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How Senior Leadership Teams are Changing: A Survey of Freestanding Community Hospital CEOs

Division of Member Services, Research
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Introduction and Overview

As health reform continues to unfold, CEOs and hospital boards are reassessing all aspects of operations, including the structure of their senior leadership teams (SLTs). While the essential functions of an SLT may themselves be clear (White & Griffith, 2010), there is little definitive guidance available to inform CEOs about optimal team size and composition. For example, some might argue that smaller SLTs are more cost-efficient and can support faster decision-making; others might argue that larger SLTs are needed to manage the increasing complexity of management decision-making in a rapidly evolving environment. Similar arguments and counter-arguments could be brought with respect to the addition and removal of specific executives from an SLT, from disciplines such as medicine, human resources, and strategy.

To help shed light on the changing nature of SLTs, the American College of Healthcare Executives partnered with researchers at Rush University to develop and implement a national survey about senior leadership teams in freestanding community hospitals. Of the 949 surveys distributed to freestanding community hospital CEOs who were ACHE members in October through December of 2013, 469 responded for an overall response rate of 49 percent. Respondents averaged 7.8 years in their current CEO position.

Results from the survey indicate considerable variety in the structure of freestanding community hospital senior leadership teams. This reflects that the size and composition of SLTs can be influenced by organization mission, structure, size, needs, resources, history and, in some cases, the desire to best leverage the talents of specific individuals.

The survey results also indicate that even in these times of unprecedented change, organizations are moving cautiously when it comes to altering the functions represented on their senior leadership teams. Where changes are being made they are more likely to be in the direction of increasing the number of roles represented on the team rather than decreasing them. In this white paper we present the survey data describing the roles or functions that are currently represented on senior leadership teams in freestanding community hospitals, how those teams have changed over the past two years and what changes are anticipated in the next two years. We also look at SLT effectiveness in several dimensions, as perceived by the CEO, and offer suggestions for areas where team effectiveness demonstrated the most opportunity for improvement.

Findings

1. Who is Included on the Senior Leadership Team

CEOs of freestanding community hospitals in our survey were asked to describe their senior leadership teams. SLTs were defined as the team of leaders most directly responsible for setting and maintaining the strategic direction of the hospital. The reported size of SLTs, including the CEO, ranged from 1 to 21 executives, with an average of 6.8 executives. Perhaps not surprisingly, senior leadership team size increased with increasing organization size, as measured by full-time equivalent (FTE) employees. CEOs overseeing small hospitals (employing 300 or fewer FTE staff) described senior leadership teams ranging in size from 1 to 18 executives, with an average size of 5.3 individuals. CEOs running mid-sized hospitals (with 301 to 1000 FTE employees) reported SLTs ranging from 1 to 11 individuals, with an average of 6.3 executives. Leaders of large hospitals (with 1001 or more FTE employees) reported SLTs ranging from 1 to 21 executives, with an average size of 9.2 individuals.

Table 1 contains a listing of the functions or roles most often reported by survey respondents as being represented on freestanding community hospital senior leadership teams, in addition to the CEO. The most frequently named top executive roles included in the SLT were finance, nursing, human resources, operations and quality, all of which appeared on the majority of SLTs. Between one-third and one-half of hospital CEOs reported that senior executives

overseeing information systems, physician groups, medical staff, compliance and patient experience were included on the senior leadership team. Between 20 and 30 percent of SLTs include senior executives overseeing marketing/PR, community relations, philanthropy, strategy and organizational performance. A small minority of organizations, less than one-fifth, include learning, legal and innovation executives on their guiding teams.

There are some marked differences between the frequencies with which some roles are included on senior leadership teams in organizations of different sizes. Frequencies with which the different executive roles appear on the SLTs of different-sized organizations are also shown in the table. While freestanding community hospitals of all sizes were very likely to have top financial and nursing executives on their senior teams, the appearance of all of the other roles on senior leadership teams was most frequent in the largest organizations. Most notably, top operations, physician group, medical, philanthropy and strategy executives were significantly more likely to be included on the SLTs of large hospitals than on those of mid-sized hospitals, and were also more likely to be included on the SLTs of mid-sized hospitals than on those of small hospitals. Top executives overseeing information systems, marketing/PR and legal matters were significantly more likely to be present on SLTs of large organizations than on those of small or mid-sized hospitals. The proportion of SLTs including community and learning executives were significantly higher in the large hospitals than in the small hospitals.

