Transcript: The Complexity of Multi-Service Organizations

[00:00:00] **Mark Jarman-Howe:** Good end of life care is about respecting people's lives, um, and allowing people for sort of to live as meaningful for as long as possible.

[00:00:08] **Chris Comeaux:** And you know, we kinda look through the rear view mirror of our life when we start to realize, oh, that might be why I was exposed to that. 'cause now I see people like Mark and Rebecca that have this diversified portfolio and you are just.

We are navigating leadership challenges that are just, they're exponential.

[00:00:25] **Rebecca Ramsay:** The challenge is how do you ensure that all employees feel like they're part of the whole, that they understand that the whole is greater than the sum of its parts.

[00:00:35] **Mark Jarman-Howe:** I think there's so many opportunities that it opens up, and I think at the heart of all of that, it's about building as many possible connections into your community and both taking advantage of those in a positive, ethical way to support the sustainability and the reach.

So it's, it's a really rich tapestry of networks that you are creating as well as maximizing the business opportunities of that relationship with your community.

[00:01:01] **Jeff Haffner - Producer:** Welcome to our crossover show with Anatomy of Leadership and TCN Talks. Now, here's our host. Chris Comeaux,

[00:01:11] **Chris Comeaux:** hello and welcome to The Anatomy of Leadership.

I am super excited today for multitude of reasons. First off, we have a returning guest with us, Rebecca Ramsay, who's the Chief Executive Officer of Housecall Providers in Portland, Oregon. How are you Rebecca? Good to see you.

[00:01:26] **Rebecca Ramsay:** I'm good. Happy to be back.

[00:01:28] **Chris Comeaux:** Yeah, exactly. So, Rebecca's back, so the fact that she's back, there's not a lot of guests that we have on a couple times, but really good guests we do bring back.

And so, but there's something that Rebecca and I talked about in the Green Room and our podcast together and when we talked about home-based primary care, 'cause she has a very unique program. And one of the things I bumped into is that Rebecca has a very diverse organization. There are multiple service lines, and I just said out loud.

Rebecca, I bet there's a lot of leadership challenges. And she said, boy, there are a lot of leadership opportunities, challenges. And then this leads me to our second guest, and this is the first time we've had two people on a podcast at the same time. And so welcome to Mark Jarman-Howe and so Mark is the Chief Executive officer of St.

Helena Hospice based in Colchester, England. So Mark is also our first international podcast guest as well. Good to see you, Mark.

[00:02:21] **Mark Jarman-Howe:** Hi Chris. Lovely to join you both feeling very privileged to be, um, first international guest and get to be on with Rebecca, so that's great.

[00:02:28] **Chris Comeaux:** Yeah. And I tell you what, Mark, we're gonna let you go first and the second I want, what does the audience need to know about you, maybe at a personal level, but why don't first just tell 'em about your program?

Because like Rebecca, you have a very diverse organization that you oversee in England.

[00:02:42] **Mark Jarman-Howe:** Yeah, so it's probably worth just very briefly sort of saying that the, um, the sort of funding model for hospices in England is very different to the states. So, um, the NHS, the National Health Service, which sort of is very much similar to sort of Medicaid, Medicare type programs, funds about a [00:03:00] third, uh, of the cost of providing hospice provision, uh, in the uk.

And then the rest is, um, generated from charitable, uh, sources. So, philanthropy and sort of income generation by the providers themselves. So, St. Helena provides a. Integrated model of hospice and palliative care, which is fairly typical. Uh, in the uk we don't make quite the same distinction and we're not funded on that separation between hospice in the last few months of life.

And then palliative care from the point of diagnosis, we don't really make any meaningful distinction. So our starting point is a very integrated model of

hospice and palliative care, but because of funding pressures that we've been facing, we've taken that a number of steps further. So, we've moved into last years of life.

Uh, we provide a number of other non-hospice services around community nursing, uh, and home from hospital type care. That's nothing to do with end of life care, but plays to the same values and strengths of holistic care. Um, and also because of, uh, the reliance on charitable or philanthropic, uh, sort of income for what we do.

We've also moved into. To some interesting commercial ventures to try and diversify and minimize the risk around those sources. So, uh, as well as sort of hospice care, we have a cleaning company. We have a very large number of thrift, uh, shops, uh, and we provide lotteries and, and a range of other activities as well, including some private care, uh, provision as well.

Um, personally, my background was in the, uh, National Health Service before I came to the hospice, both as a, what you would call a payer, what we would call a commissioner of services, but mostly as a provider in large acute hospitals, uh, but also with some involvement in community services.

[00:04:39] **Chris Comeaux:** Mm, that's great, Mark, and just maybe just anything personal that you would want the audience to know.

One of the things I just loved about you is that, you know, even though in the UK we have such common just values and passion for this work, and so I immediately just gravitated towards that when I met you, but anything along those lines you'd want our audience to know.

[00:04:57] **Mark Jarman-Howe:** Well, I think interestingly when I first got in, uh, sort of engaged in end-of-life care was in my first career, which, uh, I spent the first 10 years after leaving university in prisons, um, working, I should say.

Um, but yeah, I, I, I started on a, uh, graduate scheme as a, uh, uh, uh, in the, the prison service in, in Britain. And, um, one of the projects I got to do in the career was working with people who were gonna spend the whole of their life serving their sentences and therefore, of course were gonna die in custody.

And that really got me thinking about bringing together all these stakeholders across a number of sort of prisons about how do you balance dignity and care with the fact that they also need to serve their sentence, and they need to be, you know, we need to keep the public safe, uh, in how we do that as well.

And that. Just struck me as what a fascinating area in terms of sort of respecting individual dignity and, and, and sort of, uh, understanding the nuance and the subtlety of end-of-life care in a very complex sort of high-risk environment. Um, and all the way through the [00:06:00] health jobs that I've done, long term conditions, uh, you know, palliative care, end of life care has been a sort of a running theme.

And I think what, what really strikes me is all of it comes back to good end of life Care is about respecting people's lives, um, and allowing people for sort of to live as meaningful and as for as long as possible. Uh, and it makes you as a person involved in that think about your own values and your own life as well.

So, uh, hopefully that's a little bit of an interesting, uh, fact. There aren't many hospice leaders in, in the UK with a prison service background.

[00:06:34] **Chris Comeaux:** That's real. That's actually really good.

[00:06:36] **Rebecca Ramsay:** We could learn so much, uh, from just what you talked about. I mean, we need to be doing so much more of that in the United States.

Um, there are some pretty amazing, uh, hospice prison projects or initiatives that are going on. Um, but it, I, I think it's a little bit of a one-off, um, and not nearly probably as prevalent, um, in our country, so. That's [00:07:00] fascinating.

[00:07:00] **Chris Comeaux:** Yep. You didn't know this Rebecca, but it'll be a good cliffhanger for our listeners.

We are actually, the very first prisoner from the Angola project is actually gonna be on our podcast. And so, his name is Steven Gardner. Um, when the new warden had got to Angola Prison in Louisiana, which is a very hardened place, and the Angola project is kind of the, the model, if you will, the law, and you're so right.

