Nick Dawson

Stephen Moegling: I am thrilled to introduce our first speaker, Nick Dawson. As the executive innovation director for the largest nonprofit health care provider in the United States, Nick guides innovation, emerging tech and strategic partnerships for Kaiser Permanente's 13 million members, workers and providers. Is that it, Nick—is that all? [laughter]

Please join me in welcoming Nick to the Believe in Better stage.

Nick Dawson: I'm really excited to be here. I'm particularly excited by the mayor's opening remarks. I have long contended that the role of government at every level in our society is to take care of the health and well-being of its communities. And I'm really reflecting on those remarks and how much I appreciate it, the mayor making that a priority.

I've come here from San Francisco where we have our own waterfront promenade. It's not quite as beautiful as yours was this morning, but I was out yesterday morning for a run on our waterfront and had a head-on collision with a tech bro on an e-scooter. So if you're thinking about how to use yours for health and well-being, think about those scooters. I was pro-scooter until yesterday.

This is my grandmother who was kicked out of nursing school for the heinous crime of being married at a time when you could not be married and be a nursing student.

She went on to build two farms in Northern Virginia with her bare hands. And when I say that, I mean, she literally built every barn and every building on those farms. And there was never a problem that she looked at and said, I don't see a solution for that. Her famous phrase for all of us was, there's no such word as can't. And she would send us out on chores on the farm when I was a kid, and we'd go visit and she'd say, go pick up every rock in this field, and we'd say there's no possible way we can do that. We can't do that.

And she said, there's no such word as can't—turned out she was right, because she usually wouldn't serve dinner until we'd picked them all up. So I like to think that I picked up some of her industriousness, but I think I really just picked up coming from a long line of health care misfits.

As Stephen pointed out, I'm a designer. I didn't start my career as a designer. I started out in a lot more traditional role. I did finance for a large health system on the East Coast and had some amazing opportunities in the beginning of my career to interact

with patient advocates and I had this notion of saying, I'm going to go into the advocacy world and I'm going to explain this is how health care works.

And every time I ever tried to do that, advocates would say to me, no, we're going to tell you how it should work and it doesn't work for us. And that was a pivotal point in my career where I pivoted and decided to become a designer and went back to study design. I spent time embedded in design organizations, and had the privilege of leading design for innovation in places like Hopkins and Stanford School of Medicine, and today at KP.

I had a chance to work with the Obama administration, some to bring precision, excuse me, to bring participatory design to national policy. And one of my favorite phrases that people who worked in the White House would often say on stages like this is, I'm here under my own banner.

So today I'm here to talk about some of the work that I've been a part of in other roles and other settings, as well as some work that I've been inspired by.

I've had a chance to work in the past on things that redefine experience for patients. Things like a better whiteboard, ways to help people be seen for who they are as a person, not as the knee in room 405 or the appendectomy in 620.

I've had a chance to work with world-class stroke care leaders who said, every second counts and we need to find ways to be coordinated as a team. I've had a chance to work on reimagining something as seemingly trivial as an inpatient call button, as a way of giving people more empowerment and autonomy during a stay.

In design we often like to think that this process is a lot more complicated than it is. We use fancy terms like ethnographic, in-user research and synthesis. We say ideation, which is just a really complicated way of saying brainstorming, but it's really not that hard. This is pretty easy stuff and really to me, the simplest version of it is listening to the needs of people, trying to imagine a solution for those needs, and then testing them quickly to see, does it work? Is it desirable? Does it make somebody's life better? Does it fit? If not, let's repeat that process.

And the thing about spending most of my career in this space is you start to find patterns. You start to look at things and you start to say, there's all these small little things that we need to make better in health care.

But there's also these big, really hard, complex problems. There's the problem that we spend 20%, the largest chunk of our economy—it's probably not news to anyone in this

room—we spend 20% of our gross domestic product on health care. That is more than any other part of our economy by a long shot.

