EXECUTIVE SUMMARY
For close to ten years, the non-profit National Center for Healthcare Leadership has pursued a program of national surveys on leadership development practices in health systems, with the goal of informing the field about the role and importance of leadership and its development for improving health outcomes. In recent years, a more robust science of leadership development and talent management has begun to emerge, one that can more directly inform strategic choices about organizational leadership investments. Development work itself has also begun shifting away from a focus on the individual leader, and toward the capabilities of leadership teams within these health systems. In concert with these important trends, NCHL has substantially revised its National Health Leadership Survey, as well as its approach to recognizing excellence in leadership development.

BACKGROUND
The unprecedented pace of change in healthcare organizations today is calling not only for new thinking, but also for new leadership competencies. Taking leadership development seriously as a strategic organizational activity requires a focus beyond the development needs of individual leaders, and toward the leadership needs of the entire organization. It also means developing a discipline around leadership practices, which requires a tempered enthusiasm about ideas that are “new and flashy” to focus on maximizing proven returns on time and resources expended.

Understanding the importance of leadership development is one matter; plotting an efficient path to developing a high-performance leadership development system is quite another. Fortunately, considerable research has been completed over the past 10 years that can point interested senior leaders in the right direction. In this paper we summarize how this research has informed the redesign of the NCHL National Health Leadership Survey, and how NCHL will use this work to inform the field - both to recognize outstanding leadership development work and to help organizations take advantage of the emerging knowledge base about what works best.

DEVELOPMENT OF THE 2013 NCHL NATIONAL HEALTH LEADERSHIP SURVEY
In 2007 and 2010, the National Center for Healthcare Leadership conducted a national survey of leadership practices in the U.S. health sector. Data collected from this survey was used to further develop the evidence around leadership development practices in healthcare, and also provide helpful comparative benchmarking for survey participants. In 2013, the National Health Leadership Survey was updated in response to recent findings from the fields of adult learning, leadership, talent management, and high-performance work systems.

It also was designed to help NCHL identify ‘best practice’ organizations that should be recognized as positive role models for the field, as well as excellent places for aspiring future leaders to work. The 2013 survey was developed with the assistance of two design teams: a panel of academic researchers representing the evolving science and evidence base related to leadership development and talent management and a panel of four senior learning executives from health systems with particularly strong reputations for their leadership development systems, their quality of care, or both. (Table 1)
First, the academic team met to synthesize their separate streams of research work, cross-walking their findings against each other, including previous versions of the National Health Leadership Survey, as well as other published work to identify the most promising practices. The resulting draft survey was reviewed by the practitioner team, who responded to each of the components of the survey in terms of clarity and objectivity. This phase included substantial discussion of the sources of evidence informing the survey. Results of these discussions were then incorporated into a revised survey, which was re-circulated to both teams for final feedback. Additional revisions and reviews led to the final version of the survey.

**Survey Distribution**
A convenience sample of chief operating officers (COOs) and chief human resource officers (CHROs) was identified via e-mail lists leased from a third-party provider. The list screened eligible participants as health systems, solo hospitals, children’s hospitals, critical access hospitals, long term acute care hospitals, mental health hospitals, rehabilitation hospitals, university/teaching hospitals, and Veteran’s Administration hospitals. Hospitals with fewer than 100 staffed beds were excluded from the sample, unless they were designated as a critical access facility. Organizations and contact information was then reviewed against other sources to ensure appropriateness. The finalized list contained approximately 1,800 hospitals and health systems with a valid contact for either the CHRO, COO, or both.

Prospective participants were emailed a description of the goals of the survey (i.e., to identify case examples of high-performing organizations in leadership development and to further build the evidence base supporting leadership development practices). Survey length was described as 10-22 minutes, depending on the extensiveness of the data their organizations collected about their development efforts. Respondents were offered a copy of their survey results in exchange for their participation.

**Analysis**
Survey items were mapped to 11 dimensions (Figure 1), each representing interdependent components of a complete leadership development system. To create comparability across dimensions, the theoretical maximum score in each dimension was standardized at 100. Weightings were then created to account for differences in overall impact of some dimensions over others. Additional detail about the dimensions and weightings are provided later in this whitepaper.

