Governance, Leadership, & Goal Setting

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SCHOLAR AND FUTURIST JOEL BARKER once said, "A leader is someone you will follow to a place you wouldn't have gone on your own." Since it is human nature to fear uncertainty and change, it is essential for boards to collaborate with executives and physician leaders to lead the hospital to a desired destination. This requires a blend of "soft skills" and goal-setting tools.

Soft Skills

Noel Tichy and Warren Bennis[1] said it best (paraphrasing):

1. Making judgment calls is the essential job of a leader:
   a. With good judgment, little else matters.
   b. Without good judgment, nothing else matters.
2. Long-term success is the sole marker of good judgment:
   a. Good leaders sort the important from the trivial.
   b. They focus on getting the important calls right.
3. Leaders make the calls and see to their execution:
   a. They manage relationships with key constituencies.
   b. They align and mobilize team members for support.

This requires skills that are impossible to measure, such as critical thinking, deep listening, fortitude, and discipline. The first step in leadership and goal setting is to structure the nominating process to simultaneously bring the right hard skills (bankers, lawyers, clinicians, IT engineers, etc.) to the board, while also selecting trustees with the right soft skills. Every trustee doesn't have to embody all of the soft skills just as everyone doesn't have to bring the same hard skills.

Tool #1: Mission, Vision, & Key Strategic Issues

It is increasingly difficult for any hospital to be all things to all people. To lead the organization to a place it wouldn't go by itself, trustees need to see strategy as a leadership tool and be full participants in an effective strategic planning process that specifies the following:

- **Mission:** too often, the raison d'être for the organization is given insufficient attention during strategic planning. The strategy process should clearly identify the core business and the manner in which other business lines relate to the core. Passive acceptance of the mission statement as inviolate risks focusing the organization on what is "good" to do versus what is "best" to do.
- **Vision:** a brief vision phrase may be an appropriate way to provide inspiration. A vision statement, however, should be a clear, pragmatic depiction of a desired state for the organization at a specified period in time (five to 10 years out).
- **Key strategic issues (KSIs):** Michael Porter has stated that "great strategists get a few big things right."[2] The organization with 30 strategic priorities is, by definition, focused on tactics and operations as opposed to strategy. Effective leadership focuses the organization on three to five strategic priorities.

A well-crafted strategy, of course, has other components (e.g. external assumptions, internal assessment, resource allocation) but in terms of goal setting, the three most important are the mission, vision (the place that leaders will take the organization) and KSIs (the priorities for sustaining the mission and achieving the vision). Trustees should require an outcomes focused implementation plan for each KSI with well-defined timeframes and executive accountabilities.

Tool #2: Governance Scorecard

While most hospitals have some form of scorecard or dashboard, few in our experience have an effective board scorecard. Consequently they are missing an important goal-setting tool. The following are some premises regarding scorecards:

1. Trustees monitor strategy through mission, vision, and KSIs, but also need a scorecard to monitor operations.
2. The board scorecard is distinct from (i.e., less detailed than) the management scorecard.
3. The scorecard should compare actual performance against both desired performance and best practice.
4. The board scorecard metrics should be at a high level of detail.
5. When an indicator is red or yellow, the board should begin to ask questions.
6. Great boards have the discipline (soft skill) to relentlessly pursue satisfactory answers.
7. Paradoxically, many boards (with good intent) ask for too much information, losing the forest for the trees.
8. The board itself, with appropriate input from executives and physician leaders, should determine what indicators it will monitor. This is how effective boards participate in operational goal setting while also keeping to their own side of the policy/operations divide.

The key to getting started is to keep it simple—additional metrics can always be added once trustees are comfortable with those they already have. To do this, a board should define four to six areas (numbers 1–4 below) and pick three to six indicators (a–e below) to monitor in each area. For example:

1. Clinical outcomes
   a. Case mix index (CMI)
   b. Morbidity and mortality
   c. "Never events"
   d. Core measures
2. Utilization and market share
   a. Total adjusted and CMI adjusted admissions
   b. Selected surgical volumes
   c. Market share
3. Financial performance and productivity
   a. Operating and total margins
   b. Cost/adjusted admission, CMI adjusted
   c. Days cash on hand
   d. Debt coverage ratio
   e. Percent of uncompensated care

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1 Authors of *Judgment: How Winning Leaders Make Great Calls,* Portfolio Hardcover, Penguin Group, U.S.A., Inc., 2007.
2 Keith Hammonds, "Michael Porter's Big Ideas," *Fast Company,* Issue 44, February 2001.

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4. Image and satisfaction
    a. Community perception
    b. Patient satisfaction
    c. Physician satisfaction
    d. Employee satisfaction

Tool #3: Strategic Management

Strategic thinking and scorecard development each require a blend of logic and feel, and both should be constantly evolving. Trustees, together with executives and physician leaders, must:

1. Continuously monitor the environment and internal performance for changing trends/occurrences.
2. Conduct a formal review of both the strategic plan and the board scorecard on an annual basis.
3. Make required course corrections.