Making a Ruckus for the Patient Experience

With Denise Wiseman

Episode 86

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Denise (00:00):

The questions on the survey. They're not about providing Ritz-Carlton like customer service and too often that's how they're talked about. They are actually about seeing you as a person, caring about you as a person and did we keep you safe and did we provide quality care? The survey has an opportunity to provide value, it really does. But in most cases we don't extract that value. We're not really listening to the responses, we're not actively understanding why our patients are giving us the scores they're giving us. We're just looking at a scoreboard and trying to seek a number and that's it.

Introduction (00:39):

Welcome to the Healthcare Leadership Experience Podcast, hosted by Lisa Miller and Jim Cagliostro.

Lisa is the founder of VIE Healthcare Consulting and now Managing Director at SpendMend. Lisa and her team has generated over $1 billion in financial improvements for VIE's clients since 1999.

Since 2007, Jim has been a registered nurse working in critical care, perioperative services and outpatient settings at nationally recognized medical facilities across three states.

You'll hear conversations on relevant and trending topics in healthcare and much more. Now, here's your hosts, Lisa and Jim.

Jim (01:19):

Hi, this is Jim Cagliostro and You're listening to The Healthcare Leadership Experience. Today's guest is Denise Wiseman, Founder, President and Chief Ruckus Maker at the PX Community. Today, we're going to be talking about making a difference by making a ruckus in healthcare, specifically related to the patient experience. But I'm personally excited about this. I know I've shared before that the patient experience is something that I'm passionate about and someone who's more passionate about it is Denise. So thank you, Denise, for being on the show today.

Denise (01:47):

Thank you, Jim. So happy to be here with you.

Jim (01:50):

So I always like to take a minute with the beginning of our episode and ask you to tell us about your journey. What has prepared you for the role that you're involved in right now?

Denise (01:59):

That was a challenge when I was thinking about that question, a minute or two to tell a 25-plus year career, that's a challenge. So it's an abbreviation-

Jim (02:08):

We'll give you three minutes.

Denise (02:11):

Oh, boy, you're generous. I entered healthcare as a Registered Dietician and because clinical dietetics was not for me, I worked as a Food Service Manager and then a director for a number of years in healthcare. And then I joined the IT department for the hospital I was working with. I had obtained my MBA with a focus on IT management because I wanted to be able to make a

transition. It's too easy to get stuck in your career if you don't seek new experiences.

Jim (02:36):

Sure.

Denise (02:37):

From there, I had a wonderful opportunity to join an organization called Studer Group. For those who don't recall or know who Studer Group was, a large coaching and consultancy company focused on improving patient experience. So Quint Studer founded that just before CMS mandated HCAPS and they, of course, grew substantially in the decade that followed.

When I joined Studer Group, unfortunately a venture capital firm had just invested in them and they were working to improve their financial status in order to be acquired by a bigger organization. So they had shifted to profit as being their focus and the company was no longer the one I admired since first hearing Quinn Studer speak, unfortunately.

Denise (03:21):

When I had started with Studer Group, I was working on my PhD and so I transitioned, I left and took a little bit of time off to work on my dissertation and then when I went back to work, I joined Press Ganey. And again, I was idealized to believe that I was joining an organization dedicated to the enhancement of patient experience. And what I've learned the hard way is that for-profit organizations are typically, for the most part, for profit before all else. So I transitioned from Press Ganey to one of my clients who had just opened up a system director of patient experience. And so I joined a large healthcare system out here in the Pacific Northwest, was with them for a year and a half and then COVID hit and then I was given, as I describe it, an opportunity to redefine my career. I was fired.

Denise (04:14):

So with a lovely severance package, I had the time to really consider my next steps. I thought about going back to work for a third-party vendor, there's a few of them that I do admire. And then I thought about working within the

nonprofit sector of healthcare again and really what sat on my mind was the gap I've seen in how we're doing patient experience. And so I decided instead to lift up The PX Community. I know I had legitimacy in the decade of work I'd done in patient experience and my many years in healthcare. And so I really believed that from the outside I could reach in and help those who are on the inside of healthcare.

