EMPIRIC HEALTH

BECKER'S HOSPITAL REVIEW

Webinar: Surgical Care in 2020: 4 health system physician leaders discuss healthcare's new normal

Estimates predict that healthcare expenditures will account for 20 percent of GDP in 2020 and that waste across the sector will top $760 billion to $935 billion. COVID-19 has dealt an additional blow to an already-precarious fiscal situation. According to the American Hospital Association, revenue losses for hospitals will run to around $325 billion this year. Many hospitals are feeling the financial impact of cancelling elective surgeries earlier in the year and wondering whether things will ever be normal again.

Please join us as we welcome physician leaders from four of Empiric Health's partner organizations – Salt Lake City-based Intermountain Healthcare, Walnut Creek, Calif.-based John Muir Health, Springfield, Ill.-based Hospital Sisters Health System and Broomfield, Colo.-based SCL Health - to discuss how the pandemic has impacted surgery in their organization. In a question and answer based panel discussion, these leaders from across the country will share their perspective on adapting, persevering and creating a new path forward in surgery in a COVID-19 world.

In this webinar, you will learn:

- The impact of COVID-19 on surgical operations in California, Colorado, Utah and Wisconsin
- How physician leaders are driving change initiatives during a pandemic
- How continuing to reduce cost and improving quality and outcomes in surgery is an essential element of the path forward

TRANSCRIPT

Brian Zimmerman:

Welcome, everyone, to today's webinar, Surgical Care in 2020, 4 Health System Physician Leaders Discuss Healthcare's New Normal. I am Brian Zimmerman with Becker's Hospital Review. We'll begin today's webinar with a presentation, and we'll have time at the end of the hour, for a question session. You can submit any questions you have throughout the webinar, by typing them into the Q&A box you see on your screen. We're looking forward to hearing your questions.

Today's session is being recorded and will be available after the event. You can use the same link you used to log into today's webinar, to access the recording. At this time, I'm pleased to turn the floor over to Alycia Parker, from Empiric Heath, to begin today's presentation. Take it away.

Alycia Parker:

Good afternoon and thank you for joining us. Today, we are excited to hear from four of Empiric Health's partners, as they discuss healthcare's new normal in surgery, and how they are individually driving change

initiatives in their own organizations during a pandemic.

Today's session will begin with an introduction of today's panelists. We will spend the majority of the hour in a question-based panel discussion, moderated by Empiric Health's Chief Operating Officer, Becca LaFond. There will be 10 to 15 minutes allocated at the end for open Q&A. Please utilize the Q&A panel within this webinar platform, to submit your questions.

Now I'd like to introduce today's moderator. Becca LaFond has more than 15 years of experience in healthcare provider performance improvement. Prior to joining Empiric Health, she led the National Practice for Clinical Operations Management Consulting at Accenture. She was also managing director at Huron Consulting Group, where she focused on implementing best practices in clinical operations in hospitals, and health systems across the country. Becca currently serves as the chief operating officer for Empiric Health. In this position, she oversees all partner engagements, including the implementation of Empiric's innovative software application, the Empiric Analytics Suite. Over to you, Becca.

Becca LaFond:

Thanks, Alycia, happy to be here today. I'm excited to introduce our four physician panelists, but more importantly, I have the privilege to call them partners. Dr. David Skarda's career focus is improving value for patients. He's currently the senior medical director of Intermountain Healthcare's Center for Value Based Surgery, and chair of the Value Analysis Committee. He's a pediatric surgeon, and is clinically active at Utah Valley Hospital, and Primary Children's Hospital.

Dr. Skarda was most recently recognized as a 2020 Modern Healthcare Top 25 Innovator, for his work developing a comprehensive picture of care delivery, that includes outcomes, quality, and cost, to visualize the complete cost of surgical procedures, both before admission, and after discharge.

Dr. Nick Mickas is a neonatologist, and the medical director of clinical operations at John Muir Health in the San Francisco Bay Area. In his role, he is responsible for quality outcomes, and the reduction of unnecessary clinical variation. He is the sponsor of Concord Medical Center's surgical hospitals program, and he has worked closely with this group to recognize significant reduction in supply costs. He's been actively engaged in the health system's COVID response, as well as in the resumption of Clinical Services Workgroup.

Dr. Ashok Rai is the president and CEO of Prevea Health, a physician led, multi-specialty group that was founded in 1996 between physicians, and two partnering HSHS hospitals in Green Bay, Wisconsin. Today, Prevea has grown to more than 2,000 employees, including more than 400 physicians, and advanced practice providers, who now work in partnership with six HSHS hospitals throughout Eastern, and Western Wisconsin. Dr. Rai's passion to redesign healthcare in the US embraces the movement from fee for service, to value-based care. His passion has influenced Prevea's strategy to improve the total wellness of all communities it serves.

Finally, Dr. Simon Payne joined SCL Health as vice president, and chief medical officer, at St. Joseph Hospital in March of 2017. He now serves as the chief medical officer of clinical and operational transformation for the SCL Health System. In his role, Dr. Payne collaborates with SCL Health Leadership, associates and providers, to redesign care delivery including priority service lines, critical value levers, innovation, enhance patient, and consumer experience, and improve quality. In addition, he identifies, and guides selected organizational transformation projects that differentiate SCL Health in the industry.

