HealthLeaders Virtual Roundtable
Healthcare System of the Future: CMO

THE NEXT EVOLUTION OF CLINICAL CARE

Clinical care is undergoing transformative changes exemplified by the rapid expansion of telehealth services during the coronavirus pandemic. This HealthLeaders Roundtable discussion brought together seven physician leaders to discuss the evolving clinical care landscape.

The discussion covered a range of topics, including the vision for telehealth after the pandemic has passed, offering telehealth services in the hospital and clinic settings, how healthcare organizations can capitalize on positive responses to the pandemic, how healthcare providers can retain doctors and nurses after the pandemic, healthcare disruptors such as Amazon, making the shift from fee-for-service care to value-based care, and future models of primary care.

Jose Barreau, MD
CEO
Halo Health
Cincinnati, Ohio

Eric Eskioglu, MD
Executive Vice President, Chief Medical and Scientific Officer
Novant Health
Winston-Salem, North Carolina

Jennifer Wall Forrester, MD
Associate Chief Medical Officer
UC Health
Cincinnati, Ohio

Peter Hill, MD
Senior Vice President of Medical Affairs
Johns Hopkins Medicine
Baltimore, Maryland

Anil Keswani, MD
Corporate Senior Vice President, Chief Medical Officer of Ambulatory and Accountable Care
Scripps Health
San Diego, California

Jason Mitchell, MD
Senior Vice President, Chief Medical and Transformation Officer
Presbyterian Healthcare Services
Albuquerque, New Mexico

David Williams, MD
Chief Clinical Officer
UnityPoint Health
West Des Moines, Iowa

Christopher Cheney (Moderator)
Senior Clinical Care Editor
HealthLeaders
Middleton, Massachusetts

DRAZEN ZIGIC/GETTY.COM

HIGHLIGHTS

HealthLeaders: *How can health systems make specialty care available through telehealth?*

Jennifer Wall Forrester: I'm excited about telehealth. Prior to COVID, telehealth was available mostly to primary care; but when you think about specialty care, in a lot of regions specialty care resides in the academic medical centers and may be lacking in more rural areas.

So, what telehealth lends to specialty care is us being able to reach out beyond the cities. Telehealth gives us the opportunity to reach more patients so that they can get the specialty care that they need or at least some help for more than just a phone call from physician to physician. Patients can be seen and talk to the specialists themselves.

Jason Mitchell: As you look at the life of many of our hospital-based specialists, especially when there are so few, they can have difficult lives. Being on call multiple nights a week for 25 years is exhausting. I believe there is an opportunity to broaden call groups and reduce burden while enhancing access through telemedicine rounding and working at a multistate or multihospital level. So, to me, what is going to transform this is to provide a lot more specialty care to hospitals that otherwise would not get it and to sustain physicians through longer, more successful careers.

Eric Eskioglu: I can give two telehealth examples that we have done at Novant Health that provide healthcare equity. So, it does not matter whether you live in rural Elkin, North Carolina, or uptown Charlotte, you get the same care. One example is stroke care. We have been able to not only do teleneurology, but also layer in artificial intelligence. In Elkin, we do not have a neuroradiologist at 3 in the morning who is going to read exams. So, now they can detect a stroke and they get the same pathways of treatment.

The other good example I have is electroencephalogram. We started doing remote monitoring of EEG in all our hospitals. We have 17 hospitals, and we only have six neurologists who deal with seizures. Now, all of them can monitor EEGs remotely, so we are able to expand that service throughout all our hospitals. When you are looking at an EEG, you do not need to be there in person. You do not need to touch the patient. This will help us expand the reach of specialties, especially nonsurgical specialties.

Jose Barreau: For the specialties that have a hybrid model—meaning they need to see patients sometimes—we need a better understanding of best practices on how we work in hybrid environments. Some people are going back to the office, and some are not. What is the best practice on treating an oncology patient for different things? When do I need to see a patient and when do I not? This gives us the opportunity to study telehealth more carefully and build out a lot of best practices per specialty, so doctors feel comfortable doing it.

David Williams: I am in the middle of the country at UnityPoint Health. We are in Iowa, Illinois, and Wisconsin, and what I tell people often is my hometown of Des Moines, Iowa, does not resemble San Diego in the winter. So, getting physicians to move to Iowa is hard. Telehealth saved us during COVID, particularly in infectious disease, but we have even started to recruit hospitalists who live in Chicago. I have one who lives in Detroit. I have people living all over the country doing telehospitalist and teleICU work. There is no way I would have gotten them and their families to uproot and move to Iowa.

