21st Century Strategic Thinking

Five Insights for Boards of Trustees

BY TIM PORTER-O'GRADY, EdD, PhD, FAAN

Dr. Porter-O'Grady is vice-chair, board of trustees and chair, mission and ministry committee, Catholic Health East, Newtown Square, PA.

Now that the 21st century has arrived, trustees for Catholic health care facilities need to view the world in a new light. However, what is most important is that, based on this changing environment, they take action—and the *right* action.

As I discussed in a previous article for *Health Progress* ("Governance at the Crossroads: Post-Millennium Trustees Face Difficult Decisions in a New Age of Health Care," November-December 2000, pp. 38-41, 55) our past experience and perceptions may interfere with viewing this new age within the appropriate context. The 21st century requires a whole new set of rules for doing business. The technology and economics of the business behind health care are transforming so quickly that determining the right actions is difficult. Modern demands necessitate flexible and fluid responses that have not historically been a part of health care decision-making. Discerning the signposts of change now becomes a more valuable skill than defining direction.[1]

Even strategic planning activities require a different approach for health care facilities to remain viable and sustainable. In the past century, defining a vision and mission and building action within its parameters was the standard for setting direction and building organizational objectives. In this unfolding age, though, beginning with a vision provides a set of parameters that often limits the trustees. The vision itself may become an impediment to seeing the signposts that influence the meaning and direction of an organization. The emerging conflict between direction and discernment is at issue. For the 21st century leader, discovering the contextual framework and environmental realities ensconced in a new age is most important. These realities can then inform the vision in a way that guarantees it is cogent and relevant. These twists to otherwise familiar processes create uncertainty and unsettle leaders with regard to the "new" ways of doing business.[2]

Another major challenge in health care today is moving past the losses associated with the dramatic and rapid pace of transformation in health service. Much of what health service is becoming flies in the face of what already has been created. To remain nimble and flexible, much of the infrastructure built on an inpatient model must be slowly but continuously deconstructed.[3] The difficulty of reconfiguring health care is certainly reflected in the high rate of turnover among senior executives. Altering or even dismantling health service empires is a significant trauma, especially after the decades spent in building them.

Because of the danger of inaction or taking the wrong action, board and executive leaders must develop many complex skills. To this end, five insights deserve immediate attention. If these basics are acted on, they can assist the besieged trustee struggling to more quickly adapt to the demands of this new century.

Insight 1: Strong Leadership Requires Seeing "Potential Reality"

The key to good leadership is no longer embedded in measures of current performance but in measures of innovation.[4] Imagine, for a moment, just what mapping the human genome promises. Nearly 80 percent of therapeutics for the next two decades will be geno-, chemo-, pharmo-, or technotherapeutic. How do these therapies affect current dependence on complex surgery and bed-based approaches to service and care? Strategies that do not include radical alterations in architectural and service configuration are doomed to fail in this environment.[5] Currently, much effort is devoted to saving or getting back dollars lost from services health systems provide. However, the real issue is: How sustainable

are the services, procedures, and processes for which administrators are seeking additional financial support? In truth, the reconfiguration of payment structures indicates that many procedures and their costs may need to be readjusted, reformatted, or even eliminated.[6] As an example of proactive planning, Catholic Health Initiatives, Denver, includes a requirement in its strategic process for innovation management, ensuring that its members focus on innovation as a part of their future planning.

> Strong leadership requires seeing "potential reality."

Quantum physics teaches that there are two prevailing realities that operate at any give time: actual reality and potential reality.[7] In health care, *actual reality* is composed of all those visible, "real-time" current processes that everyone sees and to which they immediately react. *Potential reality* is a state that currently exists, but has not yet been experienced, and is inevitably the outcome of processes already under way. The role of board leadership is to become comfortable with and firmly grounded in potential reality. A strong leadership requisite is to look far and deeply enough into—not over—the horizon to be able to see what is critical and direction-setting. Leaders need to read signposts that, when looked at in conjunction with other signals, give an indication of the direction of change—thereby informing good strategic decision-making. Only when context is clear can we inform our vision and articulate our mission.

Insight 2: The Future Is About Good *Fit* More Than Good *Function*

In the Industrial Age, function became the foundation on which judgments about good processes were made and the basis for every performance evaluation, from the work to the worker.

