ROUNDTABLE

Changing Culture, Leading Strategy at Healthcare Organizations

Culture and strategy often are regarded as "soft" elements of organizational leadership, yet nothing is more vital. An incorrect strategy or resistant culture often become discernible only when an organization is on the rocks. How can leaders inculcate the right strategy and culture in their organizations? An axiom holds that "culture eats strategy," which is a barrier to enacting change in a changing healthcare industry.

Strategy is about setting priorities and allocating resources. As resources tighten, priorities for most healthcare organizations today are changing. Organizational culture is defined as a set of shared mental assumptions that guide interpretation and behavior. Healthcare leaders speak of a culture of safety, a culture of wellness, or a patient-centered culture. Often, however, culture proves resistant to change. Top executives must point the way, but ultimately culture and strategy are about leading people to a desired new state. Leaders must build trust that they are heading in the right direction.

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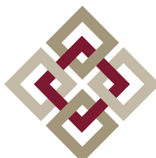

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Roundtable Highlights

HEALTHLEADERS MEDIA: *You all face different situations, yet there are commonalities. Describe culture and strategy at your organization.*

SCOTT BECKER, CONEMAUGH HEALTH SYSTEM AND MEMORIAL MEDICAL CENTER: We're a three-hospital system in Johnstown, Pennsylvania, with a large integrated physician group, Conemaugh Physician Group. Our culture of strategy was developed by a partnership between senior management, the board, and physicians. We started monthly off-site strategy sessions 10 years ago, and they continue today. Through this dedication we have completely changed the cycle of planning. Our fiscal year runs from July 1st to June 30th, and our planning year runs from April 1st to March 31st. What we've really created over this time is a planning process that drives the budget rather than the other way around.

Through that cycle of planning, one of the key questions we continued to ask was, "Can we continue to exist as we are, or do we need to make some changes?" Over a three-year cycle, we went through a series of initiatives and discovered that we are not large enough. As big as we are—a billion-dollar corporation with 5,000 employees, offering plenty of size and scope—given what's going on in our marketplace, we realized that we're just not large enough to really do what we need to do to invest in the future and focus on population health and network products. We are excited about our new partnership with Duke LifePoint hospitals.

What was fascinating about the process was what really drove the selection. In the end it was all about culture. Duke LifePoint was a natural fit. They were the right partner for us. When they toured the hospital that first time, they wore no badges (because the process had to be anonymous), but they looked our people in the eye when they shook hands. They talked to them. It wasn't just a formality. They were engaged and excited about transparency and integrity and patient safety. Those elements are important parts of the culture that we're building, and you could just see Duke LifePoint resonating with it.

CAROL AARON, PEACEHEALTH: At PeaceHealth, we have a very long legacy, grounded in the 1800s by the Sisters of St. Joseph of Peace. Our mission and our values are not something we need to re-create. ... That's why people come, that's why people stay. At the same time, now people are also questioning, "Are we still true to our mission and values with so much change going on both internally and externally?" We're taking a pause this year to do what we call a mission and values review.

We have over 16,000 employees who we call caregivers because we feel everybody's a caregiver. We have a large integrated physician provider group that's in the process of becoming a group because a group in three states is no small task. We have [10] hospitals. What we've learned through our review was that people are saying, "We don't know what you guys are doing because there is so much change." ... So it is a time in which we're going to have to rebuild confidence and trust in our vision and our strategies. And it comes back to the basics of why are we doing it? The why is our mission and values, which is really about our communities and the people we care for. We care for the most vulnerable in many of our communities.

> **"Are we still true to our mission** and values with so much change going on both internally and externally?"

Carol Aaron
CHRO, Senior Vice President
PeaceHealth

TIM PUTNAM, MARGARET MARY HEALTH: What amazes me is how similar our organization is to what the founding concepts were in 1932. We were founded as a community hospital by the community, and in 1932 in the Midwest, things were tough. You're talking a couple of years or so into the Depression. It was a long path out of it, and the community came together to build an institution to serve the neediest in the community. That heritage carries on. You won't go a week or two before someone references that. Our organization's culture is really linked to that core.

