

Securing the Safety Net

A Profile of Community Clinic and Health Center Leadership in California

*A Study Commissioned by
the Regional & State Clinic
Associations of California*

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CompassPoint Nonprofit Services
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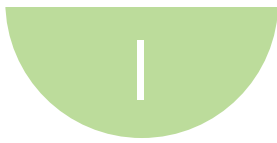
The California Wellness Foundation

Community Clinics Initiative (A joint project of
Tides and The California Endowment)

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CompassPoint gratefully acknowledges the Members of the Advisory Committee:

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Consortia Name

Alameda Health Consortium
Alliance for Rural Community Health
California Family Health Council
California Primary Care Association
Central Valley Health Network
Coalition of Orange County Community Clinics
Community Clinic Association of Los Angeles County
Community Clinic Consortium Of Contra Costa
Community Health Partnership
Council of Community Clinics
North Coast Clinics Network
Northern Sierra Rural Health Network
Planned Parenthood Affiliates of California
Redwood Community Health Coalition
San Francisco Community Clinic Consortium
Shasta Consortium of Community Health Centers

Web Site

www.chcn-eb.org
www.ruralcommunityhealth.org
www.cfhc.org
www.cPCA.org
www.cvhnclinics.org
www.forhealthoc.org
www.ccalac.org
www.clinicconsortium.org
www.chpscc.org
www.ccc-sd.org
www.northcoastclinics.org
www.nsrhn.org
www.ppacca.org
www.rchc.net
www.sfccc.org
www.shastaconsortium.org

Finally, we thank the more than 100 individual CEOs who gave of their time to complete our survey, attend a focus group, or provide an interview. We hope that this report reflects accurately and meaningfully the enormous rewards and challenges of the work that they do providing the health care safety net for California's low-income and uninsured residents.



Executive Summary

This statewide study was commissioned in 2003 by the regional and state clinic associations of California. These associations exist to strengthen and support the clinics and health centers throughout the state; as such, they are keenly interested in supporting strong clinic leadership and protecting the healthcare safety net that these organizations represent. This research was particularly concerned with the current executive cohort's remaining tenure and the degree of preparedness for an inevitable changing of the guard. With input from the collaborative partners, CompassPoint Nonprofit Services—a nonprofit consulting firm based in the San Francisco Bay Area—created a web-based survey for CEOs of California community clinics, health centers, and clinic consortia. A total of 97 surveys were completed, representing nearly half of all CEOs in the field, in addition to two focus groups and interviews.

The bulk of the report's findings address clinic CEOs with a smaller section on consortia leadership. Where noteworthy, community clinic leadership is compared to the national sample of nonprofit executives from all mission-types that was described in CompassPoint's 2001 study, *Daring to Lead*. Some key findings:

Characteristics

- Women outnumber men in community health leadership positions. Fifty-nine (59%) of clinics and 83% of consortia are run by women.
- A large majority (70%) of community health leaders are white. Among clinic CEOs, the other ethnic groups with 5% or more representation are Asian (8%), Latino (8%), and African American (5%).
- Clinic CEOs are older than the national average for nonprofit executives. Seventy percent (70%) are 50 years or older compared with 49% nationally.

Career path to CEO

- Fewer than half of clinic CEOs were recruited from within their organizations. Among the 53% recruited from outside, fewer than half were working at a nonprofit organization immediately prior to becoming CEO.
- In pursuing this work, clinic executives are particularly attracted to serving the populations that utilize community clinics—mostly low-income, uninsured Californians.

Salaries

- The average clinic CEO salary is \$93,339 and the average consortia CEO salary is \$99,311.
- As in most industries, men tend to make more for similar work in the community health field. The average salary for female clinic CEOs is \$88,986 compared with \$99,529 for males—though the discrepancy appears to dissolve among the largest clinics.

Job rewards and challenges

- Clinic CEOs are generally very satisfied by their work. They rate their job satisfaction a 5.3 out of 6.
- Stress, fundraising, and anxiety about their organizations' finances are the top challenges for clinic CEOs.

Tenure and post-CEO career paths

- Clinic CEOs have been in their current jobs longer than the national average—with nearly 41% on the job for 11 or more years.
- Less than a quarter of clinic CEOs anticipates leaving the job within the next two years, compared with 35% nationally. Forty-one percent (41%) expect to stay for more than 5 years.
- Retirement will be the next career move for 38% of clinic CEOs.

- Only 8% of clinic CEOs anticipates their next career move to be as CEO of another nonprofit clinic.
- Half of clinic CEOs have identified one or more persons as a potential successor.

Boards and other sources of support and training:

- Clinic CEOs perceive their boards to be most effective at mission advocacy and least effective at fundraising.
- CEOs at smaller clinics perceive their boards to be less effective in key governance areas than CEOs at larger clinics do.
- Clinic CEOs rely heavily on their management teams and peers as sources of support and information.

Summary of Calls to Action

CEOs

- Recognize succession planning as a necessary aspect of organizational leadership.
- Develop future leaders.
- Insist on and model a sustainable approach to organizational leadership.

Clinic Boards of Directors

- Recognize succession planning as a fundamental aspect of organizational governance.

- Take responsibility for board education and development.

Associations and Consortia

- Build awareness among members about the emerging field of executive leadership services.
- Consider board and organizational structure changes to mitigate competition and conflict among members.

Funders

- Fund realistic infrastructure costs.
- Fund executive access to leadership services.

The overall impression is of a deeply committed cadre of healthcare leaders—many of whom played founding roles in the community health movement in the 1960s and 1970s. In a context of increasing need for their services and ever-changing political and funding priorities, they have to face what they commonly refer to as the “graying of the sector.” That is, the field will have to focus its attention on the transition of a core group of its founding leaders. Of course those who aren’t leaving any time soon also need attention; the data suggest a number of opportunities to better support them. This report concludes with a series of Calls to Action—ways that CEOs, boards of directors, associations, and funders can help ensure that quality leadership is cultivated and retained.

A WORD ON TERMINOLOGY:

In this report, we use the terms “clinic” and “health center” interchangeably knowing that some organizations prefer one or the other. Although a variety of titles are used for the senior staff position at community clinics and health centers—sometimes president or executive director, for example—the term “CEO” is the most widely used, so it is the term we use throughout the report.



Introduction and Background to the Study

Across the State of California there are nearly 200 community clinics, health centers, and free clinics with some 500 clinic locations. Each year, these health centers and clinics provide health care services to more than 1 million patients: the uninsured, under-insured, and patients using government programs to pay for their health care. The clinics and health centers have been the backbone of the health care safety net—providing neighborhood based, culturally and linguistically appropriate medical services for people of all ages and backgrounds. Over the past 30+ years, many clinic leaders have been pioneers in forging this health care delivery system to assure that all Californians have access to care in their communities.

Supporting the community clinics are clinic-governed networks created over the last 25 years to help them expand access to care, join forces to facilitate their service delivery, and provide leadership in health policy at the local, state, and federal levels. Today, there are 13 networks and three statewide organizations that meet regularly to develop statewide strategy around the changing needs of the clinics and their patients.

This statewide study was inspired by CompassPoint's 2001 report, *Daring to Lead: Nonprofit Executive Directors and Their Work Experience*—a national study of 1,100 nonprofit executives from all organizational sizes and missions. The collaborative responsible for funding and guiding this project determined that *Daring to Lead* raised important questions about leadership in the community clinics and health centers in California. Clinic and network leadership recognize that a generation of community health center founders and long-time leaders is rapidly approaching retirement age and that fostering new leadership will become a clear priority in the near term.

The report concludes with a series of Calls to Action for CEOs, boards, associations, and funders and is intended to be a spark for dialogue among the stakeholders invested in preserving and strengthening the community health safety net.

Methodology + Clinic Demographics

Primary data for this study was collected through a 50-question web-based survey and from two focus groups held in Northern and Southern California.

Survey

In February 2003 a letter signed by Jan Masaoka, Debra Farmer, and Yvonne Bice was sent by U.S. mail to a list of 185 clinic and consortia CEOs. The Community Clinics Initiative provided the mailing list to CompassPoint. The letter invited CEOs to take the 50-question web-based survey. After an initial round of responses, the researchers sent a reminder email to non-respondents; additionally, Advisory Committee members encouraged participation through their peer networks. Ultimately, 97 CEOs completed the online survey: 82 from clinics and health centers, and 15 from consortia. This represents a 52% response rate. The surveys were anonymous and respondents are quoted without attribution throughout this report. Please see Appendix B for a complete list of participating organizations. Appendix A is a full copy of the online survey instrument.

The survey sample includes clinics of all budget, staff, and client population sizes from all across California. Following are the key demographics of the sample's 82 clinics (consortia are not included here).

Because many clinic corporations have more than one site, the categories in Figure 1 are difficult to apply consistently. Seventeen percent (17%) of respondents chose a combination of location types in responding to the question of primary location.

