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Executive Dialogue

Succession Planning

Ensuring Leadership Continuity



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Succession Planning: Ensuring Leadership Continuity

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With hospital chief executive turnover at an all-time high of 20 percent, and his or her average tenure being less than four years, hospital and health system boards should anticipate taking part in a leadership search during their service. Succession planning can help organizations to ensure leadership continuity and organizational success. Despite its importance, however, succession planning is lacking in hospitals today. Health Forum convened a panel of health care executives and industry experts in July in San Diego, to discuss best practices in succession planning and how organizations can develop a rigorous succession planning process. The discussion also examined board selection and development. Health Forum thanks all of the participants for their open and candid discussion, as well as B. E. Smith for sponsoring this event.





Bridgeport, Conn. We conducted succession planning down to the director level within the organization. Our succession plan was reviewed every year by the compensation committee. I had two people in mind for my role. I evaluated their strengths and weaknesses and put together a structured program for each of them, to expose them to the things they would need if I happened to get hit by a bus or relocated to Pensacola. I gave them opportunities that they otherwise might not have had because I knew it was important. It's what I owed the organization.

MICHAEL ROWAN (Catholic Health Initiatives): We conduct succession planning within the larger context of what we call talent review. We have an annual process across the entire organization in which four senior leaders review every executive down to the vice president level in each of our facilities. It's a weeklong process because we're reviewing a few hundred people. We try to understand two things: how well the individual is doing in his or her current position and what the next steps should be. It's a complicated process for us because we're involved in 18 states. We try to think about talent on a systemwide level and not just in individual facilities. That helps us to gain an understanding of what opportunities there are for people to move between organizations. This is important, in particular, because we have different kinds of organizations in different parts of the country, giving us a better opportunity to broaden people's skills across the system.

The talent-review process works well for us. Although time-consuming, it helps us to identify some rising stars in the organization. It's important for senior people who live across multiple markets to be able to understand the talent in each market across the various parts of the organization.

JASON SPRING (North Valley Hospital): It's much different in our organization because we are a critical access hospital. We don't often have the opportunity for succession planning, unless we know someone is moving toward retirement. We don't have a deep pool of resources. Occasionally, we can identify someone who wants to move up or stay in the area, but openings often are filled by interim staffing, particularly at the C-suite level. That practice primarily is because the expertise needed for each of our positions is



From my standpoint as a CEO I think succession planning is probably one of the most important things that we do in our jobs.

Susan Davis

MODERATOR: (Richard de Filippi, Cambridge Health Alliance): To what extent is succession planning routinely practiced in your organizations? What positions are covered and who is involved in the process?

SUSAN DAVIS (Sacred Heart Health System): From my standpoint as a CEO I think succession planning is probably one of the most important things that we do in our jobs. It's important for us to look for talent within the organization and find opportunities for them to develop their leadership skills. Prior to joining Sacred Heart, I was at St. Vincent's Medical Center in

usually not very deep in the organization. Our chief nursing officer recently retired after 31 years. We had time to do succession planning, bring in someone in advance and have a transition period. It's a challenge in a small hospital in Whitefish, Mont., where it is probably easier to recruit to than most places in the world, but a lot of small hospitals have a challenge getting people to move to a rural area.

MARK SULLIVAN (Catholic Health System): As a regional health system in western New York, our CEO and our chief human resources officer spend time every year working with our board and our compensation committee to evaluate the talent of our C-suite down to the vice president and director level. They focus not only on their current roles, but also the potential roles they could take on in the future. So, at each of our hospitals, we have succession plans three steps down for clinical and executive leadership. We want to expose our up-and-coming talent to more services outside of the facility, to extend beyond acute care to home care and long-term care. We all know the health care delivery system is changing and we're trying to make sure we're prepared. Our biggest challenge is growing the next level of nursing leadership at the CNO level. To assist with this, the board, our CEO and chief human resources officer are focusing on the development of nurses, their career paths and identifying who might be the next CNO.

MODERATOR: Does the succession planning process need to evolve in light of the transformation of the health care industry? How are your organizations taking that into consideration?

DOUG SMITH (B. E. Smith): In my experience in working with health care organizations, I've found that our most successful clients have the most extensive succession plans. That's not a coincidence. And the organizations with which we've worked that do not have formal succession plans in place are struggling. It's not in the forefront of their priorities.

