Motivational Interviewing in Healthcare

With Dr. Bruce Berger

Episode 78

Read the show notes or listen to the episode: TheHealthcareLeadershipExperience.com

Bruce (00:00):

We have this literally crazy idea in healthcare that we're driving the bus and the patient's a passenger, the reality is the patient has always driven the bus, what we're trying to do is influence the route.

Introduction (00:15):

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 (00:54):

Hi, this is Jim Cagliostro and you're listening to the Healthcare Leadership Experience. Today's guest is Dr. Bruce Berger, President of Berger Consulting, LLC, and Professor Emeritus at Auburn University.

Today I'm excited to talk with Dr. Berger about motivational interviewing and its role in healthcare. Welcome Bruce, and thanks for joining us today.

Bruce (01:15):

Thanks for having me, Jim.

Jim (01:17):

So I always like to start off these talks with just a little bit about yourself. How did you get into the world of consulting and what do you enjoy about what you do today?

Bruce (01:26):

Well, I started off as a pharmacist, didn't practice very long before I decided I wanted to go back to school and really learn about how to be more effective in the sense that, look, we've got data that shows that for the past 40 years, the rate of non-adherence to medication regimens hasn't changed at all, it's almost 50% in year two of a chronic illness. And this is despite the fact that 40 years ago, we had four times a day, three times a day medication. Now we got once a day, once a week, once a month, once every six months, and the rate still hasn't changed. And I wanted to understand better what's going on.

Bruce (02:06):

And I concluded that the way we talk to patients, and there's the problematic word, “to” rather than with, is part of the problem. And so, I went back to school to study health communication and health psychology. Got a PhD. Taught at West Virginia University and Auburn University, actually created a course when I was in graduate school at Ohio State University in the College of Pharmacy in grad school.

Bruce (02:32):

And after teaching for about 35 years and doing research, I left in 2009 to do consulting. Speaking, I do a lot of speaking. I've consulted for the pharmaceutical industry, health plans, individual practitioners, have a book in second edition on motivational interviewing, and we just wrapped up an e-learning program on motivational interviewing.

Bruce (02:56):

If anybody's interested, my website's very simple is mihcp.com, stands for motivational interviewing healthcare professionals .com. And I think the thing I enjoy most about consulting is the variety of work. I can be working on a study with somebody, I just keynoted a large meeting for nurse case managers, I still write pieces, especially in LinkedIn. So I like the variety.

Jim (03:24):

I have to say, I enjoy following your posts on LinkedIn. And I did fail to mention, I saw you're an author of multiple books and the e-learning. And I think it's a great thing what you're doing. I'm huge on communication. And I love what you said about, it's a lot about how we're communicating with patients. You said it's not talking to them, it's talking with them. And so, I know we're going to get into that.

So let's just get right down to it. What is motivational interviewing? How would you define it and how is it different from the traditional approach that we've used in healthcare?

Bruce (03:54):

Well, motivational interviewing was first developed by a clinical psychologist named William Miller, and it was developed back in the '70s to actually treat people with substance abuse problems. And here's the irony, Jim, to this day, it is still the most effective intervention for substance abuse, and yet, we hardly hear about it in healthcare. We've got an opioid crisis, we've got substance use and rarely do you hear people talking about using motivational interviewing to intervene. And I've done a number of webinars on this.

Jim (04:30):

I'll be honest, Bruce, sorry to cut you off, but I've been in healthcare since 2007 I graduated nursing school and really, never came across the term. It really hasn't been talked enough, at least in the medical side of things.

Bruce (04:42):

And here's one of the reasons why. We are huge in healthcare on evidence-based medicine, but not evidence-based communication. And in fact, this year, for the first time, the American Council on Pharmaceutical Education is including motivational interviewing as part of their accreditation standards. I'd like to think I'm part of the reason why, because I wrote a five-page single-space letter saying, how can you talk about evidence-based pharmacy and medicine, but not evidence-based communication?

