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## CEO origin and succession planning in acute care hospitals.

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CEO ORIGIN AND SUCCESSION PLANNING IN ACUTE CARE HOSPITALS

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A DISSERTATION

Submitted to the graduate faculty of The University of Alabama at Birmingham,  
in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

BIRMINGHAM, ALABAMA

2006

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# CEO ORIGIN AND SUCCESSION PLANNING IN ACUTE CARE HOSPITALS

AMY K. YARBROUGH

## ABSTRACT

A study of the relationships between CEO origin, succession planning, and strategic orientation was conducted using data collected from CEOs and board chairs of 722 U.S. acute care hospitals. The sample hospitals were placed into groups based on Porter's (1980) generic strategies, and hypotheses were derived from existent research on executive selection from both the strategic management and health care management literature. Results of the analysis indicate that U.S. hospitals behave in a different manner than organizations in other sectors of the economy with regard to executive selection behaviors.

## DEDICATION

I dedicate this dissertation to the people who have made a difference in my life through their support and encouragement both before and during my doctoral studies.

To the Yarbrough family who have displayed the utmost patience and support throughout the balance of my academic experiences. Specifically, thanks Dad for your understanding (particularly during my time in Tuscaloosa!).

To my best friends and support network including but not limited to Mary Beth Burner and Robert J. Landry, III. Thanks for listening and being there during both good and stressful times.

To my late friend and colleague Scott Ryland. I know you are always here in spirit.

To all the educators who have made significant contributions to my life and molded me into the person I am today.

## ACKNOWLEDGEMENTS

I want to acknowledge the leadership at both UAB Health System and the University of Alabama Hospital for providing me with this phenomenal opportunity to further my education while learning first hand about the operations of a medical center. Thanks to all of the management and staff, and particular thanks go to Robert Cofield and Joan Stelling for their patience and understanding.

I want to provide a special acknowledgement to my dissertation committee including Dr. S. Robert Hernandez, Dr. Jeffrey Burkhardt, Dr. Thomas Powers, Dr. Richard Shewchuck and Dr. Barbara Wech. Without your time and effort, this project would never have come to fruition. Thank you for setting a perfect example of what I aspire to become.

I also want to thank Andy Garman at Rush University Medical Center for his generosity in allowing me to work with his data in this project.

Finally, I want to acknowledge the faculty and staff of the UAB Department of Health Services Administration and my doctoral cohort who accompanied me on this journey. Being surrounded by great people made the trip a little easier!

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# CHAPTER 1

## INTRODUCTION

### Background of the Problem

A shortage of clinical healthcare workers, such as nurses and pharmacists, has recently received a great deal of attention from both researchers and practitioners. However, a scarcity of upper management talent in healthcare organizations has not received the same consideration. Qualified candidates for top management positions may soon be in short supply given the pending retirement of many healthcare executives over the next decade (Dye, 2005; Thrall, 2001). Hospitals are among the most complex organizations to manage (Burke & Scalzi, 1988; White & Wisdom, 1985), and although graduate schools continue to produce future managers with the intellectual capacities to manage such organizations, these individuals often lack the experience deemed necessary to assume a leadership role in a hospital or other large healthcare organization. One possible reason for this deficit of applicable experience is the elimination of many hospital middle management roles through cost cutting initiatives. Job titles such as "Assistant Director" and "Assistant Administrator" are no longer commonplace in healthcare organizations. Further, the competencies and experience required to adequately fill top management roles at such institutions have not been firmly established.

Organizational leadership, specifically top management, represents an organization's values and strategic direction. Through the decisions that executives make, strategic initiatives are implemented within organizations, and these initiatives

produce either positive or negative organizational performance (Hambrick and Mason, 1984). Therefore, the selection of organizational leaders is extremely important to the study of management. In an effort to achieve success, organizational stakeholders desire to employ a Chief Executive Officer (CEO) that will make optimal decisions for the firm. Organizations can influence such decision-making through the executive selection process. Organizations have the opportunity to select between inside and outside candidates and to choose an incumbent's replacement through the process of succession planning. Regardless of the industry, when organizations employ appropriate selection and compensation processes, agency issues are minimized and performance is optimized (Zajac, 1990).

Existent literature supports a relationship between the alignment of managerial capabilities with strategy and organizational performance (Beal & Yasai-Ardekani, 2000; Kathuria & Porth, 2003; Thomas & Ramaswamy, 1996). Both the resource-based view of the firm and the upper echelons perspective provide theoretical frameworks that explain this association. However, scarce empirical evidence exists to explain the process of management selection in organizations or to substantiate the role that strategy plays in CEO selection. The purpose of this study is to provide a better understanding of the relationship between strategic orientation and executive selection processes.

### Significance of the Study

This study of CEO selection in a hospital context makes contributions to both the literature and the practice of healthcare management. Although empirical research exists on CEO origin and succession planning in a general management context, little research

has not been performed in a healthcare setting. Studying these processes in the context of acute care hospitals lends generalizeability to existing research. Further, the relationship between an organization's strategic orientation and succession planning has not been adequately explored in any context. This study clarifies this relationship and suggests whether or not the succession planning process is influenced by strategy in the selection of inside versus outside CEO candidates. Finally, verification of the proposed hypotheses will provide a theoretical framework that incorporates strategy, succession planning, and CEO origin.

This research benefits healthcare organizations by providing them with information on the CEO succession planning process and how it relates to organizations of specific strategic orientations. With a shortage of top managers pending in the healthcare industry, a better understanding of the contributions that CEO succession planning makes for a hospital can help organizational stakeholders or decision-makers prioritize this activity. By relating organizational strategy to the planning process, hospital governing boards can ascertain, based on hospital strategy, whether or not the succession planning process is useful at identifying internal candidates. Because executive turnover is such a traumatic event for any organization, providing information to practitioners on the succession process is extremely important. In conclusion, this research makes significant contributions to both management research and the practice of healthcare management.

## Research Questions

Because top management is important to the implementation of organizational strategic initiatives, it is logical to presume that depending on a firm's strategic orientation, CEO characteristics including origin will vary. Further, succession planning will vary in importance. This study answers the following questions:

- *Does the origin of an organization's CEO vary based on strategic orientation?*
- *Does an organization's participation in formal CEO succession planning depend on organizational strategy?*
- *Does the presence or absence of formal succession planning activities influence the origin of an organization's CEO?*
- *Does an organization's strategic orientation influence CEO origin in organizations that participate in formal succession planning?*

## Plan of Work

Chapter two reviews the literature on the CEO succession process including CEO origin, manager/strategy alignment, and succession planning. Existing literature on the relationship between organizational strategic orientation and CEO succession will also be presented. Chapter three presents hypotheses derived from the literature review and describes the sample and research methods employed to test these hypotheses. Chapter four presents the results of the study including sample characteristics, response rate, and analysis of hypotheses. Finally, chapter five provides a summary of research results,



explanations for these results, practical implications, study limitations, and future research recommendations.

## CHAPTER 2

### LITERATURE REVIEW

Because top management is so important to the implementation of organizational strategic initiatives, it is logical to presume that depending on a firm's strategic orientation, CEO characteristics such as origin will vary. Further, succession planning will vary in importance. These assumptions are supported theoretically by both the upper echelons perspective and the resource-based view of the firm.

#### Strategic Typologies

Firms employ particular generic approaches in an effort to outperform other organizations in an industry (Porter, 1980). Either a cost leadership approach, a differentiation strategy, or a focus strategy might be utilized by a firm at any given time, and empirical research supports the presence of these three typologies in organizations (Dess & Davis, 1984; Hambrick, 1983). An organization without a defined strategy is simply caught in the middle without any strategic direction. Those firms that are caught in the middle do not perform as well as organizations that are committed to a particular generic strategy (Dess & Davis, 1984). Porter's strategies assume that firms take different approaches to achieving a competitive advantage, and in doing so satisfy different functional demands of the environment (Marlin, Huonker, & Sun, 2002).

Firms that aspire to be cost leaders focus on controlling costs so that high returns can be obtained. Product or service offerings are relatively stable in cost leader firms,

and employee productivity, assets, and discretionary costs are carefully managed in such organizations. Cost leaders are internally focused organizations that emphasize efficiency of existing operations, similar to the Miles and Snow (1978) Defender organization (Hambrick, 1983; Lamont, et. al. 1993; Miller & Friesen, 1986). A cost leader strategy is appropriate if an organization is functioning in an environment that demands efficiency and cost control to thrive (Marlin, et. al., 2002).

According to Porter's (1980) generic strategies, a firm might alternatively choose to differentiate itself from other firms in the industry by offering unique products or services that create value. Differentiators are externally focused, opportunistic organizations that are similar to the Miles and Snow (1978) Prospector categorization (Hambrick, 1983; Lamont, et. al, 1993; Miller & Friesen, 1986). Firms can attempt differentiation through the possession of technology, a large breadth of line, special features, brand image, or customer service. Brand loyalty is a goal of differentiator organizations. Such loyalty can result in price elasticity that in turn becomes a barrier to competition (Miller & Friesen, 1986). A differentiation strategy is appropriate when an organization's environment imposes functional demands requiring a unique product or service offering (Marlin, et. al., 2002).

Firms that pursue a focus strategy choose to do business in a narrow segment of the market based on type of buyer, geography, or product (Hambrick, 1983). Due to data limitations, focus hospitals will not be examined in this study. Again, hospitals that do not have a cost leader, differentiator, or focus strategy are simply caught in the middle and will not perform as well as hospitals possessing coherent strategies. The Porter framework has proven to be appropriate for use in the context of healthcare organizations

(Lamont, Marlin, & Hoffman, 1993; Marlin, et. al., 2002), and the Porter typologies are theoretically similar to other widely accepted strategic categories.

### Resource-Based View

According to the resource-based view of the firm, competitive advantage results from those resources and capabilities belonging to a firm that are valuable, rare, imperfectly imitable, and imperfectly substitutable (Barney, 1991). Top management is a type of intangible organizational resource. Those individuals possessing superior managerial skills generate economic rents for an organization through the utilization and procurement of organizational resources (Castanias & Helfat, 1991). Top managers utilize managerial capabilities in such deployment of firm resources. Capabilities refer to the skills that employees of an organization possess that allow them to coordinate resources to perform a task (Fahy, 2000; Galbreath & Galvin, 2004; Grant, 1991; Jack & Powers, 2004).

For managerial capabilities to be valuable to an organization, they must be aligned with organizational strategy (Beal & Yasai-Ardekani, 2000). Managers have control over an organization's strategic direction and resource utilization (Castanias & Helfat, 1991). Because organizational performance depends on strategy implementation, management talent is only valuable to a firm if alignment exists between management and firm strategy (Beal & Yasai-Ardekani, 2000). Leaders, while capable of change, are not so versatile that they function effectively in every situation (Szilagya & Schweiger, 1984; Wissema, Van Der Pol, & Messer, 1980). Therefore, according to the resource-based view of the firm, sustainable competitive advantage can only be derived from

managerial capabilities in situations of manager/strategy alignment. Based on the necessity of achieving this alignment, it seems logical that executive selection practices will vary with strategic orientation.

### Upper Echelons Perspective

The upper echelons perspective of organizations suggests that both psychological and observable characteristics of top management influence strategic choices which in turn influence firm performance (Hambrick & Mason, 1984). Observable characteristics of top managers include functional experience and prior training. Although individual characteristics influence management behavior, the behavioral choices or decision-making of top managers is limited by both the external and internal contexts in which they function and their perception of such contexts (Beal & Yasai-Ardekani, 2000; Hambrick & Mason, 1984; Kathuria & Porth, 2003; Thomas & Ramaswamy, 1996). However, due to the influence of individual characteristics, two different managers are likely to make two different decisions in the same organizational context (Hambrick & Mason, 1984). Therefore, it is important for organizations to obtain management/strategy alignment to maintain a firm's strategic direction and performance. Again, the necessity of this alignment suggests that executive selection practices vary based on firm strategic orientation.

### CEO Succession Research

Much of the research related to executive selection falls under the umbrella of CEO succession. Kesner and Sebra (1994) reviewed the literature on executive

succession from its genesis, and divided the research into three phases of succession. The first phase covers the emergence of CEO succession literature, and within this phase four areas received most of the research attention: (1) successor origin, (2) organizational size and succession, (3) frequency of succession and subsequent performance, and (4) succession contingencies. In this first phase of research, key variables and themes were identified. The second phase of succession research focused on building theory and validating such theory with empirical evidence. Again, successor origin and successor frequency were the major areas of focus. The final phase represents a period of review and growth beginning in the 1980s. Successor origin continued to receive research attention, while new topics such as manager/strategy matching and CEO succession planning began to receive attention (Kesner & Sebor, 1994).

A recent literature review suggests that three major domains of research related to CEO succession exist: antecedents, the succession event, and consequences (Pitcher, Chreim, & Kisfalvi, 2000). In an effort to understand the process of executive selection, actual succession events are of greatest interest for the purposes of this paper.

Unfortunately, most research focuses on either antecedents or consequences of CEO succession. Very little research has been specifically targeted at the succession event domain. Some research has focused on voluntary versus involuntary succession events and incumbent CEO power. However, the majority of research in this domain has been based on characteristics of the CEO successor. Specifically, insider versus outsider orientation and the functional background and experience of successor have received attention (Pitcher, Chreim, & Kisfalvi, 2000). Based on a broad review of the literature

on CEO succession, research was organized into the following categories: (1) successor origin, (2) manager/strategy alignment, and (3) succession planning.

### *CEO Origin*

The origin of CEOs has long been of interest to management researchers (Carlson, 1961; Grusky, 1964; Kesner & Sebor, 1994). The origin of a CEO refers to whether or not the executive was employed inside the organization at the time he/she was appointed CEO (Shen & Cannella, 2002b). The focus of such research has typically focused on either the antecedents to or consequences of inside versus outside CEOs rather than on the selection process (Zhang & Rajagopalan, 2004), and it has yielded inconsistent results (Kesner & Sebor, 1994; Shen & Cannella, 2002a).

Early studies on executive turnover devoted attention to the origin of CEO successors. Carlson (1961) studied school superintendents and found that inside successors make fewer changes, receive lower pay, and are perceived as lower in status than outside successors. Grusky (1964) studied successor origin in baseball teams. He found that inside successors improved team performance. However, outside coaches maintain the same record if they replace a coach that was fired (Grusky, 1964).

Researchers began to refine the definitions of inside versus outside CEOs in the 1970s, and a successor's industry affiliation was factored into research designs. Birnbaum (1971) found that successors coming from similar institutions in the same industry experienced less conflict post-succession, and Pfeffer and Leblebici (1973) found that post-succession performance differs depending on the industry of outsider origin.

Researchers have also explored antecedents of CEO origin. Environmental context, organizational age, and organizational size have been studied as determinants of insider/outsider origin (Kesner & Sebor, 1994). Pfeffer and Leblebici (1973) found that organizations in competitive industries are more likely to have inside CEO successors. Both organizational age (Helmich, 1975) and organizational size (Dalton & Kesner, 1983; Pfeffer & Salancik, 1977) were found to influence the proportion of inside successors. Pre-succession organizational performance has also been evaluated as an antecedent to successor origin. Outside succession is more frequent in average (Dalton & Kesner, 1985) and low-performing (Cannella & Lubatkin, 1983; Datta & Guthrie, 1994) firms.

Limited empirical research suggests that strategic orientation influences successor origin. Datta and Guthrie (1994) found that firms experiencing growth are more likely to have outsider CEOs. Several studies have evaluated inside versus outside successors based on strategic orientation and found that successor origin varies with organizational strategy based on the Miles and Snow (1978) typologies (Chaganti & Sambharya, 1987; Thomas, Litschert, & Ramaswamy, 1991; Thomas & Ramaswamy, 1996). Defender organizations that are internally focused are expected to hire executives from inside the organization while prospector organizations that are externally focused will hire outsider CEOs. Analyzer organizations that are more externally focused than defenders and more internally focused than prospectors, will hire more insiders than prospectors and less insiders than defenders (Miles & Snow, 1978). Limited empirical research on this topic does confirm these expectations (Chaganti & Sambharya, 1987; Thomas, Litschert, & Ramaswamy, 1991; Thomas and Ramaswamy, 1996).



The relationship between insider/outsider orientation and outcomes has been frequently studied; however, inconsistent findings and a lack of uniform dependent variables limit the amount truly known about this association (Kesner & Sebor, 1994). Helmich and Brown (1972) found that insiders implement fewer organizational changes related to personnel than outsiders. Daum (1975) used satisfaction as a dependent variable and found that group satisfaction is reduced when a group member is promoted to a leadership position. Many researchers have used traditional performance variables such as profitability and ROA as dependent variables when looking at inside versus outside succession; however, results have been inconsistent (Kesner & Sebor, 1994; Zajac, 1990).

Although much research has focused on hiring candidates of internal origin versus those of external origin, the theoretical differences between insider and outsider CEOs remain unknown. Zajac (1990) suggests that the differences between insiders and outsiders are not based on personal characteristics. Rather, insider/outsider origin contributes to the principle/agent relationship when stockholders are the principles and the CEO serves as their agent. Hiring an internal candidate for CEO can reduce the agency problem that exists between a board of directors and a CEO. Time can increase the amount of personal and professional information a board knows about the candidate, and thus reduce information asymmetry. In a study of CEOs of the U.S.'s largest corporations, organizations that selected CEOs from within were found to be better performers, lending strong support to this theory. (Zajac, 1990). If an organization has a powerful board of directors, the board will exercise more control over the CEO successor chosen than the incumbent CEO. When such power is exercised and an outside successor

is chosen, the board is likely to choose a predecessor with demographic characteristics similar to board members (Zajac & Westphal, 1996).

Zhang and Rajagopalan (2004) view an organization's decision to hire an insider versus an outsider through an organizational learning and adaptation perspective. In contrast to Zajac's argument (1990) that increased information about a candidate lends itself to the selection of said candidate, Zhang and Rajagopalan (2004) propose that organizations possessing large numbers of viable internal candidates will have an extremely difficult time selecting the candidate that best fits the available position. The board of directors and other decision-makers will have so much information about the strengths and weaknesses of all candidates that the selection of an internal successor will prove extremely difficult. In a study of CEO succession events, firms with a large number of internal CEO candidates were less likely to name a specific successor providing strong support for this argument (Zhang & Rajagopalan, 2004).

Shen and Canella (2002a) studied the influence that CEO origination has on organizational performance after a succession event through a power dynamics framework. Insider CEOs were divided into two categories: (1) contenders or candidates that assumed a top management role as a result of incumbent dismissal, and (2) followers or candidates that assumed a top management role as a result of incumbent retirement. Contenders likely achieve their new positions as a result of a power struggle, and these new CEOs are likely to try and influence organizational strategy yielding better performance. Followers are likely to follow the status quo, yielding no difference in performance. Finally, while outsiders intend to change organizational strategy, they do not have the social networks that contenders have. Therefore, organizational strategy will

be difficult to change resulting in negative organizational performance. A study of CEO succession events suggests that while the ascension of a contender to the rank of CEO yields positive organizational performance, the ascension of either a follower or an outsider yields negative organizational performance (Shen & Canella, 2002a).

### *Manager/Strategy Alignment*

Research on executive characteristics conducted in the 1970s produced results suggesting that CEOs are chosen based on the fit between candidate leadership style and organizational conditions (Helmich & Brown, 1972; Pfeffer & Salancik, 1977). These findings led to a growing literature on achieving a match or alignment between top managers and organizational strategic orientation. Abundant research exists on the relationships between managerial characteristics and strategic orientation (Chaganti & Sambharya, 1987; Leontiades, 1982; Wissema, Van der Pol & Messer, 1980), managerial characteristics and performance (Norburn & Birley, 1988; Slater, 1989), and between strategic orientation and performance (Conant, Mokwa, & Varadarajan, 1990; Desarbo, Benedetto, Song, & Sinha, 2005; Dyer & Song, 1997). However, the managerial characteristics assessed vary widely across research studies (Beal & Yasai-Ardekani, 2000; Gupta & Govindarajan, 1984; Govindarajan, 1989; Thomas et al., 1991). Managerial traits measured include demographic variables such as age and educational level (Thomas et al., 1991), managerial background traits such as functional and industry experience, and individual characteristics such as personality, problem solving style, and locus of control (Beal & Yasai-Ardekani, 2000; Gupta & Govindarajan, 1984; Govindarajan, 1989).

In an early exploration of the relationship between managerial traits and strategy, Wissema, Van der Pol, and Messer (1980) created six typologies of managers that can be paired with particular organizational strategic directions. These typologies are based on managerial capabilities that, in theory, will complement a particular strategic direction and aid in the implementation of strategy. However, no empirical analysis of these typologies was performed (Wissema, Van der Pol, & Messer (1980). Based on information garnered from case studies, Leontiades (1982) argues that managerial orientation and organizational strategy must be aligned to achieve appropriate strategy implementation. Outside of case study analysis, no additional empirical research was performed (Leontiades, 1982).

Chaganti and Sambharya (1987) empirically confirmed a relationship between managerial characteristics and organizational strategy in the context of tobacco companies. Executive characteristics such as functional experience and outsider orientation were found to vary according to an organization's strategy. Executives with marketing experience and outside origin were most often found in prospector firms. However, no significant differences in executives were found based on research and development, production, or finance experience among strategic types (Chaganti & Sambharya, 1987).

Norburn and Birley (1988) reported a relationship between the characteristics of top managers and performance both within and across industries. The relationship between organizational performance and managerial characteristics was verified when Slater (1989) confirmed that management style influences business unit performance (Slater, 1989). Some researchers have chosen to assess a richer model that includes the

alignment of managerial orientation with strategy and the influence of such congruence on performance. It is reasonable to assume that the alignment between management and strategy will enhance performance. For a strategy to be appropriately implemented, an executive must guide that process. If such an employee is not suited for the implementation of a particular strategy, successful implementation might not be possible leading to poor organizational performance. However, Leontiades (1982) cautions that implementation only leads to increased organizational performance when the appropriate strategy has been selected. Empirical research confirms that firms with particular strategic orientations tend to have executives with complementary characteristics such as organizational tenure, functional experience, and education (Finkelstein & Hambrick, 1990; Miles & Snow, 1978; Thomas & Ramaswamy, 1996).

Much evidence exists to suggest that the alignment of managerial capabilities and experience with strategy enhances organizational performance in manufacturing contexts (Beal & Yasai-Ardekani, 2000; Finkelstein & Hambrick, 1990; Govindarajan, 1989; Gupta & Govindarajan, 1984; Kathuria & Porth, 2003; Thomas & Ramaswamy, 1996). Using Porter's generic strategies (1980) as a framework for strategic orientation, Gupta and Govindarajan (1984) found that the alignment of CEO functional experiences with SBU strategy has a significant influence on the effectiveness of strategy implementation (Gupta & Govindarajan, 1984). Further, the interaction between strategy and managerial functional experience, locus of control, and decision making style was found to influence strategy effectiveness in a sample of strategic business units (Govindarajan, 1989).