Peter Hill: Even in more urban areas, with the contraction of subspecialist coverage at many hospitals, there was movement prior to COVID of patients from one hospital to another simply for subspecialty consultation; I am speaking more of the inpatient side. A lot of that does not need to occur, right? I think bringing the specialists to the hospital via telehealth rather than bringing the patient from one hospital to another is a much more efficient use of resources.

Anil Keswani: The country underwent the largest ever clinical trial with COVID-19, and that clinical trial focused on how to use telehealth in a way that makes sense for patients. Now it is time to study the outcomes. Did we deliver on the experience and the quality?

Currently, there are two areas that we are working on. On the ambulatory side, telehealth occurs in our primary care arena. During the pandemic, we deployed a "call, click, or come in" model. Patients could have telephone visits, video visits, e-visits, and/or a traditional physical visit.

"Being on call multiple nights a week for 25 years is exhausting. I believe there is an opportunity to broaden call groups and reduce burden while enhancing access through telemedicine rounding and working at a multistate or multihospital level."

—Jason Mitchell, MD, Senior Vice President, Chief Medical and Transformation Officer Presbyterian Healthcare Services, Albuquerque, New Mexico

"We have four hospitals on five campuses and more than 2,000 providers in San Diego, and we really became a unified system during the pandemic. COVID has been the humanitarian mission of a lifetime and it really brought all of our clinicians and staff together."

—Anil Keswani, MD, Corporate Senior Vice President, Chief Medical Officer of Ambulatory and Accountable Care Scripps Health, San Diego, California

However, specialty visits are just as important. For example, at Scripps Health we have a partnership with MD Anderson. There are many patients that want to seek care at the Scripps MDA Cancer Center and prefer a virtual consult. So, telehealth enhances access and convenience for patients who want to seek care with our specialists.

On the acute side, there are innovative ways that we have used telehealth. One exciting project involves continuous glucose monitoring (CGM) in the acute setting. We were hit very hard last year with COVID and were concerned about scarce personal protective equipment. Through our CGM project, we continuously monitored and managed glucose levels. This resulted in better outcomes, and the nurses needed less personal protective equipment.

HealthLeaders: *Telehealth is not a one-size-fits-all enterprise. What are the primary differences of offering telehealth services in the hospital setting versus the clinic setting?*

Hill: The consultation in an office setting is planned. It can be arranged. In the inpatient setting, consultation is sporadic.

Forrester: We need to study the outcomes from telehealth to make sure we prove to ourselves and our patients that we are doing the right thing.

HealthLeaders: *The coronavirus pandemic has had several silver linings for healthcare organizations, such as breaking down barriers to changing the status quo and increasing nimbleness. How can healthcare organizations maintain the positive aspects of functioning during the pandemic?*

Williams: U.S. healthcare has never been called nimble before. But during the pandemic, because of necessity, we did not take eight years to determine the best evidence-based practice, then spend another eight years to get it to our patients. We changed on the fly. So far, that spirit has not gone away.

And we are coming to consensus. UnityPoint Health is in three states and nine regions across the middle of the country. We have never been a health system before. We have never acted like a unified clinical enterprise. COVID changed that. Now, people care about what happens from state to state, and people on the ambulatory side care about the hospital and vice versa.

Forrester: The pandemic has also taught us the value of getting the right people in the room when decisions need to be made. We have tried to continue that. Decision-making is not top-down anymore. It is more of a discussion.

Keswani: I echo what David said. We have four hospitals on five campuses and more than 2,000 providers in San Diego, and we really became a unified system during the pandemic. COVID has been the humanitarian mission of a lifetime and it really brought all of our clinicians and staff together.

Eskioglu: The one thing we have seen—and we are trying to keep—is our length of stay for uncomplicated birth deliveries went down by a day. Moms just want to have their babies and bolt out. They do not want to stay in the hospital with risk of catching COVID. Readmissions have not gotten higher with the lower length of stay. So, we are working on keeping that momentum.

Mitchell: It is possible to sustain some of the pandemic gains. One thing that we started doing during the pandemic was a daily management system with tiered huddles. It involves the front line all the way to senior leadership daily.