Bruce (05:17):

And we graduate people who think everybody knows how to communicate, but that doesn't mean they know how to do it effectively. And so, what MI is, motivational interviewing is a set of skills and a way of being with patients. It's kind of a misnomer, it's not about motivating patients, it's an interview, in a sense, to explore the patient's motivation. "Okay, now you've found out you've got diabetes and the doctor has told you, "You got to take this medicine, watch what you eat, get some exercise." What do you think about all this? In other words, how important is it to you to get your blood sugar down? Tell me in your own words, what does having diabetes mean to you?"

Bruce (06:03):

The idea behind motivational interviewing, because it's patient-centered, and you asked how is it different than what we do? We have this literally crazy idea in healthcare that we're driving the bus and the patient's a passenger, the reality is the patient has always driven the bus, what we're trying to do is influence the route. Does that make sense?

Jim (06:27):

Yeah, I like that.

Bruce (06:27):

In other words, the patient has always decided. My doctor told me I have high cholesterol. And he looked at me and he said, "So we need to put you on a statin." Listen to the language, "We need to put you on a statin." And he knows what I do, and I said, "No, we need to change our eating habits and get some more exercise. I don't want to take a statin. What time do you want to meet me at the gym since we're doing this?"

Jim (06:53):

There you go.

Bruce (06:54):

And he laughed. Okay. Because the fact of the matter is, I'm a pharmacist, I don't want to take a statin. The other thing is I've also had a heart scan and found out that my amount of blockage, they have a score, and any score under 200 is good, mine's five. I have literally no calcification. So high cholesterol is really not going to affect me.

Bruce (07:18):

But the point is that I decide whether I want to do something. The healthcare professional's job is to explore what would make this important to you, what would make you decide to treat your diabetes, to get your cholesterol down, to take the medicine, to eat healthier? And the patient decides, the patient is driving the bus. We have it backwards. We think we're in charge. In fact, we think we're the only expert in the room, and I call MI a meeting of experts. You as a patient are an expert on what you know and understand about the illness. I need to be listening for where are the gaps.

Bruce (08:02):

We were talking, before we started doing this, about COVID. A lot of patients had misinformation about the injection, about COVID. If you don't get that misinformation or missing information corrected, and you've got to get it corrected without causing the patient to lose face, meaning you can't say to the patient, "No, you're wrong," if we do that, they're not going to listen. But if

we're able to say to a patient, "So you're worried about a computer chip and the vaccination, you don't want your privacy invaded, that's important to you." We've got to let the patient know that we're really listening to them and we value what they have to say.

Jim (08:44):

Yeah. I mean, a lot of what you're saying, it sounds like a huge piece of it is asking the right questions and listening, really listening to understand the patients, like you said, exploring their motivation.

Bruce (08:56):

My approach to motivational interviewing, one of the things that we did is we changed the approach. Miller who was a clinical psychologist, developed it for clinical psychologists treating addiction and substance use. And he developed a whole set of acronyms, people in healthcare really struggled with the acronyms. For example, one of the acronyms is READS and the D stood for develop discrepancy, that meant nothing to healthcare people. It meant create cognitive dissonance, even that would be difficult for most healthcare professionals to know what to do.

Bruce (09:33):

We changed it to a sense-making approach. So it's based upon the work of a woman named Brenda Durbin who's a researcher in communication theory and basically, it says something profound and simple, all of us are sense-makers. Even as we're talking right now, we're deciding whether we make sense of each other based upon what we bring to the conversation. So we're trying to train people to listen for, how is this patient making sense? And in their sense-making, what information is either missing or misinformation?

Bruce (10:10):

Let me give you a really simple example. Patient with high blood pressure says, "I don't know why I need this medicine. I feel fine." Right?

Jim (10:18):

Okay.

Bruce (10:19):

Now most healthcare professionals will look at the patient and say, "Listen, you can't tell when your blood pressure's up. You can't feel when it's up." And they might as well just say, "Stupid," at the end of that sentence.