Using the Miles and Snow (1978) typologies as a framework for strategic orientation, Thomas, Litschert, and Ramaswamy (1991) found that matching strategy

with executive characteristics has a positive influence on organizational performance in the computer industry. Managers of internally focused, defender organizations have longer tenures and are more likely to be promoted internally than managers of prospector and analyzer firms. More innovative, prospector organizations have younger managers with shorter organizational tenures (Thomas, Litschert, & Ramaswamy, 1991). Thomas and Ramaswamy (1996) replicated this study using three different industries: electronics, chemicals and petroleum refining. Similar results were obtained: the congruence between strategy and management was found to have a significantly larger positive influence on firm performance than industry or contextual attributes (Thomas et al., 1991; Thomas & Ramaswamy, 1996).

Beal and Yasai-Ardekani (2000) evaluated the influence that alignment of managerial functional experiences with generic competitive strategies has on performance in a sample of small manufacturing firms. They found that matching functional experiences with strategy results in superior organizational performance. Years of experience in research and development, marketing, engineering, sales, and accounting were paired with a variety of differentiation-based strategies and a low cost leadership strategy to represent the alignment of management and strategy. For example, CEO's with experience in research in development were hypothesized to positively contribute to firm performance when a strategy of innovation is pursued. In a sample of small manufacturing firms, results suggest that CEOs with research and development experience are most successful in organizations pursuing innovation strategies, while CEOs with engineering experience are successful in organizations pursuing quality differentiation, service differentiation, and low cost leadership strategies. Support for

alignment of hybrid CEO experience and hybrid strategies was also found (Beal & Yasai-Ardekani, 2000).

Evidence also supports the relationship between alignment and organizational performance at the business unit level. Kathuria and Porth (2003) studied the influence of strategy-manager alignment at both corporate and business unit ranks on performance in the manufacturing industry and found that alignment at both levels produces high levels of organizational performance (Kathuria & Porth, 2003).

Existing research on the relationship between manager/strategy alignment and organizational performance is largely focused on individual managers. However, some evaluation of top management team characteristics and strategy has been explored. Wiersema and Bantel (1992) found that the backgrounds of top management teams influence strategic change in an organization. Finkelstein and Hambrick (1990) looked at the relationship between top management teams' characteristics, strategy, and performance. Top management team tenure was shown to have a significant impact on organizational strategy and performance. Teams with longer tenure are typically associated with persistent organizational strategies, strategies that are consistent within an industry, and average industry performance (Finkelstein & Hambrick, 1990). More work needs to be done to fully understand the relationship between a management team's alignment with strategy and organizational performance (Gunz & Jalland, 1996).

Research on the alignment of managerial background characteristics, strategy, and performance is extremely limited in the service industry. In a 1979 study, Channon evaluated the largest 100 service organizations in the United Kingdom, not including healthcare. After dividing leaders into three distinct categories, he found that different

categories of leaders have different social backgrounds. Leadership type and organizational performance also varied across firm strategic orientation (Channon, 1979).

### *CEO Succession Planning*

Succession planning is the identification of a successor for an incumbent CEO. The presence of such planning in an organization indicates that top management is preparing for the future. Such a process increases the comfort level of stakeholders with the new CEO and provides training for the successor to meet future organizational needs. This type of activity can reduce any disturbances that might typically result from a CEO transition (Harris & Helfat, 1997; Zhang & Rajagopalan, 2004). Therefore, it is not surprising that organizations that participate in succession planning perform better than those firms that do not participate in such activities (Zajac, 1990). Despite the benefits attributed to planning activities, many organizations simply do not plan for CEO succession (Zhang & Rajagopalan, 2004). Healthcare organizations are even less likely to employ succession planning tactics than private-sector businesses (Garman & Tyler, 2004).

Early research on succession planning focuses on both the nature of planning and the level of planning occurring in businesses. Much of the research is largely conceptual in nature (Kesner & Sebor, 1984). Brady and colleagues (1982) surveyed over 1,400 corporate presidents and discovered that less than 30% of organizations participate in formal succession planning, and the planning that does occur is facilitated by the incumbent CEO (Brady, Fulmer, & Helmich, 1982). Rhodes and Walker (1984) identified the different planning approaches employed in organizations: informal,



decentralized, centralized, and integrated. Early normative research on succession planning deals with incorporating learning and development (Hall, 1986 & Friedman, 1990) and strategy (Kesner, 1989; Sheibbar, 1986) into the planning process.

More recent studies of CEO succession planning examine the relationships between organizational performance and planning activities, either pre or post succession. Over a 25-year period, investor reactions to CEO firings were evaluated, and market reactions tended to be more positive when a permanent successor was named at the time of incumbent dismissal. This indicates that investors positively regard succession planning (Worrell, Davidson, & Glascock, 1993). Worrell, Nemec, and Davidson (1997) used an agency theory argument to study the consolidation of CEO, Board Chair, and President into one position. They found negative market reactions to the consolidation of the position, providing support for their agency argument. However, Harris and Helfat (1998) reinterpreted these findings to suggest that a lack of succession planning is actually responsible for the abnormal negative market returns in the case of position consolidation.

Relay succession is one form of succession planning in which an incumbent CEO works with an "heir apparent" (Zhang & Rajagopalan, 2004:483) to smoothly transition leadership from the incumbent to the successor. Shen and Cannella (2003) found no investor reaction to the initiation of succession planning in the form of relay succession. However, a positive reaction occurs when the heir apparent is promoted to the CEO position (Shen & Cannella, 2003). Zhang and Rajagopalan (2004) found that organizations with positive performance are more likely to name an heir apparent than those with negative performance. Further, the same study found that firms participating in

relay succession have improved post-succession performance. This is particularly true for organizations experiencing post-succession strategic and industry instability (Zhang & Rajagopalan, 2004). Behn, Bailey, and Ya-wen Yang (2005) studied the response of markets to the presence of succession planning and found organizations that participate in succession planning and with an identified heir apparent have higher cumulative abnormal returns on the date of an incumbent CEO's death (Behn, Riley, & Ya-wen Yang, 2005). Although succession planning appears to be positive for most organizations, due to methodological issues the amount truly known about this activity is uncertain (Worrell et al, 1993).

#### Healthcare Specific Research

Although CEO selection has a large presence in the general management literature, it has received less attention in a healthcare context. Much of the research that has been performed in a healthcare setting deals specifically with CEO turnover events. Limited research is also available related to succession planning in healthcare organizations.

#### *CEO Succession Events*

CEO succession events have received some attention in the healthcare management literature. Goodstein and Boeker (1991) found that CEO succession and a change in ownership jointly influence hospital strategy as evidenced by a positive effect on service line changes. Additional outsider board representation coupled with CEO succession also has a positive effect on such changes (Goodstein & Boeker, 1991).

Alexander and Lee (1996) studied a sample of small rural hospitals and found that CEO succession increases the odds of hospital failure. The risk of hospital closure is greatest when a CEO has a relatively short or relatively long tenure; therefore, it is useful for organizations to implement succession planning so that an acceptable candidate is available when the CEO's performance nears complete organizational failure (Alexander & Lee, 1996). Wilson and Stranahan (2000) studied organizational characteristics that contribute to CEO turnover and found that smaller, investor owned hospitals are more conducive to turnover. Although research is limited, CEO succession events appear to influence hospital strategy and performance.

#### *Manager/Strategy Alignment*

Despite strong empirical support for the relationships between the alignment of managerial background experience, strategic orientation, and performance in the manufacturing industry, scant research exists to confirm these relationships in service industries such as healthcare. In a study of hospitals, the administrative climate and assertiveness of a head nurse was shown to influence the job performance of staff nurses. Based on these results, one could propose that organizational leaders have control over strategy implementation through the ability to influence staff behaviors. However, strategy was not incorporated into this study (Sheridan, Vredenburg, & Abelson, 1984). Lamont and colleagues (1993) looked at the influence that strategy-environment fit has on hospitals using Porter's (1980) generic strategies as a framework. Results indicated that hospitals achieving an appropriate fit between strategic orientation and environment are better performers (Lamont, Marlin, & Hoffman, 1993). A relationship between

organizational strategy and performance has been established in the context of acute care hospitals (Kumar, Subramanian, & Yauger, 1997; Marlin et. al., 2002), but the influence of hospital management has not been considered.

Wallick and Stager (2002) evaluated the role or grouping of competencies that healthcare managers are expected to encompass as perceived by CEOs through a role theory framework. This theory suggests that if an organization's structure supports specific role behaviors, the desired outputs of the organization will be achieved. However, the study did not evaluate whether or not specific outcomes were achieved based on a good fit between role behaviors and organizational structure (Wallick & Stager, 2002).

In one of the few available healthcare studies using the Miles and Snow typologies (1978), Golden (1992) studied the influence that corporate management has on the strategy and performance of strategic business units (SBUs) in primary care hospitals. He proposed that greater centralization/decentralization of environmental monitoring, operational efficiency, and strategic planning tasks will positively/negatively influence organizational performance and market share in hospitals depending on their strategic orientation. Golden found support for his hypotheses, indicating that SBUs experience higher performance and market share when functions not specifically related to SBU strategy are centralized to corporate management. The decentralization of strategic planning activities improved performance and market share measures for prospector hospitals (Golden, 1992). This study strictly demonstrates that management does have an influence on how strategy is implemented in an organization. It does not provide

evidence that the alignment of managerial experience and capabilities with strategy improves performance.

### *CEO Succession Planning*

Very little research on CEO succession planning has occurred in a healthcare context. Garman and Tyler (2004) surveyed CEOs and Directors of freestanding, acute care hospitals in the United States to inquire about their levels of succession planning. Survey results indicate that only 21% of hospitals currently practice succession planning. Although the respondents do feel that succession planning is valuable, immediate organizational priorities and scarce resources often prevent the employment of such activities (Garman & Tyler, 2004).

Groves (2005) performed a qualitative study on 13 healthcare organizations in the western United States. Both CEOs and senior human resource executives were interviewed to obtain best practice information about leadership development and succession planning. The executives interviewed were chosen based on their reputation for having an active role in leadership development. The study attempts to describe an integrated leadership development and succession planning process in organizations that are well known for their successes in this area. According to industry top performers, hospitals should avoid the designation of an "heir apparent," and instead focus on cultivating a large pool of managerial talent (Groves, 2005). Other than these recent studies, no empirical research on this phenomenon in healthcare is available.

## Summary

A vast amount of literature exists on the topic of CEO selection. Because CEO succession events have a tremendous impact on an organization, it is important that managers and researchers understand this phenomenon. Successor origin, the alignment of managers with strategy, and CEO succession planning have all received attention in a general management context. However, the amount of work conducted in a healthcare setting remains limited. Despite the wealth of literature on CEO succession, research findings are fragmented and inconsistent (Kesner & Sebra, 1994; Pitcher, Chreim, & Kisfalvi, 2000). These issues are likely attributed to methodological problems. Because executive selection is influenced by a plethora of organizational and industry-specific factors, obtaining reliable and valid conceptual measurements often proves difficult (Pitcher, Chreim, & Kisfalvi, 2000) and numerous variables are used in research.

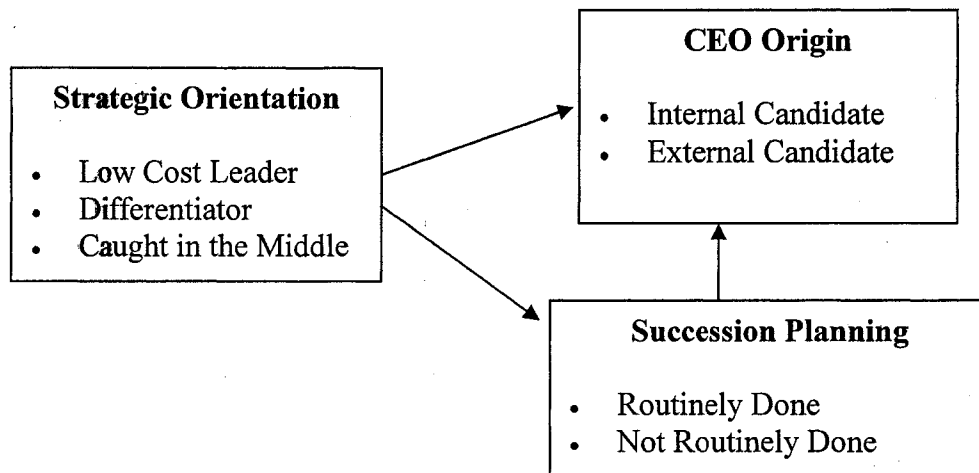
## CHAPTER 3

### METHODOLOGY

#### Research Questions and Hypotheses

Although empirical research has attempted to examine the process of CEO selection, many questions remain unanswered. The origin of an organization's CEO is important depending on the organizational outcome desired. If strategic change is desired, an outsider CEO is perceived to be a better choice than an insider candidate. If organizational stability is desired, an insider is perceived to be the better choice. CEO succession planning is good for an organization both financially and operationally, but many organizations choose not to participate in this activity due to time and resource constraints. Although the alignment of managerial characteristics and firm strategic orientation produces positive outcomes (Beal & Yasai-Ardekani, 2000; Finkelstein & Hambrick, 1990; Govindarajan, 1989; Gupta & Govindarajan, 1984; Kathuria & Porth, 2003; Thomas & Ramaswamy, 1996), the relationship between an organization's selection process and its strategy remains unknown.

The purpose of this study is to provide a better understanding of executive selection practices in acute care hospitals. By testing the following model, the relationship between strategic orientation, CEO origin, and CEO succession planning will be illuminated.



*Figure 1: Proposed Model*

Answering the following research questions in a healthcare context will build on the existing management literature and provide generalizability to existing findings:

- Does the origin of an organization's CEO vary based on strategic orientation?
- Does the presence or absence of formal succession planning activities influence the origin of an organization's CEO?
- Does an organization's participation in formal CEO succession planning depend on organizational strategy?
- Does an organization's strategic orientation influence CEO origin in organizations that participate in formal succession planning?

Empirical research supports the assumption that the alignment of managers with organizational strategy is beneficial for an organization. This logic is theoretically



supported by both the resource-based view of the firm and the upper echelons perspective. According to the resource-based view of the firm, the capabilities of a top manager are not valuable to an organization and do not contribute to its competitive advantage unless these capabilities are in line with the organization's strategic vision. Per the upper echelons perspective, an organization's top manager or CEO is ultimately responsible for the implementation of an organization's strategy, suggesting that for appropriate implementation of strategy the CEO should have skills and experience that complement the organization's strategic orientation. Therefore, an organization that is cost oriented and internally focused is likely to look for different attributes in an executive than an organization that is externally focused and entrepreneurial in nature in an effort to achieve manager/strategy alignment.

A "cost leader" (Porter, 1980) will internally select and cultivate managerial talent, giving such a firm a fairly flexible pool of individuals that are groomed to take on leadership roles within a relatively stable environment. Products and services are not subject to frequent change in organizations whose major goal is efficiency and cost leadership, therefore, internal management talent has a clear understanding of the organization's strategic direction. In such an organization, a CEO heir apparent can develop a good understanding of the activities occurring in all business units and can be fairly well prepared to take on a senior management role. Employees and future managers develop organizational commitment as a result of clearly understanding organizational strategy. Further, management trainees develop loyalty because they recognize that numerous opportunities for advancement exist within the firm, including the position of CEO. However, "differentiators" (Porter, 1980) are largely externally

focused firms that are likely to alter product or service offerings. Management roles might require new competencies and skills that internal management talent does not possess, and capable managers might need to be hired rapidly. Such firms will be forced to recruit executives from outside the firm to meet the ever-changing strategic needs of the organization.

Although a relationship between strategic orientation and CEO origin has been empirically validated in the general management literature, no evidence supporting this relationship has been provided in a healthcare context. Further, the association between strategy and origin has only received limited support in a manufacturing context.

H<sub>1</sub>: More CEOs of internal origin will be hired by cost leader hospitals than by differentiators and hospitals that are caught in the middle.

H<sub>2</sub>: More CEOs of external origin will be hired by differentiator hospitals than by cost leaders or hospitals that are caught in the middle.

Succession planning is the process of picking and cultivating management talent in advance of a CEO succession event. Research indicates that organizations that participate in succession planning perform better than those organizations that do not plan for executive succession (Worrell, Davidson, & Glascock, 1993). Succession planning is thought to reduce the internal disturbance that typically results from a succession event, and this reduction is given as one reason for the performance gap observed between those hospitals that do and do not plan. Although an organization's succession plan could involve a CEO successor from outside the organization, the decision to select an external

successor would probably not serve to reduce any disturbances surrounding a CEO succession event. Because CEO succession planning often involves the selection of an heir apparent in advance of an incumbent CEO's departure, it seems logical that most of the time the chosen successor will be of internal origin. However, no empirical evidence exists to validate this assumption.

H<sub>3</sub>: More CEOs of internal origin will be hired by organizations that participate in formal succession planning than by those hospitals that do not participate in such activities.

Because CEO succession planning is an important part of the executive selection process, the resource-based view of the firm and the upper echelons perspective support the notion that the importance placed on this activity varies with strategic orientation. Top managers are the individuals ultimately responsible for implementing organizational strategy. Therefore, based on a firm's strategic orientation, the decision to either plan or refrain from planning for CEO succession probably varies. "Cost leaders," or internally focused organizations, emphasize efficiency and the perfecting of current operations. In theory, succession planning causes a reduction in internal disturbances that can negatively impact operational functioning surrounding a CEO succession event. Since the goal of a cost leader organization is to function as efficiently as possible, a reduction in such disturbances is desired. Such organizations probably participate in succession planning more than externally focused organizations in an effort to reduce such disturbances. Although it seems logical that organizational strategic orientation is related to CEO succession planning, no evidence exists in either a healthcare or general management context.

H<sub>4</sub>: More cost leader hospitals will participate in succession planning activities than differentiators and hospitals that are caught in the middle.

Although it seems reasonable that organizations that practice CEO succession planning are more likely to hire CEOs of inside origin, based on our theoretical framework, strategic orientation will ultimately influence the origin of hospital CEOs. While we hypothesize that strategic orientation influences whether or not an organization participates in succession planning, it is possible that firms of all orientations might plan for CEO succession under some circumstances. Cost leader organizations are probably more likely to participate in succession planning than differentiators. However, some differentiators will participate in succession planning and some cost leaders will refrain from succession planning. Although succession planning might provide a moderating effect in these instances, ultimately, strategic orientation will determine the origin of an organization's CEO. However, no empirical evidence exists to validate the relationship between origin, strategy, and succession planning.

H<sub>5</sub>: CEO origin and participation in succession planning will vary based on the hospital's strategic orientation.

Because the alignment of management capabilities and organizational strategy is important to firm success, it is logical to assume that strategic orientation influences an organization's CEO selection process.

## Study Population and Data

Three existing data sets were used to gather CEO data and institutional data. In 2001, Garman and Tyler, in conjunction with Rush University Medical Center, distributed a survey to the CEOs and Board Chairs of 1,651 freestanding, acute care hospitals in the United States (Appendix 1). Approximately 722 institutions responded, representing 44% of the original sample. The surveys gathered demographic information on both the respondents and their institutions and information on the organization's succession planning activities. The origin of the hospital's CEO was also ascertained. Of responding hospitals, only 149 facilities routinely participate in succession planning activities. These data were used in determining information about succession planning and CEO origin. Further, models and composite variables were created from this information.

Data from the Garman and Tyler data set were linked to the 2000 American Hospital Association (AHA) data set and the 2000 Medicare Cost Report data. The strategic orientation of hospitals participating in the Garman and Tyler survey was ascertained using AHA and Medicare data based on Porter's (1980) generic strategies. The data were used to determine the strategic orientation of each facility and assess any relationships existing between strategic orientation and the presence/absence of succession planning and CEO origin. Three categories of strategic orientation, "Cost Leaders," "Differentiators," and "Caught in the Middle," were created. Since specialty hospitals were excluded from this survey, a category for "Focus" strategy was not generated. No individual or facility is identified in this research, and only aggregate measures are presented. Approval was obtained from both the University of Alabama at

Birmingham Institutional Review Board and the Rush University Medical Center Institutional Review Board prior to the study (Appendix 2).

### Operationalization of Variables

The following measures are used to test the hypotheses:

#### *Strategic Orientation*

Hospitals were classified according to the Porter (1980) generic strategies as "Cost Leaders", "Differentiators", and "Caught in the Middle" based on three measures of differentiation and three measures of cost orientation illustrated in Table One. This methodology was adopted from that used by Lamont & colleagues (1992) and Marlin & colleagues (2002).

Table 1

#### *Categorization of Strategic Orientation*

Measure of Differentiation	Measures of Cost Orientation
<ul style="list-style-type: none"><li>• Technological sophistication of service offerings</li><li>• Breadth of service offerings</li><li>• Number of rare service offerings</li></ul>	<ul style="list-style-type: none"><li>• Total expenses per average number of occupied beds</li><li>• Cost per adjusted patient day</li><li>• Salary per adjusted patient day</li></ul>

According to the Porter (1980) generic strategy framework, organizations that are cost leaders are internally focused, and managers pay specific attention to cost control and efficiency of existing operations. The three measures selected to determine cost

orientation include (1) total expenses divided by the average number of occupied beds, (2) total expenses per adjusted patient day, and (3) salary per adjusted patient day. By dividing total expenses by the number of beds occupied, a hospital's expense based on its current level of business can be ascertained. Total expenses and salary adjusted per patient day also express how efficiently internal finances are managed based on current business. These three measures allow us to rank hospitals based on their cost structure, and those facilities with expense structures below the mean will be classified as cost leaders. By including the average number of occupied beds and the number of patient days in these measures, the potential effects of size have been addressed.

Porter's (1980) differentiator organizations are those that attempt to separate themselves from the competition by offering some unique service or product offerings. This uniqueness can be obtained through the possession of rare or cutting edge technology or through a large breadth of service offerings. Likewise, three measures were selected to determine the level of product/service differentiation. First, technological sophistication will be determined by measuring the number of specific equipment and facilities including cardiac catheterization laboratory, magnetic resonance imaging facility, open-heart surgery facility, and organ transplantation facility. Secondly, the breadth of service offerings will be determined based on the number of services offered reported in the AHA data. Thirdly, the number of rare services offered will be determined, with rare services representing those that less than 25% of the sample offer. These measures will establish which hospitals are attempting to differentiate themselves from competitors through service offerings. Those facilities with at least one or more differentiation scores above the sample mean will be classified as "Differentiators."

Because certain organizations follow no specific strategy, the hospitals that do not fit into either the "Differentiator" or "Cost Leader" categories will be considered "Caught in the Middle." (Lamont, Marlin, & Hoffman, 1993).

#### *CEO Origin*

CEOs were asked whether or not they were hired internally or externally. Those that respond "internally" are considered to be of internal origin, while those that responded "externally" are considered to be of external origin.

