

# **Executive Leadership Development In U.S. Health Systems: Exploring the Evidence**

## **Final Report**

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# I. Executive Summary

## **Background:**

Constant and rapid change within the healthcare industry demands strong leadership within healthcare institutions, and multi-hospital healthcare systems present particular leadership challenges due to both their size and complexity. Ideally, healthcare organizations provide strong employee development and training for all levels of employees. However, how to best train and develop executives at senior levels within healthcare systems has not been determined. From a practical standpoint, executive leadership development programs may present a feasible approach that healthcare systems can use to promote both learning and development in-house while capitalizing on externally available training programs, but the training and development of senior-level health system executives has not been systematically studied.

## **Research Objective:**

The objective of this research was to study the establishment, organization, content, process, evaluation, and evolution of executive leadership development (ELD) programs in U.S. healthcare systems.

## **Research Design:**

Combining quantitative and qualitative methods, this research was comprised of a nationwide survey of U.S. health systems and semi-structured interviews with organizational key informants. Questions on both the survey and interview guide were designed to improve our understanding of executive leadership development in health systems. A total of 104 health systems returned a survey, representing 28% of the initial sample. For the qualitative study, 25 key informants were interviewed from 9 different health systems.

## **Research Results:**

### ***Executive Leadership Development Programs:***

- Across health systems surveyed, half (52%) reported having an ELD program in existence, and another 12% reported having a program under development.
- Among those with existing programs, the vast majority (88%) tied their ELD programs to health system strategic goals.
- While most respondents (94%) had heard the term corporate university used in a business setting, only 26% of systems with ELD programs used the term “corporate university.”
- Among existing ELD programs, 73% were reportedly customizable to the needs of participating executives.
- The reasons most frequently noted by survey respondents for initiating ELD included strategy, succession planning, and the desire to provide local development opportunities.
- Key informants noted three major factors contributing to the establishment of a program: 1) a desire to focus on employee development and workforce improvement; 2) the desire to become or remain the employer of choice; and 3) the desire to emphasize education and learning within the organization.
- The most frequent competency emphases for ELD programs included leadership and general management skills, in addition to communication, relationship management, and quality improvement.

- Participants included in the ELD programs described included individuals at all senior management levels of both the system and individual hospitals. In both categories (i.e., system and hospital), Vice President (VP) participation was reportedly highest, and Chief Medical Officer (CMO) participation was lowest.
- There was a wide range of program budgets reported. The average program budget was \$4,539 per participant, excluding a single outlier.

***Content and Process of Executive Leadership Development:***

- Across existing ELD programs, the average number of contact hours per participant was 52, with the median figure of 40 contact hours. Faculty for those hours of content were mixed between internal (57%) and external (43%) instructors.
- Executive coaches were reportedly provided through 86% of the ELP programs; only 20% of respondents restricted coaches to internal personnel.
- Multiple external organizations and programs supplemented system ELD. The Advisory Board Company was most commonly used (58%) followed by universities (36%), Center for Creative Leadership (25%), and National Center for Healthcare Leadership (21%).
- The most frequent approaches to determining areas of needed emphasis included asking participants for ideas (58%) and performing an annual program review (55%). Additional input was sought from the strategic planning process (51%), from other executives (47%), and, less frequently, from consultants (30%).
- ELD program participants were evaluated most commonly through performance evaluations and professional development plans (79%); 67% reported using self-assessments; and half (50%) reported using a 360 degree evaluation process.
- Key informants noted five main areas of challenge or concern about leadership development programs: 1) managing competing priorities; 2) internal program promotion; 3) program evaluation; 4) program resources and constraints; and 5) future development.

***Evaluation and Evolution of Executive Leadership Development:***

- ELD program effectiveness was most frequently evaluated on the basis of employee job satisfaction (66% in use; 15% under development), succession planning (62% in use; 31% under development), quality improvement (62% in use; 13% under development), and patient satisfaction (58% in use; 8% under development).
- Only five responding programs (9%) reported using return on investment (ROI) as an evaluation metric.
- A majority of program components were reportedly worth the investment, with several exceeding expectations for over one-quarter of responding health systems: coaching (40%), 360 degree feedback (33%), leadership skills (29%), Quality Improvement (QI) skills (28%), and self-assessment processes (27%).
- Key informants emphasized four main avenues by which leadership development programs could provide value to a health system: 1) permit a focus on employee growth and development; 2) improve support for the organization's strategic priorities; 3) improve employee retention; and 4) reduce expenditures on learning and development.
- The most commonly listed features planned for ELD programs included succession planning, coaching, tiered competency development, and use of executives for teaching/mentoring middle management. From key informant interviews, the areas of

individualized program development and opportunities for action learning were also discussed as future development priorities.

- Topics reportedly best taught by external experts included those benefiting from a broader perspective such as leadership skills, change management, executive coaching, quality improvement, best practices, negotiation, and team-building.
- The few topics respondent health systems were reportedly willing to outsource included 360 degree evaluations, executive coaching, conceptual/broad thinking, and performance improvement training.
- Key informants highlighted four different areas they considered to be critical success factors for a health system leadership development program: 1) executive support and engagement; 2) strong program leadership and personnel; 3) having an organizational value for development and education; and 4) having a linkage between the leadership development program and the strategic priorities of the health system.

## **II. Introduction**

This report presents the results of the study, “Executive Leadership Development in U.S. Health Systems,” conducted by Dr. Ann Scheck McAlearney of the Division of Health Services Management and Policy in the College of Public Health at The Ohio State University, with support from the 2006 Health Management Research Award from the American College of Healthcare Executives. Interest in studying this topic reflected a re-framing of the original research project which was designed to better understand corporate universities in U.S. healthcare organizations. Preliminary interviews and discussions revealed little industry-wide understanding of the concepts and program content associated with the term, “Corporate University.” However, these conversations also revealed a clear need for strong senior-level health system executives, and limited understanding of how executive leadership development proceeds. The study focus was subsequently revised to concentrate on expanding understanding of Executive Leadership Development programs in U.S. health systems, including considerations about the establishment, organization, content, process, evaluation, and evolution of such programs.

### III. Background

To a large extent, the success of any provider organization is dependent on its employees' cumulative knowledge and ability to apply this knowledge effectively, and the burden of directing this knowledge application often falls disproportionately on senior executives. The importance of a continuous educational effort is exacerbated by the rapid technological, policy, and procedural changes that are characteristic of the current healthcare industry. Further anticipated increases in the rate of technological change related to medical procedures, devices, and pharmaceutical products make education and development an especially important part of any healthcare organization's strategic positioning process. Although the exact nature and requirements of training and development programs vary significantly by organization, it is clear that all healthcare entities interested in remaining competitive need to develop a plan to provide individuals with appropriate educational and developmental opportunities.

Estimates show that effective training programs are often one of the top three reasons that employees accept and remain in a certain position (Shah, 2001). This is particularly critical for healthcare organizations since many areas of the industry are quite competitive, making it difficult to recruit and retain personnel, especially in executive positions. In addition to helping a healthcare organization become and remain an "employer of choice," leadership development programs have the potential to increase employee loyalty, disseminate a common organizational culture, and increase customer satisfaction (Morin, 2004; Corporate University Xchange, 2005a; 2005b). This suggests that there is legitimate potential for healthcare organizations to leverage a leadership development program to improve patient and staff satisfaction. Such advances could provide an important strategic advantage in today's competitive healthcare market.

The best leadership development programs are those that are able to provide learning that produces enduring changes in employee behavior (Kirkpatrick, 2005). Critical to achieving such success is the ability to secure executive level support and program acceptance throughout the organization (Corporate University Xchange, 2005b; Morin, 2004). Additionally, educational programming and the design of the leadership development program should ideally be developed to support the organization's mission and strategic objectives (Allen, 2002; Corporate University Xchange, 2005b).

Currently, multiple strategies exist by which training and development can be provided within healthcare organizations, but relatively little information has been collected assessing alternative approaches, nor about approaches specifically focused on executive-level leaders. In particular, it has been unclear which strategies and models are better employed under what circumstances, and how different resource needs affect program initiation and development. Little evidence exists to indicate the critical factors that should drive the design and development of a leadership development program for an individual healthcare organization, and a focus on executive-level leadership development has not been previously pursued. Further, broad questions remain. Should all healthcare organizations have their own executive leadership development program, or would centralized, shared programs or program elements be more effective from a cost benefit perspective? How do the development approaches of smaller health systems differ from those of their larger counterparts? What strategies should be contemplated to address these differences? This research was designed to study the use of executive leadership development programs in

U.S. health systems, and to explore how additional use of such programs might be beneficial to the industry.

### **Research Objective**

**The objective of this research was to study the establishment, organization, content, process, evaluation, and evolution of executive leadership development programs in U.S. healthcare systems.**

### **Study Design**

Overall, this study addressed three main categories of research questions in a combination of quantitative and qualitative approaches to data collection. For the **quantitative portion** of the research, a 35-item survey asking about executive leadership development programs was developed and distributed to chief executive officers (CEOs) of U.S. health systems (see Appendix B for Survey). This survey was organized into three main parts:

**Part 1: *The establishment and organization of executive leadership development: How is the program organized and delivered within the health system?*** (i.e., organization of program, reasons contributing to program development, what competencies are emphasized, what types of individuals participate, what is the program budget)

**Part 2: *The process of executive leadership development: How is program content delivered, what guides content selection, and how are participants evaluated?*** (i.e., number of contact hours for participants, origin of faculty, use of coaches and external programs, how topics are selected, how participants are evaluated)

**Part 3: *The evaluation and evolution of executive leadership development: How is program effectiveness evaluated?*** (i.e., methods of evaluating program effectiveness, expectations about return on investment and payoff from program elements, revisions and planned changes to program, willingness to outsource program topics)

The **qualitative portion** of the research used a semi-structured interview guide to ask health system informants about their executive leadership development programs (see Appendix D for the Interview Guide). The interview guide was divided into five sections, listed below:

- Section 1: Description of this Executive Leadership Programs and Initiatives
- Section 2: General Views about Leadership Development Programs
- Section 3: Importance of Leadership Competencies
- Section 4: Program Evaluation
- Section 5: Conclusion

## IV. Methods

### **Quantitative Methods**

#### *Survey Process*

The survey methodology followed a modified Dillman methodology (Dillman, 2000), consistent with the approach suggested by the American College of Healthcare Executives. Healthcare chief executives were mailed a 10-page, 35-question survey with a postage-paid response envelope between July and September 2007 (n=374). The survey had been pilot tested with two local health systems, and was estimated to take 15 minutes to complete. Following the initial mailing, a follow-up survey was sent to the non-respondents approximately two weeks later. Nineteen surveys were returned with incorrect addresses, leaving 355 potential respondents for the mailed survey.

Because we were concerned about reported low response rates for surveys of chief executives, we attempted to increase our overall survey response rate by using follow-up phone calls to non-respondents. These follow-up calls occurred in September and October 2007.

#### *Survey Data Analysis*

Survey data analyses used Excel and the STATA statistical package (version 8.0) to evaluate responses, as well as relationships between responses, respondents' organizations' characteristics. Preliminary analyses reported here include univariate and bivariate analyses, structured to assess both the state of the industry, and associations within the data.

#### *Survey Response Rate*

A total of 104 health systems returned a completed survey, representing 29% of the 355 health systems originally sampled.

#### *Survey Non-Response Analysis*

As described above, surveys were mailed to a total of 374 chief executives, and ACHE research staff provided a non-response analysis based on this original number of surveys mailed. Respondents were compared with non-respondents based on system size (number of hospitals), system control (ownership type), region, and ACHE affiliation of the CEO. This analysis showed that respondents did not differ from non-respondents relative to system size as measured by the number of hospitals in the system. However, CEOs in investor-owned systems were less likely to respond to the survey than those in systems under not-for-profit and governmental control. By region, CEOs in systems based in the Pacific were less likely to respond than CEOs from systems in other regions. Conversely, CEOs of systems based in the East North Central and West South Central regions were more likely to respond to the survey. The lowest survey

response rate was from CEOs from the Pacific at 13 percent, and the highest response rate was from CEOs the West South Central region where 58 percent responded. Finally, CEOs who were ACHE affiliates were more likely to respond than non-ACHE-affiliated CEOs. Additional detail about respondents compared to non-respondents is provided in the Appendix section of this report (Appendix D).

## **Qualitative Methods**

### ***Interview Process***

Twenty-five semi-structured telephone interviews with key informants from nine health systems have been held to learn more about executive leadership development in U.S. health systems. These key informant interviews followed the standards of rigorous qualitative research, using ethnographic interview techniques (Spradley, 1979; Maxwell, 1996) and thorough analysis (Miles & Huberman, 1994; Strauss and Corbin, 1998). Consistent with the research objective, questions addressed the establishment, organization, content, process, evaluation, and evolution of executive leadership development programs in U.S. healthcare systems.

Development and refinement of interview questions proceeded throughout the study and was based on information obtained from background research, interviews, and returned surveys. The interview guide was pilot tested with healthcare leaders in the Central Ohio region.

### ***Qualitative Data Analysis***

Qualitative data analyses used the constant comparative method of qualitative data analysis (Glaser and Strauss, 1967), and common techniques to code the data (Constas, 1992; Miles and Huberman, 1994). Using a grounded theory approach (Glaser and Strauss, 1967; Strauss and Corbin, 1998), interview transcripts were read, and findings discussed among investigators. This iterative process has permitted exploration of emergent themes in subsequent interviews (Glaser and Strauss, 1967). The *Atlas.ti* software package (version 4.2) (Scientific Software Development, 1998) was used to facilitate coding and data analyses, and the formal exploration of patterns and themes within the data.

## V. Results: Descriptions of Survey Participants and Interviewees

Of 355 eligible surveys, 104 completed surveys were returned, representing a response rate of 29%. Additional information about these survey responses and associated demographic data describing responding health systems are presented below in Tables V.1-V.4. Information about the qualitative interview participants is presented in Table V.5.

### *V.1: Survey Respondents and Data Available*

Surveys were returned by 104 health systems, 53 of which reported having an established leadership development program (Table V.1). An additional 12 systems reported having a leadership development program under development, with 11 of those 12 systems (92%) completing a survey to provide data for analysis. Finally, 37 health systems returned surveys reporting that they did not have an executive leadership development program. Of these 37 surveys, 16 (43%) contained demographic data to permit analysis. However, the small numbers of responding health systems with leadership development programs under development or without programs made sub-group analysis infeasible due to concerns about protecting respondent confidentiality.

**Table V.1: Survey Respondents and Data Available (n=104)**

<b>Survey Responses</b>	<b>Survey Returned (n)</b>	<b>Data Available* (n)</b>
Have a leadership development program	53	53
Developing a leadership development program	12	11
Do not have a leadership development program	37	16
<b>TOTAL RESPONSES</b>	<b>104</b>	<b>80</b>

\* Data availability varies by survey question. A complete list of survey responses by question number is provided in Appendix C.

### ***V.2: Size of Health System by Status of Leadership Development Program***

Of 51 responding health systems that had a leadership development program and provided data about health system size, health systems averaged 8.5 hospitals per system. The median number of hospitals per health system was 5 hospitals.

Among the responding health systems with leadership development programs were 16 health systems with 1-3 hospitals, 15 health systems with 4-6 hospitals, 9 health systems with 7-9 hospitals, and 11 health systems with 10+ hospitals (Table V.2). Among responding systems with leadership programs under development were 7 health systems with 1-3 hospitals, 1 system with 4-6 hospitals, 1 system with 7-9 hospitals, and 2 systems with 10+ hospitals. Finally, among responding health systems with no leadership development programs were 8 systems with 1-3 hospitals, 6 systems with 4-6 hospitals, and 2 systems with 10+ hospitals.

**Table V.2: Size of Health System of Survey Respondents, by Status of Leadership Development (LD) Program (n=80)**

<b>Size of System</b>	<b>Have LD Program</b>	<b>Developing LD Program</b>	<b>Do not have LD Program</b>	<b>TOTAL</b>
1-3 hospitals	16	7	8	31
4-6 hospitals	15	1	6	22
7-9 hospitals	9	1	0	10
10+ hospitals	11	2	2	15
<b>TOTAL</b>	51	11	16	<b>78</b>

### ***V.3: Demographic Characteristics of Survey Respondents Reporting Having a Leadership Development Program***

Of the respondents reporting that their health system had a leadership development program, the majority (65%) were Presidents or CEOs of their health system (Table V.3). An additional 18% of individuals who completed the survey were Vice Presidents, and 12% were reportedly directors. One respondent was a COO, one was an assistant Vice President, and one was a Senior Consultant.

Among responding Presidents/CEOs, their average job tenure was nearly 10 years in that role, and 70% had previously held a similar position (Table V.3). Among the responding Vice Presidents, their tenure was similarly long, at almost 12 years. Nearly half (44%) of responding Vice Presidents reported having had a similar position prior to assuming this position. Finally, among responding Directors, their average job tenure was 2.5 years, and 67% of them reported having held a similar prior position. The small numbers of COO, Assistant Vice President, and Senior Consultant respondents made sub-group analysis infeasible due to concerns about protecting respondent confidentiality.

**Table V.3: Demographic Characteristics of Survey Respondents Reporting Having a Leadership Development Program, by title (n=51)\***

TITLE	% (n)	AVG TENURE (years)	HELD SIMILAR POSITION?	
			YES	NO
President/Chief Executive Officer (CEO)	65% (33)	9.5	70% (23)	30% (10)
Chief Operating Officer (COO)	2% (1)	*	*	*
Vice President	17% (9)	10.9	44% (4)	56% (5)
Assistant Vice President	2% (1)	*	*	*
Director	12% (6)	2.5	67% (4)	33% (2)
Senior Consultant	2% (1)	*	*	*

\* Cells with too few respondents do not have detailed demographic data associated with their responses in order to protect respondent confidentiality.

#### ***V.4: Combined Demographic Characteristics of Responding Health Systems Who Reported Having a Leadership Development Program***

Of the responding health systems reporting that they had a leadership development program, there were 16 respondents from health systems of 1-3 hospitals (31%) (Table V.4). These smaller health systems had an average net revenue of \$550,769,231. Ownership structure was predominantly not-for-profit, secular systems (75%), with an additional 19% reporting state or local government ownership.

Respondents also included 15 mid-size health systems (29%) with 4-6 hospitals. Average revenue for this group of health systems was \$1,175,000,000, and ownership structure was predominantly not-for-profit, with a split between secular (47%) and religious (40%) systems.

Health systems with 7-9 hospitals represented 18% of respondents. This group had an average net revenue of \$1,857,522,222; they were predominantly not-for-profit systems. Responding systems in this category represented 67% secular systems and 11% religious systems, with an additional 22% of systems reporting state or local government ownership.

The largest health systems comprised of 10 or more hospitals represented 21% of respondents, and had an average net revenue of \$3,140,000,000. These large health systems were again predominantly not-for-profit systems, with a split between secular (45%) and religious (36%) systems.

**Table V.4: Combined Demographic Characteristics of Responding Health Systems Who Reportedly HAVE a Leadership Development Program (n=53)\***

Size of Health System	Number of Respondents % (#)	Average Net Revenue	OWNERSHIP STRUCTURE % (#)			
			Not-for-profit (NFP), Secular	NFP, Religious	Investor-Owned	State/Local Govt
<b>1-3 hospitals</b>	31% (16)	\$550,769,231	75% (12)	*	*	19% (3)
<b>4-6 hospitals</b>	29% (15)	\$1,175,000,000	47% (7)	40% (6)	*	13% (2)
<b>7-9 hospitals</b>	18% (9)	\$1,857,522,222	67% (6)	11% (1)	*	22% (2)
<b>10+ hospitals</b>	21% (11)	\$3,140,000,000	45% (5)	36% (4)	*	*

\* Cells with too few respondents do not have detailed demographic data associated with their responses in order to protect respondent confidentiality.

### ***V.5: Characteristics of Key Informants Interviewed***

For the qualitative portion of this research, 9 health systems were contacted, and a total of 25 interviews conducted with key informants. Among the 25 interviewees, 7 were executive-level informants, 7 were director-level, 7 were manager-level, and 4 were non-manager level individuals.

**Table V.5: Characteristics of Key Informants Interviewed**

<b>Level of Informant</b>	<b>Number</b>
Executive	7
Director	7
Manager	7
Non-Manager	4
<b>Total</b>	<b>25</b>

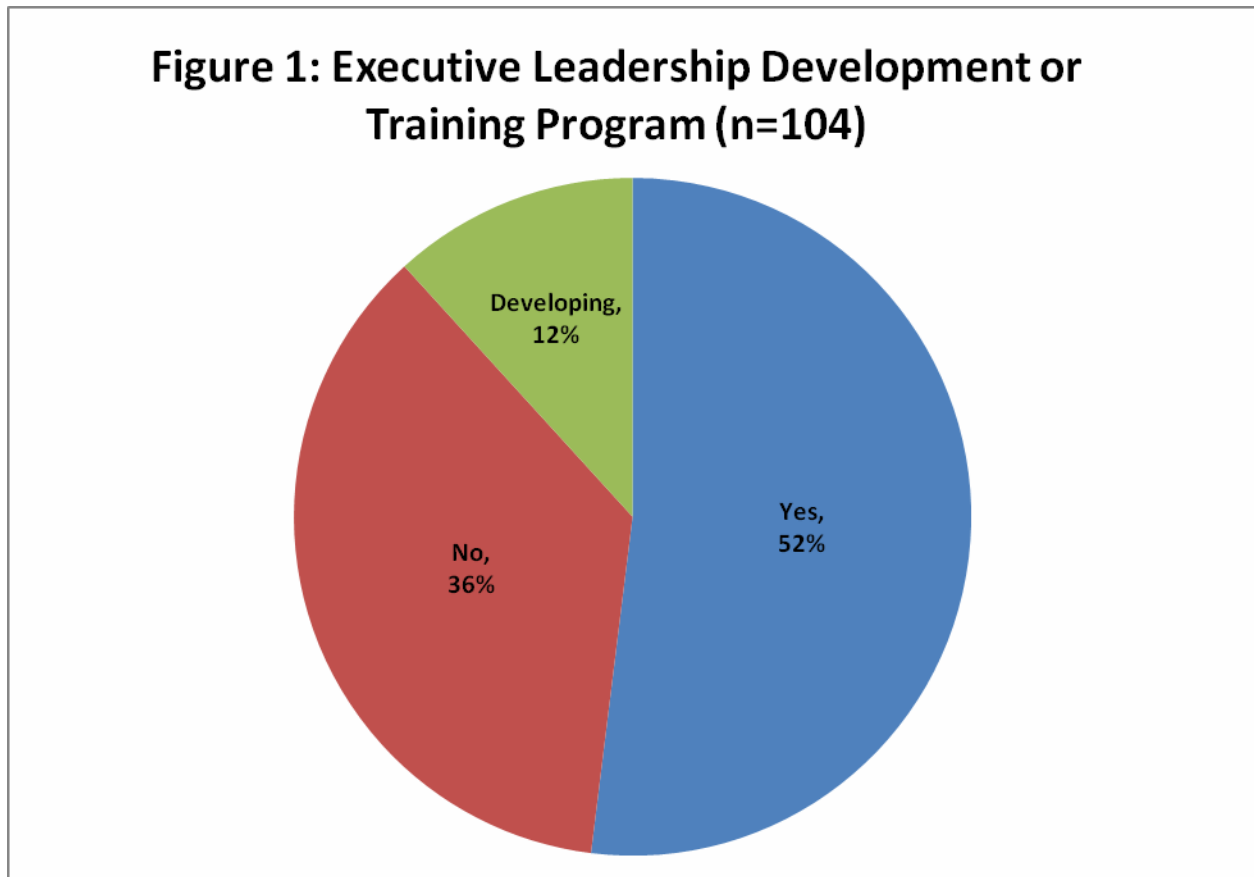
## Results: Survey Results

### PART 1:

#### **ESTABLISHMENT AND ORGANIZATION OF EXECUTIVE LEADERSHIP DEVELOPMENT**

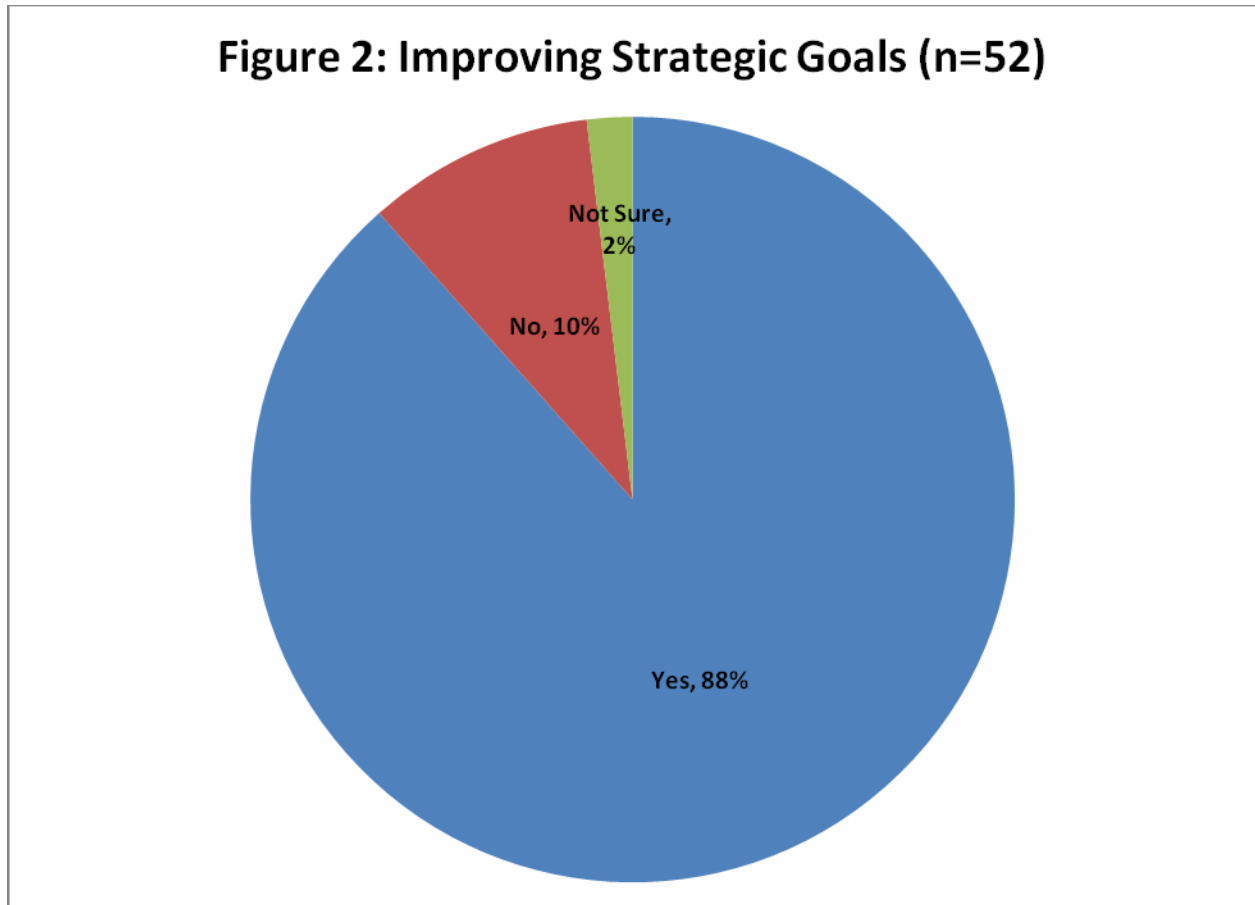
*Q1 – Does your health system have an executive leadership development or training program?*

Of 104 responses, approximately half (52%) of the health systems had an executive leadership development program (Figure 1). Just over one-third of the respondents (36%) did not have a program and 12% reported that their system was developing a program.



