ASSOCIATION OF ACADEMIC HEALTH CENTERS

LEADERSHIP PERSPECTIVES

Optimizing Financial Health: Rapidly Evolving Models of Patient Care

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PERSPECTIVE

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The COVID-19 pandemic has laid bare a number of deficiencies in the support systems we depend on every day. At the same time, it has revealed new opportunities in medicine and science, has brought to light the breadth and depth of resilience at academic health centers, and has catalyzed change virtually (in every sense of the word) overnight. These themes—opportunity, resilience, and rapid change—weave their way through the three commentaries in this issue of AAHC's ***Leadership Perspectives***.

Richard J. Barohn, MD, executive vice chancellor for health affairs at the University of Missouri, explains how his institution built an infrastructure that supported dramatic changes in telehealth. He notes that, while it is "too early to see all the lessons we will learn from the pandemic,...operating in the era of COVID-19 has already led us to make operational changes that are producing greater efficiency in our delivery of care."

Carrie L. Byington, MD, executive vice president of University of California Health, describes how the pandemic challenged normal healthcare operations throughout her system of academic health centers and how they responded with new-found strengths. She highlights how "we were pushed by the pandemic to communicate better, increase collaboration, and respond as a more integrated system." Steps taken include increasing virtual healthcare system-wide and leveraging research resources to evaluate how to achieve the best patient outcomes.

Wayne J. Riley, MD, MPH, MBA, MACP, president of SUNY Downstate Health Sciences University, describes how his institution rapidly implemented new models of patient care in "the epicenter within the epicenter" of the pandemic, Brooklyn, New York. Under his leadership, there was "better utilization of the full breadth and depth of talent in our various centers by better deployment of a wide range of outstanding professionals such as nurse-practitioners, physician assistants, pharmacists, social workers, and other critical healthcare professionals." Dr. Riley makes the case that "we should all do what we can possibly do to 'cement' these newer, more collaborative models of care into our ongoing work of developing better care initiatives and educational and clinical platforms."

When we first selected "Optimizing Financial Health" as the theme for the 2020 series of AAHC's ***Leadership Perspectives***, there had not been a single case of COVID-19. And yet, the theme turned out to be even more relevant than ever before. These three outstanding commentaries remind us that, every day, the leaders of academic health centers are called on to respond to crises, big and small. Notably, they must continually evolve to deliver the best patient care, investigate how to do it better, and cultivate the next generation of leaders—all while optimizing financial health.

Richard J. Barohn, MD

EXECUTIVE VICE CHANCELLOR FOR HEALTH AFFAIRS

University of Missouri

The delivery of healthcare is swiftly changing in response to a historic, worldwide pandemic. A prime example of a rapidly evolving model of patient care was evident through our experience during the current COVID-19 pandemic. University of Missouri Health Care underwent a dramatic change in clinical care with a rapid pivot to telehealth services. Prior to the pandemic, MU Health Care conducted a few hundred telehealth visits annually. In the course of a week as we began to greatly limit in-person healthcare, we built an infrastructure to provide more than 4,000 telehealth visits a week. Our IT team did a phenomenal job of quickly ramping up our telehealth capacity, partnering with our physician and ambulatory staff, and educating patients on how to use the service.

I believe telehealth will have a lasting impact and will fundamentally change many of the ways we interact with patients, but this modality presents interesting financial questions for health systems. Prior to the pandemic, telehealth was poorly compensated, which greatly limited its widespread adoption. It was remarkable to watch the rapid transition of federal and private payers to cover telehealth visits at physician reimbursement rates that previously applied only to in-person visits. However, there was a significant negative impact on the technical/hospital rates for telehealth services, and many health systems, including ours, were impacted by the loss of this revenue.

Like many of my colleagues, I remain concerned that policies for telehealth reimbursements will eventually revert to pre-pandemic levels. That would create an unfortunate negative incentive for telehealth at the very time when we are discovering the considerable value of that modality. I know the value of telehealth first-hand from the pre-COVID era. Before coming to MU Health Care, in my neurology practice at the University of Kansas, I had some personal experience with telehealth in successfully treating patients with amyotrophic lateral sclerosis (Lou Gehrig's disease) in the rural Midwest. I think the leaders of all healthcare systems ought to be lobbying to convince insurers of that value, in terms of continuity of care, ease of access and changing patients' expectations, and meeting the need to continue the compensation model that was developed during the pandemic.

COVID-19 has had other significant impacts on our bottom line. We saw a drop in revenues on the inpatient services because we stopped non-emergent surgeries, clinic visits, and admissions. Meanwhile, we had to unexpectedly deploy millions of dollars in support of COVID-specific care, including creating and staffing testing facilities and supply costs that were nearly tenfold previous expenditures. All told, we experienced losses of about $25 million per month for the first three months of the pandemic. While we recouped some of our expenditures through the federal CARES Act, we still experienced a significant financial impact. That led to some very difficult financial decisions, including staff layoffs and furloughs and delaying or eliminating capital expenditures.

Since then, we have actually been able to adapt fairly quickly to the impact of the pandemic. As of July 2020, our clinics are operating at more than 90 percent of pre-COVID levels, our operating rooms are full, and the hospital is quite busy with non-COVID healthcare delivery—all while maintaining proper COVID precautions, of course.

It is too early to see all the lessons we will learn from the pandemic, but operating in the era of COVID-19 has already led us to make operational changes that are producing greater efficiency in our delivery of care. In particular, we have consolidated some services that had been distributed in different parts of our infrastructure. We are actively exploring other potential ways to consolidate and streamline our processes. Also, we have accelerated conversations with smaller regional hospitals to see if there might be mutual benefits of collaborating as part of a more unified healthcare system in Central Missouri. One other benefit is that we created a new partnership with the Missouri Department of Economic Development to provide more Internet hotspots to rural areas. That will help improve access to healthcare via telehealth.