#### *CEO Succession Planning*

Hospital CEOs were asked a series of questions regarding succession planning practices in their organizations. To ascertain the extent of succession planning in an organization, respondents were asked, "To what extent is succession planning routinely done at your organization." Respondents responded either, "not routinely done" or "routinely done." The level of succession planning was ascertained for those routinely participating in succession planning by inquiring what levels of the organization are involved. Responses include, "CEO position only," "Top-level leadership only," "Top and mid-level leadership only," and "most or all levels of leadership." These questions were obtained from the recent survey administered by Garman and Tyler (2004).



### *Control Variables*

Several control variables were selected based on prior research on acute care hospitals. Organizational attributes such as size, region and ownership are often related to hospital behavior and performance (Alexander & Lee, 1996).

*Size.* An organization's size is likely to influence its financial performance and access to resources. Therefore, a larger hospital might have a greater ability to participate in succession planning from both a financial and human resource perspective. The number of hospital beds will be used as a measure of size (Alexander & Lee, 1996; Golden, 1992).

*Metropolitan Statistical Area (MSA).* Hospitals might vary in their executive selection practices based on the availability of trained managers and access to educational institutions. Therefore, facilities located in urban areas might have a larger pool of executives from which to select because the population is more dense. The U.S. Office of Management and Budget define an urban area as an MSA with a population of 100,000 or greater. All other areas are considered non-urban.

*System Affiliation.* Hospitals that belong to a multi-hospital system might have more ready access to potential CEO candidates that are within the system, but external to the hospital. This could influence both their succession planning processes, and the origin of their facility's CEO.

*Ownership.* Because for-profit hospitals must ultimately answer to investors, executive selection practices might vary from those of not-for-profit community or government owned facilities.

## Methods of Analysis

To test the proposed hypotheses, the study uses loglinear analysis to identify significant associations among variables and determine the influence these variables and their associations have on cell distribution. A multiway frequency analysis is performed to identify the significant one-way, two-way, and three way associations between the following variables: CEO origin, hospital strategic orientation, and extent of succession planning. This analysis identifies the most parsimonious model that provides an adequate fit to the data that is not significantly different from the original saturated model that includes all orders of relationships. Beginning with the three-way associations, interaction effects are systematically eliminated until the simplest model that provides the same predictive capability for cell distribution as the saturated model is identified. Finally, a linear model of cell frequencies is developed based on the significant associations. This model allows us to determine how much influence each association has on a particular case's frequency or category (Tabachnick & Fidell, 1996). This analysis addresses all research questions and hypotheses of interest.

Additional analyses are also performed in an attempt to better understand the way the variables of interest and other covariates relate to one another. In the second phase of analysis, the Latent GOLD 4.0 latent class and finite mixture program is used to create a series of latent class cluster models based on the behaviors of hospitals in each strategic category relating to CEO succession planning and origin. Composite latent class cluster models are also formed based on hospitals of all strategic orientations. The cluster analyses identify distinctly different groups of hospitals based on strategy, succession

planning, CEO origin, and other covariates including hospital size, MSA size, system membership, and for-profit status. Model parameters are created in these analyses that allow us to determine which variables of interest significantly contribute to group separation. Further, the inclusion of the covariates shows the characteristics of hospitals falling into particular groupings. Finally, D-factor models were created as another way of grouping the hospitals based on strategy, succession planning, and CEO origin. Such models separate the hospitals into groups based on unobserved characteristics and provide information on the way the groups are separated with regard to both the variables of interest and additional covariates.

In the next phase of analysis, descriptive statistics for all independent variables are analyzed, and two logistic regression equations are used to assess the influence that strategic orientation has on succession planning and the influence that both strategic orientation and succession planning have on CEO origin. These regressions allow us to control for the effects that hospital size, region, system affiliation, and ownership might have on the dependent variables, succession planning and CEO origin respectively.

## CHAPTER 4

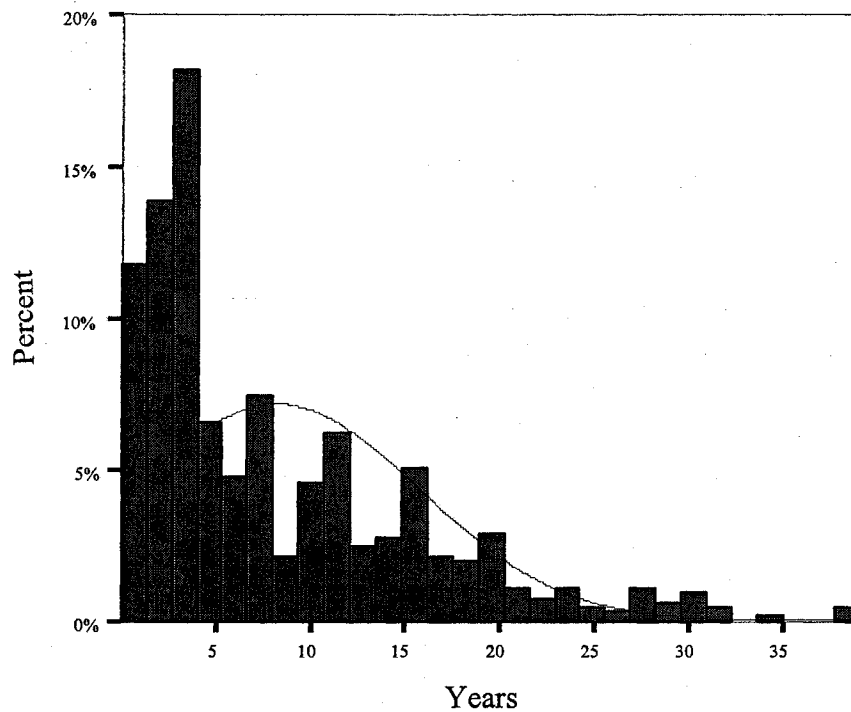
### RESULTS AND FINDINGS

The following chapter explains the results of analyses used to answer the subsequent research questions and hypotheses. Descriptive statistics, statistical tests, and other analytical work will be provided. Descriptive statistics related to respondent demographics, institutional demographics, and survey responses were analyzed and are presented in both tabular and graphical formats. Further, crosstabulations were performed to determine significant relationships between variables of interest. Loglinear analysis was used in testing the hypotheses, and additional analyses performed include latent cluster analyses, discrete factor analysis, and logistic regression. The results are presented in various tabular and graphical formats, and the way these results correspond to the hypotheses is also noted.

#### *Respondent Demographics*

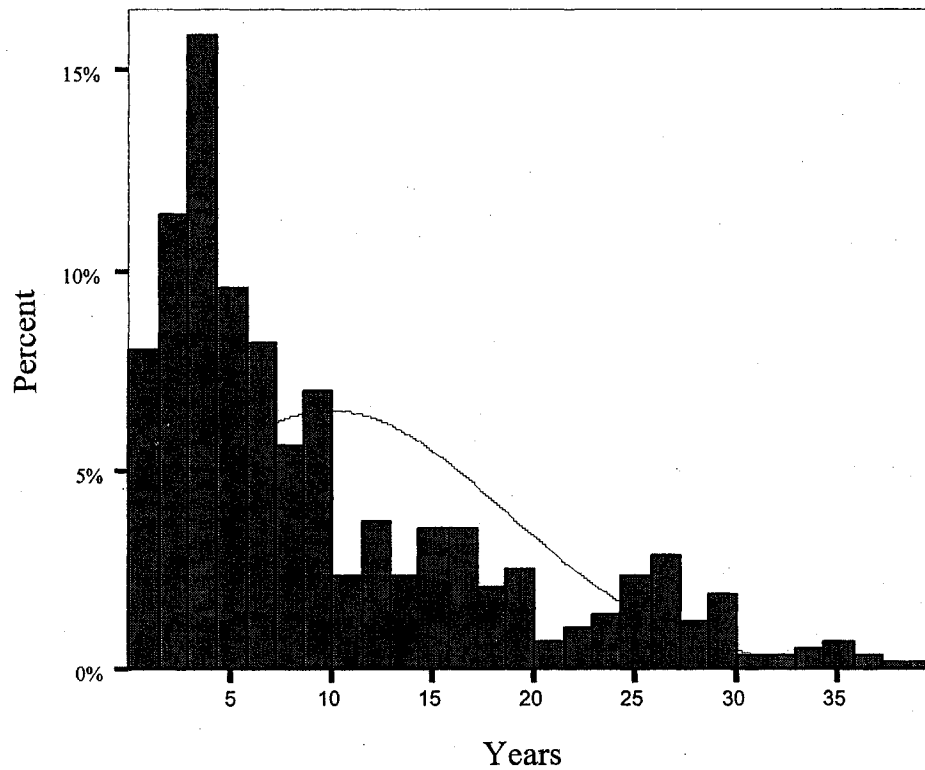
Of the 722 survey respondents, only 665 provided the data necessary to link their answers to the AHA and Medicare data. Of the 665 usable responses, 9.5% ( $n = 63$ ) were provided by hospital board chairs, and 90.5% ( $n = 602$ ) were provided by CEOs or CEO equivalents. Figures 2 and 3 graphically depict demographics of the respondents, including their organizational tenure and the tenure of their predecessor.

## CEO Origin



*Figure 2:* Tenure of respondent CEOs ranges from 3 months to 39 years. The mean organizational tenure is 8.2 years, and 50% of all respondents have been in the CEO position 5 years or less.

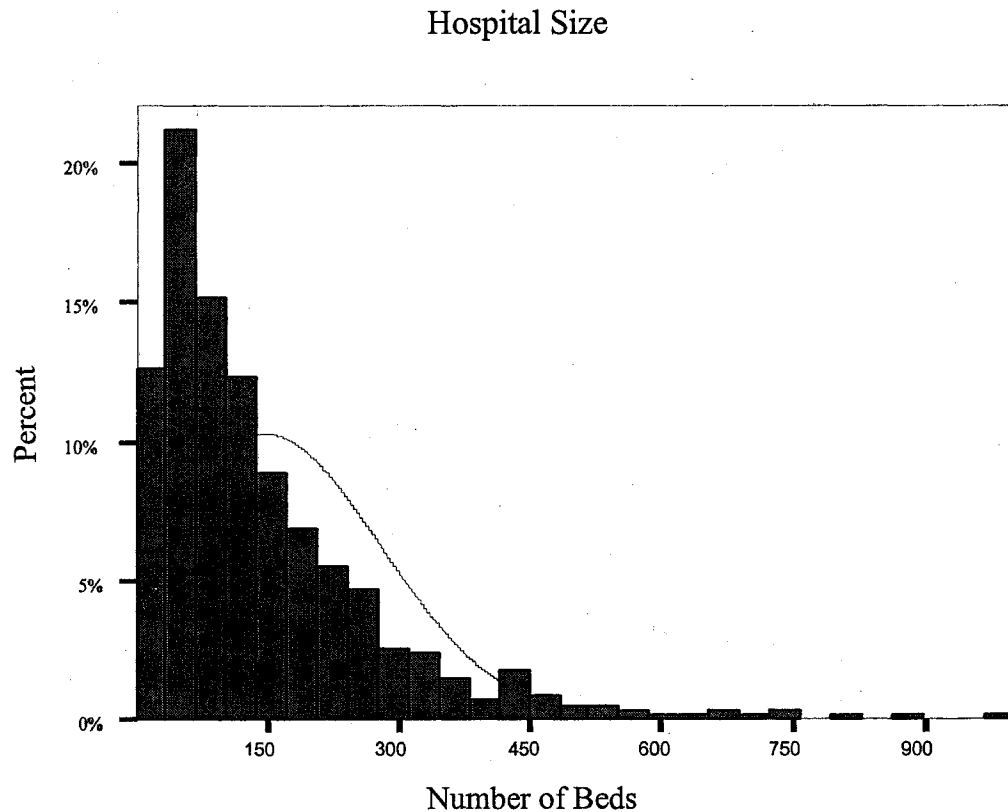
### Predecessor Tenure



*Figure 3:* Tenure of predecessor CEOs ranges from 3 months to 40 years. The mean predecessor tenure is 9.8 years, and 50% of predecessors were in the position 6 years or less.

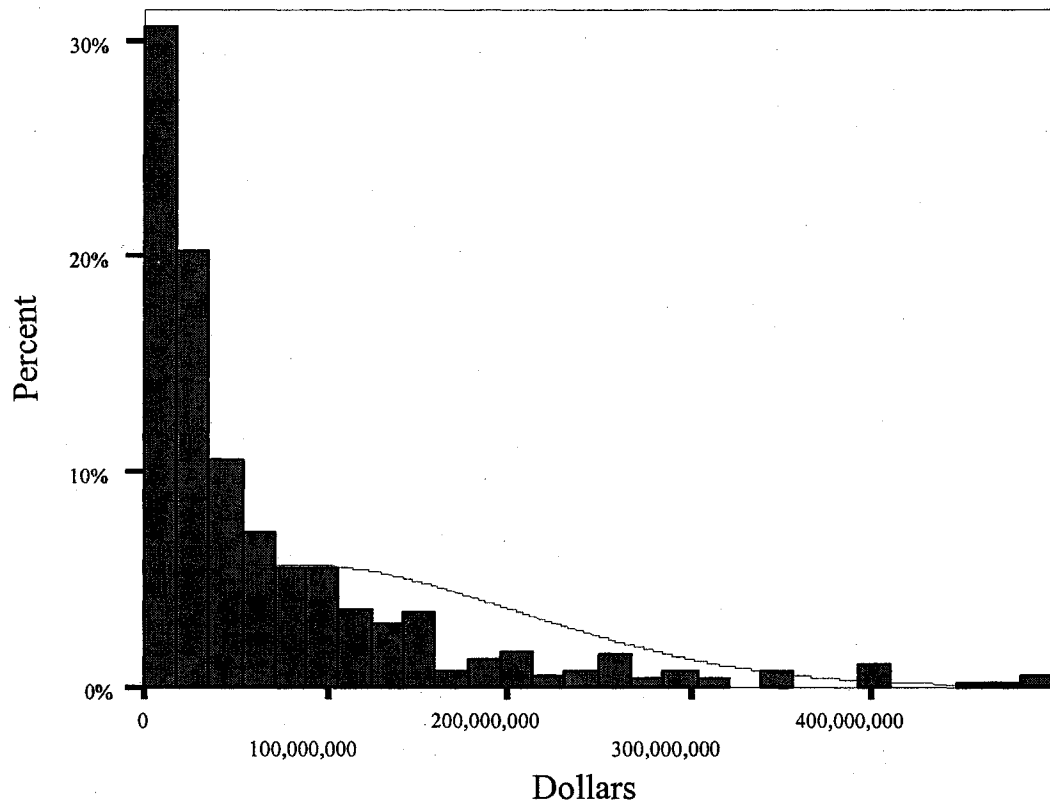
### *Institutional Demographics*

Characteristics of the hospitals employing the respondents were also evaluated. Figures 4 – 7 graphically depict institutional demographics such as hospital size, net revenue, MSA size, and corporate structure, while Table 2 reflects the hospital setting.



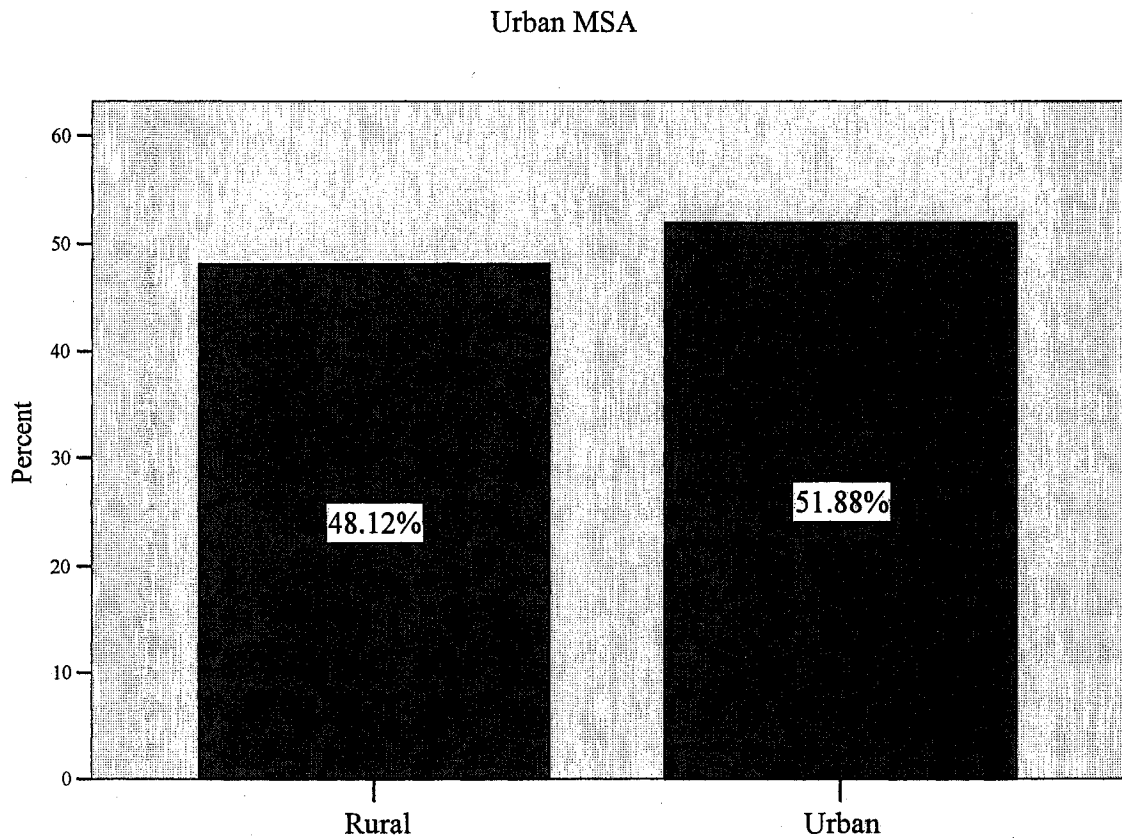
*Figure 4:* Size of sample hospitals ranges from 6 beds to 1000 beds, with a mean size of 146 beds. Approximately 50% of all hospitals in the sample have fewer than 105 beds, while the remaining 50% have between 105 and 1000 beds.

## Hospital Net Revenue



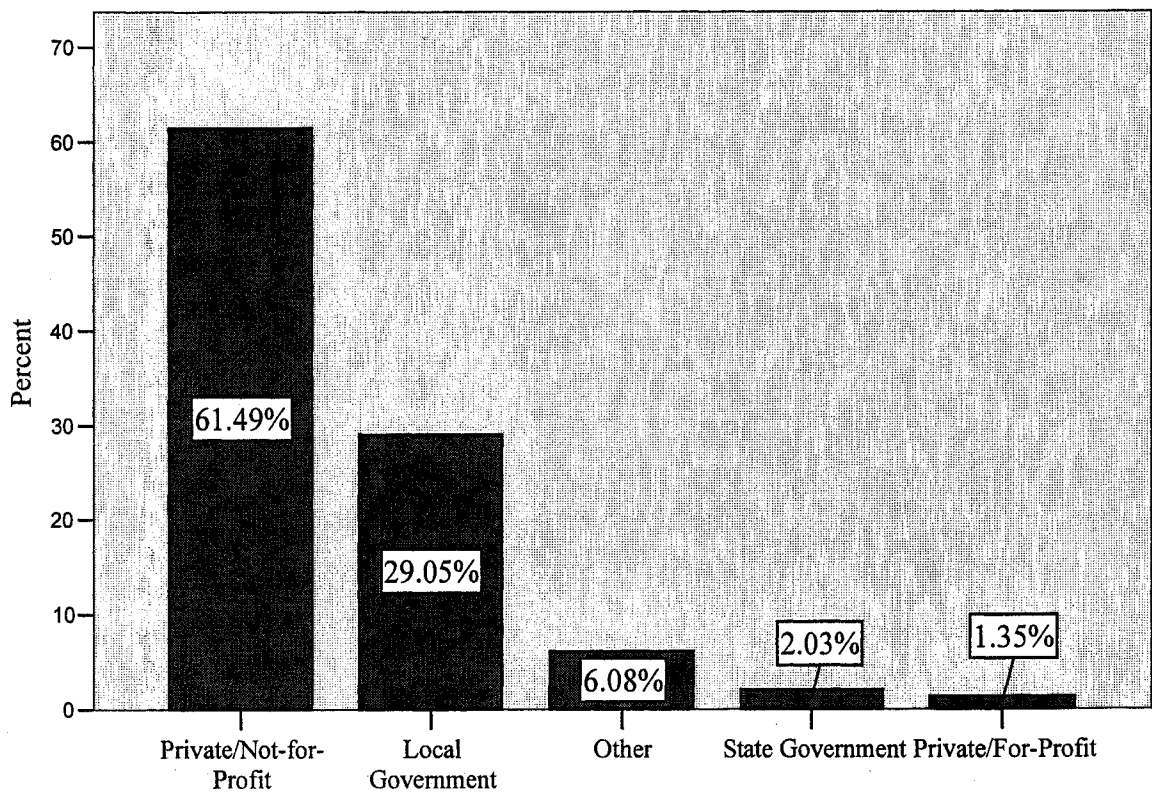
*Figure 5:* Net revenue (self-reported) of sample hospitals ranges from a loss of \$500,000 to a gain of \$1.5 billion. The mean net revenue is \$70 million, and approximately 50% of the hospitals in the sample have revenues below \$35 million.





*Figure 6:* Approximately 48% of all hospitals in the sample are in non-metropolitan MSAs (<100,000), while approximately 52% of all facilities are in metropolitan MSAs (>100,000). MSA population was established based on Medicare Cost Report Data.

## Corporate Structure



*Figure 7:* Approximately 61.5% of sample hospitals have a private/not-for-profit corporate structure, while 29% are governed by a local government. State governments operate 2% of sample hospitals, and 1.4% are private/for-profit entities. The remaining 6.1% of hospitals have some other type of corporate structure.