Figures 2, 3, and 4 are indicators of clinic size: operating budget, number of paid staff, and number of unduplicated patients per year. In order to surface any management differences inherent in running a smaller community clinic, we looked carefully at how clinics were distributed across these three variables. Interestingly, the number of unduplicated patients seen per year is the least reliable indicator of overall clinic size; that is, some clinics that see fewer than 5,000 patients per year nonetheless have operating budgets of more than \$1 million and paid staffs of more than 25 people. A cohort of "small clinic" respondents

FIGURE 1 Clinic Respondents by Main Office Location Type

<i>Location</i>	<i>No. of respondents</i>	<i>% of respondents</i>
Urban	40	49.4
Sub-urban	4	5.1
Rural	16	20.3
Frontier	7	8.9
Some combination of above	14	16.5
	82	100%

FIGURE 2 Clinic Respondents by Operating Budget Size

<i>Budget</i>	<i>No. of respondents</i>	<i>% of respondents</i>
< \$1 million	10	12.2
\$1 – 2.99 million	21	25.6
\$3 – 4.99 million	12	14.6
\$5 – 9.99 million	16	19.5
\$10 – 19.99 million	16	19.5
\$20 million and above	7	8.6
	82	100%

FIGURE 3 Clinic Respondents by Paid Staff Size

<i>Paid staff</i>	<i>No. of respondents</i>	<i>% of respondents</i>
0 - 25	17	20.7
26 - 50	15	18.3
51 - 99	18	22.0
100 - 299	25	30.5
300 and above	7	8.5
	82	100%

FIGURE 4 Clinic Respondents by No. of Unduplicated Clients Per Year

<i>Clients</i>	<i>No. of respondents</i>	<i>% of respondents</i>
< 5,000	19	23.2
5,000 – 9,999	15	18.3
10,000 – 29,999	30	36.6
30,000 – 49,999	8	9.8
50,000 and above	9	12.1
	81	100%

FIGURE 5 Clinics by Year Founded

<i>Year founded</i>	<i>No. of respondents</i>	<i>% of respondents</i>
< 1960s	3	3.8
1960s	10	12.8
1970s	45	55.6
1980s	8	9.9
1990s to present	15	18.5
	81	100%

was identified as having both of the following characteristics: paid staff of fewer than 25 people and unduplicated patients per year of fewer than 10,000. There are 14 respondents in this group—10 of whom have operating budgets of less than \$1 million (the remaining four are all under \$3 million). Where noteworthy throughout the clinic CEO findings, we distinguish between this cohort of 14 small clinics and the other 68 respondents.

Focus Groups and Interviews

The CompassPoint research team conducted two one-and-a-half hour focus groups for clinic CEOs as well as interviews with 2 executives who were unable to attend the groups. The line of questioning followed the survey instrument, with particular emphasis on job challenges, rewards, and succession issues. The focus groups were audio taped and a number of focus group/interview participants are quoted without attribution in this report.

Paula Cohen, Mendocino Coast Clinics, Fort Bragg

Orvin Henson, Indian Health Council, Pauma Valley

George Provencher, Consolidated Tribal Health, Redwood Valley

Jim Ruiz, United Health Centers, Parlier

Steve Schilling, Clinica Sierra Vista, Bakersfield

Mary Szecsey, West County Health Centers, Guerneville

Kuldip Thusu, Alta Familia Health Clinic, Dinuba

Carl Coan, Eisner Pediatric and Family Medical Center, Los Angeles

Debra Farmer, Westside Family Health Center, Santa Monica

Jann Hamilton Lee, South Bay Family Health Center, Los Angeles

Margie Martinez, CHAP, Pasadena

Kazue Shibata, Asian Pacific Healthcare Venture, Los Angeles

Gay Kaplan, Curry Senior Center, San Francisco

Nance Rosencranz, Marin Community Clinic, Marin

Findings: Clinic CEOs

A CEO Characteristics

Gender Overall, there are more female CEOs than male. Of the 81 clinic CEOs who provided their gender, 33 (41%) are male and 48 (59%) female. There are equal or nearly equal numbers of women and men in 4 out of 6 clinic budget categories. It is among clinics in the \$1-5 million range where women significantly outnumber men; among these 33 clinics, there were 23 female and 9 male CEOs¹. This trend of equal representation among the smallest and largest organizations varies dramatically from the national sample of nonprofits in which 69% of the smallest nonprofits are run by women and 59% of the largest are run by men.

Age A large majority of clinic executives are 50 years old or older. Compared with the national sample, clinic executives are significantly more likely to be in their 50s and 60s. Whereas 51% of nonprofit executive directors are less than 50 years old, just 30% of clinic CEOs are in this age group. Clearly, the baby boom population played a founding leadership role in building the community health movement and can be described as the first “senior class” of the community clinic sector. This raises concerns about the readiness of the next wave of leadership; we address these issues in Section E, beginning on page 12.

Race/ethnicity The majority of clinic and health center CEOs are European/white, with 70% of the sample in this category. An open-ended survey question about diversity yielded a range of responses from CEOs. A number of respondents mentioned specifically the dearth of African American executives among California’s community clinics and health centers; they make up 5% of the current leadership cohort. Some respondents argued that race and ethnicity ought not to be a significant factor in identifying clinic leadership—noting that the difficulty of the job requires competency first and foremost; this respondent’s comment captures this sentiment: “As we serve diverse populations, it is nice if people of color are in management positions, but only if they are competent and capable of doing the job.” Others argued that diversity should be cultivated intentionally because it is aligned with the community health mission. As one CEO wrote, “Diversity is critical as

“Unfortunately right now it’s often a choice between hiring someone because they are the appropriate minority or hiring someone who is not, but has the appropriate level of skills to take the clinic where it needs to go. Good minority candidates are in high demand – as they should be – but there aren’t enough qualified minority candidates to go around.”

FIGURE 6 Gender of Executive Directors by Budget Size

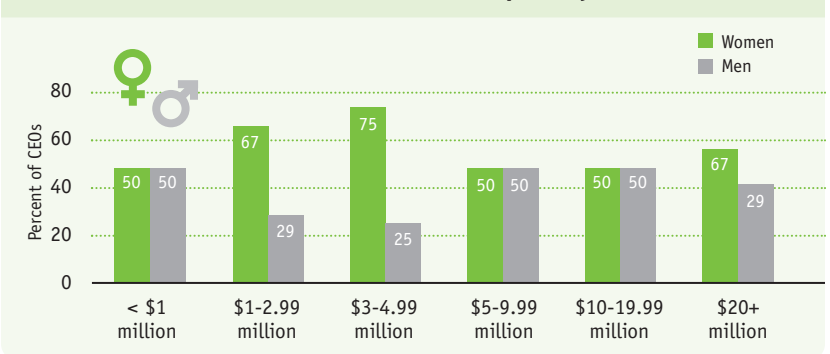


FIGURE 7 Age of Clinic CEOs Compared with Nonprofits Generally

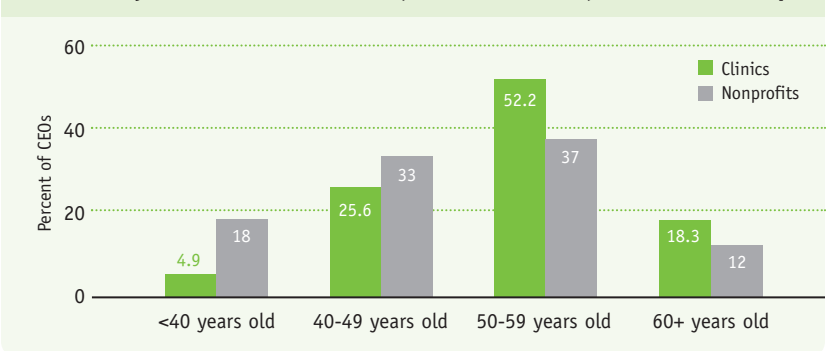
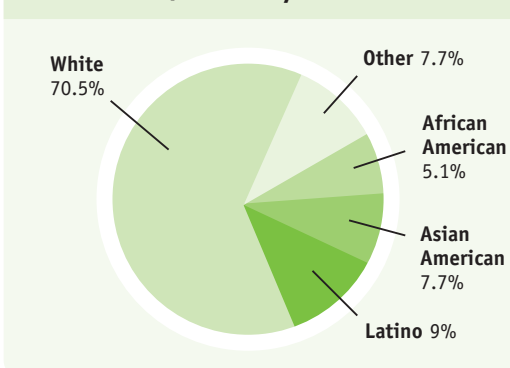


FIGURE 8 Race/Ethnicity of Clinic CEOs²



1 One respondent in this budget category did not provide his/her gender.

2 The 7.7% “Other” in Figure 9 includes respondents who identified as Native American, Middle Eastern, and “other.”

FIGURE 9 Clinic CEO Education Levels

Educational Level	% of respondents
High school	7.7
Undergraduate	25.6
Master's	53.8
Doctorate	12.9

FIGURE 10 Years in the Field

Years	% of respondents	Cumulative %
< 5	8.5	8.5
5-10	20.7	29.2
11-15	18.3	47.5
16-25	24.4	71.9
25+	28.1	100

FIGURE 11 Years in Current Position

Years	% of respondents	Cumulative %
< 2	7.4	7.4
2-4	23.5	30.9
5-7	13.6	44.4
8-10	17.3	61.7
11-15	16.0	77.8
16+	22.2	100

it relates to social justice and the populations we serve. Self determination is extremely important.” Several respondents questioned whether the pipeline of candidates is itself diverse enough: “Professional and academic institutions are failing to produce racially/ethnically diverse graduates who know about the nonprofit world, community needs, and professional approaches or solutions.”

Education Overall clinic CEOs are highly educated—slightly more so than the national sample of nonprofit executives. Whereas 58% of executive directors nationally have a Master’s degree or doctorate, 67% of California’s community clinic CEOs hold one or both of these advanced degrees. Clinic CEOs are also likely to have graduate level business or administration education: common academic pursuits included health care administration, public health, and business.

For a majority of CEOs—54%—this is the first CEO position they have held. Still, this can hardly be considered an inexperienced group of managers because of the unusually long tenure clinic CEOs tend to have in their current positions. Nationally, 20% of nonprofit executives have been in their current roles for more than 10 years; among clinic CEOs it is nearly 40%.

Among those who had been CEOs prior to their current role, the majority were in the health field—whether running another community health center, directing a public or military health facility, or playing an executive role at a private hospital or in private medical practice.

Slightly less than half of CEOs were hired from within their organizations. The 54% who were hired from elsewhere come from all sectors: nonprofit, government, for-profit, and self-employment. In fact, less than half of CEOs hired from outside their organizations were working in a nonprofit organization immediately prior to assuming their current CEO position.

B Career Paths to CEO

Like nonprofit executives generally—who tend to have years of experience in the sector—community clinic CEOs have been working in the community health field for a long time. In fact, 51% of CEOs have 16 or more years in the field; 28% have spent 25 or more years.

