Episode 4: Leading Healthcare Transformation through Empowerment, Culture and Strategic Clarity

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Geoff: Hello, and welcome to "Taking the Lead," a podcast from the Radiology Leadership Institute that profiles radiologists as leaders, seeking insight and inspiration from a variety of perspectives and experiences. I'm Geoff Rubin. Today, I am speaking with Jonathan [00:00:30] Lewin, Executive Vice President for Health Affairs for Emory University, Executive Director of the Woodruff Health Sciences Center, and President, CEO, and Chairman of the Board of Emory Healthcare, the largest healthcare system in the state of Georgia with an estimated economic impact of $8.2 billion. Within these roles, Jon oversees an organization with over 26,000 employees that manages 615,000 [00:01:00] unique annual patient visits, garners almost $600 million in annual research funding, and is currently training 5700 students, residents, and other professional trainees.

Prior to joining Emory in 2016, Jon served as the Martin Donner professor and chair of radiology at Johns Hopkins University for nearly 12 years and as senior vice president for Integrated Healthcare Delivery for [00:01:30] Johns Hopkins Medicine during his final 3 years there. Our conversation emphasizes how early work experiences influenced his approach to leadership, the critical role culture plays in an organization, and why radiologists are well suited to health system leadership. [00:02:00] Jon, welcome.

Jon: Well, thank you, Geoff. Really, it's a pleasure to be here with you to be able to spend some time chatting about my journey and I'm looking forward to this coming program.

Geoff: And we're looking forward to hearing about you and your leadership insights. Perhaps we could start by exploring some of your early influences. Tell us a little bit about your childhood growing up.

Jon: Well, I am the youngest of [00:02:30] three kids and my father was a general practitioner. In the old days when he was out maybe two nights a week delivering babies, I discovered in our basement as I was cleaning out the house equipment he used to use for surgery, removing foreign bodies from the eye, and he graduated medical school in 1938. So it was really in a day when you did everything as a doctor, as a general practitioner. I really had him as a role model of a physician from very early on, but [00:03:00] never thought I was going to be a doctor until really much later in my life. I enjoyed growing up outside Cleveland, Ohio, great place to grow up, had a wonderful time, and had a lot of opportunity to really do a lot of different things.

As I was growing up, I had a lot of very different jobs. I was somebody who, at the age of 14, told the people at a local movie theater that I was 16 so I can start working as an usher, worked [00:03:30] there through high school. But then

summers, did a variety of things, everything from blacktopping driveways to repairing air conditioners, to being a surveyor's assistant in terms of surveying sewer lines through the woods, even working for a stint for a city where I collected garbage on the back of a garbage truck. So really had a wide variety of experiences, which I think helped me understand sort of the [00:04:00] workforce that I'd have now since there aren't too many jobs out there that I haven't had something to do with that wasn't all that dissimilar.

Geoff: That is a remarkable diversity of experiences. As you think back upon them and upon how they have prepared you for leadership today, are there any, you know, vignettes that come to mind where you recall lessons that you carry with you today?

Jon: Absolutely. My [00:04:30] first pay job, other than being a paperboy, which I actually was programming for a company called Kai Corporation in the summer between eighth and ninth grade. I got a job coding, which is interesting, and it was the old days when I was working on an old UNIVAC 1108 computer with core memory. I think it was 10K of core in a computer that filled several rooms back in the early '70s. [00:05:00] And what I learned there was really the generosity of spirit. Obviously, as a, you know, eighth grader, I could not be all that good at computer coding. And the people that I worked with were so good at teaching, at keeping us moving forward. And again, I don't remember what I was getting paid, probably about $1 an hour. But it was a great experience in how impactful mentors could be in the workplace, and how important a positive work environment could be.

I think that, [00:05:30] you know, was in contrast to the experience, or literally, you know, riding on the back of a garbage truck or, you know, mowing the lawn of a municipal cemetery, which all have had their own struggles or their own challenges. And I think that probably gave me a great understanding of how hard many of the jobs are that we don't really pay attention to. In all of our institutions, there are people who are working on environmental [00:06:00] services, working in maintenance of buildings and grounds, and those are really hard jobs. And those are jobs where pride in what you do can be very important in terms of the whole organization, the whole institution. And I think as a whole, many of us don't appropriately value and appreciate what people bring to work every day to make an organization hum.

Geoff: Those are tremendous messages and tremendous learnings from a [00:06:30] very early stage. As you sort of look back and aggregate all these experiences, how would you describe your leadership style today that is undoubtedly been contributed by all of those experiences?

Jon: I think the most important thing for me, in terms of how I bring those experiences forward, is the fact that everyone comes to work with the ability to make a difference, no matter what job it [00:07:00] is in the organization. We're actually up to about 32,000 employees now in the health sciences and health system for whom I'm responsible. And I don't believe there is one of those employees who can't make a positive difference. So for me, I think it's a matter of empowerment. They know how to do their job better than I ever will at every level. So how is it that in leadership, we can create an environment where they [00:07:30] both feel that they have the opportunity to make a positive difference and where they're listened to? So when they do have an idea, when they do have an opportunity to make a difference, we don't squelch it from the top.

And I think that's the most important thing that I've learned and one of the hardest things to actually implement and execute because we in leadership oftentimes become disconnected from the reality of how hard it is to get things done. From a [00:08:00] leadership philosophy perspective, it's really the idea of delegation and empowerment. And that's, I think, the style I've tried to work on in my own personal leadership journey.

Geoff: Would you say that this has been a consistent approach to your leadership through your years from the time that you began as a division chief through your time as chair? Or has there been [00:08:30] some evolution in your consideration of your leadership philosophy as you have gained experience?

Jon: Well, I think from a philosophical perspective, I don't think that's changed a lot, but certainly from an ability to execute on that, I continue, I'm still learning. And that's, I think, an important message for the listeners is that, you know, hopefully, you never stop learning, you never stop becoming better because I hope that tomorrow I'm a little bit better of a leader than [00:09:00] I am today moving forward. So the philosophy, I think that's really how I started from the beginning, mostly just from the experiences I brought from role models that I had, in particular, you know, as I was growing up.