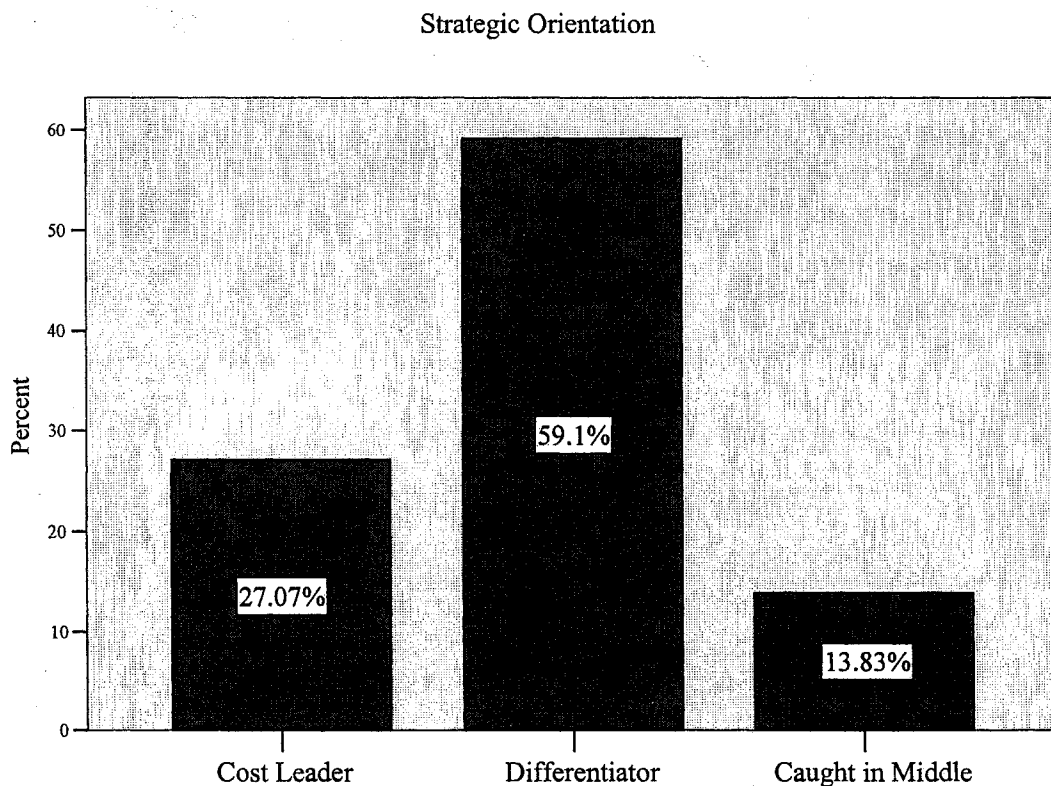
Table 2

HOSPITAL SETTING		Number of Hospitals in Setting	Percentage of Hospitals in Setting (n = 665)
Type of Setting			
	Academic Setting	48	8.0%
	Community Setting	375	62.4%
	Religious Setting	20	3.3%
	System Member	21	3.5%
	Rural Area	380	63.2%
	Urban Area	64	10.6%
	Suburban Area	82	13.6%

\*All categories are not mutually exclusive; self-reported descriptive data in which respondents were encouraged to select "all that apply" regarding the setting for their hospital.

### *Hospital Strategic Orientation*

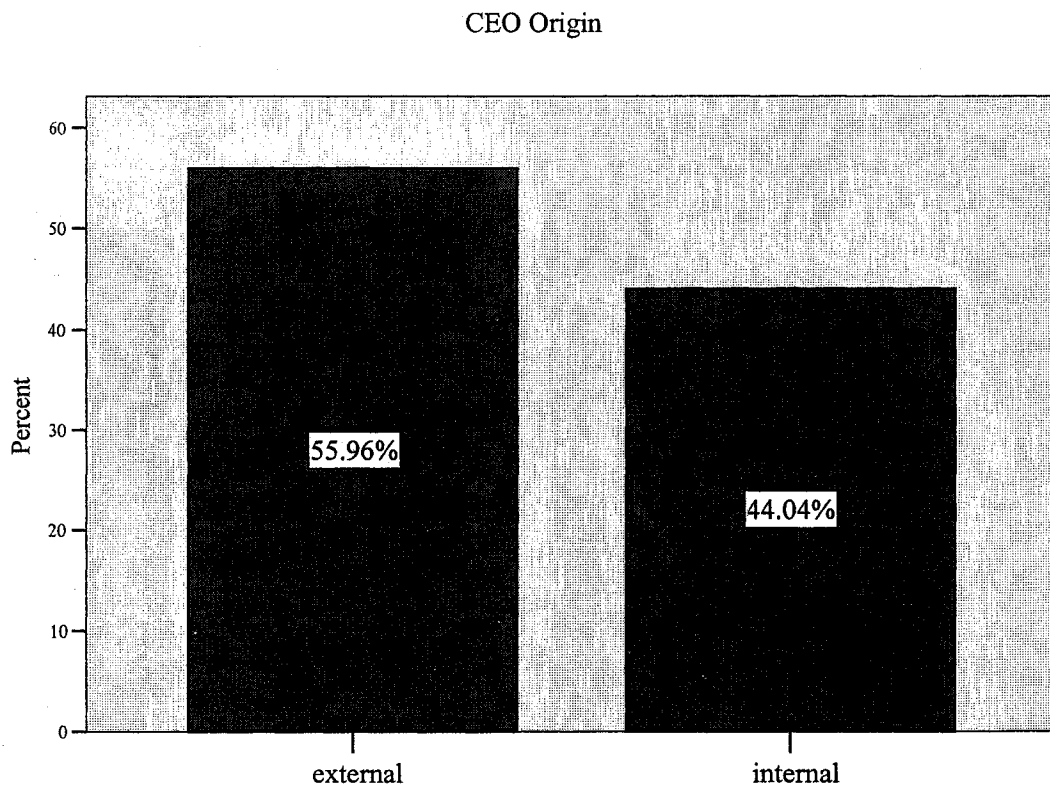
Hospitals were categorized according to the Porter (1980) generic strategies based on cost and service related variables (see Figure 8). Based on the CEO/Board Chair responses (n = 665), approximately 27.1% (n = 180) of hospitals attempt to outperform competitors using a cost leadership strategy. These facilities had lower cost structures than other hospitals in the sample. Approximately 59.1% (393) of the hospitals in the sample compete in their marketplaces using a differentiation strategy. These facilities had larger breadths of line, more technology, and rare service offerings than other hospitals in the sample. Finally, about 13.8% (n = 92) of the facilities surveyed have no clear strategic direction; therefore, these hospitals will be considered “caught in the middle.”



*Figure 8: Hospital Strategic Orientation*

### *Responses Relevant to CEO Origin*

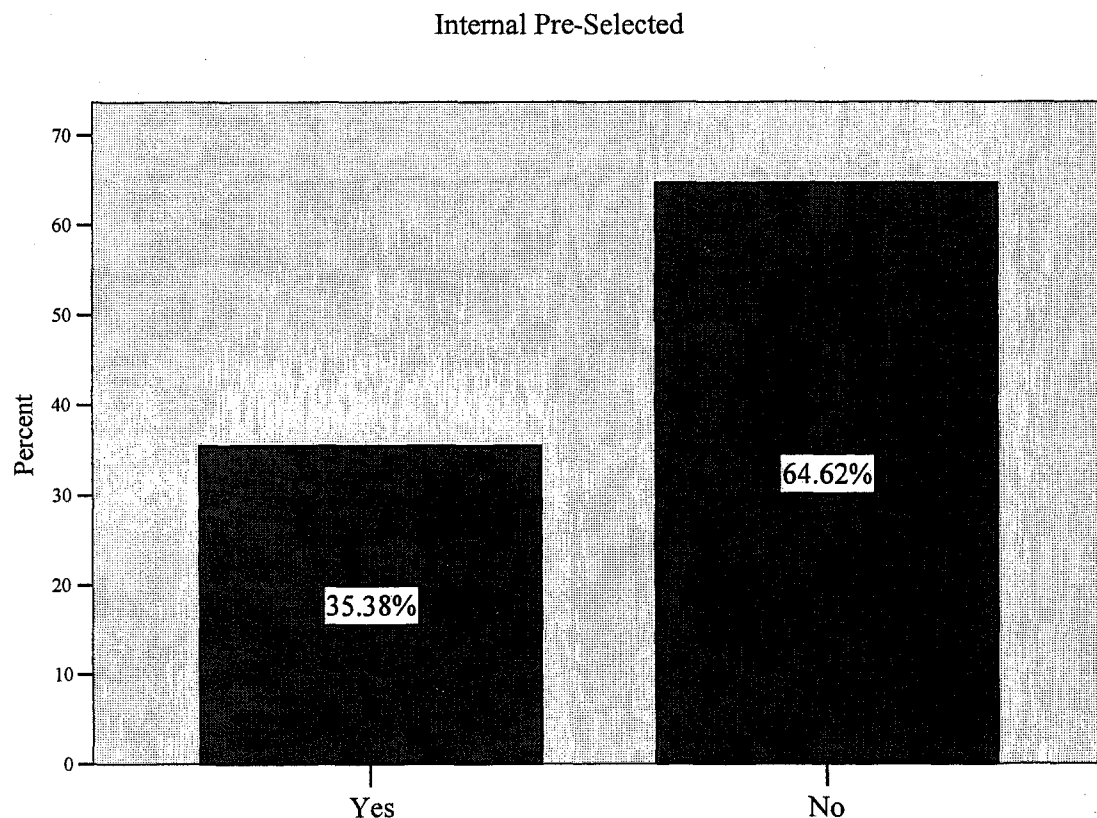
Respondents were asked if they were hired from inside the organization or outside the organization. Of the CEOs/Board Chairs that responded ( $n = 654$ ), approximately 56% ( $n = 366$ ) were hired from outside their organizations and about 44% ( $n = 288$ ) were hired from inside their organizations (see Figure 9).



*Figure 9: Internal versus External CEO Origin*

Internally hired respondents were asked a follow-up question: “Were you identified as the successor in advance of your taking the position?” Of internally hired candidates, only 277 responded to this secondary question (see Figure 10).

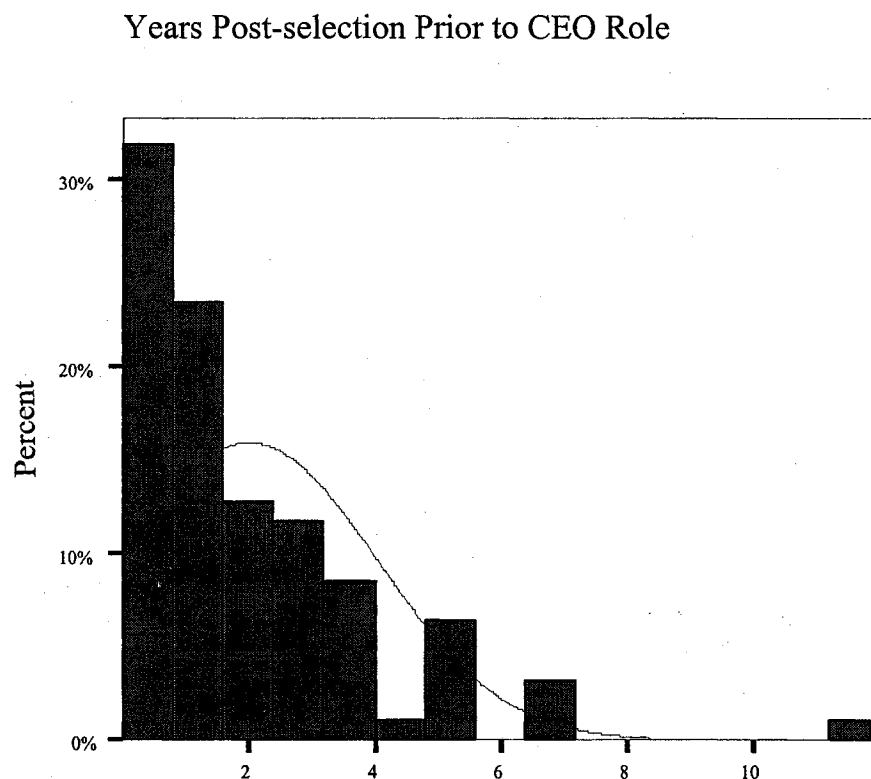
Approximately 35.4% of internally hired respondents (14.7% of total respondents; n = 98) stated they had been identified in advance to accepting the position of CEO, while 64.6% of internally hired respondents (26.9% of total respondents; n = 179) stated they did not know in advance of receiving the position.



*Figure 10: Internal Pre-selected versus Internal Not Pre-selected*

Those internal candidates that were identified in advance (n = 98) were asked the number of years between identification and actually assuming the CEO role (see Figure 11). Ninety-four responses indicated a mean gap between identification and role assumption of 2 years with a range between 0 and 12 years. Approximately 50% of these

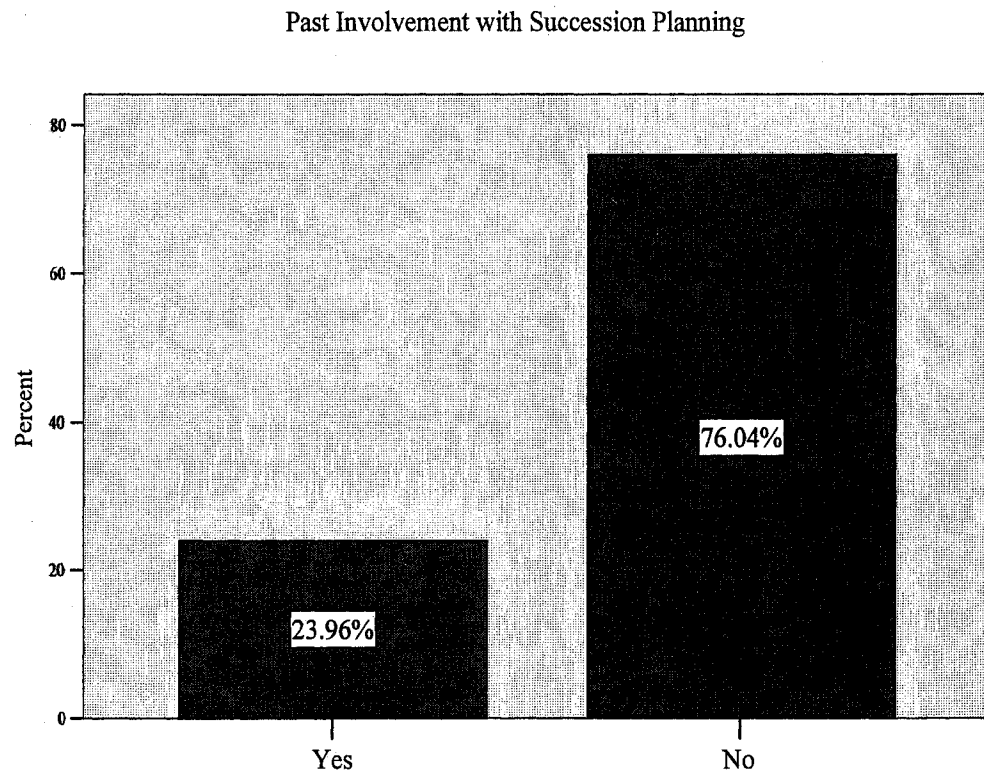
pre-selected CEO's were identified as successor a year or less prior to assuming the CEO position. However, the remaining pre-selected CEOs had gaps of 1.25 years or longer between role identification and role assumption.



*Figure 11: Years Post-Selection Prior to Assuming CEO Role*

Respondents that were hired internally ( $n = 288$ ), yet not notified in advance of their selection for the position ( $n = 179$ ) were asked if they had ever had involvement with succession planning activities (see Figure 12). Approximately 192 responses to this question were received, which is more than the 179 respondents that were internal yet not pre-selected. Therefore, it is difficult to determine who actually responded to this question. Regardless, 24% of internal, not pre-selected CEOs (6.9% of total;  $n = 46$ )

stated they had been involved in some sort of succession planning in the past, while 76 % of this group (22% of total, n = 146) stated they had not been involved in this type of activity.



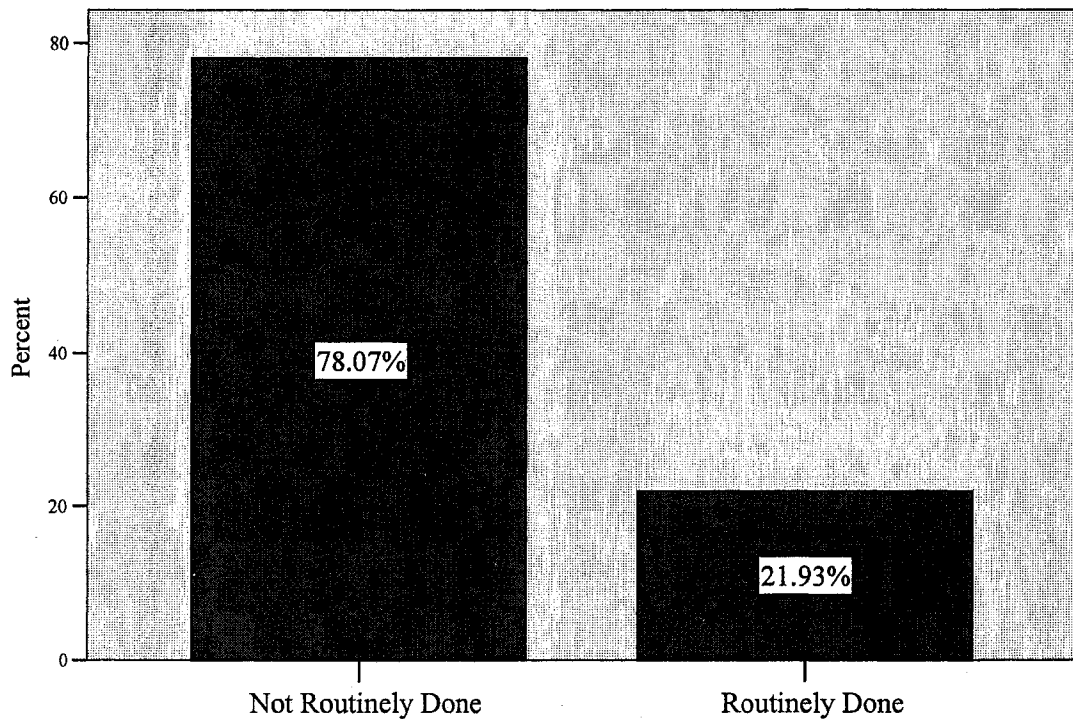
*Figure 12: Past Involvement with Succession Planning*

#### *Responses Related to Succession Planning*

Respondents were asked, “To what extent is succession planning routinely (i.e., on-going process) done at your organization?” Of the respondents (n = 643), approximately 78.1% (n = 502) stated succession planning was not routinely done, while 21.9% (n = 141) stated it was routinely done (see Figure 13).



### Succession Planning



*Figure 13: Frequency of Succession Planning Activities*

Respondents who routinely employ succession planning ( $n = 141$ ) were asked for further information on the groups targeted with the initiatives (see Figure 14).

Approximately 14.2% ( $n = 20$ ) stated they succession plan for the CEO position only. About 22.7% ( $n = 32$ ) plan for top-level positions (CEO, COO, EVP, etc.) only, while 25.5% ( $n = 36$ ) plan for top and mid-level positions (includes vice-presidents). Finally, 37.6% of respondents ( $n = 53$ ) plan for all levels of leadership, including departmental level managers.

### Groups Targeted with Succession Planning

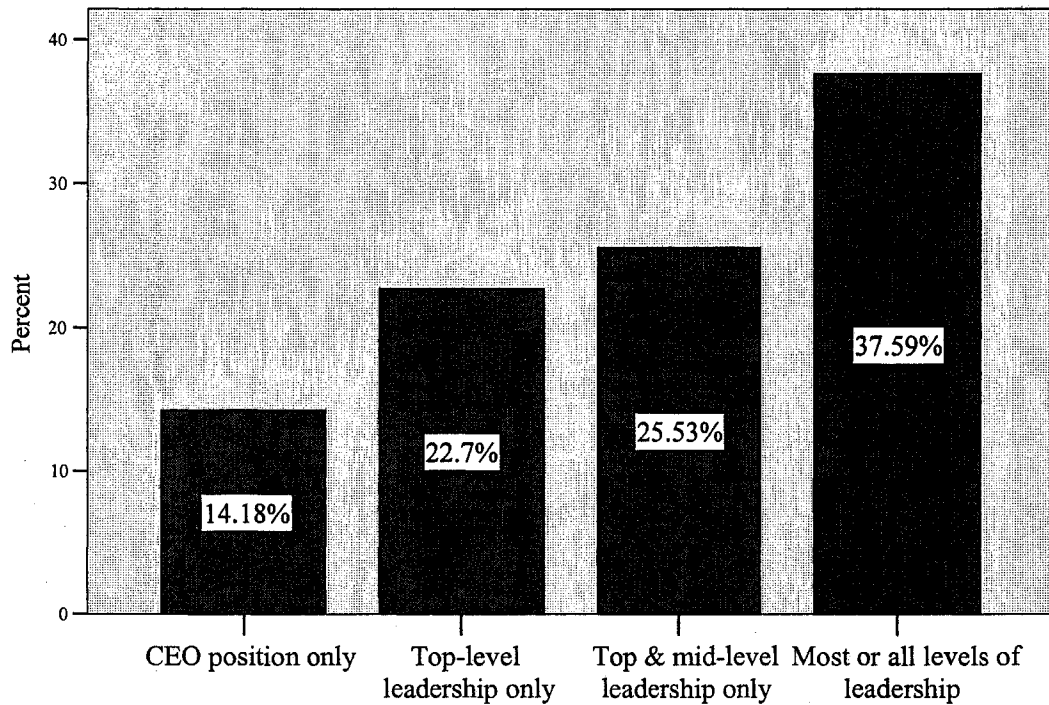


Figure 14: Groups Targeted with Succession Planning Activities

### Exploratory Analysis

Crosstabulations were performed using SPSS to determine significant relationships between the variables of interest. Hospital strategic orientation, succession planning, and CEO origin were all evaluated.

#### *Strategic Orientation and CEO Origin*

The first analysis looks at hospital strategic orientation and internal versus external CEO origin. The observed cell frequencies for the composite variable

representing all strategic orientations is shown in Table 3, and this is depicted graphically in Figure 15. The analysis results indicate ( $p=.015$ ) that the strategic orientation of hospitals and the origin of the CEOs they employ are not independent. In other words, hospitals of different strategic orientation are significantly different in their employment of internal versus external CEOs.