Table 1. Top Executive Roles on Senior Leadership Teams (SLTs)

Top Executive Roles	Number of SLTs – overall	Percent of SLTs – overall n= 469	Small Hospitals (300 or fewer FTEs) n=173	Mid-sized Hospitals (301 to 1000 FTEs) n=159	Large Hospitals (1001 or more FTEs n=137
Financial	441	94%	92%	96%	94%
Nursing	437	93%	91%	94%	94%
Human Resources	327	70%	62%	71%	77%
Operations[a]	278	59%	38%	62%	83%
Quality	268	57%	53%	57%	64%
Information Systems[b]	221	47%	36%	42%	66%
Physician Group[a]	197	42%	25%	46%	58%
Medical[a]	186	40%	12%	42%	72%
Compliance	176	38%	38%	36%	39%
Patient Experience	160	34%	32%	35%	36%
Marketing/PR[b]	134	29%	20%	27%	41%
Community[c]	126	27%	22%	25%	36%
Philanthropy[a]	118	25%	12%	23%	45%
Strategy[a]	105	22%	8%	18%	45%
Organizational Performance	97	21%	18%	18%	26%
Learning[c]	70	15%	9%	13%	24%
Legal[b]	57	12%	3%	8%	28%
Innovation	44	9%	5%	8%	17%

[a] Differences between small, mid-sized and large hospitals are all significant at $p<.05$

[b] Difference between large and either mid-sized or small hospitals is significant at $p<.05$ (but difference between small and mid-sized hospitals is not)

[c] Difference between large and small hospitals is significant at $p<.05$ (but mid-sized hospitals are not significantly different from large or small hospitals)

2. Who Else Reports to the CEO

The majority, 73 percent, of CEOs responding to the survey said they had staff reporting to them who are not included on the senior leadership team. Of those who said they had direct reports not on the SLT, the number of such reports ranged from 1 to 12, with an average of 3.4 per CEO. Most frequently cited among these was the top philanthropy executive (reported by 34 percent of respondents with direct reports not on the SLT), followed by the top public relations executive (27 percent), compliance executive (25 percent), community relations executive (23 percent), human resources executive (20 percent), and information systems executive (15 percent).

3. Recent Changes in Senior Leadership Teams

Of those who made changes in the past two years, most added roles to their SLT, rather than changing or subtracting roles from their SLT.

About half, 53 percent, of responding freestanding community hospital CEOs reported they had changed the size and/or composition of their SLT over the past two years. The most frequently reported change was to add 1 or more positions to the SLT (27 percent), followed by removing 1 or more positions (14 percent), then by both adding and removing positions (12 percent).

For those CEOs who made changes to their teams in the last two years, overall they reported adding 1.6 SLT roles for every 1 role being removed. The types of roles added to, or eliminated from, these teams were highly variable. Collectively, 31 different roles were added to 177 senior leadership teams overseen by survey respondents in the last two years. The three roles most frequently added to SLTs were medically focused (e.g., chief medical officer, medical director), which was added to 32 teams; followed by information focused (e.g., IT director, chief information officer, informatics), which was added to 29 teams and quality/risk/compliance, which was added to 24 teams. Similarly, collectively 26 roles were eliminated from 120 SLTs overseen by survey respondents in the last two years. The role of senior human resources executive was almost equally likely to have been removed from the senior leadership team as added; top human resource executives were added to 21 SLTs and removed from 25 SLTs in the last two years. The operations role (e.g, COO) was reported as being removed from 20 SLTs in the last two years.

4. Planned Changes in Senior Leadership Teams

Most CEOs are not planning to make changes to their SLTs in the coming two years. Of those planning to make changes, more are adding roles to their SLTs than removing roles from them.

Most freestanding community hospital CEOs responding to the survey reported feeling satisfied with the number of members on their current senior leadership team. About 73 percent of the CEOs said the current size of their SLT was "about right." Fifteen percent felt their current SLT was either "too small" or "much too small" and the remaining 12 percent thought their current team was either "too large" or "much too large."

When asked about the coming two years a little more than half, 56 percent, of responding CEOs indicated they had no plans to make changes to their SLT. Another 12 percent of CEOs were unsure how they are going to proceed. Twenty-one percent of CEOs surveyed plan to add 1 or more roles to the SLT; another 7 percent plan to both add and remove roles. Only 4 percent of responding CEOs plan to just remove roles.