In the change that goes on in healthcare, keeping that as an anchor is a big deal. The Affordable Care Act comes out, and you really look at that: Is this good or bad? Anything that helps us provide health resources to the neediest of our community is something we should embrace because it's what we were there for and it's easily linked back to that [history]. ... We've had success financially, so we're strong—which may be kind of a barrier if you're not pushed

to change. If the pressure just keeps coming up slowly, the heat just keeps coming up on a slow basis, then you can get into trouble before you realize it. So our situation is how we continue and look for ways to fulfill our mission better every day.

We're looking at how we can adapt to the changes in healthcare and still provide what we need to to our communities. There's always this fierceness of independence. Is our mission to stay independent? Is our mission to join a system? The conversation always falls back to: No, our mission is to take care of the health needs of this community. So far we have been successful as an independent organization with local decision-making. However, we have started to work closely with several other hospitals in groups like the Suburban Health Organization, which is like-sized hospitals in Indiana, and the National Rural Accountable Care Organization.

Scott Becker, FACHE
CEO
Conemaugh Health System

DON SEYMOUR, INTEGRATED HEALTHCARE STRATEGIES: I think the moment of truth in the provider world in the future is going to be when we change the credentialing processes and we have the fortitude to say to a doctor, "I'm sorry, you cannot be on this medical staff." It's not necessarily going to be a quality issue that they're a bad doc per se. It's going to be, "You don't want to use proven clinical protocols. That's okay, but it's not okay here." Or, "You're not an efficient practitioner" or "You don't use EHR."

PUTNAM: That's the core of the issue. Whether it's physicians, whether it's the CEO, whether it's the board, that's the core of what builds or sustains your culture.

HEALTHLEADERS MEDIA: *You've all said your missions still hold, but people in your organizations are questioning what's going on. "How can we adhere to our mission when we're being forced to do this? We have to worry about the EHR and this and that."*

PUTNAM: The caregivers, these are outstanding people. Sometimes I struggle with the challenges we face in healthcare, and sometimes we get a fair amount of bad press. … It's not for lack of good, caring people. Some of the best representations of people in this country are working in healthcare, but they're shackled with this poor system. … That's what we have to improve. It's leadership's job to work toward improving the system every day.

BECKER: Every employee that works within the Conemaugh Health System is a hero. They come to work every day and impact people's lives through the care they provide. We must always listen when those heroes are saying, "It's great that you think I'm a hero and I really appreciate that, but you're asking me to do more with less. You're asking me to go home at lunchtime if we don't have enough work for the full day." I think that's where we as leaders must continue to drive the process of education. How do we manage their time responsibly, and how do we keep focused on the fact that we're here to take care of those patients every day. Our motto and vision is "Excellence. Every patient. Every time."

SEYMOUR: Everybody's desperate to have meaning in their lives, and everybody's desperate to have leadership to show them where that is. There's an old definition that a leader is somebody you'll follow to a place you wouldn't go by yourself. Who are the leaders? It's executives, the board, and physician leaders. We all know that when that breaks down, things get really bad really quickly.

BECKER: Another major transformation is establishing a partnership between executive and physician leaders. Our mantra is "physician led, professionally managed"—the old Mayo model. We're going through a metamorphosis of what this means. We have to be patient with that because we have some physicians in their 50s and 60s who have been driving a bus the same way for 30 years, and all of a sudden we're saying to them, "That's not what leadership is anymore. This is what leadership is." There's some cultural reaction to that.

How do we reinvent physician leadership? In our case, we continue to invest in education for our board and our physician and executive leadership. We also have seven MDs, including our chief medical officer, who are members of our board of directors. So we really are trying to walk the talk of putting them in the leadership roles and educating them. … The growth of physician leadership around the country is another interesting dynamic that we face, but it's going to take a generation to make that transformation occur.

