Accelerating systemness through shared vision and culture

Received (in revised form): 27th January, 2023

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Abstract As health systems across the United States consolidate, tremendous potential exists to expand and optimise their breadth and depth by integrating services so that patient care is coordinated, supportive and equitable. The financial pressures and workforce crisis resulting from the COVID-19 pandemic have further exacerbated the need for fiscal discipline and operational efficiencies that can come from effective, system-wide integration. Yet many health systems continue to fall short of achieving the promise of post-merger integration and the value it can create for the diverse communities they serve. This paper explores one health system's journey from 'operational synergies' to full 'systemness' enabled by a shared vision laser focused on a commitment to frictionless, patient-centred care through enabling care teams to do their best work, accelerating integrated operations and building an inclusive culture. It will explore the journey of a system in name only (Wellforce) to a unified team with a single brand (Tufts Medicine) and a shared commitment to the future with a mission *to empower people to live their best lives.* This case study will describe how the system evolved, starting from the development of a transformational Strategic Vision, through the shared trials of the COVID-19 pandemic and its effect on patients and providers. Having a shared vision is an essential first step to building systemness. Bringing that vision to life requires significant discipline and culture change. It requires a systemic approach and unwavering leadership, rooted in a shared philosophy, deep commitment and aligned behaviour. The case study will continue with an exploration of the path system and entity leaders took to identify shared priorities, adapt organisational and governance structures, and engage more than 14,000 clinical and administrative staff and physicians in building an inclusive culture with a clear and actionable commitment to anti-racism. It is a story about moving from words and ideas to action and removing the barriers that impeded progress.

KEYWORDS: *systemness, culture, strategy, vision, health equity, leadership*

LAYING THE GROUNDWORK

Founded in 2014, Wellforce was created as a different kind of health system, designed to provide eastern Massachusetts hospitals and physicians with a new option for collaboration — bringing together

the strengths of academic medicine and community care in a model that respected both equally. The vision was threefold:

- Bring together academic medicine and community health care in a way that delivers care when and where the patient needs it.
- Deliver the highest quality of care while lowering the total cost of care.
- Improve the health and lives of the diverse individuals and communities of eastern Massachusetts.

The system began with the merger of Tufts Medical Center (a 415-bed academic, quaternary centre based in the Chinatown neighbourhood of Boston, Massachusetts) and its network of nearly 1,800 physicians called New England Quality Care Alliance and Circle Health (a two-campus, independent, not-for-profit community hospital system serving the Greater Lowell area and surrounding communities, about 30 miles northwest of Boston) and Circle PHO, its physician hospital organisation. A second community system just north of Boston, MelroseWakefield Healthcare, joined in 2017, followed by the Home Health Foundation in 2018. The system became an obligated group in 2019.

The system is based in eastern Massachusetts, a market characterised by intense competition and dominated by large, prestigious hospital systems that have grown over time through mergers and acquisitions. The largest of these systems (Mass General Brigham, formerly Partners Healthcare) is organised around academic centres that have invested and scaled their inpatient and outpatient capacity across the region. They have leveraged their brand to further their market position and, in some cases, to command premium prices that have allowed them to further fuel their growth. Their business model, like most systems in the state, has remained heavily reliant on fee-for-service hospital pricing and volume. Despite many early and innovative payment initiatives by Massachusetts to expand care and lower the total cost of care, the Commonwealth remains one of the most expensive states for health care in the United States on a per capita basis. As a result, there is great opportunity in the market for a 'disruptor' to challenge conventional care delivery models and to focus on consumer-centric, value-based care. In fact, the Health Policy Commission recognised in its review of Wellforce prior to its merger approval 'this transaction may actually decrease costs' — in sharp contrast to other affiliations in Massachusetts, which had raised the spectre of higher healthcare costs.[1]

One way that the system initially kept its costs down was by having an extremely lean administrative function with the intent to coordinate and drive back-office efficiencies, relying heavily on supply chain efficiencies and some vendor consolidation. Like many health systems, each entity had its own strategy, culture, governance and priorities. They could 'opt in' or 'opt out' of system-led initiatives. Their IT systems were largely separate, both clinically and financially, with many of the outdated systems in need of replacement and coordination. This approach worked in the early days, but it became increasingly clear to the Wellforce Board that the system would not achieve its potential for differentiation without integrating more fully.

When the founding CEO announced his retirement in 2018, the Board launched a nation-wide search to find a successor who could transform Wellforce from a 'system in name only' to one that could truly optimise the benefits of 'systemness'.

