10 Must Reads for the Next Generation Hospital CFO

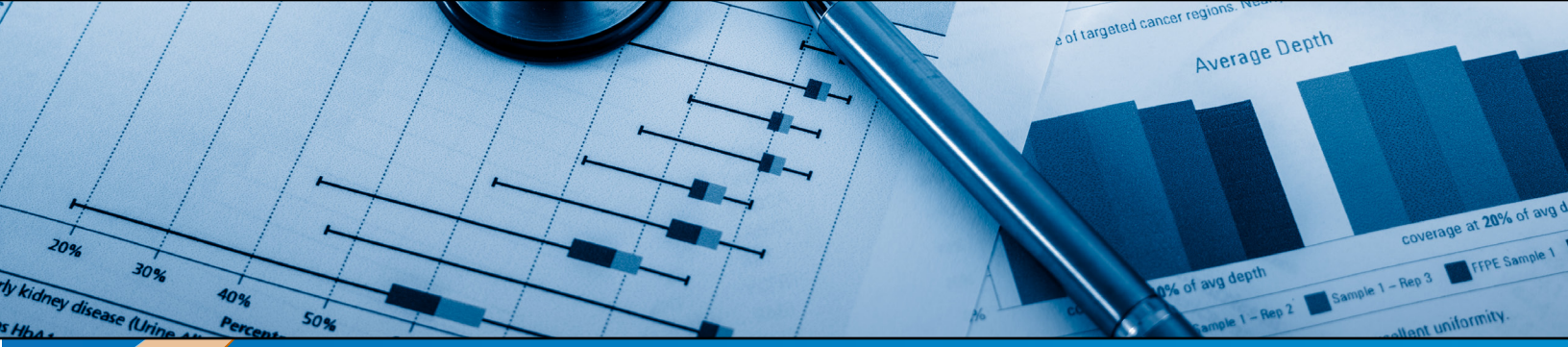
BECKER'S HOSPITAL REVIEW

workday.
Built for the future.

TABLE OF CONTENTS

BECKER'S HOSPITAL REVIEW

workday. Built for the future.



INTRODUCTION

Health systems' increasing participation in capitated and risk-based payment models is driving organizations to see value in gaining a deeper understanding of their clinical data and true costs, as well as how those data sets interact. To meet evolving financial needs, many healthcare CFOs are looking to technology to become more strategic and agile in today's business environment.

CFOs' roles within healthcare organizations are quickly changing. Instead of focusing on "what's happened" from a financial standpoint, today's CFO plays a much more significant part in defining and determining strategy across the enterprise, from operations and labor to payer contracting and risk management. Although their financial responsibilities remain central, the new role required of CFOs in the shift to value-based medicine necessitates the use and mastery of new skill sets.

As such, healthcare CFOs increasingly are the driving force behind strategic innovation across departments. At some organizations, this means replacing traditional budgeting models with more fluid approaches. Other organizations are deploying analytics to improve efficiencies and reduce costs. By taking advantage of new technology, healthcare finance leaders are helping organizations remain operational while preparing for the business needs of tomorrow.

Read on to discover invaluable executive tips, survey insights, business models and noteworthy trends in these 10 must-read articles on healthcare finance technology.

Top priorities for hospital CFOs today

By Laura Dyrda

Declining reimbursements, high deductible health plans and uncertainty from government payers are the key issues keeping hospital and health system CFOs across the country up at night. But many are developing innovative ways to address these issues with population health and waste eliminating strategies.

A panel of CFOs discusses their top priorities at the Becker's Hospital Review 8th Annual Conference in Chicago. The panel, moderated by America's Healthcare Leaders Founder, CEO and Publisher Dan Nielson, included Pittsburgh-based UPMC Physician Services Division CFO Ann Evans; Fountain Valley, Calif.-based MemorialCare HealthCare CFO Karen Testman; and Chicago-based Northwestern Memorial Healthcare Senior Vice President and CFO John Orsini.

The key priorities for the panelists included:

- **Integrating hospital and physician practice acquisitions**
- **Developing population health infrastructure**
- **Improving access to care**
- **Selecting EMR/IT platforms**
- **Focusing on ambulatory and outpatient care**
- **Lowering the cost of care**
- **Optimizing current cost structures**
- **Maximizing advanced practitioners**

The panelists took a deeper dive into outpatient investments, acquisitions and operational efficiencies to lower the cost of care.

Outpatient investments

Ms. Testman said MemorialCare's focus is shifting from the inpatient hospitals to the ambulatory and outpatient care clinics. Many patients never make it to the hospital because physicians resolve their issues in the outpatient setting.
"Our focus has been trying to buy lower cost alternatives for our patients, which is why we decided to invest heavily in freestanding ambulatory surgery centers," said Ms. Testman. "In our market, most of our competitors have ASCs as well as hospitals. We've invested in our own freestanding imaging centers whereas most of our competitors are doing that on an HOPD basis. It's been a good thing for us to get into that world."

MemorialCare recently partnered with dialysis company Fresenius to better coordinate care for patients with kidney disease. Ultimately, the system hopes to prevent the need for dialysis and when patients do need it, encourage home dialysis instead of dialysis at the more costly outpatient centers.

The health system also turned its focus to consumerism with a concierge program, which takes backend employees and moves them to the front end of the process as the patient's point of contact. MemorialCare applies the concierge program to certain elective procedures and collects payment upfront; if patients aren't able to pay, their surgery is canceled. "We always had a program in place for service collections and attempted to collect upfront," said Ms. Testman. "What makes this different is our employees are specially trained in customer service and collections…and we will go forward with canceling or postponing cases."

Integration

Northwestern's focus over the past several years has been acquisitions and integration. "We've been careful to integrate and maintain performance," said Mr. Orsini. "The integration with our IT has helped us make sure our performance hasn't slipped with the integration with the hope that when the investments are complete, our performance will continue to rise even further."

