Taking Back the Business of Healthcare

With Preston Alexander

Episode 67

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Preston (00:00):

Bridging that gap, I think really helps everybody. So, in the first way, it's just to get on the same page. We need to do the right things for patients. We need to do the right things for clinicians, deliver the best care, highest quality, all that stuff, first and foremost, absolutely. But then how are we going to cover it and pay for it and deliver it and pay people well and pay people fairly? Those are just the economic realities of the broader systems that we live and operate in. And so, people always talk in a way that's like, it's either or and I think it can be both.

Speaker (00:34):

Welcome to the Healthcare Leadership Experience Podcast, hosted by Lisa Miller and Jim Cagliostro. Lisa is the founder of VIE Healthcare Consulting and now managing director at Spendmend. Lisa and her team has generated over $1 billion in financial improvements for VIE's clients since 1999. Since 2007, Jim has been a registered nurse working in critical care, perioperative services, and outpatient settings at nationally recognized medical facilities across three states. You'll hear conversations on relevant and trending topics in healthcare and much more. Now, here's your hosts, Lisa and Jim.

Jim (01:14):

Hi, this is Jim Cagliostro, and you're listening to the Healthcare Leadership Experience. Today's guest is Preston Alexander. We're excited to learn more

about his story, his mission, and really where Preston sees and wants to see healthcare shifting for the better. So, Preston, welcome and thanks for joining us today.

Preston (01:31):

Great to be here. Thanks, Jim, for having me.

Jim (01:33):

We always like to start out with just getting to know you a little bit. So, can you share a few minutes about your story, your experience? I mean, I know you share a little bit of that on LinkedIn and on your website, but what brought you to where you are today and really what gave you the passion for what you have a heart to see in healthcare today?

Preston (01:51):

Yeah, sure. So, I'd say that I tripped into healthcare by accident typically. So, I went back to school after a couple failed business attempts and got an MBA and graduated in around 2015. Did what everyone else does, I applied to like 100,000 jobs, it seemed like the endless foray into black holes of HR departments. And I got two responses at one point, and it happened to both be healthcare companies. One was like a locum tenens organization, and one was a medical device company. And as luck would have it, I got hired into a product management position at the medical device company. It was a global manufacturer marketer of devices. And I just thought, wow, it was super cool from a business perspective, from what we were doing, strategy. I mean, we had manufacturing. It was really interesting.

Preston (02:40):

And then I started to kind of realize we had a very small perspective of healthcare. We sold disposable goods into the OR. So, it was like a tiny piece of the pie. But I was always interested in more of the mechanics and the economics behind the healthcare and what we were doing. It didn't usually sit right with me when we always talked about gross margin improvement products on our products that had 85% margins already. And I was like, why don't we try to lower cost in healthcare?

Preston (03:08):

Anyways, I went on to a couple other companies and I was in a wound care company, so I got a broader perspective into healthcare and reimbursement, things like that. And I pulled the layers back. I was like, wow, this is not right. I would have people write to me a mail and saying that they had stage four cancer, they couldn't afford our products, but they're the only things that helped them. Do we have some sort of program or assistance? And just always met with sort of a brick wall whenever I brought that up to our management team and what we could do.

Preston (03:37):

So never really sat right with me and I just didn't understand what was going on. So, I launched myself into understanding more about healthcare from a business perspective, because I'm not a clinician, not a nurse or doctor, don't have any training. Not one of those people who comes from a family of doctors or anything like that either. And as I did, I just started talking to more and more practitioners, a lot of nurses and doctors and some administrators, but really people who are providing healthcare, delivering it. And I just kept thinking, this doesn't seem right. Why are you only meeting patients for six minutes? Why is it getting harder and harder to have an independent practice? Why are all these problems happening? And it came back to this business model that is our healthcare system in the United States.

Preston (04:27):

And so along the way, I've learned a lot and really developed, as you know, this sort of thesis that in order to restore the practice of medicine and the right balance, we need clinicians to take back the business of healthcare because I think that's where we've really gotten out of sync and out of line is this business of healthcare has destroyed the practice of medicine. And that's just sort of what I work on now. I still am involved in a... I forgot that part. I founded my own medical device company actually in about 2020 and still involved in that company after we sold it at the end of 2021. So, by day, medical device hawker, by night, trying to help empower clinicians and give them the business tools they need to start businesses, grow businesses and get nonclinical leadership in healthcare.