Table 3

OBSERVED CELL FREQUENCIES (CEO ORIGIN, STRATEGY)

		STRATEGIC ORIENTATION			
		Cost Leader	Diff	Caught in Mid	Total
CEO ORIGIN	External	103	203	60	366
	Internal	70	189	29	288
TOTAL		173	392	89	654

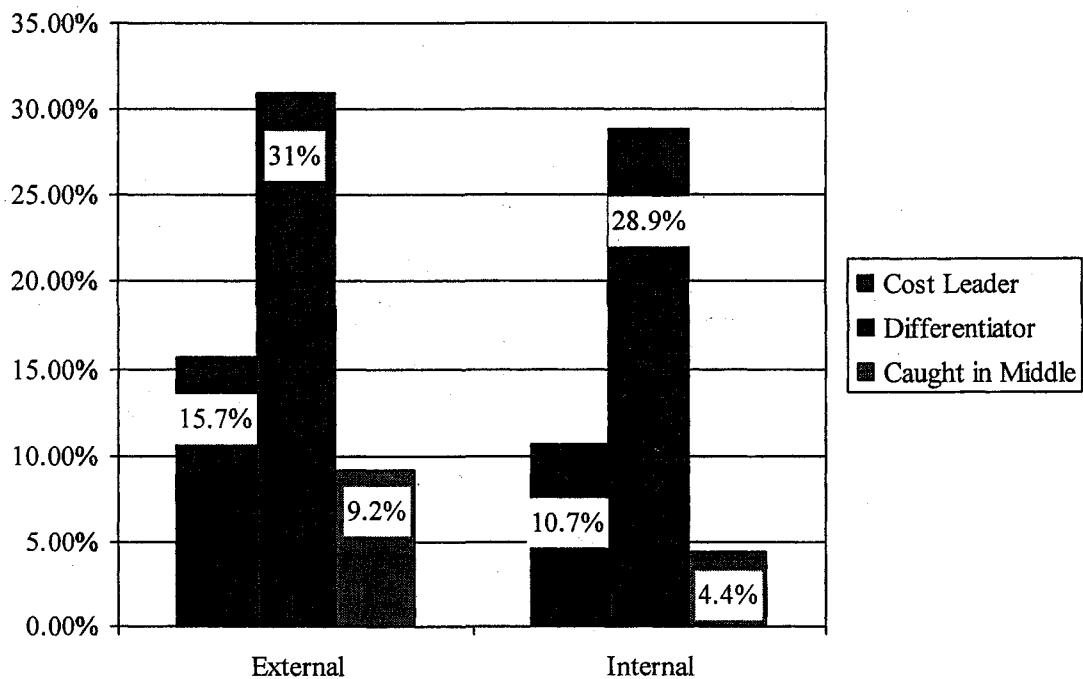


Figure 15: CEO Origin Distribution by Strategic Orientation

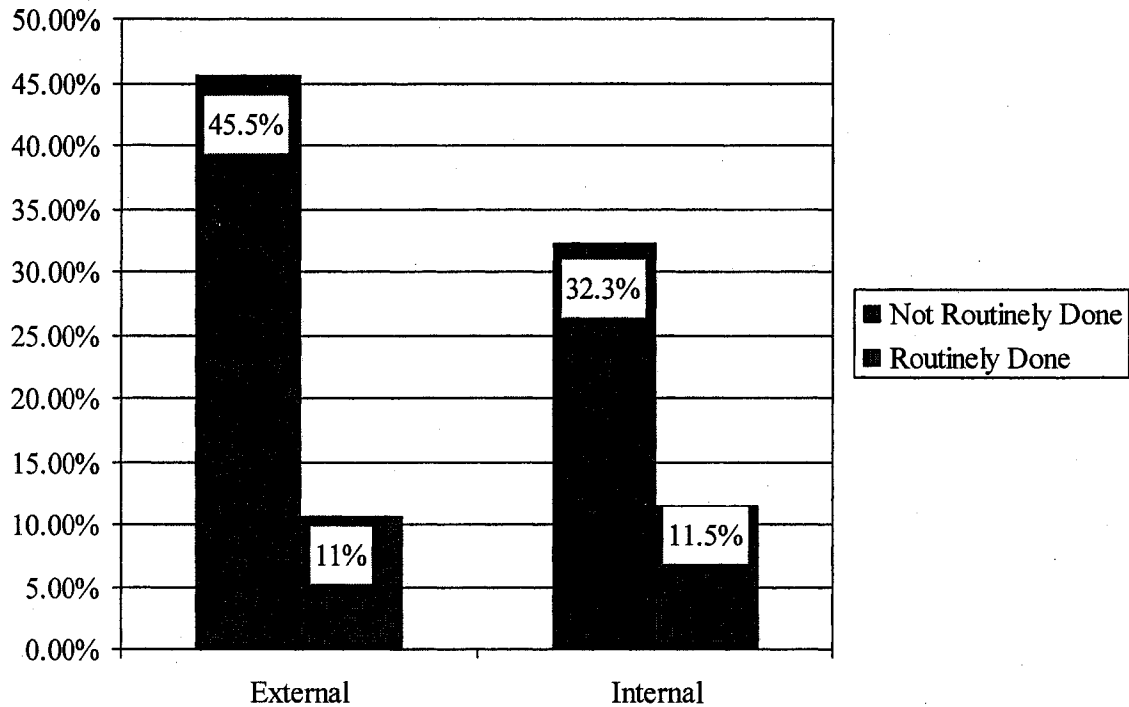
Additional crosstabulations were performed that look at individual strategic orientations and their relative associations with CEO Origin. Based on the Chi-Square statistics obtained, cost leader status and the origin of a hospital's CEO are unrelated. However, both differentiator status and caught in the middle status appear to be significantly related to the origin of a hospital's CEO.

#### *Succession Planning and CEO Origin*

The next analysis looks at the relationship between succession planning and CEO origin. The observed cell frequencies are shown in Table 4, and this is graphically depicted in Figure 16. The analysis suggests ( $p=.031$ ) that a hospital's succession planning behaviors and the origin of its CEO are not independent.

Table 4

OBSERVED CELL FREQUENCIES (CEO ORIGIN, SUCCESSION PLANNING)		SUCCESSION PLANNING		
		Not Routinely Done	Routinely Done	Total
CEO ORIGIN	External	290	68	358
	Internal	206	73	279
TOTAL		496	141	637



*Figure 16: CEO Origin Distribution by Succession Planning Behavior*

#### *Strategic Orientation and Succession Planning*

This analysis focuses on the relationship between hospital strategic orientation and succession planning. The observed cell counts for the two variables is shown in Table 5, and this is graphically depicted in Figure 17. The crosstabulation results indicate ( $p=.011$ ) that succession planning behavior and hospital strategic orientation are not independent. Therefore, a significant difference exists in the succession planning behavior of hospitals among facilities of different strategic orientations.

Table 5

OBSERVED CELL FREQUENCIES (STRATEGY, STRATEGY)					
		STRATEGIC ORIENTATION			Total
		Cost Leader	Diff	Caught in Mid	
SUCCESSION PLANNING	Not Routinely Done	145	282	75	502
	Routinely Done	28	99	14	141
TOTAL		173	381	89	643

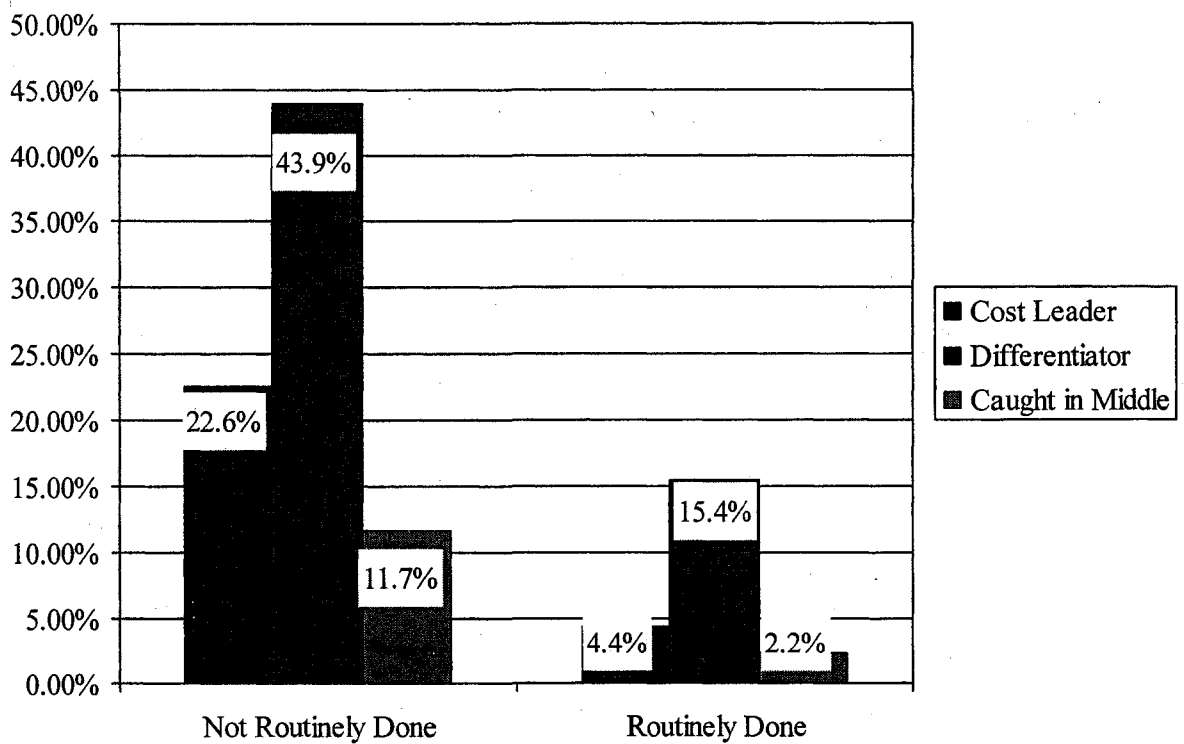


Figure 17: Succession Planning by Strategic Orientation

Additional crosstabulations were performed that looked at individual strategic orientations and their relative associations with succession planning. Based on the Chi-Square statistics obtained, caught in the middle status and hospital succession planning behavior are unrelated. However, both cost leader and differentiator statuses appear to be significantly related to a hospital's succession planning behavior.

### Hypothesis Testing

Hypotheses were tested by loglinear analyses. A series of analyses were performed to identify the significant relationships existing between strategic orientation, CEO origin, and succession planning. The purpose of the analysis is to find the most parsimonious model that adequately fits the data without being significantly different from the original saturated model which includes all orders of relationships. The models created through this process account for the observed distribution of cases among combinations of variables. Four separate models were created that look separately at cost leaders, differentiators, caught in the middle hospitals, and a composite measure of strategic orientation.

#### *Cost Leaders*

In the first analysis, the relationships between cost leader status, CEO origin, and succession planning are evaluated. Dummy variables characterize hospitals as either cost leaders (1) or not cost leaders (0), employers of CEOs of internal origin (1) or external origin (0), and routine succession planners (1) or non-routine succession planners (0). In

this analysis, the saturated model includes one 3 way effect (CEO Origin\*Cost Leader Status\*Succession Planning), three 2 way effects (CEO Origin\*Succession Planning; CEO Origin\*Cost Leader Status; Succession Planning\*Cost Leader Status), and individual effects for each variable (CEO Origin, Cost Leader Status, and Succession Planning). Each step deletes a different effect from the model, and based on the change in Chi Square from the saturated model, only the 3 main effects and 2 interaction effects are significant in predicting cell frequencies.

The interactions between CEO Origin\*Succession Planning ( $p=.031$ ) and Succession Planning\*Cost Leader Status ( $p=.042$ ) significantly increase the model's fit of the data. This means that a significant relationship exists between CEO origin and succession planning and between cost leader status and succession planning. Since no significant interaction is observed between cost leader status and CEO origin ( $p = .445$ ), no support is offered for the first hypothesis which suggests that cost leader hospitals will employ CEOs of internal origin more often than hospitals of other strategy types. Since the 3 way interaction is not significant ( $p=.445$ ) in determining cell frequencies, the no support is offered for the fifth hypothesis that suggests CEO origin and succession planning will both vary based on the hospital's strategic orientation.

The model adequately fits the data and explains the distribution of cell frequencies as indicated by its likelihood ratio ( $p=.521$ ). Differences between observed and expected cell counts are displayed in Table 6. All of the standardized residuals are below 1.0 indicating that the model fits the data well. Most of the data fall into two cells. Approximately 32% of all of the hospitals analyzed have CEOs of external origin, do not routinely participate in succession planning, and are not cost leaders. Around 24%



of the hospitals in the sample employ CEOs of internal origin, do not routinely participate in succession planning, and are not cost leaders. The first hypothesis suggests that more CEOs of internal origin will be employed with cost leader hospitals than with hospitals of other strategic orientations. The interaction between these two variables does not significantly influence the distribution of the table. Further, the observed cell counts do not support this hypothesis. Only around 10.7% of hospitals observed are cost leaders that employ CEOs of internal origin. The rest of the hospitals employing insider CEOs are of other strategic orientation.

The third hypothesis proposes that more CEOs of internal origin will be employed by organizations that participate in formal succession planning than by those hospitals that do not participate in such activities. Although the interaction between succession planning and CEO origin is significant in explaining observed cell frequencies, insider CEOs appear to be employed most often by hospitals that do not routinely succession plan. Of the 279 hospitals employing CEOs of internal origin, only 26% routinely succession plan. The remaining 74% do not participate in succession planning activities. Therefore, no support is offered for the third hypothesis.

The fourth hypothesis indicates that cost leader hospitals are more likely to participate in succession planning than hospitals of other strategic orientations. The interaction between the succession planning variable and cost leader status is significant. However, of the 141 hospitals that routinely succession plan, only around 20% are cost leaders. The remaining 80% are either differentiators or hospitals that are caught in the middle. Therefore, the analysis offers no support for hypothesis four.

Table 6

## CELL COUNTS AND RESIDUALS: COST LEADERS

CEO Origin	Succ. Planning	Cost Leader	Observed		Expected		Resid.	Std. Resid.
			Count	%	Count	%		
External	No	No	206.00	32.3%	208.15	32.7%	-2.145	-.149
		Yes	84.00	13.2%	81.855	12.9%	2.145	.237
	Yes	No	52.00	8.2%	54.496	8.6%	-2.496	-.338
		Yes	16.00	2.5%	13.504	2.1%	2.496	.679
Internal	No	No	150.00	23.5%	147.86	23.2%	2.145	.176
		Yes	56.00	8.8%	58.145	9.1%	-2.145	-.281
	Yes	No	61.00	9.6%	58.504	9.2%	2.496	.326
		Yes	12.00	1.9%	14.496	2.3%	-2.496	-.656

Parameter estimates (see Table 7) indicate that only the main effects from the succession planning ( $p=.00$ ) and cost leader ( $p=.00$ ) variables significantly contribute to the ability of the model effects to predict the distribution of data in table cells. Further, the standardized parameters (Z scores) verify that the relative strength of these two effects contributes the most to the strength of the relationships in the data distribution.

Table 7

PARAMETER ESTIMATES: COST LEADER							
Effect	Param.	Estimate	St. Error	Z	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Origin* Suc.Planning* Cost Leader	1	.044	.058	.751	.453	-.070	.158
Origin* Suc.Planning	1	.075	.058	1.287	.198	-.039	.189
Origin* Cost Leader	1	-.065	.058	-1.121	.262	-.179	.049
Suc.Planning* Cost Leader	1	-.110	.058	-1.884	.060	-.224	.004
Origin	1	.105	.058	1.800	.072	-.009	.219
Suc.Planning	1	.676	.058	11.607	.000**	.562	.790
Cost Leader	1	.578	.058	9.928	.000**	.464	.692

Based on the parameter estimates, it appears that none of the interaction effects significantly contribute to the strength of the relationships in the data distribution.

Further, based on the model estimates and data distribution, no support is offered for the first, third, fourth, or fifth hypotheses.

### *Differentiators*

In the second loglinear analysis, relationships between the differentiator strategy, CEO origin, and succession planning are evaluated. A dummy variable is used to indicate whether hospitals are differentiators (1) or not differentiators (0). The saturated model includes one 3 way effect (CEO Origin\*Differentiator Status\*Succession

Planning), three 2 way effects (CEO Origin\*Differentiator Status, CEO Origin\*Succession Planning, Differentiator Status\*Succession Planning), and main effects for the variables representing CEO origin, differentiator status, and succession planning. Based on the Chi Squares calculated after deleting certain effects from the model, only two interaction effects and the 3 main effects decrease the predictive capability of the model when deleted from the saturated model.

The 2 way interactions between CEO Origin\*Differentiator Status ( $p=.014$ ) and Differentiator Status\*Succession Planning ( $p=.004$ ) add to the models ability to fit the data. This means that the relationships between CEO origin and differentiator status and between succession planning and differentiator status are significant in some way. However, CEO origin and succession planning are not significantly related ( $p = .058$ ) in this analysis. Therefore, no support is offered for the third hypothesis. Since the 3 way interaction is not significant ( $p=.674$ ), no support for the fifth hypothesis is offered.

The model adequately fits the data as reflected by its likelihood ratio ( $p=.152$ ). Differences between observed and expected cell counts are displayed in Table 8. Based on the standardized residuals, it appears that overall the model does a good job in fitting the data. However, the model does not fit the cells representing differentiator hospitals employing external CEOs that routinely succession plan or differentiator hospitals employing internal CEOs that routinely succession plan. The standardized residuals for these cells are -1.072 and 1.121 respectively, indicating a poor fit. Most of the data fall into 3 cells. Approximately 21% of hospitals in the sample are non-differentiators that do not routinely succession plan and employ CEOs of external origin. Around 24% of the hospitals in the sample are differentiator hospitals that do not routinely succession plan

and employ CEOs of external origin. Finally, approximately 20% of hospitals are differentiators that do not routinely succession plan and employ CEOs of internal origin.

The second hypothesis suggests that more CEOs of external origin will be employed with differentiator hospitals than with hospitals of other strategic orientations. The interaction effect between CEO origin and differentiator status is significant, and based on the cell frequencies observed, external CEOs do appear to be employed more often at differentiator hospitals (199) than at non-differentiator hospitals (159). Therefore, support is offered for the second hypothesis. Again, no support is found for hypothesis 3 which proposes that CEOs of internal origin are more likely to be employed by organizations that routinely succession plan than other organizations, and this interaction effect is not significant to the model. The fourth hypothesis suggests that more hospitals of cost leader status will succession plan than hospitals of other strategic orientations. The interaction between differentiator status and succession planning is significant, and of the 141 hospitals that routinely succession plan, 99 are differentiators. This offers no support for the fourth hypothesis, and actually supports a relationship between differentiators and succession planning.

Table 8

CELL COUNTS AND RESIDUALS: DIFFERENTIATORS								
CEO Origin	Succ. Planning	Differentiators	Observed		Expected		Resid.	Std. Resid.
			Count	%	Count	%		
External	No	No	135.00	21.2%	132.91	20.9%	2.086	.181
		Yes	24.00	3.8%	23.086	4.1%	-2.086	-.408
	Yes	No	155.00	24.3%	147.29	23.1%	7.709	.635
		Yes	44.00	6.9%	51.709	8.1%	-7.709	-1.072
Internal	No	No	79.00	12.4%	81.086	12.7%	-2.086	-.232
		Yes	18.00	2.8%	15.914	2.5%	2.086	.523
	Yes	No	127.00	19.9%	134.71	21.1%	-7.709	-.664
		Yes	55.00	8.6%	47.291	7.4%	7.709	1.121

Parameter estimates (see Table 9) indicate that two interaction effects and two main effects significantly contribute to the model's ability to explain the distribution of data in table cells. The interactions CEO Origin\*Differentiator Status ( $p=.042$ ) and Succession Planning\*Differentiator Status ( $p=.008$ ) significantly determine the distribution of data in table cells. The main effects produced by variables representing succession planning ( $p=.000$ ) and differentiator status ( $p=.000$ ) also make significant contributions. The standardized parameters (Z scores) verify that the relative strength of these interactions and main effects contributes the most to the strength of the relationships in the data distribution. Of all significant effects, it appears that succession planning ( $Z=12.751$ ) and differentiator status ( $Z=-5.798$ ) have the most impact on relationships in the distribution. The parameter estimates offer additional support for the second hypothesis.

Table 9

PARAMETER ESTIMATES: DIFFERENTIATORS							
Effect	Param.	Estimate	St. Error	Z	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Origin* Suc.Planning* Differentiators	1	-.021	.051	-.406	.685	-.122	.080
Origin* Suc.Planning	1	.084	.051	1.631	.103	-.017	.185
Origin* Differentiators	1	.105	.051	2.031	.042*	.004	.205
Suc Planning* Differentiators	1	.136	.051	2.636	.008**	.035	.237
Origin	1	.099	.051	1.923	.055	-.002	.200
Suc. Planning	1	.656	.051	12.751	.000**	.556	.757
Differentiators	1	-.288	.051	-5.598	.000**	-.389	-.187

Based on the analysis, hypothesis 2 is supported and no support is offered for hypothesis 3, 4, or 5.

#### *Caught in the Middle*

The third loglinear model evaluates the relationships between hospitals that are caught in the middle strategically, CEO origin, and succession planning. A dummy variable is used to represent whether hospitals are caught in the middle (1) or not caught in the middle (0). The saturated model tests one 3 way interaction (CEO Origin\*Succession Planning\*Caught in the Middle Status), three 2 way interactions (CEO Origin\*Succession Planning, CEO Origin\*Caught in the Middle Status, Succession

Planning\*Caught in the Middle Status), and the main effects of the variables representing caught in the middle strategy, CEO origin, and succession planning. Based on Chi Square testing, it appears that only two interaction effects and three main effects decrease the ability of the model to predict cell frequencies when deleted from the saturated model.

The interactions between CEO Origin\*Succession Planning ( $p=.031$ ) and CEO Origin\*Caught in the Middle Status ( $p=.025$ ) significantly contribute to the model fit, along with main effects representing CEO origin, succession planning, and caught in the middle status. This means that CEO origin is related to both succession planning and caught in the middle status. However, succession planning and caught in the middle status are not significantly related ( $p = .164$ ). Since the 3 way interaction was not found to be significant ( $p=.835$ ), no support for the fifth hypothesis was offered.

The analysis produced a likelihood ratio of 1.976 ( $p=.372$ ) and a Pearson Chi-Square of 1.858 ( $p=.395$ ) which indicates that the model is an adequate fit for the data. Differences between observed and expected cell counts are displayed in Table 10. Based on the standardized residuals, it appears that the model does a good job in fitting the data. However, the standardized residual for hospitals that are caught in the middle, employ external CEOs, and routinely succession plan is fairly high (-.958) indicating a poor fit for this cell. Most of the data falls into two cells. Approximately 37.5% of the hospitals in the sample are not caught in the middle, employ CEOs of external origin, and do not routinely succession plan. Around 29% of the hospitals surveyed are not caught in the middle, employ CEOs of internal origin, and do not routinely succession plan. Although the interaction between CEO origin and succession planning significantly contributes to



the model's ability to predict cell frequencies, based on observed frequencies, little support is shown for hypothesis three which suggests that more CEOs of internal origin will be employed by hospitals that routinely succession plan than those that do not routinely succession plan.

Table 10

CELL COUNTS AND RESIDUALS: CAUGHT IN THE MIDDLE								
CEO Origin	Succ. Planning	Caught in Middle	Observed		Expected		Resid.	Std. Resid.
			Count	%	Count	%		
External	No	No	239.00	37.5%	242.21	38.0%	-3.207	-.206
		Yes	51.00	8.0%	47.793	7.5%	3.207	.464
	Yes	No	60.00	9.4%	56.793	8.9%	3.207	.426
		Yes	8.00	1.3%	11.207	1.8%	-3.207	-.958
Internal	No	No	183.00	28.7%	184.59	29.0%	-1.588	-.117
		Yes	23.00	3.6%	21.412	3.4%	1.588	.343
	Yes	No	67.00	10.5%	65.412	10.3%	1.588	.196
		Yes	6.00	.9%	7.588	1.2%	-1.588	-.576

The parameter estimates (see Table 11) find that only the main effects make significant contributions to the distribution of data in the cells. CEO origin ( $p=.048$ ), succession planning ( $p=.000$ ) and caught in the middle status ( $p=.000$ ) contribute significantly to the relationships between the cells in the data distribution. However, the Z scores indicate that caught in the middle status ( $Z=12.902$ ) and succession planning ( $Z=8.927$ ) contribute the most to the data distribution.

