The New Change Agents

Redefining Leadership to Position Your Organization for Healthcare's Future

A SIX-PART SERIES

The Companies of MPI

FurstGroup

NuBrick Partners

As featured in
Trustee

Healthcare has never been brimming with more opportunity than it is now.

It is in some ways a wide-open frontier, where innovation and creative leadership can make a difference for our communities and our organizations. It may have taken us a while to get here, but it's an exciting time in which to lead.

As we create and collaborate on a future where we create new models of care, the race will be won by those who can adapt most nimbly and quickly. It is for that reason that we pass along to you the results of two years of work by our team and our friends at Trustee magazine (part of the American Hospital Association) that we believe will help your leadership team and board.

It's called "The New Change Agents," and it's a six-part series examining how different healthcare organizations have innovated and adapted to the challenges that providers and payers alike are facing. We envisioned and underwrote the series and encourage you to pass it around.

Here's how it came about: We consulted with some of you, our friends, on your main sources of organizational difficulty. We worked with Trustee (part of the American Hospital Association) to fashion those discussions into trending and compelling topics. We introduced Trustee to key leaders who have experienced success in facing these issues, including the need for bold board leadership, culture change during M&A, and how the demand for talent changes when payers and providers converge. Case studies are part of all of them.

You'll find some hard-hitting material here:

We hope it spurs you to reflection – and action.

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Physician Leadership and Governance: Developing Clinicians to Lead in Value-Based Care

Spurred by the importance of clinical quality, safety and medical perspectives on business strategy, governing boards of health systems increasingly are deciding that having one or more physicians as trustees is a smart move. But if doctors aren't brought up to speed in a markedly new environment, with rules and a culture that are vastly different from the clinical world, the move may end up not being smart at all.

"Many people feel that by asking a physician to be on the board, or by asking a physician to serve on an important committee or on the leadership team, their bases are covered," says Bob Clarke, chief executive officer of Furst Group, a health care executive search and leadership consulting firm. But though a doctor may have been practicing medicine for many years, he or she is sitting down at a table "with people who have been practicing leadership, practicing governance for years. They're not at the same level."

Physicians go through a decade of medical training, but as trustees they can find themselves in roles "with literally less than five minutes of formal training in the whole world of leadership, management and board governance, and the requisite skills required for those roles," says Joe Mazzenga, Furst Group vice president. Dropping a doc onto a board can lead to disconnects: Other board members may think the doctor inherently knows more than he does; the doctor may feel he can't reveal a lack of knowledge; or colleagues may not presume to inform doctors about health care issues. Meanwhile, the physician "is potentially more intimidated about joining the board than doing challenging surgeries," he says.

Doctors have a lot of catching up to do in both the basic responsibilities and the cultural nuances. For starters, their

medical education "has not trained them on the corporate requirements of a fiduciary, so they don't understand the technical aspects of it," says Michael Wagner, M.D., president and CEO of Tufts Medical Center, Boston. Financial complexities on the hospital side "are not typically what a physician thinks about from the way they run their practice," including things as basic as accounting on an accrual basis in a health system versus the cash basis of a practice, says Wagner.

Governance is Different

Acting like a trustee also is a learned skill. "For the most part — whether it's medical school, residency, fellowship — [physician training] is very focused on clinical skills and less so on how you might as a physician participate in leading an organization," says Nicholas Wolter, M.D., CEO of Billings (Mont.) Clinic.

A key difference to emphasize in governance is that trustees don't, and can't, know about everything that lands on the table,

BILLINGS CLINIC: The Fundamentals of Team Membership

Billings (Mont.) Clinic develops both physician and executive leaders through a program that "has a lot to do with leadership skills," says CEO Nicholas Wolter, M.D. "How do you communicate? How do you have a purposeful conversation? Are you a good listener? … There are a lot of behavioral things that are discussed."

The sessions, three days at a time, five times a year, emphasize group dynamics, often the opposite of what's been considered good doctoring. "As physicians, we are trained to develop individual skills, to have a lot of knowledge about diseases, and make individual decisions about what's best for our patients," he says. "As an executive, we're often having to address complex problems for which there's no obvious answer."

Working with others is critical. "How do you deal with disagreements? How do you deal with different points of view? These are the things we address in Leadership Billings Clinic and, for both physician and nonphysician executives, these are valuable skills to learn," Wolter says.

For the development track, "We try to pick high-potential people, executives and physicians, and it does become, if you want to use the phrase, a 'farm team' for future, more permanent leadership positions."

Two physician members of the multispecialty clinic are elected to the 12-member board by the organization's practicing physicians, says Wolter. Thus, having medical staff respect and support for doctors serving on the board, which is a chief purpose, is built right in.

Once seated, physicians "understand that their role on the board is to represent the community, the region, what's really important for the organization to stress," he says. However, Billings also has a council of seven physicians, also elected by peers, and "most of the issues that are dealt with by our board of directors go to the leadership council" before the board takes them up. Physicians, then, are responsible for much of the business of the organization, says Wolter.

AURORA HEALTH CARE: Multiple Channels for Input

Milwaukee-based Aurora Health Care has two clinical experts on its board, but both fly in from out of state. All of the other trustees also are external, which means no doctors hail from the health system except Nick Turkal, M.D., who, as president and CEO, is an ex officio member.

The governing body, downsized from 21 internal and external members in 2007 to the current 11, is as a result "a very engaged board that provides input from outside the organization," Turkal says," and I think we've done that without giving up anything around physician input and, in fact, I think we've enhanced it."

The representation starts with the chief medical and nursing officers and two doctors who are leaders of the medical groups, provideing "constant input and dialogue at the board meeting even though these folks are not voting members of the board," Turkal explains. "That's the very important way we make sure that for any issue that comes up for discussion, there are clinical leaders in the room."

Board committees such as those for finance, quality and social responsibility have physicians from across the system's 14 hospitals and 159 clinic sites. "Our board members have regular interaction with physicians, and the physicians who attend those meetings have a regular view into how we're making financial decisions or how we reshape our quality programs," he says.

With the decision to get board perspective from outside, Aurora redoubled efforts to develop internal physician-led guidance, including a two-year, rapid-development leadership track. Graduates are candidates for a medical group leadership council that works through priorities such as care redesign, patient experience and how to continue integrating.

"There is sometimes too much emphasis on [having] physicians on the board vs. physician input into governance," Turkal says. "There are many ways to get what is so important here, which is clinical input, and it doesn't have to be board seats."

Mazzenga advises. By contrast, starting from residency, physicians "were discouraged from admitting they didn't know," because of peer pressures and because "that would not make patients feel comfortable."

In general, docs "are very bright, they have since kindergarten been at the top of their class and, in many ways, they are voracious learners, so that's what we have to make sure we hold onto, and recognize that they are wired that way," Mazzenga says. "However, we have to make it clear to them that we don't expect them to have all the answers, or strong opinions on everything, the way they may have in other parts of the work that they do."