FIGURE 12 Current Tenure of Clinic CEOs Compared with Nonprofits Generally

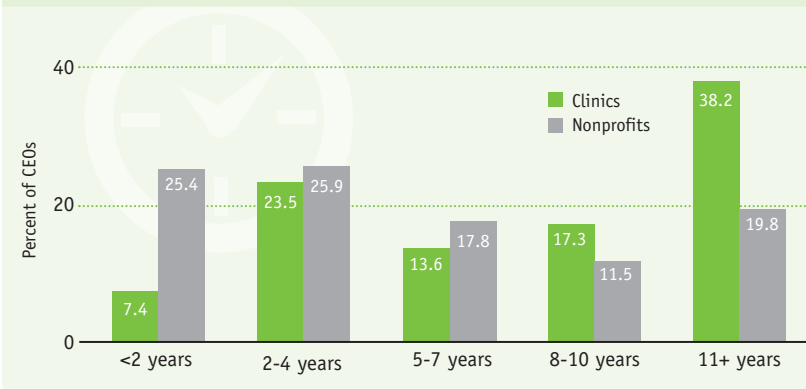


FIGURE 13 Recruitment of Clinic CEOs

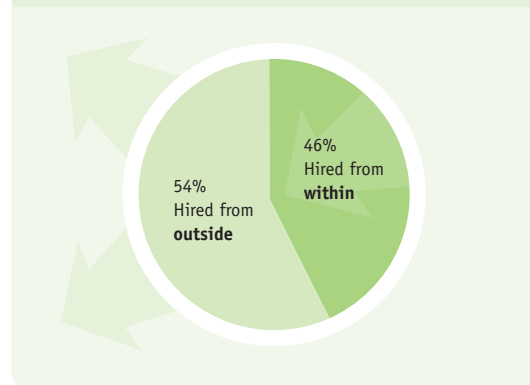
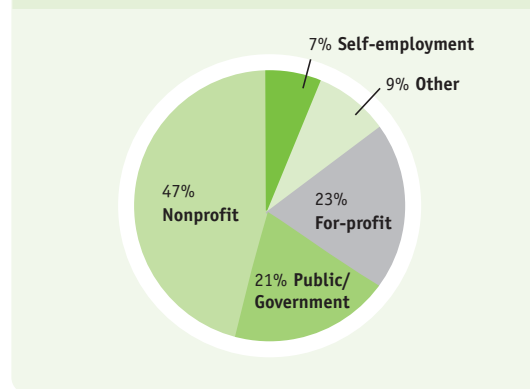
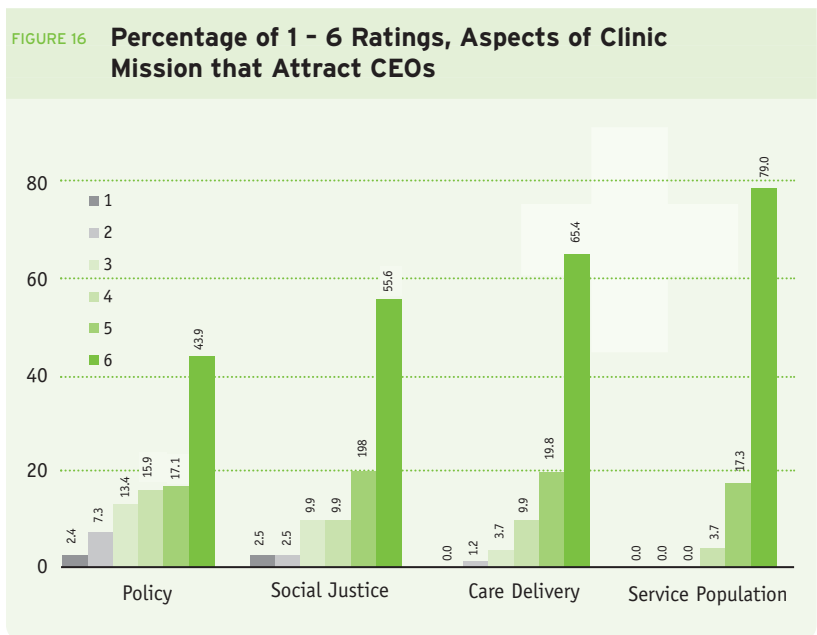
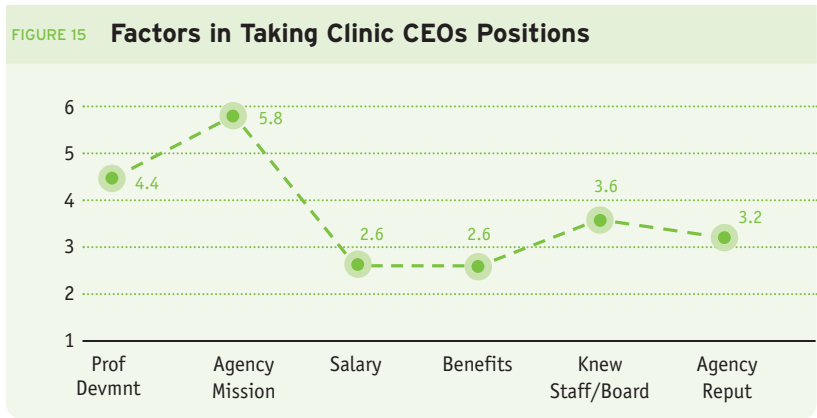


FIGURE 14 Previous Sector of Externally Recruited Clinics CEOs



Overwhelmingly respondents took their current jobs because of the mission of their organizations. Like nonprofit executives generally, money—in the form of salary or benefits—is not reported as a critical factor. After mission, the CEOs’ own professional development was the next most important factor in their decision to take the job.

People working in the community clinic field view the mission of their organizations as multi-faceted—inclusive of not only health care delivery objectives, but also of advocacy for the service population of low-income children, families and seniors, as well as health policy and broader social justice. Clinic CEOs tended to rate each of these factors as important motivators that attracted them to this work. Rating the aspects of mission on a scale of 1 to 6, with 6 meaning “extremely attractive,” CEOs appear to be especially motivated by working with the populations that utilize their clinics. This was the only aspect of mission that received no 1, 2, or 3 scores at all; 79% rated “service population” a 6 out of 6.

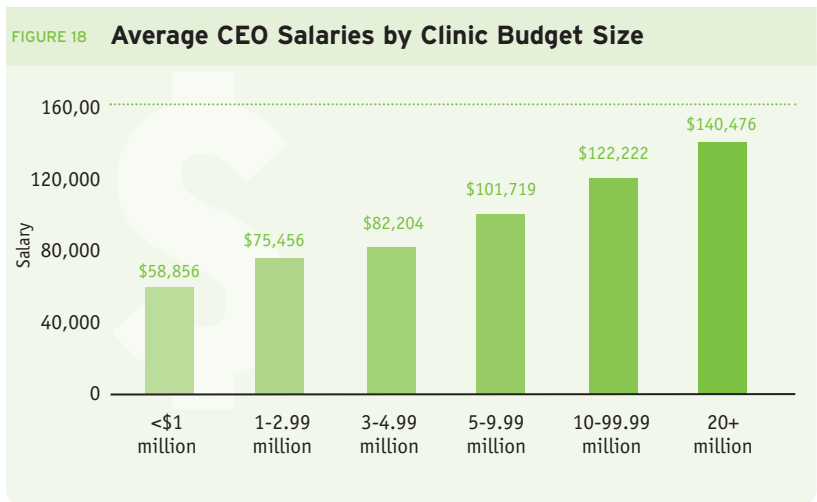


C Salaries

As part of the healthcare industry, the CEOs of California’s community clinics and health centers are paid slightly more in each budget category than national averages for nonprofit executives sector-wide. Primarily because clinics and health centers tend to have larger operating budgets than other types of nonprofits, the mean³ salary for California’s clinic executives is \$93,339 compared with \$57,332 for nonprofits generally. Still, CEOs at the smallest clinics and health centers tend to make much less than the average. There was a wide range in salary among CEOs in the small clinics cohort—from \$25,000 to \$130,000, with a mean of \$64,579.

FIGURE 17 Clinic CEO Salaries

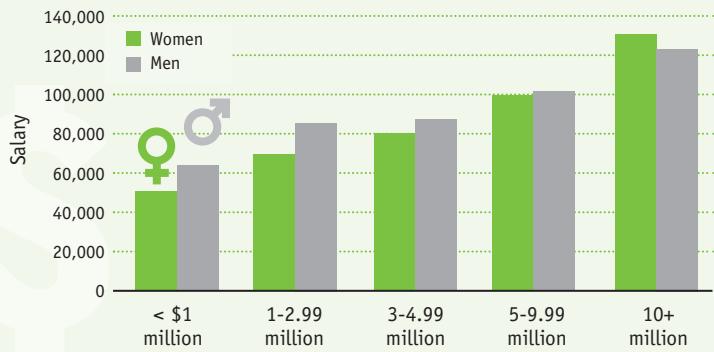
Low	\$25,000
High	\$230,000
Median	\$94,500
5% Trimmed Mean	\$93,339



Interestingly, the gender disparity across agency sizes that was evident in the national sample of nonprofit executives is less pronounced among community health CEOs. That is, there are not

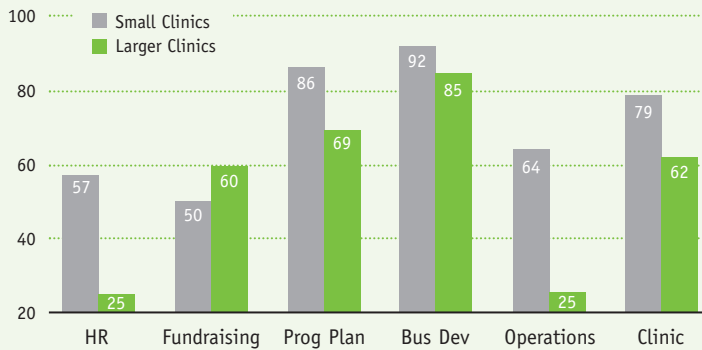
³ Throughout the report we are using the 5% trimmed mean, which is a mean calculated after the top and bottom 5% of scores (outliers) are eliminated

FIGURE 19 Gender Differential of Mean Salaries at Various Budget Sizes



“Although I find it to be very stressful and tiring, the myriad of obligations within this position and my ability to lead the organization are the things I like most about my role. Being the CEO of a community health center is like no other position in any other kind of industry.”