They're so far to go in the states. Mm-hmm. But it was kind of the initial, and so he was the initial prisoner that the warden went to and he's got a beautiful story of just his whole redemption of his own life in that program. So, to be coming, that's actually our podcast. Oh, that's great. We're actually taping in a couple weeks, so, so Rebecca, to to you now.

So what do you want our audience to know about you? And then I'm gonna tie this together. Um, there's, I'm just so excited about this 'cause you do, you both have. So much diversity that you oversee as a leader. And I think there are gonna be so many lessons, but what would you want the audience to know, Rebecca?

[00:07:52] **Rebecca Ramsay:** Yeah, so the organization that I'm leading is Housecall Providers, and we're based in Portland, Oregon, [00:08:00] and we serve patients really across the state. But, but our biggest, um, concentration is in the Portland metro region. And we a little bit, um, uniquely from some of the other, um, hospice organizations, uh, nonprofit hospice organizations in the country.

We actually started 30 years ago. We're celebrating our 30th year right now, serving our community, started as a home-based primary care program, which is basically, you know, forget about going into an exam room or a clinic, um, to get your primary care. You actually have a doctor or a nurse practitioner and nurses and social workers, even a chaplain, sometimes a clinical pharmacist who actually comes to where you are.

Um, whether that's in a private home or in a, um, you know, a a some kind of memory care or assisted living facility or senior living community. And we provide comprehensive, uh, primary care in those locations, primarily for [00:09:00] individuals that have mobility challenges, um, or significant, uh, chronic diseases that make getting out of the home really challenging.

So certainly, we don't serve everyone with this model. It's, it's, um, you know, it's expensive. And so, we're, we're really focusing on those individuals that with our care, uh, would not be, you know, maybe using frequenting, frequenting the, uh, emergency department or the hospital for their care. And then, uh, about 15 years ago, we recognized, uh, the opportunity to expand our service model and include hospice.

At that time we were. You know, we developed these pretty intense relationships over time with not only the patient, but with their family and caregivers, and about 25% of the patients we were serving in primary care each year. Would go on to, to die. And, and so we would be referring [00:10:00] these patients after having this very, um, comprehensive and deep relationship with them to an outside hospice agency.

So we thought, well, wait a minute. Why don't we keep them with this family, this, this clinical family that they know and trust? And so we opened a hospice

15 years ago and then that led us to recognize, um, you know, what about patients that are kind of in between those individuals who have serious or advanced illness.

They may have, you know, progressive end stage cancers, but they're not, they're not actually hospice eligible because they may live longer than than the six months, which is what, um, our reimbursement model pays for in the United States for hospice. So we opened a palliative care community-based palliative care program.

Uh, that program is unique because we actually. Serve a lot of low income, uh, Medicaid [00:11:00] individuals in that program. And, uh, we have about 20 20% of the patients we serve in that program are, have housing instability. So our teams are actually quite, uh, used to going out on the streets into shelters, um, et cetera, and serving patients who otherwise would possibly be dying on the streets, um, with very little support.

Um, so we have kind of a national recognition for the, the kind of palliative care team that we've developed in order to serve that population. So that's a little bit about Housecall providers. Um, yeah.

[00:11:40] **Chris Comeaux:** That's really good Rebecca. So that really gets to the point of why I thought this would make a fascinating show.

My guess is you could probably sit here, um, I know longform podcasting, you know the few people that'll listen to a four-hour podcast? Mm-hmm. I have no doubt we could do a four-hour podcast with each other. Um, but we have so much to cover. What I wanted to center that, you know, my job is to be thinking [00:12:00] what's next.

We get so much feedback about you, we love your podcast. 'cause you guys are always pushing the envelope of what do I need to be thinking about? And Rebecca, I give you all the credit. You and I were in the green room and I just said to you, I'm like, Rebecca, that continuum you just talked about, I don't think most people realize that.

That sounds awesome. Let me go do that. But the leadership challenges of overseeing that type of organization. We've gone from basic math to like trigonometry, if you want to use an analogy. I am blessed that, so I grew up in the business world, so K-P-M-G-P work and a Fortune 50 company. The, my second job, the company was modeled after General Electric and most people know who Jack Welsh is.

He's got, you know, all this interesting reputation, what most people do not realize that one of his superpowers was building an organization over a very diverse, um, portfolio of businesses. Yes, the brand was General Electric, but it was a portfolio of businesses and, you know, we kinda looked through the rear view mirror of our life and we start to realize, [00:13:00] oh, that might be why I was exposed to that.

'cause now I see people like Mark and Rebecca that have this diversified portfolio and you are just, you are navigating leadership challenges that are just, they're exponential. And I don't think the lesson is. Mark and Rebecca have challenges that no one else could overcome. That's not the point of today.

Um, they do have some incredible challenges, and if you, what is that? That Chinese term, if you want to go in the journey, ask someone who's coming back from it or someone who has been there, is the gist of the journey. The. And that's the spirit of the questions today.

[00:13:34] **Dragonfly Health Ad:** Thank you to our Anatomy of leadership sponsor, dragonfly Health.

Dragonfly Health is also the title sponsor for leadership immersion courses. Dragonfly Health is a leading care at home data technology and service platform. With a 20 year history, dragonfly Health uses advanced technology and robust analytics to manage durable medical [00:14:00] equipment and pharmaceutical services as part of a single efficient solution for caregivers, patients, and their families.

The company serves millions of patients annually across all 50 states. Thank you, dragonfly Health for all the great work that you do.

[00:14:21] **Chris Comeaux:** It is just a, a perfect place I think that I want to jump into. So, here's my question, and maybe each time we'll have Rebecca go first and Mark go second, and then of course, any kind of comments you guys wanna make afterwards. But what unique leadership challenges arrive when moving from a single service organization to managing multiple service lines under one organization?

So that's my first question.

[00:14:45] **Rebecca Ramsay:** That is such a big question and so important. Um, and I have so many answers to that, but I wanna, um, start with the one challenge that I think sort of stands above all the [00:15:00] others. Um, that to

me feels kind of like a make it or break it, uh, challenge and it's, it's really about culture.

Um, and it, it has a lot of trickle down effects. So the challenge is how do you ensure that all employees feel like they're part of the whole. And that, um, that, that they understand that the whole is greater than the sum of its parts. So to give you, just to make that really concrete, we have three soon to be four individual service lines that are all complimentary.

And, you know, ideally they make up this, um, this really beautiful continuum of care for patients who have serious or advanced illness or, or are, you know, struggling to get out of their house. But what we need is that, as an example, we need every hospice employee. So, a [00:16:00] hospice aide or a case manager or spiritual counselor, or a social worker that works in our hospice line of business should also deeply understand that when they are going into a community, when they are serving a patient in a memory care facility.

