





SHOOT THE MOON

**The power
and the danger
of setting
extreme goals**

By John Buntin

'M

ake no little plans," the Chicago architect Daniel Burnham once remarked. "They have no magic to stir men's blood."

Burnham, the most famous builder of his era, drafted Chicago's master plan after fire destroyed the city in 1871. He dreamt of a Chicago that was not "the hog butcher of the world" but rather "the Paris of the Prairie."

Chicago Transportation Commissioner Gabe Klein is a Daniel Burnham kind of guy. Today, in cities such as New York, San Francisco and Portland, Ore., transportation commissioners are dreaming big and shaping cities' futures. Klein, a self-described Vespa lover, world beach traveler and hip-hop fan, is at age 42 one of that movement's superstars. That's in part because of his immodest goals: 100 miles of protected bike lanes in four years' time; streets kids can play in; and street designs that put pedestrians first, cyclists second and automobile drivers last. Most daring of all, however, is the goal set last year to eliminate all pedestrian deaths within 10 years.

Goalsetting is among the most basic responsibilities of any executive. Yet in a world awash in case studies and management literature, it is also among the least understood. Some managers set "stretch goals" for their teams; others try to underpromise and overdeliver. Nevertheless, some of the most striking public policy achievements of our time started by setting targets so ambitious that they deserve their own label: extreme goals.

Extreme goals are ambitious. They are attention grabbing. They use the language of morality rather than cost-effectiveness.

They also often seem impossible—and that can be a problem. "Anytime a leader sets goals where people can't see how they would achieve them, it risks conflict and confusion," says Zachary Tumin, a lecturer at Harvard's Kennedy School of Government. "With extreme goals, you run that risk even more."

However, extreme goals—or what management consultant Jim Collins has called "big hairy audacious goals"—can also deliver big payoffs. That's no coincidence, says Tumin, who, along with former New York and Los Angeles police chief William Bratton, is the author of "Collaborate or Perish! Reaching Across Boundaries in a Networked World." "The guys who go broad on extreme goals, big goals, they bring in a lot of levers for change," he says. "The broader they go, the more people they can rally around the goal." Indeed, rallying a large group of stakeholders to address a common, moral issue is the point.

In setting his zero-death goal for pedestrians and bicyclists, Klein is aligning himself with those who see possibilities that others miss and is setting goals that at first glance seem implausible. This concept is easy to underestimate in an age where incrementalism and cost-effectiveness often dominate. Those who undertake extreme goals must find ways to brand

events—be they pedestrian deaths, airline crashes or central-line infections—as unacceptable, and to eliminate them by embracing collaboration and culture change rather than issuing regulations.

The story of extreme goals starts in the skies. At 8:19 p.m. on July 17, 1996, TWA Flight 800 took off from New York City's John F. Kennedy International Airport, bound for Rome. Twelve minutes later, it exploded in mid-air, killing all 230 people on board.

An investigation by the National Transportation Safety Board (NTSB) concluded that the exact cause of the explosion could not be determined with certainty, but the most likely cause was an electrical short circuit. It was the second deadly accident of the

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summer. Just two months earlier, ValuJet Flight 592 had crashed into the Florida Everglades, killing all 110 passengers and crew, after used oxygen canisters improperly stowed in the cargo hold sparked a fire. By year's end, the aviation death tally stood at 380 people killed, the highest in 11 years.

For the people who died and their families, each of these deaths was a tragedy. For the aviation industry, it was also a business problem. With 20 percent of Americans admitting to an acute fear of flying at the best of times, the accidents and deaths threatened projections that air travel would double in 10 years.



There was another reason for concern. For nearly two decades, aviation fatalities had fallen as technology improved. Then progress stalled. As a result, the airline fatality rate had plateaued at about 1.9 deaths per 100 million aircraft miles. If air travel doubled and safety rates failed to improve, the number of fatal accidents would double too, with devastating consequences. So in August 1996 when President Bill Clinton appointed Vice President Al Gore to chair the White House Commission on Aviation Safety and Security, the aviation industry enthusiastically signed on.