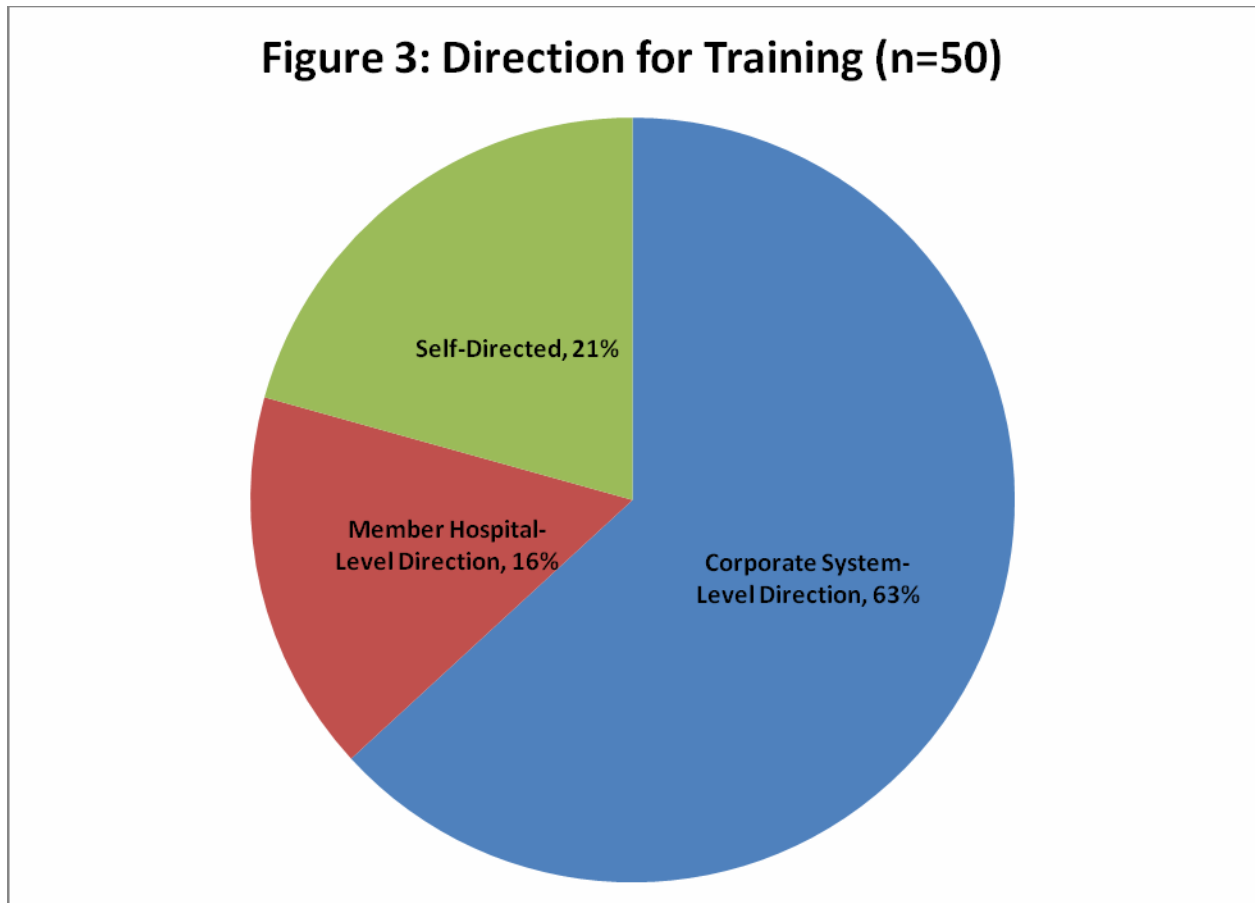
***Q2 – Program tied to improving the strategic goals of the system?***

Of 52 responding health systems that had a leadership development program, 88% of the programs were tied to improving the strategic goals of the system, while 10% of the programs were not tied to improving strategic goals, and 2% of respondents reported they were unsure whether the linkage existed (Figure 2).



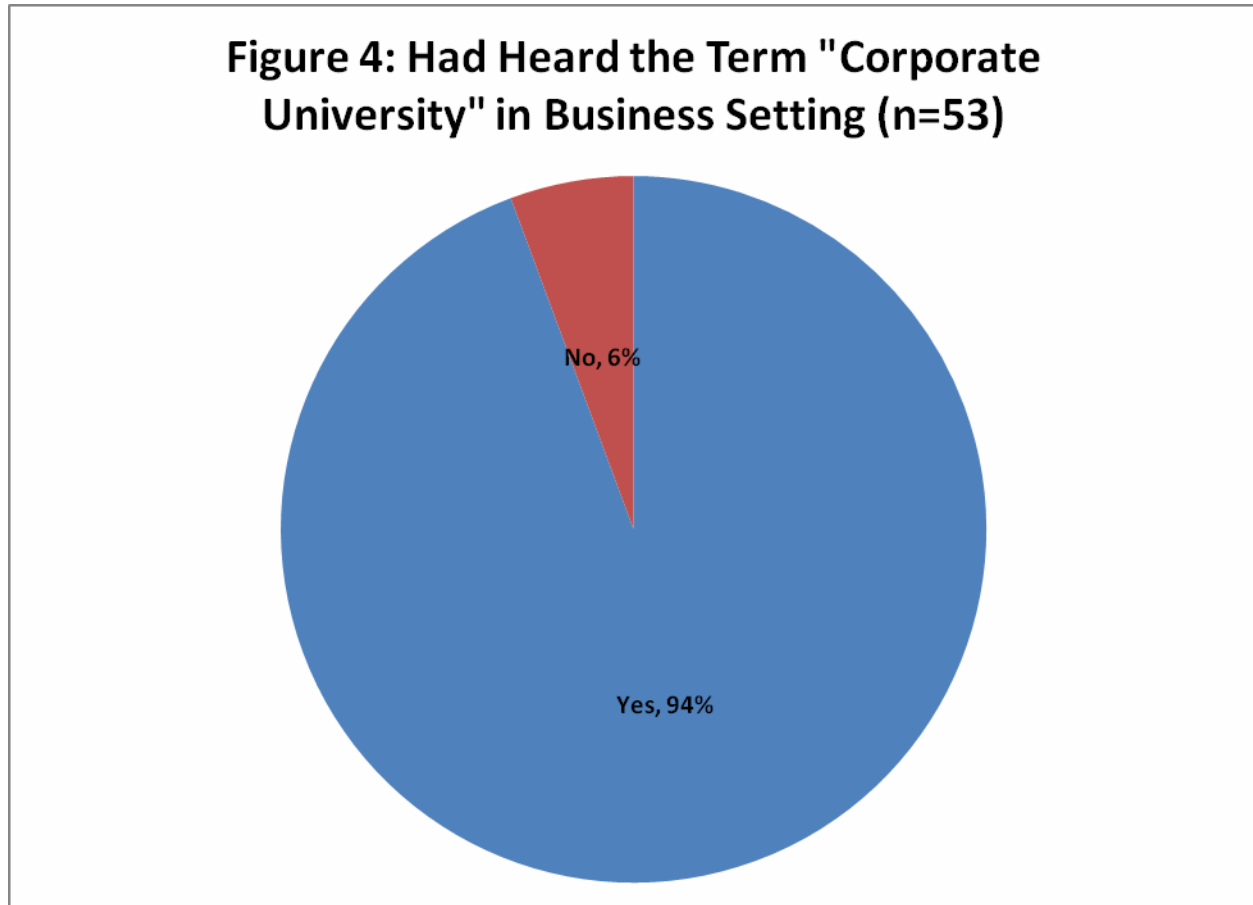
***Q3 – Percentage of training under corporate or system-level direction, member hospital-level direction, or executive self-directed***

Of 50 responding health systems that had a leadership development program, 63% were under corporate or system-level direction, 16% were under member hospital-level direction, and 21% were reportedly self-directed by executives (Figure 3).



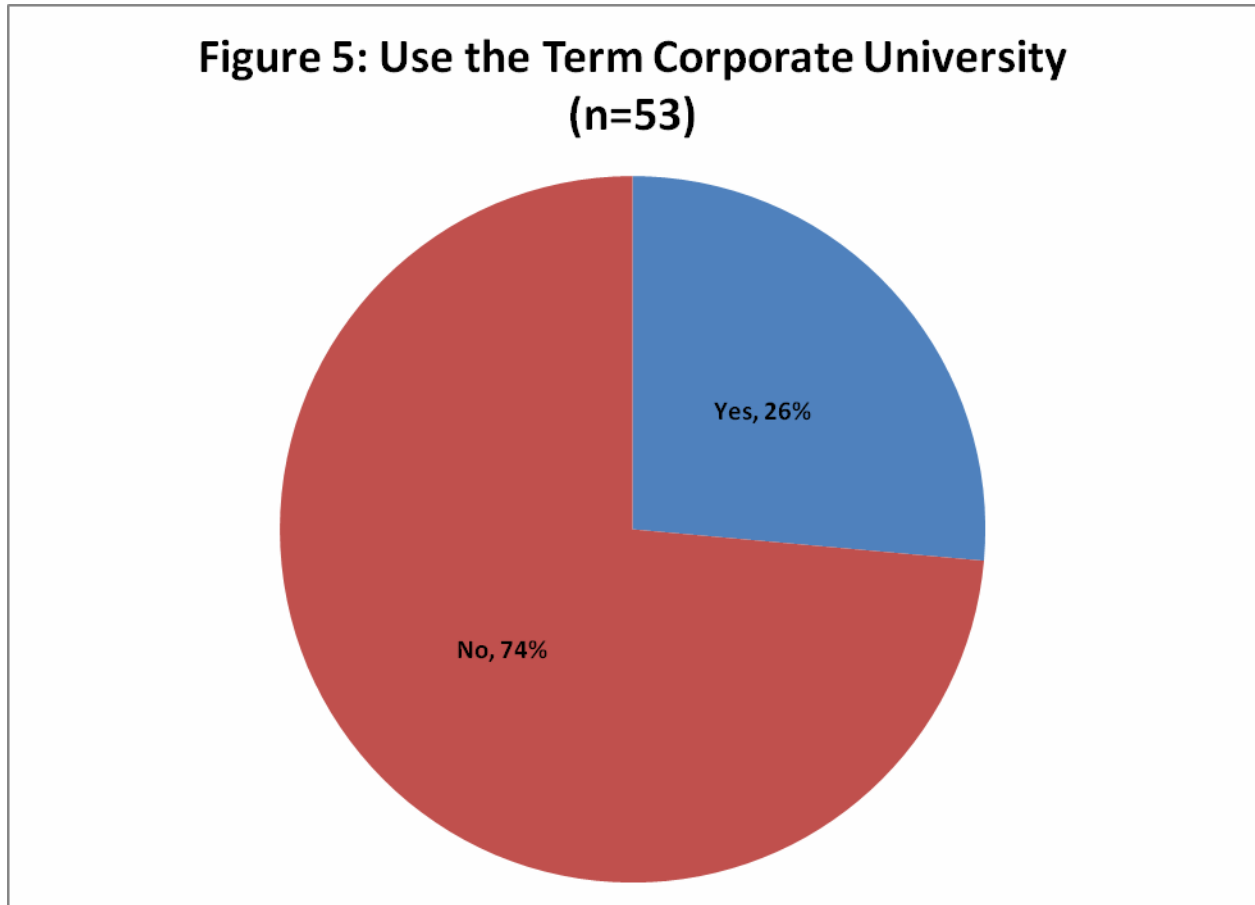
***Q4 – Recognized the term “corporate university” from business settings***

Of 53 responding health systems that had a leadership development program, the vast majority (94%) had heard the term “corporate university” used in a business setting, while the remaining 6% had not (Figure 4).



***Q5 – Use of the term, “Corporate University”***

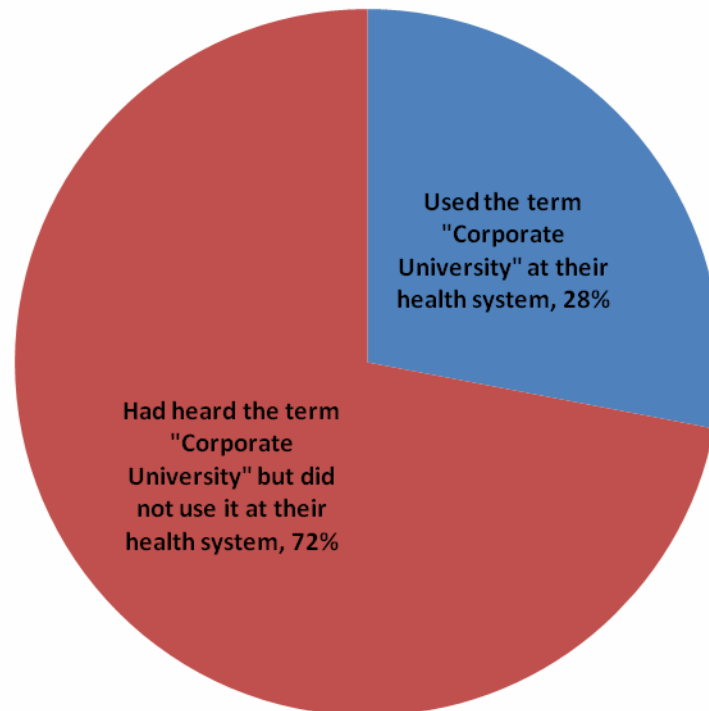
Of the 53 responding health systems that had a leadership development program, just over one-quarter (26%) reported using the term “corporate university” (Figure 5). The majority (74%), however, did not use the term “corporate university” at their health system.



***Q5 continued***

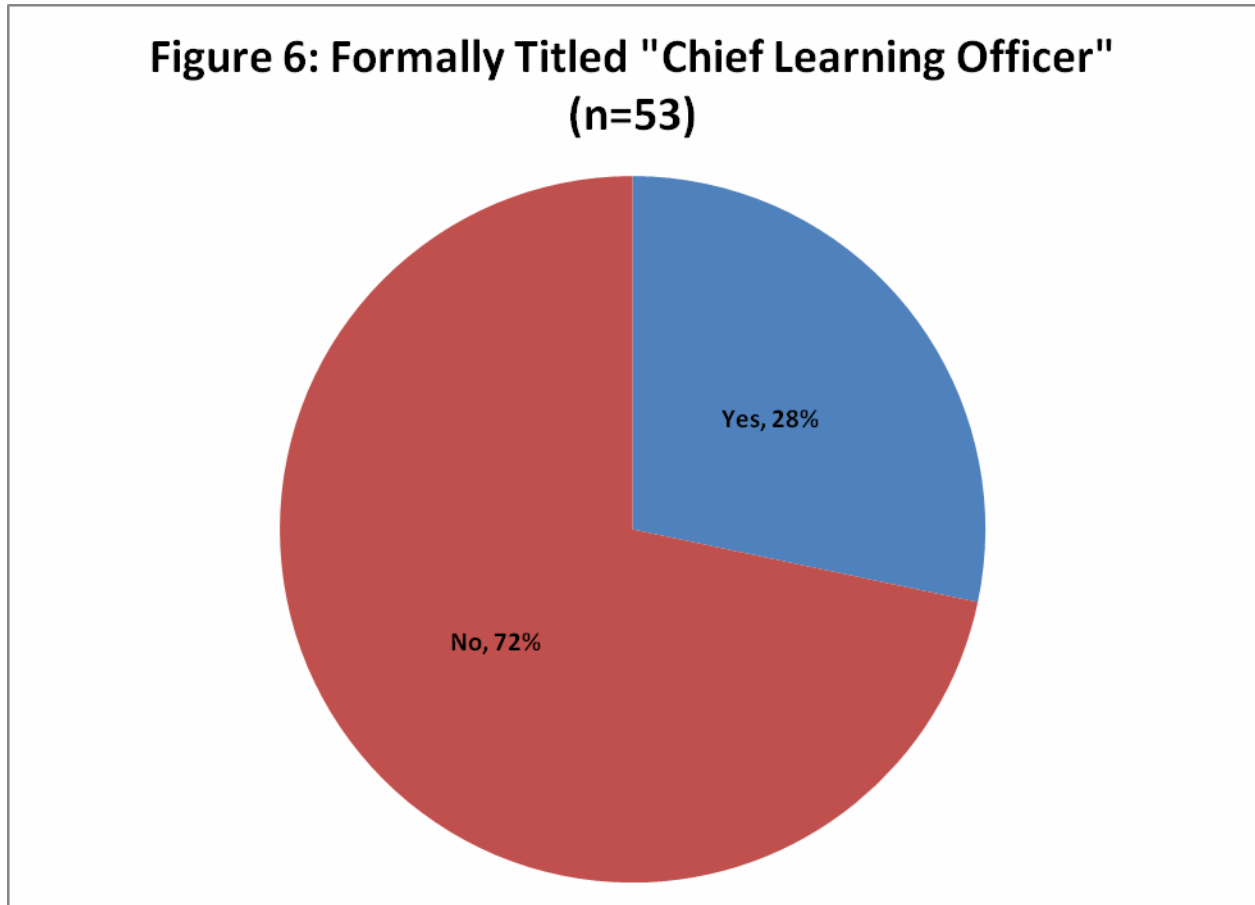
Of the 50 responding health systems that answered yes to Question 4 (94%), 28% reported using the term “Corporate University” in their health system (Figure 5a). The remaining 72% did not use the term even though they had heard it used in a business setting.

**Figure 5a: Use of "Corporate University" by Respondents Who Had Heard the Term (n=50)**



**Q6 – Formally titled “Chief Learning Officer”**

Of 53 responding health systems that had a leadership development program, over one-quarter (28%) reportedly had a position formally titled “Chief Learning Officer” while the remaining 72% did not (Figure 6).

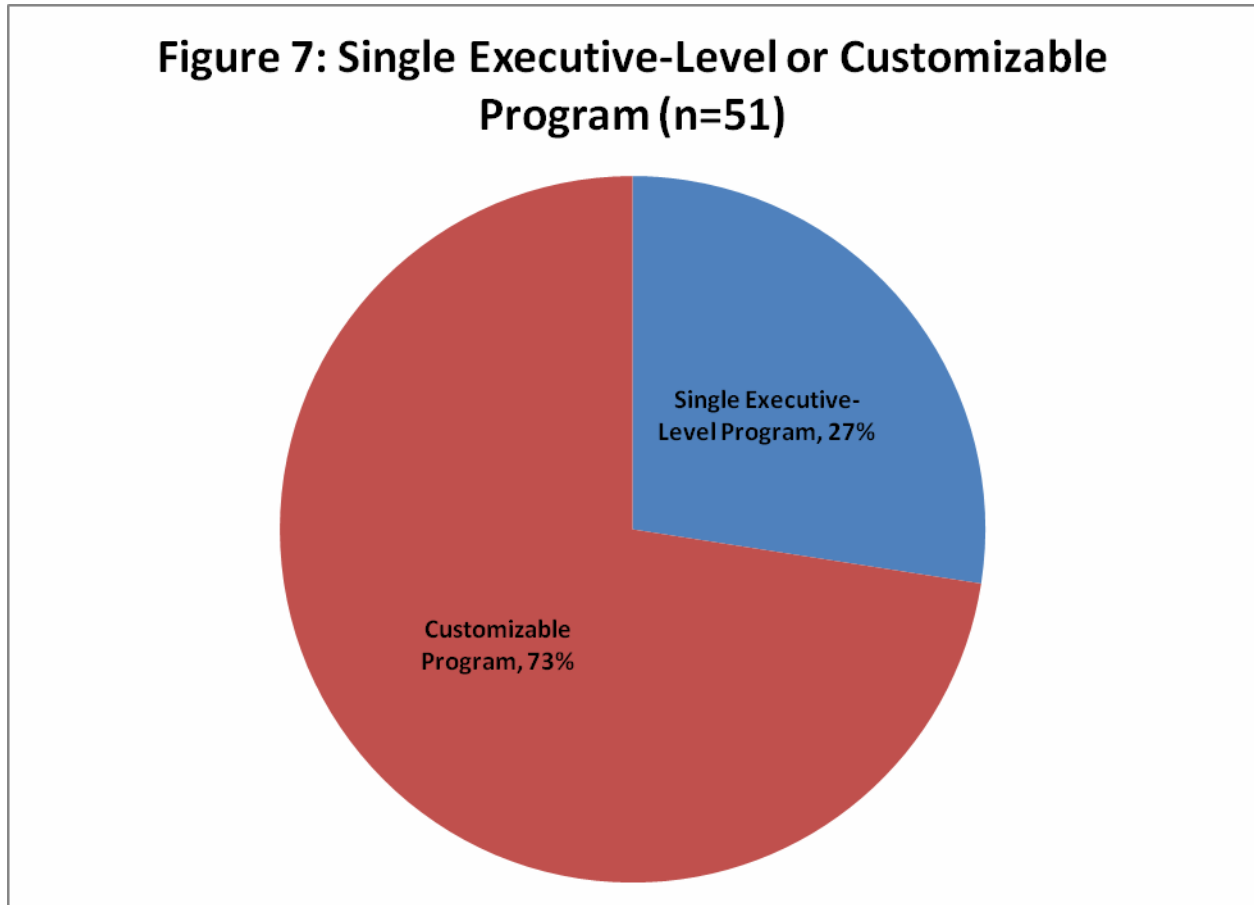


Of the 14 respondent health systems that reported using the term “Corporate University,” 8 also reported having a formally titled Chief Learning Officer.

Of the 15 respondent health systems that reported having a formally titled Chief Learning Officer, 8 also reported using the term “Corporate University” for their program.

***Q7 – Single executive-level program or customizable program based on needs?***

Of 51 responding health systems that reported having a leadership development program, 27% had a single executive-level program that included all executives (Figure 7). The majority (73%) reported having a customizable program that was based on the needs of individual executives.



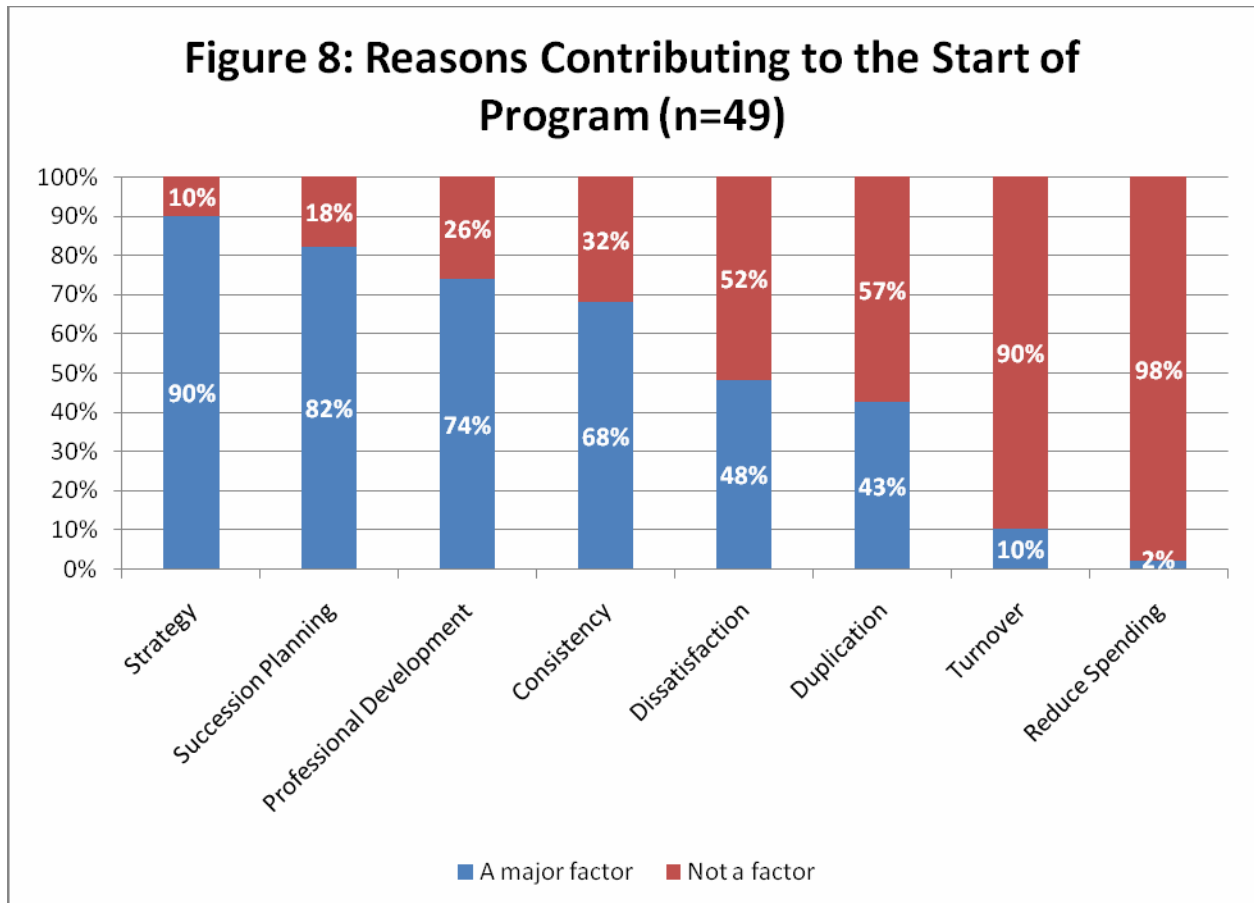
**Q8 – Reasons contributing to beginning a leadership development program**

Of 49 responding health systems that reported having a leadership development program and noted reasons for program initiation, there were a variety of reasons contributing (or not contributing) to the establishment of the program (Figure 8). Major factors noted by respondents included the wish to further advance the system’s strategic goals (90%), the wish to initiate succession planning (82%), the wish to offer executives professional development opportunities locally (74%), and the need for consistency of messages about accepted executive leadership behavior and practice (68%).

Nearly half of the programs (48%) reported dissatisfaction with their executives’ preparation for advancement to higher leadership positions, and 43% reported having a desire to duplicate the success of executive leadership development programs observed elsewhere.