Jim (05:15):

I love that, Preston, and as you're sharing, I didn't know all those details, and you mentioned about that experience that you have and it really gave you a special insight and your whole emphasis or thoughts at least on, well, aren't we supposed to be bringing costs down? It reminds me of my boss and co-host of this podcast. She was serving in a different role and realized, hey, something's going on here, and I can make a difference if I kind of come at it from a different angle. So, I love that. Like you said, you tripped into it, but man, it's exciting things, what you're doing. So, thank you for sharing that.

Preston (05:46):

Appreciate it.

Jim (05:49):

I guess I want to start out with asking why our current state or the path of the healthcare that we're on now is unsustainable, really what's wrong with how we're doing it? Maybe the big picture. Can you narrow it down for us or maybe give some examples of some of the system problems that we have in healthcare today?

Preston (06:08):

Yeah, I mean, definitely we can just list the problems in healthcare for about 15 hours on a single podcast, I would say. But I think the primary issue that I see is that, and you talk about systems level problems, is our healthcare system operates within a much broader context. The context being a system of capitalism. I don't want to get into economic doctrines or philosophy as much, but it is part of it for sure.

Preston (06:40):

And so, what we do in capitalist systems is we create a lot of for-profit-driven entities, and we all work really hard in the concepts of exceptionalism and bootstraps and making it to the top, and that the financial success is the primary success. And we miss a lot of social services as a result of that being the sort of fundamental guiding principles. And then it translates directly into healthcare. So, healthcare system is a subsystem of a much broader one. And it was created in a way, in more modern times, I suppose, if you want to look at it that way, to maximize profits. And all the systems we've designed

have created a little bit of a bifurcated system whereby you have wealthy individuals who are covered by insurance and can afford all the out-of-pocket fees and charges they have to pay if they need healthcare. And then the rest of the population who's functionally uninsured or underinsured or doesn't have insurance at all, and then what they can access.

Preston (07:43):

So, I mean, I think if you wanted to just really take one big giant swath, like what's the problem in healthcare, is that it's fundamentally profit driven first, and healthcare fundamentally is a function that can't be delivered appropriately to everyone with profit being its primary driver and outcome. Well, I mean, we see examples of it all over the place. You have insurers who are supposed to help you avoid catastrophic costs related to healthcare, who make... United Health Group, I think in 2022 profited $20 billion or something like that. So, you're just talking about outrageous numbers. I mean, it made, I was just looking at their financials this morning actually, $340 billion in revenue. And it's like, what are we getting for it? More expensive treatments, more cost, worse outcomes, lower life expectancy, less access, more people left behind by financial design. So, it's a big one.

Jim (08:44):

Well, you're making me think of a hospital that I used to work for way back. I worked in a department that was very profitable for the hospital, and this hospital used to have a mental health department for people that were coming in and that at some point closed because ultimately, I mean, we talk a lot about that with mental health, it's not really bringing in much profit to health systems or hospitals. And so, a lot of times that gets forgotten or pushed off onto other hospitals or systems. It's tough, because these people need care just as much as the ones that are bringing profit into the hospital. So that's a huge issue. I'm glad you highlighted that.

Jim (09:23):

I guess my next question would be, and this might be tough to sum up in one or two sentences, but how do you believe we can turn the ship or build a new one? I think you use that language in your LinkedIn profile, and I love it, either turning the ship or just completely building a new one because

maybe that's what's needed. What are your thoughts on that? What's the solution?

Preston (09:42):

Yeah, well, I mean, listen, if I had the solution, I think we'd all be better off and I'd be on a beach somewhere just kicking back.

Jim (09:50):

There you go.