Um, and, and working with a patient or a family member, or even a resident manager at one of these facilities that they're, that what they do and how they conduct themselves has an impact not only on the future census of our hospice, but also on the potential growth opportunity or relationship that we might be planning to have with that family or with someone they know, a friend or with that facility, uh, for our primary care program.

Conversely, we need our primary care team members to feel responsible, not just for their own program and how it's growing and how we're maintaining, you know, [00:17:00] uh, panel sizes where they need to be, but also that what they do means, you know, the difference between a hospice. Average daily census of 150 or a hundred and, you know, 10.

Um, because those patients that we're serving in primary care, we hope we will be able to continue to serve them and they will want us to serve them in our palliative care or hospice program. So, it's really about making sure that, um, that everyone understands that we're all in this together and that, you know, everything, everything, each individual employee does matters across the organization.

And that is no, I, I'm sure Mark will agree with me that it is not an easy feat. It's a really big challenge, and you have to be very intentional about building your culture. So that, that's the outcome.

[00:17:56] **Chris Comeaux:** That's very well said, Rebecca. Because it, you know, it's so [00:18:00] interesting you, you're reminding Rebecca, listening to you.

So, um, I was the CEO of four Seasons for a long time before we founded Telio and we had a corporate office and there was just a little road and then our inpatient unit and one of our operation leaders said, you would swear that road was the Grand Canyon, the difference between the inpatient unit and the community based staff.

Mm-hmm. And you're like, you're kidding me. It's just a road. But the reality is right, is that they're working in a different model, but yet they need to appreciate the sum of the whole, but they're living in an individual, whether it's an inpatient unit, um, a maid service in Mark's case. So Mark, I'd love to hear your answer 'cause I'm sure it's gonna be fascinating.

[00:18:37] **Mark Jarman-Howe:** Yeah, and I, I think I'd sort of double down on the, the sort of the points that sort of Rebecca made. I think cul culture comes first and foremost, and I think if you can't tell, uh, sort of a convincing story about how this sort of breadth of service provision, the way I see it is you're building out in order to achieve greater integration for a greater population.

But you need to be able to tell a compelling story [00:19:00] about that that aligns with the sort of the values, the vision, the mission, uh, of the organization. And I think if you can't do that, then I think you struggle with engagement and you'll struggle with sort of bringing people with you. I think interestingly, I've found that, um, often with these challenges, that telling that story internally is often more challenging than externally.

So actually a lot of external stakeholders and partners. Um, are really receptive to new ways of thinking, new solutions, you know, because all the challenges and the issues that we face as providers of hospice care, those challenges, uh, are sort of playing out on an even bigger scale within sort of health systems, uh, as a whole.

And if we think about the sort of demographic changes in our countries, and there's a lot of social issues as well as, um, health issues, uh, Rebecca's already touched on housing. So there's all those other issues that are playing out that everybody else is having to get their heads around. So what they're really interested in [00:20:00] and quite positive about actually, is when they see providers thinking differently and willing to go outside of their comfort zone

and maybe start to find solutions and contribution to those, those sort of wider issues.

Um, so ironically it's easier to get permission with some of those external. Stakeholders, including payers, that maybe it is in terms of bringing colleagues with you. Because one of the downsides of the level of specialist expertise that you often get in hospices is, um, they're so focused on the patient and the family in front of them and providing the best possible sort of holistic care that.

Taking a step back and thinking about all of those patients and families that aren't immediately in front of them, all of that unmet need, um, all of those sort of gaps and, um, problems in the wider, uh, system that, that they could be contributing to, that's really hard for them to have their, their head space and the, the sort of, the time to think about that as well as to really give [00:21:00] that highly personalized, amazing, complex care.

So I, I, I think there's something about navigating that. Some of that is around education and training. Um, I think there are some very practical issues around, uh, workforce and capability and competency that as you broaden the portfolio of programs and services that you are delivering, you need to think about your skills mix and the, um, range of.

Uh, disciplines you've got within your organization, you've gotta think about whether you grow that internally or whether you bring that in from outside. Do you do that through partnership or through acquisition or through merger? Uh, and all those sort of more sort of commercial, um, sort of ways of thinking.

And then I think there's also an implication for your back office and your sort of support services as well that you are introducing another layer of complexity potentially in terms of funding streams and billing and contracts. Um, so I think it's really easy to sort of focus on where our [00:22:00] passion is, which is, you know, integrated, joined up, uh, you know, high quality services for a bigger population.

But sitting behind that is a lot of detail and a lot of sort of commercial things that need thinking through very carefully.

[00:22:13] **Chris Comeaux:** That is so well said. Mark. I, you know, I grew up as a hospice. CEO EOS is probably more like an association, a consulting group, and a clinically integrated network, none of which I grew up in.

And so I, the idea of this was super cool. The devil in the details has been so complex. I wonder what advice you might have just 'cause I'm thinking and putting myself in your shoes, like a lottery service and, and a cleaning service and trying to, to paint the picture of a common cause and purpose of that.

Any tips about that? 'cause I imagine that that's a heavy lift.

[00:22:48] **Mark Jarman-Howe:** It is, but also, it's quite liberating, so it's, um, uh, I, I certainly would advise anyone thinking about sort of diversifying their income in terms of their non-clinical. Sources of [00:23:00] income, um, to do that in a sort of a measured, well researched way.

Um, but having said that, I think there's so many opportunities that it opens up and I think at the heart of all of that, it's about building as many possible connections into your community and both taking advantage of those in a positive, ethical way to support the sustainability and the reach of the hospice provision.

So there's a really strong USP, um, message when we are selling our, our cleaning services to local businesses. This is their way of giving back to local hospice care, um, which they and their family may need at some point. So I think there's almost like a philanthropic message that you are using to generate business for your, um, your hospice benefit.

Um, but also I think you are creating opportunities for. Different conversations and for building death literacy where we talk a lot, uh, in the UK at the moment and at St. Helena, we're really [00:24:00] engaged with public health approaches to palliative care, uh, and compassionate communities, which is all about building resilience, building understanding in the wider community about dying, death and bereavement because then people are more likely to engage with advanced care planning.

They're more likely to have open conversations with their family and professionals involved in their care. And then when they get to the stage of needing palliative or hospice care, you know, they're better set up to, uh, receive that care. And, uh, the providers are better able to understand what they need and want and then build a plan accordingly.

And I think the more you can build those networks and those conversations through a range of different channels, the easier it gets actually to provide the hospice and the palliative care. But there is also an obvious commercial. Benefit because you can then start to cross promote and cross sell across those.

And you would be surprised at some of the connections that we've seen between a customer of, um, you know, the cleaning company then donating directly to the hospice, [00:25:00] or then commissioning us to do some bereavement support training for their staff or one of their colleagues. Then needing access to some of our care and support and them recommending, and that person being referred to us much sooner than they would've done if they hadn't been using us to provide their cleaning.

So it's, it's a really rich tapestry of networks that you are creating as well as maximizing the business opportunities of that relationship with your community. I love that word. It's so interesting. Oh, sorry. Can I just, yeah, can I, I figured, I figured this is gonna be different because we're like gonna be popping off of each other.