FIGURE 20 Comparison of CEO Responsibilities by Clinic Size



D Job Rewards and Challenges

Given the clear passion for the community health mission evident in their reasons for taking their jobs, it is not surprising that CEOs reported being very satisfied overall with their work. Rating their satisfaction on a scale of 1 to 6, with 6 meaning “extremely satisfied,” respondents gave a remarkably high mean answer of 5.3 out of 6. When asked what they like most about the work, CEOs talked frequently about serving their client populations, about the opportunity to lead and provide vision and inspiration for staff, and the chance to work with others who are equally committed to community health. CEOs also mentioned the diversity of tasks they take on as a positive aspect of the work.

The relative weight of those diverse job demands varies of course by clinic size— with CEOs at the largest organizations having more senior staff with whom to share responsibilities. Figure 20 demonstrates that the CEOs of the smaller clinics and health centers are far more likely to have primary responsibility for human resources and clinic operations. Moreover, 57% of CEOs at the smallest clinics and health centers have a second in command, compared with 78% of CEOs at the larger clinics.

While CEOs across all clinic sizes tend to have primary responsibility for program planning and business development, their job responsibilities diverge when it comes to managing people and operations. Whereas larger, federally-funded health centers typically have CFO and/or COO positions to address these management demands, in smaller centers they often fall to the CEO.

Skills CEOs identified a number of skills that are important to their success. The most frequently mentioned skills include listening and communication and the ability to lead. The latter was

“We are providing primary care access to the medically indigent. This is not a profession; it is a vocation.”

more men running the larger clinics. Nonetheless, within most budget categories men are making more than women. Indeed the mean salary for women clinic CEOs is \$88,986, compared with \$99,529 for men. In fact, the budget categories where women tend to outnumber men—in the \$1 million to \$5 million range—are where the salary discrepancies are the greatest.

Again, contrary to national trends for non-profit executives, the only budget category in which women averaged more than men among clinic CEOs was the largest—those clinics with operating budgets of more than \$10 million.

Community health CEOs are very satisfied with their compensation. Low compensation was not reported to be a big stressor overall. Eight-one percent (81%) of CEOs rated their satisfaction with compensation a 4, 5, or 6 out of 6. Not surprisingly, the executives making less are less satisfied with their compensation; CEOs earning less than \$70,000 (N=16) had a mean satisfaction of 3.7, while CEOs earning more than \$70,000 had a mean satisfaction of 4.7.

"I feel that training in the nursing field really helped me in all areas: team development, supervisory skills, and most of all delegation!"

"It's my ability to walk the tightrope between too many services and too little money to pay for them."

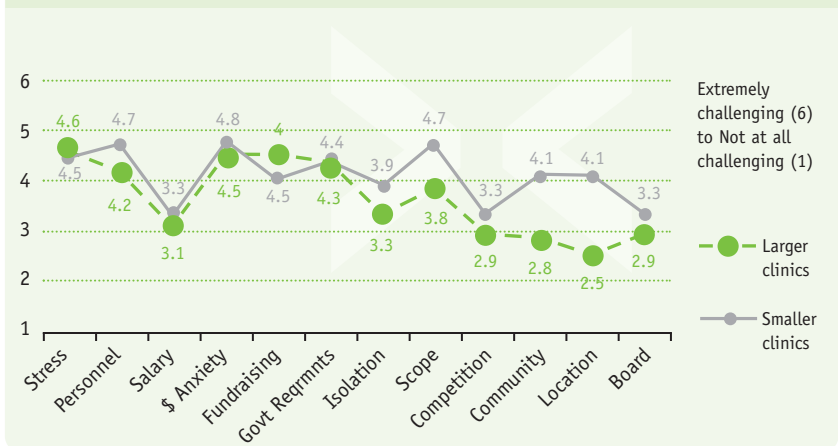
variously described as "strategic vision," "holding the big picture," and "keeping future goals in focus while dealing with day to day challenges." Many CEOs also referenced their business and financial skills, which is not unexpected given the funding complexities they deal with regularly and the graduate level business and administration training that many clinic executives have. Political skills and advocacy — whether in reference to their own staff and boards or to the broader community health landscape—was mentioned by a number of respondents as well. Finally, some respondents referenced their own clinical background as important to their executive effectiveness; indeed, a small number of CEOs maintain a clinical practice.

Challenges Still, it is clear that running a community health center can be—and usually is—a very stressful job. The complexity and politics of healthcare funding and regulation as well as competition for professional staff appear to be major stressors for many clinic CEOs. Moreover, the aforementioned scope of work that can be viewed as a positive, is nonetheless a contributor to the high stress levels reported by CEOs. Twenty-five percent (25%) of CEOs rated "Stress" a 6 out of 6 among factors that challenge them in their roles; nearly 60% rated it a 5 or 6.

Among clinics of all sizes, CEOs are challenged by high stress and financial concerns, but the CEOs of smaller clinics are notably more challenged by the scope of issues they face—likely because they have fewer management staff to whom they can delegate—as well as their clinic location and work with their communities.

Just as CEOs rated financial anxiety among their biggest challenges, when we asked them what would make their work more enjoyable, many provided money-related responses. In particular, CEOs worry about the stability of their funding as well

FIGURE 21 Average Rating of Factors that Challenge Clinic CEOs by Clinic Size



"Rural areas with low population density make it hard to have enough volume to support operations, so we have few managerial positions and others and I have to do dual jobs."

"My big challenges are uncertainty about the future of funding sources, constant change in regulations (HIPAA), and not enough top-level management to assist with important duties because there's not enough money in the budget to hire them."

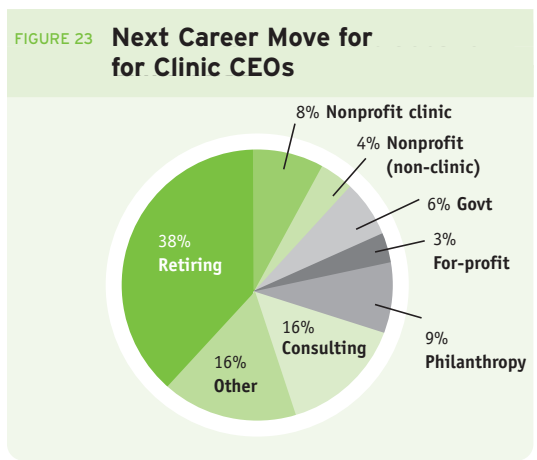
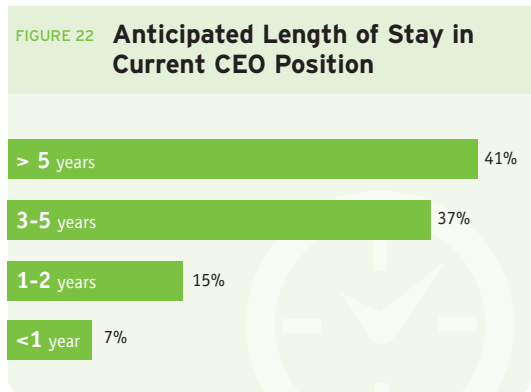
as the challenge of funding administrative and operational costs. Another theme was staffing—again the need for administrative and fundraising support staff in particular. As one CEO summarized it: "I want to have a sense of financial stability for the organization during the upcoming budget cuts and I need more trained staff to assist with the stressful and constant job duties of fundraising and advocacy."

E Tenure and Post-ED Career Paths

A primary objective of this research was to understand the anticipated career paths of current clinic leaders. How long can we expect them to stay in their jobs? Will they stay in the community health field when they leave their current positions? Equally important, what are they doing to develop and ensure a smooth transition to their successors?

Given how long many community health CEOs have been in their current roles, it is remarkable that more than 40% expect to be in their current jobs for another 6 years or more. And whereas nationally 35% of nonprofit executives anticipated leaving their jobs within the next 2 years, just 22% of clinic CEOs have the same expectation.

“In small clinics, there's not an obvious feeder role for the CEO position. We just recently added the COO role here and we are a \$5.5 million clinic. I am leaving and we have gone outside for an Interim and will for the new CEO as well.”



One inevitable factor in leadership retention is retirement. With the age data showing that 70% of current executives are in their fifties or older, many plan to retire out of their current roles. Indeed when offered a range of potential next steps, “retirement” was chosen by 38% of respondents, making it the most frequent response. Sixty-four percent (64%) of respondents in their 60s or older plan to retire out of their current positions. Still, 60% of this older cohort plans to be in their current job for at least another 3 to 5 years.

Next Jobs Where will the CEOs who aren’t planning to retire go next in their careers? Figure 24 demonstrates that similar to nonprofit executives generally, clinics leaders are not likely to run a clinic again. Instead, they have interest in philanthropy, consulting, or other personal goals such as returning to school or private practice (captured in “Other” in Figure 23).



"I have a strategic plan for my organization, but not for myself. Personally I don't believe in succession planning."

What this data suggests is that the field of community health can expect just 8% of the current cohort of executives to be available for future CEO openings. Thus many of the future CEO position openings will likely be filled by current members of senior clinic staff. This begs the question of whether CEOs are actively cultivating these potential future leaders.

Roughly half of current CEOs have identified one or more people with the potential to take their job when they leave or retire. Among these, most are looking to internal staff; 82% of these potential successors are within the organization. Chief Financial Officers, Chief Operating Officers, Medical Directors, and Deputy Directors (or the equivalent to these titles) were the most frequently identified probable successors.

