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**LEADERSHIP COMPETENCIES FOR EFFECTIVE  
HOSPITAL CHIEF EXECUTIVE OFFICERS AND  
CHIEF MEDICAL OFFICERS IN MEXICO**

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**A Research Project  
Presented to the Faculty of  
The George L. Graziadio  
School of Business and Management  
Pepperdine University**

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**In Partial Fulfillment  
of the Requirements for the Degree  
Master of Science  
in  
Organization Development**

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**by  
Alejandro García Muñoz**

**August 2013**

This research project, completed by

ALEJANDRO GARCÍA MUÑOZ

under the guidance of the Faculty Committee and approved by its members, has been submitted to and accepted by the faculty of The George L. Graziadio School of Business and Management in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE  
IN ORGANIZATION DEVELOPMENT

Date: August 2013

Faculty Committee

Committee Chair, Miriam Y. Lacey, PhD

Committee Member, Kevin Groves, PhD

Linda Livingstone, Ph. D., Dean  
The George L. Graziadio School of Business and  
Management

## **Abstract**

This study identified a leadership competency model for developing healthcare executives in Mexico based on the National Center for Healthcare Leadership (NCHL) Model. Eleven chief executive officers and chief medical officers were interviewed. They considered 86% of the National Center for Healthcare Leadership (NCHL) competencies as very important or vital and perceived a gap in the performance of these competencies. They also identified additional vital competencies beyond the scope of the NCHL's model. Participants also reported that leadership development and succession planning programs were lacking. Recommendations are to design a leadership development program using the NCHL model as a framework and further customizing the approach per the organization's unique mission, vision, strategy, values, and circumstances. The NCHL is offered as a general strategy for leader development that could be useful in the Mexican private healthcare industry, based on some "best practices" in the design and implementation of the leadership programs.

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## **Chapter 1**

### **Introduction**

The role of a top leader is intimately linked to the nature and purpose of his or her organization. If the nature or concept of the organization changes, it is evident that the concept and function of this leader also changes.

[J]ust a few people (nowadays) would doubt that the best place to stay, if one is seriously sick, is a hospital. A hospital is considered the most important institution in healthcare, both for poor or rich. It is often assumed that always was that way. However, until recently most people—particularly if they are sick—would have struggled not to go into a hospital. (Granshaw & Porter, 1989, p. 1)

This position is historically understandable because, according to Mollat (1978), hospitals were first seen as places to house beggars, invalids, and pilgrims and later as institutions to address a specific form of misery and poverty: the disease.

Agrimi and Crisciani (1995) describe the medieval hospitals as places created to fulfill the obligation of charity. Rosen (1985) explained that hospitals in the Middle Ages were instruments of society to alleviate suffering, to reduce poverty, to eradicate begging, and to help maintain public order.

Grmek (1982) distinguishes four meaningful stages in the evolution of the hospitals. The first stage occurred in the Middle Ages, up to 13th century. Monastic medicine inspired by the Order of St. Benedict prevailed. This movement united the religious ideal of hospitality and spirit of charity. Monastic medicine was an important step in the development of medical science for three main reasons. First, the monastic “writing desks” (scriptoria) were important centers dedicated to copy, translate, and transcript important medical-scientific work. Second, it was the beginning of a didactic tradition. Third, its stocked pharmacies were appropriate places to investigate and study the properties of the various ingredients used for drug development. The early monastic

centers were hospitals (*hospitium*, *xenodochium*) for beggars, invalids, travelers, and pilgrims.

The second stage spanned from the beginning of the 12th century to the first quarter of the 14th century. Hospital foundations proliferated, the didactic-monastic monopoly was lost, and there was a progressive secularization of medicine. Health institutions were leaving the hospital medical model of the great abbeys and began to form a new concept or ideology of health. The new institutions, created along these centuries by members of the nobility or private initiatives, whether secular or ecclesiastical, were led by religious orders not strictly monastic. During this period, they began to develop hospital bylaws that regulated the organization and discipline.

The third stage occurred from the second quarter of the 14th century to the mid-15th century and involved the secularization of hospitals and medical professions was consolidated. This represented a decisive step for the evolution and change in thinking about health and poverty.

The fourth stage occurred from the mid-15th century up to the present day. At this stage, there was a real medicalization of hospitals, which began a transition to modernity. This evolution is the result of the progressive awareness of the institutions' secular authorities. Increasingly, small health centers affected by economic difficulties, epidemics, and war would be unable to meet the needs of society. Consequently, general hospitals operating under the financial, administrative, and managerial control by governmental authorities emerged.

Following World War II, the activity of hospital management became more formal and in developed countries the criteria of professional competence started to increase. . . . the concept of specialized human resources for hospital management took place . . . with strict managerial criteria and within the parameters of total quality. (Malagón-Londoño, Galán, & Pontón, 1996, p. 1)

Nowadays, a hospital is conceived as a place where people receive services to recover their health or to reinforce it (Gallent, 1996). It is also a place for teaching—a learning center for future physicians, surgeons, and other professionals. Often, the hospital is also a research center where scientific knowledge of illnesses is broadened. In a sociological sense, the modern hospital is a complex organization with roles, rights, obligations, attitudes, values, and goals of their own.

### **The Hospital as an Enterprise**

As the concept and practices of hospitals have evolved, management models have also changed, from adoption of business management models, which emphasizes in self-reliance, productivity and profitability, up to meeting the needs and expectations of all stakeholders.

According to Malagón-Londoño et al. (1996), modern hospitals are companies in which complex processes of various kinds converge, such as healthcare, hospitality services, scientific research, training and education, drug manufacturing, and the attention to the typical areas of any company: human resources, suppliers, legal issues, and finance. Notably, these tasks only can be done successfully with an efficient management.

Like any typical modern enterprise, the survival and consolidation of a hospital depends on its effectiveness to meet the expectations of its the stakeholders for which it has to drive a complex system composed of elements and processes of various kinds. Hospital stakeholders include clients, patients, employees, investors, suppliers, insurance companies, government agencies, and financial institutions.

Several obstacles face hospitals attempting to manage the institution as an enterprise. The first has been the paradigm shift of hospital from the idea of a charity entity that survives on contributions from generous individuals and institutions to a self-sustaining, productive, and profitable organization.

The second difficulty, as in any enterprise, to achieve the levels of productivity and profitability is the adoption of an appropriate modern business model. The business management models have been evolved quickly, so that the practices and models which were successful in the last third of the last century no longer produce the same results, because the environmental conditions of business have changed dramatically.

According to Aitken and Higgs (2010), the main contextual factors underpinning the increasing pressures on organizations to respond to growing complexity and environmental volatility are: increasing levels of competition, investor and stakeholder demands, globalization, changing nature of the workforce, technology, legal and regulatory changes, and societal changes. Because of these changes in the business environment, a change in the enterprise managing is also required. It is needed a change in the beliefs, values, life perspective and responsibilities and competencies of the leaders and managers.

To be a good manager is no longer sufficient to perform the traditional functions of planning, organizing, directing and controlling. According to Kouzes and Posner (1998), the main functions of a leader should be challenging the process, inspiring shared vision, enabling other to act, modeling the way and, handling the increasing uncertainty and complexity.

## **Purpose of the Project**

This study sought to identify a leadership competency model for developing healthcare executives in Mexico based on the National Center for Healthcare Leadership (NCHL) Model. Three research questions were examined:

1. Is there a leadership competencies model applicable to Mexican private healthcare organizations?
2. How do top leaders in Mexican private healthcare organizations perceive their own performance?
3. What kind of framework would be helpful to develop leadership capability required by top leaders in Mexican private healthcare organizations?

## **Importance and Significance of the Project**

The exercise of effective leadership in any business is crucial to the achievement and sustainability of long-term desired results. This is even more critical for hospital companies because, by their very nature, the impact of success or failure in management is crucial.

If a company does not succeed either in production or marketing of consumer goods or the provision of certain services, it may just disappear and their stakeholders will lose something valuable. However, if a hospital does not fulfill its commitment, what is at stake, ultimately, is people's lives and health. It is, therefore, crucial that an effective leadership that attains proper coordination of people and processes. In the Mexican context, there are large areas of opportunity in business management, particularly in hospital organizations. As such, this study will be a pioneering contribution in this field.

## **Project Setting**

The information for this study was obtained from interviews with chief executive officers (CEOs) and chief medical officers (CMOs) of Mexican private healthcare organizations with 250 to 1,200 employees and serving 3,600 to 15,000 patients per year.

## **General Outline for the Thesis**

This chapter has established the need of having an effective model to develop leadership competencies in Mexican hospitals. Chapter 2 provides an overview of the main models of leadership and management in today's business world and, in particular, different models of leadership competencies development.

Chapter 3 describes the methodology used for the realization of this study. The four phases of instrumentation, candidate selection, data gathering, and data analysis are described.

Chapter 4 presents the results. Findings from the importance-performance analysis (IPA) and the interviews with the CEOs and CMOs are reported.

Chapter 5 presents a discussion of the results. A summary of findings is presented first, followed by conclusions and recommendations for CEOs, CMOs, and organizational development practitioners. Limitations of the study and suggestions for future research also are described.



## **Chapter 2**

### **Literature Review**

This study sought to identify a leadership competency model for developing healthcare executives in Mexico based on the NCHL Model. This chapter presents a review of relevant literature. First, the importance of leadership in healthcare organizations is discussed. Second, leadership concept and leaders' traits, styles, and competencies are reviewed. Third, leadership competencies models are examined.

#### **Importance of Leadership in Healthcare Organizations**

Aitken and Higgins (2010) mention that an organization's environment has the following characteristics: increasing levels of competence, demands from investors and other stakeholders, globalization, evolving nature of the workforce, technology, legal and regulatory changes, as well as social changes. Hartley and Bennington (2010) point out that there are several additional reasons why an effective leadership is required in hospitals:

- There are new challenges in terms of health, amongst them the different sorts of illnesses the world confronts today.
- There exist both a new culture and new health goals.
- Due to the Internet, there is less “deification” of professionals and medical authorities and greater expectations in terms of individualized and flexible care.
- The new health techniques and technologies require new ways to interact with patients and within and among hospital teams.
- There is an increasing emphasis in radical innovations rather than mere continuous improvement. These are required to support safety, quality, and efficiency of health services.
- Health organizations are changing—not only in their structure but above all in regards of their cultures and ways of working.

## **Leadership Concept**

Undoubtedly, there is a widespread agreement regarding the importance of leadership in the world of organizations. However, there is no consensus about the leadership concept itself and its key components. In this respect, Burns (1978) said “leadership is one of the most observed and less understood phenomena on earth” (p. 2). Yukl (2006) agreed, commenting that the investigation of leadership has experienced narrow approaches and there has been little integration of the findings emerged from different strategies.

Hartley and Bennington (2010) suggest “The Warwick Six C Leadership Framework,” which comprises a structure to classify and portray different aspects of leadership. The six Cs are concepts, characteristics, contexts, challenges, capabilities, and consequences. Each one of these elements has a myriad of definitions and approaches. For example, simply the concept and definition of leadership is highly varied.

Stodgill (1950) says that leadership can be considered as the process or the act of influencing the activities of a group organized to establish and achieve their goals. It considers leadership as an influential social and relational process that occurs within a group. It pays attention not only to the characteristics of the individuals but to what happens between the leader and his or her followers. This definition also highlights the importance of the group’s common purposes as an important condition to be met for leadership to take place.

Homans (1961) agrees with the first part of Stodgill’s definition, which says that leadership takes place in a group when a person (the leader) gives the orders in the form of suggestions, mandates, or requests and the followers act in accordance with those in

return for rewards. Common purposes are not mentioned as a key motivating component, even though the achievement of that common goal might be considered a type of reward.

Burns (1978) commented, “Leadership over human beings is exercised when persons with certain motives and purposes mobilize, in competition or conflict with others, for institutional, political, psychological, and other resources so as to arouse, engage and satisfy the motives of followers” (p. 110). Competition appears in this definition as an element that detonates group cohesion which is required for the group to follow orders from that who understands the group’s motivation.

Smircich and Morgan (1982) say leadership is realized in the process whereby one or more individuals succeed in attempting to frame and define the reality of others. In comparison to the previous definitions, this does not include motivations or values as a key element, although it can be implicitly understood that it is only possible to define other people’s reality if they find valuable what they get from their leader.

Locke (1991) approaches leadership as the process of persuading others to undertake actions towards a common objective. Again, a common objective is mentioned as a determining factor for leadership. It is also important to note that persuasion here is understood as a process rather than a specific competence. In this context, persuasion does not mean simply talking eloquently or offering powerful rational ideas, but instead to bundle a series of personal, social, and professional conditions that make a person trustworthy increasing his or her potential to influence others.

Heifetz (1994) considers leadership as mobilizing people to tackle tough problems. Burns (1978), like Heifetz, also talks about tough problems as a leadership detonator.

In the healthcare industry, Goodwin (2006) says that leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: (a) followers within the leader's own organization and (b) influential players and other organizations in the leader's wider, external environment. The leader incorporates a broader view by considering not only the influence he or she exerts in the group and on the key stakeholders within the environment.

There are substantial differences between these definitions. While some emphasize the importance of goals or purposes, others focus on the process or social dynamics. Still others center in the group, organization, or social system. While some highlight the intention of satisfying followers' needs, others include the existence of challenging situations as detonator. Despite these variations, almost all of them share the idea that leadership is mainly about the exertion of influence among and between human beings with the intention of achieving a certain purpose.

Given that there is little agreement on the definition of terms, it is not the intention to carry out a comprehensive analysis of leadership based on different perspectives and approaches. Instead, the purpose of this chapter is to draw attention to statements by several authors and institutions about the characteristics and competencies of leadership.

### **Traits, Styles, and Competencies of Leadership**

Stogdill (1974) pointed out that around the 1940s, the investigation of leadership was focused on primarily innate features or characteristics associated with effective leadership. Even though, for different reasons, this focus on cognitive and personality traits was not well received, in more recent times, it is possible to recognize traces of such approach. For example, Bass (1998) concluded based on his examinations of

transformational leadership that qualities such as intelligence, mood, optimism, self-acceptance, extroversion, and physical skills were connected to effectiveness. Adair (2007) identified enthusiasm, integrity, determination, justice, empathy, humility and trust as generic traits of effective leaders. Nevertheless, as commented by Parry and Briman (2006), Yukl (2006) and Jackson and Parry (2008), such kind of qualities may not be relevant to all leadership situations.

According with Hartley and Benington (2010), halfway through the last century, dissatisfaction with trait theory lead many authors to pay more attention to what leaders actually carried out rather than on their innate traits. This tendency was known as a focus on styles and behaviors commonly used by leaders. A very important change consisted in considering that such behavior could be acquired. Therefore, greater emphasis was dedicated to the development of leadership and less in the selection of leaders.

Some of the most representative studies of such approach are known as the Ohio studies by Halpin and Winer (1957), who identified two key dimensions: consideration (focus on people) and initiating structure (focus on the task). Blake and Mouton (1961) expanded the Ohio studies findings and by developing the Leadership Grid, which describes leadership styles along the dimensions of focus on people and focus on the task. Their work conceptualized leadership in five styles: impoverished leadership (low people, low task), authority-compliance leadership (low focus on people, high focus on task), middle of the road leadership, (medium focus on people, medium focus on task) country club leadership (high focus on people, low focus on task) and team leadership (high focus on people, high focus on task).

Subsequently, Boyatzis (1982) was one of the first to use the frame of reference for competencies to try to understand and improve the qualities of leaders. Boyatzis

defines competence as an intrinsic characteristic of the person, which triggers an effective or above average performance at work. Hirsch and Strebler (1995) address competencies more specifically as abilities, knowledge, experience, attributes, and behavior needed by an individual to effectively develop a task or function. A crucial difference between the approach on traits and the approach on competencies focuses on qualities that are expressed in behavioral terms and implies that competencies can be learned and improved, unlike focusing on intrinsic traits.

Many authors do not distinguish between the concepts of *competence* or *capability*. Regardless of the term used, competencies or capabilities are perceived with reference to the performance of a task or function and the interaction between the context and the person is therefore acknowledged.

Boyatzis (2006) emphasized that a competence results from the interaction of a person and its context, understood as work requirements and organizational environment. He explained that leadership is affected by the current situation of the leader and that it does not only depend upon his or her qualities. He said the best fit of leadership happens within the area of maximum stimulation, challenge, and performance. This best fit occurs as the intersection of individual traits (e.g., vision, values, knowledge, competencies, interests); organizational environment (e.g., culture, structure, core competencies); and job demands (e.g., tasks, functions, roles). Hirsch and Strebler (1995) believed that skills, knowledge, experience, attributes and behavior were the basic competencies people need to effectively perform a task or function. They are always located within the context of job performance and an organizational environment.

With this frame of reference in mind, a summary of some categorizations of leadership competencies developed by different authors and organizations will be

presented. It is important to note that it is not the objective to present the most accepted classifications or models of competencies, but to simply show some examples which will let perceive the amount of categorizations present in the field and the different variations stemming from them. In general terms, there are great coincidences with respect of competencies included in the different approaches; however, there are some contrasts in the way they are grouped and their particular emphasis.

### **Leadership Competencies Models**

Generic models proposed by different authors will be presented first. Afterwards, some specific models used by different organizations and businesses including healthcare organizations also will be presented.

**Generic models for leadership competencies.** Adair (2005) examined various leadership perspectives, including the Qualities Approach, the Functional Approach, and the Situational Approach. He explains that the Functional Approach is when he makes more reference to what we address as competencies. He comments that the role of leaders is to help their followers to succeed at performing common tasks, create and maintain the synergy in the team, and develop individuals. To do this, activities must be carried out, including those related to (a) achieving the task (i.e., defining the task, planning, informing, controlling) and (b) building the team and developing the individual (i.e., evaluating, motivating, organizing and leading by example).

Adair (2005) established that for leaders must develop the following skills or competencies to comply with their roles and carry out their duties:

- Coordination and teamwork: ability to procure for people to work as a team towards a common goal.
- Decision making: capability to think clearly in order to solve problems and make timely decisions.

- Communication: capability to express ideas and opinions in a way others understand and also understand the ideas and opinions expressed by others.
- Self-management: capability to effectively manage time and personal organization.

Typical behavior in each one of the mentioned categories would be as presented in Table 1.

**Table 1**

***Competencies and Behavior According to Adair***

Teamwork and Coordination	Decision Making	Communication	Self-Management
<ul style="list-style-type: none"> <li>• Sets direction and initiates action.</li> <li>• Plans and organizes.</li> <li>• Delegates responsibility.</li> <li>• Coordinates and controls.</li> <li>• Shows sensitivity to individuals' needs and feelings.</li> <li>• Motivates and encourages others.</li> <li>• Sets group standards.</li> <li>• Disciplines where necessary.</li> <li>• Seeks help and advice.</li> <li>• Plays positive role as team member.</li> </ul>	<ul style="list-style-type: none"> <li>• Analyzes problems.</li> <li>• Shows reasoning and logical thinking.</li> <li>• Is swift on the uptake.</li> <li>• Thinks imaginatively and creatively.</li> <li>• Has a sense of reality.</li> <li>• Has helicopter ability to stand back.</li> <li>• Demonstrates good judgment.</li> <li>• Has an inquiring mind.</li> <li>• Generates solutions.</li> <li>• Is decisive when required.</li> </ul>	<ul style="list-style-type: none"> <li>• Speaks audibly and clearly.</li> <li>• Uses simple and concise language.</li> <li>• Communicates on paper easily and well.</li> <li>• Listens to others with perception.</li> <li>• Reads with speed and comprehension.</li> <li>• Argues assertively but not aggressively.</li> <li>• Chairs a meeting well.</li> <li>• Ensures good group communications, upwards, downwards, and sideways.</li> <li>• Shows awareness of nonverbal communication.</li> <li>• Gets others enthusiastic about his ideas.</li> </ul>	<ul style="list-style-type: none"> <li>• A self-motivator; lights his or her own fire.</li> <li>• Able to work on own initiative with little supervision.</li> <li>• Sets and achieves challenging goals.</li> <li>• Works to deadlines.</li> <li>• Makes good use of his or her own time.</li> </ul>

Based on *How to Grow Leaders: The Seven Key Principles of Effective Leadership Development*, by J. Adair, 2005, Philadelphia PA: Kogan Page.

Osborne (2008) outlined standard leadership competencies, which include some analyzed by Adair, but adds others and classifies them in a different way (see Table 2).



Table 2

*Standard Leadership Competencies According to Osborne*

Competence	Description
Achieving excellent results	<ul style="list-style-type: none"> <li>• Delivers with energy and determination on individual, team, and overall objectives that address core business issues and contribute to achieving longer-term sustainable organizational goals.</li> <li>• Behaves in a professional and ethical way.</li> </ul>
Building relationships	<ul style="list-style-type: none"> <li>• Builds trust, listens to needs, is open to ideas, and is sensitive to the perceptions of others.</li> <li>• Questions constructively, identifies options, and collaborates to develop solutions by networking and creating relationships with strategic people and organizations.</li> <li>• Is able to work autonomously or in teams, adapt to a wide range of situations, and appreciate diversity.</li> <li>• Remains aware of the needs and concerns of others and is consistently able to focus on objectives and build relationships, even when working under pressure or in the face of personal criticism in challenging situations.</li> <li>• Good at selecting the right people with complementary strengths to work in teams.</li> </ul>
Coaching and communicating	<ul style="list-style-type: none"> <li>• Communicates a clear vision of the organization's future.</li> <li>• Enthuses and energizes people, is accessible to people, and gains ownership of the steps needed to achieve goals.</li> <li>• Knows one's own and one's team members' strengths and weaknesses and encourages initiative, accountability for objectives, and the taking on of more responsibility.</li> <li>• Invests time in coaching others and encourages effective contribution, gives constructive feedback, and knows when to support and challenge.</li> </ul>
Continuous innovation	<ul style="list-style-type: none"> <li>• Experiments with new approaches.</li> <li>• Learns from best practice, responds flexibly to change, and encourages others to question and review how things are done or could be continuously improved.</li> </ul>
Focusing on customers	<ul style="list-style-type: none"> <li>• Achieves mutually beneficial relationships with customers.</li> <li>• Manages expectations well in all interactions.</li> <li>• Anticipates needs and responds with empathy.</li> </ul>
Lifetime learning and knowledge-sharing	<ul style="list-style-type: none"> <li>• Stays up-to-date, shares knowledge and information with other people, and applies this learning to own work.</li> <li>• Encourages others to learn, develop, and share knowledge.</li> </ul>
Solving problems and taking decisions	<ul style="list-style-type: none"> <li>• Recognizes problems as opportunities, explores causes systematically and thoroughly.</li> <li>• Generates ideas; weighs advantages and disadvantages of options.</li> </ul>

Based on *Leadership*, by C. Osborne, 2008, New York, NY: DK Publishing.

This model does not specifically include group work nor self-management.

However, several competencies not explicitly mentioned by Adair (2005) are included, such as continuous innovation, focusing on customers, lifetime learning, and knowledge-sharing.

According to Mirvis, Thompson, and Marquis (2010), executives must develop four meta-skills to be successful: self-leadership, leadership towards others, leadership of systems and leadership of the company. Their definitions of these competencies are presented in Table 3.

**Table 3**

***Leadership Meta-Skills According to Mirvis, Thompson, and Marquis***

Self-Leadership	Leading Others	Leading Systems	Leading the Enterprise
<i>Cognitive sophistication and emotional maturity to deal with mental complexity; multitask requirements and the ups and downs of businesses in a globalized world.</i>	<i>Expansion of interpersonal, group and social skills.</i>	<i>Systemic thinking, employer's acknowledgement, improvisation and unveiling of meanings.</i>	<i>Global vision of the company in a borderless world and development of multi-business and multisectoral alliances.</i>
<ul style="list-style-type: none"> <li>• Self-conscience</li> <li>• Reflection</li> <li>• Tolerance of ambiguity</li> <li>• Cognitive complexity</li> <li>• Adaptability</li> <li>• Emotional resiliency</li> </ul>	<ul style="list-style-type: none"> <li>• Social intelligence</li> <li>• Group processes</li> <li>• Involvement</li> <li>• Coercion-free influence</li> <li>• Communication skills</li> <li>• Sense-development skills</li> </ul>	<ul style="list-style-type: none"> <li>• Systemic thinking</li> <li>• Identification of patterns</li> <li>• Cultural intelligence</li> <li>• Appreciation for diversity</li> <li>• Social responsibility and sustainability</li> <li>• Forecasting</li> <li>• Aesthetic intelligence</li> </ul>	<ul style="list-style-type: none"> <li>• Global mentality</li> <li>• Organization</li> <li>• Strategic planning</li> <li>• Judgment</li> <li>• Responsible leadership</li> </ul>

Based on "Preparing Next Generation Business Leaders," by P. Mirvis, K. Thompson, and C. Marquis, 2010, in M. G. Rothstein and R. J. Burke (Eds.), *Self-management and leadership development* (pp. 464-486). Northampton MA: Edward Eglar.

Different from previous authors, Mirvis et al. (2010) present an increasing complexity competencies classification framework depending on performance: self-leadership, leading others, leading systems and leading the enterprise. Rubino (2007) suggested the examination of leadership competencies through four main groups or

domains (see Table 4). Rubino's (2007) classification is very similar to that of Mirvis et al. (2010), with the difference that this model includes the Functional and Technical Competencies replacing Leading Systems.

**Table 4**

***Four Domains of Leadership Competencies of Rubino***

Functional and Technical Competencies	Self-development and Self-understanding Competencies
<ul style="list-style-type: none"> <li>• Business knowledge and business acumen</li> <li>• Strategic vision</li> <li>• Decision-making skills</li> <li>• Entrepreneurial values and ethics</li> <li>• Problem solving</li> <li>• Management of changes</li> <li>• Tolerance to uncertainty and ambiguity</li> <li>• Systemic thinking</li> <li>• Exercise of authority</li> </ul>	<ul style="list-style-type: none"> <li>• Self-awareness and self-confidence</li> <li>• Self-control and personal accountability</li> <li>• Honesty and integrity</li> <li>• Ongoing learning processes</li> <li>• Achievement driven</li> <li>• Empathy and compassion</li> <li>• Flexibility</li> <li>• Perseverance</li> <li>• Life-work balance</li> </ul>
Interpersonal Competencies	Organizational Competencies
<ul style="list-style-type: none"> <li>• Communication</li> <li>• Motivation</li> <li>• Empowerment of subordinates</li> <li>• Guidance of group processes</li> <li>• Handling and solution of conflicts</li> <li>• Negotiation</li> <li>• Formal presentations</li> <li>• Social interactions</li> </ul>	<ul style="list-style-type: none"> <li>• Organizational design</li> <li>• Team building</li> <li>• Setting of priorities</li> <li>• Political shrewdness</li> <li>• Performance management and evaluation</li> <li>• Development of collaborators</li> <li>• Human resources</li> <li>• Community and external resources</li> <li>• Management of cultural diversity</li> </ul>

Based on "Leadership," by L. Rubino, 2007, in S. B. Buchbinder and N. H. Shanks (Eds.), *Introduction to healthcare management* (pp. 1-22). Sudbury MA: Jones and Bartlett.

**Leadership competence models in specific companies.** In the following pages, several competencies models that are actually used in different companies will be presented. The purpose of this examination is to illustrate that there are no best or worst models and that they depend on the leader type each company perceive as better, according to its vision, values, purposes, and strategies.

The Corporate Leadership Council (2004b) outlined the competence models from several important companies in a study named “Global Leadership Development Programmes.” At Vodafone, competencies are clustered in six categories: Communicating for impact, delivering results, managing a changing environment, making a personal difference, performing through our people, and putting customers first. This model includes two categories that are not mentioned before: (a) managing a changing environment and (b) making a personal difference.

Nike uses a similar model (see Table 5), although simpler than what Mirvis et al. (2010) and Rubino (2007) propose in environment with increasing need of influence: knowing oneself, leading the team and leading the business. This model has the virtue of simplicity, as it helps leaders focus their efforts in the priorities. It is additionally noteworthy that, for the first time, global perspective appears as an explicitly identified competence (Corporate Leadership /Council, 2004b).

