NATIONAL CENTER FOR HEALTHCARE LEADERSHIP

National Healthcare Leadership Survey Implementation of Best Practices

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National Healthcare Leadership Survey: Implementation of Leadership Development Best Practices

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National Center for Healthcare Leadership
1700 W. Van Buren, Suite 126B
Chicago, IL 60612
312.593-6630
www.nchl.org

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Executive Summary

The National Healthcare Leadership Survey was developed by the National Center for Healthcare Leadership to assess the rate of adoption of evidence-based leadership development best practices by health care organizations and the extent to which adoption is related to certain Hospital Compare quality measures.

The survey was sent to 4,247 hospitals and 366 health care systems in 2010. Responses were received from 504 hospitals and 31 systems. The leadership survey included questions related to five categories of leadership development practices: selection, performance management, succession planning, learning and development, and governance. Survey data was merged with data from the 2008 American Hospital Association (AHA) Annual Survey to explore use of the five types of practices by hospital bed size, ownership type, geographic region, service type, and membership in the Council of Teaching Hospitals and Health Systems® (COTH). Compared to the survey population, responding hospitals were more likely to be small or large hospitals, public hospitals, general medicine and surgical hospitals from the Midwest and were also less likely to be part of a system.

Additionally, survey results were linked to data from Hospital Compare to determine the correlation between implementation of leadership development best practices and quality performance. A composite process measure score was developed for each responding hospital based on their scores in the 25 Hospital Quality Alliance (HQA) measures, similar to the "Overall Recommended Care" composite described on whynotthebest.org. We also analyzed mortality and readmissions rate scores for heart attack, heart failure, and pneumonia for each hospital and performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

As part of this study, these survey results from the hospital and health system respondents were also compared to the responses of nonhospital benchmark organizations to determine whether there are differences in the adoption of leadership best practices.

Overall, health care systems reported having adopted the best practices for leadership development at a higher rate than freestanding hospitals (4.87 and 3.69 respectively, on a scale of 1 to 7, with 1 being "not at all" and 7 being "a great deal"). Practices from the selection category (4.98), or practices used by the organization in selecting new talent, were the most frequently adopted by hospitals. The least frequently adopted practices were related to the governance category (3.39), or the involvement of the organization's board in monitoring key measures for talent management and succession planning.

Compared to medium and large hospitals, small hospitals lagged in the adoption of leadership development best practices. Not-for-profit and for-profit hospitals appear to have adopted leadership development practices at a higher rate than public hospitals. COTH members have also implemented these practices significantly more than non-COTH members. A small, positive correlation was found between the hospitals' implementation of leadership development practices and the composite quality process measure score.

The survey results are limited by the 12 percent response rate for hospitals and 8 percent response rate for health care systems. To supplement and expound on findings from this survey, further research is needed on the factors that promote the adoption of leadership development best practices, especially at organizations that have successfully implemented them. The experiences of these organizations can be profiled in case studies which highlight best practices that other interested health care organizations can apply. Further research is also needed to ascertain the link between implementation of these practices and various performance measures that are relevant to hospitals. The measures included in this survey are primarily

clinical and patient satisfaction measures. Future studies, however, could consider the use of other specific inpatient and outpatient outcome measures, efficiency measures, financial performance measures, community benefit and employee engagement measures.

Affiliation with a health care system, size, ownership structure, and teaching status were associated with greater adoption of best practices for leadership development by hospitals. There appears to be only a minimal correlation between implementation of these practices and a hospital's overall quality performance. Smaller hospitals, nonaffiliated hospitals, and other specific hospitals types may benefit from tailored implementation assistance in the adoption of proven leadership development practices.

Introduction

Leadership is especially important at a time of dramatic change. As the United States makes significant investments in health care reform initiatives, quality and patient safety improvements, and information technology, the capability to assimilate these massive changes must also be built. Fortune 500 businesses have understood that these huge investments have the best chance of delivering their expected return when they attend to the human side of the equation: ensuring that the skills, rewards, talent management, and overall organizational culture are aligned with the intended change. This is achieved when leadership best practices are adopted, cultivating the necessary competencies to inspire and manage in a challenging and changing environment. Without adequately and pervasively preparing health care leadership to effectively implement new capabilities, many transformational components of health reform may have a lower probability of succeeding or meeting the public's expectations.

Leadership development and succession planning are also crucial for the strategic development of health care organizations. According to a study of leadership best practices, "an effective leadership development program has broad organizational reach, touching both employees and affiliated professionals and spanning the organization. With this reach, leadership development programs can be used to help new and established leaders, as well as those in administrative and clinical roles, to improve their leadership skills and abilities to perform their job functions."[1]

Health care must address critical issues regarding leadership and organizational performance:

- How to assure the availability of leadership prepared to address future challenges and lead transformation
- How to transform health professionals working as individuals into high-performing teams
- How to align management systems to support culture change and continuous professional development
- How to create an organizational culture dedicated to "crossing the quality chasm"

The complexity of health care today and the changes needed to reform and improve our health care system require that providers have the skills and tools to address the questions raised. These include, in particular, the use of evidence-based care management processes, the adoption of continuous quality improvement techniques, the ability to develop effective teams, and the implementation of electronic health records and registries. Much has been written about each of these skills and tools, but they need to be considered as an integrated set of competencies required to effectively respond to the new payment incentives for providing better-coordinated, cost-effective care.[2]

Over the last decade, the National Center for Healthcare Leadership (NCHL) has served as catalyst in bringing the leadership agenda to the forefront in health care and advocating for the adoption of evidence-based best practices. Although much of what needs to be done is already known to the field, a greater challenge is putting this knowledge into action and broadly implementing best practices that have been developed in other industries or among thought-leader health care providers into day-to-day operations. The intent of the leadership survey is to raise awareness of leadership best practices and to provide hospitals and health systems with the capability to benchmark and examine their own progress with regard to these practices.

[1] McAlearney, A.S. Using Leadership Development Programs to Improve Quality and Efficiency in Healthcare. *Journal of Healthcare Management*. September/October 2008.
[2] Shortell, S.M., Casalino, L.P., and. Fisher, E.S. How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations. *Health Affairs*, July 2010.

