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Narrator

Kristen Reynolds
The Bakken Museum
Interviewer

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Jennifer Lundblad -JL
Kristen Reynolds -KR

KR: 00:00:09 Can you state your name and where you work for the record, please?

JL: 00:00:14 Jennifer Lundblad with Stratis Health.

KR: 00:00:17 Alright, lovely. Thank you. We're going to go right ahead and jump in. Again, let me know if you need a break. Would you mind just telling me about your childhood?

JL: 00:00:29 I'm a Minnesotan. I grew up in a small rural farming community in the southwestern part of the state called Jackson. It's not where either of my parents were from, so they were transplants, but they raised my brother and me there. My dad was an attorney in town, and later became the county attorney. My mom was very active in the volunteer world. She was on the library board and did other community activities. Small town living was interesting. It was good in many ways because you have lots of people looking out for you and a close-knit community, but your business is also everyone else's business. It has some adverse effects at times if you are under the spotlight.

KR: 00:01:12 When were you living in Jackson?

JL: 00:01:17 I was born in Jackson, and I lived there until I graduated from high school. So, it was all eighteen years until I went to college.

KR: 00:01:23 And when did you go to college?

JL: 00:01:26 I left for college at Macalester and did my four years in St. Paul, just across the river.

KR: 00:01:34 Tell me about your time there. What made you go to Macalester?

JL: 00:01:40 Having grown up in a small town, I knew I wanted to be in a city. I had had enough of the small-town life, or so I thought at the time. I knew I wanted to go to a small, liberal arts college. There are surprisingly a few strong liberal arts colleges located in urban places, but most are rural. Macalester appealed to me for those reasons—being urban and small. As much as I loved my high school experience, I wanted to go somewhere where no one else from my high school was going. I very intentionally chose a place where I was starting a new chapter in my life, and I wanted intentionally not bring forward all of the things from my small town.

KR: 00:02:26 Was there anything at Macalester that inspired you to enter the work you currently do?

JL: 00:02:33 Indirectly, yes. I distinctly remember the moment in my senior year in college where I decided, at least I thought it at the time, I wanted to devote my career to the nonprofit sector. All four years of my work study were in the library. I remember standing there in the library. Being a speech communication and economics major, I thought the combination of those things might lead to a path in the nonprofit sector. I had that moment of career planning standing there, by myself, in the library. That's what I wanted to do, and that's what I did. My first job out of Macalester was in Boston, Massachusetts, where I worked for a statewide adult literacy agency for a few years. Then I went onto work at Tufts University, and back here to the University of Minnesota to direct continuing and professional education programs.

00:03:25 [Those programs] helped people who wanted to go back to school post undergraduate to do continuing education programs, get a certificate, or in some cases, a master's degree doing multidisciplinary work. Overall, I was creating those programs to meet the needs of emerging professionals. That was the first decade of my career. While I was at the University of Minnesota, ironically, my Associate Dean I worked for at Tufts University reached

out to say that she had a colleague and friend at this place called Stratis Health. They were creating a new position in the organization that she thought might be a good match for me and asked if I was interested in learning more. I was not job hunting at the time, but it sounded just enough intriguing enough that I went ahead and had an interview. That's how I landed at Stratis Health twenty-five years ago now.

- KR:** 00:04:14 Wow, and what was the position?
- JL:** 00:04:17 They created a new position, which was Manager of Program Development, Communications, and Outreach. It combined the things I was doing internally at two different universities and that program development expertise I had.
- KR:** 00:04:34 Yeah, it seems like it's a seamless fit for all the expertise you cultivated in a decade.
- JL:** 00:04:39 It was a great match. Stratis Health, at the time, realized that they didn't have enough staff to have clinicians on their team. They also needed someone that could really help them design training and do program development work. So, it was a great match.
- KR:** 00:04:52 Tell me about those early years at Stratis.
- JL:** 00:04:57 In some ways, healthcare was brand new [to me]. Stratis Health gets a lot of its funding from government agencies, so it was a whole new set of vocabulary, acronyms, and complexity that I didn't know. Yet, in some ways, it felt familiar because I'd been in higher education. Higher education and healthcare have some things in common that are very unique to those two areas of work. In both cases, there's some confusion about who's really in charge. In education, is faculty or administrators? In healthcare, is it physicians or administrators? There's some confusion about who the customer is too. Is it the student, is it the parent, or the other payers of education? In healthcare, is it the patient, the health plan, or employer? There were surprising amounts of parallels as I was getting up to speed and trying to become familiar with the healthcare world. I felt quickly that I had landed in what has become my professional home because the work of Stratis Health is all about making lives better. Every day I get to come to work and try to improve health and healthcare, and there's a

passion there that I discovered over the various roles that I had eventually becoming the CEO [Chief Executive Officer] in 2006.

KR: 00:06:25 Can you briefly share some of the other roles that you had in between?

JL: 00:06:31 I was in the manager role around program development, communication, and outreach for probably a year or two. Then we had a new CEO at the time, and during her tenure there, I was promoted to the Senior Vice President of Programs and Operations. I had a broader purview and was really helping us take the organization to its next iteration of providing technical assistance and training that helped translate research into practice in healthcare organizations.

