Developing Mentoring and Coaching Skills

Materials for Distribution:

The Mentoring Cycle:
A Six-Phase Process for Success

by Shannon K. Pieper
The last several years have seen a lively debate about the state of leadership development in healthcare management. Some individuals feel that there is an alarming lack of young executives ready to step into the shoes of top leaders as they leave their posts. Others believe the problem is not a lack of talented individuals, but that the individuals with potential are not being appropriately identified and developed.

At the heart of this discussion is the role mentoring plays in leadership development. Many organizations have taken steps in the last few years to encourage mentoring and make it easier for young executives to find mentors; ACHE’s Leadership Mentoring Network, begun in 2001, is one of those efforts (see sidebar on page 22). Julie Manas, vice president of Healthcare Services for Loyola University Medical Center in Maywood, IL, and a seasoned mentor, believes these efforts are beginning to pay off. “Recently there’s been a resurgence in the commitment to formal mentoring. Mentoring is around to stay,” she says.

As more healthcare leaders step into the roles of mentor and protege, it is vital that they understand how to get the most out of the relationship. Unsuccessful mentoring experiences can discourage both mentor and protege, stymieing intergenerational communication and contributing to an overall shortage of mentors. Successful mentorships, on the other hand, can be a significant contributor toward individual and organizational success.

**Why Mentoring?**
The benefits of mentoring for the protege are well-documented and easily understood—career development, preparation for additional responsibilities, enhancement of leadership skills. But mentoring’s effect on healthcare organizations is less well known.

David A. Stark, FACHE, executive vice president and chief operating officer of Iowa Health in Des Moines, is involved with an effort to develop a formal mentoring program in his organization. “Organizations should feel compelled to support mentoring for two reasons,” he says. “One is to improve retention and leadership development. The second is the role that the organization plays in the community. Healthcare organizations are not just businesses producing a product. Communities have high expectations of hospitals, and mentoring is one way to create a learning environment that supports and fulfills those expectations.”

Whether through formal or informal channels, Loyola’s Manas believes healthcare leaders have a responsibility to mentor. “It’s inherent to what we do and who we are,” she says.

**The Mentoring Cycle**
Manas and Stark have identified a six-phase mentoring cycle that can help potential proteges and mentors better understand what to expect and maximize the mentorship’s success. Ideally, this cycle is never-ending; as the mentorship comes to a close, the protege reenters the mentoring cycle at the beginning—this time as a mentor.

1. **Choosing a Mentor/Protege**
Although Manas and Stark encourage healthcare executives to mentor and be mentored at every opportunity, beginning a mentorship is not something to be taken lightly. Potential mentors and proteges must seriously consider two factors before agreeing to a mentoring relationship: time commitment and personal fit.

   “Mentoring requires commitment,” says Iowa Health’s Stark. “You have to be prepared to have meetings, respond to e-mails and telephone calls, and work with your protege on his or her career development plan.”

   While mentors usually have more demands on their time, proteges also must think seriously before agreeing to be mentored, as the process will require them to spend time developing and meeting specific goals.

   How much time is required? Obviously it depends on the individuals involved and the goals of the mentorship, but Loyola’s Manas says that mentors and proteges can expect to spend at least two to three hours a month on the mentorship. But there are ways to reduce the time commitment. “Meetings between mentors and proteges should be structured interaction,” says Thomas C. Dolan, Ph.D., FACHE, CAE, president and chief executive officer of ACHE.

   “When I meet with a protege, I ask
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him or her to prepare an agenda ahead of time of issues to discuss, and I often bring my own agenda as well. That formalization leads to more focused, efficient meetings.”

Equally important as the time commitment is ensuring a proper fit between mentor and protege. “Assess their career aspirations, values, style, and how committed they are to the mentoring process,” says Iowa Health’s Stark. “You don’t have to be mirrors of one another, but you do need to share general beliefs and goals.”

