Mission Critical

The State of CEO Leadership in California Community Clinics

Authors   Kim Ammann Howard &
                 Sara Lepore Dube
                 BTW *informing change*

Advisor   Marissa M. Tirona
                 CompassPoint Nonprofit Services

Acknowledgements

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Nonprofit leaders often tread in unknown territory with inadequate supports to meet daunting demands.

Mission Critical:
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Introduction

The topic of leaders—finding them, training them, keeping them—regularly rises to the top of reports about organizational effectiveness. For nonprofit organizations in particular, with their double bottom line of financial strength and social change, strong leadership is essential for effectively meeting their missions. Nonprofit leaders often tread in unknown territory with inadequate supports to meet daunting demands. Still, as the leaders of their organizations, they must lay a path and provide guidance to others.

Similar to the overall nonprofit sector, community clinics and health centers are facing significant challenges in recruiting and retaining leaders.[1] In addition, there is a sense of urgency around cultivating the next generation of clinic leaders that runs parallel to clinics' immediate needs in finding and retaining Chief Executive Officers (CEOs) and Executive Directors.[2] These challenges are exacerbated by the retirement of many CEOs, competition for leaders from other sectors, a need for greater alignment between patient and provider diversity and, sometimes, geographic obstacles (e.g., recruitment to rural areas).

In 2003, two important studies conducted by CompassPoint Nonprofit Services (CompassPoint) examined the leadership needs of the community clinics field and offered some suggested action steps. These reports provided valuable information on the experience, perspective and future plans of two key groups of community clinic leaders: *Securing the Safety Net* focused on CEOs and *Bridging Medicine and Management* focused on medical directors. The two reports helped community clinics, nonprofit health care organizations and other health care stakeholders better understand the environment in which community clinics were dealing with leadership turnover and development.

Approximately five years later, two leading health care funders in California—the Blue Shield of California Foundation (BSCF) and the Community Clinics Initiative (CCI), a joint project of Tides and The California Endowment—decided to take another look at leadership in the community clinics field and assess the degree to which the situation had changed. The two funders engaged a team of consultants from BTW *informing change* (BTW) and CompassPoint to conduct this assessment of the field, with the goal of providing a snapshot of the current leadership landscape and implications to stimulate discussion and action among clinic leaders, their nonprofit and for-profit partners, funders and other stakeholders in the community clinics field.

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1   In this report, we use the term clinic to include both clinics and health centers, acknowledging that most organizations refer to themselves as community clinics but some prefer to be called health centers.

2   Many community clinics, health centers and clinic membership groups use the position title of Executive Director to designate their chief executive officer. In this report, when we use the term chief executive officer (CEO) we also include within it those leaders who hold the title of executive director.

This Report

This report is part of a set of three companion reports that together describe the findings of the 2009 Community Clinic Leadership and Workforce Studies. While the three studies are related, each one takes an in-depth look at a distinct group of staff within community clinics and clinic consortia.[3] The studies and their subject groups are:

1. This report, **Mission Critical: The State of CEO Leadership in California Community Clinics**, focused on current CEOs of clinics;

2. **Taking the Pulse: The State of Medical Director Leadership in California Community Clinics**, focused on current medical directors who hold the most senior clinical position within these settings; and

3. **The Pipeline Promise: A Study of Emerging Leaders in California Community Clinics**, focused on other staff who may become the future CEOs, medical directors or other senior leaders in clinics.

A fourth publication, an evaluation brief titled *Community Clinic Leadership in California: The State of the Field and Implications for the Future*, highlights key findings from all three studies and considers the implications across the studies. These studies and brief can be accessed from www.btw.informingchange.com.

This set of studies comes at an important time for the community clinics field. The results of these studies provide timely information about the best ways to help clinics, clinic consortia, funders and sector capacity builders who work with clinics and clinic consortia to make informed decisions as to how best to support and retain current leaders and prepare future ones.

In conducting this assessment, BTW and CompassPoint not only looked at the current state of leadership in the community clinics field but also looked for significant changes from the time of the CompassPoint studies (*Bridging Medicine and Management* and *Securing the Safety Net)* five years ago. Additionally, findings from the current assessment were compared with those in two other important reports about leadership in the nonprofit sector: *Daring to Lead*, a 2006 national study of nonprofit executive leadership, and *Ready to Lead: Next Generation Leaders Speak Out,* a 2008 national study of emerging nonprofit leaders. This comparison provided the opportunity to assess the degree to which the community clinics field is experiencing the challenges that face the broader nonprofit sector.

Mission Critical
The State of CEO Leadership in California Community Clinics

Taking the Pulse
The State of Medical Director Leadership in California Community Clinics

The Pipeline Promise
A Study of Emerging Leaders in California Community Clinics

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3   A variety of names are used to describe regional and statewide clinic membership groups, including consortium, association, council and network. In this report, we use the term consortium.
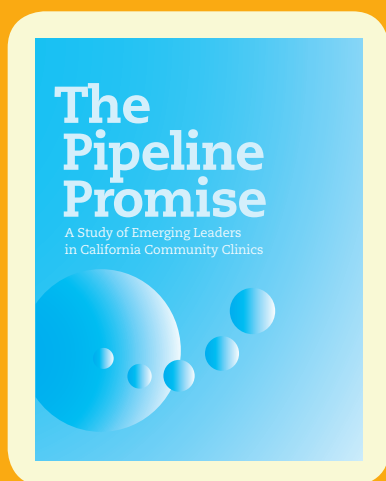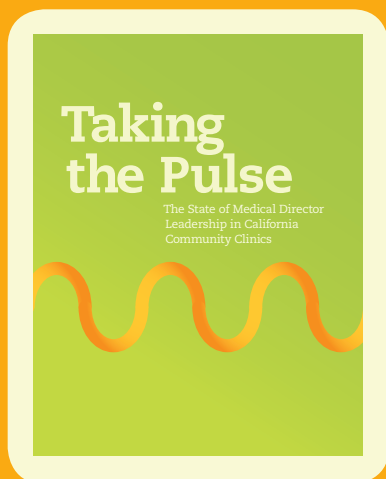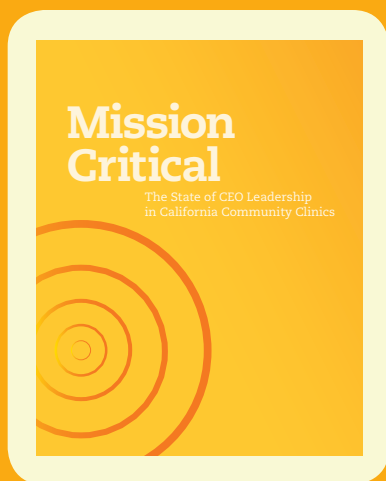
An advisory board representing different aspects of the community clinics field advised and guided this assessment and the development of the reports.

Community Clinic Leadership and Workforce Studies Advisory Board

Yasser Amman, President and Chief Executive Officer, University Muslim Medical Association

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Amanda Stangis, Director of Programs, California Primary Care Association

Dong Suh, Associate Director, Asian Health Services

Methodology

This report focuses specifically on the CEOs of community clinics and clinic consortia. Similar to the 2003 study, we focus on CEOs' perspectives on their current positions, career paths and aspirations, job challenges and rewards and professional and leadership development needs (e.g., training and support).

In November 2008, BTW and CompassPoint sent an e-mail request to executive directors and CEOs of 243 California community clinics and clinic consortia headquarters managing approximately 700 sites across the state describing the study and inviting them to participate in a web-based survey. The e-mail invitation contained the link to the survey, which was an adaptation of the one used in the 2003 study. In addition to several reminder e-mails sent by BTW and CompassPoint, Advisory Committee members encouraged participation through direct communication with non-respondents. The survey remained in the field for

approximately three months and was completed by 121 CEOs—110 from clinics and 11 from clinic consortia—for a 50% response rate. BTW also conducted four 60-minute focus groups, one in person and three via phone, with a total of 20 CEO participants. BTW also conducted a 15-minute interview with a CEO who was unable to participate in either focus group. For a list of focus group participants, please see the last page of this report.

When analyzing survey data, we explored differences across a variety of demographic (e.g., gender, age, etc.) and organizational (e.g., clinic location, clinic size, etc.) factors.[4] As part of our analysis, we also compared current survey data to findings from the 2003 *Securing the Safety Net* and *Daring to Lead* studies. We only include comparisons when there have been significant differences or shifts. Overall, there are few significant changes overtime among clinic CEOs. And while direct comparisons to the *Daring to Lead* study are more difficult due to different survey instruments, common themes across the two studies show that clinic CEOs closely represent their counterparts in nonprofits across the nation.

In addition to the information obtained in the survey, focus groups and interviews, we drew from informal conversations with a variety of stakeholders in the field as well as more formal conversations in which the authors participated during the study period. These discussions and conversations took place at health care-focused venues including BSCF's Clinic Leadership Institute training sessions and working group meeting and the California Primary Care Association's (CPCA) 2009 Statewide Community Health Center Workforce Strategy Meeting.[5]

4 When looking at differences in responses based on clinic size, we defined small clinics as those having fewer than 20 full-time employees; this comprises almost one-third (29%) of the organizations. In selecting this particular range of full-time employees as the designation for small clinic size, we examined the distribution of responses and determined that the bottom third of organizations represented by CEOs in this study most accurately reflect small clinics. We also looked at survey responses by primary clinic location (urban, suburban, rural, frontier and other as reported by CEOs) since organizations tend to experience certain challenges due to their geographic location. When exploring rural community clinics and clinic consortia, we determined that there is more variation in organizational size among rural clinics than expected; as a result, we did not pursue further analysis specific to geographic location.