A longer version of the National Healthcare Leadership Survey was initially administered in 2007 in partnership with the National Research Corporation. This initial survey included over 80 questions regarding leadership best practices. Data from 256 hospitals showed many health care systems and hospitals do not engage in succession planning and talent management for top administrators compared to benchmarking organizations from outside of health care. In fact, only 17 percent of administrative leaders received a great deal of talent management. The disparity for medical leaders and nurse leaders was even greater: 6 percent for medical leaders and 9 percent for nursing leaders. And while 18 percent of administrators participating in the survey used 360-degree feedback a "great deal" of the time, that was true among 13 percent of nursing leaders and 6 percent of medical leaders. The study also found that only 3 percent of the organizations had a succession planning and talent management process that included specific metrics to gauge the results of the process. In 2007, NCHL found that the governing board involvement in corporations was dramatically higher than in health care. In fact, talent management dashboards are often used to track performance in managing talent. Some of these deficiencies appear to continue to hold true today.

Despite the apparent lag in adoption of leadership development best practices by health care organizations, certain hospitals are engaging in leadership development and succession planning in response to changing policy and economic conditions. The leadership survey enabled us to identify the level to which hospitals and health care systems have adopted these leadership development best practices and to identify if specific organizational characteristics were associated with their adoption.

2010 National Healthcare Leadership Survey

The National Healthcare Leadership Survey is a composite of different aspects of NCHL's organizational leadership assessments. The assessments measure alignment of core processes and strategies that define a systematic and sustainable approach to leadership development in health care organizations. The survey enabled NCHL to assess the degree to which evidence-based leadership development best practices are used and to study the relationship between the talent management core processes and certain organizational performance measures, such as mortality, readmissions, patient satisfaction, and quality process measures. The survey also enabled hospitals and health care systems to compare their leadership development efforts with evidence-based best practices and benchmarks.

APPROACH

The survey had 16 questions and included several subquestions, each corresponding to a best practice for talent management and succession planning. The first question in the survey, which focuses on the use of a leadership competency model, was analyzed separately, since it had a different response structure. The question asked respondents to provide a "yes" or "no" response to whether their organization had a leadership competency model that was aligned with their strategic goal and whether the competency model recognizes behaviors required of successful leaders. The rest of the survey questions asked respondents to rank the level of adoption of various leadership practices on a scale of 1 to 7, with 1 being "not at all" and 7 being "a great deal". In order to facilitate analyses and interpretation, the questions were grouped into five categories of best practices for leadership development shown in Table 1. In this report, average response for each category is reported, but the report also reflects individual question responses where necessary.

Table 1. Definition of Variables of Interest

Categories of Best Practice	Corresponding Question(s)/ Best Practices	Range of Values
Leadership competency model	Q1a. Competency model aligned with strategic goals Q1b. Does Your Leadership Competency Model Recognize Behaviors Required of Successful Future Leaders?	"Yes" or "No"
Governance	Q2. Human capital dashboard	1 ("Not at all") – 7 ("A great deal")
Succession planning	Q3. Multiple level succession planning Q4a. Medical leadership succession planning Q4b. Nursing leadership succession planning Q4c. Administration succession planning Q5. Rigorous assessment methods Q6. Metrics for succession planning	
Learning and development	Q7. Learning and development efforts Q8. Manager accountability—direct reports Q9. 360-degree feedback Q10a. Medical leadership 360-degree	

Categories of Best Practice	Corresponding Question(s)/ Best Practices	Range of Values
	Q10b. Nursing leadership 360-degree Q10c. Administration 360-degree Q11. Action learning Q12. Relationship-based development	
Performance management	Q13. Formal performance management Q14. Manager accountability—responsibilities Q15.Identify top, average and under-performers	
Selection	Q16a. Behavioral interviews Q16b. Competency-based interviews	

Performance Measures	Description
Mortality rate	Combined risk-adjusted mortality score
Readmissions rate	Combined risk-adjusted readmissions rate
Combined process measure	Overall weighted quality score
Overall positive	Composite of most positive responses to HCAHPS survey questions, referred to as "top box" on Hospital Compare
Overall negative	Composite of least positive responses to HCAHPS survey questions, referred to as "bottom box" on Hospital Compare
Definitely recommend	Yes, patient would definitively recommend the hospital
Not recommend	No, patient would not recommend the hospital
Hospital rating 9–10	Overall hospital rating 9–10
Hospital rating 6 or lower	Overall hospital rating 6 or lower

The National Healthcare Leadership Survey was administered by Health Forum, a subsidiary of the American Hospital Association and the publishers of the AHA Annual Survey. Information about the survey was emailed to leaders of 4,247 hospitals, including AHA members and nonmembers in June 2010. An additional 366 surveys were emailed to leaders of health care systems. Between the period of June 2010 through September 2010, Health Forum sent three follow-up emails to hospital and system leaders and conducted telephone calls to nonresponders in August 2010. Responses were received from 504 hospitals and 31 health care systems, for a total response rate of 12 percent for hospitals and 8 percent for health care systems.

The complete survey instrument is included as Appendix A. NCHL subcontracted the survey analysis and development of the final report to the Health Research & Educational Trust (HRET), an affiliate of the American Hospital Association. HRET linked the survey responses to the 2008 AHA Annual Survey data to allow for analysis of responses by hospital characteristics, such as bed size, ownership type, geographic region, service type, and COTH membership. HRET also linked the survey responses to performance measures and scores from the Hospital Compare website to determine any association between the implementation of the leadership development best practices and a set of performance measures shown in Table 1.

Benchmark Organizations

The National Healthcare Leadership Survey was also sent to 24 national, nonhospital health care "benchmark" organizations in December 2010. The benchmark organizations included the top 20 Best Companies for Leadership as identified by the Hay Group research and a small sample of for-profit medical device and technology manufacturers, pharmaceutical companies, and distributors of medical supplies. A total of six benchmark organizations responded to the leadership survey. They were all large, Fortune 500 companies with a significant presence nationwide. Question 4, which asks about succession planning at the nursing, medical, and administrative levels, and question 10, which asks about 360-degree feedback at the nursing, medical, and administrative levels were eliminated from the benchmark survey, since they were not applicable. In addition, Question 16, which asks about interview practices, was not included in the benchmark survey. Results from the six responding benchmark organizations are used as a comparison point for the survey results and indicate that these benchmark organizations have been more widely adopted human resource best practices than is demonstrated by hospitals and health systems.

Results

Profile of Respondents

Responding hospitals varied by geographic region, bed size, ownership type, service type, and system affiliation. Compared to the survey population, responding hospitals were more likely to be small (6–99 beds) or large (300+ beds) hospitals, public hospitals, general medicine and surgical hospitals from the Midwest and were also less likely to be part of a system. A complete profile comparing responding hospitals to nonresponding hospitals is shown in Table 2.

