

Top 10 Mistakes in Setting Hospital Goals

By Bill Bielenda

For years healthcare leaders have been evaluated by means of a "Does Not Meet/Meets/Exceeds" scale. Subjective in nature, this type of assessment does not really indicate what the leader accomplished. A far more fair method is the use of a clear, objective, and weighted evaluation based on specific goal achievement.

The evaluation makes use of a one-to-five rating system for each goal. A rating of one is assigned when a leader has fallen below target, while two means partial goal achievement. Three denotes the goal was met. The leader who gets a rating of four surpassed the goal, while one who merits a five significantly exceeded expectations.

Further, each goal is assigned a weight — a percentage — based on its importance. One goal might be allocated 40 percentage points because of its significance to the organization, while another might be set at 15 percentage points due to its lesser priority. As a result, when leaders consider the assigned weights (all of which add up to 100 percent), they know where to put the most energy.

Goals — which should be attainable yet challenging for the leadership ranks — are typically set around key focus areas often referred to as pillars. Typically these operational dimensions are service, people, quality, finance and growth.

However, initial implementation of this leader evaluation system can be challenging for some organizations. The good news is that missteps they make can be fixed with an understanding of what went wrong. Here are the top 10 most common mistakes made during the first year of rollout and how they can be handled.

1. Inappropriately assigning organization-wide goals to middle managers.

Every hospital's senior leadership team will have a goal around making more money than it spends. Improving net income or boosting the operating margin typically appear under the "finance pillar" of the CEO and other senior leaders. Subsequently, these same targets are cascaded down through the leadership ranks. However, a middle manager such as a patient care supervisor, will not impact senior financial goals. Instead, it makes far more sense to hold middle supervisors accountable for managing expenses or other fiscal concerns which they can control.

Another example of this occurs when an organization assigns its overall patient satisfaction goal to middle managers who have nothing to do with direct patient care. Take the accounting department, for instance, which is not a part of the patient satisfaction survey. The goal instead, for that department, should not be patient oriented, but rather directed at internal customer satisfaction. Its middle managers should be rated by those who are supported by accounting.

2. Goals are over- or under-valued in their assigned weight.

Why does this happen? Sometimes leaders are too quick to assign weights, and fail to make a connection between the importance of the weight with what's being measured. The more significant the goal is to the organization's success, the higher its weight should be.

For some leaders, though, the temptation is too great to put smaller weights on things they know will be challenging, and, conversely, associate higher weights with easy to accomplish goals. Patient satisfaction is often a high priority in many hospitals. However, if a patient care leader gives it a weight of 10 percent or less, nurses on that unit are not going to make it a main concern. Yet this happens when a unit is struggling to attain good service results.

3. All leaders share the same weights for a goal, even when their responsibilities don't impact the weights.

It's not uncommon for an organization to expect its leaders to have a goal around a budget target, especially during these rough economic times. Let's say the CEO decides that meeting financial goals should be a priority for all leaders. So he mandates that everyone must adhere to their budget and assigns that target a weight of 25 percent. In addition, he says that everyone will have a productivity goal which is also weighted at 25 percent.

While this might make sense for many leaders, what about those whose responsibilities involve minimal financial oversight? Take, for instance, a quality management leader with a staff of three salaried individuals and little funding for supplies or other expenses. She has hardly any fiscal responsibilities, yet 50 percent of her evaluation revolves around finance. Her main responsibility is quality, which was assigned a mere weight of 15 percent. Essentially, the CEO handed that leader a high performance evaluation on a silver plate. Meanwhile, the manager with a staff of 30 caregivers struggles mightily to cope with the high weights attached to budget compliance and productivity metrics.

4. Instead of the outcomes, tactics such as projects or processes are used as goals.

Suppose a nurse leader sets a goal of being on time with completion of employee evaluations. However, this is a tactic that will result in meeting the real goal of reducing staff turnover. Timely evaluations help raise the satisfaction level of employees, meaning they are less likely to leave the organization. The leader would have been far better served by setting an objective, measurable goal of reducing department turnover or improving results on the next employee satisfaction survey. Still another example of this in a clinical setting is staff's compliance with hand washing policy. Yet this is actually a tactic to achieve the goal of reducing infections such as MRSA.