Issues can get escalated up to the top tier, which is the C-suite, and it's amazing. Not only have we resolved issues we would have not potentially recognized for years, but we also have found that fewer issues get escalated as the tiers develop skills to problem solve and resolve issues in the moment. This daily management system is something that we have been able to sustain and expand.

Hill: In terms of bringing the health system together, we

"For physicians and nurses, most of the time, they are in front of a patient and if they are interrupted with a phone call or a message, it is usually interrupting a patient encounter. Nurses suffer from this a lot more than physicians do, but physicians also suffer from constant interruptions."

—Jose Barreau, MD, CEO, Halo Health, Cincinnati, Ohio

certainly experienced that as well during the pandemic. One of the reasons is some of our smaller community hospitals that have a large percentage of private physicians on the medical staff are no longer a friction point. The pandemic made these physicians understand the advantages and the importance of being part of the health system.

HealthLeaders: *How can healthcare providers retain doctors and nurses after the coronavirus pandemic?*

Barreau: It is about the clinical experience. How do you make life better for physicians and nurses to do their jobs? In my world, I very much focus on interruptions. For physicians and nurses, most of the time, they are in front of a patient and if they are interrupted with a phone call or a message, it is usually interrupting a patient encounter. Nurses suffer from this a lot more than physicians do, but physicians also suffer from constant interruptions.

The other thing is the user experience with technology. We have got to figure out how to get more doctors and nurses involved in creating technology so it is easier for doctors and nurses to use.

Forrester: We have seen several physicians and some of our more experienced nurses retire early. In the past, we have seen physicians and nurses work way past their retirement age, because their work was rewarding. In the early stage of the pandemic, we did not have a problem with physicians and nurses showing up for work because it was rewarding, especially when you are saving lives. But you must focus on making sure that working is balanced with wellness. We have seen that people show up to do the right thing, but then when you push too hard for too long, we lose them.

Keswani: There are four factors to think about. One factor that is increasingly important is work-life balance. We are thinking about what this means going forward while still being patient-centric.

The second area is technology. We are on Epic, and clinicians and nurses come to us because they trained on Epic.

The third factor is focused on providing the right place for specialists to practice. To retain top-quality specialists, we want to provide a location for them to do clinical research.

The last factor is focused on diversity, equity, inclusion, and belonging. One of our medical groups started a program in which a physician will create a short video based on their viewpoint. This allows others in the medical group to understand a different vantage point.

Barreau: In nursing, one thing that needs to be addressed is device alerts. Nurses are getting dinged with false alerts constantly. It is a difficult challenge, but it can burn out a nurse quickly, and I doubt any of us here would like to live like that. Ignoring alerts and trying to figure out which ones are the real ones is a problem.

HealthLeaders: *What are you most afraid will disrupt your health system?*

Mitchell: The biggest risk is being picked apart. Everybody is looking at slices where they can pull off a profit and a customer segment, deliver a great experience, and do it better than you can if you are a big health system.

Wal-Mart has the potential to be very disruptive. Wal-Mart is everywhere. It has access to the aging population, and now it is putting in a delivery system capability and partnering with health plans.

The way to deal with disruptors is to disrupt yourself first. You need to disrupt yourself, move patients out of your hospitals to lower-cost-of-care locations, provide an excellent digital experience, and look for partnerships.

Eskioglu: Amazon represents a unique challenge and opportunity for us to compete at a higher level. I had our teams get me a one-page slide of what Amazon has done in healthcare and all the intersections with us. It was eye-opening when I looked at it. They have gone into pharmacy. They have gotten pharmacy licenses in all 50 states and the District of Columbia. They bought PillPack. They are getting ready to get specialty pharmacy licenses, which is one of our most profitable areas.

They have Halo, which is a wearable device. They have Amazon Comprehend, which is their natural language processing. They have Amazon Care. The list goes on and on. For every publicly visible project, they probably have 10 other top secret ones. To Jason's point, they are going to peel away the most attractive and the most lucrative part of our healthcare.

Hill: I am concerned about payers buying up primary care practices and creating their own network, because that will then direct where specialty referrals go to and potentially force hospitals into contracts that are not exactly in their best interest.

Williams: As Jason said, we are focusing on disrupting ourselves. The central tenet of this effort is everything that can be done outside of a hospital is going to be

"Amazon represents a unique challenge and opportunity for us to compete at a higher level. I had our teams get me a one-page slide of what Amazon has done in healthcare and all the intersections with us. It was eye-opening when I looked at it. They have gone into pharmacy. They have gotten pharmacy licenses in all 50 states and the District of Columbia."