KR: 00:07:06 Was this another position created for you?

JL: 00:07:08 Yes, it was another new position combining what had been two others. The other exciting part was that Stratis Health's work had traditionally been with hospitals and with primary care clinics. At that time, we expanded our work across the full continuum of healthcare, including long-term care facilities like nursing homes and home health agencies. It was a much broader continuum of healthcare delivery where we were trying to improve health and health outcomes.

KR: 00:07:42 From the senior vice president position, you held that for a while and then became CEO?

JL: 00:07:48 I was in that role for probably five or six years and was also completing my PhD in organization development. That was important and helpful in our work. I completed my doctoral dissertation on teamwork and safety climates in small, rural hospitals. When I earned my PhD, I was doing that full-time and working full-time. I had a conversation with the former CEO, Patsy Riley, who was just a wonderful leader. This was probably a year or two before I finished my PhD. I said, "Patsy, Eric and I are thinking we might want to take some time off since this is so intense. I'll be doing the work full-time and my PhD full-time when I'm done. We just want to take some time." She said, "What are you thinking, a month?" I said, "Well, more like a year." I give her all the credit in the world.

JL: 00:08:39 She swallowed hard and said, “Well, let’s see if we can make it work.” So, I took an eight-month sabbatical. It probably was not technically a sabbatical, but it took eight months to rejuvenate and reset. We traveled to every continent, so it was an international travel experience. I loved to travel before then, but I had these eight months to really travel in a different way—to do long-term travel without an itinerary, without a seeming obligation to see the sites, and just travel in an experience that was a really a gift. I came back thinking that it was time to make my next career move. I thought, “What will that be?” At that point, Patsy, our former CEO, had accepted another position and was moving on. I had to decide whether I was throwing my hat in the ring to be Stratis Health's CEO, or whether I would move on to another role having completed my graduate degree. I obviously decided to throw my hat in the ring. I feel very fortunate that the Board search committee selected me and that’s what landed me in the President and CEO role.

KR: 00:09:41 Wow. Just to clarify, Eric is your partner?

JL: Yes.

KR: This is obviously not on this list of questions, but I’m curious how those eight months of international travel has informed your life in your role as a CEO and your life since then?

JL: 00:09:59 It’s informed my life in so many different ways. We talked about before sabbatical, and then after sabbatical. But again, having that gift of eight months was tremendous. We planned for it for a long time. It was obviously eight months of unpaid time. But what I discovered, or maybe reaffirmed for myself, is that where I get my energy is from new people, new places, new experiences, new cultures, and new foods. That can be translated to being here locally. I don’t have to be in Brazil or in Egypt to make that happen. I can get that energy from new ideas, new experiences, and new programs. That [mindset] definitely permeated during my time at Stratis Health since having that eight months off. It also still influences what I do in my personal time. We have a goal to travel to at least one new country every year and have done that in the twenty years since we took our eight months off.

KR: 00:11:02 Wow, it sounds like in your role as CEO, you've tried to make sure that Stratis stays dynamic and responsive.

JL: 00:11:11 We have to, or we're not going to be relevant because we don't deliver patient care. We don't take care of patients. We don't pay for healthcare. We're not a health plan or a managed care organization, and we don't invent or create devices or technologies. What we do is help those healthcare organizations, and the communities that they're in, to ensure that they're delivering the highest quality care based on the best research and evidence that's available. We're only as good as our team's knowledge, relationships, and experiences are. We always have to be not only doing the work of today, and whatever programs or projects we have underway, but trying to look ahead on the horizon or what's around the corner so that we can be relevant and be helping to drive and lead that change.

KR: 00:11:56 Yeah, that makes a lot of sense. Along those lines, can you tell me more about what Stratis does and how it's evolved over the years?

JL: 00:12:12 The origins of Stratis Health were in the early 1970s. When you talked about healthcare quality in the 1970s, it largely meant quality assurance. It meant trying to get people and organizations into compliance with whatever the requirement regulation or standard was. So, quality assurance is an important part of their work. But then, in the mid-eighties, it became not only about quality assurance, but quality improvement. This was adopted from other industries, like the "total quality management" movement in Japan. Instead of getting everyone to be at the standard, how do we raise it? How do we continually improve care and care delivery? It was in the nineties that I joined Stratis Health when that movement had taken full effect. The real focus was on patient safety and continuous quality improvement. That is certainly one thing that has changed over the course of Stratis Health's existence.

00:13:15 I mentioned previously that Stratis Health's work originally tended to be very hospital-centric originally, but what that does is ignores patient's journey. A patient rarely experiences only a hospital stay. A patient typically has a primary care doctor or specialty care provider. Maybe they have an incident or something that's emergent, and they have to go to the hospital, but they're often discharged.

Then they're at a rehab facility, getting care at home, or move into a nursing home. If we're going to really think about what high quality, patient-centered care is, we have to think about what that whole patient journey is. So that's another significant change. The third thing that comes to mind for me is something that I've felt personally and professionally is important work to drive and lead. That goes back to my organization development work in the field of behavioral and social sciences.

