

# The New CEO

Four ways to make the transition a success

**H**ospital chief executives sit at the top of the health care hierarchy, numbering about 4,500 strong, the face of acute-care hospital treatment around the country.

Their selection has frequently followed cross-country searches, lengthy and sometimes acrimonious board meetings, many months and a potentially hefty price tag. Bringing in a new CEO can cost an organization at least \$1 million once severance, recruiting and organizational disruption costs are factored in, according to one consultant.

Despite what's at stake, hospital leaders are moving elsewhere at a turnstile clip.

Slightly more than half—56 percent—of the nation's hospital chief executives have held their current job for fewer than five years and 14 percent for less than one year, according to the American College of Healthcare Executives. The group's analysis, conducted in January 2009 and based on American Hospital Association data from 4,464 facilities, determined that the median CEO tenure was 4.16 years.

Those numbers concern Thomas Dolan, ACE's chief executive. "It takes five years for a person to really create change and have it stick," he says. Plus, recruitment and salary costs

don't begin to capture all of the ripple effects within a hospital organization when the CEO suite becomes vacant, he says.

"When you don't have a permanent CEO, things don't grind to a halt," he notes. "You provide care every day. But you are not going to make bold moves. Hospital-physician relations are going to be on hold. You are not going to expand clinics. The most common comment will be to say, 'Let's wait for the new CEO.'"

To guard against CEO turnover, trustees should get more involved up front and resist the urge to change focus once the new leader is on board, according to health consultants and recruiters. To that end, board members must be honest with themselves and their prospective candidates about what they both desire and need. And, as soon as they hire their new CEO, they should start prepping for the next search, including updating their succession plan.

Even prior to the passage of health care reform legislation, incoming hospital chiefs have been challenged by tight budgets, a limited supply of primary care physicians and increasing quality scrutiny, among other demands. And that's assuming that the prior CEO's tenure was relatively amicable and stable. "The margin for error in the selection and onboarding of CEOs is

By Charlotte Huff

becoming much thinner,” says Jim Gauss, chief executive at Witt/Kieffer.

For trustees, who often shoulder board responsibilities with their day jobs, the selection process alone can consume significant time and emotional energy. At Legacy Health in Portland, Ore., board members took nine months to select a new chief executive in July 2008, after the not-for-profit system’s chief executive resigned abruptly the prior fall. “Having had a CEO that you expected to be around for a long time who lasted only 18 months—you didn’t want that to happen again,” says board member Bob Cornie, who led the search committee.

Once they cast that vote, trustees too often throttle back, Gauss says. “There is a sense of relief that, ‘Now that we’ve got this done, let’s take a breather,’” he says. But their work is only just beginning, he notes. At least if trustees want the organization’s new leader to stick around.

## Succession and Selection

When Kent Wallace became Vanguard Health Systems’ president and chief operating officer in 2005, the Nashville, Tenn.-based system had a CEO turnover problem, running at 30 percent in 2004 and 2005, according to Wallace. (Since 2004, the national rate has hovered between 14 and 18 percent, according to ACHE data.) Vanguard, a for-profit system, owns 15 hospitals in four states and is poised to expand significantly. As of March, Vanguard officials had signed a letter of intent with Detroit Medical Center to add the eight-hospital system. Vanguard also has signed a nonbinding letter of intent to acquire West Suburban Medical Center and Westlake Hospital in Illinois, a sale it was finalizing at press time.

Several years ago, Vanguard hired Gallup to help alleviate their turnover headaches, Wallace says. “It’s just impossible to create a future for your organization when you’ve got CEO turnover,” he says. “If people are just turning over, you can’t get any traction in the marketplace.”

Since then, Vanguard has taken a number of steps, including more personalized onboarding of chief executives in their initial weeks on the job, more frequent CEO meetings across their national system and the launch of an internal leadership academy

to train talented managers who might one day assume the top job. As of early April, Vanguard hadn’t had any chief executive turnover in the two prior years, Wallace says.

He gives particular credit to better selection on the front end. By using Gallup’s leadership interview, Vanguard officials were able to penetrate beyond the candidate’s resume to better assess their leadership strengths and weaknesses, Wallace says.

Leaders are naturally hardwired with their own innate strengths, he says. “I think a lot of times we in hospital management think that just because one candidate has been successful in one environment that they will be automatically successful in another,” he says. By working with Gallup, he says, “we’ve had great experience in matching the right candidate to the job.”

As a general rule, leaders break down into one of two categories, says Jeannie Ruhlman, a Gallup principal consultant who has worked with Wallace and other Vanguard officials.