I think the idea of respect and empowerment was something that philosophically I understood sort of innately, but from an execution perspective, boy, I learned a lot from the early days, you know, when I hired my first employee at [00:09:30] Case Western Reserve University, University Hospitals of Cleveland, running the MRI division and trying to build a lab. And I remember I hired a computer programmer, my very first hire, and sat down, we looked at each other and figured, "Okay, what do we do now?" And I think the early days of building the lab as the research part of the MRI division was really where I got my first opportunity to see, how do you successfully create

an organization and create a culture [00:10:00] that breeds success and engagement moving forward?

Geoff: Are there any experiences in particular that you can recall related to the execution of your philosophy that stand out as real learning opportunities for you where you perhaps said, "Well, you know, maybe I could have done that a little bit differently," and it has stayed with you?

Jon: Well, I think one of the things that [00:10:30] we learned...so I should go back to sort of the early days and a little bit of context. So I had been a fellow and then was on faculty or on staff at the Cleveland Clinic, neuroradiology fellow and then on staff as a junior faculty, I guess, the junior staff as they called it there. And I got recruited to come back to University Hospitals of Cleveland, Case Western Reserve University, to fill the role of MRI division chief, and part of my interest in that was [00:11:00] the opportunity for research. And the research group, the MRI research group, was a very distinguished group, had done a lot of really important work and I had got some of my earlier research experience working with the group as a resident in developing MRI angiography techniques. A lot of firsts were there, the first gated black blood cardiac MR was done at Case Western while I was there as a resident, so it was really a [00:11:30] very distinguished group.

And as I was coming in, the group essentially on block picked up and left and moved to St. Louis, to Wash U. So I was left with an empty research facility coming into clinical, obviously clinical was still there, still working, and that was not an issue, but the research group was gone. And it was probably the best opportunity I ever had because I really was able to start recruiting folks myself, sort of finding people [00:12:00] that fit with how I wanted to work, how I saw the opportunity, and how I was able to, I think, help them succeed. And one of the most important things I did was I worked with our chair, John Haga [SP], in recruiting a partner for me on the science side, Jeff Durk [SP], who was working at one of the other local hospitals as an MR physicist. I think he was the third person to hire into the group. I had had two programmers, [00:12:30] you know, one sort of postdoc programmer and another just employed staff programmer to help with the MR research side and bringing Jeff in was really transformational for the group, and we started together to recruit students and postdocs and more staff.

And one of the things I think we determined together was the concept that can be articulated as the good people you bring in are divided by [00:13:00] the disruptors or toxic people. And your productivity is really very simple. It's just that formula. It's the good people divided by the toxic. So if you have no toxic people, no people in the group who, again, I guess bring negative energy to a

research group, you have an infinite productivity. And the minute you bring one person in who tends to be a disruptive force or toxic force, it brings you down phenomenally. [00:13:30] And so really, from the beginning, it was kind of, how do you work on avoiding those toxic or negative personalities in an organization, in a group? When you're building a research group, it was a lot easier to do that.

And I think one of the things that we learned was the mistake of bringing someone in because they have skills, because they may be a rainmaker scientifically or clinically, whatever, and not paying enough attention to the strength of character that they bring. [00:14:00] That's something again that very early, we realized together in running the lab that made a huge difference. And I think since then, I've worked hard to try to keep negative energy, pessimism, disruptors, toxic people out of an organization, or at least out of a leadership team as much as possible.

Geoff: Yeah, that's a really strong message and one that any leader can resonate with. Any specific pearl that you can offer [00:14:30] around avoiding toxic personalities?

Jon: Well, I think that can be a challenge. And again, the bigger the organization is, the harder it is, you know, to completely avoid having those people. But I think certainly for anyone who is recruiting, I think there are a couple things that are important. One is, if you have someone who's coming on to your leadership team, in particular, you're the role model for your team. And certainly, your leadership team is going to be a role model for the [00:15:00] rest of the organization. So one could never spend too much time, too much care in recruiting team members. I recently hired a new dean of our School of Medicine here about...he's now been here a little over a year, he's been absolutely fantastic.

But as I look back at the recruitment process, I probably spent three or four hours meeting with him in person before we actually made the offer and signed him up. [00:15:30] It was time very well spent because of a key role in an organization like the dean of the School of Medicine for me would have been a disaster to not get the right person. So one thing is don't skimp on time face to face, sitting talking to somebody who's a key recruitment, a key hire. The second is always do the due diligence calls yourself. You know, as you move up in an organization, you can end up with recruiters, search firms, people who [00:16:00] are willing to help who we pay to do that footwork. And that's great. And certainly, it's important to let them do their job. But I always make at least a few calls myself personally. If there's someone I know in an organization from which we're recruiting a leader, I'll try to call them so that they can say

what they need to say in person on the phone rather than through a third party. And I think that that due diligence is critical. [00:16:30] Never skimp on the time it takes to make those phone calls yourself.

And then I think the third thing is look for the attributes that are really going to be important in terms of meshing with the culture you're building. For me, it's a team player side of things. How do they describe their prior successes and failures? You know, do they take responsibility for their failures? Do they admit they have failures? I think anyone who doesn't admit they've had some failures [00:17:00] is not being either true to you are true to themselves. And how do they articulate it? Do they take responsibility? Do they blame others? How do they look at successes? Do they take responsibility or they take the credit for it? Or do they spread the credit to their team? Those are really telling things that can be very helpful in an interview. And it's really a matter of using, you know, what are called behavioral interview techniques, which I find really critical in trying to dig [00:17:30] into somebody as you're recruiting your leadership team.

Geoff: Wow. So important for our listeners to be hearing what you're saying, Jon. This is terrific. Let me jump to your time at Johns Hopkins for a few moments. You served in two key institutional roles there, chair of radiology and senior vice president for integrated healthcare delivery. I think our listeners are probably familiar with the responsibilities of the former role, but [00:18:00] how would you describe your responsibilities in the latter role?

Jon: Well, you know, there's actually a bit of a story of how that latter role was developed. I had been at Johns Hopkins as the chair of radiology for around, I think, about five or six years, and the dean at the time, Ed Miller, was just a fantastic person, a great mentor, great role model. And I started getting interested in healthcare transformation. It was before the [00:18:30] Affordable Care Act or Obamacare days, but it was clear that medicine was going to change. And I started really reading up, getting involved in healthcare transformation. And there was a small sort of a think tank that the dean had created. It was about probably around...I think there were two doctors, maybe three or four administrative leadership, maybe about six or seven other members across the organization.