00:14:11 Instead of just relying on clinical and medical science, which are critically important, we have to recognize that healthcare is delivered by people working in teams and working in organizations. If it was just a matter of me telling you as a clinician, "Oh, here's the latest evidence and here's what was proven in research, go do it," you wouldn't need an organization like Stratis Health. That just doesn't happen. People work in systems. They have processes. It's very hard to unwind something and make a change, and that's what Stratis Health's work is all about. To try to continually evolve based on that evidence, where there is evidence, and to continually think about what that patient's journey is and how we can be most responsive and helpful to the patient.

KR: 00:14:56 I don't want to get too far off track, but I'm curious how much conversation or involvement with patients you have specifically. Do you get your information about patients with one-on-one conversation or focus groups, or do you look at the literature?

JL: 00:15:15 It's a little bit of both. We certainly get information from published literature, research, and other studies, but we also have other ways that we get direct contact with patients and with those communities that we're trying to serve and support. We have a community outreach committee, a longstanding group of people that advise us from that consumer perspective. It also includes organizations that advocate for and support consumers. We're trying to get that patient voice. At times we use them as information focus groups, but mostly we bring them timely topics to have discussions. When you hear the questions they have, and how they share their experiences with healthcare, it informs how we design and deliver the technical assistance and training that we do. Depending on the initiative, those projects can include focus groups with users of a system or

with members of a community. We get that direct input as well whenever we can.

KR: 00:16:17 Because you use this language of initiative, it sounds like you are constantly developing things, testing things out, and seeing what works. Can you talk to me more about what you've learned from mistakes that may have occurred at Stratis?

JL: 00:16:41 Our work falls into one of two big categories, if you will. The first is that we try to make healthcare the highest quality, safest, and best value in the system that we have. And at the same time, we recognize that the United States healthcare system is highly flawed—we get the worst outcomes at the highest cost compared to all other developed nations. We're also driving change and innovation in terms of the next system. What's the next way we can deliver care? We're either trying to drive new models or test new models to make care as good as possible, given what we have. I think that the biggest lesson learned goes back to something I commented on a few minutes ago, which was that people who choose to work in healthcare are generally there because they care deeply about delivering good care.

00:17:37 They care deeply about patient health, but they're up against systems, processes, barriers, and both incentives and disincentives that have had them doing the wrong thing instead of the right thing. Every time we have ignored the system, process, disincentive, or incentive issues, we have run up against a brick wall in trying to support and lead change. We're reminded, time and time again, that we need to pay attention to those people factors and those team factors. That ensures that we are figuring out what the person-oriented way of designing a project or initiative. We draw on things like implementation science, which includes behavioral economics. How do you help people to make the right choices at the right time? We look to a lot of work with network theory.

00:18:32 Where are the connectors and the influencers who can help drive behavior change and organizational change? And then, how do you unwind things that are baked into policy, procedure, or process that made sense when they were first implemented, but now it doesn't make sense. We have this horrible tendency in healthcare to simply add on. There's a

process and a step, and then when something happens and something goes awry, we add onto it. Then something else happens, so you add onto it, and soon you have this cumbersome, not-helpful process that isn't guaranteed to get you to the best outcome. We're often in the business of process mapping and trying to unwind things to better ways of delivering care with the hospitals, clinics, nursing homes, and home health agencies that we're working with.

KR: 00:19:19 In that sort of trajectory, what do you think then it takes to be an innovator in medicine and technology today?

JL: 00:19:33 Ooh, that's a big question.

KR: 00:19:35 You can take your time with it.

JL: 00:19:37 What we do well with healthcare in this country is addressing the big, emergent, problems. We have great innovation in technology that helps us do that, and Minnesota is home to so much of that. We do medical devices, pharmaceuticals, and technology innovation well. What we don't do well, and where Stratis Health is trying to fill in some of the gaps, is where most people need help. They have a chronic condition, let's say a long-term cancer diagnosis. They have social factors and needs that drive what their health outcomes are—that's where we in this country generally fall down on the job. The innovation that Stratis Health is trying to drive is to address where those gaps are. We recognize that somebody else is doing the device technology and pharmaceutical work well and that they have the marketing and dissemination machinery to get that out there. That's great. We need that. And that leaves a lot of people behind who are in a rural community and don't have access to the care or the specialists that they need. Or it's perhaps in an urban, underserved area where you can't get culturally relevant care by someone who's attentive to what your needs are as a patient, a person, or a family. The innovation we make is trying to directly address those kinds of challenges that exist.

KR: 00:21:11 I'm also curious, why do you think that Minneapolis was a good place for Stratis to call home?

JL: 00:21:22 We're a Minnesota organization. We happen to be based in the Twin Cities, but our work is statewide. In fact, our work is nationwide, but we are in Minnesota and are proud to be

here because it's a good place to be for the kind of work that we do. There is a long tradition in Minnesota that is about collaboration. It's about setting competition aside when it is for the betterment of the community. That's a pretty rare thing to have happen. I can give you a couple of examples of that. Minnesota Medicaid, for one. The public programs that come out of our state, for people who qualify because of low income, have a requirement that they must complete a performance improvement project. This would be the health plans and managed care organizations that deliver the Medicaid insurance to Medicaid beneficiaries in the state. For many years, Stratis Health has facilitated and served as project manager for those health plans to come together and do that work collaboratively.

