ROUNDTABLE

High-Demand Competencies: Developing Your Own Leaders

As healthcare transitions to new incentives and requirements, the industry is experiencing a dramatic shift in key competencies. As hospitals' mission morphs from treating the sick and being paid on a fee-for-service basis to keeping patients healthy and being reimbursed on how well they manage that task, hospitals can either buy the talent they need or commit to developing it internally. Regardless, they must cultivate new competencies in areas such as risk management, case management, and medical informatics. Indeed, even senior leaders such as chief medical officers, chief nursing officers, chief financial officers, chief operating officers, and CEOs will have to broaden their capabilities and serve as a bridge between the clinical and financial.

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Inspired Healthcare Leadership

Roundtable Highlights

HEALTHLEADERS: *What are some of the competencies that you have to recruit or develop in order to meet challenges that you haven't had to deal with before?*

JEANENE MARTIN: We are focusing on business acumen, something that we haven't spent a lot of time on in the past. We're helping our managers and executives understand value-based purchasing, HCAHPS, publicly reported clinical data, and how all of those elements are going to impact reimbursement. We've partnered with some external organizations to help us, as well as using internal departments such as finance, quality, service excellence, and staff development.

DOUG SMITH: Candidates need to bring a brand to the table, and that brand now has to have the financial acumen. It also has to say, "I'm able to establish relationships across silos and bring those silos together."

MARLON PRIEST, MD: We spend a lot of time building a set of team competencies. Not everybody is going to come with the same level of financial understanding, operational understanding, or clinical experience. We've been looking for clinical leaders to pair with the traditional operational leaders. Developing a culture of risk-taking is big—that is, risk-taking in a way in which you can get to failure or success quickly so we can put the learning in place.

MANOJ PAWAR, MD: From a strategic perspective, we look for skills that will be necessary to eventually manage populations. What we need is leadership that can take fragmented system pieces and integrate them. In order to do that, the capacity to lead across silos is critical. It's important for the hospital people to understand how the medical group works as well as home health and the rest of the continuum. People tend to be pretty isolated in terms of how they see their world, and it's really going to be incumbent upon all of us to be able to get to the bigger strategic picture.

SMITH: You have to intellectually know what's going on in the hospital and what's important to operating the organization, but you also have to show an ability to build engagement with your team.

PRIEST: I listen carefully to determine if team members understand and stay focused on our customer—the patient. If you can do what matters to the patient, you can produce substantive change because you have a focal point. We use this focus to get beyond the silos. If you look at manufacturing, those who can focus on what their core product is do well. Now that outcomes is the issue on the table, the public is going to ask us to focus on them. I'm looking for people who can move quickly to what the public is asking us to do—provide an extraordinary individual experience of high value.

SMITH: It's almost taking on a retail-type mind-set. One of the things that we're seeing is the idea of bringing in people from outside the industry because they have a different set of competencies and they ask different questions.

MARTIN: Other industries have probably been more results-focused than healthcare organizations have been in the past. We have had a tendency to reward people for effort versus outcomes; moving toward a results-oriented, achievement-oriented culture is essential for our industry.

PRIEST: Even our payment system paid us for process—paid us for how much we did, not for the outcomes or the product we delivered.

HEALTHLEADERS: *How do you get your existing employees to buy into that teamwork concept?*

PRIEST: It's an interesting challenge. I probably spend 30% or 40% of my time on leader development. I have a disparate group, and we've added some who came from totally outside of healthcare. We've used some interesting exercises. For instance, the team had to prepare a meal together, with 24 hours' notice to plan it and execute. Then we critiqued not only the product but also the efficiency and effectiveness of the effort. Did they waste money? Did people get enough to eat? Did they get too much? For us, one of the biggest steps was to narrow the number of objectives that people were pursuing so that they could identify their core work.

Doug Smith
President and CEO
B. E. Smith

SMITH: There's an incredible amount of retraining going on. Teamwork is a competency, and you're going to have to learn that. A number of individuals in our industry are fighting that and probably won't make it. Mentoring is a huge thing. Experiential learning helps people learn how to deal with some of the challenges.

MARTIN: We've given executives projects that are completely outside of

their traditional area of responsibility. The team members have the base knowledge, but it gives the executive the opportunity to function outside their silo and learn a different aspect of the business. We've traditionally functioned in limited operational areas and haven't necessarily focused on how we're impacting the rest of the organization. These experiences have been very developmental for the executive, as well as others in the organization who worked with them.

PAWAR: When we think about current talent or even the talent that we're recruiting, we're concerned with the competencies that are going to be necessary to succeed based on the strategic objectives of the next decade. But our assessments and the way we evaluate people and our talent engagement processes are geared toward identifying success factors for the current state of the industry. We've got assessment processes, but there's nothing like putting people into scenarios where there's a bit of a stretch to see how they can perform.

Marlon Priest, MD
EVP, CMO
Bon Secours Health System, Inc.