In this new century, the rules of work have changed. As Peter Drucker continually reminds us, the real focus and value of work is not so much what each of us does (function), but how the efforts of each worker join with the efforts of others to advance the purposes of the organization and ensure its sustainability (fit). Perhaps this notion of "goodness-of-fit" would have better advised many who threw together mergers and alliances that did not make good sense and where fit was not readily apparent. Now partnerships must reflect a more fluid and transitional design; they will rarely be permanent structures. Many partnerships should last only as long as the next innovation or new direction driven by either new service configurations or new technology.

Nanotechnology teaches us that the goodness-of-fit between the elements of effort is the fundamental condition for sustainability.[8] Partnership, alliance, interaction, and relationship are now the foundations of viable health service. Leaders should establish essential partnerships and create the conditions in which they will thrive. The better the fit between the efforts of the partners, the lower the cost of service, the higher the quality of that service, and the more likely it can be sustained (Taguchi's Rule).[9] Leadership must know their service populations better than anyone, and the design of health service should configure tightly with the character, need, and demand of that population.

Each service setting must be configured to best meet the needs of those it serves. The old notion of designing services to fit the convenience of the provider (i.e., treating the physician as a customer instead of a partner) is useless and outdated. Health care facilities must accelerate the move away from diagnostically defined service and toward population-defined service (women, the elderly, children). For example, Scripps-Mercy Health System, San Diego, includes in all its planning activities a detailed population and demographic profile, including the political and social county health priorities in its governance goal-setting process. This step ensures that it remains focused on the population served and its health rather than solely on individual patients. All providers need to remember that it is the convenience of the end user, not provider, that creates the conditions for them to flourish.[10]

Designing services to advance the convenience of the provider does nothing to improve the conditions of the population served. On the other hand, if the perspective of those receiving the service drives design, a strong connection between the viability of the service and the users' satisfaction is established. "Fit" underpins every component of service design, from architecture to performance evaluation. The basic question of each stakeholder is not "How well did I do?" but "How well did our team's work fit together to make a difference in the lives of those served?"[11]

INSIGHT 3: SUCCESS IS ABOUT EFFECTIVENESS, NOT SIZE

A well-understood axiom states that you cannot own your way into good performance. Simply buying all the elements and components of health service will not guarantee that service will be well provided or prevent the system from going broke. In today's world, not owning all the components of your service system is often the better choice. Wise leaders understand that the more bricks and mortar they have the heavier the burden of both management and cost, and that they could be less nimble when conditions change. Partnering becomes the prevailing construct for good structure. Effective partnering allows organizations to form the coalitions demanded at a particular point in the service cycle and then to willingly unbundle them and seek new partners when both the needs and the rules change.

> The future is about good fit more than good function.

Much of the current work to be done by health care leadership is dismembering some of the health care empires that have been constructed around the notion of owning the whole enterprise.[12] The system of the future should reconfigure itself quickly and effectively to reflect changing technology, innovations, and consumer demand. Developing this flexibility is the single most challenging work of health care leadership today. Boards must take health care organizations through three sometimes-concurrent phases to ensure their ability to succeed in this new environment:

- Maintaining enough current structure to pay the bills while redesigning around more demographically specific and fluid models of service.
- Committing to transitional services and structures that position the organization for new services and technologies.
- Planning and creating prototype innovations in service design and structure to reflect the general direction of change and anticipate good and timely response.

This more adaptable model guides service structures and designs to create a more pliable framework for service applications and adjustments. For example, the board of Catholic Health East, Newton Square, PA, is focusing on context scenarios or themes before creating a vision statement for their strategic activities, making sure their vision is congruent with the emerging environment for health service as they plan for the future of their system. The more that board and executive leadership can incorporate concepts of new context, positioning, partnership, and fluid structuring into their models of health service, the more enduring the results will be for the system.[13]

INSIGHT 4: THE CHALLENGE IS TO BE DIFFERENT, NOT TO DO MORE WITH LESS

As Tom Peters articulately points out, no company ever downsized itself into success.[14] Although finding that sound ratio between cost and demand is vital to good stewardship, it is not the foundation for future success. Too much emphasis on the correct blueprint for current service delivery sidesteps the more substantive yet challenging issue related to how the organization needs to be positioned for long-term viability.

Current consumer trends demand that health care facilities provide a more immediate and intense service orientation.[15] Internet companies have created a "just-in-time" business model that is rapidly becoming the expectation of all consumers. The problem in health service is that the user is increasingly directing choice but is often completely ignorant of what to expect and what choices to make. Although only 43 percent of the population is Internet proficient, that figure is up from only 7 percent nearly 10 years ago.[16] Now we have users of health service that have wide-ranging access but do not know enough to use it wisely. This phenomenon now challenges providers to incorporate user-based service models into the infrastructure of health services. Here again, a whole new framework for designing and organizing health service is now called for.