00:22:26 They determine what area they're going to focus on. The two current areas of focus are on maternal health, especially for Black women in the state. Medicaid pays for labor and delivery of most babies that are delivered in most states. Then we have a diabetes initiative about improving disparities in diabetes, and working with and through the health plans for those who are on state public programs in Minnesota. Together, with us facilitating, we determine what the measures of success will be, what the interventions will be, and then they pool their resources to come together because they can have greater impact by working on the same thing and doing that in coordination than they can by each doing their own. When we go to other parts of the country and describe the fact that managed care environment is incredibly competitive, but that our health plans in Minnesota have set aside that competition to work together on joint improvement projects—people around the country are astounded. That's a different form of innovation. It's a collaboration as innovation that's unheard of in most other parts of the country.

KR: 00:23:37 That's one of the things that I've really been impressed with here. I hear a lot of people talk about how good healthcare is in Minnesota. I appreciate you narrating that because my husband has sickle cell, and he's had some of the best care in his life here. Having been together for almost twenty years and helping him navigate that for almost twenty years, it's been delightful to trust that he's going to get the care he needs. I really love that reflection

on collaboration over competition because I think that that really helps.

You previously mentioned something about having culturally responsive care. Can you talk more about diversity at Stratis Health and how that then translates to the work that you all do in healthcare and communities?

- JL:** 00:24:34 I'll first describe something we do externally. Going back to 2008, we received funding to develop and launch Culture Care Connection. It's an online learning and resource center intended for health professionals and healthcare organizations to better understand the different communities that they might be serving. On that site, you can do an implicit bias quiz that [generates] a bit of self-awareness on where you might have gaps or knowledge needs. You can also look up information about the largest and fastest growing cultural communities in the state. We probably have twenty-five different cultural communities profiled—sometimes that's new immigrant population that's coming to the state or a longstanding community in the state. It's also topics like ageism and older adults, which is a continually growing part of our population. You can understand and read about these things at a basic level. Of course, it's not at the individual level. It's basic, but it highlights the things you might need to be aware of if that's where your healthcare organization is. If you are seeing a lot of people from the Laotian community or from the Somali community, you need to understand their beliefs about healthcare, about death and dying, about medication, and all the kinds of things that might be important differences if you were raised in a western, white dominant culture.
- 00:25:57 That is a set of resources that is out there, and we update that, and it continues to grow and evolve. Another example is using focus groups. We did focus groups last year with users of Culture Care Connection to ask, "What could be more beneficial about this? What else would you like to see on here?" We've really expanded what's called "class standards," or culturally and linguistically appropriate service standards. It's important for healthcare organizations to assess how well they meet class standards. It's not only an external requirement, but it's the right thing to do. That's a resource that we've had that's well-used and highly regarded, not only across Minnesota—it's designed

for Minnesotans—but across the country as well. It’s a great example of the kinds of tools and training and resources that we offer. Then, training can spin off from that.

00:26:51 Maybe a healthcare organization will contact us and say, “Would you come in and do some implicit bias training for our clinicians or for our administrators?” That’s the kind of thing that we do in the health equity space. For our organization, it’s important that we have credibility to speak about that and bring that lived experience to our work. We’ve focused for a long time and been more recently successful at both our board level and our staff level in diversifying who we are as an organization. So currently, about forty percent of our Board, we sixteen members, identify as Black, indigenous, or a person of color. That number is just over twenty percent for our staff. That’s important for us as we’re trying to design the improvement initiatives where we bring those different perspectives in and have them embedded in the design process through our staff, even as we’re then going out to the community to test and execute that.

KR: 00:27:57 Did you mention that twenty percent of your staff is people of color? Wow. I think somebody who was here last week mentioned that Minnesota overall is ninety percent white. That’s significant by any company standards.

JL: 00:28:16 That’s fairly recent for us. We had to change how we recruited and how we wrote position descriptions. We subscribed to a book called *The Hiring Revolution* that is about being anti-racist in hiring, examining all the practices that you have, and rethinking them from a different perspective. That’s been incredibly helpful for us.

KR: 00:28:40 About how long ago? You said this was recent.

JL: 00:28:43 In the past three years, I’d say.

KR: 00:28:46 Who led that charge?

JL: 00:28:51 I would say we’ve been on an organizational diversity, equity and inclusion journey for a long time. It was in the aftermath of George Floyd’s murder that we said, “We’re a Minnesota organization, we’re committed to this, and our actions could be stronger. What can we do to change that?”

It was a Board-supported endeavor to bring in an organization that partnered with us to do some training. A couple of people in that organization are the authors of this book about the hiring revolution. We established a joint Board and staff, what we call our Inclusion and Advancement Team. So, I would say it came from the board, leadership, and throughout the staff. We all worked to reflect on our commitments and do a better job of turning them into action. We've done that in other ways as well. We procure all of our external services and vendors on a staggered cycle through an RFP [request for proposals] process every five years. We were due to go through that process for our independent audit firm. That's ultimately a board decision, but a staff led process. During the RFP process last year, we engaged the largest minority-owned audit firm in the country to be our new auditors. Again, reflecting that commitment to say, "We can do business differently if we think and plan for it differently." I'm really proud of it. We're still on a journey and we will be on a journey for a long time.

