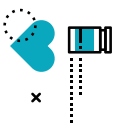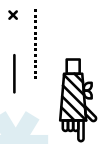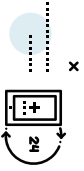# GLLG | LEADERSHIP IN THE AGE OF PERSONALIZATION®

HEALTHCARE IN THE AGE OF PERSONALIZATION℠

POSITION PAPER

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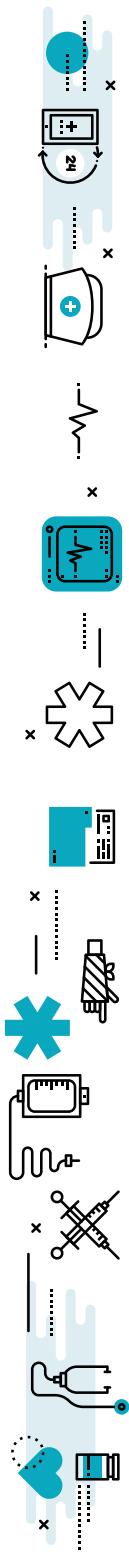
HEALTHCARE IN THE AGE OF PERSONALIZATION℠

POSITION PAPER

by Glenn Llopis
available at **Forbes**

1

HEALTHCARE IN THE AGE OF PERSONALIZATION

This is Part 1 of a six-part series on Healthcare in the Age of Personalization.

Several months back I published an in-depth series asserting that inclusion should be embraced as a growth strategy for enterprises across all industries. I went so far as to say that inclusion is a skill, one that needs to be learned, practiced and mastered by every leader starting with the CEO on down.

Inclusion is the most essential leadership skill today. Why? Because we have shifted from an age of standardization to an age of personalization. Those who master the skill of inclusion will be able to shift their engrained methods of standardization – many of which no longer apply and slow progress down – to methods of leadership in line with our new reality.

Today I'm kicking off a new series on healthcare in the age of personalization.

What do I mean by the age of personalization?

As a society, we are more diverse than ever, we are more informed than ever, we are aware of and proud of our individuality.

One person might be a Latina, an introvert, a Millennial, a morning person, a trained economist, a city-dweller, a high-potential employee. She might specialize in seeing the big picture and anticipating roadblocks, while someone else with the same credentials and title specializes in meticulously plotting the day-to-day path to a project's success.

Every single one of your employees and patients/consumers is a unique mix of strengths and expertise, and we are more aware than ever of our unique capacity to have influence and impact as individuals. We are no longer inclined to hide our identity or feel pressured to fit into the standardized version of mainstream. We are aware of and proud of our individuality. We want to influence our workplace and the marketplace in our own way.

But for the most part, the way leaders lead has not caught up to this new reality. I will be so bold as to say that more than 80% of leaders across industries have not.

In standardization, the business defines the individual. We're told what to do inside the box we're given. Progress toward the company mission is what matters and is measured. We protect our functions and work within our silos.

In the age of personalization, the individual defines the business. Our individual capacities should be elevated and activated, so we can influence the business. Progress toward individual impact and legacy should be what matters and is measured. We must value and seek interdependence across the enterprise.

What does this have to do with healthcare?

As an industry, healthcare has a head start in this era of personalization. Leaders have had to consider how to combine the efficiencies and quality of standardization (we all get the same flu shot) with the understanding that every person is different and health is affected by many factors:

- **On the clinical side** – advancements in genomics and precision medicine make personalized treatment and prevention possible, while the move toward value-based care shifts incentives toward finding a standardized way to provide personalized care.

- **On the non-clinical side** – for years healthcare leaders have been considering how people are affected by social determinants of health, things like access to housing, food and transportation. Within their own organizations, leaders grapple with how to create a diverse talent pipeline for both clinical and non-clinical roles.

As our population gets more and more diverse, keeping people healthy will increasingly depend on how well healthcare systems understand and address diverse populations. Yet, as noted above, diverse populations are not homogeneous – we are all individuals.

I've been researching how healthcare addresses this challenge for a few reasons. First, the stakes couldn't be higher for this industry – they deal in life and death and everything in between. Also, other industries can learn a lot from healthcare leaders who have been thinking about personalization

more than the rest of us.

In a conversation with Mark Laret, president and CEO of UCSF Health, I shared my thoughts on the importance of inclusion as a strategy for organizational growth, considering this new age of personalization. He responded by taking it even further: "Yes, I'll stipulate it [inclusion] as a growth strategy. Maybe this is going too far, but I'll say it's a survival strategy."

I don't think that's going too far at all. In fact, I agree completely.

For this series I interviewed 13 CEOs or other C-level executives from leading cancer centers around the country. I also interviewed eight chief HR officers from healthcare organizations. From these conversations I will publish a series of articles that dive into the following themes:

- Personalization and population health – how do they fit together?

- Health equity and social determinants of health

- Finance structures, payers, insurance – how does personalization impact the business model, and vice versa?

- Personalization in both treatment and prevention, and overcoming mistrust of the system

- HR, ensuring a talent pipeline, and creating an organizational culture of inclusion

- Methods and systems that organizations have put into place to move toward personalization, and what metrics we should be using to measure progress

Everyone I spoke with was enthusiastic about this topic and agreed that inclusion is crucial in this age of personalization.

Here's just one reason why, shared with me by Nancy Davidson, MD, executive director and president of Seattle Cancer Care Alliance:

"We know in cancer that outcomes are affected in part by differences. That different populations have different outcomes, and in some cases disparities can contribute to poor outcomes. And so we understand from the get-go that if we want to make an impact on the burden of cancer, we have to be able to do this across all populations. In healthcare, I think we've also come to realize that the best way to do that is with a diverse workforce, *a workforce that matches our patient population – because that's going to be the strategy that we can use to have the best possible connection with our patients. And I hope that's going to translate into the best possible outcomes for our patients."* You'll hear more from Nancy Davidson and Mark Laret throughout the series.

For me, even though this series will focus on the industry, this topic is bigger than just what these leading institutions can do. We also need to find a way to get individuals themselves to take ownership and become their own self advocates for care. We all must become more self-directed if we are going to make the healthcare system work for us and our communities. In our conversations, several leaders acknowledged the challenge of earning trust within communities of people who historically have not felt welcomed into the healthcare system – often for valid reasons (such is the legacy of the horrible and unethical Tuskegee syphilis experiment, among other examples).

Individuals are already forcing changes.

But here's why we can't just ignore these trends toward personalization or the tendency of some individuals to avoid seeking treatment or prevention. People's lives and health are at stake. And, of course, healthcare is a business. Organizations risk becoming irrelevant if they're not paying attention.

A recent survey from Accenture shows how personal preferences and health-related behaviors are changing.

Unsatisfied with healthcare's status quo, Millennial and Gen Z consumers in the United States are paving the way for non-traditional care models, such as retail clinics, virtual and digital services, according to results of an Accenture survey released at HIMSS19 in February.

Some of the changes (taken from the press release):

- Slightly more than half of Gen Zers and two-thirds of millennials said they have a primary care physician, compared with 84 percent of baby boomers.

- Without a primary care physician, some millennials are seeking some types of routine medical services from retail clinics (41 percent) and virtual care (39 percent).

- Nearly one-third of all respondents have used some form of virtual care — up from 21 percent in 2017 — and almost half have used a walk-in/retail clinic.

- Half of all respondents said they use a wearable or mobile app to manage their lifestyle and healthcare conditions.

- More than half use virtual nurses to monitor health conditions, medications and vital signs.

- Younger generations are more likely to choose medical providers with strong digital capabilities, such as those who provide mobile or online access to test results (44 percent of millennials vs. 29 percent of baby boomers), electronic prescription refills (42 percent vs. 30 percent), and booking, changing or cancelling appointments online (40 percent vs. 19 percent).

So how do you lead in this age of personalization?

If you have 18,000 employees and 30,000 patients, does that mean we need to have 18,000 and 30,000 different ways of treating them? Or maybe it's just 10 because we've actually taken the time to discover the like mindedness within people.

We continue to classify and categorize people – in other words, we try to standardize them. It's easier that way. It can be more efficient. I say "can be" because at a certain point that efficient standardization works against us – someone won't fit into the category we've defined. That outcome is more and more likely today because of personalization.

What does leadership in the age of personalization look like? How does the healthcare industry prepare for it? And what can the rest of us learn from healthcare along the way? This is what we will explore throughout this series. But we can make one claim that is certain. The future of healthcare and its ability to deliver value-based care, in a digitally transformed world, where operational and clinical care excellence is at a premium – demands leadership in the age of personalization.

2

IDENTIFYING THE REAL METRICS OF INCLUSION

Measuring diversity takes us further away from inclusion.

Unless we proactively interrupt that process.

That's why we need new metrics.

In the first article in this current series (Healthcare in the Age of Personalization), I introduced the age of personalization, how it's connected to inclusion, why it is significant for healthcare, and why healthcare in particular can help point the way for all industries to lead in the age of personalization.

This piece is the second half of the introduction to the series. In the articles that follow, I will share excerpts from my interviews with CEOs and other C-level executives at some of the most prestigious healthcare institutions in this country. They get it. They have big ideas about how to take on this wide-ranging challenge of meeting the needs of so many individuals. They also readily acknowledge the difficulties.

Healthcare understands the challenges of the age of personalization better than any industry.

Two massive shifts are happening in healthcare simultaneously: a shift from volume to value – making the industry more accountable for individual health outcomes; and a shift in demographics – a shift in the very populations of individuals whose health they're accountable for.

In the midst of those shifts, the industry has to improve patient experience and quality of care, reduce costs and re-admissions while keeping efficiency on individualized care and precision medicine, and move from a fee-for-service system to one based on value that rewards health outcomes rather than services rendered.

Whether or not the industry can accomplish these ambitious goals comes down to how well the industry serves individuals.

But first healthcare has to overcome the foundation that was laid throughout the age of standardization:

- Delivery of care was built around services, not the unique needs of the individual.

- An existing lack of diverse leadership, physicians and inclusive cultures, which continues to place the industry in a silo.

- Health systems that are unprepared to lead and serve populations as those populations become more diverse and their needs change.

Current investments in industry transformation are at risk if inclusion and individuality are ignored.

When I say healthcare can point the way in this age of personalization, I am not saying that the industry has figured out diversity – far from it. Modern Healthcare covered the industry's lack of diversity in the C-suite in this article a year ago: "Racism Still a Problem in Healthcare's C-Suite."

"Only 14% of hospital board members and 9% of CEOs are minorities, according to the most recent study by the American Hospital Association's Institute for Diversity and Health Equity—the same percentages as in 2013. Minorities represent 11% of executive leadership positions at hospitals, compared with 12% in 2013."

But here's the thing: if we focus on diversity we'll never reach inclusion.

Today, we are all feeling the tension and turmoil between the age of standardization and the age of personalization. Our workplaces, consumers and communities are multi-cultural, multi-generational, multi-gender, multi-skilled – we each have different needs, personalities, strengths, experiences and temperaments. Focusing on diversity and numbers makes people run away from the conversation because the people of diverse populations never really feel that they are influencing change, and people who are non-diverse feel like they are left out. Silos begin to perpetuate more than ever.