5 When reviewing the data presented in this report it is important to note that they are not without limitations. The data are self-reported by those who completed a survey and/or participated in a focus group or interview; as a result readers should take caution in generalizing these findings broadly.
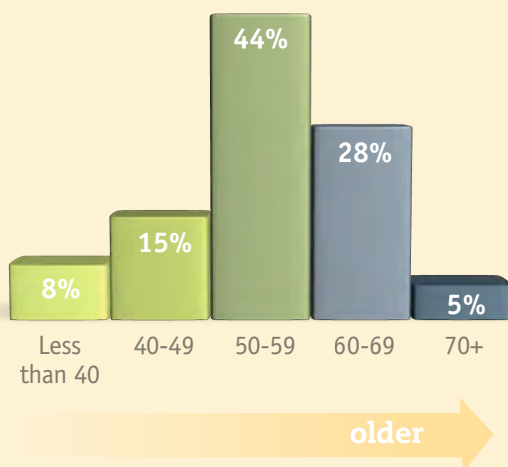
Findings

In this section of the report, we first provide a profile of the CEOs who participated in this study and the organizations where they work. Next, we present what we learned about the career paths of current CEOs and what motivated them to take on their current position. We look at their satisfaction in this position, including what they perceive to be the most significant rewards and challenges as leader of their organization and the types of supports that are most important for them to be successful in their work. Finally, we focus on clinic CEOs moving into the future, including the anticipated length of time in which current CEOs plan to stay in their positions and what preparations are taking place to prepare the next generation of CEOs.

Who Are the CEO Respondents?

► More than half (60%) of the respondents to the CEO survey are female.

► The average age of respondents is 55, with a range from 30 to 80 years old; respondents are on the older side with one-third over 60 years old and more than three-quarters (77%) age 50 or older.

► About two-thirds (67%) of respondents describe themselves as White/Anglo.

► Sixty-eight percent are recipients of graduate degrees; 51% have a master's degree and 17% a doctorate. Common degrees among CEOs include Master of Public Health, Master of Business Administration, Juris Doctorate and Master of Social Work.

► Overall, respondents are similar to the CEOs who participated in the 2003 study. The only notable exception is the age of respondents in which 77% are age 50 or older in the current study compared to 71% in 2003.

Average Age of CEOs
(n=121)

| Less than 40 | 40-49 | 50-59 | 60-69 | 70+ |
| 8% | 15% | 44% | 28% | 5% |

older →

Race/Ethnicity of CEOs
(n=121)

White/Anglo 67%
Latino/a 11%
Asian/Pacific Islander 7%
Multiracial 4%
Other 3%
Native American 3%
African American 3%
Middle Eastern 1%
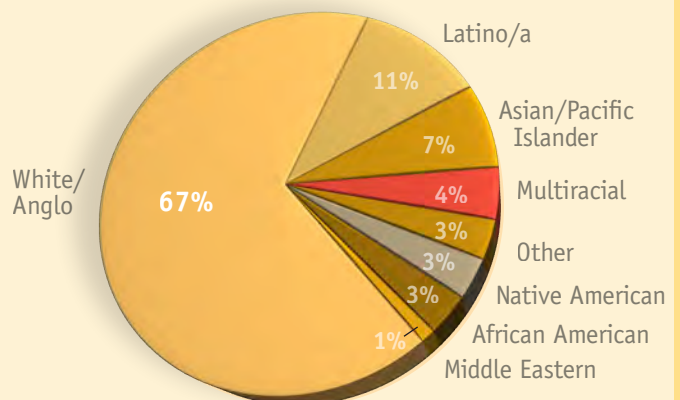
What Organizations Do Responding CEOs Lead?

▶ Most respondents are CEOs of clinics; only 9% are CEOs of clinic consortia.

▶ Almost half of respondents (47%) work at organizations located in primarily urban areas and about one-third (32%) in rural areas; most organizations (85%) have fewer than ten clinic sites.

▶ Nearly 70% of the clinics have been in existence for more than 20 years, with the highest concentration of organizations established in the 1970s (44%).

▶ Most organizations (71%) employ 100 or fewer full-time employees; almost one-third (29%) of the respondents' organizations are small organizations, which are defined as organizations having fewer than 20 full-time employees.

▶ About two-thirds (69%) have annual operating budgets of less than $10 million; most (76%) serve fewer than 30,000 unduplicated patients annually.

▶ Respondents' organizations are also similar to those represented in the 2003 CEO study with the following key differences: current CEOs' organizations are slightly smaller than those in the 2003 report (29% of current CEOs work at organizations with 20 or fewer full-time employees compared to 21% of CEOs at organizations with 25 or fewer paid staff in 2003) and current organizations tend to be more rural (32% vs. 20%).

Organization's Primary Location[6]

(n=121)

- Urban: 47%
- Rural: 32%
- Suburban: 11%
- Frontier: 6%
- Other: 4%
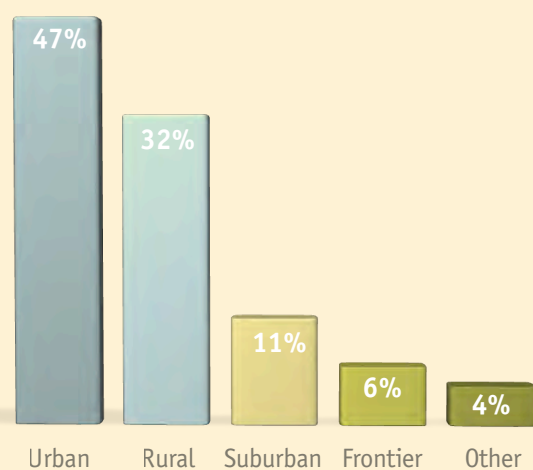
Number of Sites Within Current Organization

(n=121)

- Less than 5: 65%
- 5 to 10: 20%
- 10 to 20: 10%
- 20 or more: 5%
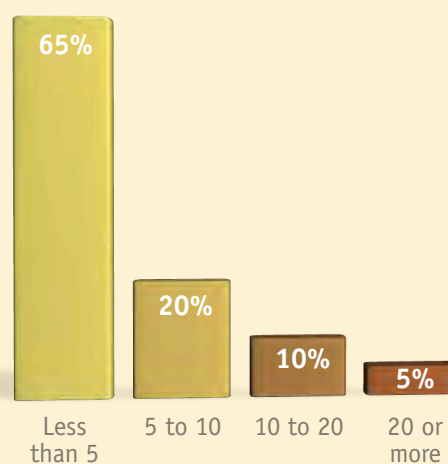
more sites →

6 "Frontier" represents areas that are sparsely populated rural areas isolated from population centers and services. Source: http://www.raconline.org/info_guides/frontier/frontierfaq.php#definition. "Other" includes organizations that CEOs did not think fit into one of the stated categories (e.g., "small town") as well as organizations that do not view one of their multiple clinic sites as a primary clinic location.

Year Organization Was Founded

(n=121)

Percentage of organizations founded in that decade:

Decade	Percentage
2000s	8%
1990s	23%
1980s	12%
1970s	44%
1960s or earlier	13%
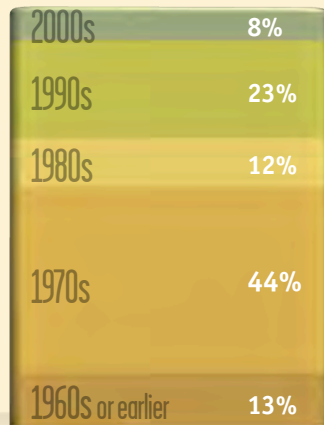
Number of Full-Time Equivalents Employed by Organization

(n=121)

- More than 250: 12%
- 1-20: 29%
- 101-250: 17%
- 21-50: 22%
- 51-100: 20%
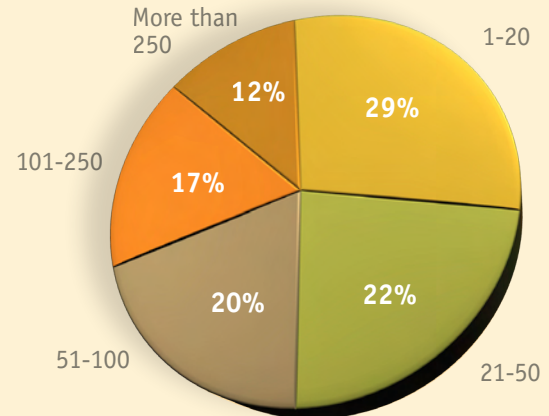
Organization's Annual Operating Budget

(n=121)

Budget	Percentage
Less than $1 million	11%
$1-3m	24%
$3-5m	13%
$5-10m	21%
$10-20m	17%
$20-30m	9%
$30m+	5%

larger budget →
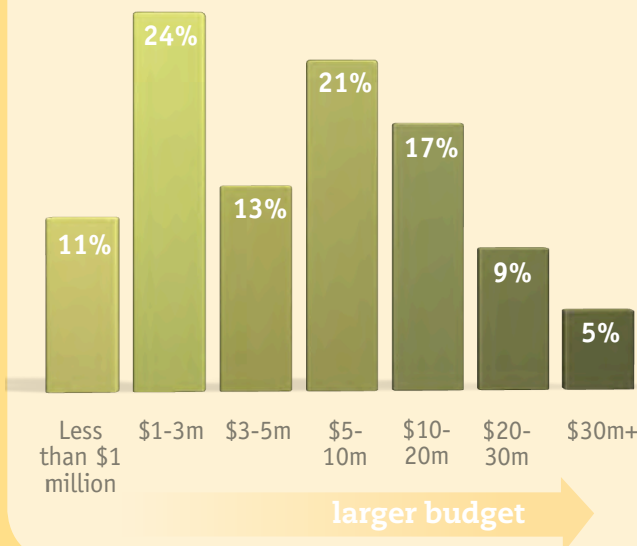
Number of Unduplicated Patients Served at Organization Each Year

(n=113)

- 200k +: 3%
- 100-200k: 5%
- 50-100k: 9%
- 30-50k: 6%
- 10-30k: 28%
- Fewer than 5k: 27%
- 5-10k: 21%
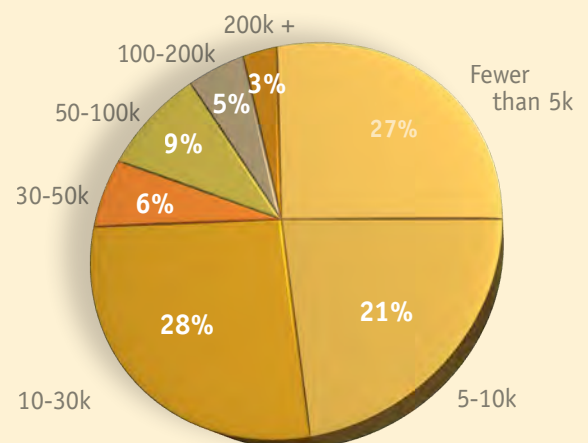
Path to Becoming Clinic CEO

Key Findings

► About half of CEO respondents are either very new to their position (20% in the position for less than 2 years) or well-seasoned veterans (24% in the position for 16 or more years).

