

# ROUNDTABLE

## LEADERSHIP RECRUITING AND DEVELOPMENT 2009

Finding the right leaders to guide an organization to the other side of this recession is extremely challenging. With half of all hospitals losing money, the housing crisis, layoffs, and a massive scale-back of services, recruitment efforts have been severely hampered. That's not exactly the environment that a new leader wants to walk into right now. What strategies can organizations use to get the right talent in the door? How can organizations develop internal leaders? What role do interim executives play in the current market? HealthLeaders Media recently convened a panel of experts to seek answers to those questions and many more.

### Panelist Profiles



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Moderator



**DOLORES MARSHALL**  
Chief Nursing Officer,  
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**DEBRA A. CANALES**  
Chief Human Resources Officer  
and Executive Vice President  
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# Roundtable Highlights

**HEALTHLEADERS:** *What impact has this recession had on recruitment and leadership development?*

**DOLORES MARSHALL:** The average tenure for a CNO now is two and a half to three years and a CEO is about the same. The time to replace these positions continues to increase and the number of qualified candidates continues to decline. For many organizations, this has translated into “real” or “perceived” instability, which could negatively impact recruitment and retention, not to mention the negative influence this could have on maintaining focus on the organization’s mission.

**DEBRA A. CANALES:** You want to emerge through this economic challenge positioned appropriately to lead. We’ve made a shift from working on transformation to focusing on our ministry. We’re looking at how we leverage people across the enterprise. This is the time when investing in people is critical to emerge strong, nimble, and ready to engage as the business evolves. We have utilized interim assignments as part of the focus on continued development and have made permanent appointments when leaders have been successful in those interim roles.

**DOUG SMITH:** One reason interim leadership continues to grow through the recession is because it gives organizations an opportunity to sit back, take a breather, and decide if they really need to fill the opening. We don’t see knee-jerk reactions to get jobs filled. This process is something that has been needed and our healthcare system will emerge out of this [recession] stronger.

**HEALTHLEADERS:** *In the current economy, should hospitals take the time to find the right fit or quickly plug a vacancy?*

**ANN WHITE:** For an area as critical as the operating room, the hospital cannot afford to be without adequate leadership for very long. The organization may get surgical procedures done, but there will be no one to look at management of supplies or financials every month to say, “Are we headed in the right direction?”

**MARSHALL:** One thing we haven’t done well in healthcare is succession planning. When there is a key leadership vacancy—especially an abrupt departure—it often sends organizations into a panic. They are forced to make a reactionary decision instead of implementing a well-thought-out plan. Given the challenge of the current economy and the crucial

role that leadership stability plays in the performance and survivability of organizations, some of the old tactics, like hastily placing people without the necessary skill sets, will not work. Caution should be taken, which means adding time to find the right fit.


**HEALTHLEADERS:** *If the organization has had layoffs, are people uneasy about going into a leadership role?*

**CANALES:** Certainly there’s anxiety from leaders, especially going into new roles that may be uncharted or based on the shift in the business model. That’s why, going back to our question about fit, you shouldn’t be placing people to shift a change in behavior. It’s making the correct decision on selection to begin with and that’s why those fit assessments are so important. My expectation is that you come to the table with the technical skills, education, and track experience. I want to understand what am I getting as a leader. People are skeptical about joining new organizations right now. We’ve tried commuting policies to let people try on an opportunity when they are not willing to make a commitment to move right away. We’ve done it for six to nine months—even a year—and had a successful outcome.

**SMITH:** The emphasis now is more on fit than expediency. For a number of reasons, we are seeing clients take longer in the search process, but finding the right fit is certainly a driving factor. They are expecting more vetting from search firms and they are asking questions at a deeper level than what we have seen in the past.

**HEALTHLEADERS:** *How has the housing market and the fact that people might not be able to sell their homes changed your recruitment strategies?*

**MARSHALL:** We have been told by potential candidates that they have received job offers out of state, but have had to turn them down because of the housing market. Moving out of town and owning two homes is not an option. Some of our leaders are commuting from several hours away. We’ve set up a hotel-type concept in some of our vacant units where nurses, who are coming from Arkansas and Mississippi, can stay and then they go home



**Debra A. Canales**  
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on weekends. It used to be you gave three months of housing, but we've put in more flexible benefit packages. They won't come to you whole if they've got things they're worried about at home.

**SMITH:** The housing crisis has been the most disruptive event in executive search—at least in my career. There is less turnover as people cannot sell their homes. When a search does come in, it will be more difficult to fill than it was a year ago. When candidates are approached, you must have a relocation solution. It has driven the price of talent acquisition higher.

**CANALES:** It used to be, "Here's the package," and we didn't have any variation. Now we're doing more front-end discussions. "What is it going to take for you to get here?" People have choices, especially if they're a very attractive talent. Now candidates—those that are coming from four or five hours away—are asking for car rental as a part of the compensation package.

