FALL 2004 PROGRESS REPORT
LEADERSHIP DEVELOPMENT IN HEALTH CARE: PRACTICAL STRATEGIES FOR HEALTH CARE ORGANIZATIONS

RESEARCH TEAM

- **Ann Scheck McAlearney, ScD (PI),** Assistant Professor of Health Services Management and Policy and Pediatrics, The Ohio State University
- **Katrina Buchholtz,** Master's in Health Administration Degree Candidate, The Ohio State University

PI CONTACT INFORMATION

Ann Scheck McAlearney, ScD
Assistant Professor, Health Services Management and Policy and Pediatrics
The Ohio State University
1583 Perry Street, Atwell Hall 246
Columbus, OH 43210-1234
Phone: 614-292-0662
Fax: 614-438-6859
Electronic Mail: mcalearney.1@osu.edu

PROJECT OVERVIEW

Project Period:	July 2002 (April 2003)—December 2004
Total Project Costs:	$ 65,818

PROJECT INTRODUCTION

This research was designed to identify and explore practical strategies and best practices for leadership development in health care. It combined interviews with recognized experts and case studies of organizations reportedly pursuing excellent or innovative leadership development strategies. It supported this information with an extensive literature review and quantitative analysis of organizational turnover data. In total, we have conducted over 150 interviews with nearly 35 experts and 50 organizations for this study.

EXECUTIVE SUMMARY

PROJECT FINDINGS AND IMPLICATIONS FOR SENIOR LEADERSHIP AND SENIOR HUMAN RESOURCES AND ORGANIZATIONAL DEVELOPMENT PROFESSIONALS

LEADERSHIP DEVELOPMENT CONTENT

Finding 1: **Required shifts in competency emphasis:** Leadership development processes for different level leaders should change gradually from a micro to a macro emphasis as individuals grow and develop throughout their careers.

Finding 2: **Include needed future competencies:** Leadership development processes should maintain a focus on needed future competencies for leaders at all levels. Existing and new programs should ensure coverage of both current and future competency development, especially in the areas of cultural competence and inclusion.

Finding 3: **Differences in health care:** There is a compelling argument to be made for specialized leadership development training in health care as a short cut, to speed up the process by including health care cases, focused stories, and so forth. And that's true in other industries as well…

LEADERSHIP DEVELOPMENT PROCESS

Finding 4: **Appropriateness of leadership development strategies:** Both internal and external leadership development strategies can be employed in health care, and their appropriateness depends upon organizational circumstances.

Finding 6: **The role of leadership development in an organization:** Determining the appropriate role for leadership development within an organization will rely on decisions about critical issues such as the placement of the leadership development function, budgetary commitment, building or buying a program, and selection of metrics for monitoring and evaluating the program.

Finding 7: **Program implementation:** Focus on six key steps in program implementation will help position leadership development initiatives for success.

Finding 5: **Evaluation of leadership development programs:** While few existing leadership development programs are comprehensively monitored or evaluated, organizations should incorporate regular measurements into program development, and attempt to tie program results to both short- and long-term organizational outcomes.

OVERALL FINDINGS

Finding 8: **Do not ignore leadership development in your organization:** If you ignore it, leadership development will not just happen, and the need for it will not go away. Even if it will take time to build organization-wide support for leadership development, it is possible to begin the effort now.

Finding 9: **From an individual perspective, responsibility for leadership development remains largely personal.** Take responsibility for your development and leverage leadership development opportunities wherever you find them in order to maximize your chance for professional success.

TABLE OF CONTENTS

OCTOBER 2004 PROGRESS REPORT
LEADERSHIP DEVELOPMENT IN HEALTH CARE: PRACTICAL STRATEGIES FOR HEALTH CARE ORGANIZATIONS

I. PROJECT BACKGROUND

The issue of developing leaders in health care organizations is a persistent problem that has gained increased attention in recent years. Constant and rapid change within a $1.3 trillion industry demands strong leadership at all levels of health care organizations. Yet, how can we be assured that the individuals we have working in our organizations develop into the inspiring and confident leaders we need for tomorrow? How do analysts and entry-level employees grow into senior executives and Chief Executive Officers? Does every employee have the potential and motivation to aspire to lead others or are their particular competencies that need to be identified early and nurtured so that these individuals can develop to their full potential? A lack of understanding across the health services industry about how to best identify and develop entry level managers into both middle managers and senior executives has led to a sense of crisis about the future leadership of American health care organizations (Mecklenburg, 2001; IFF, 2000; Schneller, 1997).

A major question for many health care organizations is, what can we do now to develop our future leaders? And, what should we plan to do in the future? Outside the health care industry, some large organizations such as General Electric have established leadership development programs that are part of an organizational culture based on performance and valuing every person in the company (Hogan, 2001). Most health care organizations have not developed the size, resources, or organizational commitment required to pursue such institutionalized leadership development initiatives. Instead, new graduates are encouraged to complete administrative fellowships, early-careerists may be paired with senior-level mentors, and middle- and senior-level managers are authorized to attend professional development conferences and workshops as they take personal responsibility for their own career development. The overall question of how to best foster leadership development in health care organizations, especially for middle- and senior-careerists, remains largely unanswered.

This research has been designed to develop an understanding of the leadership development process for entry-, middle- and senior-level health care managers. Using a combination of key informant interviews, case studies, and market research, this study explores the issues of both appropriate content and process for health care leadership development. By providing actionable findings, this research will provide guidance for health care organizations such as the corporate members of the Center for Health Management Research as they attempt to assess, build, and enhance their own leadership development processes to ensure that the leaders of the future are properly identified, recruited, trained, and retained.

II. SPECIFIC RESEARCH QUESTIONS

The goal of this research is to analyze the issue of developing leaders in health care from both applied and theoretical perspectives. This research has been designed to assist CHMR corporate members by identifying and evaluating feasible strategies for leadership development that build necessary competencies for leadership in health care. To this aim, two main research questions focus the study:

1. Leadership development content: What competencies are essential for middle- and senior-level leaders in the health services industry?

- Does the list of competencies matter?
- Does competency emphasis change as an individual moves up within an organization?
- What should be on the list for the future?

