

RESTORING HUMANITY IN HEALTHCARE LEADERSHIP

Reinvent with Personalization

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He has been a leadership strategy contributor to *Forbes* since 2010, and also contributes to the *Harvard Business Review* and *Entrepreneur* magazine. Glenn was recognized as a top 100 leadership speaker and business thinker by *Inc.* magazine. He is a faculty member at the American College of Healthcare Executives (ACHE).

After a successful career as a corporate executive with notable entrepreneurial ventures, Glenn launched GLLG in 2007 to develop high-performance leaders, teams, and cultures focused on inclusion and the power of individuality. He is the founder of the Leadership in the Age of Personalization (LAOP) movement, which has inspired a grassroots effort among cross-industry executives focused on shedding the limitations of standardization to thrive in our age of personalization.

Since 2019, GLLG has produced, hosted, and designed the content strategy for seven LAOP thought leadership summits and for more than 100 episodes of the Personalization Outbreak podcast, all featuring executives from corporate, healthcare, and higher education. Glenn has prepared more than 450 speakers, moderated over 150 panel discussions, interviewed more than 100 guests for the podcast, and led an executive consortium of 112 people to deeply examine the strategic insights and trends related to personalization in the workplace and in the marketplace. He is known for his unique and dynamic ability to facilitate and mediate roundtables and conduct executive coaching to propel next-level thinking for senior executives, leaders, and managers globally.

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Introduction

Healthcare is about the one person in front of you at any given moment.

Over and over again, every leader I speak with says the same thing: the heart of healthcare is humanity.

Leaders spanning all facets of healthcare organizations from the boardroom and C-suite to the patient's bedside—clinical and non-clinical—all agree: the center of everything we do is the person.

Patients. Families. Employees.

Individuals.

Yet, also universally, everyone admits that they've never been trained to incorporate that reality into the way they lead their teams or their institutions. That's a tragedy, because the need for this level of personalization is urgent.

We're in an era that RBC Capital Markets calls "[The Individual Revolution](#)." Power is shifting from traditional institutions to individuals. This shift is poised to redefine the global economy and disrupt existing centers of powers.

This trend toward personalization is just getting started, and you will not be able to transform and grow if you ignore it. Personalization is shaping healthcare's future, but healthcare leadership has not been trained to practice personalization.

GLLG fills that gap.

TRAINING HEALTHCARE LEADERS IN PERSONALIZATION

Over the past six years, GLLG has studied personalization and how to operationalize it throughout an enterprise.

- Working one-on-one with thousands of managers and hundreds of executives
- Assessments, exercises, surveys, working groups, design-thinking sessions, 1:1 interviews, etc.
- Clinical and non-clinical settings, from every level and department
- Hosted (4) executive summits, coached 450+ speakers and moderated over 150 panels
- Founded the Leadership in the Age of Personalization Movement
- GLLG CEO, Glenn Llopis has authored five books including his latest to be released on November 12, 2024 titled, *Make Reinvention Your Superpower*

Leaders know they need to change themselves, their organizations, and their industries. They just don't know how. They can see the vision, but can't agree how to get there.

Healthcare leaders are not alone: According to a [PwC Pulse Survey](#) of executives across industries, nearly six in 10 (59%) of executives say there's strong consensus about the company's future vision, but only 41% say there is strong consensus about how to get there.

Healthcare is an industry like no other—in its unique challenges, but also in its unparalleled capacity to enhance human life.

This manifesto is an in-depth exploration and "call to action" to healthcare leaders regarding healthcare's major challenges and opportunities, and how personalization is the industry's most urgent transformation. Using proven GLLG strategies for operationalizing personalization as a foundation, 30 healthcare experts are featured to wrestle with the challenges they face every day as nurses, doctors, administrators, marketers—as people trying to lead with personalization.

Join the movement!

Chapter 1

HEALTHCARE LEADERSHIP IN CRISIS: TIME FOR REINVENTION

Personalization is reshaping healthcare's future; yet poses a challenge for unprepared leadership. It's time for healthcare leadership reinvention amidst resistance.

Sharing our frustrations about our personal experiences with healthcare in the United States can sometimes feel like screaming into the void. Many of us feel that when it comes to our health and our very lives, we are anonymous cogs in a massive machine that just moves us along standardized paths. Sure, we might get some great treatment along the way (if we have enough money or good insurance), but we also might just feel lumped in with the masses and not seen or heard on an individual level.

The encouraging news is that those working in healthcare feel the same frustrations the rest of us do. They want change just as much as we do. They know the industry needs to evolve, but most are unsure how to make that happen in an industry with such entrenched systems.

I know this because I have spent a lot of time over the past six years interacting directly with hundreds of people at every level of the industry, both clinical and administrative. That includes presidents and CEOs; administrators who specialize in strategy, human resources, communications, and branding; and doctors, nurses, and educators. Why such a wide range? Because transformation in healthcare requires everyone.

These are just some of the themes that have emerged over the years—themes that will be explored in more depth throughout this report:

- Healthcare is big business. As it operates today, our industry incentivizes the medicine, not the cure. So, how do we change?
- As much as healthcare is about innovation and technology, at heart it's about humans as individuals. How do we keep that at the center?
- Are you trying to build empathy within a culture of bullies? The importance of organizational culture in your pursuit of personalization.
- CEOs have a lot to learn from nurses about leadership.
- People use a lot of tools to capture information

from the frontline: but do you take action as a result?

- We have to learn to be open to contrary ideas and not run away from the discomfort they bring.
- How to ensure operational efficiency without sacrificing the personalized care that is crucial for great patient care and outcomes.

IS YOUR ORGANIZATION READY FOR 'THE INDIVIDUAL REVOLUTION'?

Leaders need entirely new skills to be effective in what RBC Capital Market calls the [Individual Revolution](#). Is your organization offering training for these new skills, or are you stuck with training that solidifies irrelevant and ineffective leadership methods?

Most are stuck.

That's why healthcare organizations need to consider both patients and employees as important consumers whose needs and expectations must be met for the organization to succeed. This involves improving patient care and also enhancing the employee experience.

Employees as Consumers – Healthcare leaders must understand how to work, lead, and conduct business differently now that employees are consumers. Leaders must learn how to know employees' capacities and empower them to use their unique skills, competencies, and insights to innovate and mobilize change. This can guide healthcare providers' transformation toward a more responsive, effective, and sustainable system through the development of new care models, improved patient and employee engagement, new supply chain strategies, a more inclusive and resilient work environment, and much more.

Patients as Consumers – Healthcare leaders must understand the symbiotic relationship between employees and patients and their impact on health outcomes. This requires physicians and caregivers to know patients as individuals and learn what matters to them. This also presents the opportunity to leverage data analytics and digital technologies to create personalized treatment plans that improve patient outcomes, enhance patient satisfaction, and reduce healthcare costs.

Healthcare organizations are experiencing many threats: an [aging population](#) that needs more care, while also experiencing a shortage of [physicians](#) and [nurses](#) to deliver that care, among many other challenges.

But it's not the threats themselves that make

healthcare leaders vulnerable. It's their inability to respond in real time when those threats arise.

We have reached a critical juncture in healthcare leadership that demands reinvention in the ways that we work, lead and conduct business, given the scale, scope, pace, and interconnectedness of healthcare's challenges.

Leaders must stop ruling by standards that don't account for what matters to patients, employees, and the communities they serve. In other words, personalization is the driving force of healthcare's transformation. Yet healthcare leaders are unprepared for this new reality.

I've learned many things about operationalizing personalization over the past six years of leading this work, but one thing stands out the most. Personalization threatens standardization, and standardization fights back hard.

So, what does that mean for us as leaders? Our responsibility is to coach leaders that are stuck in the limitations of old outdated standards and help them see personalization as a critical growth opportunity in healthcare.



[Watch](#) this short video.

Chapter 2

START CARING ABOUT YOUR EMPLOYEES, NOT JUST PATIENTS

Explore the healthcare paradox driven by a desire to help people, yet employees often feel uncared for.

“What drew me to healthcare from the beginning was the great variety of options that we have available to make an impact and to make a difference with others.”

—Teresa Feidt, former chief strategy and business development officer

Ask anyone why they went into healthcare, and you will likely hear that they were at least partly (if not fully) motivated by a desire to help people. In my experience, that holds true whether you’re a caregiver or an administrator.

Yet just because a profession is centered around caring and filled with caregivers doesn’t mean employees feel cared for.

Teresa Feidt, a former chief strategy and business development officer describes her 33 years in healthcare as going from the bedside as a registered nurse all the way to the boardroom as an executive leader, as chief nursing officer, and chief strategy and business development officer—and many leadership roles in between.

She emphasized the importance of optimism and compassion amidst the ongoing challenges we face—from government regulations that often limit operational flexibility, to the ever-present uncertainties that define the medical field. Feidt’s story is a powerful reminder of the difference we can make in healthcare by staying committed and hopeful.

“One of my strengths is optimism,” she said. “So, one of the things that’s really important to me is to be able to share the hope and compassion and optimism in healthcare and in making a difference as we move forward.”

HEALTHCARE LEADERS NEED TO LEARN PERSONALIZATION SKILLS

The threat of shortages exists on across both [physicians](#) and [nurses](#) in the industry; even as more people than ever need care. Healthcare organizations will also have an increasing number of management roles to fill over the next decade: employment of medical and health services managers is projected to

grow 28% from 2022 to 2032, much faster than the average for all occupations (3%), according to the [U.S. Bureau of Labor Statistics](#).

With so much competition for talent, leaders need to know how to retain employees. As I previously mentioned, personalization is shaping healthcare’s future, but healthcare leaders have not been trained to practice personalization. (Read about what RBC Capital Markets calls “[The Individual Revolution](#).”) This trend applies not just to our patients, who want personalized care, but also to our employees, who want more control over their own careers.

People know they can no longer count on an employer for their long-term financial sustainability through their working years and retirement, so individual loyalty is to their own career rather than to any one employer. As a result, according to the RBC Capital Markets report, workers are “demanding more control over their careers, the work they are doing, when they work, and the environment in which they work.”

Feidt agreed that there’s room for improvement within organizations when it comes to providing a more individualized experience for employees. “We’ve come a long way with our patients on that individualism road, at least in my experience. But the employee experience is an area where we definitely have opportunity” to do more.

LISTEN TO EMPLOYEES

To lead with personalization, you have to practice the art and skill of listening to people.

“We need to listen to our employees,” she said. “I know many organizations carry out employee engagement or experience surveys. When you do those, you should be listening to the results. You should be telling your employees what those results were. And you should be talking to them about how you’re going to make a positive impact on those results, and follow up.”

She shared an example of how we can listen to employees in order to take a more personalized approach.

“We have so many diverse age groups in our workforce right now that we really need to be thinking about [how to tailor employee benefits.] Maybe, at this point in my career, I don’t need certain resources anymore, but maybe I want pet care insurance or long-term care resources. Is there a way we can offer à la carte, different things that we can offer to enhance our employee experience?”

SEEK INPUT FROM YOUNGER, EMERGING LEADERS

Since we have multigenerational workplaces in healthcare, I asked Feidt to share advice for how we can navigate and perhaps benefit from those differences in thought. She suggested that we take advantage of the fresh perspectives they bring to the organization.

“I would say to emerging leaders: be courageous, be brave, and speak up. Anytime we onboard a new employee, I’ve always told them to please share new ideas, fresh ideas. Because we get stuck in ruts of standardization, where we’ve been doing things for years and we don’t know why until a new employee comes in and asks, why do we do this?”

And for those of us who’ve been around for a while and might be stuck in those old ways, we need to be open to the questions and the new perspectives.

“We have to constantly be asking ourselves why [we do things a certain way]. Does it make a meaningful difference to our patients’ families or to our employees or our communities? Because if it doesn’t, let’s get rid of it.”

She shared one way to think about it.

“I recently heard this word: GROSS—get rid of stupid stuff—and it just really stuck with me. As we try to move from standardization to more personalization, what really adds value?”

Get rid of everything else.