2. Getting Acquainted
Once the significant hurdles of the first phase of the mentoring cycle are cleared, mentor and protege must spend some time getting to know each other and setting ground rules for the relationship. “You need to define the expectations up front,” says Loyola’s Manas. “For instance, how are you going to communicate? E-mail is great for some people, but not for others.” Mentor and protege should also decide how often they will meet and how long the mentorship will last. Most formal mentorships last about a year; shorter lengths of time can make it difficult to achieve concrete goals.

During this stage, many mentors and proteges create a mentoring contract, which formalizes the agreement. “The mentoring contract helps clarify expectations and seal the commitment. It’s almost a symbolic gesture, but it’s a powerful one,” says Iowa Health’s Stark. The contract should include start and end dates for the mentorship, monthly time commitment, preferred methods of communication, and a statement of confidentiality. Through the mentor, the protege may become exposed to sensitive information; he or she must agree to keep such information confidential. But confidentiality works both ways as well. “The mentor may be tempted to feel that confidentiality goes down the organization, not up. But mentors should not feel free to reveal sensitive or personal information that the protege has shared with them,” says Stark.

3. Setting Goals
Every mentorship must have defined goals to be successful. Stark suggests that both mentor and protege begin by asking, “What do I want to get out of this?” Their answers will form the basis for the mentorship goals. “Often the protege’s goals will mirror his or her career development goals, such as working on physician relationships or learning how to facilitate effective team meetings,” says Loyola’s Manas. Proteges may also want to begin by completing a leadership skills assessment to identify areas for improvement, such as conflict management or written and verbal communication skills.

Equally important are the mentor’s goals. “My first goal as a mentor is to provide a growth experience for the protege,” says ACHE’s Dolan. “But in addition, I focus on ways I can learn. I consider anyone I mentor a future leader in the field; through mentoring, I am able to better communicate with those future leaders and to understand other generations. Mentoring adds to the arsenal of skills I draw on to lead.” Other common goals of mentors include improving time management and obtaining a fresh perspective on strategic planning.

Regardless of the specific goals, they should be put in writing to ensure that mentor and protege are in agreement. Having written goals also provides clear and objective standards with which to evaluate the mentorship after it is completed.

4. Growing the Relationship
The growth stage is the longest phase of the mentorship, the time when mentor and protege meet regularly, review and adjust goals, and monitor progress. It is also the time when problems in the relationship must be addressed. “If things are going wrong, don’t ignore it,” says Iowa Health’s Stark. “Options range from committing to fixing the problem to mutually agreeing to end the relationship.”

Most mentorships never face problems serious enough to warrant terminating the relationship. Instead, they follow a growth pattern in which the protege relies heavily on the mentor at first, then gradually becomes more independent. “The most effective mentorships are ones in which there is a gradual evolution of the relationship,” says Loyola’s Manas. “It moves from a nurturing and hand-holding relationship to one more focused on supporting and facilitating. Toward
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the end, mentor and protegé are on more of a peer level."

5. Ending the Relationship

Although there is such a concept as a lifelong mentor, most formal mentorships do come to an end. Having a mentoring contract that defines a particular end date can help both parties ease out of the relationship. Whether or not you work from a pre-decided end date, however, the relationship must end mutually.

Iowa Health’s Stark notes two other critical pieces of the ending phase. “There needs to be some level of celebration, maybe a dinner together or buying small gifts for each other—something that says thank you and celebrates the success,” he says. “Also, the mentor and protégé need to define their new relationship—what level of access they will have to each other, how it will be different.” Noting that this adjustment is difficult for some mentors and proteges, Stark suggests that the mentor and protégé consider a short separation time to make the relationship change final.

