John:

Welcome to Season 4 of Healthcare Rounds. Here we explore the vast and rapidly-evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy in work.

I'm John Marchica, host of Healthcare Rounds. I'm also the CEO of Darwin Research Group, and faculty associate at the Arizona State University College of Health Solutions. Please don't forget to rate and review us wherever you get your podcasts, and send your questions, comments, or ideas for Healthcare Rounds to podcast@darwinresearch.com. Let's get started.

My guest today is Brian Paradis. He is a senior partner with CSuite Solutions, a national strategic advisory firm. CSuite Solutions is led by former healthcare industry CEOs focused on the transition and practical strategies to move the healthcare industry from volume to value. Previously, Paradis was President of Florida Hospital Central Region, a four billion dollar-enterprise with over 25,000 employees and 2000 physicians. Under his leadership, Florida Hospital was the number one-ranked hospital in Florida by U.S. News and World Report for three years running. Paradis' understanding of the role of imagination in organizational leadership helped develop a creative, results-oriented team based on a shared vision driven by a strategic innovation agenda.

So just to kick things off, I always say this through the magic of podcast recording, by now I will have read in your introduction.

Brian:

Perfect.

John:

But tell folks a little bit about your background. From your perspective, give us a little bit on your background.

Brian:

Yeah, so probably background... I always joke people. My first two majors I chose in college were social work and theology and where I ended up was an accounting degree and business degree. And as bad as I think I am naturally at math, managed to get both a Certified Public Accounting certificate as well as a Certified Management Accounting certificate. So who knows where and why life takes you on these journeys. But I always tell people what I think that meant was I learned the disciplines around the business of enterprise, but never lost the heart of what I think it's about, and that's about people.

And then as I journeyed, I think I've learned to look at the world in two different prisms. One is as a finance business, hard core, show me numbers, show me outcomes, show me results, but never losing that that's just one picture of an organization. Its people are the rest of the organization. And so I tend to look at things as well through a strategy map in my head and then adding to that the operational execution. So I think I look at things from a financial window, I look at it from an operating perspective,

"How do you execute this thing?" And then how do I look at something from a longer term vision or strategy standpoint?

And then the second layering or that prism is I've sat on the large medical group side. I've sat on the hospital side. And I've sat a little bit on the Clinical Integrated Network ACO side, although that's still very much early understanding of that. So ran a large operation 20,000-25,000 people, 2000+ physicians, concentrated a market with about eight hospital facilities all functioning as one network with all the things that usually go with a large network. And I think we grew it from a billion and a half to about four billion over my time as the primary operating executive for it.

John:

So we're going to get into your time, Brian, at Florida Hospital, but I feel like I've got to acknowledge, up from, since you're a CPA and a Certified Management Accountant. The first time I went to grad school was at University of Chicago, and I did a joint degree in business and public policy.

Brian:

Nice.

John:

I say the first time because I, like a maniac, I had a mid-life crisis and instead of buying a Corvette I decided I was going to go back and work on a Ph.D. Corvette would have been a better buy.

Brian:

Yeah, much better.

John:

But I just want to acknowledge up front that in my cost accounting class in B school, I got a 37 out of 200 on my final. That's my single worst performance in any class ever, in my life, on any test. That number is burned into my brain. That was back in 1990. It was a lot of years ago. So we're not going to talk finance, we're not going to talk accounting. I'll leave that to your expertise.

So one of the things that really caught my eye and why I wanted to talk to you is not only about the book, which I think, from what I've read so far, is fascinating, but how you were able to turn around, essentially, Florida Hospital. So tell me a little bit about that journey. I know you were with the organization for a long time. What you identified as some of the problems and then what it took to turn things around.