Table 11

PARAMETER ESTIMATES: CAUGHT IN THE MIDDLE							
Effect	Param.	Estimate	St. Error	Z	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Origin* Suc.Planning* CIM	1	-.018	.076	-.230	.818	-.167	.132
Origin* Suc.Planning	1	.112	.076	1.458	.145	-.038	.261
Origin* CIM	1	-.112	.076	-1.464	.143	-.262	.038
Suc Planning* CIM	1	-.089	.076	-1.161	.245	-.239	.061
Origin	1	.151	.076	1.977	.048*	.001	.301
Suc. Planning	1	.683	.076	8.927	.000**	.533	.833
Caught in Middle	1	.987	.076	12.902	.000**	.837	1.137

Based on the results of this analysis, no support is offered for either the third or the fifth hypotheses.

#### *Composite Model*

The final loglinear model analyzes the relationships between hospital strategic orientation, CEO origin, and succession planning. A composite measure for strategy is used representing cost leader status (1), differentiator status (2), and caught in the middle status (3). Using a backward elimination technique, one 3 way effect (CEO Origin\*Succession Planning\*Strategy), three 2 way effects (CEO Origin\*Strategy, Succession Planning\*Strategy, CEO Origin\*Succession Planning), and the main effects

of CEO origin, strategic orientation, and succession planning are tested. Based on Chi-Square statistics, only two interaction effects and three main effects decrease the fit of the model when deleted.

The interactions between CEO Origin\*Strategy ( $p=.023$ ) and Succession Planning\*Strategy ( $p=.015$ ) with the main effects representing strategy, CEO origin, and succession significantly contribute to the predictive capabilities of the model. This means that strategy is related to both CEO origin and succession planning. The interaction between CEO origin and succession planning is not significant ( $.059$ ), indicating no support for the third hypothesis. Again, no support for the fifth hypothesis is observed since the 3 way interaction is not significant ( $p = .791$ ).

The model adequately fits the data as reflected by its likelihood ratio ( $p=.257$ ). Differences between observed and expected cell counts are displayed in Table 12. Based on the standardized residuals, it appears that the model does a fairly good job in fitting the data. However, the standardized residual for differentiator hospitals that employ external CEOs and routinely succession plan is fairly high ( $-1.072$ ) indicating a poor fit for this cell. Also, differentiator hospitals that employ internal CEOs and routinely succession plan have a high standardized residual ( $1.121$ ) indicating a poor model fit for the cell. According to the observed cell counts, the majority of hospitals fall into three cells. Approximately 13.2% of hospitals are cost leaders that employ external CEOs that do not routinely succession plan. The cell representing differentiator hospitals that employ external CEOs that do not succession plan contains 24.3% of the sample. Finally, approximately 20% of the sample are differentiator hospitals that employ internal CEOs that do not routinely succession plan.

Table 12

CELL COUNTS AND RESIDUALS: COMPOSITE MODEL								
CEO Origin	Succ. Planning	Strategy	Observed		Expected		Resid.	Std. Resid.
			Count	%	Count	%		
External	No	Cost Leader	84.5	13.2%	83.33	13.1%	.667	.073
		Differentiator	155.00	24.3%	147.29	23.1%	7.709	.635
		Caught in Middle	51.00	8.0%	49.614	7.8%	1.386	.197
	Yes	Cost Leader	16.00	2.5%	16.667	2.6%	-.667	-.163
		Differentiator	44.00	6.9%	51.709	8.1%	-.667	-.089
		Caught in Middle	8.00	1.3%	9.386	1.5%	-1.386	-.453
Internal	No	Cost Leader	56.00	8.8%	56.667	8.9%	-.667	-.089
		Differentiator	127.00	19.9%	134.71	21.1%	-7.709	-.664
		Caught in Middle	23.00	3.6%	24.386	3.8%	-1.386	-.281
	Yes	Cost Leader	12.00	1.9%	11.333	1.8%	.667	.198
		Differentiator	55.00	8.6%	47.291	7.4%	7.709	1.121
		Caught in Middle	6.00	.9%	4.614	.7%	1.386	.645

The first hypothesis proposed in this study suggests that more CEOs of internal origin will be employed with cost leader hospitals than with hospitals of other strategic orientations. The interaction effect between strategy and CEO origin is significant. However, based on the observed cell frequencies, the anticipated relationship does not appear to be true. Of the 279 hospitals that employ CEOs of internal origin, only 24% (68) are cost leaders. The majority of hospitals employing internal CEOs are differentiators, which offers no support for this hypothesis. The second hypothesis proposes that more CEOs of external origin will be employed with differentiator hospitals than with hospitals of other strategic orientations. Again, the interaction effect between

these two variables is significant, and of the 358 hospitals employing CEOs of external origin, approximately 56% (199) are differentiators offering moderate support for the second hypothesis.

The third hypothesis in this study suggests that more CEOs of internal origin will be employed by organizations that participate in formal succession planning than by those hospitals that do not participate in such activities. The interaction effect between these two variables is not significant, and based on the observed cell frequencies, only 73 hospitals that employ CEOs of internal origin routinely participate in succession planning. This only represents 26% of all hospitals employing internal CEOs. Further, 68 hospitals that routinely employ succession planning employ CEOs of external origin. Therefore, no support for the third hypothesis is offered. The fourth hypothesis suggests that more cost leader hospitals will participate in succession planning activities than hospitals of other strategic orientations. Although the interaction effect is significant, of the 141 hospitals that routinely participate in succession planning activities, only 20% (28) are cost leaders. Therefore, no support is offered for the fourth hypothesis.

Parameter estimates (see Table 13) indicate that two interaction effects and all three main effects significantly contribute to the ability of the model's effects to predict the distribution of data in table cells. The interactions between CEO Origin\*Strategy ( $p=.037$ ) and Succession Planning\*Strategy ( $p=.015$ ) in addition to the main effects of CEO origin ( $p=.022$ ), succession planning ( $p=.000$ ), and strategic orientation ( $p=.000$ ) significantly influence the relationships determining the data distribution. Further, the standardized parameters (Z scores) indicate that the effects of CEO origin ( $Z=11.123$ )

and the second parameter of strategy ( $Z=12.355$ ) are relatively the strongest contributors to the strength of relationships in the data distribution.

Table 13

PARAMETER ESTIMATES: COMPOSITE MODEL

Effect	Param.	Estimate	St. Error	Z	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Origin* Suc.Planning* Strategy	1	-.057	.086	-.664	.507	-.226	.112
	2	.016	.071	.233	.816	-.122	.155
Origin* Suc.Planning	1	.088	.062	1.419	.156	-.034	.210
	2						
Origin* Strategy	1	.027	.086	.319	.750	-.141	.196
	2	-.148	.071	-2.091	.037*	-.287	-.009
Suc Planning* Strategy	1	.093	.086	1.078	.281	-.076	.262
	2	-.172	.071	-2.427	.015*	-.311	.033
Origin	1	.143	.062	2.289	.022*	.021	.265
	2						
Suc. Planning	1	.693	.062	11.123	.000**	.571	.815
	2						
Strategy	1	-.101	.086	-1.177	.239	-.270	.067
	2	.875	.071	12.355	.000**	.736	1.014

Based on the results for this loglinear analysis, only the second hypothesis is supported.

### Summary of Hypothesis Testing

Based on the findings obtained through loglinear modeling, little support was found for the hypotheses tested in this study. Results are outlined in Table 14.

Table 14

SUMMARY OF RESULTS BY HYPOTHESIS		
	Hypotheses	Supported Yes/No
H1	More CEOs of internal origin will be hired by cost leader hospitals than by differentiators and hospitals that are caught in the middle.	No
H2	More CEOs of external origin will be hired by differentiator hospitals than by cost leaders or hospitals that are caught in the middle	Yes
H3	More CEOs of internal origin will be hired by organizations that participate in formal succession planning than by those hospitals that do not participate in such activities	No
H4	More cost leader hospitals will participate in succession planning activities than differentiators and hospitals that are caught in the middle.	No
H5	CEO origin and participation in succession planning will vary based on the hospital's strategic orientation	No

Loglinear analysis is a form of multiway frequency analysis that is specifically designed for the analysis of categorical or dichotomous variables. Although loglinear analysis can test the significance of the model, or the interactions and relationships between the three variables of interest, this procedure does not classify any of the variables as dependent. Rather, it attempts to account for the distribution of cell frequencies.

Although several of the analyses did show significant 2-way interaction effects, none of the analyses showed support for a 3-way interaction among succession planning, CEO origin, and strategic orientation. Based on the analyses used to test the hypotheses

proposed in this study, support is only offered to the second hypothesis which suggests that hospitals employing a differentiator status are more likely to hire CEOs from outside the organization than hospitals of another strategic orientation.

### Additional Analyses

The balance of this chapter is devoted to additional analyses performed on the data in an effort to better understand the relationships between the variables of interest: hospital strategic orientation, CEO origin, and succession planning. In the next phases of analysis, latent cluster models and a discrete factor model were created to generate more information about the attributes of the hospitals in the sample. This analysis exposed subtle relationships among the variables of interest, and also provided information on other attributes of the hospitals. Finally, a logistic regression was performed to look separately at the models using CEO origin and succession planning as dependent variables since no such relationships were evaluated in the loglinear analyses.

#### *Latent Class Cluster Models*

The goal of the latent class cluster model analysis is to identify distinctly different hospital types based on strategy, succession planning behavior, and CEO origin. Initially, hospitals are clustered based on individual strategic orientations, and later analyses evaluate composite clusters.

*Cost Leaders.* The first latent class cluster model looks specifically at the strategic category of cost leader hospitals, CEO origin, succession planning, and MSA population. Dummy variables characterize hospitals as either cost leaders (1) or not cost



leaders (0); employers of CEOs of internal origin (1) or external origin (0), and routine succession planners (1) or not routine succession planners (0). A fourth dummy variable representing the MSA population (coded as urban (1) and rural (0)) was included in the analysis to add the power necessary to run the analysis. The model is found to be of an adequate fit with an  $L^2$  of 2.067 and a p value of 0.91. Two clusters were created, and model parameters (see Table 15) indicate that CEO origin, succession planning behavior, and MSA population all contribute significantly to group separation. However, an organization's cost leader status is not a significant discriminating variable. R-squared scores indicate that CEO origin explains 3.36% of group differences, succession planning explains 19.2% of differences, and MSA population explains approximately 5% of group variation. Therefore, succession planning is the most important variable in the model contributing to group separation.

Table 15

PARAMETERS FOR MODEL INDICATORS					
	Cluster 1	Cluster 2	Wald	p-value	R <sup>2</sup>
CEO Origin	-.4105	.4105	4.2823	0.039*	.0336
Low Cost Leader	.5887	-.5887	3.0904	0.079	.0385
CEO Succ Planning	-1.0819	1.0819	7.4458	0.0065**	.1919
MSA Population	-.5215	.5215	5.0523	0.025*	.0501

\* Significant at the 0.05 level, \*\* Significant at the 0.01 level

According to the latent class cluster profiles (see Table 16) and probability means (see Table 17), approximately 72% of hospitals in the sample belong to the first cluster, while 28% belong to the second cluster. Most cost leader hospitals fall into the first

cluster, and the probability of a hospital in the first cluster being a cost leader is higher than that for hospitals in the second cluster. Most hospitals in the first cluster employ externally hired CEOs, and the probability of a hospital in this cluster employing an external CEO is higher than that for hospitals in cluster 2. Hospitals that do not have a succession plan are found in this cluster, and the probability that hospitals in this group will not participate in succession planning is higher than that for facilities in the second cluster. Finally, more hospitals located in a rural MSA fall into the first cluster, and the probability that a hospital in this group is rural is higher than that for facilities in the second group.

Most of the hospitals that are not cost leaders fall into the second cluster. The probability of a hospital in the second cluster being a cost leader is much lower than that of hospitals in the first group. Most CEOs of internal origin are employed by hospitals in the second group, and the probability of a hospital in this cluster employing a CEO of internal origin is higher than the probability of it employing a CEO of external origin. Most hospitals that routinely practice succession planning fall into the second cluster, and the probability of a hospital in this group participating in succession planning is greater than that for hospitals in the first cluster. The hospitals in this cluster are mainly located in urban areas, and the probability of these facilities being urban is higher than the probability that they are rural.

Table 16

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**PROFILE FOR COST LEADER LATENT CLASS CLUSTER MODEL**


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	<b>Cluster 1</b>	<b>Cluster 2</b>
Cluster Size	.7184	.2816
CEO Origin		
External	.6189	.4168
Internal	.3811	.5832
Cost Leader Status		
Not Cost Leader	.6821	.8744
Cost Leader	.3179	.1256
CEO Succession Planning		
Not Routinely Done	.8925	.4882
Routinely Done	.1075	.5118
MSA Size		
Rural (<100,000)	.5472	.2987
Urban (>100,000)	.4528	.7013

---

Table 17

---

**PROBABILITY MEANS FOR COST LEADER LATENT CLASS CLUSTER MODEL**


---

	<b>Cluster 1</b>	<b>Cluster 2</b>
Cluster Size	.7184	.2816
CEO Origin		
External	.7913	.2087
Internal	.6248	.3752
Cost Leader Status		
Not Cost Leader	.6654	.3346
Cost Leader	.8663	.1337
CEO Succession Planning		
Not Routinely Done	.8237	.1763
Routinely Done	.3482	.3780
MSA Size		
Rural (<100,000)	.8240	.1760
Urban (>100,000)	.6220	.3780

---

Additional covariates were added into the model to give more information about the hospital clusters. Although none of the profile or probability means data changes on our variables of interest based on the inclusion of these variables, information on hospital size, location, system affiliation, and for-profit/not-for-profit status was obtained (see Table 18). Hospital size is classified according to bed size, and hospitals were placed into 5 ascending groups representing number of beds. Hospitals in the first cluster tend to be smaller than hospitals in the second cluster. System membership and profit status are also included as covariates in the model. Although missing data on these two variables presents a challenge, it appears that hospitals in the second cluster are slightly more likely to belong to a system than hospitals in the first cluster. However, no differences are observed based on for-profit status.

Table 18

PROFILE FOR COST LEADER LATENT CLASS CLUSTER MODEL: COVARIATES			
		Cluster 1	Cluster 2
Hospital Beds			
	Group 1	.1850	.1133
	Group 2	.1916	.1133
	Group 3	.3374	.3211
	Group 4	.1551	.2009
	Group 5	.1309	.2515
System Membership			
	Not a Member	.8875	.8243
	Member	.0276	.0410
	Missing Data	.0849	.1347
Profit Status			
	Not For-Profit	.8988	.8456
	For Profit	.0110	.0166
	Missing Data	.0903	.0166

Based on this latent class cluster analysis, hospitals in both groups can be described based on both variables of interest and covariates (see Table 19).

Table 19

CLUSTER DESCRIPTIONS FOR COST LEADER LATENT CLASS CLUSTER MODEL		
	Cluster 1	Cluster 2
<b>CEO Origin</b>	External	Internal
<b>Cost Leaders</b>	Yes	No
<b>Succession Planning</b>	Not Routine	Routine
<b>MSA Size</b>	Rural	Urban
<b>Hospital Size</b>	Smaller	Larger
<b>System Membership</b>	No	Sometimes
<b>Profit Status</b>	Not-for-Profit	Not-for-Profit

The first cluster of hospitals can be identified as rural cost leaders with external CEOs and very little succession planning behavior. These hospitals tend to be smaller and are not likely to belong to a system or have for-profit status. The second cluster of hospitals can be described as urban non-cost leader hospitals with internal CEOs and active succession planning behavior. These hospitals tend to be larger than hospitals in the first cluster, and they are slightly more likely to belong to a system.

*Differentiators.* The next latent class cluster model looks specifically at the strategic category of differentiator hospitals, CEO origin, succession planning, and MSA population. A dummy variable characterizes hospitals as either differentiators (1) or not differentiators (0), while the same variables from the first model are maintained. The second model was found to be of an adequate fit with an  $L^2$  of 3.5274 and a p value of 0.74. Two distinct clusters were created, and the model parameters (see Table 20) indicate that all variables (differentiator strategy, CEO origin, succession planning, MSA

population) contribute significantly to the separation of the groups. CEO origin explains about 5% of the separation, differentiator strategy explains around 14% of the difference, succession planning explains around 11.5% of the group differences, while MSA population explains 7.2% of the group separation.

Table 20

PARAMETERS FOR MODEL INDICATORS

	Cluster 1	Cluster 2	Wald	p-value	R <sup>2</sup>
CEO Origin	-.4790	.4790	7.6853	.0056**	.0499
Differentiator	-.9518	.9518	7.8921	.0050**	.1393
CEO Succ Planning	-.8292	.8292	12.409	.00043**	.1154
MSA Population	-.5951	.5951	8.5169	.0035**	.0717

\* Significant at the 0.05 level, \*\* Significant at the 0.01 level

According to the latent class cluster profiles (see Table 21) and probability means (see Table 22), approximately 66% of the hospitals in the sample fall into the first cluster, while 34% fall into the second cluster. Most of the non-differentiator hospitals reside in the first cluster, and the probability of a hospital in Cluster 1 being a non-differentiator is fairly high. Most CEOs of external origin are employed in Cluster 1 hospitals, and the probability of a hospital in this group employing a CEO of external origin is higher than that for a hospital in the second cluster. Most hospitals not engaging in routine succession planning fall into the first cluster, and the probability of a cluster one hospital not routinely practicing succession planning is higher than that for hospitals in the second group. Finally, most rural hospitals fall into this first cluster, and the probability of a hospital in this group being located in a rural MSA is greater than that for second cluster hospitals.

Most differentiator hospitals fall into the second cluster, and the probability of a hospital in this group being classified as a differentiator is higher than the probability of its being classified as a non-differentiator. The majority of internal CEOs are employed with hospitals in this cluster, and the probability of a hospital in this group employing an internal CEO is greater than the probability of employing an external CEO. Most hospitals that routinely participate in succession planning activities are in the second cluster, and the probability of a hospital in this group participating in succession planning is higher than that for hospitals in the first cluster. Most urban hospitals fall into the second cluster, and these hospitals have a higher probability of being located in an urban area than a rural one.

Table 21

PROFILE FOR DIFFERENTIATOR LATENT CLASS CLUSTER MODEL		
	Cluster 1	Cluster 2
Cluster Size	.6633	.3367
CEO Origin		
External	.6410	.4065
Internal	.3590	.5935
Differentiator Status		
Not Differentiator	.5323	.1450
Cost Leader	.4677	.8550
CEO Succession Planning		
Not Routinely Done	.8791	.5807
Routinely Done	.1209	.4193
MSA Size		
Rural (<100,000)	.5726	.2895
Urban (>100,000)	.4274	.7105

Table 22

PROBABILITY MEANS FOR DIFFERENTIATOR LATENT CLASS CLUSTER MODEL		
	Cluster 1	Cluster 2
Cluster Size	.6633	.3367
CEO Origin		
External	.7567	.2433
Internal	.5435	.4565
Differentiator Status		
Not Differentiator	.8790	.1210
Differentiator	.5184	.4816
CEO Succession Planning		
Not Routinely Done	.7491	.2509
Routinely Done	.3617	.6383
MSA Size		
Rural (<100,000)	.7961	.2039
Urban (>100,000)	.5421	.4579

Hospital size, system affiliation, and profit status were incorporated into the model as covariates (see Table 23). These variables were deemed inactive during the analysis and do not influence the profiles or probability means of the groups. However, more information is now available about the types of hospitals falling into the two clusters based on the variables' addition to the model. Hospitals in the first cluster appear to be smaller than those in the second cluster. Further, the larger hospitals in the second cluster are slightly more likely to be system members and for-profit than Cluster 1 hospitals. However, due to missing data the amount we can tell about system membership and profit status is limited.



Table 23

PROFILE FOR DIFFERENTIATOR LATENT CLASS CLUSTER MODEL: COVARIATES			
		Cluster 1	Cluster 2
Hospital Beds			
	Group 1	.2003	.0948
	Group 2	.2040	.1015
	Group 3	.3406	.3175
	Group 4	.1445	.2142
	Group 5	.1105	.2720
System Membership			
	Not a Member	.8980	.8138
	Member	.0284	.0373
	Missing Data	.0736	.1489
Profit Status			
	Not For-Profit	.9111	.8301
	For Profit	.0101	.0173
	Missing Data	.0788	.1526

Based on this information, a description for both groups of hospitals was created (see Table 24).

Table 24

CLUSTER DESCRIPTIONS FOR DIFFERENTIATOR LATENT CLASS CLUSTER MODEL		
	Cluster 1	Cluster 2
<b>CEO Origin</b>	External	Internal
<b>Differentiators</b>	No	Yes
<b>Succession Planning</b>	Not Routine	Routine
<b>MSA Size</b>	Rural	Urban
<b>Hospital Size</b>	Smaller	Larger
<b>System Membership</b>	No	Sometimes
<b>Profit Status</b>	Not-for-Profit	Sometimes

Therefore, the first cluster consists mainly of rural non-differentiators with external CEOs and little succession planning. These hospitals tend to be larger, they are typically not members of a system, and they are not-for-profit. The second cluster of hospitals in this analysis contains urban differentiators with internal CEOs that routinely succession plan. These hospitals tend to be larger, and they are more likely to be both system affiliated and for-profit than hospitals in the first cluster.

*Caught in the Middle.* The third latent class cluster model looks specifically at hospitals that are caught in the middle strategically, CEO origin, succession planning, and MSA population. A dummy variable characterizes hospitals as either caught in the middle (1) or not caught in the middle (0), while the same variables from the first two models are maintained. The model was found to be of an adequate fit with an  $L^2$  of 4.7781 and a p value of 0.57. Two clusters were created, and model parameters (see Table 25) indicate that CEO origin, succession planning, and MSA population contribute significantly to group separation. CEO origin explains 5.4% of the separation, succession planning explains 9.5% of the separation, and MSA population explains 7.6% of group differences.

Table 25

PARAMETERS FOR MODEL INDICATORS					
	Cluster 1	Cluster 2	Wald	p-value	R <sup>2</sup>
CEO Origin	-.4847	.4847	5.9258	.0150*	.0541
Caught in Middle	1.1975	-1.1975	1.8605	.1700	.0676
CEO Succ Planning	-.7573	.7573	7.9381	.0049**	.0953
MSA Population	-.5939	.5939	5.968	.0150*	.0763

\* Significant at the 0.05 level, \*\* Significant at the 0.01 level

The latent class cluster profiles (see Table 26) and probability means (see Table 27) indicate that 62% of the sample is in the first cluster, while 38% of the sample falls into the second cluster. Most hospitals that are strategically caught in the middle fall into the first cluster, and the probability that a hospital in this group is caught in the middle is higher than the probability for the second cluster. Hospitals in this group probably have CEOs of external origin and do not routinely succession plan. The probability of a hospital in this group having an external CEO is higher than the probability of a hospital in the second cluster. Further, the probability that a hospital in the first group does not succession plan is greater than that for hospitals in the second cluster. The bulk of hospitals in rural areas fall into this group, and the probability that a Cluster 1 hospital is located in a rural area is higher than the probability for hospitals in Cluster 2.