Preston (09:51):

But that imagery is really, because I am still going to believe, and I'm probably wrong, but that we can turn the ship because systems are what drives everything. I mean, you can put good people... It's what we see with all the nursing shortages right now. We don't really have a shortage of talent, but we have a brokenness of systems. Today, we're 300,000 nurses short. If I gave you 300,000 nurses tomorrow, we'd be short again within a year or two because the systems are broken. You can't just throw good people into a broken system.

Preston (10:24):

But people design systems, people can change systems. So, with that sort of premise foundation, the ship could be turned. We could turn the Titanic, but it's going to take leadership, it's going to take people at the top, it's going to take bottoms-up approach. It's going to take a lot. It's not an easy thing to do, neither is building a new one. But that's the alternative. We can try our hardest and get our CEOs on board or the people in charge or mutiny, so they have to listen to us or whatever the things are. Or you can say, we're going to just do something different, not to minimize it in any way, but we're going to make Blockbuster obsolete. We're going to be Netflix. We're going to create something totally different and not even disrupt the system because it's so useless to us. So, we're just going to go over here and do something else.

Preston (11:16):

Alternative insurance models, I mean, we see it with direct primary care, they've opted. Out all DPC doctors have opted out of a broken system, and they've worked on a different model. You can couple this with the stock loss insurers and these sort of pooled community insurance companies. They've said, "We're not going to do traditional anymore. We're going to do direct contracted care delivery and we're going to pool our resources and basically have a sort of pseudo insurance pool of money." So, it's, what can you do to build something outside of that traditional healthcare system? And I think both ways can work. I honestly think building a new ship is probably the best solution at this point, although I don't totally want to believe it because there's a lot of meaningful infrastructure. But also, once you build a new ship, everybody aboard the old one's going to want to come over there and you can really access a lot of that existing infrastructure in positive ways. That's kind of what my thought is. That wasn't one to two sentences, sorry, but I tried.

Jim (12:15):

No, no, that's perfect. I think you could just highlight the emphasis on the system is the issue. Actually, the previous podcast interview that I had done, that very thing came up where it's not necessarily a shortage of nursing or a shortage of, yeah, there might be pockets here and there, but like you said, a year or two later we're going to be running into similar issues because, again, I think from the nurses' perspective, but nurses are leaving the bedside or healthcare workers are leaving the bedside. So, it's not just a matter of keep filling in as people keep leaving. We got to address the system, we got to address this ship and the direction and how are we doing things.

Preston (12:51):

Yeah.

Jim (12:53):

This is something that you get into and something I know personally I've appreciated just kind of learning from you, and you have that it's the healthcare breakdown, correct? I'm saying that right?

Preston (13:01):

Yeah.

Jim (13:02):

You have that newsletter that goes out and what you're putting out on LinkedIn, and it's been helpful for me just educationally. Why do clinicians need to understand the business of healthcare? I know we talked briefly last week, and we talked about the disconnect even in terms of the language that's used from a clinician at the bedside to really understanding the business of healthcare. Why is it so important for there to be a bridge, for there to be a connection with clinicians understanding that aspect?

Preston (13:30):

Yeah, I think it's important in a couple ways. I mean, the first thing is that there are just economic realities that we have to live within. The famous phrase was like "no margin, no mission" coined by a nun way back in the day with one of the Catholic nonprofit health systems. And people say that a lot, but they just mean it to justify profitability. But it's something different. But I mean, there's something to be said about it to an extent. You know what I mean? Saline costs money, catheters cost money, stents cost money, new ORs cost, all this stuff costs money. So, if you just are going to say, "Well, screw it, all we have to worry about is doing what's right no matter what. We're going to go at it this way and do all these things."

Preston (14:18):

It's like, well, yes, we have to start there, but then we have to understand the economic realities of like, yeah, we have this humongous, underserved population in Atlanta, for example, a big hospital closed. We have this big, underserved population. And this hospital was dragging down the bottom line of a big non-for-profit health system that makes plenty of profit, believe you me. And so, they closed the hospital. And that hospital had a lot of problems. It was under-invested in for a long time. It has a troubling financial population, but they approached it the wrong way. It was finance only, right? Like, "Let's just bottom line, little investment, and then let's get out of this and not take the black eye." But you can do the right things, but also understand the economic realities, like how do you invest in a new parking deck? Which they needed, because they had a condemned parking deck. You know what I mean?