Jim (04:54):

I do want to jump back to before you joined Studer Group. Would you say this desire to improve the patient experience or this passion was already there or do you feel like it's something that grew from beginning with your time at Studer Group and Press Ganey?

Denise (05:07):

Yes, it was actually before then. So I had the privilege of hearing Quint and a few of the others who spoke with Studer Group and just be really enthralled by what they were sharing. It was in alignment with what I had seen in working in healthcare. But then Jim, I had a significant experience of my own as a patient. And when I tell this story in front of a group of clinicians and I say I had Achilles injury, so my foot was in a boot and I had been really good about that boot, wearing it and being immobile for quite a few weeks. I was over 40 and still on birth control.

Denise (05:46):

And I called the doctor and said, "I have a cramp that won't go away." And I didn't talk with the doctor. I talked with his nurse and the nurse relayed through the doctor, "Well, drink more water." And of course I went, of course, how stupid am I? I wasn't that type of clinician. I didn't know that what actually had formed was a DVT, a blood clot in my leg and two days later after talking with the nurse, I stood up and just about passed out. So the clot released and through multiple clots through my brain, my heart and my lungs and I had an opportunity for a few nights' stay in a hospital.

Jim (06:25):

I didn't realize that you had that experience and a lot of times that's how it works, even as a nurse at the bedside for so many years, really my passion for the patient experience really stems from it. I spent time in and out of the hospital around like 2016, '17, '18 with some ongoing issues and you sit there as a patient and you realize, wow, this could be so much better. This really should be different, in terms of the patient's experience. So obviously that would be a situation or an experience that would drive this in you. I appreciate you sharing that.

So I do want to jump back to your title. We have to begin by asking about your title as Chief Ruckus Maker, we always tell our kids, no, this is the last thing we want you to be, a Ruckus Maker. I'm assuming this, making a ruckus, it's connected with your call to a new paradigm. What's the old paradigm in healthcare and why is a new one needed to improve the patient experience?

Denise (07:23):

Yes. So Jim, that's actually a two-parter question because I think the first thing I need to do is define what I mean by making a ruckus.

Jim (07:31):

Please.

Denise (07:32):

So when I was given that opportunity to redefine my career, I took time to afflict and consider on what the right next step was for my career and also for my life. And so I took a few courses from Seth Godin and his Akimbo program and I don't know if you know much about Seth, but he ends his videos and his trainings with saying, "Go make a ruckus." And when he says that what he means, and this is a quote from him, "When we show up to make a ruckus, we're doing generous work. Work on behalf of those we seek to serve." And then he says, "We need to dig in and do something that might not work." And so when he is talking about making a ruckus, he's talking about thinking outside the box, embracing the unknown, being courageous and with a positive attitude and that's everything you'll see from Seth.

Denise (08:23):

It's with a positive attitude, stepping out, giving it your all, testing, trying and doing something differently. And Jim, that is exactly what we need in healthcare. And so being a Ruckus Maker, to me, is identifying those things that are problematic in healthcare. We're all aware of them. If you're on LinkedIn or in other forms, you're hearing people talk, complain about the problems of healthcare, right?

Jim (08:48):

Sure. Yes.

Denise (08:49):

And I say, let's identify it, that's fine, but let's then understand enough that we understand the root of the problem, what's really going on to cause what we're seeing and then let's do something about it. And so that's making a ruckus, right? That's doing something about it. Let's stop blaming others, let's stop waiting for somebody else to solve it and let's take action.

Jim (09:12):

That's great. Doing something about it. And also as you're describing that we recognize it's going to be something that people will be uncomfortable with, especially that have been in healthcare for a long time or this mindset of, well, this is how we've always done it. Hold on. Something different is needed. I love what you said about positive attitude. What was his name again? Can you say that again? Seth?-

Denise (09:32):

Seth Godin. G-O-D-I-N. Prolific author. Just a fantastic individual.