Bruce (10:33):

We would say, "Because you're feeling okay, you're really wondering, why do you need this medicine?" What's the patient going to say now? Exactly. And what will they have learned? That I've listened to them without judgment. Now I'm going to say, "That's a reasonable thing to ask. Would you mind if I shared some thoughts? And I'd like to hear what you think." You notice the sharing?

Jim (10:59):

Yes.

Bruce (10:59):

We're negotiating here. And so, now I would tell the patient that, "Unfortunately, high blood pressure is one of those conditions that doesn't have any symptoms, and the first symptom is stroke or heart attack. This medicine can greatly reduce your risk of having a stroke or heart attack even when you feel okay."

Bruce (11:22):

I'm now not going to say, "Therefore, you need to take it," I'm now going to say, "Where does that leave you in terms of thinking about taking the medicine to reduce your risk?" So I've listened to what the patient has said, I've heard in their sense-making that their sense is that if you feel okay, everything's okay. My job is to help them understand how you can feel okay and be at risk.

Jim (11:48):

Sure. You're making me view it as, it's a partnership, not a dictatorship.

Bruce (11:53):

Correct. It doesn't work any other way. It's the reason that non-adherence has not changed for 40 years.

Jim (12:03):

I was listening to one of your seminars last night on YouTube, and there was a quote, I had to write it down because I thought it summed it up great. You said, "We are not trying to convince them, we're trying to ask them to consider another way of thinking and invite them to change their mind." I love how you just laid it out like that.

Bruce (12:21):

We really consider it an invitation because when I now say to the patient, "Where does that leave you now?" after I've now given them new information about how they can feel okay and still be at risk and what the benefits are to them of taking the medicine, reducing that risk, right? I now am going to ask, "Where does that leave you now?" because I want to give them the opportunity to either say, "Okay, now I know why I need to take it," or, "Come on, you're kidding me. I can feel this good and still be at risk?" I want them to push back because if they don't push back in my office, they're going to go home and not take the medicine.

Jim (13:03):

Good point. Yep. Yeah. So I really think you've answered the next question I was going to ask you, unless you want to add something to it, but I think you've answered, what's the problem with the historical or current model, the approach that we have in healthcare, and where does it fall short? I don't know if you want to add anything to that. I think you've kind of covered it.

Bruce (13:20):

The only thing I would add is that I did a two-hour talk at the American Pharmacist Association meeting a couple of years ago. I divided my talk into two parts. The first part was patient has a new prescription for a new diagnosis, let's explore with them some fundamental questions. Again, I know people are going to talk about time, but this is going to lead into what's wrong with healthcare today also.

Jim (13:45):

Sure.

Bruce (13:45):

We need to ask them, "Okay, now that you have this new prescription, new diagnosis, where are you?" In other words, "How serious do you think this is? How important is it to you to take the medicine?"

Jim (13:58):

Yeah.

Bruce (13:58):

Right? That's the new patient. For a patient that's been on a medication that's having problems taking it, now I'm going to use a different approach.

Bruce (14:08):

So here's something else that I want to tell you about what's problematic about... We teach our healthcare practitioners to talk about non-adherence. Let me give you an example. Let's pretend for a moment you're a patient with high blood pressure. And on average, you take your medicine four out of seven days a week, so we would call you non-adherent, right?

Jim (14:32):

Right.

Bruce (14:33):

The crazy thing about it is you're adherent four days a week. What are we going to talk to you about?

Jim (14:38):

About the times you're not taking it.

Bruce (14:40):

That's right. And not only that, I'm going to call you up and I'm going to say, "Jim," right? Or I'm going to confront you and say, "Jim, look, I noticed you're only taking your lisinopril four days a week, you really need to take it seven days a week if you want to get your blood pressure down." And you're going to either say something to the effect of, "Okay, yeah, yeah, I know I need to do better," whatever. The point is, the next time around, guess what you're going to be doing again, taking it four days a week.

Jim (15:07):

The same thing.

