SheppardMullin

Nota Bene Podcast Ep. 127

Charting a New Path in Healthcare with Rush Health President Anthony Del Rio

Thank you for downloading this transcript.

Listen to the original podcast released May 26, 2021 here: www.notabenepodcast.global

The healthcare industry is ripe for disruption and major change. Key players in this space are looking for innovative ways to improve quality, access, and efficiency of care provided. My guest, Anthony Del Rio, is a leader in the healthcare industry and is working to disrupt the status quo through bold leadership and innovative ideas. For company leaders looking to transform their healthcare businesses, this episode will provide inspiration and practical advice on how to do so.

Guest:

Anthony Del Rio is the President and Executive Director of Rush Health and a professor at Rush University. Anthony obtained his Bachelor's degree in Business from Georgia State University and his Juris Doctor from Duke University School of Law. He practiced law for several years before joining the Rush University System of Health network.

Transcript:

Host Michael Cohen: 00:07 Welcome to Sheppard Mullin's Nota Bene, a weekly podcast for the C-suite, where we tackle the current national and international legal headlines affecting multinationals doing business without borders. I'm your host, Michael PA Cohen. Let's get started.

Michael: 00:35 Welcome to episode 127 of the Nota Bene podcast. And thank you so much to all of our listeners in more than 100 nations around the globe. We so appreciate your ongoing participation and our conversations and your feedback. Please keep it coming. It continues to help influence our programming. My guest today is Anthony Del Rio, the president and executive director at Rush Health. Anthony is also an assistant professor at Rush University Medical Center. I think he'll correct me if I got the teaching part of that wrong, but I do know, that he teaches health law and bioethics. He received his undergraduate degree in business at Georgia State University and he obtained his Juris doctorate degree from the Duke University school of law and North Carolina, where I'm presently sitting out on Cape Hatteras. Anthony started his career in private practice in Chicago and significantly, and interestingly migrated toward his undergraduate business degree over time and experience. And here he is now to tell you how he made that jump from law back into the business world, Anthony Del Rio. Welcome to the Nota Bene podcast.

Anthony Del Rio:	01:52	Thanks so much for having me. I'm glad to be here.
Michael:	01:54	It's really great to have you. I'm so grateful for your time. Anytime I can get a business leader on the show, I'm always excited, but also always mindful to make sure that we don't go over and I keep you on your daily calendar. So we will do that. I know we're going to talk a little bit about your vision for healthcare and Rush Health, but before we got to all of that, Anthony, I thought you might just take a moment to share with our listeners a little bit about your own path to your position on the planet. Particularly making that jump from lot of business, et cetera. I think our listeners would really love to hear your journey.
Anthony:	02:34	Yeah, happy to. Rush University's college of health sciences was where my academic appointment is and that's a part of our larger entity, so the Rush University system for health is a massive enterprise and the university is the academic wing of that enterprise. And it's comprised of five colleges, health science, the medical college, the nursing college, a health sciences college, and then also the graduate school. So it's about 3000 students. I teach graduate students, health, bioethics, and health law. And I also do a little bit of lecturing with some of the med students as well, but I think it's really cool stuff. I bring an interesting perspective because my legal background, when I started like, my undergrad being in business focus, it's really cool opportunity to work with students who are kind of focused on this area.
Anthony:	03:19	And frankly, it's also a good breeding ground for recruitment too, because you get students in your class that are performing exceptionally well. You want to give them a job because you want those people working for you. So I'm really happy to do it. It's a good opportunity. And college has a very strong group of kids there. So my background, how I ended up here in undergrad, when I went to college, honestly, the main driver for me was, what is the best degree for me to get where I'll be able to be successful and then get a job and have a successful career. And so, I went to business school just because of my primary interests being kind of that area. But then I focused on healthcare because in my head at the time, I think it was 17% of our GDP.
Anthony:	04:00	So in my head I did the math. I said, okay, I study this, I know I'm going to have a job. And so I started an undergrad, but then, as I was getting closer to graduation, I had a professor who was really encouraging me to explore grad school and because of my nature and I I'm one to be a bit of a contrarian. And so I ended up taking the LSAT

and then I ended up in law school as a lot of us did. And, but even when I went to law school in and out of law school, I did healthcare work. And so I initially started off doing kind of healthcare litigation and regulatory work that evolved to healthcare M and A, and then kind of naturally evolved into, being primarily focused on the healthcare business world.

