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WHITE PAPER

Developing Healthcare Leaders: What We Have Learned, and What is Next

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When NCHL was founded in 2001, there was growing recognition that the field of healthcare management had evolved more rapidly than our capacity to staff it. Systems were becoming larger, more complex, and more challenging to govern. Innovation was becoming both more difficult and more necessary. At the same time, *To Err is Human,*[1] a watershed publication of the Institute of Medicine, was signaling a new era of accountability and transparency related to quality standards and an urgency to improve patient safety.

By 2010, healthcare leadership had made many noteworthy strides forward. Accreditation guidelines from the Commission on Healthcare Management Education (CAHME) now require all graduate programs to follow a competency-based approach, and to be transparent about the career outcomes their graduates achieve.[2] Our experience suggests that leadership development, once an afterthought, has become integral to many hospitals and health systems.[3]

Today, we face a magnitude of systems change that makes 2001 pale in comparison. Every part of the healthcare system is being asked for transformational change. For all the progress the field has made in developing leaders, taking the entire system to the next level is certain to test us all.

With this as a backdrop, we consider some key lessons we have learned from recent leadership research, where we will need to go in the years ahead.

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WHAT WE HAVE LEARNED ABOUT LEADERSHIP DEVELOPMENT

Lesson #1: The journey to leadership excellence is a lengthy one.

Since 2001, new research has cast the age-old question, "are leaders born or made?" in a new light. Compelling research suggests that becoming a top performer in one's field has less to do with innate talent, and more to do with (1) the availability of opportunities early in one's career and (2) the cumulative effects of much greater-than-average practice.[4]

Our own investigations of healthcare leadership excellence suggest that it follows similar patterns. Research on the top administrative officers in nationally-ranked hospitals found that these organizations are significantly more likely to be led by graduates from CAHME-accredited health administration programs,[5] suggesting that success in this career path is most frequently associated with a focus and commitment early in one's career. From there, each successive step on the path to senior leadership requires mastery of new competencies. Surveys of succession planning practices suggest that these plans for hospital CEOs require a minimum of two to three years before they are viewed as effective,[6] and more than three years for health system CEOs.[7]

Lesson #2: To drive organizational success, "leadership" development may be as important as 'leader' development.

Right around the time NCHL was founded, an influential review of leadership development drew an important distinction between "leader" development, with its

ALDP was, in part, an early attempt to move beyond leader development and toward leadership development.

focus on building the skills of an individual, and "leadership" development, which has a focus on building the capacity of an existing team of leaders.[8] The finding stood in stark contrast to the ways in which most leaders were developed. For many leaders, the primary approach to development involved individually attending conferences and workshop programs. The concept of sending an intact leadership team through a shared developmental experience, which was becoming more prevalent among clinical staff, was still rare among healthcare leaders.

NCHL's Advanced Leadership Development Program (ALDP) was, in part, an early attempt to move beyond leader development and toward leadership development. More recent work of NCHL has continued a focus on leadership—for example, examining the role of chief nursing officers in supporting quality and safety outcomes in collaboration with the executive team.[9]

LEADERSHIP DEVELOPMENT KNOWLEDGE BASE

Lesson #1: The journey to leadership excellence is a lengthy one.

Lesson #2: To drive organizational success, "leadership" development may be as important as 'leader' development.

Lesson #3: Effective leadership development is more about "how" than "how much."

Lesson #4: Systems of practice, culture, and knowledge management also matter.

Lesson #5: Some leadership experiences provide more learning value than others.

To this day, however, many healthcare organizations that claim to provide "leadership" development are in reality mainly focused on developing individual leaders.

Lesson #3: Effective leadership development is more about "how" than "how much."

Early efforts to benchmark leadership development efforts tended to focus on how much money an organization was spending as a percent of total payroll costs. Today we recognize this approach is inadequate in at least two fundamental ways. For one, organizations differ in the extent to which leadership development investments are strategic (i.e., the extent to which they are explicitly aligned with the organization's goals).[10] Since more explicitly aligned programs are more likely to support organizational goals, they should see more substantial returns for comparable investments.

Four qualities associated with particularly potent learning experiences: a compelling need for substantial change, a set of unfamiliar responsibilities, a greater responsibility or latitude of decision-making, and the need to deal with significant adversity and/or failure.

Secondly, for organizations with particularly sophisticated approaches to leadership development, the primary expense associated with these programs is not in the external speakers or degree programs they sponsor, but rather in the personal investment of senior leaders' time, effort, and patience in identifying and developing their high-potential future leaders.[11]

Lesson #4: Systems of practice, culture, and knowledge management also matter.

