



ROUNDTABLE

Building a Leadership Culture

What attributes make for an effective leadership culture at healthcare organizations? Different hospitals and healthcare systems have succeeded with different approaches to leadership. Boards and CEOs are often preoccupied with establishing lasting leadership values, yet there is no easy method of doing so. Most healthcare organizations have created mission and values statements (combining clinical and business goals), some have developed formal leadership development programs, and many apply the standard tools of performance reviews, organizational charts, and succession planning, among others. Leadership must always be accountable for results—the right results for the organization. Four executives recently gathered with HealthLeaders Media for an in-depth, three-hour conversation on leadership, organizational culture, and the difficult environment for decision-making.



PANELIST PROFILES



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Roundtable Highlights

HEALTHLEADERS MEDIA: *How does the organizational culture of hospitals get founded?*

DOUG SMITH: Many of these roots go back a hundred years. You could be for-profit or not-for-profit. You can be a physicians' hospital. You could be a faith-based hospital, which is supported by the community. And now with all the consolidation taking place, changing some of those cultures is going to be difficult. It's going to take a while. It could take generations.

DANIEL SLIPKOVICH: Capella is eight years old now. So it's still relatively a new company. Going through the list of our prior ownership, it's HCA, Triad Hospitals, and Community Health Systems.

Community-based, nonprofit, and physician-owned hospitals are all also in our background. And we're in a JV with a faith-based system. As I think through each of those and their history, the cultures are very different. It's not that they're thinking about the world in the wrong way; it's really kind of how they evolved, how they focused on what they focused on as an organization. Depending on that background, they probably focused more or less on specific aspects of the business.

HEALTHLEADERS: *What creates change in your organizations? What levers are you able to use?*

CHRIS VAN GORDER: Right off the bat, I established what we called the Physician Leadership Cabinet because we believe culture is established through engagement and trust. I've always had pretty good working relationships

with docs ... really, there's no need for an adversarial relationship. The issue is a gap of information. The physicians don't necessarily have the business knowledge or information, and there's no forum for them to get it because they're busy taking care of patients. We [executives] may have business knowledge ... but most of us don't have clinical knowledge. So we really need to fill the gap of information together. My theory was smart people will reach similar, if not the same, conclusions.

So I brought all the chiefs of staff and vice chiefs of staff together in a room, literally within 30 days [of becoming Scripps CEO], and said, "Look, I'm going to form a group called the Physician Leadership Cabinet, and you'll be

advisors to me." ... One of the chiefs of staff in Chula Vista said, "Now we want to be a board. We got rid of the last CEO, we can do that again. We want to be a board with

real authority." And I said, "Look, why don't we start really establishing some truth here. I have no authority to take power away from the board of trustees and give it to you. They have hired me as a CEO at least as long as I'm here. I'm willing to share that role with you, but I'm not going to abdicate my role and responsibility. I can't do that." I said, "What formal power did you have to get rid of the last CEO? None. Your informal power is much more powerful than any formal power I could ever give you." I said, "Why don't we try and work together and we'll demonstrate that."

We have accepted 100% of the recommendations coming out of that group over the 14 years I've been CEO. Officially it doesn't exist. It's not in

the bylaws. It's purely advisory. Now we have physicians wanting to be chief of staff just to be part of the Physician Leadership Cabinet. Today we wouldn't even consider taking our strategic plan to the board of trustees for approval without endorsement of the PLC. We don't appoint any physicians to any task force; we take it to the Physician Leadership Cabinet. We make recommendations, but they appoint the task force.



Todd Linden, FACHE
President and CEO
Grinnell Regional
Medical Center

TODD LINDEN: As I think about the history of our organization—and I've been there just over 19 years now—at every turn it's been the community that's really been the factor in setting the culture. I think it's because in a community the size of Grinnell, there's such a personal relationship between organizations and institutions and the community. So our culture really starts and ends with our board. They are the representatives of the community. They take that responsibility very seriously and set about constantly focused on how can we have the best governance so that the next generation can enjoy the hospital.

SMITH: Strong cultures begin with the senior leadership team. Executives need to define their organization's culture

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and build it on honesty, quality, communication, and transparency. I think if you have those things, the culture will take care of itself. Where we've seen cultures fall apart is when those aspects are disintegrating—where there's a lack of consistency and factions in the leadership team.

HEALTHLEADERS: *From a cultural standpoint, how do organizations get themselves into binds?*

SMITH: We've seen cultures that needed to be turned around because organizations have gotten away from honesty, transparency, and consistency. They haven't transitioned out players who are not supportive. ... That's where culture really falls apart. When the integrity of the system breaks, it can disintegrate very quickly.

