



Building a Leadership Team for the Health Care Organization of the Future

April 2014

SpencerStuart

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Suggested Citation: Health Research & Educational Trust. (2014, April). *Building a leadership team for the health care organization of the future*. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org

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Executive Summary

As a follow-up to the American Hospital Association's reports "[Hospitals and Care Systems of the Future](#)" and "[Metrics for the Second Curve of Health Care](#)," Spencer Stuart and the AHA examined how the shift toward health care's "second curve" is impacting the leadership, talent and organizational models of hospitals and care systems. A survey of senior hospital and care system executives and additional interviews with more than two dozen leaders in the field reveal the ways health care organizations are responding to changes within the field and building the teams needed to achieve their strategic priorities.

Identifying capability gaps and evolving the executive team to address them

- Nearly 70 percent of hospital and care system leaders surveyed expressed confidence that their current senior management team has the experience and skill sets to help the organization achieve its strategic priorities.
- Experience in leading nontraditional health partnerships and population health management was seen as the most common capability gap, followed by change management experience, advanced financial expertise and data analytics.
- Sixty percent of health care leadership teams are larger than they were three years ago.
- Physicians and nurses are being tapped more often for leadership roles, including many of the new senior executive positions that organizations are creating to address specific strategic areas, or to participate in management dyads or triads and co-lead with administrators newly established or existing service lines.
- Traditional hospital roles are changing and becoming more strategic and larger in scope, to respond to the changing demands of the field. CMOs, CNOs, CFOs and COOs are being asked to develop a broader set of leadership and technical skills and increase their understanding of health care delivery beyond the hospital setting.

Experimenting with different organizational approaches

- Hospitals and care systems are experimenting with different organizational models, with the goal of identifying best practices, promoting innovation and collaboration, improving patient outcomes, increasing operational efficiency and standardization, and ensuring that care is coordinated across the continuum of services.
- Management dyads and triads, in which clinical leaders are paired with administrators to jointly oversee service lines or clinical areas, are intended to encourage systems thinking and align clinical and operational resources to improve outcomes and efficiency.
- Matrix organizations and multiple reporting relationships also are becoming more common, as are system-level leadership roles charged with standardizing practices and purchasing across the entire organization.
- Some health care organizations are creating physician strategy groups, executive strategy committees or councils on clinical innovation to encourage broader clinician participation in strategic initiatives.

Building teams through selective hiring and training

- Executives with experience in community and population health management and experts in change management will be hardest to find within the health care sector, according to survey respondents.
- As they seek leaders in new disciplines, some health care organizations today are more willing to consider candidates from outside the sector for certain capabilities; these capabilities include retail and customer insight experience, analytics, enterprise risk management and insurance expertise.
- Organizations can improve their success hiring executives from outside health care or promoting internal candidates into first-time leadership roles by carefully defining the technical knowledge and leadership skills that are required and consistently assessing candidates against those capabilities.
- Cultural fit is an important consideration; ideally, organizations will define the cultural traits that need to be developed in the organization and select leaders with traits that match the direction in which the culture needs to move.
- Seventy-nine percent of survey respondents said their organization has established in-house customized training programs for senior management during the past three years, and nearly 80 percent said training programs are focused on developing leadership skills.

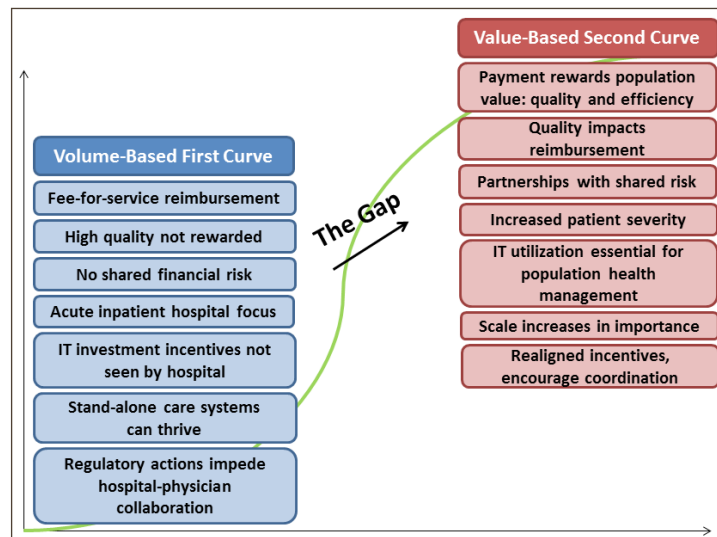
Evaluating the composition of the board and whether it includes representatives with the most relevant experience

- Many boards, especially those of regional health care systems and corporate health care entities, are adding expertise in new areas.
- Board members with expertise in consumer businesses, marketing, social media, change management and the payer side of the business all are in demand.
- Boards of national and larger regional health care organizations with sophisticated governance practices and procedures are best positioned to attract members with these profiles. However, all boards can benefit from adopting best-in-class governance processes and practices that allow members to contribute at a higher level.

Introduction

Health care reform is presenting unprecedented challenges and opportunities for U.S. health care organizations. Health care delivery is moving away from the traditional fee-for-service system, designed around “sick care” and hospital stays, toward a population health management system with value-based reimbursement and a focus on improving the quality, safety and efficiency of patient care. As the American Hospital Association detailed in two reports, “[Hospitals and Care Systems of the Future](#)” and “[Metrics for the Second Curve of Health Care](#),” success in health care’s “second curve” will require developing and executing new business and service models, forging new partnerships and alliances, and developing new capabilities and approaches to organize effectively around these new models.^{1,2} See Figure 1.

Figure 1. First Curve to Second Curve



Source: Adapted from Ian Morrison, 2011.

Such a far-reaching shift in the field of health care must drive similarly dramatic changes in the leadership, talent and organizational models of hospitals and care systems. Inspired by the AHA reports, Spencer Stuart, a leading senior executive search and leadership advisory firm, explored the talent, leadership and organizational implications of health care reform to answer questions such as:

- What leadership capabilities will become more important for health care organizations transitioning to new care delivery, financial risk and population health management models?
- How are traditional roles, such as the chief financial officer, chief medical officer and chief nursing officer, evolving in response to changing business needs?
- How might physician and nurse leaders be tapped to play a larger role in the future?
- What new roles and titles are emerging?
- How is the structure of the executive team evolving?
- What new capabilities will health care organizations need to develop or acquire?
- From where will executives with newly required leadership skills and competencies come? Within the health care system or from other industries? Or through recruitment or training?
- Do hospital and care system boards have the expertise needed to provide valuable guidance and perspective to management teams?

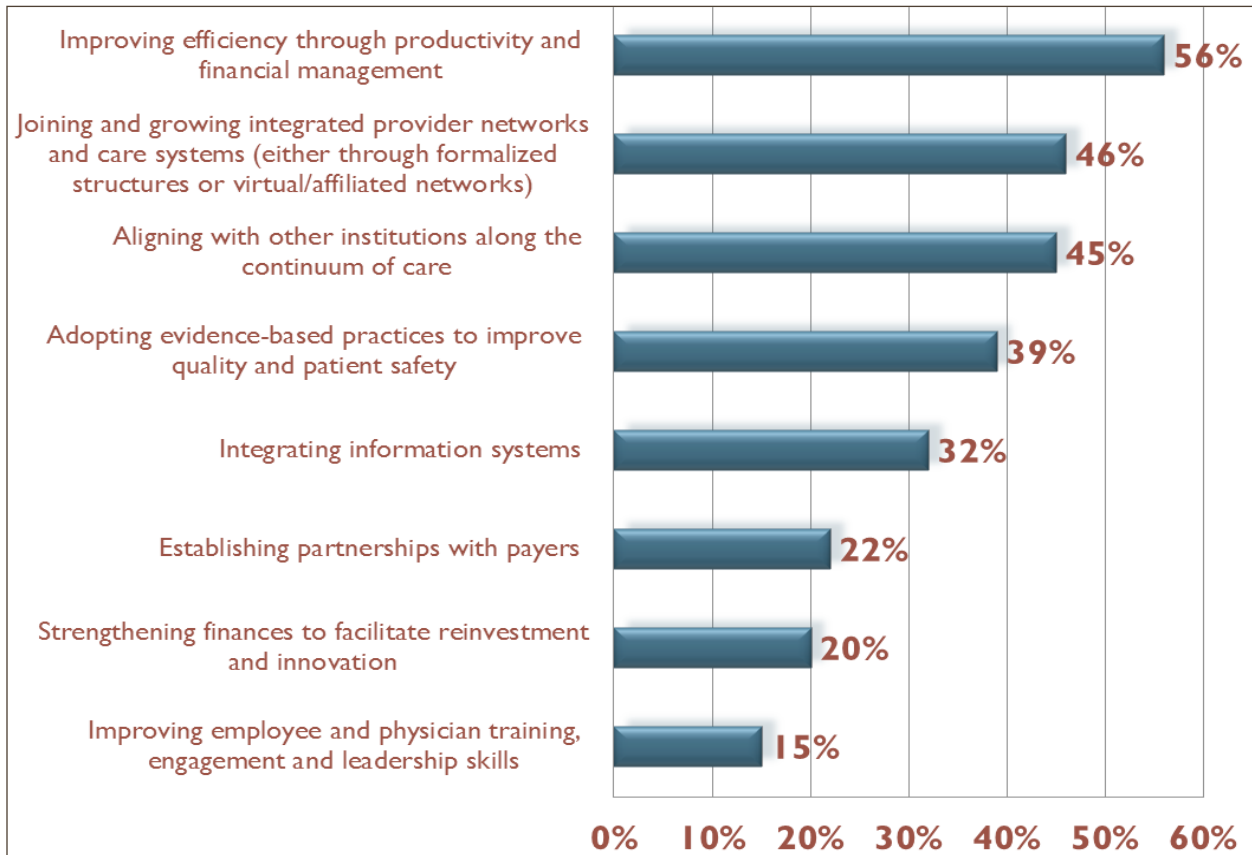
To address these questions, Spencer Stuart and the AHA conducted an online survey of more than 1,100 executives, primarily from large health care systems across the United States. In addition, follow-up, one-on-one conversations were conducted with a group of more than 25 senior health care leaders, including chief executive officers, chief medical officers, chief nursing officers and chief human resources leaders, to understand how they are responding to these questions and structuring their leadership teams for a dramatically changing health care marketplace. (See the appendix for survey methodology and respondent breakdown.)