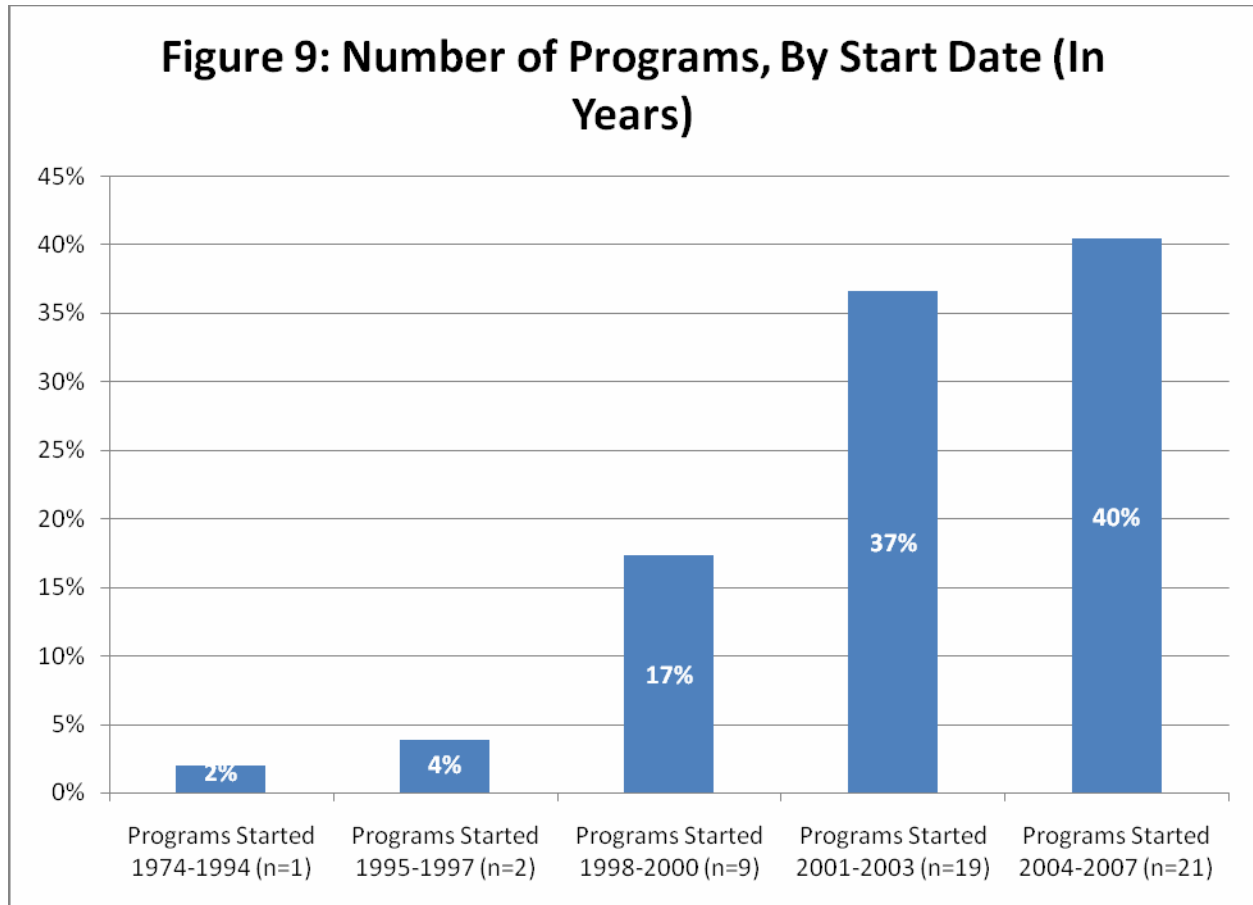
Having a concern about executive turnover rates was a major factor for only 10% of respondents, and only 2% reported wishing to reduce spending on executives’ development and training by directing the process internally.

Other factors mentioned that contributed to starting the executive leadership development program included the need to improve teamwork, networking, and cross-communication, and the opportunity to expand and align organizational culture.



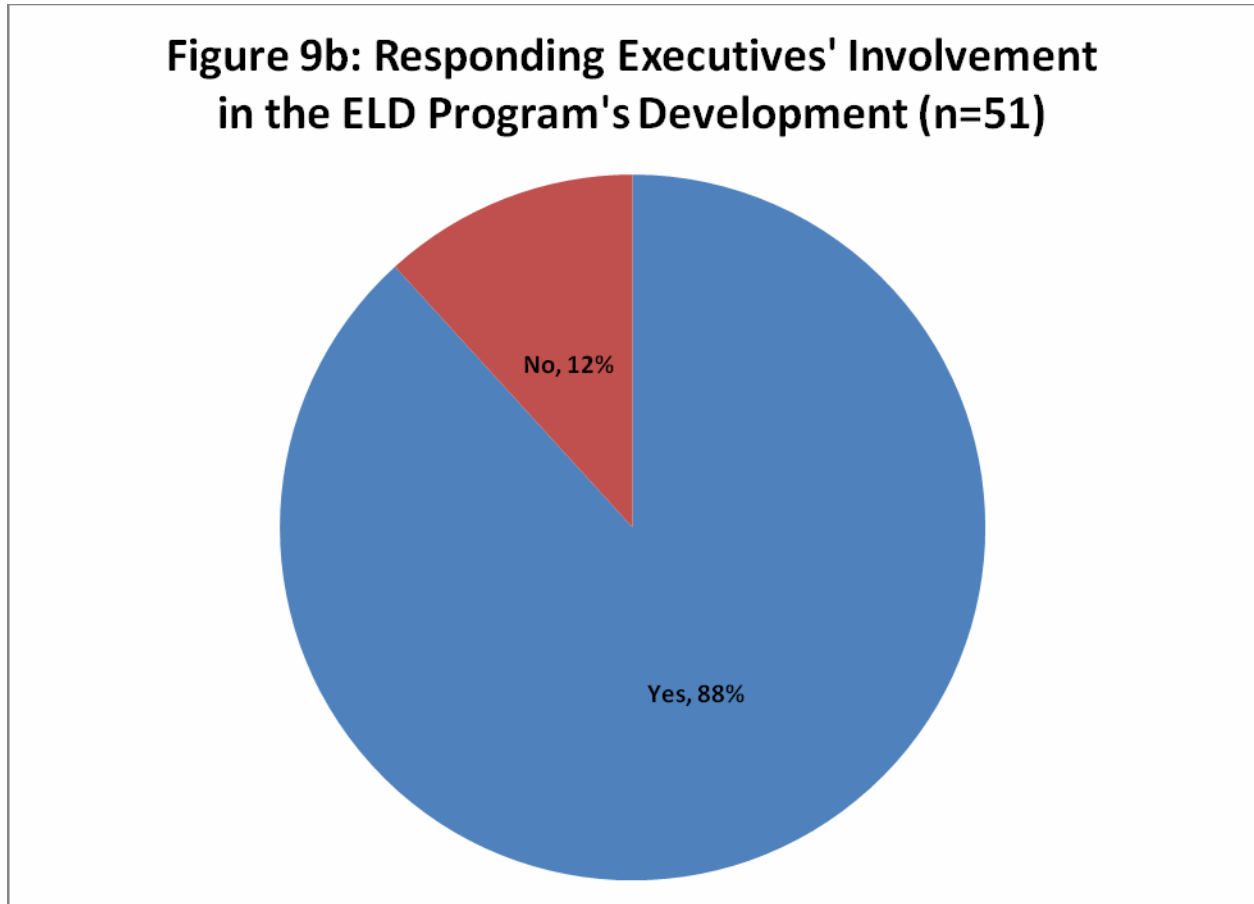
### *Q9 – Year program began*

On average, the 52 responding health systems that had a leadership development program initiated their program in 2003. The earliest program began in 1974 while the most recent program was initiated in 2007 and was continuing its development into 2008. The overwhelming majority of programs were started within the last 10 years (Figure 9).



***Q9b –Executive’s involvement in program development***

Of the 51 health systems that reported having a program, 88% of the executive respondents were involved in the development of the system’s program while the remaining 12% were not (Figure 9b).

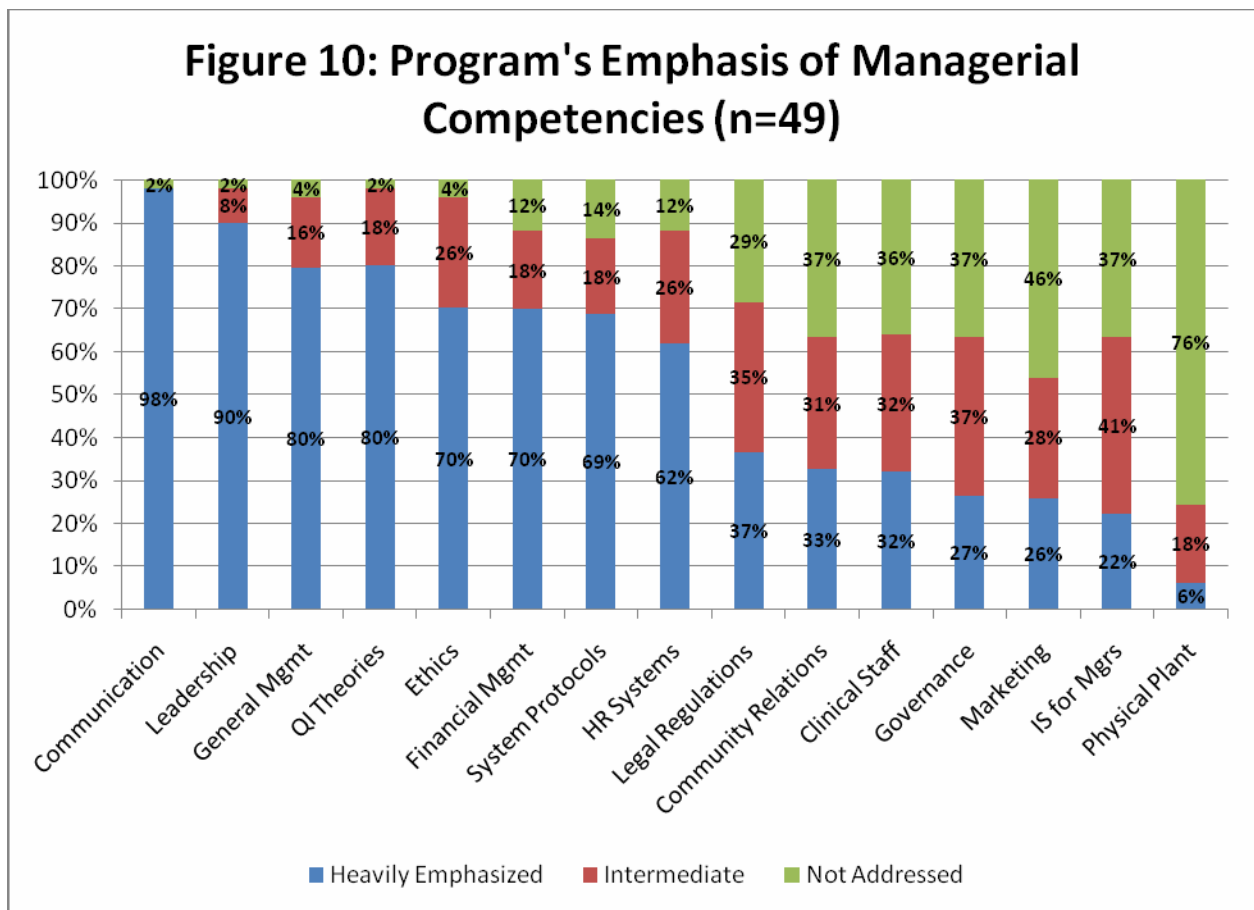


**Q10 – Emphasis on managerial competencies in program**

There was considerable variation among the 49 responding health systems that reported having a leadership development program and provided information about management competency emphases (Figure 10).

The most heavily emphasized managerial competencies were communication and relationship management (98%), leadership skills such as negotiation and motivation (90%), general management principles (80%), quality improvement (QI) theories and frameworks (80%), managerial ethics (70%), financial management (70%), system-specific protocols (69%), and human resource systems (62%).

The only managerial competency that was rarely emphasized was the physical plant; it was heavily emphasized at only three of the responding health systems with a leadership development program. See Figure 10 below for additional detail about managerial competency emphases.



### *Q11 – Other areas of emphasis*

Of 49 responding health systems that had a leadership development program, 26 programs emphasized other managerial competencies in addition to those listed in Question 10. Teamwork and teambuilding were mentioned the most (6 times). Other competencies with multiple mentions include strategic or visionary thinking, 360 degree feedback, adaptability, Catholic mission competencies, developing and retaining talent, project management, self-awareness, and Six Sigma. Listed below in Figure 11 are other competencies that were also mentioned.

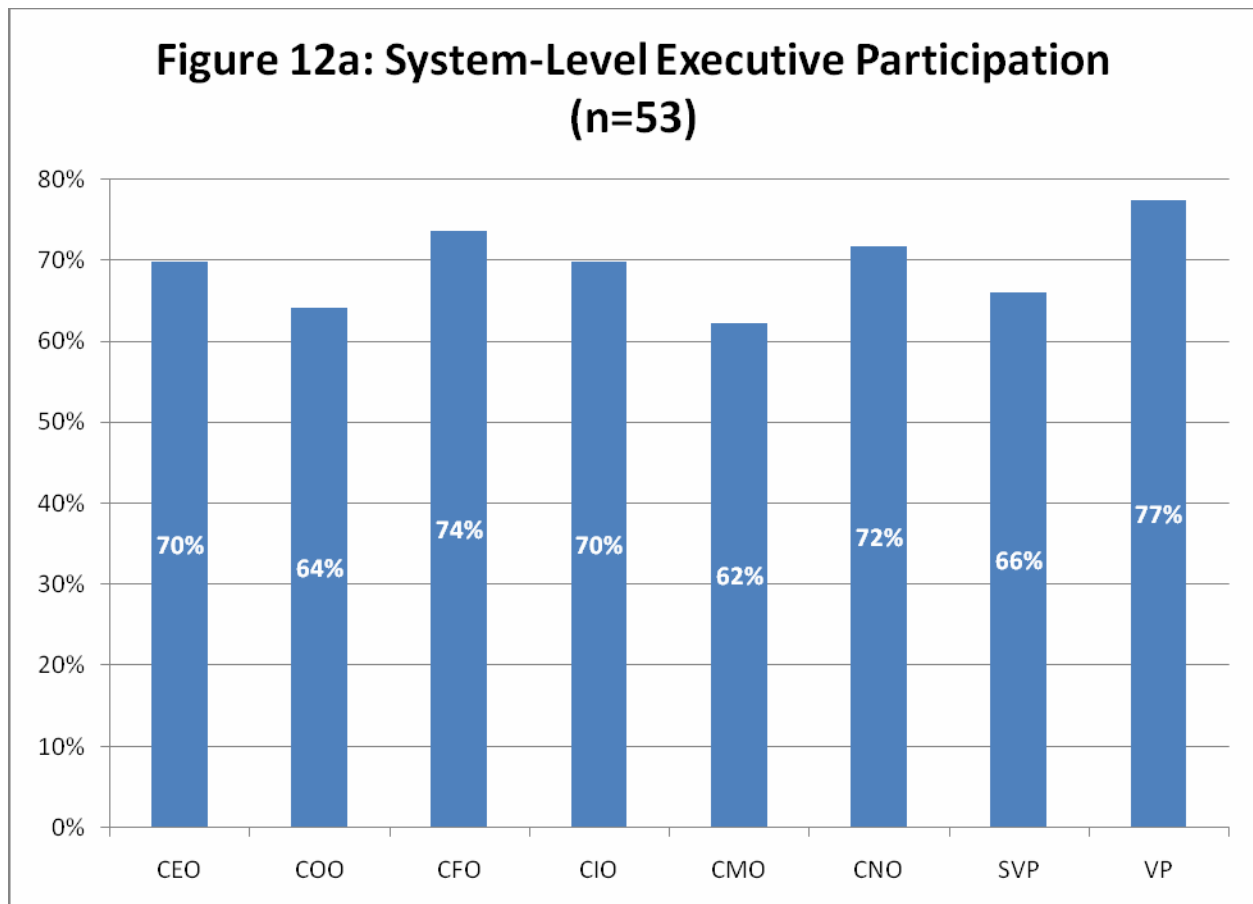
**Figure 11: Other Areas of Emphasis**

<b>More Than One Mention (#)</b>	<b>Single Mention</b>	
<ul style="list-style-type: none"> <li>• Teamwork and teambuilding (6)</li> <li>• Strategic or “visionary” thinking (3)</li> <li>• 360 feedback (2)</li> <li>• Adaptability/flexibility (2)</li> <li>• Catholic mission competencies (2)</li> <li>• Developing and retaining talent (2)</li> <li>• Project management (2)</li> <li>• Self-awareness (2)</li> <li>• Six Sigma (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriately addressing/modifying positive/negative behaviors</li> <li>• Balridge Criteria</li> <li>• Behavioral standards</li> <li>• Change leadership</li> <li>• Change management</li> <li>• Collaboration</li> <li>• Critical thinking skills</li> <li>• Customer service</li> <li>• Emotional Intelligence</li> <li>• Engaging employees</li> <li>• External speakers – motivate, organizational “personal” &amp; professional</li> <li>• Growth of services, programs, and volumes</li> <li>• Healthcare trends</li> <li>• How to coach and mentor</li> <li>• Impact and influence</li> <li>• Innovation</li> <li>• Innovation/disruption management</li> <li>• Integrity</li> </ul>	<ul style="list-style-type: none"> <li>• Intelligence</li> <li>• Initiative/action orientating command skills</li> <li>• Leader evaluation training and education</li> <li>• Leadership style</li> <li>• LEAN</li> <li>• Organizations mission, philosophy, values</li> <li>• Patient, physician, and employee satisfaction</li> <li>• People leadership</li> <li>• People management</li> <li>• Process improvement</li> <li>• Process management</li> <li>• Quality improvement</li> <li>• Servant leadership &amp; stewardship</li> <li>• Setting climate</li> <li>• Technical skill development</li> <li>• Values and culture</li> </ul>

### ***Q12 – Participants in executive leadership development program, by position***

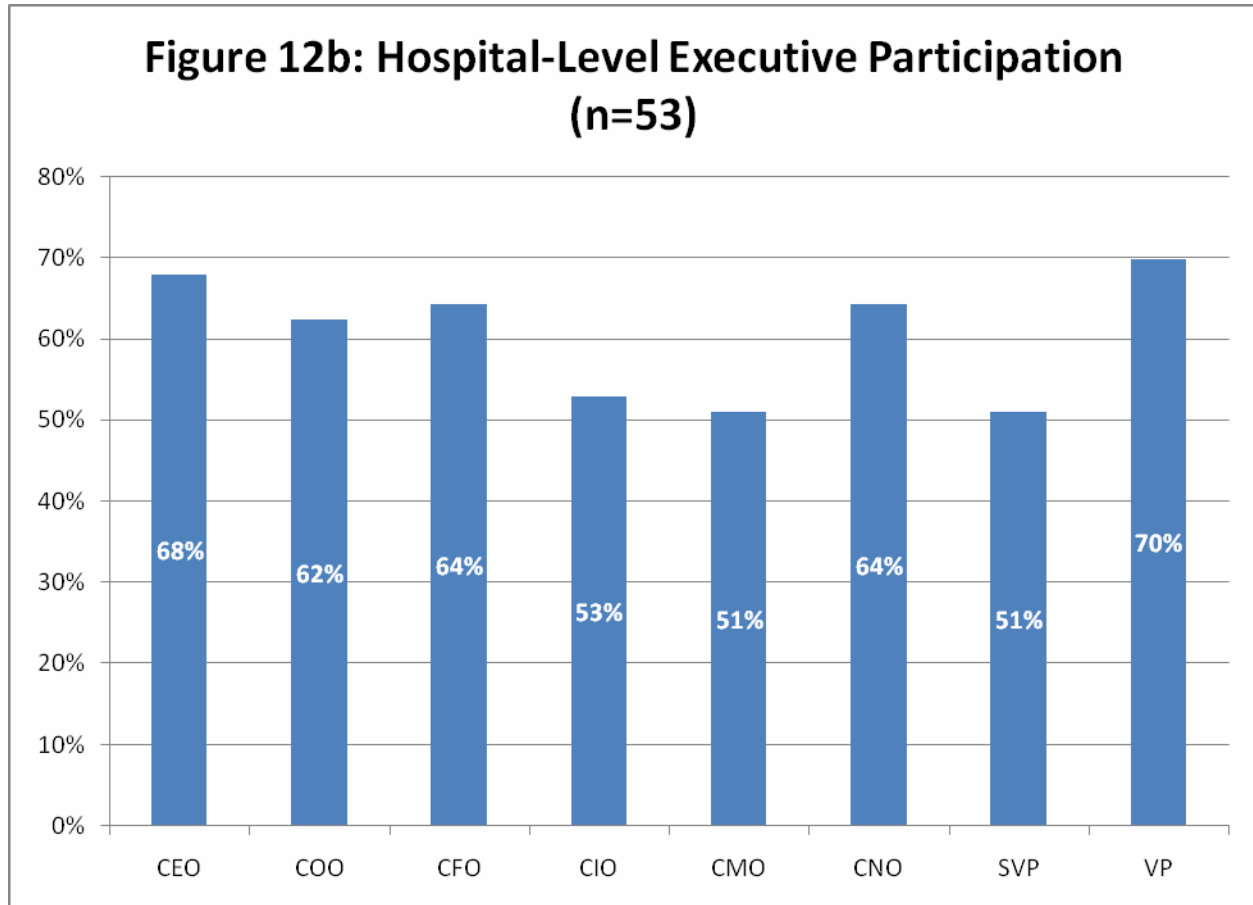
Of 53 responding health systems that had a leadership development program, both system-level and hospital-level executives reportedly participated in the program. Executive participants included the chief executive officer (CEO), the chief operating officer (COO), the chief financial officer (CFO), the chief information officer (CIO), the chief medical officer (CMO), the chief nursing officer (CNO), senior vice presidents, and vice presidents.

At the system-level, there was CEO participation at 70% of the reporting health systems (Figure 12a). There was also participation from the COO (64%), CFO (74%), CIO (70%), CMO (62%), CNO (72%), Senior VPs (66%), and VPs (77%).



**Q12 continued**

At the hospital-level, there was CEO participation at 68% of health systems (Figure 12b). There was also participation from the COO (62%), CFO (64%), CIO (53%), CMO (51%), CNO (64%), Senior VPs (51%), and VPs (70%).

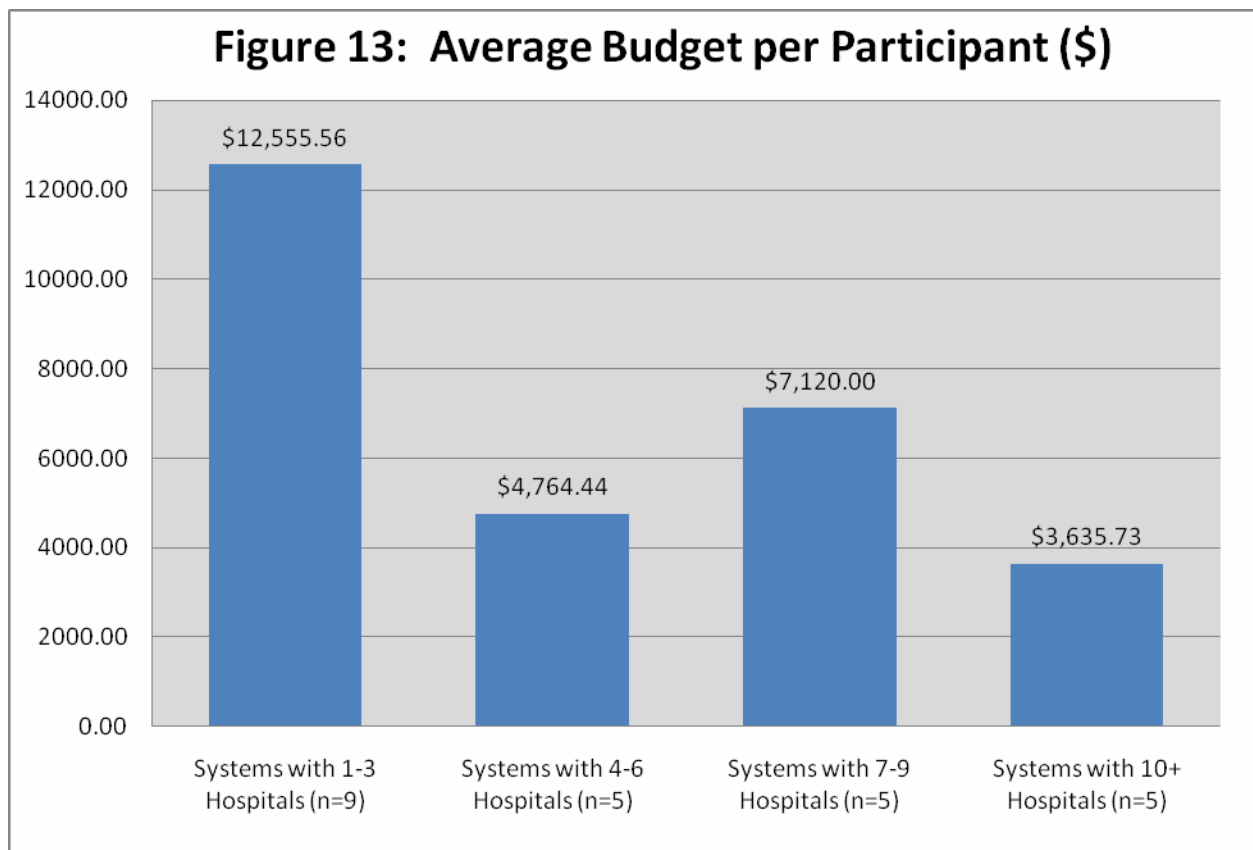


### ***Q13 – Executive leadership development program budget***

Of 26 responding health systems that had a leadership development program and also reported their annual budget per participant, the average budget per participant per year was approximately \$13,475; the median budget was \$5,000. The smallest budget was \$600 per participant and the largest budget was \$160,000 per participant, with this high budget level likely due to a frequent use of consultants for individual executive participants. Removing this program budget outlier, the median budget per program was \$4,539 and the largest budget was \$65,000 per participant. The remainder of this budget information is presented with this single outlier removed.

When comparing budget per participant to health system size, the average budget per participant for 9 responding systems with 1-3 hospitals was \$12,556 (Figure 13). For the 6 responding systems with 4-6 hospitals, the average budget was \$4,764 per participant. For the 5 responding systems with 7-9 hospitals, the average budget was \$7,120. For the 5 responding systems with 10+ hospitals, the average budget was \$3,636 (see figure below).

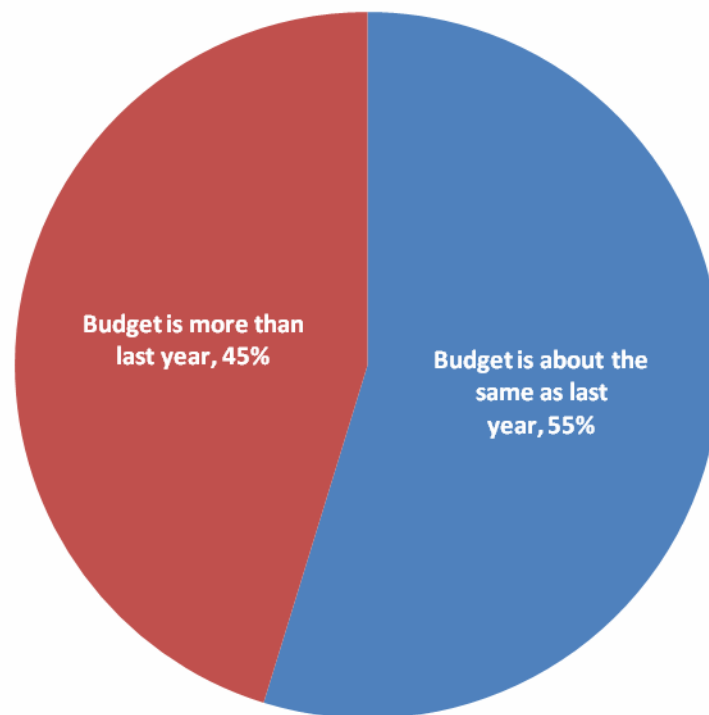
Two responding health systems reported a complete program budget. Both systems had three hospitals within their systems. One system reported having a \$1.3 million budget while the other system budgeted \$40,000 to the program.