Integration on the business side is challenging, but integrating cultures is even harder. Mr. Orsini said both sides should work together to move in the same direction to prevent culture wars from derailing the transaction.

"Northwestern is very deliberate and focused in finding the right partner," he said. "We've looked at smaller tuck-in deals that we haven't done because it wasn't a cultural fit or there were other things constricting the structure of the deal."

UPMC has also experienced significant growth through acquisitions. The health system now includes 25 hospitals and more than 600 other physical locations. In some cases, practices are under-utilized with two or more unused exam rooms at any given time.

"Our organization has grown tremendously over the past few years by merging, joint venturing and acquiring practices," said Ms. Evans. "Now we have to step back and consider whether we have the best physical footprint for our organization."

Operational efficiencies

UPMC is also creating operational efficiencies and patient satisfaction with biometrics; when patients arrive at the physician's office and use an automated system to check in. As a result, the front desk staff that formerly spent time at registration moved to the back

end to manage referrals and help patients navigate the system appropriately.

"We've gotten good feedback on that," said Ms. Evans. "I was a little bit of a skeptic initially of the biometrics because of the population in Western Pennsylvania – it's second only to Florida as the largest elderly population. But what happened in our organization is we got great feedback."

The system also mandated all employed physicians provide same-day appointment access, which means the physicians are available if patients call in needing a specialist in short order. That doesn't mean the patient will see the specialist of their choice, but a specialist will be available to see them.

"That's not the protocol our physicians were used to operating under," said Ms. Evans.

"That's underway now and a big initiative for us."

Despite the changes in healthcare and challenges for leadership, all three panelists were bullish on the healthcare industry moving toward value-based care.

"The industry in general is going to survive," said Mr. Orsini. "It draws empathetic, caring people that want to figure things out. We are facing what every other industry, except higher education, has faced. If you look at other industries, they've all gone through periods of consolidation and excess capacity. The reality is that healthcare has a lot of excess capacity so we will squeeze that out as an industry and technology will allow people to better care for themselves overall."

4 Thoughts on How Healthcare Organizations Can Eliminate Costs

By Alyssa Rege

To fight declining reimbursement rates and patient revenues, hospitals and health systems are increasingly searching for ways to "trim the fat" from their organizations. However, are there really ways to successfully cut costs without affecting a hospital's ability to provide care and service patients in their respective communities?

Chris Bergman, CFO of Dayton (Ohio) Children's Hospital; Ylone Xavier, senior business adviser of enterprise intelligence at Change Healthcare; and Jim Porter, CFO of Chicago-based St. Bernard Hospital and Health Care Center, discussed the issue during a Nov. 15 panel at the Becker's Hospital Review 6th Annual CEO + CFO Roundtable, which took place from Nov. 13-15 in Chicago.

Here are four thoughts the panelists had on how healthcare organizations can eliminate costs.

1. "I truly believe [cost saving begins with] physician utilization. … Since I became a consultant about four or five years ago, I was really surprised ... no one shares [cost-saving strategies] with physicians, and that really shocked me," said Ms. Xavier. "I believe it's because of the … 'them versus us' mentality … people were afraid to work with physicians."

2. "Time equals money. Our hidden cost is time. It begins at the beginning of the day when there's a late start on the first case of the day, and it just compounds from there. Sure, it can be dissatisfying for physicians, but in the operating room, time is money. … We don't always see that, and we don't always necessarily look at that as a cost, but we've expanded that saying across the organization. … Time may not be money, but it is an opportunity for additional revenue," Mr. Porter said.

3. "[Technology helps] to identify the areas that you really need to be working on," Ms. Xavier said, adding that once key stakeholders can understand and identify where those costs come from, they can begin to more thoroughly analyze their service lines and other aspects of the organization to determine where additional cuts can be made. "For example, at the health system I previously worked at … we used that data to show … all the [executives] step by step how the emergency room was [the hospital's] biggest moneymaker."

4. "A lot of the burden falls on the CFO to be able to communicate … that it's not just about cost or making money, it's about future sustainability of the organization. It's about creating long-term financial plans. … Most CFOs are accused of being the 'chicken littles,' [always saying] revenue's getting cut. … [But] it requires a lot of communication to get everybody to understand why costs are really important," Mr. Bergman said. "It can't be about the finance guy controlling costs; the leadership team has to be on board. Everybody has to own it."

Blockchain in healthcare: Identifying the biggest and best opportunities with Change Healthcare CTO Aaron Symanski

By Laura Dyrda

A blockchain is an open, continuous, and secure ledger stored online that can't be altered. Users can track supplies and transactions on blockchain and share information among multiple stakeholders, recording transactions between parties efficiently and in a verifiable, permanent way.

The financial and logistics sectors have used blockchain for years to record information, and now the buzz around healthcare focuses on how blockchain can solve some of the industry's biggest headaches. We caught up with Change Healthcare Chief Technology Officer Aaron Symanski, who has first-hand experience with blockchain in the financial sector and now focuses his expertise on its healthcare applications.

Note: Responses were edited lightly for length and clarity.

Question: What are the eminent opportunities for blockchain in healthcare?

Aaron Symanski: Blockchain is proving its value every minute of every day. While it's currently used in bitcoin and other cryptocurrencies, there are additional industries creating businesses utilizing blockchain, mainly around its audit capabilities. For example, logistics is an area where blockchain can be critical to healthcare. Think about pharmaceutical products that need to be maintained at a certain temperature, and to assure they're not counterfeit and really were made by their manufacturer. Blockchain can assure both.