The second group consists almost exclusively of hospitals that are not caught in the middle, and the probability that a caught in the middle hospital will fall into the second cluster is less than the probability for the first group. This group has a majority of internally hired CEOs, and the probability that hospitals in the second cluster will employ CEOs of internal origin is slightly higher than the probability for the first cluster. The majority of hospitals that succession plan fall into the second category, and the probability that a hospital in this group routinely succession plans is higher than the probability for the first cluster. Most hospitals located in urban MSAs fall into the second cluster, and the probability that a hospital in this cluster will be urban is slightly higher than that for hospitals in the first cluster.

Table 26

---

**PROFILE FOR CAUGHT IN THE MIDDLE LATENT CLASS  
CLUSTER MODEL**


---

	<b>Cluster 1</b>	<b>Cluster 2</b>
Cluster Size	.6206	.3794
CEO Origin		
External	.6523	.4144
Internal	.3477	.5856
Caught in Middle Status		
Not Caught in Middle	.7917	.9766
Caught in Middle	.2083	.0234
CEO Succession Planning		
Not Routinely Done	.8789	.6147
Routinely Done	.1211	.3853
MSA Size		
Rural (<100,000)	.5851	.3007
Urban (>100,000)	.4149	.6993

---

Table 27

---

**PROBABILITY MEANS FOR CAUGHT IN THE MIDDLE  
LATENT CLASS CLUSTER MODEL**


---

	<b>Cluster 1</b>	<b>Cluster 2</b>
Cluster Size	.6206	.3794
CEO Origin		
External	.7204	.2796
Internal	.4925	.5075
Caught in the Middle Status		
Not Caught in the Middle	.5700	.4300
Caught in the Middle	.9363	.0637
CEO Succession Planning		
Not Routinely Done	.7006	.2994
Routinely Done	.3392	.6608
MSA Size		
Rural (<100,000)	.7612	.2388
Urban (>100,000)	.4923	.5077

---

Additional variables representing hospital size, system membership, and profit status were included in the model as covariates (see Table 28). Although these variables were not active in determining the groups, they do offer descriptive information on the two clusters of hospitals. Hospitals falling into the first cluster are typically smaller than those in the second cluster. Further, they are slightly less likely to be members of a system or have for-profit status than hospitals in the second cluster. However, due to missing data, information on system membership and for-profit status is limited.

Table 28

PROFILE FOR CAUGHT IN THE MIDDLE LATENT CLASS CLUSTER MODEL: COVARIATES			
		Cluster 1	Cluster 2
Hospital Beds			
	Group 1	.1813	.1379
	Group 2	.1868	.1413
	Group 3	.3505	.3038
	Group 4	.1546	.1899
	Group 5	.1268	.2271
System Membership			
	Not a Member	.8898	.8367
	Member	.0278	.0373
	Missing Data	.0824	.1259
Profit Status			
	Not For-Profit	.9028	.8528
	For Profit	.0104	.0160
	Missing Data	.0868	.1312

Based on the analysis presented, a description of the two clusters of hospitals can be created (see Table 29).

Table 29

---

**CLUSTER DESCRIPTIONS FOR CAUGHT IN THE  
MIDDLE LATENT CLASS CLUSTER MODEL**

---

	<b>Cluster 1</b>	<b>Cluster 2</b>
<b>CEO Origin</b>	External	Internal
<b>Caught in the Middle</b>	Yes	No
<b>Succession Planning</b>	Not Routine	Routine
<b>MSA Size</b>	Rural	Urban
<b>Hospital Size</b>	Smaller	Larger
<b>System Membership</b>	No	Sometimes
<b>Profit Status</b>	Not-for-Profit	Sometimes

---

Therefore, the first cluster consists of rural hospitals that are caught in the middle with external CEOs and little succession planning. These hospitals also tend to be smaller, not-for-profit entities that do not belong to a system. The second cluster can be classified as urban hospitals that are not caught in the middle employing internal CEOs and routinely succession plan. These hospitals are larger in size than those in the first cluster, and they are slightly more likely to belong to a system or have for-profit status.

*Composite Model.* The next series of cluster models contains a variable representing all three types of strategic orientation: cost leaders, differentiators, and caught in middle. A nominal variable is included in the analysis which uses each strategic category as an indicator category. The first latent class cluster analysis offers a description of how the variables are organized based on a single cluster. According to the model profile (see Table 30), approximately 56% of the hospitals employ external CEOs, while 44% are of internal origin. Approximately 26% of hospitals are cost leaders, 60% are differentiators, and around 14% are caught in the middle. Only 22% of hospitals

routinely employ succession planning, and the split between urban and rural location is 42% and 48% respectively.

Table 30

PROFILE FOR ALL STRATEGY BASELINE CLUSTER MODEL		
		Cluster 1
CEO Origin		
	External	.5620
	Internal	.4380
Strategy		
	Cost Leader	.2637
	Differentiator	.5981
	Caught in Middle	.1381
CEO Succession Planning		
	Not Routinely Done	.7787
	Routinely Done	.2213
MSA Size		
	Rural (<100,000)	.4772
	Urban (>100,000)	.5228

Next, the three variables of interest (strategy, CEO origin, and succession planning) were split into two clusters. The model parameters (see Table 31) indicate that both CEO origin and succession planning significantly contribute to differences between the two clusters. CEO origin explains approximately 8% of the differences while succession planning accounts for around 9% of variance.

Table 31

PARAMETERS FOR MODEL INDICATORS						
		Cluster 1	Cluster 2	Wald	p-value	R <sup>2</sup>
CEO Origin						
	External	.2951	-.2951	7.3290	.0068**	.0801
	Internal	-.2951	.2951			
Strategy						
	Cost Leader	.1121	-.1121	5.0842	.0790	.0826
	Differentiator	-.5873	.5873			
	Caught in Middle	.4752	-.4752			
CEO Succ Planning						
	Not Routinely Done	.3728	-.3728	7.1511	.0075**	.0900
	Routinely Done	-.3728	.3728			

\* Significant at the 0.05 level, \*\* Significant at the 0.01 level

The latent class cluster profiles (see Table 32) and probability means (see Table 33) indicate that approximately 58% of our hospitals are included in the first cluster while 42% are in the second cluster. Most CEOs of external origin are employed with hospitals in the first cluster, and hospitals in this group have a higher probability of employing external CEOs than hospitals in the second cluster. Most cost leaders or caught in the middle hospitals fall into this cluster, and a higher probability exists that hospitals in the first group will be either cost leaders or caught in the middle than those in the second group. Most hospitals in the first cluster do not routinely succession plan, and a higher probability exists that hospitals in the first cluster will not succession plan than those in the second cluster.



Most differentiator hospitals fall into the second cluster, and hospitals in this group have a higher likelihood of being differentiators than hospitals in the first group. Most hospital CEOs of internal origin are employed with hospitals in the second cluster, and these hospitals have a greater probability of employing an internal CEO than hospitals in the first cluster. Most hospitals that routinely succession plan fall into the second cluster, and a higher probability exists that hospitals in the second cluster will succession plan than hospitals in the first group.

Table 32

**PROFILE FOR 2 CLUSTER MODEL:  
ALL STRATEGY, CEO ORIGIN, CEO SUCCESSION PLANNING**

		<b>Cluster 1</b>	<b>Cluster 2</b>
Cluster Size		.5844	.4156
CEO Origin			
	External	.6805	.3955
	Internal	.3195	.6045
Strategy			
	Cost Leader	.3436	.1514
	Differentiator	.4511	.8049
	Caught in Middle	.2053	.0438
CEO Succession Planning			
	Not Routinely Done	.8837	.6310
	Routinely Done	.1163	.3690

Table 33

---

PROBABILITY MEANS FOR 2 CLUSTER MODEL:  
ALL STRATEGY, CEO ORIGIN, CEO SUCCESSION PLANNING

---

	Cluster 1	Cluster 2
Cluster Size	.5844	.4156
CEO Origin		
External	.7077	.2923
Internal	.4261	.5739
Strategy		
Cost Leader	.7617	.2383
Differentiator	.4405	.5595
Caught in Middle	.8689	.1311
CEO Succession Planning		
Not Routinely Done	.6633	.3367
Routinely Done	.3067	.6933

---

Additional covariates were added into the model to give us more information about the hospital clusters. Although none of the profile data changes on our variables of interest, information on hospital size, location, system affiliation, and for-profit/not-for-profit status is obtained (see Table 34). Hospitals in the first cluster are typically smaller than those in the second group. Further, these hospitals are a little bit less likely to be affiliated with a system and to be for-profit entities. This cluster has hospitals that are more likely to be located in rural areas. Cluster 2 hospitals are typically larger than the hospitals in the first group. They are also slightly more likely to be system members and have for-profit status. However, missing data limits the conclusions we can draw about these two variables. Hospitals in the second group are more likely to be located in an urban area.

Table 34

PROFILE FOR 2 CLUSTER MODEL: COVARIATES			
		Cluster 1	Cluster 2
Hospital Beds			
	1 – 32	.2348	.1534
	33-71	.2387	.1440
	72-115	.2020	.1957
	116-186	.1841	.2246
	187-292	.1404	.2823
System Membership			
	Not a Member	.8957	.8331
	Member	.0281	.0360
	Missing Data	.0762	.1309
Profit Status			
	Not For-Profit	.9076	.8504
	For Profit	.0110	.0147
	Missing Data	.0814	.1348
MSA Population			
	Rural (<100,000)	.5060	.4368
	Urban(>100,000)	.4940	.5632

The clusters generated by the analysis are described in Table 35.

Table 35

**CLUSTER DESCRIPTIONS FOR 2 CLUSTER MODEL:  
ALL STRATEGY, CEO ORIGIN, CEO SUCCESSION  
PLANNING**

	<b>Cluster 1</b>	<b>Cluster 2</b>
<b>CEO Origin</b>	External	Internal
<b>Strategic Orientation</b>	Cost Leader Caught in the Middle	Differentiator
<b>Succession Planning</b>	Not Routine	Routine
<b>MSA Size</b>	Rural	Urban
<b>Hospital Size</b>	Smaller	Larger
<b>System Membership</b>	No	Sometimes
<b>Profit Status</b>	Not-for-Profit	Sometimes

Cluster 1 largely consists of cost leader and caught in the middle hospitals that employ external CEOs and do not routinely succession plan. These hospitals are smaller and located in rural MSAs. Hospitals in the first cluster are less likely to be system members or for-profit entities than those in the second cluster. Cluster 2 consists of differentiator hospitals that employ CEOs of internal origin and routinely succession plan. These facilities are larger than hospitals in the first cluster and are more likely to be located in urban areas. Hospitals in this cluster are more likely to belong to a system and to have for-profit status.

### *Discrete Factor Model*

In the next phase of the study, Latent Gold 4.0 is used to create a discrete factor model with three levels using CEO origin, hospital strategic orientation, and succession planning as indicator variables. The number of hospital beds, system affiliation, for-profit status, and MSA size are used as covariates in the model. The data does not provide enough degrees of freedom to allow for analysis beyond 3 groups in the latent class cluster modeling. However, the D-factor model allows evaluation of the sample hospitals based on 3 discrete factors or levels, and provides information on the way the groups are differentiated.

The D-factor profile (see Table 36) indicates that approximately 41% of hospitals fall into the first level, 31% are in the second level, and around 28% are in the third level. The majority of hospitals that fall into the first level employ CEOs of external origin. A hospital in this level is more likely to be a cost leader or caught in the middle than hospitals in any other level. Very few of the hospitals in the first level employ any kind of succession planning, and the hospitals in this group are typically smaller than the other hospitals in the sample. These hospitals are unlikely to belong to a system or to have for-profit status. Finally, these facilities are slightly more likely to be located in rural areas rather than in urban areas.

Hospitals falling into the second level are no more likely to fall into any strategic category than hospitals in any of the other two levels. Further, they are slightly more likely to employ CEOs of external origin, but this is a fairly close split. Most of the Level 2 hospitals do not routinely succession plan, and these hospitals are moderately sized compared to hospitals in the other levels. Level 2 hospitals probably are not for-

profit and probably do not belong to a system. These hospitals are more likely to be urban than rural, but again, the split is fairly close.

The third level provided by the analysis consists largely of differentiator hospitals that employ CEOs of internal origin. These facilities are the most likely to employ succession planning of hospitals in any level. The largest hospitals fall into this level, and these facilities are the most likely to belong to health systems and be for-profit entities. However, due to missing data, it is difficult to draw any real conclusions about system membership and for-profit status. Finally, these hospitals are typically located in urban areas.

Table 36

PROFILE FOR D-FACTOR MODEL				
		Level 1	Level 2	Level 3
DFactor Level Size		.4118	.3086	.2796
<b>Indicators</b>				
CEO Origin				
	External	.7087	.5429	.3670
	Internal	.2913	.4571	.6330
Strategy				
	Cost Leader	.3621	.2486	.1355
	Differentiator	.4036	.6488	.8287
	Caught in Middle	.2343	.1026	.0357
Succession Planning				
	Not Routinely Done	.9008	.7842	.5926
	Routinely Done	.0992	.2158	.4074
<b>Covariates</b>				
Hospital Beds				
	1 – 32	.2432	.1947	.1455
	33 – 71	.2505	.1882	.1364
	72 – 115	.2012	.2033	.1923
	116 – 186	.1791	.2054	.2282
	187 – 292	.1260	.2083	.2976
	Mean	120.89	151.03	180.34
System Membership				
	Not a Member	.9021	.8653	.8267
	Member	.0277	.0314	.0369
	Missing Data	.0702	.1032	.1364
Profit Status				
	Not For-Profit	.9137	.8793	.8448
	For-Profit	.0107	.0127	.0151
	Missing Data	.0755	.1080	.1402
MSA Population				
	Rural	.5199	.4747	.4290
	Urban	.4881	.5253	.5710

The levels generated by the D-factor model are described in Table 37.

Table 37

**DESCRIPTIONS FOR 3 FACTOR MODEL:  
ALL STRATEGY, CEO ORIGIN, CEO SUCCESSION  
PLANNING**

	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
<b>CEO Origin</b>	External	Mixed	Internal
<b>Strategic Orientation</b>	Cost Leader/ CIM	Mixed	Diff
<b>Succession Planning</b>	Not Routine	Mixed	Routine
<b>MSA Size</b>	Rural	Mixed	Urban
<b>Hospital Size</b>	Small	Medium	Large
<b>System Membership</b>	No	No	Maybe
<b>Profit Status</b>	NFP	NFP	Maybe FP

Level 1 includes hospitals that employ CEOs of external origin and are not likely to participate in succession planning. These hospitals are either cost leaders or caught in the middle, and they are typically small in size and found in rural areas. Hospitals falling into the second level are of mixed strategy, employ insider and outsider CEOs, and do not routinely succession plan. They are of medium size and are located in both urban and rural metropolitan statistical areas. Hospitals in either of the first two levels probably do not belong to a system and are probably not-for-profit. In contrast, hospitals in the third level employ CEOs of internal origin and do routinely employ succession planning. They are probably differentiator hospitals that are large in size and located in urban areas.

Level 3 hospitals are slightly more likely to belong to a system and have for-profit status than hospitals in the other levels. However, due to missing data it is difficult to conclude a significant difference in behaviors. Based on the discrete factor analysis, some support



for hypothesis five is offered. This hypothesis suggests that CEO origin and succession planning behaviors vary with hospital strategic orientation.

### *Logistic Regression*

In the third phase of analysis, two binary logistic regressions were performed with CEO origin and CEO succession planning as respective dependent variables. In the first regression analysis, the influence of both hospital strategic orientation and succession planning practices on CEO origin is assessed controlling for hospital size, MSA population, system membership, and ownership status. In the next analysis, the influence of hospital strategic orientation on executive succession planning practices is assessed with the same control variables.

All of the independent variables are nominal with the exception of hospital size. Therefore, a crosstabulation analysis was performed (see Table 38) to gauge the independence of the variables. The Chi-Squares obtained indicate that several of the variables of interest are significantly related. However, this study hypothesizes significant relationships between these variables, so the associations are expected. All of the control variables are independent with the exception of MSA population. The location of a hospital does appear to have some relationship with succession planning, for-profit status, and the strategic categories representing differentiators and caught in the middle hospitals. Theoretically, this makes sense, so the variable will remain in the analysis.

Table 38

CHI SQUARE STATISTICS FOR INDEPENDENT VARIABLES						
	SP	SM	CL	Dif	CIM	FP
Succession Planning						
System Member	2.358 (.125)					
Cost Leader	4.56 (.033)*	.011 (.915)				
Differentiator	8.984 (.003)**	.090 (.764)	357.6 (.000)**			
Caught in Middle	2.318 (.128)	.310 (.578)	39.63 (.000)**	154.27 (.000)**		
For Profit	.066 (.798)	1.9 (1.68)	1.097 (.295)	1.199 (.274)	.036 (.850)	
Urban/Rural	6.46 (.011)*	1.251 (.263)	1.66 (1.97)	8.175 (.004)**	5.817 (.016)*	4.562 (.033)*

The first regression analyzes the influence that hospital strategic orientation and CEO succession planning have on CEO origin while controlling for hospital size, system membership status, ownership, and MSA population density. A chi square goodness of fit estimate produced an insignificant value of 9.961 ( $p=.191$ ), suggesting that the addition of the independent variables into the model does not significantly improve its explanatory power. However, the Hosmer and Lemeshow test produced a chi square of 4.109 ( $p=.847$ ), indicating the model is an adequate fit for the data. The Cox & Snell R square and Nagelkerke R square values produced were .017 and .023 respectively, suggesting that between 1.7 and 2.3% of the variance in CEO succession planning is explained by the independent variables.

This analysis provides no support for the first three hypotheses (see Table 39). The first hypothesis suggests that cost leadership is significantly related to internal CEO

origin, while differentiator status is related to external origin. Neither variable representing strategic orientation is significant. However, the variable representing differentiators in the equation approaches significance with a p value of .055 in the direction opposite of what was hypothesized. According to the results, a hospital's differentiator status actually appears to increase its odds of employing an internal CEO. The third hypothesis predicts that those hospitals that routinely employ succession planning are more likely to have a CEO of internal origin. No significant relationship is observed between these two variables.

Table 39

COEFFICIENT ESTIMATES FOR MODEL						
	B	S.E.	Wald	df	Sig.	Exp (B)
System Membership	.686	.471	2.124	1	.145	1.985
Hospital Size	.000	.001	.023	1	.878	1.000
Cost Leader	.315	.280	1.266	1	.261	1.371
Differentiator	.509	.265	3.679	1	.055	1.663
Succession Planning	.265	.208	1.627	1	.202	1.304
Ownership	.132	.726	.033	1	.856	1.141
MSA Population	.096	.175	.306	1	.580	1.101
Constant	-.806	.249	10.499	1	.001	.446

The next regression equation evaluates the influence of hospital strategic orientation on CEO succession planning while controlling for hospital size, membership status, ownership, and MSA population density. Both a chi square goodness of fit estimate and the Hosmer and Lemeshow test were produced in this analysis. The chi square of 15.5 was significant ( $p = .02$ ) indicating that the predictive capabilities of the model do significantly improve with the addition of the independent variables. Further,

the Hosmer and Lemeshow test produced a chi square of 5.742 with a p-value of .676. This indicates that the model probably provides an adequate fit for the data. A Cox & Snell R square value of 0.026 and a Nagelkerke R square value of .04 were also produced by the analysis. This can loosely be interpreted as an indication that between 2.6 and 4% of the variance in the odds of routinely practicing succession planning is explained by the independent variables.

This analysis provides no support for the fourth hypothesis which suggests that cost leader organizations are more likely to participate in succession planning than hospitals belonging to either the differentiator or caught in the middle groups (see Table 40). In fact, none of the independent variables in the equation exert any significant influence on the degree of succession planning performed by a hospital. However, the population density variable approaches significance at the .05 level, suggesting that the denser the population of the hospital's MSA, the more likely the facility might be to participate in succession planning.

Table 40

COEFFICIENT ESTIMATES FOR MODEL						
	B	S.E.	Wald	df	Sig.	Exp (B)
System Membership	.693	.489	2.006	1	.157	1.999
Hospital Size	.001	.001	.800	1	.371	1.001
Cost Leader	-.014	.363	.001	1	.969	.986
Differentiator	.468	.331	1.998	1	.157	1.597
Ownership	-.084	.833	.010	1	.919	.919
MSA Population	.403	.212	3.625	1	.057	1.496
Constant	-1.932	.316	37.279	1	.000	.145

Based on the logistic regression results, none of the hypothesized relationships are supported. Further, the control variables appear to have no effect on either CEO origin or succession planning behavior in acute care hospitals.

## CHAPTER 5

### SUMMARY AND CONCLUSIONS

#### Introduction

The purpose of this study was to explore the relationship between executive selection practices and organizational strategy in a healthcare context. By analyzing the relationships between CEO origin, succession planning, and organizational strategic orientation, a theoretical framework was tested that allows researchers and practitioners to better understand the way these variables interact. Other considerations such as hospital size, system membership, profit status and MSA population were included in the analyses to find out how sizable of a role these variables play in the executive selection behaviors of acute care hospitals. Further, cluster analysis including these covariates provides a better understanding of the attributes of hospitals participating in particular executive selection behaviors. Because very little research has been done on CEO succession in a health care context, this study sheds light on the way health care facilities behave compared to other types of organizations in matters of executive selection and provides valuable information for boards of directors and others making decisions regarding the CEO selection process.

#### Conclusions and Implications

The first two hypotheses set out to answer the question, “Does the origin of an organization’s CEO vary based on strategic orientation?” Based on existent theory and

research outside the healthcare industry, it was hypothesized that more CEOs of internal origin would be employed with cost leader hospitals than differentiator or caught in the middle hospitals, while more CEOs of external origin would be hired by differentiator hospitals than hospitals of another strategic group. In fact, this study finds the opposite to be true for cost leaders, but supports the relationship between differentiator hospitals and external CEOs. The composite loglinear model shows a significant relationship between strategy and CEO origin, with cost leaders actually employing fewer CEOs of internal origin than hospitals of other strategic orientations demonstrating a significant finding in the opposite direction of the first hypothesis. Support for the second hypothesis indicates that more external CEOs are hired by differentiator hospitals, and the significance of this relationship is shown in the loglinear model results. However, both the latent class cluster analyses and discrete factor analysis find a higher concentration of internal CEOs in groups containing differentiator hospitals and a higher concentration of external CEOs in groups containing cost leader hospitals. Further, the logistic regression performed using CEO origin as a dependent variable shows no significant relationship between origin and strategy. The regression results show that the relationship between differentiator hospitals and origin approach significance, but again, in the opposite direction of that hypothesized.

