Adaptability as a Permanent Attribute of Health Care

A perspective on the need to embrace a culture of adaptability in health care to ensure its continued success.

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Even before the coronavirus pandemic, health care was facing added pressure to become adaptable, threatened by innovative and well-capitalized household names like Apple, Google, Optum, and Walmart, which all have their sights on disrupting our industry. These new forces are in addition to growing challenges within the traditional industry itself, such as reduced reimbursements, declining margins on traditional lucrative service lines (such as heart service lines), the transition from inpatient to ambulatory services, and growing demands for health care to be at risk for its total costs. Surrounded from the outside and pressured from within, health care needs to re-engineer itself to survive. This is the very definition of adaptability.

Fast forward to our current state during the COVID-19 pandemic. We all have the same obstacles, and constant change has become normal. Although the current level of crisis and energy is not sustainable for the long term, it has shown what the provider community is capable of. It has proven that organizations—both big and small—can implement changes quickly and modify in real time as needed. To accomplish this rapid response, traditional decision-making processes were dismantled and a fast-track path to action was implemented in its place. MedAxiom also had to adapt quickly to become the central knowledge hub for the cardiovascular community, disseminating fast-breaking information on how to navigate the "new normal" created by the COVID-19 pandemic. Overnight, this became the focus of most of MedAxiom's communications, webinars, and resources for our cardiovascular organization members.

These types of rapid change processes and decision-making are employed by many technology companies, including Google,[1] to better adapt to the market and increase the likelihood of being prepared when opportunity knocks. As a science, this change cycle takes the form of (1) empathize, (2) define, (3) ideate, (4) prototype, and (5) test.[2] Innovative companies make these changes in a matter of weeks, not months or years. Many in health care may have followed similar processes, formally or informally, as a reaction to the unprecedented pandemic. With the previously mentioned threats to health care only growing in intensity—and irrespective of the pandemic—it's time to take a look at "how" other innovative companies adapt to change even though decision-making for health care may not always match the "why" of other industries.

Beyond the aforementioned high-profile companies is Medically Home, LLC, a company seeking to move hospital inpatients to their homes, thereby avoiding hospital-acquired conditions and placing patients into a more healing environment. You may be surprised by the acuity of the patients Medically Home targets. In fact, Mayo Clinic recently announced the launch of a new advanced care platform with Medically Home. For Raphael Rakowski, founder of Medically Home, this model is personal and drives him forward. His father died in the hospital, not from his illness but from what he believes was a series of hospital mistakes. The global pandemic has only heightened the need for home care, with many patients avoiding necessary care for fear of exposure to COVID-19 at the hospital.

ARE THESE MARKET CHANGES HERE TO STAY?

There are many in the industry, including MedAxiom's President and CEO, Jerry Blackwell, MD, MBA, FACC, who feel that some of the emergent changes we've

TABLE 1. OVERVIEW: MEDICARE TECHNOLOGY-BASED WAIVERS DURING THE PUBLIC HEALTH EMERGENCY

Telehealth	▪ Established the pathway for the addition of telehealth through a fast-tracked, subregulatory process ▪ Expanded technology and HIPAA waivers permit the use of nonpublic-facing tools (FaceTime, Skype, etc) ▪ Beneficiaries can receive Medicare telehealth and other technology-based services wherever they are located, allowing home telehealth visits ▪ Telehealth visits are considered the same as in-person visits and paid at the same rate ▪ Providers may reduce or waive copays for telehealth ▪ Telehealth visits may be provided for new patients ▪ A broader range of providers can use telehealth services—PT, OT, ST ▪ Removal of limitations on the frequency of telehealth visits ▪ An expanded range of billable codes for hospital-based care and hospital as an originating site to reduce exposure risk
Telephone evaluation and management/assessment services	▪ Time-based payment for telephone evaluation and management visits at the same rate as office/OP visits for established patients (CPT codes 99441-99443)
Remote evaluations, virtual check-ins, and e-visits	▪ Brief virtual check-ins with technology-based communications may be billed for new and established patients with payment equivalent to office/OP visits (HCPCS codes G2010, G2012) ▪ Coverage expanded to include services by LCSW, PT, OT, ST for e-visits (nonface-to-face communication via email; HCPCS codes G2061-G2063)
Remote patient monitoring	▪ May be provided for new and established patients for acute and chronic conditions ▪ Under some circumstances, service may be billed for shorter periods of time

Abbreviations: CPT, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; HIPAA, Health Insurance Portability and Accountability Act; LCSW, licensed clinical social worker; OP, outpatient; OT, occupational therapy; PT, physical therapy; ST, speech therapy.

implemented in reaction to COVID-19 will be permanent. An example is the pivot to telehealth for office-based follow-up visits, out-of-town consults, and even daily inpatient rounds. Before the COVID-19 pandemic, adoption of telemedicine was anemic at best. It was used reluctantly and stingily due to reimbursement challenges, but most were predicting it would eventually have to be part of our daily lives. Now, it's hard to imagine that telehealth will not be a significant part of our care portfolio. In fact, based on a survey by Sage Growth Partners and Black Book market research, 36% of consumer respondents said they would leave their current physician for a provider who offered telehealth access.[3] Thus, providers who switch back entirely to in-office patient visits risk losing one-third of their patient base.

