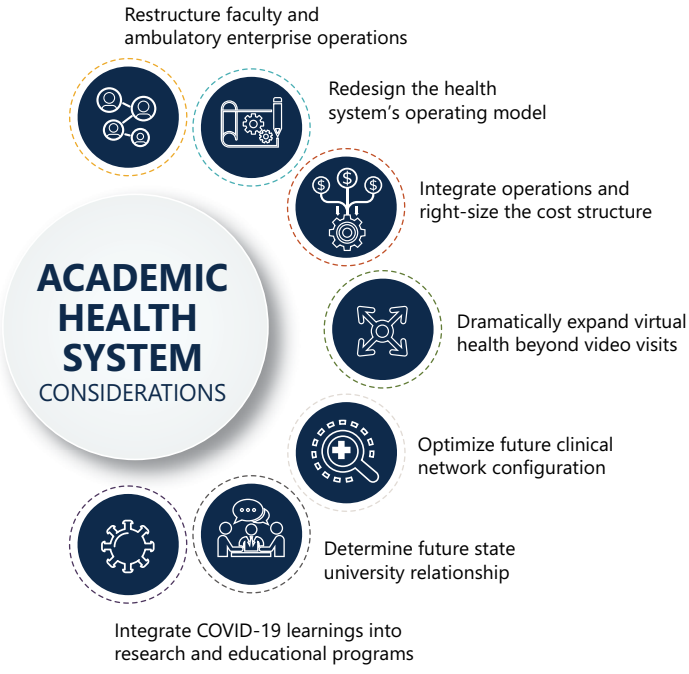
Academic health systems (AHSs) are playing a leadership role in serving the surging numbers of COVID-19 patients in many communities. This situation is taking a significant toll on the heroic nurses, physicians and other health professionals who are risking their own lives to serve these patients. Urgent and elective care is being deferred in most health systems, creating a tremendous backlog of patients needing access to care in the coming months. It is also taking an unprecedented economic toll on these organizations with projected deficits in the billions of dollars. The recent COVID-19 stimulus package is designed to help offset some these revenue losses, but details are still unclear on how funds can be used.[1] While it is difficult to see past the current morass when in the middle of such an overwhelming crisis, some members of each AHS's leadership team should be thinking about what needs to be done when the COVID-19 surge subsides to help the enterprise move forward and be prepared to act decisively when, or even before, the situation begins to improve.

Some of the factors these leaders should consider are illustrated in Figure 1.

Figure 1. Preparing for a Post-COVID-19 World



AHS leaders should think now about how they will need to operate in the coming months and years to serve this backlog of patients in a timely manner.

Restructure faculty and ambulatory enterprise operations

Serving the large numbers of patients whose care was deferred and restoring some of the revenue lost during this period will require near-term planning, even before this crisis ends. This will require a change in the operating model and culture of the clinical faculty and ambulatory enterprise at many AHSs. AHSs are typically known for innovation which makes many of them leaders in providing sophisticated care locally, regionally and nationally. *However, that innovation culture and a highly decentralized operating model often results in limited organizational discipline and operational inefficiency.*

The current situation with COVID-19 demonstrates that these organizations can operate with high levels of discipline when required due to the profound commitment of their physicians and employees to serving their communities and to the core tri-partite mission of the AHS. However, there is a high risk that post-surge, AHSs may revert to the less efficient operating model that many have historically embraced (for better or worse), at a time when continued discipline is critical.

AHS leaders should think now about how they will need to operate in the coming months and years to serve this backlog of patients in a timely manner and how they can begin to operate with higher levels of customer orientation and productivity over the longer term. For example, after an appropriate lag period to allow staff to recover from the surge, operating rooms may need to do elective surgery 6-7 days per week and well into the evening, which is rare in most AHSs (and in most other health systems). Exam room utilization will need to be managed more rigorously and capacity shared across specialties to serve larger numbers of patients. Faculty clinical effort may need to expand, and appointment templates and scheduling processes managed centrally to serve more patients. The AHS may need to provide disproportionate resources to some clinical services, such as cardiac care and cancer diagnosis and treatment, where care should not be deferred for long and margins are relatively high. At the same time, many patients may be hesitant to re-engage with healthcare providers due to safety concerns. To ensure the safety of patients, family members and staff, health systems should employ on- and off-site testing protocols to screen for potential carriers of COVID-19 as soon as rapid, reliable testing becomes feasible. Marketing will need to develop/expand proactive patient communications to activate and engage patients, and ultimately direct care. Making these kinds of changes reflects a more disciplined approach to managing the overall clinical enterprise (faculty, ambulatory and inpatient care) than is typical of most AHSs. Departmental leadership and faculty have often resisted these kinds of changes, but they may be required over the coming months and years.

