Revisiting the Mission

by Andrew Chastain

Recently, I sat in a board meeting of a leading U.S. health system as trustees were discussing their strategic vision for the system, and how the rapidly changing health care field, marketplace and regulations were having a profound impact on its future. After a particularly contemplative exchange, one of the long-time trustees wondered openly, “Is our mission still relevant? We used to ‘serve the sick’ but now we are focused on the community’s wellness and health.”

Like many systems, this organization is shifting its delivery model in response to environmental pressures, the Affordable Care Act, the changing economy, and other factors. But, like other systems, it also has not completely transitioned to an entirely new way of doing business — rather, it is hedging its bets, still pursuing traditional bricks-and-mortar investments and volume-based growth while experimenting with value-based, “population health” methods.

A mission statement is a guidepost for organizational direction. It answers the fundamental question, “What are we really about?” It guides strategic decision-making and resource allocation and directs the leadership team about where the board wants the organization to go.

The case presented above exemplifies the position boards are in during times of fundamental change. After decades operating under essentially the same guiding principles, the chair and fellow trustees wrestled with whether to make an elemental change. Ultimately, these trustees decided that it was time for a new mission statement. (They are also contemplating a name change for their organization, taking “care” out of their name to become solely a “health” system.)

These conversations and changes resulting from them are happening in many health care organizations (and likely have within your organization as well). To be sure these are not easy discussions for health care boards and leaders. The mission statement — along with core values — is the bedrock of an organization. If the mission statement is not sacred, then what is?

On the other hand, if the mission statement is written in stone can the organization truly transform?

In a 2012 AHA Center for Healthcare Governance special report, Transformational Governance: Best Practices for Public and Nonprofit Hospitals and Health Systems, author Larry Gage talks at length about this fundamental governance dilemma. Among trustees there is usually a strong, inherent allegiance to the mission statement, while at the same time an understanding that communities and health needs change. “The challenge is to memorialize the mission so as to protect it from those who may wish to abandon it in the future, while providing adequate flexibility and discretion to address unforeseen needs and financial limitations,” Gage writes.

Most hospitals and health systems likely established their mission statements assuming they would last the lifetime of the organization. The answer to the “mission statement change” question doesn’t always have to be yes, but the question should be raised every so often and should be a topic for open, healthy discussion. Boards should face the challenge with an open mind, viewing a mission statement as something that can change if there is a compelling call to do so.

It is not just the mission question that boards are confronted with today, of course. Countless issues more complex than many they faced in the past are on the agendas of today’s boards. While the basic roles and responsibilities of health system and hospital boards are not changing in response to these issues, the questions boards are asking, and those being asked of them, are.

Boards and CEOs: A Functional Model

Stewardship of the mission is one of several foundational board roles. A functional model that outlines a framework for governance in health care today, with mission as a key component, appears in Figure 1 on page 2.

As shown in Figure 1, the board also is responsible for defining the organization’s risk tolerance, measuring and incentivizing its performance, taking charge of its own composition and development and working with leadership on strategy formation. These roles are fundamental and ongoing; however, as with mission oversight, the questions around each are changing.

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**Risk Tolerance:** Boards, with their CEOs, are assessing risk differently today and should understand the distinction between risk tolerance and risk management. Risk tolerance is a concept often used in the investment world to indicate the amount of risk that an individual or organization is willing to accept. It suggests a more proactive, open-minded look at risk and the idea that boards must work with the CEO to weigh the pros and cons of opportunities in the marketplace, particularly related to affiliations and other alliances. Risk management can suggest a more reactive, process-oriented approach to addressing risk, which is not what is needed from today’s boards. (See “Can Healthcare Boards Learn to Embrace Risk?”, Directors & Boards, December 2014.)

As the field shifts rapidly, organizations are looking at their debt structures and credit ratings and asking questions such as, “Are we willing to impact our rating to make a time-critical acquisition?” They are also evaluating whether and how to invest in innovation funds for the development of health care services and technologies, seeking to serve as both an investor and incubator site. Thus, risk is a topic that boards and CEOs must embrace and proactively address, coinciding with their discussions about mission.

