HEALTHCARE INDUSTRY GROUP

What's Your Moonshot?
A Podcast Series Where World-Class Healthcare Leaders Seek To Solve Big Problems

Integration and Transformation: Wellforce is Utilizing Technology and Partnerships to Enhance Care

Transcript

[00:00:00] Michael Dandorph: One of the things that we made a decision on is we're not just going to focus on filling our hospital beds. I think that that is part of a major differentiator for us. We're in an environment with very competitive, large systems that own a lot of hospitals, they got to keep those assets full. We're a little bit smaller and more nimble in that regard. What we're trying to do is create common platforms.

We're actually implementing epic across the organization. We actually will be the first large system to put the entire platform up in the cloud and that will allow us to connect other digital assets in a way that really helps us engage with the consumer.

[00:01:13] Larry Kaiser, M.D., FACS: Welcome to A&M. *What's Your Moonshot* podcast. My name is Larry Kaiser. I'm managing director of Alvarez and Marsal's Healthcare Industry Group. I'm here with my co-host, the Honorable Secretary, Dr. David Shulkin. David, it's a pleasure today to welcome to the podcast, President and CEO of Wellforce, Michael Dandorph. Wellforce, located in Boston has more than 15,000 employees including more than 2000 physicians across several community hospital campuses, the Tufts academic medical center, and a home care program.

Mike became CEO of Wellforce in January 2020 to help pursue the goal of integrating academic medicine and high-quality care across several physician groups and the communities that Wellforce serves. However, we all know the timing ended up being just before the onset of the pandemic and I'm sure you had to pivot and adjust as you provided care for the community throughout the last few years and continue to do today, in the face of Omicron. Mike, we're very pleased to welcome you to the podcast today.

[00:02:16] Michael: Larry, it's my pleasure to be with both of you and it's nice to share some time with some old friends as well.

[00:02:24] David Shulkin, M.D.: Well, Michael, first of all, thanks for joining Larry and I on this podcast. We're really excited to have you. I think going all the way back to when Larry you and I were at the University of Pennsylvania Health System, you really taught me everything that I know about managed care. They at one point gave me the responsibility and you really were running the managed care operations. I just remember what a great job you did and then, of course, you went on to many other great things and I had the opportunity to visit with you when you were at Rush Medical Center in Chicago and now of course, as Larry said, you've taken on this new amazing opportunity.

Other than facing COVID, which has been a lifetime challenge, what are the other big issues and challenges that you're facing as the CEO of Wellforce?

[00:03:22] Michael: Yes, when I arrived here in January of 2020, it was about six weeks before COVID hit. We were really just starting to lay out a plan that would bring the

organization integrate or integration. When I was recruited, the board realized they definitely had more of a holding company model. There were four very different cultures across the organization. There was no real specific integration plan. The board realized it wasn't getting the benefits of really acting as a system that way. We quickly focused on how do we create a more aligning and clarifying vision, and really start to bring people together across the organization around that vision and that included a pretty significant board restructuring.

We really made a change from a relatively large representational board of almost 30 board members to a small 15-person board that is 50% independent board members that are represented by one of the members of the system in that way. That was a big challenge. Overall, and certainly, challenges related to COVID. We're doing that throughout the peaks and valleys of the pandemic here.

[00:04:55] Larry: As David pointed out, Michael, obviously, the COVID issue has had a major impact on health systems across the country? How is your system weathering this current COVID storm? Tell us a little bit perhaps about some of the financial implications that you've experienced? What about staff currently out and how are you covering for staff that may be out? We know across the country, many of these systems are seeing large numbers of staff out and are really challenged to continue to provide the outstanding care that they're used to providing.

[00:05:30] Michael: Well, I'd say we're hoping that we're hitting a plateau at this point in time but then we're at a height as bad as it was in the beginning of the pandemic, back in that April timeframe in 2020, late March and April. From a volume perspective, where we're seeing that, we're not seeing the level of ICU demand, but certainly, inpatients are as high as they've ever been overall.