And [00:19:00] I asked him, "Well, would it be possible for me to get involved with that?" And he gave me the opportunity to sit with this group that was charting the future of healthcare for Johns Hopkins, for how would we look at the transformation that was going to need to happen around us? Around the same time, my friend, Scott Gazelle, up at Mass General, and I were talking about this, and he told me about a program that was just getting kicked off at

the Harvard Business School on [00:19:30] managing healthcare delivery. It was a one-year kind of certificate type of program with, you know, three weeks on campus and intercession work between those sessions. And I ended up signing up and doing that as well, just to learn more about healthcare transformation and about healthcare management. And as a result of those, I ended up getting more and more ingrained in the conversations at Hopkins about, how do we address the changes [00:20:00] all around us?

Around that time, I got a new dean, Paul Rothman, who was great, very dynamic person. When he was offered the job before he actually was on campus, I asked if I would coach their strategic planning for Johns Hopkins Medicine for the combination of the medical school and the health system. And so he put me in this role and I was working with somebody who was the former secretary of Health and Mental Hygiene for the State [00:20:30] of Maryland, had recently left that role and had come to work at Hopkins in policy and strategic planning, and the two of us were given the opportunity to help create a strategic plan for the organization and it turns out there hadn't been a strategic plan since 1996. So it was pretty remarkable that, again, when we started doing this somewhere around 2011, 2012, we really started with a fairly [00:21:00] blank slate.

And in putting this strategic plan together, one of the pillars of the strategic plan was healthcare integration, integrated healthcare delivery. And that was looking at, what was our geographic footprint? How did we interact with the insurance world? How did we interact with our own insurance products? How did we look at integrating our new partners? We had recently merged several hospitals into Johns Hopkins Medicine into the [00:21:30] health system. That was all part of this integration pillar. As we went and implemented the strategic plan, and as it was moving forward, that was a pillar that just wasn't moving as quickly as the others, which were more straightforward things like research, innovation, things that were sort of more bread and butter.

As part of that and talking to Paul Rothman, the dean, and Ron Peterson, who was a health system president, I started to get more and more involved in [00:22:00] how to execute on that arm of the strategic plan. Ultimately, they asked me to take on a new role to be officially accountable for it in the senior vice president role, working with several of the other people on the administrative side. The person who ran our insurance business still runs our insurance business, or their insurance business, Patty Brown, just a brilliant person in managed care, theory, and practice. And a gentleman by the name of Brian Gragnolati who was running [00:22:30] the community division of the health system and he's now running Atlantic Health System up in New Jersey as the CEO. They wanted a physician leader to sort of take part in the

responsibility and accountability for moving that part of the strategic plan forward. And it was right in the sweet spot of what I enjoyed a lot of change management. It was a lot of developing new roles, new organizational component, and it had a lot to [00:23:00] do with culture, which is something else that I enjoyed, was the opportunity to really make a difference in the culture of our delivery system of moving forward. So it was a great opportunity.

Geoff: It sounds like a tremendous opportunity. As a radiologist overseeing the integration of healthcare delivery, did you find anyone in the organization that looked askance at this relationship of a radiologist being [00:23:30] the person at the head of this effort as opposed to somebody in a more traditional clinical care delivery role?

Jon: You know, it's interesting. One of the things that drew me to Johns Hopkins, to start with, in the chair role was the place that radiology had in the Johns Hopkins culture. So I'm fortunate, two chairs before me was Bill Brody. And for those of you who know Bill, he's just a force of nature. And he went on [00:24:00] after being the chair of Radiology to become the president of Johns Hopkins University. So two chairs in front of me, there was somebody who went out to be president who when I got there was still the president of the university. So radiology certainly had credibility with regard to Bill and his leadership abilities. The chair just before me was Elias Zerhouni. The reason Elias left Hopkins was to take the job as the director of the NIH.

So I came into an environment [00:24:30] where radiologists were seen as leaders, and there was clearly no stigma with regard to radiologists at the institution and I found myself, from the beginning, well respected amongst the other chairs and deans. So there really wasn't...for Hopkins having a radiologist in a leadership position, Elias Zerhouni, in addition to being the chair of Radiology, was the executive vice dean under Ed Miller when Ed first became dean. So they were sort of used [00:25:00] to having radiologists in leadership positions and there was no second guessing. And I think the skill set of radiologists are extremely well suited to health system and health center leadership positions.

Geoff: I agree with that. Let's turn our attention then to your current role at Emory. I understand that you have at least three distinct roles: the executive pice President for Health Affairs for the university, the executive director [00:25:30] of the Woodruff Health Sciences Center, and president, CEO, and chairman of the board of Emory Healthcare. Can you help orient our audience to all of these roles and how they interface with one another and your responsibilities within the context of each of them?

Jon: Certainly, yeah. It is a confusing slate of titles, it makes it a challenge to have a legible business card. [00:26:00] But there is a method to the madness in terms of how they interrelate. It turns out these were actually two separate jobs before I arrived. For the last, I think, decade or so, there had been a separation into two jobs. So let me describe a little bit about those two different jobs and how they interrelate. The executive vice president for Health Affairs at Emory University is one of three executive vice presidents who report to the president. The president [00:26:30] looks to the three of us to run the day-to-day operations of the university. It's an executive vice president for Academic Affairs and Provost. It's an executive vice president for Business and Administration, and myself. The three of us together form what's called the Ways and Means Committee, looking at how one distributes funds across the university. When there's a weather event, we all get on the phone together to decide whether the university is [00:27:00] going to close or remain open.

And while the president has the role of interfacing with the board, very important role of driving philanthropy, setting culture, setting priorities, setting the vision, the executive vice presidents are really the operational mechanism to allow her to work at a higher plane much of the time. The executive vice president for Health Affairs role also serves as the executive director of the Woodruff Health Sciences Center, [00:27:30] and as such is accountable for all of the health-related activities. The Health Sciences Center here at Emory includes the School of Medicine, a top-ranked top three School of Nursing, you know, top seven School of Public Health, actually the top non-human primate research center in the country, as well as the Winship Cancer Institute, which is our comprehensive cancer center.