Actionable consequences: Provide information about essential competencies, how to develop and apply a framework, and how to remain focused on the future to guide organizational leadership development strategies.

2: Leadership development process: What leadership development strategies are most appropriate for developing these essential competencies?

- What best practices exist for leadership development in health care?
- How can formal mentoring programs be used?
- What innovative practices exist?
- How do you build the business case for leadership development in an organization by considering the cost of employee turnover?
- How involved does senior management have to be?
- How can the gap between clinical and administrative leaders be bridged?

Actionable consequences: Provide information about best practices, formal mentoring program development, innovations in leadership development, the cost of employee turnover, the importance of senior leadership support, and the problematic cultural gap between clinical and administrative leaders to inform program investment and development decisions.

III. STUDY POPULATION

Leadership experts interviewed

We have conducted hour-long interviews with nearly 35 recognized experts and leaders in health care. A snowball sampling technique was used to develop this list, asking each interviewee to recommend other appropriate experts to inform our research. A complete list of key informants is included as Appendix A.

Leadership development case studies

As with the leadership expert interviews, a snowball sampling technique was used to develop our list of target organizations, asking each interviewee to recommend other appropriate places that might have innovative or best practices to inform our research.

- **Internal programs**: We have studied nearly 40 programs to date. Case studies have involved interviews with key informants at each of the organizations, with some of the studies including on-site visits. Case study organizations have included both CHMR members (n=4) and non-members (n=34). A complete list of case study sites is included as Appendix B.

- **External programs**: We have studied 12 programs to date. A list of these sites is also included as Appendix B.

IV. RESEARCH METHODOLOGY

Interviews and Case Studies
We used multiple semi-structured telephone interviews with key informants to assess perceptions of both leadership development content and processes. These key informant interviews follow the standards of rigorous qualitative research, using ethnographic interview techniques (Spradley, 1979) and thorough analysis (Miles and Huberman, 1994). Questions address the relative importance of both competency domains and specific leadership competencies for middle- and senior-level managers in health care. In addition, we asked informants questions about leadership development opportunities they have experienced or observed in practice.

Preliminary hypotheses that guided the development of the interview guide include the following:

H1: Necessary leadership competencies for early-, middle-, and senior-careerists are very similar, but the relative importance of leadership competencies varies according to level within an organization.
H2: Different leadership development activities are necessary to develop different leadership competencies.
H3: Health care organizations can promote leadership development among employees in concrete and identifiable ways.

Cost of Turnover Analysis
We completed a quantitative analysis to determine turnover costs in health care to support the need to retain high performing leaders in health care organizations. To gain a better understanding of these costs, we obtained average salaries of entry, mid-, and senior level leaders - from two salary sources: (1) American College of Health care Executives (2002); and (2) Coopers & Lybrand (1997). These salaries were further delineated by applying a differential factor arrived at by taking the average salary for all administrative positions by type of health care organization and calculating the percentage difference from the U.S. median based on Medicare cost report data (Cleverley & Associates, 2004). Salary data from the cost report was wage index-adjusted to account for cost of living differences. The U.S. Department of Labor has estimated that it cost a company 33% of annual salary to replace an employee. Based on this information, the cost of turnover was approximated by multiplying each salary by 33% for various levels of entry, mid-, and senior level health care managers. It is important to note that

the indirect costs of employee turnover are not accounted for in this equation. To arrive at a more accurate cost of turnover, a hospital should estimate both "hard" and "soft" costs. Results for these analyses are available in the Spring 2004 Progress Report.

Literature Review
An extensive review of the published literature both guided our research and supplemented our study findings. A suggested list of informative books is included as Appendix C.

Research Summary

- Interviews: Over 30 one-hour interviews with individuals considered experts in health care leadership development were conducted.
- Case Studies:
  - Internal: Sites studied included 4 CHMR members: Midwest VA; Summa Health System; Sharp Healthcare; Catholic Health Initiatives.
  - External: Sites studied include: Institute for Healthcare Improvement**;** National Center for Healthcare Leadership**;** American College of Healthcare Executives**;** Institute for Diversity**;** Healthcare Forum**;** American Hospital Association**;** Healthcare Research Development Institute (HRDI)**;** University of Michigan's program/NCHL linkage**;** Medical Group Management Association; Center for Creative Leadership.
- Quantitative analysis of employee turnover
- Extensive literature review

V. PROJECT FINDINGS

Research Question 1: *Leadership development content:* What competencies are essential for middle- and senior-level managers and leaders in the health services industry?

- **Finding 1: The leadership development process for different level leaders will change gradually from a micro to a macro emphasis on competencies as individuals grow and develop throughout their careers.**

  Implications: **For senior management, finance, HR, and OD professionals.**
  Targeting leadership development strategies to different level leaders should involve considering the needs and aptitudes of individuals at those levels, and should ensure that all tactics include the essential elements of assessment, challenge and support (McCall, et al., 1998) (Tables 1 and 2).

Table 1: Overall Approaches to Developing Essential Competencies, By Leadership Level

Entry Level Leaders: **Recruit carefully for top performers and pay attention to development**	• Assign internal administrative mentor, clinical mentor, external mentor (in another organization or at corporate level)
	• Guide process of self assessment
	• Provide regular feedback and assessment
	• Identify gaps in education
	  o Fill gaps with targeted education (classes, conferences)
	  o Encourage reading (journals, books)
	• Support networking activities
	  o ACHE, MGMA, other associations, etc.
	• Help with personal and professional development plan
	• Facilitate developmental experiences
	  o Cross-functional teams, project team experience
	  o Job rotations
	• Allow to attend meetings with senior management
	  o Internal fellowship concept
	  o Debrief post-meetings (management style, meeting content, health care issues, strategic issues, people issues)
	• Someone (boss) must invest 1-2 hours/week of one-on-one time on development (2% of your time?) (Lunches? Regular meetings?)