Jim (09:39):

Great.

Denise (09:39):

So the second part of your question was my call for a new paradigm. And so you'll hear many people talk about the current situation in healthcare as broken and I'm one of those. And in many ways, it is broken. Not everything. Not everything is broken, but we are a system in trouble. We have patients who are heavily burdened by many expectations of them, within healthcare. We have staff who are burdened by regulations, organizational policies and practices, by the current challenge of staffing, by the disconnect between those very highest in leadership and decision-making and what actually occurs in the moments of care delivery.

Our current paradigm has healthcare that is not accessible to all. Our current paradigm refuses care or at least to pay for care for far too many or inadequately pays and leaves thousands financially devastated for seeking life-saving care.

Jim (10:39):

Agreed.

Denise (10:39):

We have healthcare that it's being delivered on the backs of nurses and clinicians, they are beautifully heart-centered people for the most of the part and they're striving to do their very best. And when we talk about moral injury, it's true injury, they're suffering. So a new paradigm would be the definition of care and that's all caps, CARE. I'm talking about an experience of healthcare where there's trusted relationships between providers and patients, the patient is known by the provider, the gaps in care are eliminated, misdiagnoses and medical errors are greatly reduced if not eliminated. The new paradigm puts care, the ability to take time to care, back in healthcare. Or as my good friend Tom Dahlberg would say, "It includes love and the relationship of all connected with healthcare."

Jim (11:37):

I love how you're bringing out the importance of relationship and trust. I feel like a lot, especially since COVID in 2020, a lot of the American population, the average person has lost trust in the healthcare system at large. But also

on an individual basis, are we seeing patients as human? Are we building relationships with them? Are we giving them a reason to trust us as healthcare providers?

Denise (12:01):

That's right.

Jim (12:01):

So I think it might be important for our listeners and I always like to hear people's different definitions of the patient experience, but I always like really clarifying that. Would you mind just taking a little time to break that down for us? It's more than simply making patients happy. How would you define or how would you break down the patient experience? What does that mean?

Denise (12:22):

Yes, and you're right. And I touched on parts of it in the prior answer, but I'm happy to go further.

Jim (12:29):

Sure. If you don't mind, yes.

Denise (12:30):

I don't mind at all. And so there are three things I'm going to address here. There are many who will talk about patient experience from the perspective of the "soft stuff," the more customer service like components. And I would agree that those are elements of experience. But they're a very small part when it comes to healthcare experience. Unfortunately most of healthcare with the advancement of the industry of patient experience and that's a worthy discussion, the industry of patient experience that we've created. We are now focused on those elements more than anything else. So it's more on the side of satisfaction than experience.

Jim (13:13):

Sure.

Denise (13:14):

There's a second element of patient experience that some speak to that is also warranted. This side talks about ensuring that our patient's expectations are set. So that's a key word there that we're setting instead of meeting, and this is the psychology of experience. For example, a hospital is going to be noisier than your home. Unless you live downtown New York City, a hospital is going to be noisy, there's going to be beeps and interruptions to your sleep when the nurse comes in. You may have a dual occupancy room and you're hearing your neighbor in the next bed. We can be quieter than we often are, yes, but we're never going to be the same kind of quiet that you have within your home environment.

Denise (14:03):

And so there's an element that talks about how do we set our patients up for that expectation, to ensure that they understand what we mean by the question on an HCAP survey about quiet at night. And to help the patient understand, have that awareness and expectation so when they get that survey they understand, oh yes, it was quiet. What they told me I would expect, I expected or I received. Check, got it. And that's warranted. But here's the problem, there's a bigger issue with experience.