***Q14 – Budget compared to previous fiscal year***

Of 42 responding health systems that had a leadership development program and reported budget comparisons, just over half (55%) reported that their budget was similar to the budget from the previous fiscal year (Figure 14). The remainder (45%) reported having a budget greater than the previous fiscal year's budget. None of the programs reported having budgets less than the previous fiscal year's budget.

**Figure 14: Budget Compared to Previous Fiscal Year (n=42)**



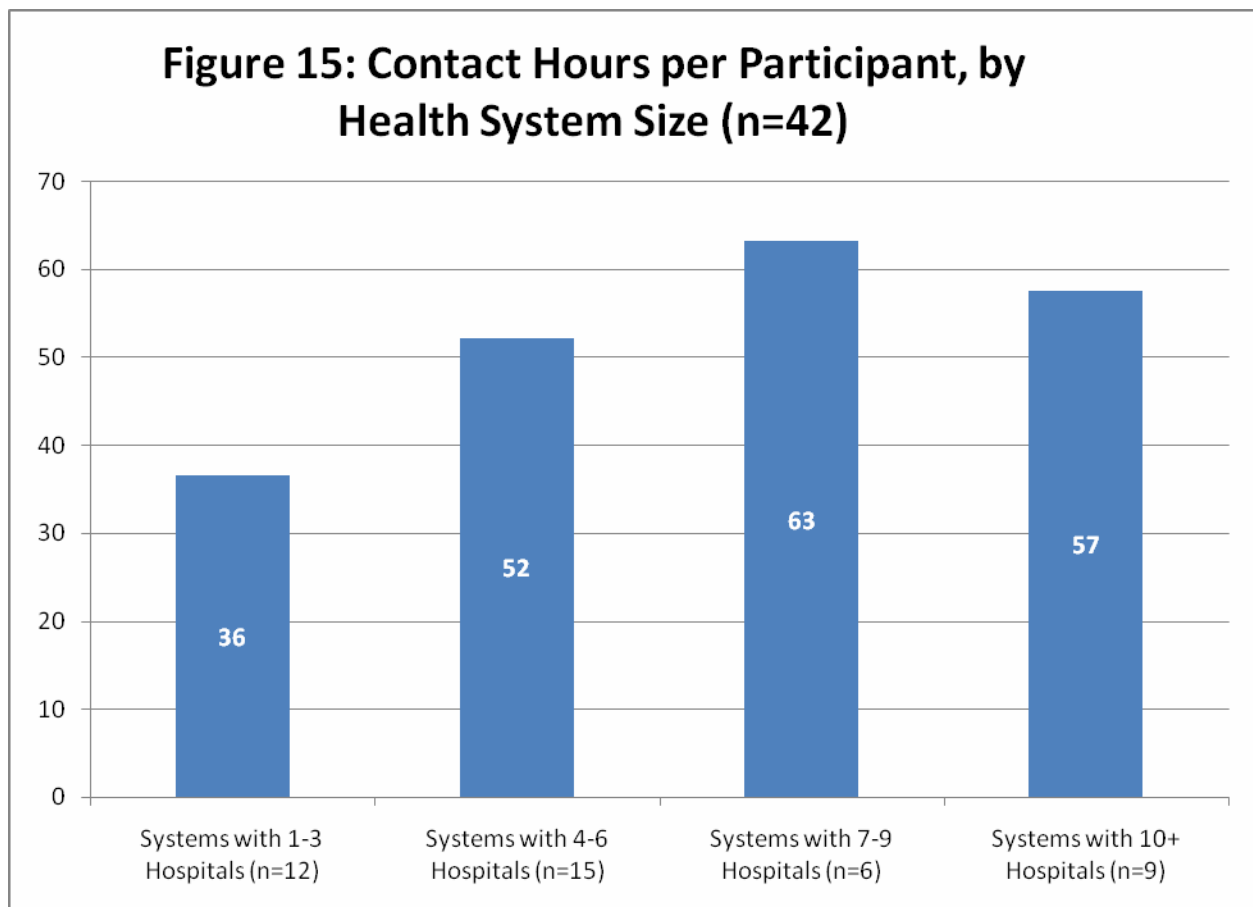
## **PART 2:**

### **THE EXECUTIVE LEADERSHIP DEVELOPMENT PROCESS**

#### ***Q15 – Contact hours per participating executive***

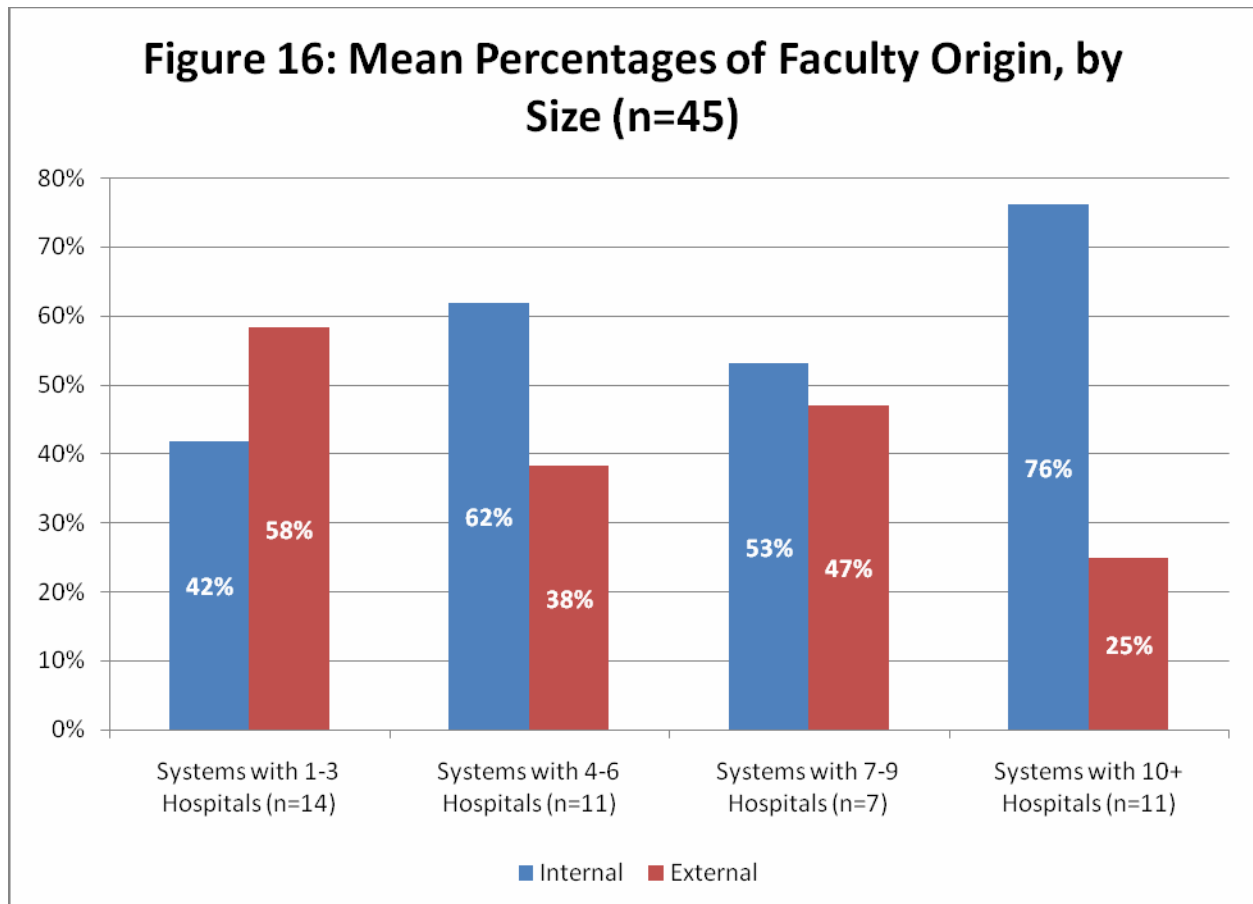
Of the 43 responding health systems that reported having a leadership development program and provided contact hour information, the average number of contact hours noted per participant was 52 contact hours; the median was 40 contact hours.

Of the 42 health systems that reported system size and contact hours per participant, the average number of contact hours per participant was 36 hours for systems with 1-3 hospitals. For systems with 4-6 hospitals, the average number of contact hours was 52 hours. For systems with 7-9 hospitals, the average number of contact hours was 63 hours. For systems with 10+ hospitals, the average number of contact hours was 57 hours.



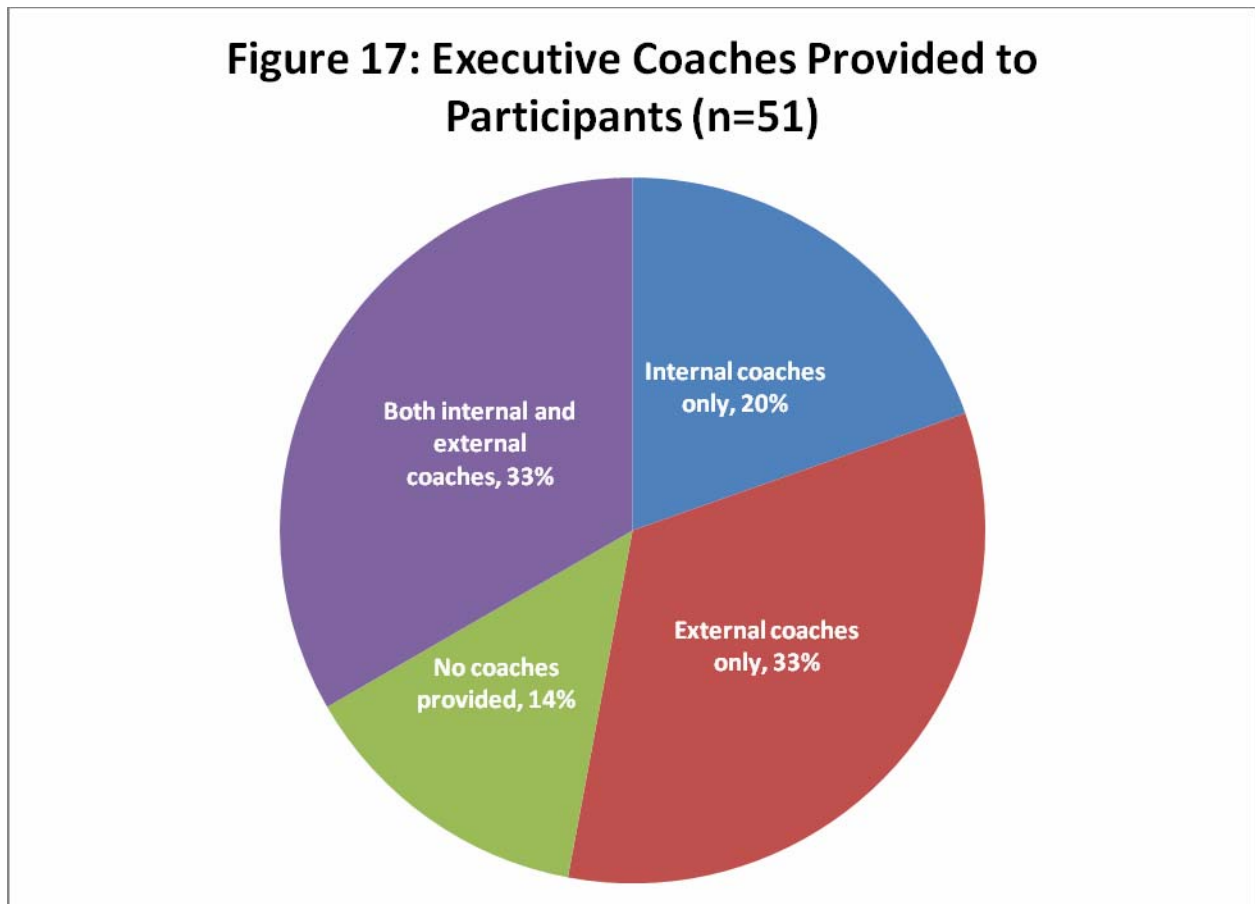
### ***Q16 – Origin of faculty for leadership development program***

Of 45 responding health systems that reported having a leadership development program and provided information about program faculty, an average of 57% of program faculty were reportedly internal instructors; an average of 43% of program faculty were external instructors. In contrast to the largest systems, small systems (1-3 hospitals) relied more heavily on external instructors (Figure 16).



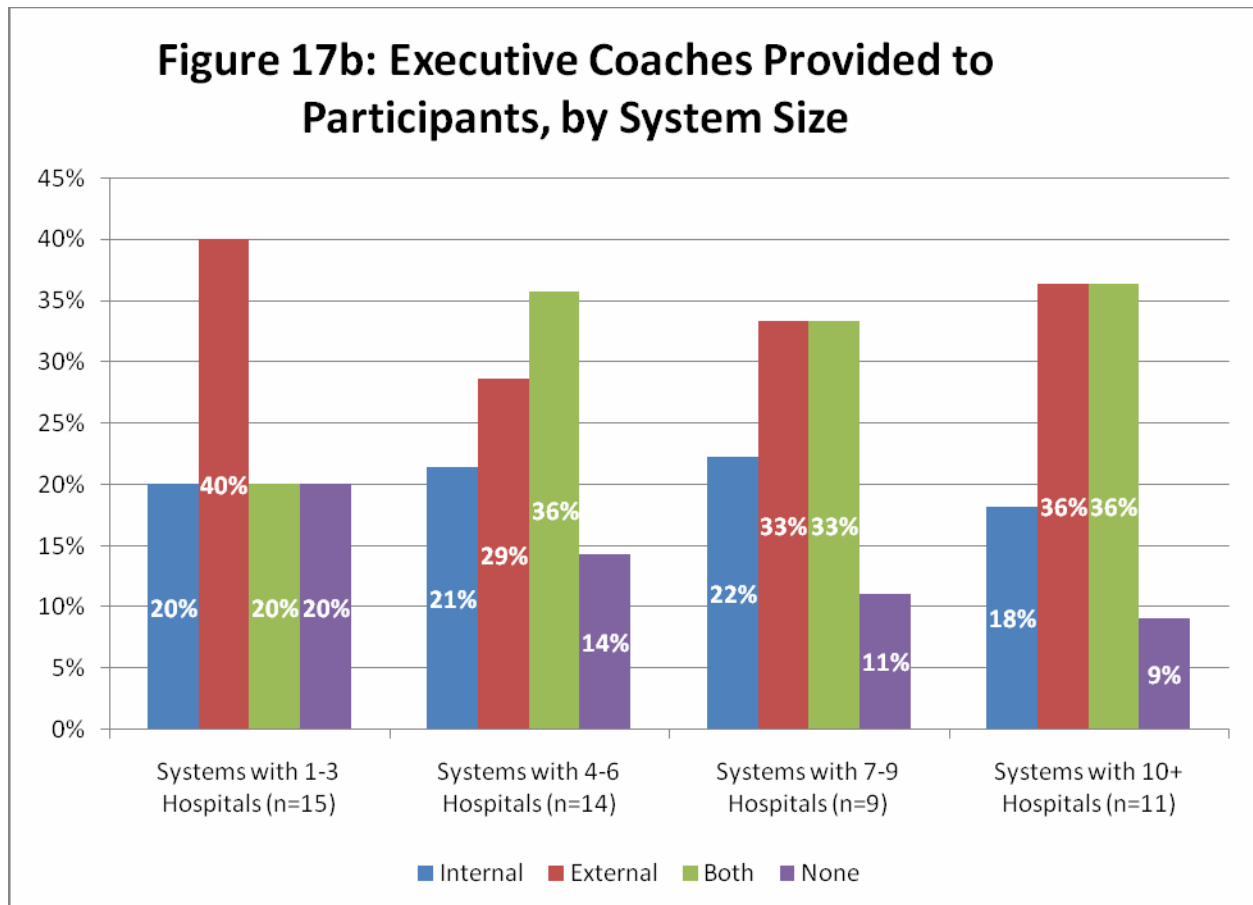
***Q17 – Provide executive coaches for program participants***

Of 51 responding health systems that had a leadership development program, 20% of the programs used internal coaches within the health system and 33% of the programs used external coaches from outside the health system (Figure 17). Both internal and external coaches were provided at one-third of the programs (33%), while 14% of the programs did not make coaches available.



**Q17 continued**

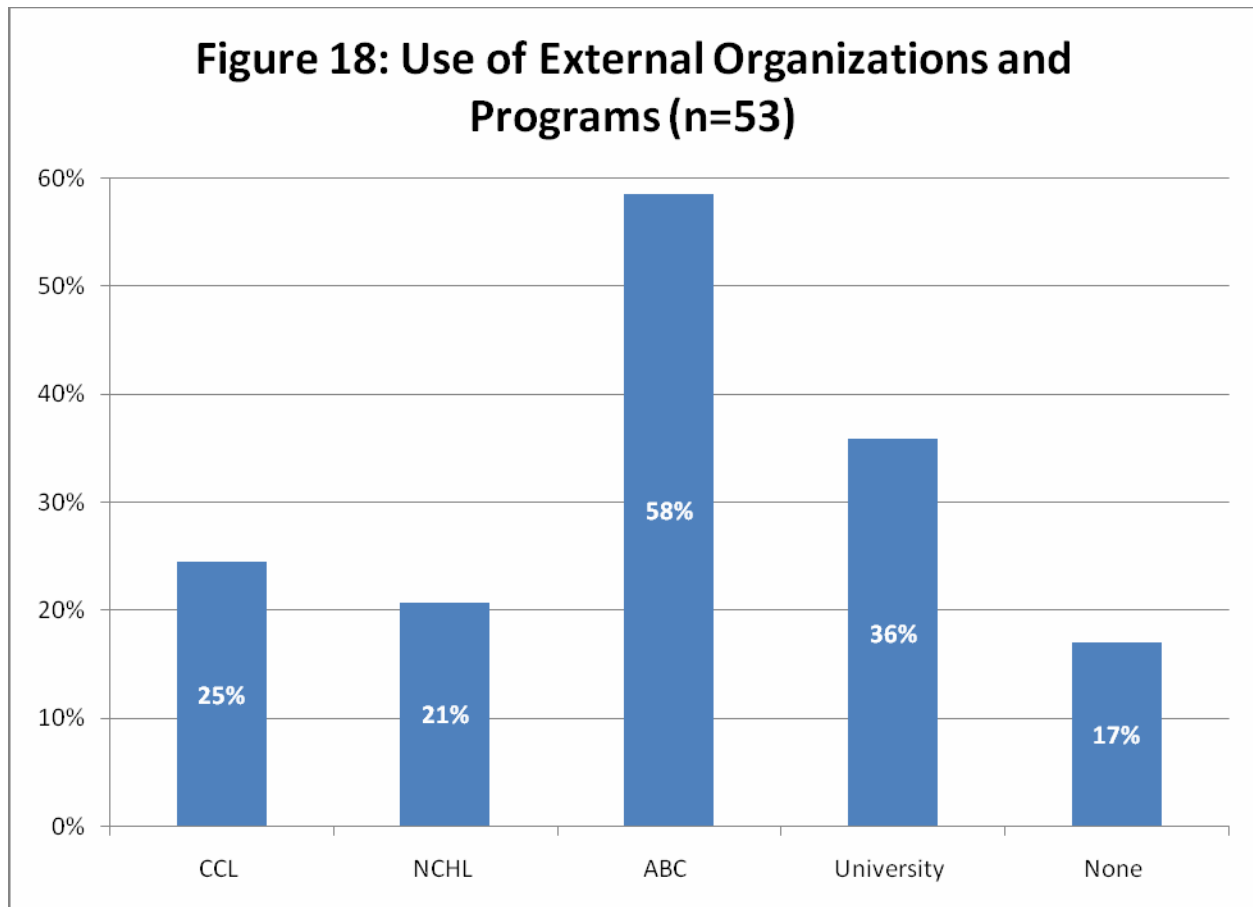
Among the 49 health systems that reported system size and availability of coaches as part of the executive leadership development program, smaller systems of 1-3 hospitals reported proportionately more provision of external coaches than internal coaches (40% versus 20%) (Figure 17b). See Figure 17b below for additional detail about the provision of executive coaches and system size.



### ***Q18 – Use of external organizations and programs to supplement program***

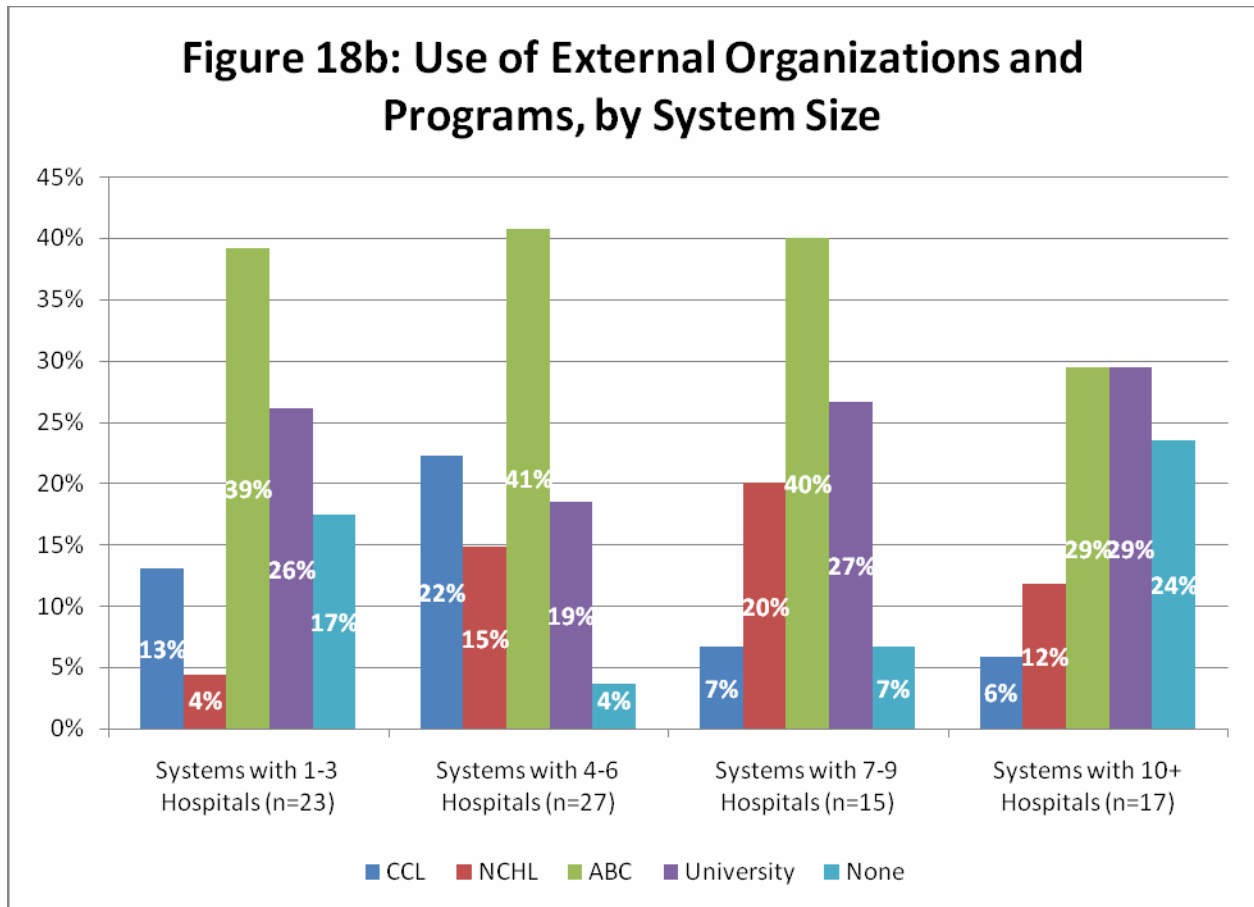
Of 53 responding health systems that had a leadership development program, many had used external organizations and programs to supplement their in-house leadership development program during the past three years. The Center for Creative Leadership (CCL) was used by 25% of the respondent programs while the National Center for Healthcare Leadership (NCHL) was used by 21% of the programs (Figure 18). More than half of the health systems (58%) supplemented their program with offerings from the Advisory Board Company (ABC). Just over one-third of the programs (36%) used a formal executive education program offered by a university. However, 17% of reporting health systems did not supplement their in-house programs.

Other external organizations and programs that were reportedly used by respondent health systems included the U.S. Department of Health and Human Services, the Studer Group, the New England School/Institute of Addiction Services, Harvard, Stanford, Cambridge, University of Michigan, Global Institute for Leadership Development (GILD), Health Management Academy, Institute for Management Studies (IMS), Catholic Health Association (CHA), and outside consultants.



**Q18 continued**

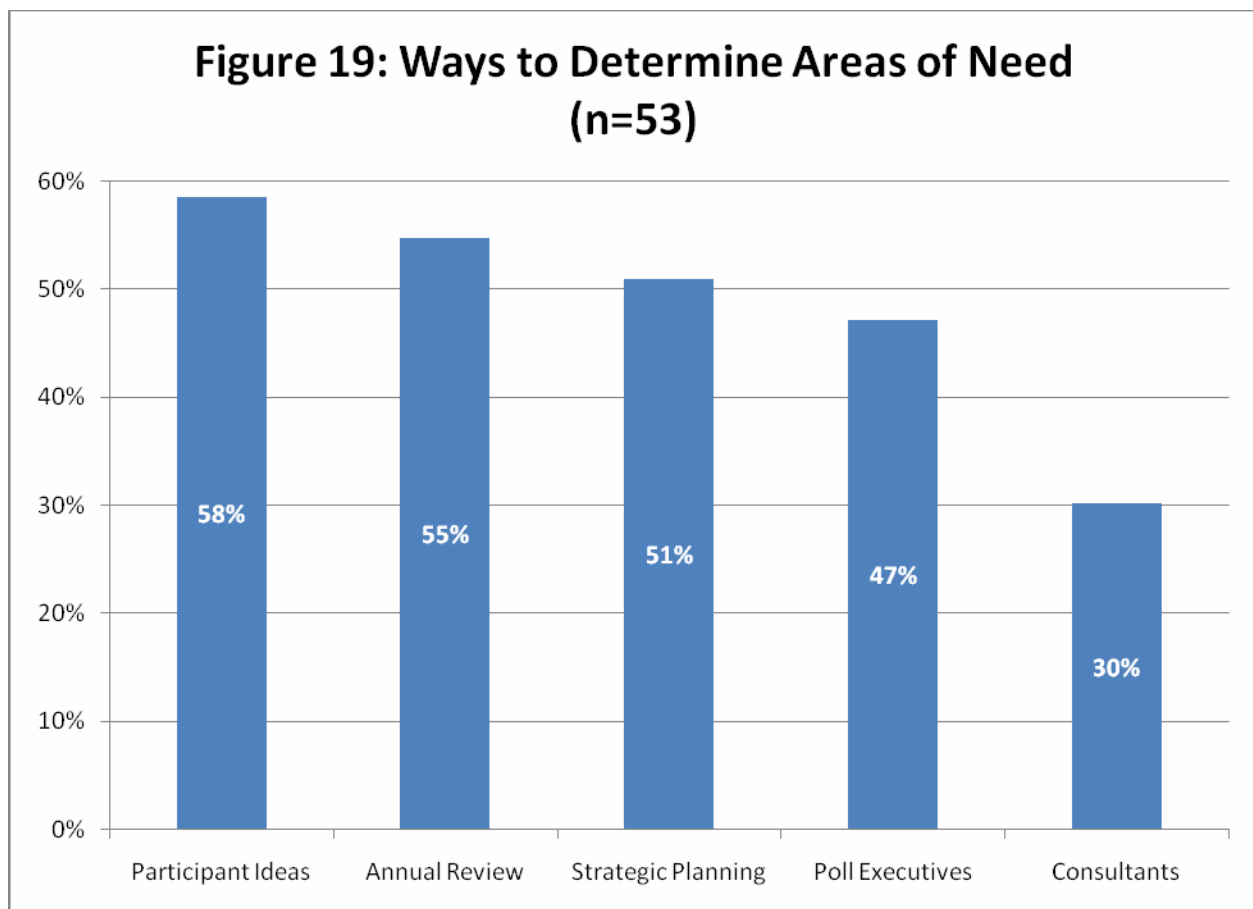
Among the health systems that reported system size and use of external programs as part of the executive leadership development program, smaller systems of fewer than 10 hospitals more commonly reported using the Advisory Board Company to supplement their leadership development program than the largest systems of 10 or more hospitals (Figure 18b). Smaller systems of fewer than 7 hospitals more commonly reported using the Center for Creative Leadership than larger health systems. Figure 18b below provides additional detail about the use of external programs and system size.