Middle Level Leaders**: Consider and create leadership opportunities in order to refine required competencies**	• Same practices as entry level PLUS • Focus on filling in experiential or educational gaps o Focused job rotation, developmental experiences • Consider or create opportunities for action learning, special projects, new programs • Consider and create opportunities in order to refine skills such as communication, critical thinking, interpersonal relations • Allow time to staff a senior management team or project • Ensure mastery of future competencies (IT, inclusiveness, community involvement)

Senior Level Leaders**: Utilize tailored options such as coaching, paying special attention to need to build external relationships and credibility**	• Tailor same types of practices as entry and middle level PLUS
	• Targeted assignments if missing areas of experience, expertise
	• Consider executive coaching, external program attendance
	• Pay attention to opportunities to work within the community, get to know the community, including opportunities to become involved in politics and political organizations external to the institution
	• Require new project focused on leadership development opportunities within the organization to encourage formation of a development mindset
	• Challenge individuals to envision and manage a new project of strategic importance
	  o Inclusion and cultural competence
	  o Information technology roll-out, adoption, implementation
	  o Culture change initiative

Table 2: Tactics to Develop Leadership Competencies Across Levels of Leaders

Competencies	LD Tactics
Lower Level (Micro Level)	
Technical Skills	• Didactic Classes • Developmental experiences • Job rotations
Communication Skills	• Developmental experiences • Mentoring programs • Feedback • Classes or targeted experience in writing, speaking, and presenting (e.g., Toastmasters)
Higher Level (Macro Level)	
Relationship Building	• Shift people to new areas • Enable new project, team-building experiences • Cross mentoring across administration and clinicians • Community-based involvement • Feedback, coaching and mentoring
Dealing with Complexity	• Enable stretch assignments • Action learning projects and experiences • Project experiences and targeted assignments
Developing Strategic Vision	• Test visioning skills with development of long-term vision for leadership development/organizational development in organization • Action learning projects and experiences • Consider external program attendance
Career Success	
Interpersonal Skills	• Encourage self assessment • Mentoring and coaching programs
Team Building	• Developmental Experiences • Projects, task forces • Human Resources-Based Internal Programs

And, as most emphasize:

"I think that everybody needs to keep reading, because you never know when you're going to run across something that will have that kind of impact on you."

- **Finding 2: Leadership development processes should maintain a focus on needed future competencies for leaders at all levels.**

  Implications: **For senior management, finance, HR, and OD professionals.** Existing and new programs should ensure coverage of both current and future competency development, especially in the areas of cultural competence and inclusion (Tables 3 and 4).

Table 3: Developing Future Competencies

Competency	Developmental Approach
Focus on Ethics and Values	• Team-based case studies • Senior leadership modeling of values, respect for others
Information Technology Capability, Fluency	• Classes • Talk to specialists in Information Systems department • Read • Practice, experiment
Cultural Competence and Managing Diversity	• Broaden exposure and experiences • Team-based case studies • Recruit and hire across cultures
Building Community Relationships	• Assign projects that involve community • Target developmental experiences with community-based activities • Encourage broad managerial participation in conversations, interactions with community stakeholders
Patient Safety and Error Reduction	• Spend time with physicians, other clinicians • Read (Institute of Medicine reports, etc.) • Encourage investigation into issues surrounding safety and errors (i.e., reporting, culture, sharing information, communication)

Table 4: Key Considerations about an Organizational Culture of Inclusion

Key Consideration	*Questions to Consider*
1. Inclusion is more than a numbers game	• Who are the women and minorities on boards? • Are we really doing well including women or is it all the heads of volunteers and donors? • Have you gone into the community to seek out influential minorities and women to encourage their engagement with your organization? (churches, community organizations, schools) • Are we attempting to hire and maintain an employee population that is representative of the entire population in the community and surrounding areas in terms of demographics?
2. Inclusion extends beyond single programs	• What happens after formal mentoring or developmental experiences for minorities have been completed? • What is happening to the non-minorities in the organization who are not able to participate in these special programs? How are they learning about inclusion and cultural competence?
3. Inclusion involves the entire organization	• Have you looked within your organization for informal leaders? In housekeeping? In nursing? In facilities? • How are you building cultural competence into your organization? What are you doing to develop your employees along these lines?

Representative Comments:

"I think hospital leadership should be a reflection of the demographics of the community that the hospital serves. So if we serve, which we do, a large Hispanic community, or we serve a big African-American community, and certainly in terms of our workforce we're diverse, then the leadership should be, I think, a reflection of that."

"There is still discrimination of both women and people of color. So the decision-makers have to do everything they can, personally to…treat everybody the same… So (1), people have to know themselves and be aware of what, how they act and how that impacts on others and if necessary modify their behavior. (2) As leaders we have to make sure that those who are managing for us are open to change and are willing to accept all people. And if they're not, we've got to move them out of the organization. (3) We also have to help those we're serving…. We always have to help the minority... know what the expectations are of the majority. Not so much that they're going to fulfill every one of

them, but at least be aware that there are cultural differences and ….sometimes there has to be kind of a cultural common ground."

"I think if there's anything historically that's been missing in that development plan I talk about is that women and minorities have not had the kind of mentoring that some of our majority applicants have had in organizations or candidates have had in organizations. You know, there is an old boy network in health care and it still exists. And if you're not a part of it, you know you're not gonna grow, you're not gonna learn about different jobs, you're not gonna get assignments with specific committees and that can hurt your development. You know, in my view, I'm a minority, and yet I could tell you I still think there's a glass ceiling out there for women. I think it's changing, but I still think there's a glass ceiling out there that needs to be broken."

"I think in some organizations people are put on a fast track and other people are not and if you're gonna really develop your leaders in your organization you've got to cut across the diversity of the make-up of your management staff and provide everybody with an opportunity to grow and develop those skill sets. If it's gonna be a fast track, it ought to be a fast track for everyone. But you get on that fast track by distinguishing yourself and by making sure that you're doing all the things that are in the best interest of the organization and making all the appropriate decisions. You know everybody can't be the CEO, but as you develop your management staff I think you have to look for an opportunity to bring the kind of diversity that's necessary for your organization to be responsive to the needs of the community that you serve."

- **Finding 3:** There is a compelling argument to be made for specialized leadership development training in health care as a short cut, to speed up the process by including health care cases, focused stories, and so forth. And that's true in other industries as well…

  Implications: For senior management, HR, and OD professionals. While there is disagreement about whether and how health care is different from other industries (Table 5), there is agreement that leadership development practices in health care can draw from best practices wherever they are found.