Bruce (15:08):

Now here's interesting, and this is part of what's problematic with the way we teach students today. If I tell you what I just told you, that you really need to take it every day, what do I learn? What do I learn as a practitioner?

Jim (15:22):

I mean-

Bruce (15:23):

Say nothing.

Jim (15:23):

Okay. Yeah.

Bruce (15:23):
Nothing.

Jim (15:25):
Yeah.

Bruce (15:25):
Nothing.

Jim (15:26):
Right.

Bruce (15:27):
The only thing I learn is that you're going to tell me, "Okay, I'll do it," and I know you're not going to. And not only that, it's a negative conversation. I'm calling you up to tell you, or I'm confronting you to tell you you're not doing this right, right?

Jim (15:41):
Mm-hmm.

Bruce (15:41):
What would happen if I said, "Jim, I noticed that you're taking your lisinopril four days a week out of the seven, and that's a really good start at getting your blood pressure under control. What's made it important for you to take it on those four days?"

Jim (15:55):
It's good to think about it, yeah, and then it builds trust in you saying all right, this guy's a good guy.

Bruce (16:00):

Will I learn something? Will I learn something about your motivation for taking this medicine that I might be able to use to talk to you about the other three days?

Jim (16:11):

Yep.

Bruce (16:11):

Even if you're taking it two days a week, I want to know why you're taking it at all. That's important information to me. That's what motivational interviewing does that's different.

Jim (16:24):

Absolutely. I think that example really, really explains to us the reason or the benefits of it. I mean, you answered this question too, how does motivational interviewing help patients? And we see that in terms of adherence and compliance, and it ultimately accomplishes better outcomes-

Bruce (16:40):

Much better outcomes. We did a huge study for Biogen. They have a drug called AVONEX for MS, they had a 13% dropout rate, and they came to us and they said, "Can you help us?" That's a huge dropout rate. We did a study of their patients, then we built for them, for their call center people, MI interventions. We did a clinical trial with a treatment group of patients that got the same thing as the control group, except they got MI interventions in the treatment group. After four months, we dropped the dropout rate in the treatment group to 1.2%.

Jim (17:21):

Wow.

Bruce (17:23):

That was a savings to Biogen, company-wide, of $93 million.

Jim (17:29):

Wow.

Bruce (17:31):

I mean, these are like five to 10-minute consultations because we learned that people were dropping out for different reasons. Some people feared the IM injection, didn't know how to do it, said it was painful, we taught them how to do it in a less painful way. Some still had flareups after they started the drug. Their sense was it was no longer working. They didn't understand it wasn't a cure, and so if they had dropped out, their flareups would've increased and they would've gotten worse.

Bruce (18:07):

So we first though had to say to them, "Because you started having flareups, you worried the drug wasn't working." So we have to first acknowledge how they're thinking, but then we've got to give them information to tell them, "You're still going to have flareups every now and then because there is no cure for MS, but if you stop taking the medicine, your flareups and your MS are going to get worse much faster. I don't want to see that happen to you."

Bruce (18:34):

So again, it's a different approach that really values the input of the patient, even when the input's misguided, because it tells me what I need to do.

Jim (18:46):

Yeah. And it's looking not just at changing the behavior, but really getting to the heart and into the mind of the patient to truly understand, and then, you can work together to achieve the desired results.

Bruce (18:58):

And to understand what's important to them. In other words, we had an asthma patient that wasn't using her daily inhaler. She said, "I just hate being reminded that I got this thing." And I said, "Let me ask you something. What could you do?" I said, "If your asthma was under control, what would that allow you to do that you find difficult now?" She teared up and she said, "I could play tennis again." Now we found out what's important to her.

Bruce (19:27):

It doesn't matter what's important to me, she's only going to be motivated by what's important to her. And so, we then start talking about steps that she could take to play tennis again by using the medication, and she became adherent, but you had to explore what was meaningful to her.