—Eric Eskioglu, MD, Executive Vice President, Chief Medical and Scientific Officer, Novant Health Winston-Salem, North Carolina

done outside of a hospital, and everything that can be digital is going to be digital.

Mitchell: The other things that we must focus on are win-win solutions and win-win partnerships. We have a health plan as well as a delivery system, but the crossover is less than 50%. With our health plan, 70% of the payments are value-based payments, and a large majority of that is outside of our own delivery systems. We have focused on creating value-based contracts and having it tiered. We are meeting providers where they are, so they can participate in value and get to the next level and do it in a way where you expect lower margins because you want to support your community clinicians. That is a win-win situation.

HealthLeaders: *How can healthcare organizations make the shift from fee-for-service care to value-based care in a way that is financially viable?*

Hill: From my perspective, it starts with the quality and ensuring that we are producing the clinical outcomes that we should produce. That is one of the two tenets of value—you need to control cost as well as quality. So, if you do not have quality, then you are dead in the water. For us, that is certainly what we are focusing on right now.

Williams: I think the best way to be successful is to be a system like Jason's, where you have vertical integration. When a health system has a health plan, saving money on the healthcare delivery side profits you on the other side of the house. If you do not have that vertical integration, it is a game of attributing patients to your health system, so you have enough scale in your value-based contracts. That way, you can stay afloat financially while decreasing revenue from hospital operations and turning your hospitals from profit centers into cost centers.

HealthLeaders: *Annual physicals have been a mainstay of primary care. What is the future model of primary care?*

"When a health system has a health plan, saving money on the healthcare delivery side profits you on the other side of the house. If you do not have that vertical integration, it is a game of attributing patients to your health system, so you have enough scale in your value-based contracts. That way, you can stay afloat financially while decreasing revenue from hospital operations and turning your hospitals from profit centers into cost centers."

—David Williams, MD, Chief Clinical Officer, UnityPoint Health, West Des Moines, Iowa

"Primary care physicians are still the hub of the wheel for patients, with specialists serving as the spokes. We do not do a great job of communication in terms of the transition from inpatient to outpatient care, and that is an opportunity for the future."

—Jennifer Wall Forrester, MD, Associate Chief Medical Officer, UC Health, Cincinnati, Ohio

Forrester: Primary care physicians are still the hub of the wheel for patients, with specialists serving as the spokes. We do not do a great job of communication in terms of the transition from inpatient to outpatient care, and that is an opportunity for the future. I am a big proponent of improving the transition of care from the inpatient setting to the outpatient setting because a lot of information can be lost in that transition. We rely on the patient too much to understand the ins and outs of what has been done in the inpatient setting.

Mitchell: We need to focus on what the evidence supports, patient preferences, and how patients want to be engaged. The people who are going to be successful in this new model are the primary care clinicians who create a good experience for the patients without an annual required physical.

Eskioglu: Artificial intelligence is going to change primary care unlike any other subspecialty. Most primary care physicians do not go back far in their notes to look at patterns. Most primary care physicians do not review all the labs if they have had a patient for 10 years or more. So, primary care physicians who adopt AI are going to be so much more efficient in prevention, diagnosing, and treating patients.

Williams: Primary care doctors need to buckle up. Their lives are going to change dramatically. I have been saying for 20 years that I could do 90% of my general pediatrics with telehealth if I could look in somebody's ears with it, and now I can.

Activate Code Teams with Context

Leading health systems count on the Halo Health platform to activate Code teams with context – ensuring every stakeholder arrives prepared.

Imagine if you could achieve a 12.5% increase in survival or 64 lives saved per year?

	2019 (Pre-Halo Health)	2020 (Post)
Total Patients	3,803	3,789
Average DTNT	57 min	49 min
<60 min	38%	80%

This health system experienced reduced Door-To-Needle Time (DTNT) post implementation of Halo Health, from 57 minutes to 49 minutes. These improvements translate to significant survival improvements in recent studies (JAMA 2020, Man, et al.)

Consolidate technology, unify code teams and key stakeholders on one clinical collaboration platform and shorten Code Stroke, Code STEMI response times.

ACHIEVE MORE

halohealth.com/activate-with-context

CUSTOMER RATED KLAS REVIEWED

Category Leader
92.7/100

High Performer SPRING 2021 · Users Love Us · Leader SUMMER 2021

halo health™