Presidents, CEOs, and the New Leadership Model

*Philip Betbeze, for HealthLeaders Media*, May 13, 2014

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It may not be obvious to the casual observer, but the responsibilities and roles of many local hospital leaders are changing drastically. That's at least partly because many hospital systems are acquiring formerly independent hospitals and, rather than allowing them to operate largely independently in a holding company model, the controlling systems are moving toward an operating company model. And this goes even for leaders of organizations that have been part of the holding company for years. That means some roles, such as marketing or revenue cycle management, are now being done at the corporate level, away from the local leader's exclusive authority.

That trend can be viewed positively or negatively, but local leaders have to make a choice: Retire, move to another organization, or accept new, and possibly diminished, roles within the operating company. As a result, the local leader's role is transitioning—even bifurcating. In some cases the CEO title may be retained locally for the acquired entity, but increasingly such individuals are being transitioned to president titles. Some look at this transition as an opportunity to lead differently, while others see it as a loss of stature and power.

At a macro level, many say the trend is past due and is a logical transition to a team-based approach to healthcare that is already well underway clinically at organizations that seek to thrive in a future where success will be determined by the level of value a healthcare organization can bring across populations.

**Silo vs. system**

The hospital, for a variety of reasons, is increasingly viewed as a cost center by many healthcare organizations. That is, in managing the health of populations, the object is to keep patients out of that most expensive site of care, if possible. Certainly achieving that goal is marked with fits and starts, and health systems can't do it without support from reimbursement mechanisms that have to change.

One outgrowth of a requirement to manage the health of populations is the importance of scale, which has brought rapid consolidation. And consolidation these days means not only shared governance at the corporate level, but also a reshuffling of management talent and responsibilities that accompany a transition from a holding company to an operating company organizational model.

The result: Individual hospital CEOs have to make the transition from having ultimate authority to being part of a team. Not only is this transition reducing the number of chiefs, but it also reflects what's going on clinically as these organizations try to better coordinate care across a multitude of sites.

David Brooks was once a hospital CEO with Providence Regional Medical Center, which was part of Providence Health & Services. Now, 18 months after moving voluntarily from the Seattle area to his hometown of Detroit, he leads a larger organization as president, not CEO. Brooks leads St. John Hospital & Medical Center, which is part of Warren, Mich.–based St. John Providence Health System, a six-hospital system owned by St. Louis–based nonprofit giant Ascension Health. It's a transition that doesn't mean much to him from an ego standpoint, but it's easy to see how it could for others.

"When you take that broader perspective, you think less as a silo and more as a system," he says.

But Brooks insists that now he's doing the work that he feels is most suited to building a better system of coordinating, organizing, and providing quality care—not just running a financially successful hospital.

"In moving toward a more population health–driven focus, the pressure comes from our systems and cultures not being set up for that," he says. "Good leaders know we need to think as broadly as we can. If we're going to be accountable for a population's care and their costs, we have to think of things as a system."

Like many other systems that are national or regional in scope, Ascension has been working on moving away from a holding company structure. Given the growing importance of being competent in maintaining and improving the health of populations, the operating company model holds a lot of appeal, Brooks says.

"The holding company model hasn't worked because it's clear that the performance hasn't been where we need it to be," he says.

While the holding company model may have improved standardization between hospital units, it didn't eliminate a lot of cost redundancies, it didn't create regional alignment, and it didn't create systemwide care protocols.

"It's tough emotionally moving through to an operating company model, but done well, that total system of care should be leaner and more consistent, and drive the triple aim much more effectively with better alignment on strategic goals," says Brooks. "You can't do that in a holding company model, because everyone has their own fiefdom and that doesn't accelerate performance."

**Changing roles**
Englewood, Colo.–based Catholic Health Initiatives, which owns or operates 87 hospitals in 18 states, has been transforming from a holding company to an operating company model for more than nine years; it's a long process and part of it means that local and regional leaders' roles have changed, says Michael T. Rowan, whose title, until recently, was executive vice president and chief operating officer of the system. He retains the COO title, but he's also now president of health system delivery.

"It used to be that the most applicable skill set was whether they had run a hospital before and how well they did that," he says. "That was the primary driver of the health system. Now, we're not hospital-centric."