Diversity does not automatically lead to inclusion. Diversity gets more attention because there's a formula – numbers to meet. Inclusion is not as easy to define, let alone measure and track.

Inclusion is active: It's a system for making sure the organization is welcoming at every level to every individual. An environment that is inclusive can be safe for people to be and celebrate their individuality. An environment that enables and celebrates individuality can lead to inclusion.

But neither guarantees the other.

In non-healthcare, the discussions around diversity and inclusion have created this whirlwind of hires for diverse people. This creates a feeling for the diverse hires that they represent the "diversity tax." I'm just here to fill a quota so the company can say it's diverse. And that's how people will feel in healthcare if we try to duplicate the efforts that have taken place in the non-healthcare industries.

That will backfire. Diverse job candidates won't trust that the industry really wants them, at a time when the industry desperately needs them. And diverse patients won't believe that health system outreach toward them is authentic.

Be Careful to Choose the Right Metrics to Measure – It Matters

Above, I referenced a Modern Healthcare article about the lack of diversity in the C-suite. What were your thoughts when you read that headline? Did you think about your own C-suite? Did the word "racism" trigger a reaction in you? Did you question the value of C-suite diversity as a metric with meaning?

I am not saying there's a right answer to any of those questions. But I want you to notice your own reactions – and to notice the power of putting forth a metric, and the risk of reacting to a metric for the sake of perception or reputation or compliance.

This happens in all industries. I had a conversation recently with the dean of a law school who told me that schools are at the mercy of *U.S. News and World Report* and their annual university rankings (which cover a range of subjects, not just diversity). She said the criteria used for ranking universities is so outdated it makes it almost impossible for a university to reinvent itself, because the perception of their brand is being controlled by a metric that makes it difficult for them to evolve.

A university could challenge the criteria or ignore the rankings, but that would be a risk. Public perception is tied to the rankings, so the school's reputation would take a hit, possibly affecting the school's draw as a top institution for academics and research. The onus is on the school to defend and explain why the metrics of the ranking shouldn't matter and why their own metrics do matter.

Solve for diversity and inclusion by creating standards for personalization

It's not that we don't need standards. Of course, we do. But if we're not thoughtful about which standards get entrenched and why, then we are bound to standards that are not accomplishing what we set out to accomplish in the first place. The standards themselves get in the way of progress.

Healthcare is in prime position to adopt systems and methods that enable inclusion that honors our new age of personalization. The key is to create systems and methods that make inclusion the de facto reality throughout an enterprise. Ask yourself:

- Does our organization have performance metrics that help us measure how well we work together across functions and silos as an organization?
- When we're hiring at any level, do we understand that experience and education are not the only indicators of potential – do we give at least equal weight to individual capability, and do we know how to identify individual capability?
- Do 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 (as appropriate, while maintaining patient confidentiality)?
- Do we have processes in place to get to know employees as individuals – so we can activate individual capacity to influence the business?

(See previous articles for a more detailed discussion of inclusion metrics related to leadership, workforce, patient/customer experience, and population health.)

A personalization model is something that the healthcare industry understands

That doesn't mean the industry has mastered it. But there's already a narrative out there around patient-centricity and precision medicine. There is an understanding that there's no one-size-fits-all about how we serve patient populations.

The stakes are high in healthcare. We can't afford to let the industry get sidetracked by metrics and false competitions that don't lead to real inclusion.

I don't just mean that being inclusive helps healthcare organizations better serve their diverse populations of patients – though that is true and it is important. I mean the organizations themselves cannot thrive, grow or even survive as business entities without inclusion.
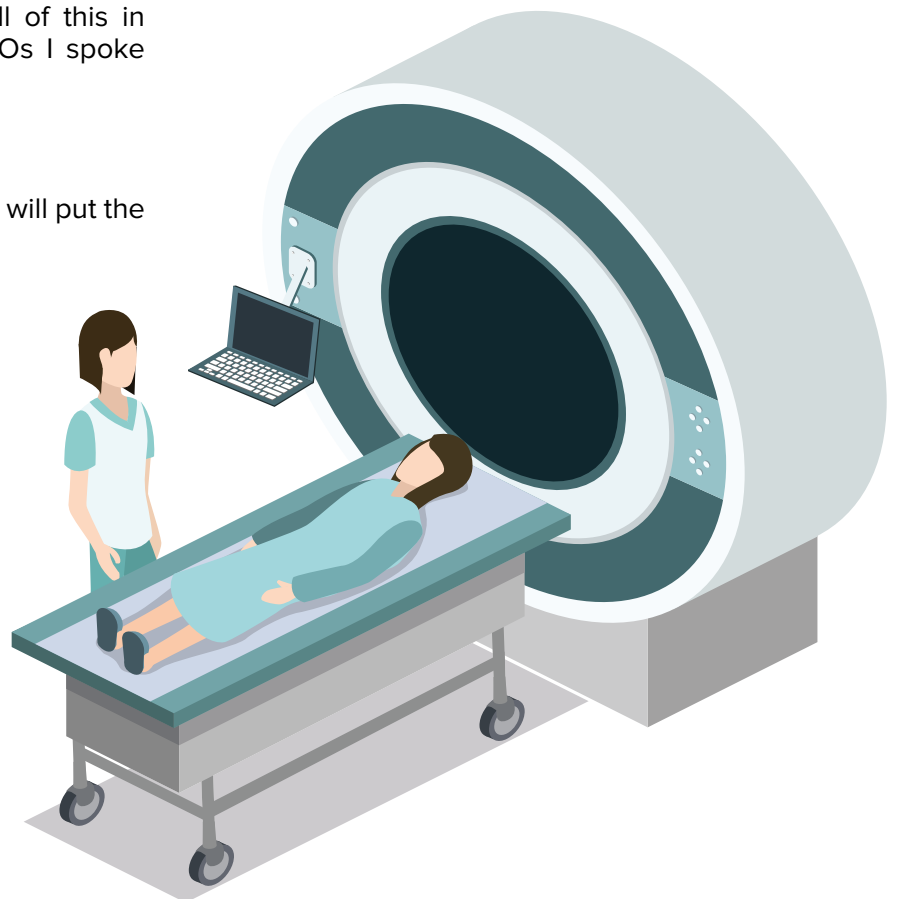
Our nation's demographics are changing. By 2043, we will be a majority-minority nation. At its highest calling, the healthcare industry is responsible for the health of all people – population health, encompassing communities as a whole; and individual health, treating and preventing disease person by person. If any given health system is not ready to serve these changing populations, that institution loses its ability to meet its goals related to prevention, care, research, talent acquisition, digital transformation and innovation.

Personalization is the lens and inclusion is the strategy for all of that. Inclusion is a strategy for growth, it's not a cost center. It doesn't belong as an initiative buried within HR. It belongs in the office of corporate strategy. Take the following assessment to learn why.

Throughout this series I'll explore all of this in more detail with the help of the CEOs I spoke with.

Don't miss the opportunity.

Don't default to the old standards that will put the industry in jeopardy.

3
HOW BUSINESS MODELS MUST
EVOLVE

This is Part 3 of a six-part series on Healthcare in the Age of Personalization.

Healthcare seems to be in a constant state of transition, as organizations move from fee-for-service to value-based business models.

But if we're not simultaneously considering how health systems will need to operate in the age of personalization, changes made today might not be relevant a few years from now.

In the first article in this current series (Healthcare in the Age of Personalization), I introduced the age of personalization, how it's connected to inclusion, why it is significant for healthcare, and why healthcare in particular can help point the way for all industries to lead in the age of personalization. In the second article (Identifying the Real Metrics of Inclusion) I discussed the need for new metrics to measure for inclusion rather than diversity – and why healthcare is in prime position to adopt systems and methods that enable inclusion that honors our new age of personalization.

When you think about getting a healthcare system ready for personalization, that process likely affects nearly every aspect of the business. In this article I will explore three of the big topics – reimbursements, leadership and the dual roles of healthcare as a public good and as a business.

- **Part 1: Reimbursements** – How to rethink the way treatments are bundled and priced in order to account for personalization in insurance reimbursements.

- **Part 2: Leadership** – How to bring top technical expertise into healthcare (hint: sometimes you have to think outside of healthcare).

- **Part 3: Public good or business?** – How to reconcile the tension between the moral imperative to care for people and community and the pressure to reduce costs.

The leaders I interviewed were open and enthusiastic in our conversations. I will structure this similar to a Q&A style, in order to give you more of them and less of me.

Part 1: Reimbursements

I discussed these trends with Dr. Alan List, president and CEO of Moffitt Cancer Center in Florida. I introduced the topic by sharing my observation that the healthcare industry was not designed to handle mass variance. I would say that about any industry – that the amount of variance (some would call it diversity, or differences) has changed the dynamics of how organizations deliver care, how they recruit and retain employees, how they recruit and retain physicians and caregivers.

Dr. List described it as a retail-ization – saying, "Individuals want quality as well as price to create the value" – and pointed out the complications this variation and retail-ization raises for the insurance industry.

Dr. Alan List:

When [insurers] are forecasting their budget for the next year, variability means there's no control over it. They would love to have situations where they know the expectations for treatment of X disease will cost this amount, there will be limited variation, everyone will be doing it the same way.

Glenn Llopis:

For me, that brings up the question of value-based care. Where do you see value-based care models today and in the future, given this mass variation that's been caused by this cultural demographic shift in our country?

Dr. List:

Certainly value-based care is something that [Moffitt has] been leading in nationally, in the oncology space. We do one thing – cancer research and cancer care – and at least on the care delivery outside of clinical trials, we wanted to be at the table with the insurers when all of this began. The movement toward a different payment model and this value-based care model means that the value is really all about cost and quality.

We've been experiencing decreasing reimbursements, but what we wanted to do is be at the table with the insurer to create these new models – to make sure we're doing the right thing for the patient, and that we can do the right thing for the patient in the future. Where we started was clinical pathways. Everyone's familiar with treatment guidelines – the National Cancer Center network has guidelines for cancer, and you can pick a chemotherapy regimen out of five.

That's not a pathway. What we've done is created

56 pathways for cancer care and individual cancers. That starts with the diagnostic workup or prevention, whether it's chemotherapy, radiation, how often do you do a PET scan, when you need a PET scan, when you don't, and all the elements of care and charges, and what you do at relapse. We select the treatments based upon toxicity and cost and efficacy. All three things are considered all the way up to hospice at the end.

That is what brought insurers to the table, because that limited variation and expectations of costs. You would know from the beginning what it is going to cost, because this is exactly what we're going to do and we're not going to have excessive billing because we're an institution following a pathway and not individual charging. That brought them to the table. We've been able to create models such as bundles.

Llopis:

Does that actually save money?

Dr. List:

I had a conversation with one of the largest insurers in the country and that conversation started with, them saying: "Listen, I can give chemotherapy cheaper in the community at a private doctor's office where there's no facility charge from the hospital." And I said, "Yeah, you could do that, but you're missing the big picture."