Table 2. Profile of Responding Hospitals vs. Nonresponding Hospitals

	Responders	NonResponders	
	n (%)	n (%)	p-value*
N	**504**	**3743**	
Geographic location			0.002
Northeast	74 (15)	506 (14)	
Midwest	180 (36)	1124 (30)	
South	153 (30)	1463 (39)	
West	97 (19)	650 (17)	
Bed size			0.012
Small (6–99)	268 (53)	1855 (50)	
Medium (100–299)	138 (27)	1272 (34)	
Large (300 and more)	98 (20)	616 (16)	
Ownership			0.000
Public	149 (30)	820 (22)	
Not-for-profit	303 (60)	2261 (60)	
For-profit	52 (10)	662 (18)	
Federal	0 (0)	0 (0)	
Teaching hospital			0.006
COTH	45 (9)	223 (6)	
Non-COTH	459 (91)	3520 (94)	
Service			0.046
Med/Surg/Gen	468 (93)	3371 (90)	
Other[3]	36 (7)	372 (10)	
System affiliation			0.000
System Members	233 (46)	2115 (57)	
Non-system Members	271 (54)	1628 (43)	

* P value based on chi-square test of independence

[3] Other category includes: Obstetrics and gynecology; eye, ear, nose and throat; rehabilitation; children's gen/med/surg; children's orthopedic; children's other specialty; and acute long-term care

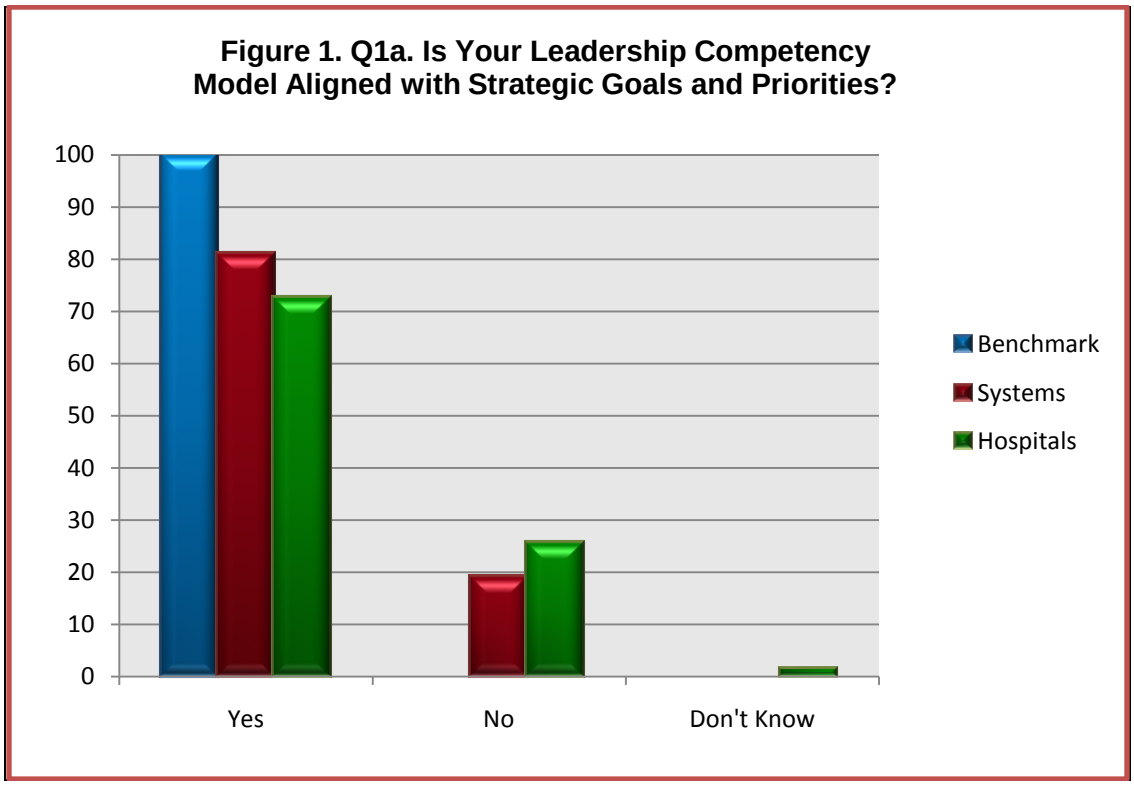
Findings

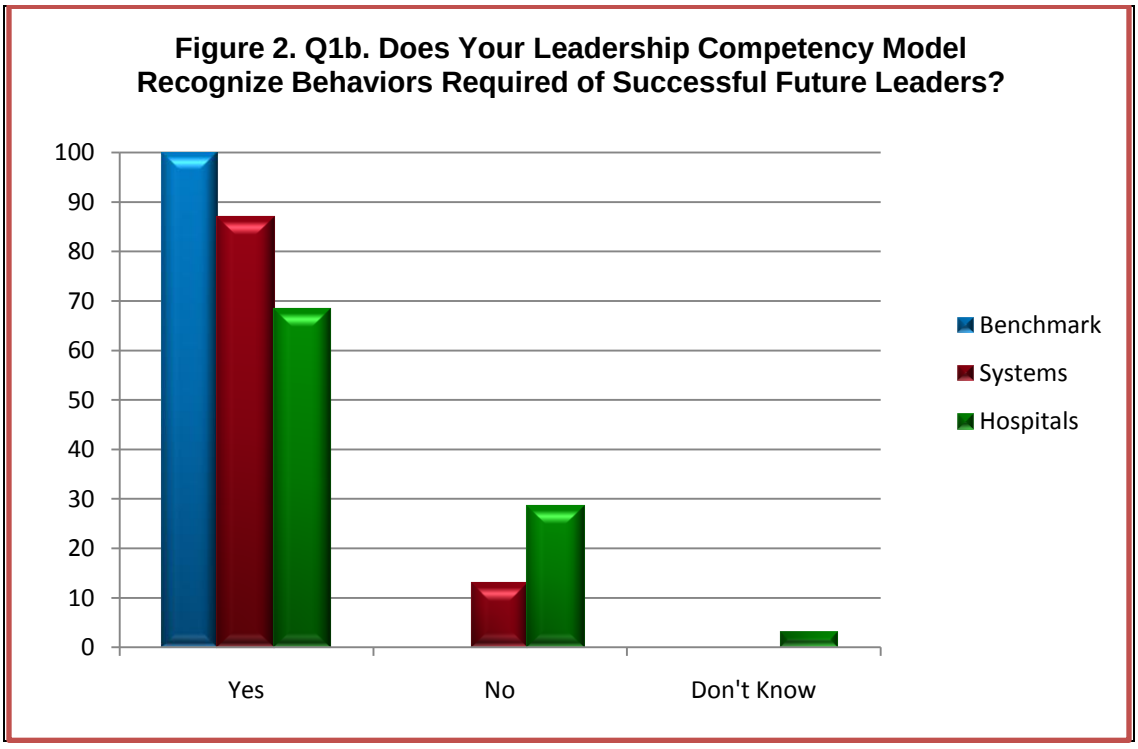
Use of Leadership Competency Model (Question One)

A competency model is a set of competencies required for exceptional performance in an organization. Question one of the survey asked if the responding health care organization has a leadership competency model that:

- Is aligned with the organization's strategic goals and priorities, and
- Recognizes behaviors that will be required of successful future leaders.