Redesign the health system's operating model

Many AHSs have accumulated assets through mergers and acquisition, but continue to operate more like holding companies than integrated health systems. This situation emphasizes the importance of thinking about how best to use all of a health system's assets in a coordinated manner to drive clinical, capital and operating efficiencies. For example, one AHS in a market where the number of new virus cases has not grown dramatically, is considering conducting previously canceled elective surgeries at one of its hospitals while reserving another of its hospitals in the same market for the expected growth in COVID-19 patients. Many hospitals continue to have duplicative programs at multiple campuses rather than consolidating services to build stronger programs and improve efficiency. While these changes can be difficult for the physicians who are impacted, this is a time to think about how the organization can operate more effectively when this situation inevitably ends and in anticipation of future resurgence of COVID-19 or another pandemic. At the same time, each AHS will need to determine how best to plan for potential inpatient admissions spikes resulting from future pandemics, given that most operate with little to no slack capacity during normal times.

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Integrate operations and right-size the cost structure

Most AHSs have achieved strong financial performance over the past decade by growing patient volumes and revenues. This crisis may demonstrate that care can be delivered with different staffing models for caregivers, though the sustainability of these approaches needs to be assessed. In addition, some health systems have not yet fully integrated their business systems and staffing across departments and sites of care. Most health systems have opportunities to automate FTE-intensive, but repetitive, business functions, such as revenue cycle, and to use artificial intelligence and robotic process automation to reduce the number of staff needed in some areas. This situation provides the impetus to more aggressively look at the organization's entire cost structure, including the physician and ambulatory enterprises, which have been growing rapidly but also require significant financial support.

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Dramatically expand virtual health beyond video visits

Most health systems have not built virtual critical care capabilities to manage patients across their network of ICUs.

As discussed in our recent paper: Robots, Chatbots, AI – Accelerating Virtual Health Capabilities for COVID-19, the COVID-19 crisis has brought virtual health into the mainstream for organizations that previously had not meaningfully invested in this area. However, providing large numbers of video outpatient visits is only a start toward harnessing these capabilities and improving patient experience, outcomes and efficiency. Most health systems have not built virtual critical care capabilities to manage patients across their network of ICUs. Similarly, health systems with large numbers of rural affiliates can create hub facilities to help staff emergency rooms in settings where it is difficult to recruit physicians and provide specialty care virtually to patients and affiliated providers in disciplines such as infectious disease, endocrinology, genetics and others. Hospital-at-home and remote monitoring has tremendous growth potential and can help expand capacity at times of peak demand if reimbursement and other issues can be addressed. Some organizations are testing remote robotic procedures in areas such as emergency PCI and stent implementation; while this approach is not yet proven and requires the remote facility to have a robot, its potential to serve patients in distant locations is tremendous. AHSs need to think about which of these business model innovation approaches to pursue and how they can quickly build the required capabilities now and over the next few years.

It should be noted that in recognition of the need to rapidly expand telehealth capabilities in response to COVID-19—both in direct support of COVID-19 patients and by expanding access to non-COVID-19 patients to free up resource capacity—the Federal CARES Act allocates $200M to the Federal Communications Commission for grants to eligible healthcare providers to support telehealth initiatives through the COVID-19 Telehealth Program. Grants will be rewarded on a rolling basis, with a final deadline for grant application at the end of July 2020.[2]

Hospital-at-home and remote monitoring has tremendous growth potential and can help expand capacity at times of peak demand.

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Optimize future clinical network configuration

The current COVID-19 crisis will create opportunities to affiliate with healthcare organizations that are unable to withstand the short-term economic or operational pressures and view AHSs as attractive affiliation partners. AHSs should think now about what kinds of assets they want to align with to avoid wasting time with opportunistic assessments of potential partners. In addition, funding strategies for these potential transactions should be considered as soon as can be practically done.

a

AHSs should be cautious when considering hospital and health system affiliation opportunities: Some community hospitals, particularly smaller hospitals, will not be financially viable and almost all potential partners will need significant capital investment. Most health systems have spent the past 20 years consolidating hospitals and physician practices. Despite the near-term challenges of insufficient hospital capacity in some communities, the number of discharges and days per thousand population nationally declined by 17 percent between 2007 and 2017 as care shifted to the outpatient setting. Population growth, particularly in the sunbelt, partially offset this decline such that total inpatient admissions declined by 4 percent during this period. Outpatient utilization grew by 16 percent during this same time period.[3] In addition, more of the remaining inpatient care is concentrated in major teaching hospitals that continue to increase their market share while admissions to non-teaching hospitals have declined significantly over the past decade. Therefore, AHSs should be careful in taking financial responsibility for hospital assets unless there is a strong strategic and economic case.

