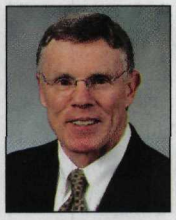
BLENDING LEADERSHIP MODELS

A Kansas-Based System Has Both Centralized and Decentralized Dimensions

BY WILLIAM M. MURRAY

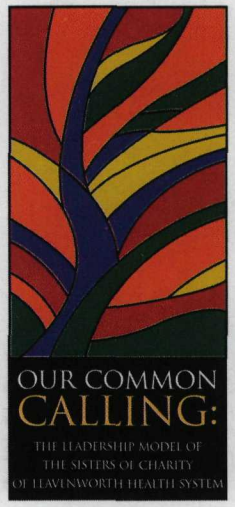


Mr. Murray is president/CEO, Sisters of Charity of Leavenworth Health System, Lenexa, KS.

In recent years, the Sisters of Charity of Leavenworth Health System (SCLHS) has developed a business model for our Catholic health ministry that has significant implications for governance and leadership. Much like our founders, the pioneer Sisters of Charity of Leavenworth, we have adapted to changing times.

In this model, we have preserved elements of the unique cultures of our eight geographically dispersed hospitals and the autonomy they enjoyed in what was essentially a *holding company*—a decentralized organization. At the same time, cognizant of the need for increasing standardization and centralization, we have moved from holding-company status toward a more centralized *operating-company* model that emphasizes our growing interdependence.

In effect, we have blended critical elements of both holding company and operating company models to position SCLHS for the future.



We have named this business/leadership model our "Common Calling." Earlier this year, we developed an attractive booklet that we use as a resource in discussions with the boards of directors and senior leadership teams of the SCLHS and its affiliate hospitals. The booklet clearly defines the model and our respective roles and expectations. We are currently discussing the model in meetings with affiliate board members and management staff.

Our goal is to maximize the strengths of this leadership model for the good of the ministry and the good of the people we serve. Interdependence, we have come to realize, means that all of our interests are mutual and must be aligned toward the success of the overall system. At the same time, we clearly acknowledge that health care is delivered on the local level and requires strong relationships with physicians, employees, competitors, and the community.

Common Calling is, we believe, the vehicle that will help us sustain our system's mission and position it for our desired future.

COMMON CALLING'S BACKGROUND

Founded in 1858, the Sisters of Charity of Leavenworth dedicated themselves to enhancing the spiritual, intellectual, physical, and social well being of all persons. From Leavenworth, KS, the sisters ventured into the expanding frontier and responded to the need for schools, orphanages, and hospitals in mining and ranching communities.

As daunting as the challenges were, the sisters found strength in their "common calling" to reveal God's healing love by responding to those who were sick or poor. In the early years, the hospitals were staffed almost entirely by sisters and directed by a missioned leader. In modern terminology, the organizations, operating in a very decentralized fashion, had a great deal of *autonomy* at a time when health care could best be described as a cottage industry.

Over the next 100 years, this ministry evolved, adapting to the unfolding industrial age with its increasing complexities. In 1972, the sisters formed the Sisters of Charity of Leavenworth Health Services Corporation (today's SCLHS) to

strengthen the hospitals both individually and collectively.

This development of a more cohesive system occurred in response to changes in reimbursement, regulations, and technology—many of which were the direct outgrowth of the Medicare and Medicaid programs. In its earliest years, the system's major needs and areas of focus were risk management and finance.

Leadership of the religious community served as governance of individual hospitals and SCLHS as a whole. The hospitals (located in California, Colorado, Kansas, and Montana) recruited local lay boards and remained largely autonomous. However, questions arose—and lingered—regarding the respective roles and responsibilities of the local hospitals, on one hand, and the "corporate" (system) office, on the other.

Over the next 30 years, SCLHS evolved further, adapting to the "information age" and the rapid globalization of the world economy. We introduced strategic planning on a systemwide basis; developed group purchasing; adopted a shared mission statement, core values, and creed; modified and expanded governance structures for both the hospitals and the system to include lay leadership; and developed systemwide plans for information technology and clinical transformation.