Recognizing that new systems of care require new roles for leaders, the system has separated the local or regional CEO responsibilities from the job of the hospital president.

"We're now seeking a broader perspective on health from the CEO, so we're looking for a different kind of person," Rowan says. "For that role, we need someone who can create an entire continuum of care that works in a coordinated fashion."

Conversely, the hospital president's focus is expected to be more operational within the hospital. While CEOs at CHI must be leaders of the market working across the entire continuum of care, the president's primary responsibility is cost-effective care moving through the hospital. Therefore, the roles have widely different success metrics and expectations, he says.

"If you're the president, your goal is to move people through effectively, to lower length-of-stay, and to lower cost per case-mix-adjusted admission while at the same time improving clinical outcomes. That's a very different job than the CEO who is the market leader and who must improve what percentage of second-graders have had their full course of immunizations or the percentage of seniors who have had their flu vaccine," says Rowan, offering an example of the distinctions.

More focused

Rowan's own role has changed as well, most recently in February, as the organization shifted two of its top leaders into more precisely defined roles. Rowan's oversight now includes the organization's core business line—87 hospitals and hundreds of other healthcare facilities in 18 states.

Given CHI's expanding offerings, which include massive investments in the risk side of the business, Dean Swindle, who is the system's chief financial officer, will retain that title but is also president of enterprise business lines. He will oversee finance and accounting, payer strategies, revenue cycle management, supply chain, and clinical engineering, among other areas.

Swindle also will highlight and identify new business ventures, ensuring that they are fully developed and that they have the resources necessary to achieve both growth and operational objectives.

Meanwhile, the system's CEO, Kevin Lofton, drops the president title and will focus on CHI's strategic direction and growth initiatives, including potential partnerships and consolidations with hospitals and health systems and other health-related organizations.

Behind the executive title changes is a conviction that CHI needs to become an integrated system nationally rather than a federation of affiliated organizations, and the reorganization at the top clarifies reporting structures and ensures the system operates as a comprehensive, integrated healthcare system, not a collection of hospitals. Rowan says a renewed push to quickly define the transformation came from the speed at which health reform is progressing from both the government and the commercial side. One reason the operating company model holds appeal is because of reduced variation, but also because the skills it is developing and acquiring through strategic corporate hires will pay off only with systemwide adoption.

"We have to bring in new people, for instance, with a plan development and insurance background," Rowan says. "For the most part, our individual hospitals cannot afford that talent by themselves. So that becomes a shared resource and you see integration there."

To take financial risk, he adds, health systems have to be able to collect rate data on populations as well as individual patients. But collection is only half the battle. Health systems have to analyze and manipulate that data and use it to make decisions. A data repository is expensive and, again, most facilities and even regional markets can't develop them on their own.

"Across the system, you have to learn to share resources, and the key to that is you have to have more and clearer standards—in other words, a CHI way of doing things," Rowan says.

For example, he notes that the organization once had 18 different definitions of an admission. Exercises as simple as determining a systemwide definition of an admission force a different kind of integration and cooperation around a set of standards. And standardization doesn't just affect the business and administrative side—systems also have to hold clinical providers to certain standards. Rowan says this is because, as you take risk with populations, you have to deliver care at a high level within a fairly narrow range of outcomes and costs.

"You can't afford a heart surgeon, for example, who does a bypass that costs $35,000 when you can go next door and a different surgeon is doing the same procedure for $18,000," he says. "You can't have that variability."

Leadership roles are no different, as far as variability is concerned. Such leaders, at least at CHI, must operate administratively within a narrow range of variation. The key challenge, Rowan believes, is that CHI and the healthcare industry have to come to grips with the fact that healthcare is moving from being a cottage industry with local standards to a big business with, in CHI's case, an altruistic mission, which means dealing with complexity in a much more sophisticated manner.

"In the past, if you were the CEO, you had a lot of room and authority and autonomy. That's being significantly narrowed. When I got here in the '80s, if you were the local hospital CEO you were probably king of your community. You contracted locally. There was a lot of influence because you could throw around service contracts and things like that, and you were a very significant business leader in the community. As we've evolved,
as a local CEO, you might have moved from being president of your autonomous local hospital system to, now, one of 45. So you don't have that flexibility."

