[00:00:01] Michele Volpe: Growth is something for the last 15 years we have been doing, we have been driving, we have grown, obviously against our mission and strategic plan, but we know that we need the dollars, one to offset losses, but two to invest in our organization.

And so what we have done is we've put together a number of work streams under a model that we call the three Rs. And the three R framework is repair, refocus and reimagine. And so everything that we do, we try to align them under one of the three R's.

[00:00:45] Narrator: Welcome to A&M Healthcare Industry Group's What's Your Moonshot Podcast series where leaders seek to solve big problems and transform healthcare. Join us for conversations to hear how their vision and bold moonshots are becoming reality.

[00:01:02] Chris George: Welcome to A&M's What's Your Moonshot Podcast series. I'm Chris George, Managing Director and head of the health system Practice. I'm joined by my co-host, Dr. David Shulkin, A&M Senior Advisor and the 9th Secretary of the US Department of Veteran Affairs. Today we're joined by Michele Volpe, Chief Operating Officer at the University of Pennsylvania Health System.

Michele is responsible for enhancing operational efficiency and program integration across the more than 3,400 bed house, a lot of beds, including more than six and a half million outpatient visits and 130,000 admissions a year. We're excited to explore how Penn Medicine approaches growth scale and long term resilience. Welcome Michele.

[00:01:46] Michele Volpe: Thank you.

[00:01:47] David J. Shulkin, M.D.: Nice to be here and we really appreciate you taking the time. Of course, I'm going to need to make a full disclosure to the audience and that is is that I used to work for Michele at the Hospital of the University of Pennsylvania and I've watched her just amazing career over more years than I'm going to say.
[00:02:06] Michele Volpe: Thank you.

[00:02:06] David J. Shulkin, M.D.: And I remember Michele when we were at of course the Mecca, the hospital of the University of Pennsylvania. The system acquired Presbyterian Hospital, which was just a couple blocks off the main campus and it was a very slow, sleepy community hospital.

If you went there today, you would not say that about Presbyterian. Presbyterian is a major medical center with tertiary care and has just transformed. And that's all under your leadership.

So can you tell us a little bit about what that journey has been like? How do you how do you take a hospital that's viewed in the community one way and integrate it into an academic system and build it into the centers of excellence? The you have.

[00:02:50] Michele Volpe: So I start out by saying it was the best time of my career. I really enjoyed the years working and Developing Presbyterian into something that was different than it was when I got there, but also fit into the Penn culture, particularly the Penn culture at that time. You might remember that I spent some time early on at Penn at the Hospital of the University of Pennsylvania, actually crossing both campuses.

And something I found early on that was very different than where I came from. I came from teaching community hospitals, but I found an academic structure that was based on the academic chair role.

And I spent the first year, first year and a half at Penn learning about that culture, you know, understanding that culture, understanding how it drive or would drive most of everything that was being done at Penn.

And I realized at that point that it would never work with Presbyterian just being a, quote, unquote, community hospital.

First of all, there was a community hospital, Misericordia, not all that far away, that maybe didn't serve the community members in our backyard, but it was only blocks away.

Second is the academic model. Was an academic model where clinical teams, particularly physicians, were employed.

Presbyterian at the time was a almost fully independent medical staff. Absolutely nothing wrong with independent medical staffs, but they were very different.

And so my first order of business, when it became clear to me that Presbyterian needed to look differently not only just for Penn, but also for the community that it served, I recruited someone from the University of Pennsylvania, actually an individual who was heading up the residency programs in the department of Medicine, and brought him over to Presbyterian and together we started on a journey.

And that journey was first to begin to employ physicians. We didn't push anyone out. Presbyterian today is still an open medical staff, although 99.9% of the physicians are employed.

But it's still an open medical staff. But we did move forward to recruit physicians, first in medicine, then we moved to surgery, then we went to the hospital based departments. And as we did that, we were able to move our residency programs from freestanding residency programs to Penn medicine residency programs. Right. Actually, we pulled together in terms, we combined our cap, that took a number of years. And then as we moved forward with medicine, and then at the time, I remember Dr. Barker, Clyde Barker, who just recently passed away, but I remember Clyde saying, Michele, let me see what you can do in medicine first, and then I'll bring surgery along.