[00:25:33] **Chris Comeaux:** This is so good. But just his one word and then Rebecca, I'll give you the rich tapestry is, to me is such a beautiful word. Like, you've created this interesting ecosystem that's crosspolinating each other. Go ahead Rebecca.

[00:25:44] **Rebecca Ramsay:** I just wanted, yeah, I just wanted to piggyback on that a little bit. Um, and say that, you know, like, I'm afraid of creating, you know, thrift stores are more common in the, in that are associated with hospices in the United States, and we've talked about opening a thrift store [00:26:00] and it just hasn't been the right time.

But, but one of the things that we have done, which is just another way at getting at this, you know, broad, um, you know, building that tapestry of networks and actually finding ways to get upstream in terms of the public health messaging and the education of the community. Around end of life, um, is that we, instead of having like a typical fundraiser, annual fundraiser every year, which we, some, we do that maybe once every two or three years, we've created an a community engagement event.

We just had it last weekend where we invite, we host it, our organization hosts it, hosts it, but we invite community partners from around the community that are serving a similar population with different, um, services. So, for instance, uh, there's an organization that, that is called store to Door. And they, what they do is they go [00:27:00] grocery shopping and then deliver meals to elderly people that can't get out of their home.

Um, we have a number of other services that are not directly healthcare, but that are really sort of, you know, adjacent to what we provide and we all get

together. And we put on this event in the middle of the summer in a park where communities are bringing their kids to go play at the playground. Um, we advertise it on the morning shows, on a couple of radio, uh, programs.

And so we get, you know, we get our network, our direct network of patients and families that know us, but we also just get the public coming through. And there's, there's this, um, area called Nonprofit Row where all of the, uh, organizations are community-based organizations, set up a tent with educational material, and they're there to talk to people who are just walking by.

And it's been great. It's been growing each year and it [00:28:00] really does change the conversation and it just helps us to, um, make sure our community knows that we're here for them and that, you know, it's not just about one single organization, it's about all of these organizations coming together to support a population that really can be invisible at times.

[00:28:20] **Chris Comeaux:** Um, that's so well said, Rebecca. In fact, I, I keep going back to this word that, that Mark said of like a rich tapestry. The other word that's coming to me is an ecosystem. And so, and I'd love that 'cause that's always been the heart of hospice, is collaborating with the community. But what strikes me is that though you both made bold moves of, but this part of the ecosystem is the part that we need to own, lead, et cetera.

So that maybe leads me to the second question. How do you, how do you balance then the mission, the margin, when you have different service lines, different payer mix or economic models? Different regulatory frameworks and then different operational demands. [00:29:00] Uh, I'm fascinated to hear your, so maybe Mark this time you go first then Rebecca, you go second.

[00:29:04] **Mark Jarman-Howe:** Yes. Yeah, I mean, like Rebecca said in, in response to the first question, there's so many things you could say about that, but I think at the, at the heart of all that, the, the pitch when I came into this job, sort of CEO at St. Helena was, um, unmet need. That was the thing I was passionate about there, there was no doubt at all that people that were lucky enough to be referred to, uh, St.

Helena Hospice were getting amazing care and support, but the organization was not taking responsibility for people, not lucky enough to be referred to it. And just that sort of mindset shift about, okay, let's not compromise our, our care and our quality. And we've doubled down on our compliance and our education and our training and you know, how we develop that expertise in-house.

But actually let's spend as much time and effort on thinking about how do we proactively identify the population that's out there. Um, we now use population approach to end of life care as the way that we describe that, which is a [00:30:00] sort of value-based a CO type way of thinking. I would love for us to be funded as an a CO for this, uh, end of life population.

Sadly, that that's not happening at the moment, but it hasn't stopped us acting as if that were the case because it's the right thing. For people with those needs. So what we started with was proactively identifying people in the last year of life in the geography that we serve as a hospice, working with a range of other health and care partners to share information and to, to negotiate information agreements around that.

We did a whole host of engagement with users of services, with family members, with uh, residential care homes, uh, with uh, family doctors, with hospital doctors, et cetera. And we came up with 10 outcomes that matter most to people and their families in their last year of life. And we started to build a dashboard where we were pulling information from all these different elements of services that they were interacting with so we could start to [00:31:00] understand.

How far away were we from an optimal model of meeting all of the needs of everybody in the last year of life in our area? And of course, we are never gonna get there in terms of, um, delivering that for everybody, but as, as a way of focusing people's minds and aligning strategies and resources within a particular health system.

It's been hugely powerful. And because we were very successful at mobilizing that engagement and getting people excited and passionate about that, what we found was we were getting a lot more people referred into our services. Unlike, uh, you guys, sadly, that doesn't mean more money coming in. It just meant that our costs were going up and we were having to work harder to close the gap.

So that then almost meant that we had to go looking to diversify how we develop our income. So that's where we started to diversify on two fronts. One was starting to bid for and win what we would call contracts, but programs of care that are not hospice. So, community [00:32:00] nursing, uh, elements of some of the primary care provision in the home that Rebecca's talked about.

Um, a lot of the home help and the personal care in the home. What we talk, talk about in terms of social care, you know, we delivered a lot of services home from hospital bridging support services, and all of that has been complimentary

to our skillset. We've been able to bring a lot in terms of our values, our ethos, our skills, our holistic approach to that wider population, but it's also generated a margin.

From those programs to reinvest in our mission to achieve the population approach. And then at the same time, we've diversified our commercial income streams. You know, our cleaning, our lottery business, we had a arts and crafts business doing after school clubs. Uh, you know, but again, all with a, a mission to build relationships at the same time as generating a profit to come back into the hospice.

So almost by starting with that population approach, we had to then think differently. And then it's just sort of [00:33:00] almost evolved quite naturally from there. And it's given us quite a broad portfolio, which is challenging, but also means that you've got lots of opportunities. And when one thing may be the wider circumstances are not right for that to progress.

Something else, there will be an opportunity. So you've always got something where you feel like you're taking steps forward.

[00:33:20] **Chris Comeaux:** Man, that's so rich. I'll make one comment, Rebecca. I'd love to hear your answer as well. But what strikes me, Rick, is listening to you is America kind of happened the opposite way and hopefully my peers won't throw something at me in this podcast.

We got a good reimbursement, I won't call it a rich reimbursement, but we had a good reimbursement and then we diversified with more community services that maybe there wasn't reimbursement or there's definitely a lost leader. But now that our reimbursement's becoming challenged, a lot of our peers throughout the country are going, well, maybe we can't do that community bereavement the way we did it before.

Because all of those things we chassis were more loss leaders 'cause it was the right thing to do for our community. Yours went the [00:34:00] opposite way. It kind of feels like, as you've described it. Yeah. How do you balance the mission and the margin when you have different service lines, different payer mix, different economic models, different regulatory frame frameworks and different operational demands.

