00;00;00;00 - 00;00;28;06
Cale
Welcome to Grin + Bare It, a show that uncovers the remarkable stories from one of the most demanding industries in the world - healthcare. From inventors and trailblazers to frontline workers and scientific experts, we explore the biggest challenges faced in healthcare and how these brilliant people have solved them. I'm your host, Cale Donovan, an award-winning entrepreneur and Co-founder of Bare, one of Australia's largest end-of-life providers.

00;00;28;08 - 00;00;52;04
Cale
Today's episode is about Healthcare in the Home commonly known as HITH, which is an acronym I find tough to say. Healthcare in the Home is a model of care which has been around for over 30 years. Yet it still faces resistance from some practitioners. I'm speaking with Doctor Mick Young, a rural generalist who's been actively involved in healthcare in the home programs for seven years.

00;00;52;07 - 00;01;21;10
Cale
Mick is the Co-founder of Hospital in Your Home, a fast growing business which now serves patients in both Australia and the US. Mick is particularly passionate about building efficient and sustainable models of care that simply focus on better patient outcomes. Today, we explore the misconceptions about healthcare in the home. As a model one, now is the perfect time to apply HITH for an array of medical conditions and what the future of home healthcare looks like.

00;01;21;13 - 00;01;29;07
Cale
Let's get into it. So, welcome, Mick. Thanks so much for joining the episode today.

00;01;29;09 - 00;01;31;11
Mick
Thanks very much, Cale. Great to be here.

00;01;31;14 - 00;01;55;13
Cale
Let's start with some context. Like when I think of literally a hospital in the home, I'm thinking of all the equipment, everything I could imagine around a bed in my literal bedroom. For those that are uninformed. Can you just paint a picture of what hospital in the home currently is and the kinds of patients it typically serves?

00;01;55;16 - 00;02;15;10
Mick
Sure. So for me, hospital in the home is – it's a different synergistic model of healthcare where patients receive the exact same level of care in the home as they would receive in hospital. And

that encompasses nursing care. So we visit, you know, multiple times per day to deliver drugs that you would normally only receive in a hospital.

00;02;15;10 - 00;02;34;07
Mick
So intravenous drugs are not just antibiotics. There's a number of different drugs that we can deliver in the home to treat a number of different conditions. Allied health – and so we run in all the allied health disciplines. So physiotherapy, occupational therapy, speech therapy. We've got them all available in our models plus some equipment. So you know we think of the IV pumps.

00;02;34;07 - 00;02;55;09
Mick
But in some of our other more specialised models like palliative care, you know we're thinking hospital beds. We're thinking, you know, a lot of the other equipment that you might see in hospital hoists, hospital beds, shower chairs and the like. So, so, it really is [a] full hospital substitute for care. So if you're not lying on a bed at home with our staff visiting [then] you're lying on a bed in hospital.

00;02;55;10 - 00;03;10;29
Mick
So it's, it's the whole shebang. But most importantly, it's also access to your care team 24 hours a day, seven days a week, which is what you do receive in hospital. In [the] hospital, if you're a little bit worried, you push the call bell. If you're in a hospital in the home model, you pick up the phone and make a call and talk to the nurse at the other end-

00;03;10;29 - 00;03;16;27
Mick
And then they can attend to your needs. So it's a very, very similar model, just slightly different context.

00;03;16;29 - 00;03;35;01
Cale
I have a bunch of questions on the back of that, but I'm going to edit myself here in real time, Mick. Before we jump into some of the specifics, I would love to hear your story. So you're now committing yourself to hospital in your home, your business, and this method of care. What led you to this point?

00;03;35;03 - 00;03;53;19
Mick
It was a short ride, but it was a long ride. It was a, it was a great ride of learning. So my background is I'm a doctor by trade, but more specifically a rural and remote doctor. So I spent many, many years working in rural communities, and I ended up being the medical superintendent of a hospital quite early on in my career, in a town called Barwon, which is an amazing place for anyone to visit.

00;03;53;19 - 00;04;14;20
Mick
By the way, for my first week in the job, I had to attend to a patient's complaint and it was quite a significant complaint. And it was an Aboriginal person that had been transferred out of town and died in a tertiary hospital, 400 KS North and I thought, okay, you know, me being a doctor, I was very much in th,e in the doctoring medical mindset at the time.

00;04;14;20 - 00;04;38;13
Mick
So I'm thinking we've got to respond to the care that we provided and you know, what happened. And anyway, it turned out that the actual complaint was not about the fact that the patient had died. The complaint was, why hadn't we communicated with the patient in their family that the patient was really unwell and likely to die? The complaint was that the patient died alone off-country, 400 KS away from their family,

00;04;38;13 - 00;05;05;12
Mick
their friends and their community. And then it costs the family a significant amount of money to repatriate that patient back to the community. So, so they could be buried on country. So to me, that was a profound learning, learning for me very early on around the need for communication, but also what was community to all of this? We all have some kind of linkage back to community, that group of people that interact and support each other, you know, with shared experiences and characteristics.

00;05;05;12 - 00;05;06;12
Cale
Yeah.

00;05;06;15 - 00;05;33;06
Mick
and that is so important. So for me, it was a really big shift to go from not that the patient died, it was where they died. And so to me that that really then started to make me think about models of care, how you can provide more care in, first of all, rural hospitals. And then when I moved to Townsville five years later and then fell into the hospital in the home model, how do you how you can take that care out of a facility and into the home and provide similar levels of care?

00;05;33;06 - 00;06;02;28
Mick
And believe it or not, a rural hospital and hospital in the home – I've got a lot of very significant synergies between, you know, the care you can provide and how you can provide it. So to me, that complaint was pivotal in my career and really drove me home towards community based models of care and nimble, and we developed the tele-chemotherapy model, which is how we

could get patients receiving chemotherapy in rural and remote locations instead of them travelling, you know, to larger centres and then getting pumped full of really nasty drugs, really.

00;06;03;01 - 00;06;23;14
Mick
And that make you feel quite hideous and unwell. If you can deliver that in a rural hospital, then you can go home and sleep in your own bed that night, which is so important. And, and that model has now been evolved to a national model of tele-chemotherapy in rural and remote locations. So it's obviously what the patients need and what the patients want, and what we can reasonably provide.

00;06;23;14 - 00;06;45;16
Mick
And I think from that then, you know, the synergy between technology and models of care, you know, how we can technologically leverage models of care to improve what we can do. So the tele-chemo model was, you know, you got two chemotherapy nurses sitting in a designated tertiary chemotherapy centre looking over the shoulder of that rural and remote nurse who's got some, some really good training but has got that support using technology.

00;06;45;16 - 00;06;46;16
Cale
Interesting.