5. Making healthcare regulations goals when they're really expectations.

Most hospitals have achieved certification by The Joint Commission, yet some want to put this as a goal under the "quality pillar." In actuality, hospital leadership and direct reports should be living an accreditation life style. Patients and their family members expect a safe healthcare experience. Likewise, occupational safety goals appear under the quality leader's pillar when adherence to OSHA regulations should be standard

performance rather than a goal. After all, healthcare workers presuppose that an organization will provide a secure environment in which to work.

6. Some leaders fail to accept responsibility for far-reaching organizational goals they directly impact.

Any leader who has influence over whether or not an organization-wide objective is achieved should own the goal. For instance, the marketing department's role is to help grow the hospital's volume. So it makes sense that the marketing leader should have hospital volume goals under the "growth pillar." Likewise, the materials management leader is responsible for obtaining the best prices for supplies. So that person should have the organization's profitability goals under the finance pillar. Since a case management leader influences when a patient is discharged, the leader should own the hospital's length of stay goals. The human resources leader has the organizations overall turnover under the "people pillar" versus the HR department's turnover, and so on.

7. Lack of uniformity in measurement.

Let's say the senior team voices the expectation that all leaders have a goal around achieving budget. What does that mean? When there is no guidance on how to meet budget — what they measure or how they count — ultimately leaders come up with their own definitions. A patient care leader interprets it as reducing agency expense or overtime. Another manager comes up with specific dollar amounts while a third manager considers managing flex expenses to be the way to meet budget. In other words, the lack of common definitions, targets or metrics means that leaders invent their own ... which results in confusion and inconsistency across the organization.

8. Leaders tend to "cherry pick" the easiest goals to meet instead of the most important.

It's very tempting for managers to focus on goals they know can be met or those based on everyday tasks which will be accomplished regardless. Cherry picking the easy goals gives staff the opportunity to achieve its targets, the leader looks good, and there is cause for celebration. However, in the long run, the organization suffers when a leader fails to concentrate on the important goals, the ones that will make the most difference.

For example, a pharmacy leader assigns a weight of 60 percent to the goal of having no expired drugs in the inventory. However, a goal such as this is not only easy to reach, but even worse is benign in terms of moving the department to a higher level.

Or a nursing unit leader establishes a goal of reducing patient falls which is weighted at 50 percent under the quality pillar. Yet the organization already has an extremely effective process hardwired which minimizes the fall rate. Thus it was a goal whose achievement was practically effortless to manage, while her real issue was a problem with central line infections.

9. Setting targets where all leaders are expected to move up at the same rate.

For example, let's consider an organization's goal of moving patient satisfaction results upward. All leaders have the same target — a 10 point increase. One manager is at the

bottom of the barrel; the department's patient satisfaction is at 5 percent. But another one has achieved results of 85 percent patient satisfaction. Each is expected to improve at the same rate — a 10 point increase. This puts the first manager at 15 percent, hardly much of an improvement. But the second one will have to hit 95 percent, a very difficult thing to do, plus it's hardly fair.

The organization needs to consider rate of improvement instead of targets founded on the baseline when setting goals such as these. It would have been better to ask the underachiever to increase to 30 percent patient satisfaction, while the high performer tries to stay at the current level or perhaps only a 5 percent increase.

10. Achieving a prestigious reward is the goal as opposed to the outcomes themselves.

A movie director knows if he makes an outstanding, critically acclaimed movie, it might earn an Academy Award. So he concentrates on the process of creating the film. Likewise, senior leadership must focus goals on getting results rather than winning top prizes — the healthcare entity dedicated to performance excellence in all areas will merit the recognition. It's the journey that warrants a Malcolm Baldrige National Quality award or Magnet status ... which takes the organization to a whole new place.

Avoiding the Top 10 Mistakes

1. Give middle managers goals relevant to their position in the organization.
2. Assign goal weights according to the target's importance and impact.
3. Make sure the weights given to leaders' goals are aligned with their responsibilities.
4. Don't confuse a tactic with a goal — a tactic is the process/project used to reach a goal.
5. Regulatory standards are not goals — they're expectations.
6. Require leaders who have influence over far reaching, organization-wide goals to own those targets.
7. Define the measurement criteria for achieving a goal and what success will look like.
8. Instruct leaders to prioritize work on goals according to importance versus ease.
9. Applying the same "percent improvement" for all leaders allows those close to the bottom to make modest improvements. Adjust your expectations based on different levels of performance.
10. Don't put the cart before the horse: Outcomes and results should be the priority — the awards will come.

Mr. Bielenda is a coach with the Studer Group and an expert in leader accountability and healthcare management engineering. Learn more about Studer Group at www.studergroup.com.