Oh, so here we go. I should be able to schedule an appointment with my physician within days, maybe weeks of needing one. But my most recent experience, I had to wait five months to schedule an appointment with a provider. Well, that's bad-

Jim (14:55):

I know exactly what you're talking about.

Denise (14:57):

... Experience from the moment I've engaged with your organization. And if I'm going to your ED and I have a two hour or more wait in the waiting room

before any treatment has begun, that's experience of care. If I then have questions about whether or not I can trust the care that was given to me for whatever reason, perhaps a misdiagnosis, medical error or just a simple lack of or miscommunication, that's experience of care. And after all of that, I receive a bill for care that I can't pay for or will cause me extreme financial hardship, that is experience of care. And we are completely ignoring that with our conversations on our efforts for the improvement of patient experience.

Jim (15:47):

I love that you touch on that, the billing side, that's a whole nother thing that I've talked about before, in terms of not just the overwhelming cost but the process of the billing. The fact that you don't know what to expect or you might get a separate bill, two or three separate bills for the same visit. A lot of patients, the average patient does not understand the process. I've been in healthcare since 2007. I don't fully understand the process, depending on where you go. So the end of it and that's the last impression you get. But then you also talked about setting expectations, which I really appreciate. I read, I forget what the book was it might've been by Fred Lee, the, What If Disney Ran Your Hospital? I'm sure you heard of that.

Denise (16:25):

Yes.

Jim (16:25):

But the idea of setting expectations, realistic expectations. And yes, we as healthcare providers need to raise the standard but also we need to help patients understand what to expect. But you mentioned a number of wonderful things there that we really can focus on in terms of improving the patient experience.

Jim (16:46):

If you're just tuning in you're listening to The Healthcare Leadership Experience and I'm your Host, Jim Cagliostro. This show is sponsored by VIE Healthcare Consulting, a SpendMend company which provides leading edge

financial and operational consulting for hospitals, healthcare institutions, and other providers of patient care.

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Jim (17:19):

Now Denise, you mentioned you had been involved with Studer Group and Press Ganey, a lot of these for-profits. And you said you had this idealized version in your mind and when you see the for-profit aspect come in, that can really put a hamper up thing. So I did want to talk about the HCAPS, the survey that's really been the gold standard in terms of measuring a patient's perspective of their care. In your opinion, are these surveys effective? Are hospitals using them effectively to assess and improve care? Or would you say there's a better way to approach care, a better way to improve the patient experience?

Denise (17:55):

That's a hot button topic of mine, Jim. So definitely something we need to talk about. We need to make a ruckus about, not just talk about.

Jim (18:04):

Sure.

Denise (18:04):

We need to do something. So we've talked about patient experience ever since HCAPS was mandated by CMS and the only thing that has really happened is the lifting up of an industry called patient experience.

Jim (18:20):

True.

Denise (18:21):

We've not improved experience, not really. The nationally publicly reported data reflects that in those first few years, we did make improvements and that's because at that time there was concern about the money, the incentives that were attached to the results and there was some fuel behind that movement. And in part I think some of it, that improvement, is attributed to Studer Group. There was a lot of effort being done. But in the last decade, I pulled the numbers just recently and I put a thing out on LinkedIn about this. In the last decade, other than the most recent declines in HCAPS because of COVID, our national data shows we're flat, we've made minimal, if any, like a one-point shift improvement across the different components of the survey.

Jim (19:12):

You said that in the last decade, right?

Denise (19:14):

In the last decade.

Jim (19:15):

Wow.

Denise (19:16):

And yet we spend hundreds of millions of dollars annually to the industry of patient experience and we've seen little value. In fact, I would actually argue that we're causing damage. So when we look at the survey, I don't have a huge problem with questions on the survey. So HCAPS, we can look at, but there are actually over 20 CAPS surveys and more are being developed and there are good reasons behind the questions they select. So communication with nurses and doctors, that is critical for our patient's safety. We have to be able to understand what we need to do to take care of ourselves. We also need to be able to express how the treatments are making us feel or any other communication.