PRIEST: There are a lot of bright and talented individuals in this service industry. If you can't create scenarios where they feel a little like it's their first college geometry test, it sort of gets old for some of them. To use a sports analogy, I think the majority of people who will succeed in leadership in the future will have to be able to audible, and you may change the play three times before executing it because the rules keep changing.

MARTIN: We have to not be afraid to fail. Sometimes I think we have analysis paralysis. We have so much data now, but business intelligence is something that's been slow to develop in healthcare, such as what data you need, in what format, and understanding what the data is telling us.

PAWAR: When you talk about work that involves collaboration across functional silos, conversations around data are a good example. Something as fundamental as generating basic agreement around data definitions is essential as we move toward systemness, and it can involve a lot of conflict. The beauty is in coming to the realization that we're not counting things the same way. There's a lot of basic conflict management, and effective conversational skills are a very important leverage point.

PRIEST: We are so uncomfortable as an industry in creating conflict. We want to manage it so it goes away, but there needs to be some healthy tension in order to produce substantive change.

PAWAR: Adequate amounts of healthy conflict are essential for an organization to grow and adapt. Part of the role of a leader is to be thoughtful about when they introduce challenges that can serve as adaptive stressors. These small tests might not consist of managing global risk for a population overnight, but might be something as simple as identifying opportunities to reduce variation in cost or quality within a service line.

SMITH: The concept of moving players around is critical. First of all, they work more strategically for the whole organization and they get opportunities to be mentored by others. I can see a new vibrancy in the way they come to work, and they don't get stale, because if they get stale they're leaving the organization. You move them around and they learn to handle change. They learn to be decisive.

PRIEST: And they have to understand that the leadership in the organization is willing to allow them to make some mistakes.

MARTIN: It takes a fairly self-confident individual to be willing to take that risk. Some people are completely out of their comfort zone, and while they can be incredibly successful where they are, moving them into another role just isn't an option. Being able to do that is not something that I think is essential and critical to an executive's success, but there certainly is value when we're able to pluck people and move them where we need them.

SMITH: They've got working relationships all over the organization, which is a silo-buster, because when you hit walls where progress slows because you're not working well with another division, they have contacts and working relationships in those divisions.

PAWAR: There's a level of comfort with ambiguity and the unknown that we want from our people. Those who don't like change and want things to stay the same—that's a tough spot to be in in healthcare.

PRIEST: On the other hand, they are very adept at their work. One of the challenges we run into is their ability to control enough of their environment for their world not to change even when it needs to change, and our unwillingness at times to identify those people and say, "You know, that clique needs a little new blood in it."

MARTIN: And [another challenge is having] a crucial conversation with that individual, because this is often

very difficult for executive leaders; it's often easier for managers than executives because they are supervising on a daily basis.

HEALTHLEADERS: *Speaking of silos, how difficult is it to get individuals to see the hospital or health system as a whole?*

PAWAR: The problem is when you are comfortable with your part of the world, you can optimize your piece of the pie. But you aren't necessarily aware of what the secondary or the unintended consequences elsewhere are. You need to have a representation of all of the pieces of the continuum in the room together. The first step is getting the right people in the room—a job we don't necessarily do well.

SMITH: And the penalties will continue to get more severe for not working together as a team.

PRIEST: For an industry that had so much expenditure and so much innovation, why did it take us so long to hold people accountable for the appropriate outcomes for the resources we have available? The public's been asking us this for a long time.

SMITH: Many healthcare professionals have been trained in a clinical atmosphere, and not with the business acumen that you see outside of healthcare. This move toward value has crept along instead of jumping, because organizations were still making money.

PAWAR: The economic pressures were not there to force people to look at this. These pressures can set the table for some difficult conversations that need to happen. It's not only specialty, role differences, and generational differences, but also geographic and cultural differences that we have to recognize in order to see the system as a whole. The heavy lifting from a leadership perspective is building some common ground initially to get closer to a whole-system perspective.

MARTIN: From an executive leadership development perspective, those are the skills that we have to help our leaders develop, and an understanding that when you're running a team, it's not going to be homogenous. You've got five generations working together. It's important for us to help our leaders at all levels to understand and appreciate those differences, much like we've done with cultural diversity.

SMITH: The vigorous debate is healthy as long as it's constructive, as long as you have a guiding set of criteria so that you end up in a good place for the organization.

PAWAR: To use a physician analogy, as executives, we're often prescribing a treatment plan before we have taken a history or really understood what was going on with the organization. You have to diagnose before you can treat, and this involves listening and truly understanding.

HEALTHLEADERS: *Much of physicians' time is spent on things that don't necessarily require a physician. Are you moving some of their responsibilities to others, and seeing physicians more as managers of patient health?*

PAWAR: It's interesting you mention the word *managers*. We're reframing our vision to see physicians as managers because that's an important part of their role. Physicians have a tremendous amount of influence over the resources we use. And they are a resource, too. When you're using a valuable, limited, precious resource it's important to leverage that resource for the biggest impact. But that's a big cultural shift, and often barriers such as financial incentives stand in the way.