And then the sixth [00:28:00] piece of the Woodruff Health Sciences Center is Emory Healthcare, which again, is a university-owned health system. In my role as the executive vice president for Health Affairs and the executive director for the health sciences, I'm accountable for that component, which is a big component of our university. It's more than two-thirds of the university because of the strength of the health sciences. So that's one of the roles. That role, you know, has been [00:28:30] filled for the last couple of decades, I guess, also has had the responsibility to be the chair of the board of Emory Healthcare as a health system. And that's typically been the link between the health system and the university leadership through the chairmanship of that board, board of directors.

Over the last probably five years or so, a couple things had been happening. The health system had been drifting away from the [00:29:00] academic mission, and the link of being the chair of the board maybe wasn't quite strong enough to keep things fully aligned. So while the School of Medicine and the

health system worked very well together, there was very little, if any, link between the Schools of Nursing, School of Public Health, some of the other areas of the rest of the university and the health system. So I took on the role of president and CEO of the health system as well, [00:29:30] which again, had been a separate person in that role. What that's allowed me to do over the last not quite three years is to bring together the strength of a leading health system market leader here in Georgia with the academic mission of the different parts of the health sciences beyond just the clinical departments of the School of Medicine.

Geoff: That's a terrific orientation. Now, coming from Johns Hopkins to Emory, what did you see [00:30:00] as the most important actions that you needed to take upon arrival? What were your key priorities?

Jon: Well, you know, one of the things that's interesting is I think my career, my responsibilities at Johns Hopkins could not have been better designed for coming into my current role. The deep responsibility for strategic planning and that the chance to put together a five-year strategic plan from scratch, when [00:30:30] I learned doing that in terms of how planning works, how implementing and executing on a plan works, I want to credit Paul Rothman, again, my former dean who was the one who said, "I don't want a plan that's going to sit on a shelf, I want a plan that we can actually execute on, follow and to help guide us in our day to day decisions." He was a great model. After we put the plan together you know, every month, we'd be sitting with him and he'd say, "Well, where's the plan now? How is it working against the metrics? Where [00:31:00] are you running into troubles? Where are things working well?"

I think seeing that kind of execution of a plan, that kind of driving execution operations was helpful. The accountability for having to integrate the culture of private practices in community hospitals that had recently been merged into the system and learning, what are the issues around private practice? Having been in academics for 25 years, you know, I knew a lot about [00:31:30] academic faculty, I knew a lot about the different departments. Being a chair, working very closely with the chairs of the rest of the department, I understood the issues in academics, but it gave me an opportunity to learn, what does it mean to a medical staff, when your hospital is bought, is acquired, is merged, is taken into an academic health system, it's a very frightening thing. So I think that aspect was great.

And then one of the other responsibilities [00:32:00] I had was looking at professionalism and culture at Hopkins. So we created a coordinating council for professionalism and ethical practice, which was an interdisciplinary council

with nursing and administrators and physicians from across the system and patient advocates on this committee and gave me the opportunity to see from a very interesting vantage point, what are the ethical and cultural issues related to delivery of medical [00:32:30] care? How does the system look at a rainmaker who is behaving badly and, you know, unfortunately, as those of us who've gone into leadership know the higher up you are in leadership, the more egregious is the behavior that you have to deal with because things that are minor get dealt with at other levels.

So typically, you know, when a behavior or bad behavior gets to a department chair or a health system administrator or a CEO [00:33:00], people are behaving badly, and how do you deal with that? How do you not blink when you have to reprimand or terminate someone who may be bringing, you know, lots of financial success to an organization but doesn't show the values that you want to see you aspire to in your organization? So those things helped give me the skill set and the practice for coming into my role at Emory.

Geoff: That's a tremendous slate of [00:33:30] action and activity to consider just upon arrival. I want to unpack a number of those various elements in a few moments, but maybe you might speak a little bit to what steps you took in order to build the trust needed with the organization in order to begin to work on some of these thorny topics.

Jon: Absolutely. A couple of things that when I first got here to Emory, really the first thing that I wanted to do [00:34:00] was do a situational assessment, spend some time learning about the organization before doing much of anything. And I think it's really important because every organization has its own culture. Cultural transformation is really...or cultural, I guess, growth is really important. But you don't want to rush it because the worst thing you can do is to come in somewhere and say, you know, "This place needs to change." Right? Every place needs to change, but you don't want to necessarily start [00:34:30] off saying that. You want people at the organization to say, "We think we need to change, we think we can be better," and then you can be successful in making that change. So first thing I wanted to do was sit, learn the people on the leadership team, learn what their skill sets were, learn what their aspirations were in terms of where they saw their careers going and how they wanted to develop, and learn about what they thought we were doing well and what they thought we could be doing better.

I spent probably [00:35:00] much of the first three months listening, learning, meeting, trying to understand where were those things that were points of pride I didn't want to mess with, I didn't want to mess up, and where were those points of opportunity? In the meantime, it became clear even as I was accepting

the job that they had not had a clear vision, unambiguous vision around the clinical strategy. So I started a clinical strategic planning process, clinical network strategic planning [00:35:30] process. I flew down two days before I officially started to kick off the process, got about 120 leaders across the institution, physician leaders, administrative leaders, the deans of the other schools to sit down and look at, how are we going to approach the markets that we served in terms of patient care?

So I started on that right away, did about a six-month strategic planning process right off the bat, but with regards to the rest of the organization, spent time [00:36:00] learning, listening and building trust, building relationships. Leadership is all relationships, relationships with your bosses, relationships with the people that report to you, relationships with front line and the people actually adding value, creating value for the patients, for the research, for the students. And it was really about learning and listening from them moving forward. So that's really how I started process in my first year [00:36:30] and spent much of my first year...well, I'm still learning. It's a big organization, but spent that first year really devoted to learning and being very careful about the changes we made and how we made them.

Geoff: Jumping right in, even the day before you officially started, to initiate a strategic planning process is bold. And I think that you're describing your experience at Johns Hopkins where, in 2011, there hadn't been a new strategic plan since [00:37:00] 1996 is something that is, unfortunately, occasionally emblematic of some of our larger health systems and the strategic planning is difficult and sometimes not widely embraced. As you came to Emory and sought to kick off strategic planning right away, was there any reluctance? Or was the organization immediately open to that process?