The challenge has been that we've been, we're managing that without the level of staffing that we had. Back then we had about 400 open positions when we were managing this the first time and now we have about 1,800 open positions. At its height, we're starting to see staff come back but we also had staff that were getting sick and infected with COVID. At its peak, we had about 900 staff that were out as well.

We had 1,800 open positions, 900 staff that were out, and they've just been doing an amazing, amazing job from a teamwork and creative innovation. How do you staff in a way that accommodates this demand? We get people backed up in our EDs, we can't get people into post-acute settings. The whole ecosystem has been challenged in this regard. We're still seeing an awful lot of people show up in our hospitals that aren't vaccinated, in addition to the breakthrough vaccinations that we've also seen.

I worry most about the resilience of our staff overall. Certainly in the short-term, we're seeing another financial deterioration more because of the contract labor issues and the traveling nurse issues, and we have to pay in order to retain and deal with some of the contract labor issues right now. It's pretty much all there. Overall, we've seen certainly some deterioration of the elective services. We've been given the demand by the state to curtail electives and scheduled services. What we've seen in the past is that will come back when we open back up again, from a demand point of view, but the staffing issues probably have me most worried.

[00:07:58] David: Yes, and, Michael, those are pretty incredible challenges that you're facing and so many others across the country are in a similar situation. What's your prediction or what are your thoughts for how long this lasts? Even if the pandemic comes to an end, or goes down to sort of an endemic level, rather than a pandemic level? Do you think the staffing challenges are around for quite a while?

[00:08:26] Michael: Yes, I think we're at this inflection point from a staffing point of view. We know, certainly, physician burnout was at an all-time high before the pandemic and the burnout of physicians and nurses for that matter was there before. We've certainly seen people retire and leave the workforce. There's a nursing shortage in Massachusetts, and we're certainly seeing that as well. I think this is a five-year challenge, not a six-month or a year challenge.

It's going to force us to rethink, how do we organize the workforce? How do we use technology to alleviate some of the burdens and how do we create a better environment overall. I think these challenges from a workforce point of view are going to be with us for a while.

[00:09:16] David: Yes, of course, one of the things that's always a challenge is trying to manage a big organization with the short-term issues, and even some of the longer-term issues at the same time, carrying forth a vision for where you want your system to go. I know that you have focused a lot on trying to make sure that Wellforce is really functioning as an integrated system, rather than a big organization with lots of separate parts. What actions are you continuing to take even in the setting of COVID to create this greater system for Wellforce?

[00:09:58] Michael: Yes, well, we've been very, very focused on what are those things that we can and should integrate to function more as a system? Actually, in some ways, even operationally, COVID has accelerated the work and the collaboration across the organization, whether it was early on thinking about how to allocate ventilators and PPE and thinking about broader supply chain issues, but also moving patients, moving staff around the system in a different way and really supporting where the needs were the greatest.

I think that gave us a springboard for some of the work that we needed to do from an integration point of view. It certainly started with trying to create an aligned and clarifying vision across the organization. We've anchored to this idea that we need to start to treat the individuals and the community members that we serve as consumers and not to think of them as just patients that we're taking care of and we purchase them a short episode, but really starting to think about ourselves as a health system.

We have community hospitals, we have a home care company, we have a broad physician network. How do we make sure we have an academic medical center that sometimes patients get transferred into and need to go back into their homes or into their community for care? How do we start to create a frictionless environment for those consumers in a way that really seamlessly orchestrates all of their needs from a scheduling point of view, or an education point of view through scheduling, through billing, through all of their follow up care needs? How do we really become a trusted partner for the consumer in a way that helps them maneuver a pretty complicated system?

We used to talk about this, David, I remember back in our days at Penn. We still have an incredibly expensive system that is very fragmented, the American healthcare system, very fragmented, very expensive, and quality is about average across the country and that's the same in Massachusetts. That's been some of the areas that we've been digging in on in terms of where our competitive advantages and areas that we might be able to win on.