Jim (19:49):

You're bringing me to the bedside, Bruce, where I would remember patients who would bring in pictures of their grandchildren and said, "That's the reason I have to get better. That's the reason I want to stay healthy and be around longer. I want to see them graduate or get married." Then you learn the motivation. Okay, I would love it when patients would have that and say that because it's like, all right, then let's do this.

Bruce (20:11):

Yeah. And you know what's sad, Jim, problem is we even then look at the patient and say, "Well, then you need to take the medicine," rather than, "You really love your grandkids." See? And I'm not talking about being false, I'm talking about genuinely connecting with what's emotionally important to the patient, and you've got to do that in order to really have influence in a positive way. And so saying to that patient, "You love your grandkids. You miss not being able to spend time with them. You want a future where you can spend time with them." And you see what I'm doing? I'm helping build pictures.

Jim (20:55):

Yeah. I'm going to say that again because I love that, genuinely connecting with what's important to patients, I think that's-

Bruce (21:00):

Emotionally. They love those kids, we need to say that out loud so they know we get it.

Jim (21:08):

Yeah. Awesome. 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 purchased services, healthcare benchmarking, supply chain management, and performance improvement. You can learn more about VIE Healthcare Consulting at viehealthcare.com.

Bruce (21:43):

Okay, Bruce, so we understand, we've been discussing that this motivational interviewing indeed helps patients, but is it challenging now, and you've touched on this already, is it challenging to adopt this approach for healthcare professionals in particular?

Bruce (21:57):

It's become more... It's not hard to teach people. In other words, I mean, we know that you need a minimum of eight hours of guided training, all right? But hopefully, the schools will take it on and do more of that, but we train people.

Bruce (22:12):

But here's the problem, where we're going in healthcare is backwards. There's a guy named Jim Farrell who's on LinkedIn. He's a brilliant guy. He

does a lot of coaching with Fortune 500 companies and C-Suite. He has told me personally that all of the industries that he deals with are moving away from what he called a World War II mentality, meaning they're moving toward, "We really need to take care of our employees. Turnover is killing us, we need to help them with health benefits, we need to help them with pensions. We need to provide them with a work environment that helps meet their needs." All right?

Jim (22:53):

Mm-hmm.

Bruce (22:53):

One industry is moving in totally opposite direction, healthcare. There are so many toxic systems out there that are putting profits ahead of people, people meaning their workers and the patients. We are watching burnout at a level we've never seen before because healthcare systems are basing staffing on things like number of prescriptions dispensed, number of immunizations given, RVUs, "Oh, you should only be spending 11.2 minutes with the patient and no more, even if the patient needs more time in order to have an effective outcome."

Bruce (23:32):

Somebody asked me the other day, "Well, what am I supposed to do if I only have, at most, 30 seconds with a patient?" Well, no amount of motivational interviewing training can solve that problem, that's a systems' problem.

Bruce (23:51):

There's a couple of videos on YouTube with me showing what happened with an asthma patient. The patient's daughter had been in the emergency room three times that year because the mother wouldn't allow the daughter to use the chronic inhaler because she looked it up and saw it was a corticosteroid, she misunderstood what that steroid was. She didn't want her daughter using a steroid. Everybody chastised her at the emergency room. I showed her understanding and in fact, said to her, "You're really worried about your daughter using a drug that you think can harm her." And for the

first time somebody understood her. After we were done, the whole conversation took six minutes, the kid had not been in the emergency room for at least three years after that.

Jim (24:41):

Okay. Makes a difference.

Bruce (24:42):

Now, six minutes, right? Some pharmacists will tell you, they don't even have a minute to talk to a patient. That's not an MI problem, that's a systems' problem.

Jim (24:54):

Sure.

Bruce (24:55):

And what's really horrible is we have people that are graduating from nursing school, pharmacy school and medicine, they have a code of ethics, they have standards of practice that put patients first, and yet they go to work for organizations that set up a moral conflict for them because if your primary goal is to put patients first and the staffing makes it impossible, this is the heart of burnout and chronic stress.