**Composition:** As governance has become more complex, I have witnessed trustees openly debating their board’s composition, asking, “Do we have the right skills to drive excellent performance from our organization? Should we have experts from outside of our market(s) serve on our board to challenge us?” Many health system boards are looking for members skilled in areas such as quality, technology, finance, regulation, human resources and marketing. These individuals often come from outside of health care. Boards also are placing a greater emphasis on diversity of board membership and on having the board reflect the constituents and patients that the organization serves. For additional resources, see the AHA’s Center for Healthcare Governance web page devoted to Board Composition and Development; and “Recruiting the Right Mix” (Trustee, June 2013) by Steven Valentine and James Gauss.

**Measuring and Incentivizing Performance:** The proliferation of health care data means it is now possible to measure individual, board and organization performance as never before, in areas such as quality, safety, and community health. These data and the increase in pay-for-performance (P4P) initiatives provide the starting point for boards to set meaningful incentives for addressing mission priorities.

**Strategy:** Health care boards are spending much of their meeting time talking strategy. How do we grow? Who do we partner with? How much risk can we handle? These are important questions, and most boards welcome these discussions for their inherent challenges as well as the opportunities they present to collaborate with their CEOs and key stakeholders.

Ironically, despite the increase in strategic conversations, discussions of mission and values may get deferred. Not that boards are forgetting the mission; however, sometimes they put mission on the back-burner in favor of focusing on pressing strategic matters. When mission is omitted from the conversation, misguided strategic work can result.

All strategic planning in health care should be mission-based. A key premise of Gage’s report is that governance “must ensure that the health system operates in conformance with its organizational documents . . . and its mission. To do so, board members must have a solid understanding of the fundamental purpose and mission of the health system.”

**Imperatives for the CEO**

The Figure 1 model’s hourglass shape reflects the CEO’s role as translator and intermediary between the board, the organization and outside forces. The forces acting upon the CEO, primarily in independent ways, include the board; constituents (such as partners, affiliates, community and staff); and other external parties—from payers to partners to policymakers.

Today’s health care CEOs must address the following key operational and strategic imperatives:

- **Ensure quality and safety.** Quality, safety and their impact on the patient’s care experience are always the top priority; and the buck stops with the CEO.

- **Develop structure to execute.** Hospitals and health systems are realigning through mergers and acquisitions or more informal partnerships and arrangements. The right structure has to be in place to carry out mission, vision and strategy for the future.

- **Oversee financial planning.** CFOs cannot operate alone, and today’s health care CEOs are becoming more directly involved with the organization’s financial performance. The CEO-CFO relationship is
perhaps the most critical on today’s health care leadership team.

• Drive cultural development. Organizational and marketplace changes require new levels of awareness and intentional development of a common culture throughout today’s expanded systems and networks. Are people on board and ready for a different way of doing things? Are they setting the tone for patient and community education and cultural competence?

CEOs also bear primary responsibility for managing the fundamental assets organizations leverage to execute their strategies. These include:

- the leadership team
- people, processes and culture
- technology
- intellectual property
- balance sheet
- facilities

**New Missions for a New Era?**

As CEOs and their leadership teams implement the organization’s mission and vision through its strategic plan and assets, the clarity and relevance of the mission they are striving to fulfill are critical.

Does re-imagining the mission and function of an organization mean “out with the old and in with the new”? Not necessarily. In fact, population health and guiding frameworks such as the Triple Aim are directly aligned with the missions of hospitals and health-serving organizations that were founded more than 100 years ago. Health care has always been about serving individuals and communities, doing good by doing well, pioneering research and education, and fostering the well-being of society.

Population health draws upon timeless ideas and practices and applies modern tools and technologies to execute them in today’s complex environment. It is important, therefore, for missions to hearken back to an organization’s traditions, interpreting them within a more modern context. The following are a few mission statements that do this well.

1. **To improve the health and well-being of individuals, families and our communities.** (MemorialCare Health System, Fountain Valley, Calif.)