At the time, the relationship between the airlines and their primary regulator, the Federal Aviation Administration (FAA), was poor. Chris Hart, who is now vice chairman of the NTSB, was assistant administrator for the Office of System Safety at the FAA when the relationship between the two was in turmoil. He describes the interplay between the FAA and the airline industry this way: “The regulator says, ‘I see this problem. And here’s the solution that I’m going to propose. And everybody needs to do this solution.’ The industry’s response frequently is, ‘Hey, FAA, you don’t fly airplanes. I’m not confident that you’ve identified the problem correctly, and I’m even less confident that you’ve got a good solution for this problem. So I’m going to fight it, and I’m going to litigate it, and I’m going to do everything I can not to have to do it, because I don’t like it.’”

The task of the White House Commission members, then, was to change that relationship. They did so by setting an extreme goal—an 80 percent reduction in fatal accidents in 10 years. To achieve it, they recommended that the airlines and FAA collaborate.

Key members from all the major stakeholders (airlines, manufacturers, employees, government and observer agencies) created the Commercial Aviation Safety Team and started gathering for regular meetings where issues were discussed, priorities set, and initiatives and evaluations were reviewed. Embedded in this collaborative approach was an important insight, namely, that it was often difficult to identify exactly what the problems were because, as a team report put it, “the problem usually relates to linkages between subsystems.” In other words, the systems required to fly planes and manage air traffic are so complex and intricate that top-down command wouldn’t work. Collaboration would.

Ultimately, the aviation world was able to make remarkable strides in safety—without issuing rafts of new regulations. By 2008, commercial aviation accidents had declined by 83 percent. It has now been more than four years since a U.S. airline experienced an accident that caused a passenger fatality, the longest such span since the dawn of the Jet Age 70 years ago.

DAVID KIDD



Today, Hart spends much of his time talking to other industries looking to replicate aviation's successes. Nuclear energy, chemical manufacturing and, more recently, offshore drilling companies have been particularly interested in understanding the aviation industry's experience because most of these fields operate in environments where the people attempting to carry out the change directly benefit from improvements.

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“There’s a saying among pilots that they are the first to arrive at the scene of an accident,” says Hart wryly. “If you’re on the plant floor in a chemical plant or a petroleum refinery, you get hurt by your mistakes.” In those industries, collaboration easily meets what Tumin of the Kennedy School describes as the critical feature of a successful collaboration: “Collaboration has to pay.”

That’s not true of most state and local government officials. Most are not attempting to implement an approach that will directly affect them. Rather, executives pushing extreme goals quickly discover that what they are really attempting to do involves changing a culture. Few cultures are more resistant to change than those of hospitals. Yet one of the most dramatic success stories in the world of public health comes from hospital intensive care units. It’s a change that started with the needless death of an 18-month-old girl in a Baltimore emergency room in 2001.

Josie King was one of four kids. One evening, while her siblings were watching TV, Josie tiptoed into a bathroom and turned on the bathtub. Her mother had floated a toy boat in her bubble bath a few nights before; Josie wanted to see it again. The nearest faucet handle was for hot water. The water heater was broken; as a result, the water was scalding. Josie fell in and started scream-

ing. Her terrified mother ran upstairs, pulled her out and called 911. When she arrived at the emergency room at the Johns Hopkins Bayview Medical Center, the triage nurse estimated that 60 percent of Josie’s body was covered with second-degree burns. Doctors placed IVs in her neck, wrist and inner thigh to ensure that she was getting enough fluid intravenously. A few days later, they replaced these lines with a central-line catheter, a tube

that runs to a place near the heart through which doctors could administer fluids, food and medicine while also monitoring heart function. After a series of skin grafts, Josie gradually began to improve. After a month, she was preparing to go home. Then, her temperature spiked. Tests revealed a bacterial infection in the bloodstream. Her doctors removed the central line and began administering oral antibiotics. She didn’t respond well. A few days later she died.

Several months later, a doctor introduced Josie’s mother to Peter Pronovost, an anesthesiologist and patient safety expert at Johns Hopkins University. Pronovost already knew that central-line infections killed between 30,000 and 60,000 Americans every year and that most of those infections could be avoided if doctors and nurses followed proper procedures. But hearing the story of Josie’s death personalized the statistics. He resolved on a new goal for the surgical intensive care unit (ICU) where he worked as an attending physician—zero central-line infections.