Knowledge Gaps OK

Nonphysician board members start with a lot to learn, too, even if they hail from leadership positions in business and industry, says Wagner. He finds that this is true of "any director on a board." Unless they were hospital executives, there are aspects of board-level conversations that trustees may not understand and may feel vulnerable expressing their ignorance.

'It's clearly important to have physician leadership driving many of the decisions we do in health care — but not necessarily in a vacuum.'

"This can be very difficult in a very highly charged place like a boardroom," he says.

Even for an incredibly successful business executive, Wolter says, "health care is very complicated, the regulatory environment in health care is unique, so they're also learning and having to ask themselves questions like, 'What do I know, what don't I know?' Physicians observe that, and so they learn from each other." Nonphysician trustees "really like having physicians on the board who understand the operation and the issues in health care around safety and quality. But, they're both on a learning curve, and they both realize that early in the game."

The value of a physician is not to become a generalist, but rather to provide perspectives and depth in such matters as quality improvement challenges and patient experience, says Clarke. "Physicians by training are scientific, there's a linear progression of thinking, which is a blessing, and a curse sometimes. But it's clearly important to have physician leadership driving many of the decisions we do in health care — but not necessarily in a vacuum."

Adding Physicians to the Board: 5 Strategies

Know the facets of leadership. Success requires being effective in several areas, says Furst Group Vice President Joe Mazzenga. *Personal leadership competency*: how a leader communicates, influences, builds trust and creates effective followers; *leading others*: how to create engagement, motivate others, develop talent and coach people; *understanding the business*: the core metrics, drivers, levers and paths to profitability; and *leading change*: emphasizing that change is constant, consistent and here to stay.

Be inclusive in teaching board strengths. New board members of any stripe should get much the same orientation that physicians require. That would include what to expect from a doctor in the mix. If other board members assume the doctor knows all, it's their perception problem, not the doc's, says Bob Clarke, CEO of Furst Group. "It is important that there is leadership development and training and interaction around the table, not just aimed at one individual."

Tap docs with boss duties. Having department head experience provides a head start in acclimating to the board, says Michael Wagner, M.D., CEO of Tufts Medical Center. Hospitals "are selecting people — or should be selecting people — who have some organizational experience in running something at the hospital or have enough of a presence from a business perspective." For example, physicians on Tufts' board include the American Psychiatric Association president; a heart center director with leadership experience at the National Institutes of Health; and chairs of medicine, surgery and radiation oncology.

Chair has duty to unify the board. New members should be acculturated to "the way people interact, and to what is an open and trusting environment. … That tenor is set by the chair and by board culture," says Wagner. One practice of the Tufts chair is to meet with physician members every two to three months to assure open dialogue without administrative leaders present. The chair also meets periodically with other members, given they might "feel somewhat intimidated by saying things in the presence of physicians."

Physician environment may not carry over. A physician is accustomed to showing up to clinical meetings in a lab coat draped with a stethoscope. When a cellphone rings, it's answered in mid-meeting. "That's absolutely normal behavior" for a doctor, Clarke says. But it changes the board dynamic and what the priorities are supposed to be. "Obviously, patients are important, but so is governance, so is that meeting." Leadership development addresses the differences between the two settings, and how to respect them.

No Longer Optional: Furthering Population Health Demands Diverse Governance

A board that guides the strategic direction of a health care system must have a keen sense of its business environment — the blend of market forces, financial realities and significant influences affecting every move the board makes. In the past, there had to be financial, legal and clinical acumen to guide decisions. That's not enough today, as providers reorient priorities toward population-level health.

From allocating capital funds to improving community health status, the diverse makeup of the service area has to be factored into decisions, and trustees steeped in the unique factors of that diversity are essential, says Kelvin Westbrook, who chairs the board of BJC Healthcare, St. Louis. "The creativity that comes from having a diverse board — and it doesn't necessarily embody itself in one particular race or another — the probing, the asking of questions, particularly when it comes to health care challenges, I think it's that mix of perspectives that can provide some greater insight into how we might approach these challenges in a different way."

Without attention to a diverse board, "what you get is a group-think," says Deanna Banks, principal of Furst Group, a health care executive search and consulting firm. "You've got similar-minded people from a singular exposure making decisions on behalf of things for which they lack insight and understanding — and sometimes empathy."

Health care "is not one-size-fits-all," says Westbrook, appointed last year as the first African-American chair of BJC's board. "Often you'll find even in a place with very outstanding health care institutions and individuals, there are pockets of the community that don't have as much access; they are not

as learned or literate when it comes to their health status and their health care." Health status is complicated by "where you live, how you're raised, what you can afford to do, the quality of your education, etc." These socioeconomic determinants have to be well-understood for their variable impact on behavior, he says.

Differences Count

At Minneapolis-based HealthPartners, where the board chair is African-American and the vice chair and immediate past chair are women, "we make diversity on our board a priority," says Mary Brainerd, president and CEO of the health system and health plan. "I think we make better decisions when our ideas and approaches are challenged by people who have had different life experiences and different ways of coming at issues."

From the time Calvin Allen joined HealthPartners in 2004 as senior vice president for strategic planning and human resources, he has made presentations twice a year on either the strategic plan or people priorities, and the board consistently raises the question of diversity. He says the questions and counsel are about progress internally on leadership, recruitment and workforce development, as well as things the organization is doing to engage the community more effectively so that it can serve people "in a very detailed, targeted, personal way."

HealthPartners routinely collects information at point of service on race and ethnicity of all patients and plan members, part of an extensive program to identify disparities of care and close the gaps. The executive team devised the program in response to a challenge the board leveled nearly 15 years ago, and it has become an invaluable capability, Brainerd says. Among other results, it detected disparities in the rate of mammograms between white women and women of color, and a push for same-day mammography has helped to close that gap, says Allen.

In St. Louis, the board was frustrated over disparities between African-Americans and white citizens regarding several health

Achieving Population Health with a Focus on Individual Differences

Anticipating health problems instead of waiting for people to show up sick is difficult enough, but this central objective of health care reform is compounded by a realization that there is no one way to go about it, says Mary Brainerd, president and CEO of Minneapolis-based HealthPartners.

"For a long time, people believed that if we treat everyone the same, that's equal care. What we've learned is … we need to … treat people as individuals and understand differences, understand that we may need to do things differently for people who have different cultural interests, different values, and are of different races."

Diversity goes further. HealthPartners has benefited from having board members at age extremes to understand those with Medicare, or young mothers. That brought home, Brainerd says, the need to expand services for more convenient access. Saturday morning appointments at clinics. More online care. Being more effective on the phone. Putting a clinic at Target Corp.'s world headquarters to reach thousands at work. All these ideas sprang from board members "who are thinking what they would do for their own families, things that might not come to the fore" on a board with the same gender, age or ethnic profile, she says.

Direction from the top has filtered down into priorities for community engagement, "to recognize some of the differences in what our neighborhoods were like 20 years go and what they're like today, and open up the conversation about what people need and expect," says Brainerd.