► Half of CEOs are recruited internally; among those who come from outside their current organization, most are recruited from the nonprofit sector (74%) and/or health care disciplines (41%).

► Whether CEOs had intentionally pursued this position or not, some common motivations to take and stay in the position revolve around a commitment to the mission of the clinic and a desire to play a significant role in providing much needed and high quality health care.

Experience in Community Clinics and Clinic Consortia

The respondents to our survey have been in their current CEO position for an average of nine years, with a range of one year to thirty-three years tenure. Nearly half (47%) of respondents have been in their current position for a relatively short period of time—four years or less. However, the majority (53%) of CEOs have been in the community clinics field for five years or more.

Number of Years in Current CEO Position
(n=119)

Under 2 years	2 - 4 years	5 - 7 years	8 - 10 years	11 - 15 years	16+ years
20%	27%	8%	8%	13%	24%
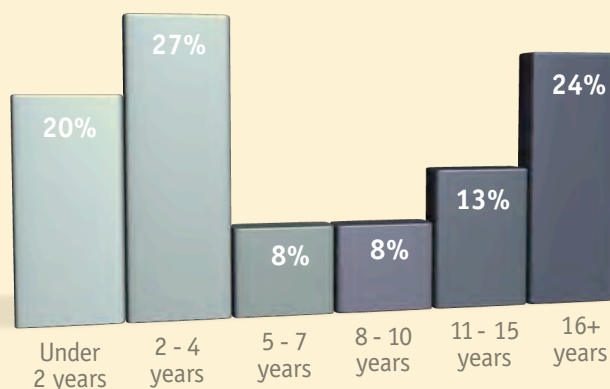
longer service

About half (49%) of respondents were hired from within their organization. These CEOs had been working, volunteering or doing both at the organization prior to becoming CEO. Respondents held a range of positions in their current organization immediately prior to assuming the CEO role, such as Senior Manager/Director, Board Member, Administrator and Program Coordinator/Manager; however, some started at very entry level positions and slowly worked their way into more senior pos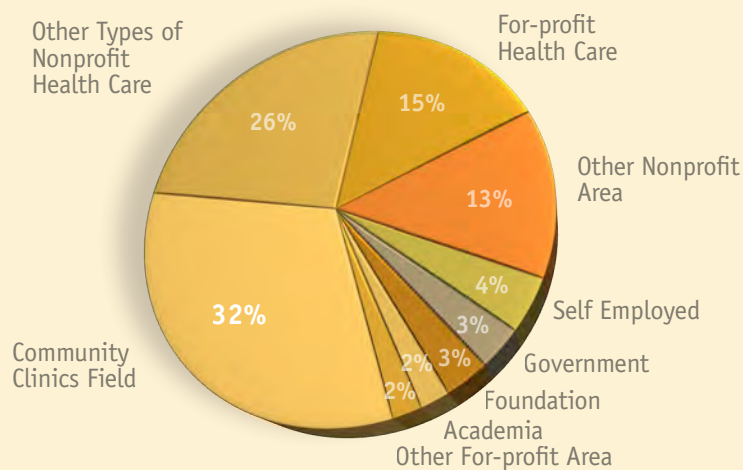itions. CEOs who were recruited from within their organizations describe how the experience allowed them to enter their CEO position with a more accurate perception of what the job entailed and the needed skills. For example, some individuals were able to identify the skills they needed for the CEO position and received specific training to develop them, generally from outgoing CEOs and other clinic staff.

The other half (51%) of respondents were hired for their current CEO position from outside of the organization; a large proportion came from a nonprofit and/or health care-related organization. Most (76%) of the CEOs who moved from another organization have worked in the community clinics field for more than 10 years. Of these, about one-third (32%) were already working in the nonprofit community clinics field and one-quarter (26%) at another type of nonprofit health care organization.

About half (49%) of respondents were hired from within their organization.

Area/Sector Worked in Prior to Becoming CEO
(n=62)

- Other Types of Nonprofit Health Care — 26%
- For-profit Health Care — 15%
- Other Nonprofit Area — 13%
- Self Employed — 4%
- Government — 3%
- Foundation — 3%
- Academia — 2%
- Other For-profit Area — 2%
- Community Clinics Field — 32%

Compared to the 2003 study of clinic CEOs, there are some significant shifts in the sectors where CEOs worked immediately prior to their current position. More CEOs now come from some type of nonprofit organization (71% in 2008 vs. 47% in 2003) and fewer from government (3% in 2008 vs. 21% in 2003) and the for-profit sector (16% in 2008 vs. 23% in 2003); many mention that these sectors typically offer more competitive compensation packages as well as other types of institutional supports and seemingly greater financial stability.

Half of all respondents have served in another CEO position, such as CEO of another nonprofit clinic, executive director of another type of nonprofit organization or

> "I didn't get too much training to being with. I just got thrown in there and had to figure out what to do. For those people who move up in the organization who have technical skills but never operated as CEO, I think some leadership training about how to work at that level is essential because it's a whole new perspective."

an executive of a for-profit organization. While CEOs describe how these previous positions helped prepare them to a certain extent for being a community clinic executive, it was still challenging for those who had not worked in a clinic setting. These CEOs describe the uniqueness of the clinic world and clinics' distinct set of needs and challenges; this is true even among those who had previous work experience in other health care settings. One CEO reflects: "For the CEO of a community clinic, it is actually a mixture of qualities, skills and knowledge that you need to have that are very specialized. I've seen people from other environments trying to make it in community health center environments; some have succeeded because they could succeed at anything, but others don't."

CEOs who were recruited from outside their current organization also mention different types of support which have been or would be helpful to as the new CEO, ranging from greater written documentation about the specific clinic they lead, support from other CEO peers and professional development related to clinic-specific practices and context. One CEO who previously led a non-health care nonprofit organization explained that she had greater support in that position than she does currently as a clinic executive; "I came from a place where there was lots of training available, to a small health clinic without a written history and resources."

Motivation for Becoming the CEO

Respondents were most motivated to take their current CEO position by a desire to make a difference in the community (mean rating: 5.75) and by the organization's mission (mean rating: 5.66).[7] In some cases, the pull of the organization even outweighed that of the job itself. "It was not the position, but the mission of the health center and what it does," says one respondent. Interestingly, a large percentage of individuals noted that, in addition to these reasons, becoming a CEO was an unanticipated opportunity; this was true among those who came from within the clinic, from another clinic or from other sectors. Less than half (46%) of respondents

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7   All mean ratings reported throughout this document are based on a 6-point scale. Though the specific values differ slightly depending on the survey question, "1" represents strong disagreement or dissatisfaction and "6" represents strong agreement or satisfaction.

for whom the CEO position was an unanticipated opportunity were working at their current clinic immediately prior and slightly more than half (54%) were working externally. Of those working externally, most came from the non-clinic nonprofit health care field (33%) or the for-profit health care field (22%).

Motivation for Becoming a CEO
(n=121)

Factor	Score
Making a difference in a community	5.75
Organization's mission	5.66
Professional development	4.26
Unanticipated opportunity	3.9
Knew staff and/or board members at clinic	3.59
Perceived financial and/or program strength of clinic	3.19
Salary	2.74
Benefits *(e.g., health care, retirement plan, etc.)*	2.47

greater motivation →
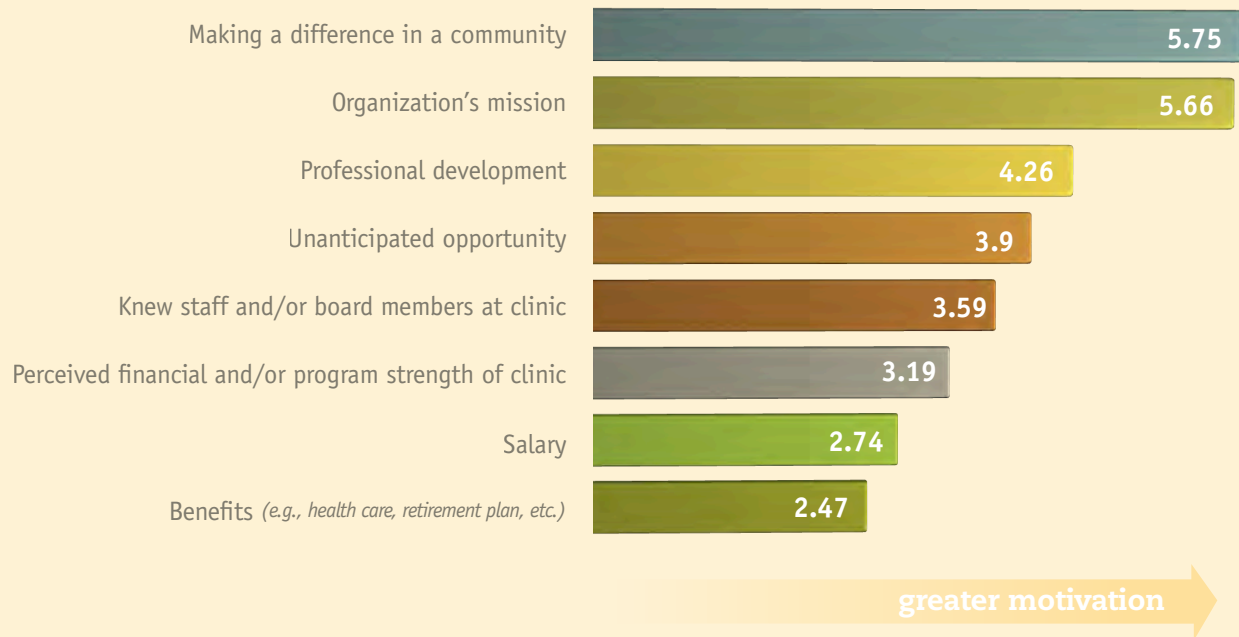
Among CEOs recruited from outside their current organization, many describe how they did not intend to become a clinic CEO or even work in a clinic. These same CEOs, years later, think that even with all the challenges they face, their belief in the organization's mission and desire to make a difference are not only their primary motivations for becoming and remaining the CEO but also are what keep them committed to leading their clinic. One focus group participant described how the organization's mission surpassed all other motivating factors for becoming the CEO: "It was completely a mission-based decision. I just have this compulsion to get up and go to work where I believe in the mission, and it's never been more true for me than here."