We're not just chemotherapy for lung cancer (we were talking specifically about lung cancer). We have all aspects of care and, because the individuals are not profiting from this, we have better outcomes at a better value. And he said, "Prove it."

> " **I find this refreshing in an industry that can often feel insular and separate from other industries in terms of hiring and recruiting. We need to break free from that and recognize the value of having people with different perspectives.**
>
> *- Glenn Llopis,*
> President and CEO
> GLLG

So, we gathered data for several thousand lung cancer patients we had treated over a sever-

al-year period. He compared us to others around the country and he said, "You're right. You have better outcomes and you're cheaper." We were in the middle to the lower end of the pack. They wanted to do a bundle.

That began bundling in lung cancer with this insurer. But we've done all types of payment models, and right now about 25% of our payment comes from these new payment models that we're testing.

Llopis:

To me this seems like a great example of standardizing personalization. There are still standards, as there should be. But those standards can be broadened to accompany more individuality — in this case, from five chemotherapy regimens to 56 different pathways for care.

Part 2: Leadership

Another business model consideration includes the decisions an organization makes that prepare it for the capabilities and technologies needed today and anticipated for the future. A big part of that is how an organization chooses to staff its executive and leadership teams. Strategic, inclusive hiring can help.

The age of personalization requires new capabilities that cross all domains, but technology is probably one of the more prominent capabilities needed, given that much of personalization is driven by advancements in digital capabilities and artificial intelligence.

Providence St. Joseph Health (with locations in states throughout the West and Southwest) is deliberately choosing to recruit leaders with backgrounds outside of healthcare. This is another valuable form of diversity — tapping the expertise and insight of people who bring completely different perspectives and experiences to the table. Read this previous article for more on the value of this approach.

I spoke with president and CEO Dr. Rod Hochman about the Cultural Demographic Shift and how Providence is disrupting its own company in order to prepare for the age of personalization.

Dr. Rod Hochman:

The concept of personalization and standardization is a good one. Every individual is different. And what we're looking at is, how do you care for each of those individuals based on who they are?

This is an age of consumerism where individuals have a lot of information at their own hands and we absolutely support that. And we're in a process of digitizing a lot of what we do in healthcare so that individuals can get their care where they want it, when they want it, and how they want it, whether it's on their iPhone, their iPad, sitting in a traditional office or getting care at home.

Llopis:

Providence seems to be comfortable with hiring from outside the industry, recognizing the need for different minds that can help strengthen the foundation that has been built over time. That can be a key strategic advantage.

Dr. Hochman:

We've been hiring from places like Amazon and Microsoft and T-Mobile, to get their take on the diversity of Millennials but also [to get their insight on] how to take care of people individually as consumers and understand what their needs are.

Five years ago we hired our chief digital officer from Amazon, to put together our digital approach to the individual and to understand what the different groups want in terms of how they receive their care. We've developed a whole group of care sites called Express Care so that they can get their care when [they want]. Beyond Express Care, we have a pretty extensive program that includes applications on their iPhones that are suited to their particular care needs.

Llopis:

When did you realize that hiring from other industries would be a good strategy? And how receptive was the organization?

Dr. Hochman:

We started this well over five years ago thinking this is the only way you can help transform an industry that's in the midst of very dramatic change, particularly with the digital revolution. We were going to need new people to help us do that.

The combination of [those outside healthcare] with the people that have been in healthcare for a while is the secret to our success.

Our chief financial officer is from Microsoft and was never in healthcare in his life, and he has been a superstar for us. As I mentioned, our chief digital officer came from Amazon, and our chief marketing officer came from T-Mobile.

Llopis:

Is it just about bringing in people from technology? Or are there other ways to bring in new thinking?

Dr. Hochman:

We've also done that [on the clinical side]. Our chief clinical officer was the head of quality for Kaiser, which is a different care model than what we're used to. Our president of population health was the chief medical officer at United Healthcare.

So we have definitely disrupted ourselves with people who can give us different points of view. I think it's made a stronger, more competitive organization as we look forward.

To survive, you really need to transform. And the way to transform is with people who afford you new viewpoints about where the world is. If you ask us the one thing that's most successful in our strategy over the last five years, it would definitely be exactly this topic.

Llopis:

I find this refreshing in an industry that can often feel insular and separate from other industries in terms of hiring and recruiting. We need to break free from that and recognize the value of having people with different perspectives.

Part 3: Public Good or Business?

I spoke with Mark Laret, president and CEO of UCSF Health in San Francisco, about the age of personalization, and he immediately expanded the conversation to include health equity.

This subject of health equity will overlap with a few of the articles in this series, because I agree with Mr. Laret that it needs to be front and center when we talk about population health, individual health, and how to pay for what's needed to ensure both. It's also a good way to introduce some of the tension around healthcare as a business and healthcare as a public good.

Mark Laret:

When we talk about diversity and inclusion, we also include the very close sibling health equity, because in a way that is almost the overlay of the

moral imperative that drives the focus on diversity and inclusion.

I think that this is right at the nexus of the interface of where is healthcare a public good and where is it a business? My argument has been that those of us in healthcare have an obligation to think about the health and wellbeing of the whole community because it helps the whole community if those who are well-off and those who are not well-off are cared for better. It becomes a moral imperative.

Llopis:

What are the challenges?

Mr. Laret:

Part of the challenge in healthcare is that the business model at large has encouraged organizations to optimize their performance, and the public companies in healthcare have as their primary obligation to return shareholder value.

The structure of the U.S. healthcare system, which is generally built on a market model, pushes for revenue optimization and business optimization – which pushes [organizations] to look to the better-off socioeconomic groups, regardless of ethnicity or anything else, and put their focus there at the exclusion of those who are less well-off. And, of course, there's a strong link between those who are less well-off and those of any minority status – those of color, sexual orientation, disability, mental illness, homelessness, exposure to violence – all those things put people in that camp.

In general, personalization and customization involve more costs than standardization. If there's one-size-fits-all, everybody gets the size and you don't have to worry about inventory or anything else.

In this country we have really struggled with healthcare costs. As we look at personalized medicine and the huge breakthroughs that are being made in cancer treatment, with genetically modified treatments to meet the needs of an individual – there are costs associated with that. I personally think this is going to be a great discussion topic [for society], and I have a strong bias that we need to at least make a minimum amount of personalized medicine available to everyone as a core operating premise of how our healthcare system could work.

Llopis:

To address your point about those who are not well-off – what I see is that many institutions view those who are struggling from a socioeconomic perspective as a cost center. When, in reality, whether we like it or not, those are the customers and the patients of the future. There has to be a solution. It's through the research that we do with these populations that will get us to better serve and understand everyone even better.

Mr. Laret:

When you talk about personalization versus standardization, this is a tension that we have all the time, because we're under constant pressure to improve the value proposition and particularly reduce costs. There's always this pressure for more standardization, which has the potential to reduce the personalization or the individual contribution. So what we end up trying to do is have individuals contribute creatively to how they can improve our value proposition. It is a tension inside the organization at all times.

I think part of the challenge in healthcare is that we're right at the interface of the weak social infrastructure that we have in this country. In our emergency department, we have homeless patients coming in, and they get treated, and they need to have some certain follow-up care, they go back down to Golden Gate Park and they're back in our emergency room at enormous costs in three days or three weeks, and that cycle continues. We spend a fortune on that.

Whereas if we were able to or had the mindset to invest more in the social infrastructure, we can take care of these patients in more of a longitudinal way, probably at much lower costs. I think when you start talking about these issues you rapidly move out of healthcare and into all the adjacent areas that we see, where there's work to be done and services that are needed.

Llopis:

How is cultural diversity being incorporated into your value-based care model, and how is it connected to the core of advancing your entire enterprise strategy?

Mr. Laret:

How we think about diversity at UCSF is largely driven by San Francisco itself. Just coming to San Francisco was an eye-opener for me, and seeing how we as a city and UCSF as an institution embraced diversity. In fact, the guy who hired me, Mike Bishop, won the Nobel prize in medicine for his work with Harold Varmus on understanding

how normal cells can become cancerous. And Mike Bishop said the reason he won the Nobel prize was because of the diversity in San Francisco and at UCSF.

What he recognized early on and has been documented in many other settings, as you know, is that diverse environments spawn creativity.

We welcome everyone, regardless of race, ethnicity, sexual orientation, religious beliefs. Whatever you do, come here and contribute. We create an environment that's welcoming to you. I'm saying that's our goal, we don't always achieve it. We've got plenty of work to do.

[If we can make you feel] safe in San Francisco and at UCSF, we are the beneficiaries of that.

Llopis

These insights from Dr. List, Dr. Hochman and Mr. Laret bring me once again to the assertion that inclusion is one of the most powerful growth strategies for organizations in any industry in this age of personalization. We can and must shape our business models to enable inclusion and to proactively seek it out.

Disrupting our own organizations to prepare for the age of personalization is not a cost. It's an investment. It's the last remaining true growth opportunities.

4 WHERE DOES IT FIT WITH POPULATION HEALTH?

As our population gets more and more diverse, keeping people healthy will increasingly depend on how well healthcare systems understand and address diverse populations. Yet, as noted in my first article in this series, diverse populations are not homogeneous – we are all individuals.

In that opening article, I introduced the age of personalization, how it's connected to inclusion, why it is significant for healthcare, and why healthcare in particular can help point the way for all industries to lead in the age of personalization. In the articles that followed, I discussed the real metrics of inclusion and how business models must evolve.

At its highest calling, the healthcare industry is responsible for the health of all people:

• Population health, encompassing communities as a whole.

• Individual health, treating and preventing disease person by person.

In this article I will explore where population and personalization intersect. How does a health system prepare for both – with systems for understanding and treating various patient populations, and also with systems that empower the organization to understand and treat individuals?

We have to do both. I would go so far as to say we can't do one without the other. We can standardize for the population while also personalizing for the individual.

Here's why it's important. Our nation's demographics are changing. By 2043, we will be a majority-minority nation. According to the National Institutes of Health (NIH), diverse populations are more likely than non-diverse to suffer chronic disease and premature death.

But it's more complex than that. The data suggests a nuance that can't be explained simply by putting people in boxes without taking into account their individuality. For example, according to the NIH, Hispanic immigrants have better health outcomes than whites – an advantage that diminishes with time spent in the United States.

Also, according to the NIH, within the Hispanic ethnic group there is variation in health outcomes based on country of origin.

Childhood trauma also plays a role, and that's something that transcends all diversity boxes. Watch this TED Talk to hear pediatrician Dr. Nadine Burke Harris (appointed to the brand new post of surgeon general for the state of California) explain how childhood stressors like abuse, neglect and high levels of trauma affect brain development and multiply the risk of heart disease and cancer later in life.

Our broad population descriptors – Hispanic, African-American, Asian-Pacific Islanders, Caucasian – certainly offer insights into our health that must be considered and planned for, but they only take us so far.

