Executive Leadership Development in U.S. Health Systems

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EXECUTIVE SUMMARY

The healthcare industry is known for constant and rapid change, highlighting the
need for strong executive leadership. Within this industry, multihospital health-
care systems present particular executive leadership challenges due to their size and
complexity, yet our understanding of how these executive-level health system lead-
ers are developed has been extremely limited. The objective of this research was to
study the establishment, organization, content, process, evaluation, and evolution
of executive leadership development (ELD) programs in U.S. healthcare systems.
Results of a national survey of health system CEOs, supplemented by interviews
with multiple health system key informants, showed that ELD programs existed in
around half of responding U.S. health systems and were especially prevalent among
smaller systems. On average the programs were fairly new, with most having been
established since 2003. ELD programs were reportedly valued by the health systems,
as reflected by respondents' perceptions of program payoffs and sustained budget-
ary commitment. Specifically, ELD programs are believed to help further healthcare
systems' strategic goals, initiate succession planning, and provide local development
opportunities. In addition, the majority of program elements were reportedly worth
the investment in improving executives' leadership skills and capabilities. Given the
imperative to improve leadership capabilities in healthcare, ELD programs provide
important opportunities to enable health systems to meet the challenges of a chang-
ing health services industry.

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To a large extent, the success of any organization depends on its employees' cumulative knowledge and ability to apply this knowledge effectively. The burden of directing this knowledge in practice often falls disproportionately on senior executives who are ultimately responsible for organizational performance (Drucker 2002; Smith, Carson, and Alexander 1984). Within healthcare organizations, the rapid technological, policy, and procedural changes that are characteristic of the industry intensify the challenges of leadership (Hearld et al. 2007; McAlearney 2006; Burke and Scalzi 1988). Multiorganizational health systems are particularly complex, making competent executive leadership even more important.

In practice, leadership development programs have been shown to be effective at training and developing organizational leaders across industries (Bass 1982; Collins and Holton 2004). These programs include activities designed to improve the ability of individuals to lead (Hernez-Broome and Hughes 2004), and formal programs focus activities specifically on facilitating leadership (Casebow 2006). A leadership development program might be made up of training and development components and include training in general management and personal leadership skills; training in the specific areas of negotiation and finance; developmental coaching and 360-degree feedback; and a formal mentoring program. The best leadership development programs produce enduring changes in employee behavior (Kirkpatrick 2005). Moreover, the design of the leadership development program and educational programming can ideally be tailored to support the organization's mission and strategic objectives (Allen 2002; Corporate University Xchange 2005a).

Leadership itself is increasingly viewed as a source of competitive advantage for organizations (Day 2000), with training and development activities receiving attention due to their potential to improve leadership capabilities (McCall 1998; Vicere and Fulmer 1998; Dixon 1993; Day, Zaccaro, and Halpin 2004). Evidence indicates that effective training and development programs are often one of the top three reasons that employees accept and remain in a certain position (Shah et al. 2001). Retention is particularly critical for healthcare organizations because many areas of the industry are competitive, making it difficult to recruit and retain personnel, especially in executive positions. Executive leadership development (ELD) programs are also important as they can promote on-the-job learning and enhance leadership skills (Baird et al. 1994; Humphreys 2005; Zenger, Ulrich, and Smallwood 2000). Effective ELD programs can benefit participants and their organizations as they promote an organizational culture that emphasizes human and social capital (Vloeberghs 1998). In healthcare organizations in particular, leadership development programs have the potential to disseminate a common organizational culture, improve patient safety, and increase patient and employee satisfaction (Morin 2004; Corporate University Xchange 2005a, 2005b; McAlearney 2008).

Despite the importance of strong and capable executive health system leaders and the potential for leadership development programs to help health systems build leaders' skills and knowledge, leadership development activities across organizations are highly varied, with little evidence available to indicate program prevalence, content, or effectiveness (Leatt and Porter 2003; McAlearney 2006). Research has shown that successful ELD programs must move beyond lower-level leadership development activities and include executive-level concepts such as learning the importance of persuasion in organizational politics, taking responsibility for delegation, and learning how to be creative and decisive in the strategic guidance of the organization (Novicevic et al. 2009; Lippert 2001; Jackson, Farndale, and Kakabadse 2003; Storey 2005; Zaccaro and Horn 2003). Yet questions remain about how ELD programs can be designed and delivered so that such programs ensure and facilitate executive-level learning and development (e.g., Conger and Xin 2000; Leonard and Goff 2003; Harris and Kuhnert 2008). Of particular note is that no prior research has specifically examined the topic of executive-level leadership development in healthcare systems from either health systems' or executives' perspectives.

STUDY DESIGN

Research Objective

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

Research Design

This study used quantitative and qualitative approaches to collect data. For the *quantitative portion* of the research, a 35-item survey asking about ELD programs was developed and distributed to a sample of chief executive officers (CEOs) of U.S. health systems. The survey defined executives as "senior leaders in your organization at the vice president level and above." In addition, the ELD program was described as "an executive leadership development or training program." The 10-page, 35-question survey was organized into three main parts to address the different components of the research objective.

The *qualitative portion* of the research used a semi-structured interview guide to ask health system key informants about their leadership development programs. Interviews were planned to last no longer than one hour.

This article highlights results from each of the three survey sections and focuses on those areas of the key informant interviews that provide additional information to elucidate survey findings.

METHODS

Quantitative Methods

Survey Process
The survey methodology followed a modified Dillman methodology (Dillman 2000). A random sample of U.S. health system chief executives (n = 374) was mailed a survey with a postage-paid response envelope in July 2007. The survey was pilot tested with four people and refined; it was estimated to take 15 minutes to complete. Following the

initial mailing, a follow-up survey was sent to nonrespondents approximately two weeks later. Nineteen surveys were returned with incorrect addresses, leaving 355 potential respondents for the mailed survey.