Brian:

That's a great question and probably one you can take multiple pathways, but I'll try to keep it as simple and clear as I can. I think first was if we looked at the organization it was like, I think, many organizations, what I call a some-some-some organization. Sometimes we had a good strategy, sometimes we executed it well, and sometimes we could sustain it. And so I became obsessed with this notion of how do we rethink the organization so it's just not one thing to the next to the next? And so the process I started was just listening. And that was really counterintuitive to me, because what I

wanted to do was do stuff. And so I had a great team around me that really forced me to step back and quit throwing the next idea out and the next push, but really listen a bit.

So I probably interviewed 200+ parts of the organization over a several-month period and began hearing this theme of the strategy changes every week, so by the time we even begin to engage... I thought, "Okay, that's something to park on the shelf and listen to." And then there was this pivotal meeting. I had a group of front-line clinical leadership in the room. And the anger and frustration that was emanating from that circle was just palpable. And I remember sitting there going, "Oh we're in trouble. If this is what's getting portrayed and this is the leadership that we have here in this place, we've got a long journey ahead to try to do something."

John:

What was the anger coming from? What was the frustration that you were getting from the clinical leadership?

Brian:

The way I would describe it is it came out... first I thought they were just angry leaders and angry people. What became very very clear is they were angry because they couldn't do their jobs. They wanted to take care of patients, they wanted to be those leaders with the front-line groups that could deliver on what they were sitting there with their own patients in front of them, but we as leaders were not giving them the tools or resources or processes (and I'll come back to that process word) to do their job. And when I really stopped defending what we were doing and trying to be the slick leader who always has an answer to what's being expressed, I just reflected what I heard. "We're angry because we don't have the way to do our job and we hate coming to work every day failing." And they thought it was some of our responsibility to do that. So I think that was the second thing is quit changing the strategies. Give us the tools and the processes we need to do the job.

And then I think the third one was, "Listen to us. Let us be involved in creating those solutions that we believe will work best at the point of contact." And we realized we have all these things, we would create a strategy here at the top of the organization, and by the time you found it at the place of execution it didn't look anything like what you'd imagined and you had no way of confirming back up that it was being executed against a result with people understanding why we were going to do it.

So I think that's a simple answer. It goes a lot deeper. And maybe the last piece is just understanding that... we use this funny language when we talk about culture. My HR friends, they often call it the soft skills. And it always just bugged me why we called things that I thought were really hard to do, like build trust, and have integrity, and work with people that had different opinions to come to a consensus of what's the best answer, and we call those skills soft skills. And that always, to me, begged the question, "What's a hard skill? Spreadsheets? That's not so hard." Being vulnerable with your leadership group, that's hard. Learning some technical thing to do, pretty easy. Figure out how the budget works, that's pretty easy.

So I think somewhere in there of really focusing on this issue of culture and meaning it, and I think, to me, that was the defining difference of... every executive I've talked to talked about culture, talked

about their people and the value of that. But if I started tracking the decisions being made, the interactions that were being produced, and the result that was coming out of that, it was pretty clear to me we weren't really focused on that. And so that's [inaudible 00:10:58].

And I think that's what led to the core of the book, this notion of people talking about creating culture and coming back to saying, "What does that really mean?" And if we really were creating culture, wouldn't it take something different than our typical business school education about how we learn those "hard skills" and ignore those soft skills?

John:

Well one of the things that you write about in the book, which is called Lead with Imagination. As I mentioned, it's very good. I'm not done with it, but I'm excited to hopefully wrap this up this weekend. One of the things that you talk about is that people bring their baggage, I'm using my words, not yours. But everybody has something that they bring to the organization, which can make it difficult to pull together a unifying culture. Again, I'm paraphrasing. But talk to me a little bit about that challenge.

Brian:

I think part of the thing is with imagination, we start to create a shared vision. So I think part of what struck me was we had to start understanding why we were doing things, not just what I need you to do and more of a command-and-control mindset. You can say, "This is the hill we're taking," and then give people their assignments and it helps, I think, if they know what hill we're taking. But if you just point them in the direction and give them specific instructions you can do it.

