COVID-19 Insights from the CXO Office with Bert Reese

Welcome to The Vurge Podcast, where we bring together groundbreakers and industry disruptors from various corners of the virtual world to ponder the future of technology innovation.

Steve: [00:00:00] I'm your host, Steve with Divurgent and on today's episode, we're going to talk about how top leadership in healthcare is responding to the COVID-19 pandemic. I have with me, Bert Reese, the former CIO of Sentara Healthcare an integrated health system in Virginia and North Carolina with 5 billion in revenue.

Bert oversaw the implementation of Sentara's enterprise health record, Epic, achieved HIMSS analytics stage seven, and continues to advise some of the nation's top health systems through his independent consulting firm in Divurgent today. I'm fortunate to have had the chance to work with Bert on multiple consulting engagements and I appreciate any opportunity that I get to pick his brain and hear about what he's been up to. Bert, welcome to the show.

Bert: [00:00:46] Thank you, Steve it's a pleasure to be here.

Steve: [00:00:50] All right, so let's jump right into this. As healthcare CXOs shift their mindset from responding to the immediate COVID-19 situation to recovering. We're seeing new business models unfold as consumer behavior changes, expectations for safety increase across employees and patients and businesses adjust strategies. So let's dig into the specifics on how this pandemic has and continues to impact healthcare.

So Bert, let's, talk about the highest priority problems faced by healthcare executives. What do you say is top of mind for these individuals?

Bert: [00:01:27] Well, I think it's very fluid, it's a very fluid situation and I wish there was a cookie-cutter approach to thinking our way through it. This is really the time for executives to really hone their critical thinking skills.

We're not out of the woods on this yet. We don't fully understand it and we fully don't have the impact on it. Some industries will mature really fast. Like retail really has jumped through it. You know, some of the food

industries that really transformed the way you pick up groceries and all that, and have really moved their model.

Unfortunately, when it gets to the healthcare industry, the buck stops with us. And so initially what the, what the CEOs, are still concerned about is understanding the way this disease behaves and what do they need to do in order to one - safeguard the workers, and safeguard the caregivers within the hospital, so they can continue to render care.

What can they do to protect and treat their communities? And the next would be the economics of it. You know, what's going to happen to them economically. Cause they don't know how things are going to be paid. Hospitals, generally are on a short, margin anyways. So the money is scarce and trying to get to a point that they can actually plan and not react.

A lot of the behaviors that they have today are reactionary and they have not, we don't have a handle on enough of the treatment of the disease or the, or the virus, and /or the economics for them to really, you know, to really find a clear path out that, that everybody agrees on.

Steve: [00:03:08] That, makes sense. It's clearly a full plate of concerns, you know, to sort through and figure out what to prioritize over the other, has got to be a difficult task. One of the things you mentioned, there is the economics of how these health systems are recovering and clearly that has to be a priority and you have to make money and sustain business.

So you know, there's a couple of ways to go about this, as you know, you could either grow revenue or reduce costs. Can you talk about what you're seeing organizations do on both of these fronts?

Bert: [00:03:45] Yeah. Sure. I think again, you've got to understand, and as we talked about a couple of minutes ago, we as healthcare really don't understand all the hydraulics around COVID. We made some, I don't want to say mistakes, but we made some calls that we probably could've made differently.

One was that the governors could not see the capacity within the provider networks of their state provider institutions. Therefore they got nervous that the hospitals were going to be overrun and so they issued declarations for no more elective admissions. Now, if you think through that, and you remember back into New York where we sent the USS

Comfort and we made the Javits Center into an emergency hospital, neither one of those facilities were full.

In other words, we were treating a virus, which has no cure, we're treating the symptoms, and the only time you really need to be hospitalized in this particular case is when you have a pulmonary failure of some sort of comorbidities or your immune system is compromised in some way.

So in talking to the IDNs, one of the things that they had was excess capacity because they could not fill their beds with elective patients because the governors were scared the hospitals would get overrun, that resulted then, in the start of the economic spin down without the elective admissions, the hospitals were economically were starving.

You also saw at the same time telehealth moved into the market and patients who were being treated by just taking a look at the symptoms that they had. Telehealth in primary care came to the front. So, what the hospitals are trying to do now is to get themselves organized, to have conversations with the state governments, so the governors are confident that they can actually monitor the capacities in the hospitals. One of the things that are being discussed in, a regional area, is that you have a center of excellence for COVID. In other words, one or two hospitals are named to be the COVID centers for that particular geographic area. All COVID patients would go there, then the other hospitals would be in the business then of taking care of the elective admissions. The other thing you've got to remember is that those elective admissions from 8 and 10 or 16 weeks ago are now moving more into the urgent category.