Preston (15:05):

So, bridging that gap, I think really helps everybody. So, in the first way, it's just to get on the same page. We need to do the right things for patients. We need to do the right things for clinicians, deliver the best care, highest quality, all that stuff, first and foremost, absolutely. But then how are we going to cover it and pay for it and actually deliver it and pay people well and pay people fairly? Those are just the economic realities of the broader systems that we live and operate in. And so people always talk in a way that's like, it's either or. And I think it can be both. And I also firmly believe that if you do the former, which is start with patient care in mind, quality, safety, take care of your clinicians, the profit and the money takes care of itself on the backside. And I mean, we've seen examples of this before.

Preston (15:56):

And then the other way that it's important and helpful is, again, to get clinicians in those nonclinical leadership roles and to be conduits between the two. Because everyone's heard this famous anecdote about some engineer, big business consultant went to a factory and the line was broken and they're losing all this money. And so, he went down to the floor and took a hammer and banged on something and then fixed the problem. And then he was like, "That'll be $10,000." And they're like, "What? What do you mean? You just banged on something with a hammer." And then he's like, "I need an itemized invoice." So, he writes this invoice and he said like, "Cost of a hammer, $5, knowing where to bang the hammer"-

Jim (16:36):

There you go. yeah.

Preston (16:37):

Like 95, whatever amount. And so, knowing what it takes, what goes into it, what the processes are, living and breathing it for years, seeing the problems, understanding what's needed is so invaluable. And it's so invaluable to the business side as well. When you're looking and making decisions based on a financial statement or your budget and your spreadsheet, and you're say, "Oh, we need to cut costs here. Look at this big line item." Well, do you know why it's a really big line item. Do you know

what's going to happen? And the implications if you say, "We need to cut this by an arbitrary 20% to make our numbers?" That kind of thinking has really gotten us, I think, to where we are.

Preston (17:22):

So that's the other way that it's super important and it's like, one, it's going to bridge the gaps and bring people together to pull in the same direction. And two, I think could potentially help get more clinicians into those non-clinical places where they'd say, "No, hang on a second. You don't understand. This is why we need this. Or come with me. I'll show you why we need this." And then can actually take the person there or the, whatever, VP and be like, "Look at this. What happens if you cut this budget?" Or whatever. So, I think those are kind of the reasons why I think it really could be beneficial.

Jim (17:55):

That's some great points, and you're making me think of, we've worked with mergers and acquisitions and a lot of times the emphasis of the focus with the merger is, okay, all the financials, and there's almost an overemphasis. I mean, you have to think about that, right?

Preston (18:08):

Yeah.

Jim (18:08):

You said it's the reality. But we also can't neglect the clinical side of things. How is this going to affect patient care? How can we provide better care as a result? What do we need to do? And so really bridging that gap and making sure we're addressing both realities, the clinical and the financial. That's some great insight. And I like that example you said with the engineer that comes. When you're bringing that knowledge and that experience, that's invaluable. Sometimes you can't put a price on that.

Jim (18:34):

If you're just tuning in, you're listening to the Healthcare Leadership Experience. And I'm your host, Jim Cagliostro. This show is sponsored by VIE

Healthcare Consulting, a Spendmend company, which provides leading edge financial and operational consulting for hospitals, healthcare institutions, and other providers of patient care. Since 1999, VIE has been a recognized leader in healthcare costs, hospital purchase services, healthcare benchmarking, supply chain management, and performance improvement. You can learn more about VIE Healthcare Consulting at viehealthcare.com.

Jim (19:07):

Okay, Preston, I love what you put out there on LinkedIn. On a LinkedIn post, you recently wrote, "The ability to analyze financial statements is an invaluable skill." I completely agree. But why do you think that's an invaluable skill? Do you mind walking us a little deeper into that?