Jon: It's interesting. There had been a number of changes over the [00:37:31] prior couple of years. There had been an attempted merger with a big community system here. And actually, when I first got contacted to be recruited, they were in the middle of this merger, and I declined. I politely declined to the search consultant, declined the nomination. That potential merger fell apart. It was very disruptive, both the idea that this leading academic health system was going to merge with a big community system, very disruptive [00:38:00] for the academic folks. There was a perception of lack of transparency in the process, but I know there were a lot of sort of hard feelings that people felt. They learned about it after it was already a done deal, didn't have a chance to give their opinion during the process.

And as that sort of fell apart, the longtime CEO had left about...I don't know, sometime maybe in the prior year. There was a temporary CEO. That person

went back to his day job and [00:38:30] left the CEO role. There was an interim, a great interim, a friend and colleague, but still interim nonetheless, just before I got there. So they've been through three CEOs in the prior year-and-a-half, two years when I got there. So there was a feeling that something needed to be done. And I think that doing a clinical strategic planning, I'd subsequently done a more broad-based strategic plan, but doing just a clinical planning process, which [00:39:00] was very, very inclusive, I think was reassuring to everyone more than anything. I think it gave them the understanding that we are really going to strive for strategic clarity in the organization. And one of my three main themes of my leadership here, top one has been strategic clarity.

And right from the beginning, it was, okay, we need to know, what is that point on the horizon that we're all aiming for? Because if we don't have a common vision of our strategic goal, our strategic aspiration, we're never going to get [00:39:30] there. So I think people found that reassuring more than anything. The process was a good way for them to learn a little bit about how I worked to, you know, realize that I really did listen to people, I tried to empower rather than tell people what to do. And I think, if anything, that was helpful in settling into the new job for me and helpful for the leaders of the organization, getting some idea of how I worked and hopefully some reassurance [00:40:00] that I wasn't gonna come in and tell them their jobs, which they obviously know how to do better than I ever would.

Geoff: How did you determine who would or should be involved in those early planning processes? And what structure did you choose?

Jon: Well, you know, it's interesting. One thing that I hadn't mentioned, but sort of the theme for my leadership here and something that I started calling out in my first sort of inaugural [00:40:30] meeting, you know, address meeting the health science stakeholders, and then in each of my State of the Woodruff Health Science Center addresses each year that I continue to reemphasize is trying to put everything I do into one of three buckets. First of those is strategic clarity, the second is effective architecture, and the third is constructive culture. And sort of everything I've done has been trying to move us forward in those three broad themes. [00:41:00] The early planning process was moving towards strategic clarity in the clinical realm, I believe that people saw that as trying to walk the talk and move us forward in terms of creating clarity and removing strategic ambiguity around where we were going as a health system. So that was the first part.

The second part, the effect of architecture, that was the goal of sitting down, listening, learning, understanding, what were people's current [00:41:30] roles? And in the strategic planning process off the bat, I took people's current

strategic roles, people that had leadership roles, chief medical officer, chief nurse executive, the director of our Strategic Planning Program or Office, interim at that point because the prior strategic program person had left the prior year, made sure that we had clinical chairs, representatives from the clinical chairs in the School of Medicine, the deans, [00:42:00] sort of the usual suspects. But also then, we created what we called subject matter expert teams, which is something we had done in the planning process at Hopkins, I'd learned there, which was to take not just the current leaders, but to go 10 years younger, to look at who are those people who were the informal authorities in the organization who were going to be the succession plans for our current leadership team? Let's get them involved 10 years [00:42:30] before they're in those roles.

First of all, it's a great retention tool. It tells them, "We value you, we value your opinion." Secondly, they are five steps closer to the front lines. They really know more what's going on than our current leaders who maybe were in those roles 10 or 15 years earlier but, you know, tend to lose connection over time. And thirdly, it brought us the wisdom of a very smart crowd to the table as we developed [00:43:00] those roles. So that was a way to make sure that we had the right people at the table for the strategic planning process to have it very broadly inclusive. Importantly, so that when we rolled it out, people across the organization would say, "Yeah, I helped write that. This is important. I can tell you it's important. They asked me my opinion, and my fingerprints are all over this plan." And I think that's probably one of the most important lessons I learned in strategic planning is you want to make sure that it's owned by the organization, [00:43:30] not by the CEO, or the Strategic Planning Office, or the top leadership team. It needs to be owned by the organization and by the people who are really doing the work to be valuable and to be executable.

Geoff: Clearly, this was a deeply premeditated approach and your experience in strategic planning seems invaluable toward informing, establishing this really well-considered process. [00:44:00] I'm curious, when considering your executive team and the organizational structure coming into Emory anew, how did you weigh considerations for relying upon experienced internal leaders with deep institutional knowledge versus reaching outside the organization for fresh ideas and new approaches?

Jon: We ended up doing some of each. And I was blessed by a great leadership team coming in, very talented people. The quality, the experience, [00:44:30] the expertise, and most importantly, the character of the team was really great. We had a few people who moved out voluntarily and who moved on to other opportunities, which was great for me because it gave us the opportunity to recruit in some outside folks without having to be heavy handed. So a lot of

what we did again on the second bucket, the effect of architecture bucket, was something that was really important. Doing the situational [00:45:00] assessment of the team in the first three to six months was important.

And then I spent time working on what's the optimal architecture for the organization? What are the structures of, you know, the table of organization, the reporting structures? What are the committee structures? What are the decision processes that would make us most effective? In doing that, I brought in the [00:45:30] leadership team, the current leadership team and said, "This is what we're thinking about. What do you think? How do you think this org chart looks? What do you think about these new roles? What do you think about the changes in the old roles?" One of the things that I did was I asked the leadership team to meet to get rid of ambiguity in terms of roles because we had multiple roles that appeared to be accountable for the same thing. And I kind of forced the people to sit down and say, okay, whose responsibility [00:46:00] is this? Is this, you know, the chief medical officer's responsibility? Is it physician group president's responsibility? Is it the CEO of our clinically integrated networks responsibility? Make sure there's clarity around who's accountable. And if there is shared accountability, you know, how are you all going to work together and make sure that there's no conflict or there's only constructive conflict in coming to the best decisions?

Geoff: Sounds like you really re-engineered, [00:46:30] from the ground up, the organizational structure.