I'd like to welcome all of you, and really appreciate you all being here today. Dr. Payne, we're going to start with

you, and let's go ahead, and dive right in. Obviously, in the last six months, a lot has changed, that's probably one of the biggest understatements we're going to make today. Especially though, in surgery. Can you talk a little bit about how your organization, and physicians have been impacted by the pandemic?

Simon Payne:

Yeah, thank you Becca, and thanks for inviting me to participate today. I'm very honored to be here and talk with colleagues from across the country. That is a great question, and probably something on all of our minds, and honestly, we could probably spend the entire hour just talking about that one question.

But to name just a few off a long list of the impacts that we felt, I would highlight a decreased procedural volume, decreased operational efficiencies, loss of revenue, complex infection prevention programs, operational, and clinical policy changes, national and state guideline implications, change in care delivery models, the need to align across our health system, across three distinct regions, in two states. The need for very rapid, and complex data analytics, and safety and staffing challenges.

And I would say on a more humanistic note, early in the pandemic, I think the greatest impact that we saw was the fear of the unknown, and I think this continues to be true today, and I'm Colorado, and we were at the front end of the pandemic, and really affect the majority of the implications in April and May. And it was understandable that many of our associates and providers were very afraid for both their patient safety, and for their own safety.

And I would say likely, as all of you have dealt with, and are currently dealing with, we had to make very rapid operational care delivery, and policy changes, without really good science to guide us, and really in an environment that was very emotionally driven, and in a high intensity environment. And to that end, we had to transition very quickly from fear of policy overreach, for example, the suspension of elective procedures across our health system, which we did very early in the pandemic, and before it became a statewide mandate, to the fear of COVID-19 itself, which led to understandably, very many challenging conversations, looking for balance between patient care, and associate, and provider safety.

I think clinically speaking, many of our greatest challenges have been related to PPE use, and testing strategy in areas such as defining aerosol generating procedures, test prioritization, and workflow, and operating under new standards and crisis standards of care, particularly for PPE use, where prioritization of respirators, or N95 allocation was difficult to reconcile, and quickly learn how to extend the use of those items through reprocessing, and et cetera.

And then lastly, I'd say, on a positive note, we as a health system really didn't appreciate the capacity for change, and for the resiliency that our healthcare system, our associates, and our providers had. And probably like most of you, our system was often slow to change. And through COVID, we were able to mobilize very quickly to a system incident management team approach, and structure, and were able to work together across our entire system to interpret data, align policy, implement telehealth strategies, engage service lines, and providers, move very rapidly, honestly, to places that we probably didn't think we could ever get to.

And then on one final positive note that was possibly one of the most impactful things is, we had great alignment and leadership with other health care systems across our state, from our clinical executive leadership, and we were really able to engage with the state, and our health department to direct policy, and I really can't understate probably the value of that piece of work.

Becca LaFond:

Great point. Dr. Skarda, kind of building on that, I think we all can recognize that at the beginning of 2020, that each of your organizations had some pretty significant strategic goals that they wanted to accomplish in 2020. Can you talk about how, as a leader, you've been able to maintain some of that momentum, despite what's going on in the world?

David Skarda:

Yeah, so, listening to Dr. Payne talk about what occurred within his healthcare system, I think one of the aspects of this that's impressive to me, is that regardless of the nature of the healthcare system that we're each a part of, in many ways, we've all gone through very similar things, and had to deal with very similar problems.

And obviously, the reduction in surgical volume has had very significant financial impact on the bottom line for Intermountain Healthcare. Nevertheless, we went into 2020 with some very specific goals regarding value improvement, and in some strange, and oblique ways, the events of 2020 involving COVID-19, have actually really helped us move down those paths of improving value in ways that we really were not anticipating.

For example, a reduction in volume provided us with an opportunity to really evaluate carefully, where we were doing certain procedures in the system. The elimination of elective procedures for a period of time, gave us a restart point, in which we could reevaluate, and potentially transition some of our more elective procedures to our outpatient surgical centers.

And I think one of the goals that we really attempted to improve upon and used COVID-19 as a launching point for, revolved around appropriate use, and location of procedures. I think it was important for us to actually view the events of COVID-19, so far in 2020, as an opportunity to help us move some of our value improvement initiatives forward.

Now that having been said, 2020 is not over, right? And right now we're actually dealing with more of an actual patient load impact from COVID-19, then we did in the Spring, or early Summer. And so, I think we still have a lot to learn, and there are a lot of adventures yet to come.

Becca LaFond:

Thanks, Dr. Skarda. Dr. Rai, like Dr. Skarda, in Utah, you're also dealing with a pretty significant increase in cases in Wisconsin right now. So, this may be a difficult question to answer. But, as you think about what the new normal looks like, can you talk about what you think that looks like? And probably equally as important, and a little bit building on what Dr. Skarda just said, some things that have occurred, or maybe been sped up in healthcare, like the change in telehealth? Are those the types of things that will stay after we get through the COVID crisis? Are there some things that maybe won't go back to normal, if you will?

Ashok Rai:

Trying to... Oh, my computer just did something. Sorry about that. Sorry about that. Somebody keeps trying to dial my cell phone, and it keeps popping up on my computer. So, I apologize for that. To build on what Dr. Skarda had spoken about, and as I look at the future, and really looking at the word surgery, and it's... Since the beginning of it being modernized, has always been tied to the word hospital.