At least 72% of hospitals and 80% of systems responded affirmatively for both questions on the use of a leadership competency model, as shown in Figures 1 and 2. The proportion increases to 100% for benchmark organizations responding affirmatively.





Individual Best Practices (Questions Two – Sixteen)

Analysis of the responses to individual questions on the survey shows that the one leadership development practice that is least utilized by hospitals and health care systems is the use of 360-degree feedback for developing medical leadership (Question 10a). The most widely implemented practice varied for hospitals and systems. Hospitals report broad use of behavioral interviewing for selecting employees (Question 16a), while systems report wide implementation of practices for holding managers accountable for carrying out their responsibilities (Question 14).

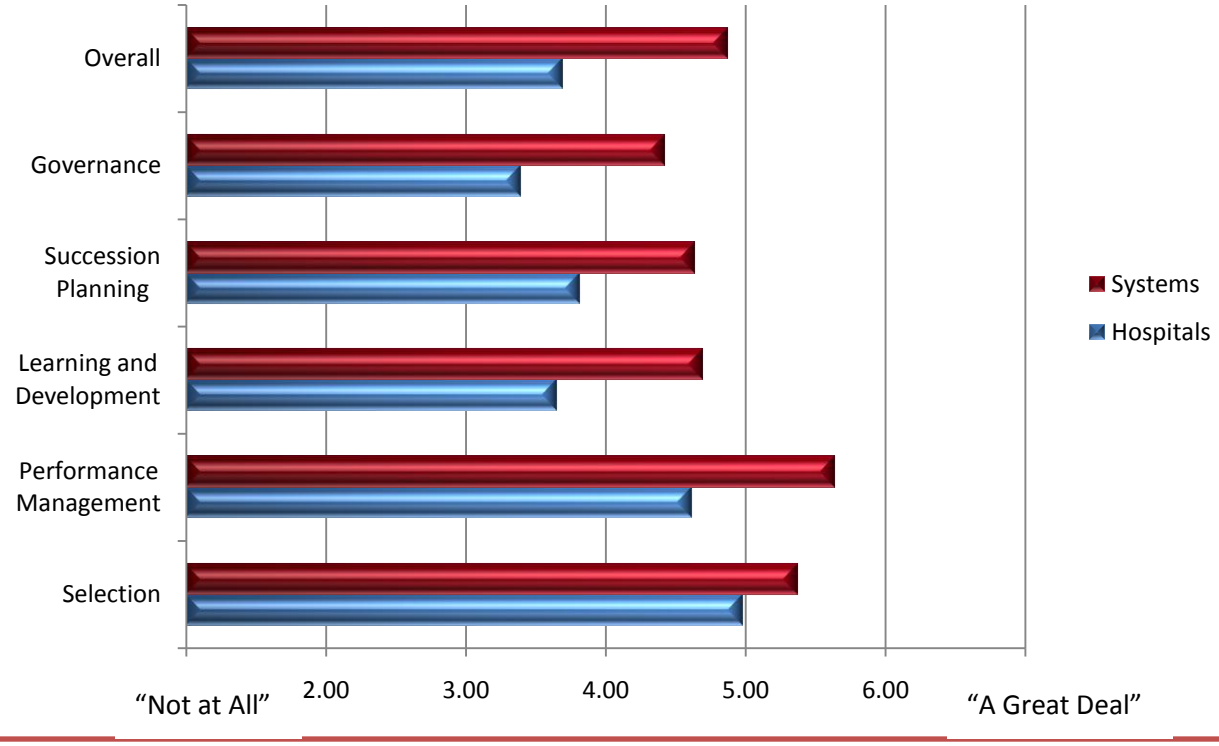
Categories of Best Practices

Figure 3 shows the reported level of implementation of the six categories included in the survey. The two categories or set of best practices scored highly by hospitals and systems, selection and performance management, are instrumental in identifying internal and external talent to fill leadership gaps in health care organizations. Selection practices may take the form of behavioral interviewing or the use of the organization's competency model to evaluate candidates for leadership positions. A rigorous performance management system that holds managers accountable for carrying out their responsibilities and is able to distinguish between top, average and low performers can also help to identify talent to develop for future leadership positions.

Both hospitals and systems ranked activities in the governance category or their organization's board's involvement in leadership development and succession planning as being low. Board involvement in certain activities usually signals leadership commitment and accountability to those activities. However, in an effort to effectively manage competing demands, boards of health care organizations may choose a set of priorities that is pertinent to their organization to focus on. Hospitals reported the highest scores for the selection category (4.98), followed by performance management (4.62), succession planning (3.81), learning and

development (3.65), and governance (3.39). Systems reported highest scores for performance management (5.64), followed by selection (5.37), learning and development (4.69), succession planning (4.64), and governance (4.42).

Figure 3. Average Level of Implementation for Systems and Hospitals



Variations in Responses Between Hospitals and Health Care Systems

To determine the differences between hospitals' and systems' implementation of evidence-based leadership development practices, we analyzed and compared responses from the 504 hospitals and the 31 health care systems. Table 3 shows the overall level of adoption of best practices at hospitals and health care systems as well as the level of adoption on each of the best practices (questions) included in the survey.

On average, health care systems have adopted best practices for leadership development at a higher rate than hospitals (4.87 vs. 3.96). This difference is statistically significant. The same is true for implementation across each of the categories of best practices. Further, the differences between systems' and hospitals' responses for individual questions were statistically significant for all but six questions: Those questions pertained to:

- Succession planning at multiple levels of the organization (Question 3)
- Succession planning for medical leadership (Questions 4a)
- Succession planning for nursing leadership (Questions 4b)
- Alignment of learning and development efforts to organization's strategic goals (Question 7)

- Use of action learning to develop leaders (Question 11)
- Use of behavioral interviews for employee selection (Question 16a)

All of these practices appeared to have been implemented at a similar rate at both responding hospitals and health care systems. A complete summary of hospital and health care system responses is shown in Table 3.

