Aligning Cultures, Vision and Values

HITTING ALL THE KEYS

BY TERRY WEINBURGER, M.S., AND SR. JENNIFER GORDON, SCL, M.B.A.

As health care systems respond to government and market forces, partnerships are proliferating. Factors driving them are well documented: the need to increase size and scope for long-term sustainability, regional concentration offering a competitive advantage, the advent of health care reform, a focus on population management, the need for increased capital and improved purchasing power, to mention a few.

A range of partnership options is now in play, each claiming to bring increased value to the consumer. But whether it is through merger, joint operating agreement, strategic alliance or any other mode of affiliation, when two health care systems form a partnership, a challenge immediately emerges — how to align and integrate two cultures. Early in the due diligence process, the systems need to assess their degree of cultural alignment and shared vision. Such assessment can forecast the risks and potential value of partnership.

Both systems typically will have statements of purpose — why the organizations exist — and both will have individual vision statements, usually an aspirational declaration looking three to five years ahead. Finally, both systems will have a set of beliefs usually identified as core values. Taken together, these three foundational elements serve to guide the day-to-day behavior for all stakeholders — board members, physicians, employees and volunteers. As the new partners combine, leadership can rely on these three elements to help develop organizational DNA, supported by orientation and assimilation processes, to intentionally shape a new, integrated culture.

An integrated culture can spur an organization to achieve outstanding results when three key characteristics fall into place, notes Chris Lowney, an author whose career has included both the seminary and J.P. Morgan & Co., in his history of the Society of Jesus.[1]

1. The culture is strong not just on paper but in a tangible way that guides day-to-day behavior
2. The culture is strategically aligned
3. The culture promotes adaptability

PRINCIPLES APPLIED

Over the past 15 years, these three characteristics have served as a cultural integration reference point for two health care systems, the SCL Health System and Exempla Healthcare. Their affiliation began in 1998 when the two systems executed a structured joint operating agreement. Under terms of the original joint operating agreement, the SCL Health System shared sponsorship of Exempla with a local foundation. At the time, both boards elected to maintain their individual mission statements, vision statements and core values.

SCL Health System, a Catholic, not-for-profit health system, serves communities in Kansas, California, Montana and Colorado. From 1864 to 1972, the Sisters of Charity of Leavenworth established or assumed responsibility for 18 hospitals from Kansas to California. In 1972, the sisters established a health services corporation for the direction and management of hospitals in their health care apostolate. In response to the increasing complexity of health care delivery, the health

care system's first combined lay and religious board was appointed in 1994.

Exempla Healthcare, also a not-for-profit, community-based health care system, serves the Denver metropolitan area with three hospitals and a physician network. The first hospital was founded in 1873 and is the oldest teaching hospital in Colorado. The second hospital was founded in 1905 as the Evangelical Lutheran Sanitarium to care for tuberculosis patients. The third hospital opened in 2004 to serve the rapidly growing community in northwest Denver. The physician network has been serving the people of Denver for more than 20 years.

NEW STRUCTURE

Anticipating health care reform in the United States, SCL Health System recognized the need for greater size and scale, and sought to expand its presence in Denver. This involved amending the 1998 bylaws of the joint operating agreement with Exempla Healthcare, and SCL Health System gained increased oversight of strategy and operations of the three Denver area hospitals. This change culminated in December 2009.

As they looked to the future, the Sisters of Charity recognized they would have fewer members available to devote full-time to health services or with the specialized education and training to navigate the complexity of the health care business environment. This recognition, combined with extensive study, prayer and discernment, led them to request formation of the new Leaven Ministries public juridic person (PJP) and to transfer sponsorship. They received canonical approval and a transfer of sponsorship and commissioning ceremony occurred in September 2011. SCL Health System moved its health system headquarters from Leavenworth, Kan., to Denver the following year.

As they amended the terms of their joint operating agreement, the two health systems recognized that cultural integration was taking root, but there needed to be additional alignment, including a revitalization of the mission and vision statements. In a phased timetable, the two health care system boards adopted identical statements.

But what about the two sets of core values?

SCL Health System assigned its newly employed senior vice president for mission integration — Terry Weinburger — to lead a project creating a single set of values for both health care systems. The project's charter outlined an inclusive process to ensure that all stakeholders would have a voice.