But there are obstacles, and sometimes one of those obstacles is us. Recently I was training emerging leaders and I said to the group, “I bet you have felt suppressed over the years, and you’ve given up challenging the status quo because you realized that you weren’t getting anywhere, even though you made all the efforts to help the organization do what’s right.” There was silence in the room until someone said, “How did you know that?”

I see it all the time.

Feidt agreed.

“Sometimes we look at what our employees bring to the table not as an opportunity for growth and better outcomes, but we see it as a threat. I’ve run into that and I’ve been in that place myself. That’s not okay. Inclusivity includes being listened to, heard, and

valued. We have to open our minds and change the way we operate our cultures and organizations and mindsets as healthcare leaders.”



[Watch](#) this short video.

Chapter 3

STOP SACRIFICING HEALTH FOR SCALING OUTDATED STANDARDS

Explore healthcare's fatal flaws, and how to fix it by embracing a personalization mindset to put patients first.

"A patient is not a case. They're not a code or a set of codes. They're a human being who has unique needs. And we've lost that under this current construct."

— Stu Clark, CEO of Premise Health

Sometimes the most influential call for change comes from the most unexpected place. I held my first Leadership in the Age of Personalization Summit in 2019. At lunch during that first summit, after we'd already had a few panel discussions about how leaders should change in order to lead in a more personalized way, four CEOs approached me and said, "Glenn, this is a noble effort, but you know how things work. We have to do things in a certain way. We have to think like the one before us. That's how we got to the C-suite."

I responded with, "I really appreciate your support. Let's talk after the summit."

I suspected they might open their minds a bit after hearing from our final speaker. After a day full of listening to keynotes and panel discussions featuring the people you'd expect—leaders with all the right credentials—I chose to end the summit with words and wisdom from an 8th-grader, [Brielle Lubin](#). She has a Jewish-American father and a Japanese mother from Tokyo. She was leading two school clubs at the time: the Gender Sexuality Awareness Club and the Asian American Cultural Club. She addressed the summit audience with the confidence of someone who already gives thought and action to these ideas of personalization. And she made it clear: her generation WILL be fully themselves and fully aware of the happenings taking place around them. And if your organization isn't ready for them, they'll move on.

Afterward, those same four CEOs told me, "Okay, I get it. Now I understand why it's been difficult for me to understand why my kids keep saying: 'Dad/Mom, your ways of thinking don't resonate with me.' As CEO, I can't imagine what my employees are really thinking and saying about me."

Those four CEOs have since retired.

I'll now share insights from three experts about how healthcare leaders can adopt a personalization mindset, and why the industry itself gets in the way, featuring:

1. Gyasi Chisley, managing director and head of corporate healthcare for PNC Healthcare and former healthcare provider CEO
2. Sharona Johnson, Ph.D., FNP-BC, NE-C, system administrator of advanced clinical practice for ECU Health
3. Stu Clark, CEO of Premise Health

HEALTHCARE IS BIG BUSINESS

Gyasi Chisley started off by calling attention to the nature of the business.

"Healthcare is almost 18% of the gross domestic product in this country, the largest sector in our nation's economy—more than defense, education, any other industry," said Chisley. "But it also has a lot of fragmentation. And the money is not in the cure—the money's in the medicine. There's tons of opportunity in healthcare to limit the medicine and focus on the cure."

Stu Clark acknowledged that reality: "We need a revolution around the importance of patient-centric care. Right now, it's around Wall Street."

What's stopping that revolution, according to Clark? A homogenous system.

"When you look at the powers that rule the healthcare system, it's very homogenous. I'm not just talking about how they look. I'm talking about how they think about what healthcare should be. When you have a system that is putting the patient second or third [in priority], you're just not going to have a good physical outcome with your patient. It's time to rethink what it is we're doing. The way that you have to start making a difference is at the individual level."

How do you do that?

Dr. Sharona Johnson starts by asking her patients what matters to them.

"What I've learned is my patient's goals, or what they want out of life, may not agree with what I want when they walk into my office," she said. "Even though my patients are dealing with starting dialysis and kidney failure, that is not how I start the conversation. My conversation is, 'What is important to you?' I may think that living a life into their 90s on dialysis is how they may need to go. And the patient may say, 'I just

really want to live long enough to see my daughter graduate from college.' So it's all starting with the patient's perspective."

Then Dr. Johnson said the words many people don't want to hear. In order to start with the patient's perspective, she said "we have to yield some authority. We have to ask the patient, how do I help you to guide your care? We have to empower them. And this newer generation—they're taking that authority. They're saying, 'This is how I want my care to be' and dictating it."

CHANGE OUR MINDSET TO CHANGE THE SYSTEM

Chisley agreed that patients need more control.

"Often in this industry, we're being told what to do," said Chisley. "We're told by the health plan, we're directed by a provider. Even down to how narrow networks function, as our employers try to steer us to the right network. All of that is hopefully changing in the sense that the consumer is now in charge of his or her own care."

To accomplish this, we have to change the industry itself, according to Clark.

"I'm in the primary care business. There aren't enough primary care providers in this country, because they can't pay their medical bills because of how primary care docs are reimbursed. If you want to start to turn the tide on disease and cost, why don't we double or triple primary care and allow that primary care doc to help people navigate to the right place in the community. Patients are not a case. They're not a code or a set of codes. They're human beings with unique needs. We've lost that under this current construct."

The system forces leaders to focus on scale, and scale strips away our individuality.

"A hospital CEO has been indoctrinated [with the priority]: I've got butts in beds," said Chisley. "My volume is great, I've done my job. That's what we report on. We have to break that indoctrination. To do that, you've got to find perspective. I always like to say perspective is not created, it's found. You have to break outside the four walls of the hospital to understand what's happening in the community."

Clark expanded on that idea, pointing out the industry's fatal flaw.

"Healthcare is in the business of scale—being able to deliver across a broad region or a broad industry very efficiently," said Clark. "Well, you can't scale without standardizing. The companies that can survive under the current economic model—fee-for-service,

volume based—have to be at scale. By their very definition, they have to be standardized, which means they cannot be personalized. So we have a conundrum here. We have a fatal flaw in the design of the system."

He gave an example of what that can look like.

At Premise, "we are primary care providers that live outside of the traditional reimbursement system because we fundamentally disagree with it. I'm not paid fee-for-service. Our docs are paid to spend as much time with a patient as they possibly can. Behavioral health is completely integrated into primary care. You can't get out of our primary care center without us talking to you about your mental health. The reason we can do that is because we're paid directly by large organizations to improve health of the population. Part of our staffing model is we need 30 minutes or sometimes an hour with a patient."

That's definitely a personalization mindset.

Dr. Johnson shared another aspect of a personalization mindset: the willingness for leaders to be vulnerable.

When it comes to vulnerability as leaders, "It's scary," she admitted. But the new generations have shown us that vulnerability is a requirement.

"Changing the mindset starts with us," said Dr. Johnson. "We have to disrupt and disruption is scary. So I think that we have to start with asking the question of what do we need? Why? And what do we want our organizations to look like going forth?"



[Watch](#) this short video.

Chapter 4

GET YOUR HOUSE IN ORDER

Explore how your organization's culture might be blocking your efforts to treat patients and employees with the personalization they crave.

"If our team members feel that they're simply cogs in a corporate machine, I guarantee you they will deliver care in that manner and patients will feel the same way."

— Mike Oshiki, MD, MS, FAAFP, FACHE, president of Riverside Regional Medical Center and Acute Care Division for Riverside Health System

An organization's culture is usually the biggest obstacle in our pursuit of those goals. Why? Because we pick up habits and perspectives from those around us.

Here's an example from Dr. Mike Oshiki, president of Riverside Regional Medical Center and Acute Care Division for Riverside Health System.

"All too often in medical training, you hear someone talk about 'the cranky gallbladder in room seven,'" said Dr. Oshiki.

So, right off the bat, the patient is only seen by his demeanor (cranky) and his reason for being in the hospital (gallbladder).

Dr. Oshiki continued with his example, suggesting that if we're trying to be more personalized, our next step might look something like this: "The difficult patient in room seven, who's here for a cholecystectomy."

But that's basically saying the same thing with more words.

"But if we actually apply personalization," said Dr. Oshiki, "let's talk about Mr. Jones in room seven, who's here with cholecystitis and has a planned cholecystectomy. But he had his appendix out 20 years ago and almost died from complications from his anesthesia. So he's anxious about this. Each one of those elevates personalization to a different level."

This is a great example of what personalization in healthcare can look like. It's also a great example of how intentional we have to be in order to achieve it. In that example, it requires ignoring our impulse to reduce everything and everyone down to the most basic and surface-level descriptions in the moment. It takes more time to see and treat someone as a full human being—and taking extra time is only possible

within an organizational culture that will value it and demonstrate it.

I'll share insights about how organizational cultures need to transform to elevate personalization.

Experts include:

- Mike Oshiki, MD, MS, FAAFP, FACHE, president of Riverside Regional Medical Center and Acute Care Division for Riverside Health System
- Daniel Gandarilla, Ed.D., SPHR, SVP, chief human resources officer of executive services for Advocate Health
- David Schreiner, Ph.D., FACHE, president and CEO of Katherine Shaw Bethea Hospital

To lead with more personalization, we must see people in their full humanity. But to do that, we must confront the force that seemingly works against personalization: standardization.

"Standardization historically is a good thing," said Dr. Oshiki. "Standardization is what we use to improve quality and safety because we're reducing unnecessary variance and making it better for the patient. But an unfortunate side effect is the depersonalization of healthcare. We create an environment where we see people who happen to be patients primarily in the context of their disease state and not as the people they are. The words we choose shape the way we approach people and their clinical treatment."

HEALTHCARE LEADERS: A CULTURE OF PERSONALIZATION STARTS WITH YOU

Daniel Gandarilla, Ed.D., SPHR, SVP, chief human resources officer of executive services for Advocate Health shared an interesting perspective about organizational culture. Advocate Health was formed in 2022 when Advocate Aurora Health and Atrium Health merged, and Dr. Gandarilla has a unique role within this new entity.

"As Advocate Health came together, we put together a function to help bring together the organization and we focused on the executive population first," he said. "It includes managing the lifecycle of the executive from when we recruit them, assess them, develop them, all the different components. It's a unique lens to look at in the organization because our leaders cast long shadows, and what they say sets up the rest of the organization."

Since they're essentially building a new organization, they have a great opportunity to define the culture.

"A lot of times organizations will have a mission, vision and values sitting on a page, but it's far more than that," said Dr. Gandarilla. "You want everybody to be able to connect to it through the work that they're going to do. What does that really mean on this team that we are saying that we are about excellence? What does that look like? There are protocols to follow, but it ultimately becomes not just the protocol, but the individual interaction around that standard that really can make it feel personalized even if it's a standard."

EMPOWER EMPLOYEES

Employees are the people who live the cultures and the mindsets that shape the way that we tend to our patients.

"That's where the congruency between words and actions in an organization is so important in establishing a culture where both team members and patients are seen as individuals," said Dr. Oshiki. "If our team members feel that they're simply cogs in a corporate machine, I guarantee you they will deliver care in that manner and patients will feel the same way. When we look at everybody as [an individual], starting with the team members, then that's how you move the culture needle."

Dr. Oshiki shared one way he tries to do this within his organization's culture.

"When I'm giving instructions to my team members, I convey my understanding of the task at hand, give some guidance, and tell them what resources I can provide," said Dr. Oshiki. "That empowers the frontline leaders to decide how they get the task accomplished. I don't tell them how to do it."

Dr. Oshiki showed how this can work by returning to the example of the so-called cranky patient, Mr. Jones, who actually is understandably anxious because of a traumatic past experience.

"The anesthesiologist needs to be empowered to look at why did that [previous bad experience] happen?" said Dr. Oshiki. "The floor nurse caring for Mr. Jones has to be empowered to do things they know will help reduce his anxiety. That food service person who's delivering his meal can be the one who figures out he's gluten intolerant and we need to change his diet. If you don't have a culture where your team members are empowered to do the mission in the way that they know they need to do it, then all bets are off."