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Carrie L. Byington, MD

EXECUTIVE VICE PRESIDENT

University of California Health

In early 2020, the novel coronavirus pandemic quickly swept the globe and challenged normal healthcare operations. In the United States, the pandemic exposed long-standing health disparities and inequities in communities. The pandemic has also forced institutions to respond creatively to simultaneously contain infection and maintain operations. The traditional strengths of academic health centers, including deep expertise in clinical care delivery and research, have been an advantage.

As the University of California Health system raced to respond to the pandemic, we worked together across our six academic health centers and 20 research intensive professional schools. We were pushed by the pandemic to communicate better, increase collaboration, and respond as a more integrated system. We developed new strengths that will serve us as we recover from COVID-19 and re-make UC Health as a more resilient and inclusive organization for the post-pandemic world.

One example is in the area of telehealth. The promise of telehealth has been discussed since the 1970s and has not yet realized its full potential. Across UC Health, we had very little telehealth activity prior to the pandemic. We documented fewer than 7,500 telehealth visits in January 2020, which was just over one percent of 600,000 total visits that month. By March 2020, much of California was under shelter-in-place orders, and we faced an immediate need to increase our capacity for virtual care. We rapidly trained clinicians, increased infrastructure, and by April 2020 were delivering more than 225,000 virtual visits per month. In August of 2020, we continue to deliver about 200,000 virtual visits per month, even as our in-person volume has returned to more than 500,000 per month.

As we re-envision our health system post-pandemic, we will use our new-found strength in delivering care virtually. We will integrate virtual care with in-person services, documenting all in a shared medical record allowing for continuity.

Virtual care allows us to work further as a system to overcome access limitations dictated by geography or scale. Our capacities as a system exceed the capacities of individual locations and allow us to offer more options for our patients. For example, a patient with a rare cancer in a rural area can access expertise from a variety of specialists from across the UC system virtually. Virtual care also allows us to more easily meet patient preferences for access to diverse providers representing multiple racial or ethnic groups, the LGBTQ community, and those who can offer language concordance. Should a specific expertise or capacity not be available at an individual location, it may be available virtually within our system.

We are also leveraging our research resources as a system of academic health centers to evaluate how virtual care can be used to produce the best patient outcomes. We have pilots related to behavioral and mental health, cancer care, chronic disease management, and virtual critical care as COVID-19 remains a threat. During COVID-19, some hospitals have deployed durable medical equipment to patients' homes for remote monitoring to reduce crowding in hospitals and the risk of viral exposure. We can use virtual care augmented with smartphone apps, cloud storage, artificial intelligence, and a suite of lower-cost medical devices to create new home-care environments that offer patients and their families comfort, convenience, and potentially lower costs.

Healthcare in the United States has been challenged by the SARS-CoV2 pandemic. Disruption can be a catalyst. We have an opportunity to re-make our organizations into more effective systems that deliver better value for our diverse populations using our traditional and new-found strengths.

> "We were pushed by the pandemic to communicate better, increase collaboration, and respond as a more integrated system."

Wayne J. Riley, MD, MPH, MBA, MACP
PRESIDENT
SUNY Downstate Health Sciences University

It is no trite cliché to note that we are living in the most interesting of times. Over the past few months, as our nation and academic health sciences centers have risen to the challenges posed by the COVID-19 pandemic, new models of improving patient care and engagement with providers of all stripes has "quickened" beyond any reasonable expectation. Here in the fabled institution I am proud to lead in Brooklyn—the "epicenter within the epicenter" of the pandemic—we have seen amazing work performed to care for our patients with chronic diseases and those unable to seek the care they normally receive.

One such example that has been a huge surprise is how rapidly both patients and caregivers adopted, designed, implemented, utilized, and embraced telehealth approaches. Whether by phone or real-time video, care of our patients even among the most vulnerable and underserved populations was one such advance that—from my perspective—is firmly established as an important and necessary tool worthy of further adoption in the years ahead.

Another pleasant and welcomed surprise was the better utilization of the full breadth and depth of talent in our various centers by better deployment of a wide range of outstanding professionals such as nurse-practitioners, physician assistants, pharmacists, social workers, and other critical healthcare professionals. Could it be that a global pandemic has finally established that these critical human resources and their important functions have more than "met the moment"? My hope and plea is it has done just that. In many cases, the hope and vision of interprofessional practice has been somewhat illusory. Given the most recent past, we should all do what we can possibly do to "cement" these newer, more collaborative models of care into our ongoing work of developing better care initiatives and educational and clinical platforms in the years ahead—even as we prepare for the next global pandemic and/or national health emergency, which is all but guaranteed to occur.

In a time of significant financial exigency wrought by the pandemic on national, state, and local economies, we will have to dig down deeper to confect more cost conscious, yet high-quality, approaches to all aspects of how we care for both patients and our communities. This admittedly will be no small task, but it is an exercise that we are not unfamiliar with having managed through the "Great Recession" of the last decade, wars and global conflicts, the implementation of the Affordable Care Act, the rise of the quality improvement era, ACO's, value-based reimbursement, and other provider payment initiatives. These and many other challenges to come remind us daily that the "preferred future" for our cherished enterprises should be one of continuous evaluation and reinvention.

Harnessing our collective abilities to do just that—optimizing the care of patients—is yet another of a plethora of strong value propositions academic health centers manifest on a daily basis, both in good times and bad, across our nation. It is our time to do so once again.

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