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### Table 1. Advisory Team

<table>
<thead>
<tr>
<th>Scientific Council</th>
<th>Practitioner Advisory Panel</th>
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</thead>
<tbody>
<tr>
<td>Matthew M. Anderson, Rush University</td>
<td>Yvonne Gardner, Sutter Health</td>
</tr>
<tr>
<td>Andrew N. Garman, Rush University</td>
<td>Grace Gorringe, Mayo Clinic</td>
</tr>
<tr>
<td>Kevin S. Groves, Pepperdine University</td>
<td>Amy Schoeny, Advocate Health Care</td>
</tr>
<tr>
<td>Ann Scheck McAlearney, The Ohio State University</td>
<td>Dave Woolwine, Sentara Healthcare</td>
</tr>
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<td>Linh Lawler, NorthShore University HealthSystem</td>
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</tbody>
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Results
A total of 103 hospitals and health systems responded to the survey. Of these respondents, 7 percent represented a for-profit organization, 65 percent a not-for-profit organization, and 26 percent a public institution. A total of 57 percent represented hospitals, while 40% responded on behalf of health systems.

Formulas were used to create a benchmarking scorecard (Figure 2). The NCHL National Leadership Development Scorecard uses a template modeled after UHC’s highly regarded Quality and Accountability Performance Scorecard. The scorecard was then reviewed with NCHL organizational members using data from their own organizations. This step confirmed that results from the scorecard were ‘face valid’ – i.e., participants agreed they were stronger in the areas they tended to score higher in and had more room for development in areas where they tended to score lower.
The highest score possible for the survey was 100. As shown in Figure 3, while the top score of a health system in the database was 64.6, the median score was 23.1, indicating broad variability across health systems in the extent to which they were pursuing leadership development.
As mentioned earlier, the survey included 11 dimensions of a complete leadership development system. Each of these dimensions is described below.

**Dimension 1. Strategically Aligning Leadership Development**

For a leadership development system to fully accomplish what it can for a health system, it needs to be aligned with the strategic goals of the organization. Many health systems have attempted to implement leadership development “from the middle,” delegating full responsibility to the human resource or employee and organizational development department or, worse, to external providers of general leadership training.

Fully aligned leadership development means, at a minimum, senior leadership has ownership of the process, even if implementation is a department-specific responsibility. Ideally, however, the ongoing agenda for leadership development should flow forward from the organization’s strategic planning process. Too often, strategic planning overemphasizes the “what” and the “how,” and underemphasizes the “who” of future plans.

Additionally, leadership development should be something in which senior leadership actively participates, not just as agenda setters, but also as mentors and learning facilitators. A study by the Economist Intelligence Unit (2006) found that senior executives at organizations that have a stellar reputation for developing their staff devote as much as 20 percent of their time on development activities. This same study suggests that at least several hours per week of a senior manager’s time should be invested in developing staff.

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**DIMENSIONS OF A LEADERSHIP DEVELOPMENT SYSTEM**

**Figure 3: Distribution of Leadership Index Total Scores by Organizational Ranking**

![Graph showing distribution of leadership index total scores by organizational ranking.](image-url)
One of the ways in which health systems can align leadership development programs with the overall mission and goals of the organization is to ensure that its leadership development activities are centralized. By centrally coordinating the activities of all of its component parts, the organization can more easily ensure vertical alignment with high-level strategic objectives.

According to the 2013 National Leadership Survey, the most centralized leadership development activity within health systems was the high-potential leadership development program, followed by leadership succession planning and physician leadership development programs. Nursing leadership development programs and performance coaching were the least centralized activities.

Another important way to create a strategically aligned leadership development program is to have significant involvement of senior leaders within the organization. The vast majority (62.5 percent) of respondents indicated that senior leaders spend between 6 and 15 percent of their time in mentoring and developing other leaders in the organization, not including administrative fellows. Only 6.3 percent of respondents indicated that senior leaders spent more than 20 percent of their time in this capacity. For those organizations with structured leadership development programs, more than half report that the CEO and CNO teach or facilitate in the program 3 or more times per year. Organizations report lower rates of participation by the COO, CFO, and CMO.

Dimension 2: Attracting and Selecting Leaders

Leadership potential is the critical raw material for successful leadership development systems. As such, organizational attention to positioning the organization as an attractive place for high-potential leaders to work is very important. The strongest leadership development systems tend to be associated with organizations that invest in developing a communicable concept of how the organization approaches leadership, sometimes referred to as a leadership “brand” (Ulrich & Smallwood, 2007). In the present study, most frequently cited recognition used for attracting new leaders was hospital reputation rankings, such as U.S. News and World Report (47 institutions), followed by magnet status (45 institutions), along with regional quality awards (39 institutions). In addition to developing this brand, investing the effort to communicate this brand through channels such as conference presentations, and the offering of internships and administrative residencies or fellowships can also expand the reach of the organization to high-potential applicants.