**Table 5**

***Nike’s Competencies Model***

LEAD THE PEOPLE	LEAD THE BUSINESS	KNOW YOURSELF
<ul style="list-style-type: none"> <li>• Creating team success</li> <li>• Effective communications</li> <li>• Nike leadership</li> <li>• People skills</li> </ul>	<ul style="list-style-type: none"> <li>• Business mastery</li> <li>• Focus on growth</li> <li>• Global perspective</li> </ul>	<ul style="list-style-type: none"> <li>• Courage</li> <li>• Personal mastery</li> <li>• Winning attitude</li> </ul>

Based on *Global Leadership Development Programme* (Catalog Number CLC1-1KEAZN), by Corporate Leadership Council, 2004, Washington DC: Corporate Executive Board.

Danske Bank classifies leadership competencies on the following categories (Corporate Leadership /Council, 2004b):

- Business: Ability to develop competent employees, market knowledge, quality focus.
- People: Employee motivation, employee communication, change management, self-awareness.

- Personal: Ability to acquire new skills, ability to handle pressure, self-knowledge.
- Strategic management: Focus on business opportunities, communication of mission statement in everyday management, understanding of organizational culture.
- Taking the business plan into action: Communication skills, ability to handle conflict, output rather than process focus.

A clear business orientation is seen in this model, as three out of the five categories have to do with it, although other competencies are also grouped in People and Personal (Corporate Leadership /Council, 2004b).

3M identifies three broad categories: fundamental, essential, and visionary (Corporate Leadership /Council, 2004b):

- Fundamental: Competencies that a person may have when he is hired but to be developed subsequently as he advances through successive managerial positions.
- Essential: Competencies that the person will develop as he becomes accountable for a functional unit or department.
- Visionary: Competencies leaders must possess in order to undertake increasing levels of responsibility. It enables them to see beyond their control area and puts into perspective their leadership decisions.

In other models, such as Mirvis et al.'s (2010), Rubino's (2007), and Nike's model, categories are used based on sphere of influence such as one's self, the team, the system, and the business are used. 3M model does not use sphere of influence as important criteria but specifies development levels or stages including fundamental, essential, and visionary (Corporate Leadership /Council, 2004b). Table 6 presents the categories and associated competencies.

Table 6

*3M Leadership Competencies Model*

Fundamental Leadership Competencies	Essential Leadership Competencies	Visionary Leadership Competencies
<p>Ethics and Integrity</p> <ul style="list-style-type: none"> <li>Exhibits uncompromising integrity and commitment to corporate values, human resources principles, and business conduct policies.</li> <li>Builds trust and instills self-confidence through mutually respectful, ongoing communication.</li> </ul> <p>Intellectual Capacity</p> <ul style="list-style-type: none"> <li>Assimilates and synthesizes information rapidly, recognizes the complexity in issues, challenges assumptions and faces up to reality.</li> <li>Capable of handling multiple, complex, and paradoxical situations. Communicates clearly, concisely, and with appropriate simplicity.</li> </ul> <p>Maturity and Judgment</p> <ul style="list-style-type: none"> <li>Demonstrates resiliency and sound judgment in dealing with business and corporate challenges.</li> <li>Recognizes when a decision must be made and acts in a considered and timely manner.</li> <li>Deals effectively with ambiguity and learns from success and failure.</li> </ul>	<p>Customer Orientation</p> <ul style="list-style-type: none"> <li>Works constantly to provide superior value to the customer, making each interaction a positive one.</li> </ul> <p>Developing People</p> <ul style="list-style-type: none"> <li>Selects and retains an excellent workforce within an environment that values diversity and respects individuality.</li> <li>Promotes continuous learning and the development of self and others to achieve maximum potential.</li> <li>Gives and seeks open and authentic feedback.</li> </ul> <p>Inspiring Others</p> <ul style="list-style-type: none"> <li>Positively affects the behavior of others, motivating them to achieve personal satisfaction and high performance through a sense of purpose and spirit of cooperation.</li> <li>Leads by example.</li> </ul> <p>Business Health and Results</p> <ul style="list-style-type: none"> <li>Identifies and successfully generates product, market, and geographic growth opportunities while consistently delivering positive short-term business results.</li> <li>Continually searches for ways to add value and to position the organization for future success.</li> </ul>	<p>Global Perspective</p> <ul style="list-style-type: none"> <li>Operates from an awareness of the company's global markets, capabilities, and resources.</li> <li>Exerts global leadership and works respectfully in multicultural environments to the company's advantage.</li> </ul> <p>Vision and Strategy</p> <ul style="list-style-type: none"> <li>Creates and communicates a customer-focused vision, corporately aligned and engaging all employees in pursuit of a common goal.</li> </ul> <p>Nurturing Innovation</p> <ul style="list-style-type: none"> <li>Creates and sustains an environment that supports experimentation, rewards risk-taking, reinforces curiosity, and challenges the status quo through freedom and openness without judgment.</li> <li>Influences the future of the company's advantage.</li> </ul> <p>Building Alliances</p> <ul style="list-style-type: none"> <li>Builds and leverages mutually beneficial relationships and networks, both internal and external, which generate multiple opportunities for the company.</li> </ul> <p>Organizational Agility</p> <ul style="list-style-type: none"> <li>Knows, respects, and leverages the company's culture and assets.</li> <li>Leads integrated change within a business unit to achieve sustainable competitive advantage.</li> <li>Utilizes teams intentionally and appropriately.</li> </ul>

Based on *Global Leadership Development Programme* (Catalog Number CLC1-1KEAZN), by Corporate Leadership Council, 2004., Washington DC: Corporate Executive Board.

The Corporate Leadership Council (2004a), as a result of a survey with about 8,000 leaders, identifies a generic model as the basis for leadership development programs, consisting of three blocks and six groups of competencies (see Table 7). Although this model takes the business as a frame of reference it classifies the competencies for the person: competencies of being, of knowledge and of doing.

**Table 7**

***Generic Leadership Competencies Model***

BLOCK ONE— WHO YOU ARE	BLOCK TWO— WHAT YOU KNOW	BLOCK THREE— WHAT YOU DO
<ul style="list-style-type: none"> <li>Personal Core—Courage and confidence, drive for results, conceptual ability, willingness to learn, emotional stability.</li> </ul>	<ul style="list-style-type: none"> <li>Experience—Business, geographical, functional track record of achievement.</li> <li>Know-how—Commercial know-how, customer and market focus, mastery of best business practices.</li> </ul>	<ul style="list-style-type: none"> <li>Business direction setting—Strategic thinking, broad scanning, business acumen.</li> <li>Execution—Holding to account, management and control.</li> <li>Taking people along—Visionary leadership, developing others, strategic influencing, versatility.</li> </ul>

Based on *Developing Leadership Competency Models* (Catalog Number CLC11TC4S2), by Corporate Leadership Council, 2004, Washington DC: Corporate Executive Board.

Dye and Garman (2006) suggest a model of leadership competencies applicable to health institutions based on a four-cornerstone structure that incorporates 16 competencies and is substantiated in a healthy self-concept. The four cornerstones are:

1. Highly cultivated self-awareness. It consists in acknowledging oneself as a leader. It implies the competencies of living by personal convictions and possessing emotional intelligence.
2. Compelling vision. It makes reference to the capability to create effective plans for the future of the organization based on clear understanding of tendencies, uncertainties, risks, and rewards. It implies three competencies: Being visionary, communicating vision, and earning loyalty and trust.
3. Real way with people. It is about making things happen through people and processes. It includes five competencies: listening like you mean it, giving feedback, mentoring others, developing teams, and energizing staff.

4. Masterly execution. It basically consists in obtaining the desired results through decision making, completion of activities, and compliance with agendas. It implies six competencies: generating informal power, building consensus, making decisions, driving results, stimulating creativity and cultivating adaptability.

The four cornerstones are developed over the foundation of a healthy self-concept. This means that the leader is satisfied with his place in the world and feels like he has a purpose in life, has a sense of control over his life and destiny, is confident with his ability to reach his goals, has a positive self-image, and feels comfortable with the way in which he interacts with others.

Authors Dye and Garman (2006) affirm that the healthcare industry faces very different challenges from other industries, such as types of relationships, nature of the job that deals with life and death, emotional stress, and financial challenges. According to this, they say, healthcare businesses require a distinct approach on leadership. Nonetheless, the presented model does not mention distinct competencies versus other industries and is applicable to any other business. Without a doubt, the context and environment is different but the competencies seem to be the same.

The National Health Service of the United Kingdom (2013) has used a seven-dimension model since 2002:

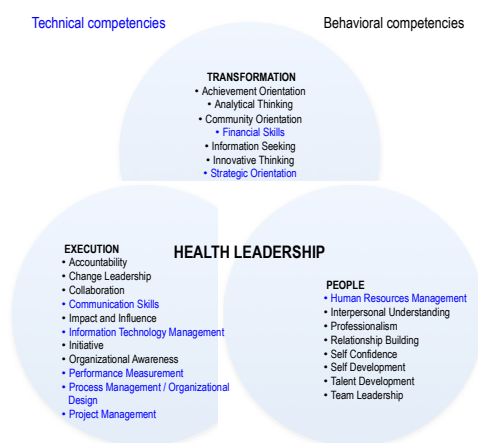
1. Demonstrating personal qualities. Developing self-awareness, managing yourself, continuing personal development, acting with integrity.
2. Working with others. Developing networks, building and maintaining relationships, encouraging contributions, working with teams.
3. Managing services. Planning, managing resources, managing people, managing performance.
4. Improving services. Ensuring patient safety, critically evaluating, encouraging improvement and innovation, facilitating transformation.
5. Setting direction. Identifying the contexts for change, applying knowledge and evidence, making decisions, evaluating impact.



6. Leading organizations and systems. Developing the vision for the organization, influencing the vision of the healthcare system , communicating the vision, embodying the vision.
7. Delivering the strategic vision. Framing the strategy, developing the strategy, implementing the strategy, embedding the strategy.

These central dimensions act at progressively increasing span of impact, widening from affecting the individual leader to affecting the entire system. All the elements in this model are subordinated to servicing the patient; however, if the patient is substituted for a client, the model can be applied to any other business.

The same can be said for the model developed by the National Center for Healthcare Leadership (2013). This model (see Figure 1), first developed in 2004, includes 18 behavioral competencies and 8 technical competencies integrated in three domains or interrelated categories: transformation, execution, and people.



From *National Center for Healthcare Leadership Health Leadership Competency Model™*, by National Center for Healthcare Leadership, 2013, retrieved from <http://www.nchl.org/static.asp?path=2852,3238>. Reprinted with permission.

**Figure 1. National Center for Healthcare Leadership Health Leadership Competency Model**

The domains and competencies are defined as follows:

1. Transformation. Visioning, energizing, and stimulating a change process that coalesces communities, patients, and professionals around new models of healthcare and wellness. The models include a achievement orientation,

analytical thinking, community orientation, financial skills, information seeking, innovative thinking, and strategic orientation.

2. Execution. Translating vision and strategy into optimal organizational performance. They include accountability, change leadership, collaboration, communication, impact and influence, information technology management, initiative, organizational awareness, performance measurement, process management, and organizational design and project management.
3. People. Creating an organizational climate that values employees from all backgrounds and provides an energizing environment for them. This competency also includes the leader's responsibility to understand his or her impact on others and to improve his or her capabilities, as well as the capabilities of others. It includes competencies such as human resources management, interpersonal understanding, professionalism, relationship building, self-confidence, self-development, talent development, and team leadership.

Each one of the competencies in the model is represented in steps to describe how it emerges as positions or functions grow in scope, complexity, or sophistication. The steps are called competence levels. Each competence has from three to six performance levels. Appendix A presents a description of the performance levels for all of the model's competencies.

Although this model has been used mostly in healthcare institutions, as with the case above, it does not offer special or distinctive characteristics from this sector and is applicable to any other type of business. The elements are basically the same. What changes is the scenario. Without doubt, the way to "operationalize" the different competencies will be different from business to business, always depending upon the nature of the products and services it offers.

Thus, from different angles and emphases, most of the approaches outlined address the same kinds of competencies. The NCHL competence model will be used as frame of reference for the following stages of the present study, given its comprehensive approach, internal consistency, and specificity.

## **Chapter 3**

### **Methodology**

This study sought to identify a leadership competency model for developing healthcare executives in Mexico based on the NCHL Model. Given the unquestionable significance of counting on effective leaders in the hospital industry, it is a requirement to depend on solid competency models to guide the leadership development efforts in this sector. The research questions were as follows:

1. Is there a leadership competencies model applicable to Mexican private healthcare organizations?
2. How do top leaders in Mexican private healthcare organizations perceive their own performance?
3. What kind of framework would be helpful to develop leadership capability required by top leaders in Mexican private healthcare organizations? This chapter is presented in three phases: Preparation, Data Collection and Data Analysis.

#### **Phase 1: Preparation**

**Instrument selection.** In this section are described the reasons why the NCHL Health Leadership Competency Model was chosen as a basic framework. The model is an evidence-based and behaviorally focused approach for evaluating leadership skills across the professions, including health management, medicine, nursing, and across career stages.

The Health Leadership Competency Model was developed from an extensive academic research and an implementation in hospital institutions and other kinds of organizations. During the initial stages of the model's development, interviews, psychometric analysis and comparative studies were carried out in different business sectors. Its implementation within the healthcare industry was based on additional

reexamination of literature, good practice analysis, opinions from panels of experts, and pilot testing.

The model includes three general domains subdivided in 26 behavioral and technical competencies. Each competency is composed of behavioral indicators or levels to facilitate both development and evaluation, as individuals advance from their initial level to medium levels and advanced stages. The model allows the identification of leadership improvement opportunities in academic and practical scenarios. The Health Leadership Competency Model is substantiated in behavioral observation, in the investigation of several approaches and models, like those of Boyatzis (1998); Boyatzis, Cowen, and Kolb (1995); Spencer (1991); Spencer, McClelland, and Spencer (1994).

**Subject selection.** To discover the most relevant leadership competencies within the context of hospitals in México, several current leaders in the sector were interviewed. Participants had to be senior executives (i.e., CEO or CMOs) with a minimum experience of 2 years in the same or higher position. Six CEOs and five CMOs from private hospitals in the city of Monterrey, N.L. Mexico, were interviewed in person in their own offices for approximately 60 minutes.

To protect the identities of those interviewed as well as the confidentiality of the information, no names were recorded for interviewees or institutions. All guidelines for the study of human subjects were followed in accordance to the Institutional Review Board at Pepperdine University.

## **Phase 2: Data Collection**

The interview was conducted in two sections: (a) competency scoring on importance and performance based on the NCHL Model and (b) open-ended questions.

Interviewees were asked to score each competency, using a scale from 1 (low) to 5 (high) for both importance and performance of the CEOs and CMOs. They were also asked to comment on the reasons behind the scores. The answers from interviewees were recorded and later transcribed, encoded, and organized. To make sure the competencies had the same meaning for interviewees, each competency was described in a card that was shown to them. It included a description of the competency with concrete examples to facilitate their understanding (see Appendix A).

For the first part of the interviews, a specific script was followed:

The cards that I will present to you describe the competencies of a high performance leader. According to your experience, what's their relevance in order for a CEO and CMO of a hospital in Mexico to be an effective leader? Observe in each card the description of the competency at issue and qualify both its importance as well as the average performance of leaders you know across the Mexican healthcare industry broadly. Use the following scale.

This scale was kept in front of them throughout the interview:

IMPORTANCE		PERFORMANCE	
5	It is vital	5	Excellent
4	It is very important	4	Good
3	It is desirable	3	Regular
2	It is irrelevant	2	Poor
1	It is completely irrelevant	1	Terrible

The second part of the interview was comprised of the following open-ended questions:

1. After reviewing the NCHL leadership model competencies, do you think there are other additional competencies needed for the Mexican context? Please name them.
2. What are the main differences you find between a CEO/Top Management leader of a given company and a CEO/Top Management leader of a hospital?
3. What was the specific formation and/or education that you received to become (CEO or CMO)?

4. What experiences have helped you become a leader as a CEO or CMO?
5. What suggestions can you make to help form/educate/train CEOs or CMOs as effective leaders for the healthcare industry?
6. What are you doing to form/train your successor? What are you doing to strengthen the values, attitudes and competencies of your successor to develop him/her as an effective leader?

### **Phase 3: Analyzing the Data**

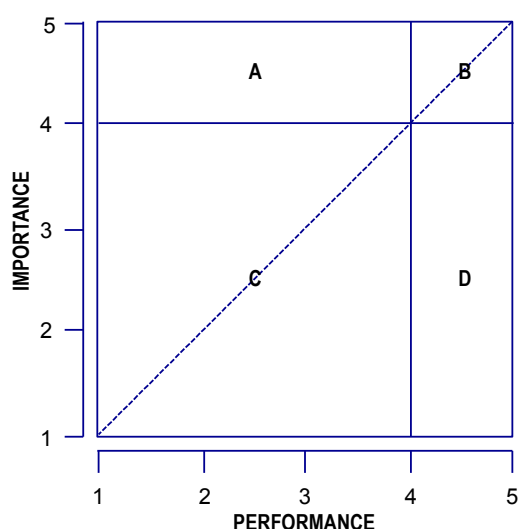
For the first part of the interviews, the IPA method was used, originally developed by Martilla and James (1977). This method allows the evaluation of each item separately, in a double dimension: the value assigned by the interviewee and the actual reality that he or she perceives. Generally, results are plotted into a two-by-two matrix, in which the vertical axis represents importance and the horizontal axis represents performance, which gives place to four quadrants:

1. Quadrant A: High importance/low performance. The items placed in this quadrant require immediate attention.
2. Quadrant B: High importance/high performance. The items placed in this quadrant represent the main strengths which must be maintained and reinforced.
3. Quadrant C: Low importance/low performance. The items placed in this quadrant represent weaknesses, although, given the fact that are not considered important, they are not priorities and do not require at the moment from additional efforts.
4. Quadrant D: Low importance/high performance. The items placed in this quadrant represent efforts, in a certain way wasted or useless, since whatever is done in this regard does not add value.

The quadrants were configured in an asymmetric form in the specific case of this research. Another important reference consists in drawing a diagonal line, since it represents the maximum congruence possible between the importance assigned to a competency and the performance perceived in respect of the same competency. If, for example, a competency was scored in average with 4.3 in importance and, also, 4.3 in

performance, then, the representation of such competency would be located exactly over the diagonal line, which would mean that there exists a complete match between the importance and the performance.

Accordingly, the diagonal line is useful as well to identify the priorities of intervention when elaborating a development plan. For example, if there are several competencies that are located in the A quadrant (High Importance–Low Performance), meaning that all of them are priorities, the specific priority degree would be assessed by observing the distance of the competency to the diagonal line, measured perpendicular to the same. The larger the distance with regard to the diagonal line, the greater the intervention priority. The outline used in this research is pictured in Figure 2.



**Figure 2. Importance and Performance of Leadership Competencies**

For the second part of these interviews with the open-ended questions, the answers were recorded, encoded, grouped and analyzed in terms of frequencies and percentages.

Data were collected from two separate groups: CEOs and CMOs. Both types of leaders are considered the most influential in the healthcare industry and also share the same importance in the organization. However, due to their profiles and fundamental objectives, certain differences in their perceptions about the importance of the leadership competencies should be expected. CEOs are the responsible for the entire business but the CMOs are the responsible for everything that has to do with the patient's treatment and care.

#### **Phase 4: Merging and Making Sense of the Data**

Once the data were grouped and analyzed for frequencies, a matchmaking process was made between the data of the two parts to make sense of it. A search was made for correlations and patterns between them and the findings were used to design the model for helping actual top management and their successors develop the competencies they most need to be effective leaders in the healthcare industry.



## Chapter 4

### Results

This study sought to identify a leadership competency model for developing healthcare executives in Mexico based on the NCHL Model. This chapter reports the findings from interviews with six CEOs and five CMOs in different private hospitals in México.

First, the results of the importance-performance analysis are presented. General findings, CEO findings, CMO findings, and areas of CEO-CMO agreement are discussed. Next, the interview results are presented. The chapter closes with a summary.

#### Importance-Performance Analysis Findings

**General findings.** The IPA helps find the gap between the competencies that are considered important and the performance perceived in those competencies by CEOs and CMOs. The action plans for improvement will reside in those competencies that have the highest importance together with the biggest gap. An overview of most important and least important are described here.

Twenty-two of the 26 competencies (84.61%) scored between 4 and 5 on a scale of 1 (low) to 5 (high). These results means the 22 competencies are considered very important to vital within the Mexican healthcare industry context. Only four competencies (community orientation, information seeking, impact and influence, and organizational awareness) received an average score between 3 and 4, meaning desired to very important. None of the competencies received an importance score below 3.2.

It is worth noting that the 22 competencies considered between very important and vital have a performance below 4, which positions them in the deficit quadrant. The competencies on this quadrant demand special attention, as shown in Figure 3. These

competencies are very important, while simultaneously not reaching expected performance levels.



N = 11

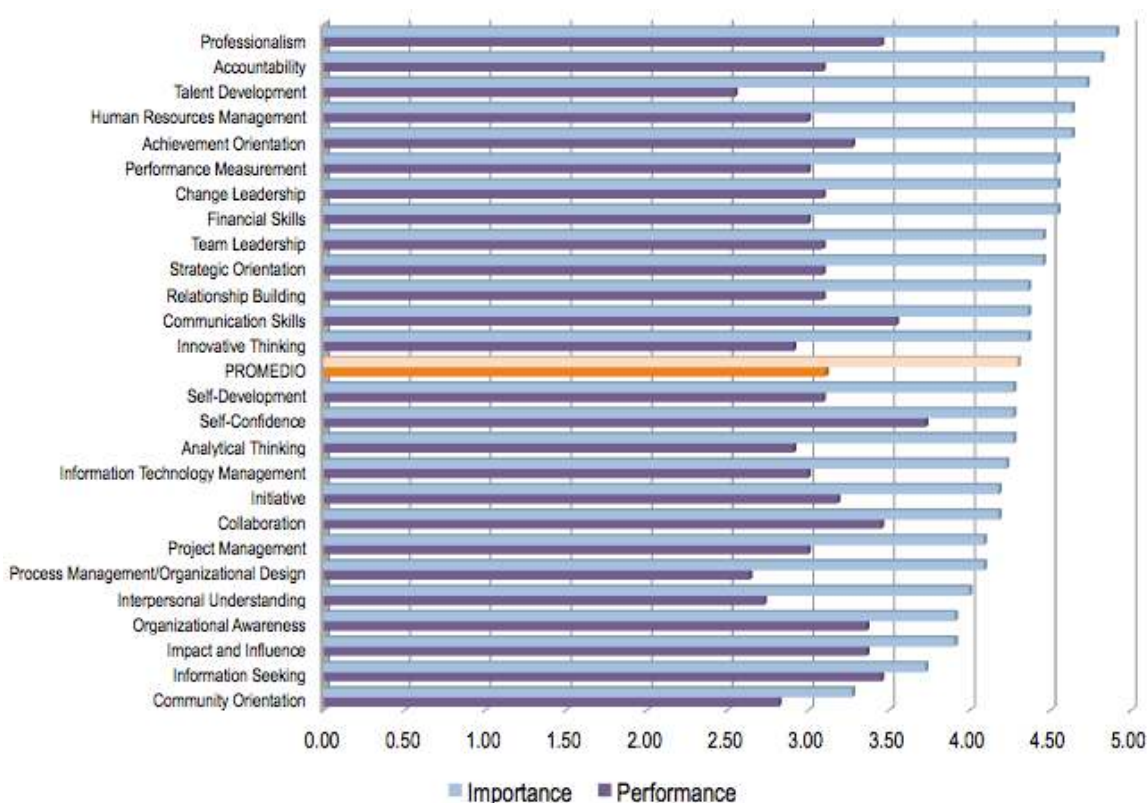
**Figure 3. Top Leader Perceptions of National Center for Healthcare Leadership Competencies**

The distance between the dot and the diagonal dotted line represents the gap between the scored importance and the perceived performance. The competencies with the greatest gaps are: talent development (gap = 2.18), accountability (gap = 1.73), and human resource management (gap = 1.64). The competency with the shortest gap between importance and performance is information seeking (gap = 0.27). For more information and clarity, the graphs of competencies separated by groups or types of Transformation, Execution and People are presented in Appendix B.

Since one of the purposes of this study consists in analyzing the degree of adaptation of the NCHL competencies model to the Mexican context, it is particularly

relevant to observe the importance assigned to each competency by the interviewees.

Figure 4 shows teach competency in rank order by the importance followed by the corresponding levels of perceived performance.



N = 11

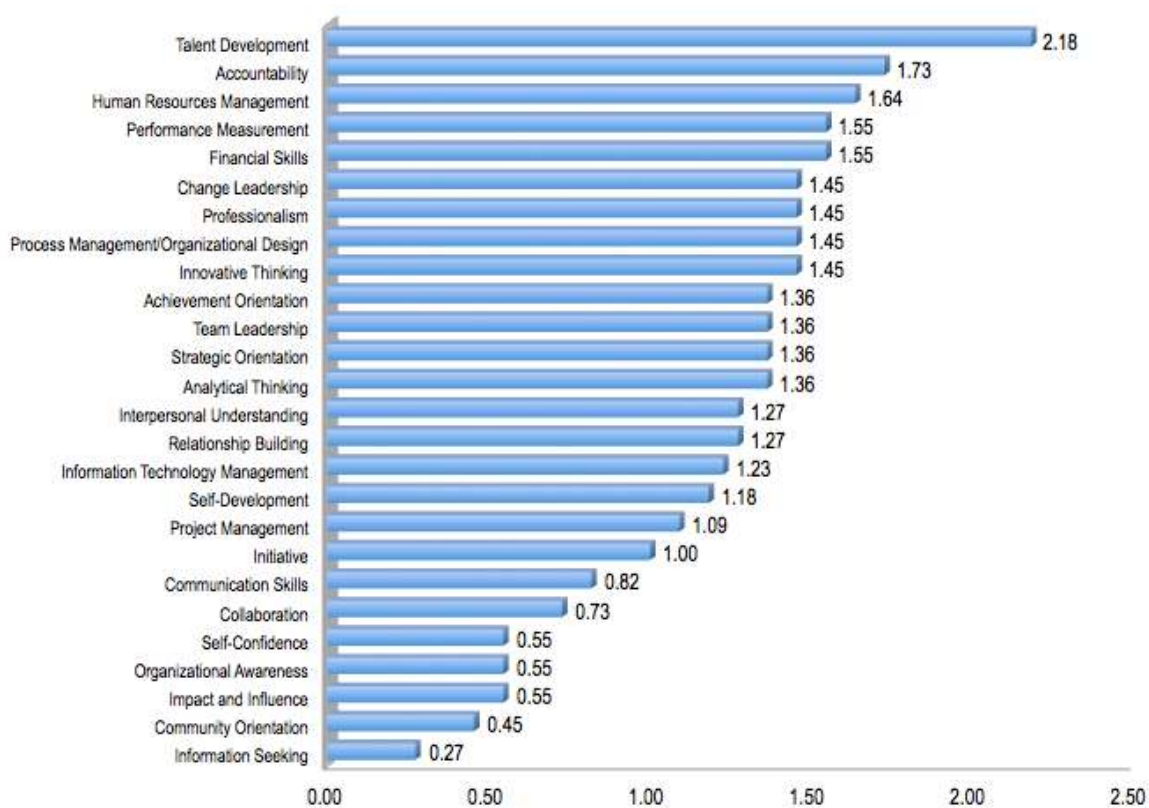
**Figure 4. Top Leader Perceptions of Importance and Performance of the National Center for Healthcare Leadership Competencies**

The competencies considered as the most important are professionalism (4.91), accountability (4.82), and talent development (4.70). Group separated competencies' graphs are presented in Appendix B. Differences between importance and performance can be observed in Figure 5.

