PREFACE: A NOTE FROM THE CHIEF FINANCIAL OFFICER

When I was first approached about the transitional care nursing (TCN) program, my response was, "Are you crazy?" What I heard was, "Invest in a program that spends money and reduces our revenue." At the time I had been a chief financial officer (CFO) for about 25 years and in healthcare finance for nearly 35 years. The goal for many of those years in healthcare finance was to control costs, spend less, and increase patient volume. I heard this program as "Spend more and decrease patient volume."

Healthcare costs have been increasing at a significantly greater rate than the rest of the economy, and over the past few years we've heard a lot about the Triple Aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. Well, the TCN program was going to improve the patient experience, sure. But it was also going to increase cost and decrease revenues for my hospital.

Around the same time this program was presented, the state of Vermont was in discussion to develop a single-payer or an all-payer model. The goal of the state and the hospital association in the dialogue was to *bend the cost curve* (i.e., slow the long-term growth of healthcare costs). The state also established the Green Mountain Care Board (GMCB) to help achieve this aim as well as other objectives.

Hearing about the transitional care program brought to mind a talk I had attended earlier in my career during which the speaker showed a picture of a smiling hospital chief executive officer (CEO), sometime in the late 1980s, surrounded by hospital beds filled with patients. As the discussion progressed, the speaker showed a picture of the same hospital but in the then-present day—the hospital beds were empty. The speaker asked what we thought the CEO's mood might be now. Well, my first thought was that the CEO found another job. My second thought was that the CFO had pulled out all her hair or found another job. Not a great picture either way.

The speaker then put up the picture with the empty beds, but with the CEO smiling. The speaker said that this is the CEO of the future, where the healthcare delivery system keeps patients out of the hospital. Instead of managing beds and occupancy, the CEO will manage the health of the community. My thoughts? *This speaker was nuts.* When the TCN program was presented to me, that talk I had attended, and those images, immediately came to the forefront of my mind.

The TCN program seemed as though it might help overall healthcare objectives but in the short term would negatively affect the hospital's operating performance. As I reviewed the merits of the program and the targeted population that we serve, and I focused on the community rather than the hospital, I could justify the program. But I would wake at night wondering how I would meet the hospital's financial commitments—including payroll, vendor payments, debt payments, and other expenses—if this program were extremely successful. Remember, this program was introduced when the hospital was being paid in a fee-for-service model, and we were only just beginning to talk about population health and bending the cost curve. I believe that had we not started this program in those years before the hospital entered the Accountable Care Organizations (ACO) model in Vermont, the hospital would have seen $3 to $5 million more in its revenues.

During the early years of the TCN program, it was in my "cross hairs" each budget cycle. In Vermont, the hospitals are given revenue targets each budget year. The annual increases have historically been around 3%–3.5%. With each budget cycle, the hospital was challenged to meet the target. But as we saw outpatient services increasing, the TCN program staff was managing patients in the home who were considered high risk and high utilizers of services, and the TCN team was keeping these patients out of the hospital. The program became an effective tool in the organization's toolbox to manage the overall hospital revenues—and we were able to meet the GMCB targets.

With each passing year, the state and Southwestern Vermont Medical Center (SVMC), along with a potential affiliation partner, kept talking of population health and fixed payment models. The transitional care program became a cornerstone whenever the population health and fixed payment models were discussed. I felt I had something to contribute.

It is important to let the reader know that at every opportunity I pointed out that I was spending hospital resources on the TCN program, an investment that was reducing the hospital's revenues and profitability. The hospital cannot even calculate a return on investment on the program accurately since the two negatives would equal a positive, which makes no sense.

Today, SVMC is an ACO model for certain attributable lives for Medicaid, Medicare, and certain insurance exchange programs. Our hospital is ahead of many of the other hospitals in the program. Because the transitional care program is mature, it is

an effective tool in SVMC's toolbox in the management of population health—especially for high-risk, high-cost individuals. It is worth noting this is only one tool in our toolbox today.

So how does the transitional care program benefit the hospital? I believe it is better to ask how this program benefits the community. The community benefits from this program more than the hospital, but the hospital is a community asset—we are here to serve the community, and the community members who receive services from the TCN program in many cases have a better quality of life than if the TCN program did not exist. I am making a value judgment in my comments—the judgment is that the high-risk, high-utilizing patients who receive services within the TCN program would rather be in the program instead of in and out of the hospital more frequently than they are. And that is a better quality of life.

The healthcare system as a whole benefits from a program like this. Though lower-cost episodes or elimination of episodes reduces a hospital's revenues, hospital admissions are typically the highest-cost episodes. If successful, the TCN program is one asset in reducing the overall cost of care in the healthcare delivery system.

A program like this goes against most of the principles many CFOs have grown up with. Many of those principles are built on the assurance that the hospital or medical center will generate revenues and thus be able to reinvest in itself for the future. I believe the future demands that we recognize that healthcare costs are growing at a greater rate than the economy can support and that our communities may not be able to afford the increases. A switch in focus from the hospital to the community is the first step.

If the hospital efficiently uses the community healthcare dollars, the hospital *and* the community will benefit. Healthcare premiums in the community will be reduced, and that money can be reinvested in the community.

CFOs need to be open-minded. Traditional financial principles are imperative—they must be kept and built upon—but hospital leaders now more than ever need to view the hospital as a community asset. And we must remember that we are the stewards of the community's health.

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