CHAPTER 2

# Leadership

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## LEARNING OBJECTIVES

By the end of this chapter, the student will be able to:

- Distinguish between leadership and management;
- Summarize the history of leadership in the U.S. from the 1920s to current times;
- Compare and contrast leadership styles, competencies, and protocols;
- Summarize old and new governance trends;
- Analyze key barriers and challenges to successful leadership;
- Provide a rationale for why health care leaders have a greater need for ethical behavior;
- Explore important new initiatives requiring health care leaders' engagement; and
- Discuss special research issues related to leadership.

## LEADERSHIP VS. MANAGEMENT

In any business setting, there must be **leaders** as well as **managers**. But are these the same people? Not necessarily. There are leaders who are good managers and there are managers who are good leaders, but usually neither case is the norm. In health care, this is especially important to recognize because of the need for both. Health care is unique in that it is a service industry that depends on a large number of highly trained personnel as well as trade workers. Whatever the setting, be it a hospital, a long-term care facility, an ambulatory care center, a medical device company, an insurance company, an accountable care organization, or some other health care entity, leaders as well as managers are needed to keep the organization

moving in a forward direction and, at the same time, maintain current operations. This is done by leading and managing its people and assuring good business practices.

Leaders usually take a focus that is more external, whereas the focus of managers is more internal. Even though they need to be sure their health care facility is operating properly, leaders tend to spend the majority of their time communicating and aligning with outside groups that can benefit their organizations (partners, community, vendors) or influence them (government, public agencies, media). See Figure 2-1. There is crossover between leaders and managers across the various areas, though a distinction remains for certain duties and responsibilities.

Usually the top person in the organization (e.g., Chief Executive Officer, Administrator, Director) has full and ultimate accountability. This type of leader may be dictated by the current conditions faced by the organization. A more **strategic leader**, who defines purpose and vision and aligns people, processes, and values, may be needed. Or, a **network leader**, who could connect people across disciplines, organizational departments, and regions, may be essential. Whichever type surfaces, there will be several managers reporting to this person, all of whom have various **functional responsibilities**

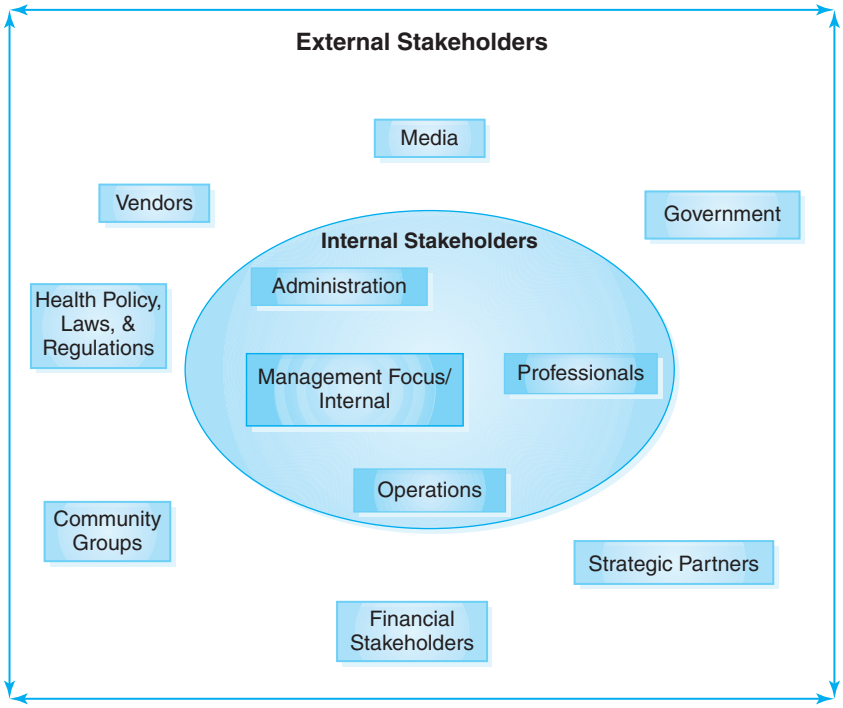


**FIGURE 2-1** Leadership and Management Focus

for different areas of the organization (e.g., Chief Nursing Officer, Physician Director, Chief Information Officer). These managers can certainly be leaders in their own areas, but their focus will be more internal within the organization's operations. They are the **operational leaders** of the organization. Together, these three types of leaders/followers produce an interdependent leadership system, a team which will prove more high performing in the current health care field (Maccoby, Norman, Norman, & Margolies, 2013).

Leaders have a particular set of competencies that require more forward thinking than those of managers. Leaders need to set a **vision** or direction for the organization. They need to be able to motivate their employees, as well as other stakeholders, so the business continues to exist and, hopefully, thrive in periods of change. No industry is as dynamic as health care, with rapid change occurring due to the complexity of the system and government regulations. Leaders are needed to keep the entity on course and to maneuver around obstacles, like a captain commanding his ship at sea. Managers must tend to the business at hand and make sure the staff is following proper procedures and meeting established targets and goals. They need a different set of competencies. See Table 2-1.

## HISTORY OF LEADERSHIP IN THE U.S.

Leaders have been around since the beginning of man. We think of the strongest male becoming the leader of a caveman clan. In Plato's time, the Greeks began to talk about the concept of leadership and acknowledged the political system as critical for leaders to emerge in a society. In Germany during the late 19th century, Sigmund Freud described leadership as unconscious exhibited behavior; later, Max Weber identified how leadership is present in a bureaucracy through assigned roles. Formal leadership studies in the U.S., though, have only been around for the last 100 years (Sibbet, 1997).