[00:34:14] **Rebecca Ramsay:** I think for our organization, what we have done to try and balance all of those is again, really focusing on our organizational culture and developing values and behaviors that all of our employees can

connect to, and that reflect the mission and the vision of the organization. And then keeping processes and expectations, um, really well aligned with those values.

And always keeping the patient the focus regardless of the service line. So for, you know, one of the biggest challenges, um, for us, and I know, um, this is probably, you know, similar for you, Mark, um, certainly, uh, [00:35:00] Teleios will understand this as well, is really keeping our workforce, um, stable mm-hmm. And resilient and.

It's one of the biggest things that we actually compete on, um, in our Marketplaces. So we, we, you know, we have in many of our programs, we have more patient demand than we know what to do with, which is great. Like, that's a, that's not always the case. But, um, we're really fortunate. The problem is it's really hard to find workforce, um, particularly after the pandemic.

It's just been so challenging. And so I really think about, um, the benefit of our organization to the community is about how we treat our, our, uh, staff, how we keep them resilient, how we keep them focused on the patient and inspired to do the work and resilient to do the work. Um, so I think, you know, that's the, that's really how [00:36:00] I look at this challenge is like, I wanna be the place that healthcare, um.

Healthcare workers in our community come to because they recognize like, this is a place where I can, I can breathe, I can do the work that really matters to me. I can continue to stay inspired. Um, and, you know, having the multiple service lines actually does benefit employee resilience because we have many examples of hospice nurses who have decided that, you know, I'm, I'm a little tired.

Um, and, and, you know, hospice work is, it's really challenging and you're dealing with a lot of loss. And they have decided to move to our primary care program where they actually have, you know, more patients to serve, but they're, you know, they're with those patients longer and it gives them a break from some of that end of life.[00:37:00]

Bereavement, um, that can get really heavy. Um, so I think, you know, there's, there's a lot of strengths in having as Mark suggested, and having the diversification both financially but also around employee resilience.

[00:37:14] **Chris Comeaux:** Um, that is excellent. Yeah. There's so many, there's a couple things in just pearls in what you just said, Rebecca.

I wanted to go back to one of them. You were talking about the processes and trying to keep some consistency. Is there a flip side to that? There's a whole school of thought about disruptive innovations versus sustaining, and you have to be careful putting the chassis of a more mature business on a more emerging business.

Have you found that subtlety that you want some consistency, but you have to be careful, it's not completely consistent 'cause of the different businesses at their very lowest common denominator or not the same business. Does that resonate?

[00:37:51] **Rebecca Ramsay:** Yes, absolutely. Um, yeah, I think for us the, the, one of the biggest challenges, um.

You know, in maintaining this, um, holistic culture is that the patient populations, the regulatory frameworks, the revenue models, the staffing ratios have to be different. Um, at least now the way we're paid and the way we're, you know, we're, um, held accountable by CMS, et cetera. And so, these, these little mini cultures kind of develop.

Um, and we've had to really think about like, is that okay? Is it okay for there to be, um, you know, in hospice, I'll just use an example in hospice, I think most of us are familiar with, like, you sort of, I mean, these are, these are individuals that are. That are experiencing, you know, the last days of their life.

We, we have this bend over backwards ethos and hospice. You know, and I think this is pretty common where, you know, you'll, we'll pretty much do anything that is, you know, within reason to create the highest quality of experience in our hospice. Um, you know, we will, we will, we will bring in VR goggles, you know, for a hospice patient to help 'em experience, you know, being at the beach.

If they've never been able to see the ocean, like we will do, just go really out of the box thinking. We'd love to be able to do that in primary care, but we're taking care of, you know, 200, 250 patients per provider in that program. And in order for them to create that kind of access, you know, they have to see six to eight patients a day.

And you know, this many visits per month and. They just can't, they can't do everything. They have to have boundaries. They have to, you know, we have to talk about it. We have to talk about what can we and can't we do. And it differs across service lines. Um, and really that's all about, again, the, the regulatory

frameworks, the, um, the [00:40:00] really primarily the revenue model, et cetera.

So, you know, it's just, it's something that we have to talk about and think about. And then we have to also identify what are the areas where we really, we can gain efficiency by standardizing and cross training. Um.

[00:40:15] **Mark Jarman-Howe:** Can I, can I just come back on that? 'cause I, I think you, you articulated that so well, Rebecca, that really resonates.

I think one of the advantages of diversifying is at least it gives you the option to, you've got agree, couldn't agree with you more. Each service line or program has, has got to stand up on its own merits and has got to fit within its own regulatory framework and meet its own standards, et cetera. I think there's an opportunity if you've diversified well to maximize those economies, particularly in the back office and in some of the support roles, but also in terms of protecting the workforce as you were talking about.

Without resilience, you can use it as a way of keeping good people in the organization. If you're having to be more efficient in one area, you can still keep hold of them by reutilizing their [00:41:00] skills in another area so you don't lose them entirely. But also, I think potentially if you've got, uh, income from a number of different sources, you can soften those boundaries.

[00:41:09] **Rebecca Ramsay:** Yes.

[00:41:09] **Mark Jarman-Howe:** At least they're semi-permeable. So, uh, whereas other providers maybe wouldn't be thinking about that and would be, you know, much more about each area delivering. I think we've got an option if, uh, with our values and with our vision to actually do some creative stuff around the margins, which I think potentially for profits wouldn't be thinking about doing.

[00:41:27] **Chris Comeaux:** That's well said. Well, Mark, then let me ask you the next question. How do you cultivate leadership and management capacity, and maybe I should say competency as well within your teams to handle such a diversity of services? Without burning them out.

[00:41:42] **Mark Jarman-Howe:** I think that's really tough and I think I have to hold my hands up and, and say at times I've, I've, I've, I've run things pretty hot, uh, and relied very much on, on people's sort of commitment to the patient and

the family to sort of see us through some sort of difficult periods where we're adjusting to taking on new services and [00:42:00] stuff.

I think, you know, there is risk involved in the things that Rebecca and I are talking about. There's no getting away from that, and sometimes you have to rely on goodwill and people's commitment to get you over a hump, uh, and to get you through an early stage, or at least I have not been clever enough to find a way of not falling back on some of those things.

So some of that comes back to the, the, the vision and the values and how well you've conveyed that. So hopefully you've got people that buy into that and for a period of time are willing to to, to give it a go and to try and make it work as long as you've got a clear. Plan to stabilize and, and, and sort of secure that going forward.

Um, I think investing in training and education is, is something that's so important and rotating staff, uh, both, uh, across programs but also across organizations where that's possible as well. Um, we have a similar situation to what Rebecca said about robbing Peter to pay Paul and people bouncing between the hospital and community and primary care and hospice.

And actually the [00:43:00] more we can do that in a joined up way, where actually we're enhancing the skills and the experience of those individuals. So, our doctor trading program, for example, involves hospital and primary care doctors coming through and spending time in the hospice, which enhances our workforce, but also.