Chronic diseases are the leading causes of death and disability in America, and they are also a leading driver of healthcare costs. It's critical that we understand what's going on at the population level and also at the individual level. The dominoes start to topple fast if we don't find ways to make healthcare inclusive to all individuals.

The key to building a culture of inclusion in the age of personalization is making sure healthcare organizations have systems and methods that make inclusion the de facto reality throughout an enterprise. Once again, the leaders I spoke with are passionate about the topic and realistic about the challenges.

Homelessness 'is the challenge of our time.'

An important factor in determining whether a healthcare organization is ready for the age of personalization with a structure designed for inclusion, is whether or not the organization has strategies, processes or partnerships in place to help it identify and resolve health disparities and inequities in their communities.

Mark Laret, president and CEO of UCSF Health in San Francisco, discussed the topic of health equity in the last article. Here he expands on that.

"When we talk about diversity and inclusion, we also include the very close sibling health equity," said Laret. "Today as I was driving, I saw a homeless camp bigger than anything I had ever seen. This is the challenge of our time. We run UCSF Health, and a part of UCSF Health is the Benioff Children's hospital in Oakland. It's a safety net hospital for the poor-support kids. We're taking

care of homeless kids."

Laret is the one who pointed me to Dr. Burke Harris and her work helping people understand the health effects of adverse childhood experiences (ACE).

As Laret put it: "So when you think about homeless kids, or any kids who have experienced these adverse childhood events like witnessing domestic violence at home, abuse from parents, witnessed very dramatic violence, murders and shootings and so forth – each one of these events takes a huge toll. This is why I feel this so passionately. I see these kids and they've got health issues, but the health issues in some ways are the dependent variable, and the causes are all these other issues."

This discussion is well-timed. The Robert Wood Johnson Foundation's 2019 County Health Rankings found a correlation between housing cost burden and health: counties where a higher percentage of households struggle with housing costs also show higher rates of food insecurity, more child poverty, and more people in fair or poor health.

"The goal in the end is not to be the hospital with the biggest balance sheet or the strongest bottom line or the highest ranking or any of that," said Laret. "It's our job to be the leaders in making sure that everyone in our community is being cared for and that we're addressing this issue of health equity. Equity not only for people of color, but for the whole diversity of individuals – the personalization that you talk about. But especially helping those who are homeless or have mental illness or other [challenges]. If we do that, then we can solve big problems."

Laret thinks big, and I like that.

> " **As medical innovations advance beyond what we ever could have imagined,** if we're not getting those advancements to the people who need them – as more of our population needs them even more – we risk being the most medically innovative yet unhealthy nation in history.
>
> *- Glenn Llopis,*
> President and CEO
> GLLG

"Not to over-state it, but I've often thought and said that if you took a few of the major healthcare enterprises in California, you could put us all together and we could take on the healthcare issues of rural California – and we could do a much better job of caring for all California, if that were our charge," said Laret. "Our business model and the incentive structure is still a competitive model, and as such we end up optimizing our individual performance and we leave many others by the side who really need help. So I'm hoping that over time we start to have a higher consciousness about what our responsibility is to our fellow humans on this ride here with us, and how we can do a better job if we act collectively to help them."

Laret references a topic I talk about a lot. By helping the populations that are more vulnerable, we help everyone.

Not just in the holistic sense: if you're healthier, I'm healthier. But also in a systemic sense: the process of thinking through how to welcome a particular subset of individuals into the organization (as employees, patients or customers) is a process that will serve you well no matter whom you are trying to welcome. The strategies can be different from each other. But the systemic way of thinking through the process is what can be replicated – standardized, even.

That's why I continue to say this every chance I get: building the skill of inclusion among leaders and throughout an enterprise is not a cost. It's an investment. Inclusion is one of the last remaining true growth opportunities.

Not just IN the community, but OF the community.

Lloyd Dean, formerly president and CEO of Dignity Health and now CEO of CommonSpirit Health, is another passionate, community-minded pursuer of health equity.

"We know there's a connection between social inequities and health inequities; that is indisputable," said Dean. "So this issue [that you have raised] of looking at the holistic person is something that I think is absolutely critical for us to be able to effectively serve communities, to engage with patients, and to be able to attract and retain a diverse and dynamic workforce."

I like that Dean tied workforce into the discussion of population health. The issue of workforce inclusion is such a critical one, and the way Dean described it shows how all of these subjects overlap in so many ways – physical health and eco-

nomic health, individual health and population heath, family health and community health.

"Unfortunately in our journey in this country, minorities have not been at the forefront of our clinical diversity and our abilities to segment out within the communities," said Dean. "And because of the lack of resources and investments in the communities and the whole dynamic around equality in employment, our families became the primary caregiver."

This is something I see in my organization's research and have experienced in my life, and I shared this example with Dean. I'm of Hispanic descent, my parents are Cuban. When I was born my father was 50 years old. We lost my dad about six years ago, and I learned a lot while tending to him as he was battling Alzheimer's. A lot of people don't know that diverse populations are often the primary caregivers for family members. In fact, we're the largest non-paid caregiver community in the United States.

It's so common, in fact, that Dean had his own similar story: "My father had a tragic accident and my mother took on the responsibility and the accountability once he was discharged from the hospital. And the option was to put him in a home, but culturally, in African-American communities and many diverse communities, it is the family that steps up. And this was just an unbelievable burden that was put on my mother, but it was culturally embedded and there was not consideration to put my father in a home. And she ended up taking care of my father 24 hours a day."

This brings me to another one of the questions I ask when assessing an organization's readiness for inclusion in the age of personalization: do you have strategies in place to help better understand the factors that influence the health and wellness choices made by a particular demographic you serve? That is a starting point for helping people take the next step of asking patients questions about their individual lives and habits when it comes to health. If we assume that someone will seek care in the same way that we do, we may miss an opportunity to deliver care in a way that would actually be received.

As Dean put it: "We don't look at it that we are hiring employees, we are hiring people. We don't look at it that we are treating patients, we are treating people. And in order to do that effectively, we know that people will listen to, people will connect with, people will relate to people who understand them culturally, who understand their language, who are familiar with the environment."

According to Dean, patients are moving from the hospitals to other access points in the communities to seek care. So it's important to him and the organization to be able to make those referrals and to integrate with and tap into the services of the community. When he was CEO of Dignity Health they established a community grant program, "because we don't want to just be in a community, we have to be OF the community. We're proud of the fact that we focus on partnerships with others in the community."

That's exactly why another factor when assessing an organization's readiness for the age of personalization is this: Do you 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?

Dean gave an example that echoes the priorities mentioned by UCSF's Laret: "What's one of the biggest challenges for minorities and for those who are financially challenged in the communities that we serve? Affordable housing. So that's why we are fully engaged and make large contributions and work with others on housing. My philosophy: it is impossible long-term to be healthy if one does not have a home."

"We cannot fulfill our mission to deliver equitable, fair, quality care to those that we serve and all of the communities that we serve if we don't have a diverse workforce, if we don't have an inclusive leadership team, and if our employees don't feel that they're connected in the community," said Dean. "This is a part of my soul because I grew up, like yourself, in communities that didn't have any health services. I come from a large family and we just didn't have access to care. So I know what it can do to a community. I know what it can do to a family. I know how it can shorten lives. And we can do better than this in this country, that's for sure."

Learning about populations, then applying and sharing that knowledge.

One way to engage populations is to create a space where people can interact, share, learn, ask questions — where people can connect with experts and with each other. An online community like Healthy Hispanic Living is one example.

Another way is for health organizations to be de-

liberate about how they work with populations of people in their catchment areas.

> ## We are working with tribal leaders and tribal members, to think about the best way to advance this program

- Nancy Davidson, MD,
President and Executive Director
Seattle Cancer Care Alliance

To assess a health system's readiness for inclusion, I ask questions to see if there are systems in place to make sure people within the organization know which aspects of health tend to vary by culture, gender or demographic. But I go further than that, because knowledge itself is not enough. We have to have systems for applying that knowledge and for sharing that knowledge throughout the enterprise. Otherwise it just gets stuck in a silo and probably forgotten.

One of the questions I ask is: can you think of an example of when you (or someone within the organization) learned something about how a particular population takes action to prevent disease (or doesn't take action), and then applied that lesson to the way you promote prevention or deliver care?

I spoke with Nancy Davidson, MD, executive director and president of Seattle Cancer Care Alliance. She agreed that inclusion in this age of personalization is not only good for the business model, but it's the right thing to do for patients.

"Cancer affects one out of two men and one out of three women in this country," said Dr. Davidson. "It is a pervasive problem, and in some ways it's only going to get worse because, of course, one of the most important risk factors for cancer is aging. And you and I know that we are facing a maturing population in the United States and around the world, and so this is something that we take very seriously. This is our job to provide the best possible care for individuals with cancer and hopefully to provide the best possible screening and prevention to minimize the burden of cancer."

She said in the Puget Sound and in the state of Washington they serve a diverse population that includes people who are Hispanic, Alaska natives, American Indian, African-American, Asian and Caucasian.

"We're focused on what it takes to provide the appropriate care for those individuals, both from a cultural perspective and also because cancers vary between those populations," said Dr. Davidson. "We want to make sure that we understand the individuals we're working with, the illnesses that might affect them, and the way that we can try to effect the best possible care for them."

For example, she said that individuals who are American Indian don't necessarily enjoy the best possible outcomes from cancer treatment, so her team is focused on that. Seattle Cancer Care Alliance had the opportunity to partner with the Snoqualmie tribe.

"They are concerned about the health of their tribal members and members of other tribes across the state as well," said Dr. Davidson. "And they focused on what is a huge scourge for anybody who's interested in healthcare, and that's the burden that tobacco places on human health. They have partnered with us and provided an unrestricted gift to allow us to really focus on their tribal population and on the way that we can try to advance tobacco cessation policies for their tribal members, and also to try to facilitate lung cancer early detection."

She said what they're learning helps them serve other populations as well.

"So I look at that as a really fantastic partnership between a group in our region who have looked at a problem that they think affects their population and actually probably affects all of our native American populations in this area," said Dr. Davidson. "They have thought about how they can partner with us as a top flight cancer center to enable appropriate medical interventions for their population, and that's going to be good for everybody everywhere. Anything we learn about how to help people quit smoking in any cultural manner is going to be incredibly important, not only for cancer — but remember that tobacco is the primary risk factor for cardiovascular disease, for pulmonary disease, for so many things."

Not only are they learning how to better serve specific individuals, but they are also making that knowledge accessible in order to better serve all individuals. I have found that to be one of the biggest benefits of inclusion — the benefits translate to all of us.

And, once again, clinical inclusion, community inclusion and workplace inclusion overlap — as she said they are looking to hire a member of the tribe.

"We are working with tribal leaders and tribal members, to think about the best way to advance

this program," she said, "and, as part of this, we're actually hoping to be able to hire a member of their tribe who's trained and interested to be able to serve as a navigator between the tribal population and our health system and the cancer center."

For more examples of this kind of inclusion, I turned to Keck Medicine of USC, which serves a wide diversity of populations throughout Southern California and even extending into Central California.