The conversations start with HealthPartners employees, says Calvin Allen, senior vice president for strategy and human resources. They're told how to not just collect but connect when they ask patients about race, ethnicity, preferred language and the like. All of it goes into the ongoing disparities analysis. "We want all our employees and colleagues to interact with the people we serve from a perspective of cultural humility. We don't know all the answers to everything as we interact with those we serve."

issues, particularly infant mortality, which varies by as much as 300 percent by neighborhood. "You have to ask why," says Westbrook. BJC has created an outreach program to identify pregnant women sooner and get them to follow prenatal protocols. "That's the sort of question that we've been asking, and those are the sorts of challenges we're putting on the table."

Seeing What Others Don't

As health care systems take heed of such population health challenges as the incidence of chronic diseases and their higher prevalence in certain neighborhoods, a heightened understanding at the board level of economic and cultural barriers to better care is essential. "Diversity on the board ensures that there is diversity of thought and a wide variety of considerations given for the varied demographics reflected in the patients and communities that are served," Banks says.

It doesn't mean merely finding a complement of minorities and women to proportionally reflect the service area, says Bob Clarke, CEO of Furst Group. Putting women and people of ethnic origin on the board just to have them "is almost worse than not paying attention to it at all, because it becomes a token appointment." Just as a board specifically seeks out banking and legal experience or clinically astute health professionals, it should seek dynamic individuals who ably represent the needs for cultural and community awareness. "And you fill those slots the same intentional way. It's not just window dressing."

At minimum, diverse representation can reduce the number of seemingly valid assumptions for expensive decisions that fail in ways that no one saw coming. Banks relates the example in which a hospital built a state-of-the-art birthing center in a heavily populated Latino neighborhood. No Latinos were part of the facility planning.

"What it didn't take into consideration was that in the Latino community, a birth is a family event." A mom's parents, grandparents and others wanted to gather, but the rooms were too small to accommodate more than a few visitors at a time, offending people who felt turned away. "It was a beautiful birthing center that people refused to use," she said. Someone from that community on the board might have raised a concern. "You may not even know you have an issue until you're bringing in somebody who's going to give you that perspective."

Assessing Diversity with 'The Shoe Test'

Health care is a challenge of cultural competency and changing business models, neither of which can be addressed without listening to different voices, says Kelvin Westbrook, chair of BJC Healthcare, St. Louis. "It's apparent that you need to have a board with a variety of perspectives so that you can share and devise the best approaches, not just for the minority community, but for the entirety of the community."

BJC's reach throughout eastern Missouri takes in rural, suburban, urban and inner-city areas, and the decision-makers need to hear what each community perceives as its challenges, he says. "Those of us who've been around the block once or twice know that not all communities see the world the same. ... You do need to get input in terms of what might work somewhere and what might work someplace else."

Part of Rhonda Brandon's job as chief human resources officer is to make sure the workforce is culturally competent to deal with the differences among groups of people. "Diversity is a pillar; it's pivotal to doing the work that we do, and doing it effectively." The board challenges management to engage directly with patients through family councils, to understand them better and, in some cases, to design facilities according to what would be a better use of space and services, she says.

Westbrook, who also chairs BJC's children's hospital and previously was on the board of one of its community hospitals, has kept one idea in mind during 20 years of volunteering in health care. "A young man told me years ago [that] if you're trying to do something for the public, in the community, and you don't meet the shoe test, it's going to be problematic. By that he meant, if you look under the table and you don't have a diversity of shoes, you're probably going to get a much narrower perspective on what can and cannot work than you would if you have a diversity of shoes around the table."

Shifting Leadership Competencies: What Happens When Payers and Providers Integrate

As the U.S. health system migrates from fee-for-service reimbursement, the traditional wall that's separated clinicians from those paying the bills will continue to crumble. Already, alternative payment approaches are reverberating throughout: shared savings efforts, bundled payment programs and population health initiatives, to name a few. By early 2013, 16 percent of hospitals had either established or joined an accountable care organization, and another 7 percent were considering such a move, according to an ongoing American Hospital Association survey to track emerging models of care.

The outstanding question: How rapidly can hospital leaders shift their mindsets and tactics? "You can't sit still, because this thing is moving too quickly," says Jim Hinton, CEO of Presbyterian Healthcare Services, Albuquerque, N.M., and chair of the AHA's board of trustees. "I think the risk is [that] it takes a long time to change the DNA of health care systems."

In short, hospitals leaders must think more like payers to develop the expertise needed to navigate the morphing reimbursement environment, says Hinton and other experts interviewed. Hospitals traditionally have focused on high-quality patient care, while the payers have held a crucial data piece, says Kevin Reddy, a vice president at Furst Group, a health care executive search firm. "They're the ones with all of the claims data," he says. "And they are the ones who can really slice and dice that data.

"When you combine these pools of talent, that's where success will come."

Strategizing First

Before deciding what expertise they need, though, hospital leaders must vet their own strengths and weaknesses. Calculate what percentage of the hospital system's revenue already stems from some form of capitated arrangement, Hinton suggests. Then break down the relative profitability of various funding sources, such as Medicare or commercial payers. "There are a lot of assumptions," he says, "that have to really be evaluated based on facts."

When meeting with prospective partners, bring more to the table than brochures about intriguing programs. Share outcomes data packaged with other statistics, such as publicly reported measures and some partnership ideas.

"Ultimately, I think the real difficult question that all health systems have to ask is, 'If you were a payer, why would you want to contract with my health system?' " Hinton says. " 'What is the value added? What do you bring to my members?' "

Presbyterian, which started its own health plan nearly three decades ago, has been expanding its various capitated arrangements for years, and now nearly two-thirds of the system's revenue is thus pre-budgeted. One of the system's recent initiatives includes the establishment of a primary care clinic at a local Intel manufacturing plant, staffed by the system's clinicians. The employees of the computer chip manufacturer benefit from the patient-centered medical home approach and Presbyterian knits closer ties with "a very key customer," Hinton says.

Fostering Expertise

Once hospital leaders zero in on their strategic path, they'll know what types of nuts-and-bolts roles they need regarding contracting, actuarial and other positions, says Kevin Sears, vice president of payer strategy and product development at CHE Trinity Health, Livonia, Mich.

"Even if you're not going to become a health plan," Sears advises hospital leaders that "it's really important to be able to, at a minimum, validate the per-member, per-month targets that payers are setting."

Hospitals leaders must think more like payers to develop the expertise needed to navigate the morphing reimbursement environment.

More challenging is finding the right mix of skills for more senior-level positions, some of which might be difficult to capture by a title and a resumé, says Bob Clarke, Furst Group's CEO. A potential candidate might hold a big title in a local health plan, but it's critical to look further at skills and vision, Clarke says. "As health plans go, are they creative? Have they engaged in interesting partnerships?"

Reddy talks about finding individuals with "learning agility" to fill these emerging multifaceted roles — someone who could think about potential players and partners in the marketplace, he says, "even if, heretofore, they'd been on opposite sides of the table. 'What should this look like, and how do we get the people?' "

Those future leaders, Reddy says, will need to have "those relationship skills and the demonstrated ability to drive that [process], and to build something that maybe doesn't even exist today."

