A Methodical Approach to Deepening Your Leadership Team’s Bench Strength

Most hospitals and health systems think they have figured out succession planning. They might have an executive who’s planning on retiring in a couple of years, and they’ve groomed someone internally to take over. But planning for what you know will happen overlooks the most probable threat to the continuity of a leadership team—the unplanned departures. HealthLeaders Media recently convened a panel of experts to discuss this important issue. Following are highlights.

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Roundtable Highlights

HEALTHLEADERS: How important is developing senior leadership continuity, and how do you do that in the face of unplanned departures?

VERONICA ZAMAN: Succession planning has probably never been more important than it is now with the ambiguity surrounding healthcare reform. We’ve undergone almost a 10-year process of identifying our interim talent because it’s expensive to replace good talent with the volatility in the market today. We have found that the discussion and the transparency around what we’re doing related to succession planning has just been a jump start. A lot of our talented frontline managers, directors, and those young VPs that are just starting off really seem energized by the fact that they could come to a place like Scripps Health and have a full career there. In fact, a lot of our literature talks about career destination. We really do take that seriously. We want you to join us and build your career at Scripps. And we go internally first when we look at replacing anyone, especially in our more senior levels.

THOMAS DEBORD: All of us have worked really hard to build confidence in our brand within our communities, and having folks in place who can step in is essential to maintaining the trust that the community has in that brand. We have a lot of folks who want to have that sense of belonging in an organization. I started at Barberton almost 23 years ago as the director of accounting and here I am as the president now. It was because I was given opportunities. I worked hard and I felt like I deserved to get the opportunities, but I had somebody helping me along the way.

DOUG SMITH: With healthcare reform, succession planning is low-hanging fruit. If you’re not going to get good at succession planning, you’re going to have trouble competing. Succession planning does instill a brand in people. Also, it instills a certain amount of pride and it establishes a strong culture, which bleeds into strong satisfaction from patients, improved metrics for quality of care, job satisfaction, and engagement.

ZAMAN: About a year ago, Chris Van Gorder, our CEO, turned our organization on its side organizationally. We’re five hospitals and had operated as very independent hospitals. Even though we were a system, we didn’t have a lot of standardization and our folks couldn’t move around. We have what we call a horizontal operations team now. I’m one of those horizontal folks, but the focus was really on the hospital operations. We pulled our VP of operations from the sites, leaving our chief executives at the site along with the chief nursing executives. We pulled out the VPs and made them horizontal corporate VPs and stepped them into a service-line concept. What we’re seeing with our horizontal alignment now is that the system is pulling together and we are achieving standardization. We did it to start to incentivize and to build that next level of executives and to start to groom, mentor, and coach that talent.

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SMITH: When we look at the demographics now of folks who are in their first five to eight years, it’s a reality that they’ll have seven jobs in their career with seven different organizations. So how do we battle that trend of lack of continuity in the context of succession planning? We’ve focused on that top third of performers within our group, and that’s where we are investing our resources. We’ve had to put a significant amount of discipline around doing it continuously and we have found that our retention among that top third has started to far exceed the rest of our peers.

ALAN BRADFORD: We have a pretty rigorous process for identifying talent. The performance appraisal is the start. But we have a calibration process in which the senior leaders participate, and within that calibration process, we look at competencies and at performance and results. We look at how they have followed through on their talent management plan, how they invested in themselves in addition to what we are willing to invest in them.

HEALTHLEADERS: Isn’t it easier to pick up the phone and call a search firm?

ZAMAN: Yes, but then you can’t promote from within, and that’s important to us. We started to look much more in detail at how we actively looked at promoting from within. We had been much like the traditional organization: Pick up the phone and call the search firm, especially for some of the more hard-to-fill positions. In the last five years we’ve targeted internal hiring. Our talent line assessment tool, which years ago we only used on senior people, we use on everyone to start to tap into that unknown potential talent.
SMITH: When I first came into the industry I recall the number being 60/40—you recruit 60% of your employees from the outside and 40% from the inside. I’m predicting it’s going to look more like 25/75—75% from the inside. I’m predicting it’s going to look more like 25/75—75% from the inside.

ZAMAN: I’m not an HR person, but what we brought into HR was someone who had the strategic operations and the clinical knowledge base. When the economy took its dive and everyone was looking at saving money, Chris came forward with two mandates. One was that we would not have layoffs. The second piece was that we would continue to support learning and development because without that deep dive into learning and ensuring that we were continuously developing our teams, we would not be successfully positioned in the future. That has allowed us create a continuous learning environment. It’s not just about classroom teaching; it is about how you take the knowledge and the development and the learning that we’re providing to the bedside.