AARON: There's not going to be enough. We're all wanting physician leaders and physicians on our boards. We launched what we call our Leadership Academy this year, with a focus on clinical providers. It's physicians and other providers. … I hardly ever hear somebody say, "We need more nurse leaders on the board or in our senior leadership roles." We have a lot of talent there as well. Investment in that leadership is huge.

HEALTHLEADERS MEDIA: *Are your organizations resisting change? Culture can halt needed change.*

PUTNAM: People want to be in a better system. People want to have better processes. If I go to my organization and say, "There's a lot of stuff happening in healthcare, but we're going to just stick to our knitting. We're going to ignore what's happening out there, because we're not really going to be affected by that"—that should scare my staff more than anything else. They really want to know how are we going to adapt. So it's not a fearful thing.

I talk to MHA students relatively frequently in three different universities. When I talk to them about what's happening today and some of the challenges we've faced, they can't wait to get into healthcare leadership and make up for the mistakes we made. I give the same presentation to a group of CEOs, and I know what they're thinking: "How much is in my 401(k) and when can I get out? Because I'm not ready for this." The MHA students are like horses in the gate at the Kentucky Derby—they are eager to be a part of creating a better healthcare delivery system.

HEALTHLEADERS MEDIA: *Change takes a long time. In a fast-moving industry like healthcare, you can't even do strategic planning a year ahead. Can organizations accommodate the change needed?*

SEYMOUR: I think there's a lot of lip service. I think there's a shortage of disciplined thinking. Healthcare today is a 10-year horizon. We have a physician shortage—how long does it take to educate new physicians? How long does it take to change a physician? How long does it take to install Epic and get it working? The list goes on. How long is it going to take for the exchanges, never mind the ACA, to be implemented? It's a 10-year horizon. That doesn't mean providers shouldn't be taking action now. The good news is that many of the things they have to do to be successful in the population health world, they also have to do to be successful in the acute care world.

BECKER: There is a separation of the haves and have-nots taking place in our industry. The constant in the haves is consistent leadership; they've been in place for a number of years, so the culture has begun to grow where they lead. Places like Mayo and Cleveland Clinic and Geisinger have had that physician leadership culture forever. The next physician leader simply steps in and continues the process.

"**People say you can't measure culture; you certainly can.** You can measure engagement of employees. You can measure engagement of physicians."

AARON: I hope it's more like three to five years than 10, but unfortunately I think we're probably at 10. But along the way you'll have some growth. You have to change the structures, the processes, the systems, the incentives, and the leaders. Do you have the right people in the right place? The scope of what we expect of some of our frontline supervisors, frontline managers, is just daunting and 24/7. You have to manage 100–150 people, engage them, make sure you're meeting your metrics, do quality, hold huddles, do all the good things we ask of them.

HEALTHLEADERS MEDIA: *So how do you get frontline people—physicians, nurses, intake coordinators—moving in the right direction, and how do you try to ensure that they are capable of taking on the changes in healthcare today?*

PUTNAM: That seems to take me back to my job as a leader, which is pretty simple: I make sure the staff has everything to do their job—whatever that is, whether it's tools, equipment, talent, information, support, education. Whatever that happens to be, that's what I need to do. That's true for the board and true for the staff, and that helps me wrap my arms around how to do my job. We have very good people doing the job and who want to do their job, but they sometimes don't have resources to do it. They don't know where we're going or how to best help this patient navigate through this system. And regardless of your size, you're never big enough to have everything you need.

Tim Putnam, DHA, MBA, FACHE
President and CEO
Margaret Mary Health

BECKER: I'm a proponent of the adage that you can only manage what you can measure. People say you can't measure culture; you certainly can. You can measure engagement of employees. You can measure engagement of physicians. Leadership has to bring processes transparently and openly through the entire organization so that we can change the culture of every unit in the institution. A talent management process, the strategic management process, must all be consistent. Commitment to process is what drives our culture.

SEYMOUR: It's the empowerment, it's the carrots to get people to move in the right direction. But then sometimes it's also the stick.