So we really didn't do ourselves a favor, because now those patients may be sicker than what they were previously. So it's a lot of, a lot of balance, there is some politics involved. I think most of all, everyone wants to do the right thing.

They are very conservative with it, and with that, then they, cause other issues, just one final, one point on that, and that is when the hospitals did not have hospital beds filled, what they did is they went, to your point Steve, laying off, laying off nurses and doctors and reducing pay, because they didn't have any income. They didn't need the nurses and the doctors in that capacity. And so, you know, they reduced their costs.

Steve: [00:07:11] Ideas that you mentioned there, you know, working with the governors and governments to, to better measure and monitor

capacity, you know, that, that seems like, you know, it was a big challenge that really, accelerated the economic challenges that these health systems faced and then I really liked that idea of, setting up centers of excellence regionally or in different geographic areas to help offset some of the concerns around keeping beds available, for COVID-19 patients.

One of the things you've mentioned to me in the past is there may be an opportunity to bring new patients into your organization that may be otherwise you wouldn't have had an opportunity to do. So can you talk about how systems, if you're seeing this are taking this opportunity to expand, by bringing in new patients.

Bert: [00:08:10] So yeah, the economics for a hospital can get better and can get different and to be clear, they could actually improve their market share. This means more volume, cleaner pay patients through their delivery systems if they are one of the first to come back online with all assets.

So if you're the only one in town, if there were three hospitals in a town and they're all doing cardiac surgery, and you're the first one back, you have a good chance of starting to pull those other surgery cases away, only because they're not ready, and the surgeries are not available in those other hospitals. So there's some thinking, and it's not so much around the economics, although economics is probably a secondary benefit, in terms of what are we good at and what does our community need? What do we bring online first and let's bring it online very quickly. Then what they try to do is anybody, all comers who need that surgery for their patients probably will get quicker admitting privileges in order to make it happen. Forming new relationships, new referral networks if you're one of the first to recover from an organizational standpoint, does that make sense?

Steve: [00:09:32] It does. It does, and it's certainly not a traditional, reactive way to respond to the situation. Instead, it seems to me like that's a more proactive approach in thinking about how the timing of reactivating certain services or specialties, you know, can work to your advantage, not just right now, but longer term.

Bert: [00:09:58] And economically the [00:10:00] economics is a derivative benefit. The real benefit, of course, is better care for that community. The derivative benefit is that you've actually because you're first back and with the capability, moved market share into your organization. Most hospitals and most hospital boards, just want normal.

They just want to be back to normal, whatever that means. What's happening with the IDNs is what I would tell you is organizational fatigue, this lack of predictability - moms going to work and having to come home and being quarantined in their own homes because of what they're exposed to in the hospitals.

I mean, the whole thing is turned upside down. So I don't want you to think that people are sitting around trying to think of, you know, the various ways in order to grab market share. They want normal back. And what I'm saying to you is if, and I say this to the IDN, If you come back well and quick and get the confidence of your patients back // that's the other big thing, what's happened as a result. Two big things.

One, is the doctors weren't seeing patients. And so all their staffs are out on, you know, unemployment and they're getting paid more on unemployment than they were in the practices. So it's hard to get them back

Two, is when this all started, patients were not going into the hospitals for congestive heart failure or heart pain because they were scared of what was going to happen there.

So, probably one of the, you know, as you bring your assets online, the other thing, the other cultural thing is you got to get your community one, your medical staff to be welcomed back and know that they're going to be safe, and that the patients themselves coming in the door know that you're a safe environment.

So yeah, you can have the service stood up and ready to go, but you have to win the hearts and minds of the people, both the medical staffs and the patients who will be coming to you.

Steve: [00:11:57] Yeah, I appreciate that [00:12:00] clarification, and you know, that ties back to one of the, one of the top priorities that you mentioned earlier on, , and that's, , rethinking the safety of your physicians, clinicians, and patients.

And that's a nice segue into one of the next questions that I have, which is around, moving to a more virtual work environment and, a little discussion around telemedicine as well. So like many industries, or I should probably say most industries, a more virtual work environment, is something that organizations have had to rapidly adapt.

Within healthcare, probably this is most prevalent around revenue cycle or other support personnel that doesn't have to be front line, clinical workers. So talk to me a little bit about how this transition to a more virtual work environment has gone within healthcare and what technologies do you hear about [00:13:00] these healthcare organizations using to support this new model?

And then lastly, on this topic, Are you seeing these organizations starting to bring their workers back into their brick and mortar facilities? Or are they sticking with a more remote model?

