EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

RESTORING CONSUMER CONFIDENCE

Differentiating with Patient Experience

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RESTORING CONSUMER CONFIDENCE

Differentiating with Patient Experience

When we begin to emerge from the pandemic, restoring consumer confidence and improving the patient care experience will be vital to renewing health care operations and achieving financial resiliency. Today, more than ever, patient experience and convenience are having a stronger influence on how consumers choose providers and whether they will seek virtual or in-person care. As a result, hospitals are seeking to bolster patient satisfaction and provide context to the Centers for Medicare & Medicaid Services' Five-Star Quality Rating System to remain competitive and capture full reimbursement values. At the same time, provider organizations must compete with new market entrants in virtual care and retail outlets offering primary care services. This will require hospitals and health systems to communicate more effectively, be more transparent about pricing and, in many cases, to assume greater levels of risk as they work to deliver greater value.

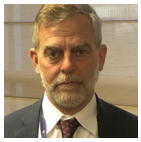
KEY TAKEAWAYS

1. Telehealth has grown exponentially in the past nine months and continues to be a robust part of the health care workplace among patients and their families. As the pandemic shifts over time, protocols will, too. Keep in mind that virtual care will supplement — not be a replacement — for in-person care.

2. With the expansion of digital health comes the greater threat of cybersecurity breaches, and adverse outcomes may result due to ransomware and phishing attacks. Hospital information technology (IT) infrastructure must be hardened to prepare for these assaults.

3. The cost of care and price transparency continue to be concerns for consumers, a growing number of whom have lost their jobs during the pandemic and with them, their health insurance. This may steer some patients away from high-quality care settings or lead them to defer care altogether.

PARTICIPANTS



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MODERATOR: *(Bob Kehoe, American Hospital Association):* **How has the pandemic changed the way that you engage with patients and what long-term changes may result?**

PATRICK CAWLEY *(MUSC Health/Medical University of South Carolina):* Yes, we have had to modify many aspects — some positive and some not so positive, like limiting the number of family members. I do have a concern that there seems to be a call from the field to remain in lockdown to a degree post-pandemic. That worries me. The reasons behind this call for a continued lockdown are safety and because there's a calmness in hospitals that hadn't been there before. Our state hospital association is discussing making some of these changes permanent. We have spent many of the past 10 years ensuring that hospitals are open and available to family members at all times. I am concerned that we might turn back from this patient- and family-centeredness.

"We are more assertive and aggressive about deciding what can be an outpatient procedure. Having a structured approach benefits our patients."

— Drew Fennell —

SUZANNE SMITH *(Penn Presbyterian Medical Center):* Our senior leadership team met and made some difficult decisions about reducing visitation. As the COVID-19 cases started declining, we opened up visitation with a lot of restrictions related to PPE (mask wearing, hand hygiene, etc.) At one point, we thought that the cases were declining enough that we could move to allowing one visitor for our inpatients and one support person for our outpatients. However, in the last several weeks, we've gone back to almost the same restrictions we had back in the spring. We continue to stress the safety. We are saying, 'For your safety and for ours, have limited visitation to patients at end-of-life circumstances.' Most understand and appreciate our efforts and for those who are unsure, we understand. It's difficult messaging when stores are fully open, people are shopping and high school sports are in play.

BRIAN BURGESS *(Penn Medicine, Lancaster General Health):* From a volume perspective with COVID-19, we're at about double what our prior peak was. We were in the low 50s in the summer and we now have more than 100 cases. Our response this time has been significantly less drastic. We have been ratcheting back on some elective surgeries, especially outpatient surgeries that require a bed, at least temporarily. Other than that, we've been trying to remain as open as possible. While we have high occupancy in the 90% range, the biggest issue is staffing. With almost all of our staff who are quarantined, it is because of community spread.

MARY DALE PETERSON *(Driscoll Children's Health System):* Unlike adult hospitals, we allow at least one parent or caregiver to be with a child at all times. For children in the intensive care unit or who are undergoing surgery, we have allowed two caregivers but that is done on an ad hoc basis when there is a surge. It's a challenge to manage when you have schools, sports, malls and even bars open. I don't think limiting family members to this extent should be the norm for the future. Family members can be a valuable resource and are advocates for patients.

DEBORAH SHEEHAN *(BDO):* **Testing and diagnosis rates for many disease states have declined during the pandemic. What preparations are you making to address pent-up demand for these services? How do you anticipate the scale and flexibility for that?**

DREW FENNELL *(ChristianaCare):* We've talked a lot about the safety steps we take, particularly in our ambulatory and outpatient settings, so that people

feel comfortable coming in. Some things like telephone consults or televisits with specialists will stay with us.