I think 2020, and the crisis, and the realization, and other things going on economically, are going to forever change how those two words are likely not going to be as tied together, or not tied together at all going forward. And I think physicians, have specifically, through the need, and through innovation, will drive this the most. Almost no hospitals have been efficient, due to need. But the need to be open 24/7 hours has driven that inefficiency.

And in reality, I think hospitals will always have an operating room. But surgery will not be headquartered there. I think that's one thing that 2020 has taught us, and those who are able to maintain some sort of financial viability, or better take care of their patients had options that others didn't. And I think it'll drive a lot more change.

And it's not only going to be driven by us as physicians not wanting to be put in that position again. But I think a huge magnifying glass has been placed on that by the rest of the country, and I think the government, the payors, through site neutrality are going to drive that change even more, both on the economic side, quality side, safety side. If we're truly going to think about value, I think 2020 will forever be the defining moment where hospitals and surgeries don't ever... They're not as intertwined as they used to be.

David Skarda:

Yeah, Becca, if I could?

Becca LaFond:

Yeah, please.

David Skarda:

you know, one of the aspects of this, which you alluded to in your question is the dramatic increase in utilization of telemedicine, and remote care. The reality is, is that that's really something we should have been doing for years. The technology has been available to us, and we've been reluctant to do it. Obviously, there were some HIPAA compliance laws that really limited our ability to do that. Not to mention some other issues, as well.

But one of the beautiful things about COVID-19, if there is anything beautiful about COVID-19, is that it has really pushed us down the path of telemedicine in a way that potentially would have taken us 10 or 15 years to accomplish. We essentially as a system had to move that direction in a period of weeks. And fortunately, the technology was available to us. And yeah, there was a learning curve to go along with it, and we're still learning. But it turns out a lot of what we used to do in office, we can accomplish remotely, and it's just better for patients. It's better for providers, and it provides our patients with better value overall.

Becca LaFond:

I think that's a great point. Anyone else on the panel have anything to add related to the trends that COVID has brought?

Simon Payne:

Yeah, I would just tag on to the telehealth trend. I mean, we were in the same boat where we were very slowly, I mean, really slowly moving towards, telehealth. And in a matter of weeks, we went from a single digit percentile of our visits being to telehealth, to more than 50%. And it was something that probably wasn't going to happen otherwise.

And I think we've also learned through it that there is a cohort of patients who, not only expect that care, but prefer that care, and we've actually, I think found providers that actually, same thing, who may prefer that care, and it allows for some more flexibility, and potentially some work life balance from a physician perspective, too, because some of those with the technology we have can actually be completed from home. If you think about working from home, or even in the office, once you get this technology down, there's a potential to bring an operational efficiency piece into this as well, that can increase value to our health systems, to providers, and to our patients.

David Skarda:

Yeah. One of the interesting things Dr. Payne, you don't know this, but I actually provide care in your Billings, St. Vincent hospital.

Simon Payne:

Oh, very nice.

David Skarda:

Yeah. And one of the things that was really amazing for me to watch was, I was there in February, as this COVID-19 was beginning to gain momentum. And then I went back again in April, and between those two time periods, I went from a clinic with no telepresence capability, to a clinic with telepresence capability, and I was seeing patients in Billings, who lived in Butte Montana, and various other cities throughout Montana very quickly, and it was an impressive thing to watch. Dr. Payne, do you think we're going to go back? Or do you think this telepresence, telemedicine thing is here to stay?

Simon Payne:

Yeah, I don't think we'll go backwards, necessarily. I think what we'll probably find, and what we're already seeing is kind of a balance. We tipped very heavily to virtual health, because we had to. And as we in Colorado, we haven't seen a resurgence of COVID cases, and our positivity rate's been in the 2% and 3% range for months now, and we've been back to what I would consider, "new normal operations," We have seen that pendulum swing back a bit, in to where we're a little more even from a in-person, virtual care standpoint. So I think what we'll probably do is find a happy medium. Having said that, I do think in areas such as Montana, or more rural environments, you're likely to see a persistence at a very high, high degree from a virtual care standpoint.

Ashok Rai:

I think from our perspective, it's really what the payer response to that is going to be, as well, I think every

state's different in contracting, so that's going to drive a lot of our decision making.

Simon Payne:

Yes.

Ashok Rai:

But I think the populace, our patients, our communities, are 1,000 times more comfortable with what we're doing right now, because this is how they're going to school. This is how they're working. So, we needed two components to happen to really drive tele. Number one, our platforms, and our providers to be ready. But for society to recognize this as an appropriate way to not only provide care, but to interact with each other.

So, because the platform is so rampant in other sectors outside of healthcare, it's all of a sudden become an expectation of healthcare, not healthcare trying to push it on to you. So, I think as the payers hopefully wake up to this, and the government wakes up to this, it's been a huge battle with the CBO for years, trying to get them to score telehealth as not becoming an abusive situation, and scoring it costing the government more, and really showing that it saves that value.