Bert: [00:13:19] This is not just a healthcare question, right? This is an American business question. You know, what jobs can actually be done remotely, and then Steve, you alluded to some of the staffing jobs, the billing staff, the back office things where you really don't have to do the laying of the hands-on a patient. I don't know about your house, but Amazon and UPS were on first-name basis with everybody, you know, we know them really well.

So one of the things that I asked the c-suite. What do you think about virtual business? And they're all over the map on it. Some say absolutely. You know, if they can get rid of the commercial real estate that they're running, that's a big, that's a big pop.

Some are saying never they'll never do it because they like to manage by [00:14:00] walking around and seeing people and doing all this, you know, hands-on. So the vote is not in on that yet. People have not decided, I have had a lot of anecdotal conversations where people say to me, well, we sent back-office staff home for our insurance company and my productivity is up by 15% and 20%, and when you ask what that number means, they said they actually worked longer during the day then they're logging hours or more than the eight hours. But when you sum it all up, it's eight hours. Meaning what they do is they get on in the morning, they look at the morning overnights. Do their emails, do their businesses do some meetings, maybe in the middle of the day, they take a little bit of a break after, you know, and then they do some more work later in the afternoon. And then later evenings, when they're binge-watching something, then they're going to do a cleanout their inboxes and, you know, get themselves organized for the following [00:15:00] day.

And so, they're seeing longer hang times on the systems as a result of working from home and they're seeing higher productivity. So, and I know

that Harvard and a bunch of others are really looking at this in great detail, but a lot of the sentiment is up to the individual leaders of that organization.

As you know, Divurgent been a virtual company for years and you all have figured out how it is that you can maintain a culture of a, geographically, nationally-based organization without ever having a brick and mortar setup. That takes discipline, culture, and dedication to the senior executive staff that wants to make it happen.

Steve: [00:15:45] And I do know culture doesn't change overnight. So, it makes sense that the vote is not in yet if that virtual work environment will stick, but, you know, certainly, there's, there's a lot of benefits to it. So that'll be [00:16:00] interesting to see play out over the coming months or probably years.

Bert: [00:16:05] I think, for all of us, that's a great business opportunity for us to understand. That's just for American business, trying to understand what is the right job, and what is the right technique? How do you manage people in a virtual world? That's not something we're used to.

Steve: [00:16:21] Agreed.

So on a related note to virtual work, more specifically, you know, to telemedicine or telehealth, whatever your preference, it's clear that the industry rapidly adopted this new technology. How should healthcare leaders think about the near term and longterm future of telemedicine?

Bert: [00:16:42] I think that's a great question. As you mentioned, telehealth has been with us, you know, for a long time and the reason why it wasn't more widely adopted pre- COVID was not because of the technology, but because we weren't getting paid for it. What happened during COVID was [00:17:00] that it was mandated that televisits would be paid at the rate of a normal office visit. The question then is, and that was necessary because COVID is primarily a medical condition, not a surgical condition. So it lended itself perfectly for the use of telemedicine. Especially with high risk, immune-compromised patients. It was good, that was the right thing for us to do as a society. The question is going to be then, what's going to happen to reimbursement of telehealth going forward. CMS has already started to signal what they're thinking and, recently within the last two weeks, issued a bulletin by which they say that they will reduce telehealth visits for home care based patients and

that's not the majority of the patients just home care, which that tells the market if they're continuing down that line, they're going back and retrenching [00:18:00] old positions for reasons, unknown to any of us, why they would do that. Wherever the reimbursement will not be there for televisits, which means we're going to be put back in the old model where you have to go, you know, you're got to go see your patient.

You're going to go see your primary care doctor or your specialist before anybody gets paid. So, we're hoping CMS wakes up and sees what they're doing. I think the IDNs and the medical staffs would welcome telehealth is just their issue, and we've figured out how to administer it better than what we do now, but I think we have to wait and see if CMS wakes up.

Steve: [00:18:37] Yeah, it's definitely a fluid situation and there's a lot of conversation one way or another on reimbursement. I know there have been some recent announcements of, making some of the changes permanent, but certainly, it's something that needs to be monitored, you know, to really [00:19:00] make that commitment to having telemedicine a part of your primary strategies.

I want to shift and talk about pivots. So I know overall, and within the healthcare vendor space specifically, companies have been forced to rapidly pivot in response to COVID-19. Tell me about what you've seen related to successful, or maybe unsuccessful pivots, in industries in general and in healthcare.

Bert: [00:19:38] Okay. Yeah. I have had a lot of conversations with healthcare IT companies, especially in the early days of COVID, and they say, well, what should we do? And I would say to them a couple of things. One is, close to your pipeline. If you have sales, close those sales, get those deals on the books and [00:20:00] get on with it. Two is, restake your revenue for 2020 and perhaps 2021. These are going to be very lean years. Two things are happening - one is the hospitals are in a real serious economic downturn and they're tired. So them buying things is not going to be something that's going to be paramount as a priority to the IDNs.