And as he watched the growth in medicine, as he watched us bring in employed physicians in specialty areas and subspecialty areas, Clyde began to recruit academic surgeons.

And then David, one thing led to another and we went on growing in that way for a number of years. And then what about, oh goodness, it seems like yesterday, but it was like seven years ago.

We moved level one trauma from HUP to Presbyterian, and it took us about a year and a half to get organized around that.

And the trauma team was extremely supportive because they were getting a brand new facility and one that they could design themselves. There were others who were naysayers, despite the fact that, you know, we were doing at Presbyterian, very high acuity work.

I remember day one, we moved the first patient.

It was successful. It went very well. And we went, like, totally forward from there. There were no more naysayers. It became so much easier to move patients between Huff and Presbyterian. With the exception of transplant. The Presbyterian does not do transplant. Will never do transplant. And so there was a vision and capitalized on that vision. It took a number of years, and Presbyterian is now an integral part of the academic system there.

[00:07:48] Chris George: Wow, what an incredible growth journey you've been on. What's your vision for growth in the future and what challenges do you see? You're obviously a more larger and more complex system today than you were when you first started.

How do you view growth going forward?

[00:08:03] Michele Volpe: So that's an interesting question, right?

I don't. And I don't think our system sees growth necessarily just as size getting bigger and bigger and bigger.

But it has to do with strategy.

And Penn does have a strategy in terms of the. I'll call it the circumference within which it wants to provide services or it feels that it can provide services.

Today we talk about that circumference as including three geographic regions. Downtown Philadelphia is one, and then we have a western area. The largest hospital there is Lancaster in that western, and then a northern region. And that northern region has two hospitals in it. One is in New Jersey, Princeton Medical center, and the other is now Doylestown. That just joined us about five months, months ago.

And so, you know, those hospitals, and, you know, in future years there may be more. There are no plans right at this point, but, you know, that fills in that circumference. And now what we are doing is we are expanding our ambulatory facilities, ambulatory home care, you know, moving out of the four walls of the hospital and moving into large as well as not so large ambulatory centers so that we can provide more and more care in these regions for the communities that these hospitals currently serve.

So our vision is to continue to do that. Currently, we are exploring our opportunities on the ambulatory surgical side. Some of our facilities do have surgical capability, others do not. But, you know, we need to move a bit faster in terms of Taking much of the work that we are doing in inpatient ORs and moving them into outpatient or ambulatory freestanding ORs. Also in terms of growth, something that I would say we at Penn look at it also as expanding access.

Right. And so expanding access requires that we employ bring on more physicians.

And so a very significant initiative that we've worked on for the last several years has been to unify our employed physician groups, our academic group and our regional group.

We call it Penn Medical, Penn Medicine Physicians.

And we are 5,000 deep right now. Yeah, that includes physicians as well as apps extenders.

And although, you know, we have those that are involved on a daily basis in the tripartite mission and others that are in the Penn Medicine medical group that are strictly clinical, like the majority of their time is clinical, just about everyone teaches or does a percentage of teaching. The Penn Medicine Medical group is integrated in terms of work that they do around quality, safety and outcomes. And they also learn from one another, which is really important.

[00:11:34] David J. Shulkin, M.D.: You know, Michele, I think that you're absolutely right in describing the 10 strategic directions have always been deliberate, well thought out and not growth at all, at all stakes.

But you and I who have spent so much time in the Philadelphia area have watched other health systems take a different approach, particularly the for profit systems. And when you take a look at what Tennant did by coming into the Philadelphia area now, I think almost eight out of the eight hospitals have closed.

We watched prospect in what's happened in I think a disaster for the Chester community and underserved population. For those who don't know it, this was a for profit system that recently just closed its hospitals.

How is Penn responding to that? Penn must be overwhelmed with patients. Aren't your emergency rooms jammed with people that just are trying to get care almost anywhere they can now?