In a healthcare organization, several problems suggest themselves. One is they're incredibly complex. And to think that I had the requisite knowledge to be able to guide all of that seemed ludicrous. And yet, there was something in what I watched in a lot of culture that led you down the track to think that's still what you had to do. And so I just broke that model and got used to simply saying, "I don't know." And at first I think that unnerved people, because they're used to this notion of their "hero leader" that knows what to do and knows how to do it. And I tried to just break that a good bit. And then once people began to understand that didn't mean we're not going somewhere, then it opened up the door to really engage people and find that diversity or that differences to go.

Doctors are some of the most well-trained, smartest people on the planet, and yet within our healthcare world you just hear story after story of people doing stuff without talking to the physicians about something that's directly clinical related. So figuring out how to get those strong opinions to the table and corral that a bit and lead it somewhere, I think became, again, this obsession of how do you do that? To me, it started with getting my own ego out of the room so that everyone's voice mattered. And as long as they understood that we were going to go somewhere, then we could figure out how to get there by the collective wisdom of the group. And so to me, it was like how do you take my puny brain and make it much bigger by the additive nature of everyone else at the table who had a perspective.

And then what really gets cool, John, is when that perspective changes someone else's perspective and now you have this synergistic or a virtuous cycle working where you make me smarter, I make the guy

next to me or the lady next to me smarter. And by the time this thing goes around the room a couple times, we've all gotten a lot smarter about what we do.

We used to joke, sometimes we called it the [inaudible 00:14:38] debate. And sometimes it was just the notion of how do we get to the best idea? The only way to get the best idea is to get them all out on the table and then start picking and poking at them until we've figured out what things had a problem, what things were going to hold up and be tested. And if you weren't capable of putting your idea out and getting it trashed, then you had too much of your ego in the room, as opposed to where's the end game we're trying to get to? Somewhere in all of that was a piece of it.

John:

It's interesting, you're using terms like vulnerability, ego, letting your ego out of the way. It sounds like, and you also write about this, the notion of servant leadership, or at least being a component of it, which has been written about a lot. Not easily practiced, I think, because my vision of your typical type A CEO, man or woman, is very driven, the exact opposite of what you're talking... and this not getting political, we aren't even going to go down that path... is in the White House. The image of the strong leader who is confident, who knows everything, who certainly is not concerned about vulnerability because he's never vulnerable. So that's one model of leadership. The way you're talking about is something entirely different. Maybe expand a little bit more on that for the leaders that are listening to this Healthcare Rounds.

Brian:

Yeah, so it hit me. There's a ton of research, as you know well, John, out there about this. And for me it started with something I used to tell my kids. If you want to learn how to lead, just keep a little notebook. And every time you're led by somebody or you observe somebody doing something that you like and that makes you more motivated, makes more of you want to come to work, makes more of you creative in coming up with ideas, then just write all those things down. And then everything you observe someone does that makes you feel diminished, makes you feel unvalued, leave much of you unaddressed or unutilized to a problem, make a list of all that, keep a little notebook.

And I said, "Here's the thing. If and when you ever become a leader," and I would say almost all of us are leaders in some capacity and some place, "then pull your little book out and do the things to other people that you liked being done to you." We can make these complex, but at some level it's really simple. Do that. And what happens, I think, to people is they make this really interesting choice as they become a more senior and growing leader. Will I lead from love or will I lead from fear? And I know that's language that maybe many of you listeners think we're going off some new age tangent-

John:

Yeah, Woo Woo Land.

Brian:

Yeah, but there is a really hard truth as a leader that you only have two choices as how you're going to lead. I'm going to lead from fear, or I'm going to lead from love. And we all see and know when we can feel a leader leading from fear (and you may have referenced some picture of that) or we can tell when somebody is leading from love. And so that, to me, becomes the first critical choice. And it's new

language for us in business. I've struggled with using it. When I wrote the book, there's a chapter called What's Love Got to Do with It? And it is the setup for the rest of the elements of leading with imagination.