Table 5: Is Health Care Different?

Yes	No
Fundamental Role of Physicians	
We work within physicians who are not employed by the organization yet use organizational resources and direct revenues to the organization	Other industries also involve work with professionals and groups who they cannot control
Distinctness of Patients and Health Care	
We work with people's lives, not selling widgets	Customer service is customer service
Our metrics such as quality of care deal with life and death	Other high-risk industries have similar intolerance for errors, poor quality (e.g., aviation, power)
Patients do not always choose our services—insurers and physicians have roles as well	Multiple customers must be satisfied
Mission and Values	
Our values are critical	Other not-for-profit organizations have important values and missions as well
Our mission is of paramount importance	As with other businesses, no margin, no mission
Finances	
Our reimbursement is affected by government, other third parties	Other industries have to deal with regulations as well
Many health care organizations are not-for-profit	Not-for-profit does not mean Non Profit
Importance of Consensus	
In health care we have to build consensus for everything we do, and this involves multiple parties, many of whom we do not control	Consensus is important in all businesses, and other not-for-profit organizations often have a similar inability for the CEO to dictate or mandate action

Representative Comments:

> *"I think there's probably a greater need for building bridges and relationships and collaboration than in other fields and part of that is because health care is really a bunch of different fields. Hospitals, insurance companies, physicians, Medicare, Medicaid, the private business sector, everybody is in sort of separate silo and they try to interact with each other so I think it's a lot different than running a company that makes cars or a company that makes pills or something, but there's a lot more small operations in health care; two or three doctor practices, small hospitals and so forth, so you're having to work together in a different way than if somebody's part of a huge conglomerate."*

> *"I think in the health care organization I think we never really got away from the three legged stool, the old traditional three legged stool of the board, the medical staff, and*

administration because it's constantly managing the relationships between those three groups--managing those multi-disciplinary teams, managing those clinical professions that really make you successful. And the more you're able to navigate those relationships, the more successful you're going to be in health care. Now in the private sector, I don't think you have to listen so much or to build such a consensus when it comes to getting things done. If you're the CEO of a company, you can pretty much mandate what you want to do. That's one way of approaching it. But you can't do that in health care. We can't do anything in health care unless you build a consensus among the people in the organization that that's the right way to go."

"I think it might be because, (1) you're not working with widgets, you're working with patients. So you've got to teach that compassion, and (2) it's so competitive because there's such a strong need for workers and all your cost is workforce primarily. You really need to engage your staff. You know we have great examples of CEOs around this town, one in particular who, as we speak, is under serious pressure because of the old style management control and everything."

Research Question 2: *Leadership development process*: What leadership development strategies are most appropriate for developing these essential competencies?

- **Finding 4: Both internal and external leadership development strategies can be employed in health care, and their appropriateness depends upon organizational circumstances.**

  Implications: **For senior management, HR, and OD professionals.** While multiple approaches to leadership development can be employed, senior management should pay attention to organizational circumstances to ensure that program options are appropriate and can help achieve the goals established (Table 6).

Table 6: Appropriateness of Leadership Development Strategies, By Circumstances

Leadership Development Strategy	Appropriate Circumstances	Inappropriate Circumstances
Internal Programs		
Mentoring Program	▪ As an inexpensive, first step ▪ Moving beyond words	▪ Stand-alone program ▪ When top management is unwilling to participate ▪ When specific skill building is needed for protégés
Job Rotations	▪ Stable institution ▪ Good communications among members of executive team	▪ Institutions with tremendous turnover ▪ Culture of guarding or withholding information
Developmental Experiences	▪ With oversight from HR, senior leadership ▪ Effective when integrated with talent management or succession management focus	▪ As means of avoiding "problem" employees ▪ When not tied to other HR activities, attention

Table 6 (continued)

Leadership Development Strategy	Appropriate Circumstances	Inappropriate Circumstances
Clinical Leadership Development Programs	▪ When tied to administrative programs and other organizational development and strategic activities	▪ As a means of segregating physicians or nurses for special training without linking development to the organization
Leadership Development within Culture Change Initiative	▪ Change of leadership, organizational focus ▪ To guide future organizational, professional development of employees ▪ To foster acceptance of culture change by middle-level management, front-line staff	▪ "Flavor of the Month" ▪ As substitute for actual leadership development strategies
Human Resources-Based Internal Programs	▪ When HR function in organization is strong and includes organizational development focus ▪ If resources do not permit greater organizational development initiative	▪ As a la carte program with catalog of courses, web-based programs, and no integration ▪ When offered with no tie to organizational priorities and strategies ▪ When teaching methods restricted to didactic courses ▪ When program topics are continually recycled
Talent Management Focus	▪ Working in parallel with HR function as organizational development strategy ▪ Strongly tied to goals of senior leadership, organizational objectives, and succession management ▪ Can be tightly or loosely coupled to HR processes	▪ "Flavor of the Month" ▪ When senior leadership unable to devote time and resources to process ▪ As defined part of HR with no link to strategic priorities of organization, leadership needs
Integrated Leadership Development with Organizational Learning and Development Initiative (Corporate University Option)	▪ With strong commitment from senior leadership ▪ Involves direct reporting relationship of Chief Learning Officer or other program director to senior executive(s)	▪ When senior leadership uninterested in providing ongoing support, organizational championship

Leadership Development Strategy	Appropriate Circumstances	Inappropriate Circumstances
External Programs		
External Conferences, Meetings	▪ Require attendance to be tied to bringing back findings, reflection to the institution ▪ Part of individual or departmental developmental plan ▪ Use metrics as concrete evidence to prove to prove effectiveness, change ▪ As opportunities for networking with peers and colleagues in other states, geographic regions, organizations	▪ Used merely as an employee benefit ▪ If unable/unwilling to listen to new ideas participants bring back ▪ If goal is to build organizational identity
External Executive Education Programs	▪ When include action learning projects or experiential component ▪ When move beyond individual education to consider needs of team, individual	▪ When content is purely didactic (exception: entry-level leaders) ▪ When program focuses only on individual development without regard for organization or teams
External Clinical Leadership Programs	▪ As part of focused, formal management and skills training to help clinicians develop required competencies ▪ When required competencies cannot be learned on the job	▪ When used as stand-alone training without helping participants learn about organizational issues and priorities
Executive Coaching	▪ When senior leadership needs outside, objective assistance with improving interpersonal skills	▪ As a substitute for targeted employee feedback and development