Among all the motivating factors, compensation packages, specifically salary and benefits, are the lowest motivations for becoming a community clinic CEO. It is interesting to note that when compared to the 2003 study of clinic CEOs, the current study's respondents have very similar motivations as shown in both the ranking of motivational factors and in the actual statistical means.

Experience in Current CEO Position

Key Findings

► Most CEOs report high levels of job satisfaction and highly rate many aspects of their job.

► This satisfaction, however, is counterbalanced by significant challenges that negatively impact their day-to-day work, and, ultimately, retention in the position.

► Financial challenges and those related to the recruitment, management and retention of clinic staff are among the most significant organizational challenges that CEOs face.

► Many CEOs mention personal impacts from the challenges of being a CEO, such as high levels of stress and feelings of isolation.

► CEOs are most satisfied and feel most effective in their positions when they share responsibilities and effectively work with their senior management team and boards.

► A variety of types of supports seem important for CEOs, with the less formal support of peers being particularly valued.

► The attractiveness of the CEO position due to organizational mission does not discount the need for appropriate levels of compensation.

Satisfaction and Challenges with Current Position

In general, most respondents report a high level of satisfaction with their current CEO position (mean rating: 5.38 out of six-point scale). The level of CEO job satisfaction has remained high over time, with respondents in the 2003 study also reporting, on average, a job satisfaction rating of a 5.3 on a 6-point scale. When asked what keeps CEOs at their jobs, many mention how their original motivations for taking the job still stand strong. They talk about being fulfilled by many aspects of their current CEO position, especially making a difference in the community (mean rating: 5.76), taking on new responsibilities and challenges (mean rating: 5.46) and working with the community (mean rating: 5.43). As one CEO reflects, "It's a very dynamic job with a lot of variety, so I'm continually challenged…. Every day is different." Another says, "It is a very rewarding job. I always feel like I am needed…. People wouldn't have health care otherwise if we weren't here."

> "It's a very dynamic job with a lot of variety, so I'm continually challenged…. Every day is different."

Factors That Contribute to CEO Satisfaction

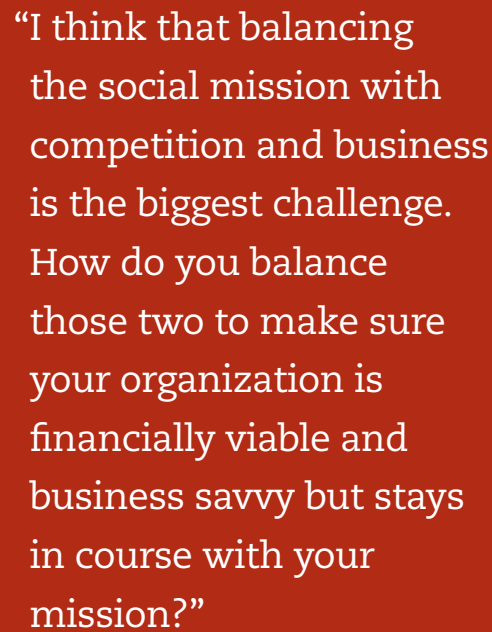*CEOs who are most satisfied with their current CEO position have:*

- Held their current position for five years or more;

- Expect to stay in their current position for at least five additional years;

- Share management responsibilities with their senior management teams;

- Work effectively with their board of directors; and

- Consider the board to be a source of personal support.

Fulfilling Factors of CEO Position
(n=121)

Factor	Rating
Making a difference in the community	5.76
Taking on new responsibilities and challenges	5.46
Working with the community	5.43
Personal satisfaction	5.38
Working with colleagues	5.27
Professional learning and growth	5.02

more fulfilling →

At the same time, the CEOs mention numerous challenges inherent in the job, and they identify some aspects of their positions as more challenging than others. When they rate the most serious challenges in their position, four of the top ten focus on finances: anxiety about finances (4.97 on a six-point scale), fundraising (4.87), dealing with government funding and/or program requirements (4.67) and accessing resources and support from the field (4.31). Many respondents talk about funding mechanisms that have become more complicated over time. As one CEO notes, "In terms of sustainability, the challenges today are different than those of ten to fifteen years ago. With the way funding streams work, there's no assured funding going forward and there are always [related] staffing issues.…There's an increased demand on infrastructure today to pull all the pieces together and be compliant across the funding streams, and [funding sources] don't give us enough to do all of that."

> "I think that balancing the social mission with competition and business is the biggest challenge. How do you balance those two to make sure your organization is financially viable and business savvy but stays in course with your mission?"

Two of the top ten CEO challenges are staff issues: staff management (4.46) and staff recruitment and retention (4.26). Many CEOs feel as though their organizations are used as professional development opportunities for staff who go on to better paid positions elsewhere: "Community clinics are a training ground for staff; that's the assumption and mentality. We provide special trainings for staff and they may go on to somewhere else." One CEO who has very successfully addressed his staffing challenges reflects on his experience: "We had problems recruiting providers when I first came here…. After we developed a workflow system, that changed a bit; the more organized and innovative we were, the more teaching opportunities we provided for jobs and the more family-oriented we were, the more we recruited and retained staff. Now we have too many people applying and we really can pick the cream of crop. It's taken several years to do that but having a well-run organization helps to recruit people."

Interestingly, working with specific types of individuals does not pose as great a challenge as does managing general organizational issues; four of the five lowest-rated challenges are working with boards of directors (3.45), senior management teams (3.07), other providers with whom they coordinate in the community (3.41) and the community more generally (3.31).

In rating the challenges of the position, many CEOs also mention high levels of stress (4.83) and long hours (4.48) combined with too many job responsibilities (4.27).

Most Challenging Factors of CEO Position
(n=121)

Factor	Score
Anxiety about agency's finances	4.97
Fundraising	4.87
High stress	4.83
Dealing with government and/or program requirements	4.67
Long hours	4.48
Managing staff	4.46
Accessing resources and support from the field	4.31
Scope and variety of issues and responsibilities	4.27
Staff recruitment and retention	4.26

more challenging →

Least Challenging Factors of CEO Position
(n=121)

Score	Factor
3.74	Feeling "lonely at the top"/isolation
3.51	Low compensation
3.5	Dealing with real or perceived competition
3.45	Working with the board of directors
3.41	Coordinating with other providers in the community
3.31	Working with the community
3.12	Geographic location of clinic/consortium
3.07	Working with the senior management team

less challenging →

Working with Senior Management Teams[8]

Many CEOs are using a shared model of leadership to accomplish their organization's mission and to distribute responsibilities among senior staff. Most CEOs have a senior management team (89%) that meets regularly: senior management teams most often meet on a weekly (44%), twice-a-month (27%) or monthly (27%) basis.[9] To different extents CEOs share responsibilities with these teams (mean rating: of 5.14) and report working with them effectively (mean rating: 5.03). CEOs also consider their senior management teams to be a strong source of support (mean rating: 5.46). Those who do not have a senior management team are disproportionately from clinics with a small number of full-time staff members. While CEOs of smaller organizations with a senior team report working just as effectively with the team (mean rating: 5.04), they are less likely to share responsibilities to the same degree (mean rating: 4.33).

> "I wouldn't be effective without a well-functioning board and senior management team, but the same holds true for all the staff. When you have good systems in place and can move forward, you can do phenomenal things. Right now, I have everything I need to do my job because everyone is doing their job."

The Impact of Senior Management Teams on CEO Job Satisfaction and Effectiveness

CEOs who are most satisfied with their current CEO position and report the highest levels of effectiveness as their organization's leader report greater degrees of:

- Sharing management responsibilities with their senior management teams;
- Working effectively with these teams; and
- Considering them to be an important source of personal support.

Most respondents (70%) have a second in command, typically this is someone who is in charge of the clinic and has decision making authority in the CEO's absence; of the identified seconds in command, 79% are Senior Managers/Directors, 12% are Medical Directors and 9% hold one of several other position titles (e.g., Clinic Operations Manager, Program Coordinator). For many CEOs, having a clear second in command allows them to focus on higher-level aspects of their job, such as organizational vision and strategy, and to pursue external opportunities that take them away from the clinic, such as advocacy, community relations and fundraising.

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8   While the survey asked about CEO "senior management teams," such teams can have other names such as "executive team" or "senior leadership team."

9   The other two percent of management teams meet every other month or "monthly and as needed."

Working with the Board of Directors

Most respondents report working effectively with their board of directors (mean rating: 5.06). To a lesser extent, CEOs consider their board to be an important source of support (mean rating: 4.58). Respondents partner with their board in a variety of ways, primarily for financial oversight and budgeting (mean rating: 4.66) and strategic planning (mean rating: 4.62); they are least likely to partner with their board on fundraising (mean rating: 3.29), one of the most significant challenges for CEOs as noted above. Specific board challenges that CEOs mention include ensuring a broad enough representation of the communities served by the clinic, a broad enough range of skills sets that align with clinics' needs, and a mix of well-seasoned and experienced board members balanced with younger and newer board members.