### ***Q19 – Ways upper management determines areas of needed instruction***

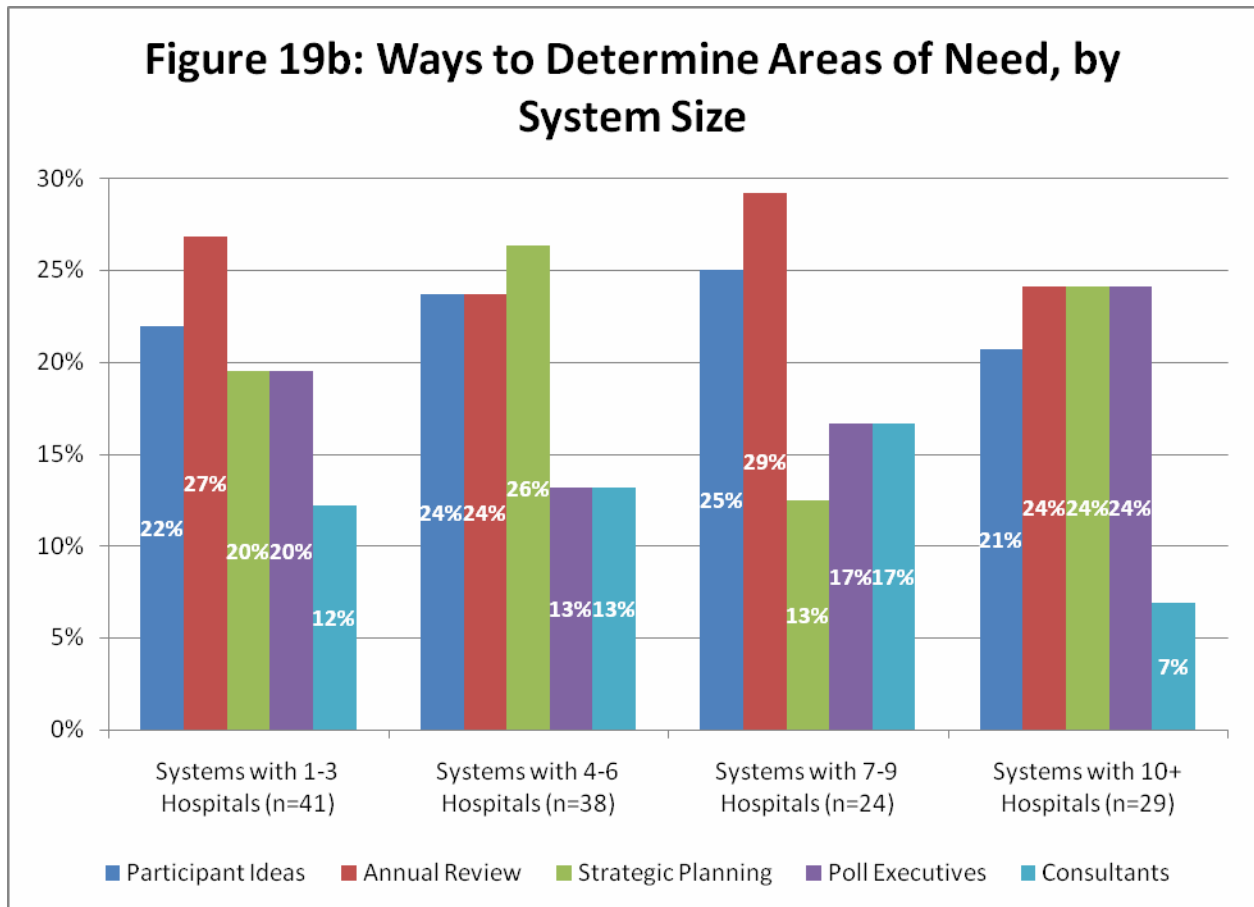
Of 53 responding health systems that had a leadership development program, more than half of the programs (58%) determined areas of needed program instruction by asking participants for their ideas, and 55% had an annual program review (Figure 19). Determining the areas of needed instruction was part of the system strategic planning process for about half (51%) of the health systems. In addition, 47% of the health systems determined areas of need by polling across health system executives. Suggestions for change by external consultants were used in fewer than one-third (30%) of the health systems with programs.

Some respondents also included open-ended comments about other ways to determine the areas of needed instruction. These areas included using a 360 evaluation process (mentioned twice), and having a leadership development committee to oversee the process, using an organization climate survey, having a policy board involved, and matching succession planning needs (all mentioned once).



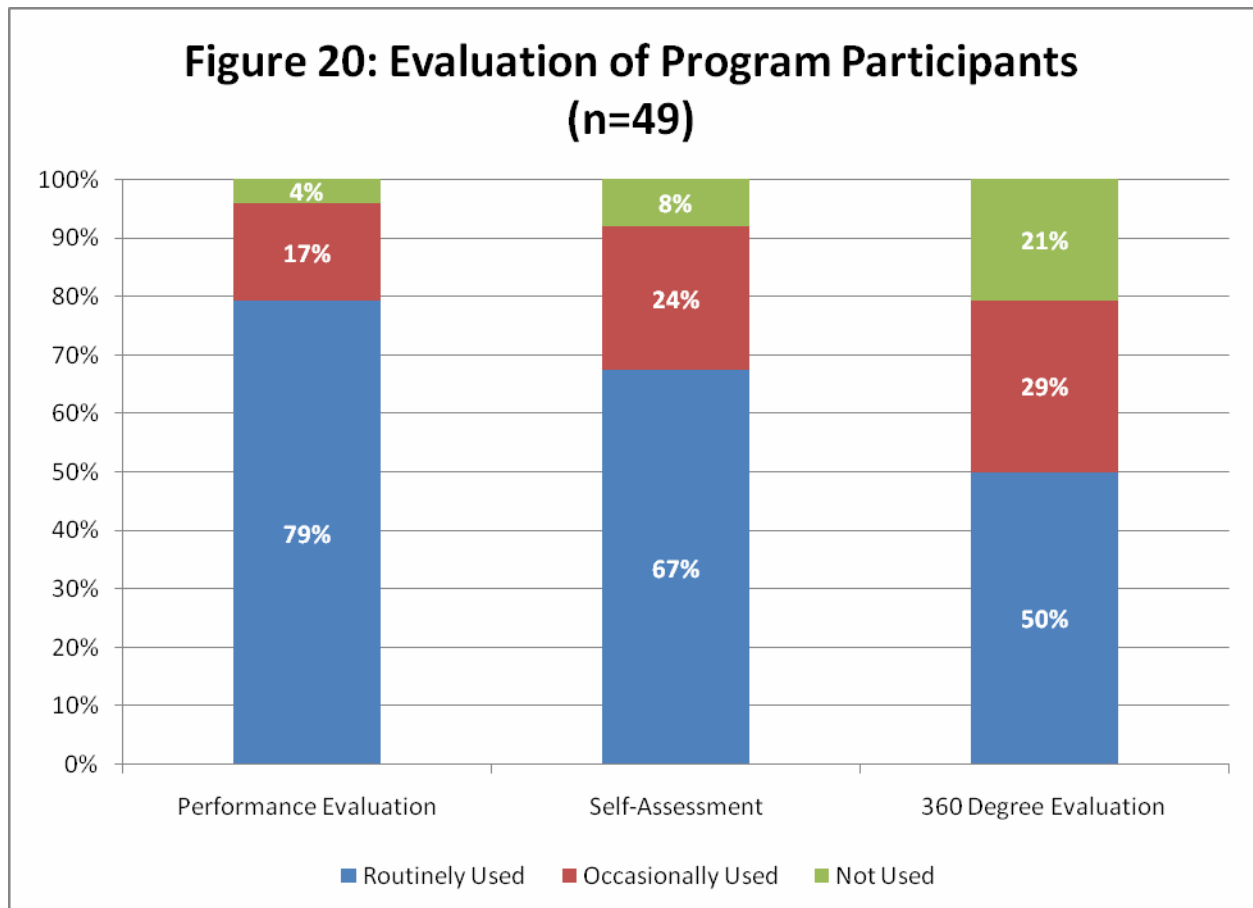
**Q19 continued**

While the methods used to determine areas of needed instruction for the executive leadership development program varied, no one method predominated either overall or by size of system (Figure 19b). See Figure 19b below for additional detail about determining areas of needed instruction and system size.



### *Q20 – Evaluation of program participants*

Of 49 responding health systems that had a leadership development program and reported on program evaluation processes, the majority (79%) of the systems routinely used the organization's performance evaluation process as part of the evaluation of program participants (Figure 20). Two-thirds (67%) of the respondent programs reported routinely using participant self-assessments. Half (50%) of the programs routinely involved executives in a 360 degree assessment process.



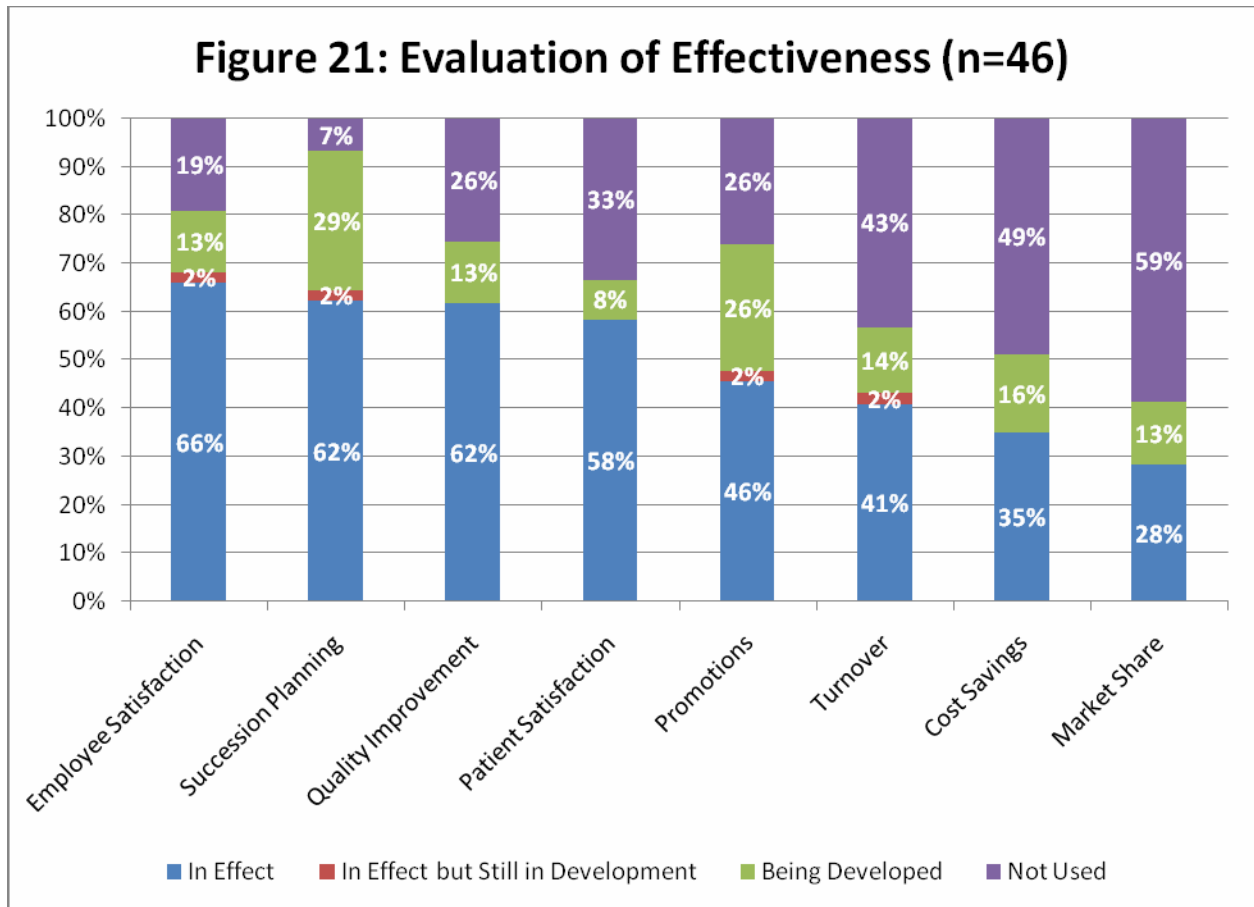
**PART 3:**

**EVALUATION AND EVOLUTION OF LEADERSHIP DEVELOPMENT**

***Q21 – Evaluation of leadership development program’s effectiveness***

Of 46 responding health systems that had a leadership development program, over half of the programs used employee job satisfaction (66%), succession planning (62%), quality improvement (62%), and patient satisfaction (58%) as metrics to evaluate the effectiveness of their leadership development program (Figure 21). Three-quarters of programs or more reported that promotion rates, employee satisfaction, and quality improvement as measures of leadership development program effectiveness were either in use or being developed.

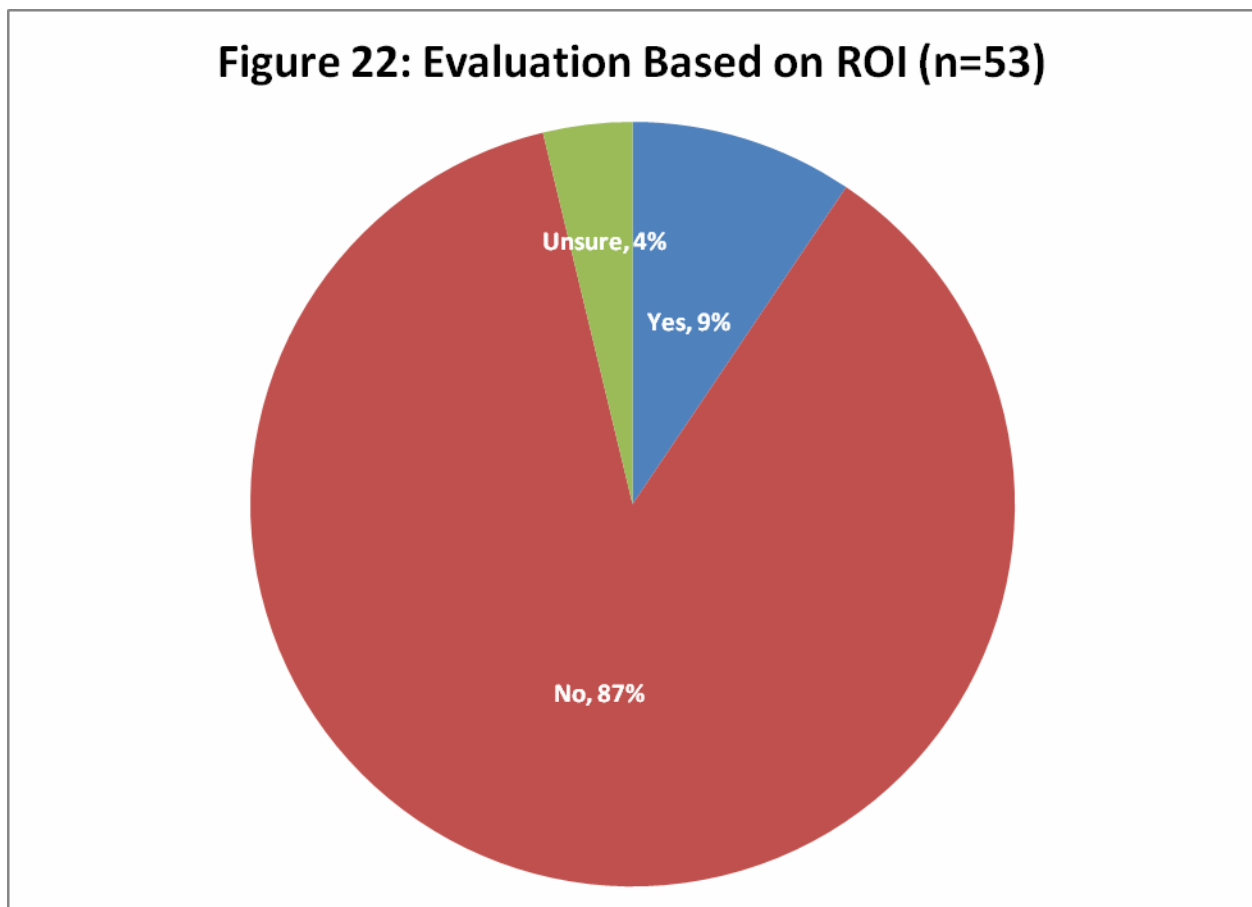
Just fewer than half of the programs reported using promotion rates (46%) or turnover rates among executive’s direct reports (41%) to evaluate program effectiveness. Over one-third of respondent programs noted using cost savings (35%) to evaluate program effectiveness, and just under one-third of the respondent programs reportedly used market share increase (28%). Additional detail about this program evaluation process is provided below in Figure 21.



**Q22 – Program evaluation based on return on investment (ROI)**

Of 53 responding health systems that had a leadership development program, the great majority (87%) reported that they did not evaluate their program based on their return on investment (ROI) (Figure 22). Only five programs (9%) reported evaluating the program based on ROI; another 4% were reportedly unsure whether or not their program was evaluated based on ROI.

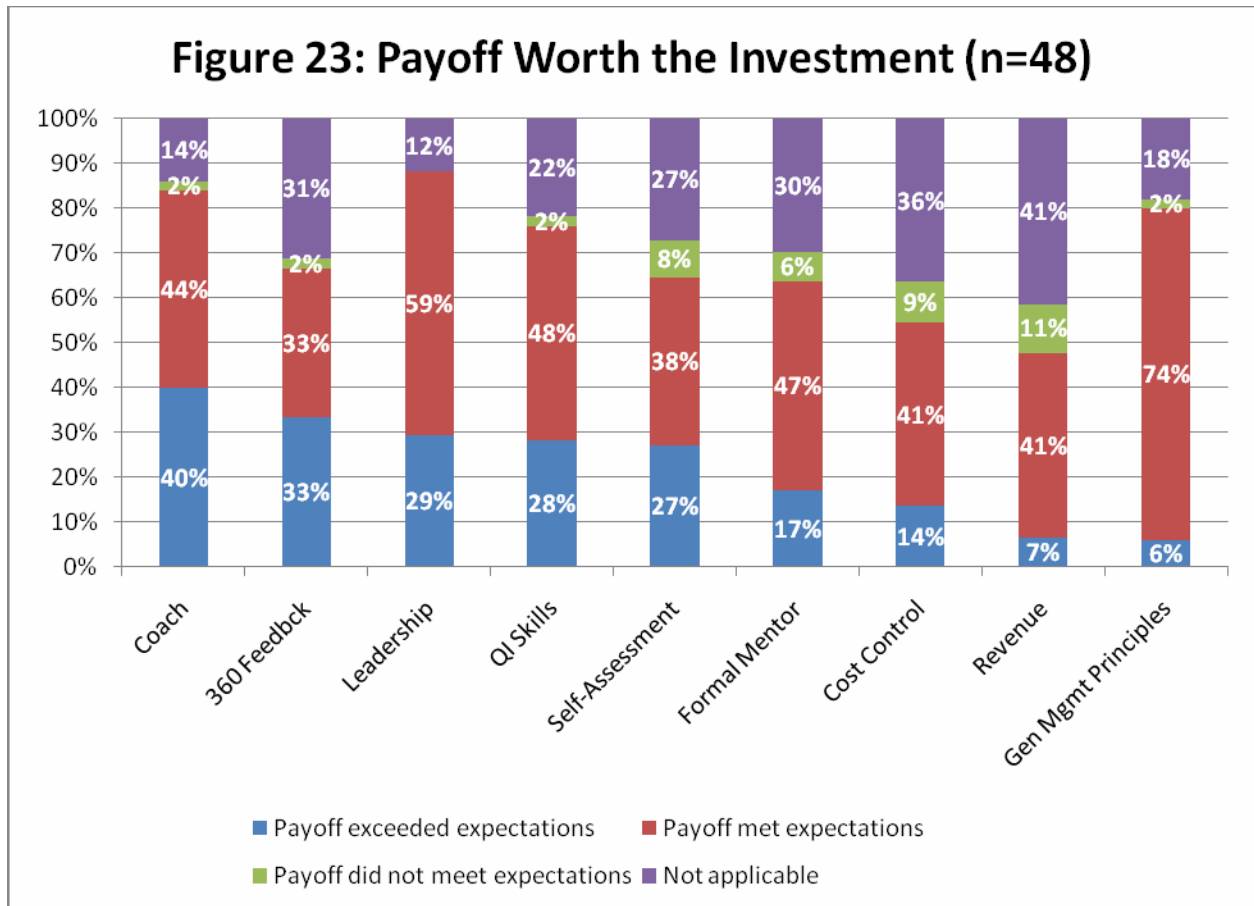
Interestingly, 1 of the 5 programs that evaluated effectiveness based on ROI reported a target ROI of 400-500%; the size of this health system was not reported. One other health system consisting of 11 hospitals reported that their target ROI changes annually, but noted an ROI of 5.4% for the most recently available year. Given the wide variability in these numbers, we were unable to interpret these responses.



**Q23 – Payoff worth the investment**

Of 48 responding health systems that had a leadership development program, the majority of program components either met or exceeded expectations (Figure 23). These program components included training in personal leadership skills (88%), coaching (84%), general management principles (80%), quality improvement skills (76%), 360 degree feedback process (66%), self-assessment methods (65%), formal mentoring program (64%). Cost control concepts met or exceeded program expectations for 55% of systems, and revenue enhancement methods training met or exceeded expectations for the fewest systems (48%). Additional detail about these payoff expectations is included below in Figure 23.

Individually, the payoff for program components exceeded expectations in varying degrees: coaching (40%); 360 feedback (33%); leadership (29%); quality improvement skills (28%); self-assessment (27%); formal mentoring (17%); cost control training (14%); revenue enhancement methods (7%), and general management (6%). The reported payoff met expectations with similar variability: coaching (44%); 360 degree feedback (33%); leadership (59%); quality improvement skills (48%); self-assessment processes (38%); formal mentoring (47%); cost control training (41%); revenue enhancement methods (41%); and general management training (74%). Additional detail about these payoff expectations is included in Figure 23 below.



***Q24 – Elements that have been deleted or revised***

Of the 53 health systems that reported having a leadership development program, 29 respondents listed elements that had been deleted or had undergone major revisions (Figure 24). Elements listed twice included the leadership model, refinement of the selection process, the Six Sigma process, and the timeframe of the program. Listed below are all elements that were mentioned:

**Figure 24: Revised or Deleted Program Elements**

<b>Elements Listed Multiple Times (#)</b>	<b>Elements Listed Once</b>
<ul style="list-style-type: none"> <li>• Leadership model (2)</li> <li>• Refinement of selection process (2)</li> <li>• Six Sigma process (2)</li> <li>• Time frame of program (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Annual group case study/projects</li> <li>• Business plan model</li> <li>• Capstone</li> <li>• Core competencies</li> <li>• Customized program specific to candidate</li> <li>• Decision making module</li> <li>• Decrease outside speakers</li> <li>• Development planning</li> <li>• Electronic/online leadership skills tools</li> <li>• Ethics</li> <li>• Evaluation process</li> <li>• Expansion of participation</li> <li>• Fiscal/financial management</li> <li>• Leadership development</li> <li>• Leadership level-specific programs</li> <li>• LEAN</li> <li>• Membership for Electronic Data Interchange (EDI)</li> <li>• Middle management focused development</li> <li>• Mission and vision</li> <li>• Modules on generational work</li> <li>• Organizational culture</li> <li>• Performance management</li> <li>• System-wide leadership meetings</li> <li>• Talent management</li> </ul>

## Q25 – New features planned

Of 53 responding health systems that reported having a leadership development program, 41 respondents listed new features that were planned for the future (Figure 25). Creating a succession planning process was listed the most times (5 times). Other elements listed more than once included coaching (3), tiered competency development (3), mentoring middle management (3), diversity (2), developing individualized assessment and development planning processes (2), performance evaluation (2), strategic goals (2), and technology (2). Listed below are the elements that were listed as answers to this question.

**Figure 25: Planned New Features**

Features Listed Multiple Times (#)	Planned New Features Listed Once
<ul style="list-style-type: none"> <li>• Succession planning process (5)</li> <li>• Coaching (3)</li> <li>• Tiered competency development; Five level leadership development program (executive pathway as top tier) (3)</li> <li>• Use of executives for teaching/mentoring middle management (3)</li> <li>• Diversity module (2)</li> <li>• Individualized assessment and development planning (2)</li> <li>• Performance evaluation (2)</li> <li>• Strategic goals (2)</li> <li>• Technology (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Change leadership model</li> <li>• Creating a center for learning/corporate university</li> <li>• Delivery methods for leadership training</li> <li>• Disruption innovation and management</li> <li>• Effective and comprehensive development plans implemented for target individuals</li> <li>• Emphasis on middle management</li> <li>• Energetic communication module</li> <li>• Function; roles</li> <li>• Incorporated education and training overall (not just assigned to Human Resources)</li> <li>• Incorporation of “learning experiences” beyond classroom training</li> <li>• Increased focus on accountability (outcomes)</li> <li>• International business development module</li> <li>• Introduced High Potential Program</li> <li>• Introduced Nursing Leadership Academy</li> <li>• Leadership evaluation tool</li> <li>• Make program more formal (similar to administrative fellowship program)</li> <li>• Membership expansion</li> <li>• Mentorship program</li> <li>• New core curriculum</li> <li>• Performance excellence</li> <li>• Qualitative &amp; quantitative assessment methodology</li> <li>• Talent management</li> <li>• Tiered competency</li> <li>• 2-day retreat to engage participants in system vision</li> <li>• University format</li> <li>• Value on decision making</li> </ul>

**Q26a – Topics best taught by internal experts**

Of 53 responding health systems that reported having a leadership development program, 33 respondents listed topics best taught by experts inside the health system (Figure 26a). The topics most frequently listed were finance (12 times), quality (8 times), and strategy (6 times). Other topics listed more than once included policy, principles, culture, governance, human resources, Six Sigma, budgeting, ethics, general management, communication, customer service, and mission and values. Listed below are all the topics listed as answers to this question.

