HealthLeaders Media | Intelligence

FREE REPORT

November 2013

Restructuring Executive Compensation for the Shift From Volume to Value

An independent HealthLeaders Media Survey supported by

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Restructuring Executive Compensation for the Shift From Volume to Value

This report reveals how the shift from volume to value is reshaping compensation and incentives and demanding new C-suite skills.

- Learn which value metrics are now driving incentives nearly as much as volume metrics
- Discover how CMC Healthcare System successfully shifted its executive incentive compensation from 90% volume-based to 90% value-based
- Find out which three key skills for CEO success have seen considerable increase in demand since 2012
- Deep-dive into over 400 charts with segmented peer data
- Learn from case study examples: CMC Healthcare System/Catholic Medical Center, The MetroHealth System, and Texas Health Resources

Perspective

RECRUITMENT, RETENTION, AND EXECUTIVE COMPENSATION IN HEALTHCARE'S PERFORMANCE-BASED ENVIRONMENT

New government regulations and technology advancements have significantly transformed the healthcare landscape, creating a period of both great opportunity and great risk for organizations and senior healthcare executives. The margin of error is increasingly thin as decreasing reimbursements, increasing competition, and leadership turnover challenge healthcare organizations. Additionally, leadership skills and executive compensation are trying to keep pace with the rapidly changing industry. This year's *HealthLeaders Media Executive Compensation Survey* demonstrates the importance of investing in your workforce and aligning executive compensation packages to the new performance-based environment.

Healthcare reform is changing many of the long-standing rules for running a successful hospital or health system. This evolution is ushering in a new set of leadership competencies for CEO and C-suite executives. Identifying, developing, and retaining pressure-proven and experienced healthcare executives who can create cultures of high performance, innovation, and flexibility will be the hallmarks for growth, quality, and efficiency. This year, healthcare executives identified optimizing care across the continuum, physician alignment, cost containment, and performance metrics as the most important skills for top executives. Training and leadership development programs can not only strengthen these skill sets in current and future leaders, but also serve as powerful recruitment and retention tools.

Leadership development programs, combined with established succession plans, can help address another challenge facing healthcare organizations: leadership turnover. The industry has struggled to successfully address this issue, particularly among senior executives. In fact, healthcare leads all sectors for CEO turnover at 17%, a near record high. Unfortunately this year's survey shows that trend is likely to continue, as 45% of executives said they would have to leave their current organization to advance their career, with 19% currently conducting a job search.

Executive compensation will play a critical role in recruiting and retaining these top healthcare executives. Organizations that offer compensation packages that are tied to performance-based metrics will have a strong competitive advantage. This is already a growing trend in the industry as an increasing percentage of executive compensation is being tied to performance metrics and performance bonuses, specifically operating margin, patient satisfaction targets, and clinical performance targets. According to the survey, healthcare executives equally cited performance metrics and performance bonuses as the elements of compensation that have evolved the most over the past two years. This trend will become more prominent in 2014 and beyond; with 88% of healthcare leaders stating executive compensation at their organization still needed further enhancement.

The transition to value-based care is placing greater financial, operational, and clinical pressures on healthcare organizations. Institutions can overcome these challenges by identifying future leaders, investing in their development, and retaining experienced leaders already in the organization. Additionally, a competitive compensation package, which leverages incentives based on performance metrics, will engage these leaders and hold them accountable in healthcare's new value-based care model.

Doug Smith
President and CEO
B. E. Smith
Lenexa, Kan.

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the November 2013 HealthLeaders Media Intelligence Report, ***Restructuring Executive Compensation for the Shift From Volume to Value***. In the full report, you'll find a wealth of additional information, including the results of all the survey questions. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Joseph Pepe, MD, President and CEO of CMC Healthcare System in Manchester, N.H., and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by The MetroHealth System in Cleveland; Texas Health Resources in Arlington, Texas; and CMC Healthcare System in Manchester, N.H.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Methodology

The *Executive Compensation Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In August 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 440 completed surveys are included in the analysis. The bases for the individual questions range from 417 to 440 depending on whether the respondent had the knowledge to provide an answer to a given question. The margin of error for a sample size of 440 is +/-4.7% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, region, purchase involvement, dollar amount influenced, and types of products/services purchased. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

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The following healthcare leaders graciously provided guidance and insight in the creation of this report.

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Manchester, N.H.

Akram Boutros, MD, FACHE
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The MetroHealth System
Cleveland

Bonnie Bell
Executive Vice President of People and Culture
Texas Health Resources
Arlington, Texas

Upcoming Intelligence Report Topics

DECEMBER: ***Cost Containment***

JANUARY: ***Annual Industry Survey***

FEBRUARY: ***Healthcare IT and Analytics***

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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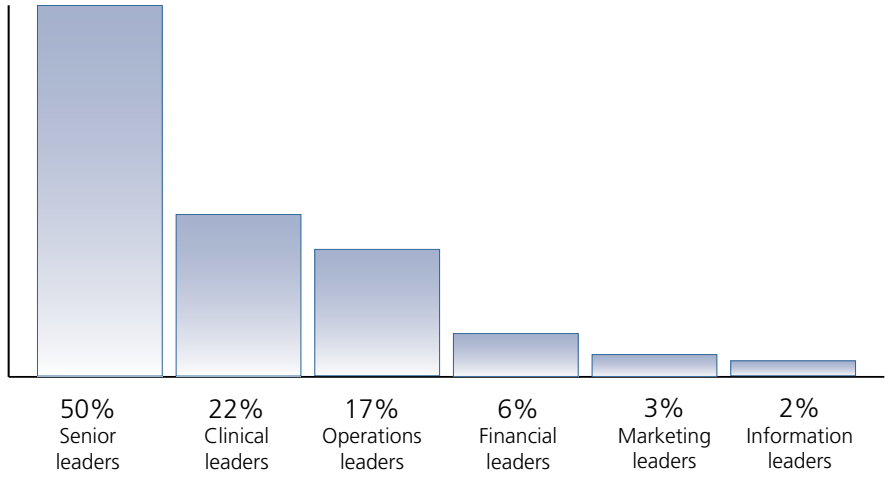
Respondent Profile

Respondents represent titles from across the various functions at healthcare organizations.

Title

Base = 440



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director,VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Financial leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 440

Hospital	42%
Health system	27%
Physician org.	12%
Long-term care/SNF	8%
Health plan/insurer	5%
Ancillary, allied provider	4%
Government, education/academic	2%

Number of beds

Base = 184 (Hospitals)

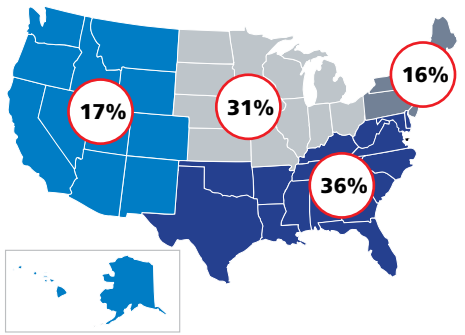
1–199	54%
200–499	29%
500+	17%

Number of sites

Base = 119 (Health systems)

1–5	17%
6–20	36%
21+	47%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Executive Compensation: New Directions, New Incentives, New Skills

MICHAEL ZEIS

The major structural shifts affecting the healthcare industry are manifested in executive compensation programs, which are starting to reflect the industry's new value-based direction. Survey results show that compensation programs emphasize collaboration, foster working with new financial models, and reward clinical performance.

Rewards based on financial performance still count, of course, but our report advisors expect that compensation based on clinical volume metrics will be on the wane. Because most industry evolution scenarios indicate organizations will collaborate a lot more, some organizations and individuals will require new skills for success in new directions. Collaboration skills are highly desired, as are physician alignment skills. And the new financial realities mean that some "old" skills, such as cost containment expertise, remain highly valued, as well.

Today we use financial and clinical metrics. Compensation has not been static, but increases are modest for most. Half (51%) expect an increase in total compensation next year. For 60% of those who expect compensation to rise, increases will be 3% or less. But we should not interpret modest compensation growth as a sign of stability. The financial foundation of the

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders concerning their challenges in developing a culture of accountability regarding patient safety and quality outcomes.

"Short-term goals are directly related to value-based purchasing metrics. Long-term incentive goal (three-year) is tied to specific initiatives related to implementing companywide initiative that supports population health management."

—Chief financial officer for a medium hospital

"This will affect executive compensation gradually, as we move toward more value-based measures. However, those stats are not yet widely accepted."

—President of a small health system

"There is a heavy emphasis on patient experience and quality goals for executive compensation and incentives."

—CEO for a medium health system

"Metrics for clinical quality and patient experience are included in incentive compensation for all C-suite."

—Chief nursing officer for a large health system

"There is less recognition of individual contribution to organization. Incentives are considered 'at risk,' not incentives or bonus."

—Chief medical officer for a small hospital

Analysis (continued)

healthcare industry is in flux, and compensation committees are redirecting the attention of healthcare leaders through changes in compensation programs, mostly with changes in incentive programs.