Representative Comments about the Benefits of Internal Programs:

"One of the problems in health care is a lot of people feel identity with their professional colleagues, but they feel no identity with the people with whom they are gonna make or break the hospital. To me there's an institutional identity that needs to be promoted as well as, if you will, a professional association identity. We traditionally have divisions in health care between physicians and the administration. Well that's because the identity of physicians is with other physicians, not with the other colleagues of this particular hospital. So I would say leadership development programs, internal programs build institutional identity where as participation in some of these external programs builds association or professional identity."

"Well basically leadership development programs -- from orientation to the ongoing formation and education and training of senior leaders are one way of shaping culture. So the mission part of that is if you are responsible for how we do what we do, if you look at say the Harvard profit-chain model, basically leadership shapes employee morale. That together with the partners, say the physicians shapes the patient experience, and that shapes the community value, and that shapes your market share and your profitability and all the rest. Basically, in the value chain, leadership is the starting point. So if you want to shape a culture or how you do what you do, there has to be an investment in the formation and development and education and training of leadership."

- **Finding 5: Determining the appropriate role for leadership development within an organization will rely on decisions about critical issues such as the placement of the leadership development function, budgetary commitment, building or buying a program, and selection of metrics for monitoring and evaluating the program.**

  Implications: **For senior management, finance, HR, and OD professionals.** Paying attention to these key decisions will affect program success (Tables 7 and 8).

Table 7: Key Decisions in Establishing Leadership Development Function within an Organization

Main Questions	Sub Questions
Where should the leadership development function reside within the organization?	• What is the role of the program director or Chief Learning Officer? • To whom does this individual report? • What is the role of senior executives? • What is the link to human resources? • Where do performance evaluations and appraisals fit in the process (or do they)? • What other organizational development activities are ongoing and how are they related?
What is the likely budgetary commitment to leadership development over time?	• Can this commitment be sustained? • Is there room for program growth and expansion given program success? • Who is providing long-term perspective for the leadership development function?
What metrics are important to this organization in evaluating leadership development?	• What is the perspective of the organization about leadership development? • Who is accountable for the program? • How is the program tied to strategic priorities of the organization?
Should the organization build its own leadership development program or buy components from outside the organization? (See Table 8 below for additional detail about this decision)	• ***Program Reach:*** Number of employees targeted, affected; types of employees targeted, affected • ***Program Scope:*** Time frame, frequency • ***Program Depth*****:** Program components, level of involvement • ***Program Perspective***: Long- or short-term perspective, role of program within organization and organizational development efforts • ***Program Goals:*** Expectations of program, of participants in program; degree of expected impact on individual employees and organization • ***Program Focus:*** Degree of customization specific to institution; focus on individual needs versus organizational needs • ***Price Tag***: Comparative cost of program • ***Organizational Support:*** Budget, resources available, organizational level of commitment to program and program integration • ***Senior Leadership Support:*** Level of involvement, time commitment

Table 8: Deciding Whether to Build Or Buy: Opportunities and Risks to Consider

	Opportunities	Risks
Build	• Ability to control program in-house • Program can be clearly tied to organizational strategic priorities • Program components can be shifted to meet needs of organization • Obvious demonstration of senior leadership commitment	• Lack of in-house expertise • Perception of less professional program • Easier to incrementally shift resources away from program as budget priorities shift
Buy	• Working with known products, expertise • Ability to sample vendors, programs • Can pick and choose components based on price tags • Variety of available programs with track record in individual leadership development	• Lack of control • Potential for unlimited price tag • Customization options may not fit organization • Program may never be fully "owned" by host organization • Developmental process may never be translated into organizational priorities

- **Finding 6: Focus on six key steps in program implementation will help position leadership development initiatives for success**

  Implications: **For senior management, finance, HR, and OD professionals.** Working through these steps in program implementation will help increase the likelihood that leadership development programs will (Table 9).

Table 9: Six Steps for Successful Program Implementation

Step 1: Get CEO, Board involved and committed	• Align program goals with organizational strategies, vision, mission, and values • Without senior management support and commitment, limit program development activities
Step 2: Designate Chief Learning Officer or equivalent	• Establish a formal plan and revise periodically • Define program accountability

Table 9 (continued)

Step 3: Invest in the leadership development program	• **Time**: 10-20% of time on development (compare to 40-50% in Good to Great Companies)—depends on definition of development • **Money**: 2-3% ideal; Goal 1-1 ¼%: plan for growth over time; You cannot afford not to do this • **Efficiency:** Recognize and plan for potential productivity losses and gains as employees progress along the learning curve and attempt to implement principles and practices learned; adjust operations accordingly • **Attention:** Because "the currency of leadership is attention," if leadership pays attention, the message to the organization is clear • **Value:** Make clear that leadership development is valued; participants are respected and not resented; value of human capital in the organization • **Flexibility:** Enable possibilities for job rotations, developmental experiences
Step 4: Establish measurement mechanisms	• Take baseline measurements • Tie program results to unit level • Include both short- and long-term metrics
Step 5: Focus on both individual and team development	• Include systematic assessment and review of participants • Consider team development activities, evaluation • Enable challenging assignments, developmental experiences
Step 6: Work to create a supportive culture	• Build ability to take risks, to fail • Foster coaching and mentoring • Ensure organizational flexibility—job assignments, rotations • Encourage openness to new ideas • Foster open, direct, honest communications • Guarantee profound respect for people, their development • Emphasize the value of human capital • Ensure that participants are respected, not resented • Focus on patient safety, error reduction, quality of care • Create emphasis on service and hospitality, respect throughout the organization ▪ To patients ▪ To physicians ▪ To employees ▪ To community

A representative comment:

"From the top leaders, there has to be a support or a value. They have to see a value in developing their leaders. They have to see a value in that or it's you know I don't think it can survive. So it does start with the leadership. It has a lot to do with what the organization's mission, vision, and values are. This organization supports not only management education, but I mean we have a long history of medical education as well. So I think the environment that the organization supports, this supports whether that's going to work or not. Again, seeing the value, what it's tied to."