**TABLE 2-1** Leadership vs. Management Competencies

| Leadership Competencies | Management Competencies |
|---|---|
| Establishing mission | Staffing personnel |
| Setting vision/direction | Assuring patient-centered practices |
| Motivating stakeholders | Controlling resources |
| Being an effective spokesperson | Supervising the service provided |
| Determining strategies for the future | Overseeing adherence to regulations |
| Transforming the organization | Counseling/developing employees |
| Networking | Managing operations |

We can look at the decades spanning the 20th century to see how leadership theories evolved, placing their center of attention on certain key components at different times (Northouse, 2016). These emphases often matched or were adapted from the changes occurring in society.

With the industrialization of the U.S. in the 1920s, productivity was of paramount importance. Scientific management was introduced, and researchers tried to determine which characteristics were identified with the most effective leaders based on their units having high productivity. The **Great Man Theory** was developed out of the idea that certain traits determined good leadership. The traits that were recognized as necessary for effective leaders were ones that were already inherent in the person, such as being male, being tall, being strong, and even being Caucasian. Even the idea that "you either got it or you don't" was supported by this theory, the notion being that a good leader had charisma. Behaviors were not considered important in determining what made a good leader. This theory discouraged anyone who did not have the specified traits from aspiring to a leadership position.

Fortunately, after two decades, businesses realized leadership could be enhanced through certain conscious acts, and researchers began to study which behaviors would produce better results. Resources were in short supply due to World War II, and leaders were needed who could truly produce good results. This was the beginning of the **Style Approach to Leadership**. Rather than looking at only the characteristics of the leader, researchers started to recognize the importance of two types of behaviors in successful leadership: completing tasks and creating good relationships. This theory states leaders have differing degrees of concern over each of these behaviors, and the best leaders would be fully attentive to both.

In the 1960s, American society had a renewed emphasis on helping all of its people and began a series of social programs that still remain today. The two that impact health care directly, by providing essential services, are Medicare for the elderly (age 65 and over) and the disabled and Medicaid for the indigent population. The **Situational Approach to Leadership** then came into prominence and supported this national concern. This set of theories focused on the leader changing his or her behavior in certain situations in order to meet the needs of subordinates. This would imply a very fluid leadership process whereby one can adapt one's actions to an employee's needs at any given time.

Not much later, researchers believed perhaps leaders should not have to change how they behaved in a work setting, but instead the appropriate leaders should be selected from the very beginning. This is the **Contingency Theory of Leadership** and was very popular in the 1970s. Under this theory, the focus was on both the leader's style as well as the situation in which the leader worked, thus building upon the two earlier theories. This approach was further developed by what is known as the **Path–Goal Theory of Leadership**. This

theory still placed its attention on the leader's style and the work situation (subordinate characteristics and work task structure) but also recognized the importance of setting goals for employees. The leader was expected to remove any obstacles in order to provide the support necessary for them to achieve those goals.

In the later 1970s, the U.S. was coming out of the Vietnam War, in which many of its citizens did not think the country should have been involved. More concern was expressed over relationships as the society became more psychologically attuned to how people felt. The **Leader–Member Exchange Theory** evolved over the concern that leadership was being defined by the leader, the follower, and the context. This new way of looking at leadership focused on the interactions that occur between the leaders and the followers. This theory claimed leaders could be more effective if they developed better relationships with their subordinates through high-quality exchanges.

After Vietnam and a series of weak political leaders, Americans were looking for people to take charge who could really make a difference. Charismatic leaders came back into vogue, as demonstrated by the support shown to President Ronald Reagan, an actor turned politician. Unlike the Great Man Theory earlier in the century, this time the leader had to have certain skills to transform the organization through inspirational motivational efforts. Leadership was not centered upon transactional processes that tied rewards or corrective actions to performance. Rather, the **transformational leader** could significantly change an organization through its people by raising their consciousness, empowering them, and then providing the nurturing needed as they produced the results desired.

In the late 1980s, the U.S. started to look more globally for ways to have better production. Total Quality Management became a popular concept and arose from researchers studying Japanese principles of managing production lines. In the health care setting, this was embraced through a process still used today called Continuous Quality Improvement or Performance Improvement. In the decade to follow, leaders assigned subordinates to a series of work groups in order to focus on a particular area of production. Attention was placed on developing the team for higher level functioning and on how a leader could create a work environment that could improve the performance of the team. Individual team members were expendable, and the team entity was all important.

We have entered the 21st century with some of the greatest leadership challenges ever in the health care field. Critical personnel shortages, limited resources, and increased governmental regulations provide an environment that yearns for leaders who are attentive to the organization and its people, yet can still address the big picture. Several of today's leadership models relate well to the dynamism of the health care field and are presented here. Looking at these models, there seems to be a consistent pattern of self-aware leaders who are concerned for their employees and understand the importance of meaningful work. As we entered the 2000s, leaders needed to use **Adaptive Leadership** to create flexible

organizations able to meet the relentless succession of challenges faced in health care and elsewhere (Heifetz, Grashow, & Linsky, 2009). Plus, today's astute health care leaders recognize the importance of considering the global environment, as health care wrestles with international issues that impact us locally, such as outsourcing services, medical tourism, and over-the-border drug purchases, giving rise to the **global leader**. See Table 2-2.

## CONTEMPORARY MODELS

Today's health care industry does not prescribe any one type of leadership model. Many leaders are successful drawing from a variety of traditional and contemporary models. It is wise for the leadership student, as well as the practitioner, to become familiar with the various contemporary models so they can be utilized when appropriate. See Table 2-3.