ASK QUESTIONS AND LISTEN TO THE ANSWERS

David Schreiner Ph.D., FACHE, president and CEO of Katherine Shaw Bethea Hospital, published a book earlier this year called *Be the Best Part of Their Day*. In his research he found that one key to seeing people as individuals is asking people questions in a way that encourages more than a yes or no answer.

"Sometimes the higher we move up in the organizational chart, the less feedback we get," he explained. "By asking great questions and listening to those answers, we can really have an impact in a positive way."

He suggested questions like: What are the things that are going well for you? What are you just knocking out of the park these days? What is making you go home at night and say, "I did a terrific job for this patient and their family"?

Dr. Schreiner also emphasized the importance of expressing our gratitude to those we lead.

He gave some suggestions: "Tell people, 'I know the work you're doing is difficult. When we were going through the pandemic, you ran toward the fire and we love you for that. And the patients you cared for love you for that.'"

Dr. Schreiner said, "We have to be able to tell people in a very authentic way how important they are and that the work they do matters."

GIVE PEOPLE OPPORTUNITIES TO SHOW YOU HOW THEY’VE EVOLVED

Another barrier to having a culture of personalization is that our organizations don’t always make it easy for colleagues and leaders to update what we know about each other as we evolve over time.

Dr. Gandarilla shared something his organization does that address this.

“We created things called ‘Me Slides’” he said. “It’s what we use to introduce ourselves. We don’t [lead with] talking about our roles. I have a slide that has pictures of my family and of places I’ve been—pictures of what matters to me. We start with that, and it’s pretty amazing how quickly you find connections to people. I’ve updated my slide twice, because things about me have changed, even though my role may [still be the same]. It’s a fascinating conversation to think about the whole person.”

As I’ve studied this work, I’ve come to learn why people want this level of connection so much. When you’ve been forced to assimilate your entire life, people want to be seen on a deeper, more authentic level. They want to be free to be themselves. It takes skill for leaders to know how to give people that freedom.



[Watch](#) this short video.

Chapter 5

THE 4 ESSENTIAL SKILLS OF PERSONALIZATION

These four leadership skills are essential if you want an organizational culture that promotes personalization.

“Create an environment where diverse thinking is allowed, embraced, and applauded.”

— Jeannie Virden, Enterprise Chief Human Resources Officer, Central Health

It's easy to say we value diverse thinking. But from my experience, many people can't tolerate it in practice. That's because diverse thinking means you have to be open to differing opinions, you have to welcome a variety of ways of working, and you have to be willing to listen to people outside your area of expertise.

We know we need diversity of thought, but we're more comfortable with conformity of thought. This is another obstacle in our quest for personalization within our workplaces. But there are skills we can develop to help us overcome these obstacles.

In this manifesto, we've established that healthcare leaders need to know how to lead with personalization, meaning they have to see patients and employees in their full humanity. We've talked about why personalization is important, and how we can shape our organizational cultures to facilitate it.

But how?

Personalization requires diversity of thought, and diversity of thought requires personalization. So, what skills do you need as a leader, to foster an organizational culture that promotes personalization?

Here I'll share highlights from a conversation with these experts:

- Robert E. Johnson, Ph.D., Board Member at MGH Institute of Health Professions and President of Western New England University
- Jeannie Virden, Enterprise Chief Human Resources Officer at Central Health
- Mark Dooley, FACHE, CEO of Gadsden Regional Medical Center

The big themes that emerged from this conversation included skills related to being more open to change and less rigid about our own ways of thinking.

LEADERSHIP SKILL NO. 1: AGILITY

As board member for MGH Institute of Health Professions and president of Western New England University, Dr. Robert Johnson is charged with preparing the leaders of the future. He said all leaders need to be able to adapt to change.

“Most [of today's] leaders were educated, trained, and gained their experience during a time and an era when everything was status quo, everything was standard,” said Dr. Johnson. “We now live in a world where things are changing at a hyperconnected pace. We're dealing with ambiguity and we're managing through ambiguity, and that requires a different set of skills.”

He mentioned one skill in particular: agility.

He said patients and employees are looking for agile organizations and agile leaders who have the ability to get things done in real time and meet the needs of individuals. He explained that our new “steady state” is one of constant change.

“People want leaders who have the ability to learn, unlearn, and relearn as a steady state,” said Dr. Johnson. “They want people who have essential human skills that cannot be replicated by AI or an algorithm. They want individuals in their workforce who have the ability to create value as a continuous mindset as they go forward throughout their organizations.”

The skill of agility is essential to your survival.

“If you don't adapt, you will die,” said Dr. Johnson. “If your organization does not adapt, it will die. The way that I am leading today, as a university president, is different than the way I was leading just three years ago. And the same will be true for you. Are you reinventing yourself to have learning agility—to manage, lead, and work in ambiguity? Are you putting yourself in the mindset to learn, unlearn and relearn as a steady state? If you're not doing that, then you're not prepared for the future.”

LEADERSHIP SKILL NO. 2: ACTIVE LISTENING

To build a culture of personalization through diversity of thought, we have to be able to listen to one another.

Jeannie Virden, enterprise chief HR officer at Central Health, agrees that the only thing that is constant is change.

She said it's common in healthcare to have hierarchal decision making, where the leaders in the C-suite are the ones making decisions and pushing them down. But we have to rethink those rigid workforce models.

"We need to ensure that our leadership teams at every single level are diverse in terms of background, experiences, perspectives, and even industries," said Virden. "In healthcare, [it's common] that every position [requires] so many years of experience in healthcare. If we can break that and invite other leaders from other industries, that brings a diverse perspective."

But that's just the first step.

"Once we have that in place, we need to make sure that we have active listening and feedback loops," said Virden, "and once those are established, we need to make sure that we're actually utilizing them to make decisions, to foster open communication and dialogue before decisions are made."

That means communicating with people to acknowledge that we heard them. Thank people for sharing and then tell them what you're doing with their input.

"Say 'thank you' and because of this, we have implemented X, Y, and Z," she said. "Or, 'thank you' for your feedback. We weren't able to do that. However, this is what we're going to do with this information moving forward."

This level of communication is key in building a culture in which people feel that it's not only safe, but also beneficial, to speak up and voice their opinion.

"[We have to] create a psychologically safe work environment where people feel that they have the opportunity to speak up and be heard," said Virden. "Just because you bring forward an idea doesn't mean that we're going to be able to use it. But if we're giving them feedback, people will feel more comfortable to speak up and bring forward an idea. That's how you create an environment where diverse thinking is allowed, embraced, and applauded."

LEADERSHIP SKILL NO. 3: RELATIONAL MINDSET

The third skill is being able to shift from a transactional mindset to one centered on relationships.

Mark Dooley is CEO of Gadsden Regional Medical Center in Alabama. He acknowledged that the transactional nature of healthcare is another obstacle to personalization in the industry.

"Healthcare is set up as a transactional business," said Dooley. "In order for us to move at the pace we need to and adapt to things—'adapt or die'—relationships are more critical now than they have ever been. You can have some success short term being transactional. But if you want true strategic long-term success, you need to have a relational mindset."

What does that look like? Dooley described the Contingent Leadership Model, which focuses on four concepts: tell, sell, consult, and join.

"At times, you're telling people what they need to do, and other times, you're selling them on why they need to do something," said Dooley. "At times you're consulting with them, giving them ideas, letting them run with it. Then the ultimate [stage] is join, when they're running the ship and you're joining in and helping them as they need it."

He said the more we can move away from the telling and selling and move toward consulting and joining, that's when we have employees with creativity that just flows out of them.

"They feel much more connected to the organization," said Dooley. "They feel much more connected to us as leaders. By having those relationships, we're able to have the conversations that we need to have to move things forward quickly rather than going through a series of steps in a transactional model."

Dooley gave an example of what this looks like.

"As CEO, when I'm working with physicians here on our medical staff, I don't have the mindset of, 'What can I get this doctor to do to help me?' Rather, [I'm thinking], 'How can I make this doctor's life easier?' It's easy to get into that transactional mindset and think, what can this person do for me? How can this person help me? Rather than how can I build a relationship so they want to help me?"

Relationships begin when we have common purpose and when we have the self-trust to embark on a conversation that you can't control. Sometimes you have to put yourself out there to know what the

possibilities are.

LEADERSHIP SKILL NO. 4: TOLERATING HEALTHY TENSION

Practicing the first three skills requires another bonus skill: the ability to embrace healthy tension. Why? Because agility means we have to change, active listening means we can't turn away when we hear something we don't like, and relational mindset means we have to make an effort to see and understand someone in their individuality. All of these things will generate tension.

But it works both ways: embracing tension requires the first three skills. They all depend on each other.

For example, when a person constructively challenges why or how a decision is made and shares an alternative perspective, ideally that will broaden the group's point of view and result in a more impactful solution.

If the leader who's being challenged is practicing agility and active listening with a relational mindset, that leader should be able to see that tension as a healthy intellectual pursuit—it's someone pushing against the status quo to discover more meaningful, purposeful and sustainable opportunities. That's the ideal.

This is healthy tension: the kind that leads to growth. It helps us learn how to work through differences and finally embrace diversity of thought and operationalize personalization.



[Watch](#) this short video.

Chapter 6

PERSONALIZATION IS WHEN PEOPLE KNOW THEY MATTER

Learn the five indicators that will help you measure whether or not your organization practices personalization.

“People start to feel respected in a process where they get to make small changes, and they’re given opportunities to help identify obstacles. Do you want to go home and be able to tell your family that I felt relevant today?”

— Tim Alba, FACHE, Partner, Caldwell Butler & Associates

Here’s one way of thinking about what personalization within a large organization looks like. It’s achieved when people know they matter.

Dr. Donna Hicks, associate at the Weatherhead Center for International Affairs at Harvard University, is an expert in human dignity and a specialist in conflict resolution. In her book *Dignity*, she identified a major obstacle in human relationships: “our failure to recognize how vulnerable humans are to being treated as if they didn’t matter.” This vulnerability is what personalization aims to acknowledge and address.

Personalization is seeing and treating people as individuals, whether those people are patients or staff.

Operationalizing personalization is the act of adapting the way a hospital or hospital system functions to make it more likely that people will have the mindset and tools to see and treat people as individuals.

How do you create an environment in which every individual does matter, and they know they matter?

Here are three common barriers to this kind of personalization within healthcare:

1. People are seen as categories rather than individuals.
2. We do not have the systems for asking people what matters to them.
3. People do not know what personalization looks like or how it’s measured.

How do we overcome those barriers? I had a conversation about how to operationalize personalization across an enterprise with these experts:

- Marcia Messer, COO, WellSpan York Hospital at WellSpan Health
- Tim Alba, FACHE, Partner, Caldwell Butler & Associates

We structured this discussion around five indicators I’ve identified as a way to see how well we practice personalization. These indicators help us assess our organizations to root out any systemic obstacles that keep us from unleashing the individuality of the people we lead and work with.

Messer brought her expertise as a system-level healthcare executive, and Alba shared from his years helping organizations solve for disruptive innovations in healthcare.

INDICATOR #1: WHO DO YOU LET IN?

A key to personalization is being inclusive. By looking at who we let in, we can examine organizational processes that might inadvertently exclude people (for example, policies around only recruiting from certain universities). The most obvious way to be exclusive is to not let outsiders into the organization in the first place.

But another way we exclude applies to people already on the “inside”—we don’t seek new or contrary voices from within our own organizations. This can be harder to change because it’s sometimes much harder to see.

Both Alba and Messer agreed that we need to be intentional about seeking new perspectives. But how do you cast the net more broadly, to tap into unconventional thinking to solve problems?

Alba mentioned tried and true techniques like the [Gemba Walk](#), a Lean Six Sigma practice of gaining deeper understanding of a process by taking time to watch how people engage in that process and talking with those who are doing the work.

“These techniques are centered around trying to capture information from the frontline leaders about what happened today, what tools did you need, what resources did you lack?” said Alba. “The challenge is, what freedom does that frontline individual have to tweak the standardized processes given to them in order to meet the unique needs of the patient, the physician, or the employee?”