We are clear about identifying what can be done in an outpatient setting. Having a structured approach benefits our patients. One of the hardest things for my physician and nursing colleagues was the constant need to improvise and change as we learned more about the virus, and having to make some of these decisions without a full body of evidence was difficult for our caregivers.

"We have embedded behavioral health specialists in all of our primary care practices and we've found that our patients welcome the ability to interact with those providers via telephone."

— Brian Burgess —

It's hard for our patients, too. We are trying to build trust with the people who come to our facilities by telling patients and caregivers, 'We're being transparent and telling you everything you need to know. But, if something changes, you can be confident that it changed because we learned something. Our posture toward science did not change, the science itself changed.' That's a difficult and complicated message to communicate.

Our future is going to be centered around figuring out what to keep from what we've learned, because there are some valuable changes that we should adopt permanently. One of my colleagues said that one thing that developed for him was a real appreciation of the role of family and visitors. Intellectually, he knew the importance of visitors to patients and their healing joiurneys, but this experience has made that benefit tangible.

MODERATOR: From a CEO's perspective, how do you look at this issue? Has there been an ebb and flows to getting patients in for routine diagnostic or other types of procedures that they need?

CAWLEY: We're not quite back to where we were before the pandemic. Some of that is driven by patients and some is driven by our providers who don't feel comfortable with patients coming in unless we can test them. When COVID-19 surges in the community, patients don't tend to come back in at the same frequency. It's going to ebb and flow with the pandemic. On the inpatient side, what I worry about most is getting our nurses and doctors to communicate with families via telehealth on a regular basis because the entire family can't come in. I'd love to hear what people are doing to make that communication part of our daily nursing and physician workflow.

SMITH: Early on, we deployed secure iPads and put one on every medical unit. Depending on how many patients were on the COVID-19-positive units, two iPads were readily available with staff trained to set up these virtual visits. We had cleaning instructions on the back of each iPad. So, instead of using our personal cellphones to contact the family, we had the tools available to all patients who were admitted either through our emergency department or as a planned surgical admission. It increased the communication and collaboration that we have with patients and patients' families when they can't be here. It has also increased our patients' satisfaction with communication.

NATHAN WORLEY *(The Hospitals of Providence):* We also used iPads to connect our patients and their families. But, ultimately, there's no silver bullet. One of my main concerns throughout this process has been with surgical patients. Families always want to know when the patient will be out of surgery and how the surgery went, so we empowered our staff in the operating room and the

post-operative areas to consistently reach out to family members by continually communicating.

PETERSON: I want to go back to some of the things we've learned that we can carry forward. I have a media request this afternoon; a reporter is pointing out in an article that there has been a significant increase in amputations in diabetic patients because people are not getting the routine care that they were getting before COVID-19. A diabetic foot exam is difficult to do through telehealth and is best done during an in-person visit. Also, people with diabetes sometimes aren't getting their normal wound care services or revascularization procedures because they are "elective," but if they don't, they could end up with amputations. We're seeing a lot of people come in with uncontrolled blood pressure and diabetes, conditions that we did not see to this extent before the pandemic.

MODERATOR: How does your digital health strategy tie to improving the patient experience? How are you using telehealth, artificial intelligence, third-party apps or other tools? How do they tie together and help you make better clinical decisions or otherwise improve care delivery?

BURGESS: In the summer, we switched to telehealth visits in our outpatient settings and, by and large, it has been a good experience. In some cases, providers who were using telehealth for the first time as well as patients who might not otherwise use telehealth expressed reluctance. Until this latest surge, we were seeing volumes decline substantially, so we had to go through resurgence to try increase volumes in elective care, diagnostics and office visits. We were back to about 97% of pre-pandemic volumes in all of those areas, but cardiac and physical therapy lagged a bit. We've seen persistent interest in telehealth but mostly in select areas. We have embedded behavioral health specialists in all of our primary care practices and we've found that our patients welcome the ability to interact with those providers via telephone.

FENNELL: Behavioral health services have transitioned easily to telehealth, which has been great. Figuring out how to maintain those advantages in other settings will be more of a challenge. While we've gone up and down in telehealth volume like everyone else, we are still growing and continue to have higher volumes than before the pandemic and, as I said, a lot of growth has been in behavioral health. The experience and the evidence we gain from this is going to lead us in the right direction for virtual care.

"The platforms we use are secure, but it is the overall complete IT structure that I remain concerned about. You have to be ready with disaster plans in place for any cybersecurity threat."