Those are the easy fits, but think about the next step in healthcare information. With bitcoin and auditing and logistics, it's about the visibility of the information being stored and available on blockchain to everyone. With personal health information, it's a different matter. We're seeing information being stored away from the chain, but the chain is used to affirm that the information is correct. We're seeing variations of blockchain where the information can be stored itself. A good deal of creative and innovative thinking is being done around this space.

There are other direct applications that aren't as exciting because they don't deal with protected information, but they're very straightforward and that's a lot of where our interest is: making that process of healthcare more effective and allowing clinicians to spend more time with patients instead of paperwork.

"With personal health information, it's a different matter. We're seeing information being stored away +from the chain, but the chain is used to affirm that the information is correct. "

Q: What are some of the challenges associated with blockchain use in healthcare today?

AS: One of the biggest challenges for blockchain in healthcare is overcoming the hype. Those who utilize it are being really innovative and creative in coming up with ideas about what blockchain can do in healthcare if it had additional capabilities. We need to separate out where the real blockchain value-add opportunities are, and what pieces require more work and significant change to leverage the technology.

Q: Will blockchain have an impact on organizational workflows or healthcare reimbursement?

AS: I think the most direct change is that the chasing and reconciliation processes will begin to separate. About 80% of the work we do with chase deals with comeback, due to misspelling or typos in the record. With blockchain, that will be separated from the more challenging claims that need chasing—the ones that require human involvement. Are we doing bundling or unbundling? Do we have multiple providers? Are the cases more complicated with multi-year and multi-origin information? We see straightforward processes being peeled away from the organizations via blockchain, so they can use their existing resources for more challenging issues.
We've seen many of the standards around communication and reconciliation go away in other industries with blockchain. The organizations work their way down the value chain killing off the low value issues first, and leaning toward the high value where you need people involved to put all the puzzle pieces together. What you'll see is a reduction in cost per case, cost per issue, and cost per event.

When you start moving your simple processes to automation, and know your counterparts are actually communicating and looking at everything the same way you are, it builds stronger partnerships. Whether you're a hospital provider or payer, there is a lot of expertise for these processes that will be adding a good deal of value.

Q: Can blockchain move healthcare organizations closer to interoperability?

AS: There is a lot of hope in the aforementioned hype. One thing that blockchain doesn't do for us, which needs to be done for interoperability, is defining the language of how information is stored and used. Are we referring to blood pressure and height in the same way? How do ICD-10 and other different languages come together? Once you and I know we are conversing in English, we can easily store that information in a record. If one of us was speaking French and the other Chinese and we were trying to put the questions and answers in the right place—that's challenging.

Blockchain is a very effective storage mechanism; what it brings to interoperability is information about where things are stored. Blockchain can take interoperability and create a conversation about what information we actually want to exchange and store.

"One of the biggest challenges for blockchain in healthcare is overcoming the hype."

Q: Are there any trends or lessons from blockchain in the financial sector that could apply to healthcare?

AS: There is a huge amount in healthcare that defined the movement of value and dollars, and payments and the reconciliation of those payments. Were the payments appropriate based on the service provided? Was the payment made? Those ideas have parallels in finance. Do we agree on the terms of the contract? Has the payment been made on the contract? However, when we look at personal health information, it gets interesting.

How can we commission what information on the chain can be seen? No financial firm wants competitors to see all their work, all their payments and customers. Healthcare will be looking at blockchain with a respectful eye and with its own viewpoint. The main lesson coming out of finance right now is that blockchain works well when there is an asset with multiple parties interacting with the asset, and the asset is tracked on the blockchain. When healthcare looks at using the blockchain against that lesson, it crystallizes about what it means to be on the blockchain.

There are a lot of organizations that sit in their own shop and do a revenue cycle management prototype, and it has success in blockchain, but they stop. Change Healthcare has worked with the technology and done our own improvement process. Right now we feel it's creating the right examples of where blockchain makes the most sense, where all parties find value. We are seeing a regulator partnering with an asset manager, or asset manager partnering with private equity.

Q: Where do you see the biggest potential for blockchain in healthcare?

AS: The most direct use of blockchain available to healthcare today is moving into those reconciliation, claims adjudication, and revenue cycle management opportunities where we have highly trained, engaged smart people, allowing them to do other things within the organization. I think the next step after that, as interoperability separately solves, is how do we create that level of patient information so in the moments of treatment, my information and your information are available? But I really think the immediate potential is in allowing us to reduce the cost of healthcare by reducing reconciliation and back-office pieces. That will allow providers to spend more time with patients.

Q: What impact will blockchain have on the healthcare system 10 years from now?

AS: Ten years from now, we will see healthcare very much as a plug-and-play infrastructure where information is correct, it is distributed, and its access is well controlled through entitlements and security. When I think of ten years from now, I see myself walk into an immediate care clinic in a city I've never been in before, and allowing that organization to have access to the appropriate pieces of my healthcare record as I determine it.

I envision being able to look at my phone and see that my insurance company cleared a set of claims; I'll see my portion and their portion of the bill, and one view will show the different providers involved in my care in one frame so I can understand the bill quickly. I can understand my responsibility and your responsibility, and I can agree to make that payment. I have a more complete, holistic picture with my interactions and experience with healthcare. It's blockchain, doing what we intended.

Why These 4 Health Systems Abandoned Traditional Budgeting

By Brooke Murphy

As markets become increasingly volatile, some hospital systems are ditching static annual budgets for more dynamic alternatives.

Traditional budgets rely on meticulous line item details to plan business expenses and anticipated revenue during the coming 12-month period. Organizations in industries outside of healthcare started ditching static annual budgets years ago in favor of a more proactive option – the rolling budget.

A rolling budget is a fiscal management approach that uses rolling forecasts, relative performance targets and increased management accountability to create a culture of continuous improvement. Due to a focus on real-time comparison, organizations update rolling budgets throughout the fiscal year.