WHERE TO START

In January 2020, Wellforce welcomed a new CEO, Michael Dandorph, who prioritised fully integrating the system at the outset of his leadership. Dandorph had previously led integration efforts at Penn Medicine and

Rush Health. While the potential benefits of systemness were real at Wellforce (eg lower cost, better quality and improved patient experience), he was keenly aware of the significant barriers to achieving it. The Advisory Board's report on Healthcare Systemness in 2015 posited that clinical standardisation was the biggest barrier to systemness around the country. Yet significant cultural and operational transformation is a prerequisite for achieving crucial clinical standardisation, let alone the promise of other benefits. Building systemness would require stepping back to articulate a case for change that demonstrates why it is needed and what would be different as a result:

- What could the system do together that the individual parts were otherwise unable to do on their own?
- What would this suggest about a compelling, unifying vision for the future that could serve as a north star for decision making and priority-setting?
- How would the entities and the people working within them need to work differently with each other to build a unified culture that could bring the vision to life?

With these questions answered, leaders could accelerate their ability to tackle the crucial enablers to making systemness possible, including realigned governance, creating physician alignment, centralising important corporate functions and enhancing interoperability through digital transformation. These enablers may sound like the familiar building blocks of systemness, yet they often take decades to achieve — if they are ever achieved. The speed with which Wellforce embraced and tackled this work was dizzying, and the results have been significant. Even before arriving for his first day on the job, the CEO set out with his new leadership team to learn as much as possible about the organisation, its people and the market — all with the intent to build a shared and motivating vision for their collective future.

DO THE WORK, BUILD THE TEAM

Launching required the leadership team to have a shared point of view about their starting point, as it is difficult to make choices about the future when decision makers are working from different assumptions and experiences. What were their *collective* strengths, important challenges and opportunities (both obvious and perhaps not so obvious)? Additionally, while each entity understood their own business and culture inside and out, local leaders were less knowledgeable about the strengths and challenges of their partners and the whole.

The leadership group also faced another challenge — they were not yet a real team. Previously, they had largely functioned in dual roles, representing and completing work for their individual, 'home' entity while also wearing a system hat. With new executive leadership, they would now be called upon to think about the system as a whole — including times when their local entity might not benefit from a decision (eg the only entity with an optimised electronic health record was asked to replace it, after the system determined that it would run on Epic). Leaders would now need to think first about what is best for the 'system', as opposed to each individual part of it. This was a significant and transformational shift and one where many other organisations fail. The joint work of creating the Strategic Vision would serve as the mechanism through which to start to build the experience and the trust the team would need over time to lead the system together. The CEO knew that a high-functioning team would be essential to shaping a vision and executing it. He focused relentlessly on building the trust and relationships needed for the team to 'own' the success of the entire enterprise — not just the piece parts.

The team first looked at some of the system's accomplishments, which included enhancements to governance; a successful bond issue as an obligated group; and operational synergies that had saved about US$70m. They also reflected on efforts that had been less successful, including strategies for ambulatory expansion, consumer preference, shared services and growth. These conversations translated into a broader effort to understand the current 'theory of the business' for the full system — the team was also well aware that reaching a shared vision would require the involvement of other strategic leaders, some who could already see the potential of systemness and others who were more reluctant.

CREATING A SHARED THEORY OF THE BUSINESS

Famous management theorist Peter Drucker said, 'Every business is built around a set of assumptions that shapes its behaviour, dictates its decisions, and defines its customers, competitors, technology, and services.'[2] There are three types of assumptions that create the theory of the business:

1. Environment of the organisation — these assumptions define what an organisation gets paid to do.
2. Specific mission of the organisation — these assumptions define what can be considered as meaningful results.
3. Core competencies needed to accomplish the organisation's mission — these assumptions define where you must excel to maintain leadership.

Leaders should base their strategy on a shared set of assumptions that people understand and that provide the basis for rational and transparent decision making. To establish these assumptions and to generate ideas for a differentiating vision, the work at Wellforce expanded beyond the corporate leadership team to a much broader set of stakeholders. A steering committee, representing each entity and a mix of clinical and administrative roles, was established and charged with the work of defining the vision. In-depth interviews were conducted with administrative and clinical leaders, as well as the Board of Trustees. An external market assessment was also conducted to inform the steering committee's work.

