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How Senior Leadership Teams are Structured Within Health Systems: A Survey of Hospital CEOs Within Health Systems

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Introduction and Overview

Well-functioning and effective senior leadership teams (SLTs) are critical to the success of hospitals. The challenges that have faced healthcare providers since the initiation of healthcare reform, including maintaining high standards of patient safety and quality of care while doing more with less, an increased focus on population health management, the increasing complexity of insurance products and the rapid pace of advancements in technology, have created a need for an evolution in the roles and expertise represented on hospital senior leadership teams (ACHE 2016).

Further, as the trend of consolidation of U.S. health systems continues, more hospital senior leadership teams are functioning within the context of a much larger organization. Hospital and health system leaders and boards are reexamining the structure and composition of system hospital senior leadership teams as those hospitals join systems and the hospital-system associations mature. This includes looking at how these hospital leaders and the boards overseeing them relate to the leadership and governance structures at the regional and system levels of the parent organization. Ideally, system hospital SLT structures should allow for effective local operation tailored to the needs of the communities they serve, while adhering to the mission, vision, direction and norms of the health system.

The question of optimal design of a system hospital SLT is not a simple one. While the essential functions of a hospital SLT may themselves be clear (White & Griffith, 2016), very little research has been completed that can inform CEOs about structural questions such as optimal team size, composition and centralization/decentralization of leadership functions in a system environment. For example, smaller SLTs might arguably be more cost-efficient and support faster decision making; conversely, larger SLTs may have an edge in managing complex multistakeholder decision making in a rapidly evolving environment. Similar arguments and counterarguments can be made about whether specific roles on an SLT are better represented by system-affiliated executives versus executives working directly for the local hospital.

To examine the current state of SLTs in system-affiliated hospitals, the American College of Healthcare Executives partnered with researchers in Rush University's Health Systems Management department to develop and implement a national survey. Of the 1,326 surveys distributed to system-affiliated hospital CEOs who were ACHE members in November and December of 2015, 398 useable responses were received, providing an overall response rate of 30 percent.

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Results from the survey reflected substantial variation in the structure of system hospital senior leadership teams, as well as the level of local autonomy with which these teams and the boards they served operated. This level of variation suggested that the size and composition of SLTs can be influenced by local needs, including specifics of the hospital mission, structure, size, resources, history and community need. There also may be significant variation between systems about how they approach local hospital leadership. Survey results also indicate that the degree to which system-level leaders participate as members of local system hospital SLTs is limited and generally confined to certain types of roles.

In this white paper, we present the survey data describing the roles or functions that are currently represented on senior leadership teams in system-affiliated hospitals, as well as the nature of relationships between hospital boards and their systems. We also look at perceived SLT effectiveness in several dimensions, and offer suggestions for areas where team effectiveness demonstrated the most opportunity for improvement. Finally, we asked CEOs of system hospitals for the advice they would offer their colleagues about how to function effectively within their systems, and those results are presented.

Findings

1. How long hospitals had been part of the system.

CEOs participating in the survey all led community hospitals (nonfederal general medical/surgical hospitals, including children's hospitals) that were part of multihospital health systems. Approximately 29 percent reported that their hospital had joined their current health system within the last 10 years. For those who joined the system within the last decade, the average length of time since the hospital had become part of the health system was 5.2 years.

2. What is the role of the system hospital board?

CEOs who responded to our survey were asked to indicate whether fiduciary responsibility for their hospital was held by their hospital's board, the system board or both. The most common response (41 percent) was that fiduciary responsibility for the hospital was held at the system level; with the hospital board being primarily advisory. Another 32 percent indicated their hospital board shared fiduciary responsibility with the system, and 23 percent of respondents indicated their hospital board had full fiduciary responsibility for the hospital.

3. How was the CEO recruited to the position?

CEOs who responded to this survey had a tenure in their current CEO positions ranging from two months to 37 years, with an average of 6.4 years. CEOs indicated that the most common path to their hiring was being recruited from outside of the organization (42 percent). This was followed by being promoted to the position from another position within the health system (32 percent) and being promoted to the position from another role within the hospital (26 percent).

4. To whom does the CEO report?

The majority of CEOs responding to the survey indicated that they report to a system-level executive (53 percent), followed by both a system-level executive and a hospital-level board (28 percent). Seven percent of respondents indicated they report to just a hospital-level board, and 4 percent indicated they report to a system-level board.