- **Finding 7: While few existing leadership development programs are comprehensively monitored or evaluated, organizations should incorporate regular measurements into program development, and attempt to tie program results to both short- and long-term organizational outcomes.**

  Implications: **For senior management, finance, HR, and OD professionals.** When developing or expanding leadership development activities, take the time to consider appropriate metrics and goals for the program. Various evaluation metrics are possible, depending on the goals and strategic priorities of the organization (Tables 10 and 11).

Table 10: Evaluation of Leadership Development Programs and Initiatives

Program Metrics	▪ Evaluation of program itself
	▪ Participant evaluation
	  ▪ Knowledge, skills, behavior of participants
	  ▪ Evaluations by subordinates, peers, superiors, customers

Organizational Metrics	▪ Quality of work life ▪ Employee satisfaction ▪ Financial metrics ▪ Amount spent as % of total expense ▪ Community health indicators ▪ Patient satisfaction ▪ Achievement of key strategic goals of organization
Human Resources Metrics	▪ Percentage of key people promoted ▪ Overall turnover rates ▪ Turnover in unit led ▪ Ability of individuals to reach goals each year ▪ Ability to fill jobs from within

Clinical Metrics (IOM Aims for Improvement)	▪ ***Safe***
	  ▪ Standardized mortality rate
	  ▪ Adverse drug events per 1000 doses administered
	▪ ***Effective***:
	  ▪ Nurse turnover, employee turnover
	  ▪ Lost work days per employee
	  ▪ Growth in market share
	▪ ***Patient-Centered***
	  ▪ Patient satisfaction
	▪ ***Timely***
	  ▪ Patient flow—people in the right place
	  ▪ Operational: third available appointment
	▪ ***Efficient***
	  ▪ Cost per adjusted admission
	  ▪ Operating margin: cash from operations
	▪ ***Equitable***

Intangibles	▪ Confidence about succession management, planning ▪ Ethical behavior and clarity of values ▪ Employee morale

Organizations want more data:

> *"I really want to do a lot more and have some more substantial evidence…concrete evidence to prove that yes, this is really making a difference and it's really working. I mean people are saying it is, but I want to have some more concrete data that I can go back and prove that this is making a difference, because it should."*

"I mean everybody says that their most important asset is their people. I don't think they really believe it. And I also believe if you can't measure it, you can't manage it."

Yet there is a fundamental measurement challenge:

"Competitive advantage today stems primarily from the internal resources and capabilities of individual organizations—including a firm's ability to develop and retain a capable and committed workforce…. However, expenditures in these areas are treated as expenses rather than investments in assets. By contrast, investments in buildings and machinery are capitalized and depreciated over their useful lives. …As a result, companies under financial pressure tend to invest in physical capital at the expense of human capital—even though the latter may well generate more value." (Becker et al., 2001)

Table 11: Top Ten Non-Financial Variables Considered by Financial Analysts in Valuation Models

Variable	Rank
Execution of Corporate Strategy	1
Management Credibility	2
Quality of Corporate Strategy	3
Innovation	4
Ability to Attract and Retain Talented People	5
Market Share	6
Management Expertise	7
Alignment of Compensation with Shareholders' Interests	8
Research Leadership	9
Quality of Major Business Processes	10

Source: Low and Siesfield, 1998. *Measures That Matter*, (Boston: Ernst and Young)

Overall Findings:

- **Finding 8:** If you ignore it, leadership development will not just happen, and the need for it will not go away.

  Implications: **For senior management, finance, HR, and OD professionals.** Even if it will take time to build organization-wide support for leadership development, it is possible to begin the effort now (Tables 12 and 13).

Table 12: Incremental Options to Initiate Leadership Development in an Organization

- Formal mentoring program
- Book/article club
- Brown bag lunches
- Direct employees to self assessment opportunities
- Allow subordinates to attend meetings, observe in action
- Hold "Executive Chats"—Encourage "real," meaningful conversations between executives and subordinates in both structured and unstructured contexts
- Monthly "Meet the Leader" talks—CEO and senior executives give brief lectures about leadership and culture
- Job swapping and job shadowing
- Debrief activities with high potentials—take the time
    - Post meetings
    - Post projects
    - Post conferences
- Model self development, listening
- Hold monthly brainstorming sessions
    - How to be a better place to work
    - Ideas from current literature
    - Crazy opportunities and innovations
- Use of recognition for risk taking, new ideas
- Town-Gown collaborative education model
- Require administrators to spend time with physicians, in physician meetings, in clinical areas, etc.

At one case study site:

"Well the whole idea is to create your own internal leadership institute, to really 1) teach the culture; 2) teach the principles of leadership; and 3) engage your top managers in that process…. And actually set it up as a curriculum that you have to achieve so many credits. You know we each teach a few different classes and then we bring in on-site speakers, so it' much more cost-effective. It gives me a chance to engage with the managers around the culture…We actually designed, we talk about it just three things, our mission, vision, and values and in our values we actually go out and we taped our best managers that mimicked that value and a movie clip that's either sort of positively or negatively reflects that value. So we go through a whole introduction of the theme, then for each value we have them in breakout sessions, where we play the video of the movie, play the clip of the manager and then talk about it. What are we doing right? What are we doing wrong? How can we embed it throughout the organization and it's awesome. That's the other thing, I mean to engage the staff. We can't get it done in three hours. I mean literally we're always pushing up to the limit of the time. Then I teach one on servant leadership, which is my whole philosophy of leadership--servant leadership. And it's a whole discussion of what that is about. So I guess it's called new management, new manager leadership."