— Mary Dale Peterson—

CAWLEY: We were already using telehealth to a great degree, so to make the pivot wasn't difficult. However, as the pandemic lessens at some of our other locations, there's been a push to drop telehealth and go back to in-person care. We are resisting this as we think moving forward, we need to continue telehealth at higher levels. When the pandemic subsides, our goal is to have 30% of our patient visits via telehealth. We're trying to be more deliberate about which patients need to be in person and who needs to be seen via telehealth.

MODERATOR: How has the patient experience changed during the expanded use of telehealth?

SMITH: Initially, it was uncomfortable and not what people preferred, but I think we're going to have a hard time going back to all face-to-face and/or in-person visits. People are now getting used to televisits for quick check-ins or follow-ups. For patients with diabetes or other chronic diseases, virtual visits can be done effectively on iPads.

PAM ULLMAN-FARRIS *(Bassett Healthcare Network):* Telehealth has become an integral part of Bassett Healthcare Network's care model to meet the needs of our patients in our eight-county rural service area. Before and during COVID-19, we involved our Patient Family Advisory Council, comprising six highly engaged volunteers who are either patients or family members of patients, to provide feedback and guidance on telehealth services and processes. The advisers helped create a document to help families connect virtually with loved ones, reviewed verbiage about being safe in our care, assisted with development of inpatient visitation communication during the pandemic, as well as other patient experience initiatives. We were able to leverage the advisory council and listen to their concerns and ideas about telehealth approaches, which was extremely helpful to our program.

MODERATOR: In what ways are cybersecurity issues being considered in virtual care and other technologies to safeguard patient care and enhance the patient experience? Who is part of that discussion?

PETERSON: This is the No. 1 disaster threat that we face. I'm working with our IT team to move everything to our co-location, which is hundreds of miles away, and testing and refining those processes. Hospitals are major targets for cybercriminals. You have to be ready with disaster plans in place for any cybersecurity threat.

JOHN RIGGI *(American Hospital Association):* Ransomware attacks have increased dramatically since the onset of the pandemic. I call it the COVID-19-induced cyber triple threat. The first leg of that threat is the expanded attack surface. Since hospitals have increased telehealth and telework, it provides foreign adversaries and spies more access points and opportunities to penetrate networks as they are expanded. The second threat is phishing emails. COVID-19-themed phishing emails went up 700% since the pandemic began. Based on the Department of Health & Human Services' Office for Civil Rights portal, there have been 167 breaches reported by organizations since Sept. 1, impacting 13 million patients. That's a dramatic increase. Ransomware attacks are the most significant type of threat and attack we're concerned about, because they have the ability to disrupt patient care and impact patient safety. A ransomware attack on a hospital is not just an economic crime; it's a threat-to-life crime and should be pursued by the government as such. And we should be given some expanded safe harbor protections as a result of the conditions that we're under.

As you deploy new technology, it is important to involve your information security team at the outset as you identify new technology and throughout the procurement process. Make sure that technology is safe, has the ability to receive security updates and that there's increased communication between the clinical engineering side and the information security side. One key vulnerability in many organizations is that often there's not a formalized communication bridge between the biomedical engineering and information security teams. One may have responsibility for the security of the devices. In a nutshell, email security is incredibly important. Multifactor authentication for remote connections into your networks, backup security and defenses around backups are key. In the incident-response plan, it is critical to have cross-functional leaders involved and to practice, including offline communications and off-hour incident-response drills.

"We've surveyed a number of patient populations and their biggest concern now is price; 60% say they will shop on price before making a site selection for care."

— Deborah Sheehan —

Any attack that delays care to a patient certainly increases the risk for an adverse outcome. About 15 ransomware attacks occurred since mid-October, which resulted in canceled elective surgeries and denial of access to electronic health records; therefore, the course of treatment is not known. Even drug allergy issues are not known as patients are treated. In some worst-case scenarios, we've seen ambulance diversions to emergency departments that are farther away. There has not been a documented case of a death, but I certainly believe delay in care has resulted in negative outcomes.

MODERATOR: How are changing market conditions, with rising numbers of unemployed consumers — many of whom have lost their health insurance — and rising numbers of Medicaid patients impacting your financial resilience?

PETERSON: As a children's hospital, about 74% of our patients are Medicaid recipients. The reason we're able to provide telehealth services is because Medicaid pays us the same as if it were an in-person visit. If Medicaid chose not to do that in the future, it would be difficult for us to maintain those virtual services. That's going to be a big challenge for health systems as the pandemic continues and people lose employer coverage.