Of those CEOs expecting to make a change in their teams, overall they plan to add 2.9 SLT roles for every 1 role being removed. Again, the types of roles chief administrators are planning to add to or eliminate from their teams are highly variable. Among survey respondents, 26 different roles are expected to be added to 121 senior leadership teams in the next two years. The roles most frequently planned to be added to SLTs are medically focused (e.g., chief medical officer, medical director), which are expected to be added to 26 teams and operations focused (e.g., chief operating officers), which are expected to be added to 22 teams. The number of roles slated to be removed from SLTs by survey respondents in the next two years are so small that the data are not reliable and so are not presented here.

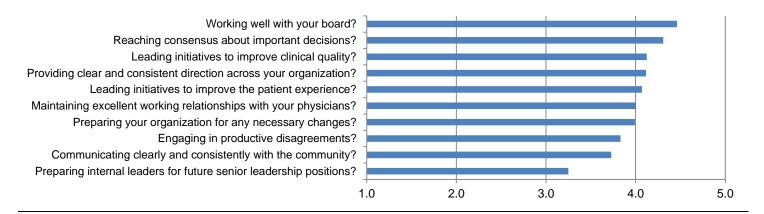## 5. Senior Leadership Team Effectiveness

Perceptions of Team Effectiveness

Freestanding hospital CEOs responding to the survey were asked to rate the effectiveness of their senior leadership teams in 10 different performance dimensions using scales of 1 to 5, where "1" is "not at all effective" and "5" is "very effective." As shown in Figure 1, on average respondents viewed their SLTs as somewhere between "effective" (about 4) and "very effective" (5) in 7 of the 10 performance dimensions. Respondents tended to feel particularly favorably about their senior leadership teams' effectiveness in working with their board (which received an average rating of 4.46). This was followed by reaching consensus about important decisions (4.31), leading initiatives to improve clinical quality (4.12), providing clear and consistent direction across the organization (4.12), leading initiatives to improve the patient experience (4.07), maintaining excellent working relationships with physicians (4.00), and preparing the organization for necessary changes (3.99).

The three dimensions in which CEOs tended to view their SLTs as less effective were engaging in productive disagreements (with an average rating of 3.83), communicating clearly and consistently with the community (3.73) and, in particular, preparing internal leaders for future senior leadership positions (3.25). Ratings varied by CEO tenure; CEOs who had been in their positions longer tended to view their SLTs' performance on these three dimensions more favorably.

Figure 1. Perceived effectiveness of the current SLT[d]

[d]   *Rated on a 5-point scale where 1 = Not at all effective and 5 = Very effective*

Ratings of perceived effectiveness in the 10 dimensions also varied by organization size. The effectiveness of SLTs in organizations in the three size categories (fewer than 300 FTEs, 301 to 1000 FTEs and 1001 FTEs or more), as judged by their CEOs, is shown in Table 2. While many effectiveness ratings are actually or virtually the same for hospitals of different sizes, CEOs overseeing large organizations are more likely to rate the effectiveness of their SLT higher with respect to the "preparing internal leaders" dimension than are the CEOs of mid-sized or small hospitals. Further, CEOs running large hospitals tended to rate their SLTs as more effective on the dimensions of working well with their board and leading initiatives to improve clinical quality than did the chief administrators of small hospitals.

Table 2. Differences in perceived effectiveness according to organizational setting

Effectiveness Dimension	Average Perceived Effectiveness[e]		
	Small Hospitals (300 or fewer FTEs) n=173	Mid-sized Hospitals (301 to 1000 FTEs) n=159	Large Hospitals (1001 or more FTEs n=137
Working well with your board[f]	4.4	4.5	4.6
Reaching consensus about important decisions	4.3	4.3	4.3
Leading initiatives to improve clinical quality[f]	4.0	4.1	4.3
Providing clear and consistent direction across the organization	4.1	4.1	4.2
Leading initiatives to improve the patient experience	4.0	4.1	4.1
Maintaining excellent working relationships with physicians	4.0	4.0	4.0
Preparing organization for changes	3.9	4.0	4.1
Engaging in productive disagreements	3.8	3.8	3.9
Communicating clearly and consistently with the community	3.7	3.7	3.9
Preparing internal leaders for future senior leadership positions[g]	3.2	3.2	3.5

[e]   *Rated on a 5-point scale where 1 = Not at all effective and 5 = Very effective*

[f]   Difference between large and small hospitals is significant at p<.05 (but mid-sized hospitals are not significantly different from large or small hospitals)

[g]   Difference between large and either mid-sized or small hospitals is significant at p<.05 (but difference between small and mid-sized hospitals is not)

6. Frequency and Length of SLT Meetings

Most chief administrators responding to the survey (79 percent) indicated that their senior leadership team meets weekly; 14 percent reported that the SLT meets every other week, and about 3.5 percent reported that the team meets daily. The most frequently reported typical meeting length was two hours (reported by 38 percent of respondents); for the rest, 46 percent of CEOs say they meet for some shorter time and 16 percent say they have longer meetings. No relationships were found in the survey between frequency or length of meetings and SLT size or team effectiveness in any of the 10 dimensions described earlier.