Strategic Priorities and Capabilities for the Second Curve of Health Care

As health care organizations focus on the Triple Aim — better care, better health, lower costs — and shift toward value-based contracting and away from fee-for-service plans, top priorities are: improving the quality and efficiency of health care delivery, providing better patient care, and aligning with partners to share risk and provide services along the continuum of care. In the survey of hospital and care system leaders about their priorities, one strategic imperative rose to the top: Improving efficiency through productivity and financial management was cited by more than half of respondents. See Figure 2.

Figure 2. Key Strategic Priorities

What are the key strategic priorities for your organization over the next three years?



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Discussions with executives largely reinforced the survey findings, as summarized below. In many cases, implementing these strategies will require organizations to build new capabilities.

- *Improving cost management and efficiency.* Clinical and operational efficiency will be critical in an environment in which health care organizations expect to serve more patients with lower reimbursements. Indeed, 56 percent of survey respondents said improving efficiency through productivity and financial management is a key strategic priority for the next three years. Since hospitals and care systems will have to be prepared to manage costs very effectively and accept more financial risk, they will need leaders who understand changing risk models and can manage care from a total-cost-of-care perspective. Clinician engagement and support will be critical for the success of cost-management initiatives, including pharmacy and supply chain management. With change on the horizon, many health care organizations have spent the past several years putting in place the infrastructure, processes and people to operate in a value-based model ahead of market demand. In the years ahead, these organizations will have to make difficult decisions about when to shift to the new value-based payment model.
- *Increasing clinical integration and expanding coordinated care.* The movement toward population health management models requires health care organizations to expand their focus beyond the inpatient setting to the entire continuum of care. To that end, organizations are making acquisitions and forging partnerships with physician groups, rehabilitation services and other post-acute providers, and freestanding emergency care organizations to create a unified enterprise with complete systems of care. These activities will continue to be a priority: 46 percent of respondents cited joining and growing integrated provider networks and care systems as a top strategic priority for the next three years, and 45 percent said aligning with other organizations across the continuum of care will be a key strategy. Hospitals and care systems will need deal-savvy executives who are well versed in due diligence, deal structures and finance, and administrators will have to partner with physicians and other clinicians to manage the clinical enterprise together. To ensure that patients receive the right care in the right setting and at the lowest cost, health care systems will need to improve quality, service and efficiency across the system and be able to coordinate care across these services. Collaboration and partnership development will be critical to clinical management and improving patient care.
- *Improving quality and patient safety.* The whole structure of health care payments is changing, and this has enormous implications for how care is delivered, the incentives that physicians receive and the infrastructure and capabilities that are needed. In a value-based environment, payment models will shift toward compensation based on patient health outcomes, efficiency and quality across specific populations. In short, quality will have an impact on reimbursement. More than one-third of survey respondents, 39 percent, said a key priority for their organizations over the next three years will be to adopt evidence-based practices to improve quality and patient safety. In addition to improving quality amid greater transparency, organizations will need to adopt a more holistic approach to health care and prevention, requiring capabilities in care management, chronic disease management, and data analytics.
- *Integrating information systems and becoming more data savvy.* To improve efficiency, organizations are building capabilities in data analytics, population health management and process improvement. Enhanced data analytics capabilities and integrated information systems will support risk-bearing activities and provide real-time financial and clinical information to help health care organizations establish benchmarks and understand their performance against quality and efficiency targets. For that reason, 32 percent of survey respondents said integrating information systems will be a top strategic priority. In addition, the ability to interpret data and apply it to the most important issues for the organization is a growing expectation for all senior health care executives.

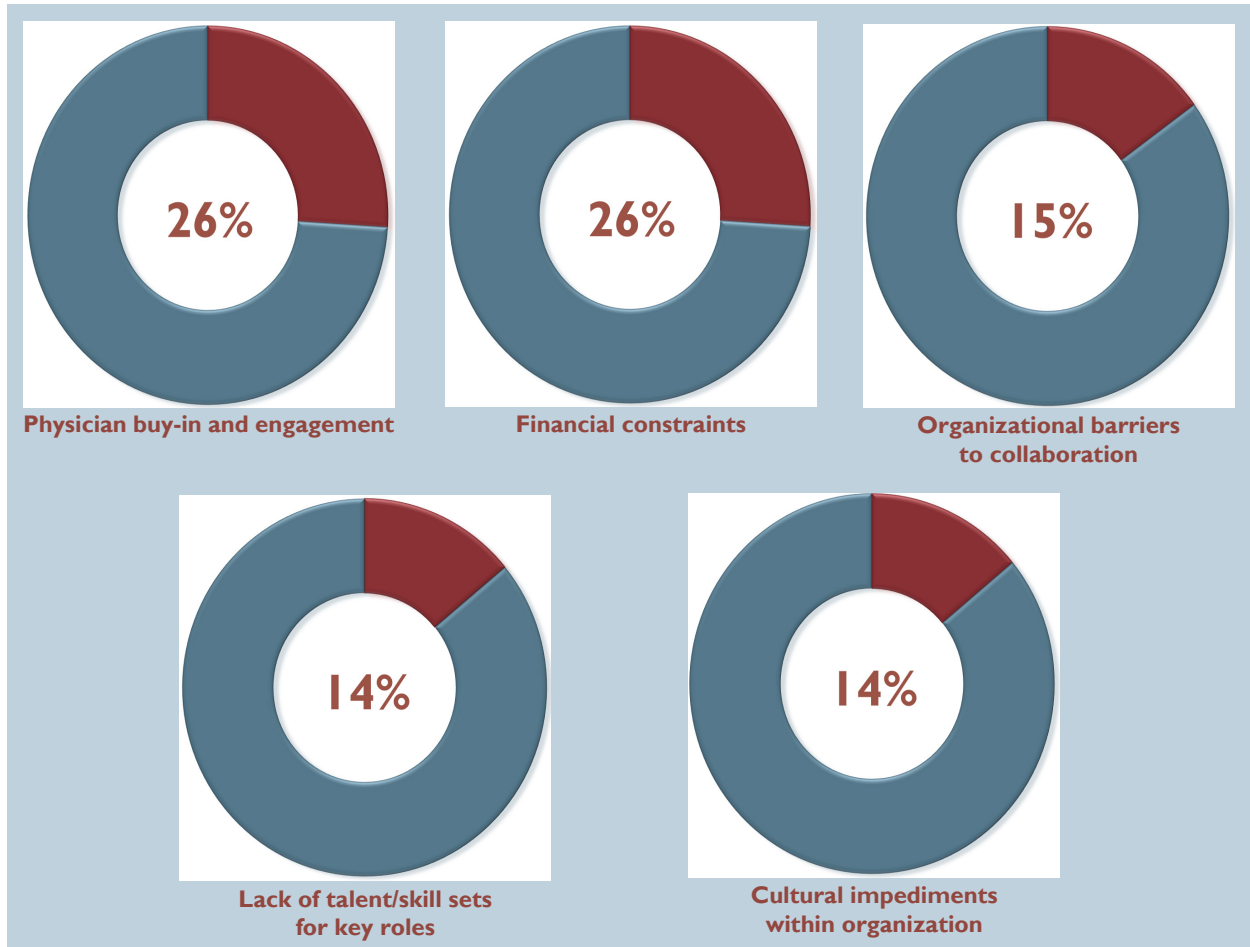
- *Ongoing innovation and change management.* The sheer magnitude and velocity of change is challenging many health care organizations, as they try to keep pace and manage amid many competing priorities. Not only are changes in reimbursement and care delivery testing organizations, traditional health care organizations also have to keep an eye on new competitors emerging from the retail and technology sectors — and evaluate whether and how to compete or collaborate with these recent entrants. As they rethink and build strategy, health care organizations need to address many more scenarios and be prepared to respond to changing assumptions. For some, responsibility for innovation and strategic thinking is dispersed across the leadership team, while other organizations place primary responsibility for innovation with committees or specific senior leadership roles. Change management also will need to be a core competency.
- *Increasing patient engagement.* In a changing competitive landscape, hospitals and care systems are looking for ways to provide more convenient access to services and a smoother, more engaging patient experience. Expertise in customer insight and retail will be increasingly valuable as organizations strive to truly understand the patient (customer) and apply those insights to patient experience innovations, especially providing more personal and memorable customer service. Many health care organizations are hiring experts in retail, marketing and communications to improve their ability to reach and communicate with current and potential patients, develop pricing strategies and provide new technology-based services.