Beyond strengthening the applicant pool, health systems need to develop a rigorous discipline around selecting the best candidates for leadership roles. Although hiring managers often prefer autonomy and discretion in their selection decisions, a substantial body of research has consistently shown that using more systematic approaches leads to much better hires (Schmidt & Hunter, 1998). As a general rule-of-thumb, the best predictor of future performance is past performance under similar circumstances; as such, methods that uncover work performance or allow work to be sampled (e.g., experience-based interviews, simulations) tend to provide the greatest accuracy.
Survey respondents reported that the most utilized evidence-based technique for selecting leaders was multiple interviewers (used more than 80 percent of the time). Behaviorally-based interviews were the second most prevalent technique. In contrast, cognitive ability assessments and assessment centers are rarely used in healthcare organizations. The frequency of each selection and onboarding tool are displayed in Figure 4.

**Figure 4. Techniques Used for Selecting and Onboarding Leaders**

![Bar chart showing the frequency of different selection techniques.](image)

**Dimension 3: Preparing New Leaders for Success**

The approaches organizations take to onboard new leaders differ widely. Those that provide a more thoughtful and systematic approach tend to find greater success rates with their newly hired leaders, both in terms of job performance as well as retention (Bauer, 2010). Practices that support effective onboarding include scheduled check-ins at 30, 60, and 90 days; planned approaches to organizational socialization, and provision of coaching.

Of respondents to the 2013 survey, 41 percent indicated they consistently (more than 80 percent of the time) utilize formal onboarding for externally hired leaders, and 43 percent of organizations reported utilizing formal onboarding for internally promoted leaders.

**Dimension 4: Identifying and Developing High-potentials**

Adequately preparing for leadership roles takes time and senior leadership roles can take many years to prepare for successfully. A strategically aligned approach to leadership development allows a health system to identify emerging leadership needs and to prepare future leaders in advance of their needing to take these positions. An important part of this preparation process
involves the proactive identification of “high potentials”, or individuals with the aptitude and interest in preparing for progressively more responsible leadership roles. High potentials can be developed through a combination of cohort learning programs (or “leadership academies”) as well as the provision of other types of developmental experiences.

As noted previously with relation to selection, a more structured approach to this process will outperform one that is driven by individual agendas; adding a structured assessment component can help ensure investments in development are getting maximized. Assessment data is also highly useful for tailoring leadership development to specific individuals’ needs.

Over 71 percent of respondents indicated that they have a process of identifying high-potential individuals likely to be promotable in the near future. Of those organizations that identify high-potential individuals, 30 percent indicated that those individuals participate in the organization’s leadership academy.

Most (53 percent) organizations that identify high-potential employees believe the organizational culture supports the development of these individuals by encouraging managers to ‘release’ high-potential employees for developmental assignments either ‘always’ or ‘sometimes’. Overcoming status associated with a high-potential designation appears more difficult, as only 40% of organizations identifying high-potential employees determined the respective culture always or sometimes de-emphasizes that status. However, while most respondents (53 percent) thought their managers viewed the process as usually or always fair and equitable, only 30 percent indicated that employees felt that way. Although the process of identifying high-potential employees can create tension between the high-potential employees and others, organizations must find a way to strike the delicate balance between developing future leaders and maintaining the engagement and satisfaction of all other employees as well.

**Dimension 5: Providing Developmental Experiences**

Although leadership academies and other formal learning programs can provide essential foundations for higher levels of performance, most leadership learning takes place through experience. More comprehensive approaches to leadership development incorporate this reality as part of the planning process by identifying good experience-based learning opportunities and assigning them strategically. Such assignments could include leadership of cross-departmental or system-wide performance improvement initiatives, participation in special projects such as building projects, enterprise-wide IT implementation, or fundraising campaigns, or even full-time rotation into other positions to provide exposure to different parts of the organization and/or system.