Messer said we need both formal and informal ways to get this kind of input. She tied this back to something shared in a previous chapter about the value of a relational mindset.

“That relational component is becoming even more important,” she said. “We have to have these formal venues to engage folks, but we also have to have those casual conversations and it has to be intentional. When we engage with our staff and our leadership team beyond soundbites, we’re able to extract what is important to them, what inspires them, what is it that they do outside of their daily work that may help them to think differently. Then, how do we bring in those leaders with this unconventional thinking to be part of the team?”

INDICATOR #2: HOW DO YOU SEE THOSE YOU LET IN?

The way we see someone affects the way we treat them. It affects whether or not we trust them, whether or not we value them, whether or not we see their full capacity to contribute and their full humanity.

When your employees are multi-generational and diverse in education and life experiences, how do you make sure you see them for the individuals they are—rather than the categories they represent?

“That’s both a complexity and an opportunity,” said Messer. “In my current organization, the age ranges from 18 to 74. I see that as an opportunity.”

Messer shared one way we can do that in practice: reverse mentoring.

“I tell [younger generations], I’m going to mentor you, but I need you to mentor me,” she said. “I need to know what’s important to your generation because that’s going to help me be a better leader and to define what the future needs to look like. I pose a problem and ask them, how would you fix this? How do you see this?”

She gave an example: “If we want to do a presentation, I ask ‘How would you suggest that we craft this to tell the story? And what technology would you use to better get that message across? We’re better together and we need to take advantage of that diversity.’”

How can organizations facilitate the contributions of so many unique individuals?

Alba suggested going directly to the frontline managers and asking them about roadblocks and how to get around them: “What are the constraints that are interrupting your day? Why do you not have time? Why can’t we get this patient out the door or get this

patient their next procedure? Then, how can we turn that into a set of actions that can be implemented near immediately to resolve that?”

The benefit? Good solutions, plus an energized workforce.

“That frontline leader will feel energized because they were able to resolve something,” said Alba.

INDICATOR #3: WHO DO YOU LET YOUR PEOPLE BE?

Once you’ve got people on board who might think differently and bring an outsider perspective, and you’ve started seeing them for what they can contribute, the next place to assess is this: have you created an environment that allows those innovative thinkers to be themselves? Or, once you hire them, are they pressured to be just like everyone else?

It’s a delicate balance.

“Culture is inherently local in every organization,” said Messer. “[We need to create] an environment where people feel respected and they bring their best selves to work every day, but there has to be some structure around how we behave when you have a large organization with 5,000 employees.”

One way leaders tend to force assimilation is the way in which we expect people to communicate and collaborate. How can we break out of that and let people work in ways that are best for them?

Alba suggested replacing huge meetings with a process more similar to speed dating.

“Instead of having huge department manager meetings that aggregate all the middle management leadership for two hours and an asynchronous report out, make it a speed dating problem-solving session,” he said. “Have the individuals go interact with their peers, have those timeout or check-ins or solution zone periods and let them collaborate.”

INDICATOR #4: WHAT DO YOU LET THEM DO?

Too often we suppress people by leaving no room for them to explore their possibilities. How do we allow for more flexibility and autonomy in the workplace?

Alba acknowledged what many leaders have said throughout this entire manifesto: that healthcare is built around standardized processes—for many good reasons, like quality of care—but that standardization is hard to overcome even in situations where an individualized approach would be beneficial.

“When the nurse or physician is with the patient, they know that patient based on that individual, based on where they come from, their background, their health status, their culture. They know they need to do a given thing that may not align with the larger standardized process, but it aligns with one component.”

Messer acknowledged the same challenges.

“There’s no one roadmap for this, and I will say that our current healthcare construct is not designed for personalization,” said Messer. “So this is a journey, and I’m trying to define how I let people be their best selves, how I let them do what they do best. We do have some operational constructs that we’re working on, so that we can elevate them so that they can shine and share with the larger organization what they know and what their ideas are.”

INDICATOR #5: HOW DO YOU LET THEM DO IT?

Advancements in technology and AI impact how we learn, work and interact with each other as humans. How will these changes impact healthcare leaders in planning for the future?

“What got us here today will not take us into the future,” said Messer. “We have to try and imagine what healthcare will be 10 years from now. We have to begin to try and be as forward thinking as we can, and skill up, and cultivate the leaders of the future with a different set of skill sets than I grew up with.”

How do we allow people the freedom to safely explore what’s possible?

“One dialogue that is intriguing is around the concept of micro innovation, making small changes, pushing micro innovation to the front line,” said Alba. “You’re not necessarily going to have a caregiver design a new cure for diabetes, but [that caregiver] might help deploy a generative AI application that takes all the variables in that individual’s background and creates a self-management plan for them that recognizes their culture, where they live, with the types of family members they have, and generates it on the fly.”

This doesn’t mean relying on AI for treatment plans, but there’s room to let technology help us be more personalized.

Alba said, “The bottom line is you’re letting the frontline manager do the things they can do to make small changes, and that engages them in the

organization. Celebrate what they do. People start to feel respected in a process where they get to make small changes, and they’re given opportunities to help identify obstacles. Do you want to go home and be able to tell your family that I felt relevant today?”

When people start to feel respected and they can see that they matter, that’s a level of personalization that will make people feel great about the work they get to do. And when people love their work, they talk about it.

 [Watch](#) this short video.

Chapter 7

INJECT PERSONALIZATION INTO YOUR EMPLOYER BRAND

Invest in employees in ways that support their humanity. Authentic investments are the only way to show potential employees the personalization they crave.

“You want to show your employees you see them.”

— Meg Aldrich, associate administrator, corporate communications, Keck Medicine of USC

Just think of what effective ambassadors, employees would be if they knew they mattered as individuals to their bosses, to their colleagues, to their organization. That feeling is not as common as it should be.

In this manifesto, we’ve established that healthcare leaders need to know how to lead with personalization, meaning they have to see patients and employees in their full humanity. We’ve talked about why personalization is important, how we can shape our organizational cultures to facilitate it, and what leadership skills are required.

In the previous chapter, I said personalization is achieved when people know they matter.

But once you’ve done all that, how do you make sure your employer brand reflects this level of personalization that so many people crave?

I had a conversation about this with:

- Meg Aldrich, associate administrator, corporate communications, Keck Medicine of USC
- Cara Williams, vice president and chief human resources officer (CHRO), Cottage Health

Employer brand rests on your most important ambassadors: current and former employees. That’s why this discussion included experts from HR and from corporate and executive communications. Your reputation as an employer depends on how existing employees feel about the work they do and how they’re treated. Those feelings are often shaped by how much of a voice they have and the range of opportunities they have within the organization.

PERSONALIZATION THROUGH EXECUTIVE AND EMPLOYEE VOICE

As associate administrator of corporate communications for Keck Medicine of USC, Meg Aldrich handles executive communications and works with colleagues in HR, media relations, and crisis communications.

She said people want to hear from their CEO about more than just corporate policies, especially when something big is happening.

“If you look back to the summer of 2020, with civil unrest and all sorts of bottled feelings and very important issues coming up,” she said, “people want to hear from their CEO. They want to hear about what happened, what matters to them, and how their personal concerns might be supported at the workplace.”

But people also want to be heard. What if they don’t agree with what they hear from the CEO? How do you maintain an individual focus when there’s something going on in the world and employees have different individual responses to it?

Aldrich uses what she calls an Issues Response Framework as a way to scale personalization in a situation when there are many viewpoints about complex issues.

“Issues Response Framework came out of the need where various people in the organization felt like we need to respond to what’s happening,” said Aldrich. “Whether the current issue is a political issue, a wildfire in Southern California that’s impacting our employees, a global conflict. What is our stance as an organization?”

She said part of her role in a crisis is looking at sensitive issues. First she advises people to consider whether or not the organization should be voicing a stance in a particular situation, offering these guidelines (extracted from her presentation slide):

1. Not too fast! Situations evolve quickly. Sometimes it’s best to wait for more information.
2. Is it about us? There are many terrible things in the world, but do we have something to add to the conversation that would be helpful?
3. Watch out for virtue signaling. Are we saying something because we authentically care or because we want to show we are aware?

“In these high-touch moments, you can make a meaningful impact with an employee,” said Aldrich. “It might just be asking our staff to be mindful and

patient and careful with their colleagues who might be going through difficult times. But this is a new space in communications. Each issue in each matter is different.”

Likewise, each employee is different.

For example, Aldrich said two of their health system’s hospitals are in different communities. Verdugo Hills Hospital is in the largest Armenian diaspora outside of Armenia, and their Arcadia Hospital is in a predominantly Mandarin-speaking community.

“We have very different audiences that we need to consider and look at and see differently,” she said.

The Issues Response Framework is about providing a process to follow, to accomplish that.

“What are the questions we are all going to ask when we huddle? What matters to us? Who’s going to be in the room? It’s a step-by-step process,” said Aldrich. “With any communications, make sure that you have your own small focus group that is diverse, because everyone reads something or receives information with their own interpretation. One group may read it and take it one way. Someone else may take it another way, and yet a third way. It’s important to gather the input and voices of individuals who have different perspectives.”

It’s a heavy lift to be in touch with what matters to different groups. A lot of those answers exist within an organization’s own employee base. Just think of how empowering it is for them to see that this reputable institution cares about what they think.

Talk about empowering somebody overnight.

PERSONALIZATION THROUGH NONLINEAR CAREER PATHS

Cara Williams is vice president and CHRO at Cottage Health in Santa Barbara, Calif. She shared what Cottage Health has been doing to be more personalized in the development, training and advancement opportunities available to employees.

“The pandemic pushed us to think differently in terms of retention because there are so many other opportunities outside of the traditional healthcare bubble, and people want that,” said Williams. “So they’re leaving in droves.”

So Cottage Health reconsidered their workforce development strategy to make it more personalized, creating nonlinear career paths.

“We send someone back to school to go do something totally different,” she said. “We call it ‘other

side of the fence’—giving people the opportunity to shadow someone in a job and see if that might be something they’re interested in. It might be something they’ve never thought of, or never thought they’d be good at. Nonlinear means that the org chart looks like a spaghetti drawing, and it’s really helping people be their best selves and giving them the tools to do that.”

By giving them the tools, she means going well beyond just paying for the schooling itself.

“There was a program where we took medical assistants and we sent them back to school to become radiologic technologists, and we paid for them to go to school, but you can’t go to school and work,” said Williams. “So we supplemented their wages so they could go to school full time and keep their full-time salary. And now they’re going to be Rad Techs, which is a better career path for them.”

But it doesn’t just help the individuals, it helps the organization build up a workforce for a job that’s hard to recruit for, said Williams. The program also takes employees, who already have relationships in town, and helps them grow their careers by staying in the community rather than moving away.

Williams said they’re expanding the program based on lessons learned along the way.

“One of the things we didn’t factor in is driving to the school and how much gas costs,” she said. “We supplemented their wages and we paid for school, but they came to us and said it’s really expensive to drive to the school, which is a little further out than where everyone lives. So we’re pushing our boundaries.”

This program shows me that the organization sees this as an investment rather than a cost.

When we invest in employees in ways that support their dignity and humanity—through financial investments that expand someone’s career opportunities, or communications investments that give people a platform for their voices to be heard—we honor their individuality. They become influential ambassadors for your employer brand, because they have experienced the personalization first-hand.

The success of an organization is no longer about the business defining the individual. It’s the individual defining the business. So we have to be careful about how we see and treat our employees. If they’re going to be at the forefront of our institution’s brand, we have to recognize the investment that we’re making, not just for the short term, but for the long term.

 [Watch](#) this short video.

Chapter 8

BETTER CARE REQUIRES HONORING INDIVIDUALITY

Seeing patients as individuals—honoring their values and family dynamics—can pave the way for a more inclusive and effective approach to healthcare.

“The [hospital room] environment for the family and the patient is just as important as the treatment of the disease, the assessment and the follow-up.”