6. Evaluating the Relationship’s Success

Every mentorship should include an evaluation process. If the protégé completed a self-assessment at the beginning, the results can be used to do a final appraisal of how the protégé grew. “The evaluation should always be put in writing, to give the mentorship finality and formality,” says Stark. “In addition, there should be an opportunity for both the men-

ACHE’s Leadership Mentoring Network

ACHE has long had a Professional Policy Statement on the importance of mentoring; those advancing to Fellow inACHEare also encouraged to complete a formal, yearlong mentorship to fulfill their Fellow project requirement. Several years ago, ACHE began looking for ways to enhance mentoring opportunities. “It became clear to us that mentoring had drastically declined within the profession,” says Reed L. Morton, Ph.D., FACHE, director of ACHE’s Healthcare Executive Career Resource Center. “Fewer academic programs were offering residencies, and executives were often too busy for traditional mentoring.” Accordingly, Morton researched “virtual” mentoring options that would allow mentors and proteges to connect without the restraints of a traditional face-to-face mentorship. In 2001, ACHE launched the Leadership Mentoring Network, which has since matched more than 300 ACHE affiliates with volunteer mentors (see pages 52-53 for the names of the individuals who have served as mentors through the network).

The LMN maintains the classic one-on-one mentoring experience, while relying primarily on phone and e-mail communication, making geographic proximity unnecessary. Prospective mentors and proteges complete a personal profile that Morton and his staff use to identify possible matches. “We ask proteges questions such as: Where would you like to work next? What are your career aspirations? Is it important that your mentor have the same career setting as you?” says Morton. Similarly, mentors can choose to specify a protege in a particular organizational type or with particular career goals. Mentors and proteges are then paired according to their responses. “Having a big pool of mentors is critical because it allows us to make appropriate matches,” says Morton.

The LMN is a natural extension of ACHE’s commitment to support mentoring within the field. “The network really has two goals,” says Morton. “The first is to help the protege become more effective as a leader and prepare for his or her next position. The second is to acquaint healthcare executives with mentoring and to encourage those who have been mentored to consider being mentors in the future.” After just three years of operation, the LMN appears to be doing just that. One protege who was mentored through the network not only became a mentor but also shared his mentoring experience with other healthcare executives through an ACHE audio conference and a journal article.

For more information about the Leadership Mentoring Network, contact Reed Morton at (312) 424-9444, or log in to the Affiliates Only Area of ache.org and choose the Career Resource Center.

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The mentor and the protege to say what they would do differently next time, what worked, and what didn’t. Such a conversation can be difficult, but Loyola’s Manas stresses the importance of openness and honesty. “Both mentor and protege have to be willing to share what they’ve learned, and they have to commit to being honest, even if they feel that the mentorship wasn’t successful,” she says.

Of course, evaluation of the mentorship does not have to be limited to when the relationship has ended. Manas believes that any formal mentoring program should include regular meetings with mentors and proteges to talk about their progress and how the program might be improved. On an individual basis, ACHE’s Dolan advocates that mentors periodically check with others within the organization about the protege’s progress.

“Occasionally it helps to find out what the protege’s relationship is like with other senior executives,” he says. “He or she may be communicating well with you, but others may have a very different impression.” This information can be used to adjust the mentorship’s goals.

### Common Mentoring Mistakes

In their experiences as both mentors and proteges—in both formal and informal mentorships—Stark and Manas have identified some of the more common mentoring mistakes.

- **Picking the wrong person.** “Don’t ever begin a mentorship if you can’t be a good mentor to that person,” says Loyola’s Manas. Both mentor and protege should feel free to refuse a mentorship if their values do not match the other person’s values, or if they question the other person’s motives for wanting the mentorship.

- **Lecturing rather than listening.** A common mistake among mentors is to assume that because they are more experienced than their protege, they should use the mentorship to impart their knowledge. “This is one of the hardest things to avoid, because you feel that you have the answer, and it’s quicker for you to just tell the protege how to do it,” says Iowa Health’s Stark. Effective mentors guide proteges’ thought processes rather than lecturing them on what to do.

- **Failing to respect the role of the protege’s boss.** Mentor and protege must stay sensitive to the fact that the mentor does not replace the protege’s boss. “Don’t allow the protege to use you and your position to get something done by going around his or her boss,” says Loyola’s Manas. “And at the same time, don’t assume that you know what’s right for the protege and interfere with decisions that his or her boss has made.”