CBO has always scored it to be unaffordable, and there was never a pay for. I think this is the year, because we're going to have evidence, because we all went to tele for six weeks, eight weeks, 12 weeks, and there's going to be data for the first time to really push that. That's the other component that's always been a lagging component, has been the payment model. And I think we'll have data for the first time, and we'll have a lot of it, and diverse data. We've all talked about how we're using it differently.

So, it's gonna be an exciting year, once we actually can get through the current. And full disclosure, I'm in Green Bay, Wisconsin, I think you know what we're at right now. So, probably my focus right now is telehealth expansion. But, it's just keeping the hospital standing. But, in the coming months, to years, there's a great opportunity to look back and to make the argument. And I think the level of innovation is going to go through the roof, too.

Nick Mickas:

I think balance is the word that definitely resonates with me, being in California where we had a bump up that we thought was a peak, and we thought we were over the peak, and then that went away, and things started to return to what we call the new normal. And then, before too long, we were up to three times the number of cases that we saw was the first peak. And now we're riding down from that.

I think it's difficult to know what our... And I think we have to be open minded about what the population is going to want from us, and what they want their care to look like, and being willing to provide the care that people want at that moment.

Helping people to feel comfortable, but at the same time acknowledging that we need their input into what that looks like, so that we can provide the care that they need, and be sure that people are getting care when they need care, and not putting care off for fear of the systems we have to deliver that care. That's something that I think we're going to be struggling with for years to come. Because I don't know that this will be... This will not be the only challenge that we face in terms of people's willingness to come to the hospital, or to seek care in a clinic

environment, versus telehealth. And I think being able to provide the range for the different populations that exist within our systems is going to lead us to success.

Simon Payne:

Yeah, I think that's a really good point. And this is probably a pivot point where healthcare starts to respond to consumer needs, because we probably have proven to ourselves internally that we can do that more quickly and do it in an effective way. And from an external standpoint, not only have the consumers seen it, but the states have seen it, the governors have seen it, and I think that's not likely to change as we go forward. So, I think you're absolutely right.

Becca LaFond:

Yeah, I think one of the points that I think you're all making is that the pandemic has really forced us to think about what's best for the patient, what's best for our providers in this current situation, probably not thinking as much about the reimbursement aspect, although I think long term, you make a really good point that that reimbursement has to be aligned, or else this doesn't work.

As you all think about the value equation, and the way that care is starting to be delivered differently given COVID, and probably into the future, how are your organizations thinking about that, from the perspective of, if we're going to be reimbursed at a different level for surgery in an ASC, versus an outpatient ward of the hospital, or a telehealth visit, versus an in person visit? Are you starting to think about the cost side of that equation yet? Or, would you say you're still heads down in the pandemic response?

Simon Payne:

From my perspective, we've definitely started to think about the cost aspect of it, and that's really one of the primary goals, and visions of our organization anyways, is how do we be the most cost effective healthcare system in our area, and deliver the high quality of care? And I suspect that's true for a lot of folks. And so, we have started to think of that in preparation for a potential resurgence of COVID, or other barriers that come up to our ability to deliver care.

And so, we have started thinking about that, and some of that is obviously with the work around decreasing variation, in not only supply costs, but in the way we deliver care. And some have already made the point, we're starting to think about initiatives as we go forward, that will help us as we will invariably continue to deal with COVID, and also continue to deal with other unexpected barriers that present themselves to us.

Becca LaFond:

Anyone else on the panel?

Nick Mickas:

I think COVID is part of... I don't know that we can... I think the separation between what we're dealing with with COVID, and what we're dealing with, with patients who don't have COVID is somewhat artificial, in the sense that as beds become necessary, and there's a premium for them, regardless of what the disease process is,

we're only going to get better if we can figure out how to move patients through the continuum, and we're only going to be serving our patients better if we can move them through the continuum.

So, although I think we all had templates drawn up of what the clinical variation projects that we had focused on, or what our utilization reduction projects had been, we're still doing the work, although it's in a very different way. So although those projects were put on hold, I think all of us are dealing with the same things, which is how can we get patients moving through, utilizing resources to the minimum, and protecting staff to the maximum, and whether it's COVID patients, or non COVID patients, the challenges are the same. Or, I shouldn't say the same. Are similar.

Becca LaFond:

Great point.

David Skarda:

I think for Intermountain Healthcare, the financial pressure that COVID-19 has placed on us, has really forced us to advance with a transition of sorts, from some of our traditional legacy approaches to value improvement, which were mainly through cost reduction. Specifically, we spent an enormous amount of effort and time working on device, instrument, and product standardization, and elimination, combined with aggressive contracting, to try and decrease the expenses of the care that we delivered in a largely fee for service world.

And even before COVID-19, Intermountain Healthcare was transitioning slowly from a totally fee for service world, to a population risk-based health care delivery environment. And that was really forcing us to think about the way we improve the value of the care that we deliver, in ways that were not just device, and product elimination, and standardization projects, but rather, moving towards a much more holistic view of the total cost of care of a patient.

Obviously, surgical patients have device, and OR costs. But it turns out, they also have a lot of other costs associated with them, that occur before the operation, after the operation. And then even after they're discharged to home. And the economic pressure from COVID-19, I think has really forced us to bring into vision, and surface, all of these other opportunities for value improvement, through the elimination of unnecessary care, through elimination of unnecessary costs, and potentially through the adoption of some treatments, and approaches that actually decrease complication rates. Which I'm sure everyone will agree, are extraordinarily costly. And this kind of overarching broad view of the total cost of care of patients, and having a mechanism to address that in a way that is a very ethical, and resonates with clinicians, I think is really helping us address the economic pressure from COVID-19.