These inputs were synthesised into a set of planning assumptions, important questions and early ideas about the Strategic Vision. Specifically, it was clear that the system would be planning for a future in which

1. Consumer expectations will continue to rise and influence the propensity to choose one provider over another — based on overall brand experience — including perceived quality, safety, service, access and cost.
2. The stress on the economy and spending on health care will generate even more external pressure on lowering the total cost of care.
3. The continued shift from inpatient to outpatient and alternative settings of care (including home and virtual care) will be more broadly adopted by consumers, providers and payers.
4. The competition for clinical and administrative talent will intensify, and the level of stress and burnout will be unsustainable (even before the COVID-19 pandemic). Unabated, these trends put the system at risk for further healthcare workforce shortages.
5. Scientific and technological advances will continue to disrupt conventional health care delivery business models. Private equity and venture capital interest in healthcare will continue growing at an accelerated pace.
6. The role of advanced diagnostics and 'big data' will become increasingly important to targeted care

and precision medicine processes; this includes the integration of augmented intelligence, predictive analytics and digital therapeutics in care processes.
7. There will be increased pressure to improve margins to reinvest in programmes and infrastructure and to service debt. This may also drive private practices and independent hospitals that are unable to invest on their own to align with larger systems.
8. Identifying and addressing the social determinants of health and the role of racism in medicine that drive health disparities will gain greater public policy attention and influence population health efforts. Similarly, work to ensure diversity, equity and inclusion (DEI) will importantly shape how health systems meaningfully engage with consumers, members of the care team, communities and everyone else who plays a role in advancing health and well-being.
9. The role of government and the adoption of public funding options will continue to be considered and debated. While unlikely to directly affect the next three years, the private commercial insurance market may erode, correlated with growth in governmental programmes, placing further stress on cash flow margins.

Themes from the interviews and the implications of the planning assumptions surfaced several important questions about what it would take to successfully respond. Stakeholders continued to believe that the market needed a value alternative — but what would it take to ensure that value would be valued and not just used as a proxy for low reimbursement? Would consumers eventually bear the cost burden enough to seek out a value option? They also continued to believe in the power of a distributed academic model — a term they used to describe the academic centre's desire to bring doctors and care out to communities rather than funnel care downtown to a more expensive academic option. Questions emerged about what the model meant in practice and whether it would be possible to innovate in a fundamentally different way than competitors who continued to tout their community hospital relationships despite lacking a value proposition and having an extremely high number of academic beds to fill. Interviews also revealed that the entities enjoyed the benefits of relative autonomy as system members; yet they questioned how to balance this individual value and what it would take overall to feel good about decisions for the system that may disadvantage individual members. All agreed that a lean central office was attractive but could start to see places where the system could provide deep value and was understaffed to do so. Would it be worth the cost to staff up? Another significant belief that emerged was that physicians were looking for a better partner and deal. The question that logically followed was, what could the system meaningfully deliver — and what would the physicians be expected to give in return?

These questions teed up larger structural issues — should the system shift from a holding company to an operating company model? Did it exist to create value for each other or for patients? Would it be stronger as a 'house of brands' versus a 'branded house'? All agreed that responses to these questions could be determined only when the Strategic Vision was clear.

Just two months into the process, the early contours of the Strategic Vision were starting to emerge. Leaders and steering committee members alike did not realise that they actually agreed on more about the system's future potential than they disagreed. It was clear that they were converging on a few important ways to differentiate the system in

their highly competitive market, including the following:

- An extreme focus on the consumer, enabling seamless navigation across the continuum
- Creating an environment that attracts physicians and enables them to do their best work
- Ensuring an optimal experience for employees
- Optimising the distributed academic model (pressing the boundaries beyond clinical to teaching and research where possible)
- Accelerating growth and scale through acquisition and partnerships
- Continuing to focus on value

With the new CEO now two months into his tenure, the steering committee meeting on assumptions and directions a success, and the crucial elements of a future vision explicit, the process was gaining momentum. Just a few days later, in March 2020, the COVID-19 pandemic shutdown was initiated, and the Strategic Vision process was put on hold.