2. **Helping people live the healthiest lives possible.** (Intermountain Healthcare, Salt Lake City, Utah)

Massachusetts General Hospital (Boston, Mass.), one of the oldest hospitals in the country, has an often-cited mission that was revised nearly a decade ago and actively guides the organization’s current initiatives and strategy as an integrated delivery system:

3. **Guided by the needs of our patients and their families, we aim to deliver the very best health care in a safe, compassionate environment; to advance care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.**

Los Angeles-based Cedars-Sinai Health System’s mission communicates new priorities with a nod to its roots:

4. **Cedars-Sinai Health System . . . is committed to:**

- **Leadership and excellence in delivering quality healthcare services.**
- **Expanding the horizons of medical knowledge through biomedical research.**
- **Educating and training physicians and other healthcare professionals.**
- **Striving to improve the health status of our community.**

**Quality patient care is our priority. Providing excellent clinical and service quality, offering compassionate care, and supporting research and medical education are essential to our mission. This mission is founded in the ethical and cultural precepts of the Judaic tradition, which inspires devotion to the art and science of healing, and to the care we give to our patients and staff.**

These mission statements (and their corresponding vision statements) demonstrate a broader, encompassing view of organizational purpose that can be “memorialized” and “protected,” as Gage notes, while also allowing flexibility for the organization to take risks and 

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**Trends in Health Care Board Roles and Recruiting**

Here are some questions today’s boards should be asking about their governance roles and practices:

1. Recruiting for competencies and skills—what strengths does our board have? What gaps?
2. Compensation for specific roles—do we need to provide compensation to get the board members we need?
3. Right-sizing—are we too cumbersome (following a merger perhaps?) or too thin?
4. Committee effectiveness/measurement/communication—is every committee functioning, aligned, and on the same page?
5. Cybersecurity and governance—does our board have expertise around data and information technologies?
6. Frequency and length of meetings—are we maximizing our time together?
7. Agenda planning—are we focused?
8. Ad hoc task forces—how do we tackle surprises or short-term needs?
9. Board education退 retreats; types and frequency—how does our board bond, grow, and develop?
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re-imagine how it can creatively operate in ways that are mission-relevant.

Great mission and vision statements also empower meaningful work. Consider the mission and vision statements of Beacon Health System within the context of health systems taking a stronger leadership role in assessing and improving overall community health (see Learnings on Governance from Partnerships that Improve Community Health: Blue Ribbon Panel Report and Community Partnership Profiles).

Beacon Health System is a community-owned, not-for-profit system based in South Bend, Ind. Its mission is “to enhance the physical, mental and emotional well-being of the communities we serve.” The health system’s vision is “to achieve:

- Innovative health care and well-being services of the highest quality at the greatest value
- Easy access and convenience
- Outstanding patient experiences
- Ongoing education involving physicians, patients and the community.”

Beacon Health System’s community health program focuses on engaging community groups to develop ideas and strategies to bridge the traditional “sick care” model of service delivery with innovative interventions and outreach to move to a “health and well-being” model of care (see mission and vision statements above).

The system tithes 10 percent of its previous year’s excess operating revenue to be invested as “seed money” in community health initiatives. Initiatives must a) evidence organizational alignment with the health system’s mission, vision and values; b) address one of the health priorities identified in the community health needs assessment; and c) align with Beacon Health System’s intent statement focusing on The Triple Aim: 1) improving the patient experience of care; 2) improving the overall health of the population; and 3) reducing costs.

Mission and vision statements, like those of Beacon Health System, that are broad in scope, state an organizational purpose relevant to community needs and provide sufficient direction to guide specific organizational work are powerful indeed.

**Partners in Mission**

Boards are addressing the mission question through more progressive relationships with their CEOs. In doing so, they encourage CEOs to advance the hospital or health system’s work within the mission context, and to cascade mission-focused ideas organization-wide.

The model shown in Figure 1 is intended to make health care boards more aware of how they and their organizations interact with their CEOs and to think deliberately about how they spend their time as a board and, especially, with the CEO.