DIANE CROSS (University of Minnesota Health): One thing that strikes me today is the fact that we're seeing a great deal of hospital CEOs being replaced by people from outside the health care industry, individuals with IT and finance backgrounds, for instance. It's surprising. I've

seen national data showing that as much as 30 percent of hospital CEOs do not have a health care background. That says something about our industry and where it's heading.

Now, we have the retail and technology industries moving into our arena, and I think we have to pay attention to that. What are the skills needed to work across these industries? At Fairview, Chuck Mooty, the former CEO of Dairy Queen, served as our interim CEO for a year. He did a fabulous job. He served on the board and moved into that role as a result of the unplanned departure of our CEO at that time. We really need to look at the skill sets required in this new leadership, knowing that health care is not going to be the same.

SULLIVAN: Over the past three years, I've seen a growing need for leaders who are strong collaborators to help adapt the care model to reflect the continuum of care. We look at that as an attribute in all of our leaders, whether it's in-home care, long-term care or acute care. We need the right leaders to build bridges and work together.

DAVIS: The skills that got us here aren't the same skills that will move us into the future because the hospital is no longer the center of the universe. The patient is the center of the health care universe. As Mark suggested, the important competencies CEOs must have going forward will be less tangible. CEOs will need strong relationship-building skills. They must be willing to change and have the ideas to make that change happen as well as the infrastructure to execute it.

ROWAN: I agree. We are looking to identify the necessary skills going forward as the health care industry shifts its focus from sick care to well care. These are two entirely different things and involve a completely different set of players. We're going through a process in our organization to help people learn and understand population health management. It has brought on the realization that population health may be beyond the capabilities of an individual facility or even a group of facilities in a particular community. It's going to be a challenge.

SMITH: Diane mentioned the upswing in nontraditional candidates for the CEO and president roles within hospitals and health systems. On



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Michael Rowan

our executive search side, we haven't seen it that much for those roles. However, we have seen a lot of it in finance and human resources.

DAVIS: There is a great article in July's *Harvard Business Review* about talent and 21st-century talent spotting. It suggests that organizations look at individuals' potential rather than at people who are good at the skills that they

have. Once potential is identified, it's important to take the individual through the organization and provide experiences that are not vertical. It's about getting them out of their comfort zones and seeing how they address the challenge and develop their skills.

SPRING: As I mentioned earlier, succession planning is harder for a small hospital, because

Panelists

Michael Rowan

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Moderator

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Susan Davis

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Doug Smith

President and CEO B.E. Smith Lenexa, Kan.

Jason Spring

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In my experience in working with health care organizations, I've found that our most successful clients have the most extensive succession plans. That's not a coincidence.

Doug Smith

we just don't have the talent pool within the organization. One of the things we're doing is working with other small facilities to create shared positions across the region. We've done this with our ICD-10 transition, for example. In some instances, we've leased staff from a larger tertiary partner. This has worked well and gives people who have the talent the opportunity to go higher than the opportunities at a critical access hospital present. It gives them a chance to become regional players and stay in the community.

DAVIS: That's a very creative approach, Jason. As a critical access hospital, you don't have the bench strength, but there is bench strength around you that you could help to develop. That's a great plan.

SULLIVAN: We have affiliation agreements with smaller organizations, providing executive leadership, IT and HR, among other things. A COO of one of our larger hospitals became the CEO of a small hospital in our region. He's down there trying to right the ship. We've developed an affiliation agreement with his organization to provide services such as IT and HR. It's a good strategy.

MODERATOR: Jason, when you think about the culture you're trying to develop in your organization, does this type of arrangement impact it in any way because you may, indeed, be sharing resources with organizations that may not share your culture?

SPRING: We really haven't seen any cultural issue arise because it's more about bringing technical pieces to the table, rather than leadership. So, whether it's a CFO or ICD-10 arrangement, they are contributing expertise and we still have someone in-house who oversees the

role and serves as the implementer. I don't know that culture has had a big impact except that it's given some people in our organization a chance to take a regional role versus having to move to a larger system for more leadership opportunities.

MODERATOR: Let's talk about the cultural issue a bit more. At Cambridge Health Alliance, which is a large safety net hospital, mostly inner city, the majority of patients are either language, race or ethnic minorities. We have strived to build and maintain a culture of openness with regard to the communities we serve. When we went through a leadership transition about 10 years ago, it turned out to be a struggle to find someone who was a strong cultural fit. How do you work to find the right cultural fit for leaders in your organization?

