Rural Focus
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The Governance Institute

Rural CEO Tackles Innovative Opportunities

An interview with Christopher Dorman, President & CEO, *Southwell Health*, Tifton, GA

TGI: You have a special bond with your organization. Can you share your story about how you became the CEO at Southwell?

Chris Dorman: I've been here for 11 years. When I began my search for a CEO opportunity, I was looking for a place with a long-tenured CEO that would allow for a good handoff period; where my kids could start in kindergarten and graduate from high school in the same community. I had moved around 13 times prior to coming here so it wasn't working for my family anymore. I also wanted to grow something from the ground up, and this organization was one of five I was considering. The CEO [Bill Richardson] had been here for 27 years, and his succession strategy was to work five more years and spend that time doing a thorough transition with the new person.

I couldn't have asked for a better mentor. He's still someone I talk to on a weekly basis, bouncing ideas off of. He is incredibly helpful and values this organization and cares a lot for the community.

When he retired, he agreed to sit on the board, which has been invaluable. He is still a board member today. He doesn't live in our community anymore, but he is very active in his role as a board member.

TGI: Many boards struggle with succession planning for the CEO and senior leadership team, as well as board leadership. It sounds like there was a lot of planning and forethought for this transition. Might someone who has been with the organization for so long, now sitting on the board, hinder or stifle the opportunities to do new things or do things differently?

CD: In this case, Bill has been the opposite. He was a very progressive CEO and is still always looking for ways to improve. He challenges many of the things I do and asks questions. He pokes holes in our philosophy to identify potential gaps. He is not at all stagnant or ok with the status quo. He also encouraged me to do the same of him when he was CEO. He wanted us to bring new ideas and innovation to the table and he was quick to accept questions and criticism of ideas and strategy. He was very interested in what was best for the organization and community.

Organization Profile: Southwell Health

With a reputation as an innovative provider of quality care, Southwell is a growing, not-for-profit health system serving 12 counties in South Central Georgia. Southwell offers more than 135 physicians with expertise in over 30 specialties. Southwell provides a wide range of care, including signature services in surgery, oncology, cardiovascular care, women's health, neurodiagnostics, geriatric psychiatric care, radiology, and more.

The Main Campus is Tift Regional Medical Center, a 181-bed regional referral hospital located in Tifton. Tifton West Campus houses various diagnostic services and the region's largest multi-specialty clinic. Cook County campus is anchored by Southwell Medical, an acute care facility that includes state-of-the-art surgical services and a 12-bed geriatric psychiatric unit. The Cook campus also includes Southwell Health and Rehabilitation, a 95-bed skilled rehabilitation facility.

Mission: to deliver a lifetime of quality and compassionate care for each patient we serve.

Vision: to be the system of choice for exceptional, patient-centered healthcare in every community we serve.

TGI: How did Southwell and your communities fare through COVID and what are the lessons you are taking from that experience to move your organization forward?

CD: We were part of the early wave of COVID. We had an individual who came from the West Coast and brought COVID to South Georgia, so our first wave began on March 16. We became inundated with patients very quickly. We had set up an incident command center on March 7 to prepare and kept it open for several months. We started planning for this when we heard of the first cases hitting the West Coast in late January.

Because of this, we were able to build the resources we needed quickly. We never had layoffs and instead repurposed our staff from elective surgeries and other areas such as perioperative and clinics, and trained them to do things differently. We created "Dofficer" roles[1] to conduct audits of certain areas. They were proficient in the appropriate use of PPE, so we had them do training and auditing of our staff's functions; they helped staff learn how to use PPE appropriately. They became extra sets of hands in the ICU and the ED wherever we needed them.

It was expensive but it helped us with retention because our nurses and respiratory therapists felt safe and they had the equipment and resources they needed to care for their patients. Our turnover rates were low. We did have some, but at the peak of our agency labor we had 102 FTEs in contract labor and quickly brought that down as much as we could. Of those who left to work in another organization, 95 percent of them came back after a short time.

TGI: It sounds like someone knew that it would be important to make that investment up front. How did that plan come about?

CD: The board was incredibly involved. They were receiving daily updates from me and engaged in helping us identify where we had resources, where we needed resources, etc. When we were running short on supplies they would help us find vendors. One of the dentists on our board could get PPE supplies through dental companies that we couldn't get through our typical supply chains. (The dental groups weren't impacted like the hospitals were.)

TGI: You cover a largely rural area and we have been hearing about ongoing continued staffing shortages across the country. Anecdotally we have heard that the workforce strategy is no longer about trying to find the people because they simply don't exist. Some are pivoting to AI and other ways to operate with fewer staff. How has this impacted you once the peaks of COVID died down and as you are looking to move forward?