**TABLE 2-2** Leadership Theories in the U.S.

| Period of Time | Leadership Theory | Leadership Focus |
|---|---|---|
| 1920s and 1930s | Great Man | Having certain inherent traits |
| 1940s and 1950s | Style Approach | Task completion and developing relationships |
| 1960s | Situational Approach | Needs of the subordinates |
| Early 1970s | Contingency and Path–Goal | Both style and situation |
| Late 1970s | Leader–Member Exchange | Interactions between leader and subordinate |
| 1980s | Transformational Approach | Raise consciousness and empower followers |
| 1990s | Team Leadership | Team performance and development |
| 2000s | Adaptive Leadership | Build capacity to thrive in a new reality |
| 2010s | Global Leader | Recognizing the impact of globalization for their industry |

**TABLE 2-3** Contemporary Leadership Models

| Model | Leadership Application |
|---|---|
| Emotional Intelligence | Tools to be well adjusted leader |
| Authentic Leadership | Follows internal compass of true purpose |
| Diversity Leadership | Culturally competent leader |
| Servant Leadership | Desire to serve others |
| Spirituality Leadership | Supports finding meaning |
| Resilient Leadership | Build inner strength and perseverance |
| Emerging Leadership | Continual learners and developers |

## Emotional Intelligence (EI)

**Emotional Intelligence** (EI) is a concept made famous by Daniel Goleman in the late 1990s. It suggests that there are certain skills (**intrapersonal and interpersonal**) that a person needs to be well adjusted in today's world. These skills include **self-awareness** (having a deep understanding of one's emotions, strengths, weaknesses, needs, and drives), **self-regulation** (a propensity for reflection, an ability to adapt to changes, the power to say no to impulsive urges), **motivation** (being driven to achieve, being passionate about one's profession, enjoying challenges), **empathy** (thoughtfully considering others' feelings when interacting), and **social skills** (moving people in the direction you desire by your ability to interact effectively) (Freshman & Rubino, 2002).

Since September 11, 2001, leaders have needed to be more understanding of their subordinates' world outside of the work environment. EI, when applied to leadership, suggests a more caring, confident, enthusiastic boss who can establish good relations with workers. Researchers have shown that EI can distinguish outstanding leaders and strong organizational performance (Goleman, 1998). For health care as an industry and for health care managers, this seems like a good fit, especially during this time of change (Delmatoff & Lazarus, 2014). See Table 2-4.

## Authentic Leadership

The central focus of **authentic leadership** is that people will want to naturally associate with someone who is following their internal compass of true purpose (George & Sims, 2007). Leaders who follow this model are ones who know their authentic selves, define their values and leadership principles, understand what motivates them, build a strong support team, and stay grounded by integrating all aspects of their lives. Authentic leaders

**TABLE 2-4** Emotional Intelligence's Application to Health Care Leadership

| EI Dimension | Definition | Leadership Application |
|---|---|---|
| Self-Awareness | A deep understanding of one's emotions and drives | Knowing if your values are congruent with the organization's |
| Self-Regulation | Adaptability to changes and control over impulses | Considering ethics of giving bribes to doctors |
| Motivation | Ability to enjoy challenges and being passionate toward work | Being optimistic even when census is low |
| Empathy | Social awareness skill, putting yourself in another's shoes | Setting a patient-centered vision for the organization |
| Social Skills | Supportive communication skills, abilities to influence and inspire | Having an excellent rapport with the board |

have attributes such as confidence, hope, optimism, resilience, high levels of integrity, and positive values (Brown & Gardner, 2007). Assessments given to leaders in a variety of international locations have provided the evidence-based knowledge that there is a correlation between authentic leadership and positive outcomes based on supervisor-rated performance (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008).

### *Diversity Leadership*

Our new global society forces health care leaders to address matters of diversity, whether with their patient base or with their employees. This commitment to diversity is necessary for today's leader to be successful. The environment must be assessed so goals can be set that embrace the concept of diversity in matters such as employee hiring and promotional practices, patient communication, and governing board composition, to name a few. Strategies have to be developed to make diversity work for the organization. The leader who recognizes the importance of diversity and designs its acceptance into the organizational culture will be most successful (Warden, 1999). Health care leaders are called to be role models for **cultural competency** (see Chapter 14 for more on this important topic) and to be able to attract, mentor, and coach those of different, as well as similar, backgrounds (Dolan, 2009).

### *Servant Leadership*

Many people view health care as a very special type of work. Individuals usually work in this setting because they want to help people. **Servant leadership** applies this concept to top administration's ability to lead, acknowledging that a health care leader is largely motivated by a desire to serve others. This leadership model breaks down the typical organizational hierarchy and professes the belief of building a community within an organization in which everyone contributes to the greater whole. A servant leader is highly collaborative and gives credit to others generously. This leader is sensitive to what motivates others and empowers all to win with shared goals and vision. Servant leaders use personal trust and respect to build bridges and use persuasion rather than positional authority to foster cooperation. This model works especially well in a not-for-profit setting, since it continues the mission of fulfilling the community's needs rather than the organization's (Swearingen & Liberman, 2004).

### *Spirituality Leadership*

The U.S. has experienced some very serious misrepresentations and misreporting by major health care companies, as reported by U.S. governmental agencies (e.g., Columbia/HCA, GlaxoSmithKline, HealthSouth). Trying to claim a renewed sense of confidence in the system, a model of leadership has emerged that focuses on spirituality. This **spiritual focus** does not imply a certain set of religious beliefs but emphasizes ethics, values, relationship skills, and the promotion of balance between work and self (Wolf, 2004). The goal

under this model is to define our own uniqueness as human beings and to appreciate our spiritual depth. In this way, leaders can deepen their understanding and at the same time be more productive. These leaders have a positive impact on their workers and create a working environment that supports all individuals in finding meaning in what they do. They practice five common behaviors of effective leaders as described by Kouzes and Posner (1995): (1) Challenge the process, (2) Inspire a shared vision, (3) Enable others to act, (4) Model the way, and (5) Encourage the heart, thus taking leadership to a new level.