Preston (19:24):

Sure. So financial statements give us an understanding and perspective of the operations of an organization, the sort of what goes into it from a dollar perspective and what it's capable of then producing. So, understanding those financial statements can be super valuable in a lot of ways. One, it can give you some, say, you're looking to invest in something. I mean, obviously you need to know is this a good investment? Are they making money? How are they making money? Is this sustainable?

Preston (19:55):

But then more applicable to our conversation, I just think it's really beneficial, again, to my previous point, of knowing what goes into and what's required to operate a large organization. When we look at hospital financials, you see line items, and I think staffing costs are the biggest line item of any hospital. And you see that it's, I don't know, $13 billion. You're like, "Oh, whoa, wait a sec, I didn't realize that. What goes into all that?" Or you see supply costs $20 billion, and you're like, "Man." But in the same breath, you see revenue, $150 billion. Not for a hospital, it wouldn't be that much, but whatever it is.

Jim (20:38):

Gotcha.

Preston (20:39):

$14 billion or something. It starts to shift your perspective a little bit and you start to see, wow, these are really big, a lot of moving parts and pieces. Here's what goes into it. It's also a way to see the red herring where it exists, because in healthcare we have a lot of issues and then everyone's going to spin it in their own particular way. So, you get the president of the AHA who wants to support certificate of need laws and all this other stuff and is going to rally and try to get higher reimbursements for Medicare and Medicaid. All this really affects clinicians. At the end of the day, if a hospital's not going to get a higher reimbursable rate, they're going to make cuts. And where do you think they're going to cut first? They're going to cut personnel first and how that all sort of ties together.

Preston (21:27):

And so, you can see, okay, we'll see a headline. Kaiser loses $4.8 billion, whatever. And you're like, oh my god. Poor Kaiser. I'm like, hold on one second, let's go look. How much of this is an investment loss? Oh, $3.7 billion. You're like, well, hang on, wait. What? And then you look at their operations and you're like, actually, yeah, they lost some money. It's a hard year. There were some bad things going on, but they only lost $40 million and that's a lot of money. But in the scheme of their operation, it's not a crazy amount. Plus, they have a super-rich balance sheet.

Preston (22:01):

So even as I'm talking now, you can kind of see how it makes sense and could be beneficial to help understand. Because I just think that the better perspective we can have on these organizations and on these institutions that make up this $4 trillion industry that keeps us alive and saves us from death and delivers us into life and everywhere in between, it's important and helpful to just understand those perspectives coupled with the financial realities and how it could be working better. Because at the end of the day, these are big organizations, operating financial institutions that happen to treat patients, with health insurers that are after a profit end of the day, period. There's no discussion there. And there's a lot of other organizations in between. They're all working on maximizing shareholder value. And so being aware of those realities and understanding the numbers behind it, I just think is important just to open more of our eyes to what's going on and also to see some of the opportunities of where we work and where we interact.

Jim (23:02):

Yeah, I'll admit, when I first got into nursing, this is going back 2007, that wasn't even a thought in my mind. But making yourself aware, educating yourself, I think that's huge to have a better understanding of, okay, yes, I'm here for patient care, but there is a financial aspect of it. And for years I never even thought about it. So, I'm glad you're digging into it and I'm glad you're sharing with others, hey, these are things that we need to consider.

Jim (23:28):

You've kind of touched on this, but maybe if we could go a little more into it, how does having experienced clinicians in leadership positions help a hospital or a health system? And we can obviously think of clinically and patient care wise, but even financially, I think you've touched some on that. How does having those experienced clinicians in leadership help that health system for the long term?

Preston (23:50):

Yeah. I mean, I think going back to that earlier point too, is understanding those processes and where dollars would be best suited for the system. You talk to any nurse, probably a nurse manager, they get hit up 15 ways since Sunday by a new medical device company or a new pharma, whatever. Trust me, I know. I used to call nurse managers in the OR all the time. They hated when I called them. I tried to call them after the morning meeting, after the ORs were running a little bit...

Jim (24:21):

There you go.

Preston (24:21):

... but they didn't like it. They're constantly getting bombarded. And then you have CFOs that are getting called on all the time. They're like, "We're going to save you money. We're going to make you more money. We're going to..." You're like, what is all this? And then some really great, awesome tech wizard, hoodie-wearing guru comes in and sells this awesome vision and whatever. And then the C-suite says like, "Yeah, let's do this. We're going to

make this extra money. We're going to capture more whatever. We're going to reduce costs here," this and that.