BURGESS: We had a five-year strategic plan in place, approved by the board, when the pandemic hit. With all strategic plans, it's always a best guess because you can't fully anticipate what's going to happen in the third, fourth or fifth year. We didn't realize we were going to have a severe recession and be in the middle of a pandemic. And we haven't yet seen an uptick, or a change in the payer mix. This is something that we're worried about. After the first round of the pandemic, we were able to get most of our ambulatory and inpatient volume back, but even if that's off by a percentage point or two or three, and we see a decline in the payer mix, it's going to have an impact on our finances. We certainly had the COVID-19-related cash crunch when we turned off the flow of revenue from surgeries and procedures.

CAWLEY: We have seen an increase in the number of patients with Medicaid, but we have not seen a significant impact in the number of Medicaid patients in our health system. Payer mix remains stable. I do share concerns that if the economy doesn't bounce back quickly — if it's going to be a slow three-to-four-year turn — that will begin to impact us in the long term. I also share concerns about telehealth reimbursement. We need national telehealth parity in which reimbursement is the same whether you see the patients in person or whether you see them virtually. The cost is similar despite the common belief that telehealtlh is less expensive.

"We have to be open to doing things in new ways as we move forward. We have to be focused on what's meaningful not just to our patients and providers, but also to our community."

— Suzanne Smith —

SHEEHAN: We've surveyed a number of patient populations and their biggest concern now is price; 60% say they will shop on price before making a site selection for care. Unfortunately, patients typically can't measure clinical efficacy, even if they can measure attributes of it. If the cost of care is valued as a much higher priority, my fear is that it may start to steer patients away from where higher-quality care is offered, or cause them to defer care more often.

Eventually, this will manifest itself as a much larger body of chronic case management. It's a scary trajectory we're on right now, because everybody's forecasting more job losses through the winter.

MODERATOR: Are you seeing much change with regard to payer mix and related issues?

WORLEY: We were beginning to push toward having a more aggressive and smarter elective surgery, bundled-payment service offering, before COVID-19 hit. Over the last couple of years, we've begun to see more consumers for services like bariatric surgery, total joint replacement and vascular vein surgery, asking, 'What is your cash pay [rate]? Can we put that in a bundle with my provider?' We looked at how to make that a competitive number in the marketplace while maintaining high quality and great service. We're pretty far behind the curve in that we're still very much a fee-for-service facility. And as we look to do a little bit more on cash pay bundles — we're part of Tenet Healthcare, so we look at other facilities and experts in the market — and try to bundle the price in an appropriate manner.

MODERATOR: What are the greatest growth opportunities as you strive to better engage patients in today's environment?

SMITH: We have to be open to doing things in new ways as we move forward. We have to be focused on what's meaningful, not just to our patients and providers, but also to our community. We will soon face a resurgence and, as John alluded, we will face this with significantly heightened security concerns because we're doing things differently. We have to focus on what we can do with what we have and then find out if our new ways are actually better.

FENNELL: Bringing value is going to mean creating portability, great experiences, moving from physical spaces to digital and virtual spaces for our patients and managing any potential security issues so their digital experiences are safe. All of these things will bring value to the people that we serve, and we're focused on the idea of truly transforming the health of people and communities, so that's where we are focused in terms of our thinking about taking on risk arrangements and value-based contracts, reexamining patient experience and providing care differently.

"Because there are more telehealth service offerings in the marketplace, a challenge for us moving forward is how we explain to consumers that our telehealth service offering provides the best value for their dollar."

— Nathan Worley —

WORLEY: Because there are more telehealth service offerings in the marketplace, a challenge for us moving forward is how we explain to consumers that our telehealth service offering provides the best value for their dollar. We need to be able to convince them that (1) the telehealth visit we offer is better; and (2) as we move past COVID-19 and it becomes safe again to move about in society, there's still real value in their health care being delivered in a brick-and-mortar setting.

MODERATOR: How can hospitals best deal with some of the nontraditional competitors that have increased in recent years and have direct connection with consumers?

SHEEHAN: As health consumers, we've been more commercialized through COVID-19. I say that because of the on-demand presence telehealth has provided, allowing patients to expect a more immediate response than they had in the past. This will be table stakes going forward. In our BDO patient experience surveys, their top priorities are knowing that they're going to be safe and having more immediate access to care. With companies like Amazon and Walmart offering health services that are not only competitively priced but easily accessed within communities, this signals a shift in consumer values. Providers' thinking must shift to address a more continuous conversation with people about their health and wellness, rather than historic episodic care.

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