Table 3: Average Scores for Hospitals and Systems

Average Score				
Question	**Hospital**	**System**	**p-value***	**<0.05**
Q2. Human capital dashboard	3.39	4.42	0.006	**
Q3. Multiple level succession planning	3.94	4.55	0.108	
Q4a. Medical leadership succession planning	3.54	4.16	0.105	
Q4b. Nursing leadership succession planning	4.33	4.93	0.113	
Q4c. Administration succession planning	4.67	5.52	0.010	**
Q5. Rigorous assessment methods	3.21	4.61	0.000	**
Q6. Metrics for succession planning	3.17	4.06	0.002	**
Q7. Learning and development efforts	4.81	5.45	0.054	
Q8. Manager accountability—direct reports	4.11	5.13	0.000	**
Q9. 360-degree feedback	3.21	4.55	0.001	**
Q10a. Medical leadership 360-degree	2.31	3.74	0.000	**
Q10b. Nursing leadership 360-degree	3.47	4.52	0.006	**
Q10c. Administration 360-degree	3.80	5.19	0.000	**
Q11. Action learning	3.18	3.82	0.076	
Q12. Relationship-based development	4.28	5.13	0.022	**
Q13. Formal performance management	4.42	5.66	0.001	**
Q14. Manager accountability—responsibilities	4.91	5.68	0.036	**
Q15.Identify top, average and under-performers	4.55	5.58	0.005	**
Q16a. Behavioral interviews	5.29	5.45	0.618	
Q16b. Competency-based interviews	4.67	5.29	0.029	**
Average	**3.96**	**4.87**	**0.000**	**

To further ascertain the impact of system affiliation on an organizations' ability to implement leadership development practices, we compared the responses of hospitals affiliated with a health care system with responses of freestanding hospitals. Of the 504 hospitals that responded to the survey, 233 belonged to health care systems but responded as individual hospitals, and the remaining 271 were freestanding hospitals that do not belong to a health care system. A profile of both types of hospitals is included in Table 4.

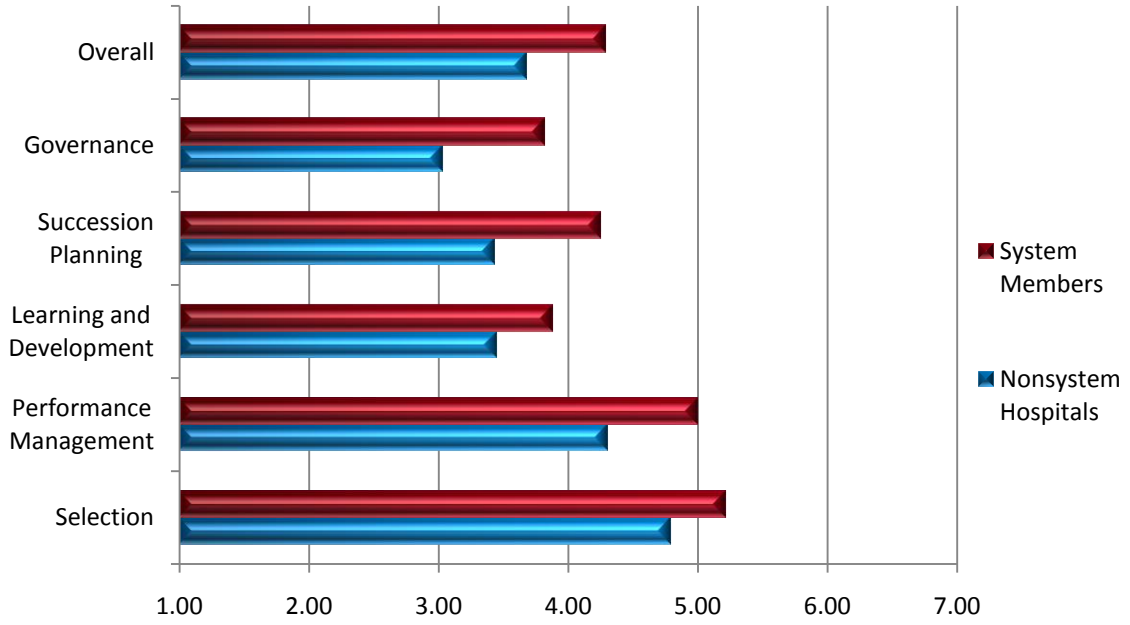
Table 4: Profile of System-Affiliated Hospitals vs. Freestanding Hospitals

	Hospitals in Systems	Hospitals not in Systems
	n (%)	n (%)
N	**233**	**271**
Geographic Region		
Northeast	30 (13)	44 (16)
West	47 (20)	50 (19)
Midwest	79 34)	101 (37)
South	77 (33)	76 (28)
Size		
Small (6–99)	115 (49)	153 (57)
Medium (100–299)	62 (27)	76 (28)
Large (300 and more)	56 (24)	42 (15)
Ownership		
Public	41 (18)	108 (40)
Not-for-profit	150 (64)	153 (56)
For-profit	42 (18)	10 (4)
Federal	0 (0)	0 (0)
Teaching Status		
COTH	25 (11)	20 (7)
Non-COTH	208 (89)	251 (93)
Service Type		
Medical/Surgical/General	206 (88)	262 (97)
Other[4]	27 (12)	9 (3)

We found a significant difference between the average level of implementation of best practices at system-affiliated hospitals and freestanding hospitals (4.29 vs. 3.68). System-affiliated hospitals also appear to have implemented best practices across each of the five categories to a higher degree than freestanding hospitals as shown in Figure 4.

[4] Other category includes: Obstetrics and gynecology; eye, ear, nose and throat; rehabilitation; children's medical, surgical, general; children's orthopedic; children's other specialty; and acute long-term care

Figure 4. Average Level of Implementation for System-Affiliated Hospitals and Freestanding Hospitals



With respect to individual questions, system-affiliated hospitals and freestanding hospitals showed differences in implementation of all leadership development practices with the exception of:

- Alignment of learning and development efforts for leaders and the organization's goals (Question 7)
- Use of 360-degree feedback for leaders in administration (Question 10c)
- Use of competency-based interviews for employee selection (Question 16b)

A complete summary of this comparison is available in Table 5.