Um, takes away that mindset into whatever specialty they end up working. You know, they've got that palliative care knowledge to fall back on. Um, and then I think there's a commercial reality around this as well. So sometimes you've got to bring, uh, new people into the organization. You've got to get new people onto the bus.

Uh, and then it's about building those relationships and about talent finding and about, you know, whether you can identify the right people that are gonna be got the right values. Um, to, to adapt to a hospice palliative care environment, but maybe bringing a different skillset and coming from a different sector.

And I think that's something we've been really successful with at, at St. Helena. So, leading our clinical program now is not a palliative or a hospice professional. It's someone that started off in a primary care role and we wanted that different perspective to challenge and be a critical f friend within the team.

So I think sometimes the way we've approached that is consciously to bring people into the organization with a different perspective, with a different skillset, but with the same values.

[00:44:19] **Chris Comeaux:** Rebecca, I know this is an area you've given a lot of thought, um, and just you know, how to, how to do the culture thing, how to get your managers, your leaders prepared to navigate a much more complex environment, just a mono focus than a just mono focus hospice.

How have you done it?

[00:44:35] **Rebecca Ramsay:** Yeah, I mean, I would agree that with Mark, that, you know, I've had times where I feel like a complete failure, um, at this, it is one of the things that I feel like I spend a lot of my waking hours worrying about. Um, my approach has been related to, to the structure of our leadership team.

And what's been most effective, uh, is to have these different tiers of leadership. Um, and to be really, um, really intentional about roles and responsibilities at each tier. So, we have an executive team of organizational officers that work across all three service lines, and those individuals have a lot of experience, um, in leadership and actually have a lot of clinical experience and understanding of the three service lines.

Below that, we have service line directors who are responsible for program strategy, finance, and a lot of external relations related to their specific, um, service line. And then we have service line managers who really focus on executing the operational strategy and the program supervisors then who support daily operations and HR functions.

And then recently we added another um, level, which is a system [00:46:00] of, um, of program or service level leads. We call them like hospice lead or a primary care lead. And they're focused on providing mentorship. So, they don't have, uh, HR responsibilities, which kinda levels the playing field, but they have more experience than maybe some of the other, um, clinical staff.

And they provide mentorship. To the frontline staff and they help with onboarding new staff, which then all this structure relieves each level of having to do all of that, right? So, I think it gives the staff a feeling of like, I, I don't just have one supervisor who also has the ability to hire fire, you know, do performance manager.

I don't just have that one person that I can talk to if I'm struggling or if I need, you know, a new idea or support in some way. Um, and then it, it also cultivates skill development among our leaders and can [00:47:00] create a career ladder opportunity. The other thing that's been really important is that in addition to that structure, we also have managers and directors that are, um, supporting like more centralized, um, functions that are.

Not exactly standardized, but we get economy of scale by creating like, for instance, a quality director, quality and population health director that works across all, um, three of our clinical service lines. And IT support an IT manager and Marketing, uh, business development communications director. So those individuals are become pretty sophisticated in understanding all three service lines, but they're not experts because what they do is they collaborate with the leaders in each service line to make sure they have the right content knowledge, but they actually then remove a lot of the [00:48:00] like actual heavy lifting in those functions from.

The directors and managers and supervisors on the service lines. So that's kind of how we've, wow. It's really been about structure. Um,

[00:48:11] **Mark Jarman-Howe:** it's a shame we're not doing the four-hour version 'cause it would be great to get our organizational charts and talk about the, the similarities and differences That Brilliant hearing you talk about that.

[00:48:21] **Chris Comeaux:** I agree. In fact, we're gonna absolutely have both your contact information. 'cause I have a film and people are gonna want to follow up. Rebecca, that is absolutely brilliant. How long, like what of a runway, because I could see like that playing out. Has that like been a three-year period a much shorter runway?

[00:48:36] **Rebecca Ramsay:** No, it's taken about eight years to put that in place. Okay. Wow. The entire time I've been CEO It was a, it was a really big problem, um, when I came on. Um, there just, there just wasn't enough leadership support at all to be honest. Um, so it's expensive. I mean, I think that's the other thing is like, it, it, it [00:49:00] requires the business.

We, we had to grow. To and bring in more revenue to be able to support this. But I just, I wanna say in case any of my leaders are listening, and I say this probably at least once a week, but I, I do now have the most incredible leadership team. And they are, I mean, they are everything. You know, I can actually go on vacation and be completely disconnected from my cell phone and

I know like they will support the organization and if one of the leaders is struggling.

You know, they, they help each other, you know, it's just, it's, it's really a family and, um, but it was, it, it took, it, it took years.

[00:49:40] **Chris Comeaux:** Wow. Well, Mark's so right about, there's so many rabbit trails. We keep going, but I, I wanna, we've got about another 15 minutes and I wanna really hear from both of you on this question.

So maybe Mark, if you'll be prepared to go first, if you were advising a hospice, CEO, let's say, UK or stateside, considering of going, man, I love what they're talking [00:50:00] about. I want to create this beautiful continuum, multiple service lines myself, what's the mindset shift they need to make and maybe one or two or three practical steps that you would recommend to them?

[00:50:12] **Mark Jarman-Howe:** So I, I think the mindset shift is just being clear about the intention. Behind that. So, so even if that's a sort of an interim goal, what is it that they're hoping to achieve by making that step? What is it that they're inspired by to want to think, okay, I want to do something broader? Is it focused around the sort of the, the workforce piece?

Is it around the, the financial resilience and the, the sort of commercial diversification? Or is it as part of a step towards sort of a CO or, you know, a better approach to a particular population? I think then you can sort of break that down into, you know, how do you eat the elephant? You can, you can then start to sort of break that down into sort of manageable, bite-sized pieces.

So I think, I think that's important. Um, I think in terms of practical steps, I think having a buffer, a financial buffer [00:51:00] is absolutely key. Um, uh, because. You know, unless you're very lucky and things fall into place really well for you, you're gonna have to invest upfront to be able to realize the opportunities.

So being clear about, um, what you can afford to do in terms of the, the level of risk and the risk appetite of your, your board, um, I think is really important to get that clear upfront. And then I think, um, the, the sort of the talent and the skills side of it and the, the sort of the leadership team, um, and whether you've got the in-house, uh, potential to develop to make that happen, or whether you need to partner or bring in someone new to take that forward.

I think those would be the sort of first steps I'd advise thinking about.

[00:51:42] **Sona Benefits Ad:** Good employers know that health benefits can make or break your business, but while employers are looking out for their employees best interest, who is looking out for theirs? Sona Benefits is an independent pharmacy benefit manager who partners with employers to optimize their pharmacy benefits while [00:52:00] supporting their business goals.

But by offering no spread pricing, contract, guaranteed rebates, and the Sona Max program clients are regularly able to save 20% to 35% off their total drug spend. The result pharmacy benefits that improve employees wellbeing and employers bottom line.

[00:52:21] **Chris Comeaux:** That's really good. Mark, Rebecca,

[00:52:24] **Rebecca Ramsay:** I absolutely agree with you.