Only 9 percent of hospitals and health systems reported providing formal job rotations. Action learning programs, on the other hand, were much more prevalent. 53 percent of the respondents indicated that they offer programs in which teams learn new skills and values by addressing important, real, organizational problems and reflecting on their experiences in a facilitated session.
Dimension 6: Providing Performance Feedback
Performance feedback is another area where the research is relatively clear: leaders who receive higher-quality feedback on an ongoing basis develop faster than those who do not. Research is also clear that more feedback is not necessarily better feedback, and poor-quality feedback will do more harm than good (Kluger & DeNisi, 1996). Ensuring performance data of other kinds are regularly available and discussed is one important approach. Additionally, the use of a well-designed multisource, or 360-degree feedback, program is another approach that has been shown to enhance performance over time (Day, Fleenor, Atwater, Sturm, & McKee, 2014).

According to the 2013 National Leadership Survey, 18 percent of healthcare organizations utilize appraisal-based 360-degree feedback regularly (>75% of the time) for senior executives, 17 percent for non-executive managers, and 10 percent for high-potential employees. For clinical leaders, 9 percent of organizations regularly utilize appraisal-based 360-degree feedback for physician leaders, and 17 percent for nursing leaders.

360-degree feedback is sometimes used for developmental purposes, where the results do not become incorporated into the employee’s formal performance review. The utilization of development-based feedback via the 360-degree feedback tool appears to be lower than appraisal-based usage. Overall, 12 percent of organizations reported regularly utilizing 360-degree feedback for senior executives, 7 percent for non-executive managers, and 8 percent for high-potential employees. For clinical leaders, use was much lower, with only 2 percent of organizations regularly conducting developmental 360 feedback for physician leaders, and 9 percent for nursing leaders.

Dimension 7: Pro-actively Planning for Continuity & Future Needs
A high-performance approach to leadership development includes ongoing attention to the need for future leaders, as well as the need to replace current leaders who may retire or move on. The broader approach to proactively planning for future needs is referred to as talent management, while the narrower activity of planning for specific roles is referred to as succession planning. Having leaders who are prepared to step in as needed to positions of greater responsibility is critically important for ensuring smooth transitions and maintaining forward organizational momentum (Garman & Glawe, 2004). However, preparing for senior-level roles, in particular, can require years of development (Garman & Tyler, 2006).

Overall, 49 percent of responding organizations reported that the senior leadership team “usually” or “always” supports the integration of talent management practices into the operations of the organization. Only 36 percent of organizations reported that senior leaders always or usually communicate a sense of urgency for investing in talent management practices, while 40 percent of organizations indicated that senior management usually or always actively participates in the talent management process. Lastly, only 43 percent of respondents indicated that senior leaders usually or always describe talent management as a strategic priority.
Only 38 percent of hospitals and health systems reported that they conduct talent reviews, where senior leaders share and discuss talent information for development and succession planning purposes. These talent reviews are conducted for individuals at varying levels, according to Table 2.

**Table 2. Percentage of Organizations Conducting Talent Reviews for Various Groups**

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Senior Executives</td>
<td>33%</td>
</tr>
<tr>
<td>Non-executive managers</td>
<td>29%</td>
</tr>
<tr>
<td>Nurse leaders</td>
<td>29%</td>
</tr>
<tr>
<td>High-potential pool</td>
<td>24%</td>
</tr>
<tr>
<td>Physician leaders</td>
<td>14%</td>
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</tbody>
</table>

Succession planning appears to be a less prevalent practice in healthcare, as only 25 percent of organizations reporting succession planning efforts for any level of leadership.

**Dimension 8: Developing Clinical Leadership Strength**

Evidence of the critical importance of clinician participation in executive leadership teams has been growing (Health Research & Educational Trust, 2014). As clinicians are increasingly asked to lead as well as partner on health system transformation, health systems need to recognize the importance of developing their leadership competencies.

Throughout the NCHL Leadership Survey were questions about the extent to which leadership development practices included clinicians. Most hospitals and health systems (82 percent) indicated that they use at least one evidence-based technique to recruit or onboard either physician or nursing leaders. Specifically related to leadership development, of all organizations offering leadership academies, half include physician participation while 68 percent of those organizations open the participation to nurses. When it comes to performance feedback, clinicians are not often evaluated utilizing the 360-degree feedback tool. Only 21 percent of organizations indicated that they utilize the instrument more than 75 percent of the time for physicians and nurses for either appraisal-based or development-based feedback.

**Dimension 9: Developing for Diversity & Inclusion**

As health systems continue their progression toward community-based care, the need to increase attention on eliminating health and healthcare disparities is growing, as well as recognition of the importance of system leadership representing the populations they serve (Dotson & Nuru-Jeter, 2012). Developing a more diverse leadership workforce requires direct and proactive attention to the diverse individuals who may eventually comprise it, including provision of strong role models as well as visible opportunities for advancement (Hom, Roberson, & Ellis, 2008).