LIVING INTO WHAT IT MEANS TO BE A SYSTEM THROUGH THE EXPERIENCE OF COVID-19

In the earliest days of the pandemic, leaders leapt into action largely as they would have in the past, where each entity initiated its own command centre, communicated with employees and developed response plans. This moment became an inflection point for the system and its new CEO. Given the disruption already created by the pandemic and the rapid pace at which the situation was evolving, was this a time to lean into systemness or hit the pause button? Dandorph leaned in, helping members across the system see their colleagues as resources and thought partners. He stressed that Wellforce would take on the challenges of the pandemic as one unified and integrated system. For example, a unified approach made it possible to keep employees and patients safe, by elevating the centralised command centre as the place where crucial decisions were made. The CEO made it clear that no single part of the system would go without resources if other members had supply to share. This was particularly true with personal protective equipment and COVID treatment and vaccine resources. The system took a coordinated approach to crucial care capacity and was able to implement telehealth at a record pace. System leaders were also able to lobby for federal funding to offset volume losses. These actions not only benefited leaders from a resources (supplies, people and finances) perspective but also accelerated transparency and trust. Where one member may have previously wondered if another member was using best practices to conserve PPE, now the information was available in shared data. This led to shared information and, ultimately, shared respect. It also built trust.

As a result, the work of building systemness was accelerated, even while the official strategic planning process was on hold. COVID illuminated the benefits of systemness in tangible ways that could not have come from steering committee meetings and roundtable discussions alone. As the first wave of the pandemic began to wane and the organisation had built its collective muscle optimising virtual communication, Dandorph recommitted to and accelerated the strategic planning process and engaged hundreds of clinical and administrative leaders across the system to bring their best thinking into the work.

STRESS-TESTING AND AFFIRMING THE VISION

In the late Spring of 2020, the Strategic Vision work was reimagined to accommodate the virtual environment. They revisited and recommitted to the earlier set

of planning assumptions and added another: The exogenous COVID-19 pandemic, and other similar global and national events, will further stress conventional health system business models, requiring organisations to restructure the way they operate and partner to best position for future success.

It was clear that the market was looking for a better alternative — a well-coordinated, 'frictionless' experience that would provide the best care in the most appropriate and convenient location when it was needed. This demand was also bumping up against the emerging workforce and burnout challenges that physicians and care teams experienced before COVID-19, which were worsening as the pandemic wore on and have continued years later. Leaders wondered what should be done to return the joy in work and to make it as easy as possible for teams to do their best. While these ideas competed for centrality, the conversation evolved to a shared belief that both were equally important. Without creating a better experience for the care team, it would be next to impossible to offer a better experience for consumers. A vision that centred on an unmatched care experience would bring these ideas together in a way that could galvanise the leadership team and drive the development of a north star that was ready to be tested more broadly. John P. Kotter writes that speaking to people's feelings is central to behaviour change; by addressing what the current experience felt like for both clinician and patient, there was a strong sense that people would not only feel a sense of urgency (which he considers step one for effective change) but would also want to create the desired positive change.[3]

Until this point, the Strategic Vision work had been held rather closely. The process helped senior leaders see the value in the Strategic Vision and understand that it would take the system as a whole to deliver on it, yet a vast majority of managers, employees and physicians knew little about the details of the strategy. This was another important moment for the system — not only to meaningfully describe the vision but to be clear about its rationale and to demonstrate that its leaders believed in and were committed to it. It would not be enough to share the vision at a high level. It would require some detail about things they were already doing (to help people see how their efforts were already advancing the vision) and a new way of engaging with people (to show that this was not business as usual).

The virtual environment expanded the breadth and speed with which the proposed Vision and supporting priorities could be shared with literally thousands of people across the system. Multiple interactive sessions were designed to share the Vision and gather crucial feedback. Prior to this, many employees had the experience of attending meetings for their respective entities, but the notion of a system-wide meeting was fairly new. The sessions were designed to be highly interactive and to create a different feeling to reflect a new way of coming together. They created new expectations about behaviour and how people could and should be working together. Leadership team members from each entity shared the responsibility of presenting different parts of the vision, which, at the time, included an unmatched care experience supported by

- **Frictionless care:** Relentlessly focusing on the needs and desires of the health-care consumer
- **Enabling Talent and Infrastructure:** Establishing a differentiated physician and care team environment
- **Distributed Academic Medical Centre:** The prominence and success of Tufts Medical Center as the academic anchor, while ensuring the provision of the highest quality, value-based care, expanding the complexity of care in community settings.

Having member organisation leaders involved was crucially important, as it had

to be clear that every organisation had contributed to the development of the shared strategy and every CEO supported it moving forward. This could not be presented as a 'corporate' initiative or appear that it was being done 'to' the members but rather 'with' the member entities.