Challenges to Achieving Strategic Priorities

As health care organizations pursue these strategic priorities, what potential challenges do they face? Among survey respondents, financial constraints and physician buy-in and engagement are seen as the most significant hurdles to achieving their organizations' strategic priorities, each cited by more than one-quarter of respondents. Other challenges include organizational barriers to collaboration, lack of the necessary capabilities for key roles and cultural impediments to change. See Figure 3.

Figure 3. Strategic Challenges

What do you anticipate will be the primary hurdle to achieving the organization's strategic priorities?



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

New Leadership Roles, New Capabilities: The Emerging Health Care Organization

Despite the breadth of capabilities health care organizations need to build, the hospital and care system executives who responded to the survey were largely confident in their senior management team. In fact, nearly 70 percent expressed confidence that their current senior management team has the experience and skill sets to help the organization achieve its strategic priorities.

Do you feel your current senior management team has members with the right experience, skill sets and talent needed to achieve these strategic priorities?

Yes 68%

No 32%

Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

The interviews revealed that building the leadership team and organizational capabilities to respond to changes in the field has been a major priority for many health care organizations during the past several years. Specifically, health care organizations have been focusing on six primary areas:

- Identifying capability gaps and evolving the executive team to address them
- Expanding the management team by creating new executive roles with a broader set of experience and perspectives, including more clinicians and executives bringing new functional expertise
- Updating the expectations for and responsibilities of traditional hospital leaders to reflect changing organizational priorities
- Experimenting with different organizational approaches to stimulate collaboration, improve operational efficiency and promote standardization
- Establishing mechanisms to promote clinician engagement in quality, efficiency and innovation initiatives
- Evaluating the composition of the board and whether it includes representatives with the most relevant experience

New Perspectives on the Management Team

Despite expressing confidence in their senior executive team, survey respondents pointed to a number of gaps in their organizations' capabilities. More than half, 54 percent, identified experience in leading nontraditional health partnerships, such as joint ventures or strategic partnerships with payers and retailers, as a primary capability gap for their organizations. In addition, 48 percent of respondents identified community and population health management experience as a talent gap. Experience in transformational change and change management was cited as a gap by 41 percent of respondents, and 37 percent said their organization lacked advanced financial expertise. Innovative thinking and creativity and data analytics experience were cited as talent gaps by 34 percent and 29 percent of respondents, respectively. See Figure 4.

Figure 4. Talent Gaps

Where are the primary talent gaps within your organization? (Choose the top three)



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Health care organizations are working to close these gaps on several fronts. Some talent gaps are being addressed by training or by expanding the roles of current executives. However, some of these gaps are being addressed through the addition of new executive team positions to lead and galvanize support for initiatives in top strategic areas. Indeed, 60 percent of survey respondents said the senior-management team of their organization is larger today than it was three years ago.

“We’re spending a lot of capital building the infrastructure so that, when the day does come, we can make gigantic strides forward in getting these covered lives and managing the associated financial risk of having those lives and premium dollars.”
—Health system CEO

Population health management is an area some organizations are filling through the addition of senior-level positions and teams — for example, insurance and risk management experts who can help the organization manage nontraditional risk and risk related to chronic disease management, and quality experts who can identify ways to improve the quality and consistency of health care delivery. Thirty percent of respondents said their senior management team includes a risk officer, and 10 percent have a chief population health manager.

A related priority for many health care organizations is expanding their capabilities in data analytics to understand how the organization is performing against quality and efficiency targets and identify new opportunities for improving patient care and the patient experience. Leadership roles in knowledge management, technology innovation, medical informatics and analytics are becoming more common. Thirty percent of survey respondents said their senior management teams include a chief medical informatics officer. “We’re spending a lot of capital building the infrastructure

so that, when the day does come, we can make gigantic strides forward in getting these covered lives and managing the associated financial risk of having those lives and premium dollars,” one health system CEO commented.

To bolster their ability to drive innovation in health care delivery and business models, some health care organizations have created leadership positions in strategy and innovation. In the survey, 44 percent of respondents said their senior management team includes a chief strategy officer, and 8 percent have a chief innovation officer. It is not unusual for health care organizations creating strategy or innovation roles to look for candidates from digital or e-commerce businesses who are creative, out-of-the-box thinkers.

Many organizations diffuse responsibility for strategy and innovation across the leadership team. While this approach has the benefit of placing responsibility for these activities closer to those who can execute them, it can be challenging for clinical and functional leaders to devote sufficient time to these efforts.

“The day-to-day management is so hard that to ask those same people to think about how they can put themselves out of work and be that kind of ‘creative’ is almost impossible.”
—Health system CEO

“The day-to-day management is so hard that to ask those same people to think about how they can put themselves out of work and be that kind of ‘creative’ is almost impossible,” explained the CEO of one health care system. Senior-level strategy and innovation executives bring new ideas to the organization, work with the management team to implement initiatives, track and communicate performance metrics, and engage the front-line staff to identify and remove barriers to change. Some organizations also are establishing executive roles in patient experience — 15 percent of survey respondents said their senior leadership team includes a patient engagement officer — to make sure they innovate on the customer service side as well.

Another priority area is operational excellence and clinical efficiency. Executives with titles such as vice president of cost containment, chief population health manager and chief clinical transformation officer are joining management teams to oversee areas such as clinical innovation, care delivery across settings and medical leadership infrastructure. See Figure 5.

Emerging titles in health care

- Chief population health manager
- Vice president of cost containment
- Chief clinical transformation officer
- Chief experience officer/patient engagement officer
- Head of technology innovation
- Chief medical informatics officer
- Vice president of clinical transformation
- Vice president of medical management
- Vice president of clinical informatics

While many of the leaders with these new job titles are considered part of the senior management team, the survey revealed significant differences in how frequently they are engaged in executive decision making. For example, 36 percent of respondents said the chief strategy officer is always involved in decision making, but only 15 percent said the quality officer is always involved. Chief medical informatics officers and patient engagement officers are more likely to be involved in decision making based on the topic. See Figure 6.

Is the senior management team of your organization bigger than it was three years ago?

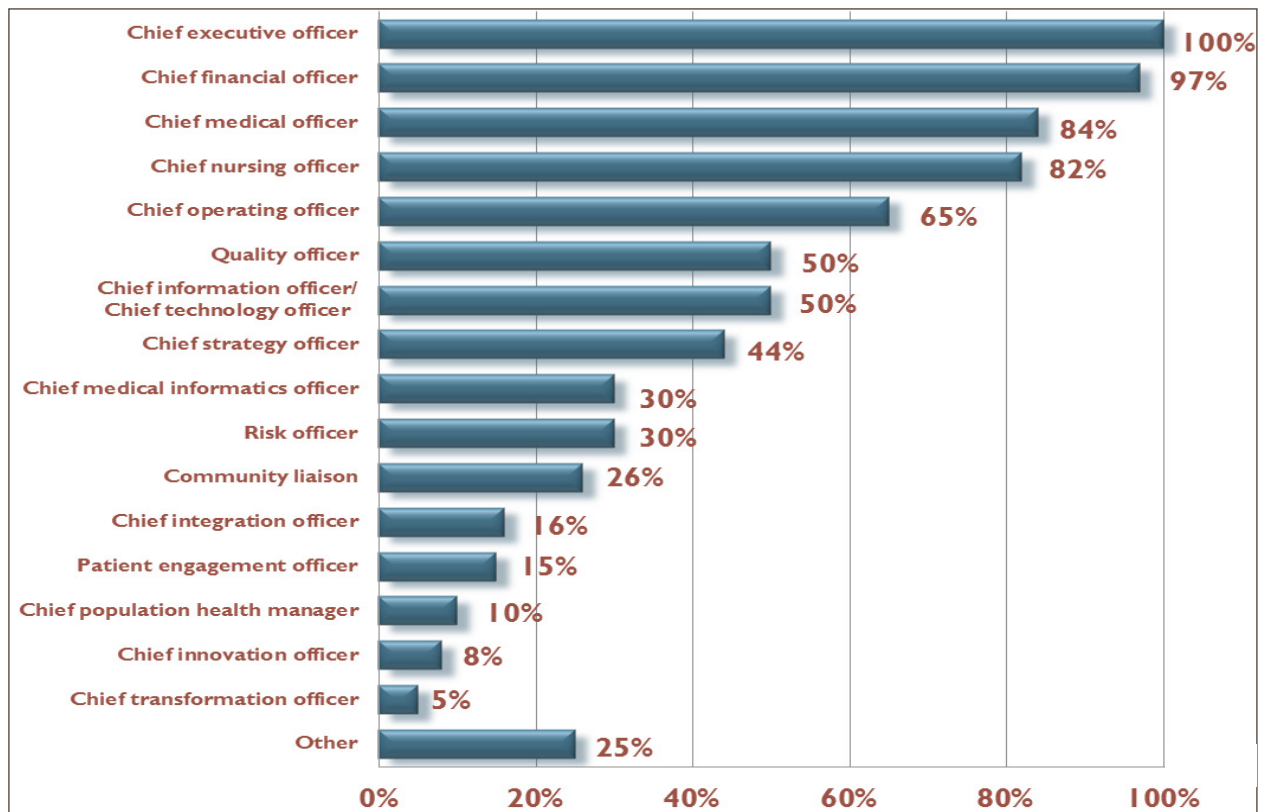
Yes 60%

No 40%

Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Figure 5. Roles Represented in Senior Management Team