And when we look at what we're getting for that money, it's not great. This is the 2000 World Health Organization rankings of health outcomes by country, globally. Now the good news is—the 2019, right?—these have just come out and while we dropped to the 37th place globally, we're still first in cost.

And it makes me wonder, what are we buying?

What do we buy for 20% of our nation's wealth of the industrious product of our country? And I think too often it's things like this; it's nicer lobbies, it's better waiting rooms, it's labor delivery suites that look like rooms out of the Ritz Carlton. By the way, I pulled this from an architectural rendering—I don't think this is anybody's real hospital, but if this is somebody's tell me afterwards and I'll take it out. I don't want to point fingers. I think these things do provide comfort to people. I think that they are important. I'm not trying to shame anybody that builds a beautiful hospital, but I don't think it's the only thing we want to buy with 20% of our gross domestic product.

This is housing in ward eight of Washington, D.C. If you know anything about D.C. and its geography and its neighborhoods, D.C. is divided up into eight geographically defined neighborhoods called wards. Wards one through eight. If you are unlucky enough to have been born in wards seven or eight, you will die statistically a lot sooner than somebody who lives three miles away in Georgetown, one of the most affluent neighborhoods in America.

If you live in Georgetown, you have access to three Whole Foods, four if you're willing to drive into Virginia—that's a very controversial thing, you can see. You have access to three or four full-service hospitals. If you live in ward seven or eight, there are no hospitals. At all. There are no grocery stores, there are no full-service grocery stores in that part of D.C., but yet it's the most densely populated part of D.C.

It's where most of the people in the nation's Capital live. It is also the place with the least access to public transportation. The place with the least access to prospering jobs and a place with the fewest schools in Washington, D.C. It's a pretty big disparity.

So as somebody who is wired to look for these problems, these hard things to solve, and to work on them through design, we've been asking ourselves and the design community, if we can work on things like experience in clinical care and better tools for clinicians, why can't we also design a better approach to community health? So we set

out to do that. We took a design team and one of our first steps was to take some of our executives from our health system and train them up in design.

We call these listening sessions, but they were really what our fancy design term was—that ethnographic end user research. And we went into ward seven and eight and we met with people in schools. We went to senior centers, we went to places of worship, we went to family resource centers. And we asked people two questions: how do you define health and well-being, and what are your barriers to living your best days?

We asked people to draw their neighborhoods and draw their health. This is one that somebody drew and said, I used to live on this beautiful tree-lined street. It's an old neighborhood in Washington, D.C. But now it's the place where all the cops park and hang out. And the problem is in D.C., we don't have enough cops, so we're employing people from Virginia and Maryland. So the people who are hanging out in our neighborhood don't know us. They don't look like us. We don't know them. And I'm now afraid to leave my house because I don't know what will happen.

People told us things about the stress they live under.

This is a photo that a 16-year-old drew about her neighborhood and what it's like to get from the bus stop to her building during the day and during the evening. During the day, there's teenagers hanging outside smoking and at night there's drugs and guns. I can't imagine that anybody in this room would want to live in a neighborhood that somebody would draw that looks like that.

We listened to a lot of people tell us things about the struggle of life, the stress that people live under. The idea that, I don't want to have to make these trade-offs. I'm not supposed to drive, but if I don't, I can't take care of my granddaughter.

So we distilled these into a couple of high-level findings. We call them insights. Again, another fancy design term. We went back to the community and said, this is what we think we heard. Are we hearing you correctly? We heard about this notion of islands and seas—that there are these few bright spots in neighborhoods, but you have to wade through shark infested waters to get to them.

I'm going to tell you a lot more about disproportionate impact in a second—we call this the zucchini problem. We heard about tightly woven fabric. It's that idea that if I don't make this bus, I lose my job. If I lose my job, I lose my house. If I lose my house, I can’t care for my family and I care for an entire generation.