"We've always had a financial discussion," says Joseph Pepe, MD, president and CEO of CMC Healthcare System in Manchester, N.H., which includes Catholic Medical Center, a 330-licensed-bed not-for-profit hospital, "but in the past quality and patient satisfaction tended to be in the background with most boards, and in most C-suites."

As Pepe suggests, operating margin, a long-standing compensation stalwart, is mentioned by 67% as a basis for incentive compensation. Virtually the same percentage say that their incentive payments are based on patient satisfaction (64%) and clinical performance targets (63%). This combination of financial performance and clinical performance at the top of the chart of incentives is virtually identical to the responses provided last year. These same items top the list of incentives for what leaders expect next year, too, with nearly identical percentages.

Although only 20% of respondents say that the transition to value-based reimbursement metrics is part of their incentive program, Pepe, who serves as lead advisor for this report, sees broad support for value-based metrics among both current and future incentives, especially when considering the popularity of metrics such as patient satisfaction and clinical performance.

"Incentives are slowly moving to the value world," Pepe says, "and I think over the years to come that gap will close, and you'll see the value metrics surpassing volume metrics." One-quarter of survey respondents (25%) say that the transition to value-based metrics will be part of their incentive program next year.

> "We've always had a financial discussion, but in the past quality and patient satisfaction tended to be in the background with most boards, and in most C-suites."
>
> —Joseph Pepe, MD, president and CEO of CMC Healthcare System in Manchester, N.H.

New structures mean new incentives. Akram Boutros, MD, FACHE, CEO of the MetroHealth System, a 731-licensed-bed health system based in Cleveland, approaches a complex long-term objective by breaking it into manageable short-term steps. He explains, "You know, everybody wants to do population health management. But population health management is so overwhelming that many people have decided not to do it. So we work it back. We want to do population health management three or four years from now. We ask ourselves what we have to do to get that. And then we walk it back from our future goal to today, and we develop the steps."

Analysis (continued)

MetroHealth expects to become an ACO starting in 2014, a step toward population health management. Boutros, an advisor for this report, explains that performance-based compensation specifically related to collaborative care will likely be folded into other metrics, especially early on. "While collaboration along the care continuum will be strategic to us, it could be baked into the financial results of the organization, or could be baked into the quality quadrant. For us right now, it is not one of our metrics. Do I see it as a critical part for success in the future, or do I see it as a metric in 2014 or at 2015? Absolutely."

As MetroHealth makes the change from volume to value, Boutros also expects to track the proportion of outpatient to inpatient services, "so that we're rewarding the transition at the pace that we've determined that's best for that institution."

To support his hospital's foray into ACOs, Pepe has put in place near-term goals that will support both care coordination and at-risk payments. "The goal for executives will be that we need to turn over a certain number of practices to a medical home. That will be part of how we get compensated in the future." Also, Pepe has made the effort toward collaborative care institutionwide by switching physicians from volume-based incentives to incentives based on clinical quality measures.

"We changed all the contracts of the primary care physicians from being based purely on RVUs, to incentives based on population health parameters such as quality, preventive measures," Pepe says. Physicians also have metrics related to how well they work with clinical staffers such as physician assistants and nurse practitioners. "That's a good part of their incentive compensation as well, to help us align everyone together."

> "In the past a CEO might have said, 'I'm going to be the captain of the ship. I'm the only guy who's going to be able to do it.' Now CEOs are saying it is really about a team effort."
>
> —Akram Boutros, MD, FACHE, CEO of the MetroHealth System in Cleveland

Advisor Bonnie Bell, executive vice president of people and culture for Texas Health Resources, a Texas-based health system with 25 hospitals and 3,800 licensed beds systemwide, summarizes the quandary that compensation committees across the industry are facing as they strive to ensure that their incentive programs are in sync with the strategic directions their organizations are taking. She says, "We are all creating this at the same time, together, as we look at or look away from traditional measures. In terms of looking for appropriate measures, finding benchmarks—they don't exist. And we don't have a common language or nomenclature around measurement yet."

Analysis (continued)

As a result, many early incentives that address, broadly speaking, health-care reform, depart from outcome measures that have been so important in defining clinical performance recently. "Our new metrics are very process driven," she says. "They are not traditional specific outcome metrics, benchmarked to a national database. But they do get us along the way."

Pepe has moved his executive team and physicians off of volume measures altogether. "When you look at what we're incentivizing, it's not just about the bottom line, the operating margin. It is growing the continuum of care, increasing the number of primary care lives, and covering quality aspects like maintaining our 30-day readmission rate below the state's or the nation's. It's increasing the percent of staff that gets flu vaccines. It is increasing the HCAHPS top-box score for cleanliness of hospital environment, and increasing the CGCAHPS top-box score for giving easy-to-understand instructions. These are all part of our incentives that we never would even consider before. Before, it was all about volume—how many surgeries, how many people need ED, and how many admissions that we were having. None of those are among our goals this year."

Care continuum skills are needed and are missing. Advisors acknowledge that addressing new challenges will require new skills. Says Bell, "Our board spends a lot of time talking about the behavioral competencies that will lead to success. And when I say behavioral competencies, I'm talking about things like the ability to successfully forge new kinds of business models, or to demonstrate bold and innovative thinking."

"Before, it was all about volume—how many surgeries, how many people need ED, and how many admissions that we were having. None of those are among our goals this year."

—Joseph Pepe, MD, president and CEO of CMC Healthcare System in Manchester, N.H.

As was the case in last year's survey, physician alignment once again is the skill mentioned most frequently as being important in ensuring CEO success, mentioned by 61%. Nearly half (49%) include the ability to optimize results along the continuum of care as a skill needed for a CEO to succeed in five years, an increase of 10 percentage points over last year's survey. In addition, both skills are mentioned most frequently as skills that their CEO is lacking.

Among non-CEOs, cost containment (64%) and performance metrics (58%) topped the list of skills that are required for C-suite success. But nearly half mentioned the ability to optimize performance along the continuum of care (48%) and physician alignment (45%). And care continuum skills and physician alignment skills top the list of non-CEO

Analysis (continued)

skills that are missing, just as they did for CEOs. Says CMC's Pepe about care continuum skills: "This is an important team skill that traditionally has not been present in the C-suite. CEOs are going to rely heavily on non-CEO C-suite executives obtaining this skill in order to move down the road of bundled services and value-based care."

Bringing skills to the executive suite. When assessing how best a CEO can add the missing skills that are needed, more than one-third (36%) say that their CEO could rely on the skills available with non-CEO staff, while 30% say that training could fill in the CEO skills gap. Training is the skill-acquisition method mentioned most frequently (by 51%) as the most likely scenario for adding those skills among non-CEOs.

It's generally acknowledged that exposure to the clinical environment helps executives with both physician alignment and collaborative care activities. Filling the skills gap by bringing in new C-suite talent from outside the organization is considered by about 13% of respondents. Recruiting physicians with leadership skills or leaders with clinical skills can be problematic for some because of supply and demand issues. As Bell points out, "We're not the only one looking for physician executives. In this market we're doing it more aggressively than others, but I talk to my national peers who are doing the same thing. The hunt is on. Right now, demand definitely is outstripping supply."

Staff development is another way to bolster executive skills. Texas Health and others run physician leadership programs for staff physicians and members of their employed physicians' group. MetroHealth's Boutros reminds us that the existing leadership team knows the organization and its culture, so he favors developing or supporting the current team. "I believe CEOs should either bring in executives now with the right set of skills, or provide opportunity for the executives who are here today who understand the culture and who have longevity with the organization. Or give your executives support in their departments to be able to manage new challenges. So you either do it by hiring new people or you do it by supporting the people who already are here. The latter is the way I prefer."

> "Our new metrics are very process driven. They are not traditional specific outcome metrics, benchmarked to a national database. But they do get us along the way."
>
> —Bonnie Bell, executive vice president of people and culture at Texas Health Resources in Arlington, Texas

Noting that 36% of respondents say their CEO will address needed but missing skills by relying on the staff (the top response), Boutros observes,

Analysis (continued)

"It says to me the CEO is using more teamwork and less self-reliance. In the past a CEO might have said, 'I'm going to be the captain of the ship. I'm the only guy who's going to be able to do it.' Now CEOs are saying it is really about a team effort."

CMC's Pepe also sees the CEO position as one requiring communication and collaboration skills. "I think education of the board and the ability to align physicians and other hospital staff are extremely important skills. Today and in the future, a CEO has to be a good communicator and collaborator. CEOs who are demanding control and are authoritative really do not have a major role in today's health systems."

The move to value: It's a big change. In just a couple of years, CMC has shifted the basis for its incentive program from 100% volume-based to one that is largely value-based. "We're still living in a volume world," Pepe says, "but I think at CMC we're way ahead of the pack when it comes to knowing where we want to go and putting our money where our mouth is. A lot of people talk about value, but they're still being incentivized almost wholly in the volume world. It's a big change, and it's a culture change, but when I talk to [our] executives, managers, and directors, they understand that we're doing this in interest of the population we serve and the community we serve. They get it. I realize that we're still living a good portion in the volume world, but we have to start making these changes or we won't be prepared for the future."