**Figure 26a: Topics Best Taught by Internal Experts**

<b>Topics Listed Multiple Times (#)</b>	<b>Topics Listed Once</b>
<ul style="list-style-type: none"> <li>• Finance (12)</li> <li>• Quality (8)</li> <li>• Organizational strategy (6)</li> <li>• Culture (4)</li> <li>• Human Resource issues (4)</li> <li>• Budgeting (3)</li> <li>• Ethics (3)</li> <li>• Governance (3)</li> <li>• Internal policy (3)</li> <li>• Business growth, development (2)</li> <li>• Communication (2)</li> <li>• Customer service (2)</li> <li>• Leadership development, skills (2)</li> <li>• Management (general) (2)</li> <li>• Mission and values (2)</li> <li>• Principles (2)</li> <li>• Six Sigma (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Balridge criteria</li> <li>• Clinical management</li> <li>• Coaching</li> <li>• Community relations</li> <li>• Compliance</li> <li>• Diversity</li> <li>• Four directions to excellence</li> <li>• Information technology</li> <li>• Legal issues</li> <li>• Managed care</li> <li>• Mentoring</li> <li>• Peer interviewing</li> <li>• Process changes</li> <li>• Product line management</li> <li>• Productivity</li> <li>• Quality</li> <li>• Recognition</li> <li>• Safety</li> <li>• Situational leadership</li> <li>• System specific issues</li> <li>• Teamwork</li> <li>• Technology</li> </ul>

**Q26b – Topics best taught by external experts**

Of 53 responding health systems that reported having a leadership development program, 30 respondents listed topics best taught by experts outside the health system (Figure 26b). The topic listed most frequently was leadership skills (listed 5 times). Other topics that were listed more than once included change management (3), coaching (3), quality improvement (3), teambuilding (2), negotiation (2), and best practices (2). Listed below are all the topics that were listed as answers to this question, identified by frequency of appearance.

**Figure 26b: Topics Best Taught by External Experts**

<b>Topics Listed Multiple Times (#)</b>	<b>Topics Listed Once</b>
<ul style="list-style-type: none"> <li>• Leadership skills (5)</li> <li>• Change management (3)</li> <li>• Executive coaching (3)</li> <li>• Quality improvement (3)</li> <li>• Teambuilding (2)</li> <li>• Negotiation (2)</li> <li>• Best practices (2)</li> </ul>	<ul style="list-style-type: none"> <li>• 360 degree feedback</li> <li>• Accountability systems</li> <li>• Catholic Health Association (CHA), American Hospital Association (AHA), and American College of Healthcare Executives (ACHE) meetings and seminars</li> <li>• Classic educational topics</li> <li>• Cost control</li> <li>• Culture change</li> <li>• Environmental trends</li> <li>• Evidence-based management</li> <li>• Innovation</li> <li>• Leadership behaviors</li> <li>• LEAN</li> <li>• Leadership assessment</li> <li>• Legal issues</li> <li>• Management principles (general)</li> <li>• Quality Management (National principles)</li> <li>• Risk-Taking</li> <li>• Scientific measurement systems</li> <li>• Service excellence</li> <li>• Situational leadership</li> <li>• Six Sigma</li> <li>• Self-assessment</li> <li>• Visioning</li> </ul>

***Q27 – Topics willing to be outsourced***

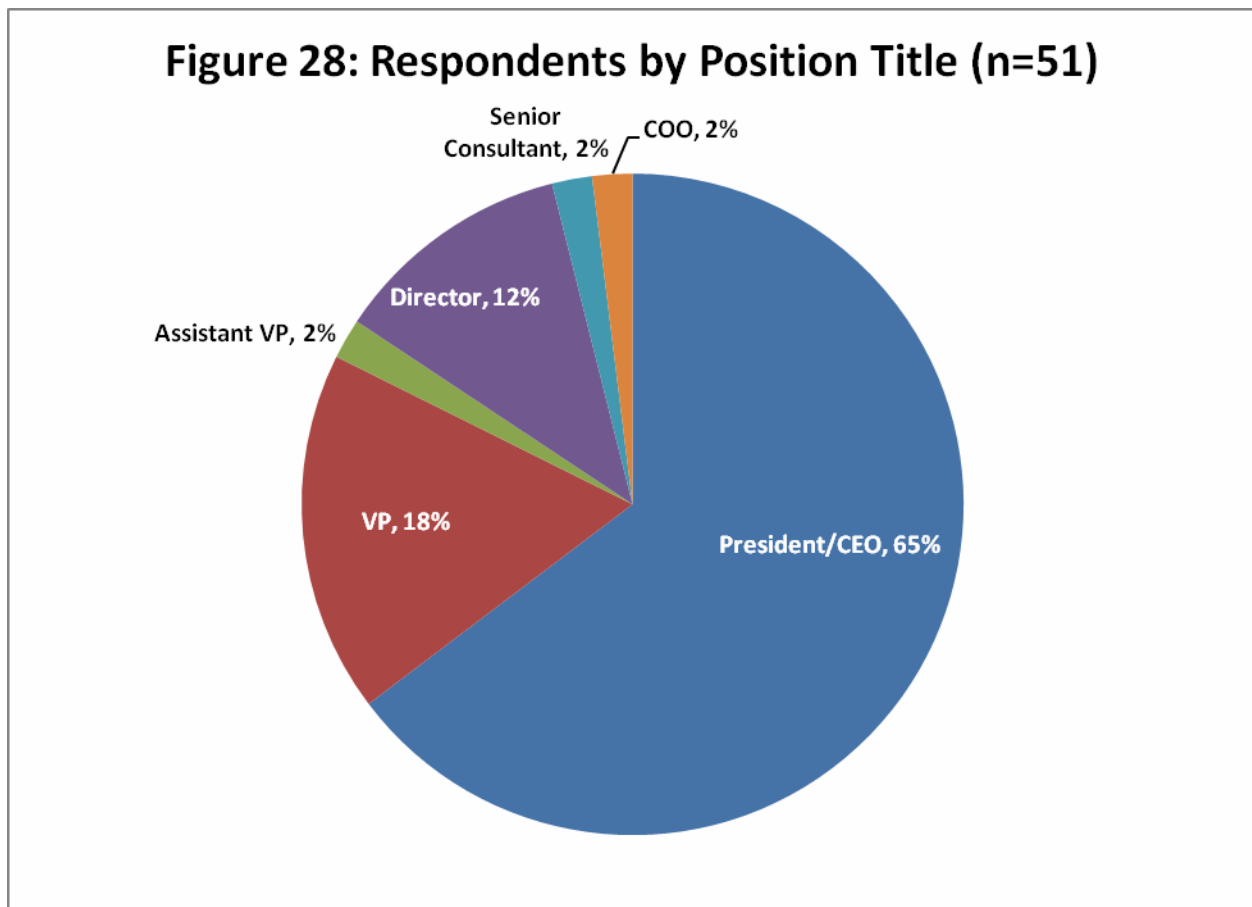
Of 53 responding health systems that had a leadership development program, 25 respondents listed topics they would be willing to outsource (Figure 27). Topics listed four times included 360 degree evaluations and executive coaching. Other topics listed more than once included the area of considering trends and health care policies in the future, and the area of performance improvement tools and scientific measurement systems. Listed below are the topics that were listed as responses to this question.

**Figure 27: Topics Willing To Outsource**

<b>Topics Listed Multiple Times (#)</b>	<b>Topics Listed Once</b>
<ul style="list-style-type: none"> <li>• 360 degree evaluations (4)</li> <li>• Executive coaching (4)</li> <li>• Conceptual future trends, health care policies (3)</li> <li>• Performance improvement tools; Scientific measurement systems (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Accountability systems</li> <li>• Best practice strategies</li> <li>• Communication</li> <li>• Conflict management</li> <li>• Executive development course</li> <li>• Facilitation skills</li> <li>• Journey to excellence</li> <li>• Leadership meeting keynotes</li> <li>• Performance management</li> <li>• Quality management, national principles</li> <li>• Running Learning Academy (Use Center for Creative Leadership)</li> <li>• Situational leadership</li> <li>• Six Sigma</li> <li>• Values and ethics through Catholic Health Association (CHA) programs</li> </ul>

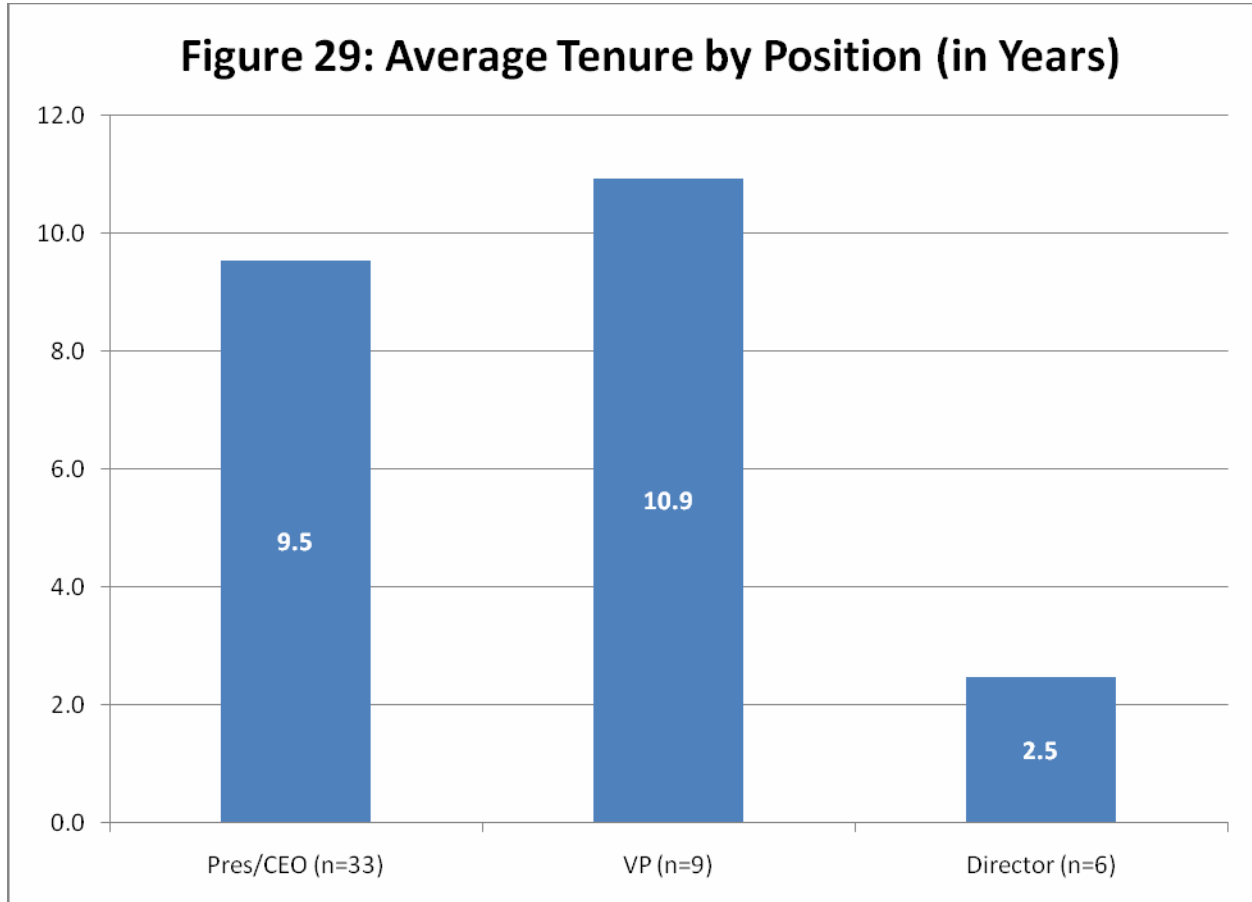
**PART 4:****SURVEY CONCLUSION:**  
**Characteristics of Respondents and their Systems*****Q28 – Respondent’s Title***

Of 51 respondents who provided their titles, the majority of survey participants reported holding the position of President/CEO (65%) (Figure 28). Vice presidents made up 18% of respondents while 12% of respondents were directors. There were only 1 assistant vice president (2%), 1 senior consultant (2%), and 1 COO (2%) who completed the survey.



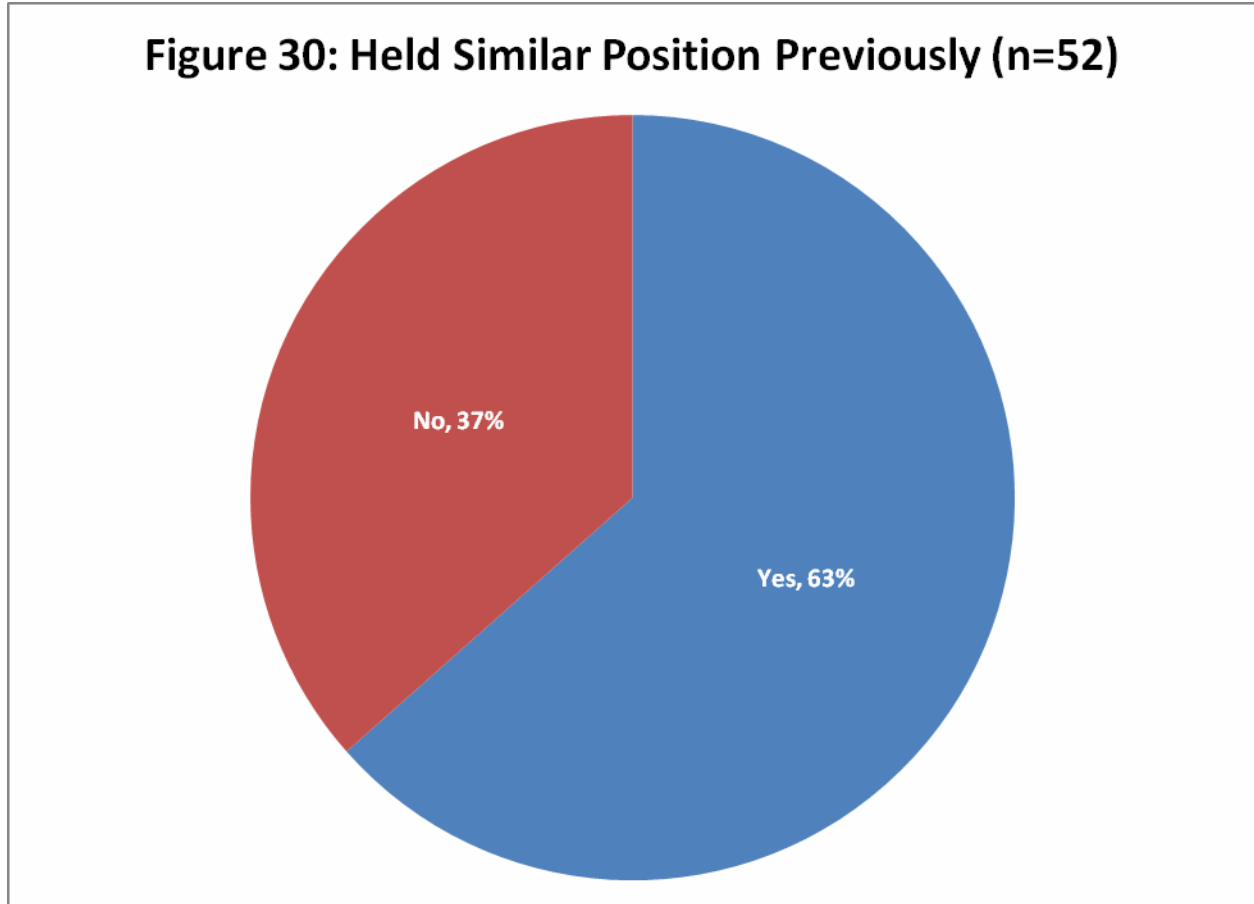
### ***Q29 – Tenure in respondents' position***

Of 52 respondents who provided their titles, the respondents who were reportedly Presidents/CEOs had held their position for an average of 9.5 years (Figure 29). Vice presidents had held their positions for an average of 11 years while directors had only held their positions for an average of 2.5 years. (Small numbers prevented further description of the COO, Assistant VP, and Senior Consultant job tenures).



***Q30 – Previously held similar position***

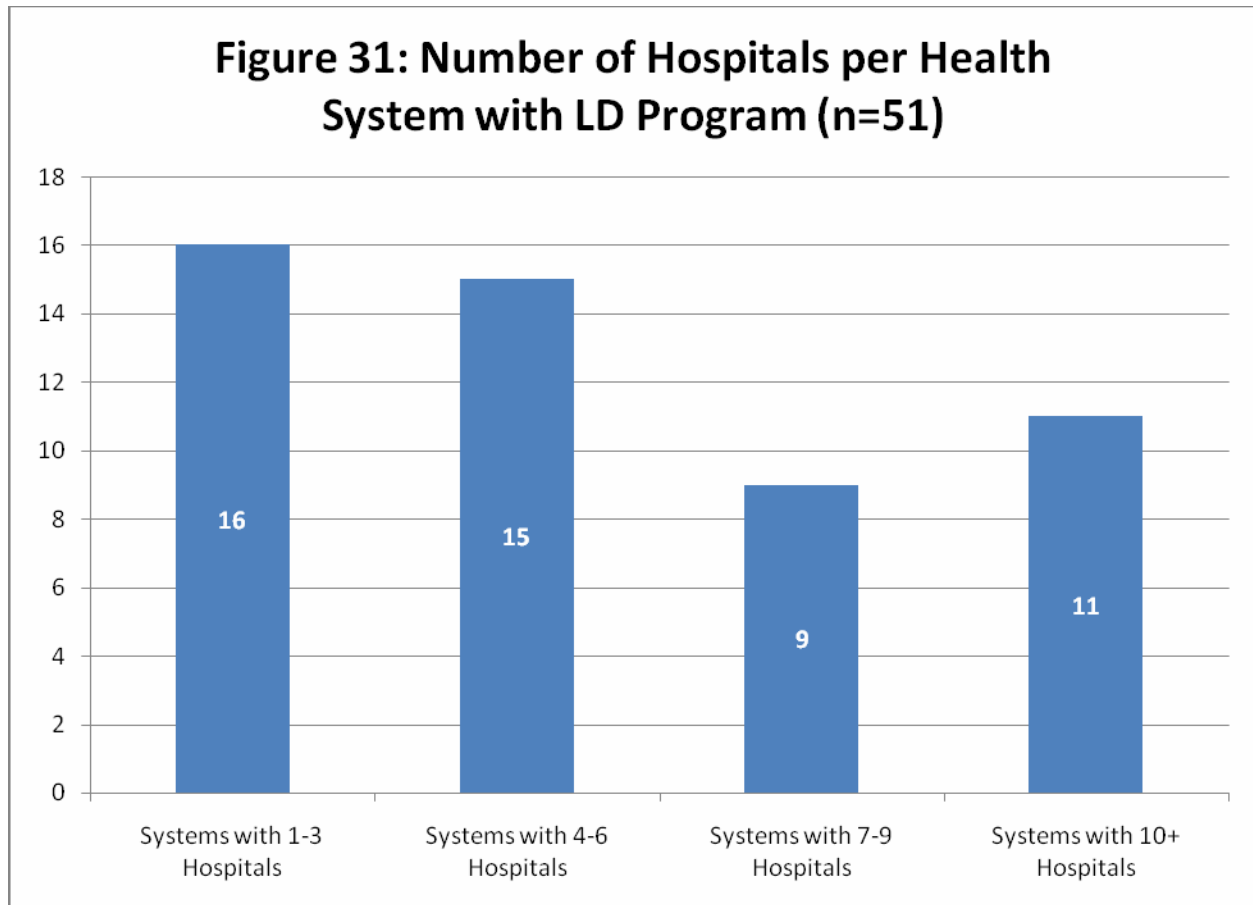
Of 52 respondents, 63% of the respondents had previously held a similar position at another organization while the remaining 37% had not (Figure 30).



### ***Q31 – Number of hospitals in health system***

Of 51 responding health systems that reported having a leadership development program, these health systems contained an average of 8.5 hospitals. The median number of hospitals per health system was 5 hospitals.

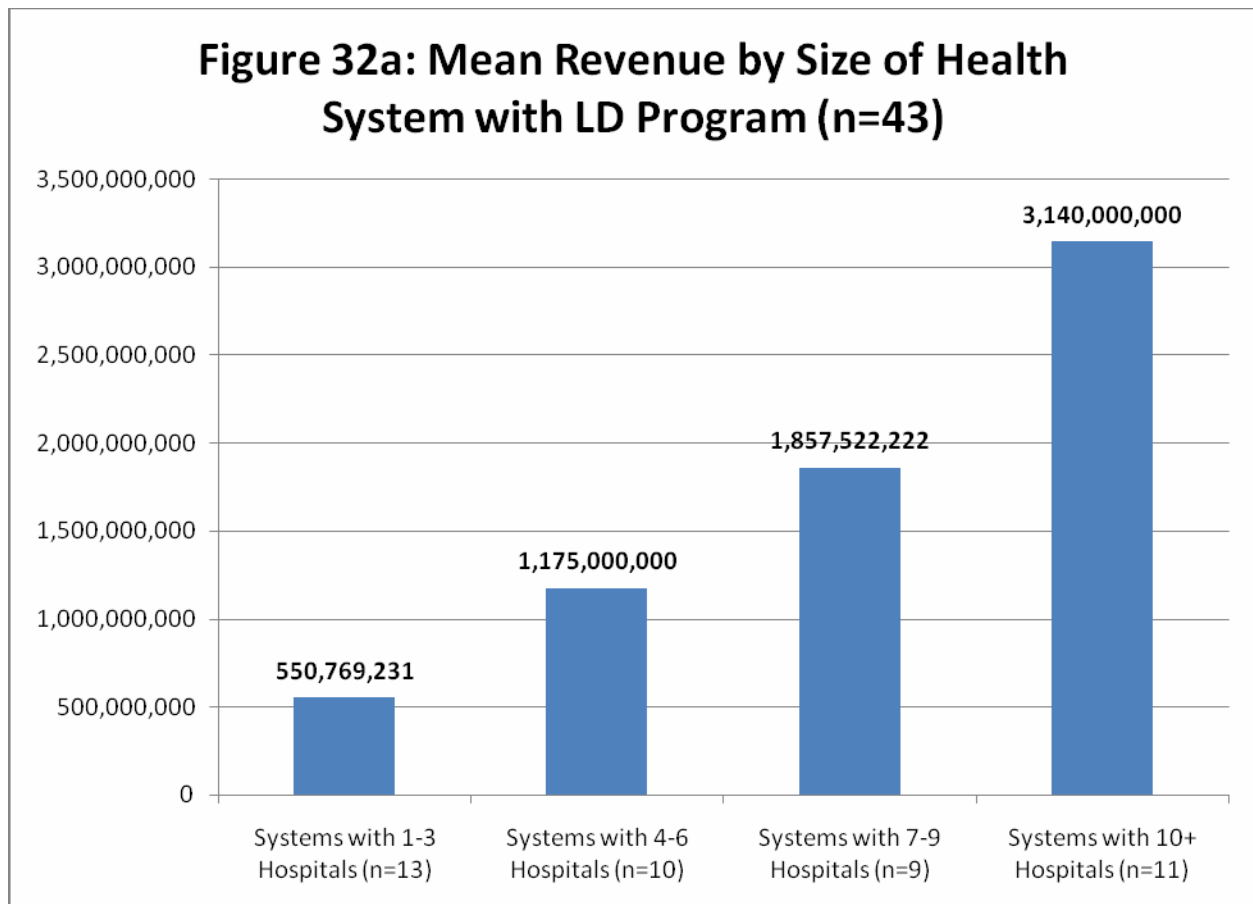
There were 16 health systems with 1-3 hospitals, 15 health systems with 4-6 hospitals, 9 health systems with 7-9 hospitals, and 11 health systems with 10+ hospitals, as shown below (Figure 31).



### ***Q32 – Net revenue of health system***

Of the 43 responding health systems that reported having a leadership development program and provided net revenue information, the average net revenue was just over \$1.6 billion while the median net revenue was \$1.2 billion.

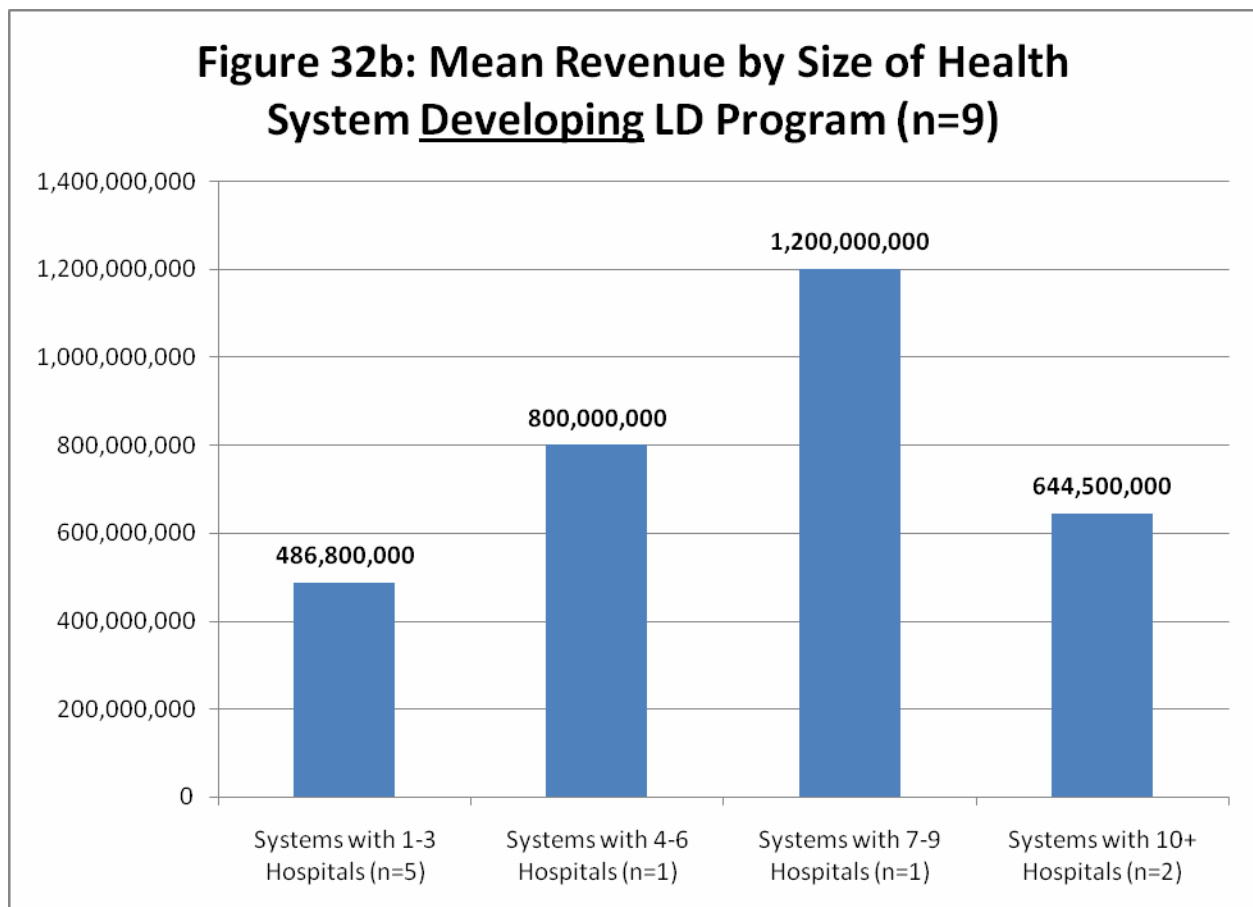
Not surprisingly, net revenue increased with system size (Figure 32a). For the 13 health systems with 1-3 hospitals, the average net revenue was \$550,769,231. For the 10 health systems with 4-6 hospitals, the average net revenue was \$1,175,000,000. For the 9 health systems with 7-9 hospitals, the average net revenue was \$1,857,522,222. For the 11 health systems with 10+ hospitals, the average net revenue was \$3,140,000,000.