ROWAN: It's something we consider when we conduct our annual talent review. Part of the talent review assessment process is looking at how people fit into the culture and their affinity for advancing the mission of the organization. We're a Catholic health care ministry. That's important, and we're focused on providing services to the underserved. We seek to find the kinds of individuals who are truly committed to that. That's a big challenge. There is always this dynamic tension as an organization because we are a business and not just a ministry. We have to have people who can be focused on the bottom line.

The other piece that's important and probably speaks to the whole issue of culture and talent is the fact that we are in multiple regions around the country that have distinct cultural differences. We question whether someone from the Deep South would want to advance to a position in the Pacific Northwest. Some of our questions are around culture and some are based on

family issues and support systems. These are important considerations.

SMITH: We often hear from clients that they have succession plans in place but, whenever a position becomes open, they feel they don't have anyone to move into the role. As a result, we're seeing clients taking more risk by promoting individuals into that role and mentoring them. We are also seeing organizations place leaders to serve in interim roles, providing experiential learning and helping the full-time candidate move into his or her new role. It helps with retention. Organizations will lose out on individuals if they do not provide opportunities. Gen Xers and millennials want variety. Organizations can't afford to train them only to have them leave the organization in two or three years.

DAVIS: Doug, are you seeing organizations asking for different competencies than you've seen in the past?

SMITH: Not so much at the senior level at this time. Even at the department director level, organizations are still looking for expertise in the trade. When they come to us, they want it all. They want the competencies and the skills to come into the job. However, there are organizations willing to take the risk and develop some of the skills in-house.

MODERATOR: What are the challenges of succession planning?

ROWAN: One of our challenges is related to relocation. Catholic Health Initiatives, as I mentioned earlier, is a large organization spread out across the country. The health care industry, as a whole, has not evolved to where it is happy with having people routinely move from one

region of the country to another every three or four years. We have to figure out whether that makes sense.

On another note, we're finding there are new and different skill sets that we need to bring into an organization. We've placed the bet on going into the insurance side of the industry as part of our move to population health management. Historically, hospital executives do not have background and expertise in insurance. Another thought is that we're good at setting up and operating clinical programs to take care of people who are sick. Who should lead the transition to population health management? How do we create a new care model? Who is good at chronic disease management? We can look around the country but, overall, there aren't a lot of individuals who have that kind of background and experience.

SMITH: I agree completely. It's a challenge for us to find individuals skilled in population health. The pool is not deep.

CROSS: We need to look at how our industry appeals to the younger generation. It's critical that we make health care careers attractive. Right now, they look at our CEOs and see them as stressed; they see a heavy workload. They're seeing boards in chaos and they're saying, 'I don't know if I want this kind of life.' It's even going to make it harder for us to find people who are willing to step into these roles and, too often, the salaries do not align with the job's duties.

Getting back to culture, it's important to look at a person who can actually reflect the culture of the organization. One of the most important things hospital executives can do is to be a role model, an inspirational leader. We've asked all of our staff what they perceive to be the top leadership characteristics and the top answers

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Jason Spring



were honesty, integrity, commitment to mission and communication. Skill sets are a given; it's the other stuff that really makes a difference in leadership.

SULLIVAN: When we are hiring someone, we have to think about how well he or she fits into the culture of the system, as well. It's not just about fitting in with the facility. A person may be perfect for a facility, but it may derail all your other strategies.

I think we're actually going to see an increase in people interested in health care careers. Health care is all over the media these days, whether it's in *Guns & Ammo* magazine, *Money*, or *Good Housekeeping*. I also agree with Diane's point about inspirational leadership. We have that level of leadership in our organization. Our CEO is committed, among other things, to making sure we care for those who really need to be cared for in the hospital, as opposed to caring for everyone who comes to the hospital. He is committed to providing care for patients in the most appropriate setting. The dynamic that this creates is different from what it was just five years ago. That's one of the biggest challenges in recruiting — finding someone who is capable of putting his or her guard down and recognizing that we're heading in a new direction.

We had a finance guy who came to us five years ago from United Parcel Service. He brought an important skill — logistics. He went from director of finance to being the COO of one of our hospitals. He didn't know how to run a hospital but, because he grasped what we were trying to accomplish, we looked out for him and helped him to grow. That's what we're looking for: someone who is a cultural fit and

can look forward. Culturally, one of the biggest challenges we face is letting go of how past success was bred, and looking for leaders who can adapt to change and really help lead us to where we need to go.