—Raelene Brooks, dean of the College of Nursing at University of Phoenix

When I’m helping a company make a big change, I always ask whether they think that change begins with the environment (the overall organizational culture) or with individuals. It’s a version of the chicken-and-the-egg question. An individual leader who wants to take a more personalized approach might bump up against organizational systems that get in the way because those systems don’t account for what matters to the individual (i.e., values, beliefs, capacities, etc.). Likewise, new organizational systems will only be successful if individuals are ready and willing to use them.

So I deeply connected with the wisdom shared with me by Raelene Brooks, Ph.D., dean of the College of Nursing at University of Phoenix. We had a conversation that bridged the employee-focused topics of the first half in this report with the patient-centric themes of the second half—revealing the importance of personal histories in helping us honor each other’s individuality.

Dr. Brooks has been in nursing for 30 years, spending more than 17 of those years as a bedside nurse in a Level 1 trauma unit in downtown San Diego, before shifting into education and earning a Ph.D. in nursing science.

“My mother was a third grade teacher and my brother is a seventh grade teacher of autistic children. I guess teaching is just innate,” she said. “I spent a lot of time reflecting in my younger years, wondering how I can have a greater impact in nursing. I was teaching all the new graduate nurses as they were onboarding into the trauma unit, and I realized that the reach is greater [as a teacher].”

Dr. Brooks said she also had started to see the barriers and confines in the way nursing education

focuses on essential skills related to delivering quality care, while ignoring important skills related to knowing how to see someone in their full humanity.

Why is that skill so important? Because acknowledging patients for the individuals they are—including their values, fears, and family dynamics—can pave the way for a more inclusive and effective approach to personalized healthcare.

PERSONAL HISTORY MATTERS

Dr. Brooks’ upbringing taught her how to navigate individuality amidst difference.

“My father joined the U.S. Navy in 1963, and back then immigrants from the Philippines were only allowed to be stewards to the U.S. naval officers. He had 12 brothers and sisters and a mother who was a widow, and he did it to help support them.”

Later, her grandmother immigrated to the United States at 51 years old, knowing just three English phrases: yes, no, and thank you.

“My father was stationed at Naval Postgraduate School at the time,” she said. “He was able to elevate and go through the naval system, become an engineer through hard work and—I’ll be honest—through lots of discrimination in the system.”

She said he was able to bring six brothers and sisters and they, along with her grandmother—10 people in all—shared a small home in Monterey, Calif.

“You can imagine with 10 people living in the home, and multi-generations—compassion and respect for each other were needed,” she said. “I learned that early on. And that has really translated into my nursing practice.”

I share so much of her life story because our personal histories inform so much of who we are and how we work. But we’re not often encouraged to bring those parts of ourselves to the workplace.

GETTING BEYOND THE CONFINES OF WHAT WE LEARN IN SCHOOL

Dr. Brooks shared a story that showed how personalization can empower healthcare providers to advocate confidently for unique patient needs. She remembered a former ICU trauma patient named Ernie, who used to end up in the ER at least twice a month.

“As a young ICU trauma nurse, I remember Ernie,” she said. “He was a veteran. He was retired. He’d always come through the ER because he was falling off a very high bar stool when drinking at a bar close to the hospital. Long-time drinking can cause some

brain shrinkage. He would [fall and] hit his head and we would have to work him up through CT scan and all the tests, to make sure that he wasn't having a brain bleed. After four or five times, I said to the EMTs bringing Ernie in, 'Can you please ask the people at the bar to put him in a chair? They didn't.'

Ernie ended up back in the ER again.

"One day, in my scrubs after work, I walked down to the bar and I said, 'My name is Rae. I'm taking care of Ernie. I need you to put Ernie in a chair so he doesn't fall so high off the ground. I rarely ever saw Ernie again. That was very empowering to me, and I [realized] there is a way that I can really make a difference outside of the confines of what I've learned in nursing school.'

Nursing school focuses almost exclusively on policy and procedure.

"It's confining and defining," said Dr. Brooks. "What we don't learn is the piece about the family and how the practices are very different in each family. And you have to be respectful and understand the background patients are coming from, and why 12 people want to be in the room in a code blue, or three people want to be in the room sleeping with the patient."

Throughout the previous chapters, a key recurring message has been that our organizational systems in healthcare have depersonalized us. We spend so much time learning the technical specifics of our roles—whether we're doctors, nurses, or even administrators—but we don't take the same approach to developing the skill of seeing patients and employees in their full humanity. That's a skill that doesn't necessarily come naturally. We need to cultivate it.

"We are teaching policy, procedures, safety, how to administer, how to treat and assess," said Dr. Brooks. "But the caring and the compassion piece, we thought the students would come with that already. Truth be told, we need to teach it."

When Dr. Brooks was a new professor, she was doing rounds in clinic with 10 students. She walked into a patient's room and saw that it was messy. She pulled the nursing student aside to ask him how he thought the patient was doing. The student answered by telling her all the things he had done: the standardized list of things required from a nurse in that situation.

"I told him, 'Excellent, great job. Now let me ask you something. Can you do me a favor and survey the

room?'"

Dr. Brooks described the room as having tissues, cups and straws on the floor, and the patient was disheveled. She asked the student, if this was your family member, how would you feel walking into that room? Again, the student only saw what he was trained to see, saying the patient "looks good, he's safe, his vital signs are stable."

He was relying exclusively on the medical model. Focusing on the medical model is good, of course, but it's incomplete.

"I said, 'Okay, but let's talk about the environment. Would you want to walk into the room and see your mother or your father in this kind of environment? Remember, we are in the business of holistic healing. We want to provide an environment where patients can heal and get better. And I don't believe that is the environment that your patient is currently in.'"

Dr. Brooks said if there's a big impact that she could make, she would want it to be "that the environment for the family and the patient is just as important as the treatment of the disease, the assessment and the follow-up. That's a mission of compassion, a mission of caring, and seeing the bigger picture healing."

 [Watch](#) this short video.

Chapter 9

INDUSTRY INCENTIVES WORK AGAINST PERSONALIZATION

Delve into the barriers that make it so hard to transform healthcare, from operations administrators talking about misaligned incentives, new technologies, and why healthcare is unique.

“We have to stop treating healthcare as any other business. It doesn’t function the same way.”

—Sumita Yadav, MBBS, MHA, system vice president for operations & cardiovascular service line for Catholic Health

Sumita Yadav, who is a physician as well as a healthcare system administrator, summed up the conundrum when we’re trying to transform an industry like healthcare.

Healthcare is an industry like no other.

“Healthcare is about lives,” said Dr. Yadav. “In other businesses, you can say you get one [product] for this amount; if you don’t have it, go away. We can’t just turn people away because they might not have the money. Healthcare functions very differently. We are giving people their health, their wellness, so they can live the best life and they can contribute to the community the best that they’ve got.”

Here I’ll share highlights from a discussion about the challenges of transforming the U.S. healthcare industry with these experts:

- Sumita Yadav, MBBS, MHA, system vice president for operations & cardiovascular service line for Catholic Health
- Alen Voskanian, MD, chief operating officer for Cedars-Sinai
- John Baldwin, chief operating officer for TriStar Southern Hills Medical Center, HCA Healthcare

INCENTIVES WORK AGAINST PERSONALIZATION

All three acknowledged the challenges of trying to change a system in which there’s so much misalignment between what we incentivize and reward versus the outcomes we seek.

Dr. Yadav, who is a physician as well as an administrator, painted a picture of the differences between what we want as a patient versus what organizations are incentivized to do.

“[When I’m a patient,] I want a person who’s going to take care of me, hold my hand because I’m anxious, I need whatever healthcare I might need, and I just want it to be sensible and holistic,” she said.

But the system is “complexity over complexity,” she said. “We don’t know what anything costs. There is no sense of what one hospital is charging versus what another is charging, what one insurance is paying versus another.”

Most of us have experienced that complexity as patients. Here’s what it looks like from the point of view of someone whose job it is to make sure a healthcare system can serve patients while also remaining financially viable.

“If the cost of something is \$1, [the government payor] pays 70 or 80 cents and they let you figure out how to do the rest,” she said. “How are you going to make up that gap? That’s when the commercial insurance jumps in, and you try to get the maximum from them, but their only criteria is to be financially profitable. So they’re incentivized to just keep denying everything. Even if ultimately they have to approve, they deny it for 60 days, they hold that money, they get interest on it.”

That’s the business model.

Dr. Yadav said the burden falls onto the healthcare providers: “They’re providing the care, they’re not getting the payments that they need to invest back. Even for the payments that they ultimately might get, they have to fight.”

Dr. Voskanian shared the same frustrations.

“All the administrative back and forth to get approvals for things that get denied, to really be able to get paid, that costs money,” he said. “No surprise, we are the highest [in terms of healthcare costs] in developed countries. Earlier this year I went to Japan and South Korea to study their healthcare systems. They don’t have that level of administrative cost and administrative burden. It’s very clear and transparent what you get paid for, how you get paid for it.”

Imagine if we had a system that just trusted that doctors are making the right decisions for their patients.

Dr. Yadav shared how it could and should be: “Our physicians know the care that’s needed and they’re not just going to operate on people for no reason. If they’re operating, something must be done. So then why do we have to make such a big deal about trying to get that payment? Why isn’t that just automatically happening so that the organization can actually invest back into the care of the patients?”

NEW MODELS ALSO HAVE CHALLENGES

Dr. Yadav mentioned the new models, like value-based care or bundle payment, and said they can be good but also have challenges.

“Some of those new models are really well thought out,” she said. “However, what they do is actually remove choices from patients or consumers. We say that if you get care within your own system, then it is going to cost less, and there is truth to that. But then you start incentivizing physicians to only refer patients within the network. Rather than the financial incentives or penalties being the things that drive behavior, if we say we’ve trained our people well, we give them the tools to make informed decisions and then hold them accountable for those results, then the entire landscape would start to shift.”

COMMUNITY PARTNERSHIPS

Baldwin said the healthcare system can’t reinvent itself on its own, and talked about the benefit of unconventional partnerships.

“As we go forward, we have to know what matters to our people,” he said. “We have to connect with them on a human and personal level. As I think about community health, I think we have to look at unconventional partnerships. We have to start to think differently. I truly believe that today the healthcare system can’t reinvent itself on its own. It’s going to take outside thinking of non-traditional healthcare providers and entities to help get into the space and innovate.”

He shared an example of an organization in his local community that has been focused on addressing hypertension within the Nashville healthcare ecosystem.

“[They had] identified that a specific ethnic group had 50% rate of hypertension, while another ethnic group had a 28% rate of hypertension,” said Baldwin. “They did a multidisciplinary collaborative effort between private and public partnership through

government, local nonprofit, and a local FQAC [federally qualified health center]. They did targeted interventions at the zip code level, to help to improve the health outcomes for these very specific individuals, and created tailored personalized approaches for their care needs. That, to me, is starting to create some unconventional partnerships and people that may not be at the table today as we see that model across our healthcare ecosystem.”

LEARN FROM OTHER INDUSTRIES, BUT REMEMBER HEALTHCARE IS DIFFERENT

Dr. Yadav agreed that healthcare needs to learn from other industries. She said she’s all for disruptors challenging the status quo, especially when it involves bringing in new skills and digital innovations. But she also offered a caveat.

She gave an example of a digital transformation that actually makes the patient experience worse: kiosks in the office reception area. They save expenses, by reducing the number of staff time needed to check people in. But it puts a new burden on patients.

“The burden shifts to the patient to self-register rather than having someone taking care of them,” she said. “The kiosk robs us of the opportunity for human connection. It’s those connections that could have led to people understanding each other, and to those patients going back and saying, what a fantastic experience—those providers really treat you like a human being.”

How can healthcare providers adopt some of these innovations, but yet continue to respect the human touch in patient care?

“Every room we are in needs a patient voice,” said Dr. Voskanian. “We need patients in our innovations. We need patients in our boardrooms. We need that voice.”