PUTNAM: You have to take on people who are talented and good at what they do, but don't fit into the culture of the organization. Maybe everybody knows they're the go-to person when you can't get this IV started, but they're hard on the staff. They're rude. They don't fit into the organizational culture. Do you have the fortitude to let that person find another organization to work for?

HEALTHLEADERS MEDIA: *Where does culture change happen? We've talked about the importance of leadership. But it's at the frontline level where people create change.*

AARON: I think it's *both/and*. It's not *either/or* because norms and behaviors may be imparted by the leadership, but change definitely happens at the front line. There are also intended and unintended cultures that are created.

Don Seymour
Executive Vice President
INTEGRATED Healthcare Strategies

BECKER: Every nursing unit or department in the institution has its own unique culture. One unified culture throughout CHS is our goal—what we ultimately want to achieve. We have to give our leaders defined and integral processes, and defined and integral measures, so that they know what's of value in the institution.

PUTNAM: I believe the culture of an organization exists in the frontline managers—the people who are still technical experts at their field and still have some level of patient care but are also responsible for leading a division, a department, a section, or something like that. … If I walked into your organizations and talked to the frontline managers, I could tell your culture.

SEYMOUR: The challenge with empowering people is that we are so over-regulated. The default for every employee is, "What does the rulebook say?" as opposed to the Neiman Marcus service experience.

PUTNAM: The difference is the number of regulatory and oversight agencies that determine operation. The state of Indiana, Medicare, insurance company scorecards, and a number of different agencies that put rules in place to protect the public—much more so than Neiman Marcus. Look at the healthcare reform law and how many regulations are included and yet to be determined by the Secretary of Health and Human Services. We can't address a real patient need because of the 2-midnight rule; we can't give chemotherapy late in the afternoon because of the physician supervision rule. It sounds like an excuse, but the regulation is daunting.

HEALTHLEADERS MEDIA: *What happens when culture goes wrong, strategic planning goes wrong, and leadership decisions goes wrong? These are high-stakes things.*

PUTNAM: Very high stakes. Speaking from a small community, when mistakes are made, when a community loses confidence in its healthcare system, it's devastating. I'll talk to new CEOs coming into their role in a small community and I'll say, "I don't mean to put pressure on you guys, but if you fail, it's not just a patient who suffers, it's not just the organization, it's your community. If you close the doors, your community's going to go down. If you lose quality healthcare in your community, there's not an industry that's going to come in here, there's not an industry that's going to expand. The companies here are not going to be able to recruit good people into your community."

AARON: In some of our communities there is nobody but us. It's as big as carrying on our mission. In some of our communities we're pretty much the last hope for people who have nowhere else to go. So my biggest fear is that in some way our mission will be compromised or not sustained, because that really is the core of our culture and why we exist.

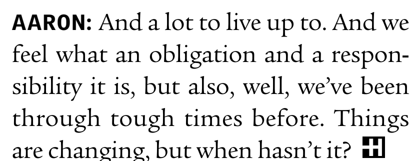
SEYMOUR: There is no capability of coasting in this industry.

BECKER: Every blessing is a curse; each strength is a weakness. We have to stop apologizing for being the biggest business in our communities and start filling the mission as a business leader. Healthcare is on the defensive all the time. If we were any other business in the world, people wouldn't be saying, "It's 17%, 18% of the gross national product." They'd be saying, "Look at that business—it's growing and developing and we need to invest in that." It's time to harness the growth and the energy and become less government-dependent and drive the process effectively. That's an exciting opportunity.

AARON: When you think about it, this is a mere little point in time. It's a minute in time in everybody's legacy. Over 100, 150 years, it's not the worst time and it's not the best time. When PeaceHealth started, we were in logging camps and the sisters were begging for money in bars, and there was a flu epidemic.

BECKER: Clara Barton founded our hospital in 1889 after the Johnstown flood. Every one of us shares in that great legacy.

AARON: And a lot to live up to. And we feel what an obligation and a responsibility it is, but also, well, we've been through tough times before. Things are changing, but when hasn't it?



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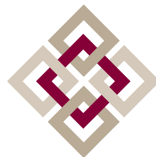

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