- KR:** 00:30:21 Can you clarify for me what an RFP is?
- JL:** 00:30:22 It is a request for proposal. We sent out a request for proposal seeking a new audit firm. The firms that want to do business for us respond to that and bid back. We had two finalists and chose Mitchell Titus, which again, is the largest minority-owned accounting and audit firm in the country.
- KR:** 00:30:43 Were they the ones that helped you think through how to rewrite job descriptions?
- JL:** 00:30:50 No, so that was an organization called Team Dynamics. They were our consultant and partner in our DEI [diversity, equity, and inclusion] work.
- KR:** 00:30:57 What changes did you make to recruiting, and how did you rewrite the job descriptions?
- JL:** 00:31:02 We stopped weighing education heavily for jobs in healthcare. There tends to be a lot of importance on credentials, but we also recognize that experience is equally important. We said that we don't want to eliminate the right person because they might not have the master's degree or a particular credential. Certainly, if they need a clinical

degree, we want an RN [register nurse] or an MD [medical doctor], but most Stratis health positions don't require that. We say, "Let's talk about your experience instead of your credentials. Let's talk about what you bring to the table." That's one example. We also changed our recruitment to use LinkedIn in different ways. We also rewrote our job descriptions. They were what I would call technically written before—here's the position, here's the description, here are your responsibilities, and here are your qualifications.

We now write them much more like they were a story—here's who we are as an organization, here's the kind of person we're looking for in this role, here are the kinds of things you'd be doing, and who you'd be working with. We ask them to reach out and tell us why you think you might be a good match. It was a more welcoming and inclusive way of writing a position description. We also started publishing salary ranges. That tends to not be very transparent in the hiring process. And like I said, we're proud that we work hard to offer competitive salaries and benefits. We tell people what it is so that they're not left guessing as an applicant. We're upfront and transparent about it. That was another big change for us.

- KR:** 00:32:41 That's cool. I love that. That's one of the first things I look for when I see a job posting.
- JL:** 00:32:45 They're not on there very often.
- KR:** 00:32:47 No, they're not.
- JL:** 00:32:50 It makes it really hard to see if the position is the right level or not. They will ask, "Is this going to work for me?" Why would we leave someone guessing? But we had left them guessing for a long, long time until just recently.
- KR:** 00:32:58 I'm really taken by not just the specific role that Stratis plays in the healthcare sector, but also the way that you all have redefined and shifted as Stratis as a nonprofit. In a landscape where nonprofits have been struggling for a long time, especially with leadership, it's amazing that you all have been around for so long. I'm curious how you view that work as being innovative in the nonprofit sector.

- JL:** 00:33:36 We take our 501(c)(3) status seriously and want to be good stewards of the fact that we have tax exemption. To do that, it starts with governance. We are active members of the Minnesota Council of Nonprofits and subscribers to something called Board Source, which is probably the country's leading source of resources and research around nonprofit governance best practices. And we push ourselves to always be on the cutting edge of what it looks like to do nonprofit governance. We spend a lot of time focused on Board recruitment, on Board orientation, and on the interactions, guidance, and direction the Board gives us. Every other year, we have a Board assessment that looks at if the Board is spending its time on the right things. We actually go back and look at meeting minutes. Our goal is to spend at least sixty-five percent of our time on strategy, leadership, and governance.
- 00:34:43 We can report out in different ways. There's nothing perfunctory about our Board meetings. You come to our Board meetings and there's only four a year, but you must be exhausted at the end of each meeting because they are intense. We are doing strategy, governance, and leadership work in the Board meetings so that we're making the best use of our Board members' time. It starts with governance, then it goes to leadership and management. We pride ourselves on our integrity with the ways we operate and the financial transparency that we have. If you give us a grant as a foundation, if we're successful in securing a federal agency or state agency contract, or you hire us directly—you know your dollars are going to the kinds of things that are going to be effective in financial management and management of whatever that grant or contract is. That doesn't mean we don't have indirect or overhead expenses because we have to invest in our people. We have to be doing training and we have to have systems and processes in place to do that. That's expensive to do, and we're really proud of all those costs because that, for us, is the cost of doing business in a way that's transparent, has integrity, and is effective.
- KR:** 00:35:58 That's also how you attract good employees to help the business stay.
- JL:** 00:36:04 One of the things I often say to our new staff as part of their orientation is to remind them that staff are the single greatest asset that we have. Not only do we offer

competitive salaries and benefits, but we invest in their professional development. Every person gets a small fund each year. That's their professional development fund to attend a conference, to order books, or do whatever. I mean, it's enough to do something substantive with it every year. We have a tuition reimbursement program. We do staff training all the time when we're together. We have quarterly all-staff meetings, and it's a lot about professional development because our staff are the single greatest asset.

KR: 00:36:46 I think when we met, you also mentioned that Stratis had gone remote. How do you view that as being in line with the values of Stratis?