"I think education of the board and the ability to align physicians and other hospital staff are extremely important skills."

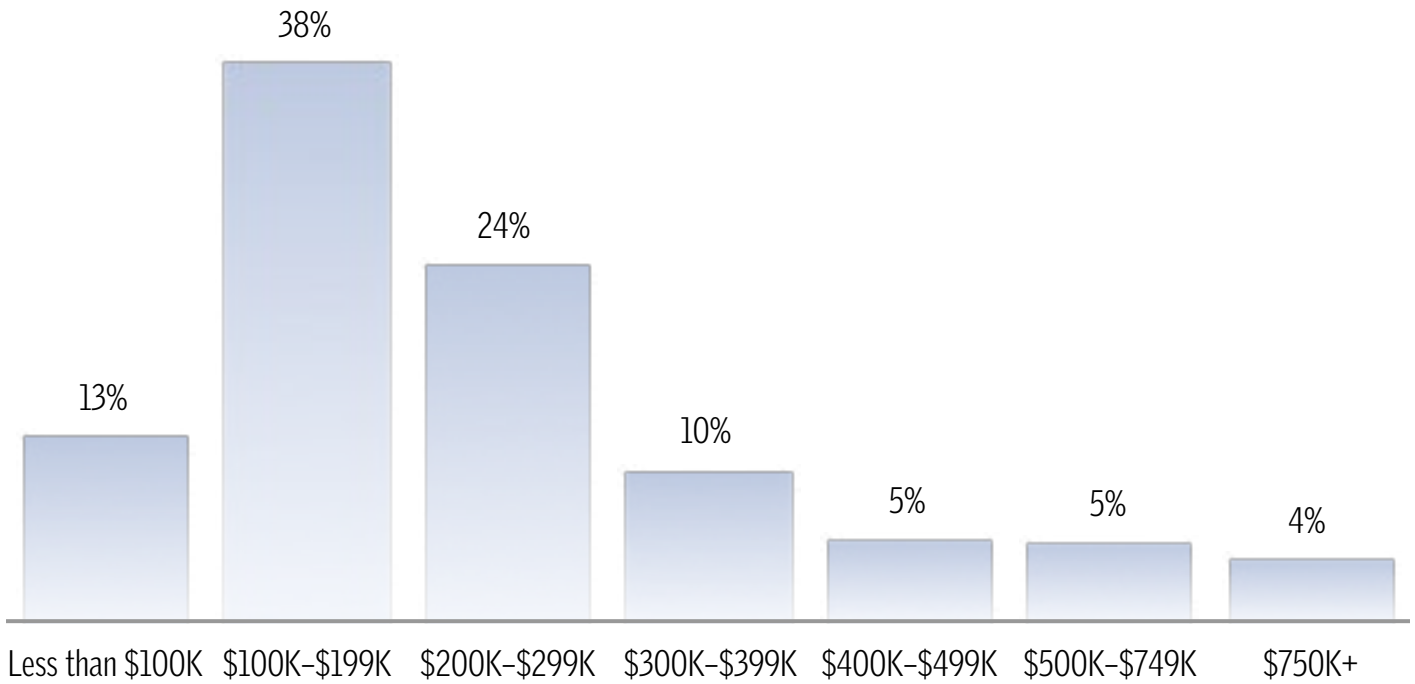
—Joseph Pepe, MD, president and CEO of CMC Healthcare System in Manchester, N.H.

Michael Zeis is research analyst for HealthLeaders Media. He may be contacted at *mzeis@healthleadersmedia.com*.

FIGURE 1 | Total Compensation

Q | Which range does your total compensation package fall into? Include cash compensation, non-cash compensation, and deferred compensation.

Total responses



Base = 440

FIGURE 2 | Allocation of Total Compensation

Q | In the current fiscal year, how is your compensation divided among cash compensation, non-cash compensation, and retirement?

Total responses

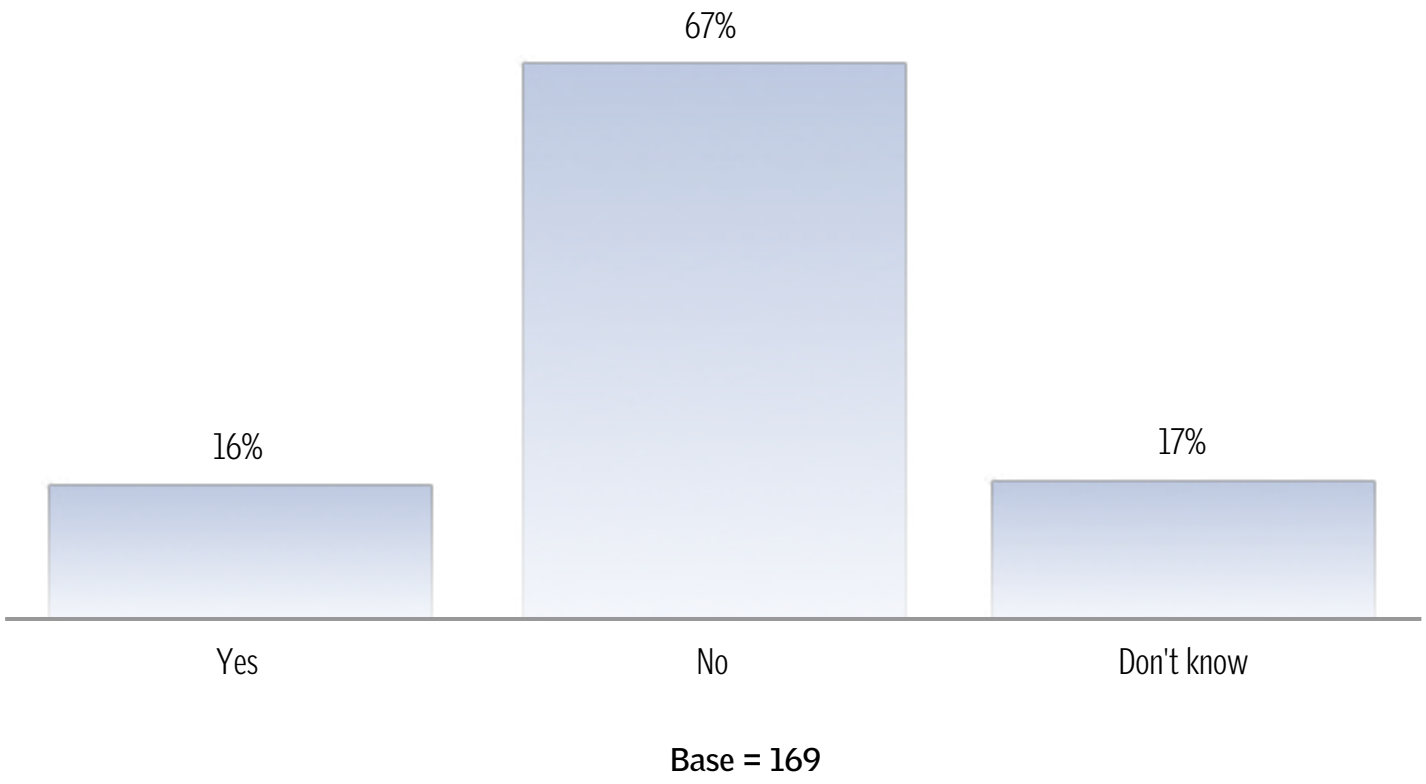
	Average
Base salary (cash)	81%
Annual incentive payments (cash)	10%
Noncash	4%
Retirement	6%

Base = 440

FIGURE 3 | Incentives Included in Compensation Package Next Year

Q | Do you expect that your compensation package will include incentives next year?
Among those with no annual incentive now

Total responses

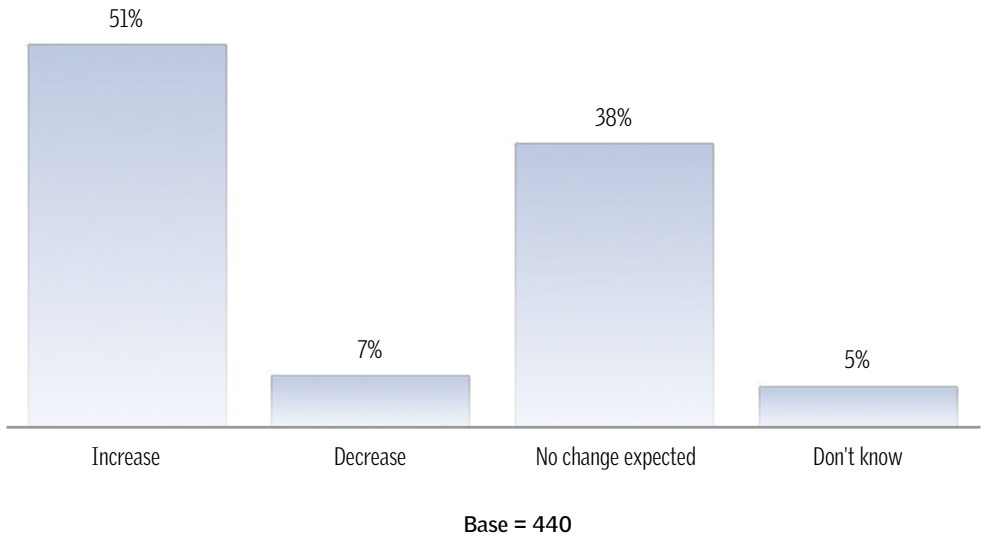


BUYING POWER REPORT SAMPLE CHARTS

FIGURE 4 | Expected Change in Compensation Next Year

Q | What change do you expect in the level of your total compensation (cash, non-cash, and retirement) next year?