Denise (20:04):

We need to be able to have that relationship and that free flow of communication between our nurses, our doctors, our other care partners. Courtesy and respect, a really great question, did our caregivers see us as a person and thus consider our needs, our individualized needs as we received care? Responsiveness, critical, if you have a need, a risk to your safety is happening, you need to be able to push a call button and have a response immediately. Even cleanliness that is all about infection. It's not just about did it look clean? Cleanliness is about was it clean, was it sanitized? And then recommendation that's a question we often focus on like a key performance indicator is recommend hospital, but we forget, we look at the yellow, red, green of that question.

Denise (21:00):

We forget that what that question is really asking is if I would recommend you. I'm saying I trust you. I would trust the care of my friends and family at your organization. That's important that we can trust. And so the questions on the survey they're not about providing Ritz-Carlton like customer service and too often that's how they're talked about. They are actually about seeing you as a person, caring about you as a person . And did we keep you safe and did we provide quality care? The survey has an opportunity to provide value, it really does. But in most cases, we don't extract that value. We're not really listening to the responses, we're not actively understanding why our patients are giving us the scores they're giving us. We're just looking at a scoreboard and trying to seek a number and that's it.

Jim (21:57):

Sure.

Denise (21:58):

The challenge with the surveys is that they fail to capture critical elements of the experience. So not to mention that we are not hearing from huge demographic populations are underrepresented in the responses, but as I hinted at earlier, the surveys have many gaps. They're not capturing critical

components of experience, they're not elevating systemic issues from our national healthcare system. And I'll stop there. I could talk on and on, Jim.

Jim (22:31):

Sure. So the gaps-

Jim (22:34):

That's great. So there is gaps within the survey but also you would say, in terms of leadership management, whoever it is, taking the information that they have and really making changes to `change the experience?

Denise (22:48):

Yes, huge gaps. When you think about the patient experience professional within healthcare, they are typically positioned with no authority. They are a single person, a very small department. When somebody talks about patient experience, all eyes turn to them as if they own patient experience. But they're your coaches, your consultants, they can't own the experience. They can help guide, they can help interpret the data, they can help with process improvement. But they're not positioned to do that. And they're not positioned with a seat at the table of decision-making.

Jim (23:28):

Sure. Speaking of the position of someone who has that patient experience role. A lot of times, again, this might've been from that book actually, the Fred Lee book, where someone asks about patient experience, we say, "Oh that's that person's responsibility." Rather than, "No, that's everybody's responsibility," in terms of having an impact on the patient experience.

Denise (23:49):

That's right.

Jim (23:50):

I really appreciate the point you made about the industry has grown, but have we really grown the patient experience or improved the patient

experience? And sadly based on the data, you said the last decade, we really haven't.

So switching gears a little bit because this is something interesting that I've heard you share on and I completely agree with, but I'd like to dig in a little bit more, you talk about the power of making connections and developing relationships outside of one's own profession. Thinking specifically of healthcare. So healthcare workers, healthcare leaders, making connections with those outside of our own profession. How is this best accomplished and why would that type of mindset be so valuable for the healthcare industry?

Denise (24:34):

Jim, have you heard of The Medici Effect?

Jim (24:38):

I've heard the name but I couldn't tell you about it.

Denise (24:41):

It's a fantastic book and what the fundamental idea is that we have ideas and innovation that get spawned because our perspective is broadened. So when we have an understanding of many points of view, when we have enhanced knowledge beyond our siloed profession and we have a diversity of experience, thoughts and perspectives, we can create connections to ideas, we can create innovative thoughts.

And so I know this personally, my career has had twists and turns and I've had many roles within healthcare. I've been across our country in academic medical centers, community health hospitals, critical health hospitals and everything else. I've been for-profit, nonprofit, just a lot of variety. And I've also met and learned from many people. And of course I have an appetite for learning that has introduced me to a large variety of concepts, from my varied experience and knowledge built through a siloed career.