With each of the above changes, two questions regularly surfaced:

- Is SCLHS moving away from our traditions of autonomy and decentralized management?
- What are the respective roles and accountabilities of the system office and the affiliated hospitals, of leadership, and governance as we make this transition?

Impetus for Change

In our most recent strategic planning process, an assessment of environmental trends and strategic choices revealed that SCLHS, to achieve its future vision, needed to make a transition from operational autonomy to a new leadership model. In 2005, we chartered what we called a "Systemness Task Force" to redefine our organizational philosophy and leadership model, provide clarity, and answer those recurring questions.

Through work of the Systemness Task Force, we determined that the characteristics of both a holding company and an operating company are consistent with SCLHS's unique culture and history and essential to sustaining its mission for the long term.

From the decentralized, holding-company end of the administrative continuum, SCLHS remains committed to a local focus in the delivery of health care. We believe that the unyielding pursuit of clinical and operational excellence requires empowered local leadership to concentrate on building strong relationships with physicians, employees, competitors, and the community. Additionally, locally based leaders—both governance and administration—are responsible for developing a strategic vision for their particular organizations and achieving operational excellence in the areas of financial and clinical outcomes.

As for the centralized, or operating-company end of the continuum (toward which SCLHS has been moving), we see in that model opportunities for building greater performance consistency among the affiliates in their pursuit of clinical and operational excellence while, at the same time, continuing to enhance systemwide quality and eliminate costs. To achieve these ends and to facilitate affiliate focus on local health care delivery, we are continuing efforts to standardize and/or centralize those functions that may be less visible to the patient but that result in improved quality and reduced costs. For example, SCLHS now has a systemwide initiative that will use technology to transform care delivery and result in electronic health records for patients served throughout all of our hospitals.

We have adopted and adapted the most salient characteristics of both the holding-company and the operating-company ends of the continuum and identified this model as our unique Common Calling.

Key Components of Common Calling

The heart of this leadership model is recognition of the interdependence between our affiliates and the system office—all centered on the mission. The model has six key components. The successful implementation of each is dependent on the full development of all of them. The key components are:

- Vision and strategy

- Common language
- Roles and expectations
- Systems and processes
- Resources and staffing
- Leadership competencies and behaviors

In increasing the level of system integration, we have committed ourselves to a leadership culture characterized by:

- Unified and common commitment to our mission and core values
- Constant trust and mutual respect among all constituents
- Transparency in management with a mutual focus on mutual goals
- Acknowledgment that, in all work processes, some will lead and some will follow; leadership responsibility will flow to those with the best expertise and qualifications to direct the work
- A deeply held belief that the success of the enterprise is dependent upon the success of all of its parts and that each part has a greater likelihood of achieving success as a member of the system ministry than it would if it were independent

Such a culture requires us to think, act, and relate differently at both the affiliate and system levels. We are adopting a common language with the help of a glossary of terms in the *Common Calling* booklet. We have clarified the roles and expectations of our System Leadership Team, our System Office Leadership Team, and Affiliate Leadership Teams. We have modified leadership competencies to reflect the Common Calling model. We have recognized the implications of this leadership model for human resources and staffing and for systems and processes.

Leadership Compact with Affiliate Boards

The Common Calling leadership model affirms the importance of the fiduciary responsibilities of the boards of directors of our affiliate hospitals. At the same time, the system has recognized a growing need for clarity concerning the local boards' role, especially as more systemwide programs are integrated with local initiatives and operations.

To provide this clarity, we developed a "compact" to describe the relevant and mutual accountabilities of both the affiliate boards and our system leadership. This compact defines how the system and local board will work to support each other.