### *Resilient Leadership*

Being a health care leader is an exciting yet challenging job. Much stress is placed on the executive and its takes a strong, **resilient leader** to overcome these pressures, bounce back, and keep the organization moving forward. Certain resilience-building practices can be used by the leader to build inner strength and perseverance (Wicks & Buck, 2013). A self-care protocol that includes self-awareness, alone time, mindfulness, and keeping a healthy perspective can be essential to not only the individual leader but also to coach his/her team members to avoid burnout and foster high staff morale.

### *The Emerging Health Care Leader*

Students of health administration do not become successful leaders overnight. It usually takes years of study and experience to become comfortable and proficient in the role. A basic foundation is necessary before a leader can emerge and certain strategies can be applied to help an individual build and grow their career (Baedke & Lamberton, 2015). Some of these include paying attention to one's character, examining self-discipline, cultivating your personal brand, and to constantly network. The best leaders are ones who are continually learning and using this new knowledge to further their development as a leader in today's changing health care world.

## LEADERSHIP STYLES

Models give us a broad understanding of someone's leadership philosophy. Styles demonstrate a particular type of leadership behavior that is consistently used. Various authors have attempted to explain different leadership styles (Northouse, 2015; Studer, 2008). Some styles are more appropriate to use with certain health care workers, depending on their education, training, competence, motivation, experience, and personal needs. The environment must also be considered when deciding which style is the best fit.

In a **coercive leadership style** power is used inappropriately to get a desired response from a follower. This very directive format should probably not be used unless the leader is dealing with a very problematic subordinate or is in an emergency situation and needs

immediate action. In health care settings over longer periods of time, three other leadership styles could be used more effectively: **participative**, **pacesetting**, and **coaching**.

Many health care workers are highly trained, specialized individuals who know much more about their area of expertise than their supervisor. Take the generally trained chief operating officer of a hospital who has several department managers (e.g., Imaging, Health Information Systems, Engineering) reporting to him or her. These managers will respond better and be more productive if the leader is **participative** in his or her style. Asking these managers for their input and giving them a voice in making decisions will let them know they are respected and valued.

In a **pacesetting style**, a leader sets high performance standards for his or her followers. This is very effective when the employees are self-motivated and highly competent—e.g., research scientists or intensive care nurses. A **coaching style** is recommended for the very top personnel in an organization. With this style, the leader focuses on the personal development of his or her followers rather than the work tasks. This should be reserved for followers the leader can trust and those who have proven their competence. See Table 2-5.

## LEADERSHIP COMPETENCIES

A leader needs certain skills, knowledge, and abilities to be successful. These are called **competencies**. The pressures of the health care industry have initiated the examination of a set of core competencies for a leader who works in a health care setting (Dye & Garman, 2015). Criticism has been directed at educational institutions for not producing administrators who can begin managing effectively right out of school. Educational programs in health administration are working with the national coalition groups (e.g., Health Leadership Council, National Center for Healthcare Leadership, and American College of Healthcare Executives) and health care administrative practitioners to come up with agreed upon competencies. Once identified, the programs can attempt to have their students learn how to develop these traits and behaviors.

**TABLE 2-5** Leadership Styles for Health Care Personnel

| Style | Definition | Application |
|---|---|---|
| Coercive | Demanding and power based | Problematic employees |
| Participative | Soliciting input and allowing decision making | Most followers |
| Pacesetting | Setting high performance standards | Highly competent |
| Coaching | Focus on personal development | Top level |

Source: Hilberman, D. (Ed.), The 2004 ACHE-AUPHA Pedagogy Enhancement Work Group. June 2005.

Some of the competencies are technical—for example, having analytical skills, having a full understanding of the law, and being able to market and write. Some of the competencies are behavioral—for example, decisiveness, being entrepreneurial, and an ability to achieve a good work/life balance. As people move up in organizations, their behavioral competencies are a greater determinant of their success as leaders than their technical competencies (Hutton & Moulton, 2004). Another way to examine leadership competencies is under four main groupings or domains. The **Functional and Technical Domain** is necessary but not sufficient for a competent leader. Three other domains provide competencies that are behavioral and relate both to the individual (**Self-Development and Self-Understanding**) and to other people (**Interpersonal**). A fourth set of competencies falls under the heading **Organizational** and has a broader perspective. See Table 2-6 for a full listing of the leadership competencies under the four domains.

**TABLE 2-6** Leadership Domains and Competencies

**Domain: Functional and Technical Competencies:**

- Knowledge of business/business acumen
- Strategic vision
- Decision making and decision quality
- Managerial ethics and values
- Problem solving
- Change management/dealing with ambiguity
- Systems thinking
- Governance

**Domain: Self-Development and Self-Understanding Competencies:**

- Self-awareness and self-confidence
- Self-regulation and personal responsibility
- Honesty and integrity
- Lifelong learning
- Motivation/drive to achieve
- Empathy and compassion
- Flexibility
- Perseverance
- Work/life balance

**Domain: Interpersonal Competencies:**

- Communication
- Motivating
- Empowerment of subordinates
- Management of group process
- Conflict management and resolution
- Negotiation
- Formal presentations
- Social interaction

**Domain: Organizational Competencies:**

- Organizational design
- Team building
- Priority setting
- Political savvy
- Managing and measuring performance
- Developing others
- Human resources
- Community and external resources
- Managing culture/diversity

## LEADERSHIP PROTOCOLS

Health care administrators are expected to act a certain way. Leaders are role models for their organizations' employees, and they need to be aware that their actions are being watched at all times. Sometimes people at the top of an organization get caught up in what they are doing and do not realize the message they are sending throughout the workplace by their inappropriate behavior. Specific ways of serving in the role of a health care leader can be demonstrated and can provide the exemplary model needed to send the correct message to employees. These appropriate ways in which a leader acts are called protocols.