Somebody's asked me, "What was your favorite chapter?" And I said, "Well that would be like asking which of my kids is my favorite?" If I have one I'm not going to admit it. They're all my favorites. I said, "But if you ask me which was the most hard one to write or the one I feared most writing, it was that chapter." Because I thought, "Well who am I to talk about love? Do I really want to talk about love in a book that is really trying to be a book on leadership?" And I finally just had to face it. I can't avoid it. As you finish the book you'll notice it's by far the shortest chapter. And it was for that reason, is I didn't want to overplay, and I wanted you as the reader to have the journey yourself of wondering what's love got to do with it?

And I really just said three things. It's hard, for one, to do it, as you've referenced. Two, don't you recognize it when you see it? Think about a teacher that you had through your growing up or childhood. The one that you remember was probably the one that was teaching from a place of love. In medicine, for crying out loud! What's the difference between a physician that is your doctor that you feel a sense of love coming through versus not? Why would we leave that what we know to be true at the door as we walk into being a leader?

So I think that's one component of it. And then the second is, as we become the leader, this thing in our ego I think makes us want to be... like you said, "I know what I need to know. Now I'm the boss. I've got to give everybody direction." And that simple phrase of just being willing to say, "I don't know. Well let's figure it out," opens the door and then models for other people that not everyone else has to know the answer as well. And I think that creates this just incredibly creative space for everyone's best to start getting to the table.

John:

You know, it's interesting when you talk about the chapter that was the hardest to write and the shortest. Years ago, back in 2002 time frame... it was published in 2004. So I wrote a book called The Accountable Organization. Not [inaudible 00:20:54], but The Accountable Organization. And the core bedrock principles, I guess you could say, were organizations founded in integrity, accountability, and trust. Those were the three pillars.

Brian:

Those are really good pillars.

John:

And, so I'll tell you the chapter that was challenging for me, in the sense that I didn't want to come across as being preachy, was the one on integrity. Because everybody wants to say that they have integrity, but it's like, "What does that word even mean?" But you know what, Brian? The chapter that I had the most difficulty writing was the one on execution. And I can honestly say that it's the one area, as other entrepreneurs will also say, they like to be on the front end of things, they like to be on the idea phase of things. You get a rush-

Brian:

Find them at the end! Yeah.

John:

Right. So you get a rush. Right now we have a new study that we're launching. I've got a meeting in about an hour after this, business development. I'm all excited about this new thing, but when it comes to execution, to ensuring that all the T's are crossed and I's are dotted, honestly if I didn't have a good team behind me that knows how to do that, and I can lay out the road map, but that knows how to do that, I wouldn't have had the organization I had before, and I certainly wouldn't have this one now. Because ultimately, you've got to execute. And one of the things... sorry, I got off. I do this often and I get off on a-

Brian:

No, no, no! You're going down a really interesting track for me too, because I think it's core to what I concluded in the end of this, was that there is a lot of talk. And what I watch executives do way too much, is if we can't execute it, let's just change the strategy. And we never really get to the root cause of why we're not executing, and it's often in that culture, like you said, of team. The one thing that you still have to do as a leader, even if you're not the person who's going to run and be the guru of execution, I'll bet your team all know that it matters to you, and that execution is absolutely as critical, maybe more critical, than the good idea that you started with. Because the idea is not worth anything if it can't execute. So I think it's really important and hope you keep writing and keep helping people understand that.

John:

Well, you've inspired me. We'll see if it goes anywhere, but I'm seriously thinking about updating The Accountable Organization. We'll have to see.

One thing I wanted to get your views on, we talked about this a little bit in our earlier conversation before the podcast, and that is how do you apply the principles that you've learned, the principles that help lead to this turnaround at Florida Hospital, to what we're facing now with COVID and what is going... because it's undeniable. Healthcare delivery has probably changed forever. The impact, for example, telemedicine, that's changed forever. How do you apply these principles, what would you do once we at least see a little bit of light, how would you advise a health system in addressing COVID?