Related to the, um, the hiring potential, I think one of the, one of the biggest pieces of advice I would give a hospice CEO, who is diversifying into, let's say, home-based primary care, um, don't assume that your leaders, uh. Are the right leaders to do both. Um, I think, uh, I think bringing in some kind of expertise, even if it's a co, you know, a consultant, um, just giving.

And I also think that, I mean, if you do it right, that will help your [00:53:00] leaders not feel completely overwhelmed and, and stretched thin. Um, they're different enough, uh, in terms of compliance and, and, uh, quality and most importantly revenue and the, the payment models that you really need that expertise. Um, the one thing that I think I would also say is that, um, you know, once you start developing these other service lines, um, you really have to intentionally think about how to foster understanding and empathy between the service lines, um, because they are different enough.

That, that mini culture, um, concept that I brought up earlier can get, um, can become damaging, um, if you're not careful. And so we've been very intentional about exposing [00:54:00] all of our service line leaders and staff to the other, uh, to all, all, um, service lines and, and really even like the structure, how the structures are different and how the payment models are different so that they understand why, you know, primary care can only spend 30 minutes with their patients and hospice can send spend two hours.

Um, what is it, what is, what's underneath all of that that makes it important? Um, one of the things that we do in our monthly leadership meetings, and this was really the brainchild of our, of my COO, um, is that we have this template

that we ask our leaders to follow. When it's their turn to report out on their specific service line.

And the template asks each leader to describe not just what they're working on in their respective area, but what the general feeling is among their staff, what wins or insights they've recently had, [00:55:00] what accomplishments have occurred, what they're concerned about, and what barriers they're experiencing.

And this has led to generating this really authentic dialogue between the leaders, um, and some of the, you know, even the, like supervisors and managers that results in a, just a better overall understanding and empathy across programs.

[00:55:22] **Chris Comeaux:** That's so good. And a follow up question, and e either one of you or both of you could actually take this, Rebecca or Mark, I wonder Chicken or egg, like if I have a business idea.

Do I then go find the leader or do I find the perfect leader and go find the business idea? Is it the chicken or the egg? Sometimes. And then the second maybe question anyone you wanna take is, I bet your dashboards are fascinating across these multiple businesses.

[00:55:48] **Rebecca Ramsay:** Yeah. Um, may Mark and I may differ, you know, Mark, it sounds like Mark, you have an entrepreneurial background a bit more than I do.

So I would, I would actually think [00:56:00] strategically about what business line makes the most sense to expand into. And then I would go look for the leader. What about you?

[00:56:07] **Mark Jarman-Howe:** Uh, I'd, I'd, I'd say have the chicken and the egg. I love that answer. I've certainly done both and both can work. Um, yeah. And then what about the dashboards?

[00:56:20] **Chris Comeaux:** I'm curious for both of you, Mark, why don't you go first? Like so many, like, you know, a office cleaning business compared to your hospice program compared to your, what I would call kind of nursing in the home business. Do you have very diverse scorecards and they roll up or they're just very much managed at that local business level?

[00:56:38] **Mark Jarman-Howe:** Yeah. And some similarities to what, uh, Rebecca said, uh, sort of described actually. I think that there are some sort of very tailored KPIs and, uh, requirements and, you know, some of the sort of

commercial underpinnings of the businesses are quite different. So, the reporting does need to reflect that. But then there are elements that do feed up into overall [00:57:00] conversations.

And when we are. Doing our sort of performance management and our financial reviews, we very much bring all of those leaders together. So, you've got all of your professional support services, um, you've got all of your, uh, fundraising, philanthropy staff, uh, you've got your commercial non care business leaders, and you've got your different, uh, program, uh, clinical leaders.

They're all coming together when we are doing our business planning, when we're doing our budgeting, when we're doing our strategic planning. Um, because we want them to have that awareness of what's happening around the organization to do the cross promotion, but also because, um, I think what we're increasingly find is as you diversify the next phase of diversification gets progressively easier.

And really what you're looking for is new magic windows of opportunity that emerge from the areas between your different service lines.

[00:57:50] **Chris Comeaux:** Ooh, that's a key point. Well, Rebecca, lemme ask it to you this way. 'cause I, I'm reflecting, I've been in a meeting this week, one of our very diversified hospices we work with.

But here's the interesting thing. When hospice pays the bills, it gets the airtime on the KPIs and the planning and then everything else. It's not an afterthought, but it's got potentially that risk because the main economic engine is the one that's paying the bills. But this interesting, you grew up a much different way.

You didn't start off as a hospice. I'm curious your answer to the dashboard, KPI, question.

[00:58:22] **Rebecca Ramsay:** We have a lot of dashboards, but we have one dashboard that's, we call our executive dashboard that the most important KPIs, um, from each service line roll up. And it's the executive dashboard, which I use with my board.

Um, and also my executive team has, as an example, has revenue expense, cost per patient, um, revenue per patient, all combined. So, you look at that first, which I think is intentional. I mean, it's just intentional at that level of our board and our executive leadership team, it's like we gotta look at the whole, the whole is what is what we're really focused on.

And then it drops down and you see those various KPIs for each service line. So you can see sort of what's contributing to the whole. But we always start with, with the whole organization. Dashboard. Um, the other thing that's really important to us is our engagement survey results. Um, we do a, an annual engagement survey across the entire organization.

And, um, I can see how the organization as a whole is performing, but I can also filter that by not only just each service line, but I can look at disciplines. So I can look at our nurses, I can look at our social workers, I can look at our physicians, I can look at our aides, I can look at our office staff.

I can also look at what's happening in leadership versus frontline staff or what's looking, what's, what's, how are engagement results for people who've been with the organization just a year versus those that have [01:00:00] been five years or, or more. And so because workforce is so important to us, um, we really focus a lot on our engagement survey results, um, and our turnover stats.

So we can do the same with turnover. We can look at where are we. Having more of a, an issue with turnover. And, and, and then, you know, what's great is because my leadership team is so close, then they can share, you know, tidbits about like, okay, when we had that challenge with turnover, this is what we did.

And it seemed to really help.

[01:00:30] **Chris Comeaux:** You're, you're both just like, I'm just, we're sitting here reflecting, you're both like a, a deep book and I'm just having to skim over the surface, and that sucks because you have so much to share. So, in that spirit, um, maybe Rebecca, you go first, final thoughts. There's a lot that we've covered in a short period of time.

I'd love to hear both of your final thoughts and maybe advice to those that are listening to the show.

[01:00:52] **Rebecca Ramsay:** Yeah, I think in summary, uh, you know, we've, we've been very transparent and authentic about how complicated it is to run, um, an organization with multiple service lines. In the end, the positives and the strengths that weigh the, the risks.

I, I really believe it is the right way. To run, uh, uh, advanced illness practice, um, in this day and age. And I think it makes us stronger. The diversification of revenue is just one part of that. I think workforce resilience, I think, um, innovation, creativity, I think brand. I mean, we are, we are definitely very

unique in the Marketplace and it's a differentiator for us to be able to say that we actually provide a continuum of services.