While CEOs typically do not specifically ask for support for board development, it seems to be an area in which support would be beneficial. Comments from CEOs with successful board relationships indicate they use specific strategies to recruit, screen and orient new board members. For example one CEO says, "We have a wonderful, fantastic board. There are a couple of things going on to keep it great. The board stays focused on the clinic and we don't have anyone with a personal agenda. Whenever we have potential new board members…the [candidates] observe a committee for three months before they are elected. This helps us to get to know them…. Some of them don't become board members."

Extent to which Board of Directors Partners with CEO
(n=121)

Financial oversight and budgeting	4.66
Strategic planning	4.62
Advocacy for the agency's mission	4.43
Community/public relations	3.93
Fundraising	3.29

greater partnership →

"The Board is key. We happen to have a Board with some members who have been there for quite some time and understand the complexity of the health care system and have some board members who are relatively newer and have a lot of energy and enthusiasm. I'm lucky to have a good mix at this time, but I know it can change – it's a vulnerable spot."

Compared to the overall group, CEOs from smaller organizations report working less effectively with their boards of directors (mean rating: 4.83), but they rate them as an equally important source of support (mean rating: 4.57) as do the CEOs of larger organizations. In addition, CEOs from FQHC clinics, which require half of their board members to be patients, appear to work just as effectively with their boards of directors as do those from all organizations, and partner with them similarly on the same kinds of responsibilities; this is encouraging as FQHC clinics have a reputation of greater challenges around developing and working with their boards than clinics in general. CEOs do note, however, that it typically requires substantially more time to orient these board members.[10]

The Impact of the Board of Directors on CEO's Job Satisfaction and Effectiveness

CEOs who report more effective working relationships with their boards and partner with them to a greater extent on tasks are more satisfied with and feel more effective in their CEO role.

10 Federally Qualified Health Centers (FQHCs) are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs of the Social Security Act and receive funds under the Health Center Program. Types of FQHCs include: Community Health Centers, which serve a variety of underserved populations and areas; Migrant Health Centers, which serve migrant and seasonal agricultural workers; Healthcare for the Homeless Programs, which reach out to homeless populations; and Public Housing Primary Care Programs, which serve residents of public housing. Source: http://www.hrsa.gov/.
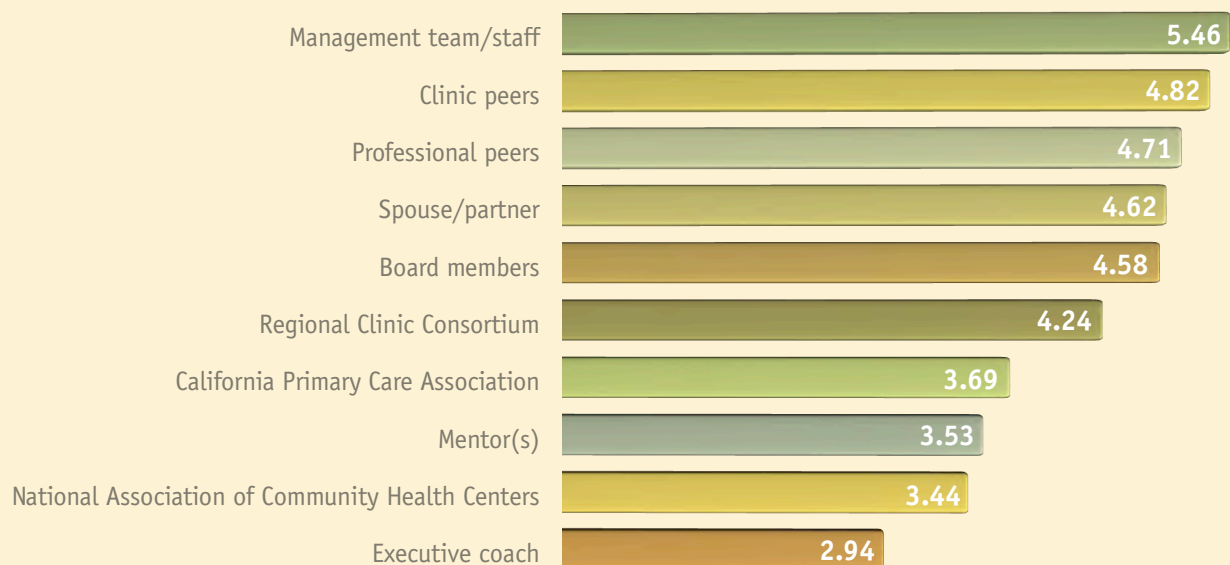
Important Sources of Support

CEOs highly value the support that they receive from others. When asked about sources of support for their position, CEOs cite peers as the most important. Peer support includes a variety of types of support, many of which are informal, such as their organization's management team and staff (mean rating: 5.46), clinic peers (mean rating: 4.82) and other professional peers external to their organization (mean rating: 4.71). As one CEO describes, a combination of these informal supports makes all the difference: "I have a great management team to lean on and share responsibility and decision-making with them….Secondly, my board chair is particularly very good….Third, I have a supportive home life with my wife and kids." Networking with peers is especially important for those CEOs who have fewer opportunities to work with colleagues; "I'm in a consortium [so] when we get out with our fellow CEOs, we get along and commiserate together, so it makes you feel like you aren't by yourself." More formal types of support, such as training or professional assistance provided by more formal organizations, tended to receive lower ratings.

"The benefit of a network…is incredible and out of that, things grow…. There are times when we all get into trouble and have to discuss things. I don't know how many structures exist like the one we have [but our network] in itself is a great thing."

Sources of Support Important to CEO Development
(n=121)

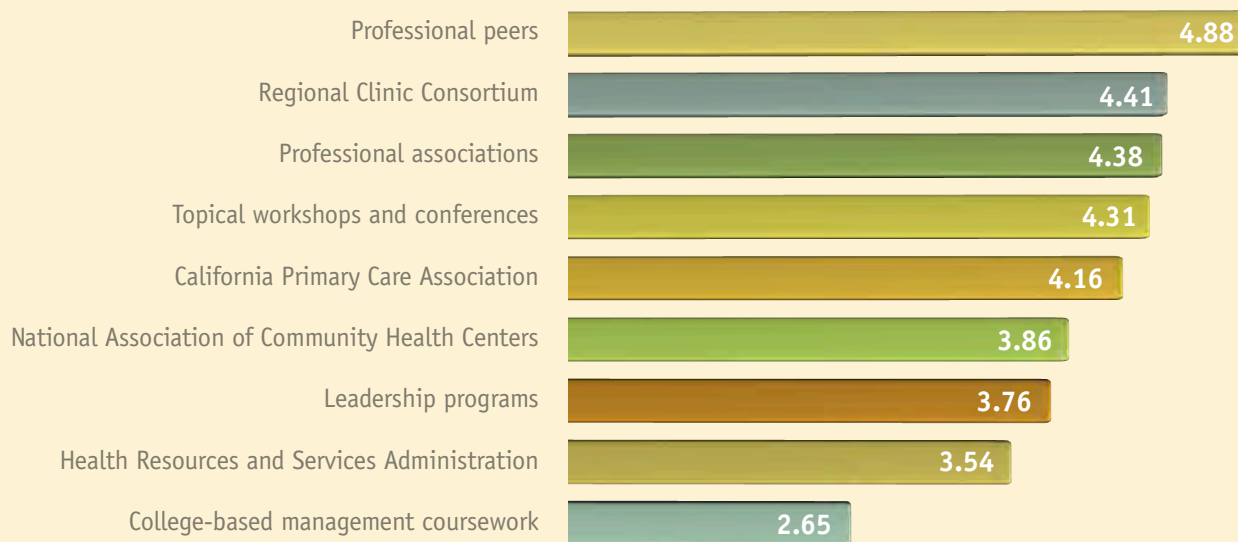| Source	Rating
Management team/staff	5.46
Clinic peers	4.82
Professional peers	4.71
Spouse/partner	4.62
Board members	4.58
Regional Clinic Consortium	4.24
California Primary Care Association	3.69
Mentor(s)	3.53
National Association of Community Health Centers	3.44
Executive coach	2.94

greater support

Training and Technical Assistance

When asked specifically about types of training and technical assistance that are important to their development as CEOs, respondents also cited peers as the most significant source (mean rating: 4.88). Regional Clinic Consortium (mean rating: 4.41) and professional associations (mean rating: 4.38) were the next most important technical assistance and training sources for CEOs, followed by a variety of other types of sources including California Primary Care Association (CPCA), the National Association of Community Health Centers (NACHC) and Health Resources and Service Administration (HRSA) as well as off-site training through topical workshops, college-based management coursework and leadership programs. Common leadership programs reported in the survey include the California HealthCare Foundation Clinical Leadership Fellowship, the Indian Health Services Training Program and the American College of Healthcare Executives. The top three sources of training and technical assistance are the same as those identified in the 2003 study.

When asked about their desire to improve their skills across a variety of areas that align with the job responsibilities of CEOs, respondents state the greatest interest in improving their financial skills (mean rating: 4.44), organizational strategy and visioning skills (mean rating: 4.34) and fundraising skills (mean rating: 4.18); least important are those focused on improving public speaking (mean rating: 3.29) and writing skills (mean rating: 2.78).