Jon: Yeah, absolutely. Absolutely. And it was something that the leadership team took part in and I think took on with gusto, trying to do it. People were a little bit uncomfortable, anxious I'd say, about creating that clarity. One of the great things about the South is people could not be more welcoming or more polite or nicer. One of the [00:47:00] challenges about the South is people could not be more welcoming, nicer, more polite. I think that some of that role ambiguity was around the fact that no one wanted to tell their buddy, for the last 10 years that they worked with, "Hey, I think this is something I'm supposed to be doing, not you." There was a little bit of politeness that got in the way of some of the difficult conversations. And I think people enjoyed digging in, creating that clarity, talking about decision processes, you know, [00:47:30] how do we run committees? How do we ascribe the appropriate roles for decision processes across the team? Creating clarity around that, I think people enjoyed and they took it and ran with it.

And the work we did, I drove it, but the ideas that we implemented were broad-based and the stakeholders, you know, on the leadership team, all had plenty of voice and plenty of input and our final architecture really reflected [00:48:00]

their wisdom. We implemented the architecture April of '17, a little over a year after I got here, and we just did a one-year sort of tune-up, made a few changes and sorted things out. We'd grown so much that I felt we needed some new structure elements. And we've just implemented that in September, and it's gone great.

Geoff: What a great opportunity for all the folks at Emory to participate in this [00:48:30] really ground-up redesign of the organization. So well-considered, Jon. It's really terrific and heartwarming to hear about. Earlier this year, you presented a formal strategic plan, as you were describing, for the Woodruff Health Science Center. And just for our listeners, there is an excellent YouTube video of your presentation, which I would recommend for all of our listeners to access. There's many leadership pearls, and the plan itself offers [00:49:00] tremendous insights into the future of academic medicine, I would say. We could spend an entire hour just discussing the plan. But I'd like to ask you to comment on one observation in particular.

The plan includes five strategic themes beginning with a constructive culture, which you already mentioned was an important pillar coming in. I noticed that during the presentation, you spent almost twice as much time discussing culture as any [00:49:30] of the other themes, emphasizing leadership cultivation and workplace joy. And then as you went through the other strategic themes, it was remarkable to me how organizational culture tended to suffuse the other priorities as well. Clearly, culture is a passion of yours and could you speak to how culture became the plan's primary emphasis and why you feel it is such a critical focus for a healthcare system? [00:50:00]

Jon: Absolutely. I think there are a couple of brilliant quotes of Peter Drucker who many people know who's just the guru of management theory for many years. He said very aptly that culture eats strategy for breakfast every day. No matter how good your strategy is, if it's incompatible with the organizational culture, it's going to fail. So there's sort of two ways you can approach that. One of them is you can just give up and say, "Well, we're not gonna be able to change anything because [00:50:30] we're not gonna be able to implement these great strategic ideas because the culture will just spit them out." Or you can work on effectively moving the culture forward in a very careful and thoughtful way. So really, culture is, you know, at the forefront of what I've been working on and hoping to do. Emory had a great culture, incredibly collaborative, very honest, integrity, the values were great coming in.

It's important not to say we're going to [00:51:00] give you a good culture. You know, that's a great way to fail. That's a good way to be looking for a new job quickly, I suspect. Really, it's a matter of saying, what are those aspects of

culture that resonate with the organization? And how do we move those forward even further? That's why it's not something you do too quickly. That's why it's easy to work on a clinical network strategy from day minus one for the first six months. But working on the culture is a much longer-term thing.

So I've been driven...you know, [00:51:30] the work I did at Hopkins in the department really looked at trying to continue to move the culture, working in my administrative roles at the higher level at Hopkins had a lot to do with culture. And that's where I see really the biggest bang for the buck here at Emory. We've done a lot and one of the things that we're doing now is doing a lean operating system transformation across the whole health system. So that's, you know, 21,000 of our 32,000 [00:52:00] employees in the health sciences are in the health system. And we're working on lean throughout, which if you look at lean, a lot of lean is culture, it's making sure that you pay attention to not only the customer, who in our case is the patient, needs to get the best care all the time every time, but also the staff, the faculty and staff need to have a great, respectful workplace. And if you do those, you know, [00:52:30] with lean, you're going to end up improving the finances, getting rid of waste and creating better resource utilization. From my perspective, it's all about culture, the strategy. Strategy without culture is going to fail every time. So you may as well just fight the...you know, take the bull by the horns and start trying to work on culture from the beginning.

Geoff: That's terrific. Jon, how would you describe the healthcare market in Atlanta at the [00:53:00] time of your arrival at Emory in 2016?

Jon: Atlanta is a highly competitive market. And it's interesting. We are sort of behind many markets in terms of the transition to value-based care. We are still predominantly a fee-for-service market. And because of that, the health systems still are competing very much, looking for volume, [00:53:30] looking for fees, looking for price leverage. And coming in, I really came into a market that was rapidly consolidating. Within essence, we're down to four major health systems. It's a big market, it's over six million people. So that's not too many systems for, you know, six-and-a-half million people. But the smaller, independent hospitals had already been scooped up for the most part by the bigger systems. [00:54:00]

When I came in, while we were doing the complex care, we were at the top of the brand hierarchy in town, we actually were tied for, you know, number three, or, you know, between number three and number four in market share based just on volume of admissions in patient market share. So highly competitive, and it was a little bit worrisome that we were not necessarily where we needed to be, given the great [00:54:30] work we were doing.

Geoff: As the dominant tertiary and quaternary care provider in Georgia, why is continued growth important for Emory healthcare?

Jon: You know, a lot of that original clinical network strategy work was looking at the question, how big is big enough? And really comes down to five reasons to drive the scale of an academic health system. Most of those have to do with the academics. [00:55:00] You have to be big enough so that you get the tertiary, quaternary patients to keep the clinical expertise. If you have top notch neurosurgeons, they want to be doing good volumes of neurosurgery, you know, top transplant programs, you need the same. So the first is you need the volumes for your clinical expertise to remain. The second is you need to be able to keep training and those fellowships, those very quaternary fellowships, you need enough volume to keep your training programs, you need to be able [00:55:30] to keep your clinical research programs going, so you'll need enough scale to have enough patient volume to reach your aspirations in clinical research.