The NCHL survey inquired about whether organizations tracked gender and ethnic composition of leadership as part of their assessment of talent management outcomes. Many organizations
responding to the survey did not provide these statistics; of those that did, respondents indicated that women occupy on average about 42 percent of senior leadership (“C-suite”) positions, while only 7 percent of these positions are held by under-represented minorities. Executive (vice president-level) positions reflect a similar composition, with women holding 42 percent of those jobs and under-represented minorities employed in 7 percent of those positions. Mid-level management appears to be more diverse, with women employed in 66 percent of those positions and under-represented minorities employed in 16 percent of positions.

**Dimension 10: Incorporating Administrative Fellowships**

Administrative fellowships are one or two-year postgraduate positions that are designed to attract and rapidly develop high-potential, early careerists for positions of increasing leadership responsibility. In healthcare, administrative fellowships represent an important and currently underutilized tool for attracting national-caliber, high-potential leaders. For example, a 2014 survey conducted by NCHL of 56 fellowship directors indicated that the average fellowship site received 84 applications for its two open slots. This suggests there are currently far more students interested in pursuing these opportunities than there are organizations hosting them, creating a ‘buyers’ market’ for this valuable talent. The American College of Healthcare Executives provides free resources to organizations interested in creating administrative fellowships, including maintaining a national directory that they make available to interested students and graduate program directors (American College of Healthcare Executives, 2014).

In total, 36 percent of responding hospitals and health systems indicated that they hire administrative fellows from healthcare management or related graduate school programs. Within those fellowships, various development activities are provided, with the most common being formal onboarding and observation and participation in senior leadership meetings (34 organizations). On average, organizations hire 2.2 fellows in a given year, and the average number of fellowships over the past five years was 9.7. On average, 63 percent of the fellows from the most recent five years are still working for their respective organizations.

**Dimension 11: Monitoring & Achieving Results**

Investments in leadership development need to be monitored on an ongoing basis against a specific set of objectives. Ideally this monitoring will involve a manageable set of outcome metrics that are straightforward to explain to senior leadership and other stakeholders. Commonly used metrics include: percent of leadership academy graduates retained by the organization over time, percent promoted to positions of greater responsibility within a specified period of time, and improvements in the leadership competencies of program participants. For organizations using leadership development as part of a diversity and inclusion strategy, additional metrics can include the percent of leaders from under-represented backgrounds at various levels of the organization.

Only 20 percent of survey respondents’ organizations indicated that their organizations track their leadership ‘bench strength,’ which refers to the number of candidates ready to fill
potential position needs. Bench strength is most frequently tracked for top and mid-level leadership positions, with 14 organizations indicating they track bench strength for those roles. Of the organizations tracking candidate source and turnover, 22.8 percent of open executive positions on average were filled by external hires. Annual turnover rates appear highest for nursing leaders, with organizations reporting an average turnover rate of 12.8 percent while the nursing staff average turnover rate is 10.7 percent. Hospitals and health systems reported that executives and senior management personnel have the lowest turnover rates, with 7.4 percent of these positions experiencing annual turnover, on average.

ADDITIONAL FINDINGS
Through the process of compiling the current evidence base into a practitioner survey, we were able to identify numerous new areas of opportunity to improve both the science and practice of healthcare leadership development. Many of the questions raised involved activities numerous practitioners viewed as common knowledge, but which, through dialog, turned out to have significant practice variation driven by differences in beliefs and philosophies about what works best. Our intention is for these compiled questions to become the focus of future research NCHL pursues on behalf of the field and for the insights from this work to inform future revisions of the NCHL survey.

CONCLUSIONS AND NEXT STEPS
In the coming years, as the science of leadership development continues to evolve, so too will the NCHL leadership practices survey. Meantime, in 2014 NCHL will re-open access to the survey to new and returning participants interested in assessing their organizations’ relative strengths and opportunities in developing their leaders. Through this program we hope to support organizations in their efforts to strengthen their leadership development programs and build awareness about the evolving science behind leadership development.

In 2014 we are also creating a formal recognition to congratulate organizations that are going the extra mile in preparing healthcare leaders for the future challenges they will face. Investments in leadership excellence pay dividends to the field far beyond the success of the sponsoring organizations and the patients they care for; they also serve as helpful role models to other health systems about the importance and value of capable, well-prepared healthcare leadership in supporting better health for everyone.
REFERENCES