These 'town hall' sessions presented an opportunity for each member of the leadership team to introduce themselves to the system's community. Each leader spoke to an aspect of the Strategic Vision that they would not necessarily be associated with (eg community hospital CEO described the distributed academic centre model). Session participants broke into smaller, facilitated breakouts to share their perspectives on what was exciting and motivating and what they saw as difficult or off-point. Their input further strengthened the Strategic Vision. It underscored the importance of building a unified, inclusive culture and emphasised that it would be essential to move to a single electronic medical record as quickly as possible.

These sessions helped people see what could be possible through a shared Strategic Vision and clarified what it would mean to live into the Vision from a practical perspective. They allowed the leadership team to demonstrate their alignment as a team and that they truly believed in the Vision. The feedback was quickly incorporated into the next, more refined articulation of the Vision as captured in Figure 1.

This graphic guided the work that continued to commit to shared priorities, to align planning cycles across entities, to cascade each priority from the system to the entity to the department and to each individual. All middle management leaders were given a preview of the strategy at its mid-point and asked to weigh in. They were again provided with an advance presentation of the finished strategy at a leader's town hall and were equipped with videos and tool kits to cascade the message to their team members.

Less than a year into the work, and still in the midst of the pandemic, the pieces were quickly falling into place, and mindsets were changing. The Strategic Vision helped people frame and make choices to support an aligned future. There was a shared understanding of 'what' needed to be done. The system was now ready to begin the

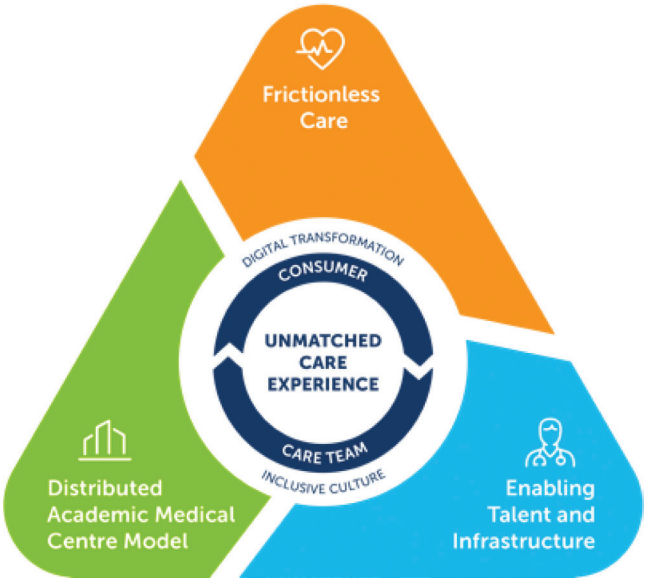

Figure 1 Final system Strategic Vision

important work of better defining 'how people would need to work together differently in the service of the Vision'.

BUILDING SHARED VALUES AND CULTURE

The new vision was bold and exciting, but what did it mean for how people would be asked to get their work done? This is a question of organisational culture. Edgar Schein defines culture as 'a pattern of basic assumptions — invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration — that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems'.[4]

In other words, an organisation's culture is its unique system for getting work done, defined by the spoken and unspoken agreements, rules and assumptions that shape the way people behave and work together. It becomes 'the way we do things around here'. Why does culture matter? Culture underlies and influences strategy, goals and ways of operating. Strong cultures improve performance, resulting in better retention, innovation, efficiency, clinical performance and financial performance. Values are the window into what matters for an organisation's culture, bolstered by the behaviours needed to bring the values to life.

Each entity had its own culture and subcultures that were largely embedded in their organisational values. In response to the feedback during the town hall sessions, the leadership team launched an effort to develop a shared set of values that would serve as the basis for the system-wide culture, and the important behaviours that would demonstrate the values in action.

The leadership team kicked off the work by reviewing all the values that were currently in place across the system. Each one felt important and precious in its own way to certain stakeholders. The real question became, what values would most help the system live into the new Vision?

The team established criteria to help them select a draft set of values and then put those values out to be tested across the system. For example, the values should help speak to consumers as well as employees. They should be used as a management tool to guide behaviour in ways that accelerate the vision and its focus on the consumer, frictionless care, people and systemness.