To establish a rolling budget, financial leaders set performance targets that represent marginal improvements over last year's actual results. Staff then run a rate forecast, or an extrapolation of current financial trends based on last year's achieved results, and compare the results to their target goals. This determines how much hospital operations must improve at any point to meet target performance goals by year's end. Switching from a structured budget to a loose financial plan can make any CFO uneasy. But representatives from four health systems spread across the U.S. explained how and why their organization abandoned traditional budgeting models.

Here are four thoughts on the advantages of fluid budgets from Mary Jo Brummel, director of finance at Nebraska Medicine in Omaha, Neb., Greg Wright, director of finance at Southern Illinois Healthcare in Carbondale, Larry Hill, vice president of finance at Mission Health in Asheville, N.C., and B.J. Miller, senior director of performance and planning at Park Nicollet Health Services in Saint Louis Park, Minn.

1. Allows for a more strategic investment of resources.

Despite the amount of effort, time and resources hospitals invest in traditional budgeting processes, the end product often produces less than desirable results. Mr. Hill said Mission Health used to dedicate four or five months – and millions of dollars in personnel and resources – to its budgeting process, only to find the budget sometimes lost its relevance after just one quarter. Nebraska Medicine accountants and finance employees utilize the costs from the first six months of the fiscal year discharged patients, when they begin the financial planning process for the following year, said Ms. Brummel.

Since Mission Health implemented a rolling budget, the system has strategically reinvested its former budgeting resources to expand and develop its operational footprint.

2. Makes an enterprise Financially nimble.

Due to today's market volatility, the ability to review performance results in real-time and course correct throughout the year is attractive to many healthcare organizations, said Mr. Wright. By their nature, hospitals systems are often slow to execute change due to their administrative structure and cumbersome size. A rolling budget decentralizes financial management and instead enhances regional management accountability across the enterprise. As a result, each hospital site has the ability to monitor its own performance in real-time and make adjustments necessary to meet changing business conditions and achieve their unique goals.

3. Cultivates an environment of continuous improvement.

The rolling budget approach is founded on the Japanese notion of Kaizen, said Ms. Brummel, which signifies continuous improvement through efficiency and the elimination of waste. All four hospital administrators agreed this approach enabled each organization to focus on long-term goals rather than short-term, annual results.

Mr. Hill said Mission Health shifted its mindset from "meeting the budget" to demonstrating improvement year-over-year. "Our numbers and targets are different every quarter," he said. This roving target allows the system to work proactively to achieve its goals. "If we're doing great we can celebrate or make plans to push that greatness forward. If we're off target, hopefully it gives us more time to react," he said. Mission Health measures and compares key operating and productivity metrics, such as total expense over unit of service and hours worked over unit of service, from the previous year.

4. Emphasizes performance management and accountability.

A culture of continuous improvement increases visibility into department and management performance. Managers know their department's performance must improve compared to last year's actual results, which holds managers accountable to maintain their margins. "The performance data is available to everyone across the system," Mr. Miller said. "This slight peer pressure drives everyone to achieve their goals."

Why the 'New Normal' for Healthcare Cost Growth Isn't Sustainable

By Ayla Ellison

The healthcare cost trend — the projected percentage increase in the cost to treat patients from one year to the next, assuming benefits remain the same — is expected to rise 6.5 percent next year for people with employer-sponsored insurance, which is in line with the 6 to 7 percent increases recorded since 2014. Single-digit growth is the "new normal" for medical costs, but this trend is unsustainable, according to a PricewaterhouseCoopers report published Tuesday.

Medical costs are growing at a rate about three times higher than general inflation and premiums for employer-sponsored coverage are rising faster than wages. According to PwC, the average health plan premium for family coverage purchased through an employer climbed 20 percent from 2011 through 2016. At the same time, wages rose by just 11 percent. "This gap erodes consumers' ability to pay for other goods and services, including housing, food and transportation," the report states.

According to PwC, medical costs are projected to continue to rise faster than gross domestic product. This means healthcare will continue to represent a greater share of the economy, which could lead to budget deficits or less spending in areas such as infrastructure and education.

For the healthcare cost trend to drop below the "new normal," healthcare organizations and businesses will have to tackle the price of services and the rate of utilization.

The PwC report identifies several factors driving the healthcare cost trend higher, including lowered interest in high-deductible health plans. Employers offered HDHPs to employees in recent years to curb health spending, but that trend may be plateauing. According to PwC, the share of major U.S. employers offering HDHPs as their only benefit option to employees has remained flat for the last three years.

"High-deductible health plans aren't taking off as quickly as we thought they would," Barbara Gniewek, principal at PwC, tells Becker's Hospital Review.

Individuals enrolled in HDHPs are far more likely to skip or delay receiving medical care than those with lower deductibles, and employers spend less on healthcare as employees with these plans use less care. However, the slowdown in the shift to HDHPs will push the medical cost trend up in 2018 by easing some of the downward pressure on utilization.

Ms. Gniewek says HDHPs may become more popular in future years due to ongoing health reform efforts that expand the use of health savings accounts that are paired with HDHPs.

"For the healthcare cost trend to drop below the "new normal," healthcare organizations and businesses will have to tackle the price of services and the rate of utilization."

Getting Real About Relifing: An Opportunity to Add Millions Back to Hospitals' Bottom Line

By *Becker's Hospital Staff*

That's the way we've always done it." More than ever, this phrase raises a red flag to hospital and health system leadership. In a $3 trillion industry experiencing substantial regulatory, financial, clinical and technological shifts, "the way we've always done it" cannot hold water.