There is no shortage of information on what protocols should be followed by today's health care leader. Each year, researchers, teachers of health administration, practicing administrators, and consultants write books filled with their suggestions on how to be a great leader (for some recent examples, see Dye, 2010; Ledlow & Coppola, 2011; and Rath and Conchie, 2008). There are some key ways a person serving in a leadership role should act. These are described here and summarized in Table 2-7.

Professionalism is essential to good leadership. This can be manifested not only in the way people act but also in their mannerisms and their dress. A leader who comes to work in sloppy attire or exhibits discourteous or obnoxious behavior will not gain respect from followers. Trust and respect are very important for a leader to acquire. Trust and respect must be a two-way exchange if a leader is to get followers to respond. Employees who do not trust their leader will consistently question certain aspects of their job. If they do not have respect for the leader, they will not care about doing a good job. This could lead to low productivity and bad service.

Even a leader's mood can affect workers. A boss who is confident, optimistic, and passionate about his or her work can instill the same qualities in the workers. Such enthusiasm is almost always infectious and is passed on to others within the organization. The

**TABLE 2-7** Key Leadership Protocols

1. Professionalism
2. Reciprocal trust and respect
3. Confident, optimistic, and passionate
4. Being visible
5. Open communicator
6. Risk taker/entrepreneur
7. Admitting fault
8. Balancing being a motivator, vision-setter, analyzer, and task-master

same can be said of a leader who is weak, negative, and obviously unenthusiastic about his or her work—these poor qualities can be acquired by others.

Leaders must be very visible throughout the organization. Having a presence can assure workers that the top people are "at the helm" and give a sense of stability and confidence in the business. Quint Studer (2009), founder and CEO of Studer Group, states how **rounding** can help leaders meet certain standard goals: making sure staff know they are cared about, know what is going on (what is working well, who should be recognized, which systems need to work better, which tools and equipment need attention), and know that proper follow-up actions are taking place. Leaders must be open communicators. Holding back information that could have been shared with followers will cause ill feelings and a concern that other important matters are not being disclosed. Leaders also need to take calculated risks. They should be cautious, but not overly so, or they might lose an opportunity for the organization. And finally, leaders in today's world need to recognize that they are not perfect. Sometimes there will be errors in what is said or done. These must be acknowledged so they can be put aside and the leader can move on to more pressing current issues.

Health care leaders today need to balance many agendas. To do so, a set of protocols needs to be followed which allows a systems-thinking perspective. The **Master Leadership** framework takes into account these competing values and encourages the leader to shift to being a motivator, vision-setter, analyzer, and task-master depending upon the immediate concern (Belasen, Eisenberg, & Huppertz, 2016). All of these roles though must be followed, and it is the accomplished leader who can develop a sense of equilibrium when he/she acts between them.

## GOVERNANCE

Individuals are not the only ones to consider in leadership roles. There can be a group of people who collectively assume the responsibility for strategic oversight of a health care organization. The term governance describes this important function. **Governing bodies** can be organized in a variety of forms. In a hospital, this top accountable body is called a board of trustees in a not-for-profit setting and a board of directors in a proprietary, or for-profit, setting. Since many physician offices, long-term care facilities, and other health care entities are set up as professional corporations, these organizations would also have boards of directors.

Governing boards are facing heightened scrutiny due to the failure of many large corporations in the last decade. The U.S. government recognizes the importance of a group of people who oversee corporate operations and give assurances for the fair and honest functioning of the business. **Sarbanes-Oxley** is a federal law enacted in 2002 that set

new or enhanced standards for proprietary companies that are publicly traded. Financial records must be appropriately audited and signed off by top leaders. Operations need to be discussed more openly so as to remove any possibility of cover-up, fraud, or self-interest. Each governing board member has fiduciary responsibility to forgo his or her own personal interests and to make all decisions concerning the entity for the good of the organization. Many believe the not-for-profits should have the same requirements and are applying pressure for them to fall under similar rules of transparency.

Although health care boards are becoming smaller in size, they recognize the importance of the composition of their members. A selection of people from within the organization (e.g., system leaders, the management staff, physicians) should be balanced with outside members from the community who represent the populations served by the organization (see Table 2-8). The trend is to appoint members who have certain expertise to assist the board in carrying out its duties. Also, having governing board members who do not have ties to the health care operations will reduce the possibility of conflicts of interests. Board meetings have gone from ones in which a large volume of information is presented for a "rubber stamp" to meetings that are well prepared, purposeful, and focused on truly important issues. A self-assessment should be taken at least annually and any identified problem areas (including particular board members) addressed. This way, the governing board can review where it stands in its ability to give fair, open, and honest strategic oversight (Gautam, 2005). A new way of looking at governance goes beyond fiduciary and strategic responsibility, whereby the board serves as the generative source of leadership, espousing the

