Operationalising personalisation in a healthcare system

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Abstract The balance of power is shifting away from traditional institutions into the hands of individuals. A top priority for every hospital leadership team is the need to provide a much more personalised experience for two primary constituencies: leaders and staff (internal) and patients, including members of the broader communities served (external). *Personalisation* is seeing and treating people as individuals, whether those people are patients or staff. It is achieved when people know they matter. *Operationalising personalisation* is the act of adapting the way an organisation functions to make it more likely that both internal and external constituencies at all levels build the skills and have the tools to see and treat people as individuals. Many barriers to personalisation exist within organisational cultures that are designed, instead, for standardisation; however, there is a methodical approach to identifying and overcoming those barriers and to creating an environment where people know they matter as individuals. One private, not-for-profit clinical research centre, hospital and graduate school embarked on this approach,

examined organisational systems over a year, identified actions to take and behaviours to change, and improved their personalisation readiness scores across four categories by 17, 21, 32 and 32 percentage points. The experiences of this organisation give other organisations a blueprint to follow in their own pursuits of operationalising personalisation across the enterprise.

KEYWORDS: personalisation, organisational culture, workforce resilience

INTRODUCTION

The US healthcare industry is confronting a troubling diagnosis. More people need health care as the US population skews older; the 65-plus group was the fastest growing age group between 2010 and 2022, with its population increasing by 42.8 per cent.[1] Meanwhile, the Association of American Medical Colleges estimates that the USA could see a shortage of between 37,800 and 124,000 physicians by 2034, with shortfalls in both primary and speciality care.[2] The U.S. Bureau of Labor Statistics projects that more than 275,000 additional nurses will be needed from 2020 to 2030; in addition, employment opportunities for nurses are projected to grow at a faster rate (9 per cent) than in the case of all other professionals from 2016 to 2026.[3]

These staffing shortages are exacerbated by industry trends that make it harder for organisations to compete for both talent and patients. According to RBC Capital Markets, organisations are not keeping up with major changes in the marketplace that affect an organisation's ability to attract or retain both staff and patients. Those changes are not small: in fact, RBC Capital Markets issued a report declaring an 'individual revolution' — saying that the balance of power across all industries is shifting away from traditional institutions into the hands of individuals. The report states: 'This will create a new world order in every aspect of the global economy and will likely be the single biggest disruptive force to existing centres of power.'[4]

The report outlines what this will mean for the healthcare industry:

> Historically, individuals have been able to consume healthcare with little regard for the cost since the vast majority was covered/paid for by their insurer. Beyond the premium, individuals rarely ever had to pay anything out of their own pockets, so have never had any incentive to ration or "shop" for services. [One] unintended consequence of this includes a market that now marginalises the consumer, since they have never really had any individual control over healthcare purchasing decisions.

Now that incentives have evolved, people are more active healthcare consumers.[5] Traditional medical institutions are being pushed to compete on experience, cost and the convenience of healthcare sites and services.[6]

Co-author Tom Jackiewicz is seeing this shift play out in academic health systems like the one he helms, the University of Chicago Health System (UCHS). Established institutions, such as UCHS, used to be able to rely heavily on name and reputation to attract patients. It was assumed that people would drive long distances to receive care from such highly regarded institutions. Now, patients have many more choices, and they are exercising them — researching patient satisfaction scores and physician rankings before choosing providers.

In response, the UCHS is implementing an ambitious growth plan

to bring patient-centred care closer to the communities they serve. Recent initiatives include a joint venture that added four Illinois hospitals and a network of nearly 50 physician offices and outpatient locations to the UChicago Medicine clinical enterprise, development of a Northwest Indiana campus with a micro-hospital and comprehensive cancer centre, and a major collaborative of providers focusing on the unique health challenges facing residents of Chicago's South Side.

This individual revolution is also evident when empowered healthcare workers exited their jobs owing to pandemic stresses, low pay, inflexible work schedules or desire for more opportunity. As RBC reports: 'In 2021, waves of labour unrest began rippling globally'[7] as people across multiple industries and countries demanded better working conditions.