00;06;46;18 - 00;07;10;24
Mick
Then now, you know all of our hospitals the home models palliative came in. The home models have all got that telehealth component to them as well. So where you can get that specialist advice or medical advice or even, you know, where allied health advice in the home using technologies. And it just works because it', it's simple and to my mind, all of our models of care that we provide are all simple, patient focused.

00;07;10;24 - 00;07;26;09
Mick
If you put the patient at the centre of the journey, all of the efficiencies will follow that quite rapidly. So for us, you know, and I think that was my learning once again, back to that incident in Barwon. That patient wasn't at the centre of that journey, and then that was my learning to, to to take that forward.

00;07;26;09 - 00;07;35;27
Mick
And I've had some really good mentors in my career and that line’s not mine. And that's from the director of nursing at the time of Barwon Hospital. That was, her, that was her mantra. And I really believe it.

00;07;35;29 - 00;07;56;25
Cale
As you say it, it seems so obvious, this combination of – in many cases it was happening in rural settings. But now with the application of technology, there's just so much that can be done at home or remotely. Why do you think– or do you think it's increasing in popularity? And why do you think this method of care is rising?

00;07;56;27 - 00;08;14;24
Mick
I think it is increasing in popularity, especially amongst patient cohorts. I mean, you know, our Net Promoter score, which is a marker of how much patients tell you our experience is 97. The average net promoter score of, of a hospital is 46. And that's a score out of 100. And so it tells us patients really, really value the model.

00;08;14;26 - 00;08;35;22
Mick
And because it is about them, when you're sitting in the home with a patient and you've got their cat sitting on your foot, you've got three generations of their families around you asking questions because they can ask questions in the, in the home, because it's their environment. They're in control of it. My environment is a hospital, right? You know, when I walk into a hospital room, I'm a doctor and you're on my terms.

00;08;35;26 - 00;09;02;15
Mick
You go into the home, you're on the patient's terms, you're on this family's terms, you know, and you've got to respond to that because you have to. And because you can't do it any other way. When you've got the, you know, all of their lifelong accoutrements sitting on the shelf around you. And as I said, multiple generations around you asking questions, you've got to answer it and you've got to frame it and you automatically frame it in the context of the environment as well, which is, you know, simple, well-considered, and once again, very, very patient-focused.

00;09;02;18 - 00;09;19;03
Mick
So I think that's why we're seeing the home base models of care starting to take off. And they have to take off going forward, Cale. Everyone knows it. Everyone talks about it every single day that we have a rapidly ageing population, who the evidence tells us, you know, they're going to need hospital, they're going to need medical care.

00;09;19;03 - 00;09;44;04
Mick
They're going to need nursing care. They're going to need healthcare. And we can't just keep building bits to meet that need, because at some stage, that Gray Tsunami is, as some people call it, is going to abate. And then we're going to have all these empty facilities at the end of the day. And so I think if we can really start to punch up the acuity of what we're treating in the

home, the diversity of what we treat in the home, and we use things like technology to augment that and make it.

00;09;44;07 - 00;09;56;08
Mick
Yeah, allow us to take sicker people, allow us to take more complex patients. I think that's going to be an integral part of how the healthcare system transitions going forward to this massive influx in need that we're going to see in the next 10 to 15 years.

00;09;56;11 - 00;10;23;09
Cale
It's interesting because I read an article which basically was talking about the obstacles to it, hospital in the home. And one of the things that they stated was there's still a significant amount of people who want to go to a hospital for their condition. Are you saying that in a particular demographic cohort of people or condition, potentially, where they are still really reliant and want to go to a hospital?

00;10;23;12 - 00;10;43;07
Mick
Very much, you know that, yes, there is a cohort that perceived that they have to be in hospital. And look, there always is going to be a cohort that need to be in the hospital. I'm not saying we can provide 100% of care in the community. We always need intensive care units, we need surgery, we need specialist nurse, nursing and medical units like cardiology and neonatology and oncology.

00;10;43;10 - 00;10;58;04
Mick
So I mean, there's always going to be a need for a hospital, but I think we've got to take people on that journey that that they think that our hospital in the home service is just for IV or antibiotics for six weeks. so I think for us and I do sit on the board of the HITH Society Australasia as well.

00;10;58;06 - 00;11;15;24
Mick
And that's something that we're very much working on towards. How are we defining what hospital in the home is? How are we defining what community level care is? And therefore we're all, we're all speaking from the same, from the same definition, in the same song sheet. And then we can take our patients, clients, whatever we want to call them on, on that journey.

00;11;15;27 - 00;11;31;08
Mick
And I think we find a lot of people say, I'll go home, but I'll be back here tomorrow. And you know what? 99% of the time they don't come back tomorrow and they stay at home and they get the

treatment that they need. So a lot oftentimes it's a lot of fear as well. And I think that's where the technology piece comes into play as well.

00;11;31;10 - 00;11;49;20
Mick
I'm a big believer in technology, in healthcare, but not technology for the sake of it. I think you've got to have technologically-leveraged models of care. You can use remote monitoring to provide better than hospital levels of care in the community, but we just need to be able to, you know, access that and let patients know that you're safe because we've got eyes on you.

00;11;49;20 - 00;11;50;23
Mick
24/7.

00;11;50;25 - 00;12;17;07
Cale
Yeah. I do want to talk about the inherent challenges of building out this hospital in the home model. Before I do, you mentioned taking people on the journey. When you're thinking about that, I almost breadcrumbed traditional healthcare into this idea of all the other patients, into this idea of, hey, yeah, we started with being able to do hospital in the home for these types of conditions or this type of treatment.

00;12;17;10 - 00;12;25;22
Cale
Did you know we're doing more and more and more and more. Is there any strategy around how you're thinking about taking people on the journey?

00;12;25;24 - 00;12;41;02
Mick
Absolutely. Look, when I first fell into the hospital in the home drive in Townsville, you know, it was a fledgling service at that point in time. It was, you know, it was, it was a newish service. And it's not a new model. The model’s been around in Australia for 30 years, but to the hospital & health service, it was a new model of care.

00;12;41;02 - 00;12;59;13
Mick
And data, data, data, data. That's all about gathering the data and sharing that data with clinicians and patients and medical administrators. So, you know, now I'm in my own business. Everyone says, well, where did you learn to pitch, to pitch your business? And I said, well I learned to pitch my business because I learned to pitch a hospital in the home service.

00;12;59;14 - 00;13;18;00
Mick

You know, when you've got a busy group of clinicians, it's only got ten minutes and you've got to try and get across to them. This is a new model of care that will support what they, you know, what they do and you've got to very quickly be able to read the room, speak very rapidly, talk to the data and then find out where their challenges are and how you can help them solve them.