**TABLE 2-8** Health Care Governance Trends

| Function | Old Way | New Trend |
|---|---|---|
| Size of board | Larger | Smaller (average 13 people) |
| Membership | Many members from within the organization | More balance of members within and outside the organization |
| Conflicts of interest | Some present, not disclosed | Must be disclosed but prefer none |
| Meetings | Voluminous detailed information presented | Strategic information and trends presented |
| Evaluations | If done, not taken too seriously | Taken seriously to identify issues and correct |
| Focus | Competence of individual providers | Focus on functioning of the system |
| Leadership | Fiduciary and strategic responsibilities | Generative source of reframing priorities |
| Goal | Keep stable | Manage change |

meaning for the organization's health care delivery and reframing the priorities (Chait, Ryan, & Taylor, 2005). The American Hospital Association Center for Healthcare Governance (2012) produced a Blue Ribbon Panel Report which identified recommendations for health care governance during this period of transformation. These included: strengthen the board and organizational capacity to manage change; encourage collaboration among providers; actively oversee physician alignment, integration, engagement and development; and create a compelling vision for the future.

## BARRIERS AND CHALLENGES

Health care leaders are confronted with many situations that must be dealt with as they lead their organizations. Some can be considered barriers that, if not managed properly, will stymie the capacity to lead. Certain other areas are challenges that must be addressed if the leader is to be successful. A few of the more critical ones in today's health care world are presented here. See Table 2-9.

Due to the complex health care system in the U.S., many regulations and laws are in place that sometimes can inhibit innovative and creative business practices. Leaders must ensure the strategies developed for their entity comply with the current laws, or else they jeopardize its long-term survivability. Leaders are expected to sometimes think "outside the box," i.e., go beyond the usual responses to a situation, to provide new ideas for the development of their business. This can be challenging when many constraints must be considered. Some examples are the government's antitrust requirements, which can affect developing partners; federal privacy laws, which can prevent sharing patient information needed for collaboration; and safe harbor requirements, which can affect physician relations. These and other laws and regulations can affect a health care leader's ability to lead.

The health care industry is unique. Major players in the arena, physicians, are not always easily controlled by the medical organizations where they work (e.g., hospitals, medical groups, insurance companies). Yet this very influential group of stakeholders has

**TABLE 2-9** Key Health Care Leadership Barriers and Challenges

1. Laws and regulations (Barrier)
2. Physicians (Challenge)
3. New technology (Barrier)
4. Culture of safety (Challenge)
5. Value-based purchasing (Challenge)
6. Women in top leadership positions (Barrier)

substantial input over the volume of patients that a health care facility receives and revenues produced. This necessitates that the health care leader find ways to include doctors in the process of setting a direction, monitoring the quality of care, and fulfilling other administrative functions. The wise health care leader will include physicians early on in any planning process. Doctors are usually busy with their own patients and practices, but if they are not looked to for their expertise and advice on certain important matters in the facilities where they work, they will become disengaged. Everybody would much rather work at a place where their opinions are requested and respected. Health care leaders must pay special attention to physicians during the current period to overcome any resistance to change as the health care system evolves. (Kornacki & Silversin, 2012).

Technology is a costly requirement in any work setting. Information systems management and new medical equipment are especially expensive for the modern health care facility or practice due to the rapidly changing data collection requirements and medical advances in the field. Health care leaders must assess the capabilities of their entities for new technology and determine if their systems and equipment are a barrier to making future progress. The U.S. Department of Health and Human Services (2009) has provided incentives for health care organizations to promote the adoption and meaningful use of health information technology through the **HITECH Act** (Health Information Technology for Economic and Clinical Health Act) (U.S. Department of HHS, 2009). Health care leaders cannot be successful if their organizations have antiquated systems and out-of-date support devices in today's high-tech world. Computer hardware and clinical software must be integrated to provide the quality and cost information needed for an efficient medical organization. Electronic medical records, wireless devices, and computerized order entry systems, as well as advanced medical equipment and new pharmaceuticals, will be items the leader must have in place in order to lead his or her health care organization in the 21st century.

Safety concerns have traditionally been a management responsibility. However, safety has become such an important issue in today's health care world that leaders must be involved in its oversight. A top-down direction must be given throughout the organization that mistakes will not be tolerated. Coordinated efforts must shift from following up on errors to preventing their recurrence to developing systems and mechanisms to prevent them from ever occurring. The Joint Commission (TJC) has leadership standards for all sectors, calling for the leaders in the health care entity to accept the responsibility for fostering a culture of safety. The focus of attention is on the performance of systems and processes instead of the individual, although reckless behavior and blatant disregard for safety are not tolerated (The Joint Commission, 2010).

**Value-based purchasing** is quickly becoming the norm. The Centers for Medicare and Medicaid Services' game-changing initiative is being adopted by private payers. It provides reimbursement incentives to accountable providers who produce high-quality

outcomes, and disincentives for the provision of poor-quality outcomes (i.e., readmissions within 30 days for some diagnoses). Health care leaders need to focus on demonstrating achievement of high-quality standards to ensure not only the operational excellence but also the fiscal stability of their organizations (Chan & Rubino, 2014).

Even though women make up the majority of the health care workforce, they are underrepresented in the top leadership positions. One recent study showed that only 24% of the senior health care executives were women and only 14% were members of boards of directors (Hauser, 2014). A call must be made to existing health care leaders to pave the way for women to be given the opportunity for these executive jobs by removing traditional barriers and providing active mentoring, introduction into the promotion pipeline, and leadership development programs.

## ETHICAL RESPONSIBILITY

**Ethics** are principles determining behavior and conduct appropriate to a certain setting. It is a matter of doing right vs. wrong (see Chapter 15 for a detailed discussion of ethics and law). Ethics are especially important for health care leadership and require two areas of focus. One area is **biomedical ethics** and the actions a leader needs to consider as he or she relates to a patient. Another is **managerial ethics**. This involves business practices and doing things for the right reasons. A leader must ensure an environment in which good ethical behavior is followed.