Jim (25:26):

Yeah.

Bruce (25:27):

And so, MI can't solve that problem. But if you give me three to five minutes with a patient, MI will make a huge difference. In fact, well, I've done a lot of work with MTM companies and also a huge chains call center where they're calling patients up that are not taking their medicines well, and I even taught them what to say and do using MI when the patient pushes back because it's cold call, "Who the hell are you calling me?" Right? Because they think it's a

scam. Well, how do we respond to that in a way that puts our foot in the door using MI?

Jim (26:02):

Sure. In a previous episode, we talked with... she's a nurse. And she was saying, in healthcare, it's one of the few industries, probably the only one where there's this expectation of martyrdom, where you talk about the staffing, you talk about it's a systems' problem. Do you believe there's other things that hospital leaders, administrators, managers can be doing to equip their staff even in terms of, I mean, you mentioned the e-learning that you offer or encouraging training, even providing that training for employees?

Bruce (26:32):

Well, yeah. I mean, all this training is out there. And you got to make sure, there's a lot of people that train MI that honestly don't know what they're talking about, so like anything, you want to get legitimate trainers.

Bruce (26:46):

But on the other hand, if you train somebody, like we put people through seven, eight years of pharmacy school and they go to work in an environment that doesn't give them any time to talk to the patient, then training is wasted. So they've got to give them the staffing they need in order to talk to the patient.

Bruce (27:08):

Last year, for the first time in this country, the cost of non-adherence to medication regimens went over half a trillion dollars, 500 billion bucks. That's tip of the iceberg because that doesn't include other health behaviors like weight loss. 70% of the people that were overweight that got COVID were the most seriously ill.

Jim (27:34):

Yeah, we don't talk about that enough.

Bruce (27:36):

You hardly even heard about it. And so, these are huge costs. We've got to get to the point where we stop this short-sighted way of thinking about what we do and look at long run kinds of results. Motivational interviewing and other evidence-based approaches like it can save the healthcare system tons of money, but you've got to have some time to talk to patients. When you have staffing that's built on just dispensing drugs and giving immunizations and doesn't build in time to talk to the patient, you can't do this stuff. And this is where burnout occurs because you've got people who want to talk to the patient and they can't.

Jim (28:23):

That's one thing that I appreciate. I worked, actually, night shift for most of my career in the hospital, and that's one thing I appreciated. Things were a little quieter in terms of going on and off the floor for tests and phone calls. You actually had time to sit and talk with the patient and listen to them and really get down to, okay, what's bothering them or what is their motivation?

Bruce (28:42):

Well, here's something else, a simple suggestion that would help a lot, and actually, some hospitals are doing this. I don't know why we do discharge counseling when the patient's ready to leave, they don't want to listen to anything, they want to leave.

Jim (28:56):

Yeah. Yep.

Bruce (28:57):

Do the discharge counsel the day before they're ready to leave.

Jim (29:01):

Yeah.

Bruce (29:02):

They're a captive audience, they'd want to talk to somebody. When they're ready to get out of the hospital, they don't want to listen to us going through their med list.

Jim (29:11):

Yep. I've worked in places where they said discharge planning begins as they're entering the hospital.

Bruce (29:17):

Right.

Jim (29:17):

And I love that where we're thinking about that in terms of what does the patient need to go home? Are there needs at home that need to be met? Or are there different challenges that this patient in particular needs help with leaving? But you're right, I've been in the patient side of it and it's like I'm just trying to arrange my ride and what else is going the rest of the day and you're not listening, you can't retain all that information.

Bruce (29:38):

And like I said, if there's anything... one message that I would give leaders in healthcare, it was you have got to stop objectifying your workers and patients. In other words, when you treat people as objects or like they're replaceable, anybody could do the job, the job's interchangeable, and you don't even give them an opportunity to have input into what's happening, you're objectifying them. And objectification begets objectification. Oftentimes, when we objectify healthcare workers, they objectify patients. It's no longer a human being, it's the diabetic in 214, that's not a person. And I'm saying, objectification is a major source of organizational problems in the delivery of care. The people in charge have got to start allowing for input on how to fix these problems and the people that are working in them and take them seriously. Right now, they're not.