00;13;18;05 - 00;13;39;03
Mick
So to my mind, that's, that's how we got the hospital in the home service rebooted in Townsville. And then from those learnings, that's how I then took that outside of, you know, working for the hospital to then working for myself and a cool private hospital in your home, in 2017, based on those, those shared learning experiences, but also an absolute passion and belief for the model of care.

00;13;39;05 - 00;13;58;16
Mick
And because I know that we can, we can continue to evolve in the model of care. I mean, I look at the patient cohorts that we were treating in 2014, we'll just barely simple the fit and healthy young people, the patient cohorts that we treat now are older. Got multiple, you know, comorbidities. You know, multiple medical conditions had a lot higher acuity.

00;13;58;16 - 00;14;25;04
Mick
They're a lot sicker than they ever were. But you know what our link of stay data tells us, and our representation data tells us that we're actually providing really good care. So we're not taking them home, and then two days later, they're coming back to the hospital. We're taking them home and staying at home, so which means that they're getting better.  Looking at those metrics, making sure that, that, you know, we're agile, we're responding, and we're and and the services that we're providing are evolving training the cohorts.

00;14;25;04 - 00;14;27;22
Mick
But most importantly of all, are safe.

00;14;27;25 - 00;14;42;20
Cale
We do have a number of clinicians of this in, in and so what some of our high level statistics say you were, you were going in you're pitching this model, What are you talking about? Just to give people an idea of how beneficial this can be.

00;14;42;23 - 00;14;59;05
Mick
I mean, I'm talking about length of stay data. And so our length of stay data, population matched to an inpatient cohort. So that's, you know, patients who are admitted to hospital is identical. For

some of our conditions that we treat, the length of stay date of hospital in the home is less than the length of stay in hospital.

00;14;59;07 - 00;15;22;27
Mick
And once again that representation data is still less than 4.5% less than that of a hospital. So that's, that's what I'm talking about. Talking about, you know, 276 different conditions that we've treated in the last ten years on the hospital in the home service. A lot of it is the top five, as we call it – so cellulitis, which is skin infections, kidney infections, heart failure, nausea and vomiting in pregnancy.

00;15;22;27 - 00;15;43;22
Mick
You know, they're the conditions that we treat mainly. But there is another 271 different conditions that we can treat. So I think that's telling us that as a service that we're agile as well, that we don't just pick a specific cohorts, we've got a model that's robust, that we can treat just about any condition that presents to the hospital, apart from those that need the higher acuity care, needs surgery.

00;15;43;22 - 00;16;00;03
Mick
I mean, you can't do surgery in the home, obviously. But you know what? They can go home earlier after surgery instead of sitting on a hospital bed for five days. They can have the surgery, stay on a bed for two days and then go home for the last three days. So therefore you provide that surgical bed for another patient to have a surgery.

00;16;00;05 - 00;16;19;20
Mick
And that's then talking to where do we get our patients from. So 70% of our patients come directly from the emergency department or from primary care, 30% coming to hospital for a day or two then they come to us. And so we're moving, say a seven day length of stay from seven days in the hospital to three days in the hospital, then four days at home.

00;16;19;20 - 00;16;37;13
Mick
So it's all about freeing up that higher acuity resource for those patients that absolutely need it. So I think co-design is really important. So, you know, not just coming and saying, here's our model of care, take it or leave it. It's tend to come in nowadays and say, here are the resources that we've got to build out a model with you.

00;16;37;16 - 00;16;44;23
Mick
Let's work together to find out where your challenges are and how we can help you, work with you to help you solve those problems.

00;16;44;27 - 00;17;01;24
Cale
It's a great segue into just the inherent challenges to providing this model of care. You've touched on the patient side, touched on the practitioner side. Are there any fundamental challenges to making this increasingly more popular?

00;17;01;28 - 00;17;21;00
Mick
No, no, I think the challenges I mean, there's, there's logistic challenges, obviously, so we can't provide it to everyone every way is, is probably the biggest challenge. You need a volume of patients to run a service 24 hours a day, seven days a week. So for us to treat about 1300 patients a year, we've got 40 nurses on staff to do that.

00;17;21;07 - 00;17;42;16
Mick
They operate on the road from 8 a.m. till 10 p.m., then they're on call overnight to respond to any of those concerns. And we're very agile, like we take referrals. If we get a referral, we want them out of the hospital within an hour. And that's really important as well. If your referral pathways convoluted or, or hard, clinicians will go back to what is the usual which is sending the patient to an inpatient bed.

00;17;42;17 - 00;18;02;12
Mick
So for us, co-designing that rapid referral pathway is so important. So it's got to be easier for a clinician to call us to get their patient on the hospital in the home than it is to call an inpatient team. And we definitely made that. So, you know, we position nurses in the hospital seven days a week that when they get a phone call, they just go to the bedside, talk to the patient and talk to the clinician.

00;18;02;12 - 00;18;19;15
Mick
And then the patient can transfer home. And so logistically I think that's that's the challenge. You know, you need a volume of patients. I'll tell you it', it's 25 to 30 patients a month. You need to make an economically viable service seven days a week, 24 hours a day. So I think that's probably the biggest challenge.

00;18;19;17 - 00;18;19;27
Cale
Yeah.

00;18;19;27 - 00;18;47;05
Mick

But from an operational perspective, we're pretty lucky. From a staffing perspective, we have a very, you know, registered nurse-heavy. And we tend to find that we leverage a lot of nursing staff who don't want to work night shift, don't want to work in a hospital system, who want to, you know, do something a little bit different. So we tend to get a nursing staff who are a little bit more mature in their career, who may very well considering leaving nursing as a career, going and working for Bunnings for a bit and then, you know, reassessing their options.

00;18;47;05 - 00;19;01;10
Mick
So they come to us and it's not uncommon for us when we employ nurses, for them to appear in my office a week later and say I was going to leave the industry, but now I've realised what care really is. You know, it's sitting in the home. It's why I did nursing because it is all about that patient.

00;19;01;10 - 00;19;16;01
Mick
When you're sitting there administering antibiotics in a home. And I do it sometimes when we're really busy, I'll head out and administer an antibiotic, and you sit there for an hour and you administer your antibiotic. But what do you do in a hospital? You plug the patient up to the drip, and then you walk on to the next patient.

00;19;16;01 - 00;19;37;16
Mick
Or if you're sitting in a, in a community environment, you sit there for an hour with the patient and you got to talk to them. It's so enlightening. And you get the backstory and it turns into why, while we all got into this industry, which is to care because you sit down and you find out about their back history, if you find out about what their careers were, what their family are doing, what they, what their fears are, and that's really important.