According to Tom Jackiewicz, CEO of [Keck Medicine of USC](#), staying abreast of the changing demographics in Los Angeles certainly is part of the organization's growth strategy. He said they adjust services and programs to reflect the shifts in Los Angeles and among the diverse patient population.

"Our recent ambulatory location expansions illustrate how we tailor services for certain demographic pockets and offer services in their native language," said Jackiewicz. "For example, we have an oncology practice in Koreatown with primarily Korean speaking patients, staffed with Korean oncologists that are bilingual and bicultural. Los Angeles has the largest Korean population outside of the Korean peninsula and many utilize our hospitals and Korean cancer service, which is unique in the nation. Additionally, our Arcadia location in the San Gabriel Valley draws from a heavily populated Chinese community and thus our staff and physicians providing care are fluent in Mandarin and Cantonese."

In addition to formal cultural sensitivity training for staff, he said they try to provide the most thoughtful interactions for patients on all levels.

"Some of our patients from our Koreatown location had to undergo treatments [in a different neighborhood] at our main USC Norris Comprehensive Cancer Center due to renovations," he said. "Our patient experience department provided bus transportation to/from with Korean television programming to make these patients feel at ease."

Keck Medicine of USC also considers the diversity and differences among rural and urban populations.

"We are the number one transfer hospital in Southern California for tertiary and quaternary care," said Jackiewicz. "We have affiliations and processes in place with community hospitals and primary care providers in far-reaching locations in Kern, Inyo and Tulare Counties to increase access and ensure those transfers and referrals are handled in a coordinated and seamless manner."

'We live this job, we don't do this job.'

Many hospitals or health systems have programs and initiatives specifically designated for Community Benefit. I put that in capital letters because it's an official requirement for non-profit hospitals or health systems. They are offered tax exemptions on the basis that they provide a benefit to the community.

But in an age of personalization, a commitment to Community Benefit must go beyond the organization's legal obligations. In fact, it should be so embedded in the ethos of an organization that it becomes a lowercase "of course we do this" activity.

[Cleveland Clinic](#) CEO Dr. Tom Mihaljevic lives this principle: "Our motto in everything that we do is pretty simple. We approach every issue in contemporary healthcare from a simple standpoint, and that is that we treat our patients and our caregivers as our family, and our organization as our home."

He also said they know that the answers to the questions about how to appropriately serve our patients cannot just come from caregivers. "Those answers have to come from the steady and continuous conversation with our communities and the patients we serve," he said.

But I wondered – how do you infuse this attitude throughout the organizational culture, to such a degree that you can replicate that culture in locations around the world? Cleveland Clinic is based in the United States but also has locations in three other countries. Dr. Mihaljevic previously served as CEO of Cleveland Clinic Abu Dhabi.

"You know, we live this job, we don't do this job," he said. "So, this is nothing less than a true calling for us. We hire people who share the same sentiment. Then, we put a lot of effort into teaching the culture. We're teaching about our values. We're teaching about the way that we solve conflict. We're sharing with them how decisions are being made in the organization. That is a process that takes a long time. In Abu Dhabi, where we have people from all over the world, we spend almost an entire week speaking only about [this organizational] culture, so that people who come from all over the world, who never set foot in Cleveland, Ohio, can begin to understand what Cleveland Clinic is all about."

Another aspect of the organization's culture that makes Cleveland Clinic stand apart, according to Dr. Mihaljevic, is the salary model. He explained that Cleveland Clinic is a nonprofit organization in which caregivers are salaried, and a team structure of care provision has been part of the culture for the past 100 years. Caregivers are on one-year contracts – they do not have tenure. This team-based, salaried model focused around the patient's needs has been strongly embedded in the culture of the organization since its inception in 1921.

"The founders wanted to remove any obstacles in providing the best possible care for our patients," said Dr. Mihaljevic. "They did not want to confuse the incentives of a provider with the needs of a patient. They wanted to make sure that those are absolutely aligned."

Again, he went back to the motto: "We treat our patients and our caregivers as our family, and our organization as our home. That is a deep ethos that runs deep in the organization."

We both share a conviction that the culture of an organization is the key to its success. As he put it: "One can put all kinds of propositions, strategies, payment measures out there. But the ability to execute on them is going to be critically dependent on the culture and the organizational framework of large healthcare providers. Probably the most inspirational part of my tenure [in Abu Dhabi] was the realization that Cleveland Clinic values can be taught, and they are warmly embraced by every culture. It's completely agnostic to geographic, ethnic, or religious [differences]."

Restoring trust.

To achieve population health in the age of personalization requires inclusion. We can't convince populations of people that we care about them if we're not also able to show care at an individual level – and if we don't recognize how clinical inclusion, community inclusion and workplace inclusion are all interdependent upon each other.

In the opening article I mentioned that several leaders acknowledged the challenge of earning trust within communities of people who historically have not felt welcomed into the healthcare system – often for valid reasons.

We have to change that. We can't help people live healthy lives if we don't have their trust.

Innovation won't save us without inclusion.

We are in a new age – getting more and more diverse, and more and more individualized. The standardization of the past doesn't work anymore. As medical innovations advance beyond what we ever could have imagined, if we're not getting those advancements to the people who need them – as more of our population needs them even more – we risk being the most medically innovative yet unhealthy nation in history.

5 CLINICAL IMPLICATIONS

This is Part 5 of a six-part series on Healthcare in the Age of Personalization.

We have new capabilities for precision medicine, but that does not automatically mean we're ready to deliver treatment and prevention for our age of personalization.

In the opening article of this series, I introduced the age of personalization, how it's connected to inclusion, why it is significant for healthcare, and why healthcare in particular can help point the way for all industries to lead in the age of personalization. In the articles that followed, I discussed the real metrics of inclusion, how business models must evolve, and how personalization intersects with population health.

This time I will explore how personalization affects or informs how we treat and prevent disease. I have written about this topic in the past, in a series on individuality in healthcare, and in this article about a co-design approach to cancer care.

Healthcare, like any industry, faces a quandary of simultaneously needing both standardization and personalization. There are standards of care for a reason: they ensure that people get treatments shown to be safe and effective. Also, without a certain level of standardization, costs would be even more out of control and organizations wouldn't be very efficient.

But personalization is increasingly possible, especially related to prevention and treatment. Innovations like genome sequencing allow doctors to know your personal health on a level of detail like never before, while technologies like activity monitors enable you to track your own health, fit-

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> Seattle Cancer Care Alliance

ness and nutrition metrics. These advancements are exciting but not universally available, and they can only take us so far within a system that still isn't quite ready to handle personalization at scale.

If I track my own metrics and get my DNA sequenced, but end up with a health plan and provider network that aren't set up to take full advantage – I am still missing out on the level of personalization I expect. The system has to be designed for it.

That's why I'm so interested in speaking with CEOs and other leaders of health systems. They see the big picture, they know the opportunities and the limitations, and they understand the system as a whole.

Many of the CEOs I interviewed for this series are leaders of cancer centers. They talked about how personalization in cancer care has expanded to include comprehending the individuality of the cancer itself, along with a deeper understanding of the individual host – the person they are treating.

Robert Stone, president and CEO of City of Hope, emphasized how personalization has shifted along with clinical advances. "City of Hope is about providing hope to cancer patients and their families by bringing tomorrow's discoveries to the people who need them today. We were founded over one hundred years ago by visionaries who believed that medicine and science would continue to evolve, but that caring for an individual - as opposed to simply treating a disease - should be a core tenant for all healthcare providers. This patient-centered approach is the essence of personalized medicine. And now that the science and the practice of medicine are finally catching up with our wholistic approach, it allows us to accelerate best treatments while tending to the unique needs of the individual."

Stone also said that personalized care at City of Hope takes many forms. "Patient-specific clinical, multiomic and patient generated data is crucial to a personalized approach to medicine. Translational Genomics Research Institute (TGen), a medical research institute focused on unraveling the genetic components of cancer and complex diseases, joined the City of Hope family several years ago. This was a crucial last step in creating an oncology continuous learning platform that allows us to derive patient-specific insights and inform evidence-based decision making. As the industry shifts to a value-based care approach, we really cannot achieve true value without meeting the patients' needs, and TGen

allows us to get their faster."

The personalization is not just about **how** to treat, but also **where** and **who**.

According to Stone, "healthcare providers unfortunately too often view the environment through the lens of competition. Cancer is the competition, not the other providers, and a truly personalized approach means, being inclusive by sharing expertise and best practices with others. This is particularly the case with community-based physicians and practices who carry the yeoman's burden of treating approximately 80% of cancer cases across the nation. One recent example is our decision to launch a transformative supportive care project to train oncologists, nurses and other health care professionals to deliver City of Hope's signature compassionate, holistic cancer care. This supportive care project will educate more than 1,500 health professionals around the county to treat the psychological, social and spiritual needs of patients and their loved ones in tandem with patients' clinical treatment. This builds on our decade-long supportive care approach that pioneered SupportScreen technology, which is a touch-screen application that asks patients a wide range of questions to address physical and psychological concerns common to their diagnosis."

I also spoke with Nancy Davidson, MD, executive director and president of [Seattle Cancer Care Alliance](#).

"What you're saying [about personalization] is music to the ears of an oncologist, because we really do believe that we're in the age of what we would call precision cancer medicine," said Dr. Davidson. "For a long time that meant that we were looking at the cancer: what do we know about that tissue, the genetic changes, the molecular changes that led to that cancer might define how it's going to respond to treatment."

"But in recent years," she continued, "we've come to realize that while the cancer is extremely important, the cancer resides in the host, in the patient. It's equally important to understand all the individual features of the host. Not only the biological qualities of that person – their genetic makeup, their heredity – but also all the things that are wrapped around [each person]. The family with whom they live, their environment, their lifestyle. At this time of precision cancer medicine, we need to be focusing on the features of the cancer and the features of the patient or the host, to understand the best path forward for that patient."

Personalized prevention – why do people age at different rates?

Morgan Levine, Ph.D., is assistant professor of pathology at [Yale School of Medicine](#). She's interested in personalized medicine and personalized aging, but her take on it is slightly different. While most personalization is focused on treatment, she is focused on personalized prevention. She researches aging and is curious about why people age at different rates.

"We know aging is the number one risk factor for most of the major diseases – heart disease, Alzheimer's disease, diabetes and cancer," said Dr. Levine. "There is a general consensus in the aging community that if you could actually target aging itself, that it would have the biggest impact on people's health and wellbeing. That's why I have focused on aging research, trying to figure out why certain people seem to be aging faster and how people are aging differently."

This is a fascinating example of taking the most universal of experiences – aging – and exploring personalization at its core. It could be easy for organizations (whether in healthcare or any other industry) to generalize whenever possible in order to streamline how they approach any given population of employees or customers. But Dr. Levine's perspective on something so universal is a good reminder that there's room and opportunity for personalization even in something we accept as inevitable for every single person. A strategic leader will design organizational processes to help understand and implement changes in the organization around how their populations' health is shaped by family, community and lifestyles.