HEALTHLEADERS: *Each of you in different ways has been thoughtful about creating structures for leadership.*



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SLIPKOVICH: We spent two years to [set up] the measurement tools. ... It's quality indicators, it's service indicators such as HCAHPS (patient satisfaction), it's employee survey results, it's physicians' survey results, it's financial indicators. We have to be very consistent. Part of what I do is, our department heads get together once a month, and I put up my Leadership Evaluation

Module goal sheet that says, "Here are my 10 major goals for 2013, here's how we're doing it." Now is everybody sitting in that room accountable to those goals? You're darn right. ... I remember early on, one of my CEOs—one of the best CEOs in the company at the time—she said, "Dan, just hold us accountable. Tell us where you want us to be as an organization and hold us accountable." For the really strong CEOs, that was easy. For the ones who were not as experienced, it was about putting a process or a platform in place to help guide them in achieving consistent and sustainable results for their organization. We spent approximately two years getting the structure in place, and the past two to three years, it's been about the accountability and supporting the use of the tools we put in place. Now, regardless of the individual leader's strengths or weaknesses—or transitions in leadership—the tools help each hospital achieve significant sustainable progress.

VAN GORDER: We weren't really doing any management education when I came to Scripps. We were relying on universities and others to do that, and we were getting a hodgepodge of different things as a result. So we created the Center for Learning and Innovation and now have over 150 different kinds of courses employees can take. ... We created the Physician Leadership Cabinet. We created the Scripps Leadership Academy for middle managers, which is now in its 14th year. About five years ago, we established a Physician Leadership Academy. There are about 80 physicians who go through a yearlong program. ... You know, doctors come

out of medical school and they've never been trained in any management. A lot of physicians to this day think that, "Well, I can go get an MBA and I can be a CEO." I think most of us would agree, we didn't learn how to be CEOs

in grad school, we learned it by experience and making lots of mistakes along the way. So we have to create environments where our physicians can get that kind of management experience if we want them to be really good future leaders. So we created mechanisms for that.

LINDEN: Our annual "Board Advance" has moved from a board and administrative focus to a full medical staff focus. Obviously we have physicians on our board, but then we started to bring the organized medical staff leadership to the advance, and then realized that the more folks we had engaged in that, the better the planning was going to be. ... So the Board Advance has become a really important tool for board and medical staff engagement.

HEALTHLEADERS: *Today's environment requires faster actions and faster turn-arounds, and is much less forgiving. Does that change the game of leadership?*

SLIPKOVICH: I've been in healthcare since the early '80s, and we're facing as much challenge today as the industry has ever faced. You don't have three, four, five years to turn things around. Consider all the issues: the regulatory issues, the big EHR changes, what are the exchanges going to mean to us, what are ACOs going to mean to us? You can go down the list. Before, you may have taken a year or two, but maybe

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you have a month or two today to make major strategy decisions. Which really gets back to the fundamentals of leadership: Do you have the right processes in place? Do you have your physician relationships in place? Do you have your boards functioning? ...

We're going to miss on some decisions. I think we're heading into two or three years where about half of what we do is going to be right and about half of what we do is going to be wrong. ... But sitting still and not doing anything at all will probably be the wrong decision.

SMITH: I'm very bullish on healthcare right now because of the speed necessary and the fact that you have to be very candid with your teams, because you don't have time.

VAN GORDER: We have market conditions today that will get people more aligned faster than we did 14 years ago. So I think that we do have to move faster, but I think we can move faster today than we used to be able to.

LINDEN: It's not the ACA. The ACA was a governmental response to the market. Nobody can afford healthcare today, whether it's the government or employers or individuals. I think that reform is the burning platform for compelling us to move quickly.

HEALTHLEADERS: *What are the requirements of leaders today? What does a good leader have to bring to the table?*

LINDEN: I think a strong sense of values, a conscience—and probably a misplaced sense of fear. I think the reality is that bold is going to be the place to be because we are in such a transition. Clearly, the communication skills we talked about, the ability to create some vision and excitement.

VAN GORDER: Any leader has to operate at a fairly high level so they understand what are the drivers in the marketplace, etc., and be able to take that all the way down to the different stakeholders. ... It's

all the way from that visionary, inspirational leader to understanding the business and being willing to roll up your sleeves and get your hands dirty.

SMITH: Ultimately, you have to own your decisions. Sometimes it's easy to lay blame or lay responsibility elsewhere. The minute leaders do, they lose with the docs and they lose with their employees. The fundamental truth is the local leader really needs to drive it and ultimately own the decision.

SLIPKOVICH: Values and integrity are key requirements for great leaders. They also have to be comfortable with risk. We're moving into a very risk-based environment, and typically in healthcare, particularly on the clinical levels, they're not used to that. ... They also have to be communicators across the spectrum of care, more so now than ever before as we move into more of a care management/case management type of environment.