00;19;37;16 - 00;19;52;17
Mick
I think, you know, a lot of people sitting in hospitals and I had a significant health scare a few years ago, and I was right, and sitting in hospital and I knew what was going on. So imagine what people are like if they're not, if they're, you know, afraid the healthcare literacy is not as high as mine.

00;19;52;17 - 00;20;21;29
Mick
You are scared witless. And then once again, because you're in the home environment, you can ask those questions that you wouldn't ask in a hospital. What's going to happen next? What's going to happen to me? And we see this a lot in the palliative space. And because one of the models of care we offer is palliative care in the home and and just being able to, you know, when you're when you're providing care to a patient just to answering those simple questions

and you and the patient and their family and their carers or go along on that journey right the way through to End of life and you know, we've got a number of patients who

00;20;21;29 - 00;20;36;16
Mick
come to us and say, look, I'm going to come to you for palliative care in the home, but when I die, I want to die in hospital. And we go, yeah, no worries, that's fine. But you know what? Four weeks later when we're getting towards that phase because you've had four weeks to build a relationship with the patient, with the family.

00;20;36;16 - 00;20;52;05
Mick
And you know what? Four weeks later you say, look, I think we're getting towards the end now. And then I say, well, do you want me to arrange for you to go into hospital? And this happened to me on, on Friday with a patient. I said, okay, well, I'll arrange a trip to hospital. And the patient's carer said, no, not at all.

00;20;52;08 - 00;21;09;14
Mick
She's here. She's here with us. Her cat in her bed. This is what she would want. So this is somebody that said to me, we can't do it. And then all of a sudden, absolutely, we don't want to do it any other way. So and that's all based on transfer of information. That's all based on a relationship with your, with your care team.

00;21;09;17 - 00;21;13;17
Mick
And that's because it's in the community. It's in the home. It's on your terms.

00;21;13;20 - 00;21;41;19
Cale
It's really interesting. speaking with someone recently who one of their pieces of advice in a palliative care setting or if someone has lost a loved one, it's actually about providing enough opportunities for conversation and just having time and presence there. And so what you're describing, I mean, this is obviously in a healthcare setting, I think it's relatable to any healthcare setting is some of the benefit of the hospital in the home model

00;21;41;19 - 00;22;01;29
Cale
is it just frankly gives people more time to connect, to give the patient an opportunity, maybe to talk about what's going on to them, get some other insight, and effectively prove that this is as safe, as effective, as, as important as potentially being in a hospital setting. So that's super interesting.

00;22;01;29 - 00;22;04;07

Mick
Yeah, yeah, it's one I'm very passionate about, Cale.

00;22;04;07 - 00;22;15;02
Cale
Yeah. Have you got nice ideas on the model? I'm interested to see if you faced any sort of backlash on going out and doing this, or has it been welcomed with open arms?

00;22;15;02 - 00;22;33;05
Mick
I wish I could say it was, but it's not. Look, I mean, I think as doctors, we've all that, you know, we work in hospitals and hospitals are the safest place to be because, you know, there's always stuff there. I think there's a bit of a disconnect between theory and practice there. And I'm not disrespecting hospitals. We need hospitals.

00;22;33;05 - 00;22;50;15
Mick
And I spend a lot of all my career around hospitals, and I've worked in administration. I've worked in clinical. I'm [a] very big believer in hospitals, but I think there is, there is a bit of a disconnect that if a patient's lying on a bed, you know, hospital that's safe. And I don't think anybody's safe when you're unwell and you're a patient.

00;22;50;15 - 00;23;06;22
Mick
But I think we've got to look at that hospital when you're 80 years of age, and we know the evidence is telling us now that if you were over the age of 65 and you lie in a hospital bed for three days or more, you're going to deconditioned, you're losing muscle strength, you're going to become an increased risk of having a fall.

00;23;06;22 - 00;23;22;27
Mick
And we know that it's going to take 12 months to get that level of strength back again. So I think, you know, that's telling us that hospitals aren't necessarily the safest place for all cohorts. you know, if you've got some cognitive impairment and put you in a completely unfamiliar environment, then you're more likely to develop a delirium.

00;23;23;02 - 00;23;40;10
Mick
and especially if you're unwell and then you're going to become more confused, more risk of falling, more risk of somebody giving you medication to calm you down. You know, we look at all the safety specials that we're seeing in hospitals at the moment. We're medicating people to keep them safe when they're having a moment. Is that moment because they're in an unfamiliar environment.

00;23;40;10 - 00;23;56;28
Mick
You know, a question [like] that. So from my perspective, I think we've got to start looking at the fact that, you know, for certain cohorts, hospitals aren't the safest place in the world. Maybe home is a safe environment for them. You know, when we've got doctors running around. But let's fight on a ward round. How long do you actually interact with your patient?

00;23;56;28 - 00;24;14;00
Mick
for every day? You know, five minutes, if you– if you're lucky. So, you know, there's a disconnect between. Yeah, there's doctors in the hospital, but there's no doctors with that patient, and there's no doctors with the patient in the home either. There's probably more availability to have a telehealth, you know, with your doctor in the home than there would be in a hospital.

00;24;14;05 - 00;24;32;28
Mick
So, I think from that perspective, that's where we've got to break down the barriers and start actually being more realistic around cohorts and around safety of in-hospital environments, and around how can we get people out of hospital into the home where you can't decondition in the home as easily as you can in a hospital. A good patient lies on a bed, takes five steps to the bathroom.

00;24;32;28 - 00;24;45;27
Mick
It goes for one walk a day with the physio up and down the corridor if you're lucky. It gets fed five times a day and a good patient doesn't. That's what happens. So I stay there and that till I get better and then I go home. But in the home you've got to get up and make a cup of tea.

00;24;45;27 - 00;25;06;27
Mick
You told, "it's always further away." People come visit you, you know, making a get-out-of-your-bed and go to get out of the lounge room. You're going to check him out at the front. So you get this, I call it passive rehabilitation. Just because you actually have to move around more in the home, less likely they get constipated, less likely to get delirium, less likely to decondition because you have to move.

00;25;06;29 - 00;25;30;17
Cale
So the biggest knock is that doctors are practitioners have a thinking that the hospital setting is always the most safe setting for any particular patient. There must be something within the timing though, which is even if I'm only seeing this patient five minutes a day, someone is available very quickly if something were to go wrong. That's the, that's the obvious argument there.

00;25;30;23 - 00;25;34;12
Cale
How does that play in a, you know, hospital in the home model?