We heard people say, I don't need more sick care. I don't need a fancy cancer center in my neighborhood. What I need is help with finances. I need better jobs. I need access to better education for my kids. Those are the kinds of things that hospitals, at least like ours, weren't traditionally prepared to provide.

And we heard people say, things happen *to* us in our community. Developers come in and the city comes in, they change something, they built something, but it's not the things we would have wanted, or they're not building it in a way we would value it. It's not the change that we need. So please hear our voices.

And we started to look at these problems, when we said the experts, the people who can best solve these problems are the people who live in the community. So we put out a call and we said, let's launch this idea of community innovators-in-residence. Let's find people in the community who are as inspired by these challenges as we were.

And we said, there has to be a few crucial components of this. First, we went to the hospital board and said, we have to pay them the way you would pay anyone else on our team. It's not fair to ask somebody to work on a problem like this and not treat them like an expert the way you would treat me or someone on my team as an expert.

We said, we have to put out a call for applications. We said, we thought, if we were lucky, we might get four or five people. We were overwhelmed with about 20 times that number of applications that we went through. And we came out with a group of about 24 people that formed little teams and each of them said, I want to work on some part of this problem.

I'm inspired by this and I'm going to work on this. For my community. This is the one that we've been calling the zucchini problem—this is that one we have labeled disproportionate impact. It's that idea of saying, I don't know if I'd like this. I have $5 to feed my family. If that's the only money that I have to feed my family tonight, why would I risk it on something that I don't know if I know how to cook, I don't know if I like, I don't know if anyone in my family's going to eat. I know that if I use that $5 on something else, that I'm guaranteed to feed them tonight.

There were two sisters that were particularly inspired by this. This is Diane and Hortense. And Diane and Hortense lived in ward eight. And said, we really want to work on this. This feels right to us.

So they started asking their friends and family, they said, what do you think about health food? How does health food sound to you? And people told them things like, if I didn't grow up with that flavor, I don't want to eat it. Right? I want to eat the things

that I'm familiar with. And other people that they talked to said one of the biggest challenges is that we don't trust where that information comes from.

Everybody is always telling us to eat better, eat healthier, but they don't know us. I'm not even sure if I trust the information source. So these two sisters set about, went through that design process. We helped coach them, we provided support, but they really took the lead to become these community designers, engaging their friends and families and communities and came up with this idea of hosting dinner parties.

I love the visual of this. I got to sit in on one of them where they would feed people these amazing meals. They were incredible cooks. They started off doing this in their houses and they would invite 10 or so folks in and sit them around their table and feed them things like chili or pizza.

And then there was this gotcha moment where they would say, now—and I'm not kidding—look under your plate, look under your seat. And under there, was a card they had written that said, we've just fed you all these healthy foods and you didn't even know it. Imagine these two sisters gleaming with pride, right?

They would say, you just ate things like turmeric. And turmeric reduces inflammation and you've just had beets and beets are good for your heart, and you just had kale and kale is good for everything. It started to grow and spread. And the key was that they were feeding people familiar things. They were feeding their friends and neighbors things that they would have eaten anyway, they just replaced the ingredients with healthier things.

So like any really great idea that started to spiral out of control, they needed to soon rent bigger and bigger spaces. I mean, this was the kind of thing that we were just incredibly moved and inspired by.

This was one of four groups, like I mentioned. Another group said, we want to work on that idea of tightly woven fabric.

So they created a community marketplace. They said, we need a place where people can come together and sell things like food and goods and crafts and art—the kind of place that in big urban areas or in popular tourist destinations, you can go in, and there's five or six little shops and little juice places and coffee bars. They said, we need that for our neighborhood. But for people who live in that neighborhood to be the people that come and bring those things together.

There were people who worked on ways to help solve some of the transportation problems associated with signing up for benefits and health services.

Some of these things continue. Some of them were just projects that lived for a period of time and had a beautiful life and then inspired other projects.