Anthony: 04:43 I left private practice about four years ago now. So I was with a national healthcare firm doing M and A work primarily. And I left about four years ago because I think it had gotten to a point where, and, you being a private practice, you experienced this, you see so many things going on, but for me, I would be a part of the journey for a deal or, a transaction of some sort and then I would move on and it would close and then I'd go do something else and do another deal. But I never got to really stick through and see, okay, well, what happens with execution? Where do we go from now? How does this impact the, the greater business? And there was kind of some hollowness to it for me. And so that's what drove me in house to say, I want to be a part of an organization that I'm going to be able to track our success and our strategy and my actions lab impact in the future.

Anthony: 05:31 And I'll be a part of that future. And then that's when I went to Russia versus system for health, and I took an in-house role there heading up the healthcare transactions and regulatory team. So I led the team that was, how Rush's healthcare transactions, acquisitions, JBS, things like that. And it was a great role. And I, a quick background on Russia, I gave a little snapshot, but as a system, there's three hospitals that are a part of systems. So there's academic medical center, our anchor Rush University medical center. And so that's about a 700 bed academic medical center in Chicago. And then there are two community hospitals in the Western suburbs of Illinois and that's Rush Oak Park and Rush Copley. And both of those have a couple of hundred beds, pretty decent sized community hospitals. And then total, probably about 1100 employed positions that are a part of the overall network.

Anthony: 06:19 And so I joined that system in that role and I served there for about three years. And then, the capstone of that was Rush Health, which is the organization I'm president of used to be a separate entity. And we were transforming the Rush into a system because before that had very complicated kind of bridge board system really complex, like lawyer organizational structure stop, and we were restructuring everything. And a part of that was Rush Health, which used to be a completely separate corporate

entity, separate organization, just completely becoming a part of the larger system. And so I kind of let up that transaction of bringing Rush Health into the organization and in that process became very familiar with Rush Health, its operations, its people, its goals. And out of that, when we did the restructure and we started looking for, an executive to take the lead or Rush how senior leadership came to me and they said, Hey, this is, you've got to know this organization so well, what kind of backwards and forwards we think this makes sense, is this something you'd be interested in?

Anthony: 07:20 And I said, absolutely. given my background, given my interests, I've been gravitating more and more towards kind of business and strategy. And so, I want to take this on, that was in March of February, I guess it's February of 2020, which was an interesting, right, right before things kind of got turned on their head, but it was a great opportunity. And so I took it and that's how I ended up here.

Michael: 07:44 It's a marvelous story. And thanks for clarifying Rush University. It was interesting to hear that put in perspective a serious, well, I'll call it healthcare higher learning institutions have to cover a lot of fields, not just the medical center and all of the colleges you listed makes so much sense. And it's super helpful to have that. In context, you take a different approach to your students. I teach international comparative competition law at Washington and Lee university school of law in Lexington, Virginia. I'm very grateful for the adjunct opportunity to teach that course to a set of brilliant students every year. But I never get involved in recruiting my students because otherwise I'm fearful. My class will sort of become a job in army if you will. so I have taken a completely opposite approach, but I do certainly appreciate your intuition that you, you come across students in your classroom that just stand out.

Michael: 08:50 It's just always the case. And I used to teach at the Monterey college of law. I think I'm still part of that faculty, but not in Monterey presently. So kind of hard to teach there. And I did, there was one standout student who joined me in practice and she has worked out tremendously well. So it is kind of an interesting insight when you get that. I think it's fascinating to hear your background and February, 2020. I mean, what a time to take over a business in your industry, right? I mean, in healthcare, the world got stood on its head and healthcare did too in amazing ways. I'd love to hear how you've weathered all of that and what you may have learned from it. But when they asked you to take over, you, you

mentioned that you had some thoughts about the business, you'd learned it front to back and that you had some thoughts about strategy forward. let's start there, what is your strategic vision with all of that interesting background that you've had in law, private practice internally, and the Rush system, all of the restructuring, what set of material kind of percolated in Anthony Del Rio to give you a vision or a strategic vision for the business moving forward.

Anthony: 10:11 Yeah, I'll set the stage of what Rush Health was and what we're kind of working towards it being more often. So Rush Health is the clinically integrated network of the Rush system. And so it has last year when I was kind of stepping into the role, roughly 1800 providers that are primarily employed, so about, the 1100 employed providers within the Rush system, and then about 700 independent providers that are either affiliated with other practices or affiliated with an independent hospital that participated in our network. And so a CIN, a clinically integrated network, and some of your listeners may already know it, but I'll quick break down. What we do is our goal is to interface with kind of divergent providers. So, our network of employers, certainly that's a little easier, but a lot of independent providers facilities and say, Hey, let's collaborate on this population.