00;25;34;16 - 00;25;54;19
Mick
And this is what I'm saying Cale. That hospital in the home is not for everyone. And I think we need to be honest about that. Like an intensive care unit is not for everyone either. So the intensive care physicians in intensive care units have got some really pretty specific criteria as to which patients I take into that ward, because they know that they're going to have a positive outcome or the most positive outcome that they can.

00;25;54;20 - 00;26;11;27
Mick
And for that same reason, hospital in the home is no different. We've got a select cohort of patients that are, you know, more mobile, if they're cognitively impaired. We've got someone at home with them, you know, [to] have the ability to pick up the phone and make a phone call, less likely to deteriorate to the point where they need to make [a] call, which is, you know, an emergency call in a hospital.

00;26;12;00 - 00;26;25;12
Mick
So, yeah, we do, we do select patients like every ward selects patients. And I'm unashamed about that. So I think that's where we've got to sit there and say hospital in the home's not for everyone. We pick our cohort that we know is going to have the best possible outcome.

00;26;25;19 - 00;26;55;03
Cale
The switching gears here, a touch like it's important that our listeners get some application in terms of like direct advice. And I would love to give you three different types of people who are in the sort of the ecosystem of deciding or trying to understand hospital in the home. And so what is the single piece of advice you would give to a patient or their family in trying to determine if this is the right model of care?

00;26;55;05 - 00;27;14;20
Mick
Ask the question first. You know, ask a clinician. Every single public hospital in Australia has a hospital in the home service, I can guarantee that in one guy's or another. Ask your training clinician. You know I've heard a bit about hospital in the home. Is this a model for me? And don't just ask it once. I ask it a few times because there's some really cool stuff being done there around

00;27;14;20 - 00;27;33;01
Mick

eligibility for hospital in the home, in hospitals, using AI to actually interrogate the patient information system, so to speak, around, you know, is this patient suitable for hospital in the home care. And what we can see is, you know, there's some patients who come to the E.D. and they're immediately eligible for hospital in the home. They live in the area.

00;27;33;01 - 00;27;49;24
Mick
They've got a condition that's amenable. They're not septic and unwell; unlikely to deteriorate. The system flags them straight away. But what we also know is that when patients go to the ward, it's a graphical thing. Over time, you know, eligible; you know, are they eligible for HITH? And you see, you know, when they first come in. No, no, no, no, no, no, no, no, no, no.

00;27;49;28 - 00;28;08;29
Mick
You know, day 5 or 6 all of a sudden their eligibility for us when the home goes up. And this is using big data and big data analytics to to tell us this. So from a patient's perspective don't just ask the question once when you're in the emergency department, ask the question [on] day two of your ward admission. Do you think I can go home? Can I get this care in another way?

00;28;08;29 - 00;28;35;21
Mick
Can I get it in the home? Have you got a hospital in the home service, that treats, you know, people like me? So from that perspective, I would say, you know, and we're all about patient or person-centred care. My director of nursing in Barwon, you know, the patient is the one at the centre of the journey. And we should always remember that because if the patient asks the question, then we should, we should give them the opportunity to consider that question and see whether there are alternative models out there where we can get them home quicker, because home is where your community is.

00;28;35;22 - 00;28;49;04
Mick
Let's face it, it's pretty hard to have a community around you in hospital. It's very, very hard because if all got to pay 20 bucks to park their car to visit you anyway, but you know, and the communities, the people, but it's also the place and it's also the other things in your community. It's it's typical at the back.

00;28;49;04 - 00;28;56;15
Mick
It's some that that's where that's where your, your community is. So I think everyone deserves the opportunity to have that considered in their care pathway.

00;28;56;16 - 00;29;10;03
Cale

You've almost answered the second example, which is the best piece of advice you would give to a practitioner who is critical or suspicious of the model generally.

00;29;10;03 - 00;29;27;19
Mick
I'll say look at the data. You know, if you've got a really good data set around your model of care. And as I said, I think hospital in the home clinicians are the best people in the world at pitching models of care, because that's what we do all day, every day. Look at the data if you are sceptical and ask your patients what they want, because oftentimes we don't do that.

00;29;27;19 - 00;29;46;00
Mick
And when you're in a hospital ward, you're on demand. Not very often that I say to a patient, what is it that you want? You know, so ask the patient, what do they want? Where do you want to receive this care? Knowing in the background, knowing the statistics of your hospital in the home service, and knowing that this patient may be, maybe a suitable candidate?

00;29;46;02 - 00;29;55;14
Cale
I'm really interested in just digging on that bit point, which is often that question isn't asked. Do you have a perspective on why that is?

00;29;55;16 - 00;30;12;15
Mick
Not really. I just think, you know, it's all about context, Cale. When you're in a hospital environment, when you're in a hospital ward or hospital room and you're a doctor especially, you're expected to be the one that knows everything that's going on. And it's very hard to say. I don't know what's going on. I don't know what's the right place.

00;30;12;17 - 00;30;26;25
Mick
And sometimes you just you know what? You know, I know that if you want a bed in hospital, I'll give you this treatment in X days. You're going to get better. But you might not know what happens in, in hospital in the home. And that's what I find really interesting, is that you think it's a controlled environment in a hospital.

00;30;26;28 - 00;30;44;24
Mick
It's not, you know, the silly things that I've heard patients do in hospitals, in bathrooms, you know, we won't even go there. That could be a whole another podcast. But, you know, patients do silly things in hospital. Very silly things at home. You know, patients drink in hospitals. They drink at home. You know, it's interesting, but you feel that you can control it better in a hospital.

00;30;44;28 - 00;31;05;05

Mick
As a clinician, you feel it is more rules around patterns of behaviour. I think you know, once again, this is about selecting the right cohort. If you select a cohort that's appropriately informed about what the care they're going to receive, I think you can get better outcomes. So from that perspective, as a clinician, it's, it's hard. And look what I ran a Covid virtual ward.

00;31;05;05 - 00;31;20;23
Mick
This is coming back into technology and what people do in the home. And some research will tell you about that in a minute. You know, I had patients flagging because the heart rate was 120. And and I rang them up and I go, what's you know, how come your heart rate's so high? I just wash the car. Oh, okay.

00;31;20;23 - 00;31;27;15
Mick
We don't wash car. And also when you're in, when you're in a hospital bed and you go, well, why would you wash a car and. Well, I hang a sack. Maybe you're feeling a little bit better.

00;31;27;17 - 00;31;28;00
Cale
Yeah.

00;31;28;00 - 00;31;44;17
Mick
You know, and this comes back to that incidental rehab. You start to feel better, you do a little bit more. And whereas in hospital you're encouraged to not do so much, you know, you got to rest up. And I could be wrong. Rest is important. And I did chastise the patient a little bit for washing the car. You know, I said, surely just put your car wash.