Rowan admits that CHI has lost a certain element of executives who have said this new type of work isn't what they signed up for.

"Execs react to this very similarly to physicians," he says. "The world has changed substantially, and some have taken well to it and some have not."

While the loss of experienced leaders who dislike the new role may have a downside, that natural selection has allowed CHI to recruit, by and large, leaders outside traditional areas, younger people who come in with a different set of expectations and skills. There is a certain drawback to the transition, however. Some elements of local character may be lost.

"Some say all healthcare is local, and historically that's been true; but it's been a mixed blessing because there shouldn't be different standards of care depending on where you are and what hospital you go to," Rowan says. "The other challenge is that the U.S. is made of many regions that are very different. So it's different when you put someone from the Northwest into the Deep South. Culturally those places function differently. We do begin to lose some of that local character, and there's probably some disadvantage in that."

Centralizing support functions

St. Louis–based SSM Health Care also is undergoing a rapid evolution of leadership roles. President and CEO William P. Thompson rolled out a reorganization plan last October that not only changes roles of many top leaders, but also, he believes, better integrates SSM's recent acquisition of Dean Health System. Among Dean's assets is a Wisconsin-based health plan that provides SSM the foundation platform for its efforts to manage the health of populations in the four states and 18 hospitals in which it does business.

The reorganization also removed some of the local support CEOs have had in the past in favor of corporate consolidation of those roles. A year ago, Thompson and the board decided to consolidate all major functional support areas.

Now, a central department of planning, finance, human resources, and communications for the entire system takes over for what were functions, and jobs, traditionally handled by local leadership. Some local control still exists, with local executives reporting to senior vice presidents at SSM. The goals are to ensure SSM has a consistent level of service in those areas in each of its markets. Second, it provides a means to transfer discovery of best practices across the system as quickly as possible.

"That was not easy to do when functions were siloed and separated," Thompson says.

Moreover, that reorganization of roles is the start of moving from what Thompson calls a "loose confederacy to a single operating company." The other major change in management philosophy is that SSM plans to operate in three distinct business units to help ensure cohesiveness: a hospital unit, a physician group unit, and a health plan unit. Restructuring the leadership at the corporate level also allowed SSM to bring aboard more physicians leadership roles.

"In particular, physicians are underrepresented in leadership," Thompson says. "When they were subordinate to hospital operations, their goal was to keep the hospital filled."

Two of SSM's unit leaders are physicians, and Thompson says they will work together because at the system and regional levels, they all have exactly the same goals and objectives as part of their performance evaluation.

"For instance, we expect to see 5% growth in patient service revenue, and certain levels of performance in quality, safety, and satisfaction, across the continuum," Thompson says. "Our expectation is that those business unit leaders will sit at the table and together determine the best opportunity for growth as a system. Working together, how can we lower the cost?"

Balance and pace of change is critical. Some 80% of SSM's systemwide revenue is still fee-for-service.

"We are still rewarded financially by having more admissions or providing more MRIs," Thompson says. "This type of strategic planning, and the reason to implement it now, is for when we reach a tipping point where we move from hospitals being the primary drivers of revenue into a capitated methodology where we assume not only performance but financial risk of delivering care to populations."

The success metric

Ultimately, systems like SSM will be evaluated on whether they can attract and retain patients. The "success metric," as Thompson calls it, will be the number of covered lives in the population for whom SSM is responsible.

"Regardless of the financial model, people will still go to providers who make it easy for them to get an appointment, who can reduce wait times, and who can make fewer mistakes and errors," he says. "That's a model we can implement today that will also be successful in the future."

But Thompson concedes it's been a difficult transition with some of the local talent. Selling the message that local leaders weren't being devalued by shrinking their responsibilities, resources, and autonomy is difficult.

"One of the ways we're positioning it is that we're not taking things away from the hospital presidents so much as giving them more time to do the things they do well," he says.

Sometimes, such leaders don't see it that way. The broader issue, and what Thompson is convinced is best for the organization in the long term, is that hospital presidents don't necessarily need to be engaged in the broader strategic plan for a region.