THE STRATEGIC MINDSET: Five Components

How can hospital leaders revamp their perspective? Krista Bowers, a director at the health care strategy firm BDC Advisors, suggests five components to becoming more payer-savvy:

1

ANALYZE THE MARKET:
Break down profit and loss across payer types, public and private, looking for potentially lucrative niches. Pay attention to market share, with primary care doctors' driving that equation. How many of them are aligned with your system?

2

THINK COMPREHENSIVELY:
To what extent can the hospital system manage or support patient care outside of its walls? Besides adding programs and services, this form of integrated care requires clinician buy-in, Bowers says. "Even if you employ [the physicians], you have to win their hearts and minds."

3

ISOLATE NICHES:
Decide what groups of patients initially should be targeted. Depending upon the market analysis, a hospital might focus on a few medical conditions or a particular insured group, such as Medicare Advantage patients.

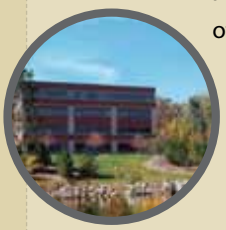
CHE TRINITY HEALTH:
Consolidating Knowledge

At CHE Trinity Health, a key benchmark for success moving forward "will be the number of attributed lives that we have as a system," says Kevin Sears, vice president of payer strategy and product development at the nonprofit system, which includes 86 hospitals in 21 states.

"Our charge is to obtain in each of our markets the right number and the right mix of those covered lives," he says.

To that end, leaders at the Livonia, Mich.-based system evaluate the relative profitability and innovative potential of prospective partners, both public and private. Along with analyzing reimbursement rates, they look at the payer's willingness to support the infrastructure and initiatives needed to transition toward population health, Sears says.

Once a partnership is formalized, tracking and dissecting both treatment and claims data are crucial. CHE Trinity Health leaders are in the process of creating a center for population health analytics. The first step has been to hire actuaries for the center, including someone with nearly 30 years of experience who previously worked for a health plan.



That center eventually will be populated by a mix of actuaries, biostatisticians, epidemiologists and other analysts, Sears says, "to help us understand not only the financial trends, but also the opportunities to improve that performance clinically and financially."

The sprawling health system, which treated about 32,000 people through population health initiatives just two years ago, now manages the care of slightly more than a million individuals nationally through ACOs, bundled payment approaches and other types of shared savings arrangements.

The goal for 2016: to treat roughly half of the system's patient volume through some type of population health initiative.

UNITYPOINT HEALTH:
Jump-starting Innovation

Hospital system leaders fall into one of two camps, according to Kevin Vermeer, executive vice president, chief strategy officer and ACO chief executive at UnityPoint Health in Des Moines, Iowa. Either they are "pretty aggressively going after developing population health capabilities," he says, or they are trying "to maximize fee for service as long as it's in existence."

UnityPoint's recent track record illustrates which philosophy their leaders have embraced.

The integrated system of 32 hospitals, once called the Iowa Health System, has facilities participating in both Medicare's Pioneer and Shared Savings programs. UnityPoint also has set up a commercial shared savings arrangement with Wellmark Blue Cross and Blue Shield, involving about 55,000 of the plan's fully insured members in Iowa. In January, the nonprofit health system acquired a health plan, Physicians Plus Insurance Corp., as part of its affiliation with Meriter Health Services of Madison, Wis.

To some extent, the Midwestern system pursued these shared savings arrangements to jump-start innovation, Vermeer says. "The way that we were really going to engage our physicians and hospitals and home care agencies around changing how we deliver care is by entering into these contracts and really forcing ourselves to build these capabilities, and to look how we deliver care differently," he says. "And it's definitely done that."

Along with developing a core group of analysts, UnityPoint also added a new senior-level position last fall, called vice president of payer innovation. "What we wanted to bring into the organization was a person who was more focused strategically on how we get paid for value," Vermeer says. "So, how do we create different relationships with payers other than straight fee for service?"

4

BRAINSTORM MODELS:
What patient services or staffer skills should be developed to more cost-effectively treat these patients? What data need to be analyzed further and what new people brought on board?

5

REACH OUT:
Should your hospital hang back or approach intriguing partners? There's already a lot of jockeying in some markets, Bowers says. "People are looking for dance partners, so I don't think it's going to be difficult."

Succession Planning: Best Practices for Managing Organizational Risk

Penny Wheeler, M.D., was barely into her tenure as CEO of Allina Health and fresh from a transition period earlier this year with retiring CEO Kenneth Paulus when the topic turned to who might replace her.

"At the first board meeting in March 2015, people were asking me about succession planning," Wheeler says. The board of the Minneapolis-based health care system takes very seriously its duty to hire, fire or replace its CEO, she says, and trustees "expect early on, as they did in Ken's tenure, that succession planning would be done … . The board really sees it as an ongoing activity and one of the most important ones that they do."

While succession planning at a new CEO's inaugural board meeting may seem aggressive, it's never too soon for an organization to begin the process. A board-led succession plan should continually be in place and updated as needed, no matter how well the current top executive is working out or how long that person figures to stay put, says Joe Mazzenga, vice president of Furst Group, a health care executive search and consulting firm.

Properly developed succession plans allow an organization to appropriately develop current employees with executive potential, alter the desired strong points of a future CEO to match evolving business strategies, and simply to avoid being caught off guard by a sudden vacancy.

While Paulus' departure was not sudden, having a succession plan that articulated the skills and experience his successor would need to implement the system's strategy provided the board with clarity during the search process. The

board placed high priority on understanding both clinical care and how to engage physicians, as the focus of business shifts to creating and proving value.

Wheeler says trustees sought someone "who could set a clear strategy and vision, make sure that we were moving toward a transformative place in health care where clinical care processes and their redesign were going to be more important." Wheeler's prior role as Allina's chief clinical officer made her a particularly good fit. Not only did she have the experience needed to lead clinical redesign, but she was a home-grown candidate.

As a physician, Wheeler says her strengths were in understanding clinical processes and how those could improve care and decrease cost. She knew she had to improve operational and financial acumen, and learn how to develop her leadership team. The board and Paulus walked her through her developmental needs, giving her broader responsibilities to see how she handled operational duties, with the results pivotal in determining her viability as a candidate for the future.

Sometimes the skills are not in-house. At St. Luke's Hospital, Chesterfield, Mo., the board decided its bench was not ready to run the organization and referenced its succession plan to look outside the system when its CEO of 15 years, Gary Olson, gave advance notice of intent to retire, says the board's chair, Gene Toombs. The consensus on competencies: a person of high integrity, characterized by a record of thoughtfully consulting with others, and a track record of CEO experience. The choice: Christine Candio, immediate past chairman of the American College of Healthcare Executives and formerly CEO of Inova Alexandria (Va.) Hospital and senior vice president of Inova Health System, Falls Church, Va.