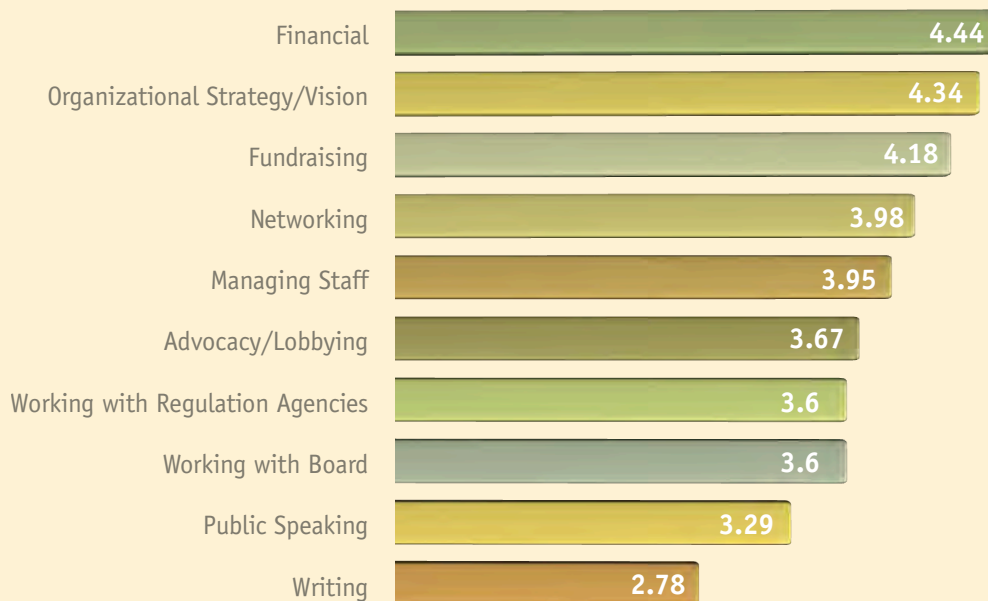## Sources of Training/Technical Assistance Important to CEO Development
(n=121)

Source	Rating
Professional peers	4.88
Regional Clinic Consortium	4.41
Professional associations	4.38
Topical workshops and conferences	4.31
California Primary Care Association	4.16
National Association of Community Health Centers	3.86
Leadership programs	3.76
Health Resources and Services Administration	3.54
College-based management coursework	2.65

more important →

Type of Skills Desire to Improve
(n=121)

Skill	Rating
Financial	4.44
Organizational Strategy/Vision	4.34
Fundraising	4.18
Networking	3.98
Managing Staff	3.95
Advocacy/Lobbying	3.67
Working with Regulation Agencies	3.6
Working with Board	3.6
Public Speaking	3.29
Writing	2.78

more desirable →

Given the growing use of technology and challenges for clinic staff to travel to trainings in terms of time and resources, CEOs were asked how they prefer to receive training. Three-quarters (75%) of CEOs prefer in-person training as compared to instructor-led web-based or online trainings. Of respondents who prefer in-person trainings, about three-quarters (74%) were 50 years or older.

While CEOs value the formal aspects of training and technical assistance, they also emphasize the importance of time to interact with peers at trainings as well as in peer groups within more formal structures such as the Regional Clinic Consortia and CPCA. The opportunity to gather with other CEOs outside of their clinic setting and share experiences and problem solve with others in like positions is particularly valuable; those CEOs who feel more isolated and lack strong sources of support within their organization find this especially important. One CEO expresses a preference for training that includes repeat meetings with peers,"…training sessions where you go every month for three or six months and learn to be a manager and leader….it may be all basic stuff, but having more than a one-shot workshop is very effective. It builds camaraderie and [lets you] build upon the things you learned last time."

Compensation

Respondents' 5% trimmed mean salary is $122,776; salaries range from $40,000 to $298,000. This is higher than the 5% trimmed mean salary of $93,000 reported in the 2003 study with a range from $25,000 to $230,000.[11]

Compensation
(n=116)

higher pay

$200k+	9%
$160k - $19k	11%
$120k - $159k	28%
$80k - $119k	33%
Less than $80k	20%
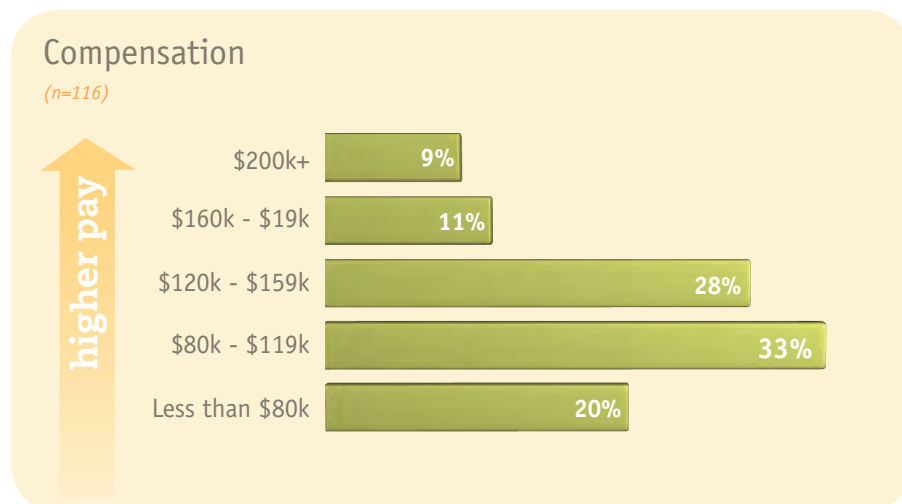
> "Leaders in clinics have to be mission driven folks. Most of the people who are successful here would be successful in other places so we need to find people who are devoted to the mission of the organization."

While male and female salaries appear to be evenly distributed across the pay scale, the vast majority (86%) of those who earn less than $80,000 per year are female. Not surprisingly, CEOs in small clinics have lower salaries, with nearly two-thirds (61%) earning less than $80,000 annually.

Compared to the 2003 study, the study finds a lower percentage of CEO respondents (72% vs. 81%) who are satisfied with their compensation. Respondents who are satisfied with their compensation package make $120,000 or more and also report higher levels of satisfaction with their current CEO position.

While CEO compensation packages do not seem to be a motivating factor for taking clinic CEO positions, the lower level of compensation relative to similar positions in other sectors is seen as a problem for retention, recruitment and the ability of CEOs to retire. This is true even for rural areas where CEOs realistically expect to earn a lower salary but find that the compensation still does not compare equitably with other sectors and does not keep up with the cost of living. The impact of compensation on CEO tenure and retirement is described further in the next section on CEO succession.

Although many respondents (74%) indicate that they have made a significant financial sacrifice to work in the community clinics field (responding 4, 5 or 6 on a 6-point scale), most respondents (72%) are at least somewhat satisfied with their total compensation package (responding 4, 5 or 6 on a 6-point scale). This aligns with the finding that CEOs are more motivated to take their position for other reasons than compensation such as the mission of the clinic and desire to make a difference in the community.

11 Both this study and the 2003 study report the 5% trimmed mean salary—a mean calculated after the top and bottom 5% of scores are removed—so that outliers do not skew the results.

# Clinic CEOs Looking Forward

Key Findings

▶ About half of current CEOs plan to leave their positions within the next five years.

▶ A large percentage of CEOs do not know what they plan to do after they leave their current position or plan to consult.

▶ About a third would consider another CEO position at a clinic or clinic consortia.

▶ More formal succession planning remains fairly uncommon among CEOs.

▶ The diversity of CEOs has stayed the same as compared to the pipeline of potential CEOs and patient populations.

▶ Needs around cultural diversity vary significantly and depend on the specific communities that clinics serve, their current staff and workforce pipelines.

Anticipated length of time in current position and next steps

About a quarter of respondents (21%) plan to leave their current CEO position within the next two years; one-third (35%) plan to leave within the next three to five years. Compared to the universe of nonprofit executives profiled in the 2006 *Daring to Lead* study, a significantly lower percentage of current clinic CEOs plan to leave their jobs within the next five years (56% vs. 75%).

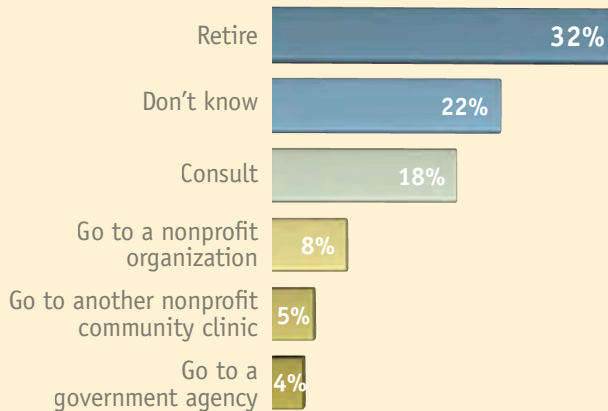### Length of Time Expected to Stay in CEO Position
(n=121)

5%	16%	35%	44%
Less than 1 year	1-2 years	3-5 years	More than 5 years

longer ➤
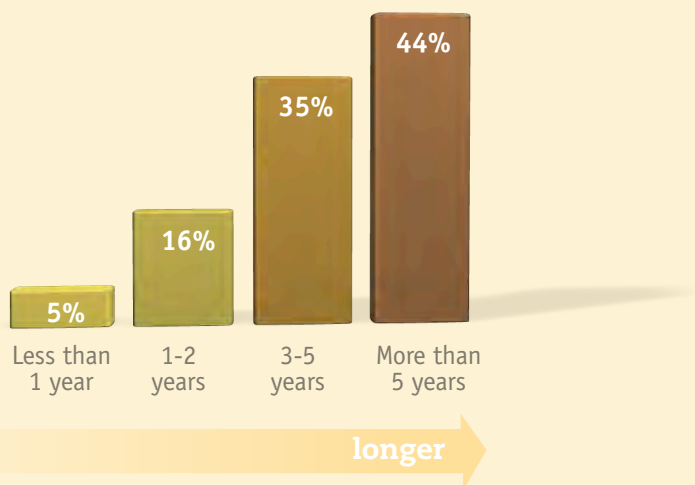
The largest percentage of respondents plan on retiring (32%) upon leaving their current position. About a quarter "don't know" (22%) what they are going to do and about 18% plan to consult.
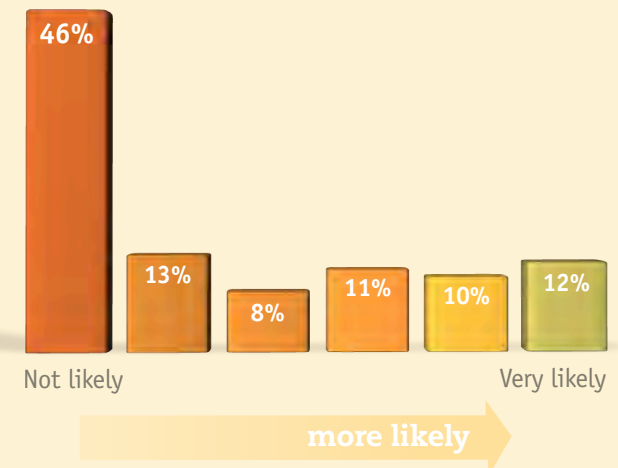
Next Career Move
(n=121)

Category	Percentage
Retire	32%
Don't know	22%
Consult	18%
Go to a nonprofit organization	8%
Go to another nonprofit community clinic	5%
Go to a government agency	4%

Likelihood of Taking Another CEO Position
{n=121}

Not likely					Very likely
46%	13%	8%	11%	10%	12%

more likely →

"It has been one of my primary goals to build the infrastructure here so that when one person leaves there's not a huge gap. That has been a challenge for me, but we've certainly made a lot of strides…and we have developed a lot of depth. I can't say I've identified one particular person who has the desire to step into the CEO role but there are of course more possibilities of people."