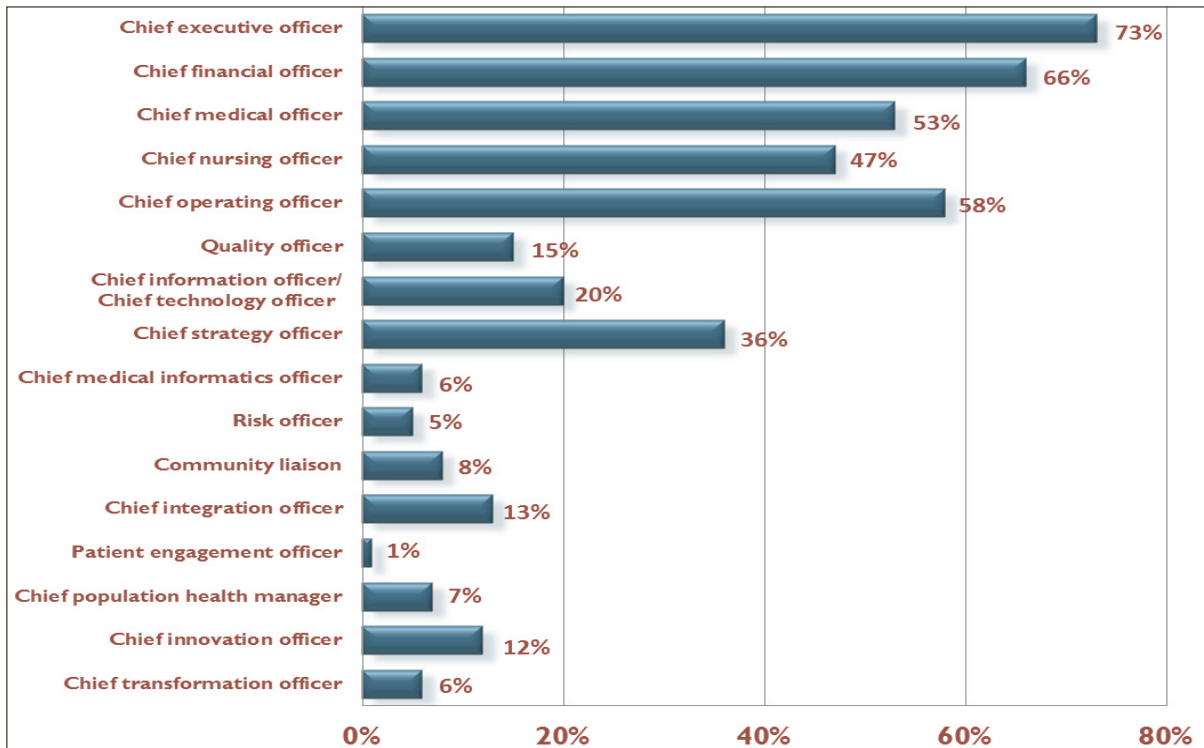
What roles are represented in today's senior management team?



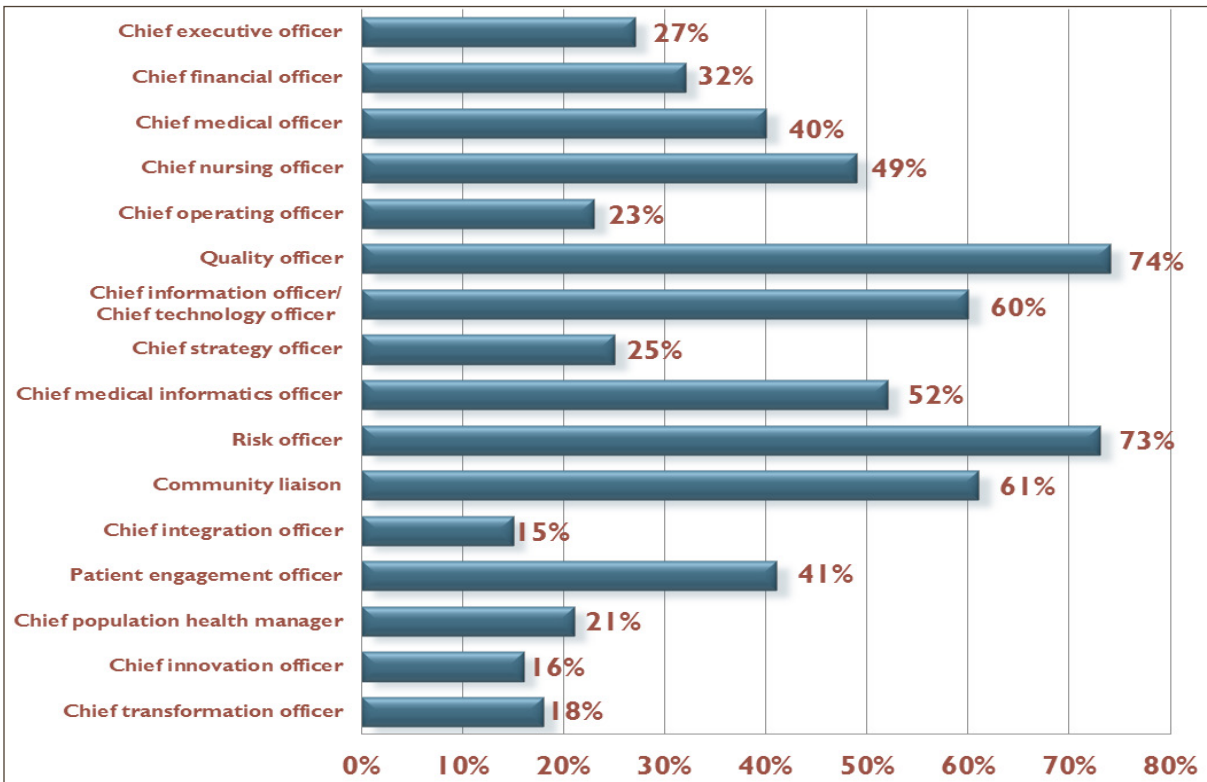
Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Figure 6. Roles in Decision-Making Processes

Which of the roles below are always involved in the regular decision-making process?



Which of the roles below are engaged in the decision-making process when necessary by topic?



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Traditional Roles Evolving

At the same time that organizations are creating leadership positions to address emerging priorities, traditional hospital roles are changing: They are becoming more strategic and larger in scope in order to respond to the changing demands of the health care field.

The chief medical officer (CMO), for example, once was responsible primarily for managing medical staff and physician leaders, often serving as a staff liaison to administrators. Today the role is more operational and strategic, focusing on quality targets and efficiency, strategic planning, long-range forecasting and decision analysis. Increasingly, the CMO drives quality, safety, patient experience, medical staff relations and the coordination of care. The CMO is regarded as a key member of the executive team in hospitals and academic medical centers, helping set strategy and drive the operational performance of the clinical enterprise. Amid the changes of health care reform, the CMO is responsible for implementing new care delivery models and analyzing evolving payment methodologies.

The CMO role also has become more outwardly focused, requiring more interaction with other organizations and more marketing savvy. CMOs increasingly need to be strong communicators and skilled collaborators with internal and external stakeholders. They need a more broad-based understanding of health care delivery beyond the hospital setting, as well as an appreciation for the field's changing economics. They must have an orientation toward customer service and patient satisfaction and the emotional intelligence to work effectively with various constituencies — including the ability to influence other physicians.

Similarly, the responsibilities of the chief nursing officer (CNO) are also broader in scope and more operational. Once viewed largely as an advocate for the nursing staff, the CNO has emerged in some organizations as a chief clinician and patient advocate, with a matrix of relationships and responsibilities across the broader organization. Like CMOs, CNOs must increase their knowledge of health care delivery across the continuum of care, including pharmacy and care management, and develop relationships across the continuum. “It’s time to get out of the nursing box and take the lead on hospital initiatives and create further relationships across the continuum of care,” according to one chief nursing officer interviewed. “Nurse executives are more widely understanding of the strategies, approaches and collaboration and are beginning to be seen more as equals.” Nurse leaders also will play a critical role in building a team- and patient-centered mindset among nursing professionals.

Traditionally viewed as a financial gatekeeper and scorekeeper, the hospital chief financial officer (CFO) is something altogether different today. CEOs are looking to CFOs to be true business partners who not only understand the finances but also can bring perspectives on risk, insurance and clinical issues to strategic decisions. Against a backdrop of market consolidation and growing numbers of mergers, acquisitions and strategic partnerships, CFOs need to help the management team evaluate the upside potential and risks of new business models and opportunities. In a capital-constrained environment, CFOs will need to find creative solutions for financing new initiatives and better managing the overall operations of the organization. They have to understand the clinical side of the health care business and possess the analytical and interpersonal skills to collaborate with clinicians and other administrators to evaluate and manage the organization’s risk.

“It’s time to get out of the nursing box and take the lead on hospital initiatives and create further relationships across the continuum of care. Nurse executives are more widely understanding of the strategies, approaches and collaboration and are beginning to be seen more as equals.”
—Chief nursing officer

The chief operating officer (COO) is becoming the “integrator in chief,” as noted by the AHA’s *Hospitals & Health Networks* magazine.³ The COO is responsible for overseeing the coordination of a range of operational activities, including managing population health outcomes and financial risk and coordinating inpatient care with physician offices and nonacute services. In addition, the COO’s command of operational issues frees more time for the CEO to devote to strategic and external responsibilities, including advocacy, philanthropy and partnerships.

