Frank A. Corvino

EDITORS' NOTE *Frank Corvino is currently the President and Chief Executive Officer of Greenwich Hospital. He is also Executive Vice President of the Yale New Haven Health System. Before he assumed his current post in 1991, Corvino was Senior Vice President and Chief Operating Officer at the hospital. Prior to coming to Greenwich, Corvino was an Executive Vice President at Our Lady of Mercy Medical Center in Bronx, New York, where he also held other management positions. He earned his undergraduate degree in Pharmacy at Fordham University and completed his graduate training at St. John's University. Corvino currently serves on the board of the Connecticut Hospital Association (CHA), Greenwich Emergency Medical Services (GEMS), Willow Towers Assisted Living, and the Connecticut Community Bank.*

INSTITUTION BRIEF *Located in Greenwich, Connecticut, Greenwich Hospital (www.greenwichhospital.org) is a 206-bed community hospital founded in 1903 and serving lower Fairfield County, Connecticut, and Westchester County, New York. A major academic affiliate of Yale University School of Medicine and a member of the Yale New Haven Health System, Greenwich Hospital has evolved into a progressive regional medical center and teaching institution with an internal medicine residency. The facility represents all medical specialties and offers a wide range of medical, surgical, diagnostic, and wellness programs. Greenwich Hospital completed construction on its main campus in Fall 2005 with the opening of the Thomas and Olive C. Watson Pavilion. Combined with the Leona and Harry B. Helmsley Medical Building, which opened in 1999, the state-of-the-art facility is a model of advanced health care design.*

Would you describe the current health care environment and where you see the industry today?

In my 40-year career, this is the most challenging time for health care. The pace of change has accelerated so quickly that we struggle to deal with infrastructure issues.

For example, in today's environment, we're seeing a rapid decline in reimbursement, both on the state and federal level; everyone is talking about cuts in Medicare and Medicaid. In addition, third-party payers are not giving us the rate increases we received in the past with many of them wanting to keep their rates flat. Add to that the impact of the sequester and it puts enormous financial pressures on providers.

The challenge for us is that we are moving towards risk models where we partner with other providers to keep the cost of health care down. Under these models, providers will not be paid on a fee-for-service basis but based upon a population health pay-for-outcomes model instead.

The difficulty is that, right now, we have one foot in each bucket. We don't know when we're going to step from one bucket to the other and, in the meantime, we have to manage it both ways.

Most of us in the field are trying to manage our way through it, not really knowing with great precision what the future looks like.

We still don't really know what is going to happen with ObamaCare. As we move toward implementation, we're realizing that it's extremely complicated and costly.

As we get deeper into this, there could be some significant changes. As a result, we manage month to month and try to innovate in ways that can bring down costs and increase revenue.

Is it difficult to continue to give high-level quality care under these circumstances?

Throughout our health system, with Greenwich Hospital being the bellwether in terms of patient satisfaction, we have been able to engage our employees and talk to them about why patient satisfaction is so important. It is even more important now because it impacts our reimbursement.

Caring for the aged is a real crisis in this country – we all know the statistics.

But we also know why our employees went into health care: to help people. So regardless of what the future looks like and what is happening to us as an industry, our patients deserve the very best. We have been able to continue to engage our employees to make sure they never forget their mission. As a result, our patient satisfaction scores have risen over the past six months.

There is so much M&A going on within the industry. The concern is that this activity will keep people more focused on growing heads-in-beds operations when there instead needs to be a focus on how to keep populations healthier and so require fewer beds. Is scale a distraction?

Two things come into play here: as the population gets older, the demand for hospital services is going to increase. We know there are 10,000 people turning 65 every day, which is going to bump up utilization.

At the same time, risk models and Accountable Care Organizations (ACOs) are designed to decrease inpatient utilization.

Regardless, the issue of scale is important in either model. For example, one of our hospitals – Yale New Haven – just did a full asset purchase of Saint Raphael hospital, also in New Haven. So now Yale New Haven is a 1,500-bed institution, which makes them the fourth or fifth largest in the country in terms of beds. That scale is important for two reasons: they can become more efficient and they are committed to taking $300 million out of the system in cost; but also, if we move toward a risk model, it allows them to more effectively manage those services.

So when I think of scale, I don't think of heads-in-beds. By increasing scale, you can take more costs out of the health care system and at the same time be better positioned for risk by spreading those costs across a wider base.

Do you anticipate that more growth will be necessary in the post-care space, and if so, in any particular part of it?

Caring for the aged is a real crisis in this country – we all know the statistics. The problem is that we're not well set up to take care of the elderly. There is a shortage of geriatricians and we have to recognize that elderly patients have different needs and memory care is a real issue. If you hit 85, you have a 50/50 chance of developing Alzheimer's Disease. We need to find a better way to meet these needs and align financial incentives in the process. We can get into all kinds of philosophical discussions about how late in life a kidney transplant should be done, for instance. This crisis will only intensify as the Baby Boom generation approaches retirement age. People who live a long, good life deserve better than that.

How important is shared decision-making and patient engagement in this quest for efficiency?

It's critical. Patients sometimes have to take control of their own health care and I think medical schools should do a better job at teaching the importance of patient engagement. There are great doctors out there but patients should always consider educated choices. It is their bodies and their lives so they should be fully informed on all of the options and not necessarily go for the hot button treatment of the day.

We do patients a disservice when we don't involve them in decision-making. So there is a real education process that has to go on.

In addition, patients are much smarter today. People know where to get the information and if you're using a valid Web site where the information is reliable, that is a good thing.

Potentially, there could be significant costs savings with shared decision-making. It ultimately results in better care when patients have a say in their health care decisions. ●