The next thing I say to them, if you sell in the clinical space and you have a COVID story, that would be helpful, anything that you can do to assist in the care of our patients in taking care of our employees will have value in the marketplace. If you're in a back office situation and not COVID facing, you're going to have a harder road to go. When in doubt, try to figure a [00:21:00] way to pivot. Can you change your product in some way?

Some companies that have done it really well in healthcare. I'll give you credit for Divurgent. Divurgent was one of the first ones that pivoted really well in New York, where, when it first started, you guys put together a series of calls centers for the New York-based hospitals, going through their electronic medical records calling patients who, who were either immune-compromised or were in a category where we thought they were at high risk. Again, giving a sense of peace and giving them a sense of clinical direction based on what those hospitals wanted to do. So that was a pivot, right?

Chick-fil-A is probably my favorite pivot because it's Chick-fil-A, right? What they realized was they wanted to provide a different customer experience during COVID, so [00:22:00] that their revenue would be protected, but they also knew that they wanted to protect and give value to the rest of society that was sort of, you know, sort of on the edge and, you know, vibrating. If you've gone to Chick-fil-A, you've seen the way they handle the service lines and do their ordering and all that kind of stuff. Very efficient, very nice, a very kind of use their technology. So when you come out of the Chick-fil-A service line, you feel like you've had a good experience.

The other interesting one is around, I'll probably butcher the name of this company, Palantir, Palantir is a California based data analytics company. It was commissioned by the government after 911 to do a lot of very high analytics about threats against the US and they take data of big data from all types of places they, and we don't ever see him as a [00:23:00] society because these are the guys that are working down in the rabbit warrens. A couple of weeks ago, President Trump moved the data management from CMS to Palantir because, we think because, he wanted that degree of high analytics.

So that's, that's a couple of good pivots. I think right now, people have been trying to do business as usual, and they're learning that those marketing and/or products probably may not fit the current environment.

Steve: [00:23:35] With all this talk about Chick-fil-A, you're making me hungry, but I appreciate those good examples. All right. The last question, are there any other trends that we should watch out for that are on the radar of healthcare?

Bert: Yeah, Steve in preparation for this podcast, I called a good friend of mine, a nationally recognized IDN in the [00:24:00] C-suite. So we're

talking a mover and a shaker, and I asked her what her thoughts were. She had, probably around five observations. The first thing, is that they are watching, as organization, worldwide what the disease is doing. You've got to understand, we don't know all there is to know about this thing and, we don't know whether we're even counting this thing the right way. So there is a lot of distortion out there. It reminds me back in 2000, for those of you who were in that battle, where we were trying to watch what was going to happen to computer processing worldwide, as the clocks turned across the world, we were watching the technical events, to help manage Y2K. So here we are again watching it now with clinical events as it comes across the world.

This IDN also [00:25:00] says both locally and nationally as the schools go back, the cases are going up. So that's given her grave concern.

And now it gets a little bit more serious, from my perspective. She also said that testing supplies are dwindling and that, probably starting this week. most IDNs will be doing day-to-day testing. They don't know whether they're going to have enough test for tomorrow. They're struggling to get their hands on testing equipment, and her biggest fear is that most hospitals will not be able to pre-test procedural patients. In other words, if you're coming in for a knee replacement, typically they would want to test you for COVID and have that opportunity to make sure that you don't have comorbidity as you go into the, into surgery. Well, she thinks that that's probably not going to be something they're going to be able to maintain. So that's, fairly serious. So when she summarizes it [00:26:00] from an operations standpoint, she says it's combat every day. Day-to-day her critical thinking skills are highly tuned, her management team's critical thinking skills are highly attended. It's like calling an audible offense in football for every play. They come in every day and they have to have to look at the landscape and make plans for the day. And she still says, as of August of this year, she's still saying, "We got to really try to understand how this thing works". So we're not out of the woods yet, and this is a nationally acclaimed IDN that we'd all be proud to go to if we need to care and they are still trying to work it through it.

Steve: Wow. All right. Well, yeah, certainly those are, those are more areas to watch, you know, that that could greatly impact things as, as we continue to work through this crisis. So I appreciate you getting those fresh perspectives, you know, direct from the C-suite. Well, [00:27:00] you know, as, as always, it's been fun.

I know that I and our listeners really appreciate your sharing, with us today. So I just want to thank you again for being with us and I wish you the best.

Bert: [00:27:11] Thank you, Steve. Thanks again for the opportunity.