Once the new CEO is chosen, the board should have a good idea of how the transition plays out, and what, if any, continuing role the ex-CEO will have. His or her knowledge and practical information are valuable, but that has to be weighed against clarity of authority. Ben Breier had moved into four different executive roles of varying responsibility during a 10-year span at Kindred Healthcare, a Louisville, Ky.-based provider of post-acute services, before succeeding retiring CEO Paul Diaz in March 2015. Breier's progression, as president of two different divisions and then chief operating officer, "allowed me to develop these deep and meaningful relationships with people from the front-line staff all the way to our management team and, I think importantly, with our board members."

As Diaz approached retirement, "it was always Paul's and the

ALLINA HEALTH: Desired CEO Experience Changes With Business Needs

Allina Health CEO Penny Wheeler, M.D., has a long view of the succession question. She started on the governing board end, having been appointed to the Allina system board in 2002 as one of two physicians added to supply an understanding of clinical care. It was just as Richard Pettingill was coming aboard as CEO, replacing an interim exec appointed after the upheaval caused by having to divest its health plan division, Medica, by order of the Minnesota state's attorney general.

The situation called for someone with demonstrated leadership and a reputation for integrity, who could stabilize the organization. "We thought we needed somebody from outside at that time, because the organization was thought to be on shaky ground and in a crisis mode," says Wheeler. Part of planning and selection is about timing, "not only the skills that you have, but the right skills at the right time."

Pettingill, she says, put Allina back on solid footing, consolidating governance, merging 11 corporate locations into one headquarters to work better together, and establishing a robust electronic health record system at a time when few others were going that far.

When in sound shape, the health system focused on having CEO successors at the ready. Three years into his tenure, Pettingill recruited Kenneth Paulus as COO, with the aim of cultivating him as the CEO successor. When Paulus assumed the top spot in 2009, the board wanted him to identify his replacement, taking into consideration where Allina was headed next.

"Dick was a healer — he healed and put in some successful infrastructure," Wheeler says. "I think Ken was a mover. He saw that we had to broaden the continuum, so he increased our primary care base and wanted to make sure that we had that primary relationship solid for our future." Paulus developed the system's integrator role, with components as varied as fitness businesses and long-term care, and he began to think about collaborating with competing systems.

Wheeler describes herself as an architect — now that the organization has all these components, they have to work together "in a way that singularly focuses on our goal of creating value for patients and community members."

The board's approach to succession was influenced by the experience of three other health systems in the Twin Cities area that saw their CEOs leave without a succession plan, requiring their respective board chairmen to take over for a period of months or years, Wheeler says. Explaining one motive for Paulus' singling her out, at the board's direction, as his immediate successor in 2011, she says, "Our board chair did not want to become the managing CEO."

ST. LUKE'S HOSPITAL: Recruiting From the Outside Brings a Fresh Perspective

St. Luke's Hospital had it good. Its CEO, Gary Olson, had made a name for himself since coming to the Chesterfield, Mo., facility 36 years earlier, the last 15 in the top executive role. Approaching age 65, he was "in very good health, very athletic and very energetic," says board Chairman Gene Toombs, and the board had no issues about performance. Then Olson announced that he wanted to retire.

"He wanted to set the stage, so there are no surprises," Toombs recalled. "All of us tried desperately to talk him out of it — I think we delayed it about six months to a year." The hospital had a succession plan in place, he says, and reviewed it periodically, which called first to see if there were any internal candidates. The hospital had a very able chief financial officer who was still relatively new to the organization. Aside from that option, "we could take a chance on a couple, but they probably were not ready."

A search firm found 10 outside candidates, half of whom were brought in for interviews before a search committee comprising two board members, a staff person and several physicians. That narrowed the choice to two, "both eminently qualified," for more interviews and, eventually, a board decision to hire Christine Candio, who has done "an outstanding job so far."

Olson was cooperative, says Toombs, not wanting to stay longer, but volunteering to stay until the board could find the right successor, and participating to some extent in the search. "We had him spend some time with the candidates. He met and had lunch with the five finalists, he was asked his view, and he was candid — he rated them frankly just as the board did, so we were lucky there. But he was not going to be the guy who said, 'This is the one.' "

'It was difficult and we still miss him, of course, but I think [Candio] has brought in a new perspective and a new breath of fresh air, which is good," he says. "We didn't need to make major changes, the hospital is on track, our strategic plan is viable, it's in place, we're following it."

board's hope that it could be an internal succession, and that it could be something that was managed in a methodical and transparent way," says Breier.

Besides giving Breier operating responsibility for the company in 2012, the board insisted on regular, "fairly intensive" performance reviews, including a psychological profile. "All of these tools were used, I think, to ensure from the board's perspective my readiness to move into the CEO role. As I think back on the experiences and the process, you can see there was a very purposeful approach taken to my development."

After Breier took helm, Diaz moved into a newly created role as executive vice chairman, designed specifically for his transition on a year-to-year basis. He still meets weekly with Breier to talk business, and "I still count on Paul as being my closest and most trusted adviser," Breier says.

CEO succession decisions are ultimately board decisions, but succession planning needs to be an ongoing organizational activity. Boards and their executive teams need to do a better job of creating an expectation and accountability that all leaders at the highest level either have an identified successor or are developing one or more, so the organization doesn't have a shortage of new leaders when the time comes, says Mazzenga. This is not something to delegate to the human resources department: "It has to start at the top and it has to come from the top, and the expectation of the significance of the succession process within the organization needs to be an executive and board imperative."

Any process should include incentives for the current CEO and other top management to seek out and groom people with high potential to attain a top executive post in due time, says Sherrie Barch, Furst Group president. Building bonus structures into compensation for evaluating and facilitating the maturation of key leadership prospects is a way to get the CEO to buy in and, in so doing, reduce risk to the organization's objectives and goals that a lack of leadership might generate, she says.

One important element of developing talent is identifying gaps in experience or expertise among candidates and working to bridge them, says Barch. The CEO and other top executives not only should identify someone to mentor, but also advocate for their prospect's progression — to make sure that he or she is exposed to working with the board, is knowledgeable about strategy and has the full set of skills to move up.

Hand in hand is the need for boards "to continually look at their bench strength: What is the caliber of, the capacity of, the bench?" Mazzenga asks. A transparent process allows current leaders to sit down with high-potential candidates and ask if they want to develop additional skills for a top position. That evaluation process should be concurrent with consensus-building among board members around the critical skills, competencies and characteristics of a CEO looking ahead, "recognizing that they may present a different set of skills vs. [those of] the current leader," Mazzenga notes. "That is not an indictment of the current CEO; it just may be that the needs of organizations change over time."

Leadership During M&A: The Unseen Challenges of Melding Corporate Cultures

Mergers and acquisitions are complex and daunting to accomplish, full of intricate legal and financial questions, business-benefit projections and formulas for extracting efficiencies of scale. All that due diligence generally is done by the time the organizations start to interact. And then trouble erupts.

"The finance people have done their homework. They know how to make all the widgets fit together, they know what services they can combine — rarely does that undo a deal," says Bob Clarke, CEO of Furst Group, a health care executive search and consulting firm. "But what's not been done is really a general understanding about how the organizations come together culturally, and that's where things tend to fall apart. People don't get along, they don't trust one another, they don't share information."