[00:12:44] Michele Volpe: Actually our emergency rooms are jammed. Emergency rooms all over our region are just completely full. Unfortunately, when you come into an emergency room today, at least in the region, in the area that I am in, get prepared to wait many hours. That doesn't mean, I mean you're triaged. Clearly if you have something that needs to drive you through treatment very quickly, you know that does occur. But outside of that you are waiting a pretty long period of time. We actually at Penn have not been overwhelmed by the closure of Crozier. We did expect that one of our facilities would be Chester County. Yeah, Chester county does see some additional volume. More of what they're seeing is in the radio and the diagnostics, you know, radiology lab, scheduled visits Mainline Health, one of Mainline Health's facilities is really underwater in terms of what they've had to take on. But it's unfortunate for those patients because something very important depend on is to push care out into communities. And unfortunately, this very large underserved, in a sense, community now has to move out of its local community to get the level and the type of care that they need. Yeah.

[00:14:09] Chris George: How are you thinking about the federal regulation changes and impact on your operation the next year or two in terms of funding reductions? And how do you rationalize that?

[00:14:19] Michele Volpe: So we're worried about it, as are all my colleagues.

How we've been preparing for it is by looking at the opportunities that we have, particularly on the expense side. I mean, growth is something for the last 15 years we have been doing. We have been driving again, not just to grow, to grow, but. But we have grown, obviously against our mission and strategic plan.

But we know that we need the dollars. We know we need the dollars, one, to offset losses, but two, to invest in our organization.

And so what we have done is we've put together a number of work streams under a model that we call the three Rs.

And the three R framework is repair, refocus and reimagine.

And so everything that we do, we call them work streams. But everything that we do, we try to align them under one of the three R's.

And so I'll give you an example of some of the work streams that are underway right now. And they're not work streams that start in January, hypothetically, and three months later.

This is work that is ongoing.

So length of stay. Length of stay has been an issue off and on for years and years and years that all hospitals have to deal with. We've got a pretty significant initiative related to length of stay. And in a minute, I'll tell you how we drive these initiatives. Periops, services, right. Or inefficiency. I mean, it's easy, you know, you know, you've got block time. You've got certain block time that certain surgeons like the best, which is early in the morning, right. But then you've got the rest of the day that's open, right? And so it's easy to have inefficiency in your ORs. And, you know, we have a whole new focus on that supplies.

Penn is large.

One would think because of our scale, that we get the best prices that are out there. That's not necessarily the case. And so, you know, we do have a, an initiative or work stream underway right now where we are Giving all of our vendors opportunities to play with us. However, we are trying to drive this work much more forcefully than we have in the past, and we're doing it through the leadership of our physicians. That's different than how we managed this before.

Our physicians know what they need. They know what they need in the ORs. They know what they need in the procedural areas.

And we are capitalizing on our physician leaders to work with other physicians in the organization to show them, you know, what saving money in this area or that area can do for our organization.

Saying all that consistency of communication.

Because, you know, when you start pushing these types of initiatives, many individuals, particularly across the workforce, feel, oh, the organization just wants to make more money. That actually isn't the case.

We do want to make more money, but we want to make more money to replace what we're going to lose, but also to reinvest and to reinvest in our workforce.

Physicians today have opportunities to go many, many places, right?

To keep them, to keep them challenged, to keep them compensated in a way that they deserve to be compensated.

You have to have the resources and the financial resources to do that.

Our workforce, to develop our workforce, to be that workforce of the future and of the future. The future is here, quite frankly.

But you need dollars to support them. And so, you know, these work streams, which will go on for years and years and years and years, are being led by our CEOs.

And what we've done, or what we do with most of them, is we pair a regional CEO up with a downtown or a Philadelphia CEO, primarily because the cultures are somewhat different and paired together.

They can bring and have brought tremendous value, understanding and value to these work streams as we've been driving through them.

[00:18:54] David J. Shulkin, M.D.: So, you know, talking about financial aspects of running the system and the sustainability of this model going forward with affordability and access, really at the national level, when you first joined Penn, there was a strategy of the system taking financial risk, building a primary care base that would be have a large population, that it would begin to start controlling both clinically and financially?