HEALTHLEADERS: *Leadership development programs in some places are very formal and in other places aren't. Talk about your approaches to leadership development.*

VAN GORDER: We decided that what we wanted to do is try to grow a lot of our own leaders, because we wanted to build and sustain a culture. Inserting people all the time from the outside was not going to be helpful. So the thought was, let's try to grow our people and then also build some loyalty. ... Staff know that the organization is going to invest in their career goals. So we developed lots and lots of programs for emerging leaders and yearlong formal mentorship programs. Then we have the administrative residencies and fellowship programs that we'll do with the academic universities as well.

What I tell people is, "I really want you to hire from within. Give people a shot from within." I went through a couple of chief information officers; they not only did not perform really well, culturally they weren't that great

of a fit. And then you have this young guy in there who probably never would have been looked at as a chief information officer, but he had all those leadership and management attributes we really wanted, so you say, "Know what? We're going to give you a job. We're going to give you a shot at this." Today, everybody we've promoted from within has performed much, much



better than anybody we've hired from the outside because, I think ... they had a great attitude saying, "I'm going to deliver because this is an organization that gave me an opportunity nobody else would ever give."

LINDEN: For us, it's identifying talent that comes into the organization. I know they may not stay long-term given the size of our organization, but I'd rather be known as a place that folks can come and do a really good job and I'll help them move on. I've got a handful of young leaders who are CEOs now [for whom] I did a fair amount of mentoring. Others hear that, and so they see there's opportunities here and then beyond.

HEALTHLEADERS: *What are sources of inspiration for your leadership culture?*

SLIPKOVICH: This last couple of years we've been really increasing our focus on patient safety, and we've partnered with Vanderbilt on their PARS [Patient at Risk Score] program. ... As part of

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the education process, we brought in a gentleman, Ridley Barron. Ridley is a minister by background, and his story was probably one of the most emotional stories you'll ever want to hear. His family was in a car wreck in Georgia and his wife was killed instantly. His youngest child was ejected in his car seat from the vehicle. This little boy should have survived his injuries, but there was a pharmaceutical error at the hospital. They gave the child an adult dose versus a pediatric dose. We had our board chairmen and our physician leaders from each of our hospitals ... and we did this one session with him where he shared the experience of where your systems break down ... from that initial ER experience where the child was brought in, to the breakdown of the process, to the really significant incident where there was the medication error and what he was and wasn't told for a 48-hour period about the child's condition, to where ultimately on his way out he was contacted by the facility attorney



Chris Van Gorder, FACHE
President and CEO
Scripps Health

rather than a caregiver. That story was so compelling, we brought our department managers together as well to hear it. ... I'll remember our doc group just sitting there, and looking at every one of their faces as we're talking about these patient safety initiatives. ... They weren't disconnected necessarily from patient safety, but it helped them see [how] that whole series of events could happen.

LINDEN: Our board and our leadership team decided a number of years ago to see how we can structurally reach even deeper into the community. ... We now have a series of advisory groups, and one of them is the Family and Patient Care Council. It's a group of either family members or patients themselves who meet every other month. They're like a souped-up focus group. We bring anything and everything we can think of to them and say, "What are we missing from the patient perspective?" They give unbelievable insight. We all think, "Oh, we're patients, too," but sometimes you do get those blinders on.


This is a group that really helps us zero in on what we're missing from a patient point of view. We share patient harm stories with them and talk about where was the breakdown and how did we work through that, but it's also a great place to introduce new concepts—for example, opening the ICU visiting hours up. The nursing staff wasn't as keen on that as I was, but rolling it through the Patient Care Council and letting them talk about why that's beneficial from a patient point of view is good. The caregivers are a lot more interested in hearing their perspective than my perspective on whether we ought to have open hours.

VAN GORDER: [Team trips to Haiti and New Orleans] were probably the most powerful experiences I've had personally and, I think, for the organization as well. I was doing surgery with my chief medical officer. ... I'm an EMT, that's the limit of my clinical training, and here I am doing surgery with him, just the two of us. For

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me to be able to connect with the patient to that degree was something that I was never going to be able to experience in the United States. We went back and presented it, and [Scripps CMO] Brent Eastman, who's now the president of the American College of Surgeons, he's taken that story international. I mean, it bonded

the two of us together lifelong. ... I often publicly call my chief medical officer my partner. I was the administrator and he was the physician lead, but together we were partners. That philosophy has gone through the organization, and that's what our medical staff and our administrative teams have got to be: partners together in care.

Another thing, and Brent Eastman was responsible for this, [happened when] we get all our managers together, probably about 600 of them, once a quarter in one big meeting to talk about the business of healthcare and the direction of the organization. He said, "There's something missing here. We need to bring a patient in here." And I said, "What a wonderful idea." So before we ever start any management meeting, the physician and that physician's patient come in and they both talk about their patient experience, be that a trauma case or whatever it ends up being. We start the meeting with that, and then I get up and say, "It's important for us to start our meeting understanding this is what we're talking about. We're going to talk about the business of healthcare the rest of this day, but it's all about that patient and that physician." It's very rare that the patient doesn't get a standing ovation. ... It's so powerful, I get that inspiration from that. 

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