Anthony: 11:03 This community with these shared goals and leverage this kind of shared resource of technology and , pop health resources and try to perform really well and then have good outcomes. And then on the payer side, we interface with the payers, be it the government or commercial, and we say, okay, Hey, here's our network. Here's what we're working towards. Here are the resources we bring to bear let's, create a contract to say, we're, we're going to cover this population of yours, these beneficiaries, this network, and here are the shared goals we're going to work towards. And if we're successful on this, here are the incentives you will share with us here, the care management fees you'll pay and all those other things. And so, and there's a lot of features that go into it, but it's essentially like, an amalgamation of decent sized system, then adding independent providers and facilities to that network to create a really nice footprint, but you're having to coordinate and collaborate across a lot of kind of different parties.

Anthony: 12:00 So it's one thing if you own the whole network, because then it's kind of easy to say, if someone's employed within your network, you say, Hey, this is our goals, work towards this, or, you get fired now. And no one goes that far

usually, but that's kind of the undertone there. But when you have kind of a network of independent people participating, it's a little more challenging. And so you really have to get people to come together and work towards something. And that's what CIN is do. And a part of our CIN is also our ACO. So our accountable care organization, that's focused on a Medicare population primarily, but it's all about, improving outcomes, improving care, improving quality, and then sharing that success with the participants. And so, when I stepped into Rush Health, that was, I would say, that's when it should be working towards, when I stepped in, it did a lot of those things on kind of the commercial contract basis, our ACO had started going, but there, wasn't what I call the material push to going further than that.

Anthony: 12:53 And so by that, people were pretty happy with, okay, we've got all, we've got, this seems to be working. Let's kind of keep it where it's at. And me looking into it. And this is, I, it was in the middle of the pandemic too. But even before that, the opportunity was where were strategically placed Rush as a system. We don't have a massive footprint. We're, we're a decent size. So, little over $2 billion in revenue, a thousand plus beds, a thousand plus positions, but, compared to a massive system, we're just not that. And so strategically we need to differentiate ourselves from the market to say, here's our value proposition. And here's why, you should work with us, be, another provider or a payer, and that's what Rush Health should be.

Anthony: 13:36 And so, my pivot into risk is where we're going from a strategic perspective, because my risk, I mean, your traditional healthcare dollars, you get fee for service revenue. So I view, I give you a service. You pay me a fee risk would mean I take, a patient, a beneficiary and say, okay, you expected to spend $12,000 this year on that patient for all of their care. If I take responsibility for that patient and you spend $11,000, I get to share some of that savings. And so thinking bears through leveraging pop health technology, efficient quality measures of an integration, we can do a better job with that patient on their outcomes and lower the cost of care. And so that's where we're going and that's the strategy I want to work towards. And that's the strategy we've been developing over the last six months a year and the benefit, and this is going to sound funny, but the benefit of the pandemic is when I was interviewing for the position, I have this thesis that, Hey, this is where we need to go strategically, because this makes sense for our current, for our structure, our footprint, our strengths, because Rush is very strong and quality.

Anthony: 14:45 It's very strong in data and analytics. We just don't have a massive footprint. And so if we'd leverage our quality, our analytics to do a really great job with the population, we'll be successful in risk that's, those are the key things you need. And so that was kind of my thesis interviewing for this position and saying, we need to, this is where we would go strategically. And, there was some buy-in on that, cause it was, innovative, creative idea that played to our strengths, but then once the pandemic hit and people stopped coming for, stop coming to the hospital and stop coming for their outpatient visits and canceled elective surgeries and all the revenue dried up, all of a sudden that said, wow, if, if we had just been taking, risk on these patients, the fact that the revenue stopped coming in wouldn't really be that negative because ultimately we would get it on the back end because if you would expect it to spin. And I mean, most of the insurance companies are kind of reaping the reward from this for 2020, you'll, I won't name names, but you're seeing a lot of insurance companies did very well in this past year. It was because people avoided care. And if you look at the health systems that were already materially in risk products, the fact that people were avoiding care didn't as negatively impact them because they were being paid to manage the overall population health, not just for that, individual episode,

Michael: 15:59 This notion of population health management and realigning financial incentives, profit, or nonprofit, just the economic incentives around the success of that population. Health management is something that seems so right. That it's hard to find something wrong with it. So, let me ask you how many systems are doing this, where does this kind of model that you laid out for our listeners Anthony stack in the American healthcare system? If that makes some sense and if not, I can try to expand on a little bit.