JL: 00:36:58 When we started growing and hiring again in 2021, we were still in the throes of the pandemic. We were still working virtually. And when we looked at the Minneapolis and St. Paul job market, we said, "We need a bigger marketplace to recruit the kind of people, skills, and diversity that we want." We made the decision then to be a virtual organization. We do our work across the country even though we're based here. We started hiring from places around the country. We believe to stay virtual is to continue to be an employer of choice, trying to compete with all the universities and health systems that would otherwise hire the kind of staff that we're trying to hire. It has worked well for us. We bring our staff together twice a year for two full days of what we call our share days, or Stratis Health all-resource engagement days.

00:37:55 On those days, we're doing team building, training, celebrating, and being connected to one another. We do that twice a year and we pay for all staff to come in for that. A quarter of our staff no longer live in the Minneapolis and St. Paul area. We bring people in to do that, and it's working well. And I think, again, to be an employer of choice, we need to do that. I will say I feel like we are missing and need to find new ways to have those sparks of innovation, spontaneity, and serendipity that happen when you're in the hallway with a colleague. Or when you're wrapping up or starting a meeting, having a conversation with someone, or just checking in a little more informally. It's hard to do that in an all-virtual environment. We're still figuring that out.

KR: 00:38:43 It sounds like it's a good problem to have because, again, the cutting-edge of the work that you do—not just for the healthcare sector, but just in terms of business modeling. You said you've been at Stratis for twenty-five years, and you've been CEO for how long?

JL: 00:39:08 Since 2006.

KR: 00:39:09 Since 2006. You're not too far from twenty years in this role. Do you still have a mentor? Do you have anybody that mentors you currently?

JL: 00:39:20 That's a great question. I have had terrific mentors over the years, including multiple of the Board Chairs that have been at Stratis Health. I have a group of colleagues that are across the country in similar roles to mine for organizations; they are peer mentors of mine. There are five of us in this group. We get together monthly by phone, and twice a year in person, to talk about our own leadership and development. I can't tell you how valuable it is to have that group of trusted colleagues to share and reach out to. It's a place where there is no question is a silly question. We can share with each other in this safe space to ask the things that I don't have anyone else to ask about, or to connect with at the same, peer-to-peer level. I count on those peer mentors of mine on a regular basis. They are my go-to people when I'm struggling with something, or when I need some advice. Sometimes we just need a sounding board, and we all use each other in that way.

KR: 00:40:33 Nice. How do you then think that your identity and culture shapes how you show up as a CEO?

JL: 00:40:48 As I said previously, I feel like I found my professional home at Stratis Health. My personal and my professional identity are really wrapped up, but not in an unhealthy way. I do non-work things and I have a healthy work-life balance. But I am so committed and passionate about what we do, and so much of what I get excited about personally and professionally is all wrapped up in the same thing. For me, it's hard to separate. What you see at work is also what you see at home or what you see I'm traveling on vacation. It's who I am as a person. I think that [Stratis Health] wrapped that up for me, having found that professional home, passion and being able to do all the things that I get to do at work. Those are the things I really get excited

about. When you just said that it has been twenty-five years, and then almost twenty years as CEO—it has flown by, and it's because every day is a new challenge. Every day is a new adventure. It doesn't mean I love all of it all the time because there are some really challenging things that happen in my role. I feel like it's all wrapped up.

KR: 00:42:08 I asked you earlier I asked you about potential mistakes that you learned from. What's something that you're proudest of?

JL: 00:42:19 Stratis Health gets a lot of its funding, as I said, from the federal agencies of health and human services. There was a period leading up to 2020 when that became uncertain. Longstanding sources of projects and programs for us weren't happening anymore. There was so much uncertainty in those federal agencies that we were in tough circumstances. We weren't laying anyone off, but anytime someone left, which doesn't happen all that often, we weren't hiring to replace them. We'd been slowly shrinking over those few years. We'd had a few years of operating deficit. Things were of concern. Some on our team said, "You know what? As we're facing our next fiscal year, we probably are going to have to do layoffs." And I said, "You know, I think we have a really strong team right now. We're on the verge of doing some really important and breakthrough work, and if we get any smaller, I think it's the beginning of the end." I don't want to be that organization that looked up and said, "Boy, I wish we'd seen the writing on the wall."

JL: 00:43:31 I actually think that the writing is on the wall said, "Here's our opportunity to do something about it." With the support of our Board, we put together a plan starting in fall of 2019 that had us doing two things. One, drawing on implementation science in addition to quality improvements and the theory and science about patient safety. The other was diversifying our revenue in new ways with new customers and building a nonprofit mission-oriented consulting practice. We put that plan before the Board with a request to use a fairly substantial amount of our investment reserves to retrain staff and make some investment in our own capacity. The board was supportive. They voted on it, ironically, in March of 2020. What was happening in March of 2020? We had this global pandemic suddenly coming down at us. It turned out that there could

not have been a better use of our time during the pandemic than the training, the repurposing, and the capacity building we did as an organization.