The American College of Healthcare Executives (ACHE, 2014) does an excellent job in educating its professional membership as to the ethical responsibilities of health care leaders. Ethical responsibilities apply to several different constituencies: to the profession itself, to the patients and others served, to the organization, to the employees, and to the community and society at large (see Table 2-10). A health care leader who is concerned about an ethical workplace will not only model the appropriate behavior but will also have zero tolerance for any deviation by a member of the organization. A **Code of Ethics** gives specific guidelines to be followed by individual members. An **Integrity Agreement** would address a commitment to follow ethical behavior by the organization.

## IMPORTANT NEW INITIATIVES

The world is constantly changing all around us and health care is no different. Several new initiatives are coming on to the scene in which a health care leader must demonstrate active engagement in order to have everyone in the organization recognize its importance.

With health care reform comes a need for a **population health** approach to health care education, delivery, and policy. The distribution of health outcomes within a specific

**TABLE 2-10** American College of Healthcare Executives Code of Ethics

| Responsible Area | Sample Guidelines |
|---|---|
| To the profession | Comply with laws<br>Avoid any conflicts of interest<br>Respect confidences |
| To the patients or others served | Prevent discrimination<br>Safeguard patient confidentiality<br>Have process to evaluate quality of care |
| To the organization | Proper resource allocation<br>Improve standards of management<br>Prevent fraud and abuse within |
| To the employees | Allow free expression<br>Ensure a safe workplace environment<br>Follow nondiscrimination policies |
| To the community and society | Work to meet the needs of the community<br>Provide appropriate access to services<br>Advocate for healthy society |
| To report violations of the code | Healthcare executive–supplier interactions<br>Decisions near the end of life<br>Impaired healthcare executives |

population will be used to measure a health care organization's success and determine its reimbursement under new payment methods. A movement away from focusing on individualized care to group performance will require the health care leader to shift his/her team's attention to innovative strategies to promote wellness and coordination of care. Productive interactions are necessary if the organization is to be successful in the new health care environment (Nash, Reifsnyder, Fabius, & Pracilio, 2011).

Health care is moving away from a provider-centeredness to **patient-family centeredness**. An astute health care leader will recognize the importance in such a shift as consumers are making more direct health care decisions based on the information now readily available. All leaders of a health care organization, from the board level down, need to embrace this concept and be actively engaged in its roll-out, serving as a role model for others (Cliff, 2012).

## LEADERS LOOKING TO THE FUTURE

Some people believe leaders are born and that one cannot be taught how to be a good leader. The growing trend, however, is that leaders can, in fact, be taught skills and behaviors that will help them to lead an organization effectively (Parks, 2005). In health care, many clinicians who do well at their jobs are promoted to supervisory positions. Yet they

do not have the management training that would help them to be successful in their new roles. For example, physicians, laboratory technologists, physical therapists, and nurses are often pushed into management positions with no administrative training. We are doing a disservice to these clinicians and setting them up for failure.

Fortunately, this common occurrence has been recognized, and many new programs have sprouted to address this need. Universities have developed executive programs to attract medical personnel into a fast-track curriculum to attempt to give them the essential skills they need to be successful. Some schools have developed majors in health care leadership or created online programs for better accessibility, and some health care systems have started internal leadership training programs. This trend will continue into the future, since health care services are expected to grow due to the aging population, and thus there will be a need for more people to be in charge. In addition, leaders should continually be updated as to the qualities that make a good leader in the current environment, and therefore, professional development, provided through internal or external programs, should be encouraged.

The **Baldrige National Quality Program** recognizes in its most recent criteria for performance excellence the need for senior leaders to create a sustainable environment for their organizations through the continual development of future leaders by enhancing their personal leadership skills, such as communicating with the entire workforce and key customers and focusing on action that will achieve the organizations' mission (Baldrige Excellence Framework, 2015). Yet Garman and Dye (2009) caution us to distinguish **leader development** from **leadership development**. They call for the need to bind leadership development activities into a collective network of leaders who are linked to organizational level goals rather than each leader's individual performance. Further understanding of the difference can be explained through decision making. A leader collaborating with his or her superior would be considered leader development, but in leadership development, the process would be team based.

Each of the different sectors in health care has a professional association that will support many aspects of its particular career path. These groups provide ongoing educational efforts to help their members lead their organizations. Another benefit for leaders is that these groups provide up-to-date information about their particular field. Professional associations are a good way to network with people in similar roles, a highly desirable process for health care leaders. Also, ethnic professional associations link health care leaders from representative minority groups as they attempt to increase diversity in the health care profession and improve health status, economic opportunities, and educational advancement for their communities. Most of these various professional groups have student chapters, and early involvement in these organizations is highly recommended for any future health care leader. Table 2-11 lists some of these associations.