While some learning professionals have shifted focus from leader to leadership development, so too has the field of strategic human resource management shifted away from a focus on individual practices and techniques,

toward more complex systems of management practices. There is growing recognition of the synergies complimentary programs provide: for example, more effective recruiting strategies work hand-in-hand with higher-precision selection systems, providing an organization with employees who will benefit more from other management systems such as training, information sharing, and recognition programs. Our review of research from across industries provides a model of what an evidence-based high-performance management systems looks like within healthcare.[12] Feedback on the model from high-performing organizations consistently pointed to alignment and engagement of staff—including communication of mission and vision, information sharing, employee involvement, and performance-driven recognition—as critical to the success of all other management systems,[13] further underscoring the essential role of the culture senior leaders set. Other work has found that culture and leadership support are linked to improvement in specific clinical improvements, such as surgical outcomes. [14]

As the quantity and intricacy of available organizational data continues to expand, we are also beginning to understand the role of knowledge management in improving organizational performance.[15] Excellent organizations understand the importance of managing not just clinical and technical knowledge, but knowledge about developing leaders and creating and sustaining organizational culture.[16]

Lesson #5: Some leadership experiences provide more learning value than others.

So far we have found no easy roads to effective leadership. However not all paths are equally fast. To use a mountain climbing analogy, some paths get you to the destination faster, in exchange for a steeper or more treacherous climb.

In terms of learning value, we can distill real-world experiences into four essential components: (1) preparation, (2) experience, (3) feedback on that experience, and (4) receptivity to that feedback. Research suggests there is opportunity to shorten the pathway to high performance by improving any or all of these steps along the way.

The "preparation" step is the one most closely associated with traditional, classroom-based leadership development: filling one's backpack before embarking on the journey. Although volumes can be written on the best techniques for teaching, one of the most important conclusions is the essential role practical experience plays in almost all adult learning. In short, the more actively engaged learners are in applying what they are learning, the more rapidly they will learn and the better they will be able to retain what they have learned.

In terms of experience, the widespread availability of multi-level competency models has helped clarify how the requirements of higher-level leadership positions differ from the positions leaders are in beforehand. As reflected in the crossroads shape of recent career pipeline models,[17, 18] preparing for these higher level leadership positions is not simply a matter of greater mastery of current competencies; it also requires development of entirely new ones. What experiences are best for preparing leaders for these new roles? A 1998 review found four qualities associated with particularly potent learning experiences: a compelling need for substantial change, a set of unfamiliar responsibilities, a greater responsibility or latitude of decision-making, and the need to deal with significant adversity and/or failure.[19]

Feedback on experience, in turn, is governed in part by the expertise of the mentor, and in part by the feedback skills of that mentor. In her book, *Multipliers*, Liz Wiseman describes differences she and her co-author found between "multipliers," leaders who build their team's skills quickly, and "diminishers," whose feedback style interferes with their team's performance.[20] Findings from large-scale research reviews largely bear this out: while good feedback can accelerate skill development, poor feedback technique (e.g., leading a person to question whether they are right for the job) will interfere with it.[21]

Even assuming appropriate preparation, high-quality experience, and effectively delivered feedback, a leader's capacity to develop will still be bounded by their receptivity to the feedback they receive. Research on feedback receptivity suggests that getting the balance right is critical. Too little receptivity, and a leader's skills will be slower to develop through experience. Too much receptivity, and a leader will be viewed as self-doubting and "wishy-washy"—too quick to change directions or cave under pressure[22]

HEALTHCARE LEADERSHIP FOR THE FUTURE: WHAT IS NEXT?

For all the progress cited above, the body of evidence supporting many widespread leadership practices remains shallow. Answers to the following questions are particularly critical, and will be guiding the work of NCHL going forward.

1. What leadership competencies will be needed in the future?

The leadership competency models in widespread use today were developed prior to the passage of the Affordable Care Act. We now find ourselves evolving into a new era, one that will likely require new competencies of our leaders.

In the coming years, NCHL will evolve its interdisciplinary leadership competency model to incorporate the new opportunities and challenges that healthcare leaders will be facing. [23] In doing so, we plan to pursue new and innovative approaches to the competency modeling process itself. Our goal in taking this approach is to provide a more flexible and accessible set of leadership competency resources, which can be used by a greater breadth of healthcare leadership educators—in education and practice settings—that can be tailored to local needs and adapted as the health system evolves.

2. Which leadership practices are most important for achieving various dimensions of healthcare organizational performance?

We believe that the field has moved beyond the "why" of leadership development; however, we still have a ways to go before reaching the "how." Our work has recently shifted toward a deeper examination of the ways in which specific leadership practices may have differential impact on organizational outcomes of interest. As we become more adept at quantifying and measuring leadership and organizational performance, we can more accurately identify relationships between and among leadership and organizational performance.

Specifically, the field has now embraced a multi-dimensional perspective on hospital and health system performance—including financial, clinical, patient experience, employee experience, and learning.[24] We have also begun to identify valid and accepted measures of leadership development best practice and leadership performance.[25] We are poised to continue to grow the evidence base regarding the relationships between leadership and performance.