The starter set of values included the following:

- **Excellence**: pursuing quality in all we do
- **Curiosity**: opening our minds to improvement and creating solutions
- **Respect**: valuing others and their differences
- **Agility**: embracing change to transform healthcare
- **Joy**: finding inspiration in our purpose
- **Trust**: believing in the good intentions of others
- **Accountability**: meeting the expectations of us and our team
- **Collaboration**: improving care and caring across the system
- **Humility**: listening to and learning from others
- **Inclusion**: actively seeking equity, fairness and diverse perspectives

The process engaged hundreds of front-line staff across the system to ensure that every voice could be heard. Nearly 50 virtual focus groups were conducted, with one in-person focus group for environmental services staff who did not have ready access to computers and Zoom in their workplace. The process also engaged the DEI Councils structure at each entity and the DEI Advisory Council composed of chairs of each local councils. Each session served as an opportunity both to reinforce the Vision with participants and invite their input on values that they

believed would produce the greatest effect on achieving the Vision.

Care was taken to ensure that participants represented a shared discipline and organisational level to help them feel comfortable sharing their ideas and perspectives. It was also important that no supervisors or managers participated in the same groups as their respective staff. By design, most of the groups mixed individuals from the different entities that made up the system and represented diversity of thought and roles. A by-product of this design helped participants connect with others in different parts of the system to get to know them as people, to see that they had shared experiences, and to create relationships where they had not previously existed. It was not uncommon for people to share their e-mail addresses with each other through the chat feature on Zoom. The focus groups, in and of themselves, were a cultural intervention that helped people across different roles see the shared challenges they faced with colleagues and minimise their experience of 'us versus them'. With the priority values identified, participants worked to explain in great detail what behaviours would serve as evidence that the values were actually being lived in day-to-day work.

The confidential transcripts of the focus groups were analysed to capture a revised set of values and the corresponding behaviours that could be embedded and spread across the enterprise in many of the strategic initiatives that were already getting under way. A short list of behaviours cut across two or more of the values, indicating that they had tremendous potential to quickly help bring the new culture to life. These were not ideas that the senior team simply anticipated might be helpful but rather specific behaviours identified by staff at all levels that could be experienced as demonstrating meaningful change in support of the emerging set of values. These behaviours and examples of actions that would reflect them can be found in Table 1.

Table 1: Behaviours to Demonstrate the Future Culture.

Behaviour	Definition	Specific behaviours to move us to our desired culture of the future
Communicate	Active, proactive communication with those around you	• Asking questions and being attentive • Checking in, communicating across care team • Truly listening to others
Feel safe	Does not avoid conflict; addresses persons, co-workers with authentic attitude and honesty	• Acknowledging, empathising with others • Being clear about what you can or cannot do; transparency • Calling out others on unacceptable behaviour • Comfortable asking for help • Feeling safe to speak up and say, 'I don't know' • Sharing how, why decisions are or were made
Go above and beyond	Go above and beyond to help patients and others	• Accomplishing your purpose for patients, outcomes • Acknowledge and value differences • Giving patients your full attention, building relationships • Going above and beyond to help others, the patient; not bare minimum
Recognise talent	Identify and support diverse talent to meet current and future organisational goals	• Building co-worker relationships • Giving autonomy, trusting others to do their jobs • Recognising, valuing others' experience • Recruiting and retaining diverse leaders and staff

Table 1: Behaviours to Demonstrate the Future Culture. (*continued*)

Behaviour	Definition	Specific behaviours to move us to our desired culture of the future
Accountable and reliable	Consistently accountable and reliable	• Doing your job with effort, without being reminded • Including others in decision making • Following up with someone quickly; responsiveness • Not making excuses • Seeing your input acted on • Doing what you said you would do • Following agreed process • Showing up to work on time • Sitting around when others could use help

This input was shared with the leadership team who worked over several months to continue to iterate on the values and to further sharpen the mission, vision and strategic priorities. This work helped accelerate what was necessary to build out a whole host of system-building initiatives, from developing a single brand to implementing Epic on a fast-track timeline to developing a clinically integrated network and creating a single source of truth for financial data and building an aligned strategy for human resources and leadership development — among many others. Changing culture is not about starting a new initiative but rather embedding and spreading culture-reinforcing behaviours in the work that is already under way.

EMBEDDING AND SPREADING THE VALUES

Although having a shared set of values is important, what is more important is how those values show up in people's daily lives. System leaders worked to help people connect the dots between the work that was being done and how and why it connected to the Vision. These are the roots of Strategy 101, but truly helping people make this connection is rarely achieved — particularly post-pandemic when workforce stresses are high and burnout very real. Wellforce was able to move beyond the gap that traps many — shifting explicitly from ideas into implementation. Leaders attempted to model the values in how they approached their own interactions and in the ways the initiatives they led were managed. Values were embedded into performance reviews, an inaugural leadership academy, and in the ways people across the enterprise engaged with each other as they sought further integration efforts and digital transformation. They were particularly present in inaugural work the system was launching on DEI.