To avoid those pitfalls, HonorHealth CEO Tom Sadvary and his team paid extra attention to the so-called soft skills. In fact, Sadvary himself led the integration team that dealt with culture as Scottsdale Healthcare and John C. Lincoln Health Network recently merged into HonorHealth in the Phoenix market.

"I can tell you," Sadvary says of the experience, "that the old adage of 'culture trumps strategy' is not overstated."

Detecting friction points and assuaging concerns should be just as essential as purely business-minded plans for leaders who want to synthesize a new and powerful difference-maker out of two or more merging organizations. Lawyers and accountants know their stuff, but are not necessarily equipped to assess whether the human components will fit, says Joe Mazzenga, Furst Group vice president.

What's needed is "a far higher level of analytical rigor on issues like culture and organizational health that clearly have the opportunity to spoil and tank the best-laid plans," Maz-

zenga says. Executive teams may sense that threat, but "they have a tendency to go back to their fastball, to go back to what they're comfortable doing."

Clear Intent

The time to visualize how people work in concert is at the very beginning. Leaders involved in the merger of Trinity Health and Catholic Health East — religious sponsors, each corporate board and executive suite — immersed themselves early on to develop a vision for the new entity, says Sister Catherine DeClercq, executive vice president for sponsorship and governance for Trinity Health, the combined system, after being formed in May 2013. Those precepts constituted "a core document, still a very significant document because we're trying to live … our vision for coming together," she says.

Culturally, CHE had a more distributed decision process, while Trinity was more centralized, though it had begun structuring itself more regionally with core groups of facilities in

SSM-Dean Health System: Integrating Fiercely Independent Physicians

When St. Louis-based SSM Health Care acquired Dean Health System, a multispecialty clinic and a health plan, in September 2013, the fortunate part was that Dean Clinic physicians were familiar partners — for decades they had practiced at and referred patients to SSM hospitals in the same service area of southern Wisconsin. The challenging part was that Dean had been a fiercely independent, physician-run organization for 90 years, "and now there is corporate ownership that is remote from them," says Gaurov Dayal, M.D., president of health care delivery, finance and integration with SSM.

But that remote organization has become more like Dean since the merger, putting doctors on the corporate board for the first time and appointing physicians to head two of its three divisions, including Dayal. The moves recognized the critical role of physician voices in both organizations as well as provided Dean with a level of comfort that "we're not going to change their world overnight, and that there will be a lot of continuity," Dayal says.

SSM also paid "an excessive amount of attention" to culture, to the extent of hiring a consultant to apply an "organizational health index," a set of several hundred parameters to determine the nature of the two cultures and identify where they overlap and don't, he adds. There's always a give and take between two combining entities, and "having very up-front clarity on what you're going to do is the best thing — a policy of 'no surprises,'" Dayal notes. "If you have a level of trust and comfort, and give the other party the benefit of the doubt, a lot of things are going to work out. But if you start a relationship that is not based on trust and common values, you can put anything you want on paper and it's not going to work."

Trinity-Health: Creating a Consolidation Leadership Team

The Trinity-CHE approach to merging took to great lengths the dual objectives of getting equal input from both sides into the integration quest, and then rising above old boundaries to a new plane of operation.

An executive team of five from each organization created a consolidation leadership team to discern how to deploy the aims of a shared vision throughout the workforce. Trinity Health had done things a certain way, CHE a certain way, and it was not about determining which way to adopt, but rather to "look out into the future, see where health care is going, and define something new," says Catherine DeClercq, executive vice president for sponsorship and governance for the combined system.

Two separate teams were formed around basic functions — finance, human resources, legal, supply chain and so on — the first to get the health care businesses through the consolidation, and the second to determine how to go about these functions a whole new way, says Clayton Fitzhugh, Trinity's executive vice president of human resources and integration management.

Meanwhile, a steering committee representing each system engaged outside consultants to help determine the competencies needed for the new board to pursue the stated vision during a time of industry transformation, DeClercq says. Trustees from both sides were given the opportunity to be considered for the new board. The consultants interviewed candidates to weigh their talents against the previously discerned requirements, and decided on six members from each prior board. Missing some competencies, the board selection process also recruited three external members.

"I think our processes have worked well," says DeClercq. "The board has coalesced; it's one board, it's not 'we' and 'they.' They're not referring to their prior lives."

HonorHealth: A Deliberate Approach

The leaders of Scottsdale Healthcare and the John C. Lincoln Health Network in Phoenix knew that their organizations had a lot in common. They were both locally governed, nonprofit and committed to a community mission. They operated in adjoining territories.

Nonetheless, Scottsdale CEO Tom Sadvary and Lincoln CEO Rhonda Forsyth proceeded with caution as their organizations merged into HonorHealth. "If you're going to start a new brand and a new brand promise, you have to be able to execute on that," says Sadvary, now HonorHealth CEO. "There's nothing worse than failure to launch."

The time from the affiliation agreement to the announcement of the new name and brand was 18 months. As a placeholder, the new organization was initially called Scottsdale Lincoln Health Network. Although the affiliation was announced in October 2013, Sadvary says the company held off on a full-asset merger until December 2014, when the bond market was more conducive.

On the cultural side, the health system interviewed 1,000 people — staff, patients and community members — to get a baseline understanding of what was important to them in choosing health care providers. The research led to the new name of HonorHealth and the brand mantra of "making healthy personal" on March 30.

Sadvary says he and Forsyth (now HonorHealth president) and their boards worked well together from the beginning as they combined forces. They learned from peers who had experience leading mergers and cautioned them about pitfalls that could derail the integration.

"We caught ourselves a couple times saying, 'We never did it this way at Scottsdale,' or 'We never did it this way at Lincoln.' You have to keep an open mind if you're going to get the benefits of a merged organization," says Sadvary, who noted that each of the legacy organizations had strengths worth emulating.

Lincoln had a very successful primary care model with employed physicians; Scottsdale's Virginia G. Piper Cancer Center includes clinical prowess as well as a research institute. Sadvary likes the complementary math engendered by the merger. "It sounds like a cliché, but 1 plus 1 equals 3, not 2."

Michigan and Iowa. That restructuring "was not completed, which was good, because it allowed us to step back and rethink," DeClercq says. Leaders of both prior organizations committed to "create something that was going to be for the mission going forward," says Clayton Fitzhugh, Trinity's executive vice president in charge of human resources and integration management. "It wasn't about who was going to end up on top."

Such a transparent partnership is important, Clarke says, because the absence of a clear, articulated vision can create anxiety about people's futures. "Just presume that 'no information' is always seen as a negative; people always fill in the gap with information that's probably worse than it is." Lack of dialogue on culture has the effect of burying cultural land mines instead of exposing them.

Rather than expressing discontent or reporting the discontent of others, an executive anxious about where he or she will land keeps quiet to avoid being cast as a malcontent, says Mazzenga. Candor is suppressed among the very people who could smooth over the cultural bumps.