Aging of the population is also affecting the design and delivery of health services. The largest segment of the American population is now between the ages of 40 and 65 years. Future generations will live into their 90s and 100s.[17] The currently configured health care system simply cannot support the needs of an aging population in the numbers we will confront during the next 50 years.

In addition, current and future generations will not be aging as previous generations have. These

generations will not wait until acute illness overwhelms them; they will be much more proactive than previous generations. They have a better chance of staying healthier longer simply because they are more educated, have access to more information and technology, and can make better choices than previous generations.

Another revolutionary factor is the fastest growing arena of health care today—alternative therapies. Alternative therapy generated $24 billion in revenue in 1998 alone. Seventy-one percent of this type of health care is self-pay and gives control and choice predominantly to the consumer.[18] Board and executive leadership should think about how these statistics alter the service framework they will create. Alternative practitioners should have inclusive arrangements that encompass notions of admission and treatment. Much dialogue has been centered around this possibility, but few examples of working models exist. The realm of health care is changing, but leaders must make it happen.

> Systems are becoming "membership communities."

Insight 5: Boards Are Now Leading Membership Communities

The freestanding hospital is quickly becoming a relic of the past. Health systems are becoming "membership communities." These communities are made up of a host of partners who, by contract and consent, have a stake in the integrity and viability of the system. Included in the relationship is their individual and collective stake in both the quality of service and fiscal success of the system. In these kinds of relationships, whether one part of the system is doing exceptionally well or another part is not does not matter. The requirement of membership communities, in which the consumer will access every part of the service structure, is that they all perform at the same high level of effectiveness and quality or the entire system is at fault. Each member in the system has its own service obligations, but all members are linked together in a relationship that affects the viability of every member.[19]

Leadership of these multiservice and multifocal systems now requires a different skill set. No longer can the boards or executives unilaterally direct and control the members of the system without their consent. For example, the board of Catholic Healthcare West, San Francisco, is struggling with better ways of creating partnership relations with their own workers—from nurses to housekeepers—reflecting a new compact with their own employee members to create a better future. Building relationships means servicing and maintaining employees and other partners in a way that keeps them invested, on board, and actively participating in decisions that affect the direction of the system. This relationship requires a high level of coordination, facilitation, and integration in the skill set of board and executive leadership. It demands a range of internal and external partnerships and strategic behaviors that keep people committed and working in concert—as well as the knowledge of when to let partners move on and form new alliances. A radically different kind of leader is needed in this new context.[20]

The Future Requires Action

These five insights are not radical or revolutionary, but they are essential. The importance is not so much in knowing about them, but in applying them. Boards must now see that their most important duty during this next decade is to completely reformat health care from the ground up. Much of that work requires modifying or deconstructing existing infrastructure, mobilizing service, refocusing on consumer control and choice, adapting to new-age technology as quickly as it unfolds, and forming and unfurling whatever new alliances good and continuous service demands.

Getting the stakeholders—from payers to patients, providers to consumers, businesses to the public sector, health service to community—around the same table and focused on constructing an effective health care system is critical. The need for innovation and new models is central to creating good fit between health services, the culture of the new age, and the demands of a new demographic. Catholic health care, mission, and ministry must now be led by those who acknowledge that, if our future includes quality health care, seeing its construction from the perspective of the future rather than the past is mandatory. That commitment is enough work for any board. □

Continued on page 46

CATHOLIC SYSTEMS

Continued from page 26

with which the system's components—corporate and local—can hold each other accountable.

- "Transformation teams," recruited from throughout the system (but supplemented as necessary by outside experts), to carry out various tasks (e.g., develop Internet strategy, buy and sell assets, build technology partnerships, create regions in especially large systems).
- A system board that is of manageable size (e.g., nine members) and holds efficient but brief (e.g., three-hour) meetings infrequently (e.g., quarterly). These meetings should follow structured agendas that go beyond reserved powers and address issues that have been thoroughly researched with the aid of transformation teams.
- Operating models that clearly show the organizational levels at which the system's various decisions are made.
- Identification of services likely to benefit from the system's size (e.g., medical and information technology).

Resolving Struggles for Control

Large health care systems typically involve three levels of operation: local (a single facility), regional (multiple facilities serving the same market), and multiregional or national. In a new system, consensus on which level should make which decisions is seldom found. All three compete for control.