A way to interpret this differences is, for example, in the case of talent development, where a correspondence between perceived performance and scored

importance of 54%, since its performance was graded as a 2.5 and importance with a 4.7 ( $2.5/4.7 = 0.54$ ).

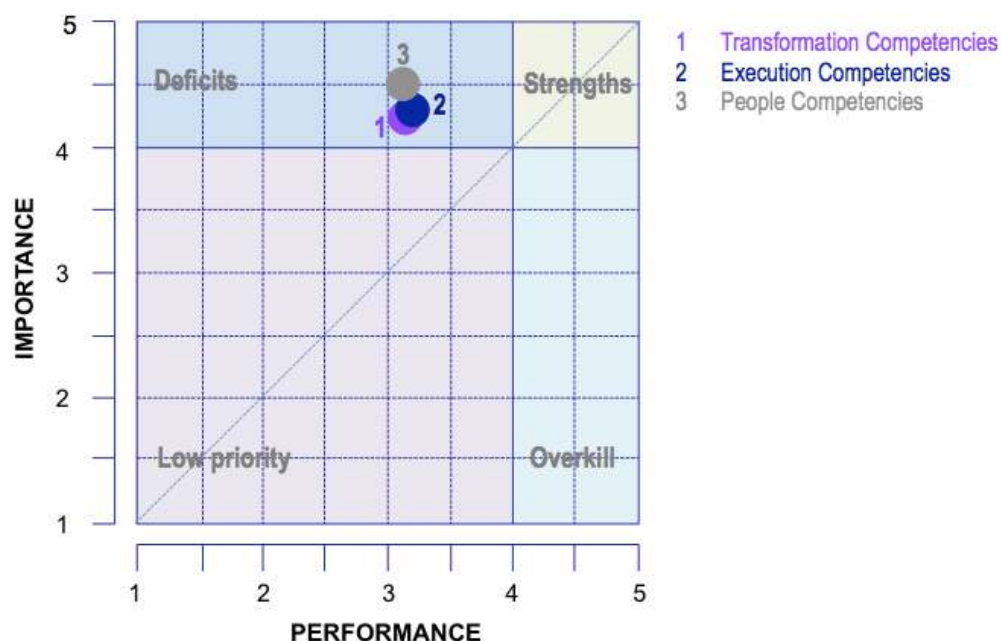
Differences between importance and performance and their respective percentage should be seen as complementary information, as they do not consider the overall context. For example, information seeking has been graded with an average of 3.7 for importance and 3.5 for performance, meaning they have a 93% correspondence between performance and importance. However this competency falls into the low priority quadrant.



N = 11

**Figure 5. Top Leader Perceptions of Differences between Importance and Performance of National Center for Healthcare Leadership Competencies**

As Figure 6 shows, no significant differences appeared in the scores that the interviewees gave to each of the three groups of competencies of the NCHL Model of Transformation, Execution, and People.



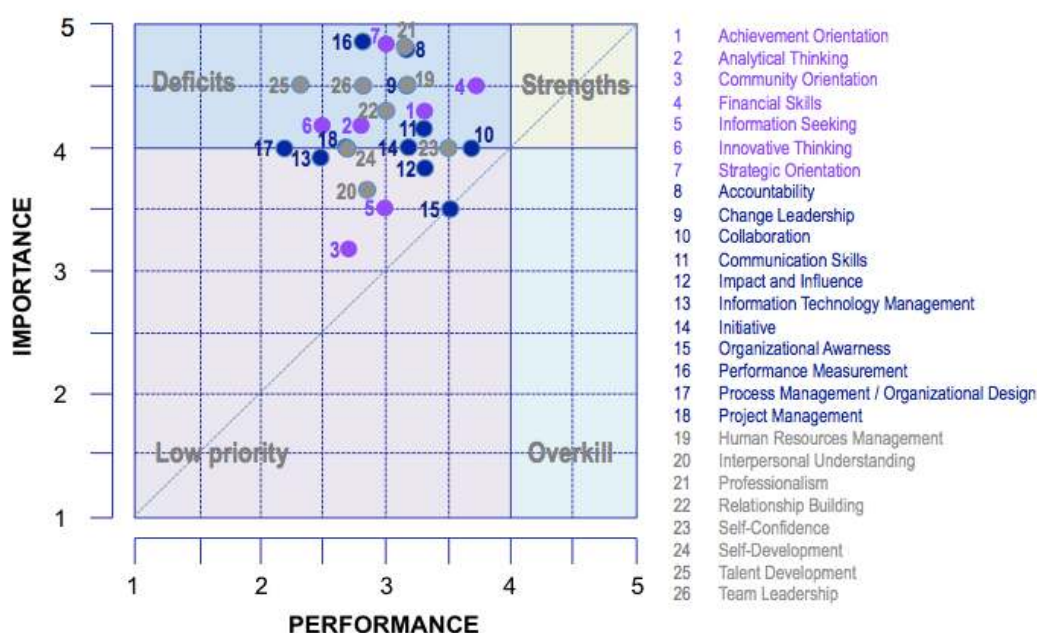
N = 11

**Figure 6. Top Management Perception of National Center for Healthcare Leadership Competency Groups**

The average scores for importance and performance regarding the three groups of competencies are located within the deficit quadrant, which means that the three groups are considered between very important and vital and have a performance that is rated between regular and good.

**Chief executive officer results.** Considering that based on only the six CEOs' answers, 20 out of the 26 leadership competencies of the NCHL Model (76.92%) are considered between very important and vital. Moreover, in all of these, the performance is closer to regular than to good, thus, locating them in the deficit quadrant (see Figure 7).

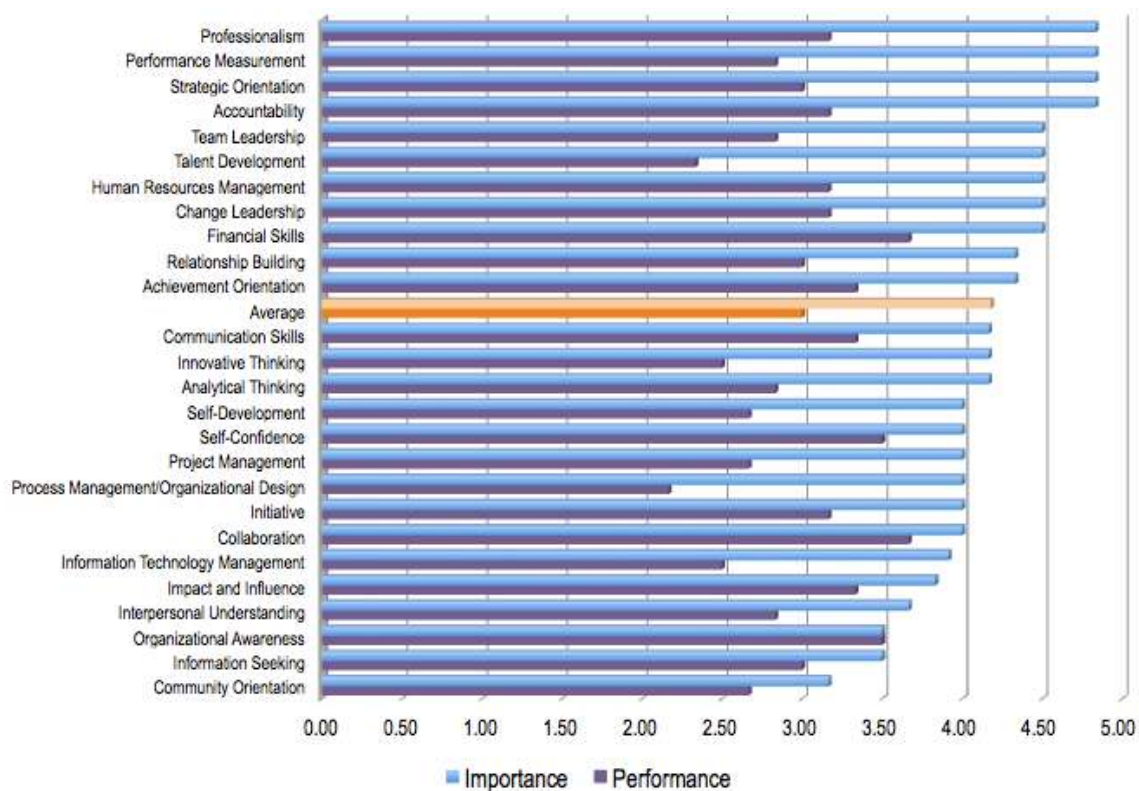
The six competencies that are below the very important level are community orientation, information seeking, impact and influence, information technology management, organizational awareness and interpersonal understanding. Appendix B presents the graphs for the scores given by the CEOs for each individual group of competencies of Transformation, Execution, and People.



N = 6

**Figure 7. Chief Executive Officer Perceptions of National Center for Healthcare Leadership Competencies**

Leadership competencies that are considered as the most important by CEOs are: performance measurement, strategic orientation, professionalism, and accountability, with an average score of 4.83. Figure 8 shows the order of importance for all of the leadership competencies pictured in the NCHL Model with its corresponding perceived performance.

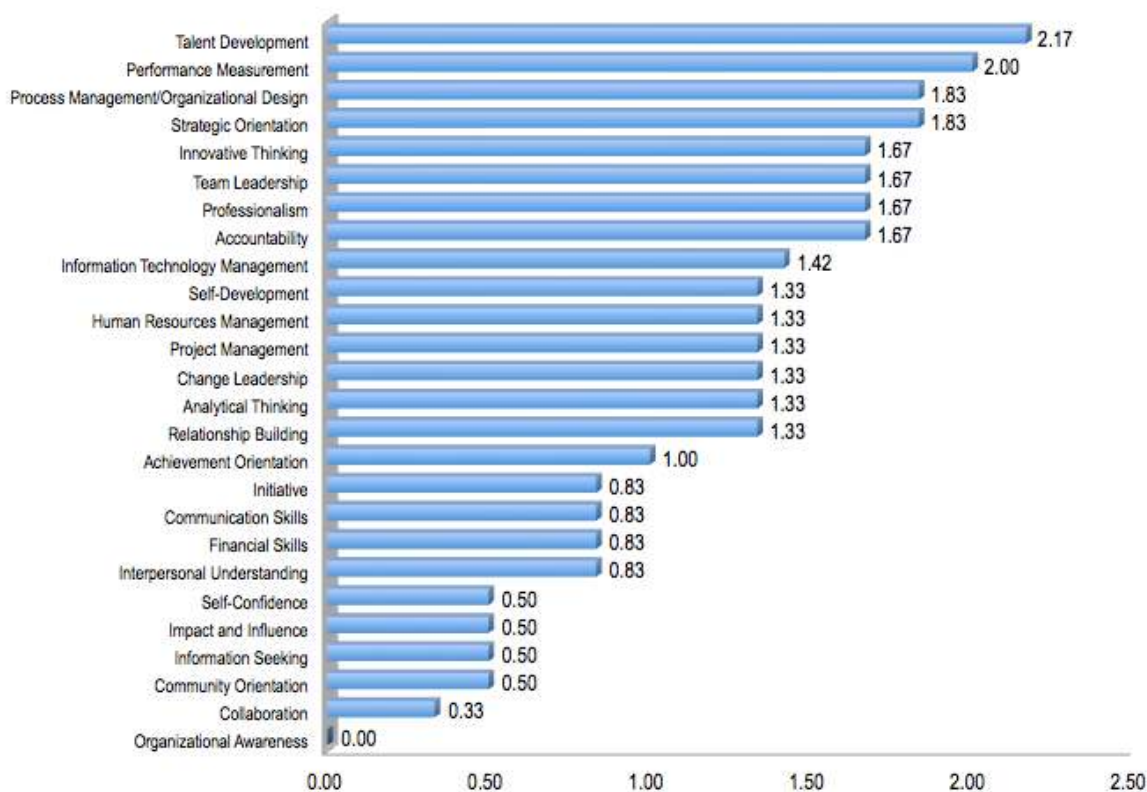


N = 6

**Figure 8. Chief Executive Officer Perceptions of Importance and Performance of the National Center for Healthcare Leadership Competencies**

Figure 9 shows the difference between the scored importance and the perceived performance of the interviewed CEOs. As it may be noticed, the competencies that have the greatest gap between scored importance and perceived performance are talent development, performance measurement, process management and organizational design, and strategic orientation.



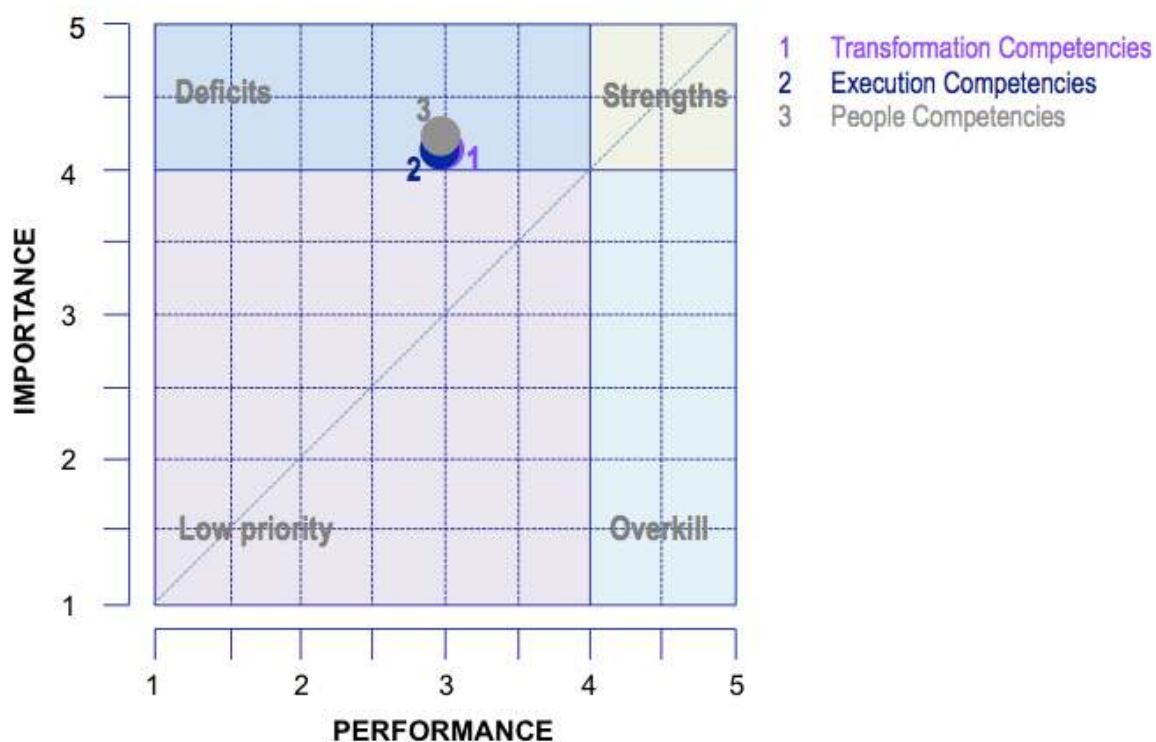


N = 6

**Figure 9. Chief Executive Officer Perceptions of Differences between Importance and Performance on the National Center for Healthcare Leadership Competencies**

From the CEOs' point of view, there are no significant differences between the three leadership competencies pictured in the NCHL Model (see Figure 10). The three competency groups of Transformation, Execution, and People are considered on average, as very important and have a regular performance, thus locating these competencies in the deficit quadrant.

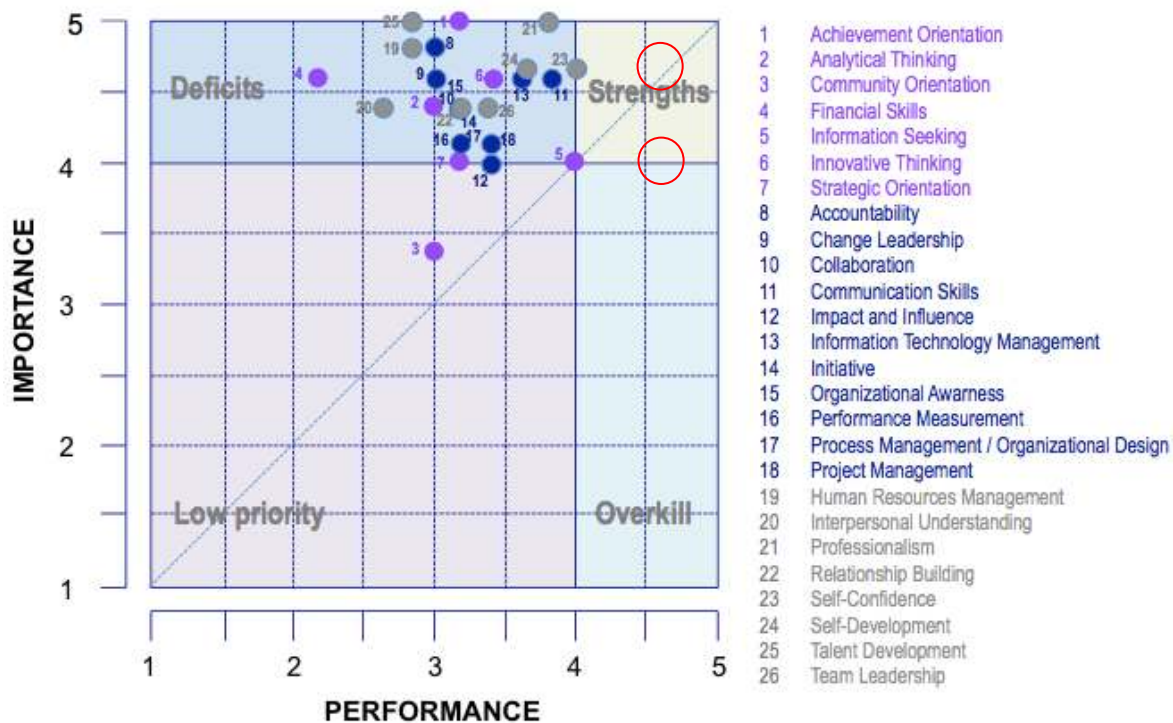




N = 6

**Figure 10. Chief Executive Officer Perceptions of National Center for Healthcare Leadership Competency Groups**

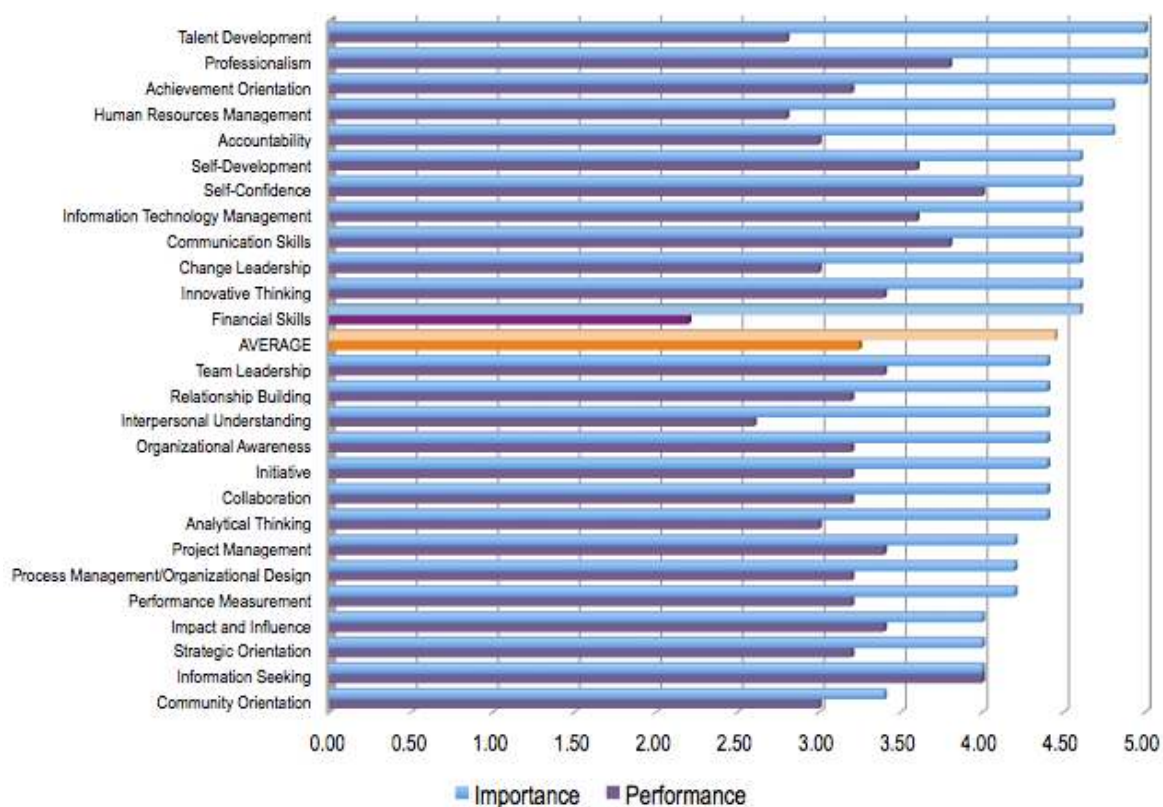
**Chief medical officer results.** Based on data from the five CMOs, 25 of the 26 leadership competencies pictured in the NCHL Model are very important to vital. It is worth noting that 23 of the competencies considered between very important and vital have a performance close to regular, thus locating them in the deficit quadrant. In contrast to the CEOs' perceptions, the CMOs believe that two competencies are located in the Strengths quadrant: self-confidence and information seeking (See red circles in Figure 11). Just one competency is considered desired, which means a level lower than very important: community orientation. For more clarity, Appendix B displays separate figures for Transformation, Execution, and People competencies.



N = 5

**Figure 11. Chief Medical Officer Perceptions of National Center for Healthcare Leadership Competencies**

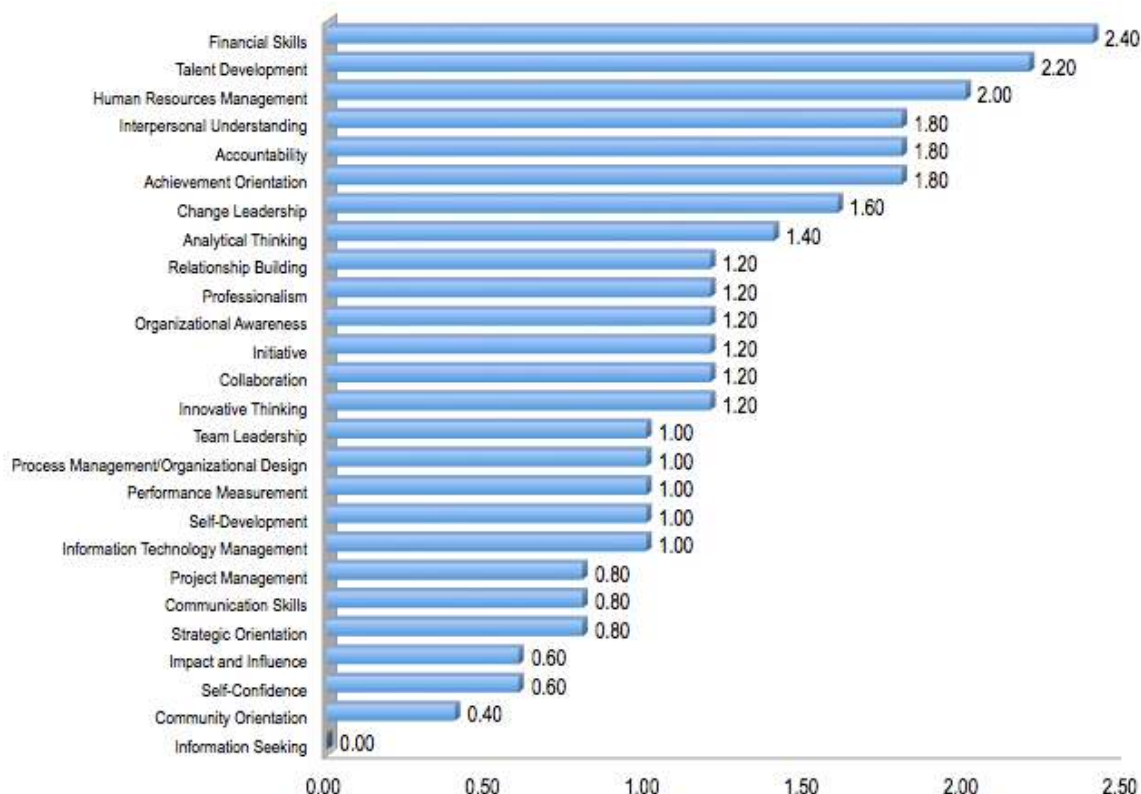
Leadership competencies that are considered most important for CMOs are: talent development, professionalism and achievement orientation, with an average score of 5. Figure 12 shows the order of scored importance to all the NCHL Competencies Model, with its correspondent level of perceived performance.



N = 5

**Figure 12. Chief Medical Officer Perceptions of Importance and Performance of National Center for Healthcare Leadership Competencies**

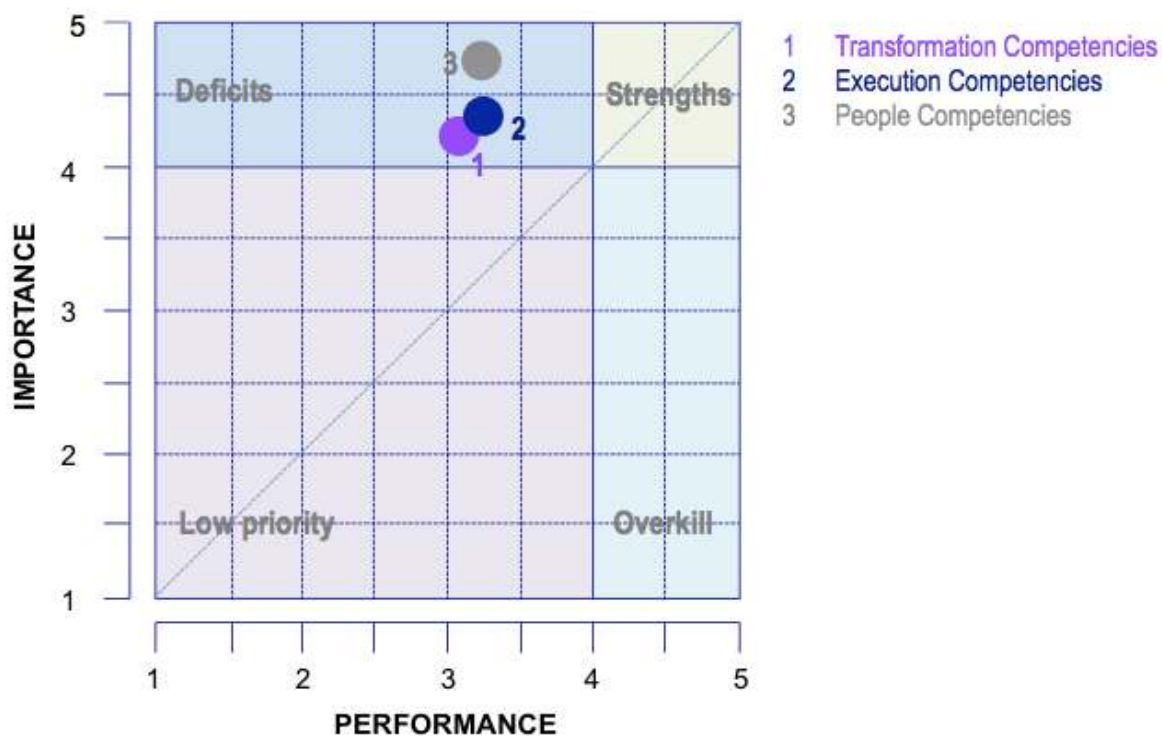
Figure 13 shows the difference between the scored importance and perceived performance of interviewed CMOs. As it can be observed, the competencies that have the greatest gap between scored importance and perceived performance are: financial skills, talent development, and human resources management.