[00:12:26] Larry: Mike, just following up a little bit on that, you have the flagship university hospital and Tufts Medical Center. You have two community hospitals, Lowell General, and MelroseWakefield. What's the community hospital strategy and how does that fit into what you just discussed with us about how you want to make this even more seamless for the consumer?

[00:12:49] Michael: We are a couple of things. One of our strategic pillars are how do we keep more care as close to home as possible and even in the home in that regard? Our community hospitals we're really investing in and recruiting in ways that we can keep more care in those hospitals. We've called it a distributed academic medical center model where there are things that are coming into the academic center that we can actually hand and should take care of in the community to keep costs down overall. Also, we're closer to family. Those patients can be better served in that environment, but increasingly, we're looking at acute care at home and other home care models that actually keep people out of the hospital altogether overall.

I'd say that the community hospitals have really become the epicenter of our population health strategy in this regard. Overall, the Tufts Medical Center is a small academic medical center. It actually has the highest case-mix in Boston overall. We're thinking about the academic center in terms of how do we take that asset, so to speak, and make sure that we have the right portfolio of services in the academic center and trying to keep more care in the community overall.

[00:14:17] David: I think that's terrific. I'm fascinated as you described your vision to be able to do all of that with this idea of a frictionless healthcare system. I just wonder whether you can talk a little bit more about what that looks like to the patient and whether you think that it includes specific things like are you about same-day appointments? Are you thinking about patients who actually understand what their bill say since it's so confusing out there to even understand what your EOB say when you get them from the insurance companies? Whether you think you can really create a frictionless system if you don't have a payer component, or maybe you're thinking about partnering with payers on this.

[00:15:11] Michael: A whole series of things. We don't have all this figured out for sure, but what we want to try to create is a second-to-none experience. Again, end to end in that regard. We think that the capabilities from a digital point of view are going to enable us in that regard. One of the things that we made a decision on is we're not just going to focus on filling our hospital beds. I think that is part of a major differentiator for us. We're in an environment with very competitive large systems that own a lot of hospitals. They got to keep those assets full. We're a little bit smaller and more nimble in that regard, but what we're trying to do is create common platforms.

We're actually implementing Epic across the organization. All of our hospitals, our home care agency, all of our physicians on one single instance of Epic in terms of the way that they're working together, but we're thinking of that as a platform. We actually will be the first large system to put the entire platform up in the cloud with a partnership with AWS and that will allow us to connect other digital assets in a way that really help us engage with the consumer. We all like to use apps like OpenTable or Resy for dining because we can choose the time and location that meets our needs. Well, why can't we do that for consumers?

All of our employed practices in about 40% of our private practices that have signed up for Epic already have agreed to open scheduling. That's going to allow us to create a more frictionless experience for the consumer so they can get same-day appointments. They may need to travel a little bit to get the same-day appointment, but they start to become more empowered in making that choice in the trade-offs that they're looking for overall. We're integrating all of radiology and all the labs, people can get their diagnostic services everywhere by the same group.

Those things are the early things that we're putting in place that start to build that foundation of how do we really create an environment where the consumer has a little bit more control in that overall. Then how do we orchestrate the experience? Oftentimes, consumers or

patients need to see multiple specialties on the same day. How do we organize all of that for them and how do we use automation in a way that allows us to do that instead of manually having to be a concierge service in the same way? We can automate some of those sorts of things with the technology that's available now.

[00:18:05] Larry: Well, Mike, you touched on it a little bit. As you know, your system resides within a very competitive market, two large health systems, Mass General Brigham and Beth Israel Lahey, each of whom controls about a quarter of the market. What do you need to do at Wellforce to position your system to be able to compete with those two giant systems who advertise nationally interestingly?

[00:18:37] Michael: We are probably not going to be able to beat them on brand alone. What we've learned is Tufts is the second strongest brand in the market overall. We want to leverage that as we start to think about even rebranding and becoming a more consumer-oriented brand overall, but that's not going to be enough. We really have to change the experience and we've thought about experience on two levels. I talked about the consumer experience. In order to create the right consumer experience, we have to have the right experience for our physicians and care team, our entire workforce, really in a lot of ways. How do we make it an easy place to work and not a big bureaucracy?