b

Independent physician groups are likely to seek partners, but strategic and economic fit should be carefully assessed: Similarly, physician office visits have reportedly declined by 40-60 percent during the COVID-19 crisis, which could rapidly increase the number of physicians seeking health system employment.[4] Many health systems and physician groups have already made the difficult decision to reduce pay, furlough employees and/or let non-essential clinicians and staff go to stabilize cash flows amidst abrupt revenue reductions. Each AHS needs to assess their physician platform to determine which physician practices would be accretive to align and the desired scale of its overall physician enterprise. Almost every health system physician group operates at a loss when looking only at professional fees, though the associated outpatient facility and technical fees can alter this financial picture as can significant revenue from value-based contracts. Potential new additions to the clinical faculty, or the AHS-employed community group where this model exists, should be assessed based on potential long-term changes in how health system medical groups function and the implications for the number and types of clinicians needed. For example, more effective use of advanced practice providers (APPs) could reduce the number of physicians needed in some disciplines.

c

Cross-continuum care providers could represent attractive acquisition or affiliation opportunities to fill network or capability gaps: Healthcare providers in other sectors of the industry — such as ambulatory surgery centers, home care, rehab, long-term care and others — may also become available. AHSs need to determine which of these businesses are a strategic fit today and how their role and economics are likely to change in a post-COVID world. In addition, many private equity (PE) firms were overfunded for the potential deals available before this situation occurred and are sitting on significant cash that they will likely use to purchase distressed healthcare assets in the coming months, potentially reshaping the competitive dynamic at a local level. This situation could create partnership opportunities with PE firms for assets that AHSs do not want to own and operate solo as well as competition for some of the more desirable assets.

d

Some AHSs might need to seek a strategic or capital partner: Depending on the duration of the COVID-19 crisis, some AHSs may decide their financial situation requires a financially stronger partner that can step in after this crisis passes. The increased number of health plans with provider business units might create new types of alignment and integration opportunities beyond traditional health system mergers.

Determine future state university relationship

Those universities that continue to own or have financial responsibility for their healthcare delivery enterprise are likely to view the financial challenges created by this crisis as the impetus to rethink the appropriateness and sustainability of this model, particularly in light of their own more challenging financial outlook. Over the last decade or more, AHS financial performance has often been a strong positive contributor to the university's financial performance. While the financial risks of healthcare delivery have always been recognized by rating agencies and parent universities, these concerns have been on the back burner due to strong performance until now. Being part of the university often allows the healthcare enterprise to borrow at attractive rates, but the credit spread between AAA-rated universities and AA or A-rated health systems has not been material. In addition, many universities have constrained their health system's growth due to concerns about the size of the healthcare enterprise in relationship to the rest of the university. Those universities that want to reduce or eliminate their financial responsibility associated with the risks of healthcare delivery and reimbursement will need to determine how best to create that firewall, while still retaining the benefits of the education and research ties across parts of the university.

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Integrate COVID-19 learnings into research and educational programs

In accordance with the tri-partite mission, AHSs advance the future of medicine by caring for a diverse set of patients, conducting cutting-edge biomedical research and educating healthcare leaders of the future. While clinical care teams are treating COVID-19 patients around the clock, AHS research labs across the country are also working diligently to develop and test treatments and vaccines, to speed up testing and to understand this novel coronavirus. Just as it is important to share real-time analytics about the virus, as Johns Hopkins is doing with its Coronavirus Resource Center,[5] AHSs should continue to research and report lessons learned from the lab and in the field so the industry writ large is better prepared for future pandemics. Federal research funding for infectious diseases should increase on the heels of this crisis, but that is highly uncertain given competing federal funding priorities. Similarly, the educational enterprise needs to consider the future implications for both classroom, small group and clinical teaching if this situation reemerges. Once medical students are back on campuses, it is also imperative that faculty incorporate these lessons learned into curriculums asthe future of healthcare will forever be changed by the COVID-19 crisis.

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Over the short term, AHSs will need to find ways to reward and recognize the heroic health professionals and support staff who have enabled the organization to care for their patients during this crisis. At the same time, these organizations need to identify changes in the clinical enterprise that are required to fulfill their tri-partite mission and remain successful over the ensuing months and years. The crisis has surely introduced new challenges and accelerated issues that AHSs and other providers were already facing. When this COVID-19 surge subsides, AHS leadership would be wise to convene their constituents across different forums, both to honor the sacrifices made to manage the crisis and to discuss lessons learned. Effective design and implementation of the strategies described above should enable AHSs to maintain and advance their leadership role locally, regionally and beyond.

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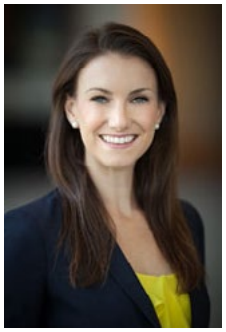

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