PROJECT DESIGN

Weinburger used internal resources and an existing infrastructure, including a mission council composed of leaders representing both health care systems, to launch the project. Following an August to November 2011 timeline, the project's

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TWO SETS OF CORE VALUES

Both health systems had core values deeply embedded into their respective cultures. The challenge was to take these two sets of values and make them one. While the specific words reflected each system's individual legacy, both sets of values expressed a confluence of similar beliefs.

SCL HEALTH SYSTEM

Excellence: We offer excellent and compassionate care.

Respect: We recognize the sacred worth and dignity of each person.

Response to Need: The health care we offer is based on community need, with a special concern for the poor.

Stewardship: We are mindful that we hold our resources in trust.

Wholeness: We value the health of the whole person — spiritual, psychosocial, emotional and physical.

EXEMPLA HEALTHCARE

Integrity: Doing the right thing.

Welcoming Spirit: Making all feel welcome.

Partnership: Together and with patients, families, community; with physicians, providers, payers.

Pride: Doing good work and making health care better.

Good Humor: Enjoying one another and our work.

guiding principle was to query all stakeholders, asking them to articulate what gives them energy, how they identify with the mission and how they engage with the work they perform each day.

Participants in the process included associates, physicians, volunteers, foundation and hospital board members; one hospital even hosted a focus group of citizens from the local community. The project was designed to invite as many people as possible to participate in a quick, easy, nonintrusive, nonthreatening and inclusive manner.

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After reviewing both systems' values and associated definitions, the mission council proposed a revitalized set for use in focus group sessions and an electronic survey:

Excellence: Challenging ourselves to consistently improve service, quality and outcomes

Caring Spirit: Honoring the sacred worth and dignity of each person in every interaction

Servant Leadership: Fostering healthy, trusting relationships built on understanding and striving to meet each other's needs

Stewardship: Holding our resources in trust and trusting there will be enough if we care for what we have

Joy: Grateful for and gaining strength from our work and each other

Wholeness: Seeking health of the whole person in the balance of spiritual, psychosocial, emotional and physical well-being

Members of the mission council developed the electronic survey and hosted and facilitated 68 focus group sessions to gather input on four specific questions:

1. Does this value express our spirit when we are at our best? Is it us?

2. Does this value give direction to the way we do things around here? Can it inspire us?

3. Does this value have meaning both for work with patients and among staff?

4. Is this — for us — the right word for the value?

RESULTS

Nearly 4,000 people participated in the focus groups and surveys. Several key messages emerged from their comments:

■ Participants said they were grateful for the opportunity to have a voice and appreciated the open and transparent process. These responses were important indicators of engagement; stakeholder input is critical when cultural changes are being introduced.

■ Respondents requested a shorter list of values. They also recommended that the definitions use simple words to help ensure that the values would be easier to remember.

■ Respondents agreed that how the systems implement the values is more important than the words. Respondents specifically asked for their leaders to "walk the talk."

Next to review the data were three leadership groups — hospital presidents/CEOs, senior leadership teams for each of the hospitals and hospital mission councils. Then it was time to gather all the survey and focus group data, the analysis of the comments and the feedback from the leadership groups to compose a revised list of values:

Excellence: We set and surpass high standards.

Caring Spirit: We honor the sacred dignity of each person.

Integrity: We do the right thing with openness and pride.

Stewardship: We are accountable for the resources entrusted to us.

Good Humor: We create joyful and welcoming environments.

At the end of 2011, both health system boards approved the recommended five new values, and Leaven Ministries, the PJP, subsequently approved the values, as well.

BY THE NUMBERS

Associates, volunteers, physicians and board members expressed appreciation that, rather than bring in a consultant, the project used internal resources and existing mission leadership who understood the culture and facilitated meaningful engagement. It took members of the mission council approximately 400 hours to design, facilitate and manage the project. The hours included the design team's work; script development;

proctoring the 68 focus group sessions; data tabulation, compilation and analysis; dialogue with leadership groups; and preparation for presentations to stakeholder groups.

To calculate the internal costs for the project, the human resource department provided an average hourly compensation rate and a benefits percentage figure for a conservative hourly computation. The calculated total project cost was approximately $14,000. Engaging an external consultant and following a "train the trainer" model with existing mission council staff would have cost an estimated $75,000.

PUTTING THE PLAN IN ACTION

Leadership from three departments in both systems — mission integration, communications and human resources — then designed a comprehensive communication and implementation plan for board members (foundations and hospitals), associates, physicians, volunteers and the public. The communication roll-out started in the first quarter of 2012, featuring a new SCL Health System logo with the new mission and vision statements and the new list of values for both systems. These were introduced in a variety of methods, including face-to-face town hall meetings, electronic communications and printed materials.