Jim (30:52):

Yeah. I think you explained it so well, Bruce, and I mean, I appreciate, not just your explanation, I believe I understand motivational interviewing much better now. I mentioned to you earlier that my wife was familiar with this motivational interviewing, and she works in the public schools, and it's something that they received through orientation, but throughout my career in healthcare, was never brought up, was never explained, didn't have any training with this, but I appreciate the value of it. And the examples that you use, I mean, the results speak for themselves.

Bruce (31:22):

And like I said, what's frustrating for me is we have this opioid crisis, and you hardly hear of anybody teaching MI to help, first of all, talk to a patient when they're going on an opioid in a way that doesn't make them think you're accusing them of anything, right?

Jim (31:40):

Mm-hmm. Mm-hmm.

Bruce (31:40):

And then, if you have a patient that has substance use disorder, opioid use disorder, how do you talk to them in a way that helps move them forward rather than get entrenched?

Jim (31:52):

Yeah. Good stuff. Any last thoughts? I really like what you summed up in terms of the objectification begets objectification. We need to stop doing that in healthcare. Any final words you'd like to leave in terms of healthcare leadership? Again, I think you summed everything up beautifully, but if there's anything else you want to add.

Bruce (32:09):

If I've learned anything over the course of my career, I have finally come to the realization that we're relational. Human beings are hardwired relational.

And the reason that's important to understand, I'm very proud, at the end of this month, I'm going to the American Association of College of Pharmacy receiving the Distinguished Service Award from the Association. I'm very proud of it.

Jim (32:33):

You should be.

Bruce (32:35):

But what I want you to understand that I understand, I'm getting the award, but I didn't do it. Meaning, you know the expression I've stood on the shoulders of giants?

Jim (32:46):

Yep.

Bruce (32:46):

Well, I not only stood on the shoulders of giants, I've stood on the shoulders of short people who are pretty darn smart too.

Jim (32:52):

Okay.

Bruce (32:52):

Everything that I have done has resulted from relationships. Somebody taught me how to think. Somebody taught me how to eat and drink, right?

Jim (33:02):

Mm-hmm.

Bruce (33:02):

Somebody taught me how to do science. Somebody taught me how to do research. Every study I've done has been involved with somebody else that

I'm getting the award, but that award is the result of all of my relationships, with graduate students, other faculty, and I'm very clear about that. So yeah, I'm proud to get it, but I also know that it would be delusional to think I did it. You follow what I'm saying?

Jim (33:30):

Well said, absolutely.

Bruce (33:32):

If leaders get that, they will treat the people they lead much differently. They'll know they couldn't have gotten to that place without so many people helping them.

Jim (33:45):

Thank you, Bruce. That's a great way to end our talk here. Thank you for being on the show today.

Jim (33:50):

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. And Bruce mentioned he's also on LinkedIn, please follow him, he puts out some great content.

Jim (34:05):

We at VIE love helping hospitals save money and enhanced the patient experience. And we're hoping that the episode today gave you some new insights, some new ideas to consider and actually use in your career and in your own healthcare organization.

Bruce, once again, thank you so much for being on the show today.

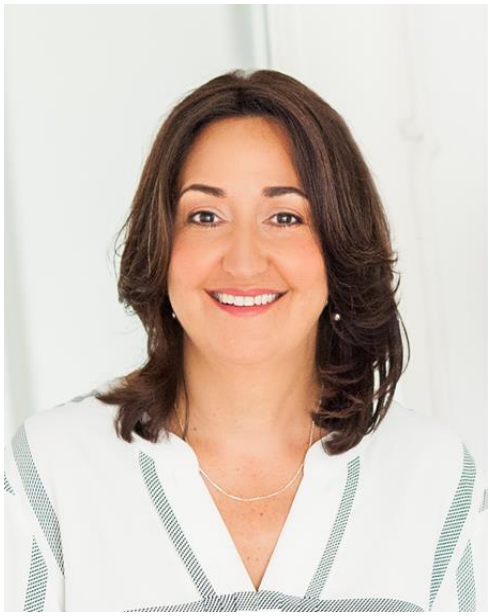
Bruce (34:22):

My pleasure.