We're not the only ones who are looking at things like this. This is Columbus, Ohio, where Nationwide Children's Hospital is. Nationwide, as you may know, is the first and still one of the only pediatric accountable care organizations in the country.

And they went through a similar process where they said, we're now responsible for taking care of the health and well-being of our community. And a pastor in the community came, and I like to imagine, I was not there for this, but I like to imagine that he went to the board of directors and grabbed the gavel and said, I'll take it from here.

He went to the board and said, I can help you with this, but it's not gonna look like what you think it does. He said, the first thing we have to do is create jobs for these kids, for something to do after school. And you can't have kids working in a bar in this neighborhood. So you need to create a job that's appropriate for them, like a bike store. And this was the actual bike store. They said, we're going to teach kids to repair their friends' bikes.

And then you need a place for parents that can go and buy clothing because they need things to be able to wear for jobs and interviews, and they need things for their families.

And then you need to build houses and you can't just build one house. You have to build three in a row because nobody wants to live in the one nice house in between the two rundown houses. But you can't just build them. You have to hire people from the neighborhood to do the work, because those parents will have jobs, and when they have jobs, the kids will stay at school.

These are incredible stories about people doing community-centered design, to change the health and well-being of their communities. But we're not doing nearly enough.

Most hospitals allocate a small, small fraction of their budget for this kind of work. We're not making a dent. If we really believe that our health systems are here to improve the lives of our neighborhoods and our communities and the people we serve,

shouldn’t we be treating them with the same kind of precision that we apply to clinical care?

If we can sequence people's genomes, and target people with individual n-of-one therapies, why are we not doing the same thing, block by block, person by person, for how they experience social health? We know that social health accounts for a lot more influence than things in our genetics alone. I've seen estimates as high as 80%. Your models may vary, but we know it's pretty significant.

So my call is to add people to help repeat this process. I don't think it's terribly hard. I think it starts with listening to the needs of the community. I think it's asking them those same two questions that we used—how do you define health and well-being? And what are your barriers to living your best days?

If you're feeling particularly brave, you can ask people to draw. It's a pretty profound experience.

Then look for the community members who say, I want to help work on that.

You can hire the design team, you may have a design team in your health system already. People will want to help support those community innovators and you have to help empower them by treating them like the experts they are. And I think we as an industry have to make community benefit a top priority. That is the way we will start to really change how we think about moving from sick care delivery to true health care.

That's my message this morning. I really appreciate the chance to be here.

Stephen Moegling: Time for Q & A and discussions. Well, let me start by saying nice work, man.

Nick Dawson: Thank you for having me.

Stephen: And I get the benefit of asking the first question and then we're going to turn it over to our amazing attendees. Kind of a philosophical question. It's early in the morning, so I get to ask the tough ones. You've had coffee, right?

Nick Dawson: I've had enough.

Stephen: Yeah. You have a pretty big vision for what you believe to be true in what true health looks like and ending sick care, and you have a great platform for that. But I'm curious because your vision is so big, how do you keep pace with that vision knowing that it's probably not going to happen in your lifetime, and that's because it's so big.

So how do you go back to the well? And I'm supposed to hand you the mic now so you can use this one.

Nick Dawson: I haven't had enough coffee for that question.

I think the thing I'm supposed to say is, you know, look for the little wins, look for the small pockets of success. Right? I can talk about Diane and Hortense for days and days on end. I could celebrate the other teams that I didn't even talk about from that program in the other versions and the other cohorts of that program that have continued and point to those things.

I think I'm also wired to be a little contrarian and reject the hypothesis, right? I don't want to wait. That doesn't make sense to me. It doesn't feel okay. I get emotional about it. Where you were born, your zip code should not determine your outcome. It should not be the thing that determines your ability to thrive and live your best days.

And if I take a long view of that, that's a depressing perspective. I don't want to take that long view. I want to do this faster and sooner.