Total responses



TAKEAWAYS

- Half of the respondents (51%) expect their total compensation to increase next year, and 38% expect no change.
- Within the health system setting, 59% expect an increase, and 29% expect no change.
- Nearly half of respondents (48%) from hospitals expect an increase, and 38% expect no change. Within the hospital setting, compensation increases are inversely related to organization size: 54% of respondents from small hospitals expect an increase, compared to 31% of those from large hospitals.

WHAT DOES IT MEAN?

The relatively large portion of respondents (38%) who expect no change in their compensation may be a reflection of general financial uncertainty in the industry, as many leaders continue to push cost containment as a way of accommodating reduced reimbursements.

BUYING POWER REPORT SAMPLE CHARTS

FIGURE 4 *(continued)* | Expected Change in Compensation Next Year

Q | What change do you expect in the level of your total compensation (cash, non-cash, and retirement) next year?

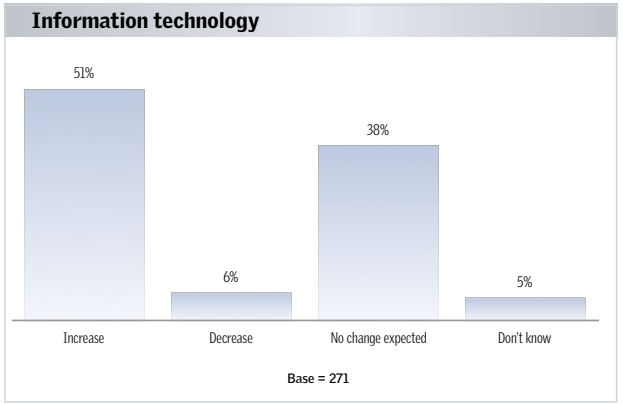
Click on these icons to dig deeper

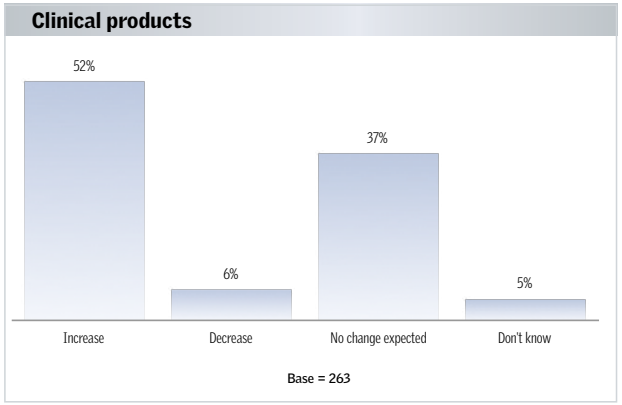
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

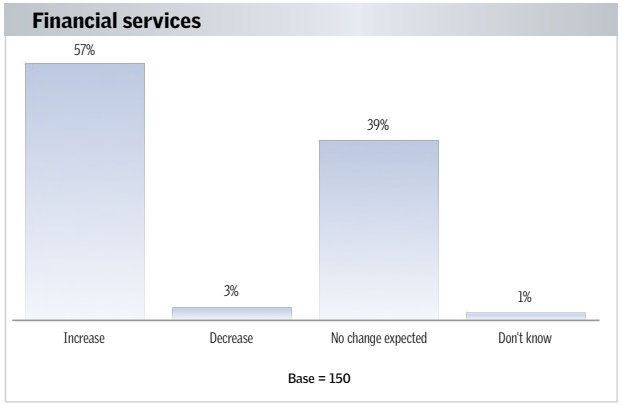
VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

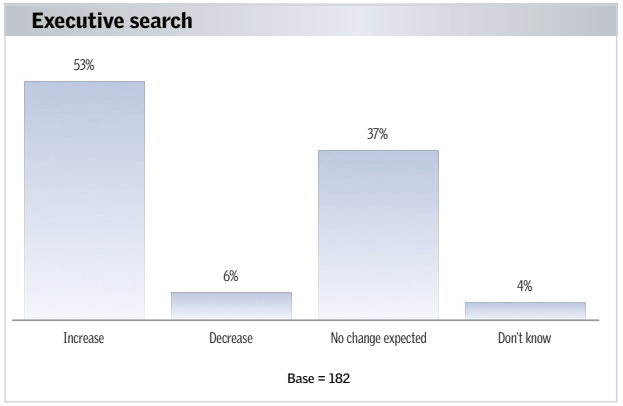
VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

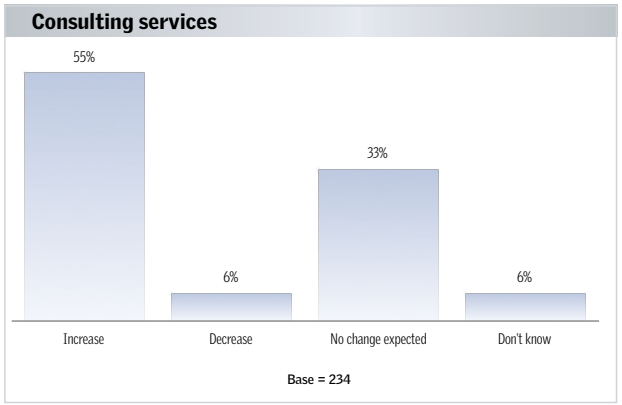
PRODUCTS/SERVICES

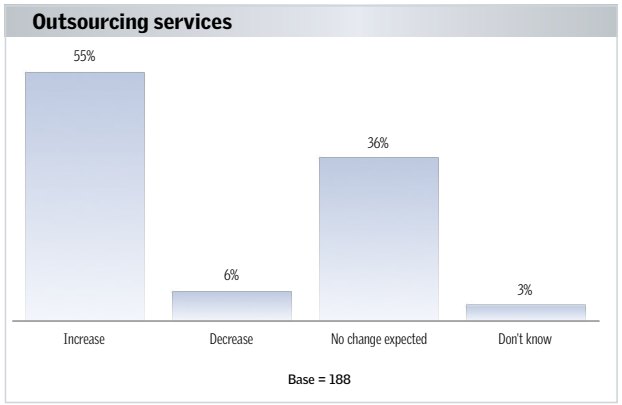












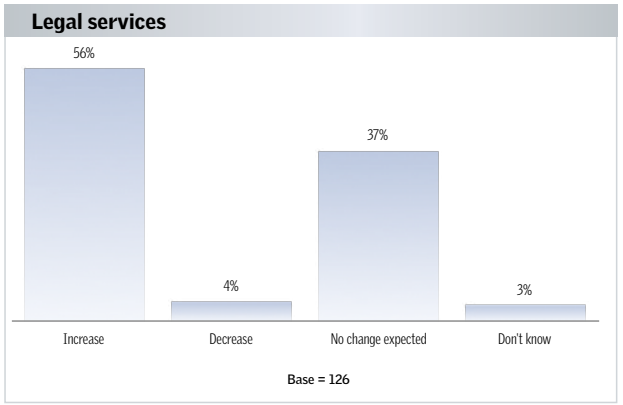
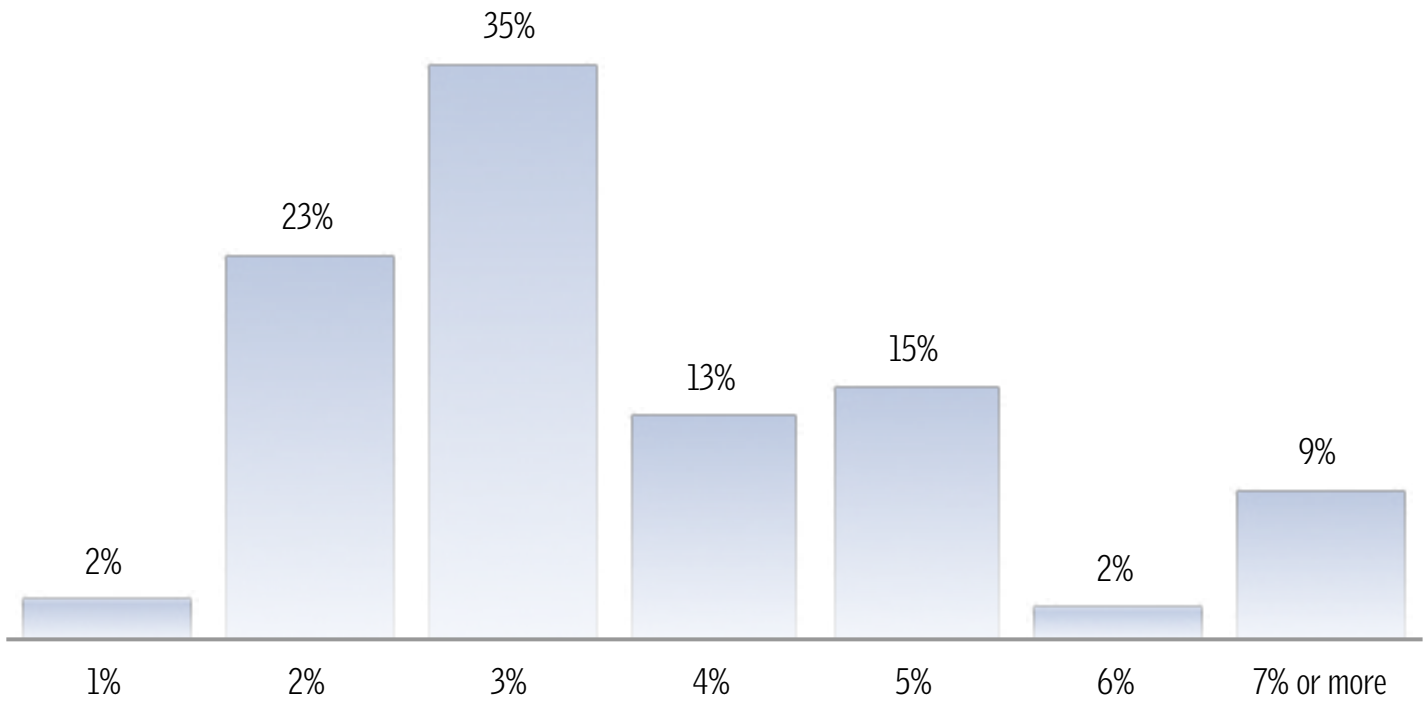