Healthcare organisations struggle to keep both staff and patients, in an era when both populations expect a more personalised approach to their care and to their careers. Therefore, a top priority for every hospital leadership team is the need to provide a much more personalised experience for its two primary constituencies: internal (leaders and staff) and external (patients, including members of the broader communities served). This requires new skills. There have already been calls for healthcare professionals to merge medical knowledge with cultural and social intelligence[8] and for healthcare organisations to develop a workforce that has empathetic team players at all levels.[9] Knowing how to operationalise personalisation is just as crucial.

WHAT IS PERSONALISATION?

First, what personalisation is not: this is not a discussion about precision medicine. While that level of personalised medicine is remarkable and important, it is not the definition of personalisation being discussed here.

Personalisation is seeing and treating people as individuals, whether those people are patients or staff. *Operationalising personalisation* is the act of adapting the way an organisation functions to make it more likely that people at all levels will build the skills and have the tools to see and treat people as individuals.

Personalisation is achieved when people know they matter

Donna Hicks, PhD, associate at the Weatherhead Center for International Affairs, Harvard University, is an expert in human dignity and a specialist in conflict resolution. Through her work, 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.'[10]

This vulnerability is what personalisation aims to acknowledge and address. But what does it look like to be treated as if one matters? Dr Hicks identified ten essential elements of dignity that provide a starting point[11]:

- Acceptance of identity: give others the freedom to express their authentic selves.
- Inclusion: make others feel that they belong.
- Safety: safe from bodily harm and from being humiliated, free to speak without fear of retribution.
- Acknowledgment: give full attention by listening, hearing, validating and responding.
- Recognition: validate others for their talents, contributions and ideas.
- Fairness: treat people with equality and in an even-handed way.
- Benefit of the doubt: treat people as trustworthy.
- Understanding: believe that what others think matters; give them a chance to explain and express their points of view.
- Independence: encourage people to act on their own behalf, so they experience hope and possibility.

- Accountability: apologise when you violate someone's dignity; make a commitment to change.

Within the context of leading employees or serving patients, how can leaders or caregivers know whether people feel like they matter, and, if not, which of these elements is lacking? The most obvious solution would be to simply ask them. But this assumes that people will answer and that they will be willing and feel safe enough to answer truthfully. Several barriers get in the way.

BARRIERS TO PERSONALISATION

Barriers to personalisation are the behaviours of organisations, often unintentional, that result in individuals thinking they do not matter to the organisation. These behaviours are often the natural result of how organisational cultures have been structured in the past, without being updated to be relevant today.

For example, the skills that made leaders and caregivers successful in the past are not sufficient today:

> Many of our conventions come from an era when healthcare was delivered primarily by doctors and nurses with elite training whose success depended mostly on content expertise. This paradigm is outdated; we now know that social, behavioural and relational factors — like social support, lifestyle, diet and even a patient's relationship with her healthcare team — are critical drivers of health. Thus, the new healthcare workforce needs more than biomedical knowledge; it needs empathetic team players at all levels who can support patients holistically. There has been little focus on hiring healthcare professionals with the traits needed to succeed in this new reality.[12]

But even if people have the skills or traits that would enable them to help employees or patients know they matter, the organisation itself might be getting in the way.

According to *MIT Sloan Management Review*, many large organisations across industries (not just healthcare) cling to old command and control leadership models 'that might have worked in the past but now stymie the talents of employees throughout their organizations'.[13]

Here are three barriers common within healthcare.

Barrier 1: People are seen as categories rather than as individuals

Seeing people as categories creates obstacles to achieving (from the preceding list) acceptance, inclusion, acknowledgment, recognition, understanding and independence, which can significantly affect their experiences while receiving care.