Audience member: Duluth, Minnesota. If you are in the Lincoln Park neighborhood, your life expectancy is 11 years less than if you're in the Congdon Park neighborhood. Shocking. How do you take this message and spread it across the country? Like you had a voice in the Obama administration—I mean, how do we do this?

Because it’s 100% it makes sense.

Nick Dawson: I think telling stories to me is a huge way of doing it. And I'm a big believer in storytelling. But I think it's not enough. The part that I didn't dwell on today is the inner economist in me yearning to break free, and if we break apart that big economic bundle that is the 20% of our GDP that represents health care, and really start to look at what are we doing with that money and where is it going, we have to also start asking the question, is that where we want to put this money? Are there better, pick my words carefully, but are there better institutions? Are there better civic uses of money like that?

And so as keen as I am on the stories and the proselytizing of this type of work, I am also keen on trying to think about how do we start to shift real economic resources to this work. It has to be as important to an organization as an MRI is, and I'm not suggesting that an MRI machine or a genetic sequencer isn't important. Right? It just has to be as important and we have to find ways to make those financial incentives there for others.

The other thing I'll say just really quickly is I went through all of the community needs assessments for all of the health systems here in Duluth, and by and large was really, really impressed and saw some amazing things, including some commitments to rethinking access to mental health services, for instance.

I saw people saying, we have engaged teams to go out and listen to community members and find out what their real needs are. So I think the other thing to celebrate is that it is happening. And that's a nice thing to see here.

Audience member: Nick, great presentation. And what we're really talking about is really changing the way people live, people's lives, their behaviors. Essentially the culture.

Question, if you can shed any light on, when you do these sorts of initiatives, how well are they sustained and can you actually, you know, embed them into the community where you can see a long lasting effect. One of the problems we have in health care is changing the culture and people move a little bit and then they fall back.

And it's really, really tough to keep the momentum going forward. If you can shed any light on the sustainability of the efforts that have been done, maybe we haven't reached a tipping point, but I'm just curious about your thoughts on that.

Nick Dawson: I do have a couple of thoughts about that.

One is kind of an interesting anecdote. We shared a lot of this work with our public health colleagues who were at first, initially pretty challenged. They said, well, everything you're describing—if you remember that one slide of the islands and the tightly woven fabric—they said, we know all of this. It's a food desert. We said, but nobody has ever told you it's a food desert because of the risk involved with trying something new. So one of the first barriers we ran up against was just getting our own professional colleagues to at least get out of the way to let us do the work.

Right. And then the question became, is this sustainable? What do you do with two sisters who are cooking meals for their friends and family out of their kitchen? Is that a business that they really wanted to run? And when they came to the end of that particular program, in that cohort that we were running, they said, you know what? We don't want to quit our day jobs, but we do want to write a cookbook. And so they kind of transitioned, that way, and said, this is going to be our closing chapter.

In another setting, the one I mentioned about the market, the city came in and said, this is too important. We want to be a part of this as well.

So I think there's these kind of short-term little pieces that serve to inspire the next thing and the next thing and the next thing. And then there's places where the city said, we want to help be part of continuing this to go along. The part that's still the biggest challenge is to convert our health care institutions that are largely wired for sick care.

And I'm not saying that to be judgemental, but it's what they're really good at. You come there when something is wrong. So how do we convert them to starting to think about putting more and more resources into these kinds of things? And I wish I could say that after our first cohort, we tripled or quadrupled the size.

We didn't. We just agreed to do it again and again and again. So I think there's these little baby steps toward getting there.

Audience member: Good morning. So a lot of what you talked about this morning is fairly grassroots. It seems kind of simple. We live in a community of about 55,000 people. And there are so many initiatives happening, so many nonprofits.

But there isn't a lot of integration, a lot of collaboration. So how do you swing that mindset? You know, so we're all sort of rowing in the same direction in helping one another achieve, you know, the kinds of things that you talked about.

Nick Dawson: I want to just begin by acknowledging that.