Anthony: 16:40 Yeah, no, that makes sense. And so I think everyone agrees. Yeah, this makes sense. So, so that, that kind of approach to care makes sense in the abstract. The challenge is we have this historic model of care that we've been structured towards delivering. And so most of us with significant assets and that Rush is one of those entities. I mean, we have significant assets. We were built to deliver on paper service propositions. And so we were capitalized. We are, have a debt load designed towards delivering on a fee for service revenue proposition. And so we, there's a lot of investments and you see this across the country where all these large systems have a lot of investments towards delivering fee for service care. And so if you look across when there's not, this is nowhere near the standard

model of care delivery risk, risk propositions, value propositions.

Anthony: 17:34 There are a couple of standouts in the country. Intermountain is kind of an obvious one and Intermountain pivoted to kind of this risk habitation proposition probably about a decade ago. And they've been kind of on a journey the last 10 years of how to really get in that area and they've done a fantastic job. And so, if there were a model I would want, our system to duplicate or imitate, and this is pure flattery, it's them because they've done a fantastic job there, but they're kind of one of the few in terms of truly large systems that have gone in this direction. Now, there were other smaller examples where people have been forced in that direction where it's been, I think of a couple of smaller community hospitals that are in a position where their only option was to do something very innovative and creative or to be acquired or to close.

Anthony: 18:22 And, some of those hospitals have said, okay, let's what can we do here? Let's go to, the payers and to our government and say, Hey, we've got this new idea. We want to flip to this risk model. Here's how we're going to do it. And some of them have been very successful, but those are kind of the extremes now. And so the reason for that in my opinion is because we are all structured from capital and assets standpoint to deliver on fee for service. We need to feel like people are going to come into our hospitals, come into our ORs and get these services. And if we're being successful in that space, there's not a lot of impetus to change because why, why rock the boat? If you're making, a hundred million dollars in margin on delivering care in that way?

Anthony: 19:04 Now the answer is in my opinion, because it won't always be that way and that's not the best way to do it and we need to evolve, but that's a pretty big pill to swallow when you've got, $500 million in debt. And that last, the last three years, 90% of your margin came from your fee for service operations. And so why would you risk cannibalizing your fee for service operations on the hope that it's going to pan out? And so I think that's been the big, detractor from going this direction. And so what you've seen is traditionally not health systems moving towards risk, but what I would call, I mean, there's kind of two categories, there's your payviders. So insurance companies that are getting into the payer, where are the provider world recognizing that this is a way to manage kind of their margin.

Anthony: 19:52 And so there's a lot of examples of that. And then also kind of what I would call disruptors. And so that would be like your Oak Street, Iora Health, VillageMD. And so these providers that don't have heavy capital assets, heavy debt loads, and they feel like, we can employ some providers in clinic setting, but we don't have those legacy assets that we have to pay for. And so we don't have to worry about cannibalizing our fee per service revenue to do this. I think that's why the market is currently at the place that it's at.

Michael: 20:20 It's super interesting. I mean, it sounds like it's in a state of flux and I was going to actually ask you, what are the impediments to doing it? And you you've already outlined them and talking about the, how this direction stacks up out there. It does. However, still strike me, such the right model because it's patient focused at the end of the day, when you're talking about successfully managing a health, are there regulatory things that can be done to incent or aid this kind of a transformation, fully subscribing and understanding and appreciating something I, that resonated with me, Anthony, that you described, which is that, we have a infrastructure out there and American healthcare that is built around this pay for this fee for service model, but that may not necessarily be the best model for patient healthcare at the end of the day, what could aid and transforming the healthcare industry into more of a risk model where the patient focus matters?

Anthony: 21:25 Yeah. So there's been a couple attempts in last decade or so to really kind of push that envelope on the government side, primarily through Medicare's CMI the centers for Medicare and Medicaid innovation through kind of various ACO type models. Some of them focused on broad population, some of them focused on specific use cases like cancer care, nephrology, things like that. I think more of those models are helpful. I think the challenge and you've seen this in the adoption of those programs is none of them have the types of incentives and protections to make most health systems feel comfortable going in that direction. And so you still see in those fields, it still tends to be innovators, innovators, disruptors, or people who have no other choice. And so most everyone else is kind of cautious to go in that direction or participate on the kind of the downside risk proposition.