Figure 7. Changing Roles for Health Care Leaders

	Historical	Today
Chief medical officer	Medical staff management	More operational and strategic, focusing on quality and efficiency targets, strategic planning, partnerships, long-range forecasting and decision analysis
Chief nursing officer	Advocate for nursing and patient care	Broader and more operational role; integral member of the management team in many organizations
Chief financial officer	Scorekeeper, financial gatekeeper	Business partner to the enterprise, advising on risk, insurance and strategic decisions
Chief operating officer	Focused internally	“Integrator in chief,” overseeing a range of operational activities across continuum, e.g., population health outcomes, coordination of inpatient care with physician offices and nonacute services

Source: Spencer Stuart / AHA Interviews, 2013.

More Clinicians in Leadership Roles

Physician Engagement

Physician buy-in and engagement were cited as the primary hurdle to achieving strategic priorities by 26 percent of respondents, the most of all the responses. Engaging physicians and other clinical staff in change is critical to improving quality and consistency and reducing the cost of care — the underpinnings of successful population health strategies.

Organizations are involving physicians in the change process on multiple fronts. At most organizations, physicians have a voice at the highest levels of decision making, with senior physician leaders serving on the management team and strategy committees. More broadly, hospitals and care systems are identifying ways to incentivize and involve physicians, both employed and contracted.

Involving physicians early in strategic and operational planning and in a meaningful capacity is critical, health care executives told us. “What physicians want is to be part of the leadership effort. They need to be the architects,” said one CEO. “People who say that they are the resisters just don’t get it.”

Physician leaders can be very influential in encouraging support for changes among the broader clinical population. Mechanisms such as performance improvement committees and medical executive committees have proved to be powerful tools for involving clinical leaders in decision making and communicating to the broader organization. “Our change management model is very physician-leadership-centric. That is to say, we’re very reliant on our physicians and the physician chain of command to secure physician buy-in and then drive physician change,” said one health care system CEO.

Health care systems also work closely with physician independent practice associations, which may take the lead on quality and patient safety initiatives and participate in strategic and operational planning. One health care system created a new board committee with physicians across the system — not just hospital-based physicians — that meets quarterly with the board to discuss strategy and solicit input on policies and plans.

Hospital and health care system leadership once was viewed largely as the purview of nonphysician administrators and, even more recently, administrators have been seen as the primary drivers of strategy and change. That perspective is quickly evolving, as hospitals and care systems alter care delivery models, evaluate clinical design and reorganize into service lines. In this changing environment, clinical thinking must be integrated into operational decisions. “It will be critical for clinical leaders to be involved at the top so that change can occur more quickly,” one executive noted.

More physicians and nurses are being tapped for leadership roles, including many of the new senior executive positions that organizations are creating to address specific strategic areas. New management team roles, such as vice president of clinical transformation, vice president of medical management and vice president of clinical informatics, are being filled by physician leaders. In addition, physicians increasingly are leading or co-leading newly established or existing service lines and participating in management dyads or triads. Organizations are also creating health system CNO roles to align responsibility for nursing under one person throughout the system, making it easier to escalate standardization and centralize resources across services.

“I just added four physicians to my senior leadership meetings, which expanded our group by about 25 percent,” said one health care system CEO. “That is a lot of people, but I felt it was important to have the physician’s voice heard at the senior leadership table. [Physicians] represent private practice. They represent faculty. They represent chairs. It’s a broad cross section of people who are going to be at the table now every week when we talk about operational issues.”

“It will be critical for clinical leaders to be involved at the top so that change can occur more quickly.”

—Hospital CEO

“It’s a broad cross section of people who are going to be at the table now every week when we talk about operational issues.”

—Health system CEO

In addition to these roles at the top, many health care organizations are establishing a new layer of clinical leadership positions to facilitate the buy-in and engagement of physicians and nurses for care delivery redesign and organizational alignment initiatives.

The physicians and nurses who will be most effective in these leadership roles have the ability to work with a variety of constituencies, including their clinical colleagues, the public, external partners and patients in a more patient-centric model. This requires a set of skills that physicians and nurses may not have needed in the past: exceptional interpersonal skills, team-management and team-building skills, an understanding of health care economics, analytical skills and the ability to influence and drive change. For some clinicians, developing a more collaborative mindset may require overcoming deeply ingrained perceptions; as one physician noted, “In medical school, teamwork was called cheating.”

Broad Leadership Skills Needed

Over and over again, in the survey and in one-on-one discussions, health care executives emphasized the need to develop broad leadership skills at all levels of the organization. In this era of unprecedented change in the field, organizations need executives and managers who are up to the task of identifying new opportunities, executing these initiatives at a high level, collaborating with different stakeholders and inspiring new behaviors. Change management is a hugely complex task that requires a very broad skill set, including business judgment and strategic insight, social intelligence, self-awareness and excellent people management skills. Health care leaders need to be able to execute plans, hold people accountable and be comfortable with uncertainty and a rapid pace of change. As shown in Figure 8, survey respondents identified critical thinking/strategic planning, innovative thinking/creativity, and transformational change/change management as the most critical skills for the future.

“Increasingly, leaders of hospitals or academic medical centers need to make sure the talent is chosen for their overall leadership skills.”

—Health system executive

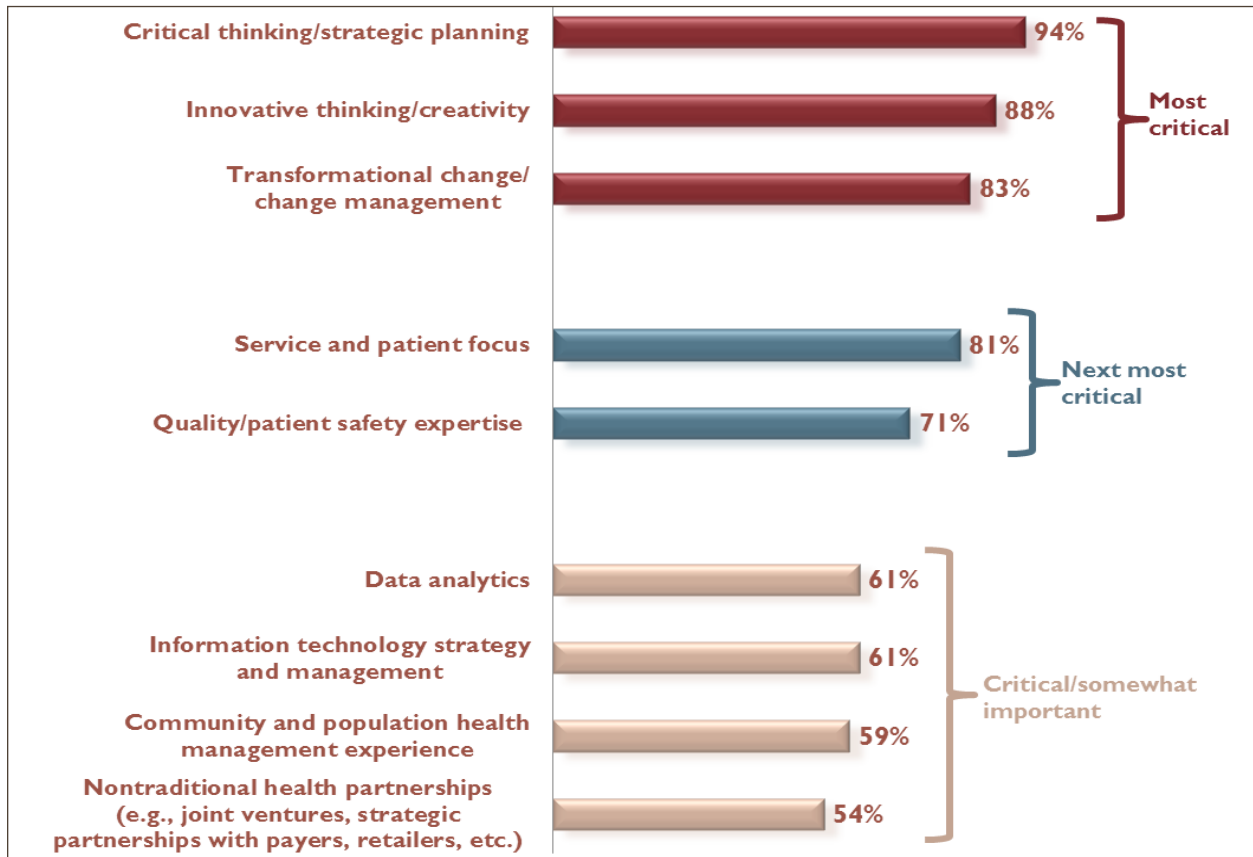
As one health system executive explained, “Increasingly, leaders of hospitals or academic medical centers need to make sure the talent is chosen for their overall leadership skills, not because they were the best physician or the best accountant or the best IT person. These are complex businesses in a fast-changing environment.”

Many health care organizations have formally identified the critical competencies that will be needed in senior leaders. One CEO, for example, identified a list of 12, ranging from personal integrity and passion for results to quiet courage and the ability to collaborate effectively with colleagues to get things done — and not just to be the loudest voice in the room.

Not surprisingly, communication and interpersonal skills regularly came up as important leadership skills in interviews. Others included: multidisciplinary orientation; a solid understanding of the broader business of health care; excellent facilitator skills; strong analytical skills; flexibility and resourcefulness; resilience; and financial management skills.

Figure 8. Critical Skills for Future Health Care Leaders

Skills that will be most critical in the next three years



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Overcoming Organizational Barriers

Breaking down functional silos to improve collaboration and information sharing is a top goal for health care organizations that increasingly need to provide coordinated care for their patients. As a result, hospitals and care systems are changing the way they work and experimenting with different organizational models, with the goal of sharing best practices, promoting innovation, improving patient outcomes, increasing efficiency and ensuring that care is coordinated across the continuum of services.