Kayla Redig's story is one example of many. Redig is a competitive athlete and elementary schoolteacher. She was diagnosed with breast cancer in her 20s and has produced a documentary film about the special challenges facing young adults with cancer.[14]

> When you're diagnosed with cancer at 24, you no longer fit in with your normal peer group. And then you go on the inside of the hospital, the space where you're supposed to be welcome, and I was lumped in with everyone who had the same diagnosis [older women in completely different life stages]. Not only did I not fit in on the outside, now I don't belong here on the inside.[15]

Some of Kayla's cancer care occurred at the UCHS, where co-author Tom Jackiewicz is president. He has had personal conversations with her about what she experienced and how those experiences made her feel. As a result, he invited her to join an advisory committee that provided guidance on the design of a new US$815m pavilion dedicated to cancer research and care.

Located on the city's South Side, the cancer centre was conceived following an extensive master design process that incorporated feedback from hundreds of patients and community members. In addition to space for advanced clinical therapies, research and clinical trials, the building will be home to wrap-around services for cancer patients and their families, including lifestyle and stress reduction classes, nutrition education and survivor support as patients go through the treatment and recovery journey. One overarching goal is to ensure spaces are tailored to patient needs rather than making patients fit into structures designed primarily for the convenience of care providers.

Barrier 2: We do not have systems for asking people what matters to them

This creates obstacles to achieving fairness, accountability, acknowledgment and understanding (Figure 1).

According to Jack Cox, MD, MMM:

> One of the biggest challenges that we have in healthcare is the way that we're reimbursed for sick care and procedures rather than health and wellness, which is what most individuals want. Organisations get paid to replace your hip rather than to help you lose weight. We don't have good systems for asking individuals, "What matters to you?" So, we end up delivering a lot of care based on OUR models of quality and value, instead of focusing on what's important to patients.[16]

An important goal of value-based care is to standardise healthcare processes, which creates a natural tension between value-based care and personalisation.

Barrier 3: People do not know what personalisation looks like or how to measure it

Lack of understanding about how personalisation is activated and measured creates obstacles to achieving accountability and inclusion.

Assessments conducted by co-author Glenn Llopis demonstrate that while 74 per cent of leaders see themselves as mindful of individual differences among the people they lead, 80 per cent of employees say their leaders are *rarely* aware of those differences.[17] Across all industries (not just healthcare), only one in five US employees feel connected to their company's culture, according to Gallup.[18]

Healthcare organisations rightly focus on ensuring patient quality and safety, using evidence-based standardised practices and protocols. Standardisation is usually the starting point of any improvement effort in healthcare; however, in the pursuit of quality and safety, individual patients and individual employees, can get lost.

Many organisational cultures are not set up for personalisation. Institutions have typically evolved over time to be efficient, to prioritise and reward certain results. Those results are worthy aims, whether they are quality health outcomes for patients,

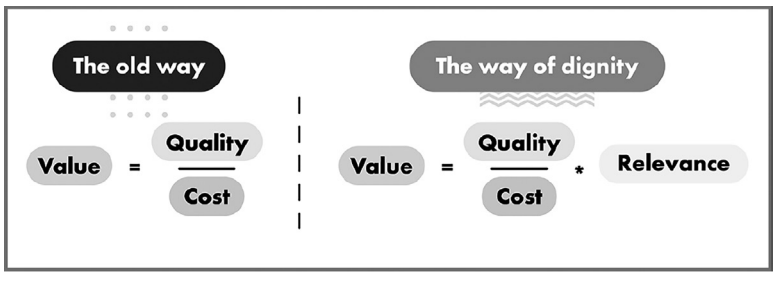


Figure 1 The way of dignity

achieving research breakthroughs or financial stability for the organisation. But any organisation optimised to achieve those goals, without also focusing on goals related to personalisation, will have to overcome the barriers mentioned previously that will impede progress in becoming a more humanised place to receive care and to work.

A METHODICAL APPROACH

It makes sense to begin with the question: If personalisation is achieved when people know they matter, what makes people know they matter? To convert this rather lofty goal into something tangible, start by turning Dr Hicks' list, presented earlier, into categories on which leaders and organisations can take action.