Because of concern about reported low response rates for surveys of chief executives, nonrespondents were contacted by telephone in an attempt to increase the overall survey response rate. These follow-up calls occurred in September and October 2007.

A total of 104 completed surveys were returned, representing responses from 29 percent of the 355 health systems originally sampled.

Survey Data Analysis

Survey data analyses used Microsoft Excel and the STATA statistical package (version 8.0) to evaluate responses. Preliminary analyses reported here include univariate and bivariate analyses, structured to assess both the state of the industry and associations within the data.

Survey Nonresponse Analysis

Respondents were compared with nonrespondents based on system size (number of hospitals), system control (ownership type), and region. This analysis showed that respondents did not differ from nonrespondents relative to system size. However, CEOs of investor-owned systems were less likely to respond to the survey than those in systems under not-for-profit and governmental control. By region, the lowest survey response rate was from CEOs from the Pacific Coast at 13 percent,

and the highest response rate was from CEOs in the West South Central region at 58 percent.

Qualitative Methods

Interview Process

Twenty-five semi-structured telephone interviews with key informants from nine health systems were held to learn more about ELD in U.S. health systems. Telephone interviews were conducted during the same time frame as the survey, in the latter half of 2007. Health systems selected for the key informant interviews had similar characteristics to those health systems surveyed, but the study design did not permit direct comparison of qualitative and quantitative data. Among the 25 interviewees, 7 were executive-level informants, 7 were director-level, 7 were manager-level, and 4 were nonmanager-level individuals.

These key informant interviews followed the standards of rigorous qualitative research using ethnographic interview techniques (Spradley 1979; Maxwell 1996) and thorough analysis (Miles and Huberman 1994; Strauss and Corbin 1998). Consistent with the research objective, questions addressed the establishment, organization, content, process, evaluation, and evolution of ELD programs in U.S. healthcare systems. The interview guide was tested in two pilot interviews. Preliminary feedback from these pilot interviews was used to refine the interview guide prior to beginning the study calls.

Qualitative Data Analysis

Qualitative data analyses used the constant comparative method of qualitative

data analysis (Glaser and Strauss 1967) and common data coding techniques (Constas 1992; Miles and Huberman 1994). Both deductive and inductive coding and analysis techniques were used to formally explore patterns and themes within the data. The Atlas.ti software package (version 4.2) (Scientific Software Development 1998) was used to facilitate coding and data analyses.

RESULTS

Survey Part 1: Establishment and Organization of Executive Leadership Development

Presence of Executive Leadership Development Program

Of the 104 responding health systems, 53 reported having an established program they identified as an ELD program. An additional 12 systems reported having an ELD program under development, with 11 of those 12 systems (92 percent) completing a survey to provide demographic data for analysis. Two responding health systems did not answer this question. The remaining 37 health systems returned surveys reporting that they did not have an ELD program.

Characteristics of Respondents with Leadership Development Programs

Of 51 responding health systems that had an ELD program and provided data about system size, health systems averaged 8.5 hospitals per system. The median number of hospitals per health system was five hospitals.

Table 1 presents the demographic characteristics of respondent health systems with ELD programs showing health system size, average net revenue, and ownership structure.

Program History and Organization

On average, the responding health systems that had an ELD program initiated their program in 2003; this was also the most common year for program initiation. The oldest program began in 1974 while the newest program was initiated in 2007 and was continuing development into 2008. The overwhelming majority of programs were started within the last ten years.

Nearly two-thirds (63 percent) of programs were under corporate or system-level direction, 16 percent were under member hospital–level direction, and 21 percent were reportedly self-directed by executives. Around one-quarter (27 percent) of systems with programs reported having a single executive-level program that included all executives; the majority (73 percent) reported having a flexible program that was customizable based on the needs of individual executives.

Across programs, 88 percent were reportedly tied to achieving the strategic goals of the health system. One in ten programs (10 percent) were reportedly not tied to improving strategic goals, and the remaining respondents were unsure whether the link existed.

Reasons Contributing to Program Initiation

Major reasons noted for program initiation included the desire to further advance the system's strategic goals (90 percent), the wish to initiate succession planning (82 percent), the intent to offer executives professional

TABLE 1

Combined Demographic Characteristics of Responding Health Systems that Reportedly Have a Leadership Development Program (n = 53)*

Size of Health System	Number of Respondents % (no.)	Average Net Revenue	Ownership Structure % (#)			
			Not-for-profit (NFP), Secular % (no.)	NFP, Religious % (no.)	Investor Owned % (no.)	State/Local Government % (no.)
1–3 hospitals	31% (16)	$550,769,231	75% (12)	*	*	19% (3)
4–6 hospitals	29% (15)	$1,175,000,000	47% (7)	40% (6)	*	13% (2)
7–9 hospitals	18% (9)	$1,857,522,222	67% (6)	11% (1)	*	22% (2)
10+ hospitals	21% (11)	$3,140,000,000	45% (5)	36% (4)	*	*

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

development opportunities locally (74 percent), and the need for consistency of messages about accepted executive leadership behavior and practice (68 percent).

Nearly half of the programs (48 percent) reported that dissatisfaction with their executives' preparation for advancement to higher leadership positions contributed to program initiation, and 43 percent reported a desire to duplicate the success of ELD programs observed elsewhere. Having a concern about executive turnover rates was a major factor for only 10 percent of respondents, and only 2 percent reported wishing to reduce spending on executives' development and training by directing the process internally. Other factors mentioned that contributed to starting the ELD program included the need to improve teamwork, networking, and cross-communication and the

opportunity to expand and align organizational culture.