We're large enough to be relevant in the market but we're small enough to be nimble. We've started to think of ourselves as how do we become less of an incumbent mindset and more of a disrupter in that regard and starting to bring tools into place to engage the consumer overall. We also know that there are physicians that are not happy where they are because they're not really being supported in that regard.

We talk about frictionless as much with the physicians and nurses and care teams as we do about the consumer cycles. They go hand in hand in a lot of ways. That'll allow us to compete for talent. In a lot of ways we look at the competitive landscape is this is about creating an environment where physicians can thrive and that becomes a strategic advantage for us as well. Then lastly, I would say is we're really interested in partnering with payers.

We do not have an interest right now of going into competition with payers. We're not going to form our own insurance company in that regard, but really move into value-based care and really be a protagonist for value-based care in the market place which is going to require us to have deeper relationships with the payers in that regard.

We've performed pretty well in value based contracting, but we need to get to version 2.0 here. How do we get more aggressively into Medicare Advantage, commercial risk? The state already has a Medicaid risk program in Mass Health so that we start to think about the patient population not segmented based on payer class, but really thinking about how do we segment them based on consumer desires and propensity to use and their issues overall. I continue to believe that our competitive advantage is going to be we're going to create a better service and experience for the consumer and over time build our brand that way than just going head-to-head for complex care or being the biggest hospital system in the market.

[00:21:39] David: Yes. Michael, I think you've really just so nicely wrapped up your strategy. I was going to come back to how you were thinking about the payers because 25 years ago, that's really what you really had such considerable expertise in, in understanding how the managed care market works. With your value based contracts and Medicare Advantage and your ability to align with the payers that really does complete your strategy. Where are you in that in terms of what percent of your business is still fee-for-service and what percent have you been successful in getting payers into an alternative type of arrangement?

[00:22:30] Michael: Yes. I would say about 30% of our business has some risk associated with it. It's not complete up and downside risk yet, but we're moving more aggressively into that. We've had early conversations with the payers, the challenge has been COVID has been in the way in terms of really having deep conversations.

We know there's probably going to be some boomerang effect as well. That's going to become part of the negotiations with the payers. By boomerang, we see people presenting now with more progressive disease. How's that going to affect the risk profile of a given patient population and how do we work through that in a way that both the payers and we can succeed in that kind of an environment and don't get too far over our skis from putting either organization at such great risk.

We should be able to get on the same side of that one. If we're really committed to lowering the total cost of care, we should be able to work with one another in that regard. We're in the process, we're in negotiations. We're trying to do some of the exploration from a risk contracting point of view, outside of the normal cycle of contract renewals, because they can tend to be pushed from a time point of view and trying to be more strategic about how do we really align with the payers in that regard around areas that we have some shared interest in.

I would add to that, David, that so fundamental to this is going to be how do we make sure that our physicians are aligned with that? Actually, when I got here, we had two separate clinically integrated networks that were doing separate contracting. We've consolidated those into one clinically integrated network that is systemwide. Bringing the assets together so to speak and the strengths that each network had in that regard, but it allows us to analyze data differently and really bring that together and have a unified voice as we're talking to the payers about what's important as well. That clinically integrated network it's about 50% private practice physicians.

We're also not only thinking about how do we employ everybody because that's not necessarily our strategy, but how do we engage private practices in this risk based contracting and value based care population health?

[00:25:13] Larry: Well, Mike you took over a system just before the onset of this pandemic, certainly one of the most challenging times that any health system executive has ever had to face. It doesn't seem to be going away very quickly although it might. What you have articulated about the patient experience and how you think Wellforce can differentiate themselves based on a seamless patient experience, I think you're well set to do that and you're well on your way to do that.