What CEOs Should Consider to Increase SLT Effectiveness

1. Senior Leadership Team Size and Composition

The significant changes the entire healthcare sector is facing are causing chief administrators to look carefully at all aspects of their organizations, including their senior leadership teams, and alter them as needed to help ensure their success in a new environment. It is clear that many freestanding hospital CEOs, like their counterparts in other types of healthcare organizations, are experiencing this change process as quite difficult. One CEO noted: "Change comes hard and slow." Another said they are "so busy with day to day, sometimes we miss the opportunity because we don't change gears on time." To the extent that CEOs are changing their SLTs, it is in the direction of growing rather than shrinking these teams. As one CEO respondent noted: "The SLT is a highly qualified and talented team. Our limitations as a small team and small hospital are primarily around depth of the team for the vast challenges in front of us." This trend of expanding SLTs is frequently seen in industries and environments experiencing significant change, and there is some evidence to suggest a larger SLT may be better equipped to make higher-quality strategic decisions (Finkelstein, Hambrick, & Cannella, 2009). Given the demands associated with health reform, it is not surprising that medically focused executives have been the most frequent additions to the team, followed by information systems and quality-focused positions.

2. Engaging in Productive Disagreements

In terms of perceived SLT effectiveness, CEOs responding to the survey identified three areas in which they felt their senior leadership teams were less successful. First, while CEOs are confident in the success of their SLTs in reaching consensus about important decisions, they are much less confident in their effectiveness in **engaging in the productive disagreements** necessary to ensure these decisions are well-vetted. One CEO noted: "Our leadership team is working on more productive disagreements." Another said: "We are maybe 'too polite.' We tend not to disagree or argue much — we are actively working on that."

When it comes to team decision-making, disagreements that facilitate consideration of multiple perspectives, carefully thinking through possible consequences and anticipating potential objections can lead to more robust decisions. It is when disagreements become personal (i.e., "relationship conflict") that the decision-making is impaired (De Dreu & Weingart, 2003; Simons & Peterson, 2000). It is not uncommon for SLTs to avoid conflict of all kinds, in the interest of not risking relationship conflict. SLTs who fall into the habit of avoiding all conflict may need more active intervention to set new group norms. CEOs can address disagreement deficits in a variety of

ways, the most straightforward of which is to allocate some time at a future SLT meeting to discuss the team's process, and ask for their help in more regularly bringing counter positions into the decision-making process. Following this expectation-setting, the CEO can then explicitly ask for alternative perspectives as part of future decisions, assign this responsibility to one of the team members on a rotating basis, or ask the help of an outside consultant to identify points where additional disagreement could be most helpful.

Some SLTs may find they have the opposite problem: team members who may be quick to voice alternative opinions but struggle when it comes to actively listening to the perspectives of their peers and moving toward consensus. In these cases, it can be helpful to keep in mind that very few senior leaders are intentionally counterproductive in their interpersonal style; it is far likelier that they lack a critical level of understanding about how they are coming across to others. CEOs can help their SLT members better recognize when their behavior may be interfering with the team disagreeing more productively by privately discussing with them what they are observing in the team context. Individual or team coaching can also be very helpful in learning new and more productive approaches to navigating conflicts. Additionally, the text, *Exceptional leadership: 16 critical competencies for healthcare executives* (Dye and Garman, 2014) provides brief, easily digestible chapters on skills such as "Listening like you mean it" and "Building consensus," which can be assigned as readings to help senior leaders gain perspectives on these and other critical competencies.

3. Communicating Clearly and Consistently With the Community

Another area of challenge that freestanding hospital CEOs identified for their senior leadership teams was **communicating clearly and consistently with the community.**

Good communication with the community is going to become increasingly important as organizations move into a more transparent and competitive environment. Health sector changes are a topic of frequent discussion across many news sources, political channels, and general conversations and people are naturally curious about how their local hospitals and health systems are responding. Whether the topic is the organization's response to the current state of U.S. healthcare, innovations to improve service to the community, public education as we move toward an emphasis on wellness, creating informed consumers regarding the quality and cost of care, or partnering with physicians or other local organizations, hospitals will only benefit by having their intentions and actions clearly understood by those whom they serve.