Speaker (34:24):

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 rate and review us. And be sure to join Lisa and Jim next time on the Healthcare Leadership Experience Podcast. Thanks again for listening.



MEET LISA MILLER

"It's important for hospitals to have a clearly defined cost savings strategy with purchased services as a component to that strategy. We provide our clients with a focused roadmap to achieve those savings through our expertise since 1999."

Lisa Miller launched VIE Healthcare Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

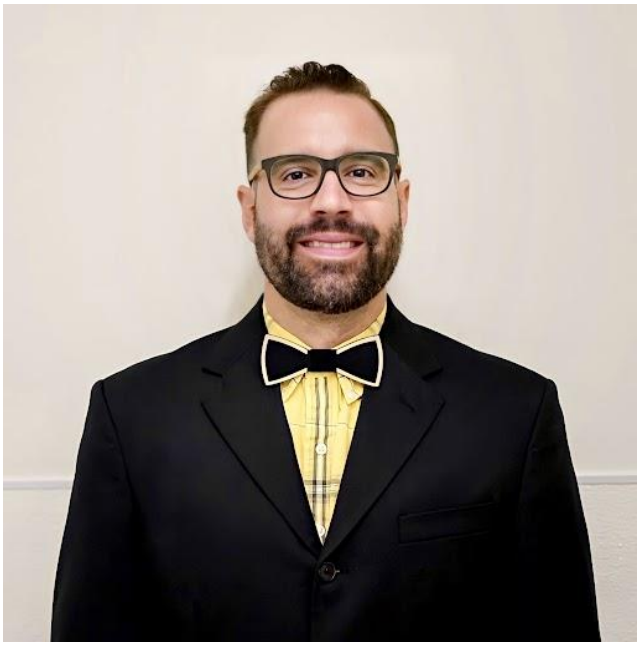
She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

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.

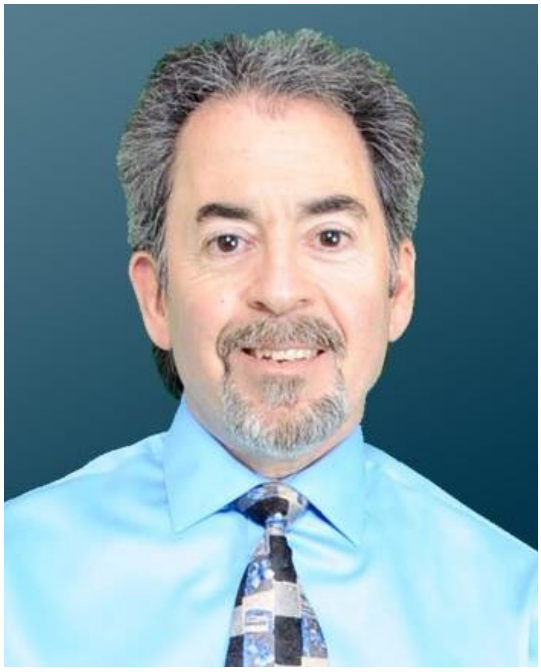


MEET JIM CAGLIOSTRO

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.

LinkedIn:
https://www.linkedin.com/in/jimcagliostro/



MEET BRUCE BERGER, PH.D.

Bruce Berger is a professional health coach, author, and keynote speaker. As the President of Berger Consulting, LLC., he has been helping health care professionals help patients manage chronic illness and health behaviors through motivational interviewing for over 20 years.

LinkedIn:
https://www.linkedin.com/in/bruce-berger-phd-b557a2b/