Such competition is likely to be especially contentious in systems whose local members are skeptical about the value of corporate services, enjoy a tradition that combines financial success with minimal oversight, or lack experience in sharing accountability with other entities. Systems whose characteristic culture involves conflict avoidance and consensus management may find control issues particularly knotty.

Resolution of such issues is made worse by the increasing difficulty that multiregional and national systems have in recruiting members for their boards. This is especially true of mission-driven systems that must ask their board members to give much time, travel long distances, and lend their wisdom and talents—in return for no compensation and little ego gratification—to the governance of a not-for-profit ministry serving multiple geographic markets in a troubled industry. (In contrast, a local facility that has, say, 100 years of history behind it will usually have much less trouble attracting talent and passion to its board.) Because systems need strong boards to help resolve control issues, the recruitment problem is serious.

Perhaps the worst thing about control controversies is that they can distract the system's leaders. In a newly formed system, local facilities will continue to face escalating market challenges. System leaders must, therefore, find a way to both resolve control issues *and* cultivate local markets.

Sponsorship and Business

Catholic organizations, which currently lead the formation of health care systems in the United States, are nevertheless handicapped by the fact that—unlike competing systems—they must focus on sponsorship issues rather than purely business ones. They must apply this focus, moreover, at a time when health care is becoming an increasingly competitive business.

Of course, Catholic organizations, being mission-driven and sponsor-led, have no choice but to focus on sponsorship issues. Catholic health care systems exist not to provide shareholders with a return, but to serve the systems' communities. Still, the sooner Catholic systems adopt explicit business transformation agendas and resolve control issues, the better situated they will be to make a positive impact on those communities. □

21ST CENTURY STRATEGIC THINKING

Continued from page 31

NOTES

1. Russell Coile, *Millennium Management*, Health Administration Press, Chicago, 1998.
2. Daniel Beckham, "The Vision Thing," *Healthcare Forum Journal* 1994, vol. 37, pp. 60-70.
3. Thomas Rundall, David Starkweather, and Barbara Norrish, *After Restructuring*, Jossey-Bass, San Francisco, 1998.
4. Diane Coyle, *The Weightless World: Strategies for Managing the Digital Economy*, MIT Press, Boston, 1998.
5. Jeffrey Pfeffer and Robert Sutton, *The Knowing-Doing Gap: Turning Knowledge Into Action*, Harvard Business School, Boston, 1999.
6. Russell Coile, *Five Stages of Managed Care*, Health Administration Press, Chicago, 1997.
7. Dana Zohar and Ian Marshall, *Who's Afraid of Schrodinger's Cat*, William Morrow, New York, 1997.
8. Don Tapscott, Alex Lowry, and David Ticoll, editors, *Blueprint to the Digital Economy*, McGraw-Hill, New York, 1998.
9. L.P. Sullivan, "The Power of Taguchi Methods," *Quality Progress*, 1987, June, no. 6, pp. 76-79.
10. John Hagel and Marc Singer, *Net Worth: Shaping Markets Where Customers Make the Rules*, Harvard Business Books, Boston, 1999.
11. Leonard Berry, *Discovering the Soul of Service*, The Free Press, New York, 1999.
12. Konrad Kressley, *Living In The Third Millennium*, Factor Press, New York, 1998.
13. John Clippinger, editor, *The Biology of Business*, Jossey-Bass, San Francisco, 1999.
14. Tom Peters, *Liberation Management*, Harper & Row, New York, 1992.
15. Joseph Pine, Bart Victor, and Andrew Boynton, "Making Mass Customization Work," 1993, vol. 71, pp. 23-33.
16. Don Tapscott, *Growing Up Digital: The Rise of the Net Generation*, McGraw-Hill, New York, 1998.
17. The Editors, "All Our Tomorrows: The Economics of Ageing," *The Economist*, 1996, vol. 338, no. 7950. pp. 1-16.
18. Dana Ullman, "The Mainstreaming of Alternative Medicine," 1993, vol. 36, no. 6, pp. 24-30.
19. Tim Porter-O'Grady and Cathleen Wilson, *Leading the Revolution in Healthcare: Igniting Performance, Changing Systems*, Aspen Publishers, Gaithersburg, Md, 1999.
20. Richard Daft and Robert Lengel, *Fusion Leadership*, Berrett-Koehler, San Francisco, 1998.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, January-February 2001