00:44:39 As we turned the corner in 2021, we grew, thrived, and had never been better positioned as an organization—I don't think, at least not in my time there. I felt like I was way out on a limb but was willing to be out there because it felt like it was the right thing to do. It has turned out to be the best investment in our people and in our capacity that we could have made. I'm just so proud of the transition that we were able to make as an organization and to come out stronger. We have an even stronger focus and are centered on health equity in our work—and we have that be reflected in who our team, staff, and organization are today.

KR: 00:45:25 It sounds like there was a fair amount of risk in there. How do you feel about the role that taking those risks plays in keeping Stratis afloat?

JL: 00:45:45 With good information and a sense of purpose and direction, I think you have to be bold sometimes. And that was one of the times we had to be bold. I truly think if we had not, we would've been an organization that was perhaps in demise, or at least not a shadow of what we are today. You have to be bold. Doesn't mean you have to be rash, but I think you can be bold and sometimes that's what is called for. It absolutely was, even though I had no window on the fact that there was going to be a global pandemic. That timing was really prescient, but I can't take credit for that. That was what was unfolding for us at the time.

KR: 00:46:32 It sounds like it's just a fair bit of preparation and then luck. I think even you are talking about coming into being in March of 2020 when everybody's like, "We'll be done by May." Then the uprising happens here in May. You already had the wills in motion for transformation, and then these other things kept coming up that it sounds like you all were responsive to. I think it is beautiful. You use the language of "we" a lot. As in, "We made these decisions." "We had conversations." Do you think that the way that you articulate these communal responses to things comes from your experiences as a woman in the world, or your experiences growing up in a small town? Or did somebody

put you on that trajectory of always thinking about the unit as opposed to “I did this”?

- JL:** 00:47:38 What an interesting question. Stratis Health’s work is really complex, and every team that leads and supports an initiative has someone that’s managing it, someone that has analytic expertise, someone that has communications expertise, and someone that has public health, epidemiology, or health education. The very nature of our work is team-oriented because no one person can have all that knowledge and all those skill sets. It’s a little bit the fact that it’s the way we have to do our work because it’s so complex. We’re very team oriented. And then in addition to that, I don’t know why though, but my leadership style has emerged to be very collaborative. It’s about bringing people along. It’s about listening, learning, and knowing that I might have good ideas, but I don’t have all the answers. I need and want others to help us all be smarter together than we would be operating on our own. It’s mostly what I’ve found to be most effective in my own leadership and management, combined with the team orientation of how we do our work at Stratis Health. I don’t know if it has to do with being a woman or not. That’s the puzzling part of your question. I don’t know if I have an answer to that.
- KR:** 00:49:05 I was just reflecting on the notion that CEOs have a very big egos, and I think there’s a lot of “I” in that mindset. There’s a lot of, “I did this.” “I had this though.” But you don’t. You have very much said, “We worked with these people, we worked with our board, or we reached out to these organizations.” I was mostly just curious!
- JL:** 00:49:29 Well, thank you for pointing that out.
- KR:** 00:49:32 I think you’ve answered everything in beautiful ways. As we wind down, I like to ask folks if there is anything that they would like to share that I didn’t ask a question about. It’s okay if the answer is no.
- JL:** 00:49:59 Well, I will close the loop going back to your very first question about my growing up experiences. I am surprised that growing up in a rural community came back around in my professional career to be one of the areas of my research, policy, and improvement work in rural health. It’s been a longstanding Stratis Health priority for now nearly

twenty-five years to reduce disparities and improve access in rural communities across the country. And Stratis Health has become one of the go-to organizations for rural health improvement nationally. I get the opportunity and privilege to be part of something called the RPRI Health Panel, the Rural Policy Research Institute Health Panel. If seven of us, and most of my colleagues come from universities where they lead rural health research centers. We come together to respond to federal policy from a rural perspective.

00:51:05 We meet and support the Rural Health Caucus of the United States Senate. We do orientation for health staffers in the Senate and the House. We meet and support federal agencies from a research base, so it's non-partisan. It's bringing research and evidence to rural health policy. For me, whenever we talk rural, I can close my eyes and go back to my experience growing up in a house that was next to a cornfield. I think about what it means to be from a small town and have a hospital there that has an average daily census of probably one and a half patients and how they have trouble recruiting a physician. You have to figure out where you're going to go if you have a serious health issue. That's ninety miles in either direction, either to Rochester or to Sioux Falls. That evokes all those thoughts for me. I didn't think about healthcare a lot as a kid, but it evokes all those memories about being in a rural, small town—places that I now get to do either improvement work or health policy work there.

KR: 00:52:07 Would you say that the problems facing rural healthcare today are the same as they were when you were a child?

JL: 00:52:13 I think they are so much worse.

KR: 00:52:15 In what ways?

JL: 00:52:16 The rural and urban divide in this country is worse than it was when I was growing up in a rural community, in every possible way. That affects everything, including healthcare. There's a distrust of science, there's distrust in our institutions, and there's distrust of healthcare. For communities that already have access problems—because there probably is only a family practice or primary care physician in the community and no specialty care or access—all those divides make it worse, sadly.