Creating an inclusive culture

This effort unfolded shortly after George Floyd's murder, along with the killings of many other people of colour. While DEI were already considered central to the new culture, these events and the greater awareness of systemic racism heightened the importance of inclusion even more. To reimagine healthcare would first require a look inside the organisation — its commitment to ensuring an inclusive, anti-racist workplace and providing frictionless, equitable care. This meant nurturing a culture of inclusion and embedding tools and practices to address the inequities that contribute to health disparities.

One of the first new roles that the system level had added to its ranks in the winter of 2020 was the Senior Vice President and

Chief Diversity, Equity and Inclusion Officer. The role was chartered to leverage existing DEI efforts, including signing the CEO in Action pledge, education programmes and early-stage DEI Councils. The scope of the role included workplace diversity, DEI education, research, racial and health equity and community partnerships. Early steps to determine where to best identify and select practices to advance an inclusive culture focused on assessing the stage of the system's DEI work using a maturity level, engaging employees at all levels to share their voices (through DEI Action Learning Sessions with more than 500 participants), reviewing policies and developing a multi-year strategic plan, summarised in Figure 2.

The crucial priority was to establish infrastructure to bring the DEI strategy to life. One of the early results of this work was the decision to embed 'inclusive culture' into the triangle that represented the system's Strategic Vision (shown earlier in Figure 1). The Center for DEI was created as an important support structure to build an inclusive culture where people can thrive and enable the delivery of equitable and frictionless care experiences. The goal of the centre would be to advance diversity and cultural competence, eliminate structural racism and reduce health disparities, by providing expertise, education, self-assessments, research, policies, culturally competent processes and consulting to system leaders, employees, communities and care teams. A significant initiative that resulted about a year later was the introduction of the DEI Academy. The academy is part of a learning strategy to provide developmental experiences and programmes to equip colleagues from across the system with the knowledge to advance inclusion, behaviours to transform the culture and skills to achieve equity.

The DEI strategy produced several important results to date, including the following:

1. Embedding elements of DEI in new human resources policies, built into the implementation of Workday.
2. Launching a leaders' equity and inclusion self-assessment with 600 leaders, with the goal of communicating to leaders practical behaviours that foster belonging and to understand their DEI

Figure 2 DEI systems-based strategy

leadership preferences, along seven domains: *Cultural Agility, Commitment and Accountability, Seek diverse perspectives, Equity and Fairness, Awareness of Bias, Trust and Respect, Humility and Vulnerability*.

3. Integrating culturally competent practices through digital transformation, in Epic and through *MyTuftsMed* App to address the needs of patients with limited English by providing the ability to send messages to providers and use voice-activated chatbots in their preferred language and to get answers to their questions improving access to care.
4. Increasing diversity of our leaders and physicians by 29 per cent across the system.
5. Partnering with the Massachusetts Center for Health Information and Analytics (CHIA) to improve health equity by standardising demographic data collection and utilisation in all payers claims data (APCD) systems, including race, ethnicity, language, sexual orientation, gender identity, disability and housing status.

Building a unified brand

Working in parallel with the Strategic Vision work was an effort to bring the system together through a shared name. The name Wellforce was crafted at the organisation's founding, to create a name separate from any one member in order to communicate the equality of all members. In reality, no one understood exactly what Wellforce was: external markets, reporters and others always qualified it as 'the parent of Tufts Medical Center', and, most importantly, no one felt emotionally attached to the name Wellforce.

The system conducted extensive consumer and physician research to find that 'Tufts' was the most well known and highly respected of the names currently owned by the system. While employees and physicians at other entities might not have an immediate connection to the name, they understood it, respected what it represented, and signalled a belief that a Tufts name would help accelerate the goals of the system. At the same time, the health system and Tufts University School of Medicine were developing a deeper relationship, preparing to name a shared position of Dean of the School of Medicine and Chief Academic Officer for the health system. A goal of the new position would be to expand teaching and research opportunities through each member organisation, essentially spreading the Tufts vision and name more widely.

The announcement of the new brand focused on how the name would tie all the organisations together. To achieve the goal of frictionless care, it would be crucial that consumers understand how the system was connected and feel that they were being guided through the system, no matter what location they might happen to be in at a point in time.