ROWAN: One thing we haven't discussed is physician leadership. Physicians are moving up the leadership ranks more than ever and most of them don't have any leadership experience. It's different from their coming from a more authoritarian role to becoming a team member. So, there is a learning curve to get them up-to-speed in managing an organization with several thousand employees. Interestingly enough, if you look at many nursing leaders, they're used to being part of a team, they're used to working in a large organization and they have a different skill set, background and mindset when working within the health system.

SULLIVAN: Leadership development is something we're focusing on in our residency program. They have to round in different team environments, so it becomes ingrained early on in their careers. Michael made a great point. If we're willing to look to those physicians to lead, we have to train them to lead as a team member as opposed to being the captain.

MODERATOR: How does all of this correlate to succession planning, specifically looking less at the operational skills and more toward relationship-building and communication skills?

ROWAN: Again, I think that it goes back to talent development. There are many talented physician CEOs and they didn't simply walk



Key Findings

- Succession planning should be incorporated with an annual talent-review process to help the organization assess its strengths and weaknesses and identify potential leaders.
- Organizations should be willing to take risk and move potential leaders around to help enhance their skills and prepare them for future leadership roles.
- Finding potential leaders who are the right cultural fit for the organization is a critical part of the succession planning process.

We've asked all of our staff what they perceive to be the top leadership characteristics and the top answers were honesty, integrity, commitment to mission and communication.



Diane Cross

from the bedside into the CEO's office. Often there is a development path. The Cleveland Clinic, for example, has a development path for physicians that allows them to take on more responsibility. There is often a track to help move them along.

DAVIS: The person who succeeded me at St. Vincent's is a physician. He's done a great job. If we think about what health care is going to look like in the future, the CEO will need to have a vision for that continuum of care and know how we're going to integrate all the various components of care. That's a natural role for physicians. It's up to us to provide them with experiences and opportunities for growth and education.

SMITH: Are the younger physicians coming out of school with skills that make them more promotable into the C-suite?

SULLIVAN: We see more physicians now coming out with MBAs. We even have physicians older than 50 who have gone back to school for their business degrees. They're realizing that to work in a role other than at the bedside, they need to expand their knowledge base. We pay for part of that, to help them grow as leaders. We're certainly seeing more diverse portfolios for some younger physicians.

ROWAN: The medical education system has started to step in and provide that kind of expectation and understanding. Our health care system is still fragmented. Physicians, historically, have not done a great job of looking across and understanding the total needs of the patient. But, I think they are starting to understand the bigger picture.

MODERATOR: Let's talk about the board of trust-

ees. Do you conduct succession planning within your boards?

CROSS: I see this from two perspectives. As a CEO of a nonprofit organization, I have a 20-member board. And what I've seen over the course of my career is that the person who steps up to engage in a board today is different from the person who participated in the past. It used to be about who you know. Boards have become more sophisticated and competency-based.

At the University of Minnesota Health, all of the board members are C-level people and not one of them has a health care background. They come from retail or banking — other industries. The health system was very strategic in its selection. Every partner was able to pick three board members: the medical school, the University of Minnesota and the Fairview hospital system each picked three. That's how we came to nine members.

One thing we haven't addressed very well is the differences among nonprofit boards, for-profit and public boards. I've had to intervene on a public board because the CEO-chair relationship was terrible. Public boards are mostly politically appointed, creating a different dynamic. A nonprofit board is more collaborative in its workings with the CEO. The CEO has much more say in who gets to sit at the board. That's how it is at the nonprofit where I work. I have a great deal of say in who sits on our board. I look for people who are going to challenge me and who don't bring their own personal agenda. So the dynamics are very different.

Boards should be diverse and reflect the community. When I was chair of the board of the University of Minnesota Children's Hospital, we were obviously not diverse. We serve a large Somali population at Fairview. We hired a consultant and brought on a board member of



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Mark Sullivan

color. She walked into her first board meeting and walked out saying, "I will not be the token person on this board." That was an important lesson for us. We have to carefully select our board members, not only for their skills, but also make sure they represent the community that we serve. Since our community assessment indicates that 20 percent of our population is Somali, shouldn't our board be represented by 20 percent of individuals of Somalian background? And, if not at the system level, at least at the advisory committee level.

Another important consideration is board size. Bigger boards provide a greater opportunity to get a broader scope of skills and diversity, but bigger boards are more difficult to manage. I feel the dialogue is less robust among bigger boards. Smaller boards are much more conversational and able to mobilize, while larger boards often struggle in these areas.