5. How much autonomy does the hospital CEO have in structuring the hospital SLT?

Respondents were asked to describe how decisions about the structure and composition of their hospital senior leadership teams were made within their organizations. In most cases, decision-making authority was shared by the hospital CEO and executives at the system level to some degree. Of the 394 CEOs who responded to this question, the greatest number (42 percent) indicated that decisions about the composition of the SLT were made by "mostly local authority"—i.e., the respondent was responsible for structuring decisions, and system-level involvement was limited to approval only. Twenty-six percent of respondents indicated that decision making was a shared responsibility, with the hospital CEO and system executives both having input into decisions about the structure and composition of the hospital SLT. About 7 percent indicated decisions were primarily made at the system level with the CEO providing advisory input. By contrast, almost a quarter (24 percent) of CEOs indicated these decisions were made entirely by them at the local level. The least frequent response,

reported by only 1 percent of respondents, was that structural and compositional decisions were made completely at the system level.

6. What roles are included on the SLT?

CEOs 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, averaged 6.1 executives, in a range from 2 to 22.

Table 1 lists the functions or roles most often represented on system hospital senior leadership teams, in addition to the CEO. Almost all, 90 percent or more, of respondents reported that the top nursing and finance executives were part of the SLT. More than half also reported that the top operations, human resources and medical executives were included in the senior team. More than one-fifth, but less than one-half, of hospital CEOs reported that senior executives overseeing quality, physician groups, support services and patient experience were included in their senior leadership teams.

The composition of system hospital SLTs varied somewhat depending on the hospital governance structure. In general, hospitals with fiduciary responsibility shared by both the hospital board and system had more roles represented more often on their SLTs than those with full fiduciary responsibility held by one board or the other. This effect was most pronounced with the top medical executive role, which was present on 68 percent of the SLTs with fiduciary responsibility shared between the hospital board and system, but only 47 percent and 44 percent of SLTs where either the system or hospital board held full fiduciary responsibility, respectively.

Respondents were asked to indicate which members of their senior leadership teams worked primarily for the hospital, and which worked primarily for the system. Most system hospital SLT members worked directly for the hospital. Although the numbers of occurrences of the following types of top executives on system hospital SLTs were small, these positions were about as or more likely to be filled by system-level executives as hospital executives: legal counsel (this role appeared on 37 SLTs in the study, and 65 percent of the time this position was filled by a system-level executive), information technology (with 60 percent of the 76 SLTs containing a top IT executive having that role filled by a system executive) and strategy (with 47 percent of the 64 SLTs containing a top strategy executive having that role filled by a system executive).

7. Frequency and length of SLT meetings.

The majority of CEOs responding to the survey (75 percent) indicated that their senior leadership teams meet weekly, 14 percent reported that the SLT meets every other week and about 5 percent reported that the team meets daily. The most frequently reported typical meeting length was two hours (reported by 36 percent of respondents). Approximately 39 percent of respondents reported different meeting lengths shorter than two hours, and 23 percent indicated they were longer. Four respondents indicated their SLTs met briefly on a daily basis, as well as for a longer period of time weekly or every other week.

Table 1. Top Executive Roles on System Hospital Senior Leadership Teams

Top Executive Roles	Percent of SLTs containing this role overall (N=375)	Percent of SLTs containing this role when fiduciary responsibility for the hospital is: Held at the system level (N=150)	Shared between the hospital board and system (N=122)	Held by the hospital board (N=85)
Nursing	93%	96%	93%	86%
Financial	90%	89%	89%	94%
Operations	61%	59%	66%	55%
Human Resources	60%	50%	66%	64%
Medical	53%	47%	68%	44%
Quality	41%	39%	41%	42%
Other	33%	31%	36%	32%
Physician Group	29%	26%	33%	32%
Support Services	22%	16%	25%	24%
Patient Experience	21%	20%	26%	18%
Public Relations/Communications	20%	21%	16%	26%
Information Systems	20%	8%	25%	33%
Compliance	20%	17%	17%	28%
Philanthropy	19%	13%	25%	20%
Community Relations	18%	15%	19%	24%
Business Development	17%	17%	17%	15%
Service Line	17%	12%	18%	21%
Strategy	17%	11%	23%	18%
Marketing	14%	14%	13%	19%
Clinical Integration	11%	9%	13%	13%
Organizational Performance	10%	8%	13%	11%
Legal	10%	4%	13%	16%
Learning	5%	4%	7%	4%
Innovation	3%	3%	4%	1%

8. Who else reports to the CEO?

A majority of CEO respondents (87 percent) said that additional staff outside of the SLT also reported to them. Of those who indicated they had direct reports not on the senior leadership team, the average number of reports was 4.8, in a range from 1 to 150.