Survey Part 2: The Executive Leadership Development Process

Contact Hours per Participating Executive

The average number of contact hours noted per participant for respondents with ELD programs was 52; the median was 40. Examining contact hours by system size, the average number of contact hours per participant was 36 for smaller systems with one to three hospitals. In contrast, for systems with more hospitals, the number of contact hours was larger: systems with four to six hospitals averaged 52; systems with seven to nine hospitals averaged 63; and systems with ten or more hospitals averaged 57 contact hours per participant ($p < .10$).

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Origin of Faculty

Across respondent systems, an average of 57 percent of program faculty were reportedly internal instructors, drawn from within the health system. In contrast to the largest systems, smaller systems (of one to three hospitals) relied more heavily on external instructors ($p < .05$).

Approach to Determining Areas of Program Content

More than half of the responding health systems with programs (58 percent) determined areas of needed program instruction by asking participants for their ideas, and 55 percent conducted an annual program review. Determining the areas of needed instruction was part of the system strategic planning process for about half (51 percent) of the health systems. In addition, 47 percent of the health systems determined areas of need by polling health system executives. Suggestions for change by external consultants were used in fewer than one-third (30 percent) of these health systems. Across systems, no one method predominated either overall or by size of system. Figure 1 provides additional detail about how systems reportedly determined areas of needed instruction, by health system size. Respondents were able to select multiple approaches to determining program needs, thus reported numbers (Ns) include all

FIGURE 1

Approaches to Determining Areas of Program Content, by System Size (n = 51)

| | Participant ideas | Annual review | Strategic planning | Poll executives | Consultants |
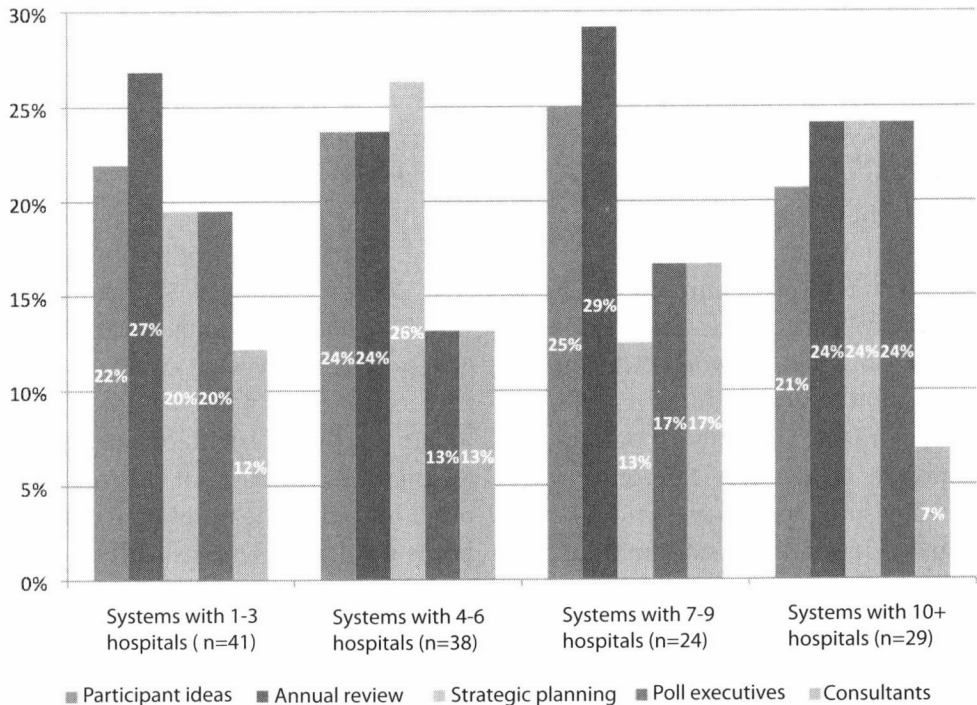
responses listed by the health systems within each health system size category.

Evaluation of Program Participants

Survey respondents were asked how ELD participants were evaluated and to determine whether these evaluation methods were used routinely, used occasionally, or not used. The majority (79 percent) of responding health systems noted routinely using the organization's performance evaluation process as part of the evaluation of program participants (see Figure 3). Two-thirds (67 percent) of the respondent programs reported routinely using participant self-assessments. Half (50 percent) of the programs routinely involved executives in a 360-degree assessment process.

Survey Part 3: Evaluation and Evolution of Leadership Development

Metrics Used to Evaluate Executive Leadership Development Programs

Respondents were able to indicate whether their health system used any of several metrics to evaluate ELD program effectiveness by indicating whether use of the individual metric was "in effect," "being developed," or "not used." More than half of the responding programs noted using employee job satisfaction (66 percent), succession planning (62 percent), quality improvement (62 percent), and patient satisfaction (58 percent) as metrics to evaluate the effectiveness of their ELD program (Figure 2). Three-quarters of programs or more reported that promotion rates, employee satisfaction, and quality improvement as measures of leadership development

program effectiveness were either in use or being developed.

Slightly fewer than half of the programs reported using promotion rates (46 percent) or turnover rates among executives' direct reports (41 percent) to evaluate program effectiveness. More than one-third of respondent programs noted using cost savings (35 percent) to evaluate program effectiveness, and 28 percent reportedly used market share increase.