However, a critical finding of this research is a tendency for ambivalence among community health leaders about succession planning generally—and in some cases about the next wave of leaders specifically. The fact that many current executives played founding roles in the community health movement no doubt contributes to this ambivalence. As one outgoing CEO said, "There's only one generation of pioneers."

Study participants readily acknowledged the "graying of the sector," but few had specific strategies in mind for their own successful transition. There is the sense in listening to many clinic CEOs talk that this field—as opposed to any one CEO—has a kind of collective "founder's syndrome." When used to describe an individual, "founder's syndrome" refers to such deep ownership of an organization that it is difficult for her/him to imagine anyone else ever taking over adequately. Not necessarily arrogance, this mind-set has more to do with a lack of boundary between the leader's personal investment and the organization's viability in its own right. In this

case, the very long tenure of most CEOs—along with founders' attachment to the community health center movement they helped to build—is certainly a key factor. For example, one executive agreed that succession planning is important but wondered how to do it given the fact that many on his staff and board have been involved with the organization for 20+ years. There simply isn't the institutional knowledge or memory of what leadership transition looks like in cases like his. Moreover the emerging recognition in the nonprofit sector that succession planning is inclusive of a number of skills beyond choosing an ideal successor when one is ready to resign—from cultivating leaders, to sharing knowledge and key organizational relationships, to insisting on a sustainable workload for senior staff and the CEO—is not yet widely evident in the way clinic leaders talk about succession. While these trends were not ubiquitous, their prevalence was noteworthy and has implications for successful and proactive transition planning.

A related issue is the perception by today's clinic executives of the next wave of leadership. A number of participants referenced how differently the next generation views the work. In addition to not having been part of the founding movement, the next generation wants a balanced life—something that was not part of the equation for most founders. Some respondents questioned the younger generation's depth of commitment to the community health center mission. Others acknowledged that older clinic leadership at times has difficulty relating to the young staff who are potential successors.

"Our generation's concern about the next cohort of clinic leaders may be about the social justice aspect of the work. Do the incoming interns have the burning righteous indignation to sustain them through the challenges they'll face?"

“My board members have accepted the need to develop into a more functioning governing body of a nonprofit agency, and their development process is very conducive to my own development as the CEO.”

“We have just instituted a consumer majority [on our board]. We haven’t done all the training we want to do yet, but I am already seeing their tendency to want to get involved in clinic operations. We are going to use an Advisory Council structure as a place for consumers to go through first and learn.”

F Boards of Directors

Like nonprofit executives generally, clinic CEOs tell a somewhat mixed story about the success of their board/staff partnership. When asked to rate how effectively their boards team up with them in 5 key areas (see figure 25 below), CEOs gave fairly high ratings to everything except fundraising. CEOs viewed board members as most effective partners in advocating for the organization’s mission.

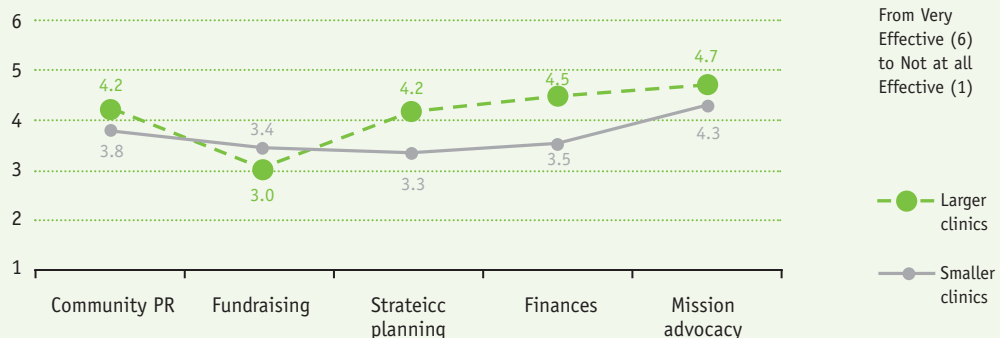
However, the CEOs of larger organizations perceive their boards to be more effective than do CEOs in smaller clinics and health centers. In the key governance areas of strategic planning and finance for instance, the cohort of CEOs from smaller clinics rated board effectiveness a full point lower or more than their colleagues from larger clinics and health centers.

A minority of CEOs complained about boards that offer little or no professional guidance, engage too much in the minutia of clinic management, and/or are not a source of personal support or inspiration. In a powerful reminder that CEOs need more than oversight from their bosses, one respondent noted: “When I had an unexpected

death in my immediate family, not one Board member sent me a message of condolence.” But the majority of CEOs described their boards as sources of personal support—many alluding to strong relationships whose boundaries and role definitions have become clearer over time. Many also used emotional terms to describe the relationship: “trusting,” “respectful,” “compassionate,” and “a shoulder to cry on.” Frequently, CEOs attributed the success of their board relationship to the board’s willingness to let them run the organization on a day-to-day basis: “They do not micromanage, but advise wisely and keep direction of mission and policy.”

An important factor in community health CEO-Board relations is the federal funding requirement for consumer board participation. As in other parts of the nonprofit sector, CEOs who are managing up to consumer boards have to address a variety of board training and communication issues. Executives in the midst of transitioning their boards from traditional nonprofit composi-

FIGURE 25 Perceived Effectiveness of CEO/Board Partnership by Clinic Size



tion to the consumer representation face a period of mutual adjustment that can be an additional stressor for the CEO. One CEO noted, “Finding board members who meet the requirements of funding sources (like being representative of our patient populations) while bringing expertise to the board, is very challenging.”

Finally, the same issue of long tenure and founder orientation seen among CEOs appears to be present on many clinic and health center boards. A number of survey respondents pointed to the many years of service of their current board members as a factor in their deep relationship. Though the survey did not address the issue directly, one is left with the impression that some clinics—presumably those not required to comply with federal Section 330 mandated governance rules—are not making use of board term limits as a means of infusing their organizations with new expertise or vision. As one focus group member commented about her clinic: “The organization had outgrown the board and is now reconfiguring itself. And it’s very difficult!”

“The board was part of the free clinic model; they wanted the hippie days. They didn't have a grasp of where the organization had gone, although they had approved every new contract that came along.”

G Sources of Training & Support

We asked CEOs to rate the importance to them in their CEO role of a variety of sources of both support and training. As Figures 26 and 27 below demonstrate, CEOs use both informal and formal networks to learn and sustain themselves—with their senior staff and fellow CEOs being particularly crucial. Formal sources CPCA and RCC had slightly higher ratings as providers of training than of support.

Several respondents noted specifically the lack of clinic executive training available. The idea of a targeted executive academy of some sort was discussed by members of one of the focus groups. Another survey respondent lamented: “One of my challenges is not having formal training on how to be an effective CEO. Although some of the learning can only happen on the job, the balance of formal training versus on-the-job training is off, which creates an environment for unnecessary mistakes and re-inventing of the wheel.” Arguing for learning from peers who’ve had success, one CEO concluded provocatively: “A business/medical education is vastly overrated as qualification for executives and sometimes gets in the way of seeing the big picture.”

FIGURE 26 Current Sources of SUPPORT for Clinic CEOs

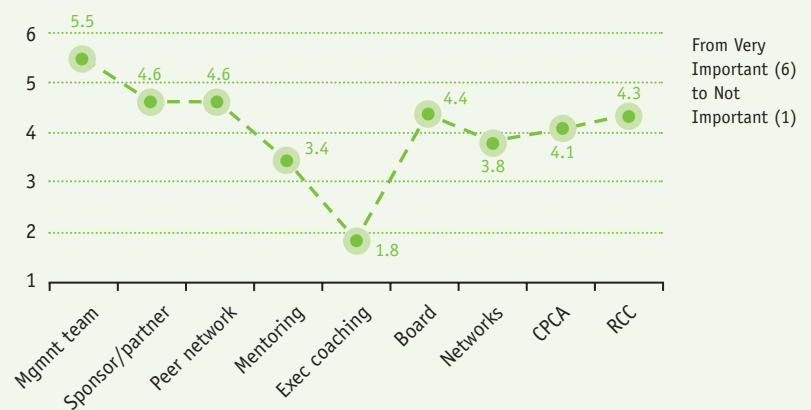
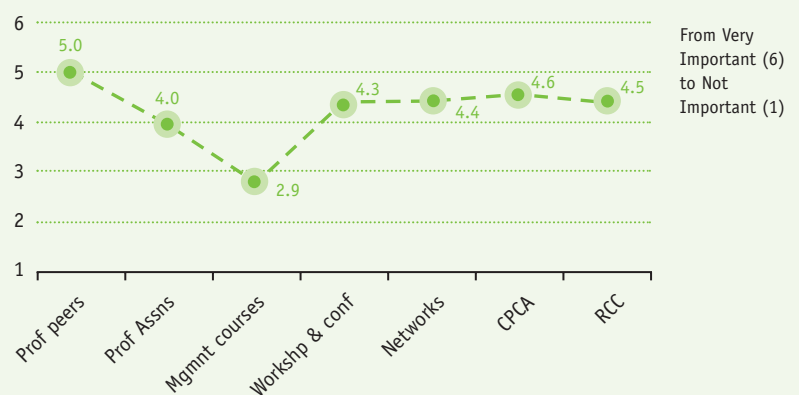


FIGURE 27 Current Sources of TRAINING for Clinic CEOs

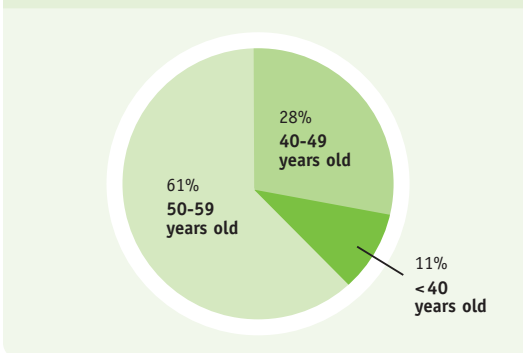


Consortia/Association CEO Findings

Though not the primary focus of this research, the clinic-governed consortia and associations⁴ across the state are a crucial element of the safety-net—advocating regionally and statewide for patients and services, fighting for adequate clinic funding, and offering support and training to health center staff and executives. Thus the CEOs of the state’s 21 such associations were also part of our study’s target; 15 responded to the web-based survey. A condensed summary of findings follows.