His first challenge was persuading people that central-line infections were a problem that could be fixed. Hopkins’ infection rate was high—15 central-line infections per thousand catheter days—but many physicians believed their patients were unusually sick, their cases unusually challenging. Pronovost marshaled statistics and evidence to argue otherwise; he also worked with Josie’s mother to inject urgency to the effort by sharing her story. Inspired by a book he had read about airline safety, he proposed an additional measure—a checklist for setting a central line. Physicians would run through it before any procedure, just as airline pilots check their planes before takeoff. His team accepted the idea in principle but not in practice. Initially only 30 percent of doctors followed every step listed.

Pronovost tried empowering nurses to serve as compliance officers. But this threatened the normal pecking order, and his colleagues resisted. “What was striking was that nobody debated the evidence, nobody challenged the items on the checklist and nobody questioned whether we should do them,” says Pronovost. “But everyone objected to the change in culture.”

It’s a truism that people resist change. But as Pronovost wrestled with this issue, he realized that change wasn’t the real problem. The real problem was loss—or perceived loss—of stature and autonomy. “What leaders of change need to do is minimize real losses and demonstrate that perceived losses are mythical,” says Pronovost. “Only then can they successfully implement cultural change.” Pronovost ultimately succeeded in raising compliance rates to about 95 percent. In a year’s time, central-line infections in his unit had disappeared.

In April 2003, Pronovost flew to Michigan to give a talk on his ideas. There he met Chris Goeschel, who ran a quality and safety institute funded by the Michigan Health & Hospital Association called the MHA Keystone Center for Patient Safety and Quality. Thanks largely to the presence of the auto industry, Michigan had a long history of collaboration between industry, insurers and large health-care providers. After the talk, Goeschel asked for Pronovost's help in implementing statewide ICU programs similar to those he'd put in place at Hopkins. A two-year federal grant provided the funding, and the collaboration set as its goal one central-line infection per thousand catheter hours, a significant decrease from the statewide mean of seven central-line infections per thousand catheter days.

As at Hopkins, many ICUs initially insisted that sick patients, not sloppy procedures, were the root of the problem. Pronovost and his team used two strategies, storytelling and hard data, to break that down. They also took pains to avoid the perception that they were imposing a solution from the top down. Although certain aspects of the checklist approach were designated as "essential," each hospital ICU was given the authority to draw up its own checklist, which gave them ownership. However, it was the peer dynamic that proved decisive.

Pronovost and Goeschel believed they needed consistent, centralized data to provide accurate feedback to participants and to judge whether the intervention was succeeding. Yet two months into the program, only 40 percent of the participating ICUs were delivering such data. At this point, Pronovost and Goeschel made a decision: ICUs that didn't provide appropriate data would be dropped from the program. No ICU wanted that.

There was another reason for hospitals to stay on. The handful that were implementing the checklist were seeing central-line infections disappear. Although the statewide goal was one central-line infection per thousand catheter hours, institutions were beginning to embrace a new goal—zero.

An early holdout was the University of Michigan Health System. It operated six high-volume ICUs, and it was clear that some at the institution were unhappy about receiving suggestions from an interloper in Baltimore. Only one of its ICUs was participating—and that ICU insisted on zero as a central-line-infection goal.

"Not embracing a zero goal would be the equivalent of you telling us that you think we can't do it," said the administrator of the participating hospital at a meeting of the hospital board. In other words, the ICUs themselves wanted—and needed—the extreme goal. Soon thereafter, the other University of Michigan ICUs joined the program as well.

Pronovost's checklist has since become famous, thanks largely to contributor-and-surgeon Atul Gawande's book, "The Checklist Manifesto." And it's given Pronovost a chance to work with states across the country. When asked about the challenges he perceives at the state government level, Pronovost cites the comment made by the astronaut Rusty Schweickart in the 1960s while orbiting

over the Middle East, "There are no lines from outer space." The need for leaders to dream big and to undertake the difficult work of changing cultures is everywhere, Pronovost notes, adding, "When I see state government, I see a whole lot of lines."