Concurrently, SCL Health System chartered a mission, vision and values steering committee through December 2013 to ensure deep and broad implementation of the new values into the culture. To promote the new values for both systems, all collateral printed and electronic material was updated with the new values and they were communicated in some innovative ways, including sharing the new mission, vision and core values with bishops from local dioceses; incorporating a mission, vision and values template on meeting agendas; daily prayer reflections highlighting the five new values; screensavers with pictures portraying new values; displaying cardboard cut-outs of the new mission, vision and values throughout the environment; developing easel-backed posters at nurses' stations to feature the new values; and including the new mission, vision and values in grant proposals to third parties.

Human resource leaders updated all recruitment material, revamped the new associates' orientation program, revised the physician onboarding toolkit, and updated interviewing formats, performance appraisals and succession

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planning documents to include the new mission, vision and values. Human resource policies are currently undergoing an intentional review through the lens of the new values, and all job descriptions are being updated to reflect the new values as well.

To further embed the new values into the culture, training modules and education curricula now start or conclude with commentary linking content to the new values; the new values are introduced at third-party contract negotiation sessions; and weekly "Mission Moment" articles are disseminated electronically throughout the health care systems, aligning storytelling with the new values. Associates' engagement surveys included custom statements assessing level of commitment to new values, and associate recognition awards reflect behaviors aligned with the new values. One hospital even developed a 2013 calendar reflecting the new values with photos.

A shared commitment to embed a culture with one unified set of values and associated behaviors continues. As one comment from a survey participant stated, "how we implement the values is more important than the words we use; it has to be our lived experience."

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NOTE
1. Chris Lowney, *Heroic Leadership: Best Practices from a 450-year-old Company that Changed the World* (Chicago: *Loyola Press*, 2003), 247.

PREPARING COMMUNITIES TO BE HEALTHY, RESILIENT

BY JULIE TROCCHIO, M.S., and JEFFREY LEVI, Ph.D.

Health care organizations have plans for preparing their facilities in case of disasters and plans for how to respond when disasters occur. But as they play a greater and greater role in community health, hospitals also have important opportunities to help their communities prepare and to promote resilience — that is, working to create a community that can stay strong in the face of emergencies and man-made and natural disasters.

Resilient communities are characterized by healthy people who have access to health care — including mental health — and who have the knowledge and resources to care for themselves and others in both routine and emergency situations. Resilient communities can adapt to adversity and rapidly restore community functioning, thus minimizing negative health consequences.

Public and private organizations share the responsibility for building resilient communities and for community disaster preparedness. Local and state health departments work with emergency management officials in coordination with the U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response; the Centers for Disease Control and Prevention Office for Public Health Preparedness and Response; and the Department of Homeland Security to plan the public health response to potential disasters. When disaster strikes, health departments communicate with the public, disseminate medical countermeasures, deal with a surge of medical patients or fatalities and activate the public health laboratories, epidemiology and surveillance necessary to detect and track outbreaks or events.

Community organizations play a vital role in disaster preparedness and response. Local chapters of the American Red Cross, Catholic Charities agencies, United Way organizations and others have well-established missions related to preparing for and responding to community disasters. Local disaster plans also may involve colleges and universities and other community organizations and businesses.

WHAT CAN HOSPITALS DO?

Disaster preparedness and resiliency are an important part of community health. As such, hospitals should include these topics in their next round of community health needs assessments. Some suggestions include:

■ **Look beyond your traditional definition of community or local service area.** For the purpose of looking at community disaster preparedness, hospitals should consider taking responsibility for a larger geographic area, for example, adding rural areas that lack local resources. Further, hospitals, working with local public health and disaster preparedness organizations, should evaluate their entire region and make sure that no communities are left uncovered if disaster strikes.

■ **Broaden the committee.** Invite facility and health department disaster preparedness staff to join the needs assessment steering committee or to be part of a resilience/preparedness subcommittee.

■ **Seek out others who have disaster plans.** Find out what other organizations have responsibility and plans for disaster preparedness for either the broad community or for special populations. For example, the local Area Agency on Aging may have disaster plans for frail elders. The area mental health association may have plans for their clients.

■ **Include community benefit staff.** If the hospital is part of or joins a local or regional disaster preparedness coalition, see if community benefit as well as disaster preparedness staff can be part of the discussions to learn about needs and plans.