Board conversations, not functions, are changing as health care organizations transform their work to adapt to the forces of change (see sidebar on page 3). A well-crafted, relevant mission statement should be the touchstone that guides discussion among the board and leadership to ensure the organization meaningfully advances its core purpose and priorities in today’s environment.


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**Governance Staffing: How Much Do We Need?**

by Luanne R. Stout

“Too many companies believe people are interchangeable. Truly gifted people never are. They have unique talents. Such people cannot be forced into roles they are not suited for, nor should they be. Effective leaders allow great people to do the work they were born to do.”

— Warren G. Bennis, Organizing Genius: The Secrets of Creative Collaboration

In most professions, there are clear and relatively consistent pathways along one’s career continuum, as well as clearly defined experiential and educational requirements. Not so with health care governance staffing, which ranges from board support provided by a CEO’s assistant all the way to a comprehensive governance support staff led by a senior vice president/chief governance officer. One possible reason for this variability is that no recognized degree program or training for governance support exists. Another factor is that health care CEOs may consider themselves to be governance experts and, therefore, are likely to place less value on training and experience for their governance staff.

Unlike other corporate functional areas, which are similarly structured in organizations around the country, there is very little consistency in approach to both establishing a governance program (or not) and staffing to support it. Work involved in governance support ranges from an assistant who types an agenda and orders lunch for the board meeting to a highly sophisticated leader who provides multi-year planning for orientation, education, communications, self-assessments, competency-based board selection, succession planning, and standardized processes and procedures. In addition, perhaps because governance is not a full-time occupation for many individual(s) responsible for supporting boards, it is not unusual to find a host of other duties blended into the governance support role (legal functions, compliance, support for the CEO and medical staff, etc.) that dilute focus.
The increasing complexity and scope of today’s health care systems, that now embrace population health, accountable care organizations (ACOs), consumerism, bundled care and more, are also driving the need for better board education and coordination. Therefore, it is not surprising that many boards and CEOs are determining whether they need a more formal, deliberate and comprehensive approach to governance management and staffing.

Fifteen years ago, CEOs I talked with were largely skeptical about dedicated governance staffing. They believed their organizations possessed the governance expertise they needed, that expanding governance support would be too expensive, and that the success of such a program would depend on having an experienced program leader who would be difficult to find. Five years later, I began receiving calls from CEOs and newly appointed and inexperienced governance staff seeking advice on how to structure and staff governance support. Today, I receive dozens of these calls from around the country asking for advice.

**Why Do Health Care Organizations Need Governance Staffing?**

I was contacted recently by the board chair of a large, urban public hospital. The board had hired two different governance consultants, both of whom had produced long reports describing what could be improved, but not much guidance on how to make the needed advances. The chair explained that she was near the end of her term and was anxious to leave her board in better stead before she stepped down. Her next words resonated then and now, “My successor should not have to work as hard as I have. Is there any way you could help us?”

This illustrates a growing trend of boards themselves seeking something more, which has led to another growing trend: governance staff being hired by and reporting directly to the board. While this approach can be challenging, the frustration and desperation behind it is understandable. Why are boards frustrated? For many organizations, governance planning and education consists of board members attending an annual retreat and a conference, with governance support handled entirely by people who have full-time jobs doing other things.

Contrast this approach with other functional areas in health care organizations. Would you ask the chief financial officer to develop a strategic plan in his spare time? Would you ask the chief operating officer to develop and manage a corporate compliance program in her spare time? No? So why is it that you would ask anyone to manage governance – the heart of decision-making for any organization – as a part-time activity?

As with anything important and worth doing, governance management deserves leadership and support from one or more people who devote their attention, education, growth, development and imagination to it full-time. The value of dedicated governance leadership holds true for all types of health care organizations: rural stand-alone hospitals; urban public hospitals; large, multi-business unit health systems and for any organization that has one or more boards.