00;31;44;17 - 00;32;02;21
Mick
But it's just interesting what people do in the home environment that I never even thought that they would do, you know, when they were unwell with Covid and know had a very high risk cohort as well. And I think that getting goes into the next thing is that we sit there and we go, well, and this is something that the Americans and the Americans have recently discovered Hospital in the Home. Since Covid,

00;32;02;21 - 00;32;22;13
Mick
it's now hospital at home. They called it something different, of course. And, and I can say this because this hospital in the US is a thing. So I've got a company over based in Atlanta, in Georgia where we're looking at replicating, you know, models of care that we've got over here, over in the US, where they're all brand new. I just happen to have ten years of training data to to support our models of care, which is fantastic for us

00;32;22;14 - 00;32;42;23
Mick
considerable competitive advantage. But in the US part of the House, I mean, the home services, you've got to have remote monitoring for every patient. So you've got to have the ability to, to monitor what patients are doing in the home. So of course, the tech, the healthcare tech people went ballistic. And so everyone was getting sick on patches, devices that were measuring their observations 24 hours a day, seven days a week.

00;32;42;26 - 00;33;00;19
Mick
And we were measuring the same things that we measure in hospital, because that's all we know. We measured blood pressure, we measured oxygen saturation, we measured temperature, measured heart rate, we measured respiratory rate, and we did it constantly. And what they found in their models over there was they were getting all the signal noise because people were doing stuff at home that they wouldn't do in hospital.

00;33;00;19 - 00;33;17;19
Mick
And so, you know, in hospital, a heart rate of 110 is something that we get worried about. But in, in the home, if you walk up stairs, your heart rate might briefly spike up to 110 and then quite rapidly drop back down again. So, you know, we had all these people flagging for what was not a very meaningful alert.

00;33;17;19 - 00;33;46;19
Mick
And so we're spending a lot of time looking at what those alerts mean and calling people. And that was quite a lot of time and risk spent analysing that data. So as a part of the we've you know, it's something that, that I've been considering, especially since, since my Covid virtual experience and, and the US experience. And so we've got together a bit of a research group sponsored by the New South Wales Smart Sensing Network that was giving us a grant as a university and, and private company consortium, to, to perform the meaningful measures at home.

00;33;46;22 - 00;34;05;02
Mick
And so what we want to look at is, is what are the measures in the community that are meaningful that, that will give us an idea of deterioration. They might very well be the ones that we already measure in hospital, but they might be something else as well. And so it's, it's basically a 12 month, 12 to 18 months.

00;34;05;04 - 00;34;22;03
Mick

It's a, it's called a metre analysis where we pull all the existing data and published literature. And we, we want to come up with the 5 or 6 things that, that are meaningful to measure in the home, that are sensitive to measure a physiological deterioration. And we can then go to the tech people and say, hey, these are the things that I want to measure because it's evidence-based.

00;34;22;06 - 00;34;29;29
Mick
You know, I want to go to my mate Bill, who makes sense of patches and say, Bill, these are the sensors I want you to put on your patch, because for me, that's going to improve my model of care.

00;34;30;03 - 00;34;51;10
Cale
My mind immediately went to even just having an accelerometer on the heart, like compared to the heart rate. And so the relationship between those two things you should or should not signal like, is this a problem? Right. So I think the triangulation probably of a few points of data versus just what's happening specifically in the body is probably, a good direction to go in.

00;34;51;12 - 00;35;05;10
Mick
And that's where I was going to come in to my mind where it's going to, you know, apply its greatest use that I see is sitting in the background measuring multiple parameters and finding those correlations between them and then and then notifying us as clinicians when we need to respond.

00;35;05;12 - 00;35;26;06
Cale
We are going to speak about the future. So I do want to get your unfiltered thoughts there. Before we, before we do, I want to finish off that final question, the final piece of advice, final person or people that I would love you to provide some advice to is maybe it is a practitioner across the healthcare spectrum that is looking to start a company.

00;35;26;14 - 00;35;39;08
Cale
Yeah, they've seen an opportunity or they've seen a model of care. They've seen a why they want to do something. If you reflect on your hospital in your home journey, is there any particular piece of advice that you would provide people that are thinking about that?

00;35;39;08 - 00;35;55;11
Mick
Absolutely. Stay true to your vision. So for us, it's very easy. When you start out, you know, you're not making much money. I'm not saying that I'm making huge amounts of money now, but, you know, stay true to your vision. Know what it is you want to achieve. Sometimes you want to be everything to everyone. And what that can do is dilute, you know?

00;35;55;11 - 00;36;10;21
Mick
Oh, yeah, just do a little bit of community nursing on the side and, you know, no, no, no, I mean, our vision is high acuity, community based care. And that's what all of our models are underpinned by, not disrespecting any other community based models of care. But our vision is, is that that's what as a company, what we provide.

00;36;10;21 - 00;36;25;11
Mick
The next thing I would want to say is be authentic. And for me, I'm hoping that your and your listeners and viewers are getting the passion that I have around this model of care and community based care in general is not just hospital in the home, it's it's all the models that we run in the community. Be authentic, be passionate.

00;36;25;14 - 00;36;40;22
Mick
Allow yourself to be passionate. You know. Believe in what you want to achieve. Once again, if you put the patient at the centre of the journey, everything will follow. And that's including profits and, you know, improve revenue and increasing your turnover and all the business stuff. If you put the patient at the centre of the journey, you're running an efficient service.

00;36;40;29 - 00;36;59;22
Mick
You have a Net Promoter score of 97. That's all. Because you know you're authentic and you've got vision. And the final thing I would say to anyone in business, whether it be healthcare or otherwise, is value relationships, my relationships with my contract holders, my relationships with my staff, my senior management, my relationships with my collaborators is so valuable.

00;36;59;22 - 00;37;16;28
Mick
And, and spending time and understanding what everyone else's challenges are, everyone else's needs, and then how we can work together to, to achieve mutual benefit. If you don't value relationships, you don't know that. You don't ask people that. And I think all of my industry collaborators would say that. That's one thing that I do do is I value relationships.

00;37;16;28 - 00;37;27;15
Mick
I find synergy and I find ways that we can work together to improve. To my mind, how I can provide high acuity, community-based care and how I can improve your business. At the same time.

00;37;27;20 - 00;37;53;01
Cale

What a brilliant answer may be very true, all of those things. But for me specifically this concept, in your example, it's being very patient, centric and Bare is the same thing, which is it's totally about the family's experience and the willingness to do the hard work, like get through the tough times, sort of do all those other things which are almost superhuman, actually is driven by the idea of we can make this better for someone.