Table 13: One Educational Model: Town-Gown Collaboratives…

Program Structure	What is Involved
• Monthly Sessions of 1 ½ to 2 hours o Extended lunch hours, books and breakfast, etc. • Targeted Development o By department/unit/team o For senior management o By topic of strategic importance • Rotating Topics o Book list and discussion topics o Case studies and questions o Experiential exercises o Action learning projects, especially across units or teams	• Work with your local university and internal experts • Resource Requirements o Commitment of 2 hours/month o Time to organize o Cost of books, other materials • Potential Benefits o Increased employee morale, enthusiasm for organization o Elevated understanding of the organization, strategic priorities, health care industry o Improved accountability of employees for learning, development o Opportunity to identify high potentials, target developmental experiences

- **Finding 9: Consensus across interviewed experts and organizations reveals that the bulk of responsibility for leadership development in health care remains personal.**

  Implications: **For individuals across organizations.** Take responsibility for your development and leverage leadership development opportunities wherever you find them in order to maximize your chance for professional success. In particular, paying attention to the contrasting characteristics of successful and derailed leaders can help focus development of needed competencies for leadership (Table 14).

Table 14: Contrasting Key Characteristics of Successful and Derailed Leaders

	Successful Leaders	Derailed Leaders
Definition	Reached the general management level or higher and remains a viable and likely candidate for future promotion	Reached the general management level but is fired, demoted, or reaches a career plateau
Key Characteristics	• Establish strong relationships • Hire, build, successfully lead teams • Has outstanding track records for performance • Adapts and develops during transitions	• Has problems with interpersonal relationships • Fails to hire, build, and lead a team • Fails to meet business objectives • Unable or unwilling to change or adapt • Lacks a broad functional orientation
Interpersonal Skills	Interpersonally adept—have ability to build and manage effective relationships. Described as: • Good listener • Collaborative • Supportive of others' ideas • Trustworthy • Ethical	Cannot establish strong relationships. Described as: • Insensitive • Competitive • Dictatorial • Critical • Easily angered • Arrogant • Manipulative

Source: Adapted from the Center for Creative Leadership, Chappelow and Leslie, 2001.

Representative Comments:

A definition of successful leadership:

"Well I guess the definition that resonates with me is that leadership is the ability to get things done through other people. It's the ability to be able to get people to understand the vision that you have and getting those people to willingly follow you and in the course of doing that creating a sense of trust on their part, trying to reflect some degree of confidence that earns that trust, and you know being respectful of what people bring to the table in helping you achieve your goal and most importantly being fair and honest."

A description of successful leaders:

"They stand out. They glow. You know that they're people that have the idea. They have the idea and the conviction. They say we can do it differently and we can do it better. I have a sense of how we can do it better, but I need people to help me. I have the conviction that we must do it better and I'm willing to stand up with the courage necessary to lead to get us to that point. I'll take the accountability. They stand out--they're very hard to miss. I think that's part of kind of our new eyesight as senior leadership."

VI. RECOMMENDATIONS FOR DISSEMINATION OF PROJECT RESULTS

Dissemination to senior management

- Share Executive Summary as overview of research findings and their implications.
- Consider requesting a customized presentation (oral or written) for your organization. Please feel free to call me at (614) 438-6869 or e-mail: mcalearney.1@osu.edu if you would like to discuss this opportunity.

Dissemination to human resources, organizational development, and training professionals

- Share Executive Summary as overview of research findings and their implications.
- Share list of suggested resources for additional learning opportunities.
- Consider requesting a customized presentation (oral or written) for your organization.

Additional dissemination

- CHMR case study participants will receive tailored reports at the conclusion of the project.

REFERENCES

Chappelow, C.; Leslie, J.B. 2001. *Keeping Your Career on Track: Twenty Success Strategies*. Greensboro, NC: Center for Creative Leadership.

Hogan, J. 2001. Thriving in Health Care…Learning Every Day. *The Journal of Health Administration Education*, Special Issue 2001: The Future of Education and Practice in Health Management and Policy: Proceedings from the National Summit: 63-67.

Institute for the Future. 2000. *Health and Health Care 2010: The Forecast, The Challenge*. San Francisco, CA: Jossey-Bass Publishers.

McCall, M.W.; Lombardo, M.M.; Morrison, A.M. 1998. *The Lessons of Experience: how successful executives develop on the job.* Lexington, MA: Lexington Press.

Mecklenburg, G. 2001. Career Performance: How are We Doing? *Journal of Healthcare Management*, 46(1): 8-13.

Miles, M.B.; Huberman, A.M. 1994. *Qualitative Data Analysis*. Thousand Oaks, CA: Sage.

Schneller, E.S. 1997. Accountability for Health Care: A White Paper on Leadership and Management for the U.S. Health Care System. *Health Care Management Review*, 22(1): 38-48.

Spradley, J.P. 1979. *The Ethnographic Interview*. Fort Worth, TX: Harcourt Publishers.

Tichy, N.M.; DeVanna, M.A. 1986. *The Transformational Leader*. New York: John Wiley.

Warden, G.L.; Griffith, J.R. 2001. Ensuring Management Excellence in the Health Care System. *The Journal of Health Administration Education*, Special Issue 2001: 19-32.

Yin, R.K. 1994. *Case Study Research: Design and Methods* (2nd Edition). Thousand Oaks, CA: Sage.

Zemke, R. 1985. The Honeywell Studies: How managers learn how to learn. *Training*, 22(8): 46-51.