**HEALTHLEADERS:** *Some baby boomers have postponed retirement because they lost a good chunk of their investment portfolio. Now you may have five generations in the workplace. What impact has that had on recruiting?*

**CANALES:** Sometimes, the older generation folks don't want to take on that leadership role, so we're sticking a lot

of generation X-ers into management jobs. We haven't done enough training on managing within those five generations and that it is causing conflict. We haven't trained them to use personality dynamics to communicate openly and honestly with each generation in order to get things done. If the communications are not workable, a lot of new managers will leave. Then it's a revolving door. You need the right fit—someone who can learn from those five generations and capitalize on everything everybody brings to the table.

**SMITH:** Theoretically, the closer one gets to retirement the more conservative they are with their savings. However, I don't think that was happening, and many baby boomers lost 30%, 40%, and 50% of their portfolio and pushed retirement out another three to five years. For the system overall, it will prove a blessing, as we are not ready for the boomers to leave. When the market bounces back, there will be an exodus of historic proportions, and it will happen quickly.

**MARSHALL:** We're not only seeing more senior employees delaying retirement because of the uncertainty of the economy, but we are also receiving applications from quite a few nurses who want to come back to the specialty areas they left 15 years ago. While we are excited to see this additional RN resource pool open, bringing them back also means investing in education to get them back up to speed. Coming into an OR after being gone for 15 to 20 years is like *Star Wars*, and we are finding that the orientation is longer for them than it is for the new grad.

**WHITE:** I was the director of nursing for a free-standing ambulatory surgery center, and the OR staff, to my delight and surprise, consisted

of nurses that I had been a staff nurse with many years before. They were senior-level nurses and clearly becoming exhausted by the heavy work. We created an "equipment tech" position and that person was responsible for moving all of the heavy equipment in the department, so the nursing staff was not pushing 2,000-lb. OR tables all day. The OR nurses had such a skill and experience level that we definitely wanted to keep them.

**HEALTHLEADERS:** *If someone postpones retirement, does an up-and-coming leader who's ready to take on more responsibility and take over that role then leave?*

**MARSHALL:** Once those individuals are ready to step up to the next level, many organizations are finding that delayed retirements, if not processed into the strategy, could cause erosion of new talent. We have developed expanded roles, which includes mentoring to new leaders. This not only helps with the on-boarding of new talent, but also maximizes the capacity and value of both the up-and-coming leader and the senior leader, creating a win-win.

**CANALES:** In some cases, it's meant creating a whole new service line. We've leveraged special assignments where we've seen growth, process improvement opportunities, even advocacy—being a voice with legislation. At the heart of the matter is creativity. When you think about the holy grail of human resources, people want to have a voice at the table. It may mean bringing a successor that's in an interim role and that leader having oversight as part of a bridge for a year until that appointment is made.

**WHITE:** How good would it be for a new person to have an excellent leader with knowledge of how the organization works to be there for a significant overlap—several months, not weeks? The organization stands to benefit by matching those two with their skills, accomplishments, and experience.



Doug Smith  
CEO  
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**Dolores Marshall**  
Chief Nursing Officer  
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**HEALTHLEADERS:** *What strategies can organizations use today to get the right talent in the door?*

**WHITE:** Will the physicians—especially surgeons—support the position? What politics have been problematic in the past? How easy is it for a new person at that level to jump in with both feet? Yes, housing helps, transportation helps, but those will go away after a while. A new person is still left at the organization trying to solve difficult issues. The work is infinitely more difficult if physician support is not present.

**MARSHALL:** The key thing is transparency, because transparency can be used to gain competitive advantages. Being able to demonstrate a clear vision of what the purpose and values of the organization are and creating a matrix to measure what talents and skills are mandatory to accomplish those goals. Capitalizing on transparency is one of the best tools that any organization has to go out and hire the right talent.

**CANALES:** You have to be strong in the top five around compensation, benefits, vacation, perks, and supervisor. We've instituted guiding behaviors that help drive our value statements, because it's what continues to engage people. We've changed our recruitment approach and offer leaders and their families and prospective candidates to come for a weekend and see what it's like. There is an additional expense, but it more than pays off as part of that commitment from that leader for the long term.

**SMITH:** Social media such as LinkedIn, Facebook, and Twitter has changed the recruitment industry. Employers have to represent themselves well online. If not, they are less than competitive for job seekers. You must impress and gain interest quickly.

**HEALTHLEADERS:** *Aside from a competitive salary, what other strategies are you seeing hospitals use to close the deal and*

*get that top leader into the organization?*

**MARSHALL:** Being very flexible with relocation packages. Look at what you're offering and ask, "What would it take—other than competitive compensation—to get you to come here?" Education and training is now being added.

Most organizations have found that nursing sign-on bonuses do relatively little to keep people there. We're finding the same thing with the executives.

**CANALES:** I'm also seeing a big shift in the continued support of executive coaching relationships, especially for senior leaders. Maybe it's a mission assignment where you're going to help with the launch of a new hospital. Or it's honoring board commitments people may have. As you look at what keeps them there, it's freedom and autonomy.