00;37;53;03 - 00;38;03;12
Cale
And so it's a very, very powerful motivator that we have a Bare. I know you have as well in your business that enables you to sustain when it's just bloody hard.

00;38;03;15 - 00;38;18;24
Mick
When you're having a thoroughly and utterly crap day, week or month, that's what keeps us all going. And business is a roller coaster. It's not easy. And you know, you've, you've broken ground in your business. So we're continuing to break ground in both of our businesses and change the way things are done. And I think that's super important.

00;38;18;27 - 00;38;38;28
Cale
Hey, let's, let's move ahead to the future. You know, obviously you've referenced the use of technology in this care model, but I can see, you know, you're passionate about the use of it more broadly in healthcare. What do you actually see as the future of home care? Any trends you're seeing things like that. But specifically what do you see the future looking like?

00;38;39;04 - 00;38;57;12
Mick
Look, I see the future is using technology to provide insights around more preventative care. We've got a very, very, very reactive healthcare system where we've got a really good health because if you're sick and you go to a hospital, my word, you get really good care. I just don't think that we're doing the preventative stuff. And when I say preventative, I don't just mean stopping you from getting diabetes.

00;38;57;12 - 00;39;19;05
Mick
But what I'm saying is, is if you've got diabetes or a chronic illness, how do we pick you up that you're deteriorating before you get so sick that you have to be in hospital? And I think we've seen a lot of that out of, out of Covid. My business in the US is, is has started off with remote patient monitoring, which is just that helping people with chronic disease better manage, take their conditions and picking them up before they get so sick they need to be in hospital.

00;39;19;05 - 00;39;40;08
Mick

And I think to my mind, that's where technology in the community and in the home is going to have the most value. And the reason why I say that is not just as a clinician in measuring data and looking at data, but the important thing is, if you collect data and you use a really good platform, and you use a really good strategy to engage patients with that data, because what we know is done.

00;39;40;08 - 00;40;00;21
Mick
So there's a guy called Don Berwick who's a really good thought leader in healthcare. He was one of the Co-founders of the Institute for Healthcare Improvement in the US. And, and Don Berwick actually written a brilliant article called Escape Fire. And what it says is it says going forward, we cannot have a healthcare system where healthcare moments only occur when there's a healthcare professional present.

00;40;00;25 - 00;40;16;23
Mick
And then we know that a population's ageing, you know, people are going to get sicker. You can't have clinicians providing insights at every step of the way. And the only way that we're going to be able to, to change that mantra is by using data and by using patients to understand what their data says and what it means.

00;40;16;23 - 00;40;44;05
Mick
And I think that's where technology's going to come into play, where where we can allow patients to, to see their own data, to understand their own data, and once again, over time, generate that relationship where, you know, they're looking at their own numbers and then they're making their own healthcare decisions. And that's where technology and visibility of data can go a long way in the next five years, I would say, and I'll tell you in my US model, we've deliberately targeted a very high risk cohort.

00;40;44;08 - 00;41;06;17
Mick
The 20% of patients that use 80% of hospital services are chronically underprivileged. Huge burden of chronic disease, especially hypertension. And we started, you know, treating these patients and contacting these patients and looking at their data remotely. And the alerts that we're seeing for the patients that we had in week one of the program, they're not alerting anymore, Cale. Their conditions are better managed.

00;41;06;20 - 00;41;24;04
Mick
And it's all we're doing is is calling them and talking to them about their data. We're not even changing their medications. If they're unwell, we'll send them to their, to their doctor and they'll have their medications changed. But what we're doing is we're, we're teaching them that if you've got hypertension, you don't feel any different if you take your pills or not.

00;41;24;06 - 00;41;41;11
Mick
But what I'm saying is if you don't take your pills, your blood pressure is going to be 190 and you're going to get a phone call from us, and we're going to say, your blood pressure's really high. Have you taken your pills? And then they're going get “no”. And then we're going to say, look, you know, I should probably take your pills because if you die, you know, and then it's just a gentle nudge every time you call.

00;41;41;11 - 00;41;57;29
Mick
And we've called a lot of people a lot of times. And those cohorts are now better managing their chronic disease. And it's because they can see their data. So I'm a huge believer in empiric thoughts. We need to, clinicians need to start informing the technologists what we're saying. And I know I apologise to anyone that's a health technologist here.

00;41;57;29 - 00;42;27;14
Mick
But sometimes we create solutions to problems that aren't there. Yeah, we sell products that don't fix problems. We sell products because we think it's a good idea. So I think for us we will look at a piece of technology and we will say, is this the best solution to the problem that we have? I don't do huge software integrations across all of my systems because I also, I get a bit of FOMO, if there's a better platform that comes out tomorrow, I want to use oh, I know, I don't want to get stuck on something, and all my technology partners know that.

00;42;27;14 - 00;42;45;20
Mick
So then they keep evolving their platforms, and it is in part. But, you know, I think we need to be looking at solutions to problems. And, you know, going forward those problems are going to be how, how do we keep complex aged patients in the home for longer. And there's some amazing technology platforms out there that we are presently about to enable.

00;42;45;22 - 00;43;02;27
Mick
You know, there are other remote monitoring platforms and other otherwise and measuring data in the home that we're looking at using. And we're advising, we're advising the technologist. This is what I want. You know, this is what meaningful measures at home is about telling the technologists, these are the things I want you to measure. And don't just measure what they measure in hospital.

00;43;02;29 - 00;43;15;23
Mick

Don't just measure something because you found a new widget that'll measure. And my friend Catherine from the NSA said, you know, let's not do gadget testing. Let's to how do we meaningfully change healthcare outcomes using technology? So that's what it's all about then.

00;43;15;26 - 00;43;37;15
Cale
Like, is it right in summarising the like, these two major themes that you're seeing, which is going from reactive to proactive in healthcare and moving it from large expert, providing you advice at sort of regular CB regular interval to individual being reminded and taking control of their healthcare.

00;43;37;18 - 00;43;54;08
Mick
Yeah. Like if you were a patient with diabetes and, and you have a piece of cake and then you measure your blood sugar an hour later and your blood sugar is 30, let's not say 30, let's say 80. And we give you a call. Our staff are going to say to you, oh, how come your blood sugar is eighty and you're gonna go, well, because I had a piece of cake and I didn't take my insulin.

00;43;54;13 - 00;44;08;03
Mick
So then, the following day, when you get to have another piece of cake, you sit there and you look at that piece of cake, and then you remember and say, last time I did this, those guys from Hospital in the Home gave me a call. So I might take my insulin or I might not eat that cake.

00;44;08;03 - 00;44;11;01
Cale
I might block that number.