For example, in a recent NCHL-sponsored national study funded by Hospira and conducted by Health Research and Education Trust, we found that the leadership development best practices were adopted at a higher rate in system hospitals (compared to freestanding hospitals), in larger hospitals, and in teaching hospitals. The study also found a small, positive correlation between the implementation of leadership practices and a composite measure of hospital quality.

More recently, we began a stream of research tying NCHL's national survey of healthcare leadership development practices to hospital performance data on both process of care and patient experience measures. Using data from the American Hospital Association's Value-Based Purchasing calculator,[26] we found significant associations between these outcomes and specific leadership practices, as shown in Figure 1. These relationships suggest that a different portfolio of practices

Figure 1: Leadership practices associated with value-based purchasing outcomes[27]

Process measures:
r = .12 (p = .02)

- Leadership learning and development is aligned with organization's strategic goals and priorites
- Succession planning includes medical leadership
- Succession planning includes administrative leadership
- Managers are held accountable for performance management

Experience-of-care measures:
r = .21 (p < .001)

- Behavioral/competency-based interviews are used for hiring
- Leadership learning and development is aligned with organization's strategic goals and priorities
- 360-degree feedback is used for medical leadership
- 360-degree feedback is used for nursing leadership
- 360-degree feedback is used for administrative leadership
- Managers are held accountable for developing direct report
- Metrics are used for succession planning

may be indicated depending on an organization's priorities. This research is preliminary, but it illustrates the potential for a greater understanding of the relationships between leadership and different dimensions of performance.

3. How can we best leverage technology to enhance leadership development?

Although real-world experience will likely remain the best context for leadership development, there are many applications in which experience is less desirable, either because it is too expensive, too risky, or too scarce. Simulations—synthetically constructed analogs to real-world experience—are becoming viable substitutes for an increasing number of these applications.

The widespread availability of internet and mobile technologies has helped drive down the cost of computer-based simulations, and their application has been expanding across a breadth of industries. The evidence base supporting their use has been accumulating rapidly, and we can now say they compare favorably with other types of training, particularly when integrated with traditional course material.[28] These results raise a particularly intriguing training question: can simulations help emerging leaders develop the competencies they will need for a health system that has not yet been created?

To help answer this question, NCHL will pursue research on the use of simulations, interactive cases, and other advanced learning technologies for developing healthcare leaders. This work will include investigations of the current state of practice, as well as assessments of state-of-the-art approaches that may be adaptable from other industries. Our goals will be to identify the most promising practices, and to find ways to make them more accessible to learners across the continuum of leadership careers.

4. How can leadership teams become more representative of the communities they serve?

Despite considerable attention to this topic over the past decade, frustratingly little progress has been made nationally in senior leadership teams becoming more culturally and gender diverse. It is becoming clear that leadership diversity is likely to require a commitment to

culture change that may take decades to fully realize—and, like the career paths described earlier, may require fundamentally different competencies at different stages of development.

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With the help of Sodexo, NCHL has been pursuing diversity leadership demonstration projects to accelerate inclusion in our healthcare leadership ranks. We are committed to continuing this work and to helping organizations committed to improving diversity find paths to realizing these goals.

5. How can leaders from across the health system collaborate more effectively?

Looking forward, the work of successful healthcare delivery organizations and systems will take place outside of current organizational boundaries. As systems of care are created and held accountable for the health of populations they serve, leaders will need to work across organizational boundaries. Improving population health will require leaders from community agencies, health departments, private practice physician groups, long-term care providers, schools, community governments, and hospitals to come together, communicate effectively, and deal with a great deal of uncertainty. In 2001, NCHL was innovative for focusing on leadership teams that included physicians and nurses.

NCHL is pursuing efforts to identify and evaluate the role of educational simulations in developing healthcare leaders and leadership.

Looking forward, leadership teams will include an even broader set of members, with different perspectives, incentives, and priorities. And the need for effective leadership teams will become even more crucial.

To help address these emerging needs, NCHL is pursuing efforts to identify and evaluate the role of educational simulations in developing healthcare leaders and leadership. Recent work with population-level simulations suggests that these approaches can not only help leaders within a given organization, they can also provide pathways to inter-organizational dialog in pursuit of common goals around system optimization and population health.

CONCLUSIONS

Worrying about the future is a core part of the job for healthcare leaders—especially these days. It is important to keep in mind another essential role: inspiring others to envision a positive future. For most of us, the opportunity for us all to pursue a higher-value healthcare system, one that makes a quantum leap forward in supporting population health, has never been better. While getting to that sustainable future is likely to test us all, planning for the leadership needs of that future will be important for us all as well.

We look forward to taking this journey with you.

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