Anthony: 22:18 I think ultimately we need to push those further, but there also needs to be an evolution in what you can offer through those programs. And by that, I mean, if you look at Medicare advantage, so Medicare advantage is essentially a contract between a private company. So, a private commercial insurer and the federal government and that

private company says, Hey, I'll take responsibility for these Medicare beneficiaries. You give me a lump sum of money and I'll bring them solutions and let me manage those solutions. And so a lot of those programs, Medicare advantage programs, you see kind of innovative ideas of how you actually manage that care efficiently, effectively, and in a way, that's going to allow the providers to also be successful. The problem though is, and this is a touchy subject. And so I would kind of cautious around it.

Anthony: 23:03 But from partisan standpoint, there are wings within each party that are concerned about the proposition of Medicare advantage, and then also the converse of that, of expanding Medicare in a way to provide more access and more dollars and more flexibility to how we deliver it because each side, and you can guess which side is on which side there each side has very strong opinions on either privatizing Medicare or expanding Medicare. And so it's a challenging proposition, but I think there's room for, bipartisan collection of saying, okay, yeah, we don't need to go to the extremes, but we need to create some incentives, some financial backstop to encourage these groups to move into and to collaborate in ways that will improve outcomes, make patients happy. And also probably cost us a little bit less than long-term because right now, the Medicare trust is on course to hit a deficit in 2025, 20, 24. Now they're going to have to do something to address that. And I would hope, some innovative risk model is a part of that

Michael: 24:09 Super fascinating insight from somebody steeped in the business. So appreciate it. Anthony, tell me a little bit about population health, population management and how that is accomplished. I, I have heard from the competition standpoint, the justification offered for consolidation is often better ability to manage a population health, but I've never really well in some cases I've understood what that has meant and others I've struggled to really figure it out, but, my world, that depends on what economist I'm talking to, which may not be sort of the best source of that information. I don't know. Talk to me a little bit about that in practical terms for somebody who leads population health management business. I mean, how do you accomplish that? has technology helped or aided that process? I getting at a subject that makes some sense here?

Anthony: 25:06 Yeah, absolutely. And so I'll give you a historically what it's meant and then where it's going through supportive technology and data. So historically pop health has been a mix of primarily care management, discharge planning, things like that. And so if you have someone in the

hospital, make sure you do a medical reconciliation with their meds and say, okay, here's what you need to take. Make sure you don't take it with this. Let's make sure it ties out to what your current medications are and all that's kind of focused on ensuring that nothing goes wrong once they leave the hospital. You see other things too, like, oh, make sure you follow up with your primary care doctor after you leave the hospital. A lot, a lot of the things around kind of hospital discharge and care management planning when people are in the hospital and leaving.

Anthony: 25:49 And that kind of came out of this concern about readmissions. And so, the readmissions was a big source of government, healthcare spend people leaving the hospital and then like a week later ending back up in the hospital. And so there are all these resources put into saying, let's make sure that doesn't happen, but on a broader level, I think we've come to realize there are a lot more things to impact. And population health manager really now is keeping them from ever ending up in the hospital because frankly, once they've had that hospital say, that's already a pretty expensive encounter. That's driven, that annual spend well above what you want it to be. And so what can we do to keep them out of the hospital and make sure that patient is in the appropriate site of care that they really need, and that they're getting the care that avoids acute issues.

Anthony: 26:35 And so what that might take the form of now is, you're different terms. my favorite lever is care traffic controller, but if someone that's, in touch with the patient on a regular basis, it's usually not going to be an RN. It's going to be essentially an MAA maybe, or even someone that doesn't have any type of clinical license or designation, but has knowledge and education say, touch base with high-risk patients. And this is where the data comes in now. So it used to be, we would just do a based off of, oh, someone coming through the records that you got, your primary care doctor or the nurse says, Hey, wait, this person has diabetes. Let's make sure we follow up with them. Now. That's not what happens. Now we have, data and we have analytics and we have programs running to say, Hey, this person based on their charts, the last three encounters, their blood, pressure's going up, their hemoglobin, we're really concerned about that.