The creation of management dyads and triads, in which clinical leaders are paired with administrators to jointly oversee service lines or clinical areas, is one organizational approach. Such models are intended to encourage systems thinking and align clinical and operational resources to improve outcomes and work more efficiently. Matrix organizations and multiple reporting relationships also are becoming more common, as are system-level leadership roles charged with standardizing practices and purchasing across the entire organization.

CEOs are enlarging their executive teams with new members to inject diverse perspectives and inviting leaders with various roles to join committees focused on specific directives. For example, to ensure a senior-level and coordinated approach to strategy development, some organizations are establishing new physician strategy groups or executive strategy committees, which bring together leaders such as the chief information officer, innovation officer and nursing officer, in addition to the traditional management team, to tackle strategy. Similarly, many organizations are establishing structures for developing innovation initiatives, including creating councils on clinical innovation charged with looking for service delivery improvement opportunities and innovation labs for testing new ideas.

Even as they are adding new leadership roles, many health care organizations are consolidating or eliminating positions to reduce overlap, streamline operations or uncover synergies across functional areas. “We have added and subtracted to our executive team. We have significantly whittled down senior management and added to the responsibilities of the senior team members to break down the silos that were in place,” according to one health system executive. “For example, what was three positions originally — vice president of physician practices, vice president of acute care and vice president of behavioral health — has been re-formed as one position. We were seeing acute care patients presenting with behavioral issues and vice versa, so streamlining these roles made sense to uncover the synergies. There have definitely been advantages to this strategically, but it makes for a big job and a lot of responsibility for one person.”

“We have added and subtracted to our executive team. We have significantly whittled down senior management and added to the responsibilities of the senior team members to break down the silos that were in place.”

—Health system executive

Building the Leadership Team for the Future Health Care Organization

How are health care organizations building leadership teams with the capabilities that they need today and for the future? Typically, hospitals and care systems are relying on a combination of external recruiting — including executives from outside the health care field — and leadership development and training.

Recruiting and Promoting Senior Leaders

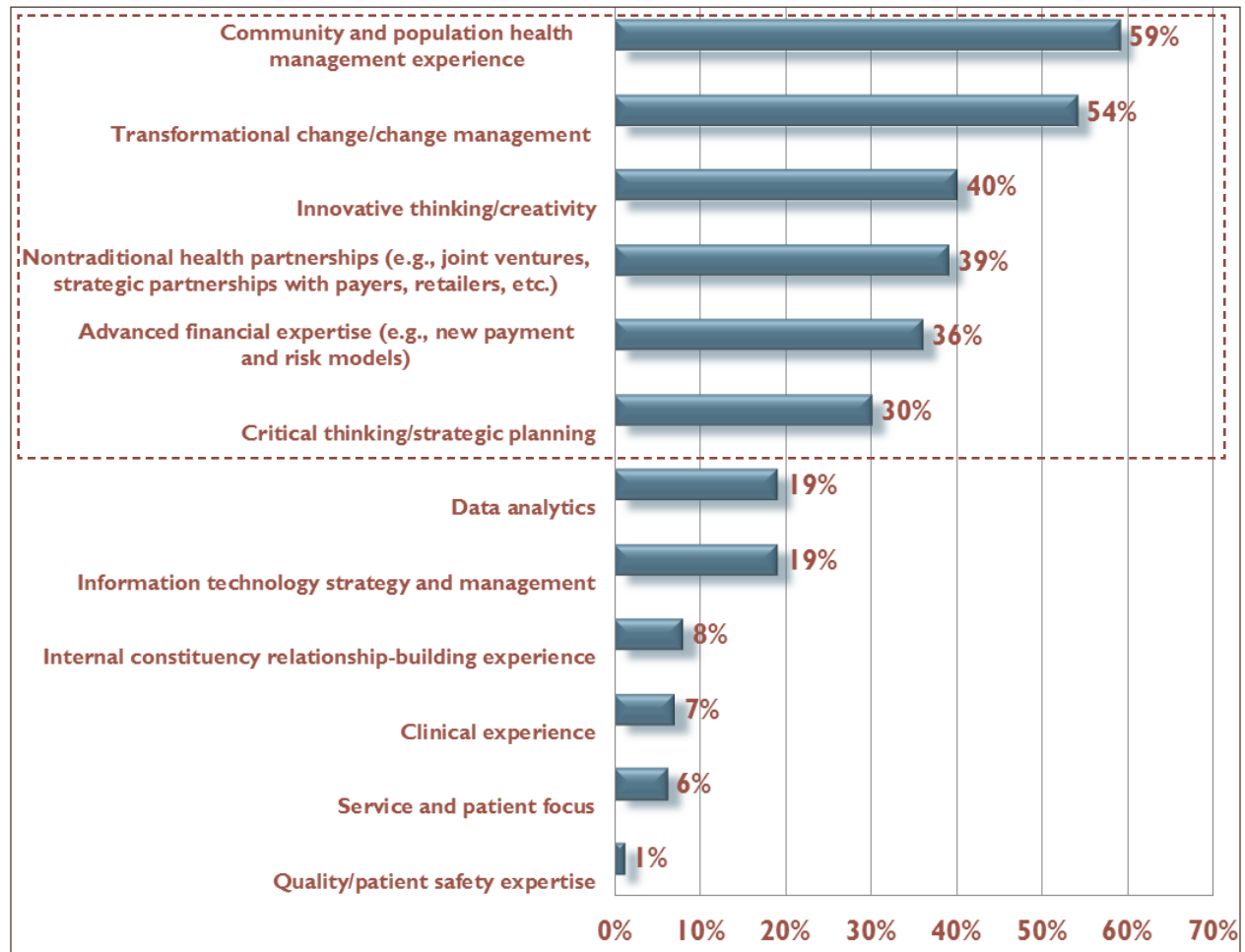
Because of the health care field's complexity, including the regulatory framework that organizations operate within, hospitals and care systems traditionally have recruited from within the sector for senior-level roles. As they seek leaders in new disciplines, some organizations have become more willing to consider candidates from outside the field for certain roles that require skills that have been less developed within health care.

Nearly 60 percent of respondents said community and population health management experience will be hard to find within the broader health care field, and more than half said transformational change and change management capabilities will be the hardest to find. Innovative thinking and creativity, nontraditional health partnerships and advanced financial expertise were other capabilities that respondents said they find lacking in the health care sector.

In the interviews, retail and customer insight experience, enterprise risk management and insurance expertise emerged as capabilities for which organizations may have to look outside the field. Senior positions in data analytics, “lean” operations, customer engagement, and supply chain and logistics may need to be filled by candidates from outside health care, for example. Even clinical innovation leaders need not come from a hospital setting if they are focused on research in the field; for example, a physician from a pharmaceutical background or from the medical device business may be considered.

Figure 9. Skill Sets Within the Health Care Field

Which skill sets will be the hardest to find within the broader health care field?



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Executives from outside health care may bring much-needed skills and a fresh perspective on the business, and many hospital and care system leaders express a preference for executives from outside the sector for marketing, strategy and innovation roles, for which creativity and innovative thinking are critical. But there are risks to these hires — namely, that health care is a complicated and regulated field that can represent too steep of a learning curve for newcomers, particularly for hospital operations and finance roles. Frequently, health care leaders gravitate toward job candidates with at least some health care experience. Spencer Stuart continues to see a preference for nonhealth care candidates for certain roles, especially marketing, innovation and strategy leadership roles, when candidates with pure health care backgrounds do not seem as fresh by comparison. Meanwhile, hospitals and care systems are becoming a more attractive career option for some executives outside the sector, some of whom are interested in being part of a field undergoing a major transformation.

Similar risk calculations have to be made when considering internal candidates moving into a senior leadership role for the first time. By definition, these executives do not have experience in the specific role for which they are being considered, and many roles are evolving to include new skill sets. For example, it is not unusual for physician leaders to be tapped for new roles for which clinical experience is critical, but many such roles are now broader in scope with more responsibility.

Organizations can minimize the risk when promoting internally or hiring from outside the sector by carefully defining the technical knowledge and leadership skills that are required and consistently assessing candidates against those capabilities. Given the pace of change in health care, both external and internal candidates should have a track record of working in environments of change and ambiguity. Another important consideration is cultural fit, both with the leadership team and the broader organization; ideally, organizations will define the cultural traits that need to be developed in the organization and select leaders with traits that match the direction the culture needs to move.

The route to the top of organizations is less structured than in the past, and new paths to the CEO role are emerging. More hospitals and care systems are developing succession plans so that high-performing executives can grow professionally without needing to leave to find new opportunities. However, executives with strong track records are in great demand and have many opportunities available to them.

Also in high demand are physician leaders, executives who have a successful track record of managing risk and those with experience working in pre- and post-hospital environments as well as acute care. One challenge in recruiting is a growing cautiousness among candidates about relocating during this tumultuous time for the field. Opportunities need to be particularly exciting to draw top performers out of good situations. As a result, the price to attract top talent continues to escalate against a backdrop of growing tension over executive compensation across all industries.