Table 5: Average Scores of System-Affiliated Hospitals vs. Freestanding Hospitals

	Average Scores			
Question	**Nonsystem Hospitals**	**Hospitals in Systems**	**P-value***	**<0.05**
Q2. Human capital dashboard	3.03	3.82	0.000	**
Q3. Multiple level succession planning	3.59	4.35	0.000	**
Q4a. Medical leadership succession planning	3.21	3.93	0.000	**
Q4b. Nursing leadership succession planning	3.92	4.80	0.000	**
Q4c. Administration succession planning	4.31	5.08	0.000	**
Q5. Rigorous assessment methods	2.81	3.68	0.000	**
Q6. Metrics for succession planning	2.76	3.66	0.000	**
Q7. Learning and development efforts	4.68	4.96	0.084	
Q8. Manager accountability—direct reports	3.95	4.30	0.030	**
Q9. 360-degree feedback	2.99	3.47	0.011	**
Q10a. Medical leadership 360-degree	2.13	2.52	0.023	**
Q10b. Nursing leadership 360-degree	3.26	3.71	0.026	**
Q10c. Administration 360-degree	3.61	4.02	0.051	
Q11. Action learning	2.94	3.48	0.004	**
Q12. Relationship-based development	4.02	4.60	0.001	**
Q13. Formal performance management	4.09	4.79	0.000	**
Q14. Manager accountability—responsibilities	4.60	5.27	0.000	**
Q15.Identify top, average and under-performers	4.22	4.93	0.000	**
Q16a. Behavioral interviews	5.04	5.58	0.001	**
Q16b. Competency-based interviews	4.53	4.84	0.055	
Average	**3.68**	**4.29**	**0.000**	**

* P-value based on an independent t-test
Total Hospitals n: 271
Total Hospitals in System n: 233

The analysis of the 31 system respondents and 233 system-affiliated respondents suggests that health care systems have more awareness of leadership development best practices and are more inclined to implement them than freestanding hospitals. This difference in implementation could be due to the level of resources available to systems versus hospitals and/or the size and complexity of the leadership structure at health care systems.

Benchmark Organizations

As discussed earlier, six Fortune 500 organizations responded to the leadership survey to serve as benchmark comparisons. The responding benchmark organizations scored highly on all the leadership

development best practices included in the survey as shown on Table 6. Their average response for the adoption of all categories of best practices for leadership development was 6.29. Benchmark organizations reported a high use of coaches and mentors for leadership development (Question 12) and the use of a formal performance management system for leaders (Question 13). Benchmark organizations reported an average response of 6.83 for each of these questions. They also scored highly (5.67 respectively) on the least frequently adopted best practices: holding managers accountable for providing development opportunities for their direct reports (Question 8) and the use of rigorous assessment methods to determine managers' career potential (Question 5).

Table 6. Average Scores for Benchmark Organizations

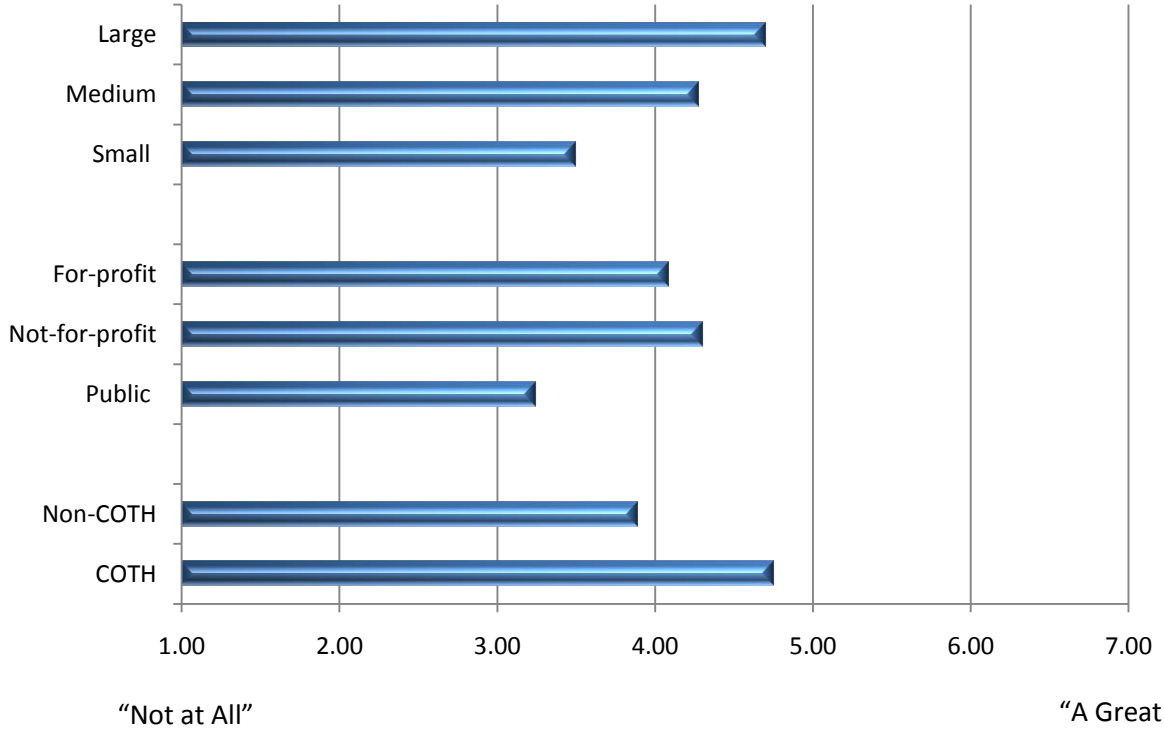
Average Score	
Question	**Benchmark**
Q2. Human capital dashboard	6.00
Q3. Multiple level succession planning	6.67
Q4a. Medical leadership succession planning	n/a
Q4b. Nursing leadership succession planning	n/a
Q4c. Administration succession planning	n/a
Q5. Rigorous assessment methods	5.67
Q6. Metrics for succession planning	6.00
Q7. Learning and development efforts	6.33
Q8. Manager accountability—direct reports	5.67
Q9. 360-degree feedback	6.17
Q10a. Medical leadership 360-degree	n/a
Q10b. Nursing leadership 360-degree	n/a
Q10c. Administration 360-degree	n/a
Q11. Action learning	6.17
Q12. Relationship-based development	6.83
Q13. Formal performance management	6.83
Q14. Manager accountability—responsibilities	6.50
Q15.Identify top, average and under-performers	6.67
Q16a. Behavioral interviews	n/a
Q16b. Competency-based interviews	n/a
Average	**6.29**

Between-Hospital Variation in Implementation of Best Practices

In addition to system affiliation, various hospital characteristics may also play a role in a hospital's ability to implement evidence-based leadership development practices. Hospitals were analyzed by bed size [small (6–99 beds), medium (100–299 beds), and large (300+ beds)], ownership type (public, not-for-profit, and for-profit), geographic region (Northeast, Midwest, South, and West), service type (general medicine and surgery and all other types), and membership in the Council of Teaching Hospitals and Health Systems® (COTH).