**What Do the Best Governance Leaders Do?**

The roles of full-time governance leaders should be focused on the fundamental components of a governance program that systematically provides for the needs, education, processes, development, growth and advancement of all boards at all levels of the organization. These components include:

- **Orientation.** Every new board member deserves a customized, organizationally specific and strategically focused orientation. At a minimum, this should include a well-written manual that does not exceed 50 pages. A properly designed and executed orientation readies a director for Day 1 and significantly reduces the average three-year window for active participation by new directors. Ideally, an orientation is followed by a structured, months-long process that covers the health care environment, the hospital or system and governance essentials and may include one-on-one meetings with the board chair and hospital executives, mentoring with an experienced trustee, and shadowing of clinicians.

- **Ongoing education plan.** To provide true value, board education cannot be periodic or infrequent. While attending educational conferences on an annual basis, such as those offered by the American Hospital Association’s Center for Healthcare Governance, can be quite beneficial to a board, ongoing education in a systematic and well-planned manner is crucial to effective board participation.
decision making. Education should be customized to advance the organization’s strategies and utilize multiple modalities to reach all generations and personality types. These can include board portals, newsletters, board meeting discussion topics, and articles and/or trustee-focused journals such as Trustee magazine and the Great Boards quarterly online newsletter available at www.greatboards.org.

- **Defined roles, responsibilities, expectations.** A board job description is critical to effective board function. Directors should have clarity about key board roles and responsibilities, as well as expectations of individual board members. While a number of excellent models are available, a model can only provide a generic guide and should be adapted based on sound governance principles tailored and customized to the individual board, organization and culture.

- **Clarity of comparative board/management authorities.** For an organization that has more than one board or governance level, it is critical that each board have a clear understanding of its roles and responsibilities relative to those of other board(s) and management. This can be accomplished through an authority matrix or grid.

- **Communication plan.** All organizations should have a communications plan for transmitting critical, time-sensitive news, announcements, and leadership messages to their boards quickly and reliably. This includes a formal process for who can send such messages, the level of approvals required, and technology utilized (e.g., blast email).

- **Infrastructure design and support.** Boards function best when they have well-designed, consistent meeting processes, procedures, agendas and reporting standards that continually are improved based on board feedback through discussion and self-assessments.

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### Governance Leadership Qualities/Attributes

- **Truly exceptional interpersonal and communication skills.** Must be completely comfortable talking to anybody at any level at any time—board members, senior leaders, staff, external stakeholders and anyone else at any level inside or outside the organization.

- **Strong writing ability.** Must be able to effectively write at a sophisticated level to produce resources such as orientation manuals, governance plans and standards and board communications.

- **Positive, glass half full, optimistic outlook and attitude.** Positivity and optimism are just plain hard to resist. Who doesn’t want to be around such a person? And, this outlook is critical to effective planning and development of governance strategy, as well as building the solid relationships that are the backbone of exceptional governance support.

- **Big picture thinker and visionary.** Those who can’t see the forest for the trees are unlikely to be effective in governance support roles. The best governance leaders not only fully see the big picture, they often see it before anyone else does and are able to project where governance needs to go next because of it. They are aware of where the organization is now and where it is planning to go, as well as the environmental factors driving the organization in that direction or that may pose barriers along the way.

- **Intelligent, innovative, creative and energetic.** The health care landscape changes constantly. It takes a lot of effort and energy to keep up, much less anticipate where things are going and creatively advance innovative governance plans and processes to stay ahead.

- **Knowledge/understanding of the health care field and how governance fits.** A governance leader reads the same journals and daily advisories as the organization’s senior leaders, attends governance conferences to keep abreast of trends, and stays informed.

- **Innate curiosity and eagerness to learn.** There are few road maps or direction signs for governance leaders. The best never stop studying, asking questions, watching and thinking about how to leverage what they learn into what they do.

- **Inspires trust and confidence.** Not only do boards need to trust and be inspired to confide in their governance leaders, CEOs and C-suite teams need to trust that they will represent the organization well, support their work and help keep their boards moving strategically in the right direction. The board chair and CEO must be able to trust the governance leader to act and anticipate needs in a way that is consistent with their own principles and vision, be their eyes and ears, and enhance their relationships with the board.

- **Strong and independently motivated work ethic.** No doubt about it—managing governance is challenging, with lots of deadlines and competing priorities that must be handled without a Sherpa. Hard work and self-motivation guide the way.