Since the topic is personalisation, it is helpful to see those elements in terms of what they mean to people on an individual level. For example, here are five statements along with the elements of dignity they may relate to[19]:

- Individuals have value: they want to be included [inclusion, acknowledgment].
- Individuals are worthy: they want to be seen in their full humanity [acceptance, understanding].
- Individuals are unique: they want to be themselves [recognition, fairness, safety].
- Individuals have experience and insight: they want to do more [benefit of doubt].
- Individuals have ideas: they want to explore their possibility [independence].

As for accountability (the tenth element identified by Dr Hicks), this entire process is designed to achieve accountability by creating a way for leaders to assess their organisations with the intention of uncovering and removing barriers to personalisation.

There is no universal metric for personalisation

There is no one-size-fits-all formula that would make every individual feel like they matter. Similarly, there is no formula for operationalising personalisation that will fit every organisation. But there is a process that can be helpful in rooting out barriers and looking for ways to improve. That is what this summary aims to provide.

First, an organisation needs to define its audiences. As noted in the introduction, healthcare leadership teams need to provide a much more personalised experience for two primary constituencies: internal (leaders and employees) and external (patients, including members of the broader communities served). A personalisation pursuit can focus on one or more:

- Do leaders have what they need?
  People can share the same vision but may want to achieve that vision in their own way. When leaders do not know how to lead within that reality, people may become disillusioned or will feel like they do not matter, leading to departures or failure to contribute fully to the organisation. An organisation's leaders should be assessed on whether they know what it means to be inclusive, have access to training and tools to improve their inclusion skills, and whether the organisation is set up to measure inclusion, not just diversity.
- Do employees have what they need?
  Organisations should assess their ability to provide an environment where anyone can harness their full capabilities, regardless of their background. Other considerations should include the ability to proactively measure how supported employees feel in the existing workplace culture and the presence/absence of cross-functional, cross-silo cooperation to make better decisions and improve outcomes.
- Do patients have what they need?
  Physicians and nurses need to generate outcomes that matter to patients.[20] Beyond patient engagement surveys, organisations should have methods to secure feedback from patients and their families about their care experience

and about their own health goals. Organisations must commit to ensuring that patients and their family members feel seen, heard and respected by caregivers, including comprehensive strategies for engaging with patients in a way that invites them to share their whole story.

The UCHS is rolling out a new, internally developed Back-to-Basics in Care programme in early 2024. The new programme is designed to better permeate UChicago Medicine's culture than a previously deployed outside programme, and it will directly address how caregivers need to shift from the stress and chaos of the COVID-19 crisis to refocusing on caring for patients as individuals. Using insights shared by patients, caregivers and community members about what is most important to them, the programme will launch initially with nurses and those who support them and will then include public safety, food service and environmental services staff. Physicians will participate at a later date since their top decile performance on patient communication indicates that additional training is less crucial at present.

- Does the community have what it needs?

  Organisations should be proactive in getting to know people and their communities and understanding which aspects of health tend to vary by culture, gender or demographic.

  The UCHS has created a Violence Recovery Program (VRP) that serves as a national model for organisations seeking to better understand the needs of the communities they serve and then tailor programmes to those specific needs. The VRP cares for approximately 3,000 patients and families each year using a network of more than 60 community-based social and behavioural health agencies to ensure comprehensive recovery and reduce the risk of re-injury and recidivism. Physicians and nurses treat a patient's physical wounds, while 20 violence recovery specialists with strong ties to Chicago's South Side work to provide other types of healing.

  Patients and families are met at the emergency department door to provide immediate support such as listening to and talking with patients who are in shock, calling family and friends and connecting patients with resources like food or mental health counselling. This support surpasses giving people a phone number to call for help. The VRP specialists are the connective tissue to community services and resources — setting up appointments and even walking hand in hand with patients and their families to appointments. They also provide support with housing, education, employment, food, chemical dependency treatment, transport and other essentials.

The violence recovery specialists have lived experiences with trauma, violence and violent responses to conflict. When VRP specialists are listening and providing guidance, it is from a place of experience and understanding. The specialists are not asking patients and their families to make changes they have not made themselves.

AN ITERATIVE PROCESS: A CASE STUDY

The method outlined here is an example of a process one organisation took to identify its own needs in this area and ways to address those needs across all four audiences mentioned previously.