Brian:

I'm glad we're getting here. I know when you and I first talked I think it was kind of like... I love talking about the book, and I'm happy to talk about the book. But I think where you and I connected as much, again, as more was on what's going to happen now in post COVID or continuing with COVID and how should health systems begin thinking about this? And again, if we're lucky, there'll be some link from the book in the way you're thinking over to that to do it. But again, I think it becomes that thing of being willing to say, "I don't know," as the first thing in the process. And before running to 20 things, stepping back and trying to imagine what's going on with it.

I'd love to hear more of your views on this, but from where I sit, it feels like clearly we are in something that isn't going to go back. So we're not going to just put the genie back in, virus makes its last hurrah

and we just go right back to where we [inaudible 00:25:40]. I think you're right. And then I think immediately, we've got this problem of volume and growth. How do we now grow back to what we created quickly? I'm with you, it's going to move away from facilities. Some part of healthcare is going to move away from facility.

And I always love the idea that never waste a good crisis. And so I see two opportunities out of this. One, what were the constraints and restraints that we thought we had but never tested? Now we had this ability to test it. And then the second side for me was always what broke? What are the things that we thought we had really robust processes around and now we realize that those broke? Or what assumptions did we make about redundancies and backup plans that also didn't hold in this particular crisis?

I think, in a microcosm, we've got to step back and just forced acknowledge that there's going to be a real growth challenge for organizations coming out of this. The world has been disrupted and won't go back exactly like it was. But then what's this opportunity of redesign? And I think the linkage to the book and imagination is that we have this ability to always think about and bring design back into it.

So I had a colleague work with me, who would stand out front of his campus or hospital and would watch what was happening. And we'd sit there and talk about it and he'd go, "You know, I don't think that what I'm watching happening is what we would have designed." I think there's this opportunity to put our creative selves back in the game here, step back and go, "If I wasn't constrained by this, and I wasn't thinking it was all about this, and I was designing a bit from scratch, what would that look like?" And I think we have some opportunity now to design out of the current business models we had been so used to maybe into creating some new ones.

And again, I think the danger is health systems, and again, I'll just put my hat as the executive sitting in a big building, I think we use those buildings as protection from things. I think we use laws like CON laws and our buildings to keep us from having to deal with the competitive threats that may have been a thing. If you see how many companies right now are doing telemedicine, how many are going to be acquired by private equity and by insurers and others? There's not a constraint anymore the way we thought of getting care by the facility I've got located down the street from you. And so I just think the world's going to be a little bit wild west for now. And for many that's going to be fear generating. But if we approach it back to love and say, "We were really trying to love on our patients and really deliver for them," what would we be designing right now before that?

So that's, I know, a long answer to your question, but that's kind of where I start is just saying growth is going to still be a real challenge. The world is disrupted and we have the chance to redesign some of what we've had. Are we up for that and what kind of imagination, creativity, and innovation is going to be required for that? And in order to do that and sustain it and execute, as you said, then what's the culture we should have or going to need to create? Who's capable of making those pivots and coming up with the ideas and then delivering to our patients and customers something that's highly valuable for them?

John:

Yeah, if we just go back to January 1, let's say, and think about what executives were thinking about, what CMS was thinking about, what the government was thinking about, it was largely, and I've been writing about this for years, is about this transition from volume to value. And getting out of the mindset where we're thinking about procedures and getting more into the value. And of course, the analogy that everybody uses is one foot in the canoe, one foot on the shore. We're still getting paid fee for service, but yet we're still thinking about value.

How that changes from now, my opinion is that what wasn't being acknowledged, or even thought about, was the notion that many health systems had gotten so good at efficiency, that their beds were pretty much so full, they were turning beds like restaurants turn tables. They had gotten that operational model, they'd pushed a lot of things out into the outpatient setting. But what wasn't being addressed was this notion of capacity, that what happens if all of a sudden there is a massive strain on the system on ICUs, on ventilators?