PRIEST: The paternal way we often manage patient care doesn't encourage the patient to be engaged. Now the payment is based on the diagnosis and the number of things you do to people. The rationale for that was sound. But the payment model has got to change from, "If I'm going to bill, I have to personally provide a codable service." We need to get more comfortable with physicians making decisions they are uniquely prepared to make and working with other team members to do what they do best. That will improve the cost per individual as well as outcomes.

Jeanene Martin
SVP, Human Resources
WakeMed Health & Hospitals

SMITH: It takes a lot of time to make such a transition, but it can be done. We have the foundation for encouraging it now, but you're talking about behaviors that have become almost genetic. When I decided to change my own organization, I was quite naive at how quickly I thought I could make it happen. I thought I could change the financial incentives, and the next day the behavior would change. Instead, we had a tremendous amount of turnover and very contentious discussions.

PAWAR: We underestimate the amount of time cultural change takes. You hear people say three years, four years. Well, it's probably more like a decade or more. For instance, just because you take away the economic barriers, it doesn't necessarily mean all physicians will want to limit their practice to only those things that require a physician's level of training, despite competition from others that may provide care for simple problems at a lower cost.

HEALTHLEADERS: *To begin to make this transition, what are some of the skills that you have had to recruit from outside the organization?*

MARTIN: Where we've typically gone outside is when we're looking for very specific skill sets. But we also do a fair amount of internal promoting. One of our most recent hires was a chief nursing officer. That's an area where I would have hoped we would have had leadership in the pipeline because it's our largest area of employees. But we were looking for someone who had moved HCAHPS scores, had moved the culture, had implemented not just tactics within nursing, but strategies within nursing, and who had created a high-level service excellence culture in another organization.

Manoj Pawar, MD
Vice President
Catholic Health Initiatives

SMITH: The way organizations manage talent is significantly evolving. It is all about precision in finding that one right candidate that can be successful in today's environment but lead within the organization of tomorrow. More and more organizations are utilizing interim leaders to stabilize the situation until that precise candidate can be found. It is too risky to leave a key position vacant, yet also too risky to make the wrong hiring decision.

PAWAR: For many of these jobs, there is a limited talent pool. But I also wonder whether systems are being a lot more selective and specific about what they want.

SMITH: That's certainly a piece. We are expected to vet our candidates much more closely now—everything from whether they can sell their home to their presence on social media to how they have changed entire organizations and cultures. Organizations are requiring more out of us to prove that a candidate is worthy, but there's clearly not enough talent.

PAWAR: It should be an expectation that if you're a leader in an organization, your job also entails figuring out who's going to take your place.

SMITH: You're going to see it get serious now, and succession planning will be essential. Supporting that planning with more formalized leadership development and mentoring all levels of the organization will be the future.

HEALTHLEADERS: *What is the most significant competency that you're trying to develop in your physician leaders?*

MARTIN: Our physician directors do a good job at running their area of responsibility in terms of having a vision and growing the practice, but where they are struggling is in the people management aspect, especially when dealing with challenging employees.

PAWAR: Part of the physician mindset is that there are certain implications in terms of how you see the world. If you want it done right, do it yourself, for example. But there's an inflection point where people start to realize, "Wait a minute, I can't do this all by myself." Making your work scalable requires you to be an effective leader of teams.

HEALTHLEADERS: *Speaking of promoting from within or recruiting from outside, what's the right mix?*

MARTIN: You don't want 100% of your executive positions filled internally. We need to have new ideas coming in, particularly if you have a long-tenured staff. We need to have new people.

SMITH: I think it's 35% you go out to recruit, and 65% you stay in. However, five years ago I think it was exactly the reverse.

MARTIN: We're at 68% internal.

PAWAR: Also it depends on the pace of change in the organization. It only takes time. But if you say you're going to start to develop folks to deal with some of the changes that are on the horizon, well, the horizon is already here. Do you have time or do you need to bring those folks in from the outside?

MARTIN: We are dealing with this in a couple of situations on the physician leadership side. We have a couple of physicians who are really bright and we need to move them into leadership positions, but a lot of development needs to be done in terms of management skill. It's not unlike other great clinical staff that we move into leadership positions; we need to invest in new leaders early to provide them with the skill development needed to manage people. At the same time, how do we fast-track them with leadership development in their clinical role so that they are ready when the opportunity presents itself?

PRIEST: We face that on a regular basis. A big part of my time is watching, helping, guiding, mentoring, and working with the local CEOs to develop leadership talent at that level. Give them another project. Put them in another place and let's see how it works. Provide support and give feedback. You can take people to class and all the training you like. But sometimes you have to be in the ring to be able to learn to change and how to create change.

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