A private, not-for-profit clinical research centre, hospital and graduate school sought to explore how to operationalise personalisation. Leaders and employees from across the enterprise embarked on a process of assessing their organisational systems, processes and ways of working to root out barriers to personalisation, identify points at which they could interrupt the status quo, and define actions that would help them pivot towards providing more personalised experiences for patients and staff.

Participants included people in both clinical and nonclinical roles, including physicians, nurses, caregivers, executives, managers and front-line personnel. The process began with participants meeting with their cohort-level peers (nurses with fellow nurses, etc). These were formal discussions facilitated by co-author Glenn Llopis, in which people were encouraged to share their experiences as leaders, as employees and as people providing services to patients and the community.

After the initial round of discussions, the various cohorts came together and discussed the issues that had been raised in the individual meetings. The full group identified opportunities for improvement related to the four important audiences mentioned previously: leadership, workforce, patient experience and preventive care. They held an enterprise-wide summit to introduce these ideas to a broader community within the organisation.

Based on their stated opportunities for improvement, GLLG identified metrics to help measure progress in each of the four areas and created an assessment tool[21] to use before and after the next level of engagement. The following are the assessment questions for each category. For each question, participants chose from Disagree, Somewhat Disagree, Don't Agree or Disagree, Somewhat Agree, Agree.

Leadership

This section assessed how ready the organisation was to give leaders the tools, training, metrics and methods essential to operationalising personalisation. Questions included the following:

- Our leaders are given training opportunities to learn how to be inclusive across the enterprise.
- It is someone's job (someone is accountable) to make sure leaders have the knowledge, skills and tools to make their departments more inclusive.
- Our organisation has performance metrics that help us measure how well we work together across functions and silos as an organisation.
- We have organisational processes for getting to know our populations as they change over time.
- We have organisational processes for applying what we learn (about our populations as they change over time) to how we deliver care.
- Our executive team is fully committed to forging external partnerships with other healthcare delivery organisations to improve how we lead and serve our diverse employees, patients and communities.
- I have access to data from across our enterprise that enables me to locate facts such as the total number of Hispanic doctors and nurses on staff, the total number of African-American researchers on staff and the total number of diverse suppliers in our network (or other totals related to particular demographic groups).
- We have methods in place for making sure our supplier network is diverse and for making sure that outcomes from our supplier network improve our ability to lead and serve our diverse employees, patients and communities.

Workforce

This section assessed how ready the organisation was to create inclusive cultures and teams (today and a pipeline for the future) in which all individuals can strengthen, showcase and harness their full capabilities. Questions included the following:

- To ensure a diverse workforce into the future (both clinical and nonclinical), we actively engage with a variety of groups representing the shifting (diverse) demographics of our service and catchment areas.

- Our talent acquisition strategy and outreach include multiple age groups — elementary, middle school, high school, colleges and universities.
- When we are hiring at any level, we understand that experience and education are not the only indicators of potential; we give at least equal weightage to individual capability, and we know how to identify individual capability.
- Our organisation feels like a place where anyone can harness their full capabilities, regardless of their background (ie culture, heritage, gender, etc).
- We have a way to measure how employees feel about the effect they can have on the organisation.
- One of our employee engagement indicators measures whether employees feel safe to be their whole selves at work, meaning that they do not have to hide aspects of themselves from leaders or co-workers.
- We have tools and resources for helping employees bridge silos and functions, to get cross-functional support to make better decisions and improve outcomes across the enterprise.
- We support employee resource groups that are voluntary social networks focused on celebrating differences.