9. Demographic information about SLT members.

CEOs

The majority, 89 percent, of CEOs surveyed held a master's in health administration or other administrative degree. This was followed by 14 percent of respondents holding a nursing degree (RN, MS, DNP and/or PhD), 3 percent indicating they were physicians (MD or DO) and 9 percent holding degrees in other clinical fields.

Other members of the SLT

Respondents were asked to describe the educational backgrounds of members of their SLTs, along with the gender and racial/ethnic diversity of their teams. The following descriptions refer to SLTs ***not*** including the CEOs. As reported above, the most common role represented on senior leadership teams was the top nursing executive. Almost all, 95 percent of the 391 respondents who answered the question, mentioned having at least one SLT member with a nursing background, and 39 percent mentioned that two or more executives with education in nursing served on the senior team. Sixty-two percent of respondents mentioned having at least one executive holding an MD or DO degree on their SLT, and 12 percent mentioned that their SLT included two or more physicians. About 12 percent of respondents mentioned their SLT included at least one executive with a clinical background ***other than*** those holding nursing, MD or DO degrees.

Not surprisingly, administrative degrees were the most commonly reported degrees held by members of system hospital SLTs. The majority, 86 percent, of respondents mentioned that one or more of their SLT members held master's degrees in health administration or other administrative master's degrees, and 64 percent had two or more executives with this educational background. Seven percent of respondents mentioned there was at least one member of their SLT with a doctorate in health administration or other administrative doctoral degree.

Almost all, 97 percent, of the 396 respondents reporting the gender diversity of their SLT mentioned that at least one woman was included on the team. On average, SLTs were composed of 54 percent women; with about one quarter of SLTs having 40 percent or fewer women members and a quarter being comprised of 67 percent or more women. Most, 392, of the survey respondents reported about the racial/ethnic diversity of their SLT. According to these reports, on average, 88 percent of members of these SLTs were white (non-Latino). In addition, 17 percent of respondents mentioned having at least one African American executive on the team, 15 percent reported at least one team member whose race/ethnicity was Asian or Pacific Islander, 11 percent reported having at least one SLT member who was Hispanic/Latino, and 3 percent mentioned their SLT had at least one member whose race/ethnicity was American Indian, Eskimo or Aleut.

10. SLT effectiveness.

CEOs responding to the survey were asked to rate the effectiveness of their senior leadership teams in 10 different performance

dimensions using a 1 to 5 scale (where "1" is "not at all effective" and "5" is "extremely effective"). As shown in Figure 1, on average respondents rated the effectiveness of their SLT structure as 4.0 or higher in six of the 12 dimensions. Respondents felt particularly favorably about their senior leadership teams' effectiveness in maintaining the confidence and trust of their board (average rating of 4.4). This was followed by reaching consensus about important decisions (4.2), maintaining the confidence and trust of the medical staff (4.0), prioritizing short- and long-term capital needs and representing those needs to system leadership (4.0), representing the community's needs to system leadership (4.0) and maintaining the confidence and trust of other employees (4.0). Respondents on average also gave their SLTs good scores for effectiveness in the following dimensions: aligning local operations with system-level operations (3.8), engaging in productive disagreements (3.8) and communicating clearly and consistently with the community (3.8).

CEOs viewed SLTs as less effective on average in ensuring their skill sets are kept current related to healthcare reform (average rating of 3.4), developing leaders within the organization (3.4) and, in particular, maintaining succession plans for senior leaders (3.0). Most effectiveness ratings did not vary by system size. However, CEOs from smaller health systems tended to view their SLTs as somewhat more effective in the dimension: "communicating clearly and consistently with the community."