Anthony: 27:28 And then the program will flag them and say, have someone reach out to them, have someone to conduct with this patient. Because if we don't, highly likely we have a, 80% guarantee in, two months, this person's going to end up in the ed. And so then we'll have someone we'll

have that data running in the background, a pop-up will come up, on one of our care traffic controllers, screens and say, Hey, make sure you touch base with X patient today and see how they're doing. Maybe you need to schedule them a visit with their PCP. Maybe they need to have a telehealth visit, or maybe they need some, remote patient monitoring or something like that, plug in their glucose, monitoring to their phone. And so we get that regular data feed.

Anthony: 28:09 And so, a week before some events that would've landed them in the hospital, we catch it and we say, Hey, go see, go see her, go to the clinic, goes to the urgent care, go somewhere or even something that's rolling out right now that isn't yet in our market that we're exploring though is send someone to them. And so get someone out there right now to their house because this patient we know has mobility needs and, having an encounter with them and help them manage their diabetes, their heart failure, whatever. And so, yeah, it's been the shift to highly data-driven, but you have to make sure you marry it with kind of clinical expertise, because what we also see is it, this is in the market and there's a lot of vendors out there now that will sell, their AI platform or whatever to say, Hey, based on the coding, we'll be able to identify X, Y, and Z.

Anthony: 28:54 But we we've seen that with some of those is I would say they're making their best shot at an educated guests, but it's clear that it was driven by data scientists and not clinicians. And so when we got so dig into the data to say, Hey, you flagged this patient with, some potential diagnoses that is absolutely wrong for these reasons. Now we understand why your machine thought, because of X, Y, and Z, this person had this. But if you look at these records, this person absolutely does not have this. And so you have to make sure, and that's part of wash Health's role is, my team, I have, I have a bunch of data scientists on my team, PhDs, very sharp, very smart people that can dig into data. But then I also have clinicians like a chief quality officer.

Anthony: 29:37 I have some medical directors that are very experienced clinicians and they bring that experience. And when you pull them together and you have a dialogue, you get really meaningful guidance and great ideas on how can we do better here? And it's, it's exciting. Because that's what population health, that's what care management means. And then we're also bringing in now, social determinants of health. And so there's a lot of rich data out there that you can get to say, Hey, this community, if you look at the data, they're 20 years behind in terms of life expectancy for

these reasons. And a lot of things that impact health are really what you would traditionally consider non-healthcare issues. And so it might be housing. It might be, food security. There's a lot of reasons. It might just be pure security period.

Anthony: 30:19 And so if someone doesn't feel safe leaving their house, they're not going to get exercise. And so you have to pull all that data together and you have to look at it as a whole and say, looking at this population, looking at this individual cause population of ultimately is about a large population, but it goes to down to the individual and you say, Hey, looking at all this stuff, here's what this person needs to be healthy and successful as an individual. And that's what our goal is. And that's the role of Rush Health. And it's, it strikes a chord with me because ultimately that's, what's most important about healthcare is having a complete and healthy and happy life.

Michael: 30:53 Anthony, I hope we get there and I'm grateful to you and others there at Rush for leading us in that direction. I have a few more minutes left with you and I'd like to use them and just kind of ask you a little bit about what you've learned, since February, 2020, I mean, here you are stepping into a leadership role in business at beginning of, to call it a sea change is not even a justice. I mean, you went from kind of the Canaan valley to the desert overnight. I mean, the whole world changed. What have you learned from this period of the pandemic personally, professionally in terms of your vision for Rush any big takeaways you can share with the audience in that regard?

Anthony: 31:35 Yeah, absolutely. I think, my biggest takeaway is that I'm lucky to be a part of this organization because this is not something that anyone can do on their own and you need buy-in across the organization to be successful in this proposition. And we have that here and we had it here before the pandemic, and that's why I brought into my role because people bought my vision. But, through the pandemic, which has been challenging to put it lightly and my clinical partners throughout my organization, I have the highest level of respect for everything they've done because it's above and beyond. But ultimately the reason for that is because they are dedicated to the community and they're dedicated to delivering the best care to the community and keeping people healthy and happy and safe. And because of that, I I'm able to partner with them and get away from these fears around, Hey, what's going to happen to us if we pivot from fee for service to risk because they know, yeah, this is where we need to get to.