Denise (25:47):

I can see things, put ideas together so that others can't. I feel this is one of my superpowers, it's one that I consistently work to develop. When we only ever

hear from the same people, people with our same experiences, when we only experience the same experiences and when our knowledge is only deep, and deep is good, but it's not also wide, there's much that we do not know and our perception is narrow, it does not mean that our perception is wrong, but it's incomplete. And so when nurses only ever talk with other nurses, physician with other physician, pharmacists with other pharmacists inside healthcare only willing to talk or listen to others from inside healthcare. And this one's really important in my opinion, when those who have positional title or are considered thought leaders within their field are invited to the conversations or to make decisions, they're the only ones there. We're hearing only from the perspective of that group.

Jim (26:54):

Sure.

Denise (26:55):

We are then only working to solve our perspective of the problem. And this is what leads to band-aid solutions and gaps that we can't bridge. So I think it's absolutely critical for us to have a highly diverse, integrated and inclusive approach. We need to hear from all, we need to pause and listen and seek to understand from each other and we need to stop competing in healthcare. We need to stop blaming each other and recognize we all own the problem, which means we all own finding the solution. So we need to unite, not divide. We need to lift each other up and celebrate the contributions and successes of each. And when one fails, Jim, we need to recognize that their failure offers us all insights to what we can learn and do it on our next attempt. Because we're never going to succeed the first time. Never. Nobody ever has, right?

Jim (27:53):

Yes.

Denise (27:53):

Or if they have, it's the 0.001%. We have to learn from our failures, which means we need to share them and that will lead us to our successes.

Jim (28:04):

I really appreciate that and especially in healthcare where we've become so specialized. Everyone is specialized, every clinician has a specialty. And yes, like you said, it's good to have that deeper knowledge. But we don't have that wider knowledge. And so we do get stuck in a certain mindset or a certain mode of, this is how we do it, and when the needs change, it's difficult for us to change our approach or our mode. So it's valuable to be listening, to truly listen, not just to say, come in, say your thing and then onto the way we always do things. But no, let's take that feedback, let's take that insight from other industries, from other experts. And you mentioned about this desire for learning. I believe being a lifelong learner is so important, especially for anyone in leadership.

Jim (28:48):

I appreciate you sharing that. So I did want to talk a little bit about, getting back to this idea of patient experience. And yes, we want to hear from those outside of the profession, those with other experience, but we also want to hear from patients and family members. We want to be listening. So many of our listeners are hospital leaders. They might be healthcare workers, but at some point in their life, like you and me, they've probably been a patient or they will be at some point. How can patients and how can family members actively participate? How can they advocate for improved patient care in your opinion?

Denise (29:23):

Well, I agree. I think patient and family members are critically important to be included in those diverse groups that I speak of. They need to also be helping us to seek the solutions to the issues because it's only through them that we really understand what they experienced and what they need.

Jim (29:39):

Sure.

Denise (29:40):

And you know, Jim, there are many physicians and others who have had their own experience and had their eyes opened to what the experience of care actually looks like from that of a patient or a family member. And they've been shocked by what they've experienced and there have been some excellent books written. There are some individuals who give just fantastic keynote presentations about it, but they're not typically brought into the conversation, not those decisions for the organization are made. They're heard, they are brought in as a keynote, but they're not really helping to make the decisions. They're not really listened to and nor are they, at the national policy level, heard. And this needs to change.

I'm unsure that we can change it from talking at leaders in healthcare organizations. And when I say that I mean our PFACs, our PFACs are critically important, underutilized, under-supported. We ask people to volunteer their time when really they need to be a partner at the table with us and perhaps be paid in some method for their contribution.