THE ROLE OF DATA

Baldwin said, when it comes to data, we have to consider what we’re trying to achieve with data, to have the right data points so that it can meet the right person’s needs at the right time to have a personalized approach.

“Our mobile device is how many of us live and operate and do what we do every day,” said Baldwin. “You can travel across the country and be able to plan an experience without having talk with someone, and then have customized and tailored choices.”

There's potential for personalization throughout a patient's care experience. Baldwin said we should be able to know a patient's needs and preferences before they come for care.

"That's where the technology companies can help us think about the care experience differently," said Baldwin. "[We could be] aggregating different data points so our providers and our caregivers can help give better, compassionate care that is empathetic to the needs of the patient of what they need at that time."

Dr. Voskanian agreed and added to that vision.

"If data is present for a physician at the time of care, that could help them with clinical decision making," he said. "[That could include] bringing forward data from a patient's chart that is meaningful to alert them to something like this patient is on a blood thinner, instead of the physician having to look through the chart."

Data can also bring to the surface considerations around health equity.

For example, Dr. Voskanian said, "If you're prescribing this medicine for this patient, based on the patient's demographics, [there might be a recommendation for] colorectal cancer screening."

Dr. Voskanian shared an example of how he uses data to personalize. Even though he's an administrator, he still sees patients.

"I often ask patients about their life, and sometimes they share a story of their excitement about their granddaughter graduating from college," he said. "And I am genuinely interested in it. I have a place in the chart where I write, this patient's granddaughter is graduating from Berkeley, or this patient just adopted a rescue puppy. And then next time they come in, I bring that up. Hey, how's your puppy doing? That's how data could also help us with personalization."



[Watch](#) this short video.

Chapter 10

4 LESSONS CEOS CAN LEARN FROM NURSES

Lessons from nurses on how CEOs and others can lead with personalization, advance new ideas, connect with employees, and keep the workforce engaged.

“Some of the things that you’re driving [as a leader], should be their ideas, not your ideas.”

— Nancy Blake, Ph.D., RN, chief nursing officer of Los Angeles General Medical Center

No one is more skilled at personalization than a nurse. Nurses are the highly trained masters of individual care. They have to see and notice and respond and act—meeting each patient’s unique needs in the moment.

Who better to learn from?

Here I’ll share highlights from a discussion about what nursing can teach physicians and CEOs about how to lead in personalization. Experts included:

- Nancy Blake, Ph.D., RN, chief nursing officer, Los Angeles General Medical Center
- Rebekah Marsh, BSN, RN, clinical nurse educator, Harborview Medical Center, UW Medicine
- Anthony Betz, business manager, nursing operations, Wellstar Health System

Anthony Betz shared a story that gives us several clues about what nursing can teach the rest of us.

He said one of the facilities in the Wellstar Health System created a virtual nursing platform, thanks to the nurses themselves.

“It was started by unit nurses who saw there was a need for personalized care,” he said. “We know that demand is going up and there’s not as many nurses, and they saw that they were losing time with their patients. So they came up with this idea [for a virtual nursing platform] and they partnered with senior leaders.”

He had the opportunity to go and see it in action, while a patient talked with a nurse virtually.

“After the virtual nurse was finished going over some medication information with the patient, the patient looked over to me and a few others in the room, and said, ‘That was amazing. I’ve never spent that much time talking to a nurse before.’”

It was a win for the patient, and also a win for the nurses.

As a result, “unit nurses can spend more time with their higher acuity patients,” said Betz. “They recognized there was a need for that. The patients feel they’re able to be seen more.”

It also creates opportunity for nurses who need more flexibility in their work schedule.

“So far with our pilot program, the participating nurses are those who can’t work a standard hospital shift,” he said. “It creates an opportunity where they can still practice their craft and do what they love, while assisting the team in general.”

As Rebekah Marsh pointed out, this story gives us so many great examples of what nursing can teach CEOs and other leaders about how to both practice and deploy personalization.

“I just think that that’s a wonderful blend of using technology to create personalization, and I love that the nurses were involved from the beginning,” said Marsh. “I think that that’s where the real magic happens is when the frontline staff at every level of practice are involved.”

LESSON 1 – LISTEN TO AND ACT ON OTHER PEOPLE’S IDEAS

Sometimes leaders get hung up on thinking they need to be the ones to have the ideas.

But Betz said, “I believe that as leaders, we can approach our team members throughout our organizations and find those ideas and create that personalization that’s so desperately needed.”

Dr. Nancy Blake has been a nurse for 44 years and has a Ph.D. in nursing. She agrees that people have ideas and they want those ideas heard. She said too often new leaders come into a new job and feel like they have to show they’re confident and show they’re in charge. But she had some advice.

“New leaders should go on a listening tour,” said Dr. Blake. “You find out what the staff needs and then you plan. I think CEOs try and come in and be in charge because they believe that that’s what they need to do. [Employees] want professional development, they want a healthy work environment. They want some control over their schedule and their professional life. They have good ideas. I need to listen to their ideas, and I need to take risks and do things that are different. If we don’t listen to them, they will walk out and go somewhere else. Some of the things that you’re driving [as a leader], should be their ideas, not your ideas.”

To that end, Marsh said she likes to see her leadership role more as a facilitator. “I define myself as a facilitator of change. As many people as I can involve in that change, it helps me feel more successful and I think brings other people along with me.”

LESSON 2 – COLLABORATE BEFORE MAKING DECISIONS

Marsh talked about the tendency of nurses to collaborate.

“When I walk out into my inpatient units, I always see nurses at the nurse’s station collaborating,” she said. “The minute that a nurse has a question, they immediately involve their team before they start formulating their own individual plan.”

This is a habit that might help leaders get out of the mindset Dr. Blake described, the one in which leaders think they have to come up with answers themselves.

“I work in an academic facility where we train new resident physicians,” said Marsh. “I see the new resident physicians under a lot of pressure to make independent decisions and to form care plans. And their second or third step might be to ask for help. But I learned that nursing is a safe space in a difficult healthcare environment, because of that true collaboration.”

It’s not perfect, though.

“I think where nursing loses the thread,” said Marsh, “is that we don’t collaborate well across levels of organizational authority and we don’t always get that collaboration with our physician providers. But at the base, we are really, really good at not making decisions until we’ve gotten second and third opinions.”

Betz agreed as well.

“There’s a lot of transition that happens, so you have new leaders coming in all the time,” said Betz. “The most effective leaders are the ones who are taking the time to get to know the people. Healthcare is so collaborative. You have to have those relationships. And if it’s just a surface level thing, when times get difficult, you’re going to have a hard time driving change and acting quickly.”

LESSON 3 – CULTIVATE AND CELEBRATE CHAMPIONS

Marsh acknowledged that we tend to place a lot of value on leaders who make decisions, but that first follower is also so important for a true change initiative

to take off.

“We need someone who believes in the initiative enough to do the work and to do it publicly,” said Marsh. “Celebrating champions is a wonderful way of celebrating the change without taking all the glory. As many champions as you can find, celebrate the good work. I think there’s so much frustration in healthcare right now, and this is the kind of recognition that people are really looking for. You see me taking extra steps to do this thing, you recognize me for doing the right thing, you recognize me for championing change. That’s what leaders can do to help people feel engaged and excited about the difficult work we have ahead of us.”

Dr. Blake shared one way her team is getting champions.

“We’ve been very successful in the last three years in improving our patient outcomes because we’ve had unit champions that are driving it, but they’ve also had an empathetic ear,” said Dr. Blake. “We have an interesting model in which we have an administrator, a physician leader, and a nurse leader who are a triad who work together, and they round weekly on the unit and talk to the staff about any issues.”

She said they listen and try and fix the problems. Staff are empowered to speak up, because they see that when they do, things happen.

“When you listen, and they see that you actually fix the problem or address the issue, they’re more apt to speak up,” said Dr. Blake. “Your priorities should be getting your team to work together and getting them to understand you win as a team and you lose as a team. Patient care should be team centric and it should be focused on the patient, not the physician, not the nurse. You should be focused on the patient needs as a team.”

Marsh offered some perspective that reminded us why we need each other so much—doctors need nurses, nurses need doctors, everyone in healthcare needs everyone else.

“Think about the first care providers in human history,” said Marsh. “I can’t imagine that it was a doctor and a nurse. It was one person. I think about the specialization that has happened in healthcare, including the development of complete professions like nursing and physician professions. Those are wonderful professions, but they’re very specialized. I think that both the nurse and the physician are missing something in forming the plan of care in our silos.”

We think of decision making for the plan of care as the realm of the physician. We think of patient perspective and advocacy as the domain of the nurse.

“People get really upset when you say doctors aren’t advocates and nurses don’t participate in care planning,” said Marsh. “We totally overlap, it’s a spectrum. When we know that we overlap in that spectrum, we can’t be making decisions without each other. If I could make one recommendation about how to advance the conversation, it’s this: go in person and talk to someone. Have an in-person conversation.”

LESSON 4 – BE ACCESSIBLE, GO IN PERSON

Speaking of in-person interactions, Betz emphasized the importance of interaction between administrators and care providers.

“Early in my education, I had a lot of opportunities to shadow physicians and nurses,” said Betz, “and I started asking people, ‘When was the last time you saw your administrator?’ I was surprised at how often [their answer would be], ‘I can’t remember the last time they were here.’ That’s really stuck with me. Working with the nursing department now, I’ve been so impressed with how rounding and talking with the team members is such an important part of nursing leadership.”

CEOs, take note.

“I believe that CEOs, physicians, anyone in healthcare, could benefit from following rounding practices as well, to touch the business,” he said. “At Wellstar, it’s well-known that our CEO, who’s a nurse by trade, still goes on rounds and will even go onto units and work with nurses alongside them to touch the business. And I think that’s critical for us to do.”



[Watch](#) this short video.

Chapter 11

DOCTORS ARE JUST AS FRUSTRATED AS PATIENTS

Two doctors share why the U.S. healthcare patient experience can't improve until the entire industry is overhauled.

"I just love dealing with human beings. I love them smiling. I love them being happier. I love them chasing their dreams. And if you're sick and not feeling good, you can't pursue your dreams."

—Greg Brannon, MD, founder and medical director of Optimal Bio, author of *Restore*

The waiting periods. There are at least two of them, and they can be the most frustrating aspects of needing healthcare in the United States.

First, there's the long wait just to get an appointment with a provider. It can take months to get in the door.

Second, once you're in the door, there's that long wait in the lobby.

These are two of the many frustrations of the experience of being a patient in the U.S. healthcare system. People often blame the doctor's office, the staff, or the physicians themselves for these inconveniences.

But in this chapter, two physicians talk about why they share those same frustrations that patients have—and why both of those wait times cannot be improved until we overhaul the U.S. healthcare system.

The physicians included:

- Julie Ann Woodward, MD, chief of oculofacial surgery at Duke Health
- Greg Brannon, MD, founder and medical director of Optimal Bio, author of *Restore*

Full disclosure: both Dr. Woodward and Dr. Brannon are my own physicians. I'm practicing what I preach. We've gotten to know each other as individuals, sharing our struggles within this industry. So I invited them to share their expert insights.

First, both Dr. Woodward and Dr. Brannon emphasized that they have their own frustrations with the difference between how they want to treat patients versus the realities of the business today.

"Nothing makes me happier than having happy patients," said Dr. Woodward. "We're doing our best. We want to see you. We want to take care of you. It makes us feel good to do that."

Dr. Brannon agreed.

"I just love dealing with human beings," he said. "I love them smiling. I love them being happier. I love them chasing their dreams. And if you're sick and not feeling good, you can't pursue your dreams."

So, what gets in the way? The rising cost of healthcare, and the many burdens of our complicated system.

NEED RESOURCES FOR EQUIPMENT AND STAFF

Dr. Woodward explained that those two frustrating wait times are largely due to a lack of resources for the necessary equipment and staff—both of which affect their ability to see more patients.