- **Bachelor’s degree and preferably master’s degree in health care administration and/or business.** Any leadership role requires preparation and knowledge provided by advanced education, which also inspires others to have confidence in the governance leader’s capabilities. Understanding health care is critical.

- **Board competencies and succession planning.** It is no secret that leading boards select their members and leaders based on competencies and perspectives that are carefully identified and balanced to foster effective governance and provide the foundation for formal board recruitment and succession planning processes.

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• **Self-assessments.** Most boards and management teams believe they are doing a great job. Great boards, however, utilize nationally recognized assessment tools that afford benchmark comparisons with other hospital or system boards, along with custom assessments regarding issues important to their own board and organization, to evaluate their performance. These boards also use their assessment results to systematically advance board function and effectiveness, as well as to plan for governance education.

These components of exceptional governance programs never come straight out of a box or toolkit. Although models abound and can be helpful, the best programs are highly customized, organizationally and culturally adapted, and continually advanced through cycles of learning. Governance leaders bring these programs to life, focusing their full attention, talents and energies on them in lock step with their organization’s senior leadership. They write, develop and progressively evolve all of the above governance program components and are never, ever, ever finished improving them.

How Much Governance Staffing Is Appropriate?

One size rarely fits all in clothing or shoes, and the same is true for governance staffing. Several key considerations can provide guidance in determining the right level of governance support. These factors include:

- **Number of boards.** For one or two boards, a governance manager may provide the right level of leadership. However, a large public hospital associated with an academic medical center with only one board may need a Director of Governance due to the level of political sensitivity and number of organizations involved. A mid-size health system with four or five boards also may be well served by a Director of Governance. A large, multi-unit health system with numerous boards likely needs an executive-level chief governance officer.

- **Complexity/scope of organization.** In today’s environment, complexity goes beyond number of boards. It is increasingly common for health systems to have hospitals, foundations, physician organizations, insurance products, payment bundles, ACOs, rehabilitation and behavioral health centers and strategic partnerships. Governing boards for these different business units, while functioning under common governance principles, also have unique infrastructure, educational and operational needs. The greater the organization’s complexity and scope, the greater the level of experience and ability needed to manage governance effectively.

- **Breadth of functions included in “governance.”** If governance operations and planning functions comprise the entire governance support function, then one governance leader with administrative support may be adequate. However, if the scope of responsibilities includes corporate secretary functions (e.g., minutes, board resolutions, maintenance/filing of corporate documents), compliance functions or other related activities, the governance leader will likely require additional support staff, such as minutes-taking specialists.

- **Stage of board maturity and sophistication.** Boards that have been the beneficiaries of a robust governance program will likely continue to push for more and evolving board education and increasingly refined board processes. Likewise, boards that have been exposed to conferences and/or governance trade journals, but have not yet adopted best governance practices, will likely want to implement them. Boards that desire to adopt more sophisticated governance practices may require a level or type of governance support different from what they have typically relied on.

- **Status of organizational health.** Boards of relatively healthy and financially sound organizations often tend to believe their governance follows suit. However, boards of organizations that face financial, quality, performance or other challenges may begin to question whether they have sufficient education and preparation to guide their organizations and help leadership improve organizational standing. In this case, more intensive or expert governance support may be required.

Boards looking for advanced governance support often wonder where to find individuals who are up to the task and what qualifications and attributes they should possess. Although the level of leadership and number of individuals needed to support governance may vary depending on the breadth of the organization and governance program, the attributes and qualifications needed are surprisingly consistent, as shown in the box on page 6.

**Conclusion**

There is no single prescription or precise formula that can be followed to either establish a best-in-class governance program or staff it appropriately. Each organization must examine how best to design and staff its own program based on the fundamental components that are the hallmark of leading-edge governance, as well as the organization’s size, scope and complexity. When it comes to governance leaders, it is less about titles, training and degrees than it is about finding that person who possesses the innovative and special qualities needed to build a sound program, continually advance it, and never stop learning or improving it.

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