Of respondents who indicate that their next career move is to retire, a little more than one-third plan to retire within five years. In addition, more than half of all survey respondents think that they will not be able to retire when they want to do so; financial concern is the primary reason cited. While this has been a consistent issue over time, it has been accentuated during this study due to the 2008-09 economic crisis which may keep some CEOs in their positions longer than would have been expected.

One-third of CEOs (33%) are at least somewhat likely to take another clinic CEO position. This is a significant change the 2003 study in which a very small proportion (8%) of respondents were interested in taking another nonprofit clinic leadership position. Respondents to the current study who are most likely to take another nonprofit clinic CEO position are younger than 60 years, satisfied with their current CEO position and work effectively with their senior management team.

The percentage of CEOs who plan to leave their positions and their anticipated next steps are the same as in the 2003 study. CEO turnover remains a concern, with some organizations experiencing multiple CEOs in the last five year period.

The Next Generation of CEOs

While one of the companion studies to this report focuses on emerging leaders and the next generation of CEOs, this study asked a limited number of questions about actions by current CEOs to cultivate the next generation of community clinic and clinic consortia leaders, including their organization's next CEO.

CEOs acknowledge the importance of cultivating clinic leadership—not just future CEOs but senior leaders for numerous clinic roles. However, the extent to which they deliberately develop future leaders varies significantly. Those who are most intentional take strategic steps to identify and develop leaders whose interests and skills match the needs of the organization, with varying degrees of success.

When asked if their organization has explicitly identified someone to become the next CEO, only 7% of CEOs report that this has taken place. Of those organizations that have identified the next CEO, the vast majority (89%) report they are looking to internal staff including senior managers/directors, operations directors, administrators and medical directors (in descending order of frequency of response). CEOs who have not identified such a person commonly describe the absence of strong internal candidates due to lack of the needed skill set or interest. They especially note the changes in the CEO position—how over time it has become more complex, requiring a greater breadth of experience and skills than other internal positions. "There's not a good training ground for nonprofit [clinic] executives today," says one CEO. "There are no steps as there were twenty years ago because organizations and regulations are more complex now. The stepping stones used to be easier. I'm not sure what to do to grow the next CEO."

In the event of their departure, either planned or in an emergency, only 16% of CEOs report that they have a Board-approved succession plan; instead many describe a more informal and sometimes unwritten plan. CEOs are likely to describe an internal leader, usually their second in command, who could take over the CEO's key leadership and administrative responsibilities in the event of their unplanned temporary absence or in the event of a permanent absence while another replacement is sought. In some cases, CEOs have confidence that more than one person is prepared to step into such a situation. One CEO reflects on the considerations when identifying someone to take on the CEO responsibilities, if only temporarily: "Having a second in command is important for me. Success and failure is really determined by the top person, but it is not that easy when the top person has no second in command. My second is my Controller…there's a difference between a second in command who has an overall view of the whole picture including the politics and experience outside the clinic and a Controller who's within the walls of the clinic."

Among CEOs who indicate that retirement is the next step in their career, 15% say they have identified someone to become the next CEO. Although this is about twice as many as CEO respondents overall, it is still a relatively small percentage. The percentage of CEOs anticipating retirement who indicate having a succession plan is about the same as all CEOs (18% vs. 16%). The fact that more than half of all CEOs (62%) expect to be in their current position for at least five or more years suggests adequate time for more intentional departure planning.

> Only 16% of CEOs report that they have a Board-approved succession plan.

Barriers to succession planning seem more acute among those CEOs who have devoted their careers to clinics. Many are founders of their organizations and seem reluctant to plan for their departure; this is sometimes accentuated by the lack of adequate financial resources for retirement. Discussions about succession planning also frequently brings forth other related issues, such as the challenge of documenting the information held in a CEO's head, which is especially critical for clinics with CEOs who have been in their positions for a very long time or transitions that take place with short notice. As one CEO says, "We have a written succession plan and a lot of information is captured, but so much information would disappear if I left."

Cultural Diversity

Many community clinics are at the forefront of California's struggle to address the needs of an increasingly diverse population. Field leaders and health care advocates know that issues of cultural competence and diversity must be considered in the process of cultivating the next generation of clinic and clinic consortia CEOs. Most CEOs think that diversity issues will continue to be important for them to address in the months and years ahead, regardless of their efforts to recruit a diverse workforce to date; however, survey respondents think that their organization pays attention to cultural diversity when they recruit, hire and promote staff (mean rating: 5.32 on a six-point scale).

To different extents, CEOs mention challenges and successes in having a staff that reflects the diversity of their patient population. About half of the CEOs who offered specific comments on this topic think that their staff are diverse and adequately reflect their patient populations; these CEOs indicate that they consistently take steps to hire a staff that reflects the makeup of their communities, citing cultural diversity as essential to providing high quality care. The other half either have more neutral feelings on the topic of diversity or think their organization's staff could be more diverse; this group of CEOs frequently state that when hiring they look foremost for the best people with the best skills, and that staff recruiting is more difficult when cultural competency is added as a hiring benchmark.

Many CEOs mention that ethnic and racial diversity that reflects the patient population is more important for certain types of positions, such as the clinical staff who work directly with patients. For many positions, just finding qualified candidates is already difficult, say CEOs, without taking into consideration cultural diversity; many simply hope that they will have enough qualified candidates of any cultural background from which to make a choice. Even CEOs who report greater successes in staff diversity agree that recruiting and retaining a culturally competent and diverse staff is a continuing leadership challenge.

It is clear that the community clinics field does not have the diverse pool of potential senior leaders that it desires.

The demographics of the CEOs in the study are not reflective of the populations served by their clinics, although in comparison to the 2003 study, the current CEOs are slightly more diverse due to more CEOs with Latino backgrounds. When asked about this diversity, CEOs tend to comment on the diversity and cultural competency of other positions within the clinic rather than reflect on their own situation or the CEO position in clinics overall.

Looking at the possibilities for future CEOs, it is clear that the community clinics field does not have the diverse pool of potential senior leaders that it desires. There seems to be an inadequate pipeline (or series of programs and sequenced positions) from which to draw an adequate number of leaders demonstrating the interest and the potential to be a clinic CEO and the cultural diversity the field says it needs. Leadership programs such as the Blue Shield of California Foundation's Clinic Leadership Institute are helping to cultivate future leaders who are more diverse.

Calls To Action

In this section we make some recommendations based on the study findings and their implications. These suggestions are directed to four types of individuals who hold key roles in the process of developing and securing high-quality leadership for California's community clinics: current CEOs; boards of directors of clinics and clinic consortia; capacity builders such as consultants, management support organizations, training institutions and professional associations; and funders.

For current CEOs of community clinics

Articulate a career path and goals to benefit yourself and your organization.

→ Develop a written career plan that can be regularly revisited and updated as part of your annual review.

→ In looking at your career plan and goals, take into account your own professional needs and desires; consider how your needs align with your strengths, with those of other senior leaders in your organization and with your organization's capacities and needs.

Obtain the professional development and leadership supports you need to be most effective in your position.

→ When identifying your professional needs, obtain input and guidance from a variety of individuals who are familiar with your interests, experience and skills.

→ Utilize a combination of supports that are tailored to match your needs but also take into account your organization's needs and the specific context in which you work.

→ Due to the isolating nature of the CEO position, seek out at least one individual external to your organization who understands the CEO position and can provide confidential input, guidance and support (e.g., a peer CEO in another organization, an executive coach).

→ Take advantage of peer support organized by CEO support networks, such as the regional clinic consortia.

→ Don't be afraid to ask for the time and resources to pursue identified needs, including ongoing or long-term requests such as adequate compensation packages that include retirement plans; this not only helps you in your current position but builds awareness and practices to ensure adequate supports for future CEOs.

Adopt a model of shared leadership.

→ Work with board members and senior leaders to determine ways to distribute leadership responsibilities more broadly across senior management teams; this will make your own job more doable, satisfying and sustainable; will strengthen organizational leaders; and will enhance your position's attractiveness for future leaders.

→ Regardless of your anticipated tenure at the organization, don't be afraid to undertake succession planning to ensure that strong leadership is ready to step in to handle either your anticipated or unanticipated absence.

→ Include succession planning as part of regular strategic planning; assess the organization's overall leadership capacity and ongoing strengthening of senior leaders as well as plans for emergency and departure-defined succession.

→ Utilize times when you are away from the office (e.g., vacation, sabbatical) as opportunities for others to "step in" to and experience some CEO responsibilities.