I think the other thing that that was critically important is for the people who work work there and the physicians and your other staff who work there making it a desirable place to work. Again, in a very competitive environment, but if you can differentiate yourself as being a great place to work as well as the place to take care of patients, I think you're really on your way. It sounds to me like you've already accomplished a lot in the fairly short time that you've been there. Congratulations to you and your colleagues.

[00:26:12] Michael: Thanks, Larry. We definitely think opportunity abounds here and we're in an industry that's right for some of these innovations and really starting to change both the costs of care and the experience of care across the board. Excited for the future here.

[00:26:29] David: Michael, thanks for joining us on *What's your Moonshot*. We're looking forward to staying in touch with you.

[00:26:59] Larry: You can see, David, again and we've been very fortunate in the firm to have been doing some work at Wellforce working with Mike and his team. Really as he's put together his team, he mentioned to you, they had to do some reorganizing of the board structure, which really was a difficult situation that he faced. He was able to successfully redo that board structure and bring in some more community members. He's in a very competitive environment and I think the strategy that he's set forth to really try to differentiate themselves I think is one that hopefully will work. They're challenged with a very small university hospital. As he mentioned, they have a very high CMI.

Interestingly, the way they work there, there are no hospitalists at Tufts Medical Center. They have resisted that. Each of the specialties admit their own patients. Nephrology admits their own patients, different than the way a lot of other academic medical centers exist.

He's been able to utilize his community hospitals as he's pointed out, integrate the two clinically integrated networks to take on some of these risk contracts, working with the payers. As you know, there's been a merger of the two big payers other than the Blues in Massachusetts. The Tufts Health Plan and Harvard Pilgrim merged, new CEO there as well. Lots of challenges in a very challenging environment.

[00:28:25] David: Yes. I think that's right, Larry. There's no such thing as an easy job anymore in running hospitals in 2022 right now with the staffing shortages and a pandemic, but I think he's got one of the tougher jobs. There's no doubt he is the underdog in Boston and when you're the underdog, you can't play by the same rules. I think he's found the right playbook just like what you said. He's got to be the alternative to the big brands there. Seems like he's creating a space for private practice physicians, he's creating a different way of running the academic medical center, but yet again, when he talks about 1,800 vacancies, you can't even begin to start thinking about that.

He's coming out of this by saying, look, the way you stay focused is you build a system that employees and physicians want to work at, that patients are going to find it easier to experience their care at, and I think he's got a good shot at this.

[00:29:35] Larry: Yes. I think so too, but I think he is also up against two large systems that can come in and recruit some of his people away. The challenge is creating an environment where those people really do want to stay there. I think he's been successful at doing that. He mentioned this concept of the distributed academic model. He's got a great opportunity to utilize the community hospitals that he has both from the standpoint of providing care closer to the home but also providing care in a less expensive environment than the academic medical center when care can be provided at those community settings and doesn't have to come into the academic medical center yet they've got the opportunity to transfer those patients in when a higher level of care is required.

He's got a lot of moving parts, I think he's been able to address a lot of those in a very short period of time despite the pandemic which has made things even more complicated obviously.

[00:30:34] David: Larry, I think you have that right. He didn't talk a lot about creating the lower-cost environment but he does talk about value and he is the CEO who understands very well contracting and managed care strategies. In the Boston environment with his interest in creating the home environment and getting care outside the big hospital setting, I think he's got a position himself as the true value player in the lower-cost environment and there is a role for that in that market.

[00:31:10] Larry: Yes, and I think he will carve out his niche. It's going to be smaller than each of Beth Israel Lahey with 25%, Mass General Brigham another 25%. Yes, there's still opportunity. You've got to be creative and disruptive to do it and I think he's well-positioned.

[00:31:33] David: Finally, I was very impressed with his argument around technology and trying to build an open cloud-based platform that is going to integrate in with all these new innovations and disruptions as part of a strategy to create this friction-less type of healthcare. I think that's a good strategy as well. We'll be following him with interest and certainly hoping that his strategy does work.