A launch video, featuring CEOs of every entity, demonstrated full buy-in for the change and emphasised that one name would help consumers connect the great care that was happening at each organisation and across the integrated network. It was made clear that in no way did this change of name elevate Tufts Medical Center over any other member but that every member would now be part of something bigger — a whole truly greater than the sum of its parts.

The leadership team was prepared for some to be unhappy that Tufts Medicine would be 'added' in front of the local hospital names and that local logos would be replaced with a shared design. While there was some sadness, the acceptance rate was higher than expected. This was largely attributed to the inclusive work that led to the development of the shared vision; case for change; and clear, system-wide priorities that had now been under way for more than a year. The time between announcement and actual change was just a few months but had to be accelerated as employees and physicians across the entities were anxious to start using the

'Tufts' name. The change helped to solidify a strategy that the organisation had been building for over a year; that Tufts Medicine was one system dedicated to providing frictionless care for team members and consumers. Rather than a major departure from the norm for many, the change of name was experienced as a natural next step.

LESSONS LEARNED

Today, Tufts Medicine has further refined its Vision, Mission and Values, with focused priorities that require it to work as a fully integrated system:

Mission

Empower people to live their best lives by reimagining healthcare, advancing knowledge and pioneering discovery.

Vision

Create the most equitable and frictionless health-care experience in the world.

Values

- One Team — We make each other great
- Respect — We put people first
- Inclusion — We listen and learn from diverse thought
- Heart — We bring compassion to health care
- Courage — We boldly challenge the status quo
- Excellence — We deliver exceptional results

Many lessons were learned along the way, but central to the early success of the work and essential to the longer term support for, evolution of and commitment to the strategy were a few important issues:

1. **Leadership, leadership, leadership:** Moving from a 'holding company' to an 'operating company' mentality represents a significant shift — strategically, operationally and culturally. Building an integrated system is incredibly hard work and takes the focus and intentionality of committed leaders. Difficult decisions must be made, and the rationale for why must be clear. Without a strongly aligned team who could understand the strategy, believe in it and have each other's backs in both good times and bad, Tufts Medicine would likely be back to its earliest days as a system in name, rather than in both word and deed. A strongly aligned team requires a strong leader. At Tufts Medicine, the CEO was deeply committed to the vision and instrumental in engaging and building the leadership team to bring it to life. None of what was shared in this case study would have been possible without the unwavering commitment of the CEO and the team and their ability to inspire change and create a new context for system-wide success.
2. **Clarity of a singular, system-wide Strategic Vision:** Building a shared, Strategic Vision that people could believe in was essential. The vision sharpened over time, with clear input from stakeholders across the system and communicated in a way that helped everyone see how it was evolving and why. The rallying theme of frictionless care was both motivating and action inspiring. Every decision made and every investment contemplated centred on the Strategic Vision. From the system level to the member entities, to the front line — priorities cascade across the enterprise.
3. **Ensure the 'words and the music' go together during execution:** Words and concepts are important, but real change happens when you can change behaviour. For example, being committed to DEI, health equity and a value of inclusion is meaningless if leaders are ill-equipped to do equity work. Creating clinical integration

necessitates aligned physicians and an electronic medical record system that makes it as easy as possible to input and extract information to deliver coordinated, high-quality care. The work itself may be hard, but people can be helped to make their efforts as easy as possible through infrastructure that supports the ways you want them to behave and the things you need them to do (training, IT, incentives, etc).

4. **DEI as DNA:** Leaders tend to talk about DEI, assuming that they all share a common definition among executives, leaders, staff and consumers. Making DEI part of the servant leadership philosophy, including how leaders lead as communicated by the CEO and how daily work is done, has been essential. Making mistakes, learning together and expecting the journey of changing culture and behaviours to take time are crucial to transforming care.
5. **Seize the moment:** It would have been easy to put a permanent pause on the strategy work during the pandemic. Instead, the pandemic was used to demonstrate the need for systemness and to help people across the system act their way into new thinking. The speed with which leadership advanced change also helped the many pieces come together and demonstrate that Tufts Medicine was committed to and well on its way to becoming a truly integrated system.

Systems contemplating big moves today may be tempted to slow or stop their work to address the significant financial and staffing crises hitting healthcare; however, this case study encourages organisations not to pause but instead use the moment to clarify their Strategic Vision, build trust and momentum in real time, and ask their teams to solve today's issues using tomorrow's structure.

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