N = 5

**Figure 13. Chief Medical Officer Perceptions of Differences between Importance and Performance of National Center for Healthcare Leadership Competencies**

Small differences were produced between the three groups of competencies; however, from the CMOs' perspective, they are not significant, as the three competency groups (Transformation, Execution, and People) are considered on average very important and have a regular performance (see Figure 14). These results mean the three groups are plotted in the deficit quadrant. However, it is worth noting that competencies such as people, on average, are considered the most important.



N = 5

**Figure 14. Chief Medical Officer Perceptions of National Center for Healthcare Leadership Competency Groups**

**Areas of agreement between chief executive officers and chief medical officers.** Only in the case of professionalism do CMOs and CEOs concur by scoring the competencies as one of the three most important; however, in general, there exists a high level of coincidence with respect of the importance assigned to all competencies. Regarding the gaps, the only area of CEO-CMO agreement is talent development. Both groups agree that one of the greatest gaps between scored importance and perceived performance appears in this competence.

## Interview Results

Interviewees were asked six questions to gather additional data about needed leadership competencies within the context of private hospitals in Mexico. This section presents the interview data and differentiates the CEOs' and CMOs' perspective.

**Additional competencies needed.** Participants were asked, "After reviewing the NCHL leadership model competencies, do you think there are other additional competencies needed for the Mexican context? Please name them."

Five out of six CEOs affirm that Business Acumen is fundamental and vital. Business acumen referred to knowledge of the business and its environment, context, or government and norms characteristic of the industry and the market. This competency by itself is not included in the NCHL Model; however, it may be considered as part of strategic orientation, because its description contains the following similar points: (a) conducts environmental scanning, \*b) develops strategy to address environmental forces, (c) aligns organization to address long-term environment, and (d) shapes industry strategy.

Other competencies that are not explicitly included in the NCHL Model and are considered very important to the CEOs are: stress management; conflict management; feedback; empathy; personal management; quality orientation; uncertainty management; and, especially, decision making. They repeatedly referenced decision making directly or indirectly throughout the interviews, stating that the CEO is fundamentally a decision maker.

The CEOs also mentioned other competencies including relationship building (i.e., with medical staff and outside doctors), ethical performance, and network building.

These competencies were included in the NCHL Model under terms such as relationship building and professionalism.

CMOs added other competencies such as empowerment, ownership, self-knowledge, synthesis capacity, resistance or perseverance, resiliency, and negotiation. CMOs also mentioned competencies that were included in the NCHL Model, such as the capacity to motivate and develop other people (talent development), self-esteem and belief in oneself (self-confidence), and financial skills. Some CMOs mentioned values or personal traits such as humility, which is not actually a competency, but rather manifests itself through specific competencies such as active listening and continuous learning. CMOs agreed with the CEOs that there is a lack of competencies such as business acumen, decision making and conflict management.

In summary, most CEOs and CMOs agreed that the NCHL Model contains the most relevant competencies for a top level leader in the healthcare industry; however, they added some competencies that are valuable and are not contemplated explicitly in the presented NCHL Model. The competencies list might be endless, making its implementation as a leadership model impossible. It seems important not to configure an exhaustive model of competencies but a general reference framework that each organization can complement and clearly align it to its mission, vision, values and beliefs.

**Unique features of hospital chief executive officers.** Participants were asked, “What are the main differences you find between a CEO/Top leader of a given company and a CEO/Top leader of a hospital?”

All of the CEOs focused on the particular attributes of the healthcare organizations. They agreed that by stating that healthcare institutions are highly complex organizations due to a series of factors: (a) they should have a continuous 24/7 operation

without holidays, nonstop; (b) they service a wide variety of clients, including patients, family members, doctors, researchers, students, and insurance companies; (c) they are highly unpredictable, as a high percentage of their operation is based on emergencies; and (d) repeated operation errors translate into loss of life and health. CEOs additionally mentioned that in this set, top leaders must develop certain competencies that allow them to handle the described complexity successfully. The principal competencies they referenced directly or indirectly were complexity recognition and management, systemic thinking, quick decision making, high uncertainty and stress management, resiliency, effective delegation and empowerment.

CMOs mentioned characteristics that distinguished healthcare organizations as complex, such as managing people while they are in a vulnerable situation, the social impact that they have, and/or the great challenge of making a profit while having a humanitarian sense. In this context, the CMOs mentioned that for the top leaders of healthcare organizations, there are certain competencies that are more critical than for the leaders in other industries. These competencies include systemic thinking, complexity recognition and management, capacity to manage highly vulnerable persons, empathy and warmth in relationships, and making a profit ethically with a humanitarian sense at the same time. Both CEOs and CMOs affirm that healthcare organizations are more complex than most organizations.

**Education received.** Participants also were asked, “What was the specific formation and/or education that you received to become (CEO / CMO)?” From the six interviewed CEOs, two are doctors, two are engineers, one is an economist, and one is a public accountant. In addition to their professional qualification, all of them have master’s degrees, business administration seminars, and masters in healthcare systems



administration. However, they unanimously recognize that they have not received a proper education to be a CEO, and much less to be leaders.

They admitted that what has most helped them become CMOs and leaders is workplace experience that enabled them to learn by doing. They recognize the importance of the master's degrees and seminars; however, they view them as complementary rather than as a substitute for experience. Similarly, one can deduce from the CEOs' answers that their formation as leaders has been thanks to certain personal qualities and personal development experiences rather than to the existence of an institutional strategy that promotes it.

The two medical CEOs affirmed that it is crucial to be a doctor and have passed through several medical middle management positions to really know and understand the internal movement of a hospital, with a fresh view, free from "contamination" from other practices. The six CEOs agree that it is fundamental to deeply know and have a wide experience in hospital operations. One interviewee commented that a factor or condition that is necessary to become a leader is being successful in his or her own medical specialty, as this generates credibility and status, which are needed to be respected in the medical community, and followed by others.

One of the interviewees addressed in his answer whether leaders are born or made. He commented that leadership is part of the essence of certain persons and that formal training is only complementary. Both the CEOs and CMOs agree that they have formed themselves thanks to their experience and proven track record in the various positions they have held within the organization.

In summary, the participants commented that the master's degrees and seminars are good for strengthening their foundation and ordering their ideas; however,

educational experiences were not considered to be determining factors in their formation as leaders. All the participants described themselves as self-taught in their leadership and a few of them mentioned the importance of observing and learning from internal and external models.

**Developmental experiences.** Participants then were asked, “What experiences have helped you become a leader as a CEO/CMO?” The CEOs’ responses reinforced their answers to the previous question. They agreed that affirming their general experience in the job has been critical, particularly as it concerned exposure to multiple decision-making situations. They also mentioned the importance of frequent interaction with various persons and institutions, such as doctors, patients, suppliers, and insurance companies.

A couple of interviewees talked explicitly about the importance of being near their immediate boss to enable them to observe how he or she performs in different situations and to receive specific coaching. Others mentioned that professionalism and accountability translate into recognition, prestige, and credibility.

One CMO specifically underscored the importance of personal discovery, meaning finding and developing one’s talents. He also emphasized the need to reflect systematically about one’s own conduct and to identify one’s successes and development opportunities. Finally, he stated that developing as a leader requires keen listening and knowing how to ask the right questions.

Both the CEOs and the CMOs mentioned the importance of the interaction with people, in both formal and informal situations. They also agreed that accepting and solving challenges and executing projects successfully were fundamental to effective leadership.

**Suggestions for training.** Participants were asked, “What suggestions can you make to help form/educate/train CEOs/CMOs as effective leaders for the Healthcare Industry?” The CEOs unanimously recommended that the candidates develop deeper knowledge and understanding of the healthcare environment and norms and that they experience the different problems facing a healthcare organization. Other recommendations were to (a) define what kind of leader is required for the size, characteristics, and circumstances of one’s institution; (b) develop a systematic, context-based training module; (c) learn global best practices regarding organization norms and clinical issues; (d) help potential successors gain more international exposure, mainly through work practices and experiences in other countries; and (e) strengthen values formation.

Similarly, CMOs recommended that leaders strengthen their values and their knowledge of the industry, healthcare environment and norms. They stressed the importance of CMOs systematically completing a series of positions to develop as leaders, starting with front-line posts, progressing through various middle management medical posts, and culminating in executive-level positions. One specific recommendation offered was to encourage the development of transformational leadership versus transactional leadership (Bass, 1990). Transactional leaders pursue a cost/benefit-based economic exchange to meet subordinates’ current material and psychic needs in return for their contracted services. Transformational leaders go further by seeking to arouse and satisfy the higher-order needs of employees. The aim of such leadership is to engage the follower’s full self and support self-esteem and self-actualization, consistent with Maslow’s hierarchy of needs (as cited in Bass, 1990).

Additional recommendations were to assign specific challenging projects to candidates, develop business sense, and professionalize the CMO post.

**Developing successors.** Participants were asked, “What are you doing to form/train your successor? What are you doing to strengthen the values, attitudes and competencies of your successor to develop him/her as an effective leader?” Findings revealed that just of the CEOs is forming his successor by making him be practically beside him so that he observes the strategy and the decision making process, and so the CEO can offer coaching to help him to relate properly with the medical staff. One of the CEOs stated that institutionally, they have clearly identified the desired profile of the successor and that they are now looking for him or her. This CEO did not mention what the hospital is actually doing to develop a specific successor. Another CEO mentioned that reaching the CEO post requires climbing through the organization rather than developing specific competencies. The remaining CEOs acknowledged the importance of forming successors; however, they limited themselves to talking about theoretical concepts such as talent identification, higher direct interaction with candidates, identification of opportunity areas, coaching, and the involvement of them in challenging projects and complex decision making situations.

CMOs discussed ideas and concepts regarding the formation of successors; however, they offered no specific and concrete actions they were actually doing for this purpose. An exception was that one of the interviewees affirmed having identified his successor and having substantial interaction with him, empowering him, exposing him to complex situations, and giving him regular coaching.

In summary, although the participants voiced good intentions and ideas, no systematic successor development process was detected. Regarding Mexican versus

United States healthcare industry, all of the interviewees agreed that everything relevant to leadership had been said; however, they emphasized that a big difference exists between the two nations regarding the specific problems of the healthcare sector and the healthcare organizations in Mexico.

## Summary

Summarized IPA and interview results are as follows:

1. NCHL Model competencies are well suited for the Mexican private healthcare organizations' context, as 86.61% of the competencies are considered by the interviewees between very important and vital. The rest of the competencies, which add up to the 15.39%, are considered between desired and very important.
2. Survey results suggested that CMOs see more room for improvement than the CEOs. Whereas 96.15% of CMOs rated the competencies as either very important or vital, CEOs rated only 76.92% of the competencies in the same range.
3. In all competencies considered in the questionnaire as very important by CEOs and CMOs, a performance deficit was noted for each, meaning there is plenty of space for development. The top-ranked disparities found were talent development (gap = 46%), accountability (gap = 36%), process management and organizational design (gap = 36%), human resources management (gap = 35%), and performance measurement (gap = 34%).
4. Leadership competencies considered most important by CEOs were performance measurement, strategic orientation, professionalism, and accountability (mean score = 4.83). Competencies with the greatest gap between scored importance and perceived performance were talent development, performance measurement, process management and organizational design and strategic orientation.
5. Leadership competencies considered most important for CMOs were talent development, professionalism and achievement orientation (mean score = 5). Competencies with the greatest gap between scored importance and perceived performance were financial skills, talent development, and human resources management
6. The interview data suggested that the CEOs and CMOs consider most of the competencies very relevant; however, they identified additional critical competencies, including business acumen, decision making, conflict management, constructive feedback, stress management, empathy, personal administration, quality orientation, uncertainty management, empowerment,

ownership, self knowledge , synthesis capacity, perseverance, resiliency, and effective negotiation.

## **Chapter 5**

### **Summary, Conclusions and Recommendations**

This study sought to identify a leadership competency model for developing healthcare executives in Mexico based on the NCHL Model. Three research questions were examined:

1. Is there a leadership competencies model applicable to Mexican private healthcare organizations?
2. How do top leaders in Mexican private healthcare organizations perceive their own performance?
3. What kind of framework would be helpful to develop leadership capability required by top leaders in Mexican private healthcare organizations?

A summary of findings is presented first, followed by conclusions and recommendations for CEOs, CMOs, and organizational development practitioners.

Limitations of the study and suggestions for future research also are described.

#### **Summary of Findings**

1. A total of 86.61% of the leadership competencies identified in the NCHL Model are considered by the CMOs and CEOs as very important or vital. The most important were professionalism (4.91), accountability (4.82), talent development (4.73) human resources management (4.64), and achievement orientation (4.64).
2. There is a gap in performance regarding all the NCHL leadership competencies. The most important areas of opportunity (mean score = with an average of 3.11) are: talent development, accountability, human resources management, performance measurement, and financial skills.
3. In addition to the competencies included in the NCHL model, the interviewees considered as relevant for the Mexican context additional competencies such as: business acumen, decision making, stress management, conflict management, feedback, empathy, personal organization, quality orientation, empowerment, ownership, self-knowledge, perseverance, resiliency, negotiation, and uncertainty management.
4. The interviewees had at least one of the following: master's in business administration, master's in hospital administration, and top management seminars and courses. However, none of them have received specific

formation to perform as leaders. They believed their leadership competencies have been developed through their years of experience at work.

5. Both CEOs and CMOs emphasized that forming their successors and strengthening their leadership competencies is of utmost importance; however, actually they don't have concrete strategies that meet that purpose.

## **Conclusions**

From the findings described above, it is possible to extract several conclusions.

These are described in the following sections.

**Is there a leadership competencies model applicable to Mexican private healthcare organizations?** With no doubt, there are models such as the NCHL Model that are good referential frames for identifying the competencies required by top leaders in the Mexican healthcare industry. Different organizations, however, will most likely wish to discover their own respective “best leadership competencies model,” depending on their context and purpose. The value of a model like this does not lay in its universality, but in its power to inspire.

The NCHL model, in particular, has the virtue of being tested in a large amount of healthcare organizations and has demonstrated its value. In this sense, it may be considered a “best practice” in the leadership competencies classification for serving as a good framework to orient the institutional efforts for leadership development.

**How do top leaders in Mexican private healthcare organizations perceive their own performance?** According to the IPA, all the competencies considered in this study are in the deficiency quadrant. This is because the performance of other colleagues in the same leadership position was perceived as lower than the level of importance assigned by the interviewees and hence represent areas of opportunity. This aligns with perceptions of leadership competencies among CEOs and CMOs of the Mexican private



healthcare industry. Being conscious of the gaps and accepting them can provide a premise for change to close the gaps between the current situation and the desired one.

**What kind of framework would be helpful to develop leadership capability required by top leaders in Mexican private healthcare organizations?** McAlearney (2008) asserts based on her studies that leadership development programs have a positive impact in the quality and efficiency of the healthcare industry through giving more strength to the workforce, promoting efficiency in organizational education and in the development activities, reducing turnover and related costs, and focusing organizational attention in specific strategic priorities. McAlearney (2010) later concluded that the executive leadership development programs are viewed by the healthcare executives in the United States as important tools to strengthen the healthcare system's strategic objectives, elaborate succession plans and offer development opportunities, and that it is worth to invest in them.

Groves (2011) discovered based on research from 15 nationwide healthcare administration systems in the United States that exemplary healthcare organizations use a talent administration system composes of six factors and their corresponding success factors. These factors are:

1. Establishing the business case for talent management. This phase's success depends on the right identification of the strategic priorities, the characteristics of the workforce, and the diversity of their initiatives.
2. Defining high-potential healthcare leaders. Success in this phase depends mainly in the clarification of leadership competencies in the context of the organization's business strategy.
3. Identifying and codifying high-potential leaders. Success in this phase depends mostly on the tools for classifying high-potential leaders as well as the evaluation process.

4. Communicating high-potential designations. In this phase it is important to emphasize the importance of the continuous development and strengthening of key leadership competencies while preventing the status associated to titles getting in the way.
5. Developing high-potential leaders. The key of this phase is offering high-potential leaders experiential learning opportunities, balancing them with their own needs.
6. Evaluating and embedding talent management practices. Consists in developing the metrics for evaluating the effectiveness of the talent management system.

The Corporate Leadership Council (2003), an international organization that gives support to more than 16,000 leaders, from more than 6,000 organizations across 60 countries, has done a large number of studies about leadership as a topic and has accumulated a vast experience about leadership development plans. In its paper “Highlights of Effective Leadership Programs,” the organization identifies the main success factors in the leader development plans. These success factors can be incorporated into a good general framework for CEOs and CMOs and are:

1. Define the required leadership profiles. Analyze the organization’s needs with precision for determining the most important skills and attributes for an effective leadership.
2. Clarify the organization’s purposes and desired outcomes. Gaining clarity about the organization’s purpose is necessary with respect to leader development to allow for objective evaluation of the effectiveness of the training activities.
3. Adapt the development opportunities to the leaders’ needs. Maximize the development impact by creating a specific plan for each leader, offering them development activities with the highest return adapting experience, and programs and opportunities to the important gaps in the competencies for each leader and the organization’s.
4. Ensure top leadership support. Every effective leadership development program must have the complete support of the senior-level managers. Furthermore, leader development is most effective when senior executives participate also as instructors.

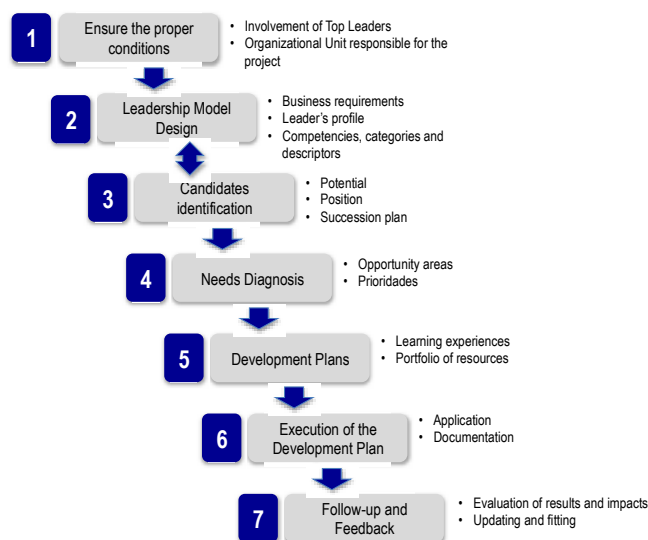
5. Link competencies to results. Competencies make sense to participants if they can clearly see the relationship between a competency and the desired results in the organization.
6. Visualize future leadership needs. It is important to take into account probable changes in the mix of leadership skills for the long run and manage proactively the development of leadership potential in every levels of the organization.
7. Create a continuous improvement and development culture. Use organizational resources to support and strengthen the impact of leadership development program “beyond the classroom.”
8. Place leadership development within the specific organization’s context. Programs should develop individuals in accordance to the nature of the organization, having in mind its culture, norms, values, work processes, and services.
9. Build results scorecards. Scorecards can motivate individuals to focus and perform with intensity. Without scorecards, a leadership development activity can be an enjoyable exercise; however, neither the executives nor the organization can expect much result without its measures.
10. Ensure managers’ responsibility on leadership development. Provide managers the tools and incentives they need to accelerate leaders’ development.

### **Recommendations**

**For chief executive officers and chief medical officers.** CEOs and CMOs are the right people within the organization to promote the design and implementation of coordinated and systematic leader development plans. Importantly, CEOs and CMOs do not need to design of the leadership development plans, as this requires a high degree of specialization and dedication and competes with their other important tasks. However, it is very important that they ensure that the institutional leader development plans are strategically oriented and that they take advantage of the learning and best practices regarding this topic. Although organization development and human resources personnel can implement, the plans need to come from and be promoted by the top leaders.

**For organization development practitioners.** Organization development practitioner should study, compare, and select an appropriate leadership development model for the organization, having in mind the best practices as described in this chapter. Next, this leadership development model chosen for the organization must be adapted to the specific needs and circumstances of the organization.

Based mostly in the Corporate Leadership Council's (2003) recommendations, a seven-phase procedure (see Figure 15) is advised to develop and implement a leadership development program within private healthcare organizations in Mexico. The following sections describe each phases, including some key ideas and suggestions for successful implementation.



**Figure 15. Phases for the General Strategy for Leaders Development in the Mexican Healthcare Industry**

***Phase 1. Ensure the proper conditions.*** In this phase, it is crucial to ensure the complete involvement and full support of top management, top leaders, and, if possible, the board of directors. It is of highest importance to present the needs and the benefits of

having a systematic strategy for leader development in the organization. The objective is that top leaders take ownership on this initiative and, consequently, be willing to give full support and the necessary resources. It is important that it does not matter where the initiative is originated, as long it is not perceived as somebody's personal project, but as an institutional initiative.

Additionally, a specific division or department must be assigned as being responsible for the following phases in this process. An indispensable condition is that the business unit designated for this takes ownership of the project with the conviction of its use and not only to cover a mere formality.

***Phase 2. Leadership model design.*** Four tasks are central to this phase. First, it is important to clarify the vision of the organization, its fundamental values, and the essential aspects of its strategic plan in such a way that a full and precise view of the role of the leaders is understood in this specific context.

Second, it is necessary to define what is the actual concept of a leader that exists in the organization and sketch a desired profile that would allow to add value to the organization and its stakeholders.

Third, needed competencies that leaders must have should be identified in accordance to the desired profile. It is suggested to make a list that includes the competencies that are considered as critical in the organization's requirements, without pretending the inclusion of all the possible competencies. Up to this point, it is desired to have a sort of leadership competencies dictionary or catalogue that serves only as a reference or start point, but not as a checklist. The competencies presented in this study are a good start point.

Fourth, it is important to group the competencies into categories for a better understanding, placing them in the organizational context, and facilitating its handling. Some examples of categories are (a) self-leadership, leading others, leading systems, leading the enterprise; (b) functional and technical competencies, self-development and self-understanding competencies, interpersonal competencies, organizational competencies; (c) leading people, leading the business, knowing yourself; and (d) transformation competencies, execution competencies, and people competencies.

Each organization must group the identified competencies based on criteria that make more sense regarding function or that adjust better to the values and strategy of the organization. However, it may be quite useful to consult how other organizations with success in having a defined leadership models for comparison and benchmarking.

For each competency, the key behaviors which represent it need to be developed. For example, behavioral descriptors can be discovered through the use of cards during an interview, similar to those used in this study. Label each card with the name of a competence along with its general description and a series of specific behaviors (see cards in Appendix A). These descriptors can be the basis for making participant diagnostic evaluations as well as measuring the degree of progress made in the development programs.

This is a crucial moment. If the leadership competencies models could be applicable with small adjustments to different types of organizations, the behavioral descriptors must reflect the typical situations of the specific healthcare organization, which converts it into a unique and distinctive model.

Next, the leadership competencies model should be presented in graphical format so it can be easily visualized in terms of the categories as well as the specific

competencies. This graphic representation serves two purposes: (a) in the design, it permits the detection of possible inconsistencies and its corrections, and (b) when communicating it to the whole organization, it makes easier the communication and its comprehension.

It is important that top leaders, managers and persons in key leadership positions are involved during the leadership model design through practical methods that allow capturing their experience and organizational sensibility with respect to leadership.

***Phase 3. Candidate identification.*** For the development strategy to have the desired impact, it should focus on those people who are in the conditions to exert influence in their respective work environment to elevate the probability of reaching the organization's strategic and operations objectives. Based on the position, it is recommended to include persons that have posts including supervisors and higher, including high potential persons regardless of position, as well as those identified as possible successors for top leaders.

Once the candidates for the leadership development plan are identified, they need to be informed of their status, and assured this is not an additional obligation but a real opportunity for growth.

***Phase 4. Needs diagnosis.*** For the proposed strategy to be a true development instrument, it must focus in the real areas of opportunity and not in general themes or topics. Before designing learning and development experiences, it is necessary to make a diagnostic evaluation of all the candidates.

It is suggested to develop a diagnostic instrument based on the identified competencies and in the behavioral descriptions. Depending on the type and quantity of the resources that the hospital has, an immediate superior evaluation, an auto-evaluation

or a 360 evaluation can be used. This diagnosis allows practitioners to identify needs held in common among the groups as well as the specific needs of individuals.

***Phase 5. Preparation of development plans.*** Based on the information obtained from the needs diagnosis, what follows is to identify (a) the “institutional” or basic learning experiences that would be applicable to a great number of candidates, (b) the learning experiences that would be useful to specific groups, and (c) the “specialized” learning experiences, destined to particular cases.

Each person, with the results from the diagnosis and with the help from the department responsible for it, should elaborate his or her own development plan which will include the competencies that need strengthening, the objectives to attain, the activities that need to be done and the indicators that will measure the progress. Such a plan should be analyzed, adjusted, and approved by the immediate superior.

To deepen the plans, using the Jennings and Wagnier’s (2011) 70:20:10 framework is proposed. This framework states that 70% of the learning is obtained through experience (experiential learning), 20% is obtained through other people (social learning) and 10% is obtained through structured courses and programs (formal learning).

Development activities in experiential learning are: On the job experience, applying new learning in real situations, solving problems, special assignments, project reviews, reading guides and manuals, new work within role, increased span of control, exposure to other departments and roles, stretch assignments, community activities.

Development activities in social learning include mentoring, reverse mentoring, coaching, informal feedback, internal and external networks, teamwork, professional associations, action learning. Development activities in formal learning include structured



programs, activity-based workshops, seminars and master classes, professional development, business schools, eLearning modules, and courses.

***Phase 6. Execution of the development program.*** Although each person should be responsible for the execution of his or her respective development plan, the organization should design a practical monitoring mechanism that permits systematically registering each person's progress. By itself, the level of progress of the personal plan is a good indicator of the interest the persons have in their own development and an element to identify the level of commitment to the organization. Besides monitoring the progress of the personal development plans, the responsible unit should systemically document the successes and shortcomings in the processes, support systems, resources, and, in general, the strategy's management.

***Phase 7. Follow-up and feedback of the strategy.*** Although the strategy follow-up starts from the execution phase, it is important to formally measure the results, the stakeholders' opinions, and their impacts to the organization. With this purpose, it is necessary to design functional instruments to obtain timely, valid, and dependable information, which can be used to strengthen the program and correct shortcomings so that the strategy does not become obsolete. Rather, on the contrary, the strategy maintains itself updated and producing better results each time.

### **Limitations of the Study**

The results of this study represent the particular perception of a small group of top leaders regarding the importance and performance of certain leadership competencies for CEOs and CMOs within the Mexican private healthcare organizations. These results are not to be generalized to the whole healthcare system in Mexico for several reasons.

First, a statistical formula was not used to determine the size of the sample of interviewees regarding the total population of top leaders of Mexican private healthcare organizations (CEOs and CMOs). What was used is the criteria of availability and accessibility for the interviews.

Second, using these criteria, a random selection of the sample was not possible. Interviewees were chosen from a list of available candidates.

Third, the importance and performance evaluation of the leadership competencies was completely subjective. In case of importance, it does not represent a problem because the objective was to understand the interviewee's perspective regarding the importance of each competency. However, in the case of performance, the interviewees were not evaluating a specific subject but the average of their known CEOs or CMOs.

Fourth, organization development practitioners should be aware that this general strategy for leaders development in the Mexican healthcare industry is a theoretical elaboration and it lacks the experimental research to confirm it.

### **Suggestions for Future Research**

A leader development strategy for the Mexican private healthcare industry has been proposed in this chapter, based on the findings of prior studies of best practices on leadership development. However, this particular strategy is still a theoretical elaboration whose validity only can be evaluated by the reality itself

For this reason, the following step should be a “pilot” application of this leader development strategy in a Mexican private healthcare organization. This would allow for validation on the strategy and corresponding adjustments. Afterwards, it could be offered to other institutions for its application, sharing results and impacts for further configuring a truly basic strategy that is applicable to the Mexican reality. A summary of instruments

or resources for executing this pilot application related to each phase is presented in Table 8.