In contrast, the great majority of programs (87 percent) reported that they did not evaluate their program based on return on investment (ROI). Only five programs (9 percent) reported evaluating the program based on ROI; another 4 percent were reportedly unsure whether or not their program was evaluated based on ROI. Overall, ROI figures were too varied to be interpretable.

Payoff Worth the Investment

To get a sense of program component value, respondents were asked whether, for individual program elements, "the payoff was worth the investment to date." Respondents could select from among four options: "payoff did not meet expectations," "payoff met expectations," "payoff exceeded expectations," or "not applicable." Across systems with programs, the majority reported that program components either met or exceeded health system expectations (Figure 3). These program components included training in personal leadership skills (88 percent), coaching (84 percent), training in general management principles (80 percent), training in quality improvement

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FIGURE 2
Evaluation of Executive Leadership Development Program's Effectiveness (n = 46)

Key Informant Interviews
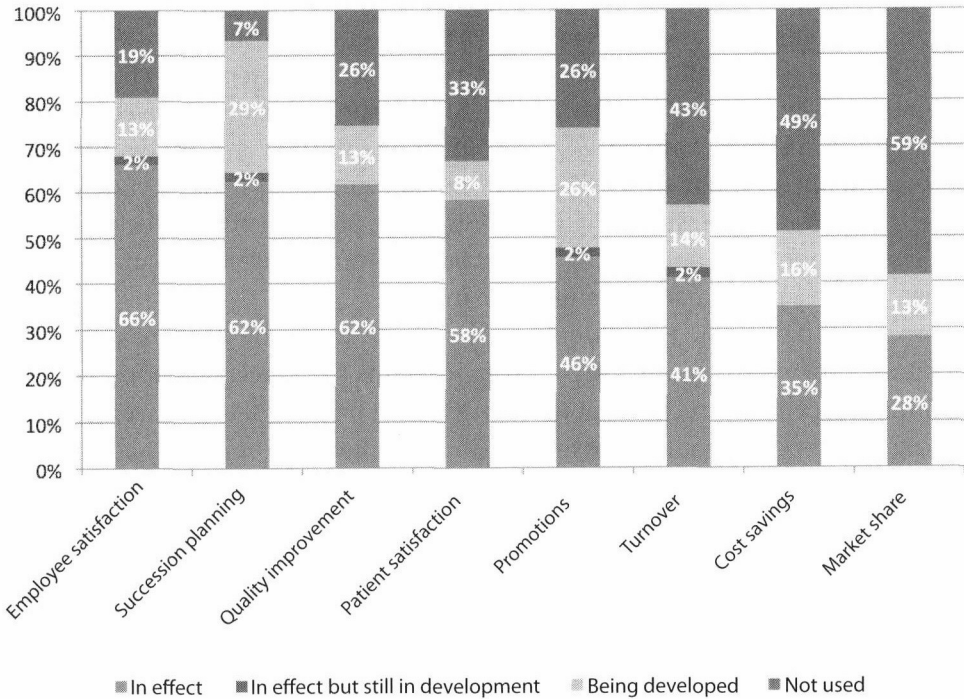
skills (76 percent), use of a 360-degree feedback process (66 percent), use of self-assessment methods (65 percent), and inclusion of a formal mentoring program (64 percent). Additional detail about these payoff expectations is included in Figure 3.

Key Informant Interviews

In several areas, questions asked in the key informant interviews provided additional information to supplement survey results. Four main topics of discussion are highlighted here: (1) rationale for program development, (2) use of coaches, (3) program evaluation, and (4) program value.

Rationale for Program Development

Interviewees were asked to describe their health system's rationale for initiating the leadership development program. In contrast to the survey question, key informants were asked to describe this rationale without being constrained by a list of possible factors. Across interviews, three main categories of answers were classified as subthemes regarding the rationale for program development: (a) focus on employee development and workforce improvement, (b) become/remain the employer of choice, and (c) emphasize education and learning. These three subthemes and supporting quotations are presented in Table 2.

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FIGURE 3
Payoff Worth the Investment (n = 48)
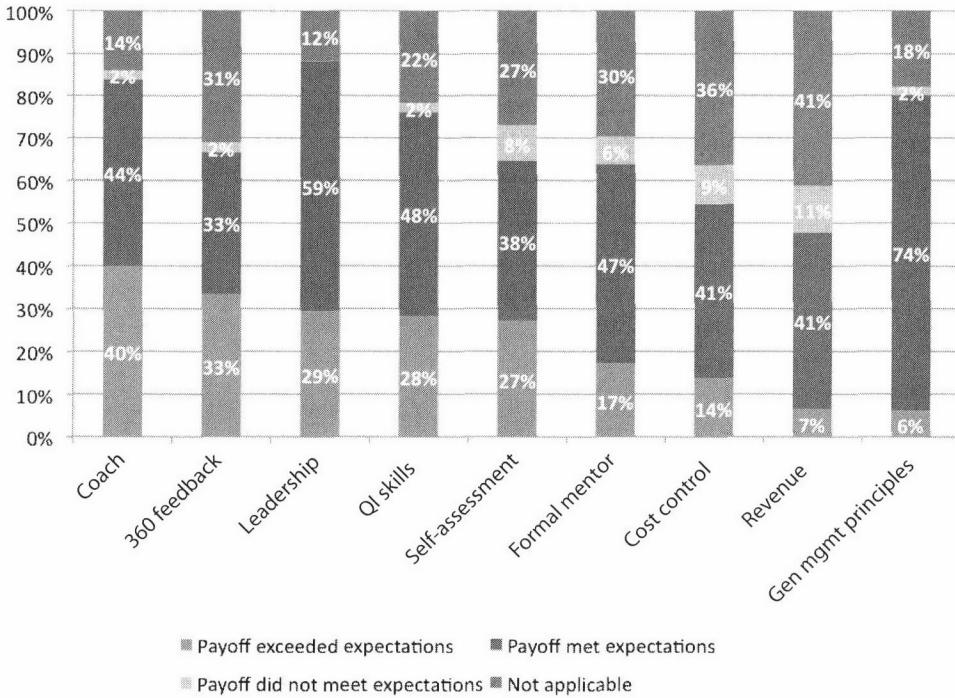
Note: QI = quality improvement.