→ If you anticipate leaving the organization in the next two years or less, it is critical to undertake departure-defined succession planning to make sure you leave your organization positioned to run effectively in your absence.

Expand strategies to identify, attract and cultivate future CEOs.

→ Observe the varied career paths of current clinic and clinic consortia CEOs and the successful ways many clinics and clinic consortia identify, recruit and develop leaders; pursue those strategies that make the most sense given your organization's resources, timeframes and specific needs and contexts.

→ In recruiting CEOs, combine forces with other clinics and clinic consortia, especially those in neighboring areas; through collaboration and avoiding competition for similar positions, your organizations can utilize resources more effectively, attract more and better qualified candidates and make better matches.

→ Since many potential clinic and clinic consortia leaders are unaware of career opportunities in the community clinics field, identify them earlier in their development and expose them to career opportunities.

→ Go beyond your typical networks to increase the number and the diversity of potential candidates for CEO and other leadership positions.

Partner with your CEO to ensure adequate supports and accountability.

→ On an annual basis, review your CEO's professional development and career plan; regularly assess how these match the organization's needs.

→ Make sure your CEO receives appropriate compensation, including important benefits such as retirement contributions; think about creative types of compensation to augment salaries.

→ Ensure your CEO has a range of supports to help with effective leadership, both ongoing and one-time supports.

→ Work with your CEO to ensure progress is being made to increase bench strength within the organization.

→ Work with your CEO and other senior leaders to develop a succession plan for the CEO's eventual departure as well as an emergency succession plan; emergency succession planning can be a stepping stone to longer-term succession planning if the CEO is resistant to discuss and plan for their eventual departure.

Take personal responsibility to ensure an effective board.

→ Model succession planning to the CEO by undertaking board succession planning; clearly state and adhere to written by-laws that define selection criteria and tenure for board members.

→ Ensure an adequate number of board members with diverse skills sets and experiences that match the needs of the organization (e.g., experience in community clinics field, patient representation, nonprofit knowledge); pay attention to specialized needs due to the type, location or life cycle of the organization (e.g., FQHC, rural, recent merger).

→ Regularly assess and address the board's areas in most need of improvement (e.g., attend fund development training, hire a consultant to assist with succession planning).

Help to identify and cultivate future CEOs and senior clinic leaders.

→ Assist your organization in identifying specific individuals who could serve as future leaders as well as potential leadership pipelines.

→ Support CEOs in cultivating and mentoring others with CEO potential, including senior leaders or emerging leaders within the organization.

→ Utilize your position as board member to invite younger and more diverse leaders to board meetings to expose them to the clinic world and career opportunities.

→ In recruiting new board members, consider individuals with potential to become future clinic CEOs or hold other senior leadership positions within the clinics field.

Offer a range of leadership and professional development activities.

→ Consider a variety of types of training to match the needs of leaders and their organizations (e.g. leadership vs. management; specific content areas vs. skills; off-site vs. on-site); determine what can be offered in groups and what needs one-on-one support; typically a combination of both techniques is most effective.

→ Only develop new training activities if relevant and effective ones are not already available; supports can come from community clinic field groups such as CPCA and clinic consortia as well as from broader nonprofit sector groups (the latter may require some adaptations to take into account the specific community clinic context).

→ Utilize clinic peers' formal and informal development activities; this can provide multiple points of connection for ongoing learning as well as support between development activities.

→ To most efficiently utilize limited resources, increase the use of technology (e.g., web-based trainings and teleconferences), especially for younger people who are more comfortable with this format; use technology to augment rather than replace in-person activities that facilitate the development of personal connections with peers.

→ Prioritize activities that address the most common or significant challenges for clinic leaders as well as those for which inadequate supports exist.

→ Target supports to meet the unique needs of CEOs; newer CEOs who are unfamiliar with the community clinics field or with the clinic CEO position have different development needs than seasoned CEOs who may be considering what they will do upon leaving the field, or than CEOs dealing with unique context issues (e.g., small clinic without senior team, isolated clinic location).

For Capacity Builders

Promote models of shared leadership.

→ Assist CEOs, boards of directors and senior teams to work together more effectively, setting appropriate expectations, shared responsibilities and development goals.

→ Utilize assessments to inform planning and address specific needs.

→ Promote a variety of shared leadership models that take into account specific organizational characteristics (e.g., culture, history, number of staff and sites).

Facilitate greater understanding and support of succession planning.

→ Offer training and technical assistance for CEOs and board members about succession planning; utilize expert consultants to work with boards, CEOs and senior leaders as needed (e.g., challenge thinking about the ideal profile for the next CEO).

→ Ensure an understanding of the different types of succession planning and best practices; include examples of different successful efforts drawn from the community clinics field.

→ Support CEOs in thinking about and determining their next career move, including ways to continue to contribute to the community clinics field as a consultant, volunteer or interim CEO.

For Funders

Promote adequate leadership planning and adequate compensation of CEOs.

→ Discuss succession planning and compensation packages with grantees, addressing adequate preparation for a CEO's career trajectory, retirement and potential post-retirement involvement in the field.

→ Support salary surveys and other related efforts to collect information for accurate benchmarking within and outside of the field.

→ Determine ways to enhance compensation packages of CEOs in addition to salary augmentation; look to creative solutions such as support of clinic positions, in all or part, by other sources such as community development programs.

Offer flexible supports for leadership development.

→ Provide or fund different types of leadership support that are tailored to the unique needs of each leader; utilize a combination of supports that complement one another (e.g., off-site trainings, peer support groups, coaching) and can evolve as individual and collective needs change.

→ Hold a field-wide view of leadership advancement and support; as it makes sense, acknowledge and promote CEO movement from one organization to another within the community clinics field as a success.

→ Ask regularly about leadership development needs and adjust supports as necessary.

Link leadership supports to the organization's capacity.

→ Since the success of the organization does not depend exclusively on the CEO, maintain an awareness of leadership needs across the entire organization.

→ Provide grants that promote shared leadership within an organization and facilitate involvement with leaders across organizations.

→ Where possible, link supports for individual leaders to other types of organizational capacity support provided by you or other funders.

Support system-level efforts to further strengthen efforts to enhance the clinic leadership and workforce.

→ Support broader health and cross-sector initiatives that connect the community clinics field to health, education and workforce development efforts (e.g., The "Connecting the Dots" Initiative).

→ Utilize existing infrastructures such as CPCA and the regional clinic consortia, and identify others to tap into.

→ Look for opportunities to promote policies and regulations that benefit leadership and workforce development efforts.

→ Support research to inform leadership and workforce-related challenges and solutions (e.g., more systematic identification and sharing of effective strategies to overcome common CEO challenges).

Resources

"Securing the Safety Net," Jeanne Peters, Catalina Ruiz-Healy and Kara Vassily. CompassPoint Nonprofit Services, 2003. www.compasspoint.org

"Bridging Management and Medicine," Catalina Ruiz-Healy, Jeanne Peters and Kara Vassily. CompassPoint Nonprofit Services, 2003. www.compasspoint.org

"Daring to Lead 2006: A National Study of Nonprofit Executive Leadership," Jeanne Bell, Richard Moyers, Timothy Wolfred and Natasha D'Silva. CompassPoint Nonprofit Services and The Eugene and Agnes E. Meyer Foundation, www.compasspoint.org

"Ready to Lead?: Next Generation Leaders Speak Out," Marla Cornelius, Patrick Corvington, Albert Ruesga, Suman Murthy and Nick Turner. CompassPoint Nonprofit Services, The Annie E. Casey Foundation, The Eugene and Agnes E. Meyer Foundation and Idealist.org, 2008. www.compasspoint.org

"Building Leaderful Organizations: Succession Planning for Nonprofits," Timothy Wolfred. CompassPoint Nonprofit Services, 2008. Commissioned by The Annie E. Casey Foundation. www.compasspoint.org

"The Nonprofit Sector's Leadership Deficit: Executive Summary," T. Tierney. Boston: The Bridgespan Group, 2006. www.bridgespan.org

"Managing Executive Transitions: A Guide for Nonprofits," Tim Wolfred. Saint Paul: Fieldstone Alliance, 2009. www.compasspoint.org

"Coaching Skills for Nonprofit Managers and Leaders: Developing People to Achieve Your Mission." M. Gislason and J. Wilson. San Francisco: Jossey-Bass, 2009.

About

BTW *informing change* (BTW) is a strategic consulting firm that provides evaluation and organizational learning support to philanthropic and nonprofit organizations. BTW strives to inform change in the nonprofit and philanthropic sectors by working in partnership with clients to design and implement evaluations, assist with program and organizational planning and conduct applied research. To find out more about BTW, visit www.btw.informingchange.com.

CompassPoint Nonprofit Services (CompassPoint) is a nonprofit consulting, education, and research organization with offices in San Francisco and Silicon Valley, California. Through a broad range of services and initiatives, CompassPoint serves nonprofit volunteers and staff with the tools, concepts, and strategies necessary to shape change in their communities. In addition to training and consulting in leadership, nonprofit strategy, finance, fundraising, governance, and executive transition management, CompassPoint frequently publishes books, articles, and research reports on topics of relevance to nonprofits, funders, and capacity builders. For more information, visit www.compasspoint.org.

Blue Shield of California Foundation is committed to making health care effective, safe, and accessible for all Californians, and to ending domestic violence. As one of California's largest health philanthropies, the Foundation serves as a catalyst for change, promoting new solutions and bringing together a diverse array of stakeholders. The Foundation blends community-based philanthropy with strategic innovation to move California forward. To learn more, visit www.blueshieldcafoundation.org.

The Community Clinics Initiative (CCI) is committed to attaining health equity for traditionally underserved communities in California through field building, collaboration, learning and reflection. CCI is a joint project of Tides, a San Francisco-based nonprofit organization that works with "individuals, groups and funders to implement programs that accelerate positive social change" and The California Endowment, a statewide health foundation whose mission is to "expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians." For more information, visit www.communityclinics.org.

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