Denise (30:52):

But if we can't do that, then I would say that we, and when I say we, I mean any of us, we need to empower patients to unify their voices and take action. We need to get them information about the systemic issue so that they understand it's not your local hospital maybe, it's something else, it's a national policy that is causing problems, it's your insurance, whatever it may be. But we need to get them that information and we need to show them why it matters to them. We need to tug at their heart and then we need to show them that they have power. So we need to give them tools. So Bruce Berger, I know you interviewed with him,-

Jim (31:30):

Yes.

Denise (31:30):

... Recently shared with me that patients and pharmacists united in Ohio to sue CVS and Walgreens and they won. So we need to identify instances like that and demonstrate that they have a voice and can force change. And then

we need to give them the tools. What do they need to know in order to do that? So that's partnering with them and then what our challenge is that we need to bring that into our local and our national politics. Real change in our healthcare system will not come until we make changes at the higher levels. We keep trying to change in our local hospitals. And yes, there is change to be done there, but the systemic issues that we are struggling with are beyond our local hospitals. They themselves are struggling with them. So we need to be able to see in our local political environments and then get it up higher.

Jim (32:28):

Denise, I am guilty, I'll be the first to admit. A lot of times I go into a situation whether it's my doctor or the lab or pharmacy and I have this mindset of, well, this is just how it is. It's frustrating. I just have to deal with it. Rather than what can I do. And it sounds like, like you're sharing, would you say a lot of hospitals, a lot of health systems are at least giving a space for patients and family members to share their experiences. But it's not necessarily going beyond that. It's not getting to the right people or if it's getting to the people that have the power to change, they're not necessarily doing something about it. Would you say that's fair to say?

Denise (33:06):

I would say that's fair. Libby Hoy has done a lot nationally for PFAC and the development of those and really strong systems. But many organizations that I've worked within have homegrown their programs and they're not effective. It's a check mark. We have a PFAC, but they're not really partnered. They're brought flyers and whatnot to take a look at. What do you think about this? They're not asked, here's a decision that we are thinking about making, let us really partner with you so that we can understand your perception, how will this influence you? That's not done in many instances.

Jim (33:50):

And you also mentioned the politics and the policy and meeting it at the higher level is so important. Do you mind, just for our listeners, PFAC, can you just share exactly?-

Denise (33:59):

Oh, sorry. Yes, thank you. Patient Family Advisory Councils. And for your listeners, most hospitals, most facilities have those available. So if you're interested, if you want to partake, reach out. They are always looking for more volunteers to be a part of those committees.

Jim (34:19):

Absolutely. Well Denise, again, this is something I'm passionate about. I know you are passionate and well-educated and well-versed on this topic of patient experience. And it's a huge topic that I think needs to be discussed more and we see a little bit more on LinkedIn, but we want to see change. So if you can, in just the last few moments we have, just share something that you've learned through your career, through your education, through your experience in terms of leadership, any leadership lessons that you've learned or that have sustained you up to this point in your career?

Denise (34:53):

Yes, so I have a PhD in Leadership and Organizational Change, Jim. The reason why I had that PhD is because straight out of college I was put into a leadership role. I described myself, at that time, I was hardly a dietician. I had just passed that RD so I was thrilled that I was now an RD and a-

Jim (35:11):

Sure.

Denise (35:12):

... Registered Dietician and I was now a Leader. I was not a good leader at all. So I sought my own mentorship, my own guidance because I was not getting it. I was not trained for the position. I was given management training, how to manage a budget and how to hire and whatnot. But I was not taught how to lead. So my biggest thing... There's a couple of things. It's such a large topic, we're only going to touch on the surface, but-

Jim (35:44):

That's okay.

Denise (35:46):

... I think the first thing is to recognize a couple of things. One, there are normal human conditions that get triggered when we're in positions of power. And so we see that organization, that's just normal people get into a position of power and assume that they got there because they are absolutely the perfect individual for that. Or they're trying really hard to cover up that they're not and to appear that they are.

Jim (36:11):

For sure.