■ **Add questions to the community health**

needs assessment framework related to preparedness and community resilience. For example, have chronically ill and disabled patients and their caregivers been counseled on what to do in case of service or power disruptions? Do we know who in our community will have special health needs in the event of a disaster or emergency?

HOW TO IMPLEMENT STRATEGIES

Addressing needs related to community resilience and preparedness can include both internal facility actions and collaborative work with other organizations. It is important that all of these activities be integrated into an overall plan and coordinated with each other.

Inpatient and outpatient clinical programs, especially those serving patients with such ongoing needs as psychiatry, hospice, oncology and dialysis, can include instructions for what patients and their caregivers should do in case of severe weather and other events where services are disrupted. If problems are predicted, such as an advancing storm, needed treatments could be rescheduled prior to the expected event, and patients given supplies adequate for a prolonged period of time.

Primary care clinics, as part of patient teaching, can instruct patients with special needs about planning what to do in case the power goes off or other disruptions occur. Where can they get emergency care? Do they have hard copies of important medical information and medication lists? Do they have friends and family who can help? Is there a family or neighborhood plan for continuing care and support for frail and dependent persons?

For patients needing special equipment such as oxygen, and devices requiring a power source, clinicians, discharge planners and case managers should be sure to make a plan for what steps the patient should take if the power goes out. If the patient has a backup generator, he or she needs to know how to use it for their specific equipment.

As a last resort, patients and their caregivers may need to know how to access special needs facilities (often nursing homes with generators are identified for this purpose) and where — such as at a local fire house — they can find a source of power for recharging devices. Hospitals should keep records of all patients having such needs so that if a disaster occurs, these people will be quickly identified and receive needed help and services. Find out if there is a community registry for persons who will need help in case of emergencies.

COMMUNITY PARTNERSHIPS

Depending on needs identified in the assessment and gaps that must be filled, health care organizations can work proactively with appropriate community agencies and organizations to coordinate plans for community preparedness.

Be sure local health department officials and others responsible for preparedness are aware of your interest. They may suggest ways the community benefit program and other services in the organization can be part of existing preparedness plans and take a role in communications, coordinated medical response and surveillance. Ask about health department and other agency efforts to build resilience, and ask how the health care organization can play a role.

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Preparedness coalitions should determine in advance who will be responsible for coordinating medical and other volunteers who typically pour into a community after a disaster. The United Way and American Red Cross often take on this role. Centralized locations also should be predetermined to receive and distribute funds and to sort the material donations that are likely to arrive. Community benefit leaders may be part of these discussions.

Community partners should plan on how mental health as well as physical health needs will be addressed immediately and in the aftermath of the disaster. Service providers should be aware that behavioral health problems may arise or be ex-

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acerbated, and emergency personnel and others should take this into consideration when treating and helping patients both during and after disasters. For example, public health officials report that in the wake of the 2012 Sandy Hook Elementary School shooting, in addition to immediate needs for counseling, mental health support became a critical long-term need in the community.

The keys to resiliency are social networks and personal support. In fact, HHS describes resilient communities as having "robust social networks and health systems that support recovery after adversity. They are prepared to take deliberate, collective action in the face of an incident and have developed material, physical, social, and psychological resources that function as buffers to the negative effects of these incidents and help protect people's health. Social connectedness is integral to a resilient community's ability to marshal resources, communicate with residents, and plan for infrastructure and human recovery."[1]

Efforts to build a sense of community and to strengthen relationships among community members will be critical to a community's resilient response to a disaster. Faith communities and other organizations such as neighborhood associations and various clubs can take a role in ensuring that the community develops a culture in which people take care of each other every day, and especially when disaster strikes. Community benefit programs can take a role in building on and supporting these community assets.

Attention to community preparedness and resiliency should be built into routine processes and relationships. If it is seen as a new or added responsibility, there is a risk that it won't be done. However awareness of the need to be prepared and to help the community be prepared, as an underlying goal and value, integrated throughout the organization, can assure we do it right.

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Is your health care organization involved with a local or state health department to prepare your community for disasters? Does your community health needs assessment include indicators related to preparedness and resiliency? CHA and the Trust for America's Health are looking for examples of successful practice. Please contact Julie Trocchio Jtrocchio@chausa.org or Jeff Levi, Jlevi@tfah.org.

NOTE
1. www.phe.gov/Preparedness/planning/abc/Pages/community-resilience.aspx.

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