And I think what's going to come out of this is going to be, not necessarily Medicare for All kind of thing, is some larger role of the federal government in dealing with emergency situations. And what that looks like, I don't know. We've seen FEMA coming in and building emergency hospitals on soccer fields and things like that. There's going to have to be some sort of planned preparedness... which, you would think would have been in place already. And I don't know if I'm using my imagination enough, I'm just trying to think about what's the biggest problem and we're still going to be thinking about getting more value out of healthcare. That notion hasn't changed. Certainly the role of telemedicine... people have been pushing for telemedicine for years. Now finally there's a reason to use it and people say, "Hey, this isn't all that bad. It's kind of convenient."

So I don't have all the answers. I'd love to be part of that discussion when we're doing the post mortem on this whole crisis. That's where I came down on it.

Brian:

What do you think you see as the biggest challenge that health systems are going to have to deal with or face in this next round?

John:

I think it is that issue of capacity. It's a couple of different things. One is there is a reliance on outpatient elective procedures to drive revenue. And balancing that against, let's say, Medicare dollars or Medicaid dollars that, in many cases hospitals, as you know, are losing money. And so balancing that out so that they can make their 3, 4, 5% margins. They've got to rethink that because patients, at least from the... I only had a handful of recent interviews with executives, largely because we stopped doing our research for about six weeks because we didn't want to be asking in the middle of a crisis to talk to people about healthcare. So I think there's going to need to be a better balance in terms of how they're working the revenue stream. I think getting patients back into a mindset of feeling safe going back to see their providers. Right now a lot of people are not going for these visits out of fear.

And then the third thing, which again, I don't have the answer for, is how to deal with emergent and capacity issues. It's difficult to say we're going to construct a facility in a matter of days. And certainly

you don't want to run a hospital with 50 ICU beds that aren't being used. So I think those are going to be the key things. And also, related to that, I sort of addressed this, but is getting consumers and patients, letting them have confidence again in using healthcare appropriately and not ignoring going to the doctor when they should be going to the doctor because it's out of fear.

Brian:

Yeah, it's kind of intriguing what you say is how we process. So people may fear that but they'll go to the beach and party without much thought of it. So it'd be an interesting thought how they do that. Something you said really stuck with me. It's this issue of efficiency. If I were back to trying to be imaginative or creative... one of the tricks I like to do is flip things. I'll do it in two ways. One is, within healthcare, maybe a dirty secret, we use the phrase a lot, "Nobody competes for the poor." So I'll flip that and go, "What would it look like, John, if we competed for the poor as a healthcare system?" What would be different in the way that we would organize what we do? What would be different in the way we interacted with those patients? What would be different in the way, back to your issue of value, if we were thinking more in a value as opposed to a volume mindset, what would we manage or do differently with that population than the way we do now?

I used to think of it, if I knew I had $110 million or more of costs sitting in my emergency room from "uninsured" or the less fortunate. So when I do that, how do I redeploy that resource to something much more effective to take care of that population? And as we all know, how do I not transfer that enormous cost unreimbursed over to the business community or the employer community in higher rates? And so what if we were all working towards that?

So the flip side is I just go, "What does efficiency mean?" And I get it, I loved when I would look at my monthly report and see that we were running 80%+ occupancy in my facilities. And then I would go, "Interesting. Is that efficiency?" Maybe that's inefficiency because what if I could get some of that population never to have come because we did a better job of managing their health conditions prior to them needing the beds? What if we had a medical-at-home model in which we would flex our capacity by the ability to take care of more of our patients in their home setting, as opposed to in my expensive hospital bed? What if the mindset of, "I need a big feeder system to keep my large tertiary hub full," was reversed and I worked to push more of that cost out to a more efficient hub out in the country?