Anthony: 32:32 And so we're going to get there carefully and methodically and very strategically, but we're going there and it's good. And I think the biggest takeaway also is validating and understanding what the drivers are for health. And so, digging into your data and seeing like, does this make sense? Cause there's a lot of assumptions people make and say, I think X drives Y well, let's really, let's devalue that and determine that and talk to the patients, talk to the providers and say, is this really what's happening here? So don't just rely on again, the data, but look underneath the data and make sure it makes sense and make sure it really works out. And that one plus one is two, because you need to know that you don't just blindly leap because, on some assumption that, of course that's what it is.

Anthony: 33:18 And then finally, and ultimately this goes back to kind of the business background while we are a nonprofit, there's kind of the saying no margin, no mission. And the pandemic made that acutely clear to everyone. A lot of health systems lost hundreds of millions of dollars and it's tough. It's tough to continue operating in that environment. And so we need to figure out, strategically, how do we pivot to where we need to get to in terms of care while making sure we're able to continue to keep the lights on. And so there's no like you can't just rip the band aid here because potentially ripping the band aid could put, 5,000 people out of a job and could Rob a community of a healthcare system. And so you need to be very strategic about it. And so everything we do, I always have to keep in mind and maybe that's part of my role as the business person here is like, what is the business impact of what we're doing?

Anthony: 34:10 And so I've got my clinicians, I've got my partners, my executive leaders that are clinicians by training. And so they bring that experience of here's. What is like, I've got the data scientists, I've got the operations managers. And my role is to look at the bigger picture and say, okay, how does this all to come together? What strategy do we need to leverage to be successful here? And is the margin going to be there in some way? And so we need to keep the lights on cause that it doesn't serve anyone well, if we can't do that. And so it's a balancing act, you've got your foot in both canoes when you're pivoting to risk, but you need to do that. The last thing I would say is, you have to be a little brave.

Anthony: 34:51 And so by that, I mean, while you can do as much planning as you want, and you can try to put safety rails in and guard rails and, belt and suspenders and et cetera, et cetera, et cetera, ultimately until the government makes

		some huge shift and says, we're going to backstop everything. You're going to have to take a leap because moving into risk, when you have these legacy assets, there's always going to be some built-in, pitfall there that you're going to have to make sure you don't fall into, or you're going to have to jump right over that. But in order to get there, you're still going to have to make the leap. And again, I'm lucky that our organization is one that is willing to go in that direction and I'm happy to be here because it's an exciting opportunity. But for other people out there, it's going to be challenging.
Anthony:	35:33	I think the why, and this is the pitch for, healthcare based systems. I think the advantage we have over what I would call, disruptors in the market is that we've been doing this for 130 years. And by the I'm talking about Rush. So Rush has been a part of this community for 130 years, and we are a part of this community and we want this community to be healthy and happy. And ultimately, while we have these legacy assets, we've still got our mission and we're going to do everything we can to balance that mission and keep the lights on, but also keep the community healthy and happy. And that's what we're here to do. And we're going to keep doing that. And so obviously the road is a little bit longer for us to get to kind of, it's a risk proposition. That's where we're going,
Michael:	36:19	Listening, or having the opportunity to speak with business leaders like you in the healthcare space gives me such confidence in the American system, through all of our craziness and dysfunction comes a great leaps forward and, Anthony, you and Rush seem to be headed in that direction. One of those great leaps forward, it's such a pleasure to have you on the note of any podcast. Thank you so much for joining us around the world today and talking about this fascinating field and your vision for it forward.
Anthony:	36:55	Yeah, absolutely. Thank you for having me. It's been an honor.
Michael:	37:02	Well, that's it for this week folks. Next week, I'll look forward to speaking with you all again. Until then as always thanks so much for listening.

* * *

Resources Mentioned:

Intermountain Healthcare - https://intermountainhealthcare.org/

Contact Information:

Rush Health - https://www.rush-health.com/
Anthony's LinkedIn profile - https://www.linkedin.com/in/anthony-del-rio-1393725

Thank you for listening! Don't forget to FOLLOW the show to receive every new episode delivered straight to your podcast player every week.

If you enjoyed this episode, please help us get the word out about this podcast. Rate and Review this show in Apple Podcasts, Amazon Music, Stitcher Radio, Google Podcasts, or Spotify. It helps other listeners find this show.

Be sure to connect with us and reach out with any questions/concerns:
LinkedIn
Facebook
Twitter
Sheppard Mullin website

This podcast is for informational and educational purposes only. It is not to be construed as legal advice specific to your circumstances. If you need help with any legal matter, be sure to consult with an attorney regarding your specific needs.