In Chicago, Gabe Klein looks at city streets as a battleground. Across the country, he says, "we're losing more people per year in auto-related fatalities than any war that we're fighting." Last year, 32,000 pedestrians and bikers were killed nationwide. In Chicago itself, cars crash into roughly 3,000 pedestrians and cyclists every year; about 50 people die as a result. As far as accident rates go, it's not that bad. In fact, Chicago is the fourth safest city for pedestrians in the country. But "accident" is a word Klein doesn't accept.

"When you think of an accident you think, like, 'Whoops, the milk fell off the counter;' 'Whoops, I stubbed my toe,'" he says. "Well, we don't view [pedestrian deaths] as accidents. We view these as avoidable casualties."

Hence the goal—zero.

Klein came to his calling from an unusual background for a government manager. He grew up on a commune in Virginia, worked in his dad's bike shop in Charlottesville, then moved into marketing and operations, becoming one of the early employees

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of the car-sharing startup Zipcar. His next foray was starting his own company—a high-quality electric-vehicle food truck in Washington, D.C.

"It was a pretty crazy idea," he says. "Now, there are food trucks everywhere, but in 2007 when we started writing the business plan, there was nothing but hot dog vendors." Klein's business, however, quickly ran into a problem—the district's Department of Transportation, which he says seemed more interested in maintaining the status quo than in accommodating a new business.



KEITH WELLER

out the city, supported the return of streetcars in the fast-developing H Street corridor neighborhood, expanded an innovative bus route through downtown called the DC Circulator and installed the largest pay-by-phone parking system in the U.S.

When Fenty was defeated in his bid for reelection, Klein's D.C. adventure was over. He went to Costa Rica with his wife, rented a jeep and started driving. Soon after returning, he got a phone call from Rahm Emanuel, Chicago's new mayor, offering him the opportunity to come to Chicago and oversee transportation there.

Not surprisingly, he was determined to approach the job in Chicago as he had in D.C., and goalsetting is a key part of that process. "When you set a 10-year goal, do you ever know that you are 100 percent going to attain that? No," he says. "But I can tell you that if we set a goal that was half that we're not going to exceed it. By setting this zero goal, it forces us in everything we do and every design standard we set to make sure we think nobody will ever get hit by a car. It changes the way we do things."

His Chicago approach, detailed in a 100-page document published last May, provides more than just an extreme goal. It lays out the steps needed to get there—lowering speed limits, fixing the intersections that top the "10 most dangerous" list each year, and adding red light cameras and school safety programs. It also proposes incremental goals of a 10 percent reduction in pedestrian accidents per year. By setting an extreme goal and subsuming these new initiatives and more modest goals under it, the Chicago Department of Transportation has attracted attention.

"It lets people know that we are dead serious about this," says Klein. "You're always going to have people that are wary of the big goal; you're going to have people question whether walking and biking, for instance, or more investment in transit, is the right thing for a city." To answer that point, Klein hauls out data from cities that have made similar infrastructure investments, such as Amsterdam and Tokyo. Those cities, he says, are more economically viable because of the investments they've made. They have more density and a bigger tax base on average, as well as better-quality schools. "We know it works," he says.

When it comes to setting big goals, "one of the insights that emerges is you can't order it; you can only set it as a vision and then rally people around it," says Harvard's Tumin. "The relentless pursuit of insight from data is really the opportunity today. It may take data to bring a goal to pass, but it is driven by a moral insight." **G**

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Soon thereafter, Washington, D.C., Mayor Adrian Fenty recruited Klein to join his administration—as the city's transportation commissioner, with responsibility for a \$1 billion annual budget. Although the public sector was new to Klein, he didn't have any trouble grasping its levers.

"The biggest opportunity I had coming into government was my absolute and total ignorance of how government was supposed to work," he says. He was accustomed to the private sector, where a business plan was followed by market surveys and feasibility analyses. "You do it all very quickly; you figure out if it's going to work," he says. "You launch on a small scale. You test things before you invest a lot of money. You have a vision. You get your whole team on board. Then you go to market and you go full bore. That's the approach that I took to government."

Like the 19th-century Chicago architect Burnham, Klein was inspired by Paris—specifically, Paris' bike-sharing program, which he brought to D.C., creating the city's wildly successful Capital Bikeshare program. He also created bike lanes through-