Simon Payne:

Yeah, I think that's actually a really, really important point. And something that we've been thinking about as well, pre pandemic, but COVID has ramped up those conversations where historically, we would think about things in silos, be it pre-hospital work, intraoperative work, post op care, you might think about addressing physicians and the care they provide, or nursing and the care they provide. But, I think it's a really important point that you're talking about, is thinking about initiatives going forward that cross those silos, and break down those barriers, and get everybody thinking together, and moving together in a holistic approach.

And, I've also failed to mention the continuum of care post discharge. And I think that's, you're right, something we're going to have to really think about in a targeted way, how we bring all those things together, and really, truly function as a clinically integrated network, or along those lines to really bring value to patients going forward. That's an excellent point.

Becca LaFond:

Dr. Mickas, in your role, you've been focused on reducing clinical variation for a long time. Would you say that your approach has been different, particularly, since 2020, and given the COVID pandemic?

Nick Mickas:

So, I think it's presented us with challenges, in the sense that there were projects that we had been working on that were very specific, and that those have somewhat gone away, because the priorities have shifted, and as patients have shown up, we've cared for them. I think the potential that others have talked about, and I think that we've learned as well is, how do we take the organic flexibility, and organic... Some of the nimble things that have happened organically within the institution, and amplify those to apply across the continuum?

So as an example, we had spent a lot of energy around looking at appropriate utilization of level of care, and within our own institution, as we've had ICU demands, and had exploration of ICU care providers, and alternative locations, while we haven't had to go there, I think we need to challenge ourselves to ask that question.

When we talked about the continuum of care a minute ago, we've always said certain patients to SNFs. Why have we sent them there? We've always sent certain postop patients to the ICU. Why is that? Is there a reason that they need to be there? Or can they safely be cared for elsewhere?

I think challenging ourselves to ask those questions, and to challenge the status quo is where there's going to be an opportunity for gain from this. So, I think it's happening, although it's happening in a very different way than we anticipated. And a lot of the projects, because of the nature of, or the impact of the pandemic, some of those projects have had to be changed. The day to day work is absolutely more fluid, and I think that fluidity is, if we can maintain it, even as the volumes decrease, that's going to serve us very well.

Becca LaFond:

I'll open up this question, I guess, to the whole panel. I think we need to recognize the reality that we're all human beings in this pandemic, and that includes surgeons, and as you all try to reduce clinical variation in your organizations, it's critical to engage those surgeons. So, maybe if you could talk a little bit about, how are you still driving change with surgeons, by engaging them, when you know that they are, expectedly, and appropriately distracted with both the change that's happening at their work level, the change that's happening in their home life, if they have kids at home, et cetera? How are you handling that as a leader in the organization?

Ashok Rai:

I had this conversation with my partners last night, because I'm not a surgeon, unlike my colleagues, but I have

many that I work with. And it's interesting, I think there's never been a time where they've listened more. No offense to my surgical colleagues on the call here. But there's never been a better learning platform for them, because usually healthcare crisis is... They've affected the ED, they've affected the ICUs.

Not many, even if you look at H1, SARS, the influenza, outside of an occasional inconvenience of a staff member being sick, you've never really taken out the ORs. You've never just benched them, and said, "All of us are going to work. You're on the bench, elective procedures done. If there's a trauma comes in, we'll call you." And that's really... This is unique. And I think you kind of look at your own susceptibility at that point, you're no longer the top floor of the hospital, you're no longer the one driving the bus. And there is this camaraderie that comes out of it, to be honest with you, this unique, "wow, I need you as much as you need me." situation.

And I've seen so many surgeons this summer, and we were all friends, I mean, we're multi-specialty groups, we actually all... We own half the company. So, we are friends. But I just saw so much of that, even last night, in a town hall, of just the camaraderie. So, when we do get them in the room, understand that when I can get you more efficient, that gives us more resources to take care of X, Y or Z.

So, the platform outside of, "Why do I have to do this, just to make the hospitals more money?" That conversation seems to be pivoted on how I can be a better partner in healthcare overall. So, I think it actually created a very unique opportunity, plus they had nothing to do for about six weeks, and it's like shining on your mortality there. You're no longer the immortal cardiothoracic surgeon or neurosurgeon. We can bench you.

Or the plastic surgeon. The first one to be put up on the bench, and last one to be allowed back in, and all of a sudden realizes that, maybe it's not all about the ORs. And so, it was a great opportunity to have these conversations, because now it's about protecting their future and their ability to be relevant, almost, in certain circumstances, in certain cases, and the pandemic really shined a light on that.

So, I think right now is actually probably the best time ever, before memories get short, and somebody else trains them to think that they're the best. This is a really good window right now, to talk to our surgical colleagues about change. And I'm saying that as an internist, who has probably more surgical jokes than anybody out here.

Becca LaFond:

That's a great point.