It is important to know whether certain hospital characteristics are associated with a hospital's ability to implement leadership development measures. Such information can focus efforts to identify challenges to implementing these best practices and better target educational efforts to promote the adoption of proven leadership development practices. On an aggregate level, there were no significant differences in the implementation of leadership development practices among hospitals in different regions and hospitals providing different types of services. However, significant differences in implementation were observed by bed size, ownership, and COTH membership as shown in Figure 5.

Figure 5. Average Level of Implementation in Hospitals By Hospital Characteristics



Bed Size. Small hospitals (6–99 beds) reported the lowest level of implementation of the best practices (3.53), compared to medium hospitals (100–200 beds), and large hospitals (300 and more beds) at 4.28 and 4.70 average response, respectively.

Ownership. Hospital responses also varied by ownership type. Not-for-profit hospitals reported the highest level of implementation of leadership development practices (4.30), followed by for-profit hospitals (4.09), and public hospitals (3.24). The differences in response are significant for public and not-for-profit hospitals, and public and for-profit hospitals, but not between not-for-profit and for-profit hospitals.

The Council of Teaching Hospitals and Health Systems Membership. COTH members are organizations that have an affiliation with a medical school. COTH is composed of approximately 400 major teaching hospitals and health systems. Forty-five COTH members responded to the survey. Figure 5 describes the differences in implementation of leadership development best practices by COTH membership. On average, COTH members have implemented these practices significantly more than non-

COTH members. Some of the differences in implementation between these two groups of hospitals may be explained by differences in bed size, as COTH members are typically large hospitals.

Variations in Responses Between Benchmark Organizations and Systems

To effectively assess the difference in the level of implementation of the leadership development best practices between benchmarking organizations and the other organizations surveyed, we compared the responses of health care systems with those of the benchmarking organizations. The responses received on the survey indicate that health care systems currently have implemented the best practices at a higher level than hospitals. Using health care systems as a point of comparison, we evaluated the responding health care systems against the responses of the benchmark organizations.

Health care systems responded to having implemented or to using the best practice of holding managers accountable for effectively carrying out their responsibilities to a higher degree than the other best practices on the survey (Question 14). Comparing the hospital response of 5.68 to the benchmark response of 6.50 shows that even on the most frequently implemented best practice, the benchmark organizations still outpace other health care organizations in the area of implementation of leadership development best practices.

Health care systems responded to having implemented to a lesser rate (3.74) the best practice of using 360-degree feedback to develop medical leadership (Question 10a). Since this question was not applicable to the benchmark organizations, we are unable to provide a point of comparison. The second leadership best practice that has been the least frequently implemented by health care systems is the use of action learning or having employees tackle real organizational problems as a way of acquiring new skills and values required of leaders. The systems provided an average response of 3.82 to that question compared to the benchmark response of 6.17, indicating a substantial gap in the use of action learning at the health care systems surveyed.

Relationship Between Implementation of Leadership Development Best Practices and Quality Outcomes

Certain practices implemented at the organizational level may impact quality outcomes of hospitals and health care systems. Survey results were compared to data on hospital performance from the Hospital Compare website to determine if implementation of leadership development practices correlates to hospital outcomes.

Using a similar approach to the one utilized by the whynotthebest.org website, we developed an overall composite score for each responding hospital based on their scores in the 25 Hospital Quality Alliance (HQA) measures that report how often hospitals delivered recommended care processes in the following four areas: heart attack, heart failure, pneumonia, and surgical care improvement. A combined mortality and readmissions rate for heart attack, heart failure, and pneumonia was also developed for each hospital using a similar approach. Finally, patient ratings of hospitals, as reported on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) were examined, specifically, whether hospitals were definitely recommended by patients or not recommended and the overall rating of hospitals.

There was no significant relationship between the implementation of leadership best practices and most of the hospital performance measures. There was however a small, positive relationship between the hospitals' implementation of leadership development practices and the composite process measure score. For health care systems, there was no significant relationship between implementation of leadership development

practices at the system level and system outcomes. The details of the analysis of hospital outcomes are included in Table 7.

Table 7: Associations Between Hospital Aggregate Response and Performance Measures

Hospital Outcomes	p-value*	r-value	<0.05
Mortality rate	0.756	0.015	
Readmissions rate	0.707	-0.021	
Combined process measure	0.000	0.258	**
Overall negative	0.374	0.046	
Overall positive	0.061	-0.097	
Definitely recommend	0.134	0.078	
Not recommend	0.390	-0.044	
Hospital rating 9–10	0.793	-0.014	
Hospital rating 6 or lower	0.957	0.003	

To further determine if there is a correlation between categories of best practices and the hospital outcomes of interest, we compared average hospital responses for each category with the combined process measure, readmissions rate, and mortality rate. Similar to the previous analysis, we found that implementation of the best practices in each of the categories only had a significant positive correlation with the composite process measure score for hospitals.

Table 8: Associations Between Category Responses and Composite Process Measure

Hospital Outcomes	p-value*	r-value	<0.05
Governance	0.000	0.196	**
Succession Planning	0.000	0.206	**
Performance Management	0.000	0.280	**
Learning and Development	0.000	0.198	**
Selection	0.000	0.215	**

It is important to note that this study is limited by the response rate, so results may or not be representative of hospitals nationwide. Additionally, only a select group of hospital outcomes are included in this analysis. In order to fully understand how implementation of leadership development best practices is associated with hospital performance measures, we need to explore additional measures that are not solely clinical. Research suggests that in addition to evidence-based medicine, evidence-based management is critical to improving the quality of medical care. Shortell, Randall, and Hsu define evidence-based management as the organizational strategies, structures, and change management that enable physicians and other health care professionals to provide evidence-based care.[5]

[5] Shortell, SM, Rundall, TG, and Hsu, J. Improving Patient Care by Linking Evidence-Based Medicine and Evidence-Based Management. *Journal of the American Medical Association.* August 8, 2007.

Future Research

Findings from the National Healthcare Leadership Survey provide an overview of the level to which hospitals and health care systems utilize certain key practices to develop potential leaders for their organization. The findings also provide basic comparison between implementation of these leadership practices at benchmark health care organizations and hospitals and health care systems. Further research is needed in order to fully understand the challenges and barriers to hospitals and health care systems in implementing these practices and to effectively promote their utilization.