I think that it's true in every community I've looked at is that there are a hundred different organizations looking at food insecurity or housing insecurity. The piece that I keep coming back to is that idea of the economic weight, the gravity that is associated with our hospitals and health systems.

In most communities, they are often the largest employer, if not one of the largest employers. They are usually the biggest business in a community. And they're usually the place where most of the money flows in and out, in a community. And so to me, I'm not saying we're there.

I'm saying there are some bright spots and we're seeing more and more of it. But, my big hope is that we will see community health systems take up that mantle and say we want to be the umbrella organization that puts as much effort and thought and resource into this as we do into any other aspect of clinical care.

Audience member: Going off of that, in your travels, in your work, have you come across any health systems that have made movements in that direction and have initiatives that have been in place long enough that they're able to see effects of that,

because a lot of these things take a long time to actually see changes in the bottom line, which a lot health care systems have to care about. But have you come across any systems that are a good example?

Nick Dawson: Yeah, I can think of a couple. The other thing—and I'll share those in a second—the other thing to acknowledge is your comment is, these things take a long time. And our current health care performance indicators aren't set up to track them.

Right? So, days of cash on hand or patient days or census, that's not the right metrics for this kind of stuff. It is really hard to look at something and say, because we kept a kid in school for the duration of their elementary school period, we reduced their early childhood trauma. And then that's going to equate to what? We don't have a measure for that.

So I think that the hard part about that might be the measurement. There are probably folks that are much more steeped in public health, in those kinds of metrics, would understand how to measure that better. But at least in the traditional community hospital settings, I haven't seen it.

I mentioned the example of Nationwide Children's. I think they've done amazing work. To celebrate our geography in common, where I came from a long time ago, Bon Secours in Richmond, Virginia did a lot of community development work in this space. And they said, this is just part of our Catholic mission. It's part of our mission as an organization to do it. And they never said, we're going to try to track the benefit of it.

Where I currently am—and I'm going to be very clear that I don't represent this body of work for the organization—the phrase that we are using is precision social health.

So how do we start to take the massive amount of community benefit spend that our organization has, is part of our mission and our nonprofit status? And how do we start to laser target it and measure the impact. We are just at the beginning of that journey. But my hope would be that as the really big health systems like the one I work for start to do that, we can start to model that, and map it for others.

Audience member: Do you think that there's a kind of an ideal for the key players in a community? I mean, if you had to think of the health system, and you've mentioned the city, you know, who else comes to mind in terms of organizations that can partner to help sustain it.

Nick Dawson: Yeah. I've thought about this quite a bit. The best models that I have seen are when there's three big players that come together. The local health system,

right? Because that is the closest thing we have to an organization that is wired for this. The mission is there.

The city, I think, has to be an integral part of it.

And the largest employer that's not the health system. Who has the most to gain from a healthy population in a city, the most to gain from a healthy workforce, and a healthy environment in a city? It's those three working together, to me, would have the biggest chance of success. Now, a fair corollary would be, have I ever seen that or had a chance to get somebody on board with that idea?

Not yet, but, if anybody is aware of a city and a government and a large employer and a hospital system that want to do it. That's been a been a life's mission.

Audience member: Do you think, I mean, you mentioned those three, let's say large organizations within a community. Is that just based on sheer weight and volume? One, the money and two, the people, and just sort of volume of getting that many people moving in the same direction. Is that key to it?

Nick Dawson: For me, it's the Venn diagram of mission and economics. So again, I look at health systems, and I've never seen a community health system that doesn't have a mission, that includes something like community and wellness and compassion.

The mission is there, right. They are usually—of the 5,500 hospitals in this country, 5,000 are nonprofit with a, presumably, with an obligation to serve the community. So I look at that as one key player. I already declared in my opening remarks that I think that that's the role of cities, predominantly, and if we kind of extrapolate that idea of social health out, the idea of improving transportation is a factor of social health. Education is. So the things that cities inherently do, I look at as drivers and influencers of health care. So those two make natural sense to me. And then you look at the largest employer, and again, they have the most to gain from a healthy workforce in kind of a healthy city, in a healthy population.