The personal characteristics of consortia CEOs are similar to those of clinic leadership though the members of this cohort are less likely to be in their 60s. Eighty-three percent (83%) are women and 61% are in their 50s. Seventy-eight percent (78%) are white—with one CEO identifying in each of these race/ethnicity categories: African American, Asian/Pacific Islander, Latino, and Other. Most consortia CEOs—61%—have a Master’s degree, but none reported having a doctorate.

FIGURE 28 Age of Consortia/Association CEOs



Like clinic CEOs, association executives have worked in the community health field for many years—more than 50% for 16 years or more. Two-thirds have been CEOs before, all but one in public or nonprofit health settings. Forty percent (40%) of association CEOs ascended to the position from within the organization from among the positions of CFO, board member, policy staff, and consultant. Nearly three-quarters of association executives have been in their current position for 5 or more years.

“One of my most important skills is political instinct: I am responsible for health policy advocacy in a very conservative region.”

FIGURE 29 Years in Current Position

Years	% of respondents	Cumulative %
< 2	13.3	13.3
2-4	13.3	26.7
5-7	33.4	60.0
8-10	20.0	80.0
11+	20.0	100.0

Consortia executives have very similar motivations in taking their roles as clinic CEOs—emphasizing mission and professional development over salary and benefits. They are equally similar in identifying health center patient populations as the most compelling aspect of the mission.

Association executive salaries range from \$45,000 to \$164,000 with a mean of \$100,941. Respondents are quite satisfied with their compensation; 87% rated their satisfaction as a 5 or 6 on a six-point scale. They are equally satisfied with their work; 87% rated their overall satisfaction with their jobs as a 5 or 6 on a six-point scale. In describing why they like their work, association executives talk about impacting a system of care and successful advocacy on behalf of member clinics. Among the skills they identify as responsible for their success: communication, vision and leadership, and political savvy.

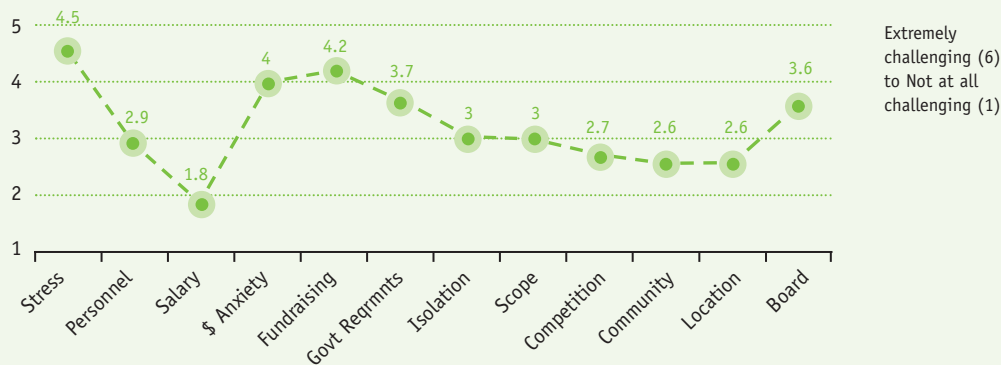
Consortia executives report being as stressed as their clinic peers; 67% rated stress a 5 or 6 out of 6. Asked to rate a list of potential stressors, they express slightly less concern about agency finances and slightly more about their boards of directors than clinic executives do.

⁴ A variety of names for clinic membership groups are used throughout the state including: consortia, associations, councils, networks, and partnerships. We refer to these as consortia and/or associations throughout the report. Please see Appendix B for a list of participants.

“What I like most is moving the clinic system forward—implementing new collaborative and integrated services that improve care, decrease costs, and improve the financial performance of health centers.”

“It’s kind of hard for the ED of a consortium to answer to the EDs of its member clinics. The structure can be awkward. As board members our roles get confused. Advocating for our own agencies, especially in the case of funds to be distributed through the consortium, can be an uncomfortable conversation.”

FIGURE 30 Average Rating of Factors that Challenge Association CEOs

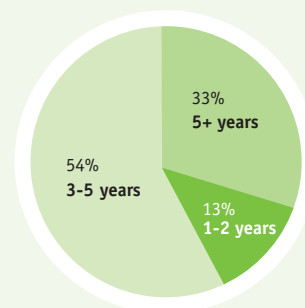


Surveys and interviews with both association executives and health center CEOs suggest that a challenge facing this health care system is the engagement and functioning of association boards of directors. While this is not new information, the opportunity for executives to speak anonymously yielded honest feedback about the inherent challenges of collaboration as well as the member clinic-association CEO dynamic. Among the issues raised: competition among board members, lack of engagement by board members, and the potential for power struggle between association CEOs and board members. As one association CEO explained, “Members have a strong conflict of interest. We are now looking at governance issues and hope that the board can be restructured to address these conflicts.” Another challenge identified is the mixture of small and large clinics in any one association, which can lead to conflict over priorities and perceptions of disrespect.

The majority of association executives expect to be in their current jobs for 3-5 more years, while 33% expect to stay for 6 or more years. None reported that she/he would be leaving within one year.

“It is challenging to build consensus and maintain a level of fairness among colleagues who are operating from different frames of reference, such as very large clinics who have a different set of needs and priorities than we who are still struggling to survive.”

FIGURE 31 Years Executives Expect to Stay in Current Position



Calls to Action

The findings suggest a number of potential responses for key stakeholders in California's community health center network. With guidance from our Advisory Committee, we propose the following next steps for clinic CEOs, clinic boards of directors, associations and consortia, and funders.

A RECOMMENDATIONS FOR Clinic CEOs

Recognize succession planning as a necessary aspect of organizational leadership.

"Your investment in consciously and continuously grooming new leadership ensures there is a diverse pool of potential executives ready to serve your community."

*Tom Adams
Annie E. Casey Executive Leadership and
Transition and Capacity Building Project*

The findings of this research confirm what many suspected about the aging of the community health center leadership cadre. But more importantly they also surface a lack of planning for that impending turnover. While succession planning is also the responsibility of a board of directors (see subsequent Calls to Action targeted to boards), a portion of the responsibility falls to incumbent executives.

Proactive consideration of career goals and their timing, promoting the readiness of the organization and its managers to function well in their absence, and regular dialogue with the board of directors on the subject of succession are all appropriate ongoing steps for CEOs regardless of their age. The key is to move beyond thinking of succession planning as something one undertakes once she has decided to retire; instead recognize it as an approach to leadership that is ongoing. Working from the perspective that the organization will be run by a number of successors over time gives a

new level of priority to developing leaders within and outside of the clinic, to insisting on competitive compensation and a sustainable workload for the CEO and other managers—in short, creating a job that somebody else would want and at which somebody would have a reasonable chance for success.

Develop future leaders.

Another component of effective organizational leadership is active development of potential successors—whether for one's own job or for future leadership needs of the field. Given that most current clinic CEOs do not expect to take another clinic CEO position, it's today's medical directors, COOs, and other senior management team members that will likely be the next class of clinic leadership. It's critical that CEOs identify and intentionally provide these staff with professional development opportunities, access to key organizational relationships, and encouragement to consider a long-term management track. This is not to suggest that one person on staff should be obviously singled out, but instead that CEOs should intentionally build the capacity of their management teams.⁵ Being mindful of developing leaders of color also appears warranted; respondents noted the under-representation of African American leaders in community clinic leadership and the overall tendency for health center CEOs to be white.

Model a sustainable approach to leadership.

Some CEOs expressed ambivalence about the next generation of clinic leadership—questioning whether they had the commitment and drive that the founding cohort displayed. While a lack of commitment is damaging to any organization, so too is extremely high stress, crisis-oriented management. By maintaining their own work/life balance, CEOs not only provide better leadership, they also demonstrate to potential successors that the job is do-able. On the other hand, executives that demand that the next generation of managers work like they themselves worked in the early days of the clinic

⁵ "Departing? Arriving? Surviving and Thriving: Lessons for Executives." Adams, Tom. *The Nonprofit Quarterly*, Volume 9, Issue 4, page 7.

movement, are in danger of pushing talent out of the pool just as it's most needed. Long-term CEOs can consider a paid sabbatical program to allow for rejuvenation as well as professional development for the management team in the CEOs absence.

"Nothing has greater impact on the outcome than a board's leadership skills in exploiting the moment of leadership turnover for its myriad opportunities."

*Tim Wolfred
Director, Executive Transitions, CompassPoint*

B RECOMMENDATIONS TO **Clinic Boards of Directors**

Recognize succession planning as a fundamental aspect of organizational governance.

One of the primary responsibilities of a board of directors is to hire, evaluate the performance of, and replace when necessary the organization's chief executive. While in practice nonprofit organizations vary widely in the strength and assertiveness of their boards, the degree of retirement and other kinds of turnover that clinic boards face in the coming years mandates that they become versed in the basic tenets of succession planning. The board of directors is the agent during succession: if a search firm is hired, the board is the client; if an interim executive is needed during a prolonged search, the board must find him or her, and so on. Moreover, the board must know enough about the executive job to determine the best successor. It's the board executive committee's responsibility to be in regular dialogue—typically during annual performance evaluation—with the CEO about her career plans and the degree to which she is developing future leaders.

Take responsibility for board education and development.

Recognizing that a high functioning board will lower the stress level of the CEO, board leadership should identify where their boards needs skills-building and secure appropriate training. If board members are uncomfortable asking for money, they make seek a development training; if most cannot read health center financial statements, they can ask the center's CPA to do an annual custom training for the board. For new board members and/or consumer board members, this is

especially important. Making the transition from a previous relationship to the organization—and respecting the boundaries between management and governance—are essential to strong governance and an effective board-CEO relationship.