There is little "how to" information in the literature to assist hospitals with creating and sustaining good communications with the surrounding community. Not surprisingly, the survey data suggested that the presence of a marketing/PR executive on the SLT is associated with greater perceived effectiveness in communicating clearly and consistently with the community. While there is no blueprint for a successful dialogue between hospitals and the public, some of the lessons of public relations seem highly applicable, including the following suggestions compiled from the work of John Kotter (2011) and Ross K. Goldberg, president of Kevin/Ross Public Relations (2013):

- **However much you are communicating, you are probably not communicating enough.** Repetition is the key to effective communication. In addition to repeating your message frequently with updates as appropriate, finding ways to engage in two-way communication, so stakeholders can share comments and ask questions, will help them feel more comfortable with and invested in your message.

- **Make your message clear**. While not always easy to craft, clear, concise and jargon-free statements are the best way of getting your intentions across. There is nothing more personal to your patients than their health or the health of their families. Consider your audience as you design your message.

- **Consistency is important.** The statements you make convey your promise to your patients. Consistency of your messages with each other and consistency of your message with your mission, vision and values will help stakeholders get a clear picture of your organization and give your promises credibility.

- **Give your message context.** Never assume that your stakeholders understand the "why" of your actions or are aware of the events that have caused the change in your organization or even how you compare with others. Make sure your communications place your intentions in context and explain your reasons for what you are doing.

- **Tell your staff first.** Communicating changes to your staff first is essential for building trust and credibility and makes it more likely that they will be champions of your message. The more they embrace the message, the better able they will be to deliver the type of patient experience you want.

Price transparency is becoming particularly important for healthcare providers. A recent report by the Healthcare Financial Management Association promotes the use of price transparency in healthcare organizations to enable patients to make informed decisions. The report includes some basic guiding principles for effective price transparency, such as making sure your messages about price are easy to understand and communicate to patients and stakeholders, ensuring that value and price are communicated together and

presenting your information in such a way that patients can make meaningful price comparisons of the full cost of care (HFMA, 2014).

4. Succession Planning

The greatest opportunity for improvement in effectiveness was associated with **preparing internal leaders for future senior leadership positions.** Much has been written about the importance of succession planning (e.g., ACHE, 2011). ACHE reported that hospital CEO turnover in 2013 was 20 percent, the highest since we began computing those statistics in 1981. Higher turnover may become a feature of healthcare organizations now that Baby Boomers are reaching retirement age. Gaps in hospital leadership following the departure of the CEO are highly disruptive to organizations, often leading to suspension of key activities and departure of other key staff. Therefore, it is prudent for hospitals to have good succession plans in place for both planned and unexpected changes in leadership. ACHE conducted a survey of community hospital CEOs in 2014, where we found that 65 percent of freestanding hospital CEOs had no successors identified for their position (ACHE, 2014). Further, only 50 percent of freestanding hospitals had a formal succession planning process for the CEO position, 42 percent formally planned for turnover in the COO position, and a quarter or less had formal plans to replace executives below that level.

Given the considerable amount of time and learning needed to become effective at an organization in a top leadership role, the best current advice is to recruit senior leaders from within. Data have shown that it takes several years to prepare a permanent CEO successor, and one year of on-boarding in the new position is recommended. Data have also shown that CEOs recruited from within the organization and groomed for the position were more successful than those recruited from

the outside or chosen from a number of internal candidates participating in a "horse race" to assume the top leadership role (ACHE, 2011).

Our 2014 study revealed that the most common barrier to identifying successors for the top leadership position in freestanding hospitals was the lack of internal candidates, reported by 42 percent of CEOs of those hospitals. Freestanding community hospital CEOs in this current study identified their organization's size as a significant barrier to succession planning. One CEO noted, "Our model does not provide staff depth to prepare internal leaders; future needs for any positions will be external search." Another noted, "We don't have the size to develop top talent from within."

Although the challenges of succession planning in smaller organizations can be substantial, there are strategies that can still be very successful in these settings, and are worthwhile to pursue. For example, the CEOs in some smaller facilities have found success in identifying future talent through professional networking and developing mentoring relationships with professionals outside of their organization who can become candidates for future position needs (ACHE, 2006). In these cases, having a strong on-boarding program is essential. Others have recruited and/or identified high-potential talent at lower levels within the organization, who may over time have the capabilities to ascend to SLT ranks through a combination of formal and on-the-job development strategies (ACHE, 2006; Garman & Tyler, 2004).

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