**SMITH:** This recession has taught us all something. It is not all about the money. People want to join and be associated with an organization they are proud to have their name associated with. Yes, they want to be paid competitively, but if the two are a great fit, rarely is compensation the deciding factor.

**HEALTHLEADERS:** *Education programs are one of the first areas organizations cut. Is it shortsighted, or just the reality of the situation?*

**MARSHALL:** It is shortsighted, and it's also a reality. If you don't do a SWOT analysis and look at exactly what the final results will be from cutting those programs, then you tend to think the easiest thing to cut is education. You don't realize the far-reaching effects of cutting education and training until you're trying to backpedal. It costs you twice as much money to put it back. Healthcare is a learning profession, so

if you take that away, how do you gain that competitive edge? You don't.

**WHITE:** There's probably no area of the hospital where there is more technology, new procedures, new physicians, new equipment, new instrumentation than in the surgical department. When I go into a facility and see that the OR staff gets an hour per month for unit meetings and inservice education, I know I'm going to have a difficult time. An organization cannot sustain an excellent reputation by cutting back staff education hours.

**CANALES:** It's easy to just default and go directly to cutting. As an HR function, how am I connecting this work around leadership development as part of driving the business and demonstrating that return on investment?

**MARSHALL:** The HR role has changed. In the past, I always saw them as a support function, but now HR departments are seen as "profit centers" and expected to have a major strategic role in managing human capital.

**HEALTHLEADERS:** *What areas do leaders need development and training on today?*

**MARSHALL:** Finance. We all have an obligation to be fiscally responsive. We don't learn a lot of finance in nursing, but we need to know the finances and economics of healthcare so we can advocate for clinical needs effectively.

**WHITE:** Anything and everything related to productivity, supply management, charging, and coding. I might have 5,000 supply items in my OR. I have to manage that. No one sat me down to teach me how. It's interesting to try and figure out what a "turn" is with inventory use or what "par levels" are.

**CANALES:** We are very conflict averse in our industry. It's something we assume our leaders are doing well, but it just does not trickle down. I had my communication person sit in our meeting to capture what our priorities are for FY 2010, so that every head of HR could go back to their senior leadership team with what we did in a session together. You'd think it was the best thing since sliced bread. It was a tool that I would have taken for granted, because my assumption was you know what the messages are and I'm not going to patronize you, but it was such a value.

**MARSHALL:** We think the message is going out in the manner that we intended and sometimes it's the wrong messenger. I kid with my staff and say, "Would you want Hitler delivering Gandhi's message?" Many of our leaders shy away from having face-to-face critical conversations. They'll send an e-mail. I think we all know that e-mail's the worst thing you can do. Delegating continues to be a hard thing. Some of my managers tell me they're overwhelmed because they've got too much to do, and I am finding that many of the things they're doing they could have delegated. They'll say, "My plate is so full," and I say, "You must start eating and eat the right thing."

**HEALTHLEADERS:** *How can organizations best use interim leaders?*

**WHITE:** When I go into an organization and all they want is "maintenance," I'll do it because it's part of the job. But they've lost a huge component of the expertise I bring to the table.

**SMITH:** Interim leadership has bloomed through this recession. Hiring a private contractor to simply hold things together is not where this new movement is going. Clients want to clearly define goals and measure progress. Joining the leadership team and playing a pivotal role moving an organization forward is the right way to do interim.

**CANALES:** It certainly has become, for us, a different alternative in using interims as part of that management transition. Bringing in someone who is overqualified brings the richness and wisdom to help us think differently and push that learning edge, which is what I've seen as tremendous value.

**HEALTHLEADERS:** *How can organizations integrate interim leaders into their culture to maximize effectiveness?*

**MARSHALL:** When I went to my assignments, I felt like I was already a part of that organization because they introduced me to key stakeholders as if I were the permanent person. The organization and I made a commitment that I would be there as long as it was going to take to get the right person into the permanent position.

**SMITH:** Proper on-boarding increases the effectiveness and tenure of executive placements. It's the same for interim leaders. Strong interims, who are on-boarded well, are extremely valuable. An issue for us is getting our interims out of the organizations. Many move from one project to another within an organization.

**WHITE:** I see my role as a real problem solver. I get in there, do as much as I can, and then it's time for a new assignment. At one facility,

the person I reported to reported to a service line administrator and she said, "You know, Ann can get away with bringing problems forward because she's only here a short time, but Ann probably couldn't do that if she were here permanently."

**HEALTHLEADERS:** *Do you have any closing thoughts on leadership development?*

**MARSHALL:** In these times, effective leadership and development strategies will be the most crucial predictors of survival. Effective succession plans should identify the who, what, and how leadership requirement for the future.

**SMITH:** We say keep the main thing, the main thing. Leadership development is the main thing. Our clients look internally now more than ever. If they can develop internal talent, that is what we recommend they do. If that is not possible, then they do a search.

**CANALES:** When you think about the value tree of delivering a great care experience, it's rooted in the engagement of your associates. We have a challenge to constantly think of alternative solutions so leadership development can be based on what economic climate you're in and ensure leadership development never gets eliminated as part of the longer-term impact. ■

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