**Table 8**

***Suggestions for Research by Phase of the Model***

Phase	Suggestion for Research
1	Ensure the proper conditions: Have a prototype or example of the presentation that should be made to top leaders with the motivations and benefits of designing a leader development strategy.
2	Develop a generic leadership competencies catalog, different examples of competencies' categorization, examples and guidelines for elaborating competencies' behavioral descriptors, and graphic examples of competencies models.
3	Examples of basic criteria for identifying candidates.
4	Institute a diagnostic instrument example, based on leadership competencies with their respective behavioral descriptors.
5	An example of a personal development plan.
6	An example of an instrument for monitoring progress.
7	An example of an instrument to assess opinions, results and impacts on the organization.

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## Appendix A: Cards with the Descriptions of the Competencies of National Center for Healthcare Leadership Model

<b>Achievement Orientation (T)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org">www.nchl.org</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  A concern for surpassing a standard of excellence.  The standard may be one's own past performance (striving for improvement); an objective measure (results orientation); outperforming others (competitiveness); challenging goals, or something that has not been done previously (innovation).	<b>MANIFESTATIONS:</b> <ul style="list-style-type: none"> <li>• Wants to do the job well.</li> <li>• Creates Own Measure of Excellence.</li> <li>• Improves Performance.</li> <li>• Sets and Works to Meet Challenging Goals.</li> <li>• Makes Cost-Benefit Analyses.</li> <li>• Takes Calculated Entrepreneurial Risks.</li> </ul>

Figure 1. Achievement Orientation. Description and Manifestations.

<b>Analytical Thinking (T)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org">www.nchl.org</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  The ability to understand a situation, issue, or problem by breaking it into smaller pieces or tracing its implications in a step-by-step way. It includes organizing the parts of a situation, issue, or problem systematically; making systematic comparisons of different features or aspects; setting priorities on a rational basis; and identifying time sequences, causal relationships, or if-then relationships.	<b>MANIFESTATIONS:</b> <ul style="list-style-type: none"> <li>• Breaks Down Problems.</li> <li>• Identifies Basic Relationships.</li> <li>• Recognizes Multiple Relationships.</li> <li>• Develops Complex Plans or Analyses.</li> </ul>

Figure 2. Analytical Thinking. Description and Manifestations.

<b>Community Orientation (T)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org">www.nchl.org</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  The ability to align one's own and the organization's priorities with the needs and values of the community, including its cultural and ethnocentric values and to move health forward in line with population-based wellness needs and national health agenda.	<b>MANIFESTATIONS:</b> <ul style="list-style-type: none"> <li>• Responds Appropriately to Community Needs.</li> <li>• Maintains Clear Communication.</li> <li>• Takes Personal Responsibility for Initiating Collaborative Planning.</li> <li>• Participates with and Understands the Community.</li> <li>• Provides Services to the Community.</li> <li>• Advocates for the Broader Health Environment.</li> </ul>

Figure 3. Community Orientation. Description and Manifestations.

<b>Financial Skills (T)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org">www.nchl.org</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  The ability to understand and explain financial and accounting information, prepare and manage budgets, and make sound long-term investment decisions.	<b>MANIFESTATIONS:</b> <ul style="list-style-type: none"> <li>• Explains the Organization's Financial Metrics and Reports.</li> <li>• Manages Budgets and Assets.</li> <li>• Understands Impact of Reimbursement Models.</li> <li>• Evaluates Financial Analyses and Investments.</li> <li>• Develops Long-term Financial Plans.</li> </ul>

Figure 4. Financial Skills. Description and Manifestations.



## Information Seeking (T)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

An underlying curiosity and desire to know more about things, people, or issues, including the desire for knowledge and staying current with health, organizational, industry, and professional trends and developments.

### MANIFESTATIONS:

- Consults Available Resources.
- Investigates Beyond Routine Questions.
- Delves Deeper.
- Conducts Research to Maintain Knowledge.
- Is Recognized as a User of Best Practices.

Figure 5. Information Seeking. Description and Manifestations.

## Innovative Thinking (T)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to apply complex concepts, develop creative solutions, or adapt previous solutions in new ways for breakthrough thinking in the field.

### MANIFESTATIONS:

- Applies Basic Rules.
- Recognizes Patterns Based on Life Experience.
- Applies "Tried and True" Concepts or Trends.
- Clarifies Complex Ideas or Situations.
- Creates New Concepts or Breakthrough Thinking.

Figure 6. Innovative Thinking. Description and Manifestations.

<b>Strategic Orientation (T)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org">www.nchl.org</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  The ability to consider the business, demographic, ethno-cultural, political, and regulatory implications of decisions and develop strategies that continually improve the long-term success and viability of the organization.	<b>MANIFESTATIONS:</b> <ul style="list-style-type: none"> <li>• Conducts Environmental Scanning.</li> <li>• Develops Strategy to Address Environmental Forces.</li> <li>• Aligns Organization to Address Long-term Environment.</li> <li>• Shapes Industry Strategy.</li> </ul>

Figure 7. Strategic Orientation. Description and Manifestations.

<b>Accountability (E)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org">www.nchl.org</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  The ability to hold people accountable to standards of performance or ensure compliance using the power of one's position or force of personality appropriately and effectively, with the long-term good of the organization in mind.	<b>MANIFESTATIONS:</b> <ul style="list-style-type: none"> <li>• Communicates Requirements and Expectations.</li> <li>• Sets Limits.</li> <li>• Demands High Performance.</li> <li>• Confronts Performance Problems.</li> <li>• Creates Culture of Accountability.</li> </ul>

Figure 8. Accountability. Description and Manifestations.

## Change Leadership (E)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to energize stakeholders and sustain their commitment to changes in approaches, processes, and strategies.

### MANIFESTATIONS:

- Identifies Areas for Change.
- Expresses Vision for Change.
- Ensures Change Message is Heard.
- Challenges Status Quo.
- Reinforces Change Vision Dramatically.
- Provides Calm During the Storm of Change.

Figure 9. Change Leadership. Description and Manifestations.

## Collaboration (E)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to work cooperatively with others, to be part of a team, to work together, as opposed to working separately or competitively. Collaboration applies when a person is a member of a group of people functioning as a team, but not the leader.

### MANIFESTATIONS:

- Conducts work in a cooperative manner.
- Expresses Positive Attitudes and Expectations of Team or Team Members.
- Solicits Inputs.
- Encourages Others.
- Builds Team Commitment.

Figure 10. Collaboration. Description and Manifestations.

## Communication Skills (E)

*Reprinted with permission from the National Center for Healthcare Leadership (www.nchl.org), Chicago, IL*

### DESCRIPTION:

The ability to speak and write in a clear, logical, and grammatical manner in formal and informal situations to prepare cogent business presentations and to facilitate a group.

### MANIFESTATIONS:

- Uses Generally Accepted Grammar.
- Prepares Effective Written Business Cases or Presentations.
- Makes Persuasive Oral Presentations.
- Facilitates Group Interactions.

Figure 11. Communication Skills. Description and Manifestations.

## Impact and Influence (E)

*Reprinted with permission from the National Center for Healthcare Leadership (www.nchl.org), Chicago, IL*

### DESCRIPTION:

The ability to persuade, convince, influence, or impress others (individuals or groups) in order to get them to go along with or to support one's opinion or position. The "key" is understanding others, since Impact and Influence is based on the desire to have a specific impact or effect on others where the person has a specific type of impression to make, or a course of action that he or she wants the others to adopt.

### MANIFESTATIONS:

- Expresses Logical Intention but Takes No Action.
- Takes a Single Action to Persuade.
- Takes Multiple Actions to Persuade.
- Calculates Impact of Actions or Words.
- Uses Indirect Influence.
- Use Complex Influence Strategies.

Figure 12. Impact and Influence. Description and Manifestations.

<b>Information Technology Management (E)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org/">www.nchl.org/</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  The ability to see the potential in and understand the use of administrative and clinical information technology and decision-support tools in process and performance improvement. Actively sponsors their utilization and the continuous upgrading of information management capabilities.	<b>MANIFESTATIONS:</b>  <ul style="list-style-type: none"> <li>• Recognizes the Potential of Information Systems in Process and Patient Service Improvement.</li> <li>• Actively Promotes Information Systems Implementation.</li> <li>• Champions Decision-Support Systems Implementation.</li> <li>• Seeks and Challenges the Organization to Use Leading-Edge and Developing Information Technology.</li> </ul>

Figure 13. Information Technology Management. Description and Manifestations.

<b>Initiative (E)</b> <small>Reprinted with permission from the National Center for Healthcare Leadership (<a href="http://www.nchl.org/">www.nchl.org/</a>), Chicago, IL</small>	
<b>DESCRIPTION:</b>  Identifying a problem, obstacle, or opportunity and taking action in light of this identification to address current or future problems or opportunities. Initiative should be seen in the context of proactively doing things and not simply thinking about future actions. The time frame of this scale moves from addressing current situations to acting on future opportunities or problems.	<b>MANIFESTATIONS:</b>  <ul style="list-style-type: none"> <li>• Reacts to Short-Term Opportunities or Problems.</li> <li>• Is Decisive in Time-Sensitive Situations.</li> <li>• Looks Ahead to Take Action Short-term.</li> <li>• Takes Action on Longer-term Opportunities.</li> <li>• Acts Over a Year Ahead.</li> </ul>

Figure 14. Initiative. Description and Manifestations.

## Organizational Awareness (E)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to understand and learn the formal and informal decision-making structures and power relationships in an organization or industry (e.g., stakeholders, suppliers). This includes the ability to identify who the real decision makers are and the individuals who can influence them, and to predict how new events will affect individuals and groups within the organization.

### MANIFESTATIONS:

- Uses Formal Structure.
- Applies Understanding of Informal Structure.
- Adapts Actions to Climate and Culture.
- Considers Priorities and Values of Multiple Constituencies.
- Uses Insights of Stakeholders' Underlying Actions and Issues.

Figure 15. Organizational Awareness. Description and Manifestations.

## Performance Measurement (E)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to understand and use statistical and financial methods and metrics to set goals and measure clinical as well as organizational performance; commitment to and employment of evidence-based techniques.

### MANIFESTATIONS:

- Monitors Indicators of Performance.
- Monitors a "Scorecard" of Quantitative and Qualitative Measures.
- Uses Evidence-based Approaches to Support Community Wellness.

Figure 16. Performance Measurement. Description and Manifestations.



## Process Management / Organizational Design (E)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to analyze and design or improve an organizational process, including incorporating the principles of quality management as well as customer satisfaction.

### MANIFESTATIONS:

- Conducts Process Flow Analyses.
- Benchmarks Good Processes and Practices.
- Evaluates Organization Structure and Design.
- Understand the Basics of Organization Governance.

Figure 17. Process Management / Organizational Design. Description and Manifestations.

## Project Management (E)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to plan, execute, and oversee a multi-year, large-scale project involving significant resources, scope, and impact. Examples include the construction of a major building, implementation of an enterprise-wide system (patient tracking, SAP), or development of a new service line.

### MANIFESTATIONS:

- Prepares a Detailed Project Plan.
- Manages Projects Effectively.
- Provides Project Oversight and Sponsorship.

Figure 18. Project Management. Description and Manifestations.

## Human Resources Management (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to implement staff development and other management practices that represent contemporary best practices, comply with legal and regulatory requirements, and optimize the performance of the workforce, including performance assessments, alternative compensation and benefit methods, and the alignment of human resource practices and processes to meet the strategic goals of the organization.

### MANIFESTATIONS:

- Is Familiar with Basic Employment Processes and Law.
- Uses Alternative Compensation and Benefit Programs.
- Aligns Human Resource Functions with Strategy.

*Figure 19. Human Resources Management. Description and Manifestations.*

## Interpersonal Understanding (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to understand other people as well as to accurately hear and understand the unspoken or partly expressed thoughts, feelings, and concerns of others. It measures increasing complexity and depth of understanding of others and includes cross-cultural sensitivity.

### MANIFESTATIONS:

- Recognizes Emotions and Concerns of Others.
- Interprets Emotions and Verbal Content.
- Commits to Understanding Others.
- Displays Sensitivity to Cultural, Ethnic, and Social Issues.
- Actively Increases Diversity and Multicultural Approaches.

*Figure 20. Interpersonal Understanding. Description and Manifestations.*



## Professionalism (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The demonstration of ethics, sound professional practices, social accountability, and community stewardship. The desire to act in a way that is consistent with one's values and what one says is important.

### MANIFESTATIONS:

- Acts Openly and Honestly.
- Promotes Organizational Integrity.
- Maintains Social Accountability.
- Promotes Community Stewardship.

Figure 21. Professionalism. Description and Manifestations.

## Relationship Building (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to establish, build, and sustain professional contacts for the purpose of building networks of people with similar goals and that support similar interests.

### MANIFESTATIONS:

- Develops or Sustains Informal Contacts.
- Builds Friendly Rapport with Associates.
- Sustains Formal Contacts.
- Establishes Important Relationships with Key Leaders.
- Sustains Strong Personal Networks.

Figure 22. Relationship Building. Description and Manifestations.

## Self-Confidence (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

A belief in one's own capability to accomplish a task and select an effective approach to a task or problem. This includes confidence in one's ability as expressed in increasingly challenging circumstances and confidence in one's decisions or opinions.

### MANIFESTATIONS:

- Acts Confidently within Job or Role.
- Acts Confidently at the Limits or Slightly Beyond the Limits of Job or Role.
- States Confidence in Own Ability.
- Takes on Challenges.
- Chooses Extremely Challenging Situations.

Figure 23. Self-Confidence. Description and Manifestations.

## Self-Development (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The ability to have an accurate view of one's own strengths and development needs, including the impact that one has on others. A willingness to address needs through reflective, self-directed learning, and by trying new approaches.

### MANIFESTATIONS:

- Seeks Feedback.
- Improves Own Performance.
- Considers the Impact One Has on Others.
- Pursues Long-term Personal Development.

Figure 24. Self-Development. Description and Manifestations.

## Talent Development (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

The drive to build the breadth and depth of the organization's human capability and professionalism, including supporting top-performing people and taking a personal interest in coaching and mentoring high-potential leaders.

### MANIFESTATIONS:

- Expresses Positive Expectations of Others.
- Gives Short-Term, Task-Oriented Instruction.
- Provides Constructive Feedback and Support.
- Supports Ongoing Development.
- Acts as a Developer of Talent.
- Develops Health Industry Talent.

Figure 25. Talent Development. Description and Manifestations.

## Team Leadership (P)

*Reprinted with permission from the National Center for Healthcare Leadership ([www.nchl.org](http://www.nchl.org)), Chicago, IL*

### DESCRIPTION:

Sees oneself as a leader of others, from forming a team that possesses balanced capabilities to setting its mission, values, and norms, as well as to holding the team members accountable individually and as a group for results.

### MANIFESTATIONS:

- Manages Team Meetings Well.
- Keeps People Informed.
- Promotes Team Effectiveness.
- Obtains Resources / Takes Care of the Team.
- Demonstrates Leadership.
- Is a Role Model for Leadership.

Figure 26. Team Leadership. Description and Manifestations.

## Appendix B: Tables and Graphs with the Participants' General Results for Importance-Performance Analysis

Table 1.

*Average scores of the National Center for Healthcare Leadership Model competencies provided by CEOs & CMOs Together*

CEOs & CMOs Together		
TRANSFORMATION	Average	
	I	P
1 Achievement Orientation	4.6	3.3
2 Analytical Thinking	4.3	2.9
3 Community Orientation	3.3	2.8
4 Financial Skills	4.5	3.0
5 Information Seeking	3.7	3.5
6 Innovative Thinking	4.4	2.9
7 Strategic Orientation	4.5	3.1
Average	4.2	3.1
CEOs & CMOs Together		
EXECUTION	Average	
	I	P
8 Accountability	4.8	3.1
9 Change Leadership	4.5	3.1
10 Collaboration	4.2	3.5
11 Communication Skills	4.4	3.5
12 Impact and Influence	3.9	3.4
13 Information Technology Management	4.2	3.0
14 Initiative	4.2	3.2
15 Organizational Awareness	3.9	3.4
16 Performance Measurement	4.5	3.0
17 Process Management/Organizational Design	4.1	2.6
18 Project Management	4.1	3.0
Average	4.3	3.2
CEOs & CMOs Together		
PEOPLE	Average	
	I	P
19 Human Resources Management	4.6	3.0
20 Interpersonal Understanding	4.0	2.7
21 Professionalism	4.9	3.5
22 Relationship Building	4.4	3.1
23 Self-Confidence	4.3	3.7
24 Self-Development	4.3	3.1
25 Talent Development	4.7	2.5
26 Team Leadership	4.5	3.1
Average	4.5	3.1

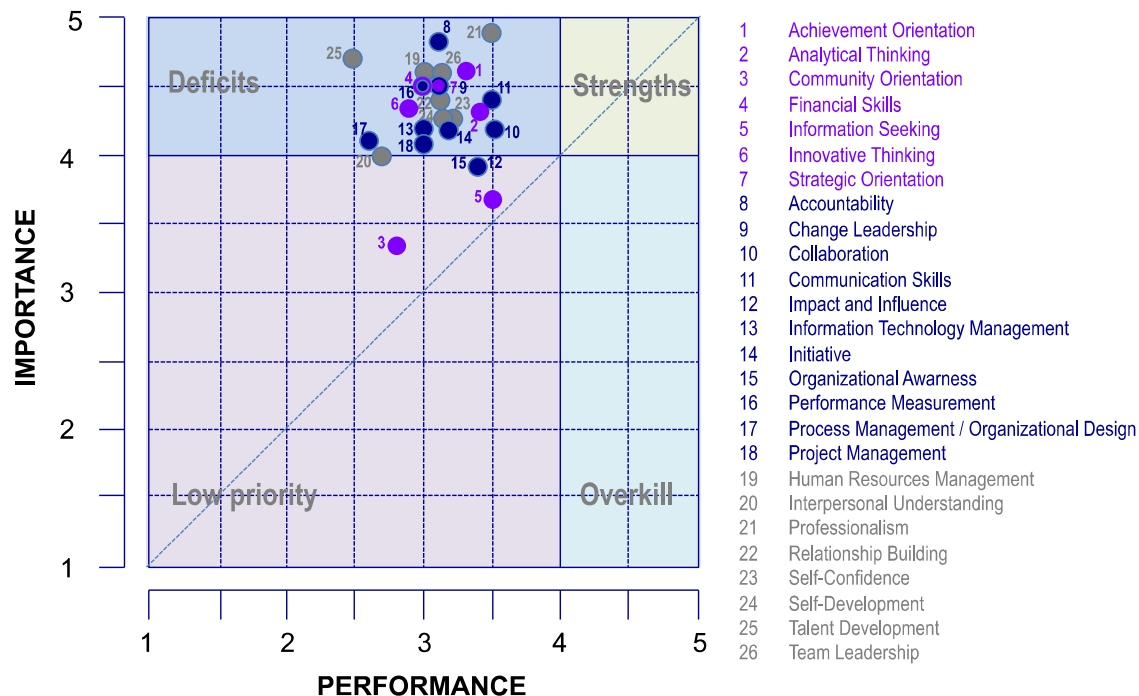


Figure 1. Mexican private healthcare organizations top leader's perception of the National Center for Healthcare Leadership leadership competencies.

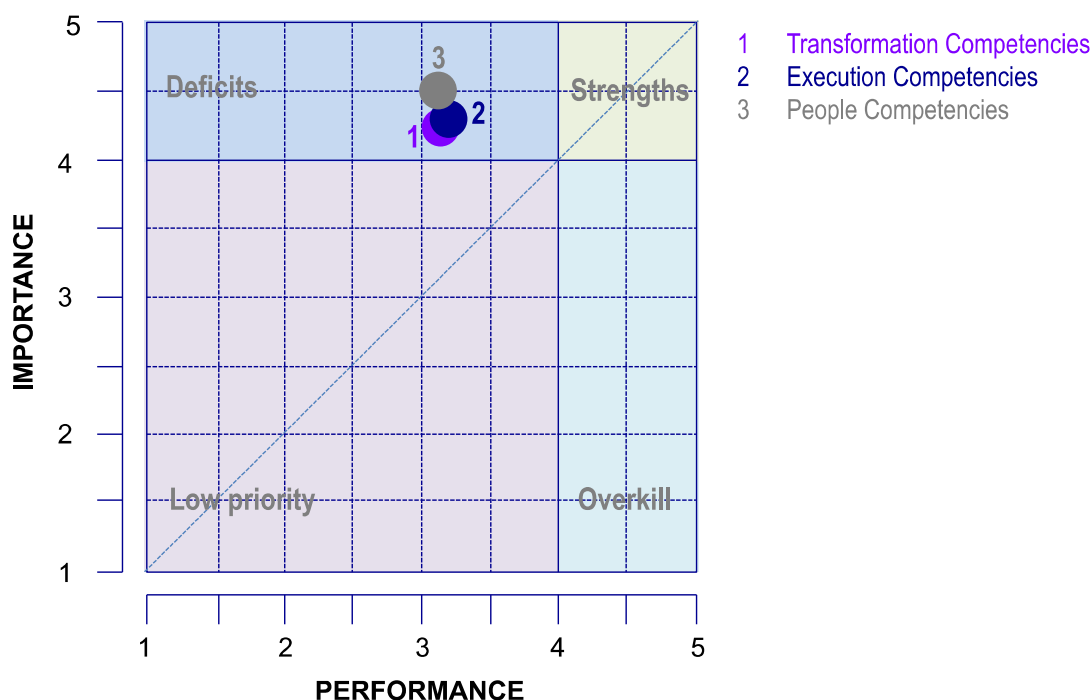


Figure 2. Mexican private healthcare organizations top leader's perception of the National Center for Healthcare Leadership leadership competencies groups.

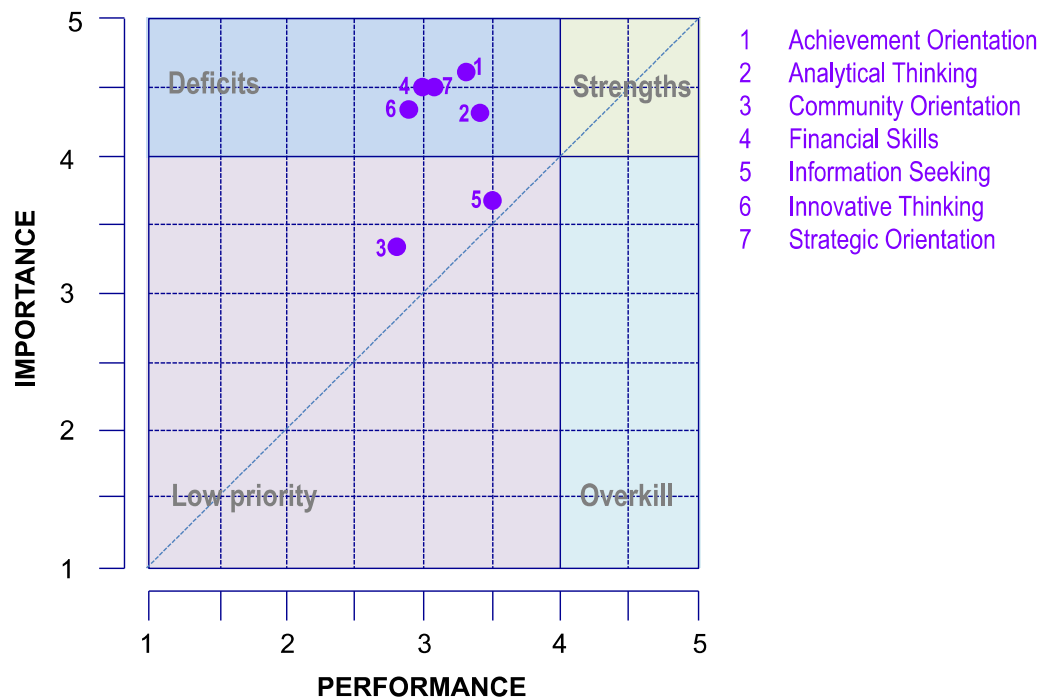


Figure 3. Mexican private healthcare organizations top leader's perception of the National Center for Healthcare Leadership Transformation group competencies.

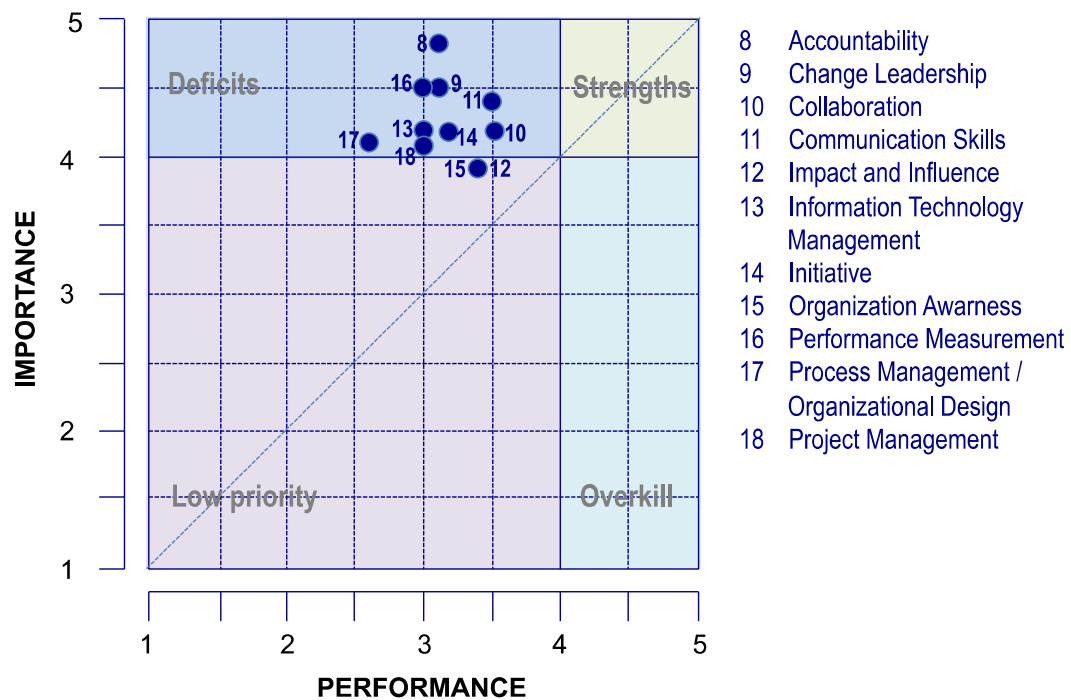


Figure 4. Mexican private healthcare organizations top leader's perception of the National Center for Healthcare Leadership Execution group competencies.

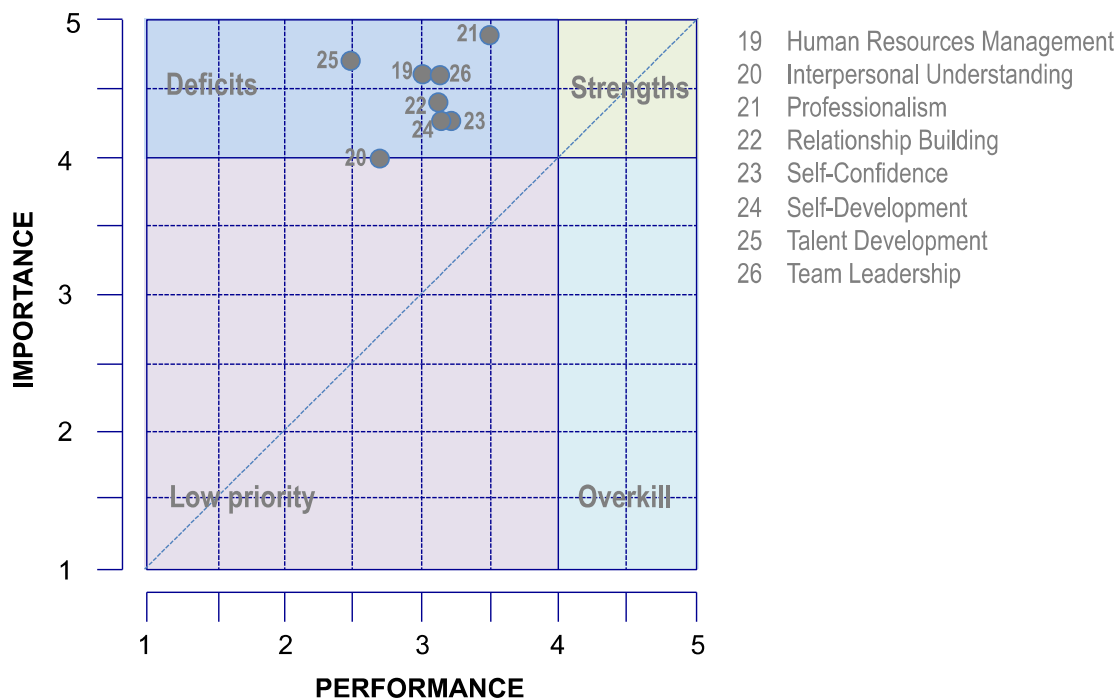


Figure 5. Mexican private healthcare organizations top leader's perception of the National Center for Healthcare Leadership Person group competencies.