00;44;11;03 - 00;44;31;05
Mick
We've had people do that. Not very many. Not very many. But yeah, yeah, they can do that for sure. Yeah. And that's fine. You know not – these are, these models are not for everyone. And I think we've got to realise that. But then that's where the next point I want to bring up, Cale is passive versus active engagement in these models.

00;44;31;05 - 00;44;43;13
Mick
I think at the moment, you know, with the technology that we've got at the moment, if you if you want to do a finger prick, you know, if you want to make sure you got to do a finger prick or put a continuous glucose monitor on, or do your blood pressure got to go put a blood pressure cuff on.

00;44;43;15 - 00;45;00;28
Mick

You know that it involves a degree of patient activation to do that. And I think in these higher risk cohorts, you know, it's that low socioeconomic, low educational status, low health literacy, sometimes you need to start people off with a, with a passive form of monitoring. And that's where I think patch based modalities are going to kind of come into play.

00;45;01;02 - 00;45;17;03
Mick
Going forward, where, you know, you can start people off with a patch and then and then they don't need to do that step of, of taking a measurement in the home. You know, we can just get that data and then contact them and talk to them about it and then bring them to a greater level of health literacy at a greater level of understanding.

00;45;17;08 - 00;45;39;01
Cale
Is it naive of me to think that your focus, you know, people who already have preexisting condition and really aiming to solve that component? If you project that out further? And yeah, we have all the ability to measure. We have people who are taking greater control of their general health that that cohort just completely shrinks all together. And we are having truly proactive healthcare.

00;45;39;08 - 00;45;45;03
Cale
Is that a world you envisage or is that naive of me to think that way, that, that could be a, that could be a future.

00;45;45;06 - 00;46;07;07
Mick
Cale, I think, you know, everything's on a bell curve. There's always, you know, what we want to do is push it a little bit to the right, but we're always going to have populations that that we struggle to engage with that, that we need to think about more. And when I call it culturally appropriate models of care, and that's I mean, that's, that's a term very much in the, in the indigenous healthcare landscape where we provide culturally safe and culturally appropriate models of care.

00;46;07;07 - 00;46;27;08
Mick
But I think, you know, when we when we blow it up, there's this different cultures and there's different cohorts, and we've got to be listening to those cohorts, listening to what they want, what they want to achieve, and then how we can engage them to, to help them. That's no different to business. You know, it's so much of what I do in medicine is true transferable to business, you know, how do you engage a patient turns into how do you engage a cohort?

00;46;27;08 - 00;46;40;28
Mick

How do you design a model of care that the people actually want to engage with? And so I think that's, that's where the human factor is always going to come into play. The technology can be amazing, but if people can't connect to it, don't know how to connect to it, don't want to connect to it. There's really no point.

00;46;40;28 - 00;46;59;06
Mick
So I think we're always going to have to be looking at how we, how we implement those models of care in different cohorts. And there's a city in the US, we've deliberately haven't gone for middle class white America as our target population. All of our competitors are playing there, we, we don't want to play there. We want to play with the cohort where we can show a significant improvement in healthcare outcomes.

00;46;59;09 - 00;47;14;15
Cale
Super interesting. Hey, you're obviously super passionate about this particular care model and the business and an array of other things that you've got going on. So you getting excited probably isn't an issue. But what does get you up in the morning?

00;47;14;20 - 00;47;19;05
Mick
My kids.

00;47;19;07 - 00;47;41;02
Mick
True that. That's why, to my mind, I just want my kids to be the best people that I can be going forward. That's my lifelong goal. And what keeps me up from, from the business perspective, is definitely how we can use technology to improve patients lives and outcomes, how we can use technology in models, how we can, how we can change the way we do things to get people living a better life.

00;47;41;02 - 00;47;59;28
Mick
And that's what it's all about with healthcare. You know, I want to be proactive. I don't want you to go to hospital all the time. I don't want you to have a high burden of chronic disease. I want you to understand what conditions you've got, how you can better manage them ultimately going forward, how we can use wearable technology to prevent us from getting chronic diseases.

00;47;59;28 - 00;48;13;26
Mick
You know, how we can keep our weight down, how we can keep our sugar down, how we can eat better, these devices that sit on our wrists at the moment, I've got so much potential to do

that. So that's what gets me excited at the moment and has gotten me excited for a long time. You know, back from rural hospital's days.

00;48;13;26 - 00;48;37;15
Mick
How can I deliver better care to this cohort of patients in the community in which I live? And now I'm just looking at my community, it's just getting bigger and bigger. It's not Barwon population of 10,000. It's currently the world, actually. So how can I do that? And you know, how can you do it one step at a time? How can you collect the evidence to then iterate your model to, to get into new new patient groups, to talk to different clinicians, to go to a different country?

00;48;37;19 - 00;48;59;21
Cale
Well, Mick, we're very glad that you are, you're taking on bigger views about cohort a lot but bigger groups of people in greater need. So that's, it's been amazing to chat with you. The final question that we have on the show is that the advice of Grin + Bare It is often given when people are faced, you know, with a particular challenge, just get on with it, you know, move on.

00;48;59;23 - 00;49;25;27
Cale
If we're going to finish up on one single piece of advice to people that are confronting that challenge, you can pick in any challenge you choose, whether that's starting a business, whether that's, you know, a hospital in the home as a model, whether that's technology and its application. I'll leave that with you. But what is the greatest piece of advice that you would provide people that are really confronted with a seemingly insurmountable challenge?

00;49;26;03 - 00;49;46;19
Mick
I've already, you know, to stay true to your vision, be authentic, and value relationships. I think if you can do that, no matter what comes along, you know, if you're a patient that's confronting [the] end of life, what's his vision? How do you feel about it? Who's around you to help you with that? In business, the same, surround yourself with really good like minded people who understand what it is you want to achieve.

00;49;46;19 - 00;49;51;24
Mick
And in healthcare, in business, in anything. Those three things I take home and that's what I live my life by.

00;49;51;24 - 00;50;02;06
Cale
Words to live by for sure. Thank you so much for joining. It's been an absolute pleasure. Looking forward to hearing much more about hospital in your home as you grow. Thanks for joining.

00;50;02;12 - 00;50;09;20
Mick
Thank you very much, Cale, and thanks for your time.

00;50;09;23 - 00;50;33;26
Cale
Thank you so much for listening to this week's episode. Hope you enjoyed it. As always, I would love your feedback, questions, or any suggestions that you have to someone that I should be speaking to next as our guest. You can find me on LinkedIn, or you can find the Grin + Bare It podcast on TikTok and Instagram. Now, the best way to support this show, if you did like it, is leave your feedback.

00;50;33;28 - 00;50;49;14
Cale
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