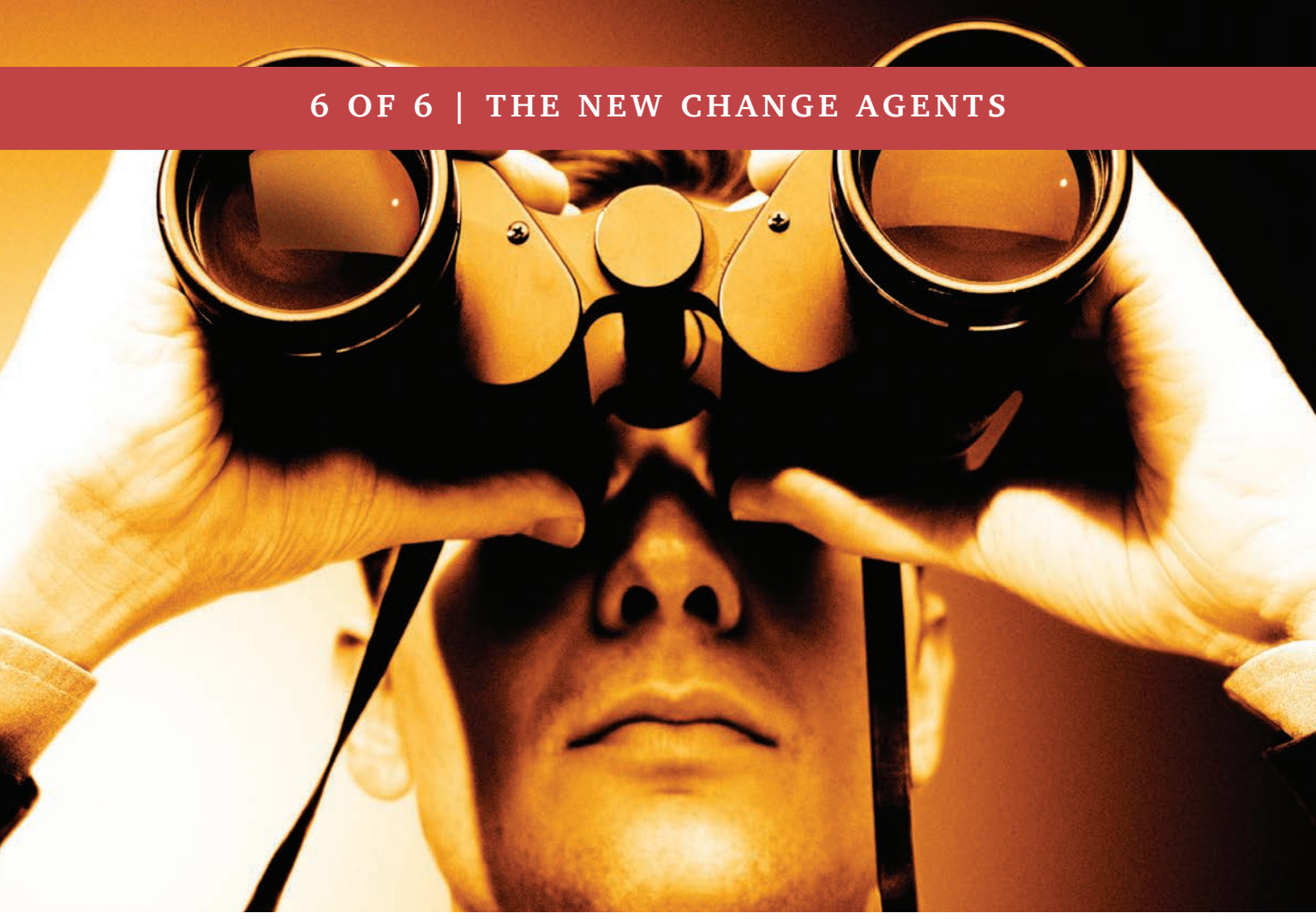
Truly Listening

Listening and sharing expectations with the combined complement of people are the conduits for bringing cultural issues to light. At one current client organization, says Clarke, within the first 90 days of having merged, the CEO held at least 25 sessions with all staff, including both employed and independent physicians. He gave people a chance to challenge him. "You have to be a pretty brave soul to do that, because you also have to be able to recognize that you may have to walk back something you've said or put forward," Clarke says.

At IU Health, an Indiana health system that has grown rapidly to 18 hospitals, discussions with physician leaders of a new hospital, built in conjunction with a multispecialty clinic, led to granting them a degree of decision-making latitude that was different from that of any other system facility, says Dennis Murphy, executive vice president and system chief operating officer.

In fact, he sees the shared-decision model of IU Health Arnett Hospital in Lafayette as an alternative to the hierarchical structure now prevalent throughout IU Health. "We're now bringing that back to our main academic hospitals, looking at that structure in smaller community hospitals. It created for us a tangible example of how you can do that really well, so we're trying to replicate that."

The biggest mistake of the acquiring health system in a merger is presuming its culture is the one to keep, says Clarke. "Instead of planning 'how to get everybody into our culture,' this should be an opportunity to ask what people like and don't like about it, and build toward a new ideal."



Bold Board Leadership: Meeting the Challenges of an Evolving Era

Say goodbye to the passive, insular, marginally informed health care board — or else.

The change required of hospitals and health systems in the transition to value-based care calls for a highly aware, forward-looking and inspirational collection of trustees, alternately leading and being led by an equally visionary chief executive officer.

"I've been in health care for 30 years, and there's never been a more challenging time in health care, but also more opportunity right now for really bold and innovative leadership to positively impact the health care system that's emerging," says David Strand, CEO of health technology firm LifeNexus and previously an executive at Allina Hospitals and Clinics, Minneapolis, and the Cleveland Clinic.

"Moving a large health care system forward takes an enormous amount of vision, willpower and resilience," Strand emphasizes. "If you don't have a great board of directors, a board that understands the challenge that is in front of us today and is ready to embrace that change, it's going to be very difficult for the CEO of an organization to succeed."

Conversely, a board predisposed to be bold might be stymied without an executive equipped with the right thinking and dynamic background to push beyond current or past strategies that no longer apply. A key trait to look for in such a CEO is "applied competence," an ability to succeed in different environments, regions and circumstances, says Sherrie Barch, president of Furst Group, a health care executive search firm. "Has this executive been able to go into different markets and yield results?"

Barch points to Anthony Armada, CEO of Swedish Medi-

cal Center, Seattle, as an example. Armada joined Swedish in late 2013 after five years as president and CEO of Advocate Lutheran General Hospital, Park Ridge, Ill., five as president of Henry Ford Hospital and Health Network, Detroit, and five as a senior executive for Kaiser Permanente's Los Angeles region. In addition to his multifaceted career path, Armada says, Swedish trustees valued his experience with Advocate's accountable care organization "when all the activities and discussions were going on relative to what accountable care looks like or what it could be."

Different Expectations

Wealth of experience alone is not sufficient. The mantra that past performance connotes future success, especially if it involves tenure in the same place, "truly is no longer valid," says Bob Clarke, Furst Group's CEO. "Just because you've done this for 30 years, in fact, may be a negative," he adds, "because it no longer prepares that person to be in a much more dynamic market."