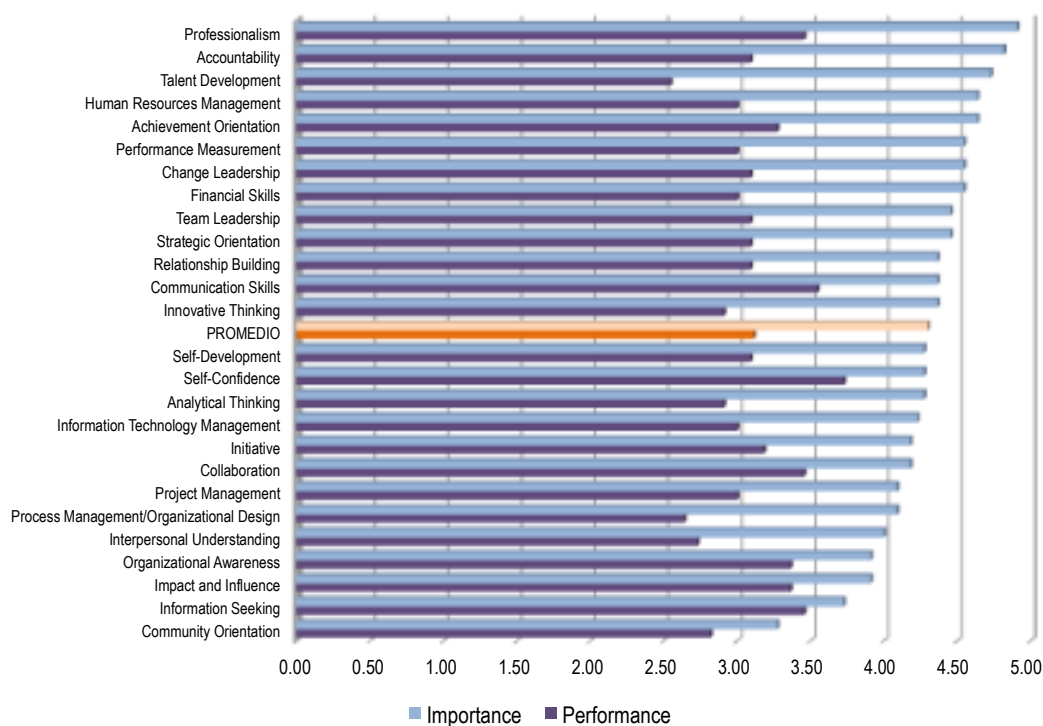
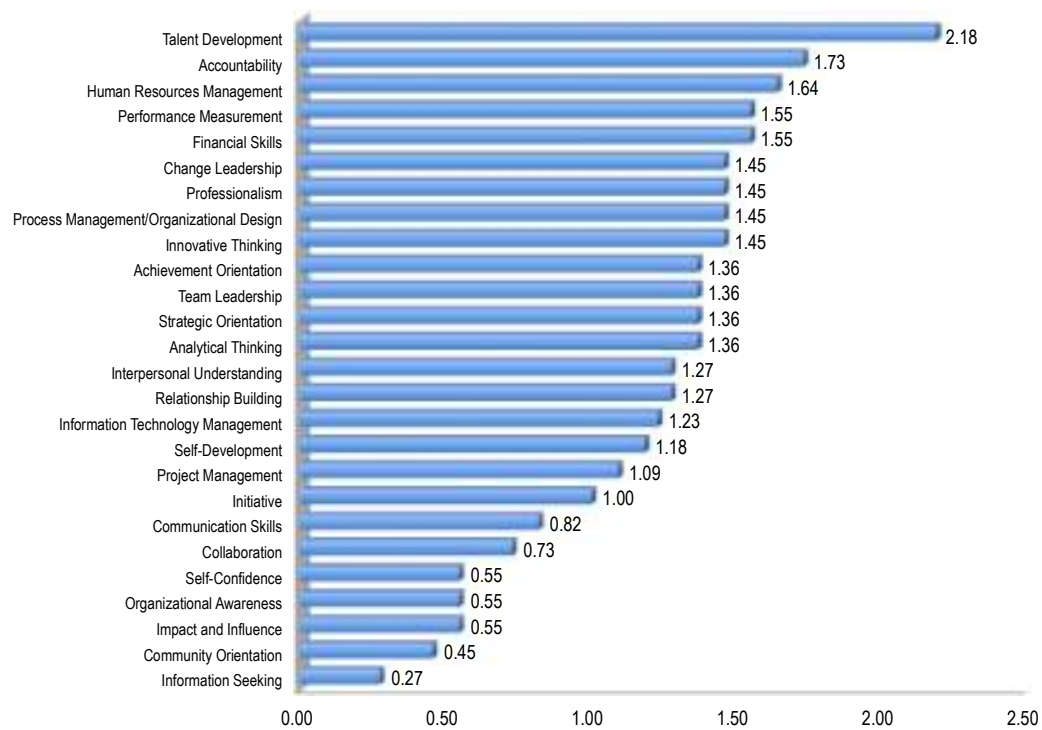
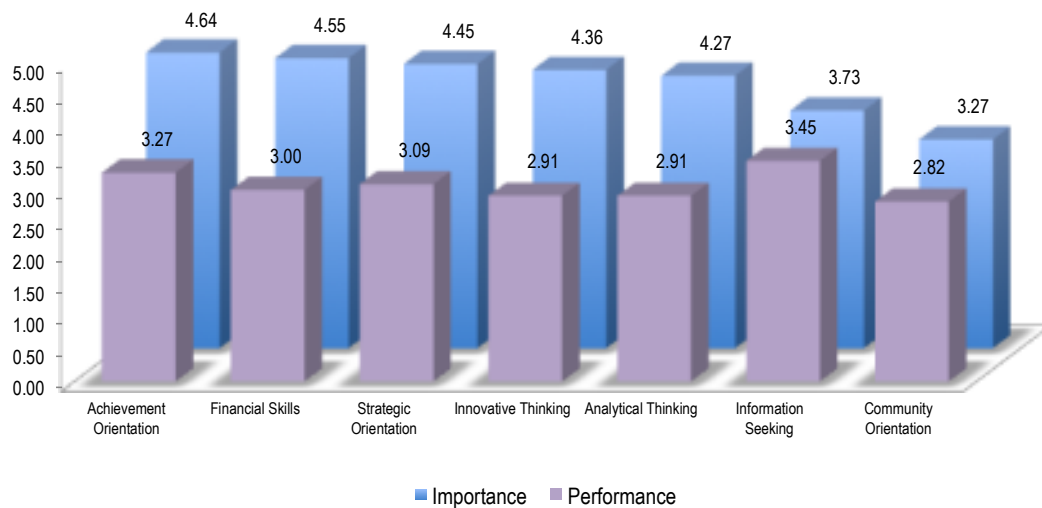


Figure 6. Importance and Performance of the National Center for Healthcare Leadership Model leadership competencies as the perspective of the top leaders of the Mexican private healthcare industry

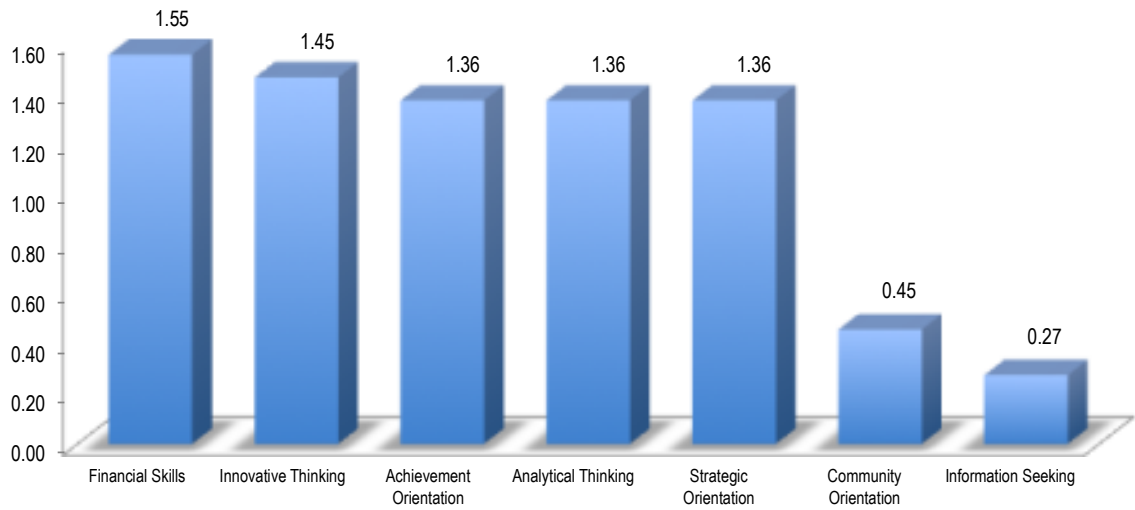


*Figure 7.* Differences between Importance and Performance in the National Center for Healthcare Leadership leadership competencies as perceived by top leaders

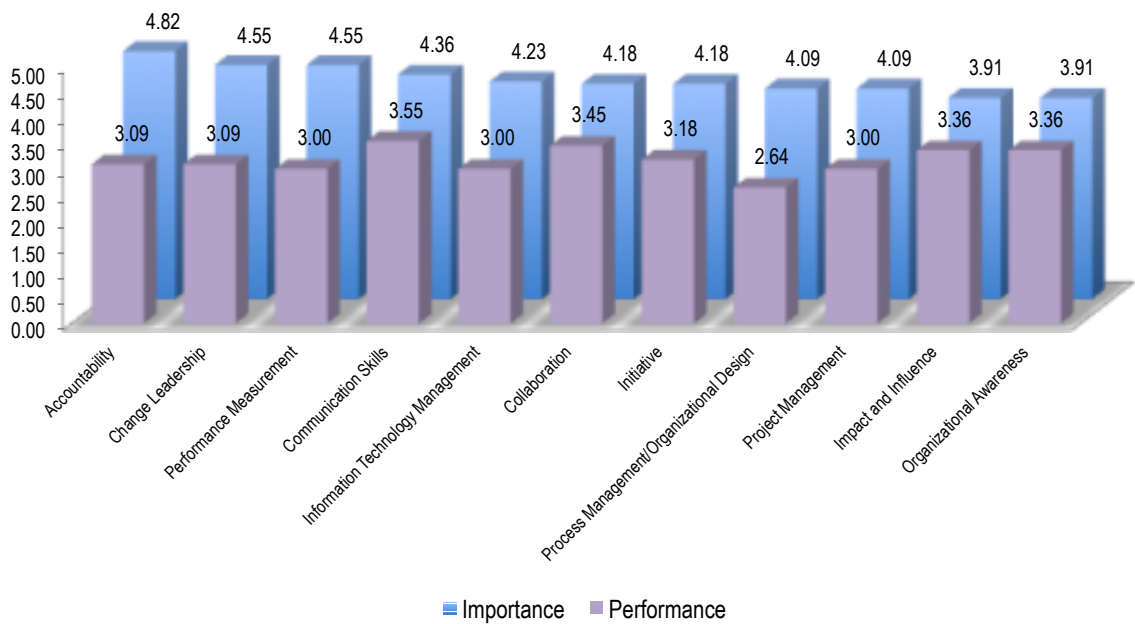


*Figure 8.* Importance and Performance of the National Center for Healthcare Leadership Transformation competencies as perceived by top leaders of the Mexican healthcare industry

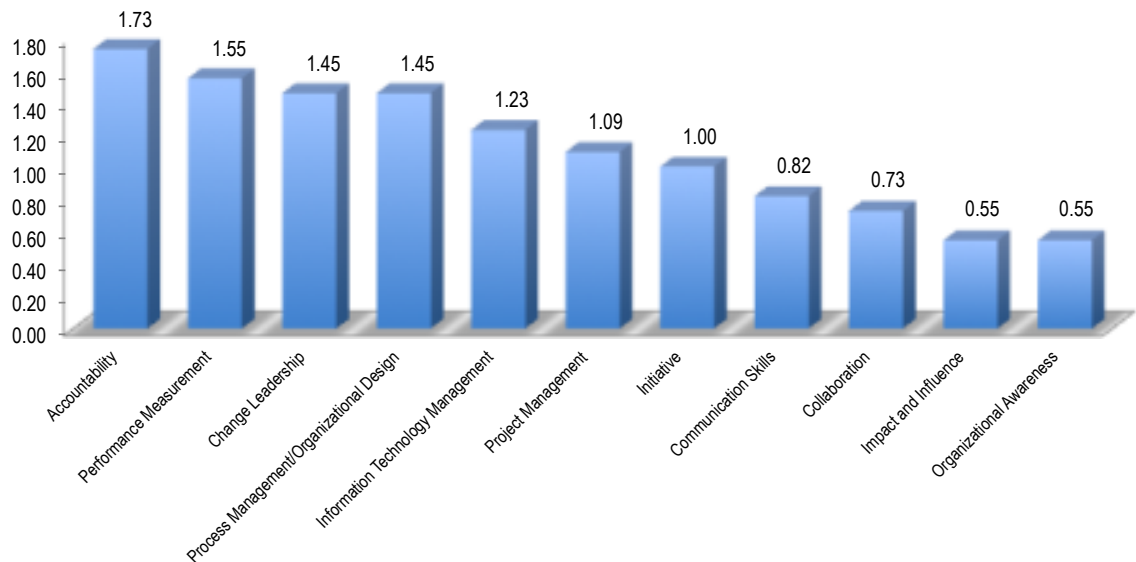




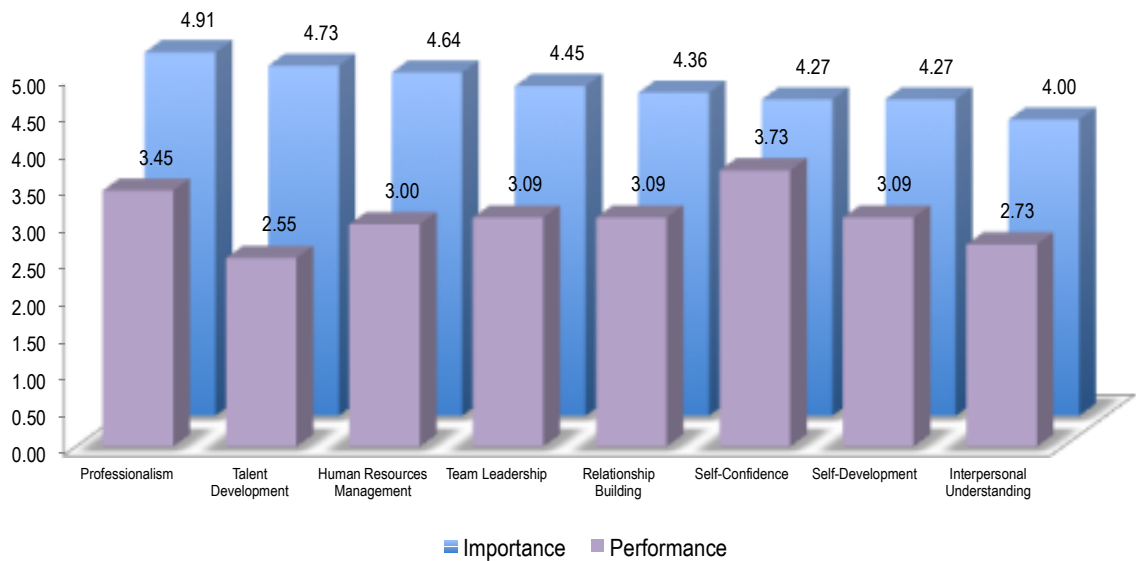
*Figure 9.* Difference between Importance and Performance of the National Center for Healthcare Leadership Transformation competencies as perceived by top leaders of the Mexican healthcare industry



*Figure 10.* Importance and Performance of National Center for Healthcare Leadership Execution competencies as perceived by top leaders of the Mexican healthcare industry



*Figure 11.* Differences between Importance and Performance of National Center for Healthcare Leadership Execution competencies as perceived by top leaders of the Mexican healthcare industry



*Figure 12.* Importance and Performance of National Center for Healthcare Leadership People competencies as perceived by top leaders of the Mexican healthcare industry



*Figure 13.* Differences between Importance and Performance of National Center for Healthcare Leadership People competencies as perceived by top leaders of the Mexican healthcare industry

## Tables & Graphs with the CEOs' General Results on the IPA (Importance – Performance Analysis)

Table 1.  
Average scores given to the National Center for Healthcare Leadership competencies by the CEOs

CEOs														
TRANSFORMATION	CEO1		CEO2		CEO3		CEO4		CEO5		CEO6		Average	
	I	P	I	P	I	P	I	P	I	P	I	P	I	P
1 Achievement Orientation	5	4	5	3	4	3	4	4	3	3	5	3	4.3	3.3
2 Analytical Thinking	4	3	4	2	4	3	3	3	5	4	5	2	4.2	2.8
3 Community Orientation	3	3	2	2	2	3	4	4	5	2	3	2	3.2	2.7
4 Financial Skills	4	4	4	4	5	4	4	3	5	4	5	3	4.5	3.7
5 Information Seeking	3	4	3	2	3	3	3	3	4	4	5	2	3.5	3.0
6 Innovative Thinking	5	3	4	3	3	2	5	2	5	3	3	2	4.2	2.5
7 Strategic Orientation	5	2	5	2	5	3	5	4	4	4	5	3	4.8	3.0
Average	4.14	3.29	3.86	2.57	3.71	3.00	4.00	3.29	4.43	3.43	4.43	2.43	4.1	3.0

CEOs														
EXECUTION	CEO1		CEO2		CEO3		CEO4		CEO5		CEO6		Average	
	I	P	I	P	I	P	I	P	I	P	I	P	I	P
8 Accountability	5	3	5	4	5	3	4	2	5	4	5	3	4.8	3.2
9 Change Leadership	5	2	5	3	5	4	4	3	4	4	4	3	4.5	3.2
10 Collaboration	4	4	3	4	5	5	3	3	5	4	4	2	4.0	3.7
11 Communication Skills	5	4	4	2	3	3	4	4	5	4	4	3	4.2	3.3
12 Impact and Influence	5	3	3	4	3	3	3	3	4	4	5	3	3.8	3.3
13 Information Technology Management	3	2	4.5	2	5	2	4	2	3	4	4	3	3.9	2.5
14 Initiative	4	3	4	3	3	2	3	4	5	4	5	3	4.0	3.2
15 Organizational Awareness	4	3	3	3	2	4	3	3	4	4	5	4	3.5	3.5
16 Performance Measurement	5	4	5	3	5	2	4	3	5	3	5	2	4.8	2.8
17 Process Management/Organizational Design	4	2	3	2	4	2	4	2	4	3	5	2	4.0	2.2
18 Project Management	5	2	3	1	5	4	3	3	5	4	3	2	4.0	2.7
Average	4.45	2.91	3.86	2.82	4.09	3.09	3.55	2.91	4.45	3.82	4.45	2.73	4.1	3.0

CEOs														
PEOPLE	CEO1		CEO2		CEO3		CEO4		CEO5		CEO6		Average	
	I	P	I	P	I	P	I	P	I	P	I	P	I	P
19 Human Resources Management	5	3	4	2	4	3	4	4	5	4	5	3	4.5	3.2
20 Interpersonal Understanding	4	2	3	2	3	4	3	3	5	4	4	2	3.7	2.8
21 Professionalism	5	2	5	2	5	5	4	3	5	4	5	3	4.8	3.2
22 Relationship Building	5	4	5	2	3	3	4	3	5	4	4	2	4.3	3.0
23 Self-Confidence	3	3	5	4	3	3	4	4	4	4	5	3	4.0	3.5
24 Self-Development	3	3	5	2	3	2	3	4	5	3	5	2	4.0	2.7
25 Talent Development	5	1	5	2	5	4	4	2	4	3	4	2	4.5	2.3
26 Team Leadership	5	2	4	3	4	3	4	3	5	3	5	3	4.5	2.8
Average	4.38	2.50	4.50	2.38	3.75	3.38	3.75	3.25	4.75	3.63	4.63	2.50	4.3	2.9

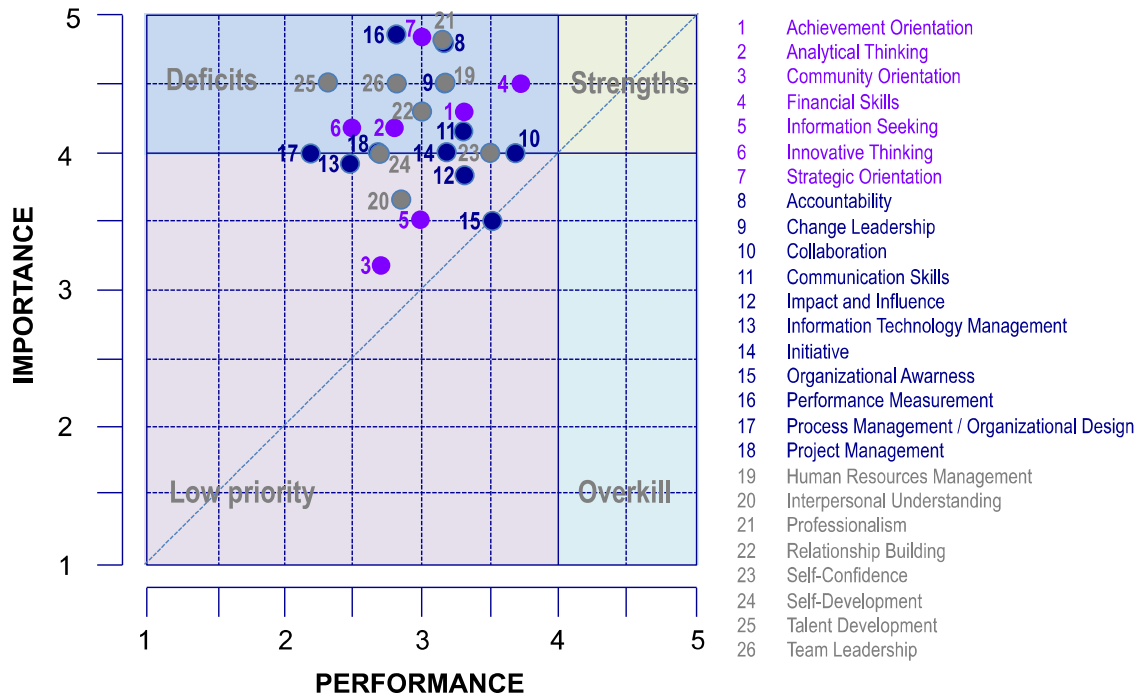


Figure 14. Mexican Private healthcare institutions' CEOs' perception on the National Center for Healthcare Leadership leadership competencies

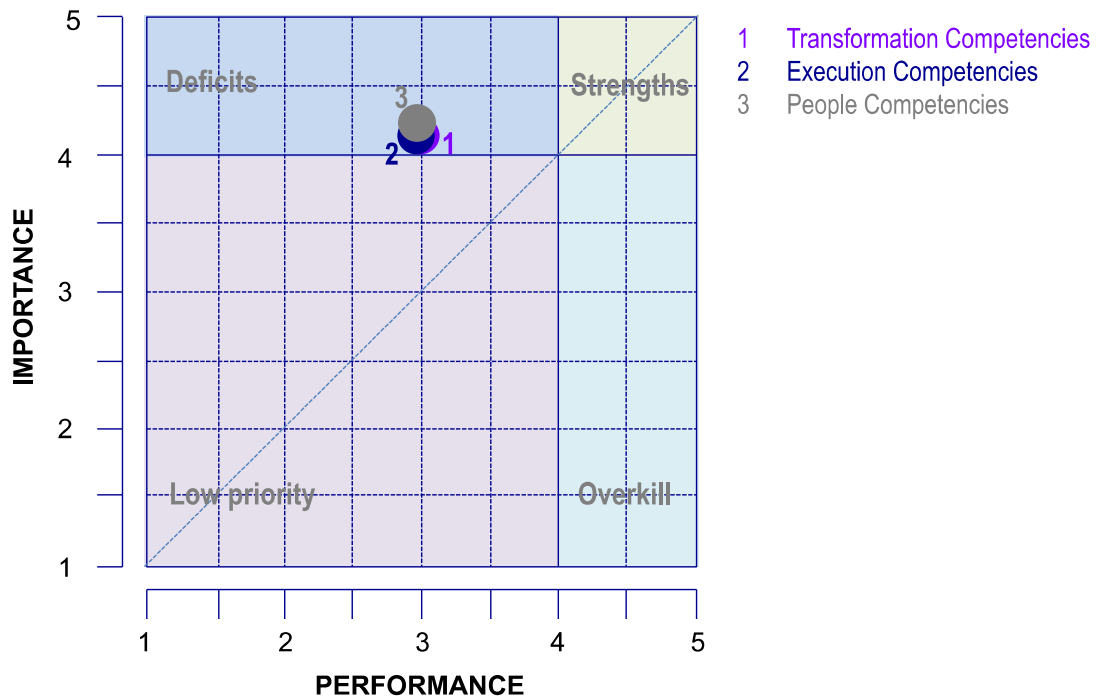


Figure 15. Mexican Private healthcare institutions' CEOs' perception on the National Center for Healthcare Leadership leadership competencies groups

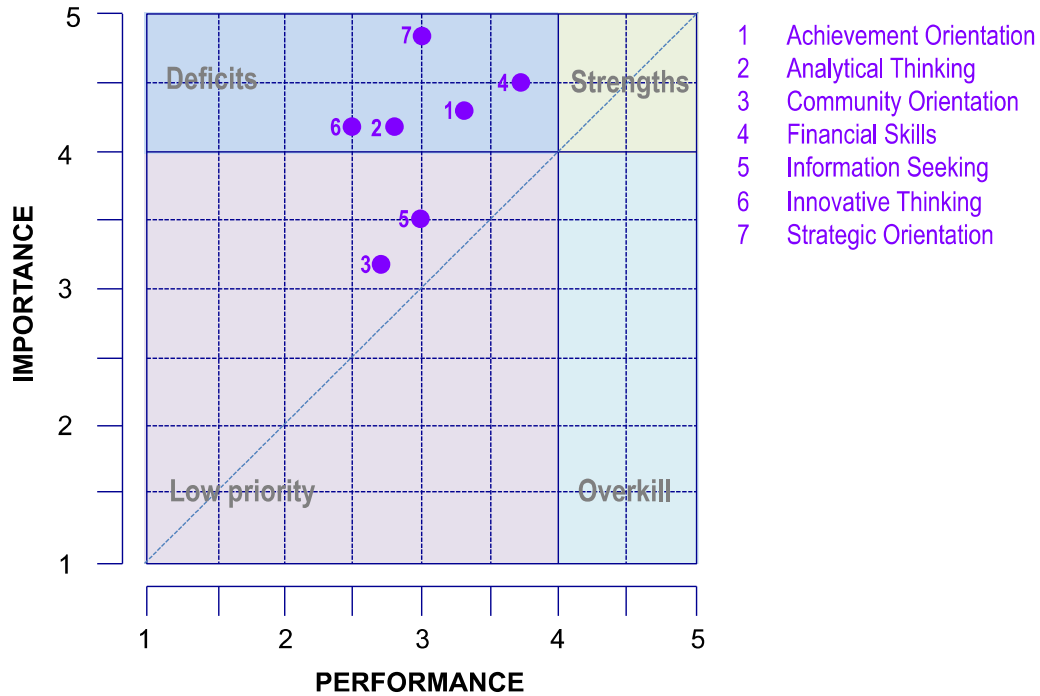


Figure 16. Mexican Private healthcare institutions' CEOs' perception on the National Center for Healthcare Leadership Transformation competencies