- KR:** 00:53:01 If I hadn't asked you that question, we would not have gone in this direction. How is Stratis Health intervening in these issues?
- JL:** 00:53:09 We do a number of things in the rural health space. One is to help those small rural hospitals and clinics, who tend to be under-resourced, change what their practices and protocols are so they're, again, delivering high quality care. Just because it's a small place doesn't mean a patient doesn't have every right and opportunity to have the highest quality care. We're trying to do that in ways that look different than how we support Allina, the Mayo Clinic, or Essentia Health. We're trying to support those very small rural places. For us, that means sometimes we're at the elbow with them trying to work through what that looks like. We had initiatives for a few years helping them select electronic health records that were designed to work for small, low-volume facilities without an IT [information technology] department or analytic capacity. We work on how you make choices wisely to get a system with an electronic health record that is affordable, is not going to put you under, and doesn't have so many technical requirements that it's not going to work. We do that elbow technical assistance support for small rural facilities and nursing homes as well. That's one way that we do our work.
- The other is that we try to put a spotlight on rural places that have been innovators so that others can see that it's possible. Some of the best stories and learning come from when a rural physician, a rural clinic, or a rural hospital can see what someone else is doing. They're not going to do the exact same thing, but when they understand that's possible, then we can help them take those next steps as they're trying to improve safety, quality, and value. We do a lot of rural profiles, spotlighting innovation and dissemination of those best practices that are rural-specific. Rural is not a smaller version of urban. It is a different set of services, support, and approach to healthcare.
- KR:** 00:55:08 Speaking of culturally competent care...
- JL:** 00:55:09 Speaking of culturally competent care. Exactly.
- KR:** 00:55:13 And there's something that you said that triggered a thought. You had mentioned that one of the issues facing

folks in rural healthcare settings is a distrust of science and a distrust of healthcare. And so, is Stratis doing anything about patient education?

JL: 00:55:34 We're not doing work in patient education directly in rural settings, only bit of it in some of our initiatives. We are making more efforts that are about leadership in rural healthcare organizations, which is also then about community leadership because the boards of trustees at a local community hospital are the local banker, the local teacher, and the local veterinarian. By supporting that kind of education and leadership in that local community, we're also reaching out to help them make connections in their own communities. For example, we also have a longstanding body of work that we do about building rural community capacity for palliative care. That's not hospice or end of life care, but it's for people that have long-term, chronic illnesses; are frail or elderly; or have a long-term cancer diagnosis. They need care differently than another patient might.

00:56:35 Since there's not board-certified palliative care physicians in rural communities, like I said, this depends on a family practice physician or a primary care physician. We're helping rural communities to build the assets that they have to create palliative care services and support. It might be bringing in a faith-based community leader onto that team. It's bringing nursing into that team, or maybe home health onto that team, and figuring out how to care for that patient and their family in ways that are responsive and leverage the assets that are there. This is opposed to lamenting that the resources and specialists that aren't there. We've been doing that work for a long time, and that has some direct patient work involved in it around shared decision-making and engaging with the patients and families about what their long-term care plans are.

KR: 00:57:22 As we continue to learn more about the impact of COVID-19 and long-term healthcare outcomes, are you already seeing things about how COVID-19 is exacerbating these issues in rural communities?

JL: 00:57:37 Yeah, absolutely. First, the change in workforce that COVID-19 caused is so much worse in rural communities. Rural nursing homes can't hire certified nursing assistants. CNAs take care of our most vulnerable neighbors, family

members and community members living in nursing homes, and they tend not to be paid wages that allow for recruitment and hiring because you work at Walmart for more money. When those nursing homes turn away residents, they can't take a hospital discharge because they can't staff the beds. That leaves people in the hospital or a rehab facility longer than was what would be medically called for. That continues to move upstream and exacerbates those problems in rural communities.

00:58:30 There's today a huge use of traveling nurses because they can't get nursing staff in those hospitals and clinics. They end up having to pay traveling nurses high amounts, much higher than the wages they would normally pay, for hospitals that are barely operating at break even. Traveling nurses are highly skilled, but they're not invested in that community. They're not invested in the quality and care of neighbors, family members, or fellow members of a faith community that tend to be there in those local communities. The workforce challenge in rural areas has particularly been exacerbated because of, and since, COVID-19.

KR: 00:59:12 Would say that some of what you see happening in rural communities is the canary in the cold mine for urban areas or larger areas?

JL: 00:59:32 I don't know that. I would say that again, it's different enough and it's its own characteristics that I am not sure about that.

KR: 00:59:42 I was just curious.

JL: 00:59:42 I haven't thought about that before.

KR: 00:59:44 Sometimes we see things happening in communities that are overlooked or under-resourced, and then they become bigger issues in other places. Then folks are like, "We never saw this coming!"

JL: 00:59:54 "But it was right here!" That's an interesting question about what's happening in rural and urban health.

KR: 01:00:01 ...It was just a passing thought. Sorry to hold you in that line of thinking, but I wanted to keep going in that direction because it's important, good work. I appreciate that Stratis is doing work in both rural and urban areas, and in doing

racial, ethnic, and I presume gender competent care. Thank you for indulging those last questions.... Thank you so much for sharing your story with us and joining us today.