"Studies are showing that if you do a cost analysis over time, physicians are being paid about 25% less than we were 10 years ago," said Dr. Woodward. "It's not just our personal pocket that upsets us, it's the ability to pay staff and to have the tools we need to take care of our patients. Sometimes physicians have anxiety because we're afraid if an important piece of equipment breaks and we have to wait a year or more to replace it. We just want to have all of our tools that we need, everything from Q-tips and gauze to major pieces of capital equipment to do our best job taking care of patients."

She said this lack of resources creates a crunch on the entire health system in general.

"The only way we can make up for it is seeing more patients," she said. "If I used to see 20 patients in a half of a day, 10 years ago, now I may have to see 30 patients. That makes the wait times longer for patients to get in. It makes the wait time longer for the patients in the lobby. We have patients who are sick, who are depressed, and they need a lot of handholding, and we want to be able to have time to do those things."

Another added stressor: online reviews.

"Patients are very happy with their care, but they may be upset about wait time to get in or a wait time in the office," said Dr. Woodward. "Those are usually the things that pull down those online review scores. The scores are not always necessarily reflective of the

physician's care, yet a lot of physician management groups and also universities are contemplating using those scores to pay the physician bonuses."

THE STANDARDIZATION IS OUT OF CONTROL

Dr. Brannon said one of the things that gets in the way is bureaucracy—the standardized processes imposed on the system, which create a lot of work and additional costs for healthcare providers.

"They have great intentions, but they have this bureaucrat trying to make these little boxes for us," said Dr. Brannon. "We [physicians] have to first make decisions based upon these hurdles, not what's best for the client. That's the problem, the layers upon layers upon layers."

That standardization makes it harder to honor the humanity in each individual—the goal we've been exploring throughout this entire manifesto.

"We're all humans," said Dr. Brannon. "The humanity is key, not the percentile, not the quartile, not this group or standardization of groups. When you look in somebody's eyes and you look at them as a human, that's where things happen. The magic of interpersonal relationship occurs. We cannot lose the focus on the individual. I'm a huge believer in liberty, but liberty demands responsibility. And when given the tools and the opportunity, the knowledge, then people can make decisions that are best for themselves."

One challenge: the process required to keep electronic records. It's a requirement that interrupts that person-to-person interaction that's so crucial.

"The electronic records bother me," he said, "because when you just go look at the record, the boxes filled out, you miss out on seeing how the family's reacting, how the patient's truly feeling. That's why these little boxes bother me. It's better to make rounds every morning. You see how the patients are doing, how the team was, how the patient was the night before. All those things are interpersonal relationship communications. We're lacking that with standardization."

He asked the question at the heart of how to improve the U.S. healthcare system: "How do we continue the standardization in the sense of collecting data so we can learn from that, but never lose the interpersonal communication?"

He shared one way his own company is trying to tackle that challenge.

"At Optimal Bio, we meet every Tuesday as a team, including the health providers and the management

team," he said. "We have about 50 employees. The providers of healthcare and the team that runs the business talk every day."

He said everyone is considered to have an ownership stake in the patient experience.

"When you answer the phone, you're helping a patient," said Dr. Brannon. "When you answer a lab result, you're helping a patient. When you're advertising, you're helping a patient. We're here to educate so people have the knowledge to make a decision."

THE SHORTAGE WILL GET WORSE

Dr. Woodward shared what's at stake.

"They're predicting an extreme shortage of surgeons over the next 10 years," she said. "It's going to be harder and harder for patients to be taken care of when they need surgical care. We need more physicians."

The shortage is already so severe it's affecting the health of physicians.

"Doctors are working as hard as they can," said Dr. Woodward. "Come lunch, we're shaking because we're hungry. I know more than one doctor who has stretched their bladder out from not taking enough breaks during the day. We really want to take good care of you, but we don't want to be so overburdened that we're damaging our own health."

What can be done? Dr. Woodward shared one idea: medical schools can allow more students in.

"It's very difficult to get into medical school," she said. "I have colleagues whose children have 4.0 grade point averages, they've published, they've done volunteer work, and they're being told they need to take one or two gap years to do extra research just to be able to get in."

We need more doctors, but it's more than that.

"There's no space to put more doctors," said Dr. Woodward. "There's not enough operating rooms. And the biggest problem is, we need more nurses. There's not enough people going into nursing. Even if we do build more operating rooms, are we going to be able to hire enough nurses to staff all the surgeries that need to be done?"

It's a huge snowball effect. Right now, that momentum feels ominous. But it is possible to shift momentum in a new direction.

Dr. Woodward talked about the momentum of morale, at the personal level.

“Morale comes from the top,” said Dr. Woodward. “If whoever’s at the top is not a positive energy person, it trickles down that way. When everybody’s in a good mood, we’re able to take better care of our patients. And that’s absolutely our number one goal. Nothing makes us happier than having happy patients.”

Now we just need to create that positive momentum at the systemic level.



[Watch](#) this short video.

Chapter 12

YOU CAN'T BUILD TRUST WITH PATIENTS IF YOU DON'T EMBODY TRUST

Building a trusted healthcare brand by first embodying trust, by meeting the needs of younger generations, and by accounting for what matters to the individual.

“What other industry is there where someone’s paying high dollar for something that they don’t know what they’re going to get, where they’re emotionally and physically invested, and they don’t know if it’s going to work? That’s the chance of healthcare.”

—Molly Luton, chief marketing and communications officer, Ballad Health

As I’ve mentioned throughout this manifesto, healthcare isn’t like any other industry. The challenge Luton mentions is one reason it can be so hard to build trust with people before they’ve ever experienced a provider’s care or services.

“If you’re booking with Hilton (Hotels), you know what you’re getting,” said Luton. “With healthcare, you’re trusting another human being to deliver something to you that has yet to be defined, and there might not even be a definition for it if you don’t have a diagnosis by the end of your visit. So the amount of trust that has to happen ☐ it’s crucial that we listen, think, feel, and do for the patient first, and use that to then react and build a business.”

In this chapter I’ll share highlights from a discussion about the role of communications and branding in helping healthcare systems earn patient trust.

Experts included:

- Molly Luton, chief marketing and communications officer, Ballad Health
- Angharad Bhardwaj, director of communications, WelbeHealth
- Jennifer Bollinger, senior vice president, chief consumer and brand officer, Sutter Health

HELP PEOPLE UNDERSTAND THE SYSTEM BEFORE THEY EVEN NEED IT

Bollinger shared a story most of us can relate to. Her brother-in-law was in the hospital, and she was there with her sister trying to support and advocate for both her sister and her sister’s husband.

“He couldn’t communicate,” said Bollinger. “No one ever addressed us as the two people who sat in that room all day, every day. Finally, I went out and asked for the charge nurse. It was not in my hospital, but it very well could have been.”

But not everybody knows who or what to ask for, and that made Bollinger ask herself: “How do we help patients understand in advance, What are the rules? How do you engage? What should you expect? I’m a big believer in setting expectations and then meeting them. We often don’t stop and look at what’s happening and say, okay, this is a problem. This family member is alone. No one has talked to them in three shifts. Why didn’t anybody notice?”

That brings up a great point: building trust requires much more than communicating a brand identity. It requires starting with a brand identity that embodies trustworthiness.

Luton agreed and shared this example.

“We’re not marketers in the same sense as the consumer would understand that word,” said Luton. “I look at us as marketing operators. We have to understand the operations. We have to know how the business is being built. Is the house in order before we put it on the market? If the house is messy and disheveled and the roof’s falling off, I’m not going to put it on Zillow.”

She said marketing and communications officers are the protectors of the brand, and so they need a seat at the table when it comes to making decisions not just about messaging, but also about how the health system operates—because they bring the consumer voice into the conversation.

“We need to keep pushing and advocating for the patient in a very different way—by bringing their voices together to make change in the operation,” said Luton. “There’s nothing more valuable than that. No brand building can be any more valuable than advocating for the patient and what they need.”

But you can’t always change how things are done. People don’t like to wait for test results, but sometimes the wait is unavoidable. What then?

“It’s about feeling heard,” said Luton. “If something does, in fact, take five days to get a scan read because of volume, we have to have that two-way communication, saying, *‘this is what’s happening, here’s an update, this is what’s going on.’* It’s about understanding how that consumer wants to receive that message and then giving it to them the right way. Don’t send them letters in the mail. We need push notifications. We need an app. We need those kinds of things that audience is going to resonate with. So it’s stopping and learning and listening to what they have to say and adjusting our tools and our function to that audience’s need, which is then that piece of personalization. It’s giving them what they need.”

Speaking of what they need...

HEALTHCARE HASN’T KEPT UP WITH MODERN EXPECTATIONS

All companies, in every industry, are always trying to figure out how to appeal to the younger generations. An organization’s survival depends on its ability to continue growing its customer base, and that depends on building trust with new generations. That’s a challenge, because new generations have their own expectations—and healthcare organizations don’t seem prepared to meet them.

One key expectation: “Transparency,” said Bhardwaj. “They can see a standard message or an AI response from a mile away. You really have to be transparent; you have to do your best to take time and personalize your message. They don’t want a standard response.”

Bollinger agreed and extended that beyond communications to include the business model itself.

“What we offer today, that generation is not going to buy for very long,” said Bollinger. “The patient’s expectations are shaped outside of healthcare. In any other experience that I have, if I have to call [rather than chat or go online], something has gone terribly wrong. Yet, in healthcare, you have to call for everything. Do we even have an offering that’s going to resonate with them, before we even market it? Because what we offer today—call, wait, come in—they’re saying, ‘I’ll just go somewhere else where I can just get it immediately.’”

IT’S NOT ABOUT WHAT YOU WANT TO SAY

What does it mean for healthcare leadership to stop

ruling by standards that don’t account for what matters to the individual?

Bhardwaj said you have to empower people.

“I started my career in hospitality, and a lot of times you empower your teams to make decisions that aren’t always standard,” she said. “You have your baseline, we have a lot of compliance that we must stay in, but often there are ways we can [personalize by saying], ‘Hey, how do we help that patient understand what I’m saying?’ Or how do I make a communications plan and provide that feedback to leadership through the eyes of hospitality, empowering our teams and empowering leaders?”

Luton also added that we have to use language that resonates. She said we often build communications plans based on what we want to say, rather than on what people need to hear.

“If we don’t understand the linguistics of what our patient’s needs are and the vernaculars that they use, [the message won’t get through,]” she said. “We can talk about oncology all day long, but they use the word cancer. If we’re trying to use the word oncology in our advertising, and if that’s a word they [wouldn’t search or] don’t know how to spell, we’re not resonating. We’re actually alienating ourselves even more and creating a divide.”

Bhardwaj circled back to that idea of empowering in the moment, if it seems like a message isn’t getting through.

“We really need to meet patients where they are and empower our teams to say, I don’t think that message landed or I don’t think that they receive the letter they needed to receive or the reminder that they needed to receive,” said Bhardwaj. “Our employees really are the people who are day-to-day on the ground with our patients. In our communication and in our marketing materials, we need to showcase the fact that we have listened to our employees. We want to provide a safe place that they can provide that feedback. If there was a gap, we need to be able to say, you know what? We listened and you can tell us, Hey, this isn’t working for us. And that’s the other cultural shift that has to happen with leaders.”

It’s time to stop viewing marketing and communications as a cost center and start seeing us as an integral part of the reinvention and growth strategy.

 [Watch](#) this short video.

Chapter 13

TECH'S POSSIBILITIES AND THE INDUSTRY'S BARRIERS

Technology can improve patient experience in the digital era, but there are still many barriers. Learn about the possibilities and what's keeping them from becoming real.

"Healthcare is a human-centric business. Patients want that feeling of being cared for, [to know] someone's listening, someone understands I'm in pain."

— Kathy Azeez Narain, chief digital and innovation officer, Hoag Health System

Digital technology can support the mission of improving people's lives, but it's not the end in and of itself.

"Patients want the best doctor, and that's a human," said Narain. "You can't just digitize them and take them completely out of that human connection. People want that connection."

In this chapter, I'll share highlights from a discussion about boosting patient experience in the digital era.