FIGURE 5 | Percentage Increase in Total Compensation Next Year

Q | By what percentage? Use your best estimate.
Among those that expect an increase

Total responses

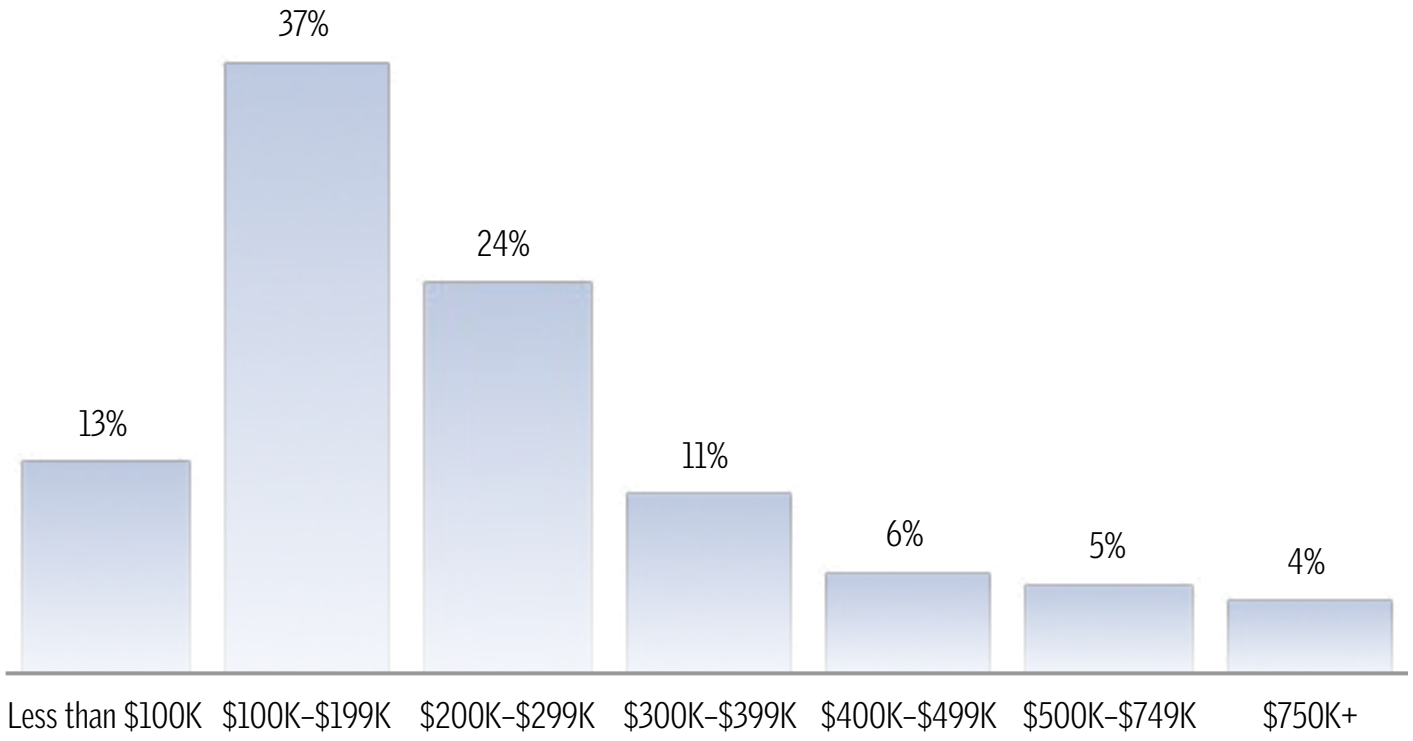


Base = 223

FIGURE 6 | Total Compensation Next Year

Q | Which range will your total compensation package fall into next year? Include cash compensation, non-cash compensation, and deferred compensation.

Total responses

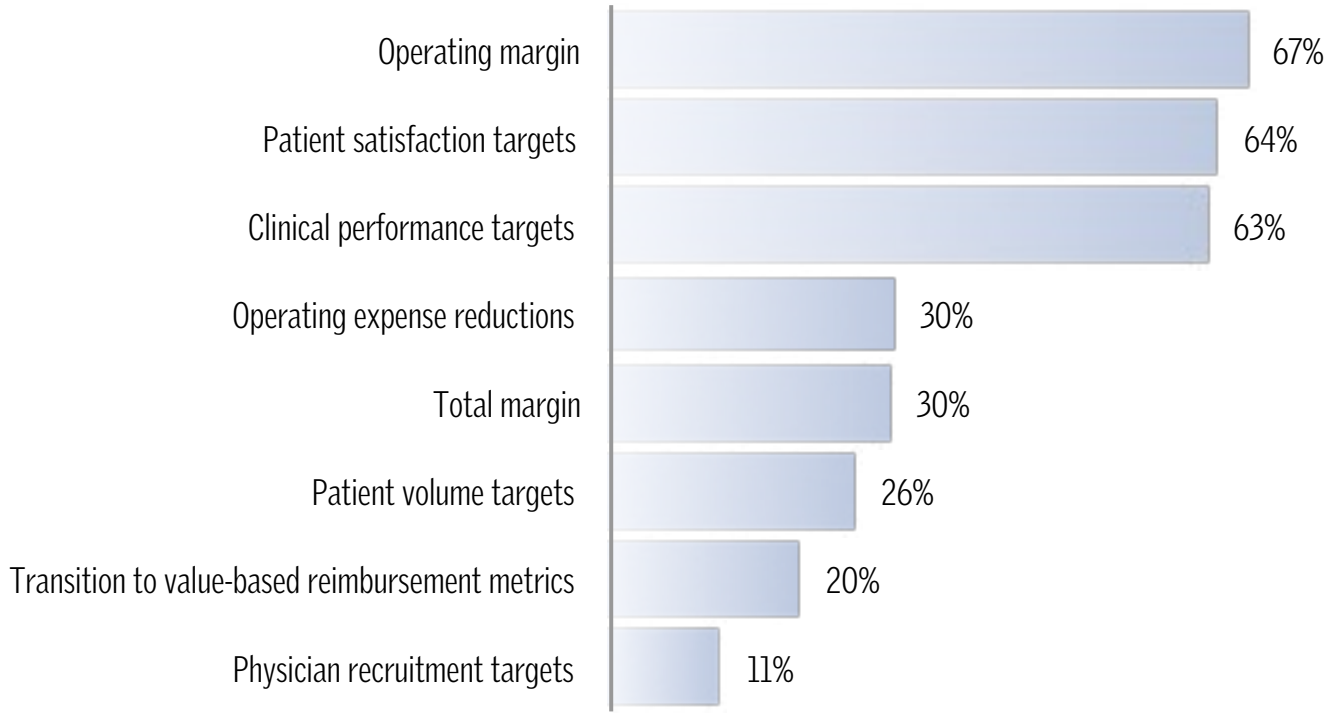


Base = 417

FIGURE 7 | Basis for Current Incentives

Q | On which of the following are your current incentive payments based?
Among those with incentives now

Total responses



Base = 264, Multi-Response

PREMIUM REPORT SAMPLE CHART

FIGURE 8 | Basis for Incentive Payments Next Year

Q | On which of the following will your incentive payments be based next year?
Among those with incentives now or next year

Total responses

Base = 288, Multi-Response

TAKEAWAYS

- Incentives show little difference between this year and next. Incentives based on operating margin (67%), patient satisfaction (65%), and clinical performance (61%) top the list.
- Next year, slightly more will be compensated for efforts supporting the transition to value-based purchasing (25% here vs. 20% in Figure 7). This includes 24% of physician organizations, more than twice the 11% recorded for the current year (Figure 7), and 33% of health systems, up from 25% this year.