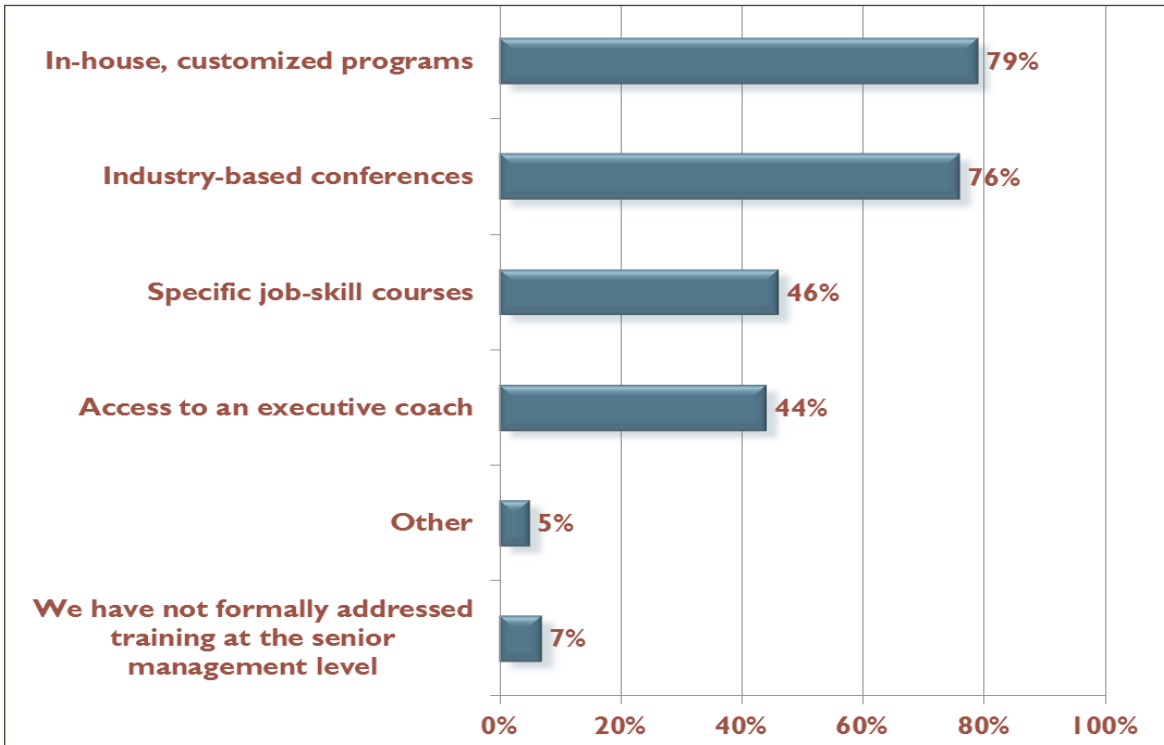
Leadership Development and Training

Most senior- and mid-level hospital leaders now being confronted with the dramatic shifts in health care payment and delivery grew up in the fee-for-service environment. As a result, training and leadership development are priorities for many organizations. Seventy-nine percent of survey respondents said their organization has established in-house, customized training programs for senior management during the past three years, and 76 percent said they offer access to conferences.

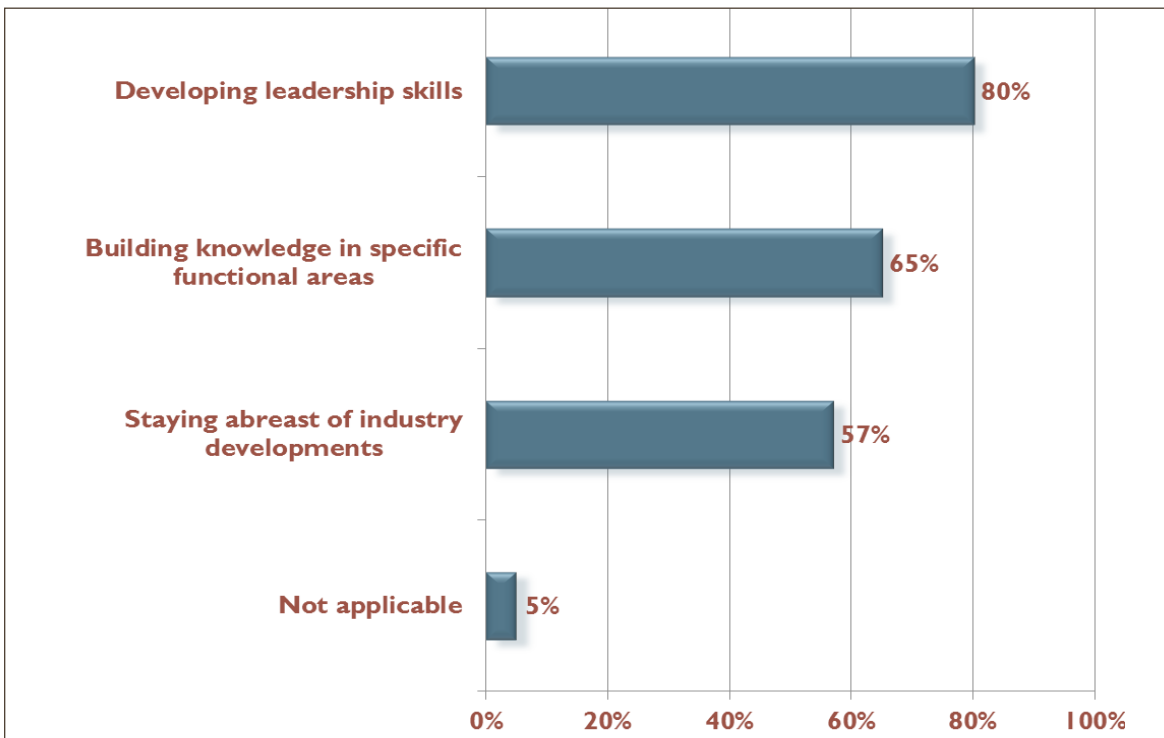
Much of the focus of these efforts is on developing leadership skills. Nearly 80 percent of survey respondents said training programs are focused on developing leadership skills; 65 percent said training programs are focused on building knowledge in specific functional areas. In-house, customized programs and sector-based conferences are the most common training approaches, followed by specific job-skill courses and executive coaching. Respondents said their organizations prioritize training in service and patient focus (73 percent), quality/patient safety (62 percent), data analytics (53 percent) and critical thinking/strategic planning (51 percent).

Figure 10. Management Training

What kind of training options has the organization put in place for members of the senior management team during the past three years?



What has been the focus of these training programs?



Which of the following skills will your organization develop internally with training and education?



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

While leadership development and training are a growing priority for health care organizations, interviews revealed a wide range of training capability and sophistication. “Leadership training and development are a major emphasis for us; in the past two years, we have recruited new people in leadership development and offered new courses for internal groups,” explained one human resources executive. Other executives describe leadership development as more of a “work in progress” in their organizations. One common challenge health care organizations face: getting time-strapped clinical and administrative leaders to devote time to these initiatives.

Given the growing cadre of physician and nurse leaders, some health care organizations offer programs targeted specifically to clinical leaders. Physician executive academies, mini-physician-MBA programs, skill development boot camps, and physician leadership universities are a few of the examples identified during the interviews. Many of these programs incorporate coursework and team projects and cover negotiation, basic finance, team work dynamics, communication, leading other physicians, trends in health care, and technical and soft skills. Many health care organizations also have established physician and nurse mentorship programs, which pair new clinical executives with experienced leaders to provide them with a resource to navigate relationships and answer questions.

Other leadership development programs bring together clinical leaders with administrative and business executives, with the goal of promoting integrated thinking and mutual learning, or target particular development needs, such as change management, employee engagement, service excellence and lean management techniques. One health care system, for example, sends 20 to 30 people at a time from all levels of the organization to an intermediate improvement science program. Over the past several years, this initiative has created a small army of improvement gurus scattered throughout the organization.

Evaluating Board Composition

Hospital and care system boards have a reputation for being large, regionally focused and, sometimes, unwieldy. A question for CEOs amid so much change is whether their boards have the diversity of expertise in strategic areas to truly be a valuable resource. Boards of local or regional systems, in particular, may have large representations of community leaders and lack access to national perspectives from other health care and nonhealth care entities. For many health care organizations, it may be time to take a fresh look at the composition of the board.

“As we’re talking about the transformation of management, there’s a similar transformation that we need to have on boards and governance,” said one health care system CEO. Boards should be evaluating their composition with an eye to the expertise and skills the organization will need in the evolving health care environment: Is there a need for a director who understands health insurance and risk management? Is there anyone on the board with expertise in information technology or innovation? Does the board reflect the diversity of the populations and the health of the communities that the system is serving or the full range of system services, or is it hospital-centric?

“As we’re talking about the transformation of management, there’s a similar transformation that we need to have on boards and governance.”

—Health care system CEO

When boards do not have relevant expertise, CEOs have to devote considerable time educating members about the changes to health care and cannot benefit from the probing questions and challenges to strategy or the background knowledge that can improve decision making. “I see it as a major weakness. Our board is very supportive. They strategically understand why we have to change, but they’re still struggling when we have to make decisions today in the boardroom. We spend so much time trying to explain the difference between the old and new models.”

One area that can be ripe for conflict, for example, is the role of the hospital in the overall health care system. Local board members can be very attached to the hospital, and conflicts can arise when management proposes selling excess hospital capacity to free up capital to invest in other parts of the organization’s system.

Many boards, especially those of regional health care systems and corporate health care entities, are adding expertise in new areas. For example, board members with expertise in consumer businesses, marketing, social media, change management and the payer side of the business are in demand. Boards of national and larger regional health care organizations with sophisticated governance practices and procedures are best positioned to attract members with these profiles. However, all boards can benefit from adopting best-in-class governance processes and practices that allow members to contribute at a higher level.