Dr. Levine [has an interesting approach](#): "I'm starting to think that we shouldn't have just one biological age," she said. "You have all these different organ systems, and organs and tissues, and maybe you have multiple biological ages – and it's how that mosaic makes you the individual you are in terms of your aging trajectory."

She explained how it could work.

"We use different statistical approaches that model the whole system and understand how just one individual's system can make them susceptible to various outcomes compared to another individual," said Dr. Levine. "From there, [we could] understand why Individual A is aging faster in some systems than Individual B. It might be genetic, or it might be lifestyle, diet, exercise."

She wants to look at the whole individual, their social circle and their lifestyle, and use that information to determine what they should be doing in terms of health behaviors and medical care. They could gain insight into what an individual can do now, before developing that first chronic disease, to decrease the chance they develop a disease 10 or 20 years early and have a shorter life expectancy.

Dr. Levine is also interested in the outliers and what leads to resilience.

"The other thing I'm really interested in is not just mean – this group seems worse or better than another group – but also variance within groups," she said. "That's what I think of as resilience. Why are there these robust people, and what is it about them that enables them to maintain health? And can we target that to help everyone as a whole?"

Her work also reflects what the previous article mentioned about population health – the toll that various stressors can take on health. But, again, it comes down to individuality.

"I've also done a lot of work looking at socioeconomic status and financial strain, and also discrimination and stressors and how that translates into these different measures," said Dr. Levine. "Again, we find exactly what we would expect – individuals who are facing these chronic stressors and hardships throughout their life are definitely appearing to be aging much faster. From there the question is: how do you target the populations? What do they need to reduce that disparity?"

This is where personalization can help inform population health.

"That's why I'm really focused on this resilience idea," said Dr. Levine. "Why is it that person A who seems to have the exact same profile, at least from a socio-behavioral standpoint, is not doing as badly as person B? What is it about them that makes them able to withstand this?"

Getting to know patients as individuals.

Patient and family advisory councils are a popular way for healthcare providers to learn about how people feel about the care they receive.

Laurie H. Glimcher, MD, President and CEO of Dana-Farber Cancer Institute in Boston, explained why they are so useful.

"We established Patient and Family Advisory Councils (PFAC), which include current and former patients, caregivers, parents, bereaved family members, and Dana-Farber faculty and staff," she said. "PFAC members serve as the voice of the patient and family, and bring their perspective and experience to policies, programs, projects and services across the Institute, including by helping to shape our organizational efforts around inclusion and diversity. They are highly engaged in our operations and processes, including using their experiences and perspectives to shape the design and opening of our largest outpatient facility the Dana-Farber Yawkey Center for Cancer Care, and in ongoing projects and satellite facilities."

Tom Jackiewicz, CEO of Keck Medicine of USC, discussed several different ways they get to know patients and put that knowledge to use, saying that providing appropriate and personalized care to their diverse patient population inherently brings continual opportunities for culture changes within their organization.

"We identified an opportunity to provide stronger value-based care for our senior surgical patients," said Jackiewicz. "About 30% of our patients over 65 suffer from various forms of neurocognitive disorders and are at a higher risk for post-operative issues such as delirium that can ultimately result in increased length-of-stay, readmissions, costs and morbidity. Our Brain Health Initiative involves members from departments of Geriatrics, Internal Medicine, OT, Pharmacy, Nursing, Anesthesiology, Surgery and Center for Health System Innovation. Pre-op patients over age 65 are assessed for neurocognitive concerns and their inpatient care program is tailored accordingly – for example, rooms with more natural light, less interruptions such as lab work at night. Family members also receive education to make the transition to home safer and easier."

Jackiewicz said education plays a large role in value-based care for total joint replacement patients as well, many of whom are seniors.

"All joint replacement patients attend a class led by a Keck nurse navigator that focuses on pre-op preparations, as well as expectations during inpatient stay and after discharge," he said. "Nurse navigators then follow the individual patient throughout the continuum of care."

This ties into another question I ask leaders, when assessing their organization's readiness for inclusion: Do you have processes in place to get to know patients as individuals, and to make sure that knowledge is shared across the contin-

uum of care? My intent is to go deeper than the usual health-related questions. Beyond just basic questions, do you have strategies for engaging with patients in a way that invites them to tell us their whole story – beyond how they're feeling that day?

Jackiewicz described a few different programs in place to create structures for getting to know patients.

"Our No Passing Zone program came out of a Patient and Family Advisory Council and was designed by patients," he said. "Anytime a patient light is on, staff members must stop by the room. There are algorithms around what tasks can be handled based on clinical or non-clinical position. For example, a request to use the bathroom may require a staff member to inform the nursing station, while a request for an out-of-reach item such as a magazine can be handled by anyone."

Keck Medicine of USC also has adopted some nursing best practices to facilitate personalization.

"Keck Hospital nurses do a great job getting to know their patients and have several tools at their fingertips, depending on length of stay – from a simple form to share non-medical questions about family, pets or hobbies – to an in-depth living history interview of the patient and family members that is compiled in a story that resembles a newspaper article," said Jackiewicz. "The story and photos are laminated and posted in patient rooms to help doctors, nurses, lab technicians and other providers understand more about each patient and provide an avenue to develop personal connections about children, grandchildren, pets or favorite travels."

He said the oncology team led the way in developing this tool, and that the tool is typically reserved for Cystic Fibrosis, transplant, heart surgery or cancer patients staying more than a week.

"Another way Keck nurses develop that personal connection with patients is through a two-minute sit, a procedure where bedside nurses pull up a chair to spend two minutes each day with a patient talking at eye-level about non-medical issues such as family or pastimes," said Jackiewicz. "Nurse managers created videos of this exercise with each other to facilitate training throughout the nursing staff."

After-care – what happens in the community after treatment?

I spoke with two leaders from the University of Pennsylvania: Jaya Aysola, MD, MPH, is assistant professor of medicine and pediatrics at the Perelman School of Medicine and described herself as working in health equity; and Eve Higginbotham, SM, MD, is vice dean for inclusion and diversity of the Perelman School of Medicine.

They work together to take the concepts of inclusion and equity and translate them into action items that can be operationalized within the health system – focusing on culture to enhance patient care delivery, scientific innovation and retention efforts.

They conducted a qualitative narrative analysis to better understand what can be done to improve inclusion within healthcare organizations. I'll share more about their study and results in the next article, where I'll discuss non-clinical aspects of personalization.

But for now, here's an example Dr. Higginbotham shared that ties in with the topic of clinical implications and patient experience.

"The business case of diversity is always something that one needs to address, and we're tying that into a specific measure – financial gains based on 30-day all-cause readmission rate," said Dr. Higginbotham. "One of the [Centers for Medicate & Medicaid] rubrics is to reward systems that have lowered their readmission rate. To do that, you have to understand the components that go into the readmission rates. One of those is the disparate delivery of patient care across communities. So that's where the work that we're doing on a health equity side is so important. If we can identify that patients from a particular neighborhood aren't following up on their discharge instructions, we [engage] another one of our initiatives: the community health worker."

Dr. Higginbotham said it's about being mindful of the need for something like the community health worker, having the data so that you can assess the impact of that need, and then having the strategies to respond to that need: "That's where we do have all those things aligned here at Penn Medicine. Of course, we can always do more and that's where the opportunity is."

Her example relates to another question I ask when assessing organizations for inclusion: Can

you think of an example of when you learned something about how a particular population accesses care, and then applied that lesson to the way you deliver care?

Dr. Higginbotham said they are also in the process of learning more about wait times in Emergency Rooms.

"We're finding that diverse populations have different wait times, they tend to wait longer than others," said Dr. Higginbotham. "So as part of that project there is the opportunity for patients to tell us their perception of how long they waited and how they felt about it, and what their recommendations are. We're just at the [early] stages where we're understanding what questions to ask and what those questions will actually present as data that we can learn from and develop a strategy."

I appreciated the willingness of Dr. Higginbotham and Dr. Aysola – and of all the people I interviewed for this series – to share with me initiatives that are still in progress. It's so important for leaders in healthcare to be open because we all need to learn from each other. We're all still trying to figure this out.

I also appreciated that Dr. Higginbotham and Dr. Aysola brought the discussion beyond today to the need to diversify the medical knowledge of tomorrow.

"The thing that resonates with me in terms of what you said [about personalization]," said Dr. Aysola, "the way our healthcare systems have been designed and the way our medical knowledge has been generated to date has been primarily from a single cultural perspective. We're all acculturated in that norm. It's not merely diversifying the front lines, you must diversify your leadership and also those that generate the medical knowledge of tomorrow – to get to a point where we're designing systems with a diverse perspective, and we're innovating and generating the medical knowledge of tomorrow with a diverse perspective."

Expanding participation in clinical trials.

It's hard to diversify the medical knowledge of tomorrow if diverse populations are not represented in clinical trials.

According to this article by Victoria Forster, a postdoctoral research scientist focusing on childhood cancers, most cancer clinical trials don't meet their enrollment targets and the reasons are varied – structural barriers often get in the way. Dr.

Forster cites a new study published in the March 2019 issue of the Journal of the National Cancer Institute. Barriers range from patient access – no clinical trial nearby, and no financial means to travel to participate in trials elsewhere – to varying degrees of support offered to participating institutions: trials sponsored by pharmaceutical companies get far more support than those sponsored by the government.

Once again, I turn to Nancy Davidson, MD, executive director and president of Seattle Cancer Care Alliance. She is a physician scientist, medical oncologist by training and trade, and her personal interest is in breast cancer.

"As somebody who's passionate about clinical trials, I tell every patient that everything I know about how to treat you today is because of the clinical trials that doctors and patients before us participated in," said Dr. Davidson. "I want the trials that we're doing today to be the new therapy for tomorrow, and we can work together to be a part of that. So that's something that I feel passionately about for everybody."

She stressed that participation in trials is low for all populations.

"When you start to talk about our ethnic minority populations, I think you're right that sometimes it's even lower and that probably reflects several things," she said. "One is failure on our part as doctors and researchers to make sure that we're making these opportunities available widely to everybody. We certainly have the opportunity to partner with our advocate colleagues to make sure there's awareness across all populations about the importance of doing [trials] and actually about how you as an individual may get even better care. You may be getting the care of the future by participating in these trials."

She acknowledged the challenge of earning trust.

"I think that we've come to realize that we have to be culturally appropriate and [employ] special efforts for some minority populations who might be distrustful of the medical system and worry that they're being asked to serve as a guinea pig," said Dr. Davidson. "That's something that we're all working very hard on because we're only going to make headway in the diseases that we call cancer if we're able to have our clinical advances apply across the board."

That ties into the importance of trust. We can't force the issue of trust. We can only build it over time. That requires a systemic approach – with training, methods and processes in place that

make connection and trust a proactive, measurable pursuit.

Understanding people's choices.

It's only once we have those trust-building systems in place that we can actually start understanding the factors that influence the health and wellness choices made by individuals.