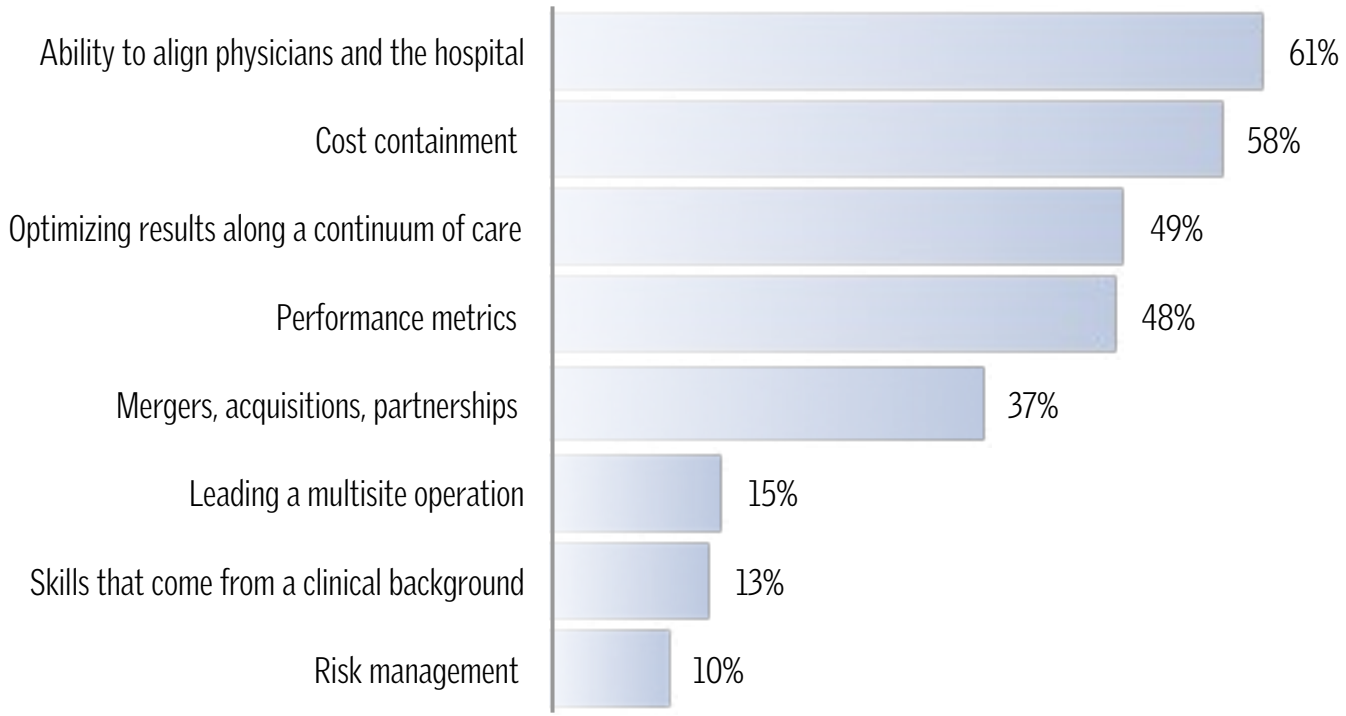
WHAT DOES IT MEAN?

Because incentives tend to be linked to the organization's most important initiatives or strategies, the levels of the incentives change more frequently than the functions or activities on which the incentives are based. However, comparing one year to the next, we see early signals that boards and leaders acknowledge the pending switch from fee-for-service to value-based purchasing by virtue of the slight nudge up in the percentage of those who will be compensated on the transition.

FIGURE 9 | Top Three Skills for CEO Success in Five Years

Q | Considering your organization's direction and the direction of the industry, which of the following are the top three skills or experience sets that will help a CEO succeed in the next five years?

Total responses



Base = 440, Multi-Response

FIGURE 10 | Missing Skill Needed Most by a CEO

Q | What missing skill or experience set is needed most by a CEO to address the industry trends and the challenges they present over the next five years?

Total responses

Optimizing results along a continuum of care	30%
Ability to align physicians and the hospital	19%
Skills that come from a clinical background	15%
Mergers, acquisitions, partnerships	8%
Performance metrics	7%
Cost containment	5%
Risk management	5%
Leading a multisite operation	4%
Other	4%
None	4%

Base = 440

FIGURE 11 | Scenario for Adding Missing CEO Skills

Q | Which is the most likely scenario for adding those missing skills?
Among those reporting a missing CEO skill set

Total responses

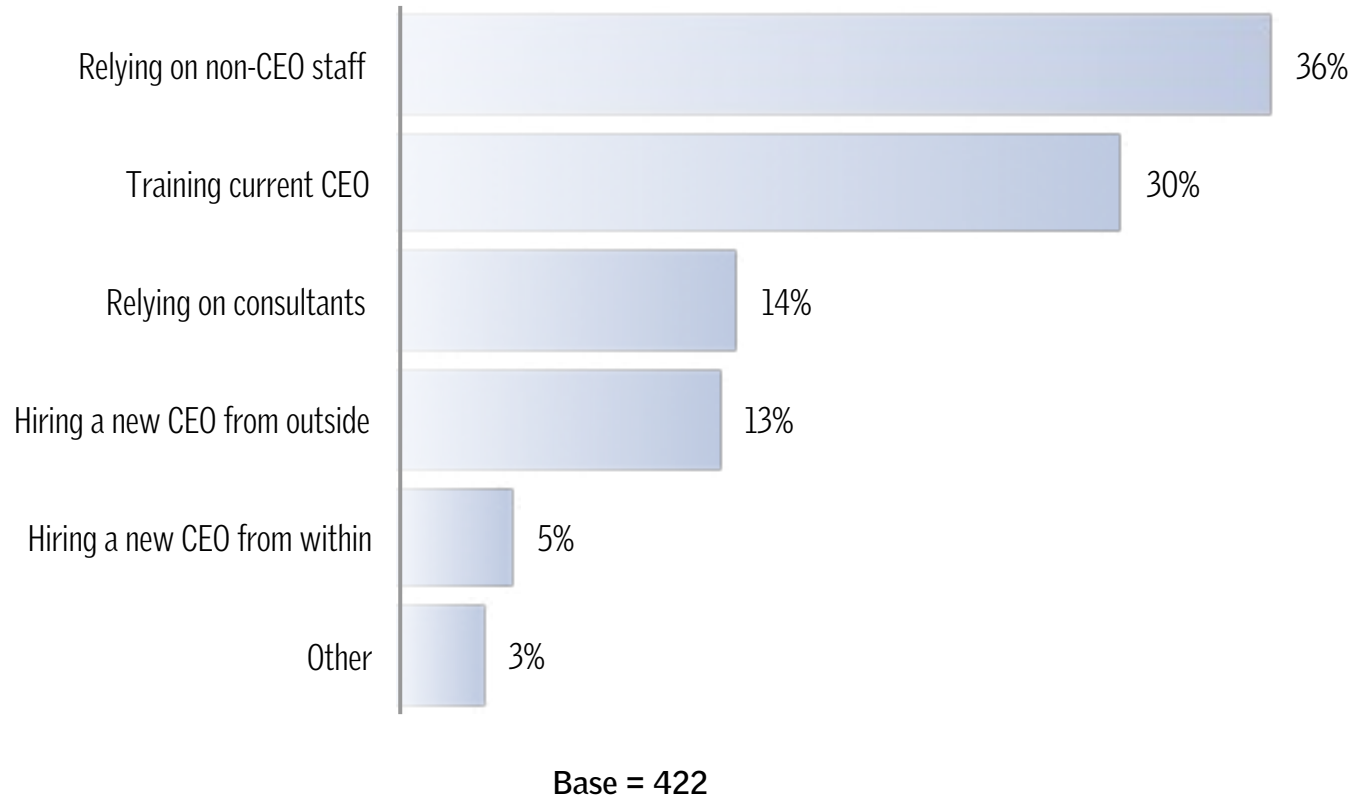
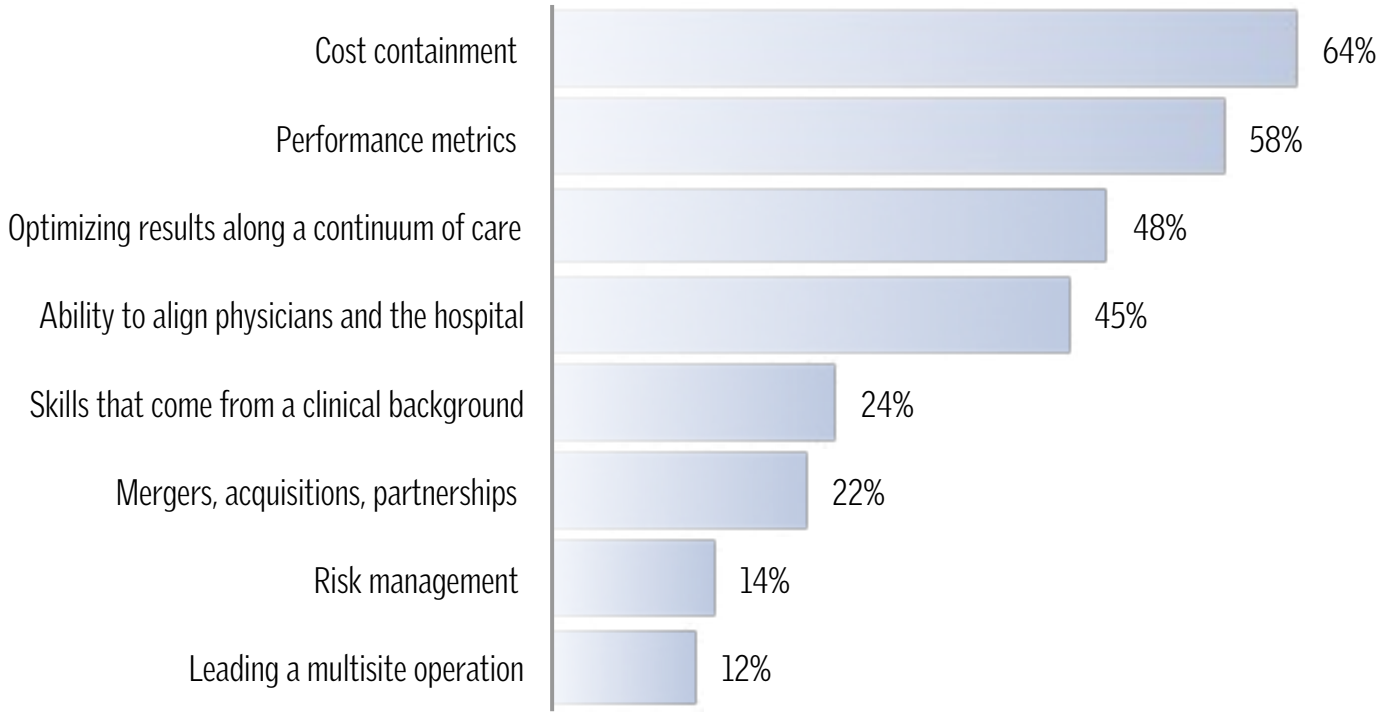