Some exhibit surgeonlike tendencies, preferring to move in and “stop the bleed,” taking the bold steps necessary to salvage or revamp a hospital system, she says. Others are better suited to building upon existing momentum, more like a physical therapist, she says.

Trustees, who typically have a laundry list of desires for the CEO role, want both personas in their next chief executive, Ruhlman says, but “very, very seldom do I see these [two types of] people housed in the same person.”

Gauss expresses a similar sentiment. Board members should be more honest not only with prospective candidates, but also with themselves, he says. Otherwise a chief executive may arrive with expectations and related skills that don’t match the reality on the ground. “Oftentimes when a CEO is appointed, there is often more of a perceived mandate for change than there is for real change itself,” Gauss says.

Besides identifying the right leadership style, Ruhlman also says that boards should guard against what she dubs as “the potential for organ rejection.” Part of the selection criteria is identifying the right leadership match for that particular hospital system, she says.

“If you bring somebody in with great talent, but they are surrounded with people where their talent level doesn’t match, or it’s just oil and water, how do you set them up to win?”

## Transition and Onboarding

During the first 100 days, the trustees and the new chief executive must cover a lot of ground, says ACHE’s Dolan, who doesn’t agree with the sentiment that boards tend to lose steam following the CEO hire. “It would be kind of like stopping your golf stroke halfway through,” he quips. “The job’s only half done. Onboarding that CEO is just as important as selecting them.”

Along with meeting with senior management and key community leaders, the incoming leader should immerse herself in every aspect of the hospital system. Ideally, she should walk the hallways as much as feasible, including on different shifts, Dolan says. “Those are going to be long days, those first 100 days.”

Trustees also should be specific about benchmarks, experts say. Write down goals, including target time frames, they advise. Sometimes trustees are averse to drilling down to this level, says David Nash, M.D., dean of the Jefferson School of Population

### TURNOVER-PROOF YOUR EXECUTIVE

To better support a new executive, the American College of Healthcare Executives encourages a systematic onboarding process. The group’s recommendations, issued in a policy statement late last year, include:

- Clarify expectations prior to the start date.
- Direct the executive to devote his or her initial weeks to “active listening” focused on learning about the organization rather than immediate action.
- In the first month, help the new executive not only to develop goals, but also to distinguish between short- and long-term priorities.
- Provide the executive with some early opportunities for success to boost credibility.

Health in Philadelphia, who also consults with boards on quality issues. "I think that boards are ambivalent about getting into the details versus the big picture and the fit of the personality," he says. "But boards have to do both when it comes to the CEO hiring or firing decisions."

A significant onboarding component involves briefing the incoming CEO on the organization's backstory, such as the history, political cross currents and internal morays that could trip up a promising leader, Gauss says. That cultural component, along with meetings with all the key players, should ideally occur before the first day on the job. Otherwise the new leader might meet a major donor, for example, and treat them like just another community leader. "That's a foot in mouth pretty quick," he says.

Detailed onboarding is particularly crucial if the board has charged the new CEO with steering the hospital system in a new direction, says Julee Thompson, senior vice president of consulting solutions at B.E. Smith. Take the chief executive who has been hired to expand physician specialty services for the hospital system, she says. That leader needs to understand, in advance, the sentiments among the system's primary care physicians.

Otherwise, she says, "I start putting my plan in place and making that plan work and I may get too far into that before I realize that I have a very fractured medical staff. And now I have to go into repair mode. That may cause the board some concern because they may look at me and say, 'Why do we have these

problems?' It gets to be a bit of a vicious circle."

Trustees also can take steps to protect the incoming chief by clarifying the communication and handoff details with the outgoing CEO, even if the transition is amiable, Thompson and others say. They should specify the level and type of interaction between the two leaders and even, as obvious it sounds, the former chief's departure date, Gauss says. "It is amazing to me that oftentimes, even though the chief executive is leaving, there is no definitive date associated with that," he says.

The board also should make sure that they've made a clean psychological break from the prior chief executive, so there's no "halo effect" at work, Thompson says. In short, the new chief should be able to put her own stamp on the organization without feeling like she is constantly being benchmarked against her predecessor, she says.

Dolan cautions against impatience, saying that trustees shouldn't rush to judgment. It typically takes a year to know if the new leader is working out, he says. "If [board members have] done a good job in selection, they need to give that person time," he says.

But Lloyd Dean, chief executive of San Francisco-based Catholic Healthcare West, believes problems become apparent within six months, and potentially sooner. "I would say in 90 days, you know if it's a fit or not," says Dean, whose not-for-profit system includes 41 acute-care hospitals. "It becomes pretty clear and it becomes pretty clear to them also."