Today's hospital and health system financial leaders should assess some accounting and financial reporting functions that were handed down from their predecessors. One specific function to examine is the rate of depreciation for a hospital's fixed assets. For many hospitals and health systems, the calculated useful lives of assets no longer reflect reality. This can affect bond financing, capex expense and insurable values, to name a few.

By reassessing the depreciation of assets through a process known as "relifing," organizations can incur savings averaging $2 million for an individual hospital to $50 million for a hospital system. To understand relifing and how hospitals may mistakenly approach facility lives today, Becker's Hospital Review caught up with two experts from Chicago-based Principle Valuation LLC, a member of Prism Healthcare Partners.

What is asset life?

Asset life refers to the periodic depreciation expense of hospitals' fixed assets, such as the buildings or equipment. Relifing occurs when executives review the estimated useful lives of fixed assets and adjust the assets' lives based on their actual use.

In the broader field of accounting, relifing is often overlooked, and fixed asset accounting is rarely taught. Instead, many finance professionals learn this technique on the job. "Depreciation and fixed assets are kind of orphan areas of accounting," says John Holmes of Principle Valuation. "CFOs may look at these areas only when the organization needs to borrow money, but in reality, regular review can yield significant financial benefit."

How does relifing affect hospitals' bottom line?

Relifing itself does not increase an organization's cash reserves or improve a hospital's operating processes. Depreciation is a non-cash item, but if hospitals write off assets quicker than they should, it negatively affects their ability to borrow and their fair market value. "You will end up paying more for your money than you should have to and receive less than the entities are truly worth in a sale or merger," says Mr. Holmes.

Rapidly writing off buildings or equipment creates a gap between long-term bonds and the assets supporting them, which are effectively being amortized in 23 to 25 years. This increases the debt-to-equity ratio. The costs of over-depreciated assets vary. "In some cases we have seen the bottom line impacted by $2 million to $3 million a year. In other cases, for health systems, it's as high as $50 million a year," says Timothy H. Baker, managing partner of Principle Valuation.

Relifing has a similar effect as an annuity, since the adjusted useful lives will maintain the ongoing reduced depreciation expense for the remaining life of the asset while it is owned. The new lives also provide a lower depreciation for future construction projects.

"Updating a useful life estimate to reflect longer utilization results in both an immediate and long-term positive financial result," says Mr. Holmes. Additionally, it better facilitates achieving the age-old accounting concept of matching revenue with expense. Compared to years past, now is the time for nonprofit hospitals in particular to reexamine their fixed assets and, if appropriate, revise those lives. There are several reasons for the urgency.

Why relifing and why now?

Despite policy change, many hospitals have over-depreciated their assets for years.

"Back in the late '60s and early '70s, Medicare included depreciation as a cost when it started to reimburse hospitals on an actual cost basis," says Mr. Holmes. "It was in hospitals' best interest to write off assets. They sought the shortest possible useful lives for assets to receive their Medicare payment as quickly as possible."

"CFOs may look at these areas only when the organization needs to borrow money, but in reality, regular review can yield significant financial benefit.."

Medicare fully eliminated depreciation payments in 2001 after phasing them out for 10 years. "But in many hospital accounting departments, things continue to function as 'the way we've always done it,' or pre-2001," says Mr. Baker.

Hospitals and health system accounting teams have typically assigned asset lives based on recommendations in the American Hospital Association's publication, "Estimated Useful Lives of Depreciable Hospital Assets." The AHA has published and updated this resource for some 50 years. The guidelines were initially drafted to maximize depreciation, but that need has grown obsolete since Medicare no longer reimburses for depreciation. The actual expected useful life of an asset should be used.

Furthermore, the AHA's published asset life recommendations are only an estimate for hospitals. "The AHA specifically says these are guidelines, they're not written in stone," says Mr. Baker. "There can and should be adjustments."

Mr. Baker and Mr. Holmes helped spearhead a national study of hospital buildings and equipment, initiated in 2000, based on more than 400 hospitals. They found most healthcare organizations use their assets longer than the suggested lives published by the AHA. Annual depreciation using AHA lives is often half as much of the useful lives identified in other studies, which are arguably more realistic.

For example, if a hospital assigns a 40-year life to building structural components and 20 years for building service components (such as electricity, plumbing and HVAC), the hospital will effectively write off the entire property in less than 23 to 25 years. However, there is substantial evidence of hospital buildings lasting longer than 40 or 50 years. In fact, some hospital buildings are 100 or more years old, highlighting the disconnect between actual useful lives and the significantly shorter lives used when depreciation was reimbursed.

It is in healthcare organizations' best interest to reassess their assets' useful lives and determine whether the depreciation of their assets reflects actual usage.

CFOs Look Into the Crystal Ball: The Future Business Model of Healthcare

By Karen Wagner

Hospitals and health systems must react faster to the quickening pace of change in healthcare by innovating and adapting their business model - or they probably won't survive.

That cautionary note was the overall theme delivered by CFOs from Wake Forest Baptist Medical Center, the University of Virginia Medical Center, and ProMedica during a standing-room only session on "Creating Healthcare's Future Business Model" moderated by Strata Decision Technology CEO, Dan Michelson, during the Becker's Hospital Review 8th Annual National Meeting held in April in Chicago.

Panelists contended that the traditional business strategy that health systems have relied upon, centralized on maximizing inpatient revenue streams from a steady stream market of customers, won't be enough and won't be around to keep the doors open in the not-so-distant future.