Where do you see the future for Penn? Do you think that it needs to continue to have financial risk, or do you feel like sticking as a provider system and delivering that care is really where the Penn system is going to continue to excel?

[00:19:44] Michele Volpe: So we will continue being a provider of services as a system now in terms of taking risk, you know, we're not taking risks as a payer in addition to being a provider, right?

[00:19:58] David J. Shulkin, M.D.: Yeah.

[00:19:59] Michele Volpe: Is that in our future?

I would say not in our Immediate future.

Things can change over time.

And so our direction, Penn's direction, is to leverage our research as much as we possibly can.

And leveraging research is very important. And the healthcare system, the hospital system, you know, moved a fair amount of dollars into that research engine. Why, it comes back in spades.

Right. When you think it's. Think of some of the advances that all academic medical centers have had, but particularly at Penn, we've had a number of firsts.

[00:20:37] David J. Shulkin, M.D.: CAR T therapy you've got.

[00:20:40] Michele Volpe: Right? Yeah. And there are more. Right. When you look at the impact of that, the impact has been to the lives of our patients in these communities. And also, at the end of the day, it really reduces costs. It might be more expensive up front, but it reduces cost on the back end. Patients get the type of treatment that they need more frequently the first time around than needing to come back, come back, come back, come back. Right. When you look at some of the advances in the radiation oncology area, you know, in terms of flash therapy and things like that, you know, it reduces the, you know, the amount of time patients have to spend in treatment. That's money.

That's money. On the flip side. And so Penn will continue to support research and in a very strong fashion to be able to couple it with actual practice of patients so that we can bring that research to practice and elevate the care and the lives of the patients that we take care of.

[00:21:49] Chris George: Yeah, that's wonderful. I have to ask one last question.

[00:21:52] Michele Volpe: Okay.

[00:21:53] Chris George: About AI. How are you. How are you thinking about AI and what. What do you see as the biggest use cases in your.

[00:22:01] Michele Volpe: Yeah, yeah.

So we're only at the beginning of this. Right, right.

And in all honesty, our team at Penn is trying to learn. We're trying to learn every single day from our colleagues, a lot, from our physicians, because many of our physicians are really up on a lot of this. They really, really are.

So one of the first things that our health system CEO did was to actually restructure the IS area. Right. And so innovative technology work is.

Our data, scientists, our data have now all been pulled together in a large division. Right.

And so this is a system division.

So it's centralized. That's the importance of, you know, me saying it's division at the. At the system level. It is physician led.

Our previous academic chair for radiology is now heading up this division.

And in developing the structures under him, you know, he's bringing in more and more physicians to do this work.

And so, you know, where is most of our AI work being done right now, it's in two areas.

One is in terms of the patient experience, right? Centralizing call centers, digitizing a lot of what patients have to work through before they get to an appointment or to a treatment.

So we've spent a fair amount of time doing that kind of work. It takes a pretty long period of time. You've got to test this stuff, make sure it's making sense. And it's also expensive. It's not inexpensive, right. At some point in time, it will be less expensive.

The second area is in variation of care, reducing variation of care. And so particularly in radiology, radiation, oncology, these are areas that really lend themselves to AI models to be able to reduce the time that physicians may need to spend reading. But yet a physician does, you know, an overview read or whatever, so is to reduce variation as well as to get it as right the first time as possible in terms of a diagnosis. So I would say that those are the two areas that we are focusing most of our time and our energy.

Now, you take someone like me, you know, I've been asking Dr. Schnall, who heads up this whole thing, you know what? How about if we go out and we buy a bunch of little robots, right? I'd love on the operational side to have a bunch of little robots running around the health system, you know, delivering supplies from our storeroom to the units and whatever. So I think that there are so many applications that, you know, as time goes on, it is going to be a major part of that reimagine that I talked about.

[00:25:00] Chris George: Yeah, that's great. Well, Michele, thank you very much for joining us today. I'm sure our listeners will appreciate your insights and sharing the story, so thank you very much.

[00:25:09] Michele Volpe: Thank you. Thank you.

[00:25:19] Narrator: Alvarez and Marsal, Leadership Action results.

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