And then on the academic side, as you know, we've not found a model yet for academics where clinical hospital revenues or profit don't need to subsidize the academic mission. So you need to be big enough so you can take enough money from the [00:56:00] bottom line of your health system and contribute, invest in the academic mission for the School of Medicine and the rest of the health sciences. On top of that, you need enough scale that you remain market significant. And I mean that by the fact that if you're number four in a market or five in a market, a big insurer can say, you know, "We really don't need them in our network to be able to offer products." So you can get narrow-networked out if you become too small [00:56:30] or too insignificant even if you are the top brand and the tertiary, quaternary provider of choice. The insurers don't necessarily care about that as much in as they try to deal with rising prices and rising issues as well.

And the last is you need enough of a market position and population density to be able to deliver population health. If you're too small or too diffuse, you can't effectively be a population health value-based [00:57:00] provider.

Geoff: Within the context of growing your position in the healthcare market, I understand that you've adopted strategies for both affiliation in the case of Kaiser Permanente, as well as acquisition as with DeKalb Medical. Can you discuss the considerations that have led you to these approaches?

Jon: Sure. The original clinical strategic planning left us with three different major buckets of [00:57:30] work. And one was our local strategy. One was a regional strategy for statewide and beyond. And one was national-international.

So for the local strategy, most of the work we've done has been in the local and the regional, not so much global and international-national yet. But on the local side, what we wanted to do was to take care of 750,000 to a million unique patients. We already take care of most of those, but they're not necessarily [00:58:00] as closely linked, they're mostly referred from other health systems who could narrow-network them and try to retain more as they move up-market.

So to approach that, we looked at our geography and said, "What should our footprint be?" Mapped out where we were going to grow ambulatory predominantly. DeKalb Medical is a system...is about a half a billion dollar system, big emergency room, about 150,000 emergency room visits a year. So [00:58:30] it's sort of a major local system and it fit like a puzzle piece in our footprint. There was an area that we had delineated for future growth and ambulatory and when they came out in the market, we were not going to be acquiring or merging. It was really a member substitution merger, although we're the bigger so they merged into us but it was too strategically aligned align to pass up. So realistically, we're not out to acquire [00:59:00] and I doubt we're going to have many, if any, future acquisitions over the next couple of years. That was one that just we couldn't pass up. There were 140 physicians plus a bunch of advanced practice providers, practicing in areas that we wanted to have a footprint.

Kaiser Permanente was very different. That was a way to look at, how do we lock in a population of patients for those tertiary, quaternary services [00:59:30] in an efficient and effective manner? So we became the exclusive core hospitals for Kaiser Permanente of Georgia. Two of our hospitals are now their main hospitals, we had to add a couple hundred beds and a bunch of ORs and other imaging equipment, etc. to be able to accommodate those volumes, but we essentially brought a 375,000 member population now directed to [01:00:00] Emory. Kaiser does a great job with primary care, secondary care, even many tertiary services at their own centers and their ambulatory hubs. But now, all of their patients come into our hospitals when they need an elective admission. When they're emergency admission, we try to transfer them from that hospital to ours when they're stable. And we work in an integrated matter with the Kaiser Permanente physician staff to really try to provide value-based [01:00:30] care in an effective manner for a large population of new patients.

Geoff: I would imagine that with the implementation of this affiliation with Kaiser as well as some of the mergers that you discussed, that there can be some pretty substantial shifts in volume in the practice particularly for those quaternary care providers who are the recipients or the beneficiaries, I should

say, of these new relationships. How do you prepare the organization [01:01:00] for sudden increases in volume?

Jon: Well, you know, I have to credit our operating team. They did a phenomenal job of doing just that, Kaiser Permanente in particular. The DeKalb Medical merger was huge. We onboarded 4,000 new employees over a couple month period into HR, payroll, orientation. We had to work on IT integration, just a huge amount of work on the merger [01:01:30] side, but the Kaiser Permanente side was a more interesting process, in part because it was under nondisclosure agreement until pretty close to the end of the negotiations. So we had a pretty good idea that it was going to happen and started preemptively building out. So as our CEOs of the two hospitals that did the building will talk about, their folks thought they were crazy because we started opening up...building out new beds. We built out a [01:02:00] new Labor Delivery Unit. We built out new ICUs. We built out new floors, new patient care floors.

And as they were doing it, their leadership teams are looking at them as like, "Wow, you're sure building a lot of capacity. You know, are you sure we're going to be able to fill it?" When they heard about the partnership with Kaiser Permanente, they all of a sudden realized why, but we built enough capacity for about 200 patients a day in our hospitals and the associated capacity for the operating [01:02:30] rooms, etc. So the physical build out, we spent over a year building. It's still not quite done, it should finish up this month. What was really challenging was staffing up. We've hired 700 new nurses, other clinical frontline staff to be able to take care of these new volumes. And in a very competitive market for workforce, that's been the biggest challenge has been recruiting quality workforce to staff up these [01:03:00] new beds, new operating rooms, new Intensive Care Unit facilities.

Geoff: I can only imagine the challenge of all of that hiring and the integration of people from the community into the culture that you and your teams have been working so hard to hone. Can you speak briefly about managing friction points between community and academic cultures and helping to bring about cohesion when the models [01:03:30] of care, that folks have participated in, may have been very different and that you're trying to integrate?

Jon: Sure. You know, that was an area, I think, of great concern for our partners, whether it was DeKalb Medical or whether it was the Permanente Medical Group. And one of the things that we did was, as a leadership team, spent a lot of time talking with both our clinical chairs, speaking, you know, with the department [01:04:00] chairs, speaking with the CEOs of the hospitals, speaking with their leadership teams about the importance of respect, the importance of engagement, and the importance of being a welcoming

organization for these new folks. And I think as people on our side were anxious about getting everything prepared and bringing in all these new doctors and, you know, we onboarded, I think, close to 600 Permanente group doctors along with, I think, the medical staff at [01:04:30] DeKalb is about 800 doctors, mostly private practice.

As we talked about how to do that, we reminded them that it may be challenging for us, but it's even scarier for them. Because, you know, these are folks that either have been an independent system, independent community hospital system for dozens of years successful who's now joining sort of the mammoth Emory Healthcare. That's very frightening. Or for Permanente, you know, they've worked at 2 other hospitals for the last 20 [01:05:00] years, all the sudden they get in the car and they drive to a new hospital, new workplace. And so we really worked on being welcoming. And I have to say, both the Permanente group leadership working with our physician group leadership sort of greased the skids for a frictionless integration and same thing on the DeKalb side. We've had very few points of conflict.