Appendix A: Key Informant Interviews

Key Informant	Organizational Affiliation
Diane Appleyard	President and CEO, Healthcare Research Development Institute
Thomas Chapman, EdD.	President and CEO, HSC Foundation
Molly Coye, MD	Former Commissioner of Health, New Jersey; President of Health Technology Company
Pamela Davidson, PhD	Faculty and Senior Researcher, Center for Health Policy Research, University of California, Los Angeles
Dick Davidson	President, American Hospital Association
Thomas Dolan, PhD	President and CEO, American College of Healthcare Executives
Lorayne Dollet	The Hay Group
Janice Dreachslin, PhD	Professor, Penn State Great Valley School, and Chair of AUPHA Diversity Forum, leading initiative to define domains and core competencies for diversity leadership in health services management
Carson Dye	Executive Search Consultant, Witt/Kieffer; Facilitator, Healthcare Roundtable; Leadership Seminar Educator, ACHE
Rupert Evans	President, Institute for Diversity
Ray Grady	President, Evanston Hospital
Don Hutton	The Morgan Executive Development Institute, Jacksonville, FL
William Jessee, M.D.	President and CEO, Medical Group Management Association
Kathryn Johnson	Former President, The Healthcare Forum
Michael Kieffer	Chairman, Quick Leonard Kieffer (Executive Search Consultants)
Anthony Kovner, Ph.D.	Professor, New York University
David Leach, MD	Executive Director, Accreditation Council for Graduate Medical Education (ACGME)
Stephen Loebs, PhD	Professor and Chair, Health Services Management and Policy, Ohio State University
Larry Mathis	Former CEO, The Methodist Hospital
Gary Mecklenburg	President and CEO, Northwestern Memorial Healthcare
Reed Morton, Ph.D.	American College of Healthcare Executives
Diane Peterson	President, D. Peterson & Associates (formerly President, American College of Health care Executives)
Janet Porter, PhD	Professor, University of North Carolina (formerly Interim President, AUPHA)

Key Informant	Organizational Affiliation
James Reinertsen, MD	Consultant, The Reinertsen Group Institute for Healthcare Improvement Senior Fellow Former CEO, CareGroup, Beth Israel Deaconess, Park Nicollet,
Thomas Rundall, PhD	Professor, University of California, Berkeley, and Co-Director, Center for Health Management Research
Roger Schenke	Executive Vice President, American College of Physician Executives
Eugene Schneller, PhD	Professor, Arizona State University
Jeffrey Selberg	President and Chief Executive Officer, Exempla Healthcare
Stephen Shortell, PhD	Dean, University of California, Berkeley, and Past CHMR Director
Marie Sinioris	National Center for Healthcare Leadership
Gail Warden	President and CEO, Henry Ford Health System
Carla Wiggins, PhD	Professor and Chair, Health Systems Management, Idaho State University

Appendix B: Organizational Case Studies

Internal programs studied

CHMR Members

- Midwest VA, Minneapolis, MI
- Summa Health System, Akron, OH
- Sharp Health care, San Diego, CA
- Catholic Health Initiatives, Denver, CO

Non CHMR Members

- Affinity Health System, Menasha, WI
- AnMed Health, Anderson, SC
- Avera McKennan Hospital and Health System, Sioux Falls, SD
- Botsford Health Care, Farmington Hills, MI
- Columbus Children's Hospital, Columbus, OH
- East Alabama Medical Center, Opelika, AL
- East Jefferson General, Metairie, LA
- Evanston Northwestern Hospital, IL
- Fairfield Medical Center, Lancaster, OH
- Forum Health, Youngstown, OH
- Heartland Health System, St. Joseph, MO
- John Muir/Mt. Diablo Health System, Walnut Creek, CA
- Kaiser Permanente, Oakland, CA
- Kaweah Delta Health Care, Visalia, CA
- Lehigh Valley Hospital and Health Services, Bethlehem, PA
- London Health Sciences, London, Ontario, Canada
- Mayo Clinic, MN
- Mercy Health, Toledo, OH
- Miami Valley Hospital. FL
- Montefiore Medical Center, NY
- Mountain States Health, Johnson City, TN
- Northwestern Memorial Hospital, IL
- Norton Health care, Louisville, KY
- Ohio State University Medical Center, Columbus, OH
- OhioHealth, Columbus, OH
- Orlando Regional Health Care System, Orlando, FL
- Providence Health System, Seattle WA
- Saint Joseph's Hospital, Marshfield, WI
- Saint Alexis Medical Center, Bismarck, ND
- Saint Luke's Regional Medical Center, Boise, ID
- Shore Health System, Easton, MD
- Trinity Health System; MI
- University of Wisconsin Medical Center, Madison, WI

External programs studied

- American College of Healthcare Executives
- American College of Physician Executives
- American Hospital Association
- Center for Creative Leadership
- Health Care Advisory Board
- Healthcare Forum
- Healthcare Research Development Institute (HRDI)
- Institute for Diversity
- Institute for Healthcare Improvement
- Medical Group Management Association
- National Center for Healthcare Leadership
- University of Michigan's program and NCHL linkage

Appendix C: Suggested Resources

Becker, BE, Huselid, MA, and Ulrich, D. 2001. *The HR Scorecard: Linking People, Strategy and Performance*. Boston, MA: Harvard Business School Press.

Bossidy, L, Charan, R. 2002. *Execution: The Discipline of Getting Things Done*. New York: Crown Business.

Buckingman, M, and Coffman, C. 1999. *First, Break All the Rules: What the World's Greatest Managers Do Differently*. New York: Simon and Schuster.

Collins, J. 2001. *Good to Great*. New York: HarperBusiness.

Conger, JA, Benjamin, B. 1999. *Building Leaders: How Successful Companies Develop the Next Generation.* San Francisco: Jossey-Bass.

Fitz-enz, J. 2000. *The ROI of Human Capital: Measuring the Economic Value of Employee Performance*. New York: AMACOM, American Management Academy.

Bulmer, R.M., Goldsmith, M. 2001. *The Leadership Investment*. New York: AMACOM.

Giber, D, Carter, L, Goldsmith, M. 2000. *Best Practices in Leadership Development Handbook: Case Studies, Instruments, Training*. San Francisco: Jossey-Bass/Pfeiffer.

Low, J, Siesfield, T. 1998. *Measures that Matter*, Boston: Ernst and Young.

McCall, M.W.; Lombardo, M.M.; Morrison, A.M. 1998. *The Lessons of Experience: how successful executives develop on the job.* Lexington, MA: Lexington Press.

Mintzberg, H. 2004. *Managers Not MBAs: A hard look at the soft practice of managing and management development*. San Francisco, CA: Berrett Kohler.

Pfeffer, J. 1998. *The Human Equation: Building Profits by Putting People First.* Boston, MA: Harvard Business School Press.

Smart, BD. 1999. *Topgrading*. New York: Prentice Hall Press.

Ulrich, D, Zenger, J, Smallwood, N. 1999. *Results-Based Leadership*. Boston: Harvard Business School Press.