C RECOMMENDATIONS TO **Associations and Consortia**

Build awareness among members about the emerging field of executive leadership services.

Clinic CEOs need exposure to the emerging field of executive leadership services. There is a growing realization in the nonprofit sector that paying attention to leadership is critical to the sustainability of organizations. Given this report's findings on the age of community health CEOs as well as how unlikely current CEOs are to take another executive position, it's critical that the field learn the concepts and begin to promote the value of intentional executive transition planning. Through membership meetings and conferences, associations can introduce this thinking and serve as channels of information about services available to CEOs locally and regionally.

Consider board and organizational structure changes to mitigate competition and conflict among members.

It appears that some associations are struggling to make their founding governance structures and systems continue to work despite the changing needs of member clinics. Participants in this study raised issues of conflicts of interest, discord between member clinics of various sizes, and the challenge of the association executive-clinic executive relationship. What each association may

need to consider now is a strategic planning process that addresses the question, “What are the *current* goals of our affiliation?” And from this, “Which governance and organizational structures will best meet the member clinic needs?” Part of this strategic thinking should be consideration of what role the associations are best suited to play: service organizations or trade associations?



RECOMMENDATIONS TO Funders

Fund realistic infrastructure costs.

Much of the financial anxiety described by participants in this study stems from the full costs of

their services not being paid— whether by governmental or non-governmental sources. Moreover, CEOs face changing funding priorities and budget cuts tied to the current administration and the fledgling economy. When asked what would make their work more enjoyable, many CEOs talked about infrastructure: facilities, technology, support staff, and operations. As one frustrated CEO put it: “We need to educate all the organizations we

deal with that there is an administrative cost to everything we do. No one wants to pay for administration!” While infrastructure costs may seem less appealing to funders seeking demonstrable patient impact, in fact sufficient infrastructure is essential to organizational effectiveness as well as retention of high-performing staff. Some respondents in this study talked about doubling up administrative roles in one person or going without key positions, which are clear paths to eventual staff burnout and/or lower quality work.

“A big stressor is the changes in clinic financing. In the old days, if you added a \$100,000 doctor to your staff in order to expand, those new costs would be covered. Not anymore. While that doctor is getting up to speed, the clinic has to cover those costs in some other way. Medi-cal doesn't pay for expansion any longer.”

⁶ This program is administered by CompassPoint Nonprofit Services.

⁷ This was a joint project of CompassPoint, Marin Nexus, and Resource Center for Nonprofits at the Volunteer Center Sonoma County.

Fund executive access to leadership services.

Philanthropy is beginning to recognize the value of investing in executives—both as a means of improving organizational performance and of sector retention of our most experienced talent pool. In California, the leadership of The California Wellness Foundation and the Durfee Foundation (Los Angeles) in establishing paid executive sabbatical programs is a prime example. Launched this year, the Wellness Foundation’s sabbatical program⁶—which is targeted to nonprofit health executives throughout California—had 91 applicants for 6 awards! Clearly there is ample room for additional philanthropy-sponsored sabbatical programs.

Less expensive but highly impactful is executive coaching. Long established in the for-profit sector, coaching is beginning to take hold as an important tool for executive burnout prevention and leadership skills development in the nonprofit sector. A recent evaluation by Harder+Company of the Executive Coaching Project⁷ in the San Francisco Bay Area concluded, “EDs reported statistically significant improvement in the clarity of their vision for the organization, as well as staff and Board alignment with the mission.” Coaching also had positive impacts on executives’ levels of confidence and ability to balance the demands of their personal and professional lives. The stress levels indicated by this research suggest that coaching could be of enormous use in the community clinic field.

Especially important is providing support to long-time executives who are approaching transition—as well as the boards of directors who will have to identify their successors. The arena of executive succession planning has developed rapidly over the last 5 years and now includes training for executives who are contemplating resignation/retirement, interim executive placement, consulting to the board during transition, and executive placement services. Financially strapped clinics may not have the resources to direct to this effort, so the leadership of philanthropy in encouraging and funding this work is crucial.

Conclusion

The heroism of clinic, health center, and association leadership is evident throughout these findings. Their passionate commitment to the millions of uninsured and under-insured residents of California is what inspires them to work long hours, struggle to find adequate funding, and advocate politically for those with little power in Sacramento or Washington D.C. The system of hundreds of clinics and health centers across the state that this cohort of founding leaders has built is a remarkable model that is even more critical today than it was 30 years ago. The regional and statewide associations commissioned this report to inspire dialogue about how best to ensure its future.

One way to do this is to invest in clinic, health center, and association leadership. These CEOs and board members are faced with tough decisions and arduous political battles on behalf of their patients. This report's findings suggest that the next several years are the right time for the clinic and health centers across California to focus on developing the next class of leaders, building the savvy of the boards that will guide them, and strengthening the networks that leverage their individual strengths into regional and statewide forces protecting California's healthcare safety net.

Survey Instrument

California Community Clinics Executive Director/CEO Leadership Survey

PLEASE TELL US ABOUT YOUR CAREER PATH

1) How many total years have you worked in community clinics (in any capacity)?

- a. Less than 5 years
- b. 5 - 10 years
- c. 11 - 15 years
- d. 16 - 25 years
- e. More than 25 years

2) For how many years have you been in your current Executive Director/CEO position?

_____ Years

3) Have you previously held an Executive/CEO position?

- a. Yes
- b. No

4) If YES, Please list number of years and field of service for each position

- a. As a Nonprofit ED (e.g. human service)
- b. As a Government Executive (e.g. public health)
- c. As a For-profit Executive (e.g. for-profit hospital)

5) Were you working or volunteering at your current agency before you became the Executive Director/CEO?

- a. Yes
- b. No

6) If YES, for how long?

_____ Years

7) If YES, what was your role in your current agency immediately prior to becoming Executive Director/CEO?

- a. Associate Director
- b. Development Director
- c. Medical Director
- d. Director of Finance/Administration
- e. Board Member
- f. Other (please specify)

If you selected other please specify: _____

8) If NO, in which sector were you working immediately prior to becoming Executive Director/CEO?

- a. Nonprofit
- b. Public/Government
- c. For profit
- d. Self-employed
- e. Other (please specify)

If you selected other please specify: _____

9) On a scale of 1 - 6, how important were each of the following factors in your decision to take your current job as Executive Director/CEO?

- My professional development*
Not At All - 1 2 3 4 5 6 - Very Much
- The organization's mission*
Not At All - 1 2 3 4 5 6 - Very Much
- The salary*
Not At All - 1 2 3 4 5 6 - Very Much
- The benefits (e.g. healthcare, retirement plan, etc)*
Not At All - 1 2 3 4 5 6 - Very Much
- Staff and/or board members I knew at the agency*
Not At All - 1 2 3 4 5 6 - Very Much
- The perceived financial and/or programmatic strength of the agency*
Not At All - 1 2 3 4 5 6 - Very Much

10) On a scale of 1 - 6, how much did each of the following aspects of a community clinic's mission attract you to your current job as Executive Director/CEO?

- The public policy and advocacy aspect of the mission*
Not At All - 1 2 3 4 5 6 - Very Much
- The social justice aspect of the mission*
Not At All - 1 2 3 4 5 6 - Very Much
- The health care delivery aspect of the mission*
Not At All - 1 2 3 4 5 6 - Very Much
- The service to under-served populations aspect of the mission*
Not At All - 1 2 3 4 5 6 - Very Much

PLEASE TELL US ABOUT YOUR CURRENT EXECUTIVE DIRECTOR/CEO POSITION

11) What is your current annual salary (excluding benefits and other non-monetary compensation)?

\$ _____

12) On a scale of 1 - 6, how satisfied are you with your total compensation package?

1 - Not Satisfied 2 3 4 5 6 - Very Satisfied

13) On a scale of 1 - 6, how satisfied are you overall with your current job as Executive Director/CEO?

1 - Not Satisfied 2 3 4 5 6 - Very Satisfied

14) Which three (3) of your skills are most responsible for your success as Executive Director/CEO?

- Skill 1

- Skill 2

- Skill 3

15) How much longer do you imagine that you'll stay in your current position as Executive Director/CEO?

- a. Less than 1 year
- b. 1 - 2 years
- c. 3 - 5 years
- d. More than 5 years

16) What do you like most about your job as Medical Director/CEO?

17) To what degree are these factors challenging to you in your role?

- High stress*
Not A Challenge - 1 2 3 4 5 6 - Very Challenging
- Personnel Issues*
Not A Challenge - 1 2 3 4 5 6 - Very Challenging
- Low compensation*
Not A Challenge - 1 2 3 4 5 6 - Very Challenging
- Anxiety about agency's finances*
Not A Challenge - 1 2 3 4 5 6 - Very Challenging
- Fundraising*
Not A Challenge - 1 2 3 4 5 6 - Very Challenging
- Dealing with government funding and/or program requirements*
Not A Challenge - 1 2 3 4 5 6 - Very Challenging
- "Feeling ""lonely at the top""/isolation "*

Survey Instrument (continued)

Not A Challenge	-1	2	3	4	5	6 - Very Challenging
<i>Scope and variety of issues and responsibilities</i>						
Not A Challenge	-1	2	3	4	5	6 - Very Challenging
<i>Dealing with real or perceived competition</i>						
Not A Challenge	-1	2	3	4	5	6 - Very Challenging
<i>Working with the community</i>						
Not A Challenge	-1	2	3	4	5	6 - Very Challenging
<i>Clinic(s) geographic location</i>						
Not A Challenge	-1	2	3	4	5	6 - Very Challenging
<i>Relationship with board</i>						
Not A Challenge	-1	2	3	4	5	6 - Very Challenging

18) Please list any other factors that are very challenging to you in your role:

19) Have you identified one or more persons with the potential to be the future Executive Director/CEO of your organization?