FIGURE 12 | Top Three Skills for Non-CEO C-Suite Executive Success in Five Years

Q | Considering your organization's direction and the direction of the industry, which of the following are the top three skills or experience sets that will help a non-CEO C-suite executive—such as the CFO, CIO, CMO, or COO—succeed in the next five years?

Total responses



Base = 440, Multi-Response

FIGURE 13 | Missing Skill Needed Most by Non-CEO C-Suite Executives

Q | What missing skill or experience set is needed most by your non-CEO C-suite executives to address industry trends and the challenges they present over the next five years?

Total responses

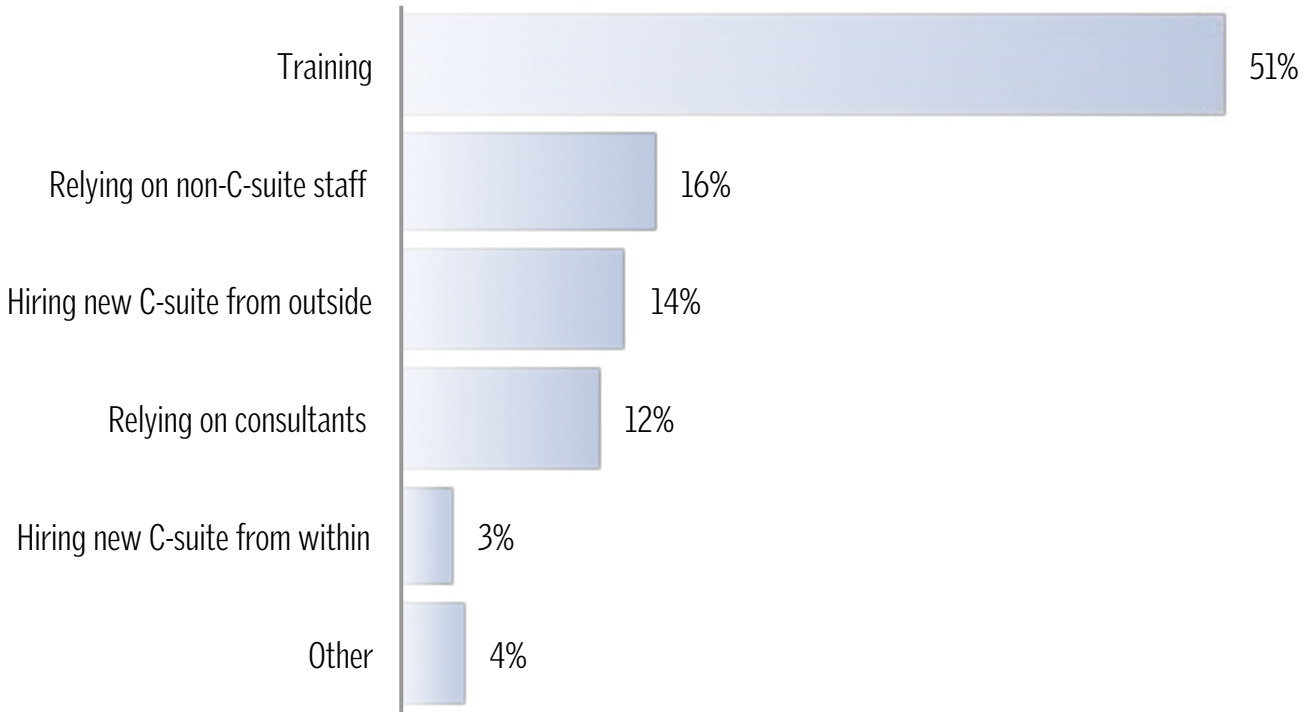
Optimizing results along a continuum of care	32%
Ability to align physicians and the hospital	13%
Skills that come from a clinical background	11%
Performance metrics	11%
Cost containment	9%
Mergers, acquisitions, partnerships	8%
Risk management	6%
Leading a multisite operation	6%
Other	2%
None	3%

Base = 440

FIGURE 14 | Scenario for Adding Non-CEO C-Suite Executive Skills

Q | Which is the most likely scenario for adding those skills?
Among those reporting a missing non-CEO C-suite skill set

Total responses



Base = 425

FIGURE 15 | Outlook for Career Advancement

Q | Which of the following best describes the outlook for your career advancement?