Nick Mickas:

I could not agree with you more. I think the dialogue that's happening amongst our physician community is in a different place than it's ever been before. And to call out our surgical specialists, when we initially shut down the ORs, our trauma surgeons came and said, "Okay, so how can we help with the ICUs?" And one of the things that happened again on that very organic level was, they made themselves available as a procedure panel, so that if we needed to talk about tracheostomies, needed to talk about emergent access to free up our intensivists, the trauma surgeons made themselves available to basically provide procedures.

So, I think that camaraderie, and that conversation around how we all need one another, now is the time to capitalize on that, and I think... We've started with the conversations around what projects can we talk about that make your life easier. So not asking you to do something that you haven't done before, but of the things that are truly just waste, what can we work on? And our surgicalists have been responsive to that.

Group:

Yeah.

Simon Payne:

Go ahead.

David Skarda:

No, go ahead.

Simon Payne:

Well, I was just going to add on, to that, and agreeing, I think even beyond the surgical specialties, we saw that across all specialties. Hospitalists, obviously, being in the thick of this as well. And we've been talking about always wanting to engage the physicians to help us lead change, but that's always a... It's a good conversation, but it's always hard to make happen.

And I think through the pandemic, what we saw on kind of the administrative leadership side, and what the physicians saw from a care delivery side is, we did need one another. And we needed their leadership to get through this from a clinical standpoint, and they needed our help and leadership from an administrative standpoint, and policy standpoint. So, I think, in a lot of ways, it opened doors for us to work together because of the burning platform that is COVID.

And as we think about going forward, I do think that's opened a lot of opportunity for us to engage physician leadership in a different way and be part of those conversations in the beginning. So almost a cultural flip from where it's a reaction to what somebody did to me as a surgeon, and flipping that to, how can I be a partner early on? And from the healthcare system perspective, making sure that we want the surgeons, and other providers to be partners early on. So, I think it's a great opportunity, similar to what everybody's been saying.

David Skarda:

Yeah, as a surgeon, so, one of the one of the really important perspectives, I think, that this reality check for surgeons, is that for a healthcare system that's making a transition from a fee for service model, to a population risk based model, one of the most impressive transitions, and new perspectives for hospital administrators, as well as for surgeons, is the reality that in a fee for service model, the operating room, and the OR environment is basically an economic engine that drives the hospital.

But as you transition to a population risk based model, that economic engine suddenly becomes a cost center, and for surgeons to go through the process of a pandemic, where they've been put on the bench, and essentially told to come in for emergencies, that's a very early canary in the mine kind of warning signal of the relatively dramatic transition that surgeons will have to deal with, as hospitals and healthcare systems make that transition from fee for service, to population risk based care. And it's going to drive dramatic change, and it's going to drive very dramatic changes in conversations between administrators, and surgeons. And my sense is that COVID-19 has given hospital administrators, and hospital systems, a little bit of a taste of what's coming

down the pike as it were, as we make this transition.

Becca LaFond:

Yeah, Dr. Skarda, I think you're right. And I think as we think about the path forward, if you will, in surgery, and certainly in the short term that's about getting through COVID, and coming out on the other side, ideally of COVID. But it also talks about that transition to value-based care, which I think is happening in most markets. And I think you're absolutely right, that COVID is speeding that up for all the reasons that you all have talked about.

Dr. Payne, I don't know if you want to take a stab at this one. But, when you think about the new path forward, if you will, in surgery, what does that look like? And how is the value equation, and reducing costs, but more importantly, improving outcomes, related to that path forward?

Simon Payne:

Yeah, that's a great question, and I think it's a tough one. I mean, I think the new path forward is complex, in that we have to be, as previously stated, ready for recurrent waves of COVID, or other unexpected interruptions, and surgical procedures. And one thing that we saw too, was patients delaying surgical care, even after we returned to full operations, and this is likely to be part of the next normal for the foreseeable future.

Patients are going to be weighing their elective surgical, or procedural needs against their perceived, and real risk of infection exposure. I think we'll also potentially see less operational efficiencies given the need for preoperative COVID testing, as well as the increased time potentially between OR cases, secondary to infection prevention needs, such as airflow exchange and other considerations.

I think, lastly, another ongoing impact may be an increased cost of care with increased PPE use. I mean, that's something that we've been, for six months trying to figure out. What's the appropriate PPE use? How much can we procure? What's the cost of procurement? I mean, a lot of things that are going to drive the need for operational changes, and I think, as related to reducing costs, improving quality, and how does that fit together?

I think given these COVID related impacts, and probably even before COVID, probably all of us on this call, we're thinking about focusing on reducing costs, and maintaining, and improving the quality of care. And if we operate under the assumption of decreased surgical volume going forward, of decreased operational efficiency, increased PPE, and other infection prevention related costs, it's becoming clear that reducing surgical cost is a must as we go forward.

And I think, we touched on this, but the areas of focus in that new normal are likely going to be in care delivery variation from not only a supply cost standpoint, but from a clinical standpoint, and we'll need to focus on that pre-hospital work, the perioperative work, and post-operative care, and initiatives that probably, many places are looking at already. But, enhanced recovery after surgery, the use of care pathways, big data analytics, and being able to actually have live functioning dashboards that we can all react to, artificial intelligence solutions are likely to play important roles. So, I think all of those things are going to be important in the next normal for surgical care.