I spoke with Johnese Spisso, president of UCLA Health and CEO of UCLA Hospital System, about balancing personalization and standardization. As she described it, there's a need to balance "individualized, personalized medicine to make sure we're getting the right patient the right test or procedure at the right time. Then, also, the need to reduce variability where appropriate according to evidence-based guidelines to achieve the best outcomes for patients, and to demonstrate value-added care that is affordable as well. As health system leaders, we have to be exploring both."

She said cultural diversity is at the core of everything they do, starting internally with the workforce, and extending to the community to include "not only in our patient care but also our research, our education, and our scholarly efforts in community engagement in reaching vulnerable populations."

To provide an example, she shared what the organization is doing through an internal LGBTQ committee made up of people who are experts in understanding the needs of the patient population.

"Our goal has been to continue to advance our policies and procedures, educate staff and involve patients and families so that we can be a leader in serving the LGBTQ population," said Spisso.

She mentioned having patient and family advisory councils for all of the system's hospitals and clinics. Patients and family members offer input on things like service, diversity, equity, inclusion, "and what they feel when they come into our institution," she said. "We get really good feedback. Sometimes we think we know the best way to design these processes that represent what patients and families want, but by listening to the patients, we get a lot better information and intel on what we can do to make a difference."

Based on the feedback from the LGBTQ committee and focus groups, UCLA Health has changed the way they designate information about next of kin in medical records, they updated their website so people can find healthcare professionals who have experience supporting patients who are LGBTQ and the needs of that patient population, and the organization has sought out opportunities to sponsor and participate in job fairs in the LGBTQ community.

She said they look for ways to design care processes that take into account patient needs.

"It's always a work in progress, but I've been pleased with the willingness of our staff to listen to patients, and then to see their leadership in taking these initiatives forward and communicating with us things that we need to do better."

I also posed some questions to Anthem CEO Ms. Gail Boudreaux about how the organization is responding to the need for inclusion in healthcare and sharing inclusion insights throughout the organization.

"It is important that we have employees and teams operating in the community, and even more important that we have the right mechanisms and processes to incorporate their learnings and insights into the broader organization," she said.

One way they do this is through the Anthem Whole Health Connection tool.

It "allows different teams inside the organization to work together to better understand the unique and personalized needs of our population," said Boudreaux. "Leveraging this tool allows us to bring together the medical, dental, vision, and pharmacy interactions of our patients to organize their care and ensure that they receive targeted solutions for their specific needs."

Among several specific programs, she mentioned progress related to the needs of seniors.

"We have an innovative **Togetherness** program for seniors first launched within our CareMore model to combat loneliness," she said. "Of the approximately 780 members who've engaged in the program to date, we find improved health outcomes as result of the more intentional acts of socialization. Our most recent analysis shows that as engagement rates with this specific audience went up more than 20% over the previous 12-month period, their need for medical treatment declined by 20% during that same time."

From the insurance perspective, Dr. Shaden Marzouk, managing director of health for AXA, told me about some initiatives designed to help get

health innovations to more people.

"AXA has embraced innovation and technology as one way to more fully engage with customers across the continuum of care," said Dr. Marzouk. "This includes championing telemedicine around the world as well as investing in health-tech start-ups that have an impact on the lives of patients."

This brings me back to my opening statement about the importance of making new innovations more accessible to all people.

"For example," Dr. Marzouk continued, "AXA facilitates patient journeys by supporting Moroccan start-up DabaDoc, tackles innovations in alcohol rehab through an investment in Annum Health in the US, and enables UK elders live more safely in their own homes by incubating Birdie. DabaDoc helps thousands of patients a month connect with doctors. Annum Health provides evidence-based treatment in patients' homes for alcohol use. Birdie utilizes technology to bring together the elderly, their families and caregivers."

As you can see, there's incredible work being done to advance the way we can prevent and treat disease at the population level and at the individual level.

But how can we really put these advancements to work if we don't have the systems for personalization? Everything comes back to the need for getting to know people as individuals, and for structuring organizations in a way that is welcoming to every individual at every level.

6 PEOPLE EXPERTS
WE NEED YOU

This is Part 6, the final part of this series on Health-care in the Age of Personalization.

This entire series has been about this new age of personalization – the need for organizations to elevate and activate individuals. And who in an organization is responsible for the people of the organization? Human Resources.

But most HR leaders have been trained in stan-dardization. They report to CEOs and boards steeped in standardization. They manage clinical and non-clinical leaders who are used to stan-dardization.

Even when HR leaders agree 100% with the need for inclusion that honors this age of personaliza-tion, and even when the people they lead and report to agree as well – we are all up against massive systems designed for the opposite.

In the opening article of this series, I introduced the age of personalization, how it's connected to inclusion, why it is significant for healthcare, and why healthcare in particular can help point the way for all industries to lead in the age of person-alization. In the articles that followed, I discussed the real metrics of inclusion, how business models must evolve, how personalization intersects with population health and the clinical implications.

This time I'll explore the role and opportunity for HR to move this transformation forward.

As I've said before – the way an organization func-tions, and the way its leaders function, depends on the systems and methods and processes that are in place. We can have all the high-minded goals we want, but we will not reach them if the system is designed for something else.

We have to change the system. HR can either be the biggest advocate for creating a system de-signed for personalization, or its biggest hurdle.

Individuals are in control now – of your work-place, of your brand, of how they want to experi-ence your services and care.

HR needs to play a much greater role in influenc-ing the decisions that are made not only among patients, but also among employees and the role that the entire enterprise plays in shifting the mindset of the healthcare industry from services to individuals.

The way we work is changing.

One of the reasons this is so urgent is the world of work itself is changing drastically. I spoke with Anton Andrews, director of Office Envisioning at Microsoft.

Andrews described the emergence of what he called the "discoverer's mindset" within an orga-nization: "In an age of uncertainty, in order to stay relevant, people are having to constantly redefine themselves. Whether it's a government, whether it's a large company, whether it's a hospital. So the ability for people to learn and grow is becom-ing increasingly critical. And that doesn't happen if you have a static job description and a static job function."

No matter our place in the organization, we have to adopt this mindset of being entrepreneurial with our own careers. And HR needs to build the system that enables people to do that. As you'll see throughout this article, healthcare needs to boost its ability to attract top talent and keep peo-ple included and engaged in meaningful work.

As Andrews put it: "The idea of fluidizing internal-ly is not a fancy idea. It's an idea that really accel-erates learning and growth of individuals, and by doing that accelerates the ability of the organiza-tion to fully tap in to the power and the energy of the people in it."

There is so much overlapping change happening in healthcare (for all the reasons I've addressed throughout this series). It's critical that HR use its influence to tap into the power and energy of people.

This brings everything together – this age of personalization, the corresponding need for in-clusion, and the strategic role that HR can and should be playing to help organizations make these transitions.

Uprooting ourselves from standardization.

I spoke about this topic with CEOs and chief HR officers for major U.S. healthcare organizations. They share my emphasis on inclusion and were open about the challenges of evolving an organi-zation and an industry.

Teri Fontenot is CEO Emeritus of [Woman's Hospital](#) in Baton Rouge, Louisiana — the only independent, nonprofit women's hospital in the country. In February 2019 Fontenot announced her plans to retire.

She offered some insight into why evolving out of standardization can be so difficult within healthcare in particular.

In this industry, "people are used to working under policies, procedures and protocols, and are accustomed to and comfortable with working in routines that are known and proven to them," she said. "Because we are talking about healthcare, and so there's not a lot of experimenting that ought to go on in healthcare, except in the most controlled circumstances. Patients want what they want, but they don't always know what is going to be safest or best for them. On the other hand, providers cannot act like they know what's best for a patient either."

But adherence to standards is a practice that has been instilled and reinforced throughout entire careers, from early training through to leadership positions.

"Physicians who entered practice 30 years ago were taught: 'you are the captain of the ship, you are completely responsible for this patient,' — that's why they call it 'writing orders,'" said Fontenot.

But she said that's changing.

"I think it's really moving more into a team and multidisciplinary approach," she said. "I'm really pleased and proud of our business sector. The healthcare field has worked very, very hard. The medical schools are training physicians differently. The disruptors are the clients, the customers, the patients. We think a lot in healthcare about disruption coming from other competitors doing things that are progressive or innovative. But it's really the patients as consumers who see new ways of accessing services that better meet their needs than the traditional way."

She also mentioned the challenge of trying to change an industry when the regulations hold you back.

"Another reason why there's been a drag on transformation is all the governmental regulations just don't keep up with what we're trying to do," said Fontenot. "So it's also having to navigate around those other kinds of limitations."

She sets a great example of leadership based on the future.

"My job is to aspire and inspire," she said. "My job is to be thinking about where we're trying to be five or 10 years from now, not what we're doing today, and try to think strategically about how we're going to get there."

HR needs to be part of corporate strategy.

Margie Vargas is senior vice president and chief human resources officer for [Memorial Healthcare System](#) in South Florida.

She agrees that the role of HR needs to evolve to be consultative.

"We have to evolve the practice of human resources to truly be consultative," she said. "I think HR professionals have developed that skill over time — to be a consultant that impacts all areas of the industry, not just human resources."

But she also sees the challenges embedded within a function that has been born and bred to be compliance-driven.

"Back in the day, when you became an HR professional you really honed your skills on the HR-specific competencies that were necessary to be compliant," she explained. "Just be compliant, that was all that was needed, right? Tell the organization what it needs to do to be compliant."

She said that's changing.

"I had a conversation with a group of HR business partners that we're mentoring right now, where none of their mentoring learning objectives have anything to do with HR," she said. "[The objectives now] have to do with how involved are you in understanding what drives your business? What is your business acumen? Where is your contribution to the critical evaluation of program development? What drives the organization, and how are you connected to the mission?"

She gave an example of one way HR is contributing to the larger business goals. She said they're looking to see if there's a correlation with employee turnover and patient satisfaction.

"We correlated the turnover to the employee engagement survey to the patient satisfaction scores over the last 12 months and to leadership performance," she said. "That's the type of people analytics that tells a story, so we can then cre-

ate strategies on how to improve the patient experience, elevate caregiver contribution, and also identify gaps in leadership and create strategies to mitigate some of those gaps."

The usual starting point – unconscious bias training.

Whenever the subject is inclusion, especially related to HR and compliance, the common starting point is unconscious bias training. I usually view that as a PR-motivated move as a way for a company to manage its reputation, often after a race-related scandal.

I always have a similar thought: I don't want to hear about your unconscious bias training – I want to hear about what comes AFTER your unconscious bias training. How are you using that as a starting point? How are you pivoting from that training to then start to create the structure that will embed awareness about our individuality into every project, every team, every department, every interaction with peers and patients?

Pamela Abner is doing just that. She is vice president and chief administrative officer of diversity and inclusion for [Mount Sinai Health System] in New York City. She's laying a foundation for inclusion by developing education and training, by creating best practices for things like how they collect patient information, and she and some people on her team are even getting certified as patient experience professionals. All so they help embed inclusive thinking throughout the organization.

She uses unconscious bias training as a starting point. But that's just the beginning.