Denise (36:13):

But in those positions, they're also under a lot of stress, they are triggered. And so I think the most important thing that I have learned working across our country and meeting with many different leaders is leaders are humans. They are. I believe the majority of our leaders in healthcare, at whatever level they are, they truly come to work each day wanting to do the very best. Often they're not positioned to do their very best and they're struggling. And so when we talk about healthcare leaders, it's an area where we place a lot of blame. I see too much of that where we blame the leaders for the current situation in healthcare. And I think instead we need to seek to understand, we need to understand the very difficult positions they're in and why are they acting the way they are and making the decisions they are rather than just placing judgment on them.

Denise (37:08):

We need to be able to extend a hand to help and we need to be able to give some grace, if, when a leader makes a mistake because they will, we need to be able to give them grace and to let them correct. And then I think the other thing is each and every one of us, no matter what our position is, are leaders. And so how can we consider our own way of actoring, mentoring, guidance, and leading in order to role model it to those around us, to those

above us, et cetera. So instead of blaming and saying, well, they're acting that way, I don't have to be any better. I think each and every one of us owns our own actions and our own leadership in the space that we reside within.

Jim (37:59):

Love it, Denise, and well said. Thank you so much for being on the show today, and thank you to our listeners who spent time with us today.

If you have any questions about VIE Healthcare Consulting, a SpendMend company or if you want to reach out to me or Lisa Miller, you can find us on LinkedIn.

Denise, I should say, I know you're on LinkedIn, the website for PX Community, do you mind sharing that with us too?

Denise (38:19):

Thepxcommunity.com. Real easy and then join us in the community.

Jim (38:26):

Great. So we at SpendMend love helping hospitals save money and we hope today's episode really gave you some insight, some new ideas to consider and use, especially this area of patient experience. We hope that it really reaches into your organization. Denise, thank you so much for being on the show today.

Denise (38:42):

Thank you, Jim, I enjoyed this conversation.

Speaker (38:45):

Thanks for listening to The Healthcare Leadership Experience Podcast. We hope you've enjoyed this episode. If you're interested in learning new strategies, best practices and ideas to utilize in your career and healthcare organization, check out our website at thehealthcareleadershipexperience.com. And, oh, yeah, don't forget to rate and review us and be sure to join Lisa and Jim next time on The Healthcare Leadership Experience Podcast. Thanks again for listening.

MEET LISA MILLER

"It's important for hospitals to have a clearly defined cost savings strategy with purchased services as a component to that strategy. We provide our clients with a focused roadmap to achieve those savings through our expertise since 1999."

Lisa Miller launched VIE Healthcare Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin improvement, process improvements, technology/ telehealth, the patient experience, and growth opportunities.

Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping®, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

Lisa has developed patented technology for healthcare financial improvement within purchased services; in addition to a technology that increases patient satisfaction through frontline insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey.
She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta. Her book The Entrepreneurial Hospital is being published by Taylor Francis.

MEET JIM CAGLIOSTRO

Jim joined VIE Healthcare Consulting in 2018 and brings to the role over a decade of critical care nursing experience at highly regarded medical facilities across three states.

During that time, he observed both the 'good and bad' of hospital operations in a number of regions, giving him a unique insight and understanding which he brings to VIE Healthcare Consulting's clients.

LinkedIn:
https://www.linkedin.com/in/jimcagliostro/

MEET DENISE WISEMAN

MBA, CPXP. Founder, President, and Chief Ruckus Maker at The PX Community

Denise Wiseman, a forward-thinking social entrepreneur, embarked on a healthcare journey with a mission to reshape the support for Patient Experience and healthcare professionals. In 2021, she established The PX Community (PXC), a ground-breaking venture removing barriers to vital thought leadership and resources in healthcare.

Denise Wiseman advocates for transformative thinking, collaborative partnerships, and meaningful impacts in the healthcare landscape.

LinkedIn: https://www.linkedin.com/in/wisewoman1/