## THE INTERNAL VS. EXTERNAL CEO TRANSITION

**Mary Greeley Medical Center in Ames, Iowa, had benefited from a long-standing chief executive, with 12 years tenure and counting. She was so talented that "we knew she was on every headhunter's speed dial," says Sarah Buck, board chair for the city-owned 220-bed hospital. "So it was probably only a matter of time."**

**The board kept its succession plan updated and when Kim Russel announced her departure in late 2007, they activated it. As planned, they named a vice president as interim leader and quickly interviewed the three search firms already on their short list. Witt/Kieffer was hired to recruit nationally and then narrow the field of candidates first to four and then finally two: one internal and one external.**

**In mid-2008, the five-member board announced that they had chosen one of their own: Brian Dieter, the system's long-time chief financial officer. Thanks to the national search process, board members knew that he had been thoroughly vetted and would provide the collaborative leadership style they desired, Buck says. "Because we were in a good position with the prior CEO, there was not a lot of fixing that needed to be done," she says.**

**As boards select and launch new chief executives, the question is often raised: internal versus external. While external candidates typically require more onboarding support during the initial months, internally promoted executives also have to clear some institutional hurdles as they move**

**into the top spot, says Jim Gauss, chief executive of Witt/Kieffer. "Everybody knows what your strengths and weaknesses are—that's both good and bad," he says.**

**Board members can help avert some potential disasters by nurturing talented senior leaders as part of their succession planning process, says Julee Thompson, senior vice president of consulting solutions at B.E. Smith. And that development should include opportunities for failure, she says. Senior leaders should be given opportunities to stretch with new projects or responsibilities so they can hone related skills, without excessive helicoptering, as Thompson describes it. "When they move into a CEO position, that safety net is not there," she says. "As hard as it is, you have to afford them the opportunity to bump their nose."**

**To train future leaders, Vanguard Health Systems recently launched its own leadership academy. After all, those leaders already understand the system's working style and culture, says Kent Wallace, Vanguard's president. "We want to get where we fill 70 percent of our executive jobs internally," he says.**

**The initial group of 45, who started a 15-month, part-time training program earlier this year, includes physicians, clinicians and administrative leaders. "We see these as really our shining stars," Wallace says. "We think that in the next couple years, two or three years, they will be taking leadership positions within Vanguard and among those will be CEOs."—C.H.**

## Two-Way Communication

To get as much input as possible into the selection of Legacy Health's new CEO, a large search committee of 13 people was formed, including clinical, community and board representation, Cornie says. But that search committee was pared down once they settled on a short list to guard against candidates' interest getting back to their current employers, he says.

The search committee was frank about its expectations during the interview process and following its selection of George Brown, M.D., as the new CEO, Cornie says. With the assistance of Witt/Kieffer, they developed a detailed description for the position, including an ability to think strategically and to elevate the system's profile in the Portland region. "We wanted somebody who was a leader, not just an administrator," Cornie says.

Since Brown began work in fall 2008, the board has kept the channels of communication open, Cornie says. "He's certainly leading and that's what we hired him to do," he says. "We need to be responsive to where he wants to go."

It's lonely at the top, as any hospital leader knows. In many cases, the trustees likely serve as the new CEO's only safe sounding board, as he attempts to navigate the politics of the new organization, including the strengths and weaknesses of its own executive team, Gauss says. At Catholic Healthcare West, Dean has encouraged the pairing of new hospital presidents with another president within the 41-hospital system, someone similar in personality or who runs a hospital with similar demographics.

Board leaders also shouldn't flinch from giving their chief executive direct feedback, Dolan says. "Nobody wants to give bad news," he says. Otherwise, when a financial situation or other type of crisis flares, it seems like the board abruptly terminates that individual, he says.

Patient safety issues can be just such a trigger, according to Nash. "It's what makes news: a hospital death, a wrong-side surgery, a disgruntled patient, a huge malpractice case. All of that gets into the news and puts pressure on board members who otherwise may not have been paying attention. All of the sudden there is rumbling that, 'Joe is not doing a good job.'"

And now the biggest trigger point of all is looming, in the form of health care reform, Nash says, echoing a point made by others. "Anxiety comes from the unknown," he says. "And this is hugely anxiety-provoking."

Still, despite the frequent caution that trustees can't expect their next CEO to have it all, they will likely keep recruiting—and hoping. And some, like Cornie, will feel like they've achieved that goal.

Brown has proven to be remarkable, Cornie says, in his adaptive and strategic leadership abilities. "We did need to change, but we also needed a team builder," he says. "We wanted it all—we did. In George Brown, I think maybe we've come as close as you could hope to." **T**

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