Becca LaFond:

Yeah, great points. I'm actually going to move us to the open Q&A. There's actually a couple of questions that have come in that I think are really relevant to what you were just talking about Dr. Payne. Before I move there, let me just remind the audience, if you would like to ask a question, you're welcome to put that into the Q&A box on your screen, and we'll be looking at those over the next 10 to 15 minutes.

I'll open this one up to the whole group, but I think it speaks really clearly to what you were just talking about Dr. Payne, with the certain elective cases being pushed off, whether that was mandated by the government, while that was because the health system is not able to do that. Or in some cases, because I think everyone is aware, whether that's an economic decision, because certain people have lost health insurance, and therefore, their view of getting that elective surgery done today, it looks a little bit different.

One of our attendees asked the question, has the pandemic response and initial delay in procedures performed, provided an opportunity for health systems to implement prehab interventions, to improve surgical outcomes, and reduce costs? Thinking about patients not being able to have their surgical care right away, what are some of the things that you're putting in place to, I guess, address that while they're waiting to have that surgery?

Simon Payne:

Yeah, I think that's a great question. And I will say, I think we are just at the beginning of that conversation. And, prior to, and through the pandemic, we were really working on enhanced recovery after surgery across our entire healthcare system, in all service lines. And the initial focus of a program like that typically is, once you arrive at the hospital, and through the hospital stay.

And so, our phase two of that is we're going into 2021, is that prehab question, and how do we start to align our employed providers, our non-employed providers, or employed providers from other healthcare systems, who operate in our facilities. How do we bring everybody together to do things like procedure name scheduling process, so that patients can then be put into a prehab queue if you will, where they get the same education before surgery, so that you can improve not only their inter-operative outcomes, but decrease their length of stay, and decrease their chance of readmissions and things. So, I think it's an unanswered question. But I think something that we're going to be tackling, very pointedly, particularly beginning early next year.

David Skarda:

The idea of prehab is critical, and obviously, having the, essentially elimination of elective procedures for several weeks of the early part of this year, really forced all of those patients into a kind of a forced prehab scenario, where they're dealing with this issue, this disease, this problem that led them to have the elective procedure scheduled, and now they weren't having that elective procedure.

One of the interesting questions, and I have opinions on this, but my suspicion is that we're going to find that a percentage of those elective procedures that were scheduled and not done, will simply never get done. That the process of taking time, prehab, whatever it is, we may find that a percentage of those procedures that got canceled, simply turns out were unnecessary to some degree. And I think it may help us to think carefully going forward, about appropriate use. In essence, we're going to have some really unique data from this year, to help us to understand potentially how we can identify which procedures we've historically done, that may not necessarily need to be done.

Becca LaFond:

Great point. One of the other questions that was asked, and it's somewhat maybe related to prehab, but also potentially post-surgery, what are some appropriate uses of telehealth in surgery?

Ashok Rai:

I think the expansion of post-up care through telehealth took off like crazy for us. For a variety reasons, we've been doing it somewhat for remote, people that traveled significantly to have their surgery, but even some of the simplest post op care, to be able to do it by telemedicine.

Also, understanding that maybe not every post op visit needs to actually even happen, as not every surgery needs to happen. And we saw a lot of that evolve here over the summer. But so we saw an ever growing role for tele, and the ability to do a lot of presurgical work by tele as well. So, it just wasn't only post op, but the ability to review your biopsy results, to plan your surgery, to do all that via tele, and not have to do that in person.

And sometimes even more efficient, because you can show images on the screen, and you can walk through that, and answer questions, and have a dialogue sometimes even with more than one person in a room, in a safe manner. I think we saw tele in the surgical environment, in the surgical oncologic environment, the breast cancer environment, in the preop, being a huge ability there to expand our reach. And in the post-operative care, pretty much all specialties, and we have been toying with it in trauma, because we are a trauma center, so people may be helicoptered in from two, three hours away. But we're starting to see that radius get smaller and smaller, to people just down the road, to be efficient in that manner. So, I think there's a huge window for telemedicine in both preoperative, and post-operative surgical care, now.

David Skarda:

Yeah, your words are ringing very true in my ears, right? So, kind of stepping away from my role as an administrator, and kind of talking a little bit from my perspective as a clinician, when we were in the full shutdown mode, and not doing elective procedures, and not seeing patients electively in clinic, I lost track of how many patients I essentially diagnosed with a problem over the phone, brought them into the hospital, into the OR through same day surgery, saw them for the first time in the preoperative holding area, confirmed the diagnosis, put in a history and physical, and then they went immediately to the operating room.

Post operatively, I had one conversation with the parents. They went home, and then the follow up was a phone call from me to them, a month or so later, to make sure that they were doing okay, and it transitioned a process that would a pre op clinic visit, a same day surgery event, and then a post-operative clinic visit to just one event. And it felt very appropriate at the time, and my sense is going forward, that's going to continue to feel pretty good.

Simon Payne:

Yeah, I agree. I think the majority of post-operative care can be done virtually. Obviously, there's some that cannot, or have complications arise. But the old view that you need to see folks in the office is, I think simply just not accurate at this point. And one area to think about in the preoperative is, the concept of the centralized preoperative testing for an entire health system across multiple states.