Figure 1: Perceived effectiveness of the current SLT*

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

What CEOs Should Consider to Increase SLT Effectiveness

1. Maintaining succession plans.

The greatest opportunity for improvement in perceived effectiveness was associated with **maintaining succession plans for senior leaders in your hospital.** Much has been written about the importance of succession planning (e.g., ACHE 2011). ACHE reported that hospital CEO turnover in 2014 was 18 percent, which was down from the historical high of 20 percent in 2013 but still one of the highest rates since ACHE began computing those statistics in 1981. Higher turnover may become a feature of healthcare organizations as baby boomers are reaching retirement age. Gaps in hospital leadership following the departure of the CEO are often highly disruptive to organizations, and can lead to suspension of strategic initiatives as well as departure of other key staff. To avoid these problems whenever possible, hospitals should maintain robust succession plans for both planned and unexpected changes in leadership. A recent survey of community hospital CEOs conducted by ACHE found that about 52 percent of CEOs leading system hospitals had no successors identified for their position (ACHE 2014). The study revealed that the most commonly cited reason for having no successors identified for the top leadership position in system hospitals was that the CEO was too new to their position (cited by 31 percent of respondents), followed by "it is not a high priority for the board right now" (26 percent). Further, only 54 percent of system hospitals had a formal succession planning process for the CEO position, 58 percent formally planned for turnover in other C-suite positions, and roughly one-third or less had formal plans to replace executives below that level.

Given the considerable time and learning required to become effective in top leadership roles, hospitals are often best served if they can recruit and prepare future senior leaders from within. Prior research suggests it typically takes several years to adequately prepare a permanent CEO successor, and one year of on-boarding in the new position is recommended. Research also suggests 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). System hospitals may be at an advantage over freestanding organizations in that there may be a broader pool of potential candidates to draw on from other organizations in the system. While recruiting successors from within the system does not eliminate the need for an effective hospital CEO on-boarding program, successors from inside the system will begin with an understanding of the system structure and how it functions.

2. Developing leaders and keeping them current.

The next two largest opportunities for improvement in perceived effectiveness were both related to staff development and organizational learning: **developing leaders within your organization,** and **ensuring your senior leadership team keeps their skill sets current related to healthcare reform.**

The accelerated pace of change healthcare is experiencing may be one of the most important drivers of this perceived need for enhanced learning. Numerous respondents cited acute levels of both environmental and structural change as barriers to a longer-term focus on developing their leaders. While this is likely to be the current experience of many senior leaders, it is equally likely that this pace of change is going to continue into the

foreseeable future, and may continue to accelerate.

This underlines the need for continual professional development for senior staff. To succeed in an evolving environment, there needs to be on-going assessment of leader competencies, skills and knowledge against the needs of the organization, and educational programs need to be sought out to keep senior leaders current and forward-looking in healthcare. Good leaders are hard to find, and continuing education of proven executives can be a good investment for organizations. Keeping skills and knowledge current is also of value to those looking to develop their careers. Learning programs that effectively deliver relevant content, as well as allow interaction with peers facing the same challenges, should be strongly considered.

This level of change occurring in healthcare is not specific to the field, and has been the focus of considerable attention in the business literature in recent years. Promising approaches to managing continual change have begun to emerge. After researching organizations that had been particularly successful in navigating change, noted scholar John Kotter articulated a "dual operating system" model (Kotter, 2012, 2014). The model recognizes the importance of a robust hierarchical structure to maintain efficient operation of the organization. To address emerging issues, the model suggests strategies for supporting its evolution by creating "strategy networks"—temporary, nonhierarchical systems created by volunteers from the organization—around topics about which the organization needs to learn more. These strategy networks may seek out information, including drawing on the expertise of knowledgeable professionals outside of the hospital; run experiments; and eventually develop recommendations to the hospital senior leadership. The strategy network may recommend changes to operations and strategy, or identify needs for staff professional development on identified topics.

In addition to systems approaches to facilitating rapid learning and change, a number of promising new approaches to individual and team learning are starting to emerge. For senior leaders, there has been expanding use of "reverse mentoring," in which an early careerist is paired with a more senior leader to help get them up to speed on critical emerging topics. While the practice is currently more prevalent outside of healthcare, the approach may hold promise for addressing some of the learning needs of senior leaders, and can provide skill development and professional network benefits to the early-careerist mentors. (For a good description of how the approach has been used in the technology firm Cisco, see Earle, 2012.)

Another trend is greater use of "microlearning," involving the development of very brief (5 minutes or less) learning modules that employees can access when they have availability or emergent needs. In addition to the speed and flexibility benefits for employees, the modules themselves may be more readily updated as circumstances change. (A good primer on microlearning design can be found in Paul, 2016.)

What CEOs Should Know About Being Effective in Their Roles

CEOs in the survey were asked what advice they would give to a colleague about how to be effective as the leader of a hospital within a health system. Respondents were both thoughtful and generous in their responses. Table 2 contains the most frequently offered counsel. Advice offered by 30 or more respondents is indicated in bold-faced type, in approximate order of frequency.