"We want to embrace or recognize that we have varying backgrounds," she said. "I want us not talking about one particular thing – whether it's race, sexual identity, sexual orientation, gender identity, state of ability, disability or religion. Those are all things that fall into that bucket. All that means is that we're thinking about everyone. Then, what do we do when we're aware and we're thinking about everyone? If we can even assume that everybody is aware that people are different, it's how do we then provide the appropriate care and bring people what they need that's right for them. That's the hardest part, for sure."

The training can be valuable and can have a direct impact on patient care. Because bias is not just about stereotypes – it's about how our brains use shortcuts to help us understand the vast array of stimuli the brain processes every minute.

Those shortcuts can be helpful, but they can also limit our ability to understand each other. Abner shared an example with me.

She said the head of their trauma unit was doing rounds. Before he walked into a room, someone gave him the summary of the patient. He was told the patient was an elderly white woman who they said had dementia.

Abner said this doctor happens to be black and Jamaican. He went into the room and started asking the screening questions you ask when you hear someone has dementia.

"The person seemed to respond fine," said Abner. "She did not seem to present at all as someone with dementia. However, she had an incredibly thick and authentic Jamaican accent. The doctor turned to his team and he said, 'this patient doesn't have dementia. She's Jamaican.'"

This is where the shortcuts our brains take can actually slow us down.

According to Abner: "This is a bias thing, because they see the woman as being white, and people sometimes don't realize that in the Caribbean you have island people who are white, or otherwise Caucasian-looking, but they speak just like the island folks. When we teach about unconscious bias we say 'hear with your eyes.' They saw something their brains could not connect as a Jamaican accent. They just thought: there's something wrong with this woman. She must not have all her faculties. Now, if that attending physician had not been a person from a background different from the rest of the team, that woman would have been treated and handled as though she had dementia when she did not."

That's such an important lesson about bias – it goes well beyond the stereotyping we usually associate with it, to include general misunderstandings among people. In healthcare, misunderstandings can lead to the wrong kind of treatment. Worst case, it can be a matter of life and death.

"When we teach we say don't be fooled by what you hear and what you see because your mind plays tricks on you," said Abner.

Her approach beyond the unconscious bias training is intentional and specific.

"Those are my two favorite words, by the way – intention and specific – because you don't get anywhere without some intention and being specific," she said. "Once we identify what [inclusion]

problem we're trying to solve, and what have we identified as our key issues, then let's start to measure something. We have to come out of this endeavor with a measurement."

If people are so mission-driven these days, why does healthcare have a talent shortage?

In a [survey of healthcare leaders](#) released in January 2019, J.P. Morgan found that the talent shortage is top of mind, with 92 percent of respondents saying they were at least somewhat concerned with finding candidates with the right skill set. For 35 percent of respondents, the talent shortage is one of their top three challenges. While the physicians and nurses topped the list of most challenging positions to fill, nearly a third (29%) of respondents said it's hard to fill mid-level management, 21% have trouble filling administrative positions, and 18% said senior management positions are most challenging to fill.

In an age when more and more people say they want their careers to be meaningful, they want to do something with purpose – why isn't healthcare able to overcome its talent shortage? Of all possible career fields, if your goal is to make a difference in the world, healthcare should be at the top of your mind as a place to anchor your career, whether you're a caregiver or an accountant.

But it's not. Why? At least partly, it's because healthcare struggles with this transition to personalization.

I talked with Joe Moscola, senior vice president and chief people officer for [Northwell Health](#) in New York, about how to prepare for the age of personalization. He agreed that there is a lot of innovation needed in healthcare today.

"The consumer is looking for [individuality], because it exists in the rest of our lives – that ability to have that individual approach that is unique to them, their own thumbprint," said Moscola. "To be able to get my own medical records in a way that is useful for me, that I can understand, in the language that I speak, and the ability to communicate with someone who communicates the way I need to communicate."

Those are big challenges that require many different types of expertise to meet those challenges. Now if we can just help people see the opportunity to make their own impact.

Moscola talked about the role of HR in the context of all that: "How are we able to build a pipeline, build enthusiasm around the work that we're doing, grow diverse skill sets, with people who understand all those complexities and those challenges that exist in each individual community, each individual culture and gender? And how do we begin to really advance that strategy through the talent that we bring in? That's a big part of how we're beginning to look at it."

As it so often does in this age of personalization, it comes down to the experience that each individual feels like he or she can get as an employee. He said when people leave an organization, it's often because they don't feel like they can follow their mission there.

He described it like this: "To dig down a little bit deeper, [people are asking themselves] 'am I able to go after my career mission? That passion I have to help people or to cure people – can I follow that mission here?' And I think the way we begin to have really changed leadership, and how they think on it. This is just one person's opinion, but do I think it goes back to some basics about how to unlock someone's total, maximum potential through the mentorship, the coaching, and then sponsorship of that individual. And then, how many people can you realistically do that for? And what tools do you need to do that?"

Challenge of talent pool – people don't think of healthcare careers beyond doctors and nurses.

The industry needs to be better at selling itself beyond the obvious medical careers.

Cathy Fraser is chief human resources officer of [Mayo Clinic](#), and she shared some of those challenges with the talent shortages. She said she visits middle schools and high schools and asks the students why they're interested in healthcare. They all say they want to be doctors and nurses. But there are so many other ways to help people live healthy lives.

"One of the best things we also can do is treat healthcare as a vertical, as an industry, it is not a function," said Fraser. "Kids are taught early that you see yourself as a caregiver in some form because you helped your teddy bear when it got ripped, and you took it to your mommy to give it a band-aid. That's caregiving. But there's also

the ability to be successful in healthcare as a finance person, as an IT person, as a mechanic, as a glassblower – you can do it because the vertical has every job in it. We have not done a good job as an industry to promote the concept that healthcare is all professions, not just clinical."

Her own career path includes multiple industries before moving into healthcare. She values a diversity of experience, and has created a structure within the organization for people to move around and experiment with their careers.

"We hire good people and we give them the freedom to do a lot of different things in the organization," said Fraser. "The guy who was my second person, my next level in HR, just took a job working as the vice chair of administration of research for Mayo Clinic's research organization. You don't typically get someone who's a high-level HR executive going over to run an administration job in research. But we see more and more of that here because we are looking at talented people, and we're rotating them through different roles, sometimes full-time, but sometimes they're only part-time."

She said people can take a six-month agile staffing opportunity, experience something new, and then come back.

"This allows people to navigate their own careers, and with actually pretty robust programs for tuition reimbursement as well," she said. "Humans want to learn, they want to expand, they want to grow, but most organizations make it really, really difficult to do something new."

She said it's difficult to be a successful CHRO if you've only come up through the HR discipline.

"People meet me, and they'll think, 'you're in HR, that's odd,' – I get that a lot," she said. "It has to do with the fact that when I came out of grad school I was a finance person working for an airline. Then I actually worked at McKinsey & Company and worked on retail and consumer goods. It's that variety of experience that makes it easy for me to see things clearly that are not traditional HR. So the best thing I would ever advise someone who's coming up through HR is to get out of HR, go spend some time somewhere else, enhance your ability to see things from a different view."

A systematic approach to inclusion.

In the last article I mentioned my conversation with two leaders from the University of Pennsyl-

vania: Jaya Aysola, MD, MPH, assistant professor of medicine and pediatrics at the Perelman School of Medicine and executive director for Penn Medicine Health Equity Initiative; and Eve Higginbotham, SM, MD, is a professor of ophthalmology and vice dean for inclusion and diversity of the Perelman School of Medicine.

They work together to take the concepts of inclusion and equity and translate them into action items that can be operationalized within the health system – focusing on culture to enhance patient care delivery, scientific innovation and retention efforts.

They conducted a qualitative narrative analysis to better understand what can be done to improve inclusion within healthcare organizations.

They said something I agree with wholeheartedly: Some of the first ways in which to operationalize inclusion is to measure it. They looked into identifying the key factors that organizations can look at when they're thinking about inclusion.

Through their study, they found six factors were consistent regardless of subgroup. The study (see link above) offers the details, but I'll rely on how Dr. Aysola described the results to me.

Overwhelmingly, minorities and women said they feel like there isn't a level playing field, that standards in general within an organization aren't applied equally. Many reported micro-affirmations and nepotism at play in favor of white males.

There was also a significant narrative around the silent bystander: "Often, discriminatory remarks or bigoted remarks happen in an environment with many witnesses, who remain silent," said Dr. Aysola.

She believes empowering those silent witnesses is a key first step in changing an organization's culture: "It can be as simple as when, in a committee meeting, a female might raise a really wonderful point, then that point is repeated directly by someone else and presented as their own point. That's an opportunity for the chair to say, 'Oh, that's really great, Dan, that you highlighted Mary's point.'"

That's such a concrete way that leaders can operationalize inclusion in the moment and begin to move the culture toward personalization one interaction at a time.

Build trust by building relationships.

How do you take people who are not engaged and are unwilling to show their true individuality if they don't trust leaders? How do you tackle that?

Nikki Sumpter is senior vice president and chief HR officer for Atlantic Health System in New Jersey. I asked her about building trust and her first response was to say: "This is my favorite part of what I do."

From previous jobs, she shared examples of taking care of employees, addressing issues of living wage, increasing the training that's available for development. When she joined Atlantic Health she saw that the organization already had a strong foundation of trust. That came in handy as she helped navigate what she described as a tremendous amount of transformation: a new CEO, other new executives, the rollout of a new Electronic Health Record (EHR) system.

"We have to listen," said Sumpter. "I can focus HR and get a whole bunch of stuff done, but it may not be what the organization needs today. If we can't be inclusive in our thoughts, if we can't get any of that right, you will have silos. How do you break through those barriers? By meeting people where they are, literally. Literally. It's taking things in one bite at a time in building trust. Culture doesn't happen overnight."

She brought it back to relationships and to making sure HR plays a role in organizational strategy.

"I think relationships are important," she said. "Start with everyone on the executive team and find out what the priorities are. But it's not enough to just know what their goals are. What role does HR play in every one of the goals? Because all of the work occurs through people. I mean there's nothing that is happening that a person isn't touching. How is HR supporting everyone's goal? If you could figure that out, that's the start."

To be ready for personalization, you need your people.

It all comes back to people. To individuals.

To return to Anton Andrews from Microsoft: "New challenges are going to be arising constantly in real time. Is your organization making use of the people in it? Is your network making use of the

people in it and allowing them to actually cluster around those challenges as they arise, and bring their expertise to those challenges?"

This is the role HR must play in the age of personalization.

At a time when we are personalizing healthcare, HR should be one of the most sophisticated departments in the organization. You're the ones who can see what needs to be solved at every level throughout the organization, help individuals know what they are uniquely suited to solve for, then connect people so they can cluster around those challenges and work together to overcome them.

You're the ones who connect all the dots (take this assessment to measure your effectiveness).

In this age of personalization, the role of chief people officer is the most important role in any organization. It's **PEOPLE** who will deliver the innovation needed to take advantage of opportunities for growth. It's **PEOPLE** who will revolutionize the way you serve patients, employees and your community. It's **PEOPLE** who will transform healthcare for this age of personalization.