The CFOs zeroed in on four key strategies they believe are essential to incorporate into business models to enable healthcare organizations to thrive:

1) Aligning with other healthcare organizations

2) Shifting from revenue cycle management to margin and outcomes management

3) Developing new revenue streams

Embracing a consumer-based model

4) Aligning with other healthcare organizations

Aligning with other healthcare organizations

Although every market offers a different environment for alignment, partnerships enable the disparate organizations to create leverage and capitalize on each other's strengths, said CFO Michael Browning of Toledo, Ohio-based ProMedica health system. Alignment doesn't necessarily mean mergers or acquisitions. Browning referred to a partnership between WakeMed Health & Hospitals, Raleigh, N.C., where he previously served as CFO, and Duke University Hospital, Durham, N.C., that combines the organizations' cardiology service lines into one program, which provides the opportunity to improve quality and service and reduce costs.

"I think that was a very innovative way to look at it," Browning said. "Organizations have to give up on some of those things that have historically been important to us, like our sole independence, and look at how we can provide the best healthcare while making sure that we're meeting all the needs of the people in our community."

Other partnerships may involve consolidating business functions, such as the revenue cycle. "I think those are types of joint ventures that many organizations will be working on in the future," he said.

Chad Eckes, CFO of Wake Forest Baptist Medical Center, an academic medical center in Winston-Salem, N.C., likened merger and acquisition activity in the healthcare industry to the previous period of mass consolidations in the banking industry. The trend in healthcare, driven by this need for back office improvement, can also be achieved through other forms of partnering, such as outsourcing, he said. Wake Forest Baptist just completed an outsourcing arrangement for physician billing services, which represents the fourth outsourcing arrangement completed since Eckes started with the organization about three years ago.

Shifting from revenue cycle management to margin and outcomes management

The participants were unanimous in their belief that the decades long focus on growing the top-line and revenue cycle management had run its course. Each CFO stated that over the next five years they believe that revenue cycle management will give way to margin and outcomes management.

One of the enabling technologies currently leveraged by all the organizations on the panel is advanced cost accounting and financial decision support. With this in place, organizations are able to understand both their true cost and margins, a critical set of data for both negotiating and performing effectively under bundled care contracts.

Leveraging that cost data together with clinical outcomes is central to measuring value, which is increasingly becoming the new currency for these organizations.

Developing new revenue streams

Healthcare delivery organizations are increasingly creating new streams of revenue from new sources, including non-patient services.

As providers become more proficient in population health management, marketing successful wellness programs to other providers can be a way to capitalize on existing expertise, said Nick Mendyka, CFO of the University of Virginia Health System, Charlottesville, VA. "We're the ones who provide that service, yet we're contracting with payers to do that work," Mendyka said. "So we can deliver wellness services in the vein of population health management and we can grow it, scale it, sell it to other smaller providers or employers." Browning said traditional revenue sources will only be so helpful to the hospital's bottom line. To counter the loss in volume under value-based care, healthcare organizations have to gain access to the healthcare members' premium dollar. Value-based care is a central strategy but the long-term business model is still unclear, he contended. "It's the future, yet it's currently set up in a way where the insurance companies are the ones accruing the most benefit from all the great work everyone is doing. We've got to figure out how to create balance and share in that dollar as much as we can," Browning said.

ProMedica's insurance arm, Paramount, covers 350,000 lives and is "a major catalyst for our future," Browning said.

Embracing a consumer-based model

The panelists agreed that consumerism has changed and will continue to change the way healthcare is delivered and therefore managed. The approach to the market has changed dramatically in the past five years, Eckes said. "Back then, we didn't worry about consumer behavior, understanding buyer vs. non-buyer decision-making, or impacts of social media" he said.

"We worried about referrals from physicians and having convenient ED's. Our customer is no longer just the patient and the referring physician. Our customer is now the employers, payers, family/friends of patients, and CIN's [clinically integrated network]." Such changes mean healthcare organizations have to be much more aware of the patient's desires, competition and patient experience.

"We have to articulate our value story and answer the questions of 'Why should the patient entrust their care to us. It's key to reinforce the quality that you should expect from the health system and the total patient experience that you'll get from us before, during and after'" the clinic or hospital visit, Eckes said.

Serving the consumer better also means price transparency, which requires healthcare organizations to have a better understanding of their cost structures, Mendyka said.

Hospitals must be able to provide consumers with a more accurate estimate of their out-of-pocket costs, he said. "Whether that deductible is $1,000 or $15,000 there's still a greater likelihood that a patient will pay all or a portion of that bill when they know they're making the decision, they know what it costs," Mendyka said.

And, although no organization has yet to be 100 percent successful at this, finance managers have to fully understand their market segment and how patients choose providers. "It changes the equation and how we assess and set strategies," Mendyka said.

Redefining success

Overall, healthcare organizations, particularly finance departments, will have to redefine how they measure success. No longer will AA bond ratings be the sole determinant, Browning said.

"Ten years from now it's going to be more about what we do for our community. The quality we deliver, the service we deliver," he said.

Mendyka concurred. "The way that we're going to measure our organizations' or any individual's contributions is going to be very different in the future," he said. "It can be about community benefit. There will be new and very different things that we are going to be judged upon. Organizations must get ahead of this or they may not survive" he said.

These new success factors will mean making some tough business decisions, such as turning an acute care hospital into an outpatient center, Browning added. Healthcare leaders sometimes want to push such strategic decisions into the long-term future, but, he said, "The future is right here right now."

"The way that we're going to measure our organizations' or any individual's contributions is going to be very different in the future"

5 Skills CFOs Should Develop in the Next 5 Years

By Brooke Murphy

Healthcare organizations are transforming their traditional, insular operating structures to become more nimble and centralized. This means hospital systems need financial leaders equipped with a different skill set to achieve future success.

Financial leaders discussed how the hospital CFO role has evolved in the past five years and predicted what a future CFO might look like during a panel at Becker's Hospital Review 5th Annual CEO + CFO Roundtable in Chicago Nov. 8.

Here are five ways panelists see the CFO skill set changing in the next five years.

Strategic thinker.