Preston (24:53):

And then you go to implement this $5 billion whatever thing you just signed up for. And then all of your clinicians are prepared to mutiny because you just jacked their workflows in an incredible way. And they're just like, "How much more work do you expect me to do to realize this sort of pipe dream that somebody sold you? And had you just had the previous chair of surgery now working in a nonclinical leadership role, who could have been in on those conversations?" Not to say that every hospital leaves clinicians out of the discussion, but I mean, they're a minor part. But when you can be at the table and say, "This is a terrible idea. Do you know what this is going to do to our workflows? This is not a good investment."

Preston (25:39):

So, it can help really dictate not only don't cut this cost or don't cut this cost, it can really propel the financial health of an organization forward in meaningful ways too, to say, "We have these resources. This is where they'd probably be best allocated for patient care, for patient experience." And it's like, "And here are the returns that you can get from that improvement in patient care and experience." Because I think that's just such a big piece that's missing is the short-sighted financial management to lower expenses and maximized revenue. No one's saying like, "Well, hang on, how is delivering better care going to contribute to those two things? How do we make that the contributor?" But that's how clinicians think. You think about care delivery first, the patient comes first. How do I give them the best outcomes? And when we can be outcomes focused first, then like I said earlier, the other stuff can follow. But it takes the clinicians, I think being in nonclinical leadership so that they're not like the token, okay, we got clinical feedback. So, I think that's that important difference.

Jim (26:43):

Right. Great point. And that example used, I love because it's not just, oh, hey, having a clinician, hey, we can help make decisions that are going to make us more money. But even preventing this is a decision that's being made that's going to waste time and resources and make the workflow even

worse. You can address it from both angles there. I love that example. So, Preston, other than signing up for your newsletter, what are some other ways that clinicians can be educated and prepared for positions of leadership?

Preston (27:13):

Yeah. Well, I think the newsletter's a great place to start. Plus, I try to make it as hilarious as possible. But I think the one thing that is super powerful and helpful is just to make friends with people who are in nonclinical positions. So, I talk to people sometimes who wanted to make that jump in administration or something, and I say, "Well, go spend time in the purchasing department with supply chain, go set up internal meetings." I used to do this all the time in my previous companies. And I mean, listen, I get it. Everyone's super busy. And when you're on shift, bless you if you can find a bathroom break time. It's hard. You know what I mean? I totally understand that.

Preston (27:52):

But it can be very, very meaningful and helpful not only from a political want to move around in an organization perspective, but from a learning perspective is when you can make those relationships and talk with the director of accounting, VP of finance, chief of investments, whomever those people are who are close to the money, the revenue cycle management folks to build those relationships. And more often than not, I know people are strapped, I get it, but you can forge some relationships and start learning that business aspect coming from the angle of what is it that you do? Help me understand. I want to be a better X, Y, Z. So, I just really would love to understand what are you dealing with all day every day? What are the practicalities? What would make your job easier? What makes it super hard? What's the most important thing to be successful in this type of position? And then you can really start to learn those fundamentals and the mechanics and the big drivers of that type of thing.

Preston (28:50):

And then I think that would be the single biggest thing that if anyone's very serious about, I want to move into either just to understand or move into a different nonclinical type of role, is go to where those nonclinical folks sit and

spend time with them and understand what they do on a day-to-day basis and the pain points they experience and how they can teach you the business from their perspective is the biggest thing.

Jim (29:15):

That's a great point. The relationships and the conversations and everything we can learn from one another. Preston, I'd say, I mean, this has been very insightful for myself personally and I'm sure for our listeners. Any parting thoughts, any words of wisdom for our listeners, especially in terms of leadership, anything that you've learned along the way or anything that you'd like to pass on to say, hey, if you're considering leadership in a number of different ways, what's something to keep in mind?

Preston (29:39):

Well, I'll do my best. I don't consider myself terribly wise, so I don't know how wise this parting thought will be.