Patient experience

This section assessed how ready the organisation was to build connection and trust with patients — with training, methods and processes that make connection and trust a proactive, measurable pursuit. Questions included the following:

- In addition to patient engagement surveys, patients and their families have ways to share their feedback and thoughts while care is being provided and about how they feel treated by us.
- We require physicians, nurses and caregivers to complete cultural competency training to best serve our diverse patient populations.
- We have processes in place to get to know patients as individuals and to make sure that knowledge is shared across the continuum of care.
- We have strategies for engaging with patients in a way that invites them to tell us their whole story — beyond how they are feeling that day.
- We have organisational processes to make sure our patients and their family members feel seen, heard and respected by us.
- We have organisational processes to help us understand and implement changes in the organisation around how our growing diverse patient populations' health is shaped by family, community and lifestyles.
- We have processes in place for addressing patient preferences that may affect cost of care in a way that does not diminish the experience for patients and their families.
- I can think of an example of when we learned something about how a particular population accesses care, and we have applied that lesson to the way we deliver care.

Preventive care

This section assessed how ready the organisation was to be proactive in getting to know people and their communities — and how those communities affect the health and wellness of individuals. Questions included the following:

- Our commitment to 'community benefit' goes beyond our legal obligations.
- We actively evaluate our community health needs assessment results to identify gaps that will help us continually improve strategies to best serve diverse populations.
- We have strategies, processes or partnerships in place to help us identify and resolve health disparities and inequities in our communities.

- We have one or more strategies in place right now to help us better understand the factors that influence the health and wellness choices made by a particular demographic we serve.
- We have active partnerships with civic, faith-based, non-profit or other community groups that are tackling disease prevention by addressing related factors like poverty, food insecurity, lack of public space and others.
- We know which aspects of health tend to vary by culture, gender or demographic.
- We offer our leaders and employees resources for learning about the health needs relevant to particular demographic groups.
- I can think of an example of when we learned something about how a particular population takes action to prevent disease (or does not take action), and we have applied that lesson to the way we promote prevention or deliver care.

Their initial overall scores were as follows:

Enterprise leadership:	45 per cent
Workforce:	54 per cent
Patient experience:	56 per cent
Preventive care:	69 per cent

The scale:

- 0–50.1 per cent = Unprepared
- 50.2–87.9 per cent = Average
- 88–100 per cent = Ready

After establishing this baseline, four working groups were formed around the four categories of audiences. Members of these groups met biweekly to discuss how they could advance the organisation in each category, using the five 'dignity' themes summarised previously as starting points for their conversations.

What follows is an overview of the questions they asked themselves, opportunities for interruption they uncovered and actions they took to pivot towards personalisation.

It is important to note that the results of the assessment, as well as the results discussed next, are not peer-reviewed research results. Instead, they are narrative overviews of the process this organisation undertook. While results are important, it is the process itself that can be useful for organisations because, as stated previously, there is no one-size-fits-all formula for personalisation. Other organisations may choose to ask themselves different questions.

Individuals have value: They want to be included

The organisation's participants asked themselves and their colleagues:

- Whom does the organisation, our teams or our industry have the hardest time including?
- If an employee or a patient has a need, is there a way for them to bring it forward?
- Are we proactively looking to remove barriers that are keeping employees or patients out of decision-making processes?

They determined that their organisation's leaders were not adept at seeking new or contrary voices when they were making decisions or trying to understand a problem. They did not let outsiders in, and official organisational hierarchy was prioritised. Their pivot was to unlearn the bad habit of negative judgement, which manifested as seeing the 'glass half full' in the people they did not engage with regularly.

They also acknowledged that they do not ask patients what matters to them. A new protocol was implemented, which required that caregivers ask patients for feedback about what matters to them.

Individuals are worthy: They want to be seen in their full humanity

The organisation's participants asked themselves to consider someone they conflicted with or who frustrates them:

- What assumptions are being made about this individual?
- How can you proactively plan for more conversations that expand your perspective about who people are?
- Does your leadership training stop at unconscious bias and/or cultural competency?

This exercise determined that the organisation tended to see people in narrowly defined ways and to make assumptions about who belonged where, doing what and how. The pivot was to start learning about their employees' life experiences and adversities, which helped them begin to see how people could contribute beyond their existing roles and responsibilities.

They discovered that their leadership training focused on making people compliant with the institution's needs rather than helping employees explore their own capacities. Leadership started offering training to help employees discover their full potential for the betterment of the individual's career goals, regardless of their long-term loyalty to the institution.