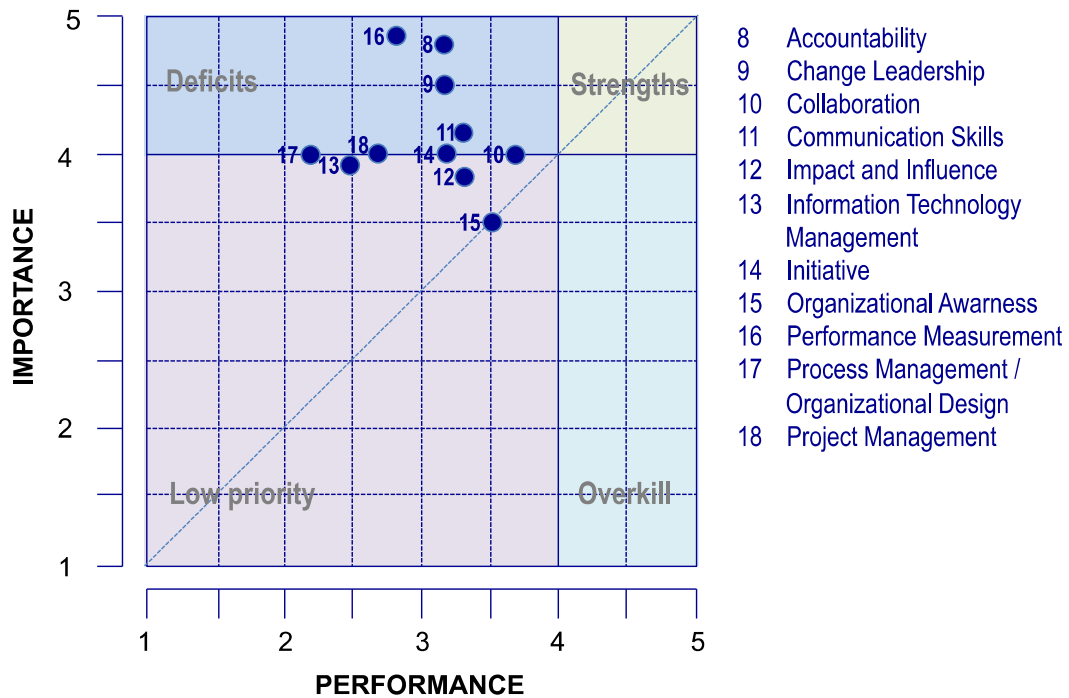


Figure 17. Mexican Private healthcare institutions' CEOs' perception on the National Center for Healthcare Leadership Execution competencies

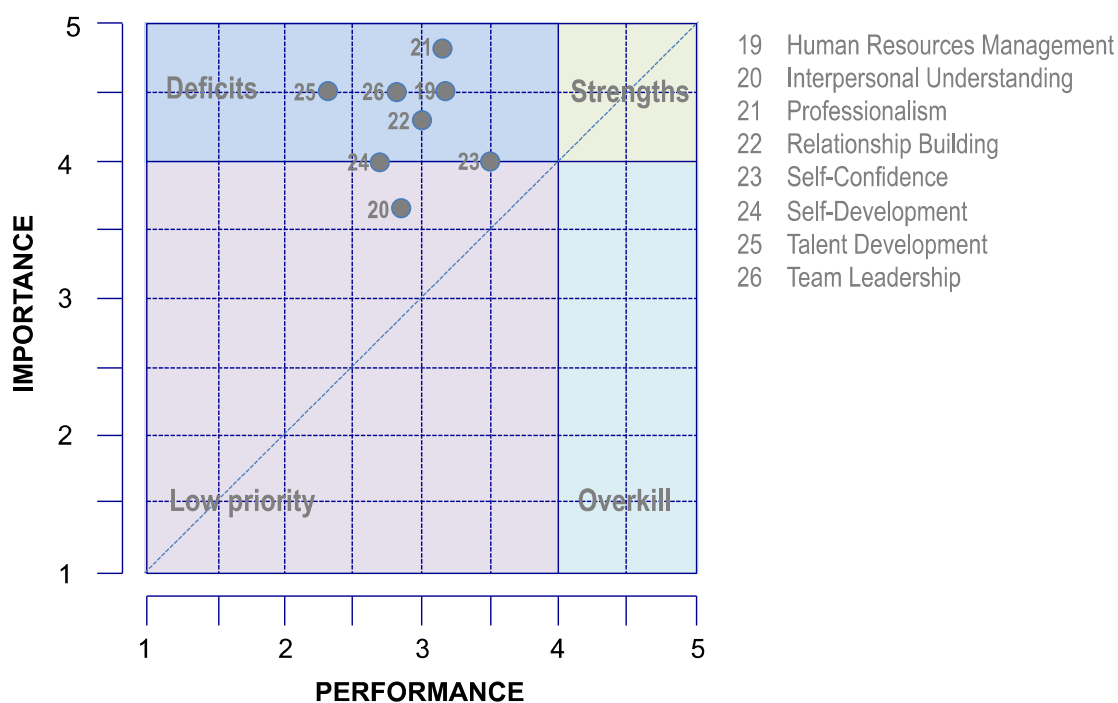


Figure 18. Mexican Private healthcare institutions' CEOs' perception on the National Center for Healthcare Leadership People competencies

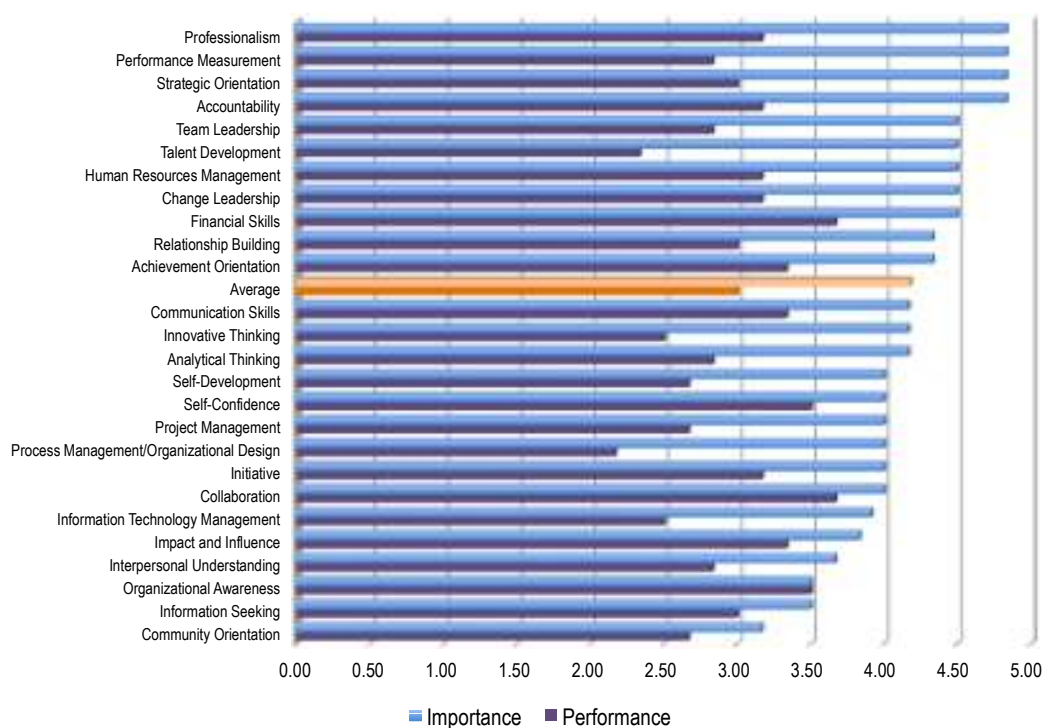
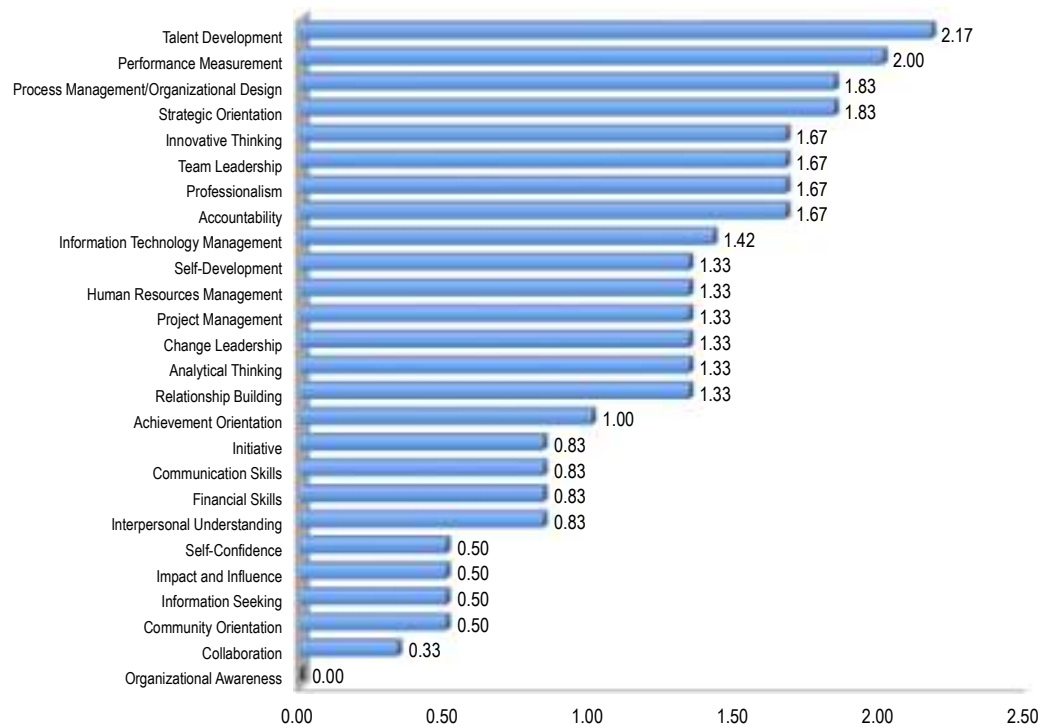
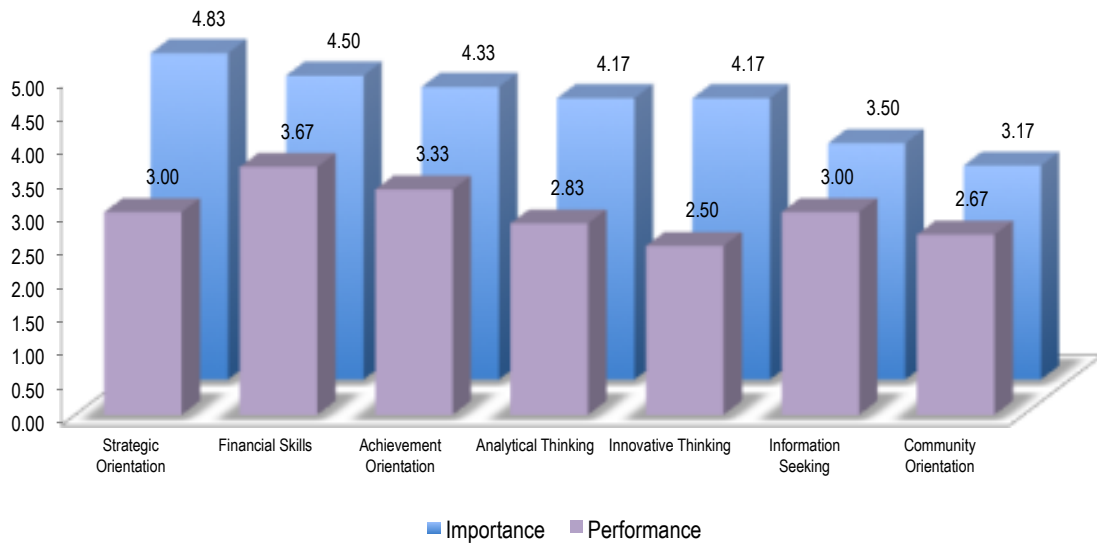


Figure 19. Importance and Performance of National Center for Healthcare Leadership leadership competencies as perceived by CEOs of the Mexican healthcare industry

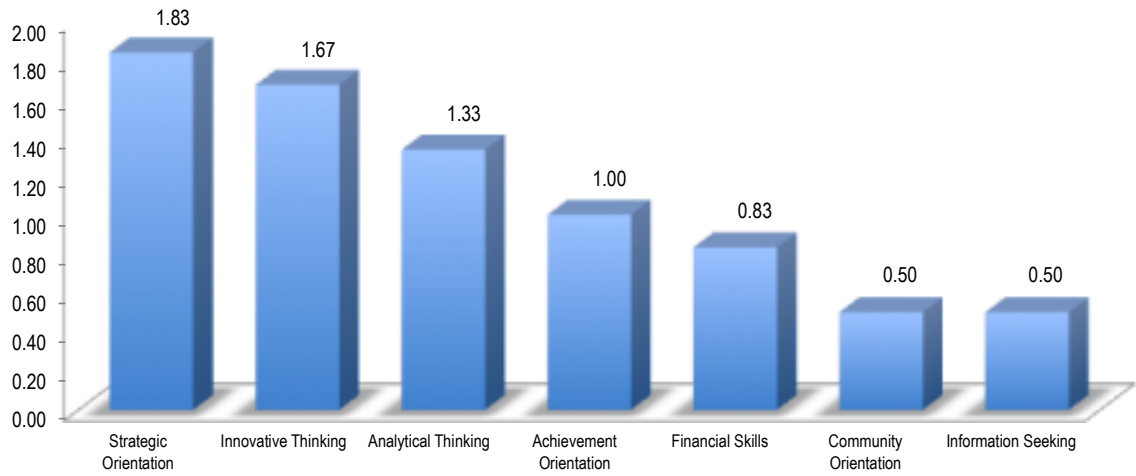


*Figure 20. Differences between Importance and Performance of National Center for Healthcare Leadership competencies as perceived by CEOs of the Mexican healthcare industry*

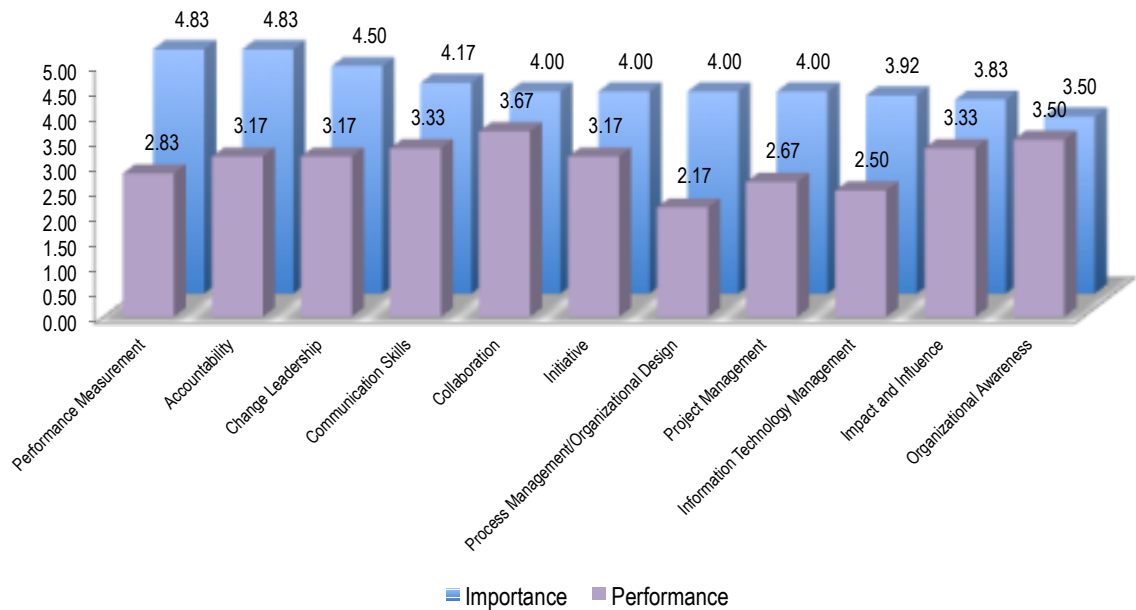


*Figure 21. Importance and Performance of National Center for Healthcare Leadership Transformation competencies as perceived by CEOs of the Mexican healthcare industry*





*Figure 22. Differences between Importance and Performance of National Center for Healthcare Leadership Transformation competencies as perceived by CEOs of the Mexican healthcare industry*



*Figure 23. Importance and Performance of National Center for Healthcare Leadership Execution competencies as perceived by CEOs of the Mexican healthcare industry*

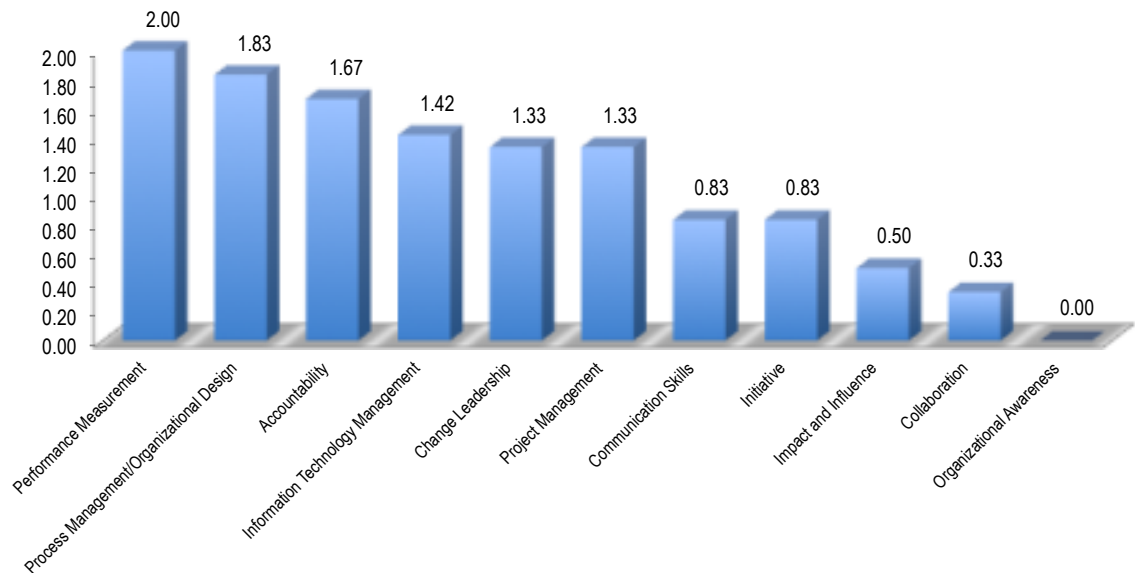


Figure 24. Differences between Importance and Performance of National Center for Healthcare Leadership Execution competencies as perceived by CEOs of the Mexican healthcare industry

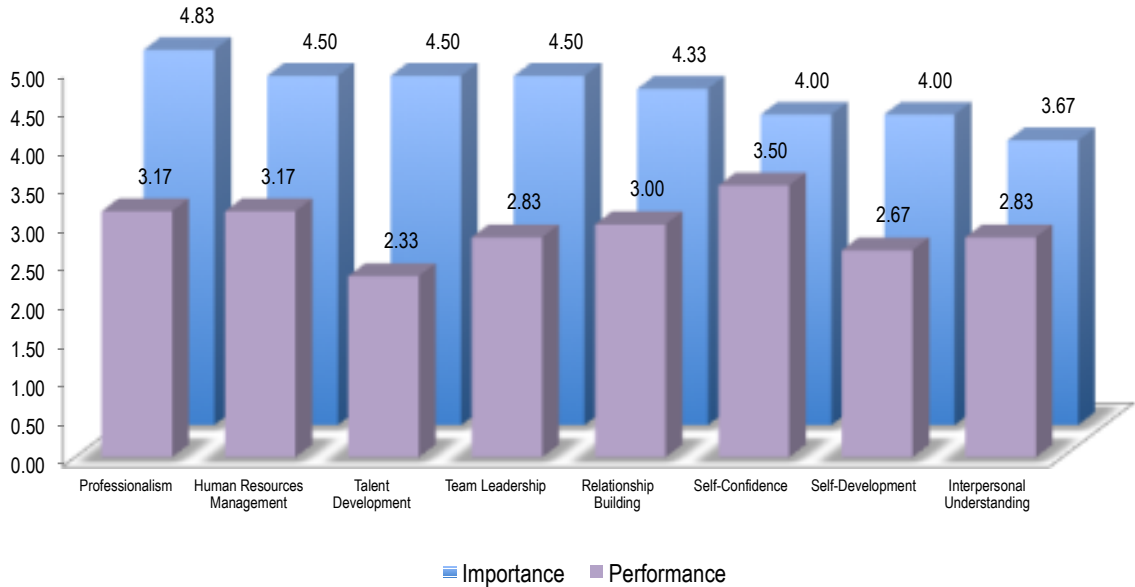


Figure 25. Importance and Performance of National Center for Healthcare Leadership People competencies as perceived by CEOs of the Mexican healthcare industry



*Figure 26.* Differences between Importance and Performance of National Center for Healthcare Leadership People competencies as perceived by CEOs of the Mexican healthcare industry

**Tables and Graphs with the CMOs' General Results on the IPA (Importance – Performance Analysis)**

Table 2.

*Average scores given to the National Center for Healthcare Leadership competencies by the CMOs*

<b>CMOs (Chief Medical Officers)</b>												
<b>TRANSFORMATION</b>	CMO1		CMO2		CMO3		CMO4		CMO5		Average	
	I	P	I	P	I	P	I	P	I	P	I	P
1 Achievement Orientation	5	4	5	2	5	4	5	4	5	2	5.0	3.2
2 Analytical Thinking	4	3	4	4	5	3	5	3	4	2	4.4	3.0
3 Community Orientation	4	3	2	2	4	3	4	3	3	4	3.4	3.0
4 Financial Skills	5	3	4	1	5	3	5	2	4	2	4.6	2.2
5 Information Seeking	4	4	4	4	4	4	4	4	4	4	4.0	4.0
6 Innovative Thinking	4	3	4	3	5	3	5	5	5	3	4.6	3.4
7 Strategic Orientation	3	3	3	2	5	3	5	4	4	4	4.0	3.2
Average	4.14	3.29	3.71	2.57	4.71	3.29	4.71	3.57	4.14	3.00	4.3	3.1

<b>CMOs (Chief Medical Officers)</b>												
<b>EXECUTION</b>	CMO1		CMO2		CMO3		CMO4		CMO5		Average	
	I	P	I	P	I	P	I	P	I	P	I	P
8 Accountability	4	3	5	2	5	3	5	5	5	2	4.8	3.0
9 Change Leadership	5	4	4	2	5	4	5	4	4	1	4.6	3.0
10 Collaboration	4	2	4	2	5	4	5	5	4	3	4.4	3.2
11 Communication Skills	4	3	4	4	5	5	5	5	5	2	4.6	3.8
12 Impact and Influence	3	2	4	3	4	4	5	5	4	3	4.0	3.4
13 Information Technology Management	5	4	5	2	5	4	5	4	3	4	4.6	3.6
14 Initiative	4	3	5	3	4	4	5	4	4	2	4.4	3.2
15 Organizational Awareness	4	3	3	2	5	4	5	5	5	2	4.4	3.2
16 Performance Measurement	3	3	5	3	4	3	5	4	4	3	4.2	3.2
17 Process Management/Organizational Design	4	4	4	2	4	3	5	4	4	3	4.2	3.2
18 Project Management	4	4	4	1	4	4	5	4	4	4	4.2	3.4
Average	4.00	3.18	4.27	2.36	4.55	3.82	5.00	4.45	4.18	2.64	4.4	3.3

<b>CMOs (Chief Medical Officers)</b>												
<b>PEOPLE</b>	CMO1		CMO2		CMO3		CMO4		CMO5		Average	
	I	P	I	P	I	P	I	P	I	P	I	P
19 Human Resources Management	5	3	4	2	5	3	5	3	5	3	4.8	2.8
20 Interpersonal Understanding	4	2	4	2	5	3	4	4	5	2	4.4	2.6
21 Professionalism	5	2	5	4	5	4	5	5	5	4	5.0	3.8
22 Relationship Building	4	3	4	3	4	3	5	4	5	3	4.4	3.2
23 Self-Confidence	4	4	5	4	4	4	5	5	5	3	4.6	4.0
24 Self-Development	4	4	5	3	4	4	5	4	5	3	4.6	3.6
25 Talent Development	5	3	5	2	5	3	5	4	5	2	5.0	2.8
26 Team Leadership	4	4	4	3	5	3	5	4	4	3	4.4	3.4
Average	4.38	3.13	4.50	2.88	4.63	3.38	4.88	4.13	4.88	2.88	4.7	3.3

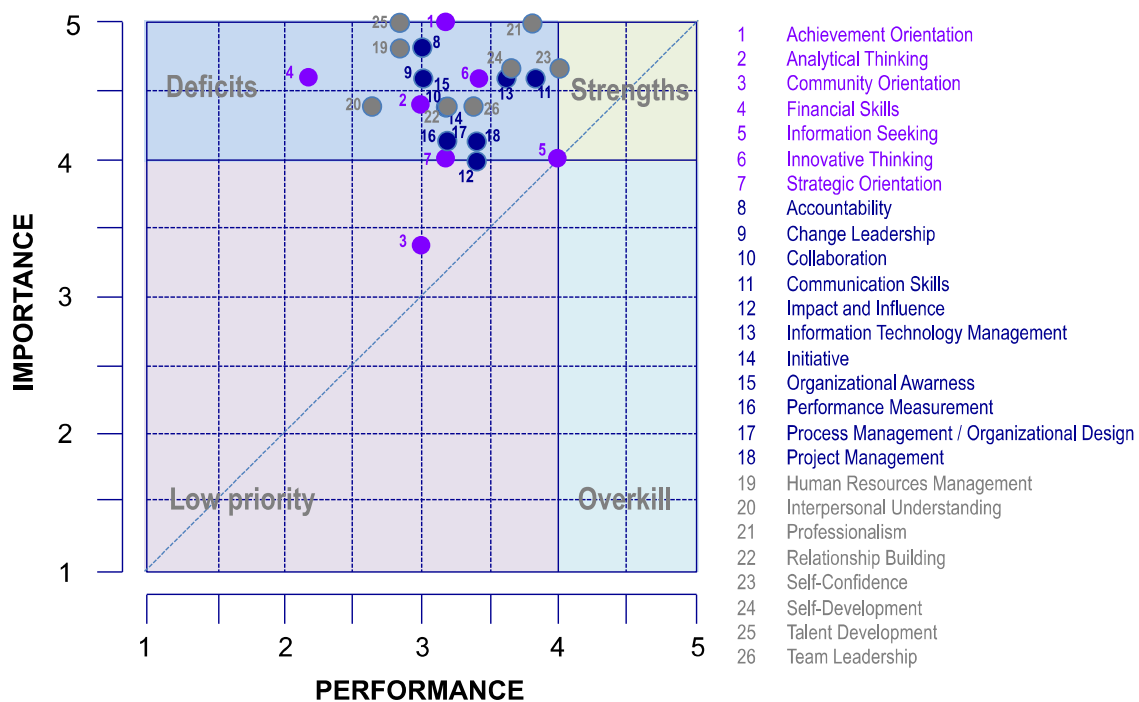


Figure 27. Mexican Private healthcare institutions' CMOs' perception on the National Center for Healthcare Leadership leadership competencies