While health care boards are becoming increasingly professional, compensation for members continues to be rare and controversial in the field. Even many of the largest health care organizations provide no compensation to board members. And when compensation is provided, it tends to be significantly less than the compensation for board members of public companies. Health care organization boards, especially nonprofit organizations, continue to rely on their mission to attract members.

Conclusion

As the health care field continues to move toward the second curve, hospitals and care systems are putting in place the structures, processes and teams to compete in a value-based health care model. This model focuses on quality, safety, efficiency, population health management, patient engagement and seamless care delivery across the continuum. To be successful, health care organizations will need to do the following:

- Define their value proposition to patients (customers) and develop strategies to deliver on those customer service expectations and execute at a very high level. Organizations must define long-term strategies while protecting the short-term financial picture.
- Adopt flexible organizational structures, processes and cultures that allow them to adapt quickly and efficiently to market opportunities and changes. This is a time to be nimble. Each member of the team must more than carry their own weight in a changing environment.
- Develop change management as a core competency. Executives across the organization need to have business judgment, strategic insight, comfort with uncertainty, social intelligence, self-awareness and people management skills to manage in a changing environment. Embracing change and taking prudent risks are musts in today's environment.
- Based on the strategic priorities and direction of the organization, define the capabilities that will be needed by the senior leadership team going forward. Identify talent gaps and thoughtfully consider how to best address gaps, whether through training, leadership development or targeted recruiting of leaders from outside the health care field.
- Experiment with different organizational approaches to stimulate collaboration, improve operational efficiency and promote standardization across the organization in order to provide high-quality, coordinated care for patients. Senior executives must work together as a team and realize that the organization's leadership roles and management structures must adapt to the new demands on hospitals and care systems.

The American Hospital Association and Spencer Stuart will continue to monitor the leadership and organizational changes occurring at hospitals and care systems and promote dialogue among leaders in the field as they continue on this journey.

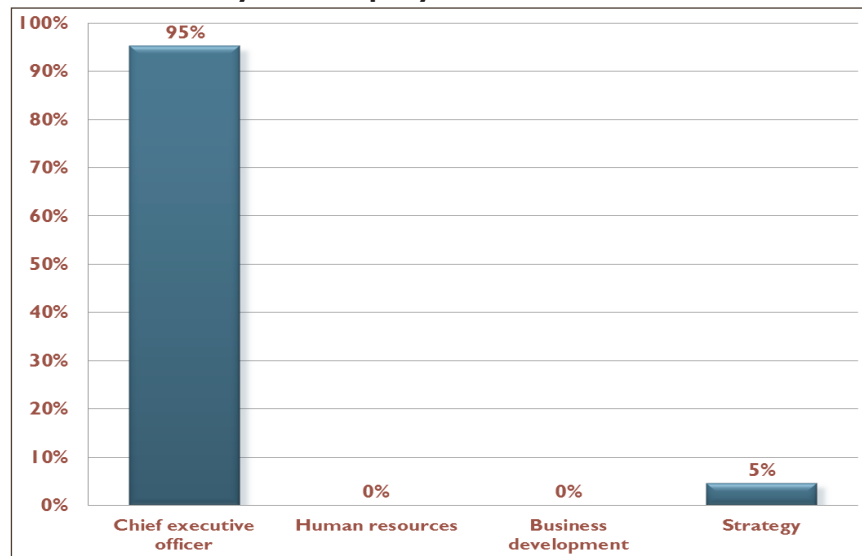
Appendix

About the Survey

The online survey was sent to 1,140 health care executives in April 2013 and received 111 responses, a 9 percent response rate.

Figure 11. Respondent Role

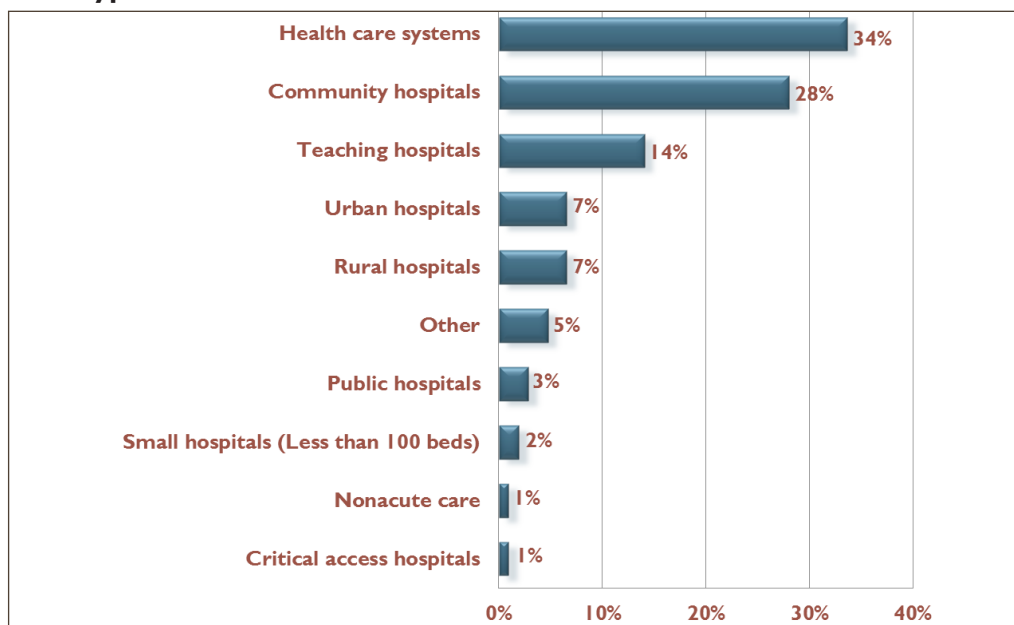
What is your title or role with your company?



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Figure 12. Respondent Organization

Organization type



Source: Spencer Stuart / AHA Leadership Survey, 2013. (n=111 respondents)

Interviewee Organizations

Survey findings were supplemented with interviews of more than 25 senior health care executives, primarily from large health care systems, including chief executive officers, chief medical officers, chief nursing officers and senior human resources executives from the following organizations:

- Advocate Home Health Services – Advocate Healthcare
Oak Brook, Illinois
- Advocate Physician Partners – Advocate Health Care
Oak Brook, Illinois
- Aroostook Medical Center
Presque Isle, Maine
- Baptist Health South Florida
Coral Gables, Florida
- Beth Israel Deaconess
Boston, Massachusetts
- Carolinas HealthCare System
Charlotte, North Carolina
- Cedars-Sinai Medical Center
Los Angeles, California
- Cincinnati Children’s Hospital
Cincinnati, Ohio
- Desert Regional Medical Center
Palm Springs, California
- Eaton Rapids Medical Center
Eaton Rapids, Michigan
- Franciscan Health System
Tacoma, Washington
- Intermountain Medical Group
Salt Lake City, Utah
- Lakeland Regional Medical Center
Lakeland, Florida
- Medical University Hospital Authority
Charleston, South Carolina
- Memorial Hermann Health Center
Houston, Texas
- Mercy Hospital Springfield
Springfield, Missouri
- Northwestern Memorial Hospital
Chicago, Illinois
- Ochsner Clinic Foundation
New Orleans, Louisiana
- Providence Health & Services
Renton, Washington
- St. Mary’s Health System
Lewiston, Maine
- Texas Health Resources
Dallas, Texas
- UCLA Health System
Los Angeles, California
- University Hospitals Health System
Cleveland, Ohio
- University of Wisconsin Hospitals and Clinics
Madison, Wisconsin
- Wyoming Medical Center
Casper, Wyoming

Endnotes

- 1 American Hospital Association. (2011, September). *Hospitals and care systems of the future*. Chicago, IL: American Hospital Association. Retrieved on April 23, 2014, from <http://www.aha.org/content/11/hospitals-care-systems-of-future.pdf>
- 2 American Hospital Association. (2013, April). *Metrics for the second curve of health care*. Chicago, IL: American Hospital Association. Retrieved on April 23, 2014, from http://www.hpo.org/Reports-HPOE/Metrics_Second_Curve_4_13.pdf
- 3 Larkin, H. (2012, January 1). Focus on the C-suite: Integrator in chief. *Hospitals & Health Networks*. Retrieved on April 23, 2014, from http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2012/Jan/0112HHN_FEA_boardroom

About HRET

Founded in 1944, the Health Research & Educational Trust (HRET) is the not-for-profit research and education affiliate of the American Hospital Association (AHA). HRET's mission is to transform health care through research and education. HRET's applied research seeks to create new knowledge, tools and assistance in improving the delivery of health care by providers and practitioners within the communities they serve.

About HPOE

Hospitals in Pursuit of Excellence (HPOE) is the American Hospital Association's strategic platform to accelerate performance improvement and support delivery system transformation in the nation's hospitals and health systems. HPOE shares best practices, synthesizes evidence for application and engages leaders in the health industry through education, research tools and guides, leadership development programs and national engagement projects.

About Spencer Stuart

Spencer Stuart is one of the world's leading executive search consulting firms. Privately held since 1956, Spencer Stuart applies its extensive knowledge of industries, functions and talent to advise select clients — ranging from major multinationals to emerging companies to nonprofit organizations — and address their leadership requirements. Through 55 offices in 30 countries and a broad range of practice groups, Spencer Stuart consultants focus on senior-level executive search, board director appointments, succession planning and in-depth senior executive management assessments.