Total responses

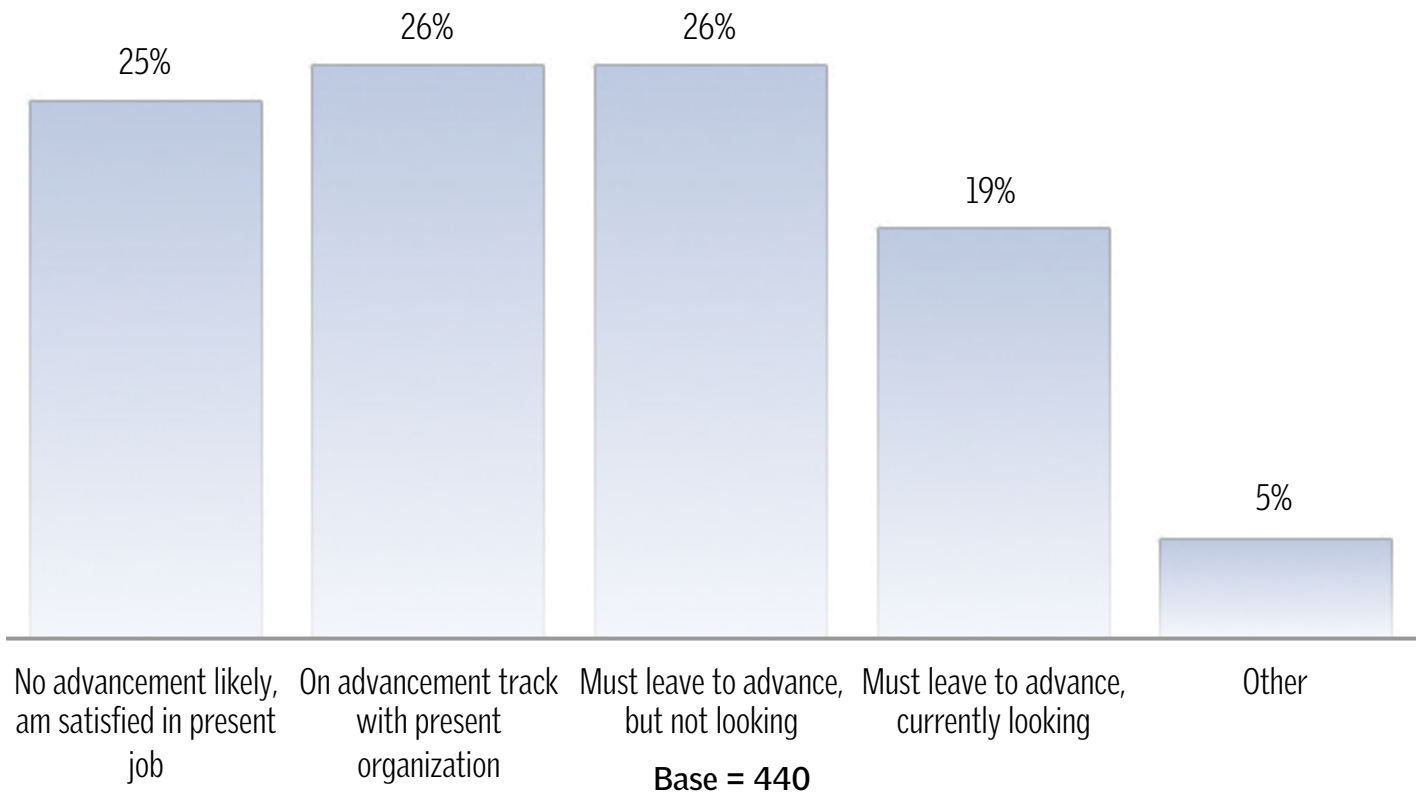


FIGURE 16 | Most Evolved Aspect of Executive Compensation Over Past Two Years

Q | Which aspect of executive compensation has evolved most over the past two years at your organization?

Total responses

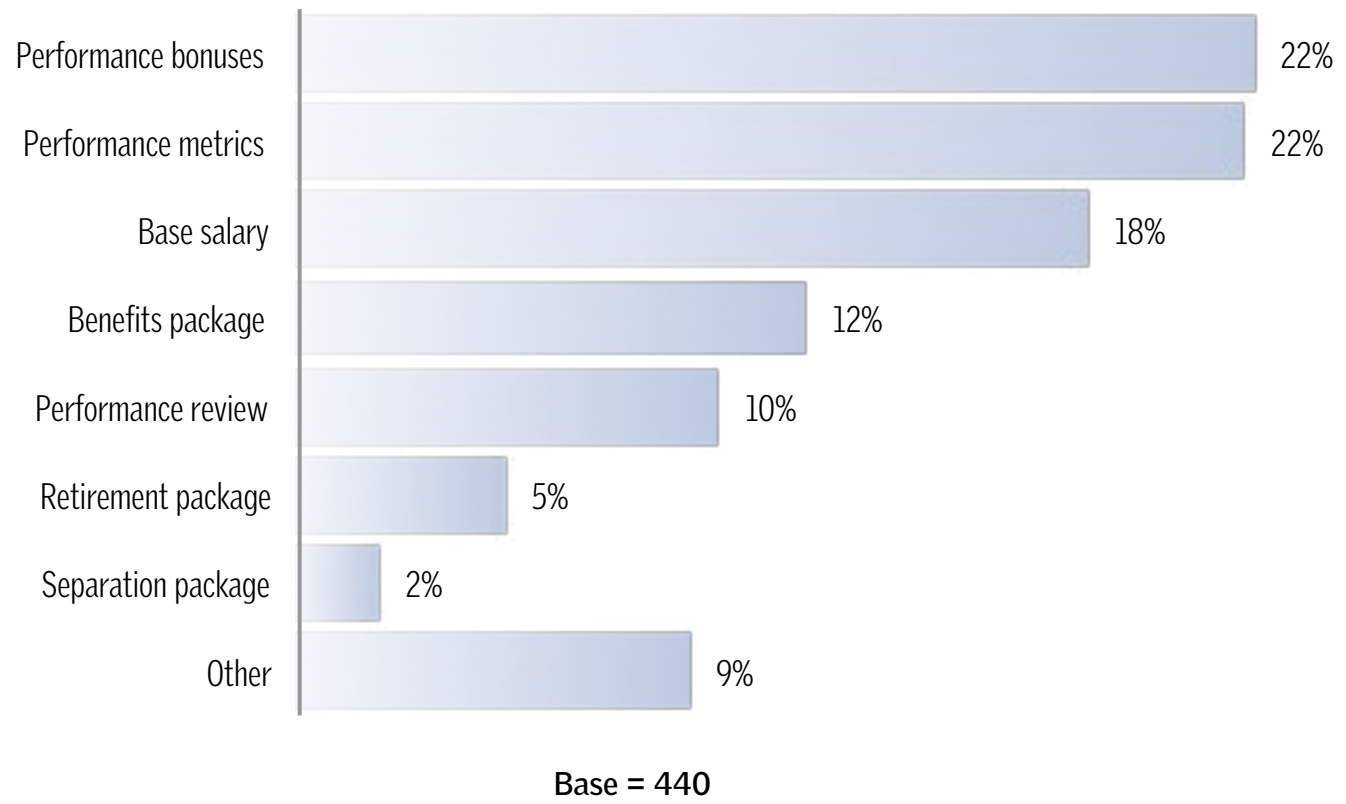
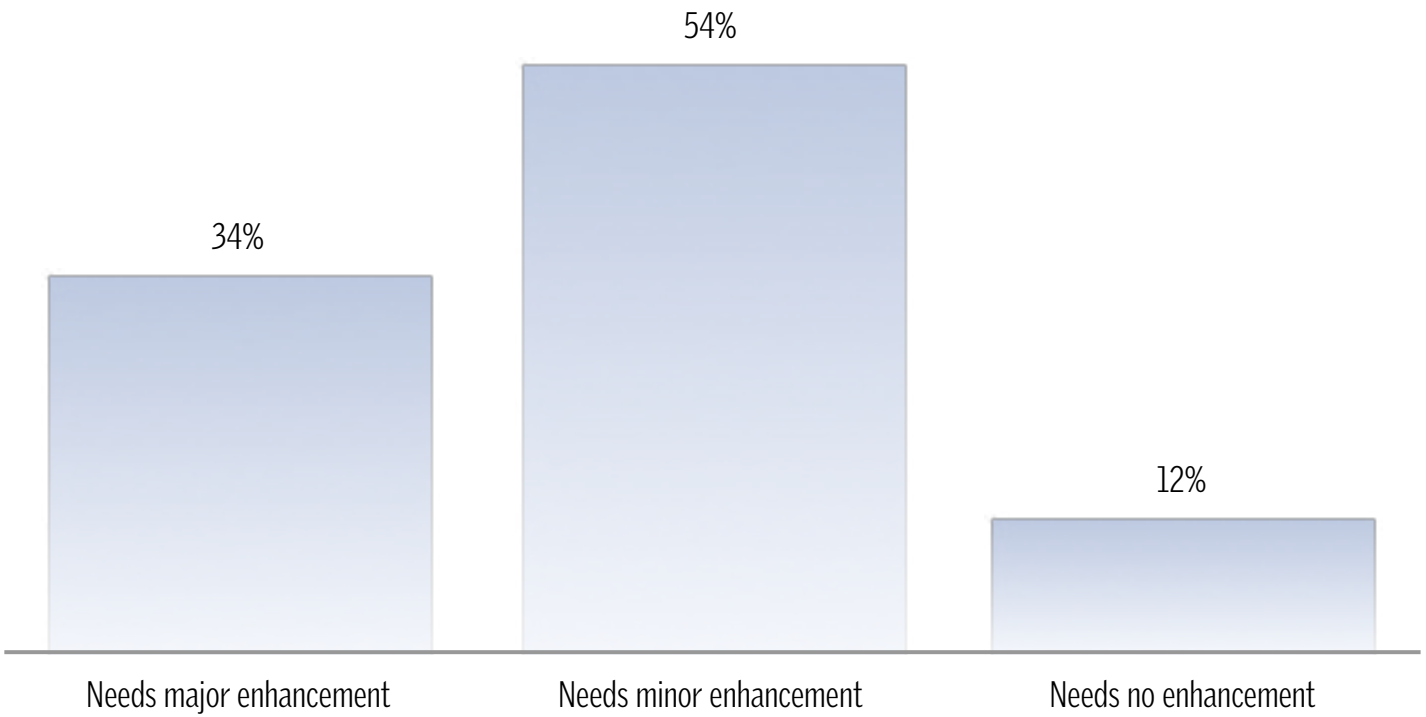


FIGURE 17 | Outlook for Executive Compensation Structures

Q | To attract, retain, and engage leaders, what is the outlook for executive compensation structures at your organization?

Total responses



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