- a. Yes
- b. No

20) If YES, what is/are their title(s) or position(s)?

21) If YES, are they internal or external to your organization?

- a. Internal
- b. External

22) What are you most likely to do upon leaving your current position?

- a. Retire
- b. A for-profit position
- c. Another non-profit clinic
- d. A philanthropy position
- e. Another non-profit (non-clinic)
- f. Consulting
- g. A government position
- h. Other (please specify)
- i. If you selected other please specify:

23) What one or two things would make your work more enjoyable?

PLEASE TELL US ABOUT YOUR NONPROFIT ORGANIZATION

24) Your clinic or consortium/association name?

25) City of your organization's main office/site?

26) If you are a community clinic (not a consortium or association) which of the following describe the service area(s) of your organization.

- a. Urban
- b. Sub-urban
- c. Rural
- d. Frontier
- e. Some combination of the above
- f. NA - we are not a community clinic
- g. Other (please specify)
- If you selected other please specify:

27) If you are a consortium or association (not a community clinic) which of the following describes your geographic scope.

- a. Regional
- b. State-wide
- c. NA - we are not a consortium or association
- d. Other (please specify)
- If you selected other please specify:

28) In what year was your organization founded?

29) How many paid full-time and part-time staff does your organization employ?

30) What is the annual operating budget of your organization?

- a. Less than \$500,000
- b. \$500,000 - \$999,999
- c. \$1 million - \$2,999,999
- d. \$3 million - \$4,999,999
- e. \$5 million - \$9,999,999
- f. \$10 million - \$19,999,999
- g. \$20,000,000 or more

31) If your organization serves clients directly, what number of unduplicated patients does your clinic serve in one year?

- a. Less than 5,000
- b. 5,000 - 9,999
- c. 10,000 - 29,999
- d. 30,000 - 49,999
- e. 50,000 - 99,999
- f. 100,000 - 199,999
- g. 200,000 or more
- h. NA, We Don't Serve Clients Directly

32) For each of these executive functions check the proper column to mean that you are primarily responsible for it OR that others on your staff have primary responsibility.

- a. Human resources management:
 My Responsibility Others Responsibility
- b. Fundraising:
 My Responsibility Others Responsibility
- c. Program planning:
 My Responsibility Others Responsibility
- d. Business development:
 My Responsibility Others Responsibility
- e. Operations:
 My Responsibility Others Responsibility
- f. Clinic leadership:
 My Responsibility Others Responsibility

33) Do you have a Management Team?

- a. Yes
- b. No

34) If YES, please list the management team's titles:

35) If YES, how frequently do you meet with your entire management team?

- a. Weekly
- b. Monthly
- c. Quarterly
- d. Semi-annually
- e. Annually

36) If YES, is the management team authorized to make decisions in your absence?

- a. Yes
- b. No

Survey Instrument (continued)

37) Do you have a 2nd in Command?

- a. Yes
- b. No

38) If YES, what is the 2nd in Command's title?

PLEASE TELL US ABOUT YOUR TRAINING AND SUPPORT NETWORK

39) On a scale of 1 - 6, how important is each of these sources of training to you in your ongoing development as an Executive Director/CEO?

- Professional peers*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Professional associations*
Not Important At All – 1 2 3 4 5 6 - Very Important
- College-based management course work*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Topical workshops and conferences*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Networks, such as: "National Association of Community Health Centers "*
Not Important At All – 1 2 3 4 5 6 - Very Important
- California Primary Care Association*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Regional Clinic Consortium*
Not Important At All – 1 2 3 4 5 6 - Very Important

40) On a scale of 1 - 6, how important is each of these sources of support to you in your ongoing development as an Executive Director/CEO?

- My management team/staff*
Not Important At All – 1 2 3 4 5 6 - Very Important
- My spouse/partner*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Clinic peers*
Not Important At All – 1 2 3 4 5 6 - Very Important
- My mentor(s)*
Not Important At All – 1 2 3 4 5 6 - Very Important
- My executive coach*
Not Important At All – 1 2 3 4 5 6 - Very Important
- My board members*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Networks, such as: "National Association of Community Health Centers "*
Not Important At All – 1 2 3 4 5 6 - Very Important
- California Primary Care Association*
Not Important At All – 1 2 3 4 5 6 - Very Important
- Regional Clinic Consortium*
Not Important At All – 1 2 3 4 5 6 - Very Important

41) List any other sources of training and/or support to you:

42) On a scale of 1 - 6, how effectively does your Board of Directors team up with you in the following areas?

- Community/public relations*
Not At All – 1 2 3 4 5 6 - Very Much
- Fundraising*
Not At All – 1 2 3 4 5 6 - Very Much
- Strategic planning*
Not At All – 1 2 3 4 5 6 - Very Much
- Financial oversight and budgeting*
Not At All – 1 2 3 4 5 6 - Very Much
- Advocacy for the agency's mission*
Not At All – 1 2 3 4 5 6 - Very Much

43) In what ways is your Board of Directors a source of personal support to you as Executive Director/CEO, if at all?

44) What are your thoughts on issues of diversity (race, gender, class, sexual orientation, etc) among community clinic executive leadership?

PLEASE TELL US ABOUT YOURSELF

45) What is your age?

46) What is your gender?

- a. Male
- b. Female
- c. Transgender
- d. Other

47) What is your race/ethnicity?

- a. African American
- b. Asian/Pacific Islander
- c. Latino/a
- d. Middle Eastern
- e. Native American
- f. White/Anglo
- g. Other (please specify)

48) What is your sexual orientation? (optional)

- a. Heterosexual
- b. Gay/Lesbian
- c. Bisexual
- d. Other

49) What is the highest level of formal education that you have completed?

- a. High school
- b. Undergraduate
- c. Master's

50) What was your degree in?

THANK YOU VERY MUCH FOR YOUR TIME!

APPENDIX B

Survey Respondents

Clinics and Health Centers

Alliance Medical Center
Anderson Valley Health Center
Asian Americans for Community Involvement
Asian Health Services, Inc.
Bill Moore Community Health Clinic
Brookside Community Health Center
CASA de SALUD Family Health Clinic
Chinatown Service Center Family Health Clinic
Clinica Msr. Oscar A. Romero
Clinica Sierra Vista
Coastal Health Alliance
CommuniCare Health Centers
Community Care Health Centers
Community Health Alliance of Pasadena
Community Health Partnership of Santa Clara County
Community Medical Centers, Inc.
Copper Towers Family Medical Center Inc.
Darin M. Camarena Health Centers, Inc.
Del Norte Clinics, inc
East Valley Community Health Center
Economic Opportunity Commission, Inc.
Eisner Ped. & Family M.C.
Golden Valley Health Centers
Haight Ashbury Free Clinics
Haight Ashbury Free Clinics Inc.
Hill Country Community Clinic, Inc.
Indian Health Center of Santa Clara Valley
Indian Health Council, Inc.
Inland Behavioral and Health Services, Inc
KCEOC Family Health Center
Korean Health, Education, Information & Research Center

La Maestra Family Clinic, Inc.
Laguna Beach Community Clinic
Lassen Indian Health Center
LifeLong Medical Care
Livingston Medical Group
Long Valley Health Center
Mendocino Coast Clinics
Mendocino Community Health Clinic
Mountain Health & Community Services
Mountain Valleys Health Centers
Native American Health Center
Neighborhood Healthcare
NHSI
North of Market Sr. Center (now Curry Senior Center)
Northeast Valley Health Corporation
Northeastern Rural Health Clinics
Our Saviour Center/Cleaver Clinic
Planned Parenthood
Planned Parenthood Mar Monte
Redding Rancheria Indian Health Clinic
Redwood coast Medical Services
Redwood Community Health Coalition
Roseland Children's Health Center
Salud Para La Gente, Inc.
San Francisco Free Clinic
Santa Barbara Neighborhood Clinics
Santa Cruz Women's Health Center
San Diego Community Clinic
Sequoia Community Health Foundation, Inc.
Share Our Selves Free Medical/Dental Clinic
Shasta Community Health Center
Siskiyou Family Healthcare

South of Market Health Center
St. Anthony Free Medical Clinic
St. John's Well Child and Family Center
The Children's Clinic Serving Children and Their Families
The Effort
Tiburcio Vasquez Health Center, Inc.
Tri-City Health Center
Tulare Community Health Clinic
Valley Community Clinic
Venice Family Clinic
Vista Community Clinic
Warner Mt. Indian Health
West County Health Centers
Western Sierra Medical Clinic
Westside Family Health Center
Women's Community Clinic

Consortia and Associations

Redwood Community Health Coalition
San Francisco Community Clinic Consortium
California Family Health Council
Shasta Consortium of Community Health Centers
Council of Community Clinics
Central Valley Health Network
Coalition of Orange County Community Clinics
Community Clinic Consortium of Contra Costa
Alameda Health Consortium
Northern Sierra Rural Health Network
Community Clinic Association of Los Angeles County
North Coast Clinics Network
Community Health Partnership
Planned Parenthood Affiliates of CA
CA Rural Indian Health Board, Inc.

APPENDIX C

CEO Succession Bibliography

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About CompassPoint Nonprofit Services

With offices in San Francisco and San José, CompassPoint Nonprofit Services is one of the nation's leading consulting and training firms serving nonprofit organizations. Through its 39 staff and hundreds of volunteer professionals, CompassPoint provides management consulting and training to nonprofits in fundraising, technology utilization, strategic planning, nonprofit finance, executive transitions, boards of directors, strategic internet presence, and other topics. Last year CompassPoint conducted more than 600 workshops for Bay Area nonprofits, and consulted to more than 300 nonprofit organizations. In addition to workshops and consulting, CompassPoint conducts several research projects each year, and publishes two free electronic newsletters—Food for Thought and the Board Café. CompassPoint's mission is to increase the effectiveness and impact of people working and volunteering in the nonprofit sector.

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