First, we need to understand what factors promote the adoption of the leadership development best practices at certain health care organizations. The study suggests that the practices have been widely adopted at for-profit health care organizations such as pharmaceutical companies and distributors of medical supplies. The study also shows that health care systems have adopted these practices at a higher rate than hospitals. It is therefore important to understand what factors have facilitated implementation of the leadership best practices at benchmark organizations and at health care systems. This can be documented in the form of case studies which highlight best practices that other interested health care organizations can apply.

Second, pertaining to the minimal correlation found between implementation of these leadership development best practices and certain hospital outcomes of interest, it is important to note that only a select group of outcome measures was included in this study. To fully comprehend the relationship between the leadership development best practices and quality outcomes, a variety of measures—such as specific inpatient and outpatient outcome measures, efficiency measures, financial performance measures, community benefit and employee engagement measures—will have to be studied.

Conclusion

This survey provides a snapshot of the extent to which health care organizations have implemented certain evidence-based leadership development practices. Systems and hospitals affiliated with systems appear to have implemented these practices more than individual hospitals. The reason for the difference could be the fact that system-affiliated hospitals, defined by COTH membership, comprise larger facilities that may have more resources to implement these practices. Even organizations that show a high level of use of these best practices report responses that are still average on a scale of 1 to 7, indicating an opportunity to stimulate national awareness of these leadership best practices and further promote their adoption. With the exception of size, ownership status, and COTH membership, there were no other differences in the use of leadership development practices by other hospital characteristics.

There is a significant positive relationship with hospitals' overall score on the reported HQA process measures and their implementation of leadership development practices. This positive, albeit small, correlation is not surprising since the leadership development practices identified contribute to the overall strength of an organization, rather than to individual care areas. As such, there is no significant relationship between hospital's use of leadership development practices and mortality rates, readmissions rate, and scores on the HCAHPS survey.

The results of the 535 hospitals and health care systems responding to this survey may not capture the experiences of the thousands of hospitals that did not participate. Despite the sample size and the minor differences between the profiles of responding hospitals and national hospitals, the responses offer a baseline assessment of their leadership development practices. This survey will therefore be invaluable in helping to determine next steps for education, promotion, and uptake of leadership development practices.

The results of the survey provide several opportunities for next steps to help health care organizations with talent management and succession planning processes. The first opportunity involves educating health care leaders and boards about the importance of talent management and succession planning to the viability of their organization. Next, education efforts will need to focus on how to implement the proven best practices that are currently being underutilized by health care organizations, such as action learning to develop leaders, 360-degree feedback for leaders at all levels of the organizations and for all professional groups, and regular, rigorous assessment methods for leadership development planning.

Appendix: Survey Instrument

	Yes	No	Don't Know
1. My organization has a leadership competency model that is[6]			
a. Aligned with the organization's strategic goals and priorities	☐	☐	☐
b. Recognizes behaviors that will be required of successful leaders in the future	☐	☐	☐

	1 Not at All	2	3	4	5	6	7 A Great Deal	Do Not Know
2. The Board monitors a 'human capital dashboard' that includes key measures of talent management and succession planning.	☐	☐	☐	☐	☐	☐	☐	☐
3. The succession planning process involves talent management at multiple levels of the organization, not just senior levels.	☐	☐	☐	☐	☐	☐	☐	☐
4. The succession planning process involves talent management for the following professional groups of the organization:								
a. Medical Leadership	☐	☐	☐	☐	☐	☐	☐	☐
b. Nursing Leadership	☐	☐	☐	☐	☐	☐	☐	☐
c. Administration	☐	☐	☐	☐	☐	☐	☐	☐
5. To determine managers' career potential and drive development planning, the organization employs rigorous assessment methods that are repeated at numerous times during a leader's career.	☐	☐	☐	☐	☐	☐	☐	☐
6. The succession planning and talent management process includes specific metrics to gauge the results of the process.	☐	☐	☐	☐	☐	☐	☐	☐
7. Learning and development efforts for leaders are aligned with the organization's strategic goals and priorities.	☐	☐	☐	☐	☐	☐	☐	☐

[6] A competency model is a list of competencies (behavioral and technical characteristics) to which exceptional performance can be attributed. The model can be used to identify the competencies individuals need to develop to achieve performance goals in their current job or to prepare them for future opportunities.

	1 Not at All	2	3	4	5	6	7 A Great Deal	Do Not Know
8. Managers are held accountable for providing development opportunities to their direct reports.	☐	☐	☐	☐	☐	☐	☐	☐
9. 360-degree feedback[7] is used for developing leaders at all levels of the organization (e.g., executives/senior managers, directors/managers, and frontline managers).	☐	☐	☐	☐	☐	☐	☐	☐
10. 360-degree feedback is used for developing leaders in the following professional groups within the organization:								
a. Medical Leadership	☐	☐	☐	☐	☐	☐	☐	☐
b. Nursing Leadership	☐	☐	☐	☐	☐	☐	☐	☐
c. Administration	☐	☐	☐	☐	☐	☐	☐	☐
11. Action learning[8] is used for developing leaders.	☐	☐	☐	☐	☐	☐	☐	☐
12. Relationship-based development (coaches or mentors) is encouraged and supported.	☐	☐	☐	☐	☐	☐	☐	☐
13. There is a formal performance management system for leaders that is integrated with other leadership development efforts.	☐	☐	☐	☐	☐	☐	☐	☐
14. Managers are held accountable for effectively carrying out their responsibilities regarding the performance management system (e.g., setting goals and objectives, giving and receiving feedback, observing and rating performance).	☐	☐	☐	☐	☐	☐	☐	☐
15. The performance management process makes clear differentiations between top performers, average performers and underperformers.	☐	☐	☐	☐	☐	☐	☐	☐
16. If interviews are used for employee selection, they are:								
a. Behavioral, using questioning that asks how candidates have behaved in situations representative of the job in question	☐	☐	☐	☐	☐	☐	☐	☐
b. Competency-based, using a competency model aligned to organization strategy	☐	☐	☐	☐	☐	☐	☐	☐

[7] This is multi-rater feedback where an individual's competence is assessed based on the perceptions of their manager, direct report, peer, and self.

[8] Action learning is a learning method in which important, real, organizational problems are tackled by individuals or a team in order to acquire new skills and values.

National Center for Healthcare Leadership

1700 West Van Buren Street, Suite 126B

Chicago Illinois 60612

www.nchl.org

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