MODERATOR: How can organizations go about finding the right board composition that addresses both skill sets and diversity?

CROSS: We use a matrix to help define all of the characteristics we want for our board. It's very similar to the matrix organizations use to define the characteristics they want in the CEO. It's important to assess whether the potential board member is a good cultural fit for the organization. We look for people who are future-focused and are willing to speak up. In the past, I have sat through board meetings in which the CEO did not speak the entire time. Or a large percentage of the board sat silently. I always left wondering why these individuals accepted board membership if they didn't want to participate. At Fairview, we developed a matrix of what makes a good board member, we defined

the characteristics and developed job descriptions for the board member. We also have a robust orientation plan for board members. We have a separate job description for the board chair whose role is, obviously, different from that of the rest of the board. Having all of that systematized is really important.

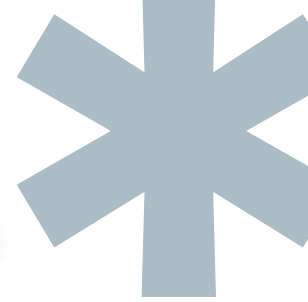
MODERATOR: Have you been successful thus far in terms of implementing that system?

CROSS: Time will tell, but we feel that it will work well. The new nine-member board is a first for us because none of the members are really enmeshed in health care. It's going to be interesting because they are setting strategy for the new integrated care delivery model. It will be interesting to see how it evolves and whether it's successful. Now, as far as succession planning, we're so new that we don't have a plan in place. I'm sure we'll go back to the plan of having each of these groups elect a member so everyone has an equal say in the process.

DAVIS: Diane, have you thought about implementing a mentoring program for your board? I'm working on that with my board members. Our board members are members of our community and they don't understand the complexities of our organization and the health care delivery system. Establishing a mentorship program is one way to help them develop the level of knowledge they need to be effective members of the board.

CROSS: We haven't done anything at this point, but it's a great idea. I have heard of organizations that have done this successfully.

MODERATOR: Jason, what does your organization



do by way of board selection and development? Is it any different for small, rural hospitals?

SPRING: Our process is not that different from what Diane described. We also use a matrix. We look seriously at the time commitment and whether that will be a factor in the individual's being able to actively participate. The best, brightest minds are no good if they can't attend meetings and don't have time to educate themselves about health care. It takes time to get them up-to-speed. Time and again, I'm amazed at how board members are surprised at the financials and comment about the craziness of the industry. I'm fortunate to have a strong board.

When filling board positions, we consider geography. We try to find representatives from all of the communities we serve. We want individuals with a strong sense of community so we will have a handle on the communities' needs. We also look at our foundation and our volunteers as possible sources for board member recruitment. We are a self-perpetuating board, so the board makes the decision. I am involved in helping them find board members. We look at other boards that function well in the community and see who the players are, and we place them on our waiting list for future board service. We also trade board members with our larger tertiary partner that I mentioned earlier. One of our board members is joining its board and one of theirs is joining our board so we can gain a better sense of what the two organizations do as competitors and collaborators.

SMITH: Another big learning curve for many board members is adjusting to a mission-based environment. Many board members have a for-profit mindset; this requires a big shift in thinking. The demands on boards are great, particularly in shaping the new delivery system. We may see the transition to board compensation in order to attract the right people for the task.

ROWAN: Another consideration is that with consolidation, we will see even more of a time commitment because we will be dealing with regional-sized organizations. There will be more of a time commitment in terms of travel as the board members will come from across the region. Some may even have to fly and leave the night before to participate in the board meetings.

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SULLIVAN: If we were holding our first board meeting today, we'd come in and approve an agenda and strategies for which we lack context. We are working to provide as much up-front education as possible for our board members, and not just to orient them to our financials, but to our strategy as well. We assign a senior leader to work with the board members to answer their questions, particularly around our regulatory constraints and compliance challenges. They need that level of awareness when they're voting on issues that will shape the organization. We have to provide them with enough background to make those difficult decisions.

SPRING: Our board is struggling with whether there is a fiduciary responsibility. Their fiduciary responsibility is to their hospital, but should it be to the population or to the community? Sharing or trading board members affords an opportunity to ask what we should be doing for our community versus thinking about our hospital and our logo. And that's a real struggle for them at this point — trying to identify where the responsibility lies. They are spending a lot of time thinking about this, and they're also spending time educating themselves about what they think health care is going to look like.

Thanks

Health Forum would like to thank the panelists for taking part in
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