The Centers for Medicare & Medicaid Services provided new weapons to battle the impact of COVID-19 on cardiovascular health in the form of telehealth waivers under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. These waivers help us mitigate the risk of spreading COVID-19 and address the growing backlog of essential care services created by the pandemic. Although these waivers are only in effect for the duration of the public health emergency, we hope the implemented changes will lead to long-term reimbursement changes to support telehealth services (Table 1).[4] Regardless of the reimbursement, these aforementioned data coupled with the rise of companies such as Medically Home show that patients want convenient and low-cost virtual options. Providers who ignore these facts to follow reimbursement do so at their own peril.

Related is the state licensing construct. Many legislatures have already considered or are considering relaxing licensing requirements to help alleviate perceived provider shortages around certain services due to the COVID-19 quarantines. Will these all sunset when the COVID-19 crisis is over? Or, have we entered a new era of national credentials that create the commoditization of certain medical services, including some staple cardiovascular essentials such as echocardiography and other advanced imaging?

Where there are threats in an industry, there are also opportunities for adaptation. The migration of formerly inpatient-only procedures such as elective percutaneous coronary interventions to the ambulatory setting is one example. An entire industry is springing up around

this transition—financing and developing ambulatory surgery centers focused on cardiovascular procedures. Heightening the magnitude of these outside forces is their tendency to focus on the most profitable aspects of the cardiovascular service line. Losing these margins—or even maintaining them at a reduced rate of return—has compounded effects on organizations as a whole. All this creates an urgency for adaptability.

DISCIPLINE VERSUS OBSOLESCENCE

Cardiovascular organizations take pride in financial discipline. This is evident in the painstakingly detailed annual budgeting processes, the need for formal business plans to justify even minor off-budget expense increases, and the requirement of C-suite approvals on budgeted replacement staff. This level of control routinely leads to changes—even some measured at < 1% of our total annual budget—implemented in months or years, certainly not days or weeks.

There are many examples of companies that no longer exist due to their inability to adapt. Household names that have largely disappeared include BlackBerry, Kodak, and MySpace. Certainly, there were unique circumstances around each one, and the world is always clearer in hindsight. However, something they all share is the trait of being slow to implement change and adhering to models that made them successful in the past, despite strong signals that those models were dying. Does that sound familiar? Are we hanging on to fee-for-service and volume too long? Would our telehealth systems be further along if we were more adaptable?

CREATE A CULTURE OF ADAPTABILITY

Effective governance and leadership for health care systems and high-functioning cardiovascular programs are a bedrock foundational element for organizational success. It has been poignantly illustrated during the pandemic that health care needed to pivot fast or simply turn out the lights. Even beyond a pandemic, it is imperative that health care leaders embrace a culture of adaptability, including the inherent necessity for rapid decision-making required for organizational survival.

A culture of adaptability recognizes that not all decisions can emanate from the top of the organization or require its approval. Instead, an adaptable culture trusts its providers and care teams. It empowers those working on the front lines, who have intimate knowledge and understanding of the real world, with the ability to make decisions in real time. In health care, as in most industries, our largest investment is our human resources. We need to learn to set free that collective wisdom.

COVID-19 has shown us that it is no longer enough to simply do what we do well. We can create a beautiful office setting with physical design that promotes maximum patient flow and a staffing model that operates at peak efficiency, and suddenly patients aren't coming into the office. No one could have predicted an almost total shutdown of our facilities, but those that were already making the shift to offer virtual services were ahead of the curve when the pandemic struck. Some in the MedAxiom membership community embraced this trend long before COVID, despite the dearth of reimbursement, and deployed it extensively around innovative outreach or cost avoidance strategies. They weren't predicting the future pandemic; they appreciated a valuable trend around them and embraced the change within their own organization.

The simple truth is that even before the pandemic, the United States health care system was on an unsustainable economic trajectory. In a calculation made before the impact of COVID-19, the Congressional Research Service reported to Congress that at the current pace Medicare would become insolvent in 2026. Now, to keep the economy afloat, the United States government has issued $2 trillion in borrowed relief, with a big chunk of that support going to health care. As an industry, we are going to need to learn fundamentally new ways to deliver our services at a much lower cost point. This is the essence of adaptability!

CONCLUSION

It has been amazing to watch the MedAxiom community and cardiovascular industry respond and react to the COVID-19 pandemic. The speed at which major changes have been implemented is encouraging, and the positive impact to the cardiovascular patients we serve is immeasurable. However, eventually the emergency will end, and I hope we as an industry don't move back to business as usual with respect to our decision-making and adaptability.

Beyond COVID-19, there have been and will continue to be myriad challenges for health care and our organizations. Our traditional and disciplined industry has shown that we can adapt quickly under extreme pressure. Let's learn the value of this adaptability from the pandemic and hang on to this innovative spirit as strongly as we hold discipline to traditional business models.

Creating a culture of adaptability emanates from leadership embracing change over the status quo. It is a belief that the wisdom of the many—our work force—is better than the few, no matter how smart or talented these few may be. Harnessing this collective market prowess is not only smart for business and proven by successful

organizations such as the Walt Disney Company, it has also been proven to alleviate clinician burnout.[5] As health care leaders, we must instill in our organizations a culture of adaptability. The ability to adapt is not just about vitality, it's about viability. ■

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