You know, that starts with primary care, palliative care, hospice, and now we're actually starting to develop a, um, more of a point of care testing line of business [01:02:00] where we're supporting one of our payers and going into the home and getting some of the gaps in care, clinical care. So we're using, um, I. We actually just purchased, uh, mobile, um, DEXA scanners.

So we can go into, um, individuals homes who've had a fracture like older adults, um, primarily females who've had a fracture and we can actually do, if they can't get out to get their bone scan density scan done, we, we can do it with a mobile device. We're doing retinol, um, exams, uh, retinol eye, diabetic eye exams, also with, uh, mobile device.

So we're, we're starting to develop that. And again, like for me, that was, um, very intentional look, looking at what the gap, I think Mark talked about this, like what are the gaps in, in care that we could fill? And we learned about those by serving the population, understanding like they can't get out to get their, their, um, retinopathy because they're.

[01:03:00] Mobility impaired or, um, wow. So anyway, I, I took a little, uh, yeah,

[01:03:05] **Chris Comeaux:** I think that's actually a good one. That's a really good one. And I love

[01:03:08] **Rebecca Ramsay:** took a little road off, but Yeah.

[01:03:10] **Chris Comeaux:** But that, I think, I mean, imagine, does the word innovation, like just very fluent in your culture, Rebecca? Or is there a different way you describe that?

Focusing on the patient and, and then what results in what I would call innovation? Do you talk about it a different way?

[01:03:23] **Rebecca Ramsay:** I, I think we talk about it in a number of ways. At the leadership level. We probably talk about it, um, related to clinical innovation, but I think the, the, at the more like direct patient level, it's more about like what gaps are you identifying?

Um, where are your patients not getting care that they need?

[01:03:42] **Chris Comeaux:** That is actually a brilliant answer at some point. I'll tell you about Tom Foster, who's been in our show a couple of times in your, your lexicon of levels of work is a whole body of knowledge and very few people know what you're poking on. And one of the things I picked up from him is, 'cause I, I always like, I love [01:04:00] language painting the picture, but when I paint the picture, big picture, you have to speak at a different way depending upon the level of the organization, which is why every organization we have communication issues.

[01:04:09] **Rebecca Ramsay:** Mm-hmm.

[01:04:09] **Chris Comeaux:** It's almost like you have to translate. And I, so your answer is brilliant on a whole different level. And Tom Foster's one of the few people I ever heard talk about that. And he, it's a funny way he talks about, he goes, you talk about your big picture, but then the staff is like, what the hell is he talking about?

And you have to translate in a way that's the language that they understand on a day-to-day basis. So, Mark, I'd love to hear your final thoughts as well.

[01:04:33] **Mark Jarman-Howe:** Yeah, so just, just pick up on the innovation point quickly. I think, um, 'cause we don't tend to talk about, uh, innovation, although I think we are an innovative organization.

I should have said, our values are bold, passionate, and caring. And it's our passion to provide amazing caring that enables us and encourages us to be bold. So, when we talk about being innovative, what we talk is let, let's be bold. Um, and I think the, the sort of that is grounded in the fact that hospice is both special.

And also, hugely transferable. So, you know, all of the things that make hospice care special are relevant to bigger issues within our healthcare system and bigger social issues and problems that people face around looking at not just the individual but their family, about thinking about what's important to individuals and what might be right for one individual isn't right for another about thinking about the value of home-based and community-based care as opposed to the expense of hospital care, which often doesn't deliver the same outcomes and the same experience at end of life care.

So, there's. There's a specialness in the, uh, personalization, the holistic approach, the coordination, uh, the focus on the family, the focus beyond just the medical condition that hospice brings. The wider population of people living

with frailty, living with dementia, living with progressive illness would benefit [01:06:00] from being able to access.

And equally, there are the sort of the skills, the principles, and the business case to apply those hospice principles on a bigger scale and to benefit the health economics and the outcomes for a population on a bigger scale. So I think my advice would be don't be afraid to be bold and brave. If you are in hospice care, you are in a great starting point to have impact at, say, even bigger.

Scale, which will be great for, you know, reinforcing, uh, the sustainability and the reach of your hospice program, but actually your hospice program could be doing so much more good, uh, for your communities as well if you embrace that. So I think there, there, there's great opportunity there. Um, I think in terms of advice, I think just, uh, don't lose sight of not just thinking about the clinical side of what you do, but the opportunity to integrate, uh, the philanthropy and the community relationships and the public health approach and, you know, the engagement type activities that Rebecca was giving a great [01:07:00] example of, you know, that is just as important as what you are doing on the clinical side.

And they are entirely complimentary. They don't have to be at odds. And the more you embrace that, um, positive relationship between them, the stronger your overall programs and your reach will be. Yeah.

[01:07:15] **Chris Comeaux:** That's so good. Well, thank you. I've learned, just sitting here listening to both of you. Again, I think we could do this for hours.

Maybe we'll figure out how to do a part two, something whether, you know, Mark, maybe we get you to the state side and um, you know, maybe sometime in the future, my guess is at a minimum you two are gonna talk again because there's a lot of synergy, but then your different approaches, um, again, I, I've taken, I've taken a page of notes just listening to both of you 'cause there's so many great pearls in your answers.

And it's interesting, I underlined it three times. What strikes me as necessity is always the mother of invention. Thinking about the model you had to create Mark, but then the way Rebecca created in a totally different way and then mission focus just keeps coming back to me. Um, I've had this sense that going back to Jim Collins, good to great.

The wisdom is like we need to like relearn that. And it's actually some of the wisdom you're poking on and some of your answers. Things that have now become cliche about first the who, then the what, get the right people on the

bus. What is the hedgehog concept? Technology is an accelerator. Things that have become cliche that if you go back and pull that out, like, oh, someone wrote a book about some of this stuff.

So I've been kinda on this kick of going what old was, what is old is new. Let's bring that wisdom back. And whether you two know it or not, you exemplify a lot of the principles that he was actually teaching in that book. So, hats off to both of you. You're or both the treasure, and thank you for taking the time to share some of your wisdom.

So again, glad to have both of

[01:08:43] **Mark Jarman-Howe:** it's been a pleasure.

[01:08:45] **Chris Comeaux:** And to our, listeners, we really appreciate you. The end of each episode. We always wanna share a quote, a visual that'll create like a Brain Bookmark, like a brain tattoo, that's a, a thought prodder, almost a summary of what we talked about today. We're looking to further your learning and hopefully it'll stick in your brain.

Please be sure you subscribe. We're gonna include Rebecca's contact information. Marks as well. And then we're gonna go ahead and leave you now with our Brain Bookmark. So, thank for, thanks for listening to today's show. Here's today's Brain Bookmark.

[01:09:15] **Jeff Haffner – Brain Bookmark:** "Leading organizations with multiple service lines is like going from basic math to trigonometry." By Chris Comeaux.