Jim (29:45):

Go for it.

Preston (29:46):

I think that what it all boils down to in a lot of ways is how we can infuse more empathy into everything that we do, which is also wonderful to think about from a clinical perspective because, I mean, clinicians are dripping with empathy. Why else did you go decide to forfeit years of your life and hundreds of thousands of dollars of your money so that you could go take care of other people? We talk about systems, but I believe people change systems, people who are served by the healthcare system, people who are delivering the care in the healthcare system. And all people really want is to be seen, heard, and understood. And that's empathy. You can be quite the leader in any way, a leader of yourself, a leader of others, a leader of huge organizations if you start with that empathetic mindset that we're here to serve other people and we want to meet them where they are and understand that person's experience so that you can best serve that individual.

Jim (30:48):

That's perfect. What are you talking about? That was exactly what we needed. Seriously, that's a great thing to leave our listeners with. Preston, thank you for being on the show today. And thank you to our listeners who spent time with us. If you have any questions about VIE Healthcare Consulting, a Spendmend company, or if you want to reach out to me or Lisa Miller, you can find us on LinkedIn. You can also find Preston on LinkedIn as well. We at VIE love helping hospitals save money and enhance the patient experience, and we're hoping that the episode today gave you some new insights or ideas to consider and use in your career and in your own healthcare organization. Preston, thank you, once again, for being with us today.

Preston (31:25):

Great to be here, Jim. Thanks for having me. Really appreciate it.

Jim (31:28):

Our pleasure.

Speaker (31:29):

Thanks for listening to the Healthcare Leadership Experience Podcast. We hope you've enjoyed this episode. If you're interested in learning new strategies, best practices, and ideas to utilize in your career and healthcare organization, check out our website at the healthcareleadershipexperience.com. And, oh yeah, don't forget to write and review us and be sure to join Lisa and Jim next time on the Healthcare Leadership Experience Podcast. Thanks again for listening.

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She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin improvement, process improvements, technology/ telehealth, the patient experience, and growth opportunities.

Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping®, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

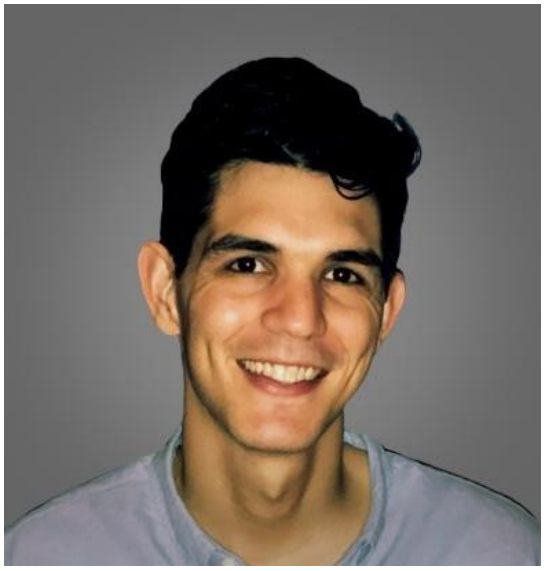
Lisa has developed patented technology for healthcare financial improvement within purchased services; in addition to a technology that increases patient satisfaction through frontline insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey.
She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta. Her book The Entrepreneurial Hospital is being published by Taylor Francis.

MEET JIM CAGLIOSTRO

Jim joined VIE Healthcare Consulting in 2018 and brings to the role over a decade of critical care nursing experience at highly regarded medical facilities across three states.

During that time, he observed both the 'good and bad' of hospital operations in a number of regions, giving him a unique insight and understanding which he brings to VIE Healthcare Consulting's clients.



MEET PRESTON ALEXANDER

Healthcare founder and operator.

Over the past decade, Preston Alexander has managed over $100M in business for global healthcare companies. Then, he decided to leave and founded a medical device company.

Preston has since sold that medical device company and helps other start healthcare companies, grow their healthcare companies, or break into the business of healthcare.

He also consults with, and advises early to mid-stage HealthTech, MedTech, and Digital Health companies.

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