Table 2. Advice on being an effective hospital CEO

LEADERSHIP
Exhibit the personal traits of a good leader. **A good leader is committed, caring, humble, fair, treats others as s/he would like to be treated, works collaboratively, is a true servant leader who leads by example, is committed to continual learning and open to new ideas, is flexible, and has a high tolerance for ambiguity and a good sense of humor.**
Communicate, communicate, communicate. **Frequent and effective communication with all parties, including your boss and other executives in the system, the board, physicians, your staff, the community and other stakeholders is vital. Never underestimate the number of stakeholders you need to keep in the loop. Be sure to communicate both the good and the bad.**
Have good leadership skills. **Keep a strategic focus and be able to think critically and strategically. Have a thorough understanding of finances. Be able to make decisions, communicate expectations clearly, be consistent and be available. Be purposeful in the culture you create. Be accountable, set specific goals and deliver results. Require excellence.**
Be able to communicate your vision and inspire others to follow it. **You need to be able to clearly communicate your vision, mission, direction and expectations. You need to inspire others to help realize that vision.**
Listen. **Listen more than you talk. Ask questions and be open to new ideas.**
Be knowledgeable. Educate yourself about what is important to your institution. Understand the clinical side. Know the current state of healthcare (e.g., the Affordable Care Act, reimbursement, electronic medical records, regulations).
Work well in the matrix. You need to be able to work well in a matrix environment.
Exemplify the mission of your organization.
Take care of yourself. Learn how to allocate and manage your time. Make sure to maintain a healthy work/life balance.
Respond promptly. Respond promptly to communications and requests from those above you in the system, employees, physicians, patients, etc.
Know yourself. You need to be self-aware and maintain a high level of emotional intelligence.
RELATIONSHIPS
Create and maintain good relations with the medical staff. **A strong, trusting relationship with the medical staff and medical staff leaders, physicians in particular, is essential to your hospital's success.**
It's all about relationships. **Build relationships with those above you in the system, board members, physicians, your staff, your system peers, those in the community and any other stakeholders or colleagues.**
Work with the community. **You need to have high visibility and participation in the community. Make connections in the community and be involved in local organizations.**
Maintain good relationships with your board(s). **Establish good relationships with board members and communicate with them frequently.**
Ask. Seek mentors within the system. Ask other CEOs in the system for help and advice. Ask CEOs in other systems what they are doing. "You do not have to reinvent the wheel."

Table 2. Continued: Advice on being an effective hospital CEO

BEING EFFECTIVE IN THE ORGANIZATION
Understand the system and your role in it. **Take some time to clearly understand your system and how it functions, and what your place is in it. Know who the formal and informal leaders are. Understand roles and responsibilities and how decisions are made. Understand the different agendas of other leaders in the organization and the organizational politics. Make sure you keep a good relationship with your boss and maintain a clear understanding of what is expected of you.**
Be the champion of your hospital. **You need to keep an eye out for the interests of your hospital and community and advocate for those needs to the system. Find the balance between what is good for your hospital and system priorities.**
Recognize you are part of a larger organization. **You need to work closely with your system and surrender some control. You need to align with system goals and support the system. Take advantage of the system resources and embrace shared governance. Know when to compromise to strike a balance between hospital and system goals. ("Don't die on every hill.") Build good relationships with your peers across the system. Role model objectivity and cooperation. Understand that decisions may be slower and require more stakeholder input.**
Maintain your focus on the patient. **Be sure to focus on the patient, on improvement in the quality of patient care, and patient satisfaction.**
Be visible. **Be visible in your hospital, in your community and in medical staff activities. Round with physicians and other staff. Manage by walking around. Be visible in your system and volunteer for system initiatives.**
Be a team builder. Develop consensus.
Balance time between the system and hospital. Find the right allocation of time between system and hospital activities, both for you and your vice presidents.
WORKING EFFECTIVELY WITH STAFF
Engage and develop your staff. **Focus on employee engagement. Coach and develop your staff, and hold them accountable. Celebrate successes. Compliment and recognize team members.**
Assemble a good team and let them help you. **Put together a strong senior team, trust them, delegate to them and get their help. Hold them accountable. Assemble a diverse team and look for people who are smarter than you. Make sure senior team members are a good cultural fit for the organization.**
BUILDING A CULTURE OF TRUST
Create trust. **Be honest, transparent, true to what you say and operate with integrity at all times. Create a culture of trust. Admit when you are wrong or when you don't know.**
Do the right thing. Always do the right thing and the rest will follow.

ACHE wishes to thank the hospital CEOs who responded to this survey for their time, consideration and service to their profession and to healthcare management research.

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