SMITH: I’ve been part of cutting training dollars and I’ve seen my clients cut training dollars. Traditionally, training has been very expensive and we needed to find a way to lower costs but still have the same outcomes. Essentially we’ve mobilized internally to do development, so the cost has come down, but the return in value has probably increased. The rule of thumb has been that for each dollar invested in development, you get nine dollars back. Today, the input cost is less expensive and the output may have doubled.

BRADFORD: Senior leadership, starting at the board, has to support it and be the advocate for it. Many organizations, if you talk to some of our peers, in 2008 they cut every training and development dollar they could find. That’s a huge risk. Without that advocacy, you’re not going to have the funding to do it or the interest. Fortunately we have a board and a CEO who listens and understands that the cost of not doing it far outweighs the cost of doing it.

DEBORD: It’s collaboration between HR and senior leadership. HR certainly has an infrastructure to help make sure that it happens, but it takes the senior leadership and the board to have that vision to make sure that we’re driving it through the organization. At Summa, Tom Strauss, our CEO, actually teaches a four-hour class called Servant Leadership. Most of our education is internal. You need senior leaders teaching the classes.

HEALTHLEADERS: What’s the balance between HR’s role in developing educational opportunities versus senior leadership’s role?

BRADFORD: Our senior leadership team now clamors to get their ideas and projects put before these learning groups because they’ve seen the results that have been yielded through their work. They spend six to nine months on this. They do large presentations back to the senior group and to each other. We had one working on medication safety, for example. We all know what a big issue that is in our industry. Not only was there a huge ROI, but we think we saved lives. We’ve been doing this for almost four years and we’ve only lost one person out of about 120 people that have participated in the program.

SMITH: We believe experiential learning is important and a worthy investment. Another key to retention and engagement is knowing that leadership cares about me as an individual and wants to develop me. That can have immediate and long-term benefits. So a change in policy to focus more on succession planning and leadership development within the institution, especially when it’s performed internally, will generate an immediate spike in engagement.

DEBORD: We created probably about 50 performance improvement teams, maybe more, where we took the director of a function, say the lab, to look at lab within our region. What contracts do we have? What processes can we change? We found a lot of success in that. And one of the things we found as we were doing it is that some people needed some more training. Healthcare reform is coming and it’s going to be even more critical for all of us to be as efficient as we can, so we’ll have a lot more of those teams over time.

ZAMAN: We’ve done similar types of things. We call them RPI initiatives where we’ve taken some of our strong
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Progressing collaboratively with the learning organizations in our community. For example, we’ve started to retool some of the basic core competencies at the nursing schools. Practically, that took the form of a partnership in that last year they’re in school. There is a tremendous amount of orientation for people who we’ve already tapped—who we know are coming into our system. What it’s also done is create a yearlong residency program, which we’re now expanding outside of nursing into allied fields, so that short-term immediate need that we had has now turned into a long-term investment and it’s paying us top dollars on the type of talent that we’re getting in. Our turnover rate is less than 8%, which is huge in today’s world. Our vacancy rate is at less than 4% right now. So we’re in a good position to fill hard-to-fill positions that are the most critical to us.

HEALTHLEADERS: Have any of you reached a place where succession planning is part of the performance appraisal?

BRADFORD: We track metrics on performance, but every director in the organization has a goal for that and we have a performance dashboard that has many metrics. So by virtue of that, they have to participate actively in the succession-planning process, and it’s become interesting to watch the commitment and behavior. It’s the old saying: What you measure gets managed.

Planning and leadership development were key components of our last three-year strategic plan whereby each entity had to create an entity-specific business plan to help meet the objectives of the system plan. And a lot of those things from those business plans were then incorporated into the leaders’ evaluation tools as far as action items that they had to be working on to help achieve goals.

HEALTHLEADERS: Many of you have mentioned mentoring. Have you ever had indications from senior leaders that they are insecure about mentoring younger groups for fear of training their replacements?

ZAMAN: People were very suspicious when we moved to everybody having an assessment. At that point we were going through affirmative action initiatives. One of the first jobs I had was to re-create our affirmative action plan. Part of it was how we looked at people who were getting promoted and how we developed them. We still have that age-old problem where a manager has a department with two or three top performers. They don’t want them to go anywhere. They really depend on them to help their department run. We’re getting better about it. The year-long leadership essentials program that everyone has to engage in has been a key culture change for us. Over the next couple of years as we continue to evolve and focus on change, we’ll become very good at it because we are beginning to take a little pride in our internal ability to develop leaders.