**Q32 continued**

Of 9 responding health systems that were reportedly DEVELOPING a leadership development program and provided revenue information, the average net revenue was approximately \$635 million while the median was \$560 million.

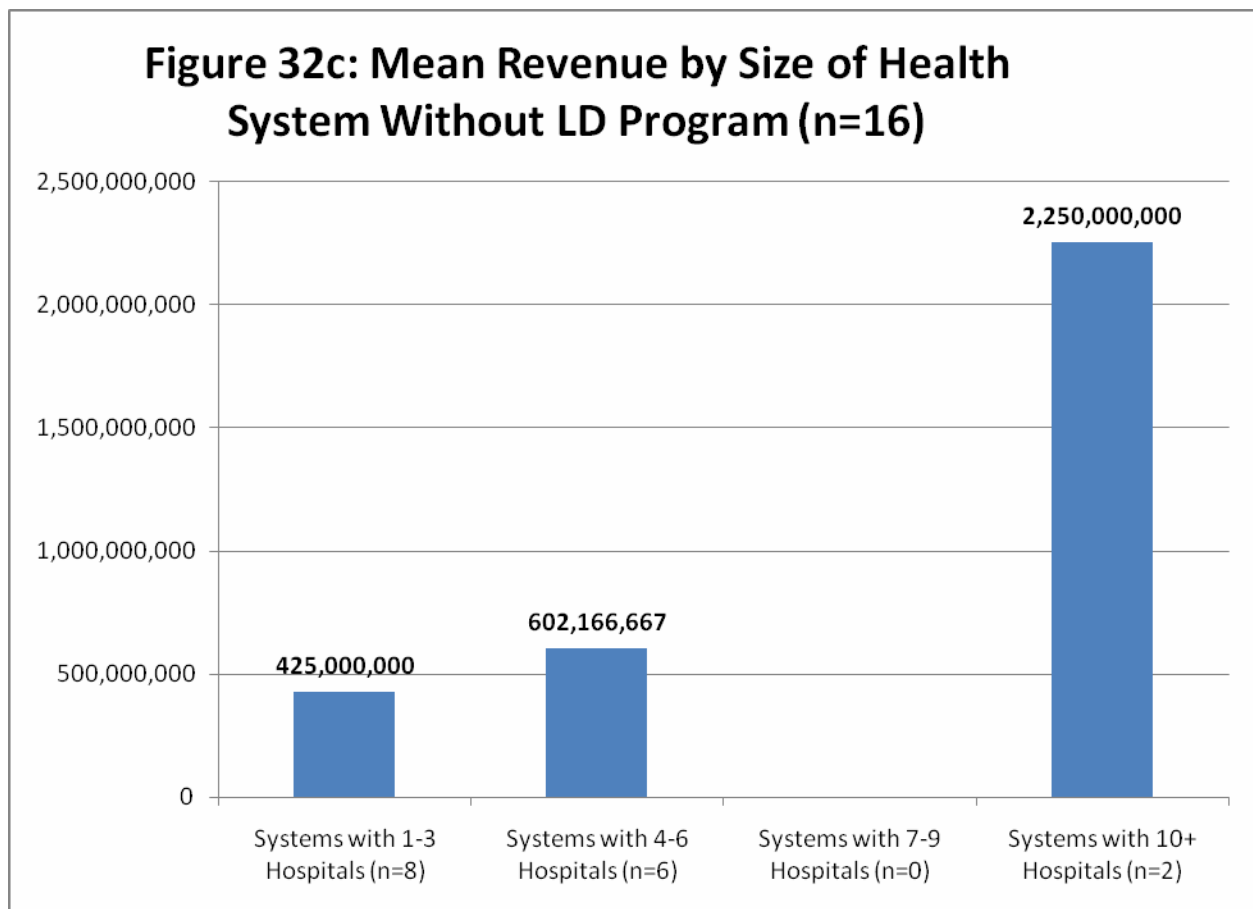
By system size, for the 5 health systems with 1-3 hospitals, the average net revenue was \$486,800,000 (Figure 32b). For the 1 health system with 4-6 hospitals, the net revenue was \$800,000,000. For the 1 health system with 7-9 hospitals, the net revenue was \$1,200,000,000. For the 2 health systems with 10+ hospitals, the average net revenue was \$644,500,000. Small numbers make it inadvisable to interpret trends from these reported data.



**Q32 continued**

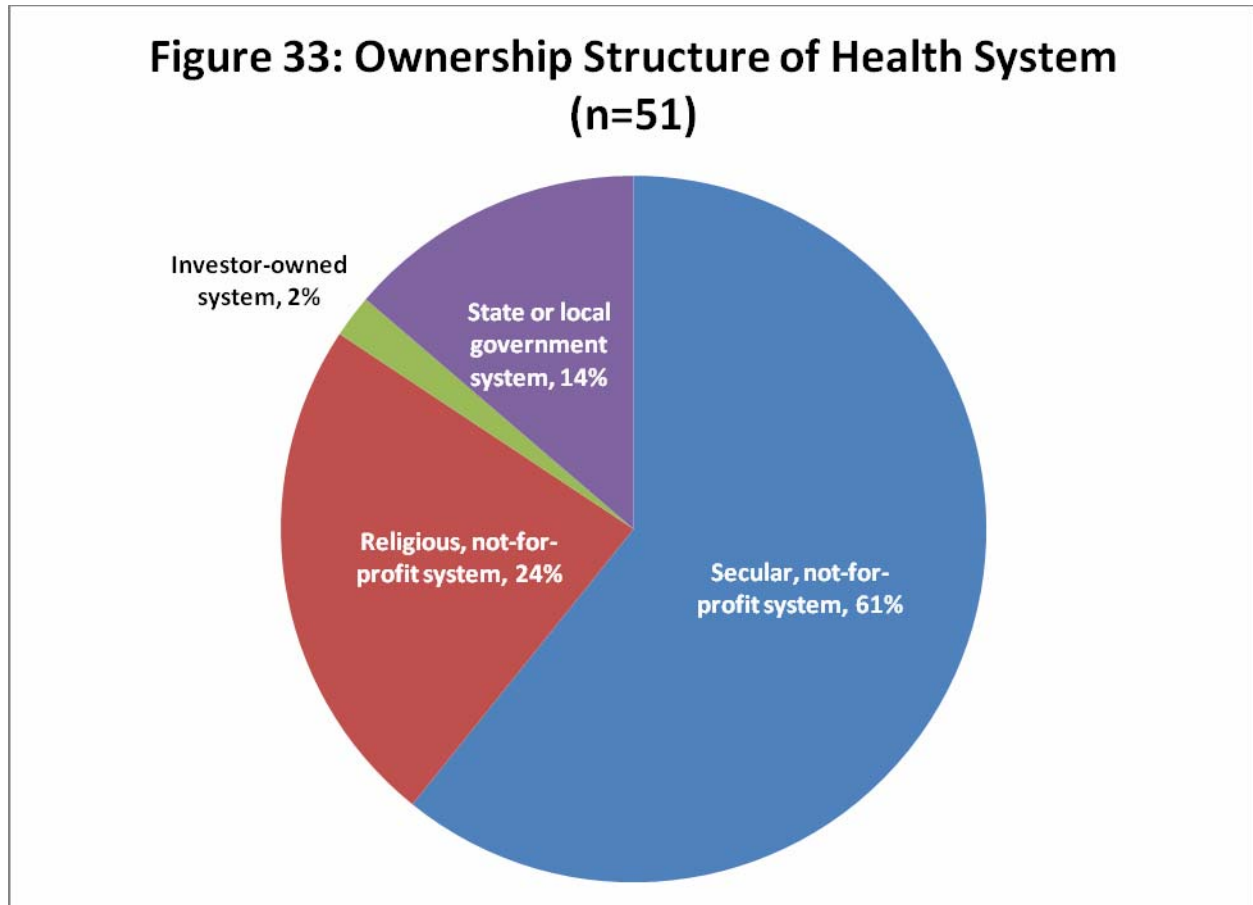
Of 16 responding health systems that did NOT have a leadership development program and reported revenue information, the average net revenue was approximately \$720 million while the median was \$502 million.

By health system size, for the 8 health systems with 1-3 hospitals, the average net revenue was \$425,000,000 (Figure 32c). For the 6 health systems with 4-6 hospitals, the average net revenue was \$602,166,667. For the 2 health systems with 10+ hospitals, the average net revenue was \$2,250,000,000. There were no responding health systems with 7-9 hospitals that did not have a leadership development program. Again, small numbers make it inadvisable to interpret trends from these reported data. Overall, revenues were lower among systems that had no leadership development program.



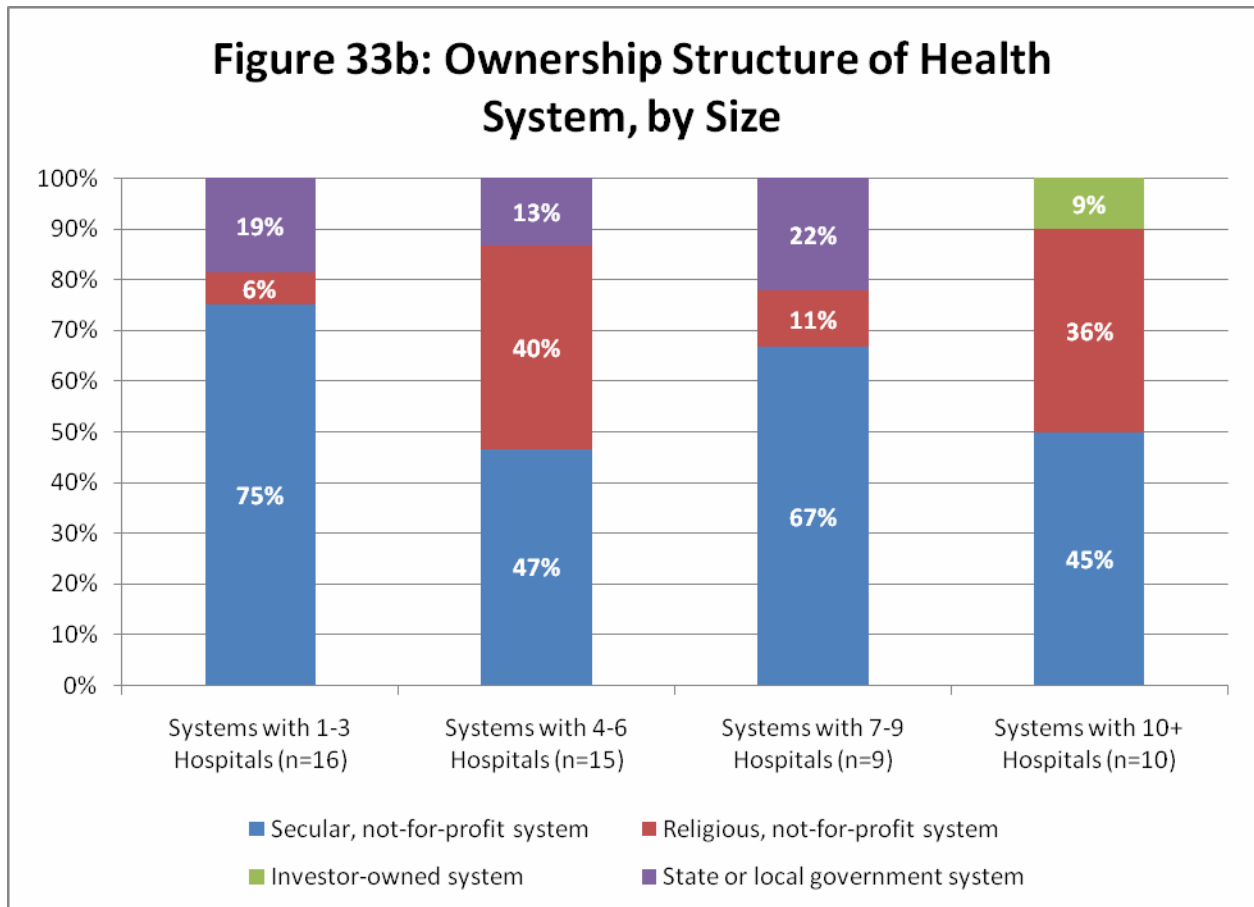
### ***Q33 – Ownership structure of health system***

Of 51 responding health systems that reported having a leadership development program, the majority (61%) were secular, not-for-profit systems (Figure 33). One-quarter (24%) were religious, not-for-profit health systems, and 14% were state or local government systems. A small minority were reportedly investor-owned (2%).



**Q33 continued**

Among the 51 health systems that reported system size and ownership structure, the only investor-owned systems that responded were large systems of 10 or more hospitals (Figure 33b). Smaller systems of 1-3 hospitals were comprised of proportionately more not-for-profit, secular systems. Figure 33b below provides additional detail about respondents' ownership structure and system size.



## Results: Qualitative Results

Key informant interviews were held to explore information related to questions asked in the ELD survey, and to obtain additional insight about the general topic of Leadership Development (LD) in Health Systems. Here we focus on four key thematic areas of exploration that contribute to our understanding of the survey findings. These four thematic areas are: 1) Program Rationale; 2) Challenges and Concerns Associated with LD Program Development; 3) Program Value; and, 4) Critical Success Factors for LD Program Development. Each of these thematic areas is described further below, with representative verbatim comments from study interviewees incorporated to illustrate each theme.

### *1) Program Rationale*

Across interviews, three main categories of answers emerged to questions about program rationale. These sub-themes provided a rationale for a focus on leadership development in the health systems: A) Focus on Employee Development and Workforce Improvement; B) Become/Remain the Employer of Choice; and C) Emphasize Education and Learning. These three sub-themes and supporting quotations are presented in Table Q1 on the following page.

**Table Q1: Rationale for LD Program Development**

<p><b><i>A) Focus on Employee Development and Workforce Improvement</i></b></p>	<p>“One of the things that we identified when I first came here was that we needed to build more bench strengths in our leadership overall. We tended to go outside to hire managers. We were doing a lot of promotion from within but we were also doing a lot of promotion from without. A lot of roles were changing and responsibilities were changing and as you know in health care people tend to have to take on more responsibilities and one of the things that the executive have identified is they felt that we needed to have some people in the bullpen, being able to step up to the plate.”</p> <p>“because we determined that we are not putting enough money, time, and resources into the succession planning and development of our management and clinical leaders....”</p> <p>“If you have good leadership at the top, and that continues to trickle down, which is what we are working at .... That’s how you affect organizational performance.”</p>
<p><b><i>B) Become/Remain Employer of Choice</i></b></p>	<p>“Because we really recognized that to provide care in the long run we have to attract the best people and we have to give them the skills to do that. And just going to nursing school or just getting your MBA is not going to give you the skills. Flopping you down in a job is not going to give you the skills to continuously improve. Improve as a manager, improve as a leader, improve the care in the product that you’re producing. So by taking time for education and development, you’re creating a better employee and the best employees are seeing you as the employer of choice. And fundamentally whether it’s patient safety, financial performance, market share grown, provider of choice, if you weren’t the employer of choice you would be able to do any of those.”</p> <p>“ensuring that we remain the employer of choice.”</p> <p>“I think the business case is if you want to be a player in this market then you need to understand the benefit of providing education.”</p>
<p><b><i>C) Emphasize Education and Learning</i></b></p>	<p>“We have been trying to be identified as a learning organization for years. We have always had different opportunities for learning, but it wasn’t until the structure of the corporate university was founded, that is structured it up more and made it more of a corporate initiative.”</p> <p>“I just think you will never be able to sustain your position as a leader in the community or just a leader in terms of being a great employer if you’re not a learning organization.”</p> <p>“There’s a belief that as an academic medical center-driven system that we have to do this.”</p> <p>“I think as healthcare becomes more transparent and we have more knowledgeable consumers, that education is going to become more and more critical, and it will be something that we will be, we will actually be advertising to patients that we have well-educated and well-trained employees, and this is how we know that.”</p>

## 2) Challenges and Concerns Associated with LD Program Development

When asked about the process of designing and developing the LD program within a health system, interviewees described five main types of challenges and concerns: A) Managing Competing Priorities; and B) Internal Program Promotion; C) Program Evaluation; D) Program Resources and Constraints; and E) Future Development. These five sub-themes and quotations associated with those sub-themes are shown below in Table Q2.

**Table Q2: Challenges and Concerns Associated with LD Program Development**

<p><b>A) Managing Competing Priorities</b></p>	<p>“I think we are going through an enormous amount of change. It never stops. And trying to support the staff and the system in those challenges is very difficult. It’s very stressful.”</p> <p>“You have such tunnel vision of only looking at your own world and not thinking of the plans and efforts and everything that someone else is working on.”</p> <p>“...the institute can have great stuff but if I don’t let my people go to it because they’re “too busy” that’s not acceptable.”</p>
<p><b>B) Internal Program Promotion</b></p>	<p>“I don’t know that I do as good a job of selling what we do internally. I try to tell the executives what we do but I don’t know if they understand the depth of what we are doing. Maybe they do and they just don’t tell me. I think that is a barrier.”</p> <p>“Many times people are not aware that classes are there online. Sometimes people want a face to face class but it may be available online.”</p>
<p><b>C) Program Evaluation</b></p>	<p>“Learning is always hard to measure. You can look at our results and target the departments of concern. You can link the people who aren’t doing well.”</p> <p>“We have to continue to show our value. We have to continue to find educational learning events. The outcome should be learning. How are you going to evaluate learning, not the presentation?”</p> <p>“We are going to go back perhaps 6 months and a year later, go back and look at those folks and see where they are at in the organization and who has been promoted and what types of additional responsibilities and from their leader’s perspective, has their skill level developed at all.”</p>
<p><b>D) Program Resources and Constraints</b></p>	<p>“You have to get funding for all of this.”</p> <p>“...you have to have a strong financial base. Because it takes money to support that type of education.”</p> <p>“I think technology is always going to be an issue for us. I think in healthcare even though we are technical people we are not as hooked into the technology.”</p> <p>“I’m concerned that we keep up with the demand. I’m concerned that we are as innovative as we can be, that we don’t ever get bureaucratic.”</p>

<p><b><i>E) Future Development</i></b></p>	<p>“I think we are always looking to do better and be better and look to the outside.”</p> <p>“You’re always searching for opportunities to develop people and looking for the best in people. I’m not just finding people who I want. It’s all about looking for opportunities to do better than you are.”</p> <p>“We are really developing program changes based on benchmarking and research.</p> <p>The high potential program is coming up and so is the physician leadership education. High school mentoring program.”</p> <p>“Action learning is big.”</p> <p>“I would like to see a little more individualized plan of care/plan of education. More individualized approach.”</p>
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### 3) Program Value

When asked about the value of the LD program to the organization, interviewees noted several areas of perceived value. These were categorized into four main themes: A) Focus on Employee Growth and Development; B) Improve Support of Organization's Strategic Priorities; C) Improve Employee Retention; and, D) Reduce Expenditures on Learning and Development.

**Table Q3: Value of LD Program to the Health System**

<p><b>A) Focus on Employee Growth and Development</b></p>	<p>“Growth and development of employees, and really so that each employee can reach their own personal potential whatever that might be.”</p> <p>“It provides people the opportunity to really develop their leadership skills. The ability to provide all managers with tools to continuously improve their work.”</p> <p>“And the value of it is that you have better employees who are better prepared to do their jobs.”</p> <p>“you don’t make or create an environment where employees want to work when their immediate supervisor is somebody that nobody wants to work with.”</p> <p>“Leadership is what drives results and we have multiple opportunities for leadership development.”</p>
<p><b>B) Improve Support of Organization's Strategic Priorities</b></p>	<p>“...a very effective way to ensure strategic initiatives are understood and are being executed.”</p> <p>“In order to meet our strategies you have to invest in them and make it easier for them to learn. Create offerings for people to learn and develop.”</p>
<p><b>C) Improve Employee Retention</b></p>	<p>“We think the ROI is based on retention of employees and managers.”</p> <p>“We said at the end of five years we would look at our retention rates to see if we have made a difference. ...it is seen as the most outstanding system-wide service that we have available.”</p> <p>“If you expect a lot of people, from people, then you should be willing to give them as much as you can. And in giving I’m not talking about money, I’m talking about giving them opportunities, giving them development. I think if you expect a lot then you should give a lot. And we do expect a lot.”</p>
<p><b>D) Reduce Expenditures on Learning and Development</b></p>	<p>“Because people see the huge economy one can get by doing this, by paying attention to leadership development and doing it on a larger scale because it’s expensive. And if you can do it on a larger scale, there’s huge economies to it.”</p> <p>“...ease of use for all mandatory educational things for staff. What used to take all day now takes a few hours online.”</p>

#### 4) Critical Success Factors for LD Program Development

A fourth major area of focus in key informant interviews involved discussion about the critical success factors for LD program development. Answers to these questions were categorized into four main sub-themes: A) Executive Engagement and Support; B) Strong LD Program Leadership and Personnel; C) Organization Valuing Development and Education; and, D) Linkage Between LD Program and Strategic Priorities. These sub-themes and key informants' associated comments are shown below in Table Q4.

**Table Q4: Critical Success Factors for a Health System LD Program**

<b>A) Executive Engagement and Support</b>	<p>“Executive engagement. You have to have the top person very engaged in the process in terms of defining what is important for the leadership in that organization and then holding people accountable. So executive engagement and accountability.”</p> <p>“Our CEO is unbelievably phenomenal in terms of supporting development.”</p>
<b>B) Strong LD Program Leadership and Personnel</b>	<p>“I think it’s takes good leadership.. leadership in terms of communicating a plan and showing the business case for it and those kinds of things gets her what she needs in terms of the support from the organization.”</p> <p>“Dedicated employees within the ranks is also crucial.”</p> <p>“I think you have to have a good leadership team within the corporate university.”</p> <p>“The staff: very qualified and user-oriented.”</p>
<b>C) Organization Valuing Development and Education</b>	<p>“I think the organization has to value development in general, whether it’s developing the staff for clinical competencies or their leaders for their leadership competencies.”</p> <p>“You have to have an organization that values development and ongoing development.</p> <p>“Upper level management must buy into education.”</p> <p>“As long as we can make improvements and show improvements, people will continue to support us.”</p>
<b>D) Linkage Between LD Program and Strategic Priorities</b>	<p>“You need to demonstrate program value and our way of demonstrating that is linking it to the strategies and the metrics that are important to us.”</p> <p>“I think it’s really finding out what’s important to your senior leadership, including the board. Where are their touch points, what types of programs and things will they define as success?.”</p> <p>“It is a dynamic process and it’s not about the money its about the process in the end. If we walked to corporate management and said it would cost 4 billion, we would approach it as if it will improve the health of the patients then it would be looked at.”</p> <p>“You have to have good leaders and a system that listens to the end user because if you have someone who sits in their office and says what they think the organization needs, then that is not going to be successful. You have to have an ongoing survey process.”</p> <p>“Consistent content and a way of evaluation rather than everyone and their brother deciding how to do things.”</p>

## VI. DISCUSSION

### Summary of Results, by Survey Section

#### *Part 1: Establishment and Organization of Executive Leadership Development*

Across health systems surveyed, half (52%) reported having an executive leadership development program in existence, and another 12% reported having a program under development. Among those with existing programs, the vast majority (88%) tied their leadership development programs to strategic goals for the health system. This evidence of the prevalence of programs and the strategic focus of most suggests the recognized importance of leadership development at the executive levels of health systems, and the potential opportunity to direct programs toward areas where they will be most strategically advantageous.

While most respondents (94%) had heard the term corporate university used in a business setting, only 26% of responding systems with leadership development programs used the term “corporate university” for their program. Across respondents, 28% of the programs in existence reportedly had a “Chief Learning Officer” (CLO), potentially reflecting heightened emphasis on learning and development in health systems with this type of executive in the “C-suite.”

Among existing programs, 73% were reportedly customizable to the needs of participating executives, perhaps reflecting the need to tailor development opportunities to the highly constrained schedules and targeted educational needs of senior-level executives.

The reasons most frequently noted for initiating executive leadership development included advancing strategic goals, succession planning, and the desire to provide local development opportunities. This was consistent with the competency emphases most frequently noted that included leadership and general management skills, in addition to communication and relationship management, and quality improvement. In contrast, more technical or specialized competency areas tended to receive a proportionately lower emphasis at this executive level (i.e., physical plant, human resource systems, information systems for managers, legal and regulatory issues, community relations, clinical staff structure, and marketing). Other areas of emphasis additionally listed by respondents were similarly less technical and included feedback and development, teamwork and team management, organizational change management, strategic and visionary thinking, and self-awareness.

Participants included in the leadership development programs described included individuals at the executive or senior management levels of both the system and individual hospitals. In both categories (i.e., system and hospital), Vice President participation was reportedly highest, and Chief Medical Officer participation was lowest. Given the apparent broad reach of most programs, the question arises as to why some executives are not included in some programs.

With respect to budget, there was a wide range of program budgets reported. The average budget was \$4,539 per participant, per year (with one outlier budget removed); however detailed information about what contributed to the budget figure was not collected in the survey. Across

responding health systems, no program budgets had decreased, while 45% reported increases from the prior year and 55% reported that their budget had stayed the same.

### ***Part 2: The Content and Process of Executive Leadership Development***

Across existing leadership development programs, the average number of contact hours per participant was 52, with the median figure of 40 contact hours. Faculty for those hours of content were mixed between internal (57%) and external (43%) instructors.

Executive coaches were reportedly provided through 86% of the existing leadership development programs, and only 20% of respondents reported restricting coaches to only internal personnel. The larger the health system, the more frequent was provision of executive coaches.

Multiple external organizations and programs were used to supplement internal programs, with the Advisory Board Company most frequently used (58%) followed by universities (36%), the Center for Creative Leadership (25%), and the National Center for Healthcare Leadership (21%).

Among existing programs, the most frequent approaches to determining areas of needed emphasis included asking participants for their ideas (58%) and performing an annual review of the program (55%). Additional input was sought from the strategic planning process (51%), from other executives (47%), and, less frequently, from consultants (30%).

Participants in executive leadership development programs were evaluated most commonly on the basis of performance evaluations and professional development plans (79% used these approaches routinely), with 67% reporting using a self-assessment process and half (50%) reporting using a 360 degree evaluation process.

### ***Part 3: The Evaluation and Evolution of Executive Leadership Development***

Respondents reported evaluating program effectiveness most frequently on the basis of employee satisfaction (66% in use; 15% under development), succession planning (62% in use; 31% under development), quality improvement (62% in use; 13% under development), and patient satisfaction (58% in use; 8% under development). Notably, succession planning was reportedly not in use as an evaluative measure by only 7% of respondents.

Three-quarters of programs or more reported that promotion rates, employee satisfaction, and quality improvement as measures of leadership development program effectiveness were either in use or being developed. Broader organizational measures were less frequently used including market share (59% did not use), cost savings (49% did not use), and patient satisfaction (33% did not use).

In contrast, only five programs (9%) reported using return on investment (ROI) as an evaluation metric. Target ROI figures provided could not be clearly interpreted.