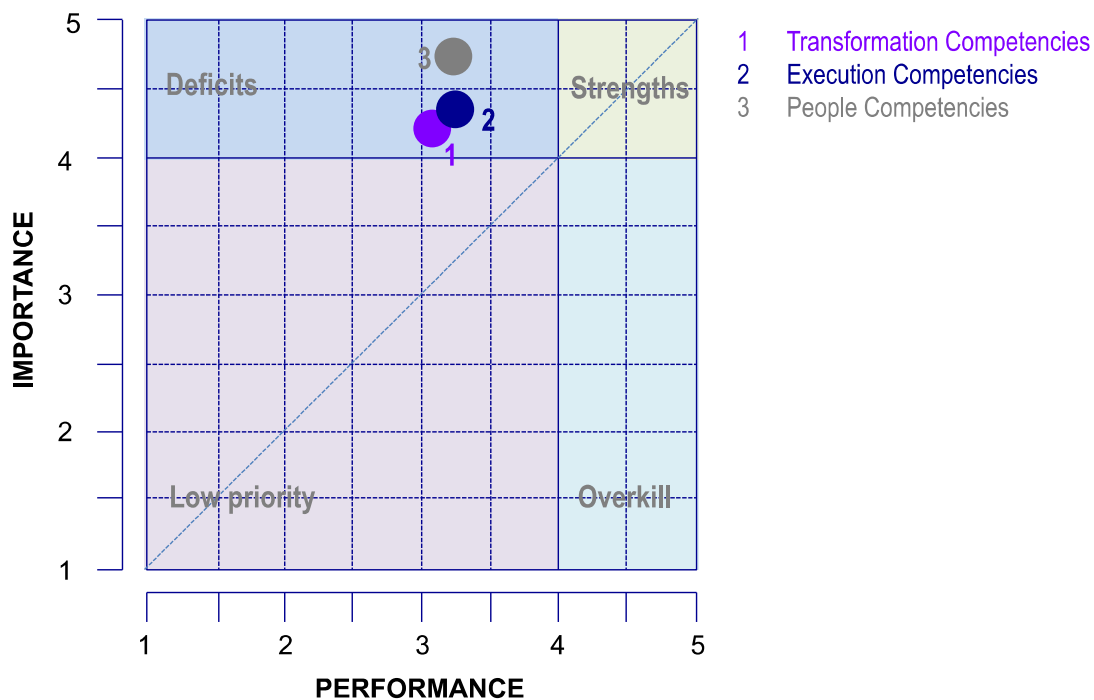


Figure 28. Mexican Private healthcare institutions' CMOs' perception on the National Center for Healthcare Leadership leadership competencies groups

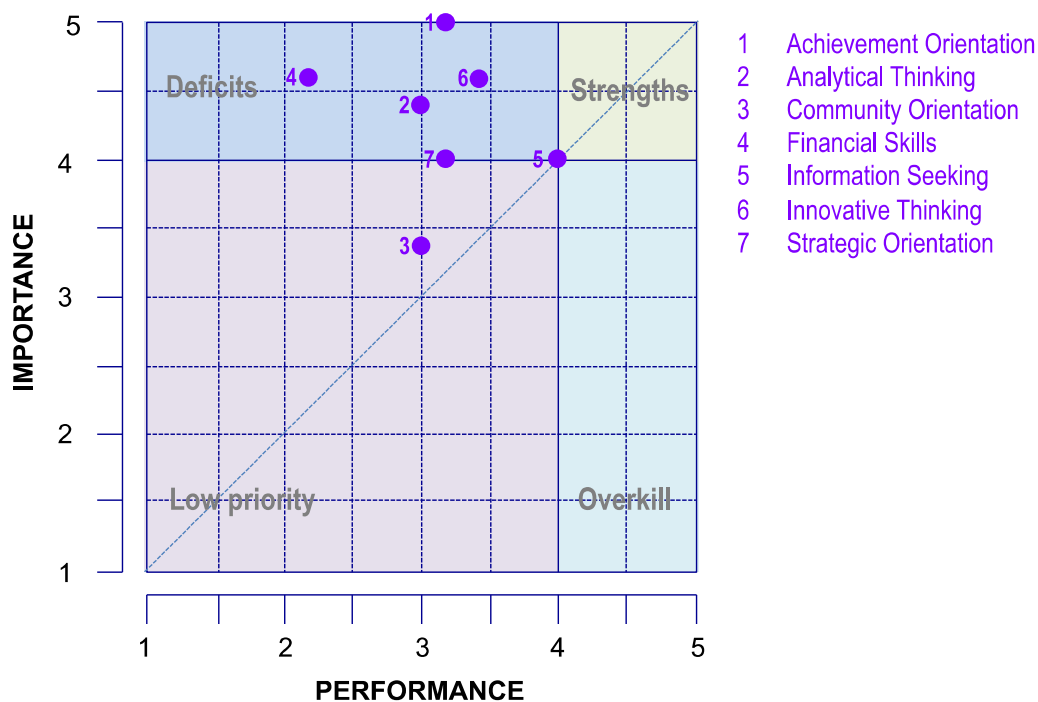


Figure 29. Mexican Private healthcare institutions' CMOs' perception on the National Center for Healthcare Leadership Transformation competencies

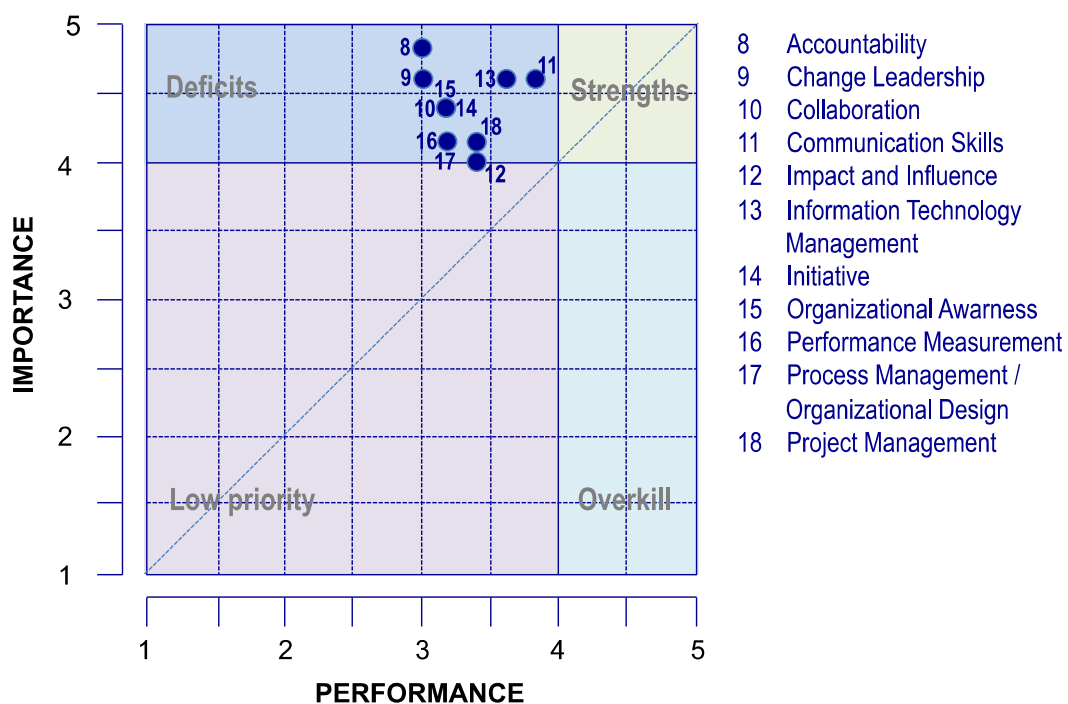


Figure 30. Mexican Private healthcare institutions' CMOs' perception on the National Center for Healthcare Leadership Execution competencies

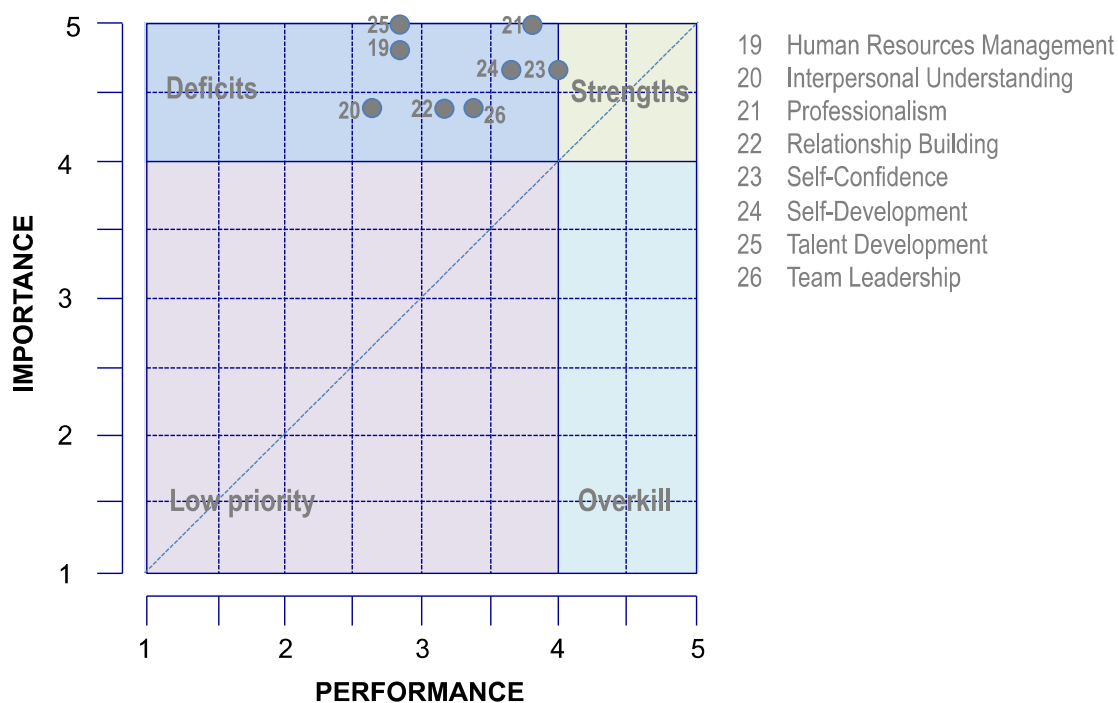


Figure 31. Mexican Private healthcare institutions' CMOs' perception on the National Center for Healthcare Leadership People competencies

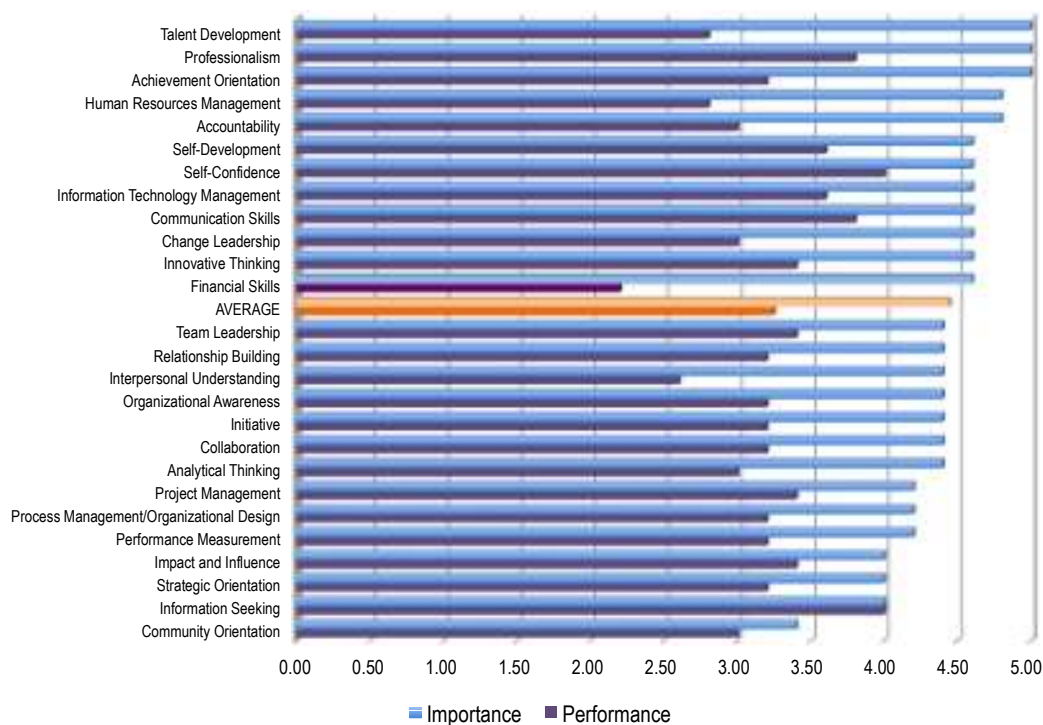


Figure 32. Importance and Performance of National Center for Healthcare Leadership leadership competencies as perceived by CMOs of the Mexican healthcare industry

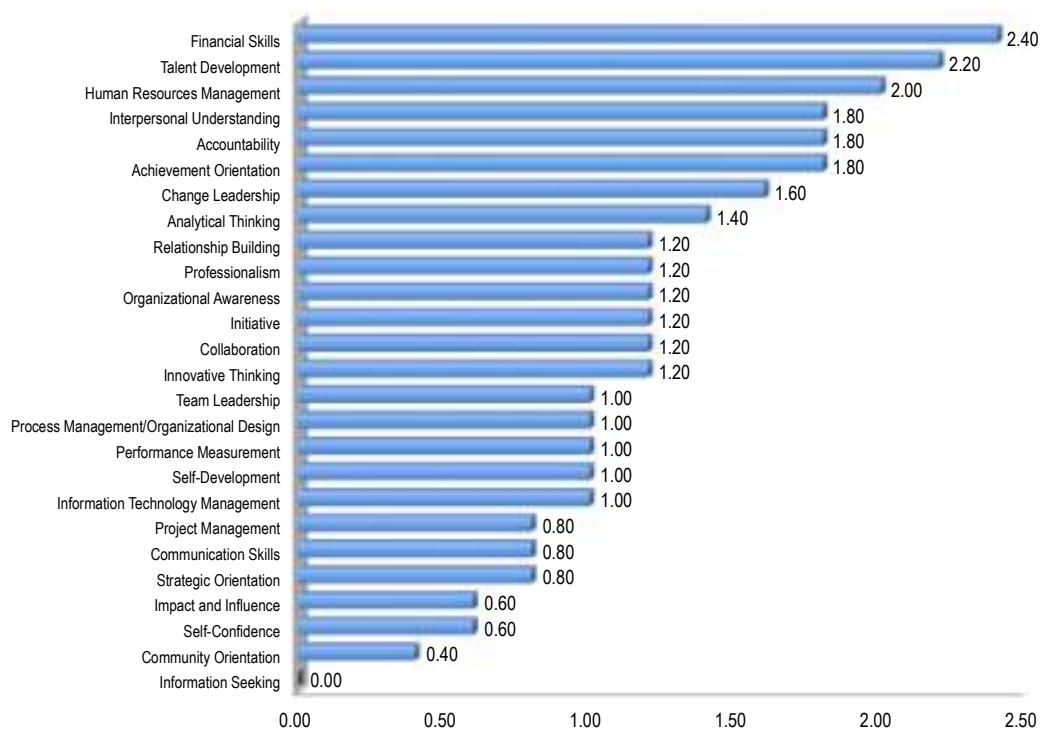


Figure 33. Differences between Importance and Performance of National Center for Healthcare Leadership competencies as perceived by CMOs of the Mexican healthcare industry

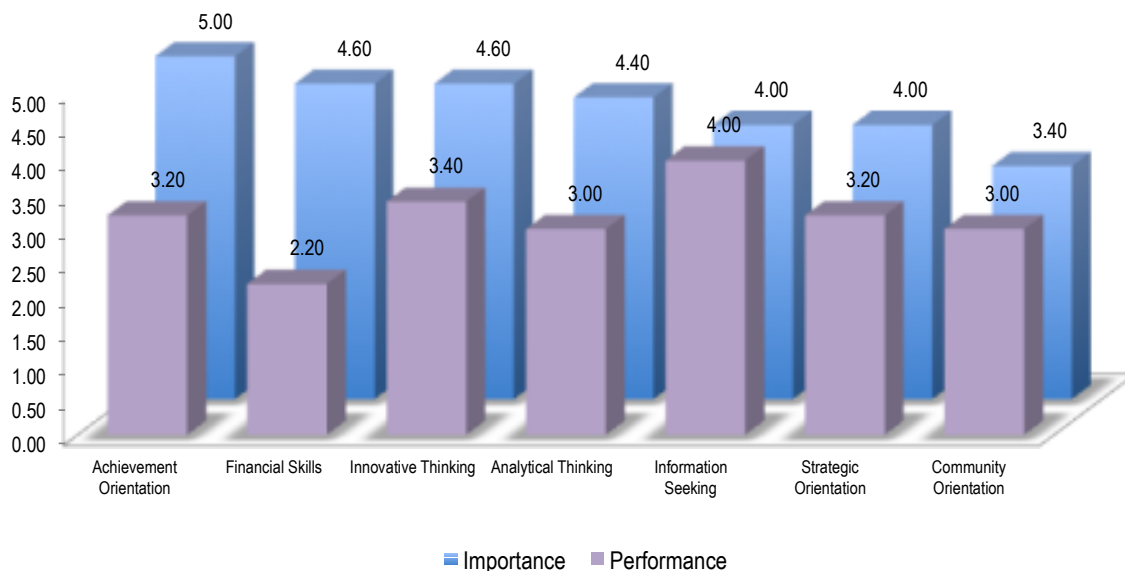
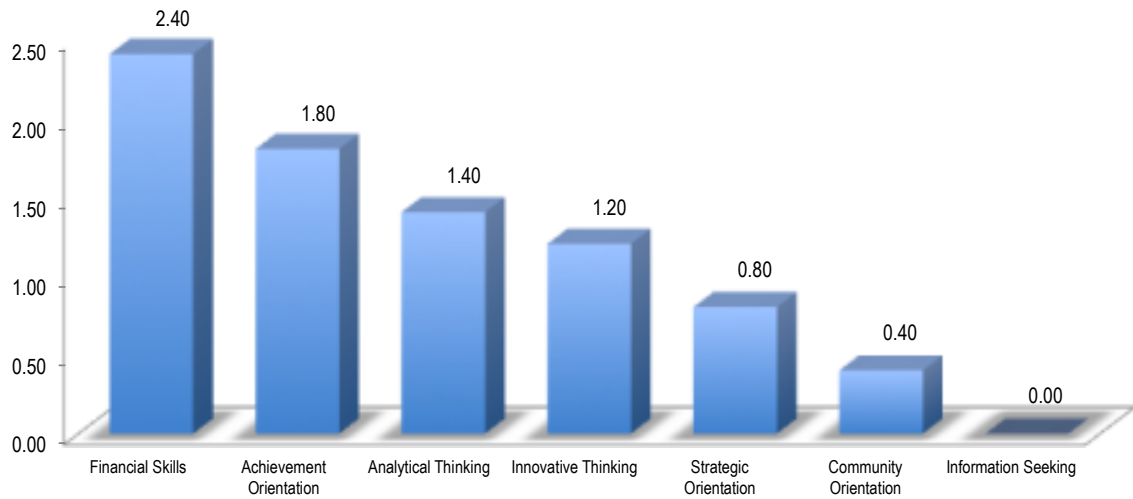
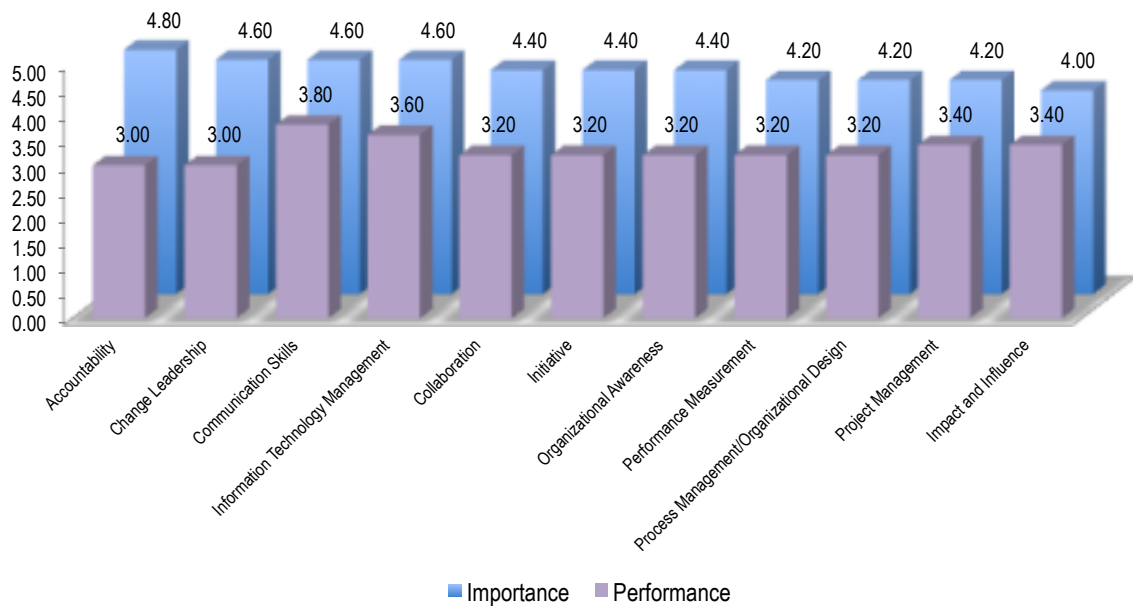


Figure 34. Importance and Performance of National Center for Healthcare Leadership Transformation competencies as perceived by CMOs of the Mexican healthcare industry





*Figure 35.* Differences between Importance and Performance of National Center for Healthcare Leadership Transformation competencies as perceived by CMOs of the Mexican healthcare industry



*Figure 36.* Importance and Performance of National Center for Healthcare Leadership Execution competencies as perceived by CMOs of the Mexican healthcare industry

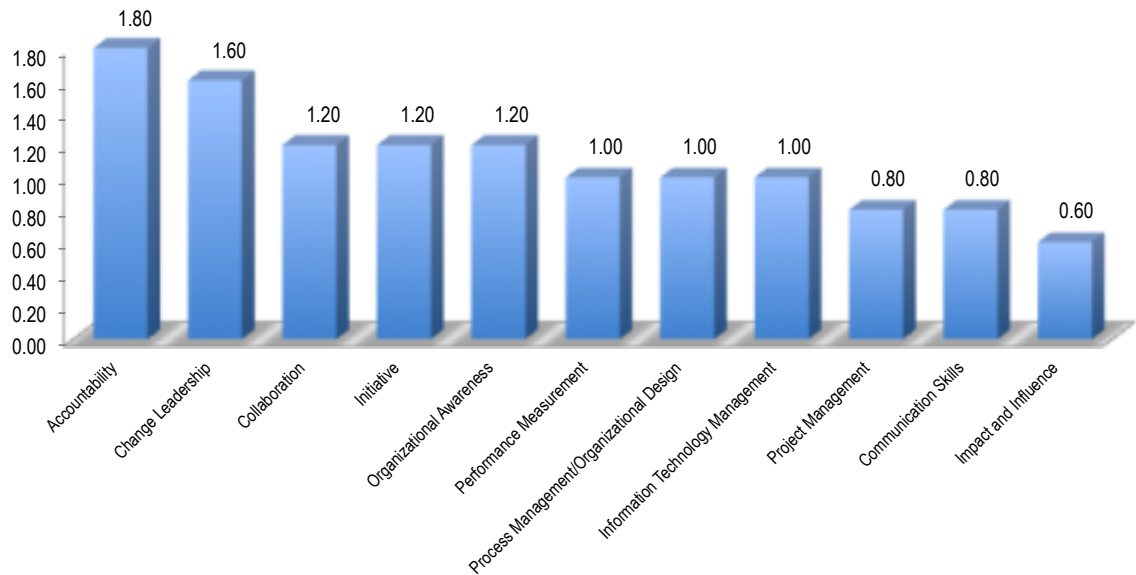


Figure 37. Differences between Importance and Performance of National Center for Healthcare Leadership Execution competencies as perceived by CMO's of the Mexican healthcare industry

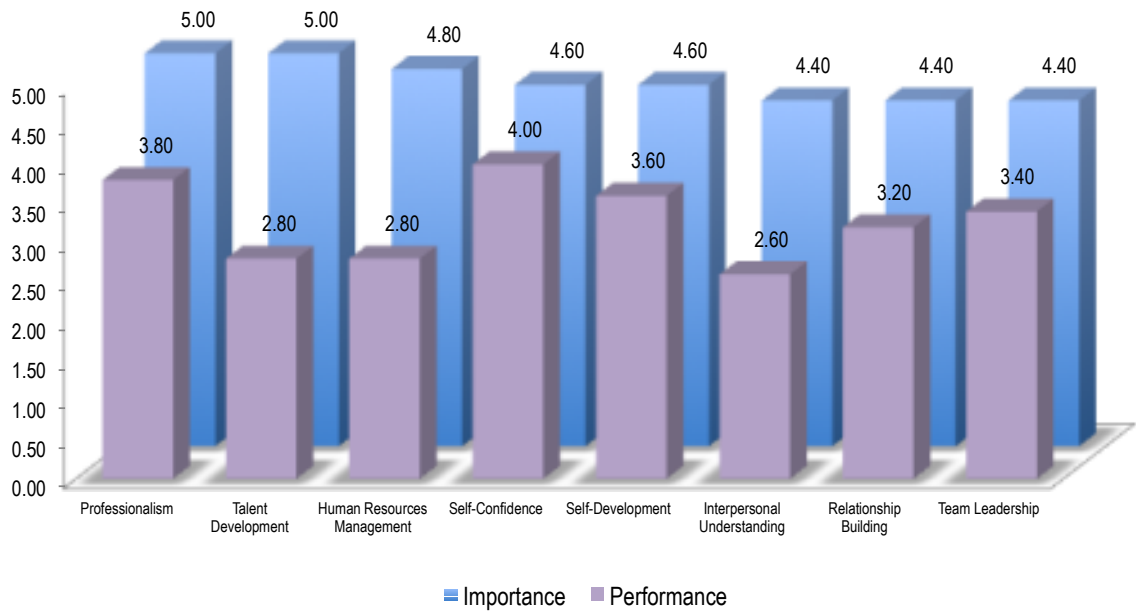
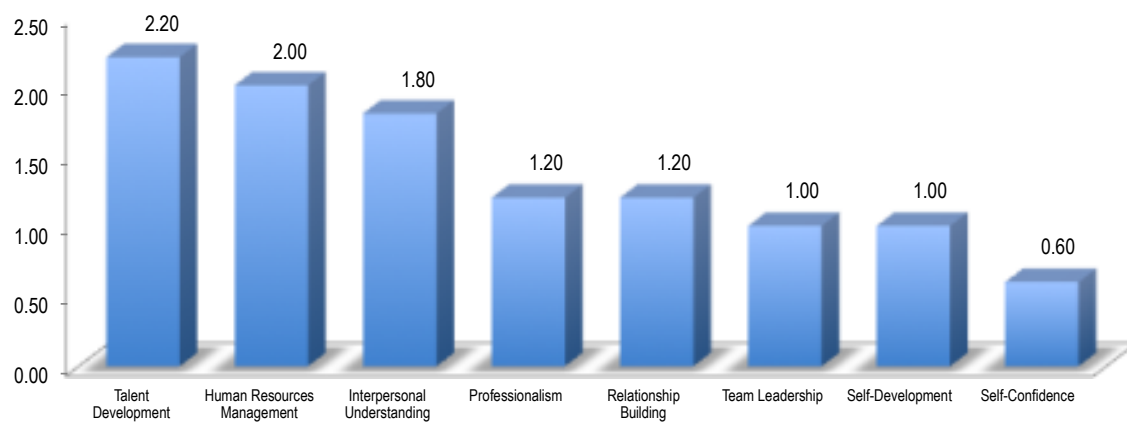


Figure 38. Importance and Performance of National Center for Healthcare Leadership People competencies as perceived by CMOs of the Mexican healthcare industry



*Figure 39.* Differences between Importance and Performance of National Center for Healthcare Leadership People competencies as perceived by CMOs of the Mexican healthcare industry