So to me, it's a combination of mission, kind of the role of government, from my point of view, and economics.

Audience member: Good morning. A really excellent presentation. Thank you so much. You know, you mentioned the financial resources and the devotion of and commitment to financial resources to do this kind of community based design work.

I'm curious, how was the example that you provided funded and what do you see as kind of a mechanism or a catalyst for committing financial resources to do this really great work.

Nick Dawson: Shame and fear are two very good motivators. When we looked at, both in my organization, and when I've talked to others about this, when you look at requirements for community benefit spend, right—and you could even take a step back and say, outside of the ACA's requirements for community benefit spend, requirements to continue to prove a nonprofit status are a pretty big driver. I think that we will probably, if I was going to prognosticate, see that come front and center even more over the next four to eight years probably.

So when we looked at what is our community benefit spend, right? What is the part, after we write off what we called the loss on Medicaid. I have a whole other bugaboo about that. Right? What else are we doing. And is that number where we want it to be for our board? Is it where we want it to be for our nonprofit obligation?

It was pretty easy to say that what we're talking about here is hundreds of thousands of dollars, not millions and millions of dollars, which is a relative drop in the bucket. It's a huge amount of money. I'm not going to suggest otherwise, but $250,000 to run a program like that is a drop in the bucket compared to the overall revenue of most community health systems.

It is a small thing to do. And to be able to do that and say that is part of our community obligation and part of our nonprofit status was a pretty easy sell and a pretty easy fit.

Audience member: You mentioned a couple of times, if we could just let the health system get out of the way, and let the workforce. So how, in your perspective, is this a conscious getting in the way, a subconscious getting in the way? How can you help the health system understand how they're getting in the way? So we can, so we can get out of the way. I'm just curious what your thoughts are about the barriers that you're seeing.

Nick Dawson: That's one that can take quite a bit of air time, but I'll try to be succinct and not too rambly about it. One thing that I see all the time, and this is, I will admit, a little bit of a pivot in my worldview, is that physicians and nurses, and this is not a surprise to you in this room, all got into that work because they wanted to care and help people.

They wanted to care for their communities. They wanted to care for people in need. Increasingly we are putting them in a position of saying, 20 visits a day or 10-hour shifts, right? And those are so highly regimented around a particular model of care. I've

often wondered, what does it look like to say that part of your compensation, part of your RVUs, part of whatever your model is, is some part of community care.

So how do we, how would we just get out of our way to do that? Now, then there's the question of how would you reimburse for it? These are billable resources, right? But that to me is one of those places where I say, if we are nonprofit charitable organizations, isn't that something we should be doing?

So I don't have an economic reimbursement model for it. I just have a moral compass around it, I guess. I think that's one area. The other area is most hospitals are these amazing conglomerations of technology and operational expertise. And we bring that to bear in start times for ORs and we bring it to bear in food service delivery and the way we handle medical records.

What would happen if we scraped off a little bit of that expertise and operational know-how and said, let's also apply that to community health and well-being. How do we get out of our own way to do those kinds of things? And if you said much like Google—I think this might be a little bit apocryphal—but there's that notion of 20% time. What happens if you say to your health IT team and your operations team, take 10 or 20% of your time and apply it to community health and community improvement? What would it look like to get out of our way for that?

Audience member: A related question to that. I'm sure this is a topic that comes up a lot, but the sick, the sick care is right now, I think, where a lot of the health systems make a lot of their money, and so that stuff is financially incentivized. Do you ever run into issues with people saying, yeah, but if we're doing these programs out in the communities and they're going to be healthier and better, and then we're going to get fewer people coming, to pay for our services.

Nick Dawson: Never doing community design, and community health design, I have been part of two readmission redesign programs that were stopped because we were getting paid for readmission. And that is a really, really depressing thing to ponder.