The CFO position is increasingly removed from daily financial processes as more hospitals choose to either centralize or outsource some financial services, such as revenue cycle management, accounts payable or collections.

Economic uncertainty has caused many healthcare organizations to seek partnerships as a way to retain their market share and ensure financial stability. The new CFO is "someone who is still conversant in financial terms, but maybe has an MBA instead of an accounting degree, who is comfortable doing business in a matrix environment and capable of seeing the big picture," says Patrick McGuire, executive vice president at Ascension Health in St. Louis and CFO of the Michigan market at St. John Providence Health System in Warren, Mich.

Michael Allen, CFO at OSF HealthCare in Peoria, Ill., also expressed the critical importance of business acumen for CFOs. "I need to think beyond the numbers on the spreadsheets and be a visionary [as CFO]," Mr. Allen says.

Exceptional social skills.

Planning long-term hospital business strategy and forming partnerships has made relationship building a key part of the CFO role. Alternative business models and transactions require collaboration and trust, and "the CFO needs the social and emotional intelligence to do that well," Mr. McGuire says.

Interdisciplinary approach to problem solving.

"Money touches everything," says Mr. Allen, meaning that increased pressure to improve a hospital system's financial performance and reduce spending

has spurred financial leaders to address operational efficiency across the enterprise. Cost containment efforts are increasingly focused on areas such as performance improvement, capacity management and materials management – departments outside of finance leaders' traditional wheelhouse. "I've seen increased overlap between the CFO and COO roles as both chiefs partner to lead process improvement efforts," said Kenneth McGee, CFO at LorettoHospital in Chicago.

Equipped with an extra-industry sensibility.

Leaders who gained their professional experience outside of the healthcare industry can bring fresh perspective, says Jim Cockey, senior vice president and market executive of specialized industries and global commercial banking at Bank of America Merrill Lynch. "There's already an incredible number of folks cross-pollinating into the healthcare industry, asking questions and bringing and outsider's perspective," Mr. Cockey says. Extra-industry leaders may be more likely to question entrenched processes to drive innovation, look to translate successful models from other industries into the healthcare setting and use creativity when approaching healthcare problems.

Knowledge of alternative payment models.

Panelists agreed the CFO and CMO should jointly helm a hospital's implementation of alternative payment models and risk-baring contracts. "As financial leaders who are accustomed to dealing with data and analytics, I think we can step in and play an important role in developing and implementing these alternative payments," Mr. McGuire says.

"There's already an incredible number of folks cross-pollinating into the healthcare industry, asking questions and bringing and outsider's perspective."

Modeling the Future of Healthcare with Analytics

Written by Ian Duncan, FSA, MAAA, FCIA, FCA, FIA

What's the future of healthcare? Ask a health executive and there's a good chance they'll say predictive analytics.

As the engine that turns the raw materials of "big data" into actual insights that can be used to tailor services, anticipate needs, find fraud and eliminate waste, predictive analytics is increasingly valuable.

Actuaries like me are in the business of creating predictive models and, more important, translating the models built by predictive analytics into the business insights that improve products and services for health providers and insurers – but we need executive support to truly transform the industry. The Society of Actuaries recently conducted a survey of health payer and provider executives to glean key insights into how predictive analytics trends will temper financial pressures and contribute positively toward the Triple Aim of healthcare – improving patient care, patient health and per capita costs.w

Health executives have a strong opinion of the future of predictive analytics in their field, as 93 percent believe predictive analytics is important to the future of their business. And in an industry that's increasingly focused on value-based care, it's clear that achieving the Triple Aim is top of mind for survey respondents. For both payers and providers, the top four outcomes identified as most valuable to predict – cost, clinical outcomes, patient satisfaction and profitability – all directly impact the goals of the Triple Aim. Further, more than half of executives surveyed say predictive analytics will save their organization 15 percent or more over the next five years, and a quarter of executives forecast saving 25 percent or more in that span.

Overall, the survey results highlight how executives view predictive analytics as essential to providing value-based care. Predictive modeling can be used to identify patient health risks, helping doctors anticipate their healthcare needs, mitigate their conditions and uncover needs that can be addressed with new solutions for patients and providers. These capabilities represent an especially important growth area for providers who currently lag behind insurers in terms of predictive analytics use. However, the survey also reveals providers are expected to be on par with insurers within five years, as the industry seeks tools to effectively manage risk in a value-based world.

Despite the anticipated financial benefits from predictive analytics, 16 percent of healthcare executives still indicate that a lack of budget is the biggest challenge to implementation within their organization. In my experience, budget concerns are less about having the money to invest and more about major organizational change necessary to fully implement predictive analytics. Operationalizing the changes that predictive analytics requires and prescribes is a big task. The changes, financially sound as they are in the long run, can require investment in new infrastructure and systems, as well as adjustments down to hiring for specialist roles, new skills and even day-to-day operations changes.

Regulatory issues, specifically compliance with security requirements in the face of recent highly publicized data breaches, were identified by executives as the second most challenging aspect of implementing predictive analytics. Given the recent prominence of hacking, as well as the size and scope of the data breaches that have become worryingly common, I view the security of user data and records as the biggest challenge. Health data can easily be used to identify individuals, so the prospect of having records hacked is very concerning for both payers and providers. Nevertheless, the financial benefits that predictive analytics brings to the table outweigh the potential negatives.

Challenges for implementation of less concern to executives surveyed include incomplete data and a lack of skilled applicants. But the data we have now is much more complete than in the past, and we are finding new, better ways of collecting data from sources both traditional (like health records) and nontraditional (like wearable devices). Similarly, healthcare may need to start looking at nontraditional professionals to hire for predictive analytics roles, such as actuaries. After all, predictive analytics is the cornerstone of the actuarial profession, and we have been analyzing complex big data since our inception – long before it was popular.