Use of Coaching

The use of executive coaches in ELD programs also emerged as an important factor in the survey. This use of coaches was widespread (only 14 percent of systems did not use coaches), increasing (multiple mentions were made of coaching in planned future program developments), and reportedly exceeded or met expectations for nearly all health systems that used coaches. Key informant interviews provided additional insight about the use of coaches, particularly about the selection of external over internal coaches for ELD activities. Specifically, interviewees emphasized the importance of external consultant coaches for very senior executives. As one explained, "Our executive level goes to consultants. We don't want to coach executives. We don't think it's appropriate. So we partner with the consultants."

Program Evaluation

The difficulty of ELD program evaluation, both of the program itself and of participants, was highlighted by survey responses showing substantial variability in how programs were evaluated and by limited information about overall program evaluation. Key informants repeatedly emphasized the difficulty

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TABLE 2
Rationale for Leadership Development Program

Focus on Employee Development and Workforce Improvement	"One of the things that we identified when I first came here was that we needed to build more bench strengths in our leadership overall. We tended to go outside to hire managers. We were doing a lot of promotion from within, but we were also doing a lot of promotion from without. A lot of roles were changing and responsibilities were changing, and as you know in healthcare people tend to have to take on more responsibilities, and one of the things that the executives have identified is they felt that we needed to have some people in the bullpen, being able to step up to the plate."
	"Because we determined that we are not putting enough money, time, and resources into the succession planning and development of our management and clinical leaders."
	"If you expect a lot of people, from people, then you should be willing to give them as much as you can. And in giving I'm not talking about money, I'm talking about giving them opportunities, giving them development. I think if you expect a lot then you should give a lot. And we do expect a lot."
Become/Remain Employer of Choice	"Because we really recognized that to provide care in the long run we have to attract the best people and we have to give them the skills to do that. And just going to nursing school or just getting your MBA is not going to give you the skills. Flopping you down in a job is not going to give you the skills to continuously improve. Improve as a manager, improve as a leader, improve the care in the product that you're producing. So by taking time for education and development, you're creating a better employee and the best employees are seeing you as the employer of choice. And fundamentally whether it's patient safety, financial performance, market share growth, provider of choice, if you weren't the employer of choice you wouldn't be able to do any of those."
	"Ensuring that we remain the employer of choice."
	"You don't make or create an environment where employees want to work when their immediate supervisor is somebody that nobody wants to work with."
Emphasize Education and Learning	"I just think you will never be able to sustain your position as a leader in the community or just a leader in terms of being a great employer if you're not a learning organization."
	"There's a belief that as an academic medical center–driven system that we have to do this."
	"I think as healthcare becomes more transparent and we have more knowledgeable consumers that education is going to become more and more critical, and it will be something that we will be, we will actually be advertising to patients that we have well-educated and well-trained employees, and this is how we know that."

of program evaluation and, in particular, the need to move beyond tracking program participation to tracking learning. This difficulty was again reflected in comments about perceived program value, as explained next.

Value of ELD Program

When asked about the value of the leadership development program to the organization, interviewees noted several areas of perceived value. These were categorized into three main themes: (1) focus on employee growth and development, (2) improved support of organization's strategic priorities, and (3) improve employee retention. Representative quotations associated with each theme are presented in Table 3.

Notably, key informants were eager to discuss notions of program value, with the topic discussed in the context of program rationale and value of the program to the health system. Key informants were not asked to assess relative value of individual program components, as listed in the survey, but the components listed in the survey (i.e., training in personal leadership skills, general management principles, quality improvement skills, coaching, and mentoring) were all specifically mentioned when informants described program value.

DISCUSSION

Across U.S. health systems surveyed, half reported having an ELD program and another 12 percent reported having a program under development. Further, among those with existing programs, the vast majority (88 percent) reportedly tied their ELD programs to strategic goals for the health system. This evidence of the prevalence of ELD programs and the strategic focus of most suggests the recognized importance of leadership development at the executive levels of health systems and the potential opportunity to direct programs toward areas where they will be most strategically advantageous. Findings from this study are largely consistent with findings from other studies reporting the value—both perceived and actual—of executive leadership development and training in general business settings (Baird et al. 1994; Humphreys 2005; Zenger, Ulrich, and Smallwood 2000; Vloeberghs 1998) and in healthcare organizations in particular (e.g., McAlearney 2006; Leatt and Porter 2003).

Yet these results extend beyond prior research by providing a snapshot of ELD programs in U.S. health systems. Among existing programs, nearly two-thirds were reportedly customizable to the needs of participating executives, perhaps reflecting the need to tailor development opportunities to the highly constrained schedules and targeted educational needs of senior-level executives, consistent with the constraints that exist in other industries. In addition, new findings about the prevalence of executive coaching as part of current ELD programs appear to contradict existing literature, which reports coaching in healthcare as "underutilized" (e.g., Henochowicz and Hetherington 2006) despite its apparent potential to help in the ELD process (Kombarakaran et al. 2008; Jones, Rafferty, and Griffin 2006).