HEALTHLEADERS: How do you go about matching people with mentors?

BRADFORD: We have a profile on everyone, and it’s not only that the potential mentor is strong in the areas where we have deficiencies with the potential person to be mentored; it also can be how they translate that into actionable steps in success, whether they’ve been trained, and whether they actually want to mentor.

DEBORD: It’s critical that you have somebody who’s really willing to spend the time because you don’t want them forced into a situation. It’s also critical that you have somebody who’s aligned with the values of the organization and who truly is passionate about that.
the person within the department who really is a mentor and not a direct report.

**SMITH:** It is hard for me to imagine someone not wanting to be a mentor, but some are substantially better at it than others. We do it one-on-one and then we rotate those every eight to 10 months. We require our mentors to meet with their mentees once a month for an hour and a half and we give them guidance as far as what direction to take the conversation.

**ZAMAN:** We put a lot of responsibility on the mentee. We can assign mentors and we can partner you up, but unless both the mentor and the mentee are really committed to this, it doesn’t work. So the responsibility of the mentor is to make sure they make the time and that they hit certain plateaus of what we want to take place in the program. The mentee must take on responsibility for ensuring that they are reaching out to schedule their meetings and they are completing the tasks. We invest a lot in those early days of getting that mentee and mentor both to know the expectations.

**HEALTHLEADERS:** What are mentee expectations about promotion and when that should happen? You have to manage that, right?

**BRADFORD:** You have to be bluntly honest with them: We’re training you and developing you because you’re showing potential, but we don’t have a clear, defined role open for you. But when we do have a position, we’re not going to hire it from the outside if we have a viable candidate inside. We’ll take a risk on someone internally that we wouldn’t take on an external person. But we’re transparent that it may be two years, five years, seven years before something develops.

**DEBORD:** The message is that there will be opportunities but they are not necessarily going to get the first opportunity. That’s part of setting those expectations. When I recently filled a position on my executive team, we had some great internal candidates. I probably could have hired any one of them and I think each one of them would have done a good job, but I couldn’t hire each of them. It doesn’t mean that any of them are not worthy of this position. There will be other opportunities.

**ZAMAN:** When you’re hired at Scripps, one of the first things we do at our new employee orientation is an assessment. It’s a process by which we talk about who you are, what your goals are, and where you see yourself going in the organization. We encourage each of them to participate in our Center for Learning and Innovation in a talent development counseling session. It helps set realistic expectations.

**HEALTHLEADERS:** Given the additional parts of the care continuum that hospitals are taking on these days, are you cross-training these talented people who you’re trying to develop?

**BRADFORD:** We’re teaching folks on the inpatient side how to operate in an ambulatory fashion. The new economic model is a customer service model, and we’re struggling with it without a doubt. But the biggest risk is that we get entrenched in a certain methodology of doing things—particularly around skills—when the skills that are needed are going to change based on reform, the economic model, and the economy. We’re learning, but we haven’t yet cracked that nut.

**DEBORD:** We’re trying to set an expectation that we’re going to be doing cross-training, but initially it’s just between our hospitals. But we have ambulatory centers now as well. We are in the process of building two freestanding emergency departments and there’s imaging, infusion, there’s radiation oncology, fast health clinics, and we’re looking for people who will float through different areas. We haven’t gotten there yet, but when you’re struggling to get something staffed, I can see why people have to mandate this kind of training.

**SMITH:** Role change is going to be a retention issue for this next generation. We believe they thrive on change, and that’s the way you’re going to retain them.

**ZAMAN:** We do a lot of talking amongst ourselves or our leaders about this. I see patients now on a medical-surgical unit that 10 years ago I saw in an ICU. What is going to be happening as we shift the whole dynamic of how healthcare reform is going to impact us resides in the outpatient arena.

**HEALTHLEADERS:** This kind of cross-training seems to offer a real opportunity to break down the silos in healthcare. Would you agree?

**DEBORD:** You won’t survive healthcare reform unless you break down those silos. There’s a lot that we don’t know, but we know it’s going to be different. We know it’s going to be harder. We know there’s going to be less money there. And so we have to be more efficient. We have to be more fluid. We have to be more flexible or we’re not going to survive.
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