It's clear that executives are confident about the benefits of predictive analytics – 88 percent of respondents said they currently use or are planning to use predictive analytics. And the survey found that the top two expectations for the future of predictive analytics are the refinement of data collection methods to increase security (20 percent), and investment in people with the necessary expertise. These results indicate that executives are also confident that the industry will invest in solutions to the biggest present and future challenges for the healthcare industry.

***

Mr. Duncan is Adjunct Professor of Actuarial Statistics at the University of California Santa Barbara and president of Santa Barbara Actuaries Inc. From 2010 to 2014 he served as Vice President, Clinical Outcomes, Analytics and Reporting at the Walgreens Company. He founded Solucia Consulting (now SCIO Health Analytics), a provider of analytical and consulting services to the healthcare financing industry in 1998.

Practical Applications of AI in Hospitals: Questions with Dr. Andrew Pendley

Witten by Abbie Crouse

Dr. Andrew Pendley is the medical director of the emergency department at Emory Healthcare. A self-professed Operations Nerd, Dr. Pendley has always been fascinated by the conflux of hospital operations, lean principles and medical best practices. Brought together, these can have tremendous impact on patient flow and the clinical work environment. Dr. Pendley recently spoke with us about the role of technology in hospitals and how it has changed hospital processes.

What technology trends have had the most impact on hospital operations?

Dr. Andrew Pendley: Healthcare, due to the scale of care, is generally slow to adopt technology. To look at a technology that has the biggest impact in hospital operations, you have to look at things that people take for granted today, like electronic medical records (EMR) or computer physician order entry, or the fact that we have a data warehouse. [Consider] those early transitions from paper-based record keeping that were indecipherable, to now, with something electronic and user-friendly – it provides a wealth of information quickly and lets me synthesize the thinking of a huge body of medical experts to bring more to each clinical interaction.

Were there other trends that you thought had an impact?

AP: Most people have had an EMR for a few years. They recognize there's a need to evolve and iterate beyond that. EMR adoption opened the space for big data, analytics, predictive analyticsand artificial intelligence. I don't think we've gotten to the point yet where we have really been able to take data to the next level and use it. We're just now coming out of the cave of EMR adoption and looking to extract value and impact from the terabytes of data the EHR captures.

What other technologies had a big impact on the way healthcare is practiced?

AP: Tools, such as UpToDate and PEPID synthesize, current evidence-based practices and serve as really robust resources to reference on-shift and on your phone. That's really powerful for decision-making and your practice. Technology has also helped individuals keep up with medical literature, trying to figure out what's most relevant to us. I would say there are many tools and a massive amount of information that help the individual practitioner be better, but not a lot of that helps us act as a really nimble group more reliably. We are still looking for those tools that can streamline collaboration across care teams and inpatient-outpatient.

How does technology impact your lean efforts?

AP: Lean initiatives rely heavily on being able to track key performance indicators, but it's hard to get that data from a logistical perspective. We have great technology solutions, and they generate troves of data that flow into huge databases. But employees have to pull from that data, and that leads to a lot of variation between departments in terms of quality of analysis. A lot of times, conversations break down over data disagreements, so it's really hard to just get things done.

What's been the biggest challenge to deploying new technology?

AP: Just the weight of the institutional inertia and resources devoted to IT. There are lots of barriers to entry. For a startup, they need a partner that really knows what it's doing, that's in the right place in its own evolu-

tion, that is willing to take the risk and has the capital to invest in deploying IT resources. You have to give access to clinical data and deploy without upsetting hospital operationsof a lot of different departments. You need the right mix of visionary leadership, mission alignment, inspired care teams and a responsive healthcare market.

What new technology shows promise for helping support care teams?

AP: We would like to see solutions that allow more efficient high-quality evidence-based care. It needs to be easy for care providers, patients and families to interact with, which is a huge barrier right now. Those providing care get a similar pleasant experience for showing care completed and displaying data that reinforces their performance. There are systems that exist, but they're not always pleasant to use.

Where do you see the potential for artificial intelligence in hospitals?

AP: AI has potential for helping interaction with patients and families in being able to provide evidence-based learning and analytics around individual patient situations. Using AI for patients to self-diagnose and to educate could help lower resource consumption and improve interactions with their healthcare providers. It can help us as clinicians make diagnoses and provide treatments more quickly and accurately, particularly in lower-resourced environments. It could help patients feel more empowered, and healthcare feel less nebulous and convoluted. With AI looking at the operational data in the hospital, administrators could strategically deploy staffing to aid patient flow in ambulatory settings more easily, as well as create work queues based on maximized patient flow and positive outcomes.

Is your organization using AI, and if so, in what areas?

AP: We're starting to determine how to leverage AI, and I'm really excited. We have a predictive analytic flow dashboard that is leveraging AI. It's so cool. I'm able to monitor my emergency department in a more user-friendly way. I can log on securely from anywhere and have a real-time look at choke points and how the clinical teams are distributed. I'm going to start setting alerts to help build partitions that help blend workflow balances. The information provided by the AI system is easily accessible, visualized and consumed across the organization, which isn't always the case when individuals are trying to pull data and use their own sets of variables. With the AI empowered system the data is consistent no matter who is pulling it. It has allowed me to sit down with department directors without having to bother our data analysts, we have agreement on the data, and we have had collegial conversations based on shared insights.

What would you tell your peers considering AI applications?

AP: Adoption of AI applications, or any technology, requires visionary leadership and an organizational approach. The value is much greater in helping teams work more diplomatically and seamlessly while easily interacting with other departments and ancillary services. Your CEO, CMO and CFO need to be on board. Make site visits to organizations using AI. Talk to your peers. See how the tool is affecting someone else's operations to get a sense of what it might feel like for you on a daily basis.