These findings indicate the relationship between CEO origin and strategic orientation is different in the health care industry than in other types of non-service industries. Past research in the manufacturing industry suggests that cost leader organizations are more likely to hire internal CEOs, while differentiator organizations are more likely to hire external CEOs. These findings are theoretically supported by both the

resource-based view of the firm and the upper echelons theory. In theory, cost leader organizations are more internally focused organizations that maintain a stable line of product offerings. Maximizing the efficiency of existing operations is the goal of such organizations; therefore, to avoid the disruption of hiring a CEO or executive from outside the organization cost leaders are expected to hire insider or internal CEOs. In contrast, differentiator organizations are more likely to change product or service offerings and require new skills from upper managers that are not available internally. Differentiator firms will be more likely to hire external CEOs because such organizations need to recruit from a wider pool of managerial talent.

Although this study finds support for the relationship between differentiator firms and CEOs of external origin, it also finds that cost leader organizations are less likely to hire CEOs of internal origin than hospitals of other strategic orientations. One possible explanation for this finding is that cost leader hospitals are typically smaller facilities with more limited service offerings. Potential executives might be forced to seek advancement outside of the organization in order to further their careers, limiting the pool of internally available talent. Therefore, such hospitals are forced to hire an executive from outside the organization to obtain a leader with the skills and abilities desired. In contrast, differentiator hospitals might be able to cross-train internal candidates in a wide variety of fields. These hospitals tend to be larger with more service offerings. Therefore, more middle-management opportunities probably exist for potential executives. Rather than being forced to leave the organization to make an upward move on the organizational chart, these individuals can take advantage of leadership positions available in many different service lines and associated ancillary areas.



The second question in this study proposes a potential relationship between succession planning activities and CEO origin. Hypothesis 3 suggests that more CEOs of internal origin will be employed by organizations that participate in formal succession planning than by those hospitals that do not participate in those activities. The loglinear analysis offered no support for this hypothesis, and this finding was supported by the logistic regression results. However, both the latent class cluster models and the d-factor model found that more hospitals employing CEOs of internal origin were present in groups that have high concentrations of succession planners than in groups with fewer succession planning facilities. Therefore, organizations participating in formal succession planning appear to also employ internal candidates.

Theoretically, the findings of the cluster and factor analyses for the third hypothesis make more sense than those of the loglinear and logistic models. One reason why organizations participate in succession planning activities is to try and reduce the disruption associated with a CEO turnover event. The identification and grooming of an internal candidate serves to further reduce any turnover related turbulence. One possible explanation for the conflicting findings is the fit of the models. The cluster analyses and factor analysis probably provide a better fit for the data. These models suggest that larger organizations in urban areas are likely to participate in succession planning activities and hire internal candidates, which is a logical finding. While the cluster and factor analyses demonstrate that internal CEOs and hospitals that employ succession planning group together, more research is required to evaluate exactly how these two variables relate to one another.

The third question addressed by this analysis concerns whether or not an organization's participation in CEO succession planning varies with organizational strategy. The fourth hypothesis suggests that cost leader hospitals are more likely to participate in succession planning activities than differentiators and hospitals that are caught in the middle. No support for this hypothesis was provided. In fact, the loglinear analyses, latent class cluster analyses and the d-factor model produced significant results suggesting that the opposite is the case. Differentiator hospitals are grouped with hospitals that participate in succession planning suggesting that differentiators are more likely to succession plan than hospitals of other strategic orientations.

To maximize organizational performance, firms seek to align managerial capabilities and experience with organizational strategy. Since cost leaders are seeking different types of leaders than differentiators, it is logical that these firms will go about selecting executives in a different way than differentiators. Cost leader organizations are those focused on the efficiency and effectiveness of existing operations. In contrast, differentiator organizations are externally focused facilities that frequently expand service/product offerings. In an effort to reduce the disruption of existing operations, it is logical to propose that cost leader hospitals will participate in succession planning activities to smooth the turnover of executive leadership more often than differentiator hospitals. Theoretical support for this notion is offered by both the resource-based view of the firm and the upper echelons perspective. However, this study finds that differentiator hospitals are more likely to employ succession planning than cost leaders. This can possibly be explained by the other characteristics associated with differentiator hospitals. These hospitals are typically bigger, and based on the limited knowledge

available; they are more likely to be members of a system. It is possible that these differentiator facilities have more resources available for succession planning activities. Further, they probably have a larger pool of management talent to pull from when developing a succession plan. Cost leaders are smaller hospitals that probably have fewer managers and administrators. These hospitals might be hard pressed to find excess time, money, and human resources to invest in succession planning.

The final research question addressed in this study concerns the relationship between strategic orientation, CEO origin, and succession planning. The fifth hypothesis suggests that CEO origin and participation in succession planning will vary based on hospital strategic orientation. Although no relationship was detected in the crosstabulation and loglinear analyses, support for this hypothesis is evident in the latent class cluster models and the d-factor model. Aside from the significance of the models, an obvious pattern exists when looking at the clusters these hospitals form. Cost leader hospitals are consistent with CEOs of external origin and hospitals with few succession planning activities in all analyses. Further, differentiators are categorized with CEOs of internal origin and hospitals that succession plan in the analyses. Caught in the middle hospitals, as expected, exhibit no pattern. Therefore, some relationship between these three variables probably exists. Again, a possible explanation for the conflicting results obtained is the fit of the model. Because the latent cluster models and discrete factor analysis produced more logical results, it is likely that these analytical techniques fit the data better.

Both practice and theory are affected by the implications of these findings. First, it appears that health care organizations do not behave in a manner consistent with

manufacturing organizations. Health care organizations engage in less succession planning than other organizations. Further, based on the strategic management literature, we expected certain relationships pertaining to organizational strategy and executive selection behavior to be observed. Results indicate that acute care hospitals behave in a different way than manufacturing firms. Because little research has been done in service organizations, it is difficult to tell if this contrary behavior is specific to health care organizations or to all service companies.

One possible explanation for these surprising findings is the overwhelming number of not-for-profit hospitals in the sample. Most of the research performed in the manufacturing sector focuses on for-profit, publicly traded organizations. Such organizations have easier access to capital than not-for-profit organizations such as hospitals, granting them greater flexibility to devote resources to activities such as succession planning. While hospitals have some access to capital through the bond market, for-profit organizations can quickly obtain cash through issuing more stock. Hospitals have limited resources including cash and full time equivalent employees; therefore, ancillary activities such as succession planning are probably not a priority when compared to the replacement of capital equipment and the provision of patient care. Additional research is needed to explore this issue. These findings indicate that conventional strategic management research might not always be generalizable to a health care context.

Secondly, a relationship between succession planning and organizational strategy was tested for the first time in this research. Although the results were contrary to our expectations, a relationship does appear to exist. Several of the findings ascertained in

this study were unexpected. However, an association exists between the three variables representing CEO succession planning, CEO origin, and organizational strategic orientation. Prior to this study, no test of this theoretical framework had been completed in any context. This work extends both the strategic management literature and the health care management research.

The study presented in this dissertation offers practical as well as theoretical implications. Results offered in this analysis are valuable to health care executives and board directors for acute care hospitals because they quantify the lack of planning for CEO turnover events that exists in the hospital industry. Further, it appears that although there is some variation in executive selection behaviors, hospitals of different strategic orientations do not behave as expected. When executive selection practices are not aligned with organizational strategy, executives can be chosen that are not well suited to achieve the goals of the hospital. Since the strategic management literature indicates that such planning and alignment is beneficial to organizations both operationally and financially, this is an area that needs consideration by current leaders in the health care industry.

This study also contributes to the health care management body of research on CEO succession behavior. Scant research exists on executive selection in the literature, and virtually no work has attempted to relate this topic to organizational strategic orientation. This analysis provides a baseline from which future health services researchers can begin working in this field. Because a shortage of healthcare executives looms on the horizon, the concepts of succession planning and CEO origin need further

exploration to ensure that hospitals and other organizations are adequately prepared to deal with the pending labor crisis.

### Limitations of the Study

Several limitations to this study exist, but the primary issues relate to the measurement of hospital strategic orientation and the utilization of CEO respondents regarding executive succession planning processes. Hospital strategic orientation was extrapolated based on techniques used in existent research and the availability of secondary data. Although these measures probably do an adequate job of capturing the strategy a facility is actually following, the spirit of the strategy decision, or the intended strategy, may not be captured by these measurements. It is unknown whether the respondent would actually consider his/her organization's strategic direction the same as the categories created in this analysis.

A secondary issue relates to a potential bias created by the heavy presence of CEO respondents versus board chairs. Approximately 90% of the respondents to the executive selection survey are hospital CEOs or CEO equivalents. Although we assume these individuals are responsible for making decisions regarding executive selection in their institutions, the role that the Board of Directors plays in this activity needs to be better ascertained in future research.

System membership is also a limitation of this study as it relates to the internal versus external origin of a CEO. This analysis was done at the hospital level, so all executives hired from outside the organization are considered to be external hires. This distinction is made regardless of whether or not the outside organization is a member of a

health care system. Further, the sample does not have very many system-affiliated organizations, and there is a fair amount of missing data on this variable. These results may not be generalizable to a hospitals in a system. Further, organizations pursuing a focus strategy were excluded from the sample, so results may not be generalizable to this population either.

Finally, as with all studies using self-reported data, accuracy is questionable. Both the American Hospital Association data and the survey data is self-reported by organizational leadership. However, surveying executives and board chairs is probably the best way currently available to assess executive selection practices in hospital organizations.

#### Recommendations for Future Research

As this study only begins to answer questions regarding executive selection practices in health care organizations, many other opportunities for future research exist. In the area of succession planning, several questions remain unanswered. First of all, the role that the board of directors typically plays in the succession planning process remains unknown. A survey of board members or board chairs might shed some light on exactly how executive selection decisions are made in acute care hospitals in the United States. Further, how board members work in concert with existing hospital executives to plan for future leadership changes can be explored. A parallel survey of board members and executives can identify any knowledge deficits on behalf of either group and any activities that the board might be undertaking to which the executive team is not privy.

Secondly, the circumstances surrounding succession planning in hospitals needs to be explored. Reasons why a hospital is performing succession planning need to be explored. Some hospitals might have been participating in succession planning because they anticipated a CEO turnover event in the near future. Some facilities might continually engage in this behavior for all levels of the organization. More details on this rationale need to be analyzed. Because this study only examines a snapshot in time, a follow-up study should be conducted to see if those hospitals currently participating in succession planning continue the behavior. Also, it can determine if any other hospitals have adopted such behavior in the past 5 years, and if so, why they chose to begin succession planning activities. Additional research needs to explore differences in succession planning practices between free-standing acute care hospitals and those hospitals belonging to a health system. This study was limited due to a low number of respondent hospitals belonging to some type of system. A special effort to communicate with these facilities needs to be employed.

Opportunity also exists in the health care industry to explore the relationship between executive succession planning and organizational performance. In the strategic management literature, several studies in the manufacturing sector suggest that organizational performance is higher in organizations that practice succession planning. In the health care industry, the relationship between succession planning and organizational performance needs to be evaluated. Studies in the manufacturing sector typically quantify organizational performance as stock price or another financial indicator. In the health care industry, the relationship between succession planning



behavior can be related to various performance indicators including financial performance, employee satisfaction, patient satisfaction, and quality indicators.

Finally, strategic management researchers have done significant research attempting to link the alignment of managerial capabilities and experience to organizational strategy in an effort to relate such alignment to organizational performance. Research in a health care context can tell industry leaders and academics alike how important strategy is in health care organizations in contributing to the operational and financial viability of a facility. Establishing the presence or absence of this type of relationship can help health care leaders make tough decisions regarding the dedication of valuable time and financial resources to executive selection activities.

### Summary

Health care managers and researchers need to educate themselves on the pros and cons of succession planning and other aspects of the executive selection process. With an impending shortage of upper level management talent in the health care industry, fierce battles will be waged to attract and retain capable executives. A scarcity of research on executive selection in the health care management literature limits the amount that researchers and practitioners know regarding the behavior of health care organizations in these situations. In extending the strategic management literature, this study attempted to garner a little more knowledge about the way acute care hospitals in the United States go about making hiring decisions for upper management positions. Although there is much left to learn, this study can serve as a starting point that challenges health services

researchers to empower industry practitioners with the knowledge necessary to make educated decisions.

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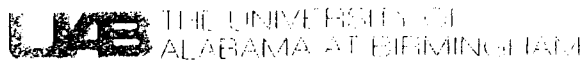
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Right to Life, Right to Health

Form 4: IRB Approval Form  
Identification and Certification of Research  
Projects Involving Human Subjects

UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56 and ICH GCP Guidelines. The Assurance became effective on November 24, 2003 and expires on February 14, 2009. The Assurance number is FWA00005960.

Principal Investigator: YARBROUGH, AMY

Co-Investigator(s):

Protocol Number: X060222003

Protocol Title: *CEO Origin and Succession Planning in Acute Care Hospitals*

The IRB reviewed and approved the above named project on 03-28-06. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received EXPEDITED review.

IRB Approval Date: 3-28-06

Date IRB Approval Issued: 03-28-06

Marilyn Doss, M.A.  
Vice Chair of the Institutional Review  
Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.

170 Administration Building  
701 20th Street South  
205 934 3789  
Fax 205 934 1301  
irb@uab.edu

The University of  
Alabama at Birmingham  
Mailing Address  
Box 470  
1530 3RD AVE S  
BIRMINGHAM AL 35294-0104

**CEO Version:**  
**CEO Succession Survey**



UNIVERSITY OF ILLINOIS  
 MEDICAL CENTER



25th Anniversary

Succession research (CEO) - 1

ID: \_\_\_\_\_

**Background**

1. How long have you been in the CEO position in this organization? \_\_\_\_\_
  2. About how long was your predecessor in the CEO position at this organization? \_\_\_\_\_
  3. Were you hired (check one): ☐ internally (from within the organization), or ☐ externally?
- IF INTERNALLY: Were you identified as the successor in advance of your taking the position?
- ☐ Yes → IF YES: how long before you took the position? \_\_\_\_\_
- ☐ No → IF NO: Have you ever been involved with succession planning before?
- ☐ Yes ☐ No

**Succession Practices**

4. Has a *specific* successor(s) for your position been identified? ☐ No ☐ Yes
- IF NO: What are the key barriers to identifying a successor? (Check all that apply):
- ☐ I'm too new to the CEO position.
  - ☐ It's not a part of our "culture."
  - ☐ It's not a high priority right now.
  - ☐ I do not view succession planning as useful
  - ☐ There are *no* internal candidates who we could prepare
  - ☐ There are *several* internal candidates who could succeed me; therefore succession planning would be very difficult politically
  - ☐ I have not been offered a retirement/transition package
  - ☐ Others? \_\_\_\_\_
- ...SKIP TO QUESTION 5, next page
- IF YES:
- a. Who was involved in making the succession decision?
    - ☐ Myself alone
    - ☐ Myself in collaboration with
      - ☐ The board chair
      - ☐ Board Executive committee
      - ☐ External consultation
      - ☐ Executive search consultant
      - ☐ Industrial psychologist
      - ☐ Other? \_\_\_\_\_
    - ☐ Other board members
    - ☐ Other hospital executives

(CONTINUES)

## Succession Practices (cont'd)

- b. How was this successor chosen?
- ☐ Informally (e.g., internal discussion)
  - ☐ Formally, using (check all that apply)
    - ☐ Peer nomination
    - ☐ Structured interviews
    - ☐ Assessment tests and/or an assessment center
    - ☐ Other: \_\_\_\_\_
- c. Who were considered as potential successors?
- ☐ Internal candidates only
  - ☐ External candidates only
  - ☐ Both Internal *and* external candidates
- d. What kinds of developmental activities will the successor be involved in?  
(Check all that apply):
- ☐ Mentoring (e.g., regular 1:1 meetings with the current CEO for this explicit purpose)
  - ☐ Coaching from an external consultant
  - ☐ Structured "socialization" (e.g., meeting with key stakeholders to develop these relationships)
  - ☐ 360-degree feedback
  - ☐ Developmental ("stretch") assignments
  - ☐ Job rotation
  - ☐ Other? \_\_\_\_\_
- e. About how long will the succession process take in total, from inception to transition? \_\_\_\_\_
5. To what extent is succession planning routinely (i.e., on-going process) done at your organization?
- ☐ Not routinely done → *SKIP TO QUESTION 7, page 3*
  - ☐ Routinely done for
    - ☐ CEO position only
    - ☐ Top-level leadership only (e.g., CEO, COO, EVP only)
    - ☐ Top and mid-level leadership only (includes above plus vice president)
    - ☐ Most or all levels of leadership (includes above plus department heads)
- IF ROUTINELY DONE: Is succession planning formally evaluated?
- ☐ No
  - ☐ Yes → IF YES: How is it evaluated? (Check all that apply)
    - ☐ Incumbents are appraised on how well they identify/prepare successors
    - ☐ Statistics are kept on the success of transitions
    - ☐ Costs / benefits of succession programs are estimated
    - ☐ Other: \_\_\_\_\_

(CONTINUES)

<p>6. The last time succession planning was done, to what extent was ethnic diversity a factor in assembling...</p> <p>a. the <i>long list</i> of potential candidates? <i>(Skip to 'b.' if no long list was used)</i></p> <div style="margin-left: 100px;"> <input type="checkbox"/> Diversity was considered mandatory.  <input type="checkbox"/> It was viewed as very important, but not mandatory.  <input type="checkbox"/> It was somewhat important  <input type="checkbox"/> It was not considered important.         </div> <p>b. the <i>short list</i>?</p> <div style="margin-left: 100px;"> <input type="checkbox"/> Diversity was considered mandatory.  <input type="checkbox"/> It was viewed as very important, but not mandatory.  <input type="checkbox"/> It was somewhat important  <input type="checkbox"/> It was not considered important.         </div> <p>7. Overall, how effective do you believe your organization's practices are for <u>identifying</u> and <u>preparing</u> successors for the CEO position? (Check one box in each row):</p> <div style="display: flex; justify-content: space-around; margin-bottom: 5px;"> <span>Very Ineffective</span> <span>Very Effective</span> </div> <div style="display: flex; align-items: center;"> <div style="width: 30%;">a. Identifying appropriate successors</div> <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 10px;"></div> </div> <div style="display: flex; align-items: center;"> <div style="width: 30%;">b. Preparing successors for the role</div> <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 10px;"></div> </div>	
<b>Organization Background</b>	
<p>8. Net revenue of your hospital in the most recently completed fiscal year \$ _____</p> <p>9. # of staffed beds _____</p> <p>10. Corporate structure:    <input type="checkbox"/> Local government                                             <input type="checkbox"/> State government                                             <input type="checkbox"/> Private / not-for-profit                                             <input type="checkbox"/> Private for-profit                                             <input type="checkbox"/> Other (please specify): _____</p> <p>11. Type / Setting (check all that apply):    <input type="checkbox"/> Academic/Teaching    <input type="checkbox"/> Rural           <input type="checkbox"/> Community                <input type="checkbox"/> Urban           <input type="checkbox"/> Religious affiliated    <input type="checkbox"/> Suburban           <input type="checkbox"/> Member of a system</p> <p style="text-align: right; margin-top: 20px;">(CONTINUES)</p>	

Your Demographics	
12. Year of birth: _____	
13. Gender (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female	
14. What is your educational background? (Check all that apply)	
<input type="checkbox"/> BA/BS	<input type="checkbox"/> MHA
<input type="checkbox"/> PhD/DrPH	<input type="checkbox"/> MD
<input type="checkbox"/> MBA	<input type="checkbox"/> MPH
<input type="checkbox"/> DO	<input type="checkbox"/> Other: _____
15. (Optional) Which of the following best describes your race/ethnicity:	
<input type="checkbox"/> White / Caucasian	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Black / African-American	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> American Indian, Eskimo or Aleut	<input type="checkbox"/> Other: _____
16. Are you an affiliate of ACHE? <input type="checkbox"/> No	
<input type="checkbox"/> Yes: I am a... <input type="checkbox"/> Member <input type="checkbox"/> Diplomate <input type="checkbox"/> Fellow	

ACHE's Role (optional)																
17. What can / should ACHE be doing to assist hospitals such as yours, and CEOs like yourself, in succession planning? Please let us know by responding to the following scales. (Assume any services would be competitively priced and provided by highly qualified professionals)																
1. A Seminar on succession planning 2. A Session at the Annual Congress on Healthcare Management 3. An audio conference (90 minute) 4. A book on succession planning 5. Other : _____	<div style="margin-bottom: 10px;">             We would <i>almost certainly</i> use this product/service              ↓              We <i>might</i> use this product/service              ↓              We <i>probably would not</i> use this              ↓           </div> <table border="1" style="margin: auto; border-collapse: collapse; text-align: center;"> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> </table>															

**Follow-ups:**

1. Would you like a summary of the results of this research? If so, please tell us the e-mail address it should be sent to on the line below. (Note: we will only use your e-mail address for this single purpose.)

\_\_\_\_\_

2. Do you have a succession planning story or best-practice that you'd like to share with others? If so, we'd like to hear more about it. Please let us know how you would prefer to be contacted in the space below and we will do so.

\_\_\_\_\_

Please return this survey in the attached, postage-paid envelope or fax to: 312-942-4957.

*THANK YOU* again for your participation. We look forward to providing results from this research to you and to the healthcare executive community.

6. The last time succession planning was done, to what extent was ethnic diversity a factor in assembling...

a. the *long list* of potential candidates? (Skip to 'b.' if no long list was used)

\_\_\_ Diversity was considered mandatory.

\_\_\_ It was viewed as very important, but not mandatory.

\_\_\_ It was somewhat important.

\_\_\_ It was not considered important.

b. the *short list*?

\_\_\_ Diversity was considered mandatory.

\_\_\_ It was viewed as very important, but not mandatory.

\_\_\_ It was somewhat important.

\_\_\_ It was not considered important.

7. Overall, how effective do you believe your organization's practices are for identifying and preparing successors for the CEO position? (Check one box in each row):

Very Ineffective Very Effective

←-----→

a. Identifying appropriate successors 

--	--	--	--

b. Preparing successors for the role 

--	--	--	--

Organization Background	
8.	Net revenue of your hospital in the most recently completed fiscal year \$ _____
9.	# of staffed beds _____
10.	Corporate structure:    ___ Local government ___ State government  ___ Private / not-for-profit ___ Private for-profit  ___ Other (please specify): _____
11.	Type / Setting (check all that apply):    ___ Academic/Teaching    ___ Rural ___ Community            ___ Urban ___ Religious affiliated    ___ Suburban ___ Member of a system

(CONTINUES)

Your Demographics	
12. Year of birth: _____	
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