**TABLE 2-11** Professional Associations

| Name | Acronym | Targeted Career | Website |
|---|---|---|---|
| American College of Healthcare Executives | ACHE | Health administrators | www.ache.org |
| Healthcare Financial Management Association | HFMA | Health care chief financial officers | www.hfma.org |
| Association for University Programs in Health Administration | AUPHA | Health administration education program directors | www.aupha.org |
| Medical Group Management Association | MGMA | Medical group administrators | www.mgma.org |
| American College of Health Care Administrators | ACHCA | Long-term care administrators | www.achca.org |
| American Academy of Nursing | AAN | Nurse leaders | www.aannet.org |
| American College of Physician Executives | ACPE | Physician leaders | www.acpe.org |
| National Association of Health Services Executives | NAHSE | Black health care leaders | www.nahse.org |
| National Forum for Latino Healthcare Executives | NFLHE | Latino health care leaders | www.nflhe.org |
| Asian Health Care Leaders Association | AHCLA | Asian health care leaders | www.asianhealthcareleaders.org |
| Rainbow Healthcare Leaders Association | RHLA | LGBT (lesbian, gay, bi-sexual, transgender) health care leaders | www.RHLA.org |

To prepare an organization for the future, its leader needs to be looking out for opportunities to partner with other entities. Health care in the U.S. is fragmented, and to be successful, different services need to be aligned and networks need to be created that will allow patients to flow easily through the continuum of care. Leaders must determine who are the best partners and negotiate a way to have a win–win situation. Of course, these efforts to develop partnerships must be in line with the organization's mission and vision, or the strategic direction will have to be reexamined. The health care leader who is concerned about the future, as well as today's business, must continuously reassess how he or she fits in the organization. Nothing could be worse than a disenchanted person trying to lead a group of followers without the motivation and enthusiasm needed by great leaders. A leader should consider his or her own **succession planning** so that the organization is not left at any time without a person to lead. Truly unselfish leaders think about their commitment to their followers and do their best to ensure that consistent formidable leadership will be in place in the event of their departure. This final act will allow adequate

time for a smooth transition and ensure the passage of accountability so that the followers can realign themselves with the new leader.

## SPECIAL RESEARCH ISSUES

A leader who is concerned about the future will stay on top of things in the health care industry. Reading newspapers, industry journals, and Web reports, as well as attending industry conferences, helps to keep leaders in the know and allows them to determine how changes in the field could impact their organization. Leaders who remain current will be better positioned to act proactively and to provide the best chance for their organizations to seize a fresh opportunity.

A new appreciation for **evidence-based management** commands today's health care leader go beyond the typical sources of current information and dive deeper into the latest peer-reviewed research articles on health administration. These secondary sources of information will review how to improve leadership capabilities, and thus organizational performance, based on demonstrated studies in the field. White papers prepared by government, as well as private agencies, are easily obtainable through the Internet and can provide important insight on how to address common industry issues.

An exciting opportunity is upon us to go beyond what has been analyzed before due to the emergence of **big data sets**. With electronic medical records, various information systems, and advanced biomedical devices, organizations have more data and information than ever before. The potential benefits of integrating and analyzing the abundance of cost and clinical information exist to support data driven decision making. Leaders must become executive champions in knowledge management and use technology to have their teams develop new projects which will reduce costs, optimize quality, and increase performance. Better strategic planning resource utilization, unit productivity, and insurance contract risk management are just a few of the areas which could be enhanced by leveraging new information technology and putting big data to good use (Hood, 2011). Some examples of big data sets available to the public are at the end of this chapter.

## CONCLUSION

There has been a lot of struggle to roll out the **Patient Protection and Affordable Care Act**. This Act may not have provided the U.S. with full health care reform, but it has dramatically altered the way health insurance is administered and care is delivered. Millions of Americans have selected affordable health plans through insurance exchanges and many have qualified under Medicaid expansion. Yet, there will continue to be challenges to the Act in the years to come (Antos, 2014).

A call is made for a new breed of leaders at every level to tame the chaos associated with this dynamic industry (Lee, 2010). Johansen (2012) writes how leaders will make the future by continuously cycling through phases of foresight (seeing the big picture), insight (being able to sense what is important), and action (being able to decide on a strong path ahead). These will certainly be challenging times for health care leaders, and some of the key elements identified for success will be perspective, adaptability, and finding their inner passion as a personal driving force (Sukin, 2009). There is no doubt there will be opportunities for leaders in all disciplines to make a difference for their organizations and their communities as we enter this exciting new phase of American health care delivery.

## DISCUSSION QUESTIONS

1. What are the key differences between leadership and management?
2. Are leaders born, or are they trained? How has the history of leadership in the U.S. evolved to reflect this question?
3. List and describe the contemporary models of leadership. What distinguishes them from past models?
4. What are the leadership domains and competencies? Can you be a good leader and not have all the competencies listed in this model?
5. Why do health care leaders have a higher need for ethical behavior than might be expected in other settings?
6. Do health care leaders have a responsibility to be culturally competent? Why or why not?
7. Why is emotional intelligence (EI) important for health care managers? Identify three ways someone who is new to the field can assess and develop his or her EI quotient.
8. What are some ways health care leaders can use research to improve their ability to lead?

Cases in Chapter 18 that are related to this chapter include:

- Metro Renal Clinic—
- Sustaining an Academic Food Science and Nutrition Center Through Management Improvement—
- Emotional Intelligence in Labor and Delivery—
- Recruitment Challenge for the Middle Manager—

Case study guides are available in the online Instructor's Materials.

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## Additional Websites to Explore

| | |
|---|---|
| American College of Healthcare Executives | http://www.ache.org/ |
| Center of Healthcare Governance | http://www.americangovernance.com/ |
| Coach John Wooden's Pyramid of Success | http://www.coachwooden.com/ |
| Healthcare Leadership Alliance Competency Directory | http://www.healthcareleadershipalliance.org/ |
| Health Leadership Council | www.hlc.org |
| Institute for Diversity of Health Management | www.diversityconnection.org |
| National Center for Healthcare Leadership | www.nchl.org |
| National Quality Forum | http://www.qualityforum.org/Home.aspx |
| World Health Organization Leadership Service | http://www.who.int/hrh/education/en/ |

## White Papers for Healthcare Leaders

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