"While it is important for regional hospitals to participate in the strategic conversation, it is more critical that they spend their time implementing and improving strategic performance," he says.
Although the health system has not yet rewritten job descriptions to reflect the new reality locally, Thompson says they're working on it.

"We purposely don't use the term CEO, but we focus on the need to deliver high levels of service within the four walls of the hospital they're responsible for," he says, offering three areas of interest. "They still have to focus on that episode of care within the hospital, and second, he or she has to be fully engaged with physicians and employees because he or she doesn't deliver care at the bedside. Third—and this goes hand in hand with delivering quality and value—they have to be very strong expense managers."

Thompson says that's because the resources SSM—and, indeed, all health systems—will be able to devote to inpatient care will be challenged in the future. How to do it with fewer resources is the question he wants his hospital presidents to try to solve every day.

**Communicating the message**

Thompson and the board at SSM, for example, don't want local presidents to have to worry about things like human resources, a job that can be done more cost-effectively and with better standardization across the system.

"Or if we have an outstanding person in marketing, why not leverage that across the entire system?" he argues.

But he realizes such concepts can ring hollow to a certain cohort of leaders who are used to running their own show.

"Intellectually, they get it until the day arises and there's no longer a VP of planning sitting next door and they can't develop a program locally," Thompson says. "That's where the intellectual and visceral intersect. But each of them plays a critical role in the success of our organization as a whole. Unless they are delivering the best-quality care within their area, the whole organization will be suboptimized."

Thompson admits the transition, which extends well beyond redefining the local top executive's role or duties, is a learning process.

"We have not done it as well as we could, but we're moving so fast as an organization that more than once in a while, we are not doing a good job communicating the whys and wherefores."

He cites the example of his recent letter to the entire group of local presidents concerning benefit changes about which he received some vocal pushback. On reflection, he realized the letter did nothing to explain why the change was being made.

"We did it because we wanted to reduce variation and try to become more equitable and eliminate the special deals in return for values of fairness and respect," he says.

Such rapid change in roles means SSM runs the risk of losing talented people it wants to retain, says Thompson. Part of the effort to prevent those losses in talent runs directly to his office and is a matter of good talent management.

"One of the things we're learning is we have to do a better job of identifying our top performers and telling them that often, no matter where they are: 'Your job may be changing, but you are a vital contributor to our success, so we want to know where you want to go in the organization. Just because you're doing this job now doesn't mean there won't be future opportunities.' "

Besides, he says, even if the role of hospital president is more limited than in the past, there are systemwide opportunities to chair task forces that give presidents an opportunity to display their capabilities to a larger audience. Slimming down responsibilities in the name of better focus applies to him as well.

"Literally every day, I ask myself what I need to be involved in and what I can pass off to someone else," he says. "More and more, my responsibilities are to the system as a whole."

And responsibilities, while lessened in some areas, are broader in others.

"We're still calibrating this," he says. "But ultimately, because of our triad structure, it's more important to the business unit leader to get the support of other members of the triad than it is to get my approval."

**Making the change**

The transitions in responsibilities that Ascension, CHI, and SSM are trying to implement at the local leadership level have been less jarring for St. John's Brooks than he anticipated. He realizes that even as a president and CEO, he was never in total control and those who think they are, even at the very top of the organizational chart, are deluding themselves.

"I've never thought of it that way. The stakeholders we have, the constituencies, the complexity, has always led to leadership being a team sport," he says. "The CEO is captain, but should be very team oriented. Frankly, if total control is what you need, these aren't going to be the right roles for you."

On the other hand, if you like to be a leader in a team construct and can work well in a "matrixed" management environment, "you'll find great support in real tough situations," Brooks says.

"There's a tradeoff, absolutely. If you need minimal ambiguity, this won't work, but think of the other side of the coin," he says. "When you're in total control, it's lonely because it always falls to you. But if you want to flourish in an environment that can adapt and move quickly, this transition can be complicated but wonderful."

Today's local leaders have to want to be collaborative.
"Leadership's job is to make improvement. That's the only reason we exist," Brooks says. "If it's about turf, that will all feel very antagonistic. Our role is to create great systems of care. Not great hospitals or great doctor's offices or great home care. It all has to fit together. The joy is you're not just limited to the walls of the acute care model."

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