Individuals are unique: They want to be themselves

The organisation's participants asked themselves and their colleagues:

- Are there ways for people to share what they know whether they are directly asked?
- Are people free to connect with leaders in ways that differ from that leader's usual way of communicating?
- Are existing rules of conduct still relevant today? Do they serve a purpose and elevate trust?

The organisation discovered limitations in regard to how leaders viewed the people they led. Leaders wanted people to assimilate to fit into the corporate culture, which inhibited people from taking ownership of their work and results. The pivot was to nurture a culture that values authenticity over assimilation.

They also discovered that leaders did not update their perspectives about what people could contribute, even as those individuals evolved and grew in their careers. Leaders began to break down silos across departments to communicate, grow with people and evolve together more effectively. Through continuous learning and comprehensive listening, trust was elevated across the enterprise.

Individuals have experience and insight: They want to do more

The organisation's participants asked themselves and their colleagues:

- Does the organisation hold people to rigid industry or organisational standards that are no longer relevant?
- Is there a process in place to suggest a different project or path?
- Do people have to wait for assignments, or can they initiate on their own?

Organisation leaders realised they set the course for how employees were supposed to live the mission, rather than letting people live the mission in their own way. They learned that employees and caregivers felt that their ideas, recommendations and opinions were not being heard. The pivot was that leaders started giving employees the room and flexibility needed to ensure their own sense of belonging within the mission. Leaders began to conduct listening

tours to react and respond to assessments that identified time-sensitive gaps.

Individuals have ideas: They want to explore their possibility

The organisation's participants asked themselves and their colleagues:

- Are people held accountable to completing tasks in certain ways?
- Is there a strict process for improvement, or can people pursue growth in their own directions?
- Are there people outside the team's essential discipline they could be collaborating with?

The organisation discovered they were holding people accountable to outdated standards and providing rewards for the 'what', not the 'how'. Ways of working that limited an employee's capacity and fulfilment at work were incentivised, and leaders were dictating how employees and caregivers should do their work. The pivot was a process for evaluating the relevance of existing metrics and a renewed focus on developing high-performance teams. Leaders also began to identify ways to give people freedom within the frameworks, allowing them to experiment to help modernise old standards with the individual in mind.

Results

This operationalising personalisation process ran for one year, after which the organisation took the original assessment again. This time, their scores were as follows:

	New	Change from before
Enterprise leadership:	77 per cent	+32 percentage points
Workforce:	75 per cent	+21
Patient experience:	88 per cent	+32
Preventive care:	86 per cent	+17

The scale:

- 0–50.1 per cent = Unprepared
- 50.2–87.9 per cent = Average
- 88–100 per cent = Ready

CONCLUSION

To be well equipped for personalisation for any of these audiences does not mean personalisation has been achieved and the process is complete. It means there are tools and processes in place to make personalisation more likely.

Remember the definitions: *Personalisation* is seeing and treating people as individuals, whether those people are patients or staff. *Operationalising personalisation* is the act of adapting the way an organisation functions to make it more likely that people at all levels will build the skills and have the tools to see and treat people as individuals. The act of adapting is a continuous process.

A one-size-fits-all formula for operationalising personalisation does not exist; however, this case study serves as a guide for how the process can be implemented for continuous evaluation and evolution:

- *Assess:* Conduct an enterprise-wide review of policies, practices, programmes and behaviours that inhibit the ability to operationalise personalisation.
- *Interrupt:* Co-design practices and communications that enforce behaviour change and accountability.
- *Pivot:* Deploy solutions that reshape the environment and reinforce the organisation's commitment to operationalise personalisation.

Personalisation not only creates better experiences for patients but can also improve their health outcomes and reduce avoidable healthcare costs like readmissions. Likewise, personalisation not only creates better experiences for employees but can also

activate people to achieve at their highest levels of individual capacity.

Personalisation has the potential to dramatically improve what people experience when receiving health care, while fostering human-centred working environments for the employees who support and deliver individualised care. For healthcare providers that are being challenged on multiple fronts by chronic and seemingly unsolvable problems, these are two wins that are within reach.

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