And I think people were...you know, we've created teams across both organizations [01:05:30] that resolve issues when they arise and the things that end up getting escalated have been, you know, things like parking or things that are really very minor things like making sure that we have the right equipment in the OR for a specific surgeon that we hadn't anticipated needing, you know, different style of instrument, whatever. So they've been pretty operational, pretty minor, and the cultural integration, knock on wood, has been really [01:06:00] going well. We started DeKalb in September, and we were about six weeks in or so into the Kaiser Permanente integration. So it's a matter of preparation, and it's a matter of respecting that people at community hospitals have real skill sets and real expertise that we can learn from as an academic center. And hopefully, they can learn something from us, is really the culture and the respect that makes the biggest difference.

Geoff: What [01:06:30] do you see as unique advantages and potential blind spots for radiologists seeking roles beyond the radiology department?

Jon: Well, you know, I think advantages, I think are many. As radiologists, and particular as leaders in radiology departments, we see, we know every part of the organization. You know, other than maybe dermatology and not as much with ophthalmology, we know the businesses of the other clinical departments in a [01:07:00] way that most of the clinical departments don't, to be frank. We have a better insight on what the challenges are of other clinical departments. And we understand business because for most radiology chairs, if you're not spending most of a hospital's capital, non-building capital, that's an unusual

situation. We are the biggest cost center. We're one of the biggest, I guess, margin centers of most of our health systems.

So typically, we have the skill sets [01:07:30] that lend themselves very nicely to higher roles within healthcare delivery. The only blind spots are perhaps if we don't pay attention to the clinician on the front line, not just the radiologists and, you know, our issues in terms of challenges with packs [SP] and challenges with our IT systems, understanding what motivates the physicians and advanced practice providers [01:08:00] on the front lines of care. What are the challenges that they're dealing with? I think that the blind spot may not be taking the opportunity to really talk to our colleagues enough to understand their pain points. Easily remediable, but maybe something we don't necessarily all pay enough attention to.

Jon: Has your view of the role of radiology department chair changed since you've become a health system CEO?

Jon: Well, I'm fortunate. I have one of the best chairs in [01:08:30] the country, you know, bar none, Carolyn Meltzer, here at Emory, who runs an unbelievable department. Lucky, like Hopkins, I came into an institution where radiology is well respected. But as I talked to friends at other centers, it depends on how the radiology department looks, how they approach their work. There are still too many radiology departments who are seen as locking the doors and saying, "Don't bother me, I'm in my dark little room trying to [01:09:00] crank out my RV use as quickly as I can, and don't disturb me." And that's a road to extinction, I think, for radiology. Really getting involved, making sure that we're in the middle of patient care decisions, that we're well respected as value-add to an organization is something that's critical.

So I think getting radiologists out of the basement and into the conversation is something that's really important. It's something [01:09:30] the radiology organizations, the ACR and others, have been proposing for a number of years now. As a health system leader, a health sciences leader, the more visible radiologists and radiology leaders are in organizational leadership, the better they'll be at moving up in an organization into more responsible and more accountable roles.

Geoff: Professional burnout and achieving work-life balance [01:10:00] are concerns nationwide. What opportunities do you have in your role to tackle these issues at a system level?

Jon: That's a great question and a huge challenge. We just actually wrote a white paper on that as part of a group, a brain trust I work with or think tank I

work with, the Blue Ridge Academic Health Group that's out on the web, as what a CEO can do for burnout. I think [01:10:30] the key things we can do to try to address this national epidemic of burnout is first to try to remove the barriers to doing people's jobs. We put as health systems, as IT systems, electronic medical records, we at every step, put barriers in front of our clinicians that keep them from doing their job and [01:11:00] trying to see what those are, remove those as much as possible is one of the things we can do.

The second thing I think that we need to do is to engage and empower the frontline clinicians. We need to make sure that they not only feel like they're being listened to, but we actually do listen to them. And we take the ideas that they have for addressing those barriers and implement those. Really be serious about listening, learning, and [01:11:30] engaging those frontlines. And unless and until those clinicians feel like they're really being heard, burnout's going to continue to just increase at all of our institutions.

Geoff: Final question. Last month's guest, Jonathan Breslau, mentioned that back in the day, you were both in a band together, no doubt a future all-star radiology leaders band, back in Cleveland. I know that you're still playing, including a few holiday parties this season as you [01:12:00] mentioned to me. What role does music play in your efforts to unwind and achieve balance?

Jon: Music is incredibly important. I actually had a jazz quartet in Hopkins before I took the job. I was fortunate enough to have run into Bruce Wasserman. He was looking for a saxophone in his quartet, as I was interviewing for the Hopkins role. And that jazz quartet or quintet for a few of those years, for that 12 years at Hopkins was just critical to peace of [01:12:30] mind. And here, I finally have found a few likeminded jazz musicians to get together every month or two to make some music. And I think it's critical for leaders to keep perspective that what they do in their leadership role is only one part of their life, their family, their spiritual life, their hobbies, their avocations are equally important to have a well-balanced life and to be a good leader. So for me, the opportunity to continue [01:13:00] to play music is incredibly important. I don't have as much time to do it as I'd like, but the time I do take is critical to being an effective leader.

Geoff: Dr. Jonathan Lewin, you have enriched us with your insights and sharing your experiences today. I can't thank you enough for spending the time with us and providing the perspective from the C-suite as a radiologist, and so many lessons learned. Thank you for joining us on [01:13:30] "Taking the Lead."

Jon: Well, Geoff, you are far too kind, but it's really been an honor, a privilege, and a pleasure to spend the time with you today. So thank you.

Geoff: Please join me next month when I speak with Catherine Everett, a radiologist and mother of 5 who after 20 years serving as a managing partner of Coastal Radiology in New Bern, North Carolina, [01:14:00] became its president 11 years ago. She has subsequently earned an MBA from the Yale School of Management, became an active leader in the ACR, including service on the council steering committee, and recently merged Coastal Radiology with Radiology Partners of private equity-backed company with over 1000 radiologists providing service to more than 750 clinical sites across 17 states. We discuss the challenges of leading a small town radiology practice, [01:14:30] the tough issues that led to the group's merging with Radiology Partners, and the tremendous passion and joy that drives her to succeed in new leadership roles while realizing the remarkable degree of balance across a wealth of personal and professional interests.

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