Experts included:

- Kathy Azeez Narain, chief digital and innovation officer, Hoag Health System
- Chase Idleman, vice president, market development and strategy, Zimmer Biomet

WHAT DO PEOPLE ACTUALLY WANT?

As chief digital and innovation officer for Hoag Health System, Narain spends time researching what people actually want when they hear the words "digital experience." What do they actually want that experience to look like?

"The digital technology can't be front and center," said Narain. "What it can do is play a secondary role in how easy it is for that person to reach who they need to or connect with a physician. But healthcare is a human business. It's not a commerce business. It's not shoes, it's not an iPhone. Healthcare will continue to operate in a very unique space."

For one thing: "The technology decisions [a health system is making] are not just up to the system. You have payors ... you have regulatory environments ...

there are physician needs, patient needs, [all of which] drive the experience. That makes healthcare complex."

That said, there are certain basics that people want—the efficiencies they experience when buying things like shoes or iPhones.

"All the administrative things that we make people do in healthcare—those have been improved upon in many, many other industries ... investing in how to make frictionless journeys around doing basic things, foundational things that we don't think about often, but they actually create barriers for people to do something."

She mentioned those dreaded phone calls again, as discussed in a previous chapter.

"If I have to call to schedule an appointment, I'll probably never get the appointment, I'm never going to find the time to call," said Narain. "But my ability to do that in a digital capacity makes it something that I might actually schedule and get care for something that I'm delaying. I just didn't want to pick up the phone."

She said there's still so much room for healthcare to be more personalized. While technology can help with personalization, it's also one of the barriers.

"There are micro moments of personalization, but from a consumer lens, we haven't attacked or even scratched the surface on what that could mean and or look like," said Narain. "And the systems themselves have invested so much on electronic medical records (EMR) platforms that I see that as a barrier in how they're going to be able to actually achieve personalization. I'm not convinced that going in my patient portal is personalized. That just tells me all the bad things that happened to me. And I think there's a lot of benefit to unpack in some of the foundational pieces, but there's still a lot of room that we haven't covered."

TECHNOLOGY IN PATIENT CARE

Chase Idleman is vice president of market development and strategy for Zimmer Biomet, one of the largest orthopedic implant companies in the world—known for knee and hip implants. He said they surveyed patients and people within the orthopedic musculoskeletal wellness space, asking: What is most important to you before, during, or after getting a knee or hip implant?

The response: People want to know if their recovery process is on track. So that's a place where Zimmer Biomet has developed technology to help improve the process.

Idleman said that was an epiphany moment: they have data, they can do remote monitoring—but how can they make it actionable, so it's useful for the patient and for the care team?

“When someone goes in for a typical orthopedic experience, they're given some paper with preoperative education and how they need to recover,” said Idleman. “We took that and we made a digital experience, called mymobility. It's our patient engagement tool.”

This tool provides education and things like self-directed video exercises to patients, and updated monitoring data to caregivers.

“A care team member can see that this patient has moved 432 steps over the last five days,” said Idleman. “He's moving around two miles per hour on average. He's knocked out 50% of his exercises, 25% of his education.”

They also use artificial intelligence to see how a patient's recovery compares to others in his cohort—comparing gaits and walking speed.

“We can start to look at days 15 through 40 in that postoperative window and be able to tell you with a high degree of fidelity where that patient is going to end up on day 90,” said Idleman. “So that allows you to intervene early [and with more insight].”

One barrier: limited resources.

Idleman said there are often gaps in what digital capabilities are available versus what any given healthcare provider can manage in terms of their own resources needed to make that technology available to their patients.

“Not everyone has a care team member who can spend the time on this,” said Idleman. “Reimbursements are going down. So people are being asked to do more with less resources. And they're saying, ‘Hey, I have to sign on to another tool to monitor patients?’”

Another barrier: payors.

According to Idleman, payors are still trying to determine what they'll cover in terms of this new technology.

Narain said they experience the same uncertainty within health systems.

“We all talk about health in the word healthcare, but our system is designed to support you if you have a need, a sick moment—and to achieve that word health whenever you do something, there's no billable way for me to do anything on that preventative spectrum,”

said Narain. “So the cost always goes back to the person trying to engage in some of these products.”

There are key benefits that digital technologies have brought to patient experience in healthcare, according to Narain. Benefits like expanded access through technologies that let people connect in new ways, and the technologies that improve patient care like what Idleman described.

Her role as a digital and innovation officer, in seeking ways to solve this challenge of using technology to create a better experience for people, often goes beyond the technology itself.

“The work of digital officers and transformation people in healthcare—our work is not technology based,” said Narain. “I spend so little time looking at the tech and more of my time trying to solve things like, *How do you even bring the data together?* I need payor data, I need electronic medical record data, I need all this data from this person's [digital health tracking app] before I can even whisper the word personalization as a potential possibility.”



[Watch](#) this short video.

Chapter 14

SIX STRATEGIES ESSENTIAL TO LAUNCH YOUR REINVENTION

Don't get overwhelmed by the healthcare industry's challenges: get inspired.

Six strategies for seeing and acting on new opportunities.

"The transformational changes we need in healthcare begin with the exchange of information and ideas and thought-provoking discussions with respectful tension that challenges the status quo."

—Scott Wolf, DO, MPH, FACP, physician executive, associate director with Berkeley Research Group

I opened this manifesto by calling attention to the many challenges and threats facing healthcare organizations, but by also saying it's not the threats themselves that make healthcare leaders vulnerable: it's their inability to respond in real time when those threats arise.

Here I'll share highlights from my discussion with Scott Wolf, DO, MPH, FACP, physician executive, associate director with Berkeley Research Group. Dr. Wolf was a practicing physician and he's also led health system organizations as president and in various administrative positions.

We addressed the question: What are the most critical reinvention strategies for healthcare leadership in today's age of personalization?

We framed that conversation around six strategies I've identified over the years as the foundation for innovation.

STRATEGY #1: SEE OPPORTUNITIES IN EVERYTHING

Dr. Wolf reiterated some of the major challenges the U.S. healthcare industry faces, many of which have been discussed throughout this report.

"We're approaching or almost exceeding 20% of our GDP on healthcare in the United States, yet our quality outcomes lag far beyond those in other developed nations," said Dr. Wolf. "We have supply chain issues, we have unprecedented workforce challenges, we have regulatory and compliance issues. The future of healthcare depends on the leaders of today and the impact they can have on learning,

unlearning, relearning, repeat—the mantra that you started us out with."

We have to see these challenges and threats as opportunities. But that can be challenging when we're in the middle of it.

"One of the reasons we don't see opportunities is because we're constantly dealing with the fires of the day," said Dr. Wolf. "We're going from a financial fire, a quality fire, a workforce fire. We need to address the immediacy of some of those issues so we can create some opening in our minds and our thinking and really provide that time for our teams to come together to think about what those opportunities are."

But we have to be intentional.

"We have to be specific about answering particular questions, because so many opportunities might be out there," he said. "And for every one of those opportunities, there's a 'shiny light.' And often we chase those shiny lights because we feel that they're going to come and resolve a problem for us without actually asking, is that shiny light answering a very specific question?"

STRATEGY #2: ANTICIPATE THE UNEXPECTED

Answering a specific question is one thing. But we also need to go in search of questions that we're not even asking ourselves yet.

"To anticipate the unexpected, we have to engage those perspectives of all of the stakeholders sitting around our table," said Dr. Wolf. "Our patients, our colleagues, all of the providers and the caregivers in the organization from the very top of the organization all throughout—everybody brings a different perspective. What might be very apparent to one person might be a complete blind spot to somebody else."

It's also not enough to just invite people to participate. We have to show them that it's not only safe, but also beneficial, to share their ideas and perspectives.

"We need to develop a culture of total engagement," he said. "You need to create that funnel of innovation. The top of the funnel is very large, where everybody is invited to put ideas, and then it goes through a discernment process. So, at the bottom, you have a well-thought-out solution. But those ideas are coming from everybody in the organization and even from the community, to help direct the ideas and the strategies that would then take you to that next level."

STRATEGY #3: UNLEASH YOUR PASSIONATE PURSUITS

People will surprise you with what they're capable of when they feel unleashed—when they feel free to achieve at their highest capacity.

“There's nothing more empowering and invigorating than offering people the opportunity to contribute,” said Dr. Wolf. “The key is engaging, welcoming those thoughts and input. And it's empowering people to make a decision.”

Dr. Wolf gave an example of this in action. At one of his previous organizations, there was a surgical tech who arrived at 5:30 every morning, and it was his job to make sure that all the ORs were stocked with the appropriate materials for the day. During the day, if anything ran out, he'd have to run down the corridor and around the corner, get more supplies, bring them back. One day, he brought an idea to Dr. Wolf.

“If I could just put floor-to-ceiling racks outside of every operating room, I would stock the racks so that during the day I would be able to just open the door and there would be my materials.”

They did it.

“It was a small investment, but we did it,” said Dr. Wolf. “It saved turnover time because he didn't have to waste a few minutes. If you multiply a few minutes several times a day, it adds up.”

But saving time was not the only benefit.

“The passion that this young boy had, because his idea was welcomed and acted upon, was immeasurable,” said Dr. Wolf. “And then it led to a number of other ideas and thoughts from his colleagues in the group. So just by engaging, just by inviting and recognizing his input, unleashed tremendous passion.”

STRATEGY #4: LIVE WITH AN ENTREPRENEURIAL SPIRIT

You don't have to be an entrepreneur to be entrepreneurial. You just have to have an entrepreneurial attitude.

“Our current state is not working, so you have to welcome that entrepreneurial spirit and be willing to take a risk,” said Dr. Wolf. “Failure is going to happen, but you just have to fail fast and learn from those experiences. But you have to be willing to at least take that chance, think differently, and garner the support

and input from your colleagues so that you're doing it together.”

If you're not seeing much innovation from within your organization, take a close look at the systems you've built and the culture you've established. You might be getting in the way.

“That spirit of innovation has to be cultivated in an organization in order to be able to think differently, look differently, and act differently,” said Dr. Wolf. “Like the saying goes, you get the results that your system is designed to get. We can't expect any changes in our outcomes if we are not changing our systems.”

Sometimes the hardest part of reinvention and transformation is first removing everything that is standing in the way.

STRATEGY #5: WORK WITH A GENEROUS PURPOSE

I believe that healthcare was born on the spirit of giving and sharing and serving others. How can we remain in that mindset while working to meet the challenges every day?

“It's the concept of servant leadership—serving others before yourself,” said Dr. Wolf. “I've tried to emulate that my entire career. I've always hit lumps and bumps—after a while, you get mired in the status quo. And so it's about reigniting that passion so that you can lead with servant leadership. You can lead with that generous purpose and that feeling of giving.”

In this industry, the stakes are so high.

“The outcome of [leading with a generous purpose] will be the perception by the patient,” said Dr. Wolf. “They know when they are truly being served. And it's the same with our healthcare providers and our employees—they know when they're being served by the organization, but even more they know when they're not being served.”

STRATEGY #6: LEAD TO LEAVE A LEGACY

Leaders have so much influence over the direction of the organization: How are you using your influence?

“This one is one of the most important and rises to the top,” said Dr. Wolf. “Leaders today have to serve as coaches and mentors, because you might have three or even four generations of people working in your organization serving a common good. If our leaders don't lead with the desire to leave a legacy, with the desire to be a mentor, to be generous with

their leadership, there's going to be a gap in our future leaders."

That's so true, and it also goes both ways: leaders also have to realize there's a lot they can learn from younger people who come to this industry without all the baggage of the status quo.

"As leaders, we have to be vulnerable," said Dr. Wolf. "We have to be vulnerable to invite innovation and ideas. That's the job of a leader. The leader is not supposed to have every idea. The leader is just supposed to pave the way, so when those brilliant ideas come forward and percolate up to the top, that can actually be impactful. They smooth the way to allow those ideas to be executed."



[Watch](#) this short video.

Case Study

OPERATIONALIZE PERSONALIZATION IN A HEALTHCARE SYSTEM

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Glenn Llopis, GLLG President

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