I think, to me, that's where we get trapped into our ways of thinking that would let us not be thinking of these new models. And again, you know as well as I do the problem with some of that is that it's not all lined up. So this medical-at-home idea is a really interesting concept, but until liability changes, there's some liability things with that, the payers don't know if it's outpatient or inpatient, how to pay it. So there's always these challenges around it. But I think it starts with opening up our minds a bit and challenging the way we've typically thought about things. We may not get to the perfect answer yet, but I think we start to see things a little bit differently and can approach the problem maybe a little more rationally than we might just head down, do the same thing we did yesterday hoping it produces a different result.

John:

Yeah, I think that what you're talking about, Brian, is at least related to the notion of value in healthcare and some of the population [crosstalk 00:38:23] initiatives.

Brian:

Absolutely.

John:

I've interviewed people on this show who have done partnerships with supermarkets, say for example. Or new food co-ops to eliminate the food desert problem in certain areas. You've got Kaiser out there building housing. You've got Quantifieur installing air conditioners and patients who've got asthma, installing air conditioners in their home. So I think there is some of that thinking, and the question is, being an accountant, being a CFO, how do you quantify those things? It feels like the right thing to do.

I would add, at least on paper, and the press releases and everything else, Geisinger has been advocating for what you're talking about. I saw the former CEO, his name escapes me, but I saw him speak at conference a few years ago and said, "We don't acquire a hospital," something to this effect, "without the intent of closing its doors." We only want the sickest of the sickest of the sickest people in our hospitals who really require hospital care. Everybody else we want to treat them in the community. And at best, be able to treat them preventatively and make sure that they have no reason to be in an acute care setting in the first place.

Brian:

Yeah, that's great. And again, I always try to think about how do I make my circles bigger? The other thing I do is I don't just flip something. How do I make my circle bigger and think from a bigger perspective? Take one [inaudible 00:40:16] in this post COVID world, I think we've learned a lot about interconnectedness and about how if our workforces in the health system aren't healthy and we can't keep them well, how do we serve the larger community? And then I go, "Okay that's one circle. Now how do I make that circle bigger?" What about all the other employees in my community? Can I as a health system have a much better ability to create value into that health system? And today, it always feels like to me the gap is pretty far to get to those employees. Because we go through a lot of inelegant design in order to communicate directly with those employees and work directly with the employer about what they're really trying to accomplish.

So if I think of it, okay now I've got two circles I can open up now. One is we move from health to health and wellbeing. And so there's nothing wrong with those strategies that many people are doing. The problem with them is they're usually not comprehensive, or they're not holistic. They're targeted at one symptom that they see without dealing with the larger whole. So again, in an imaginative world, as a leader, to me, is how do you get things more whole, more systemic in your understanding of it, and then work back to where the lever points that you can create effect?

So I always think, "How do we move from healthcare to health and wellbeing?" Because if we can do that, as you've said, we start to create this byproduct of more value. There's a really frightening statistic by the Milken Institute that only 20% of health and wellbeing is created by healthcare. So if we're going to be in the health business, which every health system I know of has billboards up that try to convince the public that they're in the health business, not the healthcare business. And so if we're going to live closer to that ideal, then how do we get closer to employees particularly, as they have a lot of influence to where we make change?

And then the second is, how do I start to own the message in the medium of getting to those people? So I had a great friend who taught me that in the population health space there's two jobs. One, how do we get the horse to the water, in one sense? And the second job is how do we get them to drink? And 80% of the efforts out there are often directed at the access and the engagement. Go to Google or go to the App Store, there's something like 40,000 apps that are trying to do that access engagement part, but very few people, to your point in your book, which was why I think you do need to update the book from what you've learned in the last number of years-

John:

Fifteen years.