ELD programs were reportedly difficult to evaluate, with much current work

TABLE 3
Value of Leadership Development Program to the Health System

Focus on Employee Growth and Development	"Growth and development of employees, and really so that each employee can reach their own personal potential whatever that might be."
	"It provides people the opportunity to really develop their leadership skills. The ability to provide all managers with tools to continuously improve their work."
	"And the value of it is that you have better employees who are better prepared to do their jobs."
	"Leadership is what drives results, and we have multiple opportunities for leadership development."
Improve Support of Organization's Strategic Priorities	"A very effective way to ensure strategic initiatives are understood and are being executed."
	"In order to meet our strategies you have to invest in them and make it easier for them to learn. Create offerings for people to learn and develop."
	"If you have good leadership at the top, and that continues to trickle down, which is what we are working at....That's how you affect organizational performance."
Improve Employee Retention	"We think the ROI is based on retention of employees and managers."
	"I think the business case is if you want to be a player in this market then you need to understand the benefit of providing education."
	"We said at the end of five years we would look at our retention rates to see if we have made a difference....[The leadership development program] is seen as the most outstanding systemwide service that we have available."

reported as ongoing in this area. Three-quarters of programs or more reported that promotion rates, employee satisfaction, and quality improvement as measures of leadership development program effectiveness were either in use or being developed. Nonetheless, broader organizational measures were less frequently used, including market share, cost savings, and patient satisfaction, and only five programs reported using ROI as an evaluation metric. The lack of evaluation standards and general difficulty reported around program evaluation highlight the opportunity for health systems' ELD programs to focus on developing consistent evaluation metrics and attempting to explicitly tie program results to organizational performance.

Findings from key informant interviews generally supported and elucidated survey results. The slight exception occurred when interviewees responded to questions about the rationale for initiating the ELD program.

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Interviewees consistently first described issues such as dissatisfaction with executives' preparation, and later in the interview they mentioned those areas with stronger support in the survey—the needs for succession planning and advancing the system's strategic goals. Thus, while interviewees might agree with the list of factors rated important by survey respondents, the emphasis appeared different in the interviews when informants were allowed to discuss the reasons for program development unconstrained by a predetermined list of factors. The three main categories of reasons for ELD program development that emerged from the interviews were to (1) focus on employee development and workforce improvement, (2) become or remain the employer of choice, and (3) emphasize education and learning throughout the organization. Interestingly, these categories of espoused reasons are largely consistent with the literature that highlights development and training programs as a top factor supporting employee retention (Shah et al. 2001).

Practical Implications

U.S. health systems interested in developing strong executive leaders and furthering their strategic goals in the face of increasing fiscal uncertainty are advised to consider the findings presented in this research that emphasize the value of ELD programs. When two-thirds of health systems currently have programs in existence or under development, it is conceivable that developing ELD programs could soon become a strategic necessity for those without programs or plans.

Given that nearly nine out of ten programs reported a link between ELD programs and health system strategic goals, the opportunity to leverage such programs to emphasize strategy and strategic focus is clear. Further, a majority of respondents noted that a "wish to further advance the system's strategic goals" was a factor contributing to ELD program initiation, providing additional support for the notion that ELD is strategically important for these health systems. In addition, given the considerable challenges facing health systems, such as the need to plan for executive succession and the desire to provide local development opportunities, ELD programs can reportedly help these organizations achieve their objectives.

Finally, the results specifically highlight the fact that the opportunities provided by and perceived impacts of ELD programs in U.S. health systems are valued by these systems' chief executives. When measured against executives' expectations, a majority of program components were evaluated as providing a payoff that either met or exceeded systems' expectations. These findings, along with general support for the value of ELD to health systems, suggest that ELD programs are indeed important initiatives that U.S. health systems should not ignore.

Limitations of the Study

For the quantitative portion of this research, this study has limitations consistent with all survey research. First, perceptual biases and recall issues create concern for this type of survey. For instance, respondents' recall of the factors contributing to the initiation of

an ELD program may be affected by the length of time that has passed since the program began. Second, while the survey was directed to health system CEOs and the majority of respondents (88 percent) were indeed CEOs, the remaining respondents were other executives; this raises some questions about the consistency of information provided across different types of respondents. Third, although the response rate was reasonable and comparable to other studies of CEOs, a higher response rate would have been preferred. Fourth, the relatively small numbers of some categories of health system respondents limited the ability to make subgroup comparisons. Additional research may be required to determine whether, for instance, for-profit health systems differ as a group from the aggregate group of health systems in this study.

For the qualitative portion of the study, despite the rich and detailed insights gained using qualitative methods, the capacity to generalize from a qualitative study is another predictable limitation of this research. Participants were selected from a broad range of health systems and multiple key informants within each system were interviewed to enhance the transferability of these findings and minimize this limitation. Finally, while it would have been informative to link qualitative responses to the survey findings, this was not possible due to the study design and the need to protect respondents' confidentiality.

Suggestions for Future Studies
Future quantitative research studies may want to consider expanding the project scope to consider the ELD activities of those healthcare organizations that are not part of health systems. In addition, new research designed to link ELD programs to specific organizational performance metrics would help to inform our understanding of the impact of these programs. Further, moving beyond the executive level to quantitatively study the leadership development process for non-executive leaders (e.g., middle managers, frontline supervisors) and make comparisons to ELD would be invaluable. Opportunities also exist to learn directly and concurrently from other industries outside healthcare, whether through qualitative or quantitative methods. Finally, a major opportunity exists to use a longitudinal design to study the experiences of individuals as they participate in an ELD program (using both qualitative and quantitative methods) to better understand the focus, experiences, and perceived impacts of such programs.