I mean, there is a way to be much more operationally efficient with use of far less resources, and deliver a more centralized approach to care where patients get the preoperative, or prehab information that they need, that's delivered in the message that is most meaningful, not only for the patients, but for the system as well. So I think there's a ton of opportunity in that, and that arena.

Becca LaFond:

Many of you have talked about things that maybe were already on track but have maybe been sped up by COVID. Is there anything that has surprised you in the last six months with the way that either your colleagues, or your health systems, or the patients have responded?

Simon Payne:

I think two things for me. One, from the patient perspective, we saw pretty clearly in Colorado, that patients, either being forced to delay care, or being afraid to get appropriate care, we saw an increase in out of hospital acute MIs. We saw a decrease in routine screening, colorectal cancer screening, so some really significant impacts on patient health.

So, as we move to protect patients from COVID, we actually harmed patients in other ways. And so, I think that was one of the big learnings, and I think, surprises for me. I think from a healthcare system standpoint, I mentioned this before, is the capacity for change, and the resiliency of our system, of our providers, of our associates was much, much higher than we had anticipated. And I think using that and learning from that going forward is going to create a wonderful opportunity for meaningful change, and engaging all interested stakeholders going forward.

Ashok Rai:

I would agree, I think we've demonstrated our ability to be nimble for the first time in healthcare. We're not exactly well known for that. This is the way we've always done it, is probably something that the three of us have all said at one point, even in our own careers. Whether it's in care Practice or administratively.

And the nimbleness that was demonstrated, just the creativity, and letting people think about thinking outside of the box. Not in six-month increment, but in a 24 hour increment. I look at our infrastructure for testing. So, I gave the challenge to our ops team, and in 24 hours they had designed two construction trailers, two storage trailers, they learned how to play Legos with a crane, and they had 12 sites in the state set up for locally here, all within a 72 hour time period, before we even had enough swabs, or the machines to run them on.

And since June 1, we'll probably have crossed today 90,000 people tested. And we're not that big of a group. 75% of those patients aren't ours. But now, their medical records are, and we'll have an opportunity to engage with them in different ways going forward. And we were able to demonstrate that, just everybody, they wanted to not get furloughed. So, they creatively found solutions to keep people working in good ways, not repetitive ways, not wasteful ways. But, just allowing people that ability to be creative, and stepping out of the way. And some of our old adages, and some of our restrictions, and the boxes that we put healthcare in, all got torn apart.

And you think about telehealth implementation, some of us did in a week, which would have normally taken our systems what? 24 months? It would have taken the lawyers 24 months to get to the contract. And we were able,

and everybody knows what I'm talking about. Yeah, I'm the CEO, I'm supposed to be able to tell the lawyers what to do, and it doesn't always work that way.

Everything we were able to do so quickly, that's never been done before, and it was done in the best interest of public health, the patients, and really our own operations and our survivability. That can't go away. If anything goes forward is, we now have demonstrated the ability to change at a rate that has never been seen in healthcare before, and it would be probably the biggest disappointment. We have saying around here when it came to testing, "Never waste a good crisis." And in healthcare, we can't waste this crisis. We have demonstrated our ability to evolve at light speed, and to be different, and I think we can't forget that.

Nick Mickas:

In some ways, it's brought us back to what we do, right? We're all problem solvers. We want to help make people better. And I think the challenge is going to be in the translation, because you mentioned testing, but I would add the same thing too, how do you optimally manage a COVID patient? And proning, think about how quickly we were able to come to consensus around proning, around different drug regimens, around treatments that immediately became available?

And I would challenge us to then look at, "Okay, so what do we know about a standard cholecystectomy patient? And can't we come to consensus around that? And hard wire that, so that we free up our brains to be focusing on the other things.

Becca LaFond:

Dr. Mickas, thank you. Unfortunately, due to time constraints, I think we're going to have to cut that wonderful conversation off, which I apologize for, because I think it's really been very engaging. I think one of the things that I took away from the last couple minutes, was that maybe the adaptability of our workforce, of our patients, of our communities, will allow us to look at clinical variation, and clinical practice variation in a different way, and maybe a more open minded way because of COVID.

All of you have been working on that for years before COVID ever hit, and I think it is certainly speeding up the ability for people to engage in that change, in their own behavior, and in the systemic behavior, I think, as you have all pointed out within the healthcare system.

I want pause, and just thank all of you for such a really great conversation. It's been really engaging, very inspirational. I know all of you are battling very difficult situations in your own organizations right now, given the COVID crisis. I want to specifically thank obviously, Dr. Skarda, Dr. Mickas, Dr. Payne, Dr. Rai, for being here, and for sharing your thoughts with all of us, all of the listeners. I'm going to turn it over, back to Alycia for just a few closing remarks.

Alycia Parker:

Before we close, today's webinar was brought to you by Empiric Health, and four of Empiric Health's partner organizations. Empiric's proprietary methodology evolved from a five-year program at Intermountain Healthcare. But today, Empiric uses AI, machine learning, and natural language processing to create apples to apples comparisons, or cohorts, that physicians can trust, and optimize for high value care.

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Brian Zimmerman:

And on behalf of Becker's, I just want to thank today's speakers for that excellent conversation, and Empiric Health for sponsoring today's webinar. Enjoy the rest of your day everyone, and we look forward to having you join us for future webinars.