- **Using mentoring as a disciplinary tool.** Occasionally organizations use mentorships as a way of keeping closer tabs on a problem employee. Stark strongly advises against this. “The focus of a mentorship should not be disciplinary. If you have a problem employee, use a coach to address the problem, not a mentor.”

Whether you are a mentor or protege—participating in a formal, one-year mentoring program or a lifelong informal relationship—mentoring is an unparalleled learning experience for both parties. “As they develop the future leaders in our field, mentors have an opportunity to create a legacy,” says ACHE’s Dolan. In turn, those new leaders will become mentors, continuing a cycle that has become critical to the future of healthcare organizations and the profession itself.

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Mentoring’s Value in Action:  
A Fellowship Case Study

In his first year as an administrative fellow for Rapid City (SD) Regional Hospital, Ryan J. Lambert, CHE, completed a four-month pharmacy project that is estimated to reduce the hospital’s pharmaceutical purchasing costs by $4.5 million in FY2005. “My experience is a key example of how mentoring in the form of a fellowship can bring significant value to the organization,” says Lambert. “The savings that we realized are annual savings—it’s not a onetime deal. Long after I’m gone, the organization is still going to be saving a significant amount on pharmaceutical purchases.”

While Lambert’s experience is perhaps unusual, his mentor and boss, Timothy H. Sughrue, FACHE, chief executive officer at Rapid City, argues that fellows bring a unique blend of perspective and skills that can translate to measurable benefits for all organizations, not simply for the individual. “Historically, the fellow has brought us the latest conceptual framework on healthcare issues from an academic program, excellent data management skills, and the prospect of filling critical staff needs upon completion of the program,” he says. Sughrue and Lambert also believe that recent graduates bring a fresh outlook that can help move projects along faster. “Fellows can respectfully challenge the status quo,” says Lambert.

Many organizations offer fellowships, but Rapid City’s program is an intensive two-year fellowship that maximizes the benefits for both the individual and the organization. “The distinguishing characteristic of our program is that we treat the fellow as a member of the administrative team,” says Sughrue. “Rather than delegating menial tasks, we encourage the fellow to tackle initiatives that hold the prospect of producing significant yield to the organization. The fellow is granted the latitude and time to make profound change.” Following are some of the components that make this unique fellowship so successful.

“Shadowing” senior executives. The first year of the Rapid City fellowship is an intensive orientation into the management areas of the organization. Lambert spent one month shadowing each vice president, attending committee and board meetings, and meeting with employees at all levels. “This will be the only time in my career where I am paid to shadow doctors, nurses, managers, security personnel, and even custodians,” he says. This global view of the organization provided Lambert with information that will have a profound effect later in his career.

High-level projects. In his first week at Rapid City, Lambert was asked to help implement a plan of action for eight major issues that needed to be addressed in the hospital’s pharmacy department. He has since chaired committees, helped with the strategic plan, and created formal presentations.

“When furnished with tough, challenging objectives in a supportive environment, a fellow can achieve remarkable results,” says Sughrue. “It really comes down to the organization having enough courage and faith to unleash the considerable potential of most fellows.”

High-level decision making. Closely related to high-level projects is the fellow’s involvement in decisions at the highest level of the organization. “I was consistently brought into meetings where key decisions were being made, and my input was valued. At 28 years old, I was voting with the most senior members of the administrative team,” Lambert says. “That’s key because I got the big picture. I came to understand the politics and the thought processes behind the decisions of upper management.”

As more hospitals and healthcare organizations face budget crises, fellowships are becoming more endangered. However, Lambert’s experience shows that the time and resources required to organize a formal mentoring experience such as a fellowship can generate considerable return on investment for the organization. Just as important, fellowships help build a new generation’s commitment to mentoring. “Twenty years from now, I will be much more willing to take on a fellow or a protege, because I have seen firsthand how valuable it is,” says Lambert. “Fellowships are an essential way to continue developing new leaders.”

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