CONCLUSION
This study found that the use of ELD programs by healthcare systems is fairly common and expanding, with programs being especially prevalent among smaller systems. While multiple strategies exist by which education and development can be provided within healthcare organizations, the option of providing programs focused on executive-level leaders is apparently valued by health system representatives, as reflected by reported perceptions of program payoffs and sustained budgetary commitment. ELD programs thus provide important opportunities to further healthcare systems' strategic

goals, initiate succession planning, and provide local development opportunities, with the majority of program elements reportedly worth the investment in improving executives' leadership capabilities.

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REFERENCES

Allen, M. 2002. *The Corporate University Handbook*. Chicago: American Management Association.

Baird, L., J. Briscoe, L. Tuden, and L. Rosansky. 1994. "World Class Executive Development." *Human Resource Planning* 17 (1): 1–10.

Bass, B. 1982. *Stodgill's Handbook of Leadership: A Survey of Theory and Research*. New York: Macmillan.

Burke, C., and C. Scalzi. 1988. "Role Stress in Hospital Executives and Nursing Executives." *Healthcare Management Review* 13 (3): 67–72.

Casebow, P. 2006. "Learning: How to Get the Right Blend." *Training & Management Development Methods* 20 (5): 107–13.

Collins, D., and E. Holton. 2004. "The Effectiveness of Managerial Leadership Development Programs: A Meta-analysis of Studies from 1982–2001." *Human Resources Development Quarterly* 15 (2): 217–48.

Conger, J., and K. Xin. 2000. "Executive Education in the 21st Century." *Journal of Management Education* 24 (1): 73–101.

Constas, M. 1992. "Qualitative Analysis as a Public Event: The Documentation of Category Development Procedures." *American Education Research Journal* 29: 253–66.

Corporate University Xchange. 2005a. "Getting Past Go: How to Jumpstart the Process of Creating a Corporate University." [Online article; retrieved 4/23/06.] www.corpu.com/newsletter/go.asp.

Corporate University Xchange. 2005b. "Learning and Development in Health Care: The Challenges of a Corporate University in a Hospital Setting." [Online article; retrieved 4/23/06.] www.corpu.com/newsletter/ld.asp.

Day, D. V. 2000. "Leadership Development: A Review in Context." *Leadership Quarterly* 11 (4): 581–613.

Day, D. V., S. J. Zaccaro, and S. M. Halpin, eds. 2004. *Leader Development for Transforming Organizations*. Mahwah, NJ: Erlbaum.

Dillman, D. A. 2000. *Mail and Internet Surveys: The Tailored Design Method*, 2nd ed. New York: John Wiley & Sons.

Dixon, N. M. 1993. "Developing Managers for the Learning Organization." *Human Resource Management Review* 3: 243–54.

Drucker, P. 2002. *Managing the Next Society*. New York: St. Martin's Press.

Glaser, B., and A. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.

Harris, L. S., and K. W. Kuhnert. 2008. "Looking Through the Lens of Leadership: A Constructive Developmental Approach." *Leadership and Organization Development Journal* 29 (1): 47–67.

Hearld, L., J. Alexander, I. Fraser, and J. Jiang. 2007. "How Do Hospital Organizational Structure and Processes Affect Quality of Care? A Critical Review of Research Methods." *Medical Care Research and Review* 65 (3):259–99.

Henochowicz, S., and D. Hetherington. 2006. "Leadership Coaching in Health Care." *Leadership and Organization Development Journal* 27 (3): 183–89.

Hernez-Broome, G., and R. Hughes. 2004. "Leadership Development: Past, Present, and Future." *Human Resource Planning* 27 (1): 24–32.

Humphreys, J. 2005. "Developing the Big Picture." *MIT Sloan Management Review* 47 (1): 96.

Jackson, S., E. Farndale, and A. Kakabadse. 2003. "Executive Development: Meeting the Needs of Top Teams and Boards." *Journal of Management Development* 22 (3): 185–265.

Jones, R. A., A. E. Rafferty, and M. A. Griffin. 2006. "The Executive Coaching Trend: Towards More Flexible Executives." *Leadership and Organization Development Journal* 27 (7): 583–96.

Kirkpatrick, J. 2005. "Transferring Learning to Behavior." *T+D* 59 (4): 19.

Kombarakaran, F. A., J. A. Yang, M. N. Baker, and P. B. Fernandes. 2008. "Executive Coaching: It Works!" *Coaching Psychology Journal: Practice and Research* 60 (1): 78–90.

Leatt, P., and J. Porter. 2003. "Where Are the Healthcare Leaders? The Need for Investment in Leadership Development." *Healthcare Papers* 4 (1): 14–31.

Leonard, S. H., and M. Goff. 2003. "Leadership Development as an Intervention for Organizational Transformation." *Consulting Psychology Journal: Practice and Research* 55 (1): 58–67.

Lippert, R. 2001. "Whither Executive Education?" *Business & Economic Review* 47 (3): 3–9.

Maxwell, J. A. 1996. *Qualitative Research Design: An Interactive Approach.* Thousand Oaks, CA: Sage.

McAlearney, A. S. 2008. "Using Leadership Programs to Improve Quality and Efficiency in Healthcare." *Journal of Healthcare Management* 53 (5): 319–31.

———. 2006. "Leadership Development in Health Care Organizations: A Qualitative Analysis." *Journal of Organizational Behavior* 27 (7): 967–82.

McCall, M. W. 1998. *High Flyers: Developing the Next Generation of Leaders.* Boston: Harvard Business School Press.

Miles, M. B., and A. M. Huberman. 1994. *Qualitative Data Analysis.* Thousand Oaks, CA: Sage.