It's why I keep mentioning the economics of it, right. I think it's, until we change some part of that model, it is a gravity that will continue to pull resources and attention to where ...

Audience member: We need to find a way to financially incentivize it.

Nick Dawson: Yep.

Audience member: And that hasn't been really solved yet.

Nick Dawson: I agree with that.

Audience member: Okay. I just have another question. When you outlined the way to do this in a community with the three entities, is that written down anywhere? Is there, like, could, are you available to consult with the community? How do we spread this?

Nick Dawson: Yeah. I didn't have a sell from the stage, but if I did, it's a free one.

I would help any health system or any community that wanted to do this. With my own time and own passion. And I'm full of a community of people who would do the same. Most of us in design are attracted to this kind of work, in these kinds of problems and feel like it's what we're here to work on.

There are some things and there's some resources that I can send you all and some places where we wrote this up and published some things. And I'm happy to share that. To me, the really simple toolkit though is for a community health system, that, if they have a design team, that's great, but we're pretty rare, we're rare breeds inside of health care. But almost every city, especially one of the size of Duluth or Minneapolis has design firms in town who would love to coach and partner and work with organizations to do stuff like this.

Audience member: You talked about the job description maybe for people in the community being the ones that need to do the work.

I think one of the ways we can get out of the way is by stopping pretending that people that look just like us can solve the problems for people that don't look like us. So I'd be curious if you could share more about what does that job description look like and how did you get so much success in getting so many people to apply for those positions?

Nick Dawson: I want to just start by celebrating what you said and wish I could take my rambly answer back and replace it with that. Thank you. So we did a couple of interesting things, and this was by design and it might sound really nuanced and detailed. The first thing we said is, we don't want to make folks employees.

Our employee process is really onerous. There's background checks and drug checks and it takes six months and you have to open a job rec. And job recs have to go all the way up the food chain. The other thing we said is, people that are showing up to do this work are giving their time to do it.

They might be taking time away from jobs to do it, or families. It's really important that we pay them upfront. So the first thing we did is we structured them as contractors and

then we said, we're going to divide this work into three phases. It was those same three that I outlined, listen, imagine, do, and said we're going to pay you upfront of each one of those phases.

So that you're not waiting to catch up, right. That you have fuel to go on. You're not spending out of your own reserves because they're not really contractors. And then the third thing we said is we're going to also give you a cash stipend for supplies or transportation. So whatever you need to do, if you want to take an Uber to get from one side of the neighborhood to the other, you should not have to get reimbursed to do that. We wouldn't. We would put it on our corporate cards to do it. So the structure was a really big part of it, when we set it up. The other big piece was the application process, and we said, we can't be so onerous that no one will do it.

We were really worried about not getting any applications, but it can't be so loosey-goosey that we don't know who's going to do what. So we asked some essay questions and said, why is this work really important to you? How committed are you to doing it? And then the real big piece was, can you show up on these couple of dates?

So we'd had a couple of key dates where we said, one of these is going to be some training in design. One of these is a meeting with the mayor that we had already prearranged. So as long as people could meet that, then all of a sudden we were just wading through this list of applications. It was much bigger than we expected.

The other thing we did the first time, and have not repeated since, but really loved, was asked people to film a video and said, just whip out your cell phone. Film a video, send it to us as a clip, whatever works. And just to see the faces of people and put those, hear those stories in their own voices. And their passion for that work was really powerful.

So it wasn't a true job description and it was a pretty nontraditional process. It was a little bit cumbersome to get our treasury to issue a check ahead of somebody doing work with something we had never done before, as you can imagine. But it was the kind of thing where we said, that's what empowerment looks like.

Empowerment doesn't look like asking you to get a credit card and treat yourself like a contractor that's going to go become a consultant around the country or something.

Stephen Moegling: Thank you, Nick.

Nick Dawson: Thank you.