A majority of program elements was noted by respondents to be worth the investment as these program elements reportedly either met or exceeded expectations. Specifically, leadership skills (88%), coaching (84%), and general management principles (80%) reportedly provided value for more than three-quarters of respondents. Notably, several program component areas exceeded expectations for over one-quarter of responding health systems: coaching (40%), 360 degree feedback (33%), leadership skills (29%), QI skills (28%), and self-assessment processes (27%).

Program revisions or deletions were generally listed only by only one respondent. However, two respondents listed each of the following areas as being revised: program customization, the leadership model, the participant selection process, the Six Sigma process, and the program time frame. Program elements listed a single time were generally linked to specific modules or individual program needs.

New features planned for executive leadership development programs included succession planning (listed 5 times), coaching (3 times), tiered competency development (3 times), and use of executives for teaching/mentoring middle management (3 times). In addition, the inclusion of a diversity module, individualized planning and assessment, performance evaluations, strategic goals, and use of technology, were all listed twice, and an extensive list of planned features was listed once among respondents.

Of program topics reportedly best taught by internal experts, topics whose application could be considered system-specific such as finance, quality, strategy, culture, human resources issues, internal policy, ethics, governance, and budgeting were each mentioned by more than one respondent health system. Topics reportedly best taught by external experts included those benefiting from a broader perspective such as leadership skills, change management, executive coaching, best practices, quality improvement, negotiation, and team-building, all of which were listed more than once. The few topics respondents were reportedly willing to outsource included 360 evaluations, executive coaching, conceptual/broad thinking on future trends and health policy, and performance improvement training.

## **Comparative Analysis of Quantitative and Qualitative Data**

In several areas, questions asked in the qualitative interviews provided additional information to help with interpretation of survey results. Here are highlighted four main areas: 1) Rationale for ELD Program Development; 2) Use of Coaches; 3) Program Evaluation; and 4) ELD Program Value.

### ***1) Rationale for ELD Program Development***

Interviewees were asked to describe their rationale for developing their ELD program. Survey respondents were asked about whether each of eight factors were reasons contributing to starting their health system's ELD (Figure 8, p. 24); interviewees were asked to describe their rationale for initiating the program without being constrained by a list of possible factors. While

majorities of survey respondents listed the desire to further advance the system's strategic goals (90%), the wish to initiate succession planning (82%), the wish to offer executives professional development opportunities locally (74%), and the need for consistency of messages about accepted executive leadership behavior and practice (68%) as major factors, interviewees consistently described issues surrounding dissatisfaction with executives' preparation first, and mentioned the needs for succession planning and advancing the system's strategic goals later. As shown in Table Q1 (p. 60), the three main themes that emerged around program rationale were to focus on employee development and workforce improvement, to become or remain the employer of choice, and to emphasize education and learning throughout the organization. Thus while interviewees might agree with the list of factors rated important by survey respondents, the emphasis appeared different in the interviews when informants were allowed to discuss the reasons for program development unconstrained by a pre-determined list of factors.

## ***2) Use of Coaching***

The use of executive coaches in ELD programs also emerged as an important factor in the survey. This use of coaches was widespread (only 14% of systems did not use coaches, p. 35), increasing (multiple mentions of coaching in planned future program developments, p. 46), and reportedly exceeded or met expectations for nearly all health systems that used coaches (p. 44). Key informant interviews provided additional insight about use of coaches, and particularly the selection of external over internal coaches for ELD activities. Specifically, interviewees emphasized the importance of external consultant coaches for very senior executives. As one explained,

“Our executive level goes to consultants. We don't want to coach executives. We don't think it's appropriate. So we partner with the consultants. And sometimes a consultant when working with an executive or other people in the organization will say ‘they will refer them to us’ and we will be able to set something up.”

## ***3) Program Evaluation***

The difficulty of ELD program evaluation, both of the program itself and of participants, was highlighted by survey responses showing substantial variability in how programs were evaluated, and limited information about overall program evaluation (pp. 41-43). Survey respondents reported that participants were commonly evaluated as part of their performance evaluation process (79%), with additional use of participant self-assessments (67%) and 360 degree evaluations (50%) of executives. Overall program evaluation, however, was less clear, with over half of respondents noting use of factors such as employee job satisfaction, succession planning, program evaluation, and patient satisfaction as metrics, yet fewer than one in ten actually noting a calculated return on investment (ROI) analysis (p. 43). Key informants repeatedly emphasized the difficulty of program evaluation, and, in particular, the need to move beyond tracking program participation to tracking learning (p. 62). This difficulty was again reflected in discussion of perceived program value, as explained further next.

#### **4) Value of ELD Program**

Survey questions asked respondents to estimate whether individual components of the ELD program exceeded, met, or did not meet program expectations (p. 44); training in personal leadership skills, coaching, general management principles training, and training in quality improvement skills were all reportedly valued by more than three-quarters of survey respondents. Interestingly, substantial proportions of respondents were unable to report any payoff with respect to training in cost control concepts or revenue enhancement methods, ostensibly reflecting that their ELD programs did not emphasize training in these areas.

Notably, key informants were eager to discuss notions of program value, with the concept of program value discussed both in the context of program rationale (p. 60), and of the value of the program to the health system (p. 63). Even discussion of critical success factors (p. 64) highlighted the importance of perceived program value, especially with respect to engaging executives and building a case for program sustainability. Key informants were not asked to assess relative value of individual program components, as listed in the survey, but training in personal leadership skills, general management principles, quality improvement skills, coaching, and mentoring were all specifically mentioned in discussions of program value.

### **Limitations of the Study**

For the quantitative study, this study has limitations consistent with all survey research. First, perceptual biases and recall create concern for this type of survey. In addition, while the survey was directed to health system CEOs, not all respondents were CEOs, raising questions about the consistency of information provided across different types of respondents. Third, although the response rate was reasonable and comparable to other studies of CEOs, a higher response rate from the targeted study population would have been preferred. Fourth, the relatively small numbers of some categories of health system respondents limited the ability to make subgroup comparisons that might have been interesting.

For the qualitative portion of the study, despite the rich and detailed insights gained using qualitative methods, the capacity to generalize from a qualitative study is another predictable limitation of this research. In this study participants were selected from a broad range of health systems to enhance the transferability of these findings across health systems, but this is still a limitation. Further, since the development of executive leadership development programs is relatively new in many health systems, some of the interviews necessarily focused more on plans for the future rather than historical evidence. Extending the qualitative portion of this study to interview more health system representatives reflects an attempt to account for this bias.

### **Suggestions for Future Studies**

Future quantitative research studies may want to consider expanding the project scope to consider the executive leadership development activities of those healthcare organizations that

are not part of health systems. Further, moving beyond the executive level to quantitatively study the leadership development process for non-executive leaders (e.g., middle managers, front line supervisors) would be invaluable. Opportunities also exist to learn directly and concurrently from other industries outside healthcare, whether through qualitative or quantitative methods. Finally, a major opportunity exists to use a longitudinal design to study the experiences of individuals as they participate in an executive leadership development program (particularly using both qualitative and quantitative methods), to better understand the focus, experiences, and perceived impacts of such programs.

## **Conclusion**

Use of ELD programs by health systems is common and expanding, and especially prevalent among smaller systems. ELD programs are apparently valued by the systems, as reflected by reported perceptions of program payoffs and sustained budgetary commitment. Given the imperative to improve leadership capabilities in health care, ELD programs provide important opportunities to further systems' strategic goals, initiate succession planning, and provide local development opportunities with the majority of program elements reportedly worth the investment.

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## Appendix A: Suggested Resources

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## **Appendix B: Leadership Development Survey**

(complete survey follows on pages 75-83)



American College of  
Healthcare Executives  
*for leaders who care*®



COLLEGE OF  
PUBLIC HEALTH

## **Leadership Development: A National Survey of Health Systems**

### **SURVEY INTRODUCTION**

To help us understand how executives are developed and trained within your health system, we have developed this survey, organized into three main parts:

- Part 1: The establishment and organization of executive leadership development
- Part 2: The content and process of executive leadership development
- Part 3: The evaluation and evolution of executive leadership development

**The survey should take about 15 minutes to complete.**

### **YOUR RESPONSES TO THIS SURVEY ARE CONFIDENTIAL**

FOR QUESTIONS PERTAINING TO THIS SURVEY, PLEASE CONTACT:

Dr. Ann McAlearney, Project Director

Phone: (614) 292-0662

Email: [mcalearney.1@osu.edu](mailto:mcalearney.1@osu.edu)

**PLEASE COMPLETE THIS QUESTIONNAIRE BY MAY 7.**

**YOUR ASSISTANCE IS VERY MUCH APPRECIATED.**

**Thank you, in advance, for your time and assistance with this important study.**

**PART 1: ESTABLISHMENT AND ORGANIZATION OF EXECUTIVE LEADERSHIP DEVELOPMENT**

Please Note: By “**executives**” in this survey, we are referring to senior leaders in your organization at the Vice President level and above.

1. Does your health system have an executive leadership development or training program?
 

Yes .....	1	→ Continue with Q. 2
No .....	2	} Go to box at end of survey, p. 9
Being developed .....	3	
  
2. Would you say that the executive leadership development program is tied to improving the strategic goals of the system (e.g., improving quality, efficiency, profitability, market position)?
 

Yes .....	1
No .....	2
Not sure.....	3
  
3. What percentage of the training of your system’s executives is under system-level direction, what percentage is at the hospital-level at the member hospitals, and what percentage is self-directed?
 

Enter percent under corporate or system-level direction	_____
Enter percent under member hospital-level direction	_____
Enter percentage self-directed by executives	_____
Total:	100%
  
4. Have you heard of the term “corporate university” in a business setting?
 

Yes .....	1
No .....	2
  
5. Does your health system use the term “corporate university”?
 

Yes .....	1
No .....	2
  
6. Does your system have a formally titled “Chief Learning Officer”?
 

Yes .....	1
No .....	2
  
7. Do you offer a single executive leadership development program that pertains to all executives or do you modify programs based on the needs of individual executives?

- Single executive-level program ..... 1
- Customizable program..... 2



**Please Note:** If you have more than one executive leadership program answer the remaining questions with reference to the highest level track (for your most senior level leaders).

8. To what extent did each of the following **reasons** contribute to your system beginning its leadership development program?

	Not a factor				A major factor
Wish to reduce spending on executives' development and training by directing internally.....	1	2	3	4	5
Need for consistency of messages about accepted executive leadership behaviors and practice	1	2	3	4	5
Concern about rates of executive turnover .....	1	2	3	4	5
Desire to duplicate success of executive leadership development program observed elsewhere.....	1	2	3	4	5
Dissatisfaction with executives' preparation for advancement to highest leadership positions.....	1	2	3	4	5
Wish to initiate succession planning.....	1	2	3	4	5
Wish to offer executives professional development opportunities locally .....	1	2	3	4	5
Wish to further advance the system's strategic goals (e.g., quality, productivity, revenue growth) .....	1	2	3	4	5
Other main motivators:(please specify)					
_____					
_____					

9. In what year did your executive leadership development program begin?

YEAR: \_\_\_\_\_

9a. Were you involved in developing your system's executive leadership development program?

- Yes ..... 1
- No ..... 2

10. Following is a list of **managerial competencies**. For each, please indicate how extensively your executive leadership development program addresses each. (Circle one number on each line.)

	<u>Not addressed</u>				<u>Heavily emphasized</u>
Governance: structure and function .....	1	2	3	4	5
General management principles.....	1	2	3	4	5
Quality improvement theories & framework.....	1	2	3	4	5
Clinical staff structure and function.....	1	2	3	4	5
Communication & relationship management ....	1	2	3	4	5
Managerial ethics .....	1	2	3	4	5
Information systems for managers.....	1	2	3	4	5
Legal & regulatory issues .....	1	2	3	4	5
Financial management .....	1	2	3	4	5
Human Resource systems .....	1	2	3	4	5
Physical plant .....	1	2	3	4	5
Marketing.....	1	2	3	4	5
Community relations.....	1	2	3	4	5
Leadership skills (e.g., negotiating, mentoring, motivating).....	1	2	3	4	5
System-specific protocols (e.g., ways of working in your organization) .....	1	2	3	4	5

11. Apart from the above listed competencies, what other areas are emphasized in your executive leadership development program?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. Participants in this executive leadership development program include the following individuals: (circle all that apply)

SYSTEM-LEVEL		HOSPITAL LEVEL	
Chief executive officer (CEO) .....	1	Chief executive officer (CEO) .....	9
Chief operating officer (COO).....	2	Chief operating officer (COO).....	10
Chief financial officer (CFO).....	3	Chief financial officer (CFO).....	11
Chief information officer (CIO)....	4	Chief information officer (CIO).....	12
Chief medical officer (CMO).....	5	Chief medical officer (CMO).....	13
Chief nursing officer (CNO).....	6	Chief nursing officer (CNO).....	14
Senior vice president(s).....	7	Senior vice president(s).....	15
Vice president(s) .....	8	Vice president(s) .....	16
Other _____		Other _____	

13. In the current fiscal year, approximately how much money is budgeted for your executive leadership development program per participating executive?

ENTER SUM: \$ \_\_\_\_\_ PER PARTICIPANT

14. Compared to the previous fiscal year, is the budget this fiscal year: (Circle one number.)

- Less than last year..... 1
- About the same as last year ..... 2
- More than last year ..... 3

**PART 2: THE EXECUTIVE LEADERSHIP DEVELOPMENT PROCESS**

15. What is the scope of your program offerings (e.g., contact hours per participating executive)?

ENTER NUMBER OF HOURS \_\_\_\_\_

16. Please indicate the origin of faculty for your leadership training program. How many instructors are staff of the health system and how many are external to it?

INTERNAL INSTRUCTORS	_____ Number	_____ Proportion	
EXTERNAL INSTRUCTORS	_____ Number	_____ Proportion	
Total	_____ Number	100%	

17. Do you provide executive coaches for your executive leadership development program participants? (CIRCLE ALL THAT APPLY)

- Yes--we use **internal coaches** within the health system..... 1
- Yes--we use **external coaches** outside the health system..... 2
- No--we do not make coaches available ..... 3

18. Following are several external leadership development programs that your health system may use in developing your executives. Please indicate if you have used the following organizations and programs to supplement your in-house leadership development in the past three years. (CIRCLE ALL THAT APPLY)

- Center for Creative Leadership (CCL) ..... 1
- National Center for Healthcare Leadership (NCHL).... 2
- Advisory Board Company ..... 3
- Formal executive education offered by university ..... 4
- None..... 5
- Other: (please specify) \_\_\_\_\_ -
- \_\_\_\_\_ .

19. Curricula revision. How does upper management determine the areas of needed instruction?  
(CIRCLE ALL THAT APPLY)

- Executives are polled..... 1
- External consultant suggests changes..... 2
- Executive participants are asked for their ideas ..... 3
- There is an annual program review ..... 4
- It is part of the system strategic planning process ..... 5
- Other (please specify)\_\_\_\_\_
- \_\_\_\_\_.

20. How are participants in the executive leadership development program evaluated?

	<u>Not used</u>	<u>Occasionally used</u>	<u>Used routinely</u>
Executives are involved in a 360 degree assessment process.....	1	2	3
Executives have assessment process built into performance evaluation and professional development plans .....	1	2	3
Participants provide self-assessments .....	1	2	3
Other: (please specify)_____			
_____			

**PART 3: EVALUATION AND EVOLUTION OF LEADERSHIP DEVELOPMENT**

21. Following are some ways to **evaluate the effectiveness** of leadership development programs. Please indicate if any of these measures are used to demonstrate your program’s effectiveness.

	<u>In effect</u>	<u>Being developed</u>	<u>Not used</u>
Promotion rates .....	1	2	3
Employee job satisfaction .....	1	2	3
Succession planning .....	1	2	3
Turnover among executive’s direct reports.....	1	2	3
Market share increase.....	1	2	3
Cost savings .....	1	2	3
Quality improvement .....	1	2	3
Patient satisfaction .....	1	2	3

22. Does your system evaluate its leadership development program on the basis of its return on investment (ROI)?

- Yes ..... 1 → Go to Q. 22a below  
 No ..... 2 } Skip to Q. 23  
 Don't know ..... 3 }

22a. If yes, what is the target ROI for the program?

ENTER PERCENTAGE \_\_\_\_\_

22b. What is the ROI for the program for the most recently available year?

ENTER PERCENTAGE \_\_\_\_\_

23. Following are several elements that may or may not be part of a leadership development program. If your program offers that component focus, please indicate if, in your view, if the payoff was worth the investment to date. (CIRCLE ONE NUMBER ON EACH LINE)

	Payoff did not meet expectations	Payoff met expectations	Payoff exceeded expectations	Not applicable
General management principles taught .....	1	2	3	8
Personal leadership skills taught (e.g., negotiating, mentoring, motivating) .....	1	2	3	8
Quality improvement skills taught .....	1	2	3	8
Cost control concepts taught .....	1	2	3	8
Revenue enhancement methods taught .....	1	2	3	8
Self assessment processes used (e.g., Myers-Briggs) .....	1	2	3	8
360 degree feedback process used.....	1	2	3	8
Formal mentoring program included.....	1	2	3	8
Coaching provided .....	1	2	3	8

24. What program elements have been deleted or have undergone major revision in your leadership development program? (PLEASE LIST)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

25. What new features are planned for your leadership development program?

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26. In your view, are there topics that are best taught by experts within the system? Are there topics best taught by experts external to the hospital? Please list these topics in the appropriate column.

**Topics best taught by experts inside the health system**

**Topics best taught by experts outside the health system**

LIST Topics

LIST Topics

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27. In your view, are there topics that you would be **willing to outsource**?

LIST Topics

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**CONCLUSION**

28. What is your title at this organization? \_\_\_\_\_

29. How many years have you been in this position at this organization? \_\_\_\_\_ years \_\_\_\_\_ months

30. Have you previously been in a similar position at another organization?

Yes ..... 1

No ..... 2

---

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31. How many hospitals are in your health system? NUMBER \_\_\_\_\_

32. What is the net revenue for your health system? \$ \_\_\_\_\_

33. What is the ownership structure of your health system?

- Not-for-profit, secular ..... 1
- Not-for-profit, religious ..... 2
- Investor-owned ..... 3
- State or local government ..... 4
- Other (please specify) \_\_\_\_\_

34. Please include any descriptions, including curriculum and course syllabi, that you use in your executive leadership development program.

35. If you would like a copy of the final report, please enter your email address: (Please note: This page with your email address will be separated from the remainder of the survey data prior to analysis to maintain confidentiality and anonymity of results).

\_\_\_\_\_

**Thank you very much for completing this survey on leadership training and development in health systems. By so doing, you have enhanced our understanding of executive leadership development in healthcare organizations.**

Please return the survey (and any supplemental materials) to us in the enclosed prepaid envelope. If you have misplaced the envelope, please mail the survey to:

Professor Ann Scheck McAlearney  
Division of Health Services Management and Policy, College of Public Health  
The Ohio State University  
1841 Millikin Road, Cunz Hall 476  
Columbus, OH 43210

## Appendix C: Survey Responses by Question

**Table C: Number of Responses by Survey Question for Health Systems with Leadership Development Programs**

QUESTION	# RESPONSES
<b>PART 1</b>	
1	53
2	52
3	50
4	53
5	53
6	53
7	51
8	49
9	52
10	49
11	49
12	53
13	26
14	42
<b>PART 2</b>	
15	43
16	45
17	51
18	53
19	53
20	49
<b>PART 3</b>	
21	46
22	53
23	48
24	29 (of 53)
25	41 (of 53)
26a	33 (of 53)
26b	30 (of 53)
27	25 (of 53)
<b>CONCLUSION</b>	
28	51
29	52
30	52
31	51
32a	43
32b	9
32c	16
33	51

## Appendix D: Survey Non-Response Analysis

Surveys were mailed to a total of 374 chief executives, and ACHE research staff provided a non-response analysis based on this original number of surveys mailed. Respondents were compared with non-respondents based on system size (number of hospitals), system control (ownership type), region, and ACHE affiliation of the CEO. Numbers reported in this non-response analysis are slightly different from the numbers presented in the remainder of this report due to slight differences in available data bases, but overall comparisons are statistically similar.

### *D.1: Comparison of Respondents and Non-Respondents Based on Health System Size (Number of Hospitals)*

**Table D.1: Size of Health System of Survey Respondents and Non-Respondents (n=374)**

Size of System	Respondents N (%)	Non- Respondents* N (%)	TOTAL
1-5 hospitals	71 (29%)	177 (71%)	248
6-15 hospitals	24 (27%)	64 (73%)	88
16+ hospitals	9 (24%)	29 (76%)	38
<b>TOTAL</b>	<b>104 (28%)</b>	<b>270 (72%)</b>	<b>374</b>

\* There were no statistically significant differences between respondents and non-respondents based on health system size.

***D.2: Comparison of Respondents and Non-Respondents Based on Health System Control (Ownership Status)***

**Table D.2: Health System Control of Survey Respondents and Non-Respondents (n=374)**

<b>Health System Control</b>	<b>Respondents N (%)</b>	<b>Non- Respondents** N (%)</b>	<b>TOTAL</b>
Catholic Church	16 (37%)	27 (63%)	43
Other Religious	6 (46%)	7 (54%)	13
Investor-Owned	4 (6%)	65 (94%)	69
Non-profit, State/Local Government Ownership	78 (31%)	171 (69%)	249
<b>TOTAL</b>	<b>104 (28%)</b>	<b>270 (72%)</b>	<b>374</b>

\*\* Compared to respondents, non-respondents included proportionately more investor-owned health systems (p<.0001).

***D.3: Comparison of Respondents and Non-Respondents Based on Region***

**Table D.3: Health System Region of Respondents and Non-Respondents (n=374)**

<b>Region</b>	<b>Respondents N (%)</b>	<b>Non- Respondents*** N (%)</b>	<b>TOTAL</b>
New England	7 (41%)	10 (59%)	17
New York/New Jersey/Pennsylvania	9 (20%)	35 (80%)	44
Southeast	17 (30%)	39 (70%)	56
East North Central	19 (44%)	24 (56%)	43
East South Central	6 (21%)	22 (79%)	28
West North Central	5 (25%)	15 (75%)	20
West South Central	15 (58%)	11 (42%)	26
Mountain	5 (42%)	7 (58%)	12
Pacific	5 (13%)	33 (87%)	38
2 Regions	6 (14%)	36 (86%)	42
3-4 Regions	5 (22%)	18 (78%)	23
5+ Regions	5 (20%)	20 (80%)	25
<b>TOTAL</b>	<b>104 (28%)</b>	<b>270 (72%)</b>	<b>374</b>

\*\*\* Compared to respondents, there was a statistically significant difference among non-respondents ( $p < .01$ ) based on region. Respondents were more likely to be from the East North Central and West South Central regions, and less likely to be from the Pacific region.

# Appendix E: Qualitative Interview Guide

## Executive Leadership Development In Healthcare Organizations

### Key Informant Interview Guide

#### INTERVIEW QUESTIONS

##### Section 1: DESCRIPTION OF LEADERSHIP DEVELOPMENT PROGRAM

###### *1. Description of Leadership Development Program*

- Could you please describe the leadership development program at this institution?– get historical perspective
- What are the components of the leadership development program in this organization? How is it related to other activities/programs?
- Why was the program initiated? When?
- How was it introduced?
- Was there a specific individual who introduced the program?
- Do you use the language associated with corporate universities for this program?
- Where is the program connected within the organization? Is the human resources department involved? (If so, How? How much?)
- Do you outsource any services as part of leadership development?
- How would you describe how well leadership development is embedded in your organization? How well is this program accepted? (Is the program institutionalized?)

###### *2. Program Philosophy*

- Is a particular theoretical framework or philosophy used to guide the program or the leadership development process at your organization?
- Have any models or theories been purposely explored in the development of this program?
- What principles (or values) would you say guide this leadership development program?

###### *3. Program Implementation Process*

- How was this program implemented within your organization?
- What resources are needed for the program? What resources are allocated?
- How are individuals selected to participate in the leadership development program?
- Are assessment tools used? (If so, which ones?)

- How are management learning and adult learning principles used in this program?
- Does this program work to incorporate external leadership development activities such as conferences and seminars? (If so, how?)

**4. Program Implementation: Barriers/Challenges and Facilitators**

- What barriers have you/this program experienced in its introduction/implementation/continuance?
- What strategies have you used to develop and promote the leadership development program in your organization? How do you promote this program within the organization?
- What facilitators have you found in developing and implementing the leadership development program and its activities?
- What barriers do you anticipate might be problems affecting the future of this leadership development program in your organization?

**5. Use of Technology**

- How is technology used within the leadership development program?
- What would you like to be able to do with technology in the leadership development program?
- What challenges have you experienced incorporating technology into leadership development program activities?
- What barriers do you anticipate might be problems affecting the future of technology in the leadership development program in your organization?

**6. Organizational Commitment and Program Evaluation**

- How is leadership evaluated in this organization?
- How is program success/progress of the leadership development program evaluated in this organization?
- Who is accountable for the success or outcomes of the leadership development program?
- What does this accountability mean?
- How is leadership believed to be linked to organizational performance? Is this measured?
- Have management changes been observed or measured as a result of this program? Can you provide specific examples?
- Have there been changes in human resources practices for the organization? Can you provide specific examples?

**7. Program Results and Anticipated Program Enhancements/Changes**

- How has the leadership development program changed over time?
- What changes/modifications are anticipated for the future?
- How did you anticipate that a leadership development program could be used to change/improve this organization? How has this worked?

- What managerial concerns do you have about the leadership development program?

#### 8. *Effect on Organizational Change and Learning*

- How is this leadership development program and its programs working to foster organizational learning? Can you give specific examples?
- How has the leadership development program expanded/spread over time? Is there a plan to expand use?
- Do some participants move beyond this leadership development program and its programs to explore other leadership development options?

### **Section 2: GENERAL VIEWS ABOUT LEADERSHIP DEVELOPMENT PROGRAMS**

- What do you think about leadership development in healthcare in general? How about corporate universities?
- Is leadership development in healthcare different from leadership development needs in other industries?
- Does cynicism and/or disillusion about leadership limit the supply of potential leaders or the ability to develop leaders?
- Do you believe that there is a shortage of future leaders in healthcare?
- Who benefits from leadership development programs?
- How do organizations benefit from leadership development programs?
- What benefits do you see in external leadership development programs and conferences?
- Do you have a particular definition of leadership that resonates with you?

### **Section 3: IMPORTANCE OF LEADERSHIP COMPETENCIES**

- What do you consider to be critical competencies for current health care leaders?

#### *Future Competencies*

- If you consider the future of health care five to ten years from now, does this list change? (Given change as a constant in health services organizations, what leadership skills would you recommend that individuals emphasize?)

#### *Relative Importance of Competencies*

- How does the relative importance of these competencies change as individuals move up within an organization (or does it)?

#### *Competency Models*

- Does your organization use a competency-based model for its leadership development program and its programs? Why or why not? Is this good (or bad)?

#### **Section 4: PROGRAM EVALUATION**

- How can you or do you evaluate leadership – both from your own perspective and from the perspective of your organization?
- How is leadership believed to be linked to organizational performance? Is this measured?
- How do you think leadership is linked to employee satisfaction? Is this measured?
- If you were to develop a balanced scorecard approach to measuring leadership development, what would you include in this scorecard?

#### **Section 5: CONCLUSION**

- What are the 3 most important things a leadership development program provides for the organization?
- What are the 3 most important things an organization can do to develop its leaders?
- How is the case for investing in leadership development best built in health care organizations?

#### **INTERVIEW CLOSURE AND FOLLOW-UP**