Morin, L. 2004. "Participation in Corporate University Training: Its Effect on Individual Job Performance." *Canadian Journal of Administrative Sciences* 21 (4): 295.

Novicevic, M. M., J. T. Heames, J. G. P. Paolillo, and M. R. Buckley. 2009. "Executive Development: History Lessons Learned from Barnard." *The Leadership Quarterly* 20: 155–61.

Scientific Software Development. 1998. Atlas. ti, 4.2 ed. Berlin: Scientific Software Development.

Shah, A., C. Sterrett, J. Chesser, and J. Wilmore. 2001. "Meeting the Need for Employee Development in the 21st Century." *SAM Advanced Management Journal* 66 (2): 22–28.

Smith, J., K. Carson, and R. Alexander. 1984. "Leadership: It Can Make a Difference." *Academy of Management Journal* 27: 765–76.

Spradley, J. P. 1979. *The Ethnographic Interview.* Fort Worth, TX: Harcourt.

Storey, J. 2005. "What Next for Strategic-Level Leadership Research?" *Leadership* 1 (1): 89–104.

Strauss, A., and J. Corbin. 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* Thousand Oaks, CA: Sage.

Vicere, A. A., and R. M. Fulmer. 1998. *Leadership by Design.* Boston: Harvard Business School Press.

Vloeberghs, D. 1998. "Management Development in a Context of Drastic Changes." *Journal of Management Development* 17 (9): 644–61.

Zaccaro, S., and Z. Horn. 2003. "Leadership Theory and Practice: Fostering an Effective Symbiosis." *Leadership Quarterly* 14: 769–806.

Zenger, J., D. Ulrich, and N. Smallwood. 2000. "The New Leadership Development." *Training & Development* 54 (3): 22–27.

PRACTITIONER APPLICATION

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As the United States makes significant investments in systems and technologies designed to transform the healthcare industry, the capabilities to assimilate these massive changes must also be built. *Fortune* 500 businesses have long understood that these large investments have a much better chance of realizing their expected return if the companies attend to the human side of the equation, that is, ensure that the skills, rewards, talent management processes, and organizational culture are aligned with the intended changes. This alignment is achieved when leadership best practices are adopted, cultivating the necessary competencies to inspire and manage in a challenging and changing environment. However, this type of leadership is often lacking in the midst of radical change. In fact, more than half of large scale changes have historically failed to deliver on their promised return on investment (Kotter 1995). Unless healthcare leaders are adequately and pervasively prepared to guide their organizations through this change, many potentially transformational elements of healthcare reform will most decidedly fail.

Ann McAlearney's study of the establishment, organization, content, process, evaluation, and evolution of executive leadership development (ELD) programs in U.S. healthcare systems provides a timely and informative overview. The widespread adoption of ELD programs since 2003 and the general perception of their value certainly seem to be promising signs that healthcare executive leadership is moving toward adopting best practices. The study offers sound rationale with respect to establishing an ELD program, including the importance of aligning such programs with the mission and strategic goals of the organization, their contribution to effective succession planning, and the importance of systems that evaluate the impact of ELD programs on leadership behavior and overall organizational performance (i.e., employee and patient satisfaction, employee retention, quality improvement, and cost reduction). The widespread use of executive coaches reported in the study is also promising; this strategy is consistent with best practices used in other industries and represents an effective means of promoting individualized development. The only caveat is that coaching needs to be based on defined behavioral competencies that drive exceptional performance.

Some of the study findings, however, seem less promising. For example, when asked about their approach to creating ELD program content, the most common responses were to "ask participants for their ideas" and "poll their executives." While these techniques can help align learning with organizational priorities, they fail to take into account the leadership competencies required to deliver exceptional performance at different levels of management across the professions and that serve as the foundation for competency based learning and assessment (Calhoun et al. 2008, 2009).

Findings from the National Leadership Survey (coproduced by the National Center for Healthcare Leadership and National Research Corporation) uncovered wide disparities in the quality and comprehensiveness of leadership development systems across administration, nursing, and medicine. The survey showed that 17 percent of administrative leaders received "a great deal" of talent management, compared with just 6 percent of medical leaders and 9 percent of nursing leaders (McGill and Yessis 2008).These disparities need to be addressed if health systems are to function with effective teams. Not only will health systems benefit greatly when all members of management receive leadership development but also the teams themselves will benefit from the opportunity to work and grow together with programs that emphasize team-based action learning.

McAlearney points out that ELD can be a unique competitive advantage for health systems. I agree and, most importantly, emphasize that a well-designed ELD that is competency based, addresses health professions' leadership needs equitably at different levels of management, and provides opportunities for team-based action learning is essential to meeting healthcare's obligations to the public for consistently safe, high-quality, cost-effective care.

REFERENCES

Calhoun, J. G., L. Dollet, M. E. Sinioris, J. A. Wainio, P. W. Butler, J. R. Griffith, and G. L. Warden. 2008. "Development of an Interprofessional Competency Model for Healthcare Leadership." *Journal of Healthcare Management* 53 (6): 375–89.

Calhoun, J. G., J. A. Wainio, M. E. Sinioris, M. Decker, L. R. Hearld, and L. E. Brandsen. 2009. "Outcomes-Based Health Management and Policy Education: Baseline Findings from a National Curriculum Development Demonstration Project." *Journal of Health Administration Education* 26 (3): 171–91.

Kotter, J. P. 1995. "Leading Change: Why Transformation Efforts Fail." *Harvard Business Review* (March/April): 59–67.

McGill, A. R., and J. Yessis. 2008. "Leadership Development Highly Valued to Drive Organizational Excellence, But Not Common Practice." *NRC Picker Patient-Centered Care Institute Newsletter*, June.