Boards also could fall prey to that competitive assertiveness if they don't step up and intelligently engage their administrators, says Bob Skandalaris, an authority on entrepreneurship

SWEDISH MEDICAL CENTER: Improvement Across the Board

Things were in flux when Anthony Armada came to Advocate Lutheran General in 2009. He was the fourth CEO in 15 months. Advocate was heavily into structural change surrounding the launch of an accountable care organization, for which Armada served on the board of the physician participant group.

Five years later, things are in flux at Swedish Medical Center. He's the fourth CEO in two years; accountable care is coming; the facility lost $100 million two years ago. But lessons from Lutheran General and stints at Henry Ford and Kaiser are in hand, including a balanced-scorecard approach focusing on safety and quality, high-reliability performance, patient/physician/employee satisfaction, and growth — all at once. Systems "get caught up in only one or two of those things," and can achieve, say, a well-satisfied organization, "but if there's no operational discipline and everything's costing too much, you'll be out of business," Armada says.

From years at Kaiser as senior vice president for both provider and health plan performance in metro Los Angeles, Armada brought a concerted discipline to the Henry Ford business operation, which included the flagship hospital and an 18-site medical group. He improved the business intelligence of front-line staff and medical professionals to illuminate the drivers of costs and how they affect a given department. In 2006–2007, a $39 million loss was reversed into a $65 million gain.

Advocate Lutheran was a different challenge. Successful programs reduced a readmission rate from 19.7 percent in 2009 to 8.9 percent in 2012. But drops in hospitalizations and emergency visits reduced revenue. Armada introduced "backfill strategies" to increase market share with new programs, such as a cultural-responsiveness initiative aimed at Korean-Americans, and an expanded robotics institute.

Now comes the ticking timeline for ACOs in Seattle. "It's happening, and we need to get someone in here who understands it," Armada says.

HENRY FORD HEALTH SYSTEM: Betting On the Unconventional

"When you build a new hospital from the ground up, which is a rare occurrence in our industry, you don't build it like all the others; you want to have it be different," says Nancy Schlichting, CEO of Henry Ford Health System, recalling the launch of Henry Ford West Bloomfield Hospital in 2009. "And that was my thinking when I decided to hire Gerard van Grinsven to be the CEO."

Perfectly logical to her, but a head-scratcher for many in metro Detroit at the time, was that van Grinsven was a longtime executive with Ritz-Carlton, head of food and wine for the entire hotel chain, and master of execution in opening 22 Ritz hotels around the world. Hired three years before the hospital's debut, he helped with design and construction phases. That included a day spa; a demonstration kitchen with spectator seating for chefs to teach patients and families how to cook and change eating habits depending on medical conditions; and private rooms with sleeping space designed for family members.

Just as important, he knew how to open large enterprises, managing costs while hiring people when there were no customers to bill, says Schlichting. "He knew how to ramp up, he knew how to hire the talent, he knew how to orient them." He hired a lot of Ritz people in food service, housekeeping and valets in front. That was just one unanticipated dividend of Schlichting's executive gamble.

"People tell me this was the boldest move, but the minute I hired this guy, I could sleep at night about having this new hospital," she says. What he lacked in health care knowledge he asked about in regular meetings with Schlichting. Evidence of his health care uptake was conclusive: In 2013, he was hired away by Cancer Treatment Centers of America to be its president and CEO.

who is on two boards in Michigan: Crittenton Hospital in Rochester, and Barbara Ann Karmanos Cancer Institute in Detroit. Too many boards "tend to just want to do the same thing the same way — they get together, they have dinner, there's a presentation, there are very few questions asked," he says. "They take a secondary position, whether it's to administration or the doctors. … Maybe 25 years ago that was the right role. Today, I think the board is responsible for giving the best product to the market it serves, on a competitive-cost basis, with outstanding safety and quality."

Continuous Development

A bold board first has to be constructed that way, says Clarke, with complementary skills and perspectives, from different industries as well as consumer and legal input — and not necessarily from the community. For example, patient safety knowledge may have to be recruited from elsewhere, as would someone with a more competitive market perspective than what the board currently has. So one trait in a bold CEO is the presence of mind to bring a bold and inquisitive board together, given that "the board's readiness to adapt to change is paramount to the CEO's success."

> 'If an organization were to sit still and ignore the pace and velocity of change that's confronting it, it won't be here in five years,' says LifeNexus CEO David Strand

Part of that readiness is constant enhancement of the board's knowledge base, says Strand, so that trustees comprehend the changes facing the organization and the industry. "Understanding how those challenges translate in terms of the organization's own ability to succeed, it's easier for them to understand and grasp the boldness that's going to be required to lead effectively in the future."

The worst tactic for CEOs would be "trying to control their boards, keep them in the dark, give them only information that's filtered through [management]," Barch says. That undermines the board's ability to think creatively and formulate a strong, shared vision with administration.

"Anybody who needs to be encouraged to think creatively and innovatively probably hasn't been paying much attention lately," Strand says. "There's really no choice right now. If an organization were to sit still and ignore the pace and velocity of change that's confronting it, it won't be here in five years."

HOW BOARDS CAN BE BOLD: 5 Strategies

1. **ROUND OUT THE BOARD FROM OUTSIDE THE COMMUNITY:** Patient safety, quality improvement and digital health strategy are areas of acumen that may not exist in the service area, but need to be represented "to bring that learning into the board and to make sure the discussions reflect the knowledge base that comes from people who have that experience," says LifeNexus CEO David Strand.

2. **USE TRUSTEES TO INFORM TRUSTEES:** "Instead of the whole board trying to get up to speed, we take board members based on their expertise and make smaller board ad hoc committees," says CEO Nancy Schlichting of Henry Ford Health System. Examples: growth initiatives, affiliations and partnerships, and the enterprisewide information system. This approach can "tap the talent and channel it."

3. **REGARD BOARD MEMBERSHIP AS THE START, NOT THE FINISH:** For many boards, selection of a board member "is the end of the work," says Strand. But trustees need to think critically with management about organizational performance and strategy, which takes effort — "not their weekend thinking but their best thinking — and to make sure you have people willing to give the time and energy."

4. **STAY FUTURE-FOCUSED TO STAY CURRENT:** "The time to be discussing new ventures is when you don't need them," says Furst Group CEO Bob Clarke. Play a five-year what-if game: What happens if (pick an example) comes to pass? It may never happen, but the scenario forces a discussion at an entirely different level.

5. **ABOVE ALL, LEAVE THE PAST BEHIND:** "This whole world is changing, and changing fast," says entrepreneur Bob Skandalaris. The object is not to keep current operations humming, but to anticipate new moves in a new world. Most boards "aren't composed of people who do that well" but they'd better learn. "If you're planning more and more beds for open-heart surgery today, you're probably in trouble."

What does leadership sound like?

The frequent changes in healthcare and in our organizations can make it hard to keep our leadership teams flourishing and functioning with cohesion. We help you assess, recruit and retain top talent and improve the way you work together – more symphony, less noise.

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