CD: Fortunately, we were able to maintain a good percentage of our staff as I mentioned, especially in the clinics. As everyone went virtual, some of our administrative support began working from home for other companies. We started looking for ways to optimize and become more efficient in our revenue cycle and IT departments, which were areas where we had more turnover. We also created our own work from home programs to compete with outside companies, as well as to be able to recruit talent from across the U.S. We have allowed those teams to continue work remotely to ensure that we can retain them, and since then we have attracted talent from Seattle, California, and other areas we would not previously have been able to recruit to a small rural community.

1 DOFFICERS' Rapid Response Program, derived from the words: donning, doffing, and officer, was created to refer to trained healthcare personnel who would be responding to requests for PPE training and education.

TGI: Is this remote work going to be for the duration going forward?

CD: Yes absolutely. Many of those departments have exceeded their productivity at home compared to when they were working on site. It is working very well. The engagement level has stifled a bit, but the teams are doing some innovative things now to engage people virtually. They have a garden club that meets virtually, and different athletic clubs and other groups. It's not the same, but they are identifying opportunities to continue with the higher level of engagement that we have enjoyed in the past.

We saw the biggest swing in workforce on the physician side. Anesthesiology became a huge market that has been difficult to recruit and retain; pulmonary, critical care, and hospital medicine as well. They could go work anywhere and make more money. In the past, rural communities would pay more for recruitment, but now the larger cities have increased their rates because they needed the talent, so we are in a continuous loop of increasing salaries. Instead, we created our own internal recruitment pool with a scholarship program to recruit medical students from our communities. I have about 50 students who are coming in with us right now, and we will help them through school and provide stipends for residencies and fellowships. It's an expense to our organization, but at some point we will no longer have locum labor. Then these new doctors will be committed to the community because they are from the community.

Our community recognizes the value of having a large employer. From a future growth standpoint, having a hospital system with the level of service we offer is a benefit the community recognizes.

TGI: That engagement journey sounds like an excellent strategy. Do you see yourself as an anchor institution, to the degree that it is important to keep your communities vibrant as a large employer?

CD: Absolutely. We are the largest employer. We have around 3,000 employees and the second largest employer is the school system with about 1,000. Our community recognizes the value of having a large employer. From a future growth standpoint, having a hospital system with the level of service we offer is a benefit the community recognizes.

TGI: How are you tackling access to care for the patients who are struggling the most?

CD: We are working on expanding telehealth. Technology in our communities and access to broadband remains a huge challenge. Everyone has a smart phone but many of our rural communities have limited or no access to Wi-Fi. We have integrated our outpatient case management group. They will help manage patients via phone or schedule home visits. A year ago, we implemented our paramedicine program where paramedics go to the homes of high utilizers who don't have access to a primary care physician. Those patients are managed in their home and that program has been successful.

TGI: What keeps you and your board up at night—the biggest challenges you need to tackle?

CD: The biggest challenge is Medicare Advantage [MA]. We saw about a 70 percent swing from traditional Medicare to MA, and they are paying about 72 percent of traditional Medicare reimbursement. That has been a huge swing in the wrong direction. Everyone is interested in the aggressive marketing schemes of those companies. The claims denials and payment delays have been terrible. We just notified our largest MA payer that we will be going out of network. The MA programs play by their own rules. Understanding who to admit, when to admit them, they don't follow the two-midnight rule. I will be testifying to Congress on MA and how it affects systems like ours. I think having [affordable insurance] products available for our communities is important, but we have to be able to provide services to those patients and it's not sustainable.

Our board is very well versed in these issues due to their engagement in board education.

TGI: It sounds like you've done an incredible job maintaining financial health while investing in programs to meet the needs of your patients. What kinds of partners are you leveraging to sustain these investments now and into the future?

CD: One of the hardest things for boards and CEOs to recognize is that you can't be everything to everyone. We have sought partnerships in certain areas, primarily around supply chain and purchasing. We have a joint purchasing organization and created our own supply chain company to leverage scale. We have not had to pursue any conversations beyond that at this point. Who knows what the future holds. From a balance sheet perspective, we are in a good position and have made some good investments over the last 20 years. We have a strong foundation. We are always looking at resource optimization. We don't need a large IT shop when the hospital down the street doesn't need one either, so partnering in that manner is an important strategy for organizations like ours that want to maintain independence but still achieve economies of scale.

The Governance Institute thanks Chris Dorman, President & CEO of Southwell Health, for sharing his story with us. He can be reached at chris.dorman@tiftregional.com.