The compact acknowledges affiliate boards of directors as the voice and presence of the SCLHS mission in the communities served by our hospitals. We have asked the boards to continue to:

- Promote the mission, vision, and core values
- Participate in the selection of the affiliate CEO and in the evaluation of his/her performance
- Review, and make recommendations concerning, affiliate strategic plans, operating plans, and budgets; and hold management accountable for their implementation/execution
- Represent the interests of the community to the hospital and the interests of the hospital to the community
- Ensure that clinical quality, service quality, and patient safety meet standards that board members want for their own family members
- Ensure that the hospital (leadership) is viewed as a "champion" for the health of the community and has good relationships with physicians, employees, community leaders, competitors, and Catholic Church leadership
- Ensure that all business conducted by the board and executive leadership is transacted in a respectful manner and meets the highest ethical standards

The compact delineates the above as local board members' key responsibilities. It clearly aligns the governance role of affiliate boards with the local relationships and local ministry of each respective hospital.

System leadership (i.e., the SCLHS's Board of Directors and the System Office Leadership Team) exists to render accountability to our external stakeholders (sponsors, communities, and bondholders) and promote the well-being of the affiliates through shared services. System leaders have the pivotal role of communicating and connecting the affiliate boards and hospitals with the system office and systemwide initiatives. System leaders are linchpins in the circle and cycle of interdependence.

In this compact with the affiliate boards of

directors, the system's leadership agrees to:

- Promote SCLHS's mission, vision, and core values
- Involve each affiliate board in the selection and annual evaluation of the hospital CEO; and provide semiannual assessments of the affiliate's performance from a system perspective
- Provide orientation for, and continuing education to, affiliate board members concerning SCLHS's mission and vision and developing trends in the health care industry
- Provide consistent representation at the quarterly meetings of the affiliate board of directors
- Communicate decisions regarding the implementation of systemwide strategic initiatives, including rationales for the decisions, milestones, progress reports, and a continuing evaluation of the value proposition of the services provided
- Ensure that the system and affiliates are acting as prudent stewards of community resources
- Oversee audit and compliance programs and ensure that regular reports are made to affiliate boards and audit committees

We acknowledge that this governance compact is a work in progress as we strive to improve how we work together and to strengthen the connectivity, interactions, and relationships between system leadership and affiliate boards and between affiliate boards and the system's board.

With our leadership model, we have acknowledged that autonomy of our geographically dispersed hospitals is no longer a viable mode of operations. Technology has dissipated barriers of distance and time by enabling communications that travel at the speed of light. Economies of scale, critical mass, and agility are essential if we are to sustain the ministry, achieve excellence, and heed the spirit of the Common Calling.

More than ever before, we have accepted that we *must* restate and redefine our Common Calling in light of these 21st century dynamics and challenges. We have chosen to do this by preserving elements of the autonomy of a holding company while adopting characteristics of an operating company. We continue to grow in our understanding of the implications of this model as we provide clarity of roles, expectations, and responsibilities for leadership and governance.

Since we introduced the Common Calling leadership model, we have had requests for additional tools for board members, written delineation of role expectations, ongoing education, and opportunities for networking with other board members—at both the system and affiliate levels. We believe this high degree of interest reflects a depth of commitment to our Common Calling.

An Enduring Call

Historically, when the Sisters of Charity of Leavenworth went out on their mission assignments, they received a letter that concluded with these words: "May God continue to bless you as you respond to our common call." The sisters may have been assigned to hospitals or elementary schools in different parts of the country, but they shared the call to serve in common.

That call has endured almost 150 years. It has reverberated across the western United States in our health care ministry and touched the hearts and lives of many patients and their families, as well as those of employees, physicians, board members, and volunteers. Even as the context and environment have changed dramatically, the spirit of the call has remained constant as expressed today in our mission statement and our pledge *"to reveal God's healing love by responding to those who are sick or poor."* ■

The author wishes to acknowledge that Barbara Shomaker of Accord Limited, a consulting firm, facilitated discussion of the SCLHS Systemness Task Force that led to the development of this model and the adaptation of the McKinsey 7-S Framework, upon which the circular diagram, p. 66, is based (source: R. Waterman, T. Peters, and J. R. Phillipps, Business Horizons, *vol. 23, no. 3, June 1980, pp. 14-26).*