Brian:

Fifteen years. Because how do we get people to drink? And execute is the real issue. It's easy to get people interested, but how do you get that all the way to the execution? And I think the health systems that are going to define themselves in the post COVID world are those that can do these two things: migrate from the healthcare to the health and wellbeing business. And then second, how do they control... in the marketing world we talk about medium and message. And we're all pretty clear we have to control our message, usually. But we can get lost quickly and do we need to control the medium? And I think the answer there is equally yes. Because otherwise your message can get distorted, it can get detracted from, or it can get co-oped through that. And I think of that as the relationship that could exist between a health system and their community, at least initially, via their employers. And how do we have that direct relationship, the ability to not have distortion going on or co-opting that in the medium of getting to that?

So we've got all this message over here at our health system, but we have no idea how it actually flows into a particular employee at a company. And how do we help that company think bigger about it? And I think you may have seen this statistic, and it's frightening, that more important than your primary care doctor to your health is your boss. And so if that research holds up and gets added to, then if I'm the health system managing a "population" how interested and how big does my circle have to get to start thinking about the leadership models within the companies in our community?

And then if we can drive health from there, if I make the circle even bigger, then I'm going, "Wait a minute, what does that look like? Community wellbeing?" And if I can get to that, can my health system actually be helping the community be more competitive across the landscape? Because employees in this community are healthier, and usually the science is pretty clear when they're healthier they're more productive. And if the cultures are built in that ecosystem well, then we're probably more creative and imaginative and innovative to do that.

So to me, what gets crazy is to keep drawing that circle the next bit bigger and going, "What would be different if we were trying to have a different relationship with employers?" And what would it be that we would bring that would be valuable not only to that employer, but then to the larger community that we serve?

John:

Real quick, I wanted you to clarify something. I think I get what you're saying. When you said the person who's more influential on your healthcare is not the physician but your boss, expand on that. What exactly do you mean?

Brian:

I think like I do the Milken report. If we in healthcare think that we're the ones affecting people's health and wellbeing and yet the Milken study is pretty clear, we only affect 20% of that. It's social determinants, it's the environments we sit in, it's the physical location we are. I think in healthcare we have this other learning we're learning is the number one predictor of health is your zip code. And so it's in that mode. So now if I take that up or down a level into an employer, the day to day interaction I sense or feel in my work environment is going to have more direct impact on my overall health and wellbeing than the good primary care doctor that I see once every six months or when I have some condition.

So I think it's in that mode that if we really want to affect the health of a population, we can't just sit on the back end waiting for them to show up or how to be efficient in the way that we treat them once they present with symptoms. We've got to get higher and higher up to the source and understand the systemic view, and the systemic view is that your mental health is very connected to your physical health. And we don't do a good job in healthcare on integrating those two things. We tend to think of one way and have a whole other side show that occurs around mental health.

And then second is as people get down into their communities and the areas where they spend more of their time, if I'm in a toxic environment at work, that's going to show up in some form. Any HR person, I think, typically understands this, they see it in claims that come in a work unit, they can see it in workers comp claims that are done. Some of those are legitimate, but we all know much of that is probably the result of the work environment that they don't like being in. So symptoms show up, whether real or mental health-related, they all end up at the same place. That's what I mean.

John:

Sure. Sure. Well, Brain, it has been a pleasure. I could continue to talk about these topics and leadership for longer. We've actually run a little bit over. That's fine. I don't have a set time that I try to get these interviews done in. I think people will get a lot from our conversation. And I also think that they'll get a lot with your book, Lead with Imagination, I'm giving you a quick plug here.

Brian:

Thank you.

John:

But I think that the issues that you write about are as relevant for frontline people as they are for leaders within an organization. And I like your writing style, too.

Brian:

Thank you for that.

John:

It feels like it's coming from the heart.

Brian:

It is. Thank you very much for sharing that.

John:

Wish you the best of luck, and let's definitely keep in touch, Brian. I enjoyed it.

Brian:

Absolutely, thank you.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Healthcare Rounds is produced by me, Kim Asciutto and is engineered by Andrew Rojek. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems and the global shift toward value-based care. Find us at darwinresearch.com. See you next round!

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